

Parliamentary Health Select Committee

Response on behalf of the specialty societies for Genitourinary Medicine

Authors

George Kinghorn	Clinical Director for Communicable Diseases & Consultant Physician in Genitourinary Medicine, Sheffield Teaching Hospitals NHS Trust. Immediate past-President of MSSVD <sup>1</sup>
Angela Robinson	Consultant Physician in Genitourinary Medicine, University College Hospital, London President of MSSVD <sup>1</sup>
Colm O' Mahony	Consultant Physician in Genitourinary Medicine, Countess of Chester Hospital Chairman, AGUM <sup>2</sup>

---

<sup>1</sup> The Medical Society for the Study of Venereal Diseases is multidisciplinary, has been established for 75 years, and is principally concerned with educational and research issues in STIs/HIV.

<sup>2</sup> The Association of Genitourinary Medicine represents doctors working in Genitourinary Medicine and is principally concerned with service issues.

## **Summary**

The clinical discipline of Genitourinary Medicine is the principal provider of specialist clinical services for the management of sexually transmitted infections and HIV throughout the UK.

It strongly supports the aims, objectives and national targets contained within the national strategy for sexual health and HIV.

The clinical demands placed upon GU Medicine clinics have rapidly increased during the past 5 years in response to changing lifestyles and the rising incidence of STIs. The annual numbers of newly diagnosed HIV cases have increased because of continuing transmission within the UK augmented by the detection of infections in persons originating from high prevalence countries.

The removal of sexual health from national health priorities has resulted in a virtual stalling of consultant expansion and absence of new investment in GU Medicine services with which to meet this increased demand.

The ideal of immediate open-access services to prevent onward transmission of communicable diseases is no longer possible within clinical services that are working beyond their safe capacity. Waiting times for new appointments have increased to a median value of 14 days throughout England. Over 40,000 patients are currently experiencing unacceptable delays in accessing services.

This has many adverse health consequences for individuals and communities as well as serious economic consequences for future healthcare expenditure. The effects of poor service access will be inevitably felt most by the young and those who are from socially disadvantaged communities. Thus, inadequate provision of services and delays in GU Medicine clinic access are exacerbating inequalities in sexual health and jeopardising clinical governance requirements.

Support for training and education of primary care practitioners, and for the further development of local networks of sexual health services is also being impaired.

We have advised both government and the Department of Health that the national health education and HIV testing campaigns should be delayed until there is additional investment to immediately expand the capacity of GU Medicine clinics. Even targeted campaigns will inevitably increase clinic workload that cannot be met by currently available resources. Thereafter, a coherent medium term plan to develop service manpower and infrastructure is needed if the strategy aims and national targets are to be achieved.

## **Background**

1. Public health services for the clinical management of Sexually transmitted infections (STIs) were first established in 1917. Since then, a UK network of over 250 clinics, led by consultant physicians in Genitourinary Medicine has evolved which is held in high regard within Europe and beyond.

### **Features of services**

2. The service is open-access, so that patients can self-refer, provides free treatment, and is characterised by confidentiality, non-judgmental attitudes, the availability of immediate diagnostic tests supported by sophisticated microbiological investigations, and support for contact tracing. Secondary prevention activities also include one-to-one health promotion, advice upon risk reduction strategies, and partner management. Ideally, there should be no waiting lists because rapid diagnosis and treatment is essential to prevent onward transmission of STIs and the avoidance of costly complications.

3. GU Medicine is also the main provider of HIV diagnosis and treatment, although in some locations HIV care is also provided by other medical specialties. The presence of STIs facilitates the transmission of HIV, hence public health control of STIs is an essential feature of HIV control programmes.

4. GU Medicine clinics provide many other sexual health services including contraception, colposcopy for the early diagnosis of precancerous anogenital cancers, erectile dysfunction clinics, and services for victims of sexual abuse. There are many clinical linkages with other medical specialties related to inpatient care of STI and HIV complications. There are also increasingly close community links with other sexual health services, including sexual health promotion, contraception, and psychosexual services.

### **Staffing**

5. The multidisciplinary clinic staff of GU Medicine clinics is consultant-led. Consultants undertake their initial training in general medicine and gynaecology and then must complete 4 years of specialist training in the discipline to gain their certificate of completion of specialist training (CCST). About one third of the total consultants are single-handed, some covering more than one site, and with more than one employer. This is unsatisfactory for clinical governance.

6. Consultants are supported by doctors in training (predominantly in teaching hospitals), and /or by non-consultant career grade doctors and/or GP clinical assistants.

In larger clinics, there is dedicated nursing staff but these may be shared with other specialties where the service is not full-time.

Health advisers, who are derived from a variety of disciplines, usually nursing, take the major role in contact tracing and partner notification, and also have important roles in epidemiological surveillance, health education and in counselling / support of HIV patients.

The clerical and receptionist staff have a vital role as the first point of contact for patients.

In larger clinics, dedicated psychologists, pharmacists, and social workers may provide additional patient support especially where there is a high HIV workload.

### **Academic centres**

7. The growth of academic centres for GU Medicine has lagged behind other disciplines. There are now three professorial units in London and one in Liverpool.

## **Current Problems and consequences**

### **Numbers of new patient attending and total attendances**

8. The annual number of new patient episodes in England, Wales, and Northern Ireland doubled between 1990-2000 to a total of around 1.2 million. The capacity of clinics to provide optimal care has now been exceeded. Very few clinics are now able to offer immediate care for all who present and waiting times for new patient appointments have become unacceptably long.
9. Although STIs are more prevalent in London and major conurbations, the excessive pressures on clinics has occurred throughout the UK and poor access is widespread.
10. During 2002, the unprecedented demand for GU Medicine services has increased with a corresponding deterioration in patient access times, especially in larger cities. The median time to first appointment in 2002 has lengthened to 12 working days for men and 14 working days for women, compared with 5 and 6 days respectively in 2000 when concern was first expressed. The numbers of new patient appointments attending GU Medicine clinics each week is around 15,000. Thus, the number of new patients currently waiting unacceptably long to be seen is now in excess of 40,000 and continuing to grow.
11. For most GU Medicine clinics, the numbers of women attending exceeds that of men; appointment delays are longer because of their longer consultation times. Delays for urgent cases are also more likely to affect the young, those from deprived communities, and others less able to negotiate immediate attention especially where English is not their first language.

### **Increasing incidence of STIs and HIV**

12. The incidence of STIs and HIV appears to be rapidly increasing.
  - a) Outbreaks of infectious syphilis, previously a rare and usually imported bacterial infection, have occurred in many parts of the UK. They have now spread to other towns and cities from outbreak epicentres, especially in the North of England and London. The numbers of annual cases more than doubled between 1995-2000, and provisional CDSC figures for 2001 show a further doubling of cases compared to 2000.
  - b) Cases of infectious syphilis are now appearing in women and we fear that congenital infection will reappear in neonates, as happened in similar circumstances in the USA during the 1990s.
  - c) The incidence of gonorrhoea, including antimicrobial resistant infection, is increasing. Cases diagnosed in GU Medicine clinics doubled between 1995-99, and preliminary analyses suggest a further 16% increase has occurred between 2000 and 2001.
  - d) Diagnosed cases of the commonest bacterial STI, chlamydia, also doubled between 1995-99 and further increased by 9% during 2000-2001. Many clinics are reporting increases in the number and proportion of complicated cases, consistent with deteriorating access. In most parts of the UK, adolescent women who have the highest prevalence of chlamydial infection do not have access to the most sensitive, non-invasive tests.
  - e) The ascending complications of bacterial STIs have a disproportionate adverse effect upon the health of women. In the non-pregnant woman, ascending infection causes pelvic inflammatory disease, increases the risk of ectopic pregnancy, and tubal damage and infertility commonly ensue. In pregnant women, infections may cause miscarriage,

- prematurity, and neonatal death. Such complications are associated with delayed treatment, which is more likely in the young, ethnic minorities and other less privileged sections of society. There is a clear association between high STI rates and the local health authority deprivation index.
- f) The annual numbers of newly diagnosed HIV have accelerated, especially in women where they have more than trebled since 1990 (now representing 40% of the annual total). A substantial proportion of these are women from high prevalence countries, especially from sub-Saharan Africa that places additional burdens on the need for developing acceptable, appropriate, and culturally competent services.
  - g) Co-infection with STIs and HIV is regrettably common, facilitates their onward transmission, and often causes treatment difficulties. Up to 50% of homosexual men diagnosed with infectious syphilis in London are HIV positive. Although most are previously undiagnosed, there is also concern about continuing partner change and unsafe sexual behaviour in those who are already aware of their HIV diagnosis.
  - h) In homosexual men, who have a high prevalence of HIV, alarming increases in STI cases have occurred between 2000 and 2001. Preliminary analyses show that new cases of infectious syphilis trebled, of gonorrhoea increased by 50%, of chlamydia and new genital warts each by 72%, and of first episode genital herpes by 44%.
  - i) Co-infection with HIV and tuberculosis, including multiple drug resistant strains, is becoming more common in ethnic minorities. Such cases increase workload substantially and, with the dispersal of asylum seekers, often involves less experienced or single-handed clinicians with little infrastructure.
  - j) New national targets to normalise HIV testing and increase test uptake will reduce the numbers of individuals with unrecognised HIV infection but will also add to the expanding numbers requiring long-term care.

### **Service provision**

13. Thus, inadequate provision of services and delays in GU Medicine clinic access are exacerbating inequalities in sexual health and jeopardising clinical governance requirements.
14. Many clinics throughout the UK have experienced rapid increases in HIV workload, especially in migrant workers and asylum seekers, many of who do not have English as their first language. This has often occurred without any increase in the staffing or infrastructure needed to provide good clinical care for a group of patients with complex needs whilst still maintaining open-access provision of sexual health services.
15. Some districts still have no GU Medicine service provision and rely upon patients' ability to travel often considerable distances to clinics in adjacent districts.
16. Many single-handed consultants, especially those covering more than one district, find themselves unable to take leave for either continuing professional development or even annual leave in extreme cases lest their service be left with unsuitable cover arrangements.
17. Changes in commissioning arrangements are exacerbating current problems. Strategic Health Authorities are not yet up and running and experienced sexual health commissioners in PCTs are rare. There remains a lack of clarity about specialist commissioning for HIV and the

toolkit for GU/Sexual Health is not yet available. Not surprisingly, Sexual Health has fared badly against other priorities in the annual SAFF bidding process.

#### **Infrastructure requirements**

18. Although many clinics in the larger cities and towns are in dedicated premises, there are still many part-time services that share facilities with other specialities that are often not involved in sexual health service provision. To eradicate inequalities in service access, we have strongly recommended that clinics should be open at least one session each working day.

19. Many services that are being provided in dedicated facilities are very short of space. Not only are patient confidentiality and privacy jeopardised but also effective working of the entire clinical team is compromised. A majority of clinics do not have adequate facilities either for partners who wish to attend together or for mothers with small children.

20. Support, including translation services and social care, especially for recent migrants and asylum seekers is becoming increasingly required.

21. IT support in many clinics needs to be upgraded in order to modernise routine clinical practises, including electronic filing of laboratory results, and to provide more relevant disaggregate epidemiological and surveillance data.

#### **Communicable Diseases Strategy**

22. The recently published Chief Medical Officer's Communicable Diseases Strategy ("Getting Ahead of the Curve") has again emphasized sexually transmitted viruses as a priority area. In our response, we have restated our view that bacterial and viral STIs are inseparable and that the public health control of all STIs including HIV must continue to be a priority. We also have commented about the relevance of STIs and blood borne virus infections to the other infection priority areas of tuberculosis, hospital acquired infection, and antimicrobial resistance.

23. Public Health Laboratories are the mainstay of routine diagnostic support for GU Medicine clinics in large parts of England. Proposed changes to the PHLS have raised concerns about the continued provision of high quality laboratory diagnosis of STIs, and the wider introduction of new technology to improve the timeliness of STI detection.

24. GU Medicine clinics provide most of the surveillance data for STIs to the Communicable Diseases Surveillance Centre that are the basis for informing the Department of Health and government about current trends, progress towards national targets, and the consequent refinement of national strategy. Robust reporting mechanisms must be maintained.

#### **Primary care**

25. The national sexual health and HIV strategy proposes that there should be 3 levels of care. Levels 1 (general sexual health) and 2 (specialist services) will be based in primary care and will support the existing level 3 (consultant-led specialist care) services that will continue to lead on the development of clinical protocols, referral pathways, and local clinical networks.

26. The Royal College of General Practitioners has made clear that GPs have neither the time nor the training to take on additional sexual health care provision at present because of the pressures of other priorities. The introduction of the sexual health promotion campaign and of chlamydia screening will inevitably increase patients' demands upon primary care, and both GP and patient frustrations will increase if specialist providers are unable to cope with additional referrals in a timely fashion or provide the necessary support to other providers.

27. Workload pressures are also inhibiting the contribution of specialists to the education and training of primary care practitioners, and to further development of local sexual health networks. This will hinder the enhanced collaborative working that is necessary if both the teenage pregnancy and sexual health targets are to be achieved.

### **Costs of delay**

28. Delay in treatment of STI promotes their onward transmission, the development of expensive complications, and the spread of HIV.

- a) We are seeking to address the current dearth of UK information about the costs of treating STIs and their complications. It is estimated that the cost of treating pelvic inflammatory disease in the USA is at least \$3 billion per annum.
- b) The average annual cost of managing HIV patients in the UK is £15,000. Thus, for the prevalent caseload of 23,000, the annual treatment costs in 2002-3 can be expected to be in excess of £345 million, and the cumulative lifetime costs of prevalent HIV cases by 2007 to be in excess of £5 billion. However, if the growth in annual numbers of newly diagnosed cases between 2000-2007 continues at 15% rather than 10%, these cumulative lifetime costs will be in excess of £7 billion.
- c) In the national strategy document, the cost benefit of preventing a single HIV case is quoted as being upwards of £0.5 million. The cost benefit of preventing 2000 new infections will be at least £1 billion. In 2001, the annual total of newly diagnosed HIV cases is expected to be over 4000.

### **Solutions**

#### **Short-term**

29. Current service capacity is super-saturated. The current crisis must be resolved rapidly by immediate strengthening of GU Medicine services.

30. The national sexual health promotion and HIV testing campaigns will inevitably increase patient demand. In Wales, the consequence of the recent national sexual health promotion campaign was the doubling of GU Medicine clinic appointment delays from an average of 3 to 6 weeks. We have strongly recommended to the Minister for Public Health and DH that these national campaigns be delayed until service capacity has been expanded. Short-term capacity increases may be achieved by increasing the number of weekly clinic sessions and extending clinic hours of work.

#### **Medium term**

31. In our responses to the consultation document, we have emphasized that progress towards national targets requires the restoration of growth in consultant numbers and additional health adviser, nursing, and administrative support.

32. Around 70 doctors will complete their specialist training in GU Medicine during 2002-3. These could contribute to the government target of 7500 new consultant posts by 2004 contained in the NHS Plan, and accelerate progress towards the additional 250 consultants required to

achieve the Royal College of Physicians recommendation of 1 consultant per 113,000 population. In each year thereafter until 2007, a further 30-35 additional specialists will complete their specialist training, of whom one third will be required for retirement replacements and the remainder will be available for consultant expansion.

33. Unless new posts are created, in line with manpower planning expectations 5 years ago, some of this expensively trained resource could be lost away from front-line patient care in the UK.

34. Targeting new posts to currently single-handed consultants whilst ensuring that all posts additionally have some clinical sessions within the nearest inpatient (usually teaching) centre, will ensure that capacity requirements are improved throughout England. It will also promote clinical governance, the development of service networks, contributions to local multidisciplinary planning teams, outreach work and increased support for training in primary care.

35. Funding support for continuing professional development of non-consultant grade doctors in GU Medicine, many of who also work in primary care, could make further contributions to level 2 service developments and promote linkage of the teenage pregnancy and sexual health strategies.

36. We also strongly recommend that there should be incentives for other primary care practitioners to obtain training in sexual health care, such as in the Sexually Transmitted Infections Foundation (STIF courses), to support level 1 service provision.

37. Implementation of these proposals would require around £14 million in pump priming. We are convinced that improved patient access will reduce onward transmission of STIs and HIV, will boost service morale, and increase our capacity to meet the national targets.

38. It is important that improvements to clinic infrastructure also be addressed. The executive summary of a report "Modernising Genitourinary Medicine Services in England and Wales" prepared in June 2001 is appended.

39. The cost of the support requested to increase service capacity and curb the spread and treatment costs of STIs and HIV is several orders of magnitude less than the inevitable healthcare costs of delay.

## **MODERNISING GENITOURINARY MEDICINE SERVICES IN ENGLAND AND WALES**

### **Executive Summary**

The incidence of STIs and HIV in England and Wales has risen dramatically since 1997. Although most GUM departments operate an open access policy for patients who need to be seen urgently, recent surveys have shown that most GUM services are experiencing severe workload pressures that are exacerbated by restrictions in the physical infrastructure of clinics. This has resulted in unacceptable patient waiting times for accessing GUM services, which will inevitably have a very detrimental impact on the control of STIs.

In April 2001, MSSVD and AGUM set up a working group to investigate the need for improvements to clinic infrastructure and to estimate the associated national costs. Clinics were classified into units based at London teaching hospitals, at Regional Teaching Hospitals, at District General Hospitals (subdivided into services served by more than one and by single-handed consultants), and within integrated sexual health services. The Group developed a template for assessing needs. Building cost calculations were based on detailed costings from nine representative units, which have either been modernised recently or are about to undergo major rebuilding programme. In addition an informal telephone survey of other centres took place to identify their needs.

The survey identified the urgent need for substantial investment to improve service effectiveness, accessibility and acceptability. For most centres, this would mean refurbishment (including extensions where necessary) to improved access, especially for the disabled and facilities for patients with young children. If all clinics were refurbished, we estimated the total cost to be £151.5 millions.

The deficiencies of some clinics are so great that a major rebuild rather than refurbishment will be necessary. We believe that this will apply to 20% of current clinics. This increases the estimated total building costs to £248 millions. This figure does not include professional fees or VAT.

Service delivery and effectiveness were also impaired by inadequate information technology. Virtually all units need to improve or develop computer links with laboratories and update of existing IT systems to enable efficient archiving of clinical records, and improvements to telephone systems. We estimated this to cost a further £28.5 millions.

Extending opening hours, subject to availability of resources and manpower, may also enhance accessibility to some clinics. A separate working group is currently assessing these immediate needs.

The Group recommends that a clinic modernisation programme be phased in over a period of 6 years. We recommend that each Region make its own comprehensive assessment of premises over the next 12 months to enable fully costed proposals to be made for a capital programme.