Clinic experience with SE and adoption

Reference 1 - 4.37% Coverage

And that's as part of an economics evaluation as well with [name]. And then we've also been moving some contraception online. That was a PhD project with [name] with [name] and the SH:24 team. So yes, in terms of evaluating, I think we're pretty good at doing things, and getting things up and running. The evaluation, it always, you know, it always relies on, you know, are you collecting good data in the first place?

00:09:02

R Right.

P And, you know, what is your baseline? So in terms of partner notification, we had no real baseline, because we had audits every once a year that showed that we're nowhere near hitting the targets. And then as soon as we had a tool with a real time KPI, we could see that, you know, there was nowhere to run or hide. You know, you could see how it was performing in different groups. So there, the trick is to really understand what your baseline is. So we know our baseline around diagnostics, for example. We know that 75% of our results are coming in at 72 hours, which is rubbish.

And the trust is supporting us to get a machine in [clinic] for a Panther machine, so we can actually bring some of the lab into our service, so that we can actually test things in real time. But also, you know, things like we did an evaluation very early on about bringing in a diagnostics force, syphilis PCR. So [name] developed a syphilis PCR. We showed it was working, it was picking up infections more acutely, in terms of primary chancres. We embedded it with our herpes test to make sure that it got easily adopted, and been using it since then. We're now decoupling that syphilis test now it's an established test, from the herpes, because obviously we don't need to do that for all the low risk heterosexuals. But we are diagnosing people earlier with syphilis because of that PCR.

00:10:34

And then the other thing we evaluated a very long time ago was the HIV point of care tests, and how that affected the pathway. Initially we had a 20 minute test, but we've moved to the INSTI™ one minute test, because that's good. And we're bound to move to the INSTI™ HIV and syphilis test. So in terms of point of care testing, we're very keen to try and speed up the time to having some useful information. So, yes.

But you know, the… We worked very… We've… We're very… We're getting better evaluating stuff. We all on quality improvement projects, they're really trying to understand the baseline. And getting that discipline amongst staff to actually understand where we are, and then thinking about where they want to go is really important in the sort of quality improvement change management.

Reference 2 - 0.71% Coverage

Rationale, and you know, what is… What would be your, you know, what would you actually measure? What would be your change drive, you know, your driver diagram? You know, what sort of things would you have on your run rate, if you were going to measure something. You know, what specifically, and getting people to actually say, look, that is the important measure. And we all just, you know, we'll implement change. So we…

Reference 3 - 0.39% Coverage

And I think, yes, we've been, you know, evaluating the service for a long time, in terms of say the senior model. That's another thing we evaluated. But didn't really publish on it, which is a shame. But… We still could I suppose.

Reference 4 - 1.08% Coverage

And we have a little matrix that allows us to understand, you know, how many people are in the waiting room, how many staff do we have, and then how many hours left in clinic, and how many we can let through. And then we got triaging on top of that. So, you know, we're getting a lot more rigorous about looking at the services, and now of course, because we can do that, we can then turn around to staff and say, well, why aren't you seeing that many patients in the clinic? You know, what's wrong? What barriers do you have? What can we do to remove those barriers? So yes, you can start having more focused, fruitful conversations with people.

Reference 5 - 0.96% Coverage

Well, yes, that is the challenge of any projects. This, you know… You won't take everybody on board with you. You know there's always the laggards who have got, you know… Usually vociferous laggards are the enemy of any development, to be honest. But they exist, and you just have to deal with them. But there, the thing is, the frame that we've put around all the changes that we've brought in the last five years is that we need to keep on developing things. We don't know what's… What, what's going to work, but we all give everything a go, you know, as safely as possible.

Reference 6 - 1.93% Coverage

You know, we're getting better. You know, there's more to do. And certainly we, we can certainly tidy up a few of the anomalies that have existed. You know, it's only when you start unpicking, and lifting up the hood, and you realise oh, the money is in this place, but those aren't the right signatories. And you know, the person, you know… The… It's just all those finer details. But the philosophy in the department is, you know, let's give it a go, and let's evaluate it, you know.

And an example would be the trust said to us, these are new tourniquets you have to use. So, we got the tourniquets as per the corporate wish, and we started using them, and we looked at the price. And then we realised that the tourniquets, as nice as they were, represented half a healthcare assistant's annual wage. So it was a point of, you know, point five whole time equivalent of a healthcare assistant. Well, we would rather use the older tourniquets, and have half a healthcare assistant, than pay money for these fancy pants things. So we just turned around to the trust, and said thanks, but no thanks, we're going to go back. You know, we can't justify that.

Reference 7 - 2.27% Coverage

So, yes. So new to follow up, that's something that, when I came to the service, took the lead role, gosh, how many years ago is that now? It's about six and a half years, seven years. You know, we had a follow up ratio of 40%. You know, it's ridiculous. Lots of people coming back for cryo, lots of people coming back for their results, lots… You know, it's just nonsense.

So anyway, we just reconfigured all those pathways, you know, bit by bit. So women coming back for repeat pills, they get a year as per faculty guidance. People coming in with any genital warts, they go onto topical treatments, you know, you know, if they go through one, and you know, the two topical forms before they end up on cryo. So that we, you know, we just make sure that we default to good practices that release capacity in the service. And now we're like point, what's it? Well it's about 15, 18% are follow ups now. So we've halved that.

00:23:41

And we… And the reason why our follow ups are so high is because we diagnose so many infections, and bring people back. But clearly, if we could diagnose people on the day, then we wouldn't need to bring them back. So, that's where, you know, when we're looking at that final 15, 18%, we realise a lot of that is around not being able to make a diagnosis on the day. So we have this delay, and the feedback loop is too long.

Reference 8 - 2.96% Coverage

On the hand… A handful say, oh, well I need to know where it is, because I then know who I need to tell. I… But you know the argument is, look, it's probably in your throat. And if we didn't find it in your throat, you know what I mean? If we find it in your rectum, and to be honest, you're better off telling everybody anyway. You know, it's… And, you know, trying to break it down like that doesn't really add value.

00:30:03

So, yes. We got the… Once the paper was published, I then presented it to our clinical director, and said look, it's now official, it's… But they'd… We'd already talked about it to them, and they'd already realised it was going to be tons of savings in… On many levels. So, we… Yes, we just rolled it out. We just said right, this is the new normal. So, well they seem to, [unclear] rolled it out.

With the partner notification tool, it was a Public Health England grant, we ran it for a year for free. We started January 16, we proved very quickly that we could actually deliver more effective partner notification than ever before. We found that, yes, we were getting partners seen and tested in all over the country thanks to the tool. And it was picking a 30 to 50% of the work up. So as soon as you…

At the end of the trial, I just turned around to my colleagues and said, here's the evidence, you know, 30 to 50% of the health advisor time is saved by this tool. And will you be happy to pay for it? And so they said, yes. You know, but you just need to have… You need to prime these things with trials or with, you know, grants to make things free, so that people can see it working. But also get the data to prove to themselves that it's fine. And then it's just a case of saying, look, this the objective data, what do you think?

Reference 9 - 1.85% Coverage

But the… Yes, there was another project I wanted to do, it's like patient feedback. We have 1600 patients a week, we should have about 160 people giving feedback on our service each week. Right, so we should have 800 to 1000 feedback pieces of information each month, right? I, I'm a great fan of the software company iWantGreatCare. [name] set that up. It's a fantastic transparent platform, allows patients to feedback. And you know, just I wanted to put that link in the hands of every patient who came through the door.

The trust, well, wanted to use another system, people are scared about patient feedback for some reason. SH:24 I think gets… Something like 56% of its users give feedback. And it's got a net promoter score of 4.96 out of five. SXT asks users who choose a single provider to give feedback. 15% do, and 77% give a score of eight or more out of ten. I think it works out about 8.6 out of ten is the net promoter score of the service.

And there are… There's been, say how many, 14 000 users or 16 000 users since the beginning of the year, and we got, you know, that much feedback.

Reference 10 - 2.33% Coverage

It's just in the week. But you know, this is… It's very… It's important information, you know. So how do you… So I work for the young person's charity. I haven't mentioned it, but I work for them. And what's fascinating, is I presented iWantGreatCare to my colleagues in the charity. And you know, it was, I know it was going to cost, the dashboard was going to be like five grand or something, and… And it… And nobody had that money, or didn't want to give me that money. But now there's a new CEO and there's a new digital team. And it's so funny, because, you know, three years later they're coming back to me, and they're saying, do you know what? We think we should have feedback, and we found this great company called iWantGreatCare. And I'm just, you know, sitting back, smiling, saying yes, let's do it. So they want to have, you know, every service on iWantGreatCare, because they see the voice of the patient.

R Yes.

00:53:02

P You know, young people as being a great tool for advocacy. You know, you can't be an organisation saying that we're here for sexual reproductive health services, and education, and advocacy, and not have the voice being flowing freely to be the true advocate. So, it's really nice to then see the new team. And I think the correct team coming in with that culture, and realising that it's a force for good. So, yes, patients are really important in this mix.

Reference 11 - 0.58% Coverage

But at the same time, you know, for the last seven years in particular, we've been, you know, always positive balance, doing innovative things. Moving the, you know, moving the agenda forward, you know, in terms of nurse development. We have, you know, we stand out, you know, as a service in terms of, you know, working on new pathways, we stand out.

Reference 1 - 0.76% Coverage

I think all departments need to evaluate their services. We look at various aspects of it. And part of my role as quality improvement is looking at how can we improve our services to make it in line with the best standards of care that are published nationally, but also to incorporate advances within the field. So there's a lot that is happening. And how we manage STIs, how we test for STIs, how we interact with our patients.

Reference 2 - 1.91% Coverage

So I think that I'm lucky that in the department I work, we have a commitment to research. And we're looking at how can we... the research improving clinical performance, clinical morale, and also adoption.

So we are quite interested in... I think that evolving science of implementation science, I think that's the way to success. It's become very trendy at the moment, but there's still very little that's happening as to implementation science. But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

Reference 3 - 0.75% Coverage

And being through quite a few service development implementations, we don’t get extra money. If you ask commissioners for extra money, it's always no. And you can generate it. And again, the other thing is to look at your business services management [unclear]. Just look at how do you make a business plan. The income-generating methods that you can use to... you could provide private services that can support these changes.

Reference 1 - 1.18% Coverage

I think that we’re an organisation that likes to adopt change comparatively. We like to try new things.

I think sexual health is probably our most innovative service. I think some of that comes from the fact that they’ve learnt to not ask for permission for a lot of things.

Reference 1 - 3.21% Coverage

P Yes. I think I have a pretty active role in that process. I think, as a department, we are quite open about trying to find new ways to do things. And if there is an easier way to do something, or a more efficient or a more accurate way to do something, then we are really quick to jump onboard that. And the clinic lead is really, as our clinical lead, is all up on the technologies. So, he is always looking for us to adopt new things.

And he would come to me and the matron. That would be the head of nursing. And talk about, hey guys, I want to… I hear we have this idea to improve our service and get results faster. Or get people, you know… Have to stick a needle in someone less. Blah, blah, blah. And then we think about doing it. Come up with a plan in order to put it into effect. Yes.

So, I feel I am very much a part of the process that’s kind of thinking of the ideas. But, also, I suppose mainly implementing them. And thinking about pathways. And who does what and how is it going to be used, and with who? That kind of thing.

Reference 2 - 1.63% Coverage

P Yes. I think that, as service, our service in particular. We’ve gone through a lot of changes with our structure and what people’s roles are. And what responsibilities and even what tests on my time. We never did any kind of phlebotomy or swabbing or any of that stuff, until about a year and a half ago. We’ve added that to our list of duties as a way of bringing us into the multi-disciplinary team. Being able to help out when we need to… When the staff group that does that need our help. Which is a nice thing to be… To do.

Reference 1 - 4.06% Coverage

P One of our principles within our service development model and service delivery model is using technologies where possible to further our aspirations around self-management and around reducing process steps and creating simplicity in sexual health services. It does come down to we have got financial obligations to meet, such as making sure we’re… I said we wouldn’t get interrupted; apologies.

R It’s okay.

P I’ve said we’ve got our obligations around breaking even, and there are elements around how technology can streamline services, simplify services, and reduce process steps, which we feel, and people, service users we work with, have suggested as well that reducing steps in any process is desirable. We look to technology and the implementation of new technology to make things simpler and quicker and hopefully increase quality, and that’s one of our guiding principles.

00:06:24

We moved onto our online testing using online triage methods linking to test requests. Help for home sampling was very much linked to our principle of adopting technology to support with the pathway. The difficulty that we do experience with this is that quite often, the immediate response is, you’re taking my job away by doing that.

Reference 2 - 3.44% Coverage

R Let’s go back for a second to the example, because you said that you recently introduced a home testing system. What was your role in that? Were you overseeing it, was it you who introduced that to the service?

00:08:39

P We actually started working with a company before we won the contract to develop a self-testing platform, and that was back in, oh, probably the end of 2014. We were always looking to develop online services. It just so happened that we worked with a subcontractor, because we weren’t as far as developed as they were. We recognised the need.

And always within our model of service was the idea of, if we could get somebody to do it themselves safely and appropriately, then we should be making that happen, and technology was a way we could do that, technology in terms of the sampling technology which was already there, but also using the Internet to record information and allow us to process the information in a way that sorted people out, who were appropriate and who weren’t appropriate for self-management.

Reference 3 - 9.84% Coverage

Yes, I think once you have the data and everything else, marketing, apps, a marketing process so you can really flag it, because the way I look at it is that marketing’s there to flag benefits, it’s not there to convince people. Because if your business case is there, if your data’s there and you’re trying to introduce something that truly has got… Technologies will bring about advantages, you’d think it would sell itself, but I think it needs to be sold. We’ve got another example, where we have developed an app for condom distribution.

Condom distribution schemes, great public health interventions: young people access free condoms, undertake assessment from a one-to-one basis, so they see somebody, a nurse or another sort of clinician or a trained person, they go through an educational session about effective use of condoms but more importantly sex, about appropriate relationships, safety, safeguarding, consent, all of those areas. And then if they’ve gone through that, they’re then given a physical card, and they can use this card to go to any number of little outlets, venues, community pharmacies, to get free condoms.

00:23:04

That’s a great scheme, but there’s never been any data associated with it, there’s never been any stock management associated with it. Basically, places said, I’d like to sign up for the scheme, they were sent a load of condoms, and you never knew if those condoms were given out or they weren’t, you never knew what places were active and what weren’t.

Young people never actually knew whether their community pharmacy would actually have somebody in there when they asked, when they said, can I use my card, whether somebody would say, don’t know what you’re talking about or would give them some condoms. Basically, it was a great scheme, a great idea, but there was nothing to it that gave it any sort of… There was no evidence associated with the activity, there was no monitoring, there was no intelligence.

We’ve developed an app which covers the educational element. It covers data gathering, because we ask for postcode, gender, date of birth, and their mobile phone number. We have a geolocation system on it that tells everyone where the outlets are on a map. We have complete stock management, we know when stocks run to halfway and we send more out. And also, in addition, it has the education and test element on it.

Basically, we’ve used technology to turn condom distribution into something that was a really nice idea but with zero evidence on its effectiveness to something that gives us health intelligence, gives us accountability for the money we’re spending on actual condoms, and gives the ability to start targeting where we should do more work. And what I’m saying is, what helps, I think, with adopting any technology is whether technology in itself, whether you actually have evidence to bring in that technology, or whether the bringing in of that technology will produce evidence for what you’re doing.

Reference 1 - 6.78% Coverage

R So what is your role when it comes to adopting new technologies? Are you a part of that?

P Yes. Ultimately if it’s on a service and even across the whole of the [name] Sexual Health Service then yes, that would be part of it to ensure that it’s rolled out across the team that we’ve got here and staff. Or if it was something just local to us, then that would be for me to decide whereas we were going to adopt it and then if we are to roll it out and to support everybody and promote, ensure that we’re all doing it.

R And do you find it challenging?

P It depends. I’ve got clinical background so it depends on what we’re doing. My IT skills probably aren’t the same as somebody who’s got an IT background but I’m prepared to give it all a good go, give anything a go and stuff and some of this clear pathways that go with it, then we’ll give things a try. Some of it are going to be of benefit to patients or just speed up processes then we’re prepared to give things a go.

00:03:29

It’s a recent thing but we got a label print which is a very small step, but for the clinic it was a very big step because we were having to hand write labels. But we’ve got them installed, then a little bit temperamental but we’ve got there in the end and it speeded up the process and obviously for quality and stuff it’s definitely a lot better.

Reference 2 - 4.70% Coverage

So what were the main challenges in that process?

P First of all, I think, the installation that’s been done by IT. So it’s liaison with the third party to get them to do it, then they weren’t installed correctly so it’s going back again to do it again. And then just with the training of staff who are clinical that whereas maybe something like IT isn’t there, isn’t their main thing so it’s getting them to understand the processes, have they got their computers to work and stuff with them.

But we’re all there and we’re all using them, we’ve cracked it. Some people are quicker than others but we all get there in our own time, don’t we?

R Yes.

P We all get there in our own time.

00:04:43

R Well, those processes turn to be time consuming and energy consuming, right?

P That’s it. They’ll be time consuming and sometimes you have to go back over a few steps a few different times, but we’ve got there in the end.

Reference 3 - 8.63% Coverage

The service changes that we’ve actually made with the new contracts and stuff, I think have made people be prepared to change their practices. Because people had maybe got a bit stale in the past and having new contracts and stuff and moving forward has made people change their practices and look at things in a different way, and just what we’re doing and how we do things.

R And when were those contracts changed?

P April 2016, it started.

R And what was the difference, could you just briefly explain to me how that change and why? What was... ?

P Some of us obviously said this is a great step that’s now being joined up as to one service, whereas say in the past we didn’t have any online testing which we do now with being teamed with SH24. So there’s online testing available which wasn’t available before. In the past the consultants really wanted everybody to be examined, whereas now we only examine people with symptoms.

00:26:41

If somebody is asymptomatic they see a support worker and a support worker does an asymptomatic screen, so they don’t even have to see anybody clinical. So just general move forwards in the right direction, looking at patients been able to take some steering responsibilities for their own sexual health needs by steering them to online has benefit appropriate. So it’s a general shift into, that not everything has to be doctor-driven, we’ve got mainly nurse services.

We do adopt here but not as often as there ever used to be. We don’t have a consultant on premises, our consultant is based in [clinic]. Like I say, support workers are stating a bigger role in seeing patients. So just general shift in a positive way, what we think is the positive way.

Reference 1 - 1.87% Coverage

P And the communication within the services. And we've implemented the impact really effectively, and we fully recruited within two months of going live, our evaluation of BD, point-of-care HIV test. And there have been a lot of things we've implemented, which everybody has bought into. We’ve reconfigured all the rooms in the last six months, so there's been changes. But as long as people understand why you could see the benefits of it, they...

Reference 1 - 2.18% Coverage

P The, we have, we do have a point-of-care test that we use, which is the HIV point-of-care test, so that we rolled out last year. It wasn’t sort of a formal adoption process really, because this is something that’s been around for quite a long time and lots of clinics used it. And I used it at my previous trust before I came here, as did all of the other consultants as well.

So in terms of that, that wasn’t really a formal adoption thing that we went through. We really needed an SOP for the test, and that was about it, about proving the test to be used, rather than anything else.

Reference 2 - 4.27% Coverage

For the data collection part of it, I don’t know. I think that will be sort of an… Yes. I’m not sure we have anything in place specifically for this. But, yes, I mean, in terms of our sort of management meetings, we have everybody on board who will be able to support. So we do have our business manager who has been through, and we’ve been through, part of the PrEP trials, because she’s very good at sort of taking on all the admin role and sort of stuff that needs to happen for that.

And our team sort of used to now, because we are part of another major national trial, in terms of how to actually select patients, particularly talk to them about trials and things. And they have all… Those that are involved in the trial have all gone through the good clinical practise as well. So that, I guess, gives us some sort of knowledge about entering a trial.

00:12:08

In terms of adopting a test, we’ve been… I guess we’ve been through it with the whole bucket thing anyway, although that was pretty much everybody that had to do it. Yes, I guess, it would be sort of similar again. I don’t know if we have anything specific that is in place to do it.

Reference 1 - 5.40% Coverage

But there's some change that can be introduced in a very seamless way, which is not as dramatic. And then they sudden change, that's so obvious, because everyone else can see and say, oh, this is too big. And you have to explain the steps and the stages.

So there is gradual change, and then there is some change that is really dramatic that it's affecting the way people have always worked. But, yes, I wouldn’t say that the change is not happening. Because even at the moment, I think we are going through a lot of changes.

R What are those changes?

P The way we run clinics. So we are changing the way we run clinics from only booked clinics to walk-in clinics. We are changing the way...

R That’s massive.

P Yes. So we are changing the way we order test, like I said, so ordering them differently. We are changing the way we use clinical rooms. So there's various things that are happening, but it's getting people to look at the bigger picture of this is actually what we want to achieve. And sometimes it's really the most difficult, but you have to choose your words properly and try to make people see where you're coming from.

Reference 1 - 6.08% Coverage

R Right. That’s very interesting. As a result, are there any new technologies being adopted?

00:05:17

P Yes. We’re using far more online provision, especially around STI testing. We use the freetest.me kits that people can request online. It’s sent to their home address or an address that they wish it to go to. Where they can do a chlamydia test, an HIV test, a gonorrhoea and syphilis test.

That gets sent off and they get a result within, I think it’s 48-72 hours. Then they can go off to community pharmacy, they’re contacted by the trust. They go off to their community pharmacy and they can pick up their treatment. If it’s chlamydia, and obviously anything else, our Sexual Health Service will pick up the care of that patient from there.

That has proved very popular because it has meant that a footfall to the trust for, oh, I need an STI test because I changed partners. That person can be more responsible for their own health care. It has been very, very popular with our community.

R So, it’s also popular with patients?

P Yes, it’s saving them having to wait for appointments.

Reference 2 - 2.78% Coverage

My role, obviously, is commissioning research to get better value for money. Also, with the technicalities behind it I’m responsible for making sure that the patient group direction for treatment is in place, such as, azithromycin treatment for chlamydia. We have a patient group direction with our community pharmacies to enable them to deliver and also get paid for doing that work. And also, making sure that the pathways are in place and communicated, etcetera, in the best way that patients know.

Reference 3 - 2.72% Coverage

An example of that at the moment is the way that we’ve offered all of these services out using what’s known as a Dynamic Purchasing System. Where it means that anybody who’s a qualified provider can offer to deliver the services. It’s all done online but then they have to provide myself and my colleagues the information that we require. Such as, continual professional education around a particular topic, signatures on PGDs, and things like that, and also registration of their pharmacy.

Reference 1 - 2.94% Coverage

And it has sort of in a way given us an opportunity to look at different technologies that are available to us but also looking at other ways we can income generate as well. So we’re a pretty innovative service, quite small, we see around about 600 patients a month, roughly, and as I said, we do sort of provide a one-stop shop for most of the patients. We do everything that a larger clinic would do but in just a very much more of a smaller area and… But we see the same sort of infections and issues and problems that a large clinic would see but maybe just obviously not in the numbers. What else can I say about our service?

Reference 2 - 2.40% Coverage

Well we… Last October we approved… We’re working with our commissioners who are actually quite supportive, we’ve looked at using online testing. It had been… Prior to then we were running the chlamydia screening program and that was actually through an off-site laboratory but all the kits, the actual testing kits, we were distributing around the island through various means. So it would have been through pharmacies, different groups of people that we work with, GP surgeries, youth groups, that sort of thing.

Reference 1 - 3.34% Coverage

P Okay, so obviously a lot of these things are based on research techniques, in order to identify benefits of doing things differently. Service evaluations have been undertaken with different testing platforms for other infections in the past. And in order to try and understand the differences and the benefits of adopting different ways of working, we've changed ways of service delivery, changing patient flow through clinic. And tried to then evaluate how it's had an impact, looking at patient numbers, patient waiting times, that kind of stuff.

Reference 2 - 2.85% Coverage

P I think more often you sort of introduce an idea, and then evaluate it, rather than necessarily trialling things. I… You know, that we have had occasions where we've just… There was a couple of years ago, a concept within the hospital called Fresh Start. And so for one week we did things differently, and we did a number of different things. Some of which we've carried on, some of which we haven't, some of which we are trialling again in a slightly different way.

Reference 1 - 11.78% Coverage

And do you have an experience of the adoption process within the NHS, service evaluation as well?

P So, yes, so, I’ve been a consultant a long time now, so… and probably in terms of technology, we’ve done a few things really, going right the way back to probably 2012, we implemented, when I was a consultant elsewhere, but it’s still NHS, we implemented full electronic patient records, so that was probably a big… that was a big implementation process from a… from being paperless.

00:03:06

Most recently, what have we done? We’ve implemented a… we didn’t take over, but we acquired the contract for an HIV service remote from the main hospital site. So, a lot of implementation is actually getting the IT to work and getting remote links and things which perhaps have been somewhat problematic.

So, that would be another kind of implementation process for quite a big change in the service. And then in between, lots of little things, really. So, texting, setting up automatic results text messaging, emailing patients projects, online booking, those types of things. So, sort of little things compared to the bigger things I’ve mentioned.

R Yes, and would you describe those processes as smooth?

P Not in any way at all.

R Oh, right.

P I think, because we’re… sexual health tends to be quite self-contained, and it tends to use its own IT, so our own electronic patient records, which means that there’s no… when you’re implementing something, you have to have the approval of the trust, and normally the trust IT department.

00:04:35

Now, on a day-to-day basis, they don’t actually have any involvement with the system at all. So, what you tend to have to do is educate a whole load of people about what you actually do before you make any changes, the reason for making the changes, and then quite often you’re trying to fit changes which are completely appropriate for sexual health into a general kind of NHS structure. And it… quite often it doesn’t fit.

The NHS is incredibly conservative about information governance. So actually, just an example, trying to get negative text messaging, which… text messaging is an old technology now, so everywhere does it, but to sort of an NHS organisation it’s seen as a big risk, there might be a problem.

You meet lots of… I would call it obstruction actually. You do meet a lot of obstruction from people that you get the impression that they’d prefer it if you were just on paper notes doing everything on paper, because that’s secure, you can lock it away again.

So, yes, I don't… there’s never been a drive to develop… nearly all kind of IT technology type development has come from the clinical team, or the group, to say, actually, we want to improve this. This is really old-fashioned. A trust would quite happily, or the NHS kind of hierarchy in general, would quite happily just let you carry on doing the same old things, because it’s tried and tested and safe in their eyes.

00:06:16

So, we still use fax machines here. So, I think that’s a really good example of where the NHS generally is at, at the moment.

Reference 1 - 1.54% Coverage

P So if we, all of our opinions are respected, so if we found something and we proposed it, we could always have a role within that. So I know the most recent thing, no, I can’t even think now. So we do, if we did need to change anything, like we’ve recently taken on the online testing, the Pan-London online testing, we all had a role in getting the training, the posters, how we advertise it. That was something that we’ve recently changed.

Reference 1 - 1.86% Coverage

We've had lots of changes, we always have lots of changes, we have the computer system, we have lots of different things around prescribing. We've not got Preventx so we have lots of new ways of working which we're constantly being told to adapt to.

Culture of clinic

Reference 1 - 1.88% Coverage

We have a number of studies that, you know, the biggest challenge is making sure everyone's GCP trained. So we've got a training session tomorrow which is running from eight till noon. To make sure that we can, you know, do all the various days that we have. But what we're getting better at doing is thinking about parcelling off staff to research studies, because a lot of research studies, because they involve seeing patients, and delivering regular care, they also get paid under tariff. So we get paid under tariff, and we get, you know, any research income or access to new technologies, or new drugs, or whatever it is.

So it's a nice blend. We're finally getting to a point where we can do that. You know, we're not just chasing our tail for targets, and thinking about restructuring the services, because we've gone through that. So we now come out of the other end. So I've… As of April last year, we closed three of our six clinics, and we moved everyone to a new contract, and everyone started working weekends, so all of that was very disruptive. But, you know, we're a year later now. So it's time to move on.

Reference 2 - 0.64% Coverage

But you know, the… We worked very… We've… We're very… We're getting better evaluating stuff. We all on quality improvement projects, they're really trying to understand the baseline. And getting that discipline amongst staff to actually understand where we are, and then thinking about where they want to go is really important in the sort of quality improvement change management.

Reference 3 - 0.27% Coverage

It's all plan, do, study, act. And just getting people to think about what was in research type mentality, which I think a lot of healthcare workers don't have.

Reference 4 - 1.08% Coverage

And we have a little matrix that allows us to understand, you know, how many people are in the waiting room, how many staff do we have, and then how many hours left in clinic, and how many we can let through. And then we got triaging on top of that. So, you know, we're getting a lot more rigorous about looking at the services, and now of course, because we can do that, we can then turn around to staff and say, well, why aren't you seeing that many patients in the clinic? You know, what's wrong? What barriers do you have? What can we do to remove those barriers? So yes, you can start having more focused, fruitful conversations with people.

Reference 5 - 0.96% Coverage

Well, yes, that is the challenge of any projects. This, you know… You won't take everybody on board with you. You know there's always the laggards who have got, you know… Usually vociferous laggards are the enemy of any development, to be honest. But they exist, and you just have to deal with them. But there, the thing is, the frame that we've put around all the changes that we've brought in the last five years is that we need to keep on developing things. We don't know what's… What, what's going to work, but we all give everything a go, you know, as safely as possible.

Reference 6 - 1.93% Coverage

You know, we're getting better. You know, there's more to do. And certainly we, we can certainly tidy up a few of the anomalies that have existed. You know, it's only when you start unpicking, and lifting up the hood, and you realise oh, the money is in this place, but those aren't the right signatories. And you know, the person, you know… The… It's just all those finer details. But the philosophy in the department is, you know, let's give it a go, and let's evaluate it, you know.

And an example would be the trust said to us, these are new tourniquets you have to use. So, we got the tourniquets as per the corporate wish, and we started using them, and we looked at the price. And then we realised that the tourniquets, as nice as they were, represented half a healthcare assistant's annual wage. So it was a point of, you know, point five whole time equivalent of a healthcare assistant. Well, we would rather use the older tourniquets, and have half a healthcare assistant, than pay money for these fancy pants things. So we just turned around to the trust, and said thanks, but no thanks, we're going to go back. You know, we can't justify that.

Reference 7 - 1.31% Coverage

And I think, you know, we were the first department to do that, because that's the culture we have, is we look at it. Yes, we're a corporate player, but at the same time, it's got to fit, you know. And it's got to… You know, we're conscious about, you know, how do we get the right patients through the door? How do we get them through as expeditiously as possible? How do we stop them coming back for follow up, and make sure that they get a one stop shop? All of those things, you know, you continue a focus, you know. And I think making sure it's very patient centric, and public health minded means that we can just, you know, stop the sclerosis of, you know, old systems, you know, carrying on. Just, you know, they unfortunately do, unless you look at them. Shine a light on them.

Reference 8 - 0.95% Coverage

Oh there's always room for improvement. Oh tons. Yes. That's the exciting thing about it, there's tons of things we could do. We could have more staff trainings. We could have… We could certainly… With the appointment module, will be interesting to see how we develop that over time, you know. It's not very prescriptive on how it should be developed, it's just very flexible so people can use it. But, there's no reason why we couldn't, you know, improve the journey for patients. Certainly when focusing more on the partners to start with, the journey for all patients.

Reference 9 - 0.68% Coverage

Everything. You know, talking to patients, that's who we serve, you know. We can find out where the holes are, to fill them. You know, I've got no problems about, you know, putting it… You know, we know what our biggest issue is, the waiting area. If you look at the our clinic’s iWantGreatCare website, not promoted, but still people are filling it out. We've got like, I don't know, 120 responses, not much.

Reference 10 - 0.90% Coverage

Our department's got a good relationship with the directorate. Mainly because before we were bringing in money, and not losing money, of course since we've been cut, we've been bailed out recently by the trust for a short, small amount of time. We'll see how long that will last. But essentially they know we add value. We're, you know, we're part of the STP, in terms of, you know, public health agenda. You know, we are an important service, and we have the HIV prevalence in the UK in our, you know, in our two boroughs. So they get it.

Reference 11 - 0.58% Coverage

But at the same time, you know, for the last seven years in particular, we've been, you know, always positive balance, doing innovative things. Moving the, you know, moving the agenda forward, you know, in terms of nurse development. We have, you know, we stand out, you know, as a service in terms of, you know, working on new pathways, we stand out.

Reference 1 - 1.79% Coverage

So your main responsibilities are providing care to patients.

P Providing care to patients. Part of it is making sure that we provide good quality care when it comes to sexual health care, and also making sure that our services are accessible, making sure that we have the capacity to see the patients that want to be seen in our service. And having an accessible health care service will improve the outcome, sexual health outcomes. We can see that within England and definitely within London, there is increases in STIs and some STI, sexually transmitted infections, are disproportionately increasing.

00:01:49

So syphilis is a good example. Gonorrhoea, we see pockets of increase. And they're trying to increase the number of people with STIs that we see, which basically means that these are the people, if we can get to test and treat people in a timely manner, reduce on the transmission of infections. And the overall aim of our department is to reduce the burden of STIs in the community that we cater to.

Reference 2 - 4.33% Coverage

So there's lots with digital healthcare that we could do, which can make it more efficient and basically make it more patient-centred but not dependent on the service but actually to empower patients to look after themselves. So when you talk about service evaluations, as part of NHS clinic, what we are expected to do is to review how we run our services against national standards of care and make sure that we are meeting the standards.

But actually, we want to do more than that, so we've moved away from what we used to do as audits, which is kind of saying, how do you do next to a national standard. We actually say, how can we give the best care that we can and making sure that we are above the minimum standard? So rather than aspiring to the national standards, we want to say, we want to outperform those and basically have a service that is sustainable.

So obviously, we want to provide the same standards of care throughout whenever we're open. So it doesn't matter when a patient accesses us that they would get the same level of service, whether it's a weekday evening or weekend, the people get the care that they need. And so we have a program of quality improvement, which basically is looking at making sure that we deliver on the standards but then defining for our service what our aspirations are and how we can aim for seeing more patients have better quality of care and improve both staff and patient experience of that patient encounter and the patient journey throughout.

00:05:20

So that's what we try to strive to do. It is difficult, but we do have a program that's looking at doing that, and basically looking at it as a long-term thing, a marathon, and not a race. So it's not just take something off and then say, look, we've done this and not sustain that. We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

So you're basically trying to do it with a goal post that’s changing all the time. So what you need to do and what you are expected to do, it's what was an extra last year might be an expected basic minimum next year, and then say, how do you do that, and looking at what priorities are, looking at what priorities are within our control to adopt and what are imposed on us.

Reference 3 - 0.93% Coverage

But we have a duty to provide great care, and great care is more than... care basically means being up-to-date with everything and being able to deliver the best we can that is available now, which basically means that it won't be the same as it was last year.

R So that means adopting new technologies as well into service.

P New technologies, new perspectives, new ways of working, evolving rules of staff groups to react rather than say, this is a doctor role, this is a nurse role, and this is a health care assistant role.

Reference 4 - 1.26% Coverage

It's basically having a very in-depth view of what that entails, looking at what the knock-on effect of the change is going to be, how it's going to change working, looking at how it improves patient experience, and also looking at, if you are going to have a service that can say that you are going to spend your usual time in the clinic, get the results right away. That's a service people would want to go to. And that's what you want to be. You want to be the best.

00:20:02

People don't want to be just working in a place that's okay. They want to work in a place that's the best. And the best places are able to use the best tools. And I think that the ability to implement new technologies would be the best.

Reference 5 - 0.72% Coverage

Obviously, if the technology is super expensive, and they're saying that we need to improve development cost and we want to get our bonuses, then it looks like, well, it’s not affordable. You probably need to look at a different market. But it's a thing. And National Health will need to have good quality affordable care, because the service that we provide needs to be accessible, equitable, and sustainable.

Reference 6 - 0.42% Coverage

So we are quite interested in... I think that evolving science of implementation science, I think that's the way to success. It's become very trendy at the moment, but there's still very little that's happening as to implementation science.

Reference 1 - 1.18% Coverage

I think that we’re an organisation that likes to adopt change comparatively. We like to try new things.

I think sexual health is probably our most innovative service. I think some of that comes from the fact that they’ve learnt to not ask for permission for a lot of things.

Reference 2 - 0.73% Coverage

But I think as an organisation we’re very much encouraged to adopt new technologies. That’s what we’re about, but I wouldn’t say there’s a formal environment to do that.

Reference 1 - 0.68% Coverage

So, it was good to, like, no, no blame culture. Everybody was still being supported, because even the clinicians, some of them weren't coding, or they weren't clicking on the right thing, or missing something. So everybody was in the same position, because we were just learning, it was just about support. So… Which I thought was quite good.

Reference 2 - 0.17% Coverage

So yes. So, it's about working what you've got, and trying to go that extra mile to…

Reference 3 - 2.61% Coverage

So, when they’re complaining about IT, yes, I agree. We do have a problem, but, you know, we have to, there’s nothing we can do. It’s out of our control. So, yes, it’s not as if it’s something that our department can control. All we can do is report things and report things. But, I would recommend this department.

The thing is, a lot of staff, they stay here for years, and years, and years. So, they must be happy. I mean you do get the ones that are, deep down, yes. But some just like to talk and just have a say. You know, I’ve tried to leave a few times actually, just, not in a negative way. Like, I’ve been asked, like, there’s a friend or a friend, and they say, oh, there’s a job going, and they want you. Like, when I’ve applied before for a few jobs, like higher roles. Once your colleagues hear that you’re going, they’re just like, no, please. And they, like, so I think that’s why I’ve always ended up staying.

00:08:47

P I’ve never been, like, career hungry, as such. I think it’s more about job satisfaction, in my opinion, rather than chasing extra bump, or the title. So, just be… So, yes, every time. And then I feel guilty, and like, I’ve sent in my resignation and I’ve retracted it. And just, like, you know, okay, I’ll stay. What it shows is that they appreciate you, don’t they?

R Yes, thank you.

Reference 1 - 3.35% Coverage

Lots of sexual health services talk about removing stigma, but when it comes to working in isolation, sexual health services have been the worst for working in isolation. Generally speaking, they’ve almost presented a preciousness around information sharing and sensitivity of service, which has probably been to the detriment of your average person attending because there’s been very little connection with other services.

We’re very much into bringing sexual health services out of that age of isolation and into the mainstream, because the reality is if it’s not put into the mainstream, you’re never going to get rid of the stigma. We’ve got a common vision, we’ve got shared values, and we’ve got principles that the partnership works on, and they’re our foundations for how we move the service forward.

It is quite tough because you are talking about services and operational staff within those services that have worked in these more traditional ways in the past, and change isn’t easy for any clinical group.

Reference 1 - 4.50% Coverage

P No, we’re pretty up for new technology and we’ll give it a go. I think we’re quite positive and we’re quite proactive into about moving things forward. We can’t go back, we need to step forwards and obviously patients do want things as quick as possible and as easy as possible, but obviously it’s got to be as accurate as possible. We don’t want to be it to be quick but it’s got to be accurate as well. We don’t want to be sending people off with false information and stuff.

Like I said, we’re pretty... The service changes that we’ve actually made with the new contracts and stuff, I think have made people be prepared to change their practices. Because people had maybe got a bit stale in the past and having new contracts and stuff and moving forward has made people change their practices and look at things in a different way, and just what we’re doing and how we do things.

Reference 1 - 4.82% Coverage

P Yes. So obviously, all staff can't attend the meetings, and so whatever is discussed at the meetings then get discussed at more general meetings, like we hold regular nurses' meetings. So if anything particular that's discussed at the SDU meeting, then that's a good opportunity to discuss it then and just keep people updated. And also, the SDU leader's very good at communicating via email. She does a monthly newsletter, which she pings out to all members of staff, including reception, just to keep them updated on what's going on, what's being discussed, what we're looking at, you know, the future plans, that kind of thing. So everyone is kept up to date with what's going on.

Reference 2 - 3.00% Coverage

R Right. And do you think those benefits the whole team to make an effort to make the technology work?

P Yes, of course. Yes, because we like to please patients. We like to do as much as we can for them. So it's about that staff satisfaction as well as the patient satisfaction. If the patient's happy, then the staff are going to be happy as well. We don't like to have upset patients or angry patients to have to deal with.

Reference 1 - 2.88% Coverage

So, yes, collaboratively, we do work across the board, but decision making is done… I suppose the decision making comes eventually from our finances. So, if we know we can’t afford something we say, okay, we can’t afford that, we can’t do it.

But our Director of Public Health and Associate Director of Public Health will support the decisions that are then made, or not, if they don’t want to make it. But I would say that the decisions are made collaboratively. And it’s always in the best interests of the patient.

Reference 2 - 4.99% Coverage

R Would you be able to identify the structures that are already in place that are supporting adoption of new technologies? You’re describing those collaborative processes.

P I think, across the STP… Has anyone talked to you about the STP, Sustainable Transformation Partnership?

R No.

P Maybe go and have a look at the STP for this area. There is a whole element about new technology. If we come up and say, actually, this sits with STP design, etcetera. I also work very closely with my colleagues in [clinic] and [clinic] and [clinic] too.

00:12:13

R So, there is a specific programme design?

P Yes. And actually, you would look for the STP.

R And these are the main things that help?

P Yes, I would be working towards that. And obviously if we decided something individually, I would then obviously, like you say, make a business case and take that to our senior management team here for a yes or a no [unclear].

Reference 1 - 3.10% Coverage

P Absolutely, I don’t think there’s any place for a unilateral decision-making. It’s a very collaborative team here, what I would always do with something new is have a high-level overview of what is this? Why are we bringing this in to the service? What are we hoping to get and to do differently? Is it cost-saving? Is this a service improvement? Is this to do with patient satisfaction? Is this driven by legislation? I would hopefully be able to bring to my colleagues a clear, succinct summary; why are we doing this? And then get them on board with it; we’re doing this because… And they can see why it makes sense to be doing what we’re doing.

Reference 2 - 5.03% Coverage

Are there any people within the clinics that are likely to introduce new ideas?

00:07:33

P We have the sort of team where we welcome new ideas and creative thinking. We would, in the clinical staff, if any of the staff at whatever grade level comes up and says hey everybody look at this or I went to a conference and I saw that or I was at study day and I’ve taken home this information. There’s a very free forum for discussion and it’s a supportive one and it’s very equal opportunity, everyone has the opportunity to share their advice or information or their interest in something new.

It wouldn’t always be head-down. Some things are, that’s the nature of stuff, a senior nurse in the hospital says we’re going to be doing this and this is the new policy on that and that’s what we’re doing. When it comes to the local service, what we’re doing, how we work, changing hours, changing clinic times, something as simple as that, then it could be any member of staff that says I’m thinking we might want to try this, what does everyone else think?

Reference 3 - 2.52% Coverage

And I think the relationships within the team are useful and create a beneficial working environment. I know things constantly change but I think there’s… I think if you start with the mindset it’s changing, it’s all terrible, then you probably will find yourself becoming very miserable, very quickly. But if you can say, things will change, how can we respond in a useful way to these changes? How can we be creative with what we’ve been given? How can we make the most of what we’ve got? That, I think is a helpful mindset.

Reference 1 - 0.68% Coverage

So, within our department we are forward thinking but obviously we are just, you know, a group within an organisation that’s got a lot of financial pressures. So, we have to appreciate that as well.

Reference 2 - 1.60% Coverage

So, but definitely I mean I think I’m fortunate that where I’m working right now is there’s a team that’s really into, you know, looking at new products and looking at new ways of working. Because obviously we’re all aware of the fact that our budgets are going to get cut but we need to make sure we see the same number of people or the people with a need. Yes, and make sure that we don’t miss them. So, we have to look to technology because, yes, it is what it is.

Reference 1 - 0.46% Coverage

P So if we, all of our opinions are respected, so if we found something and we proposed it, we could always have a role within that.

Reference 1 - 5.28% Coverage

RE So when you say that this clinic is particularly good because it embraces, how do you think, why do you think that is?

PA Calibre of staff, staff that have been here a long time, a lot of staff been trained to do a lot of things, they're professionally well-developed. Kind of interested in the subject, you know, we don’t have agency staff, we have permanent staff it's all just permanent staff who work here all the time. I think that's an advantage. A lot of us have worked here a long, long time. That's a group dynamic thing. We're quite happy to support each other. Obviously there are issues but not as many issues as perhaps there could be.

RE Right.

PA So we're pretty good embracing change.

Reference 1 - 1.13% Coverage

P Absolutely, yes, our clinical lead and our lead nurse who we have in post presently are very interested in moving things forward and, you know, looking at really what’s best for our patients.

Future plans

Reference 1 - 1.88% Coverage

We have a number of studies that, you know, the biggest challenge is making sure everyone's GCP trained. So we've got a training session tomorrow which is running from eight till noon. To make sure that we can, you know, do all the various days that we have. But what we're getting better at doing is thinking about parcelling off staff to research studies, because a lot of research studies, because they involve seeing patients, and delivering regular care, they also get paid under tariff. So we get paid under tariff, and we get, you know, any research income or access to new technologies, or new drugs, or whatever it is.

So it's a nice blend. We're finally getting to a point where we can do that. You know, we're not just chasing our tail for targets, and thinking about restructuring the services, because we've gone through that. So we now come out of the other end. So I've… As of April last year, we closed three of our six clinics, and we moved everyone to a new contract, and everyone started working weekends, so all of that was very disruptive. But, you know, we're a year later now. So it's time to move on.

Reference 2 - 0.64% Coverage

But you know, the… We worked very… We've… We're very… We're getting better evaluating stuff. We all on quality improvement projects, they're really trying to understand the baseline. And getting that discipline amongst staff to actually understand where we are, and then thinking about where they want to go is really important in the sort of quality improvement change management.

Reference 3 - 0.15% Coverage

And so we're trying to move the whole department in that direction. Easier said than done.

Reference 4 - 3.51% Coverage

We can certainly be, you know, a lot of the management of common things like vaginal discharge related to, say, BV or thrush, we could easily make sure that we self-sample for the important STIs, and get these women to be treated syndromically, and rapidly. You know, if they fulfil certain criteria.

Certainly we could move a lot of things online now. I was in a meeting last night with SH:24 about managing any genital warts and recurrent herpes online. Contraception we could move a lot of that online. We're looking at using SH:24 to do that so women coming in for repeat pill, they can easily get that online. Obviously we don't have every single pill online. But you know, if they're on, you know, bog standard, you know, estrogen, and Levenorgestrel, you know, the Microgynon, the Rigevidon, and Levest, and all the other brands of that version, if they're on that. Or Desogestrel pill, there's no reason why they couldn't just get that online.

00:45:04

And we've got at least 6000 women a year we see, that we could move online for that. We don't need to see them. You know, everything, they can get screened online as well. So there's tons of things we can do. And I... You know, the job over the next year is just stripping away all the simple stuff, you know, that can be managed remotely. And focusing on the… Where we add the most value. You know, the people who've got symptoms, who need diagnosis, who need treatments, who need implants, who need IUDs, who need, you know, counselling, whatever, you know.

R Yes.

P Because that's where the… We add the most value, is the level three service. You know, we'll still be, you know, screening people, and there's… We'll still have some, you know, some of the simple things coming through the door, of course we will. But, there are patients that are in streams three in particular, who could be managed remotely. You know, pill repeats, recurrent herpes, any genital warts, all those things we could easily move them online. That would be fun. And then we got, you know, hopefully that'll be another five, 6000 spaces for other patients.

Reference 5 - 1.03% Coverage

But you know, we've consistently been pushing it along, and you know, as our research agenda picks up, that's also going to be good. And the next thing we need to focus on is how do we deliver more effective education. We've already got great scores from our GP trainees, and from our registrars. And we've reconfigured our training around them to make it more responsive. But I'd still like to have better metrics on how we can make sure they're all trained to… As expeditiously as possible, and you know. So yes, put some relationships, it takes a while to build those up. And it's… You've got to do it with data. Yes.

Reference 6 - 0.70% Coverage

Yes, no we can see it changing pathways, lots of key pathways. So at the moment we see 350 partners a month, mostly of chlamydia and gonorrhoea. We would like to double that. And with the appointment module, we should be able to double that. And if we double that then we're going to increase the number of infections we make, and therefore we'll do more partner notification, and it will be this lovely positive loop...

Reference 7 - 0.82% Coverage

Drilling through the sexual networks, and trying to get all those key people in. And it's just going to be really exciting once we get that up and running. And the mantra [?] of partners is… Hinges on point of care testing. You know, to do that properly. And especially if we're looking at, you know, for partners in mycoplasma, or partners of gonorrhoea, can we use Ciprofloxacin to treat them or not? Are… You know, there's lots of really interesting things that we could do, and do well.

Reference 8 - 1.15% Coverage

We can manage that. But that was, that'd be… The issue is making sure that it all fits, you know, and how do we, you know, how do we track the samples, and you know, you know, just the logistics of it. You know, we'll just be sending less samples to the lab. Maybe initially we wouldn't as we're testing it. But you know, eventually we'd be sending less samples to the lab. And certainly if we manage to double the number of partners we see. So if we did get, say 700 or 900 partners in a month through the system, then we're currently sending, was it 1400? We're sending about 5000 a month to them. So if we got more partners in, we'd… You know, they'd see a fifth and a drop of the line.

Reference 1 - 4.33% Coverage

So there's lots with digital healthcare that we could do, which can make it more efficient and basically make it more patient-centred but not dependent on the service but actually to empower patients to look after themselves. So when you talk about service evaluations, as part of NHS clinic, what we are expected to do is to review how we run our services against national standards of care and make sure that we are meeting the standards.

But actually, we want to do more than that, so we've moved away from what we used to do as audits, which is kind of saying, how do you do next to a national standard. We actually say, how can we give the best care that we can and making sure that we are above the minimum standard? So rather than aspiring to the national standards, we want to say, we want to outperform those and basically have a service that is sustainable.

So obviously, we want to provide the same standards of care throughout whenever we're open. So it doesn't matter when a patient accesses us that they would get the same level of service, whether it's a weekday evening or weekend, the people get the care that they need. And so we have a program of quality improvement, which basically is looking at making sure that we deliver on the standards but then defining for our service what our aspirations are and how we can aim for seeing more patients have better quality of care and improve both staff and patient experience of that patient encounter and the patient journey throughout.

00:05:20

So that's what we try to strive to do. It is difficult, but we do have a program that's looking at doing that, and basically looking at it as a long-term thing, a marathon, and not a race. So it's not just take something off and then say, look, we've done this and not sustain that. We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

So you're basically trying to do it with a goal post that’s changing all the time. So what you need to do and what you are expected to do, it's what was an extra last year might be an expected basic minimum next year, and then say, how do you do that, and looking at what priorities are, looking at what priorities are within our control to adopt and what are imposed on us.

Reference 2 - 0.12% Coverage

R So that means adopting new technologies as well into service.

P

Reference 3 - 2.82% Coverage

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

And so that's where you're having a higher management team throughout the structure, which is looking at the longer picture, saying that you have all these things, you have contingency plans for the [unclear] of the system where things change. But you know that your commissioning is not going to change dramatically. So you only know that you're considered at risk because we are an at-risk department financially because we have a lot of performance targets, which are unrealistic.

And it’s unguaranteed money, which can change at any time, which basically means that you need to look at how you can get with things, but they're always [unclear]. And if you can get research to take on a large proportion of your routine work, it's paid for by research. It basically means that you make your target. At least that's a good mix, good [unclear] sense to look at that. But it also means that you have real world implementation science, I think, is the way forward, especially with new technologies.

00:29:46

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it.

Reference 1 - 1.49% Coverage

As I said, my job is to make sure that all of these various elements work together in a way that forms a partnership rather than what would be a traditional subcontract, even though it is a subcontract, because what we hope to achieve is a transformation of sexual health services so we move from dependency on services, dependency on clinicians, to more of a model that promotes independence and self-management, a model which actively removes stigma.

Reference 2 - 3.35% Coverage

Lots of sexual health services talk about removing stigma, but when it comes to working in isolation, sexual health services have been the worst for working in isolation. Generally speaking, they’ve almost presented a preciousness around information sharing and sensitivity of service, which has probably been to the detriment of your average person attending because there’s been very little connection with other services.

We’re very much into bringing sexual health services out of that age of isolation and into the mainstream, because the reality is if it’s not put into the mainstream, you’re never going to get rid of the stigma. We’ve got a common vision, we’ve got shared values, and we’ve got principles that the partnership works on, and they’re our foundations for how we move the service forward.

It is quite tough because you are talking about services and operational staff within those services that have worked in these more traditional ways in the past, and change isn’t easy for any clinical group.

Reference 3 - 4.06% Coverage

P One of our principles within our service development model and service delivery model is using technologies where possible to further our aspirations around self-management and around reducing process steps and creating simplicity in sexual health services. It does come down to we have got financial obligations to meet, such as making sure we’re… I said we wouldn’t get interrupted; apologies.

R It’s okay.

P I’ve said we’ve got our obligations around breaking even, and there are elements around how technology can streamline services, simplify services, and reduce process steps, which we feel, and people, service users we work with, have suggested as well that reducing steps in any process is desirable. We look to technology and the implementation of new technology to make things simpler and quicker and hopefully increase quality, and that’s one of our guiding principles.

00:06:24

We moved onto our online testing using online triage methods linking to test requests. Help for home sampling was very much linked to our principle of adopting technology to support with the pathway. The difficulty that we do experience with this is that quite often, the immediate response is, you’re taking my job away by doing that.

Reference 1 - 8.63% Coverage

The service changes that we’ve actually made with the new contracts and stuff, I think have made people be prepared to change their practices. Because people had maybe got a bit stale in the past and having new contracts and stuff and moving forward has made people change their practices and look at things in a different way, and just what we’re doing and how we do things.

R And when were those contracts changed?

P April 2016, it started.

R And what was the difference, could you just briefly explain to me how that change and why? What was... ?

P Some of us obviously said this is a great step that’s now being joined up as to one service, whereas say in the past we didn’t have any online testing which we do now with being teamed with SH24. So there’s online testing available which wasn’t available before. In the past the consultants really wanted everybody to be examined, whereas now we only examine people with symptoms.

00:26:41

If somebody is asymptomatic they see a support worker and a support worker does an asymptomatic screen, so they don’t even have to see anybody clinical. So just general move forwards in the right direction, looking at patients been able to take some steering responsibilities for their own sexual health needs by steering them to online has benefit appropriate. So it’s a general shift into, that not everything has to be doctor-driven, we’ve got mainly nurse services.

We do adopt here but not as often as there ever used to be. We don’t have a consultant on premises, our consultant is based in [clinic]. Like I say, support workers are stating a bigger role in seeing patients. So just general shift in a positive way, what we think is the positive way.

Reference 1 - 15.23% Coverage

From my perspective, [name] service is in a whole period of transformation. And we’re collaborating with all potential providers of services and looking at how we can change service delivery, make it more accessible for patients, and that is a huge challenge.

00:01:50

R Is this something recent? Those changes?

P Well, we had a contract offer that was offered for sexual health services for an integrated service. We put a contract offer out for that which recently failed. We had absolutely no bids for that contract at all. And that means now we have direct award with our current provider. Which isn’t a problem because they provide really adequate services. More than adequate, they provide excellent services.

But we are in financial constraints because obviously everybody has to save money, and the council, in particular, has to save money, and we can’t afford what we used to afford. So, anything that means that we’re reducing or saving money and stopping unnecessary or unneeded attendance to expensive clinics is welcome within our services and our service redesign.

R What does that mean for people working with patients in clinics, and for patients?

P Well, for patients it means, hopefully, that they don’t actually see very much difference. It might mean that they may be seen by a different person in their GP practice. Because we’re in a situation at the moment with our GPs that many don’t have sexual health practitioners who are qualified to fit coils, for example, or implants. So, some are contracting with our specialist service, so they may go in and do that. But patients should not see any difference.

00:03:44

We’ve got community pharmacies who offer emergency hormonal contraception and chlamydia treatments. We’ve got a good community service.

It just means that behind the scenes things are done slightly different. So, we’ve really got the patient going to the right place at the right time to see the right person. Rather than everybody just going to the Sexual Health Service for absolutely everything, so it could be delivered somewhere else.

An example of that is, repeat prescriptions for the pill, which actually, GPs are paid to do that in their core funding that they receive from government. We’re actually double paying for that because the Sexual Health Service were actually picking the whole tab up nearly for that. So, they were getting a bit of a freebie on that one. So, we’ve stopped that. Ladies are having to go back to their GP for initial and repeat prescriptions.

So, behind the scenes, lots of things have been changing but hopefully the patient isn’t seeing too much disruption at all. We haven’t, at any time, stopped any services at all. We’ve just made them delivered in a different way.

Reference 1 - 3.83% Coverage

We’re currently, I’m not sure whether you’re aware, we should have been moving into a brand new build which was delayed because of the contractors that were working have been... went into liquidation or whatever the word is.

So, I think what the plan was we were going to move department. And when we moved we were then going to look at a totally different new timetable, maybe different ways of working. So, we were going to use that to enable us to look at different ways of working, that now is on hold. But with the leadership team are still trying to implement some things that we can whilst we’re still in the current environment that we’re in.

Interpersonal relationships

Reference 1 - 1.87% Coverage

That's another thing, it's about, you know, everybody seems to want to contribute something, and you know, there's the problem about, you know, being in the sort of perpetual sort of revolving door of… Of asking people too, you know, what's their opinion, and you know, can they think of any barriers? You know, people always can. The answer is they always can. So there's someone who can say no, or maybe, and then it puts it… The project on hold for yet another week, month, year.

So unfortunately we tend to… We're a bit paralysed by the sort of consensual process, you know. And at times it's just a case of saying to people, look, I know it's not perfect, we're just going to do it, and we're going to do it for this time period, and then we're going to evaluate it. And we can either say yes or no going forward.

00:15:45

And then I… It kind of upsets people, that approach. But the reality is, nothing happens otherwise, you know. You end up surrounded by people who want to get the perfect, you know, the perfect scenario before you launch into a new project, or… And then what happens is, nothing happens.

Reference 2 - 0.96% Coverage

Well, yes, that is the challenge of any projects. This, you know… You won't take everybody on board with you. You know there's always the laggards who have got, you know… Usually vociferous laggards are the enemy of any development, to be honest. But they exist, and you just have to deal with them. But there, the thing is, the frame that we've put around all the changes that we've brought in the last five years is that we need to keep on developing things. We don't know what's… What, what's going to work, but we all give everything a go, you know, as safely as possible.

Reference 3 - 3.01% Coverage

So the main time my staff come together is a Wednesday morning. Okay, and the Wednesday mornings I ran teaching and training, but also a chance to talk about new things.

R Yes.

P Okay. And they are important times, because people get to see the department's moving forward, it gives a chance for people to air, you know, their gripes. You know, some people, you know, are very articulate about that. Other people, you know, they tell you quietly, and then you raise it on their behalf. But it's a good opportunity for people to sort of thrash out problems.

00:26:03

We have… So that's all the department. We have all the senior doctors meeting at least once a month on a Wednesday. We have a research meeting every two weeks now, myself and the tutor. We… But before every clinic, we also have a synchronisation meeting where everybody turns up, we talk about how many people are there, how many patients we can see, what research studies we're doing, what stock issues we have, what training needs we have. And that happens before every single clinic. And that's been the case for the last six years.

And the beauty of that is you, you know, everybody's on the same page at the beginning of the clinic. Instead of, you know, strolling in, and you know, not really understanding what the focus is. And so yes, we… That's just a straight rip and burn from a talk of one day's checklist manifesto, you know. Just making sure you know what your aim is, and what you're trying to see. So you know, it's no surprise then that we got so many trial patients coming through the door, or so many women for an IUD, or whatever. So that's the purpose of those meetings. But they also become good places for people to articulate problems, and then we can then collectively come to the Wednesday morning meetings.

Reference 4 - 0.90% Coverage

Our department's got a good relationship with the directorate. Mainly because before we were bringing in money, and not losing money, of course since we've been cut, we've been bailed out recently by the trust for a short, small amount of time. We'll see how long that will last. But essentially they know we add value. We're, you know, we're part of the STP, in terms of, you know, public health agenda. You know, we are an important service, and we have the HIV prevalence in the UK in our, you know, in our two boroughs. So they get it.

Reference 5 - 0.60% Coverage

You know, the relationships, you build them over time, and people realise that, you know, you're doing the best you can, or you're trying to push things forward, and you know, for the patients. And I think, yes, that's what's appreciated by, you know, the people who are our direct managers, and then trust itself. But it takes a while to get to that point.

Reference 1 - 0.85% Coverage

Yes. So you just said that it is very important to have everyone engaged, and it is an on-going process. So who do you collaborate with daily?

00:07:08

P So the core body of the work is with the clinic staff. So that's the doctors, nurses, and health care assistants and health advisers on the floor and reception and administrative teams. And that's when we collaborate with working together for daily running. But we also have people who have other supportive roles within the team.

Reference 2 - 1.70% Coverage

New technologies, new perspectives, new ways of working, evolving rules of staff groups to react rather than say, this is a doctor role, this is a nurse role, and this is a health care assistant role. It's kind of saying this is a team role. Everyone with the skills can do this. And basically, nobody is higher than anybody else. Everybody works together. And we're saying that it's about the patient rather than about my goals, what I'm going to be, that there would be a hierarchy, you would need that to run things.

00:10:57

But that hierarchy is a responsibility rather than power. So it's not to make anybody feel disempowered. But the thing is that, I have responsibility, so I have the duty to look after this and support everybody else as a consultant on the floor. And then the next person with the higher responsibility would have the duty for everybody else who has less responsibility than them. So having that supervisory, making it more supportive.

Reference 3 - 0.54% Coverage

I think that you have a management team that is receptive to change, which allows quite a lot. We are talking about a model that we have testing in-house, in-clinic testing. And we're just working out how we can implement that. So from that point of view, yes, I would say, in a very supportive environment.

Reference 4 - 0.53% Coverage

Nobody actually tells you that you will deliver it in this way. They'll tell you what you need to deliver. And it's up to you how you are going to deliver that. It is a lot of work to implement change, to look at new technologies and how you're going to implement them and nobody else has done it before.

Reference 5 - 1.09% Coverage

Yes. But also, the thing is that you can be creative about saying the lab has oversight of those testing. They are in charge of the ordering and everything. So basically, they could get the thing and charge us purchase. So basically then, they can get something that is doable, get a business plan. So it's basically seeing that we get a business plan that is feasible for both us and them. And you have support from the higher up, from the organization, which basically means that you have the power to basically tell the lab, if you don’t do this, the organization supports us in doing this and you're going to get that.

Reference 1 - 1.90% Coverage

P Yes. So, within the clinic, we, you know, there is… The model is that you would have, you know, a couple of doctors. A couple of senior nurses. A couple of junior nurses. At least one health advisor. And a healthcare assistant. So, everybody kind of doing their own things in the context of the clinic, but there to do our own specialities, really. So, we do work quite closely alongside all of them. Yes.

We also are very much connected to the results administration team. So, the team that does all the calling people with their results and sending out text messages. So, we do… We help with that quite a bit. Yes.

Reference 2 - 2.37% Coverage

You know, on my team we have team meetings every week. So, we are always… I try to keep the kind of environment where people would feel like they can make suggestions about. That… What usually comes out of that is new processes rather than new technology necessarily.

It would be nice to have people. You know, people who are kind of working at the clinic level, coming to us and saying, hey, I’ve got a great idea about a new test to use. But most people aren’t quite. They are just kind of doing the day to day work. Wouldn’t necessarily know about what technology is out there. But I like to think that there is a pretty open environment for encouraging people to come forward with, hey, here is an idea. So, yes.

R So, it’s really a very democratic process.

P Yes.

Reference 1 - 1.87% Coverage

And thing is as well, everything falls on your shoulders, but then you're still liaising with your managers to see where you are. And then they're feeding back to, like, their managers, because there's a chain isn't there? So… But on the ground level, everything's fine, and they're confident, no problems.

R Right.

00:07:38

P And I'm always fed back, there's no problems. Or if there was a problem with, like, the printing, and then you've got, like, IT, they will come out and try to fix what's… Because I'm not technical, so I don't know that side of things. So that circumstance is beyond my control. But at least I'm liaising, and having these telephone calls, testing there and then, running from room to room. It was, like, a lot of work, but I enjoyed it. And it was a learning process as well. So I think when you get something else, you remember what you did previously, and then it makes it even more easier. That's how I find things. So…

Reference 2 - 0.68% Coverage

So, it was good to, like, no, no blame culture. Everybody was still being supported, because even the clinicians, some of them weren't coding, or they weren't clicking on the right thing, or missing something. So everybody was in the same position, because we were just learning, it was just about support. So… Which I thought was quite good.

Reference 3 - 2.64% Coverage

We all get together as a team to discuss it. But the deputy general manager, service manager, obviously the general manager, but the service manager will lead on it. And then will feedback to the deputy general manager. But we all get together as a team, and discuss what's our business planning for the year. And it goes… Goes quite well, because I think the service manager shares the office with the other service managers within the, like, directorate. And then obviously they can all bounce off each other, and see where they're at. But, you know, I think they have little competitions going. So it's quite good to know that, you know, what… You obviously like your plan is the best, and like… Because when it's sent up…

R Yes.

P To be evaluated, or checked, or whatever. And then, you know, if there's a few comments, then it's good. But if there's lots of comments, then, you know, if there's less then it means you're on the right path. So… And then obviously it's got to get signed off. So, yes. And there, again there's a deadline for that. So it's important that everybody… You know, because we have a set agenda to discuss certain things. And then if that's on it, you know, we might spend a bit more extra time on that for that day, so that it's signed off. So… I think we've got a really good team, actually, quite supportive.

Reference 4 - 0.74% Coverage

But you just send up your items if you've got anything to discuss, or any other business. And everybody's listening too. And it's not to… And you know, and like, sometimes we, like, we have a laugh and a joke. It isn't… Nothing's ever taken, like, seriously. And so you can see everybody's quite like close knit, and you know, quite supportive of each other, which is good.

Reference 5 - 6.05% Coverage

R Then you keep people, you support people…

P Yes.

R At each step. But you also keep the paperwork organised.

P Yes.

00:40:54

R How all those details are actually important for the success, right…

P That's the thing, yes.

R Of the project.

P Definitely, because if… The reason why I say that is because a patient might come up after two hours, oh could you tell me where you are in the queue? And then you're looking on the system, and you can't see them. And that's because their paperwork's gone astray somewhere. And it can…

R Yes.

P You know, because imagine, you're taking back, say 60 registration forms. So you need… Everything needs to… You need to have a plan. And you need to communicate. You can't have one person, oh I'm taking that registration form, or somebody else. No, you have, like, you know.

R Yes.

P So that's why. And it does work. So every morning, right, what do you want to do today? Do you want to hand back? Do you want to take out? I don't mind. I'm like, everybody's like laughing and joking. And so, you know. And then I say, if you need me, I'm upstairs. Because then you'll get somebody who's with a patient, and want to complain about something, or somebody on the phone that's not happy about something.

00:41:48

So, you know, to keep the clinic running smoothly, I will say I will deal that. When you get the patient that comes out, and they're very angry with the clinician, because they didn't get what they want, and they're shouting at the front of reception. I will come down, introduce myself, would you like to come this way? So that this reception is kept, like, flowing. Because there's nothing worse than you having that patient who's at reception, they're shouting, and then you can't call the next patient, because he's being disruptive. So that… Or if I hear shouting, I quickly come downstairs. Just because I don't want to sort of like just take over, because sometimes they're handling it fine. And I would just add fuel to the anger. But I just wait for them to…

R Yes, just be there in case.

P Just… Yes, just in case, yes. So…

R Yes.

P You know, and then they… They like that, because you know, I have feedback to say, oh you know we… I said my name, sorry. We wouldn't… We would, you know… We know you're in quite a senior role, but you're really hands on, and you know. And I said, well, I've worked my way up, so it's not that, you know, I… What's the saying? Do what you expect someone else to do.

00:42:58

R Yes.

P No, what was it? I wouldn't do something that I wouldn't expect somebody else to do.

R Yes, yes, yes.

P Yes. I said, oh no, no. I said, this is… I'm a people person, I'm there to support everybody. And even the nurses as well. Or even the clinicians. Anybody, if there's… They're having problems with something, I'll… We know you're busy. I say, no, no, no, come on. That's, you know, go in the room, what's happened? You know, if they're having a slight issue with their computer, or… You know, I help them. So, no, it doesn't matter who it is, I'm always there for everyone. So…

Reference 1 - 4.00% Coverage

P Yes. I feel like, at the sister role, you’re that gatepost between, so you’ve got the people on the floor, who are just getting on and doing the job, you’re not high up in management, you’re not actually making the key decisions. And actually, during the consultation, the three sisters, we weren’t a part of the consultation, it was the people above us who actually planned it, implemented it, went to the meetings.

00:06:26

So, it was quite difficult, because all the staff assumed that we knew exactly what was going on, but actually we weren’t in any of the meetings at all, we weren’t part of any of the decision-making, and often we were told things not particularly long before the staff were told things. But yes, I think generally as a sister you’re in that role between… like, you’re sort of on the floor still, more than any other manager, but then obviously you do go to some meetings, and know about things, and you do line-manning stuff, so you’re sort of that channel, I think, between the two. So, it’s an interesting role, I think.

Reference 2 - 2.90% Coverage

If it’s a very big change, it probably does involve the directorate management team as well, but I suppose that’s a bit more in the background to most staff, they maybe don’t know that actually that has gone through the directorate management team, they have signed that off, and now that’s why it’s being implemented. I don’t think people always understand that, or they’re not told that that’s the process.

00:08:37

Like, I know the clinical lead wants to bring in a change to appointments, so he’s already written a business case, which has already been read by the DMT, so there is a process. But I think if it’s just kind of, not such a big change, it doesn’t have to involve them all the time, so then I think it probably would just be those three people.

Reference 3 - 4.16% Coverage

P Yes, and we have an operational group that meets every, sort of bi-monthly, so any sort of operational idea will be discussed there. And I guess that’s meant to be where you sort of thrash out ideas, and you have your say if you think something… and it might be, this is a good idea, but we haven’t thought about this and that.

00:09:59

And also, I think it depends who brings the idea, because people know their own team, or their own… you know, if you’re a doctor, or if you’re a nurse, there’s always going to be that slight breakdown where, you’re not a nurse, you don’t understand fully what it is to be a nurse, and how they work.

So, that’s where we’d come in and say, actually, that wouldn’t work for our team, because of this – so, it’s not that it’s a bad idea, but at the moment, in that format, it won’t work, we need to look at something else. I think it’s quite a good meeting, because there’s a representative of every sort of staff group in this department, so the nurses, the doctors, the health providers, and the admin, are all represented in that meeting, which is good.

Reference 1 - 8.56% Coverage

R And so from your descriptions I'm getting this idea that all those implementations that involved everyone sort of, I just have this image. But who are the key decision makers would you say?

P What do you mean by key decision makers, in any changes or any…?

R So for example, if there was a new diagnostic test to be implemented in the clinic, who are the people that are likely to introduce an idea like that? And then who is more invested?

00:13:13

P I think that is, you have to come to the idea [?]. [Name of the company] actually, I work for [name of the company], not that I work for [name of the company] but [name of the company] is the organisation that provides sexual health service across [name of the area]. So I think you need to speak to those key people in [name of the company].

R So those people are more likely to introduce [overtalking].

P Yes, exactly. And I think you need to get involved with our clinical lead as well, and so clinical lead will give the input to the decision makers.

R And then the final decision whereas to implement it or not let's say after the period of a service evaluation, is it also [name of the company] and clinically…?

P Yes.

R But the collaboration with [name of the company], that's quite recent, relatively recent?

P Sorry?

R So what I'm saying is that your collaboration with [name of the company] that's relatively recent, is that right?

P No, not really because the service changed, so we were with the [name] Hospital. [name] Hospital is still part of it but then the service went out to tender [?] going on [?] three years ago and then [name of the company] took over, so we have been with [name of the company] for three years now.

Reference 2 - 1.82% Coverage

R And what about interpersonal relationships within the service, are they important, would you say?

P I think so, yes.

R Do they play a part?

P Yes, certainly.

00:18:38

R Is this something that has to be improved or is it something that's already being supported?

P I think we have very good interpersonal relationships, so I don't think it's an issue.

Reference 1 - 2.34% Coverage

P Yes. The process was supported because there was a big strong case for it. And I think the fact that also there was a very close working relationship networking between the key drivers, myself and microbiologist, that was very supportive, so that if there’s a stumbling block in the microbiology department, like they would push it and get it sorted. If there was stumbling block on my side, I would get it sorted. So you need all the stakeholders to acknowledge and to accept that it’s an important thing and that we work on it. So I think that was the most important thing to get it on the ground.

Reference 1 - 7.53% Coverage

R I see. And you’ve also described the restructuring and reorganisation of the services that was quite recent. Do you think that made it easier for technologies to be introduced or…?

P I don’t really know. I think it was interesting, because when we brought this service together in April 2016, it was five different teams all working in different ways, and we had very vocal people saying self-management was wrong, that everyone should be coming to see somebody face to face because that’s only where the quality lies, that by bringing in technologies, you’re potentially bringing in technologies that don’t involve…

00:10:48

That allow self-management, bringing in technologies that move away from not necessarily human oversight but human delivery is reducing quality, is increasing risk. And that was a challenge. Least of all, to me, one of the biggest challenges about all of this is there’s still this idea, there was always this idea, that clinician knows best, and what I used to have remind people of was that you had a whole cohort of people out there that heard stories, whether they be true or not, about sexual health services that were making make them think, I’m never going to that even if I do have a problem.

You must know the myths about sexual health services. Some people describe them almost like entering in for voluntary torture, and if you’ve got that hanging over your head, then I don’t know, I couldn’t live with myself as a service if the average person said, well, when you go to that service you get an inverted umbrella pushed down your penis. And I’m not exaggerating by saying that that’s a common myth. Albeit it’s a myth, it still needs transforming.

And this is where self-management and using technology to support self-management would hopefully just through example and experience dispel some of these myths. In answer to your question, I think the restructure gave us a great opportunity. I think it’s also probably made it easier to introduce technologies because we were not starting from scratch but we were rebuilding the foundation and we were clear with the vision, we were clear with the principles surrounding that vision, and we were clear with the process of how we were going to review what was going on, on those principles.

Reference 2 - 6.32% Coverage

P Yes. I think the status quo can be an obstacle as well. I think the medical establishment can be an obstacle. I think there are power plays that come into the introduction of technology. People like to maintain their own power, and sometimes technology liberates others. And to some people that’s good, to others in positions of specific power, then it doesn’t. I think it’s an important area to consider.

00:32:38

R Could you give me an example of that?

P Yes, I will give you an example. If you were to not bring about technologies that supported self-management, you’d still get the queues at the door. You get the queues at the door, you maintain your need, you maintain your power. And as far as I’m concerned, I’ve always worked in healthcare from the point of view of I’m trying to work myself out of a job. I’d love it if everyone was so public health orientated, so responsible, so lifestyle conscious that they would never need any help or they’d always manage their health. I’d love that.

I know it’s never going to happen, but if I always keep that in mind, I think I’m probably going in the right direction. The time that always frightens me is when clinicians feel they need to be clinicians because what would they do without me? I think it’s a very, very dangerous position for any clinician to be in, because people aren’t passive recipients of care, they’ve always got a say and they’ve always got a part to play in their own recovery. I don’t want to work with people… As far as I’m concerned, if someone isn’t going to play a part in their own recovery, you’re probably fighting a losing battle.

And I’ll say that for everyone: everything from palliative care all the way through to neonatal care, it always has to involve recognising the power and the potential of the person you’re working with. And I think there is that element, that the status quo is, I think, quite important.

Reference 1 - 11.91% Coverage

R And in your opinion, who are the key stakeholders? Who’s more likely to introduce a new idea and then who’s more likely to take charge of adopting it?

P So probably our contract managers ultimately, which would probably be the keepers or the drivers for these obviously came from him. So that was from, he’s the contract manager and he’d set up the contracts with the lab and this is what was needed to be able to work with the lab and stuff. So he would definitely be one of the key drivers.

But I think equally if some of the heads, some think that they wanted to bring to the table for everybody, then we would take it to our strategy group meeting and we would present it and then everybody would be able to give their opinion as to what they thought. We’re quite democratic as a whole.

R So who’s a part of those meetings?

P Who is?

R Yes. Who can come to those meetings?

00:06:21

P So it’s obviously quality assurance from [company], there’s contract leads and all the integrated sexual health team leads, practice and development team, safeguarding and sexual preventions, there’s the medicines management, the consultants and our partners as well, so [name], [name] and stuff like that. So our partners come through as well.

R Well, that’s a lot of people coming from different potential perspectives, right?

P Yes, different perspectives and stuff. So it may be that if it’s not relevant to everybody then you would have a sub-meeting afterwards or just, but it would be introduced. If it was something that needed to be introduced to majority of people, that would be the first forum for introducing it to people and get people’s thoughts and feedbacks and ideas.

R Having so many different perspectives of people coming from different departments, do you think it helps or it may actually?

P Not always.

R So why is that?

P Just because everybody has got different ideas as to what’s going on. Some people don’t understand an awful lot about the actual clinical processes or about patient journey. So for them something from... It’s harder for them to get to groups with what we’re talking about because they don’t have that knowledge base and stuff that goes with it. So it’s just a case of trying to help people to understand what the processes are and how maybe something new is going to improve that process.

Reference 1 - 5.40% Coverage

You can normally pick out the people who have more resistance, and then actually work out what their issues are and why they're challenged by it. And especially if you've got enough lead in time, actually, you can usually work around what the barriers are, particularly if you got a well-developed referral pathway and why you're doing something is quite clear and is to an advantage to the patient or the clinic, then actually I would be very surprised if you can get people to actually buy into it in terms of...

R So they would be working with individuals and spending time...

P Well, people who may find it less easy to understand the advantages, yes.

R Would you be the person to do this?

00:19:39

P It would depend on who they were, and if it was a doctor, then probably yes. If it was, for example, a health care assistant, then I would probably get one of the nurses who was closer to them, so a less threatening person, someone who already sees the value of it to talk them through to it. And with introducing the order comms, we've done a cascade thing. So myself and [name] sorted out the doctors and the senior nurses, and then the nurses sorted out their more junior nurses.

So there's been very much a team approach and everybody helping each other to do it, working through it.

Reference 1 - 4.71% Coverage

R So if there is a disagreement during meeting and people, then you would consider, for example…

P I think we would discuss it just to make sure what the issues were. Yes. And I think even when we brought out the previous point-of-care tests there were still a few concerns about that, which I think is good. Because it means that we are considering it and are thinking about it. And you bring it to the table and discuss it and say actually, is that a real concern or is that not a real concern? Or is that a misinterpretation of something, or the concerns that they have, how large would that actually be in reality? So I think that’s one of the things…

And with this particular test it is going to be just like our HIV point-of-care test that we select a population of patients that have it, rather than everybody having it. So, yes, it is important to hear what people’s concerns are about, you know, either the group that you’re selecting or otherwise. And there’s always going to be a group of people who ask for it, that you don’t think necessarily would be suitable perhaps or that you think not necessarily will be able to have it. So that’s always an issue about how you deal with that as well, within the clinics, so that’s always good to discuss that beforehand.

Reference 1 - 4.82% Coverage

P Yes. So obviously, all staff can't attend the meetings, and so whatever is discussed at the meetings then get discussed at more general meetings, like we hold regular nurses' meetings. So if anything particular that's discussed at the SDU meeting, then that's a good opportunity to discuss it then and just keep people updated. And also, the SDU leader's very good at communicating via email. She does a monthly newsletter, which she pings out to all members of staff, including reception, just to keep them updated on what's going on, what's being discussed, what we're looking at, you know, the future plans, that kind of thing. So everyone is kept up to date with what's going on.

Reference 1 - 2.88% Coverage

So, yes, collaboratively, we do work across the board, but decision making is done… I suppose the decision making comes eventually from our finances. So, if we know we can’t afford something we say, okay, we can’t afford that, we can’t do it.

But our Director of Public Health and Associate Director of Public Health will support the decisions that are then made, or not, if they don’t want to make it. But I would say that the decisions are made collaboratively. And it’s always in the best interests of the patient.

Reference 2 - 4.99% Coverage

R Would you be able to identify the structures that are already in place that are supporting adoption of new technologies? You’re describing those collaborative processes.

P I think, across the STP… Has anyone talked to you about the STP, Sustainable Transformation Partnership?

R No.

P Maybe go and have a look at the STP for this area. There is a whole element about new technology. If we come up and say, actually, this sits with STP design, etcetera. I also work very closely with my colleagues in [name] and [name] and [name] too.

00:12:13

R So, there is a specific programme design?

P Yes. And actually, you would look for the STP.

R And these are the main things that help?

P Yes, I would be working towards that. And obviously if we decided something individually, I would then obviously, like you say, make a business case and take that to our senior management team here for a yes or a no [unclear].

Reference 1 - 3.10% Coverage

P Absolutely, I don’t think there’s any place for a unilateral decision-making. It’s a very collaborative team here, what I would always do with something new is have a high-level overview of what is this? Why are we bringing this in to the service? What are we hoping to get and to do differently? Is it cost-saving? Is this a service improvement? Is this to do with patient satisfaction? Is this driven by legislation? I would hopefully be able to bring to my colleagues a clear, succinct summary; why are we doing this? And then get them on board with it; we’re doing this because… And they can see why it makes sense to be doing what we’re doing.

Reference 2 - 5.03% Coverage

Are there any people within the clinics that are likely to introduce new ideas?

00:07:33

P We have the sort of team where we welcome new ideas and creative thinking. We would, in the clinical staff, if any of the staff at whatever grade level comes up and says hey everybody look at this or I went to a conference and I saw that or I was at study day and I’ve taken home this information. There’s a very free forum for discussion and it’s a supportive one and it’s very equal opportunity, everyone has the opportunity to share their advice or information or their interest in something new.

It wouldn’t always be head-down. Some things are, that’s the nature of stuff, a senior nurse in the hospital says we’re going to be doing this and this is the new policy on that and that’s what we’re doing. When it comes to the local service, what we’re doing, how we work, changing hours, changing clinic times, something as simple as that, then it could be any member of staff that says I’m thinking we might want to try this, what does everyone else think?

Reference 3 - 2.52% Coverage

And I think the relationships within the team are useful and create a beneficial working environment. I know things constantly change but I think there’s… I think if you start with the mindset it’s changing, it’s all terrible, then you probably will find yourself becoming very miserable, very quickly. But if you can say, things will change, how can we respond in a useful way to these changes? How can we be creative with what we’ve been given? How can we make the most of what we’ve got? That, I think is a helpful mindset.

Reference 1 - 1.08% Coverage

As I mentioned, we have a very good relationship with our commissioners who actually would look to us as the experts in the field, so to speak, to actually advise them what we think is going to make sure that it’s a quality service.

Reference 2 - 4.00% Coverage

speak.

R So you have those established styles of communication and the relationship with…

P Yes very much so, I meet with the commissioners on a regular basis to look at service development, usually at least once a month. And they would… Yes, so we have got very good communication levels with them. I suppose the other stakeholders ultimately if we wanted to roll this out wider, would be the GPs and even potentially the pharmacies. And we already have got those links to them through various mechanisms really, but there are pharmacies that we work really closely with in as much as that they already provide treatment for Chlamydia. And also we work closely with them through training and looking at sort of updating PTDs and things like that with them. So we’ve already got those channels in place to actually link with them in the event of needing to.

Reference 1 - 2.35% Coverage

R I see. And what about social facilitators? Would you say that the social relationship within the services help or create barriers?

P We don’t have any involvement in that because we are purely contracted to provide a service. How we choose to provide it is a decision within this organisation. Provided we deliver on the quality of the results and the turnaround time, we wouldn’t… that wouldn’t be something that we would have that much engagement with outside.

Reference 1 - 2.28% Coverage

P So I think the communication thing is important, but I think it’s also nice to avoid just a top-down approach. So I think it’s, what often can happen is the consultants, for example, might be more aware than other staff of new guidelines or new technologies and say, we really want this for our clinic. But sometimes changes are driven from other staff members, so from out nursing staff for example.

And I think that’s really, really positive to getting things introduced. So I think even if, depending on where the idea comes from, but if the idea comes from a nurse, that’s really positive. But if not, having a nurse then champion, is really helpful. So I think having an open atmosphere where all staff feel they can come up with ideas and identify potential new opportunities, it’s really important.

Reference 2 - 0.56% Coverage

And I think to do that you really need to involve all members of staff in delivering your, for example, your education programme and your meetings, so that everybody’s got a voice and it up to date.

Reference 1 - 2.10% Coverage

P Yes, so what I’d go with, senior management team would be consultants, lead nurse, a select senior experienced nurses who kind of are opinion leaders. So, where one goes, the others follow. And that tends to be quite a core team. The admin staff as well, and the analysts within the team. If it’s IT related, they have to manage different data, or…

But normally, it comes from the senior consultant leadership team to say, look, well, we want to do this, we want to move this forward. So that’s where the actual impetus for a project comes from.

Reference 2 - 9.87% Coverage

And then it’s the implementation, is getting people outside the department on board with it, especially if it’s seen as a threat to what they do already. And nearly every… if you’re kind of going down a different EPR routes to the trust, it’s seen as a threat to the people who ware instigating generally the [unclear] in the trust. If you’re going with a different test, that’s seen as a threat to people in the lab who are already doing the tests.

So, there’s lots of ways it can be sort of slowed down and blocked if you don’t have the right people onside. So, a really good example would be an HIV point of care test that we use. So, we use a fourth generation Alere test, which is fine, we’ve come to realise that all commercial point of care tests are actually, the way we use them, we could use any one of them really. So, it’s actually far better if we used something like an INSTI, which is cheaper, and you get the result quicker.

Now, for reasons unknown, they’re not here anymore, but there was a laboratory point of care test lead, who… so wasn’t in the department, but had overall responsibility in the trust. They just said, no, the clinicians wanted to go and change this point of care test, but they basically said no, and we were stuck with something that we… was fine, but it was more expensive and actually didn’t add any more benefits to what we could have done with a cheaper point of care test.

00:21:37

So, it’s kind of things like that. And quite often it’s personality driven. Somebody’s had a problem with somebody else previously and they wait until the next thing comes up and are purposely obstructive. It’s… the NHS is like a big school, I think, in some degrees.

Personalities, especially people can bear a grudge sometimes, and… but it’s… yes, it’s interesting, and nearly everything… key relationship… back to the key relationship question, it’s getting people outside the department on your side to advance things, will be the… that’s the key thing where projects fail.

Convincing people within the department is not such a problem, because it either, as a clinical team, clinical management team, you say we are doing this, accept it, move on, and it happens. Or everybody saying we really want to do this, we need to change this.

So, kind of at a clinic small team level, getting changes made aren’t that big of a problem. It’s when you try and involve people in the general management or ecosystem of the trust, where everyone’s got their kind of silo working and their set agendas, and that’s where things get obstructed in my experience.

Reference 1 - 5.64% Coverage

R Yes. And it’s... Do you sometimes have to work with other people who maybe they’re less for new technologies?

00:01:16

P Yes. I will sit with them. I will, as the patient come in and we’re telling them about it, my colleagues are there with me. So they know exactly what I’m saying. So they can actually say it to them. And when I’m actually doing it with the patient and they see how simple it is, they start taking it on board. Because they realise; oh, I don’t have to do it this way anymore which is more, not as convenient. But this one’s much... But it’s re-educating people and letting them see that... They understand by example. Rather than just telling them; you have to do this. If they can see it for themselves they understand better.

R So is it you have a way of approaching them that works?

P Yes. We, I believe that you have to sit down with all staff member. Be at the forefront with them. So they’re not in the deep end of what’s happening. They can see you’re there supporting them as well. And they realise how simple and straightforward it is.

Reference 1 - 0.46% Coverage

P So if we, all of our opinions are respected, so if we found something and we proposed it, we could always have a role within that.

Reference 2 - 3.87% Coverage

R Right. So you can also take initiative and try and be a part of something even more, then it’s effective maybe

P Yes. Because if you know, if you express and interest they will jump, which is good, because if you have an interest in something they will jump on you and get you to do some work towards that. Such as when we wanted a new microscope. Then I was looking at models and brands and putting in my input there because I was one of the more senior microscopists.

00:04:00

And when we think about changing our EPR, because I’ve worked with three other systems before, my opinions have been taken into account. So I think if you know enough and you do use your initiative, they will use it.

R Right. And that, when we say they will use it, it’s clinical leads or commissioners?

P So it would be the matrons, the lead nurse, the lead consultants and the people involved in that. So, the higher up nurses as well.

R Right.

P So they do look at that and think, who can, not who can we get to do the work, but who’s got an interest enough to do the work properly, to make it a bit more evenly distributed.

Reference 3 - 1.11% Coverage

P Yes. There’s still this thing between doctors and nurses that doctors get a lot of training, and they get particular leave for training whereas we have to fight a little bit more for training. So I’ve paid for a few things myself. Because it’s just easier. Unfortunately. So there’s bringing up money and study leave.

Reference 4 - 4.75% Coverage

P Just trying to think. So I mean, we do have a, within the top, there’s always ways to feed back. So there’s always an on-list to your, not an on-list, to your matron, there’s feedback. We’re doing a consultation at the moment, so we’re all being asked to email in our views and then that’s being taken further up. But that’s already gone through commissioners and has come back to us to then go back to commissioners.

It, yes, I’m just trying to think. Yes. I’m just want to think what’s actually in place. We do our, we try and do monthly staff meetings. So, and anything urgent, they put in an urgent, all-staff meeting which is where everyone can share.

00:12:16

R So everyone goes to those meetings.

P Yes, everyone should. Everyone’s invited. So we’re all invited, whether people go or not, that’s their own decision. And we have had them before when it’s just been for nurses, just for healthcare assistants because it’s about them. And then, when you’re talking about the actual way the clinic runs on a daily basis, at the beginning of the clinic we have what we call a take-five.

So if something has changed we can feed that back. Such as if we’re changing our first line UTI treatment, we can feed that back at that meeting, that little collection of people as well as updating all the guidance on the shared drive. So that’s a daily thing that happens.

Reference 1 - 0.80% Coverage

PA Yes, well no, I suppose the senior management introduce the ideas but we're the ones that implement it.

Reference 2 - 1.39% Coverage

Yes, right. So we have training, we probably all have training as a collaborative as a department but if you're in charge of the clinic that day you will ensure that that is being done.

Reference 3 - 6.65% Coverage

But it's just a matter of, we have a Take Five every, before every clinical session, so we have a… We bat out what's happening… And that's when people can… But there'll always be certain people who say, I can't do it. I can't do it. I won't do it, I can't do it. And you just have to support them.

RE And how do you do that?

PA Well you just encourage them and you say right, well okay, let's see I'll do this with you or I'll work with you this morning, or let's see how that can go or take your time over that patient or… Do you know what I mean? Because we have a time limit for patients, so if we don't see them in half an hour. Some people take ten minutes to see patients, some people take an hour and it's difficult to support those ones who take longer to, kind of, get them to speed up a bit. So sometimes we work with them, we talk to their manager about it, it's just difficult.

Reference 1 - 8.46% Coverage

R And in terms of inter-personal relationships, is there something that helps or maybe speeds up?

P I think so. Because we don’t meet as often as we used to. The Point of Care team used to have a monthly meeting and since we’ve had a new manager, I’ve not been able to attend those meeting. But certainly I think we all work well together so I wouldn’t have thought that would be difficult, it’s just again, it’s timeframes you need to plan this. And often, and then previous with the last thing I implemented, we had a project manager involved too.

So of course the more people you involve, the longer this can take to implement, it seems to get a lot more drawn out and there’s all the paperwork involved with that as well that has to be inputted on too. We’ve got a cue pull system in place now. So it needs a lot of planning, put it that way. So maybe there’s somebody that I can point you towards. I’m trying to think of the name. Perhaps I’ll ask and then scribble down some names and I’ll forward your email and I’m going to CC you in, if that’s okay?

Reference 2 - 6.66% Coverage

R Yes, but this is important what you’re saying. So in a way there’s a lot of bureaucracy or there’s so many steps that you have to take but at the same time they’re already in place.

P Oh yes, we have these things in place.

R So it can make actually things easier in a way, that’s interesting.

P Yes. We have got these things in place within the various departments and it’s easier now because I suppose, we’re all working together under one roof now. So the project managers will not just be for bacteriology, they’ll work with virology, clinical, chemistry. So everybody, I suppose they know each other, know those conversations to be had which are always easier face to face, aren’t they?

R Right.

P So break down those barriers, really.

R So in a way there would be a way to do it face-to-face meetings?

P Yes, I think so.

Reference 1 - 2.85% Coverage

P We have a very close working multi-disciplinary theme which consists of doctors at all sorts of levels, consultant level, it’s a consultant led service, down to SBRs and more junior doctors below that. But we also have teams of nurse practitioners that are very experienced who basically operate as independent practitioners in the same way that our doctors do.

It’s a big team but one where everybody in spite of their background will work together to see patients and for the most part the nurses will see patients in the same way a doctor would. Did that make sense?

Pathway and services

Reference 1 - 2.41% Coverage

We have three clinics that see about 1600 patients a week. We diagnose about 1400 infections a month, and that's my main role. I do HIV clinic once a week. And what else do I do locally? Oh yes, I'm involved in SH:24 which is a home sampling service. And I'm involved with all set up SXT which is a partner notification tool. And this afternoon we're going to go through the final bits before we go live with the appointment module.

So partners are getting told they’ve been potentially exposed to an STI, and then they'll be able to book an appointment. Which means they have a full digital journey from being told to getting tested. So it's kind of exciting. So those are the things I do. In the clinic, my role is… The clinical lead role is only eight hours a week, but that's… It takes a bit more time than that, just trying to help obviously move the service forward.

00:01:20

The day to day is delivering an integrated sexual reproductive health service. And training as many staff as we can, and trying to make sure that we can get through the volume that we need to do. The clinic's run seven days a week. And we start off with a group hug in the lab at 8:20. We start seeing patients at 8:30. And then we have three clinics over the day, and we're seeing patients until seven PM every day of the week. And then on the weekend it's an 8:00 and… Two eight hour shifts on Saturday and the Sunday. So that's the service. That's what I do.

Reference 2 - 1.93% Coverage

Well we have close links to HIV Service. We have close links to Women's services, so the Colposcopy unit, the unit which does, you know, have medical gyne. The early pregnancy advisory units, urology departments. We have links with SH:24, because we look after a lot of patients who test at home. Have a reactive test, and need to be managed, all those sort of positive for gonorrhoea need to be treated.

We are… Yes, we… Those are the main links. You know, we, in terms of research, we are starting to, you know, build relationships with the rest of the other trust. So Professor [name], for example, is you know, realises that we're, you know, a big recruiter in special and [unclear] services. Yes, as a directorate, we're linked to the HIV department, the infection department, rheumatology, genetics, dermatology, so those are all within our directorate. So there are, you know, there are some links, referrals to dermatology. Rarely do we have links to, you know, or need to send patients to rheumatology. But every now and then, we do have reactive arthritis. It's not common. But the biggest pathways to HIV, we diagnose five a month at least with HIV.

Reference 3 - 0.68% Coverage

The Qudini was a queue management system, but using SMS. Seen in the commercial sector, brought from restaurants to our service, and we had loads of complaints from patients, how long they were waiting. Complaints from reception team about the behaviour of patients who were frustrated at waiting. And as soon as we brought in that system, the complaints disappeared. So we evaluated it in that respect.

Reference 4 - 0.94% Coverage

The partner notification tool we brought in through SXT, that has a real time dashboard on that. And for the first time we could see our key performance indicators in real time. And we are hitting them for the first time ever, and actually can see that in, you know, on a daily basis.

SH:24, in terms of channel shifting, that's been evaluated very heavily in terms of working with the SH:24 about channel shifting, and moving people online. And that's as part of an economics evaluation as well with X. And then we've also been moving some contraception online.

Reference 5 - 0.95% Coverage

But we evaluated all our staff, and realised that, you know, we can get patients in and out from start to finish in 40 minutes. You know, even if they just, you know, a gay man with syphilis, and, or rectal discharge, or a woman coming in for an STI screen, and IUD, or an implant, or a change. So we can get all of these patients in and out in 40 minutes. So, you know, you can then start, you know, running the clinic based on, you know, having 40 minute appointments. And then obviously if you go faster, which most of the time we do, then you can let in extra people.

Reference 6 - 2.27% Coverage

So, yes. So new to follow up, that's something that, when I came to the service, took the lead role, gosh, how many years ago is that now? It's about six and a half years, seven years. You know, we had a follow up ratio of 40%. You know, it's ridiculous. Lots of people coming back for cryo, lots of people coming back for their results, lots… You know, it's just nonsense.

So anyway, we just reconfigured all those pathways, you know, bit by bit. So women coming back for repeat pills, they get a year as per faculty guidance. People coming in with any genital warts, they go onto topical treatments, you know, you know, if they go through one, and you know, the two topical forms before they end up on cryo. So that we, you know, we just make sure that we default to good practices that release capacity in the service. And now we're like point, what's it? Well it's about 15, 18% are follow ups now. So we've halved that.

00:23:41

And we… And the reason why our follow ups are so high is because we diagnose so many infections, and bring people back. But clearly, if we could diagnose people on the day, then we wouldn't need to bring them back. So, that's where, you know, when we're looking at that final 15, 18%, we realise a lot of that is around not being able to make a diagnosis on the day. So we have this delay, and the feedback loop is too long.

Reference 7 - 2.86% Coverage

Does it mean that it's also quite easy to introduce new pathways, and experiment with different pathways?

P Well yes, no, it certainly is. You know, we have five streams at the… Well actually we have six streams for patients. So stream one is very symptomatic patients, they see healthcare assistants. Stream two are for band six and five nurses, and they're for people returning with positive STIs, or partners with infections, or people for vaccinations. But we can easily move that to a, you know, we're going to soon have appointments for partners as I said. And they'll go straight to health advisors.

00:42:03

We got stream three, which is simple symptomatics, and that's just urethral discharge, vaginal discharge, you know, very simple stuff, lumps and bumps. And then stream four, pelvic pain, testicular pain, you know, dyspareunia, sexual assault, IUD fitting, you know, implant fittings. So, we have different streams. And stream five are our health advisors doing asymptomatic screenings in people, evaluating people for pep, reviewing people for impact, the trial. But yes, counselling works. So stream five does a lot. And then stream six are some private patients, we're doing a bit of private vaccination, and private things.

So we already, you know, have different streams, different pathways, different members of staff, you know. If we had a new pathway, we'd just say, like… You know, for example, if you were going to test all partners for chlamydia and gonorrhoea, we'd just book them into a specific stream. Save, like, less… We'd run it that way. So it's very easy to bring in something new and just run it for a short while and see how it works, and then just keep on developing it.

Reference 8 - 1.22% Coverage

Everything. You know, talking to patients, that's who we serve, you know. We can find out where the holes are, to fill them. You know, I've got no problems about, you know, putting it… You know, we know what our biggest issue is, the waiting area. If you look at the our clinic’s iWantGreatCare website, not promoted, but still people are filling it out. We've got like, I don't know, 120 responses, not much.

00:51:56

But you know, most of the things are… They love the service when they get through. But they can't stand the wait. Well we know that, you know. But we're the only open access service open on the weekends. We get no complaints on the weekends by the way, because people know there's nowhere else to go, right.

Reference 9 - 0.70% Coverage

Yes, no we can see it changing pathways, lots of key pathways. So at the moment we see 350 partners a month, mostly of chlamydia and gonorrhoea. We would like to double that. And with the appointment module, we should be able to double that. And if we double that then we're going to increase the number of infections we make, and therefore we'll do more partner notification, and it will be this lovely positive loop...

Reference 1 - 3.54% Coverage

P But then the… When there's more of a demand, then the thing was that it's not for every area. It's only if you live in this area. So we'd get round it by saying, so why don't give your… They don't… It's not an address they need to give, just a post code.

R Yes.

P So I said, why don't you give the post code for the area where you work? Oh right, okay. So you know, like little things that we're just trying to help the patients to get around it. So that was, like, quite helpful as well.

R Right.

P So, because then it's back to square one. Those patients will need to book a time slot. And if the time slots are released weekly on a Friday, so once they're full, you have to wait for the following week. So they think, oh, can I book it now? Oh, no, you have to book it online. No, you have to book it yourself, because the patient has to take responsibility, because if they've made a mistake, then the onus is on them. So that's why we've got a little bit strict with that as well, because some patients were saying, but you booked it and you made a mistake.

00:28:54

So no, if they've made a mistake then, you know. Because it clearly says as well, if you have symptoms, you can't be seen. And some of them were still booking it, because they were desperate. And then we would have said to them, you've just seen that it's what it says. And you can't be seen. And then we explain to them that if a healthcare assistant is not qualified to see you. So you'll make them think, oh, better not try that trick again.

R Yes.

P You know. So little things like that. And then, you know, some of them admit that they were trying to be seen. But it doesn't work.

R Oh, patients do that?

P Yes. They do, yes. So yes. So, it's about working what you've got, and trying to go that extra mile to…

Reference 2 - 6.56% Coverage

And you know like little things like for… A patient's come in for pills, and we've reached full capacity. Have you tried your GP? Oh, does the GP… Some of them don't know the GP does that. Oh, you know there's some selected pharmacists that do… Oh, right. So it's giving more information to the patient. Because some of the reception, they didn't… I've been doing this job for so many years.

R Yes.

P And I know that these things are in place. So I said, did you know… Oh, right. Some of them said didn't know. The ones that always used to work here. Because before they weren't working cross site, so. I worked with the patient experience manager to put something in place to hand to the patients, to help with the turn aways as well. To say, did you know you can go here? Did you know you can go here? Did you can get information here?

R Yes.

P So that was a big help as well. And also, we were diverting the patients to our sister clinic because that's less busy. We say to them, 45 bus, ten minutes. Encourage them to get on the bus to go to the clinic. So that was, again, trying to work with what we've got, and taking the pressure off this clinic.

R Right.

00:30:41

P Oh, some of them didn't even know there was a clinic there. So, because if they had a friend that came here, they're telling… You know, they're spreading the word, and then they… We would say to them, oh did you know they have the clinic even in… Like, [location], we said, did you know there's clinic in [location]? Oh, I didn't know. So we tell them. Oh, right. So it takes the pressure off, and then hopefully they will spread the word.

R Yes.

P Kind of thing.

R Right.

P So… And then if they say, do you know a clinic that does appointments? Because we don't do appointments. The [clinic] does time slots for symptoms. Oh, right, do you know their number? If you just Google it, because numbers change, we don't have that information. Or we have to give them a leaflet. So things like that. Encourage them to take responsibility.

R Yes.

P So obviously though if somebody's language is not… Their first language is not English, we'd obviously assist them and help them with that.

00:31:27

R Okay.

P Yes, there's patients that, like, like really stress. Can't get into time slot. So I will book one for the following week, because I'm allowed to obviously book the slots on, but in reception, and not because I have the rota, and I can see who's going to be working, that's qualified to do that. So I can get around things like that. Anything to stop a complaint. They say, can you try and manage this informally? If something goes to power, that the patient's been coming on a certain amount of days, been turned away, then I say to… Can't accommodate them, so if you go to the [clinic], it's less busy, the doors open at eight o'clock. Make sure you get there. And then they're there. I check on the system to see if they're there, and they've, you know, they're there. So you can see that, you know, there's patients that are listening, and doing what you tell them to do.

R Right.

P And you… It makes you feel good, because at least you can… You know, that you are… I know there's hundreds out there. But if you help ten for the day, at least, you know, you've done something. And if they've been seen…

R It's an impact.

P Yes, exactly.

Reference 1 - 6.17% Coverage

R And outside of point-of-care testing, do you have experience with adopting of new technologies in the current clinic where you work?

P Not really because all our testing are basically done by the central laboratory and the only thing that we do is actually, like urinalysis and microscopy. We have point-of-care testing for HIV and syphilis, and we don't use it very often but we do sometimes. So I think it's useful because some patients are really, really nervous, really, really anxious so they would like to get the results as soon as possible. To be honest, the new lab is really good because we obviously have changed our laboratory service maybe a couple of years ago and the turnaround time is really, really short now.

So within two days, we get the results back. So I’m quite happy with that compared to the previous time. So yes, I mean feasibility issues is the other thing because sometimes when you do a test and you’re not actually doing it as a kind of a laboratory technician… I mean they are quite used to doing the laboratory tests but all these people are clinical as I said, they are clinical people so we deal with the stuff related to the patient and we are completely away from the testing.

Reference 1 - 2.52% Coverage

We’re not commissioned to provide termination of pregnancy services, HIV treatment and care, or sexual assault survivors screening. We hold the contract as lead provider, and it’s my role to manage this contract upwards in terms of our commissioner and downwards in terms of our subcontractors. And our subcontractors include what’s called [subcontractor’s name].

It used to be as [name] Hospital but now is known as [subcontractor’s name]. It’s one hospital trust, [subcontractor’s name]; one community trust. And a number of more specialist subcontractors, including [name] clinic, which focusses on young people; [name] NGO, which focusses on adults in a vulnerable, risky area; and we also subcontract to a specific laboratory provider and a manager of community pharmacy.

Reference 1 - 4.02% Coverage

P So here in [region] it’s part of the general [name] Sexual Health Service as the quadrants there and the overall contract managerialists, [company]. But we work close with [NGO] and [Trust] based with us for HIV Services and our lab that’s up in X, so we collaborate with those.

00:01:11

R And is there anything about the collaboration between contracted providers and NHS Trust that you think is interesting in particular? How do you find it?

P [company] provides a service but it’s NHS contracts. We don’t link in with any acute trust directly apart from the lab which goes to [name] lab which is an acute trust. Otherwise we don’t link in with any acute trust as part of the services or part of [company], it’s an NHS contract obviously from [name] County Council.

Reference 2 - 8.63% Coverage

The service changes that we’ve actually made with the new contracts and stuff, I think have made people be prepared to change their practices. Because people had maybe got a bit stale in the past and having new contracts and stuff and moving forward has made people change their practices and look at things in a different way, and just what we’re doing and how we do things.

R And when were those contracts changed?

P April 2016, it started.

R And what was the difference, could you just briefly explain to me how that change and why? What was... ?

P Some of us obviously said this is a great step that’s now being joined up as to one service, whereas say in the past we didn’t have any online testing which we do now with being teamed with SH24. So there’s online testing available which wasn’t available before. In the past the consultants really wanted everybody to be examined, whereas now we only examine people with symptoms.

00:26:41

If somebody is asymptomatic they see a support worker and a support worker does an asymptomatic screen, so they don’t even have to see anybody clinical. So just general move forwards in the right direction, looking at patients been able to take some steering responsibilities for their own sexual health needs by steering them to online has benefit appropriate. So it’s a general shift into, that not everything has to be doctor-driven, we’ve got mainly nurse services.

We do adopt here but not as often as there ever used to be. We don’t have a consultant on premises, our consultant is based in [clinic]. Like I say, support workers are stating a bigger role in seeing patients. So just general shift in a positive way, what we think is the positive way.

Reference 1 - 13.43% Coverage

The service is a… As I said, it’s integrated, so we cover a number of different specialities in as much that we do STI testing, treatment and care including HIV treatment in care. We also do contraceptive services, the pregnancy advisory service which is a termination of pregnancy service and psychosexual counselling. We host a clinic who are commissioned to provide the vasectomy service we host and provide the staff for supporting that service.

We do training for the local healthcare professionals, so we’ve got faculty trainers for… from the Faculty of Sexual and Reproductive Health Care and provide training for family planning basically to our GP and practice nurse colleagues for the 17 practices. We do outreach work, going into different areas… It’s more satellite clinics into mental health services and we operate services for under 18s. And we also do education within the local schools, mainly to the year 10s around sexual health and wellbeing. So we sort of cover quite a vast area of subjects.

00:02:15

We’re a small team, there are about 20 of us that I manage, the majority of whom are part time and that’s admin and clerical and clinical staff. It is a nurse led service, so we do have doctors, but they are two associate specialist doctors who are local GPs with a speciality around sexual health, to come into the clinic one afternoon a week. So they are with us for a short period of time. And we have one consultant medic who is with us one day a week mainly to look after our HIV cohort of patients and any very complex patients we might see. So the majority of the… The clinics are actually run by Band 6 nurses and we do have a consultant nurse as well who works for us. We are commissioned…

The majority of our services are commissioned by public health as are most sexual health services in the UK which we… You’re probably aware that public health was moved from NHS to local authority a couple of years ago. This has brought some interesting sort of dynamics with it inasmuch as the local authority, even though the money was supposedly [unclear] have been cutting budgets. And we have found ourselves… We have had our budget cut significantly which has obviously made us look at different ways of working.

00:03:55

And it has sort of in a way given us an opportunity to look at different technologies that are available to us but also looking at other ways we can income generate as well. So we’re a pretty innovative service, quite small, we see around about 600 patients a month, roughly, and as I said, we do sort of provide a one-stop shop for most of the patients. We do everything that a larger clinic would do but in just a very much more of a smaller area and… But we see the same sort of infections and issues and problems that a large clinic would see but maybe just obviously not in the numbers. What else can I say about our service?

Reference 2 - 12.21% Coverage

Well we… Last October we approved… We’re working with our commissioners who are actually quite supportive, we’ve looked at using online testing. It had been… Prior to then we were running the chlamydia screening program and that was actually through an off-site laboratory but all the kits, the actual testing kits, we were distributing around the island through various means. So it would have been through pharmacies, different groups of people that we work with, GP surgeries, youth groups, that sort of thing.

00:06:07

So we were actually providing the kits to them and then they would be sending them off direct to… It was the doctors laboratory [unclear] that was being used at that point. And then we would be managing all the results, so any positives we would see but they would be able to get their medication either through us or through pharmacies or GPs. So that was happening via the chlamydia screening program up until October last year. The commissioners, because of the funding situation, decided that we would no longer run the chlamydia screening program but what we would do is actually operate an online testing service.

So we promote the service, so anybody, any age group can go online, get a kit sent to them direct, they would do their self-swabs or urine and send it off to the company. And then we again manage the results by actually picking up any of the positives to make sure they get treated and the partner notification done. So that’s our experience really of sort of, dipping our toe into using the new technologies that are available to us. The mainstream side of it is obviously patients who we see face-to-face we actually… Well when we test them it will go to our local laboratory which in fact then sends all the gonorrhoea and chlamydia testing off-site to that laboratory.

So the online testing has proven to be very successful, we obviously… We tend to use it just for a-symptomatic patients if they contact us and if they haven’t got any symptoms then we will sign post them to the online testing. The, I suppose, difficulty that we have as a service is that it’s obviously removed so there’s no opportunity for us to actually check up on things like, if they’re under…

00:08:21

If they’re quite young people, around safeguarding issues or if they are symptomatic or indeed if they need any other service such as contraception. So that’s the downside of that because we don’t have that patient contact. But from purely a testing point of view for chlamydia, gonorrhoea, HIV and syphilis which they do finger prick blood sampling, it has proved to be very popular.

Reference 1 - 2.85% Coverage

So we have five consultants, myself included. And a selection of other doctors, and then a large nursing team, nurse practitioners. And health care assistants that deliver the care to patients in the clinic. We also work in the hospital with the infectious diseases department to deliver outpatient HIV care. Outside of the hospital, we work closely with our community sexual health colleagues, who deliver community sexual health, sexual and reproductive health care.

Data

Reference 1 - 0.65% Coverage

Okay. So, we have a real time dashboard where we can see, you know, numbers. As in the absolute numbers, but also number of diagnoses. And that's a sort of a background check on what's happening in the department. We have brought in a number of new digital technologies. And we have tested out a number of things being, you know, brought in, things to see how they work for the service.

Reference 2 - 1.21% Coverage

The evaluation, it always, you know, it always relies on, you know, are you collecting good data in the first place?

00:09:02

R Right.

P And, you know, what is your baseline? So in terms of partner notification, we had no real baseline, because we had audits every once a year that showed that we're nowhere near hitting the targets. And then as soon as we had a tool with a real time KPI, we could see that, you know, there was nowhere to run or hide. You know, you could see how it was performing in different groups. So there, the trick is to really understand what your baseline is. So we know our baseline around diagnostics, for example. We know that 75% of our results are coming in at 72 hours, which is rubbish.

Reference 3 - 1.33% Coverage

And the trust is supporting us to get a machine in [name] clinic for a Panther machine, so we can actually bring some of the lab into our service, so that we can actually test things in real time. But also, you know, things like we did an evaluation very early on about bringing in a diagnostics force, syphilis PCR. So [name] developed a syphilis PCR. We showed it was working, it was picking up infections more acutely, in terms of primary chancres. We embedded it with our herpes test to make sure that it got easily adopted, and been using it since then. We're now decoupling that syphilis test now it's an established test, from the herpes, because obviously we don't need to do that for all the low risk heterosexuals. But we are diagnosing people earlier with syphilis because of that PCR.

Reference 4 - 0.71% Coverage

Rationale, and you know, what is… What would be your, you know, what would you actually measure? What would be your change drive, you know, your driver diagram? You know, what sort of things would you have on your run rate, if you were going to measure something. You know, what specifically, and getting people to actually say, look, that is the important measure. And we all just, you know, we'll implement change. So we…

Reference 5 - 0.62% Coverage

Yes, and it takes a while to get, you know, people up to speed. And I think a lot of people in healthcare just think, you know, healthcare is an art, and it's all about, you know, all the soft stuff. But it isn't, you know, it is that, but it's not just that. You know, there's a lot of objective, you know, training, and objective measures that we can bring into that.

Reference 6 - 1.08% Coverage

And we have a little matrix that allows us to understand, you know, how many people are in the waiting room, how many staff do we have, and then how many hours left in clinic, and how many we can let through. And then we got triaging on top of that. So, you know, we're getting a lot more rigorous about looking at the services, and now of course, because we can do that, we can then turn around to staff and say, well, why aren't you seeing that many patients in the clinic? You know, what's wrong? What barriers do you have? What can we do to remove those barriers? So yes, you can start having more focused, fruitful conversations with people.

Reference 7 - 0.41% Coverage

So, the perfect is the enemy of the good. So you need, you just have to make good. And set it up, run it, evaluate it, and say, yes, no, maybe. And if the maybe, then what do we do to test it definitively before we either adopt it or drop it? Yes.

Reference 8 - 0.67% Coverage

So yes, that… And then of course, so the adoption thing is you say what the problem is. And you say, okay, what are potential solutions? And then how do we quickly try them? And how do we try them in a rigorous way that should prove to ourselves the value. And so, you know, we've, we've spent a long time talking about, yes, what can we do to shave off, you know, minutes here, hours there of time.

Reference 9 - 0.44% Coverage

But we had to wait for the study to be published, and as soon as it's published, we then adopted it. But we did all the preparatory work before that, and we were involved in the three in one study that was, you know, presented by [name] and others. So we're part of that.

Reference 10 - 2.24% Coverage

With the partner notification tool, it was a Public Health England grant, we ran it for a year for free. We started January 16, we proved very quickly that we could actually deliver more effective partner notification than ever before. We found that, yes, we were getting partners seen and tested in all over the country thanks to the tool. And it was picking a 30 to 50% of the work up. So as soon as you…

At the end of the trial, I just turned around to my colleagues and said, here's the evidence, you know, 30 to 50% of the health advisor time is saved by this tool. And will you be happy to pay for it? And so they said, yes. You know, but you just need to have… You need to prime these things with trials or with, you know, grants to make things free, so that people can see it working. But also get the data to prove to themselves that it's fine. And then it's just a case of saying, look, this the objective data, what do you think?

00:31:35

And yes, if there isn't… If it's, you know, if there isn't a… My favourite statistic is the bloody obvious test. If it isn't bloody obvious that it's working, then it's hard to adopt it. But you know, that's a statistic most people get, you know, without having to, you know, do some fancy mathematics. So yes, when it's clear for them, you know, it must be… It makes a big difference.

Reference 11 - 0.63% Coverage

So if we were to bring in other point of care tests, and we could show where they fit in the pathway, then we would just send less samples, if we could show it's non-inferior. You know, ideally it would be superior. But usually to prove something's superior, is harder than proving it's non-inferior. You know, that’s just the way it is with pharmaceuticals and diagnostics.

Reference 12 - 1.28% Coverage

And obviously that's going to involve us, you know, doing a bit of work proving that it's as good as. And then it will… And, and, and obviously there are other trials that we can build on. So we don't have to do the whole trial ourselves. You know, we can say there are other trials showing this. And we can show that our results corroborate with that. But the issue is going to be a lot of people come in with STIs are men having sex with men, and a lot of the tests out there are only being evaluated is from vaginal and urethral samples, which of course is going to make it trickier.

And the reason why three in one took so long to get adopted, because we were ready to roll with that nine months before we did, is because we were waiting for the publication.

Reference 1 - 1.19% Coverage

And having an accessible health care service will improve the outcome, sexual health outcomes. We can see that within England and definitely within London, there is increases in STIs and some STI, sexually transmitted infections, are disproportionately increasing.

00:01:49

So syphilis is a good example. Gonorrhoea, we see pockets of increase. And they're trying to increase the number of people with STIs that we see, which basically means that these are the people, if we can get to test and treat people in a timely manner, reduce on the transmission of infections. And the overall aim of our department is to reduce the burden of STIs in the community that we cater to.

Reference 2 - 3.25% Coverage

The other thing is looking at, obviously, technology is one of, I think, the biggest advances in the specialty, the advances in eHealth. So they've been raised in which we could interact with patients using technology but also looking at different ways in which we can manage conditions. So, obviously, there'll be new ways in which we can communicate results, new ways in which we can test, also new ways in which we can use existing technologies.

So rather than having things about saying that the testing is going to be in the lab, there's no reason why you can't bring your lab into your service, which basically would mean that you have a little bit more control onto what you can do. You can change the turnaround time. So how can you get a more timely result? So working in sexual health, what is the most important thing? We want to reduce the time from when somebody has contracted an infection to treatment of that infection because it reduces the time period in which they can spread it to other people, and saying you're going to test somebody and get the result back in two weeks.

00:12:47

It's two weeks where it's under transmission. And then there are lots of other things. And it's not that simple, because once somebody has come to your clinic, and it’s gone. Getting them back is quite difficult. Life happens. You spend a lot of time and effort and money in trying to get people back. Sexual health services are open access, which basically means that somebody will come here and go somewhere else. So you can't actually be sure how much of an impact you're having.

And just because somebody doesn’t come back to you doesn’t mean that the problem is solved. So it's looking at how can we best use resources that are available, and how can we facilitate new technological advances to be adopted in, which is a difficult thing.

Reference 3 - 1.55% Coverage

For example, if you have a rapid test that you would be using in paper who don't have any symptoms, there's no reason why you can’t have a sample first to people. So, say, you have a test that takes, I don't know, an hour to get the result, and you know your waiting time in clinic is about an hour to two hours. And these are people who are, at the end of the day, just going to give samples anyway.

You can get them to do the samples when they check in, and then collect all the information that you want. And then at the end of the consultation, you might do your part in, which the result is there so you actually don't have to... and then you can basically, in your business plan, look at how many infections you would have detected that you have treated on that day, which means that you are not going to spend near a thousand pounds and personal time recalling those people.

Reference 4 - 2.86% Coverage

And there are different ways in which you can do service implementations. You can make it a health technology assessment as a research project, saying that I'm going to study and I'm going to have partners, and you're going to say that we're going to do this in different settings so that you can show others how to do this.

But get research funding to allow implementation, and then show to people that if you can actually get good quality data, that shows that you can actually save money by showing a research project that actually looks at that rather than saying, oh, I'm going to do a model, and then you go, well, it’s just a model, and say that I'm going to do a health technology assessment study.

I'm going to do an implementation science that's going to look at what are the cost implications of this change and say that we get this properly funded as a study. You get the device or the new technology through the study, and then you put it into a real world scenario. And then they have a real time look at what the exact, say, changes in work time because you're going to measure everything. And I think that's probably one of the way forward.

00:21:34

And it's one of the things that I look at my role, which puts in together quality improvement and research, is that you can actually bring the two together and then have this culture of evaluation. Because if you can evaluate yourself and show that you are good at evaluating yourself, you know that you can be trusted to make changes because you get to measure it. You'll know very early on that the things are going the way you expect them to go or not.

Reference 5 - 1.67% Coverage

And it's usually the lack of ability to deliver on this because you're not able to get results quickly but what is currently available. New technologies are looking at faster results. You're looking at tests, which don't require a lab that has 15-meter square and a whole lot of things. You're talking about things that might be logging in to have something the size of a refrigerator that you could have in the OptiMix.

Or you could have something that's a desktop that you can have in the rooms and then saying, how do you do that? And then it's looking at you've gone [unclear], saying that if I have... so far, our patient, we see about 1,700 patients a week. Those 1,700 patients a week, how do we manage to do them on different models? And you can look and say that how many do you need and then seeing that in having that negotiation to go, what is going to be cost-effective, what can we actually afford to do, and which model we can go for.

Reference 6 - 3.96% Coverage

But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

00:28:04

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

And so that's where you're having a higher management team throughout the structure, which is looking at the longer picture, saying that you have all these things, you have contingency plans for the [unclear] of the system where things change. But you know that your commissioning is not going to change dramatically. So you only know that you're considered at risk because we are an at-risk department financially because we have a lot of performance targets, which are unrealistic.

And it’s unguaranteed money, which can change at any time, which basically means that you need to look at how you can get with things, but they're always [unclear]. And if you can get research to take on a large proportion of your routine work, it's paid for by research. It basically means that you make your target. At least that's a good mix, good [unclear] sense to look at that. But it also means that you have real world implementation science, I think, is the way forward, especially with new technologies.

00:29:46

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it.

Reference 7 - 7.95% Coverage

Again, they're different populations, so you do both. The problem with Mycoplasma genitalium testing is that there are lots of beliefs about it. If you look at people and say, don’t do a symptomatic testing because it's transient. How transient is it? At the end of the day, I think you need to think about it as like it’s an STI, then you treat it like any other STI. You find it [unclear] Chlamydia is transient, gonorrhoea is transient. Do you want to test? Do you want to reduce burdens, you have to test into it.

01:04:49

So actually, having the full pathogen one is more attractive to me. If it was going to cost the same as to pathogens, at the moment, we have two [unclear] testing. So we have Trichomonas testing for certain populations because that’s all we can afford to test. Ideally, I would want to test everyone. But not everybody would want to tell us that their partners are high-risked ethnicities. And it's super awkward asking people what ethnicity are your sexual partners.

Whichever way you face it, that’s just like, why? And you're basically making judgment in what's most common with patterns that can change. So actually, if you have the ability to test everybody, I would do that. If it's [unclear] you to, that's what you would do. So the four pathogen tests would be useful, and then you have a separate one, which allows you to test for resistance. And then you basically make sure that you have residual sample to do that.

And you know that you're going to be doing the resistance ones in a smaller proportion of patients. And it might be that you want to have the resistance ones as separate. So you have a gonorrhoea resistance cartridge, your Mycoplasma resistance cartridge. We don’t know enough about Chlamydia and Trichomonas to do any resistance testing. But these two, where you make a treatment decision. And then you can again change your pathways.

01:06:29

Somebody has got Chlamydia infection. You pop them off to a health advisor to talk about their partner notification and do that while you find out what is the best antibiotic to give them with your cartridge number two. And that’s going to be a small proportion of patients. So we're going to say it's going to be about a third to a quarter of your patients, depending on the population, who would need that, which means that the bulk of them would test and go, ta da, you don’t have anything.

So the fourth testing one is attractive form of testing, and then you say that for gonorrhoea, you have the resistance one as your confirmatory asset. That also tells you about what they think is [unclear]. And if you can actually make it more savvy and increase your antibiotic susceptibility prediction to other antibiotics, it had to be that. If you can tell, tell me that this gonorrhoea is resistant to azithromycin, we won't waste time adding azithromycin to the treatment.

If I know that this has got [unclear] resistance, I would make sure that I get at least one of the antibiotic with it. So then you can personalize the treatment. And it's especially important for Mycoplasma at the moment, because quite often, you end up treating and retreating them. Because by the time you find out azithromycin doesn’t work, you already given them azithromycin and go, actually, you have to come back, we have to give you [unclear].

01:08:22

So actually having that could be better. So I would go for four pathogen first, followed by resistance would be my preferred one. I know that you guys have done work with patient groups, but I'm not quite sure if that’s... we need to be informed about what actually that means before you can just say, if you're able to present the scenario to patients saying that this is... but we're also looking at how does having the two pathogens versus the resistance together versus four pathogens affect the clinical pathways.

R So is there anything else in terms of adoption of new technologies that you think that you haven't had a chance to mention? Because I've ran out of questions.

P No, I don't think. But I think I've talked about lots of the key things. I think the things to reiterate is that actually looking at avenues to service implementation studies and to make them as studies rather than say just make cost to things basically, then would make it attractive for companies to say that you have that implementation thing funded by research. And then you have all the data to make a business case. That's probably the strongest thing. And then getting organization leads.

Reference 1 - 1.23% Coverage

So it wouldn't surprise me if these did significantly change the way we're managing our service over time. I don't think it would be an immediate thing. This maybe seems like you need to see the results, prove that it works first.

R Yes. Do the local validation as well, yes.

P Exactly.

Reference 1 - 2.92% Coverage

This was to do with opening times. There was a site that was opening at 11 o'clock, and the other sites were open at nine o'clock. So two hours productivity was being lost in the morning, and patients were queuing up. As soon as you open the doors, you had the mad rush. And we were trying to say if that clinic opened a little bit earlier, it would… You know, it would be in line with everything else. But there's always sometimes you have resistance. Didn't affect the… They looked at the rota, staff were already in at that time anyway, but just down to start clinic at 11.

So what we did was, you have first of all staff meetings. And it's, like, discussed, so everybody's aware. And then you have a team of people, like, you call it a little project. And say, right you, I want you to be involved in this project. Again informing the staff what… The department, we're going to start doing a survey for the patients to see what they… Times they prefer. And it came back that they all wanted early.

00:15:21

Collected the data, so that it was clear for the department to see, so to make sure that they're all involved. Everybody has their comments. And even though you will still get somebody who's still not happy, but the overall majority, and the data will speak for itself, because you know, you have to have the proof. And then we say from this day, we're going to go live with the time, the opening times, with the change. So that's the way to address things as well.

Reference 1 - 6.54% Coverage

You said that evidence is important, I’m thinking it has to be data coming from a robust research...

00:10:13

P Yes.

R I assume? Yes.

P So the evidence was there in terms of the robustness of using a PCR testing for NAAT. It was now a question of deciding what platform we were going to use for our specific set up. So the key thing was not about doing another study, it was about just implementing what is already, has become a part of a standard practice elsewhere in most clinics. So we were evaluating the platforms we have within the laboratory. Can they run a similar test? Can we get their reassurance about the quality? Is there an in-house system for us to check to reassure ourselves that the quality is okay?

And that was set up with the laboratory. I think in the initial stage all the samples tested here using the platform PCR were counterchecked in our reference lab. So that was like a quality assurance process to make sure that this new system we’re going to use is going to give us reliable results. And once we had that reassurance that our machine in the pathology is generating reliable results, after a period of time sending test samples we then started working on a process of how to roll it out and what to do during the transition phase?

So the first step is to make sure that we have the right machine to do the testing, we have the right kits to get the samples. And once we had that reassurance then we know that we can now safely move to the next step. So it was just testing that machine that was in the lab already there to make sure that whatever result it’s going to generate is reproducible by another independent pathology laboratory.

Reference 2 - 5.61% Coverage

R What would be needed if it was a new technology? What would be needed, what kind of structures or what kind of data would be needed for that, to encourage people to...?

P If it’s not popular?

R Yes, if it’s not commonly used.

P I think the first thing would be to understand why that particular technology has not been widely adopted. So maybe something new and there is no confidence. And the question is if there is no confidence, what can you do to build confidence? You can find the other partners who are already using it and what challenges they’re going through and what sort of safety, quality assurance they’ve got in place. So you have to understand why something that is new but has not been quickly adopted, what has happened?

00:13:48

It could be that cost may be compared with what is already been available there, being used, might be cheaper than this new technology. So this new technology is not going to have a huge impact in any change. Or it could be the fact that maybe the new technology is a bit clumsy in how you do the whole process. There is no... You need to really reset, you need to put a lot of other extra resources to get it running and that can put people off especially during this time when there’s a lot of financial stress.

So I think the key thing would be find out if anybody’s adopted it, what sort of advantages, challenges and benefits and then you can decide to do a case for it. So yes.

Reference 1 - 1.88% Coverage

R Is there anything else that helps? You also mentioned data that supports.

P Yes, absolutely. A business case that’s driven by data and not egos and personalities helps. I think in the past it’s been, well, I’m clinical lead, I’m this, I’m that, I’m the hospital, I’ll demand, and quite often that’s worked. In the real commercial world, that’s not the way it would work. If there’s a justification for a new technology and that technology can make things safer, more cost-effective, and more satisfying and acceptable to people, then absolutely, it’s a no-brainer.

Reference 2 - 1.78% Coverage

But if it just makes someone’s life a little bit easier, if it just makes their day job a bit more exciting, if it just adds a little bit of queue loss to their organisation, then these are reasons which probably aren’t going to hold weight anymore, oh, it’s great if… I think the clear things around new technologies are safety, cost-effectiveness, and acceptability.

00:21:06

R And acceptability in terms of patients or also…?

P Yes, patients and staff, I think I would [sound slip] the two together, but maybe they should be split off.

Reference 3 - 1.91% Coverage

I know it sounds a roundabout way thing, but there’s lots of work that goes on in healthcare, not just sexual healthcare, where there are a lot of anecdotes, there’s a lot of expert opinion, and sometimes it has just been what everybody’s always done. Technology which can start verifying that, I think, in a sense, is its own justification. Again, this is where things like the use of technology to support clinical recording so that clinical recording can be brought together and looked at as a mass of data, I think all of these things support the introduction of technology.

Reference 1 - 2.73% Coverage

P Well, I think you have to keep the service modern. I don't introduce everything just for the sake of it, but if they can see an added value to it, yes. It's like when the national guidelines come out, you look and you say, what is in it for us? In terms of where you are, I'm probably an early adopter, but I like to know that things work before I adopt them. So I will critically evaluate something, but I will look at new things and actually see if there is some added value.

00:05:49

So I won't be someone who puts everything in right up front without the evidence. But I do like to be an early adopter rather than dragged to the gate as it were.

Reference 1 - 4.44% Coverage

P It depends on why we are adopting it and how it’d impact on the service, I guess. So our commissioner’s very keen for us to be, you know, being sort of part of innovation and, you know, and bringing on innovation. I don’t think that being a problem at all, I don’t think that will be a barrier, and she would certainly support that, but it just depends on what it means in terms of our numbers, our, you know, our service that we’re providing.

Is this actually…? How is that going to impact and what kind of difference are we going to make if we take on this test as opposed to if we didn’t at all. So, yes, what difference are we making in terms of patients and patient outcome? And certainly, from a public health point of view, you could argue that knowing your results immediately would impact, because partner notification would happen at that time.

You would be able to stop infection, rather than letting your patient go, and only telling them results, say, in what, ten days’ time, where they could potentially infect another ten people in that time. So actually, you could argue that a point-of-care test, knowing your diagnosis sooner is definitely better for patient outcome anyway. Yes.

Reference 1 - 0.91% Coverage

P Of course, in health care, there will always be changes depending on new evidence that’s coming up. And then that involves us to change in practice depending on new studies that have come up.

Reference 1 - 5.64% Coverage

P Yes, I think that would be really helpful. Because there isn’t a widely-available MGen test available at the moment. And a lot of services are not able to offer MGen testing routinely. The national guidelines are still just being discussed at the moment. International guidelines, a lot of people are not even familiar with them. So, I think that would, it would definitely move that conversation along about how MGen was managed. And the concerns that are already being discussed about MGen resistance and antibiotic resistance. So, I think having a point-of-care test for MGen and then being able to give the appropriate antibiotics would definitely help. In terms of antibiotic guardianship.

When it comes to trichomoniasis I think that the prevalence of trichomoniasis is relatively low here on the… Well the presence of all infections is relatively low here, where I work. So, I think being able to… And not everyone is so good at the microscopy in relation to trichomoniasis. Because there is so little of it and we see so little of it. So, I think that would definitely add something to the diagnostics. And to the patient experience of being able to get results quickly.

Reference 1 - 3.38% Coverage

Again, at the moment, I have no idea about sensitivities. I think we need to sort of have some understanding about the differences in sensitivities of the assay compared with a standard laboratory assay, and the impact that that might have on the wider public health. You know, if we're missing infections because it's not as accurate, is it still better because we test more people?

R Right, yes.

P Do you make more diagnoses overall with a less sensitive test, because you're testing more people?

R I see. Thank you. I'll switch off the recorder now.

Reference 1 - 1.43% Coverage

P So I think, I mean, I think a lot of introduction is driven clinically, so for example, guidelines change or research developments happen. And as the senior clinician, so for example, at the moment we’re looking at mycoplasma, and we don’t offer that in our clinic, and trying to get that introduced. And we currently offer TV culture, which is obviously is suboptimal and we’re trying to get PCR. So I think a lot of the demand for technology is driven by the clinicians because see the clinical need.

Reference 2 - 2.59% Coverage

And then obviously we need to work with our microbiology lab colleagues to make sure they’ve got capacity there. I think the bottom line is it comes down to commissioning. So we’re obviously all in financially squeezed situations and at the moment we’re not commissioned to test mycoplasma and so that’s negotiating with our commissioners about how that would happen. So I guess, the ultimate thing comes down to finances.

As I said it’s about, we’re partly helped by guidelines so if guidelines say something has to happen, it’s easier to get commissioners to accept that. But sometimes it’s about if you can demonstrate a cost saving. So, for example, if you could reduce workload and chasing somebody up, for example, and you could demonstrate that it was actually going to cost less money to do it in this way, then you avoid the commissioner issue and then you can get your own trust to approve it and fund it.

Reference 1 - 9.32% Coverage

P I think data. I think you have to have a clinical case for doing anything. So, the status quo will always be the status quo, because it works. So, why do you need to do something different?

So, you need audit data, financial data and mostly clinical data to say, well, if we did this, it potentially would do this. So… and it’s kind of a funny circle, because you almost have to have that data… well, you have to have that data really to institute the thing that you want to institute.

00:15:43

And sometimes you don’t… you’re not going to have that data until you institute the thing. And that’s why… pretty much in the NHS you have to pilot everything to get some initial data, to actually say, well, this… look, this scaled up this many times will probably do this.

So, it’s having the data to back up why you want to do that, so that… and that’s mainly clinical data. But you also have to, if anything, you have to show nearly everything now has to be shown to make a cost saving. If it’s going to cost more, it’s dead in the water, in the current climate.

R Yes. And it has to save money for everyone.

P I think it has to save… probably save money across the unit and the trust as a whole. So, same example there, there are people whose entire job is to look at quality efficiencies, basically. Now, they will go and say, yes, this is great, but potentially this impacts on this department over here, meaning we don’t do it.

And… so it all has to equal out. So, our best… if you can show it improves quality of care, at best it has to be cost neutral. But if it makes an efficiency, it’s more likely to go through if it improves quality of care or efficiency of care probably, but also cost saving as well. It’s almost certainly going to go through at that point.

00:17:19

If it’s cost-neutral, then if it’s got a clinical champion or a group that really pushes it through, then you probably will get through. But if it’s going to cost significantly more to what you’re already doing, it’s very unlikely to be pushed through, unless what you’re doing is sub-standard.

And nearly all… the current level of care is that, it’s the level of care. So, anything above it is an improvement, but… I think people will say well, if it costs more, so, the current level of care is adequate. So, carry on doing what you’re doing.

And that’s essentially the default position of the entire NHS at the moment, not just sexual health.

Reference 1 - 3.80% Coverage

R Right, so did you have part in adopting that?

P Just a small bit really about how it’s going to run in the clinic. And at the moment we’re also looking at a department of education and compliance for patients that come in to the [name] clinic having had an online testing kit done. Because we don’t have a pathway for that at the moment. So that’s just a thing that we just need to consider. Just to make sure that they’ve completed the treatment and haven’t had any problems with the treatment and haven’t had sex and that kind of thing.

So we have, when we have results that come in, that we do here, we have a point of reference to contact patients. But when they’re done through Sexual Health London, we don’t have that result to trigger the partner notification compliance. So we’re looking at a pathway to do that.

Reference 1 - 3.85% Coverage

Usability, obviously, from our practitioners will be a huge issue if there are issues around reliability or if it’s fiddly or too time consuming will have a negative effect. If it’s something that works really well that will go a long way to that. Also patients, what they think about it, if it’s what they want. I think with point of care testing and new ways of working that often is what patients want but they probably don’t realise it at the time because nobody tends to ask them that.

So, I think, probably all the way around, at the end of the day, it will come down to finances but actually we can prove that we can be more efficient, see more patients, bring more income into the Trust as a result of new technologies that will also go a long way towards approval.

Need

Reference 1 - 0.40% Coverage

We're now decoupling that syphilis test now it's an established test, from the herpes, because obviously we don't need to do that for all the low risk heterosexuals. But we are diagnosing people earlier with syphilis because of that PCR.

Reference 2 - 0.96% Coverage

Well, yes, that is the challenge of any projects. This, you know… You won't take everybody on board with you. You know there's always the laggards who have got, you know… Usually vociferous laggards are the enemy of any development, to be honest. But they exist, and you just have to deal with them. But there, the thing is, the frame that we've put around all the changes that we've brought in the last five years is that we need to keep on developing things. We don't know what's… What, what's going to work, but we all give everything a go, you know, as safely as possible.

Reference 3 - 1.31% Coverage

And I think, you know, we were the first department to do that, because that's the culture we have, is we look at it. Yes, we're a corporate player, but at the same time, it's got to fit, you know. And it's got to… You know, we're conscious about, you know, how do we get the right patients through the door? How do we get them through as expeditiously as possible? How do we stop them coming back for follow up, and make sure that they get a one stop shop? All of those things, you know, you continue a focus, you know. And I think making sure it's very patient centric, and public health minded means that we can just, you know, stop the sclerosis of, you know, old systems, you know, carrying on. Just, you know, they unfortunately do, unless you look at them. Shine a light on them.

Reference 4 - 0.95% Coverage

And, you know, we have… You know, so, you know, when it comes to how do you adopt something, and take it through? It's, you know, we look at the problem that I have, and the thing is about all things, you need to focus on the problem. And clearly there is a problem around turnaround, antibiotic stewardship, being able to reduce follow ups, and release capacity for more news. So all of those things allow us to think again about, you know, bringing in other options. So, you know, that's where the point of care test sort of story starts is around the patient journey.

Reference 5 - 0.80% Coverage

So in terms of bringing new things in, you know, it's really… It's, yes, it's public… The public health drivers are clearly there for sexual health. The financial drivers are seeing you and patients, and then delivering everything in one go are all there in terms of integrated sexual health tariff. And then, you know, it's just logistically so much easier if you can get everything done on the day, than bringing people back, because you know, we've got more new people to see.

Reference 6 - 1.22% Coverage

Everything. You know, talking to patients, that's who we serve, you know. We can find out where the holes are, to fill them. You know, I've got no problems about, you know, putting it… You know, we know what our biggest issue is, the waiting area. If you look at the our clinic’s iWantGreatCare website, not promoted, but still people are filling it out. We've got like, I don't know, 120 responses, not much.

00:51:56

But you know, most of the things are… They love the service when they get through. But they can't stand the wait. Well we know that, you know. But we're the only open access service open on the weekends. We get no complaints on the weekends by the way, because people know there's nowhere else to go, right.

Reference 1 - 1.19% Coverage

And having an accessible health care service will improve the outcome, sexual health outcomes. We can see that within England and definitely within London, there is increases in STIs and some STI, sexually transmitted infections, are disproportionately increasing.

00:01:49

So syphilis is a good example. Gonorrhoea, we see pockets of increase. And they're trying to increase the number of people with STIs that we see, which basically means that these are the people, if we can get to test and treat people in a timely manner, reduce on the transmission of infections. And the overall aim of our department is to reduce the burden of STIs in the community that we cater to.

Reference 2 - 0.10% Coverage

I think all departments need to evaluate their services.

Reference 3 - 1.11% Coverage

So obviously, we want to provide the same standards of care throughout whenever we're open. So it doesn't matter when a patient accesses us that they would get the same level of service, whether it's a weekday evening or weekend, the people get the care that they need. And so we have a program of quality improvement, which basically is looking at making sure that we deliver on the standards but then defining for our service what our aspirations are and how we can aim for seeing more patients have better quality of care and improve both staff and patient experience of that patient encounter and the patient journey throughout.

Reference 4 - 0.66% Coverage

So you're basically trying to do it with a goal post that’s changing all the time. So what you need to do and what you are expected to do, it's what was an extra last year might be an expected basic minimum next year, and then say, how do you do that, and looking at what priorities are, looking at what priorities are within our control to adopt and what are imposed on us.

Reference 5 - 3.25% Coverage

The other thing is looking at, obviously, technology is one of, I think, the biggest advances in the specialty, the advances in eHealth. So they've been raised in which we could interact with patients using technology but also looking at different ways in which we can manage conditions. So, obviously, there'll be new ways in which we can communicate results, new ways in which we can test, also new ways in which we can use existing technologies.

So rather than having things about saying that the testing is going to be in the lab, there's no reason why you can't bring your lab into your service, which basically would mean that you have a little bit more control onto what you can do. You can change the turnaround time. So how can you get a more timely result? So working in sexual health, what is the most important thing? We want to reduce the time from when somebody has contracted an infection to treatment of that infection because it reduces the time period in which they can spread it to other people, and saying you're going to test somebody and get the result back in two weeks.

00:12:47

It's two weeks where it's under transmission. And then there are lots of other things. And it's not that simple, because once somebody has come to your clinic, and it’s gone. Getting them back is quite difficult. Life happens. You spend a lot of time and effort and money in trying to get people back. Sexual health services are open access, which basically means that somebody will come here and go somewhere else. So you can't actually be sure how much of an impact you're having.

And just because somebody doesn’t come back to you doesn’t mean that the problem is solved. So it's looking at how can we best use resources that are available, and how can we facilitate new technological advances to be adopted in, which is a difficult thing.

Reference 1 - 3.83% Coverage

P Yes. I think symptoms, yes. Using it for people with symptoms. Using it for contacts and infections. But yes, using it for people who are just anxious. Oh, no. Nope. I would be very against that. Because, for me, as someone who is a councillor, I want to… I am more interested in kind of thinking about their anxiety.

00:27:08

So, why is this person feeling so anxious about this? Yes. So, that would be what I would be interested in. Finding out from them.

R Yes. So, you think that they would actually benefit from a longer process?

P No. Well, I think… I think there is no… I think, clinically, it wouldn’t… Like, there is no… So, just because this person is anxious, does that make them… They are asymptomatic. They’ve not been in contact with anyone. They might have only had sex once in the last year. Does that person need their result in 30 minutes? They don’t need it.

If it was… If we were able to do it, clinically. Like we had the capacity to do that. Then yes, then I would be in favour of it. If we had other people that would have more of an urgent need to use the two machines, then I would say we are not going to do it on the Mister Anxious. And start with apologise, but, you know, that’s how we do the assessing. So, yes.

Reference 1 - 2.92% Coverage

This was to do with opening times. There was a site that was opening at 11 o'clock, and the other sites were open at nine o'clock. So two hours productivity was being lost in the morning, and patients were queuing up. As soon as you open the doors, you had the mad rush. And we were trying to say if that clinic opened a little bit earlier, it would… You know, it would be in line with everything else. But there's always sometimes you have resistance. Didn't affect the… They looked at the rota, staff were already in at that time anyway, but just down to start clinic at 11.

So what we did was, you have first of all staff meetings. And it's, like, discussed, so everybody's aware. And then you have a team of people, like, you call it a little project. And say, right you, I want you to be involved in this project. Again informing the staff what… The department, we're going to start doing a survey for the patients to see what they… Times they prefer. And it came back that they all wanted early.

00:15:21

Collected the data, so that it was clear for the department to see, so to make sure that they're all involved. Everybody has their comments. And even though you will still get somebody who's still not happy, but the overall majority, and the data will speak for itself, because you know, you have to have the proof. And then we say from this day, we're going to go live with the time, the opening times, with the change. So that's the way to address things as well.

Reference 2 - 2.53% Coverage

R What are those decisions? What… I'm asking about the nature of them. What would they be?

P I'd say for… Like, for example, if there was a specialist clinic.

R Yes.

P On a site that I believed that shouldn't be on a site, because this site would have been benefitted a bit more. And obviously I would give the reasons and the rationale why. Speak to the lead clinician, because there was another clinician that didn't agree. But then I gave the rationale. And he agreed with me, and moved the scanner machine here. Set up a specialist clinic here, so that you could have one… It didn't make sense having specialists, oh sorry, the specialist clinic in the smaller clinic. When you had a clinic… You did have a specialist clinic nearby, but this is the busier clinic. And the patients would benefit more here. And it was set up and it works.

So… And then the clinician's happy. Because sometimes everyone has, like, a site where they prefer to work, so it's more to that as well. But you have to look at the bigger picture. Because I like, I was happy to be at the [name] site at one stage, you know. But then this is the more busier site, more problems, needed a more senior person here, so I was… Had to come here. But they're not used to it. So… But my heart is always at [name] site, but…

Reference 3 - 1.96% Coverage

And I’ve saved them quite a bit of money as well, with redesigning my little team upstairs, because there was a patient access team, and like, a secretary. But some staff left from that department, well, not that department, from that, what do you call it, team. Team within the department. So, I just looked at it and I thought, well, we don’t really need the staff. We don’t need to recruit, perhaps we could give this person to do, even though they’re doing it already. But, just tweaking some things, because if something’s removed from her job description, because have a complex specialist service anymore.

00:03:57

P Because that went through the consultation, so that’s been removed from their work load, so you give them something else to replace it with. So, I save money by just having a team of two, rather than having a team of four. So, that was cost saving, and at the time the trust was working hard, every area was having to save money. So, and we met our target, which is good.

Reference 1 - 5.53% Coverage

R So this is interesting because my next question is about… Well, the long-term plans for Atlas or Binx Health as they call now, is to produce a point-of-care test that will also give results for Mycoplasma and TV. So that would be a four pathogen test. So how do you think, would that be useful?

00:26:34

P That would be useful, certainly, because we don't test for Mycoplasma at the moment. So that would be something that we would be interested in. Yes, certainly. If you can have four tests in the same platform that would be better, I think.

R Maybe not because patients would be anxious about their result, but it's more about not having those tests available at the moment at all?

P Yes, because Mycoplasma and TV, I don't think even half of the patients that we see do not know about the TV actually. We need to talk about it before we test them. And I don't think from patients’ point of view they are bothered about TV or Mycoplasma, but obviously as clinicians we know that it's important testing for Mycoplasma. It’s recommended for some people. So yes, I think it will be useful.

Reference 1 - 7.53% Coverage

R I see. And you’ve also described the restructuring and reorganisation of the services that was quite recent. Do you think that made it easier for technologies to be introduced or…?

P I don’t really know. I think it was interesting, because when we brought this service together in April 2016, it was five different teams all working in different ways, and we had very vocal people saying self-management was wrong, that everyone should be coming to see somebody face to face because that’s only where the quality lies, that by bringing in technologies, you’re potentially bringing in technologies that don’t involve…

00:10:48

That allow self-management, bringing in technologies that move away from not necessarily human oversight but human delivery is reducing quality, is increasing risk. And that was a challenge. Least of all, to me, one of the biggest challenges about all of this is there’s still this idea, there was always this idea, that clinician knows best, and what I used to have remind people of was that you had a whole cohort of people out there that heard stories, whether they be true or not, about sexual health services that were making make them think, I’m never going to that even if I do have a problem.

You must know the myths about sexual health services. Some people describe them almost like entering in for voluntary torture, and if you’ve got that hanging over your head, then I don’t know, I couldn’t live with myself as a service if the average person said, well, when you go to that service you get an inverted umbrella pushed down your penis. And I’m not exaggerating by saying that that’s a common myth. Albeit it’s a myth, it still needs transforming.

And this is where self-management and using technology to support self-management would hopefully just through example and experience dispel some of these myths. In answer to your question, I think the restructure gave us a great opportunity. I think it’s also probably made it easier to introduce technologies because we were not starting from scratch but we were rebuilding the foundation and we were clear with the vision, we were clear with the principles surrounding that vision, and we were clear with the process of how we were going to review what was going on, on those principles.

Reference 2 - 2.75% Coverage

Even if a clinical lead said, but we must have this because it would improve our turnaround rates, if there was no clear public health outcome associated with that other than people got their results quicker, it’s unlikely it would be supported.

00:17:01

And that is a tension, especially for me. You’ve got to remember, it’s clinical as well. It is a tension because I’d like, in the nicest possible… I’d like the ideal world scenario where everyone who has a problem, if we’ve got a solution to it, we can do it. But the reality is it’s within a price, and we’re stuck in a position whereby we’re not like these big hospital trusts with blank cheques, too big to fail, we’re a social enterprise that are working on a commercial basis like every other business in the country except for big government institutions like hospitals.

Reference 3 - 4.84% Coverage

R And what do you think are views on point-of-care testing in your service, individuals’ views on point-of-care testing?

P I think I’d like to get to the position where that was the norm rather than the exception, but I understand that we are… And my partners in the laboratory we commission will probably hate me saying that, but at the moment, we’re in a position where I think it has its place and its designation in certain areas, e.g., where we had partners attending, I’ve had a report that I made… Someone’s told me they’ve got chlamydia. I don’t know.

We go through treatment. The rule is we treat and test, and the risk is we overtreat. I’d like to get rid of that risk. With antibiotic resistance, overuse of antibiotics, I’d like to get rid of that risk by being able to say then and there, actually your partner may have tested positive for chlamydia, but you don’t. I think that’s really useful. I think with certain risk groups, it would be really useful for some people who wouldn’t necessarily engage or follow up on treatment, those people that perhaps have particular vulnerabilities

00:37:32

I don’t know, no home address, those people with chaotic lifestyles, those people that have limited understanding, I think that would be useful. And I think, more practically, for those sorts of things like contraceptive procedures that involve the need to rule out infection certainly have a place there.

R So coil [overtalking]?

P Yes, that’s right.

Reference 1 - 2.47% Coverage

R So I can hear that there are key things that drive implementations. So that’s patient needs?

00:13:11

P Yes.

R And also the new technology being cost effective?

P Cost effective, patient needs, I would say. So definitely patient needs have got to come first. It’s not going to make any impact really on the patients and there’s no improvement to their service or their care, then there’s not much just bringing something in. It’s got to be a key driver with an improvement there.

Reference 2 - 10.35% Coverage

R So now I’m wondering, what is your opinion on point-of-care tests and what in your opinion is the general approach to those point-of-care tests in the service?

P I think they’ve got massive benefits for patients. I think they’ve got massive benefits for groups of patients. It’s a case of also using them but being able to remind the patients about the need to follow up their testing as well. So if it is a case of they still need to come back in X amount of week’s time or whatever, it’s making sure that we’ve given all the right information because sometimes patients just want the results right now.

They don’t always listen to the rest of the information when you’re saying to them yes, but you still need to be tested in X amount of weeks. They can’t just stand to that bit so they’ve got their results now and that’s it, that they’re off. So I think it’s a whole this massive benefits but it’s also about making sure that we’re not sending them all off with, not forcing information but reminding them about the need to come back if they need to. Does that make sense?

R Yes, definitely.

P Because I know sometimes with HIV, we don’t do point-of-care testing for HIV but Terrence Higgins do and they were saying the same. That was brilliant but as soon as they’ve got their results that’s it, everything else you said to them, they’ll just forget. They say, no, yes, we’ve done this or that but you still need to come back and have another one done, but they don’t always listen to that bit.

00:17:27

It’s about the here and now. But like I said, I think for those who could have chlamydia and gonorrhoea point-of-care testing, especially for those young people that maybe are going to struggle to get back into clinic again, then it’s brilliant. For the high risk patients, maybe those who have been assaulted and actually having the trauma of coming back into clinic and pre-coil fix, all those ones that potentially you do need your results right here, right now. Then yes, I think there are actually benefits to it.

Reference 1 - 2.06% Coverage

P Well, I mean, I think in terms of service evaluation, there needs to be some feeling within a service that whatever we've currently got may not be the best thing. It may be past its sell-by date, there are better tests out there. It's not very efficient. There needs to be something that whatever you're currently doing isn't as good. And so, for example, doing the Vagina Panel, we don't have nucleic acid testing for TV here. So doing an evaluation of a test, you get buy-in straightaway.

Reference 2 - 7.93% Coverage

P I mean, I think it depends where you sell it to. If you can see an advantage or something, and you can then convey that to the staff, then yes. Then I think everybody becomes very invested in it. And I think if it's something you're told you must do from the top-down, then there's usually... unless they can see the really good... I think at the end of the day, the people who should be most interested are the people at the shop floor dealing with the patients if they can see the benefit of it. And that's why I always feel quite strongly.

You actually need to be able to see what the benefit is and explain that to the people seeing the patients. And if you can't do that, then you probably shouldn’t be... unless there's a cost saving in this. For example, you're looking at a different NAATs test exactly the same performance in the lab but it's cheaper, then that doesn't need to go anywhere. But on the shop floor, if you're actually changing pathways, then actually, the people who need to invest here are the people seeing the patients because they need to somehow we're making that change and what the benefits are.

00:07:19

Whether it's the cost or simpler pathway for patients or a quicker pathway for patients, it needs to be bought into it at that level. I mean, one of the recent ones are electronic results and order comms, which we bought in. We started that very slowly. And very rapidly, all the staff could see that there was a huge benefit base for them and for patients in terms of getting results electronically and being able to text patients their results. So everybody bought in very quickly.

Well, the fact is that the driver had come from the commissioner, so we went out to tender saying they want a DPR [?]. But by choosing to go with the lab bit first, all the staff could see actually this was a really good thing. And so they were bought into it very quickly.

Reference 1 - 3.50% Coverage

P It’s usually the area that requires the test that does most of the pushing. For instance, when the community required point of care analysers for FBC and CRP, they were the ones, well I mean, they got in touch with me. But they were more the ones who were pushing it forward, because they had deadlines. They had deadlines where they had to have it in place by. So, we worked together with them, but the relationship comes from the service user who wants the equipment.

Reference 1 - 2.38% Coverage

R So would you say that it's the clinicians and nurses... so everyone who deals with patients that they are the most interested as well in new technologies?

P I think so, but probably the commissioners as well.

R And that is because...

P Because of the patient needs.

R Yes, as well.

P Yes. I think most of it is more down to patient needs. But if it makes work much better for clinicians, both patient's needs and clinicians work, then it works better, I think. Well, I think it's a bit of both.

Reference 2 - 0.99% Coverage

So in a way, the patients' needs, that as well can make a case for a new technology.

00:08:00

P That can, yes. But I think it's a combination of patients' needs and staff willingness as well to embrace it.

Reference 3 - 4.27% Coverage

P I'm not very much involved with the lab. But having said that from a clinician's perspective, what you want is a result. So how you get it, it's interesting. With the lab, at the moment, it takes a bit longer to get results, so that's why it gets to patients' needs. So what I find now, because of technology, the expectations of patients are high from health services. So if they want a test, they want a result now. I find that in clinic a lot, that the demand for wanting to get the result now is much higher than it was probably years back.

So it might be possible that it might help in terms of that, but I don't know how that would work with the lab. That's a political one. I think that's for the lab. But for me, if I can get a result, that's my own interest, I think.

00:12:15

R And the sooner, the better.

P The sooner, the better. If it's reliable and you get the result, that's good.

Reference 4 - 7.76% Coverage

P I think for patients, they would love it. I'm saying it's longer time. But for them, they are having to wait two weeks to get their result. So for them, that would be amazing to get the result when they visit. But it depends on what time we've done the test, because even now, some patients complain that they are waiting longer within the clinic for their appointments. So if we have to make them wait even longer, I'm looking at some patients going, I'm going home, so ring me up.

00:28:26

So that would mean more time with the same patient ringing them up, telling them the result that they could have got in the clinic. So, yes. In that way, it might. For some people, it might be all right. But for some, they would think that being in clinic for another 30 minutes would not work.

R And what about those patients who are aware of the test but then find out that they can't have it?

P I think that will always happen. That will always happen, because even now, you'd be surprise that people come in and ask for the test. Because if some people have travelled to some country that, this test I used at United States, they'll come back and say, could I have my result now then? And with technology, they are reading a lot. People would sometimes, oh, you do in-clinic, it's clarifying what people have already read on the internet. So, yes.

R I could imagine, yes.

P So they know I'm a practitioner in the United Kingdom. We are not using this test here yet, blah, blah, blah. But some people would ask for them and would have to see and manage the expectations accordingly, because people do ask.

R Already?

P Yes, people ask.

Reference 1 - 3.01% Coverage

R Right. And do you think those benefits the whole team to make an effort to make the technology work?

P Yes, of course. Yes, because we like to please patients. We like to do as much as we can for them. So it's about that staff satisfaction as well as the patient satisfaction. If the patient's happy, then the staff are going to be happy as well. We don't like to have upset patients or angry patients to have to deal with.

Reference 1 - 5.15% Coverage

R So, would you say that a point-of-care test in the Sexual Health Clinic would improve the service?

00:19:35

P Personally, I think it would because I know that they struggle with the laboratory. I know the laboratory is criticized for being slow. And I often think that the online testing is used to circumnavigate the internal laboratory anyway.

When we had our committee screening programme, we used exactly the same online testing practice rather than the local laboratory for the urine sample testing, purely because the turnaround time was so slow, it was unworkable. Whereas an online test, everything was posted off, and the answer, a positive or a negative, was back within 48 hours, 72 at the most.

So, yes, I think it would help patient pathway. Yes, it certainly would speed up the process. But we would probably then be criticized for reducing the need for our laboratory. But they are slow, they are pretty slow.

Reference 1 - 4.72% Coverage

P Most people like point-of-care testing when they improve the delivery of care for the patient. For example, a pregnancy test, being able to do that in front of a patient, with a patient means you’re getting alongside that patient at a time when they need additional support. Again, this morning, a little earlier I did a point-of-care HIV test. And that’s with a patient who was so worried and clearly, it had a great benefit to him, to be able to address his anxiety very quickly.

It then meant, again, with the patient having the pregnancy test, you can work with the patient, with what you’ve got in front of you. There isn’t that maybe, yes, but well let’s see what this result says, come back next week, come back in two days, come back later today. The point is, you’re able to be responsive immediately to the patient. And then make a plan of care that is useful and relevant to them.

R You think that the point-of-care test has the potential to improve the service?

P Yes.

Reference 2 - 3.01% Coverage

R Sure and would it impact the patient experience?

P Yes, I think it would. I think there’s going to be those patients that come in and would be very keen to know what their diagnosis was as quickly as possible. If a point-care-test was as valid as a laboratory-based NAAT test, then that would be really, really, really helpful. And if you could do lots of point-of-care tests all at the same time and perhaps test everybody who attended the clinic in the morning. And then by the end of the afternoon be able to tell them, yay, your tests are negative, or your tests are positive. I think that would be really, really helpful.

Reference 3 - 5.64% Coverage

P Yes, I think that would be really helpful. Because there isn’t a widely-available MGen test available at the moment. And a lot of services are not able to offer MGen testing routinely. The national guidelines are still just being discussed at the moment. International guidelines, a lot of people are not even familiar with them. So, I think that would, it would definitely move that conversation along about how MGen was managed. And the concerns that are already being discussed about MGen resistance and antibiotic resistance. So, I think having a point-of-care test for MGen and then being able to give the appropriate antibiotics would definitely help. In terms of antibiotic guardianship.

When it comes to trichomoniasis I think that the prevalence of trichomoniasis is relatively low here on the… Well the presence of all infections is relatively low here, where I work. So, I think being able to… And not everyone is so good at the microscopy in relation to trichomoniasis. Because there is so little of it and we see so little of it. So, I think that would definitely add something to the diagnostics. And to the patient experience of being able to get results quickly.

Reference 1 - 11.71% Coverage

R Right. So, when you’re assessing this, are you thinking about a certain population or just even a bigger context?

P When I look at the fact that what cartridge testing is and how quickly we can get results, I see that in terms of… It means that, for transmission, I’m not sitting waiting two weeks for a test result. So, I can get that person treated a lot quicker than sleeping with more people, having sex, spreading infection around. Keeping the cost down, which means we won’t be getting more partners in. We won’t be using more medication on people. That’s the way that I’m looking at it. So that we can minimise forward transmission of things. And hopefully it will get people in to us, at Sexual Health, thinking I can get a result quite quickly here instead of waiting.

And I also feel, living on [location] and knowing the population that we have, there are people of low income. And actually getting to us can cost £10 on the bus. So they would rather not get to us. But of course mental healthwise, it feels good to feel loved, and if that means having sex, fine. They’ll just go ahead. And that’s what happens because it makes you feel good for those moments. Because we all know the impact that that has. Us being able to go out if the unit is transportable, to be able to go out into community, go to where these people are, and start getting them to act [unclear].

I’m a firm believer in being able to go to these places of deprivation and getting those people tested. And getting those answers quickly and getting them treated quickly and working for the people really, and making sure that they are serviced properly and looked after properly. And I think that’s really important, because alternately that has an impact. We don’t have a big purse here. You know the NHS isn’t a never-ending, giving, open bank account. We only have so much money, and that works out for… That is a bigger picture of it.

00:05.35

People go on holiday. People come to us for holiday. We see spikes when we have a festival here. We will see a spike six weeks later with unintended pregnancies, or we’ll have infection spikes happen to us. We have had people come back from Spain. Things where you’re concerned about gonorrhoea, and actually they’ve had sex with people over there. And yet they knew they were negative when they went over. So we are seeing that actually we haven’t managed to treat some things, so we have to get them in for a different type of antibiotic. So, we’re seeing that here. And to be able to offer a service that we can say, we can do this quickly, we can do it efficiently, we can do it cheaper.

And cheaper doesn’t necessarily mean the unit, for example using your own like the [unclear] unit, but even cheaper on the NHS as a whole, healthcare as a whole. And population of course under WHO. That all counts. And we know what’s happening with gonorrhoea at the moment, and syphilis. We’re seeing pockets of syphilis. So we know that we are able to access those areas or access those people. Get to know the results quickly. It’s got to be a win-win situation. It’s great for the consumer, the person coming through the door, and it’s good for us at the Health Service to be able to look after them.

00:07:08

And keep those costs, both monetary and the health costs, down. I might have gone around and round, but it’s so important. It’s not just about the money here. It’s about everything else going on as well, because of course one infection can lead to something else and it does have its effects on health. It’s not just about clearing a chlamydia infection. That’s all fine. But It’s also the damage that can also be done by that. Or indeed anything else. To be able to have something convenient is a good thing.

Reference 2 - 2.72% Coverage

And no other pitfalls, because technology has moved on and is allowing us to do this. I just think, if it’s possible… Because the [name] location, because of our natural water, because the numbers aren’t skewed by anything else, you get a very clear analysis of what happens. Yes, it is really interesting. And this I found when I was in my degree, when you look at things like that, yes we’re in [location], yes you’d think that there would be money here, the affluent.

Right now this week, we’ve got Cows’ Week going on. There’s the richest of the world’s rich here in Cows’ right now. And yet there’s people sleeping down by the river, and that’s where they sleep all the time. So, we need to access these people. It’s a right for everyone. Doesn’t matter how rich or poor you are. STIs don’t care, do they? And it’s getting people festive and getting it all out.

Reference 3 - 3.45% Coverage

In Australia, the TTANGO they call it, don’t they? I don’t know if you know that. And it’s T T A N G O. And I think it’s Take the Test And Go. And just think that’s’ fantastic. It’s just amazing. And I said to service manager, I said, can you imagine just saying let’s TTANGO, or when was the last time you took the TTANGO? Or you can see the straplines. I know it belongs to Australia, but it’s brilliant. These little things. And it’s just bouncing these ideas off. She said, you’re doing your homework then? I said yes, because I’m interested in it.

00:026:07

I think it’s a good thing to do. And to say just take the test and go. To know that you can sell it quicker than a free test. When I say to people. if you do it today, as in on a Monday morning, if you phone or if you go online today, you’ll have the test kit possibly tomorrow. Definitely by Wednesday. Pee immediately. Get it in the post. You should have your results by the weekend. They’re sold. They’re absolutely sold on it. And I get the results too. And they know that, because I’m telling them that. And they do it. Which is great.

Reference 4 - 5.31% Coverage

This afternoon we are going out to a different clinic elsewhere because we just say that we’re going to do a clinic here. We’re going to go into mental health and we’re going to do a clinic there. And we pick up a suitcase, fill it with whatever we need. And we sit in a mental health hospital, and these people come and test. Because if we don’t do that, they can’t come to us.

R There was a lot of outreach?

00:28:48

P Yes. There has to be. And this is what I said when I joined almost eight years ago. I said it’s okay to do a community screening programme, but they’ll never come to us. We need to do outreach. Then I was in with all the shelters, Salvation Army, and all of those, working there constantly. Because if they can’t get to us, they still need their sexual health testing. And it also creating a space badge. And I very much felt that some of these people are frightened of badges. Frightened of seeing something and thinking that…

If they’ve been living with Social Services or something for all their lives, it’s not necessarily a positive thing to see a badge. And it was about breaking down all those barriers. And saying this is a positive thing, and you are worth it. Let’s have a chat. Talk about anything. For a start, look after your sexual health. And all that time you’re bringing up their mental health. I’ve had young people go into education because why don’t we make the phone call together? And it’s about that type of thing, looking after all of it.

And if you can do something really fast with testing whilst you’ve got everything else going on as well, it’s a good thing. It can never be a bad thing to look like that. It’s what I would always want to achieve.

Reference 5 - 3.01% Coverage

R That’s okay. So, at the beginning you said that you’re quite… that you like the idea of a point of test?

P Yes.

R And that’s because you can give those results on the same day, and therefore you can treat people within the same visit, and obviously stop infections?

P Yes. Stop forward transmissions. Reduce all of that. Lower clinic costs, lower costs to the NHS, and further costs outside of that. Things that could happen later on their lives. Ectopial pregnancies for example. All of that going on. And fertility. But it doesn’t matter how many times you talk about it on the phone to a young person. They still aren’t going to believe it until it happens to them. To be mobile, or to be able to have that ease of use, the aesthetic unit. Just saying we’ve got this new technology in our clinic and being better prepared to improve their access.

Prompt diagnoses. It’s good. It’s great for the public health purse. It’s hugely beneficial for everyone.

Reference 6 - 2.81% Coverage

P I think it’s really good. We’ve seen… And worth the price. We seem to be getting more and more TV which, gets very exciting around here. And I hadn’t known about mycoplasma until last week, which sounds really strange. But we had somebody in from London who received a text whilst they were in clinic. They were here on holiday. And she asked me what it meant. So, I went off, I thought hang on a minute, because obviously I know what it is, but I just need to see because we’re not testing for that, and it’s good to know. And have then gone off and read about it, I’m thinking this is really something that we need to look at. It’s like the next chlamydia.

00:39:07

So I think it’s great. I think it’s absolutely great that you are able to offer that as well. And let’s not miss anything, because it all has an impact. So, that’s how I feel about that, yes. It’s all good. That’s how I see it.

Reference 1 - 2.57% Coverage

And obviously it’s cost effective, so we are very much involved in introducing any changes to the service and it’s actually almost that nothing is done without our say so, where at all possible.

00:09:50

I mean, budgets unfortunately don’t… We can’t influence them but if there are any changes to the way that we work then we are very instrumental in actually making sure that it’s something that can be delivered. And also that it is actually going to be something that’s needed and also that is going to offer the quality of service that we want.

Reference 2 - 2.63% Coverage

We don’t have electronic patient records and we don’t have the systems in place to be able to facilitate that, so I think we’re quite a long way off from actually introducing that. And I would suggest that if we already had that in place and we were getting results a lot quicker then maybe we wouldn’t be looking at something like point of care testing, if I’m honest. But actually because of the situation that we find ourselves in with those results, I think that would really help the quality of care that we could give to the patient and the patient experience.

Reference 3 - 7.72% Coverage

P Yes. I think the key thing for us… I mean the main thing is the fact that we can get results back to patients in a much more timely manner, that would be the first thing that I think would be a great plus. But I think also by using that we could also then be able to give treatment more appropriately so sometimes we start treatment thinking that maybe the results are going to come back as positive, maybe a contact or something like that. Whereas maybe we wouldn’t necessarily have to start the treatment you know, literally as they are with us, we could within a few hours have a result and then decide whether treatment is appropriate or not.

00:25:44

So maybe we would reduce the number of treatments we actually provide because we’d have more accurate information to go on. So I think it’s the time of the results from the patients experience is that we do less treatment than we are currently much more appropriately. And I think also from thinking about the onward transmission, again we would probably… Potentially I don’t know, we’d have to think about how to put it all into practice, there may be situations where we are waiting for results that patients are actually… Because they haven’t got a definite positive, maybe then they are going out and having unprotected sex and therefore the onward potential of transmission.

So there could be a little bit about actually controlling onward transmission by having those more or less you know, straight away results that would actually emphasise the need for abstinence or you know, that would help with the advising side of it as well. I think those are the three benefits that we would see.

Reference 1 - 4.39% Coverage

P No, because if the laboratory feels that there is better technology that we should be implementing, then we will put the case forward. Certainly the last big change we made here was because we were in a position where we couldn’t staff our out-of-hours and it was a case of, well, the out-of-hours would have collapsed anyway. And by bringing this piece of technology in, we were able to maintain them being able to have results during the night because it was something that could be operated by staff in another department.

` So, I mean, that was implemented without much issue because it was an extremely high risk; if we didn’t implement they would have had no service at all. So it really is based on what is the change, how necessary is the change, and if it’s just something you’d like to do but there’s no real benefit, it’s unlikely that it will be approved.

Reference 2 - 3.39% Coverage

P Well, the TV would be useful because at the moment we do microscopy and it’s not particularly sensitive and with patients in the clinic, they don’t send swabs to us for a routine genital investigation unless they suspect bacterial or a parasistic infection. So a lot of those patients potentially aren’t even being screened. So I think there would be some benefit there.

But, again, it would depend how the test was going to be used. I mean we do a combined… that test we do at the moment is combined chlamydia and GC. So if what you’re going to implement is just a chlamydia test that is actually giving less… a less accurate result than what we’re currently doing.

Reference 1 - 1.79% Coverage

But I think ultimately, if we can facilitate rapid diagnosis and treatment of patients, I think that's going to have a huge positive public health impact. Will facilitate and encourage people to get tested, because they're not hanging around waiting for results. So, I think those are positives.

Reference 1 - 1.43% Coverage

P So I think, I mean, I think a lot of introduction is driven clinically, so for example, guidelines change or research developments happen. And as the senior clinician, so for example, at the moment we’re looking at mycoplasma, and we don’t offer that in our clinic, and trying to get that introduced. And we currently offer TV culture, which is obviously is suboptimal and we’re trying to get PCR. So I think a lot of the demand for technology is driven by the clinicians because see the clinical need.

Reference 2 - 3.33% Coverage

I think also there’s a degree of patients leading this processes as well. So, for example, BASHH has just published the draft mycoplasma guidelines and they’ve done a big publicity hit about that. And we now have patients who are coming into clinic saying, am I going to be tested for mycoplasma.

00:21:11

Now at the moment we can’t offer that test, but there is, I think there is a patient drive for new technologies and certainly, in some clinics, for example I think it’s [clinic], you can get your results within a couple of hours. And patients who’ve experienced that, want that, obviously, and so I think there’s the pressure from patients to bring in new technology. And that’s good.

And I think it’s, patient pressure can sometimes bring political pressure as well, so if people sort of ask these things it then puts pressure on commissioners and governments to commission tests and technology. So I think that can be really useful. I think use of the media to galvanise patients in that is very helpful.

R Alright. Yes, so I guess you can also use media or what’s already there, public opinion. to then influence commissioners.

P Yes, absolutely.

Reference 3 - 0.45% Coverage

So I think the quicker clinic time, clinic result time, particularly driven by our MSM population, you know who are screening regularly and want results quickly.

Reference 4 - 4.33% Coverage

And so we do quite a lot of expectation management at the moment. So we text out negative results and we ring with positive results. And we’re basically saying to patients, your results will be available within two weeks.

00:32:40

If you’ve not heard at two weeks, chase us up because you should hear automatically. And actually although we’re getting lots of results out within five to seven days, we’re using the two weeks because it is taking that long for some patients’ results. And I think lots of patients are surprised when we say to them, your results will take up to two weeks because, that does seem like a, I think to patients that feels like a long wait-time.

They’re used to having blood tests done at their GP where they’re getting the answer back in a couple of days. And so I think there is an expectation there that it should be faster. And actually the patient doesn’t have any choice because that’s all we’re offering them and I think maybe they’re pleasantly surprised when it comes under two weeks.

But I think the demand is certainly for faster results time and I think we’re living in an increasingly rapid world where patients… You can get Amazon Prime and get whatever you want, delivered the next day. And we seem very backward in comparison with that.

And I think it would, it is beneficial for patients to get results faster. Not just for reducing any complications from an infection, but reducing transmission and even those patients who will have negative results, it’s a form of reassurance.

Reference 5 - 7.18% Coverage

P Yes, I think that will be brilliant. So I think having just chlamydia and gonorrhoea is slightly limiting. So for our clinic, at the moment, we’re offering substandard TV testing, but certainly in other clinics that I’ve been in, we’re only offering wet microscopy, we didn’t even have TV culture. Currently we’re not offering mycoplasma testing and these things we’re looking to introduce now. But obviously that’s going to take, that process is going to take some considerable time.

It doesn’t look like anything’s going to happen in the next month, for example, maybe even years, who knows. But I think having a four-test system would be very valuable. Yes, absolutely. I think, I guess the only thing I wonder about mycoplasma is, on the BASHH, their new draft guidelines, they’re saying that actually we shouldn’t be routinely testing asymptomatic patients due to issues over testing.

We don’t have a good antibiotic regime and its risk of apprising antibiotic resistance at a population level. Now I think if you test somebody for mycoplasma, it’s impossible to say to somebody, you have mycoplasma, but because you don’t have any symptoms we’re not going treat you. You may or may not have problems due to it in the future. I just, I wouldn’t accept that as a patient, that would be impossible.

00:35:45

So we might then end up at a point where if we can’t turn off the mycoplasma element, we’re ending up testing lots of asymptomatic patients. And then what we then do with those results, based on the current BASHH guidelines, is difficult. I think if we could turn it off, that would save those problems.

I guess as a clinician I slightly struggle with the draft guidelines whereby they’re saying, we have this known sexually transmitted infection which can cause problems in a number of patients, but we’re not going to routinely test patients for it. I find that quite difficult. And so my personal opinion would be, we should be testing everybody for it and then treating them, and then doing test-of-cure, particularly for mycoplasma, to make sure we’ve eradicated it, given the difficulties in antibiotics.

And that’s certainly the opinion of other, I don’t know if it’s the opinion of all the consultants within clinics, but certainly a number of consultants would share that view. I guess then we’d have to decide whether we were going to institute a local policy whereby we would offer mycoplasma testing. That would obviously put us at odds with national guidelines and we’d need to think quite carefully about that

Reference 1 - 4.82% Coverage

But I mean it definitely has a use. I think another place, I mean, if you’re looking at non sexual health settings where, you know, people are a little bit, oh, I’m a little bit worried about this pregnant woman, do you know what I mean. I mean, there’s, you know, pregnancy, young people and pregnancy, you know, they test for HIV, syphilis and hepatitis B but they don’t test for chlamydia and gonorrhoea.

00:29:08

And we know there’s a lot of chlamydia and gonorrhoea in the under 25s. And there have been pushes to make, you know, testing universal with HIV and syphilis in this age group. But it hasn’t really happened because the midwives haven’t adopted it. But, you know, maybe having something like this because it wouldn’t be, like, a massively big, like, sexual health unit it might be there’s one 25 year old or one 21 year old amongst a... you know.

That’s another interesting setting there, you know, put it in terms of... Because there actually it’s quite useful particularly if a woman books at 30 weeks or 37 weeks and you find she’s got chlamydia, you know, you’ve saved that baby’s eyes potentially. So, that, you know, and you’ve given her the answer and you just give her the treatment straight away because that’s where I think it’s quite a nice... It’s got, I mean, where it’s not a massive footfall of patients unless they increase the number of tests they can do at the same time.

Reference 1 - 5.15% Coverage

R And this feedback from patients, have you see it having a real impact in terms of that it actually led to a change?

P So we had a, very broad example, but a transgender patient who wasn’t very happy that we had a male and female form and that at the reception he had to register as one or the other. When in theory he would have liked to… I think he was born female, so had female genitalia but presented as a man and wanted to be treated as a man.

But the question didn’t apply because actually what they were about was a female problem. And it was, so we got this comment on the feedback and then the matron sat down with me, because I’d had the experience with more different genders, different varying backgrounds, and we went through and we just changed the form completely, and within a week that was implemented.

00:08:54

So that changed quite a lot. So that was one bit of feedback that’s changed our complete registration form and allows people to put, other. So we haven’t put transgender, intersex, anything like that because it would get too confusing. So it’s, male, female, other. And we can put other on our computer system.

Because the previous barrier was on our system. If we put male, we couldn’t order vaginal swabs, and if we put female we couldn’t order some of the tests that we need for men like urethral swabs. So, but it was good that we’ve come up with that.

R So now you can put other and then you can order.

P Then you can order everything, yes.

Reference 2 - 4.61% Coverage

P We’re encouraged to save as much money as possible. We’re trying to, as I think with every NHS trust, we’ve got to cut a certain amount of the budget. So it’s quite, that would be a barrier to new technologies because unless it was being seen as something to correct something that was wrong, they might say, but why we going to introduce that, because that’s going to cost more in the short term.

One example is we were having computer issues with our results coming through, so we switched to doing instant HIV-syphilis tests. So that was, even though they were more expensive than the lab, because the lab’s on a bolt contract, it was seen as essential until we got the computer system sorted because we did not want to miss an HIV positive or a syphilis positive result. So that was seen as an essential, and therefore a justifiable cause.

00:16:49

But as soon as the lab was fixed we had to stop using them and go back to venous bloods. So finance is a very big thing. And it’s also the training of the people, what staff would be, because that would take staff out of clinic, and what staff are actually going to do the testing and things, because we don’t’ want nurses to be stood next to a machine for half and hour because that’s not the best use of their time. So that what would also have to be considered as well.

Reference 3 - 1.85% Coverage

But actually thinking about new technologies, and I know this is about point-of-care testing, is it can save a lot of time and therefore resources on calling people back, because if we know a result within half an hour that will take out the three weeks of recall we have to do when we have a positive that’s not being treated. And that takes a lot of time trying to write to people, call to people, voicemails, everything. So that’s another way to look at the financial things, is time. Not just the money but the time things take.

Reference 4 - 2.18% Coverage

R Right, and are there, what would you say are individual’s views on point-of-care testing? Would that be, will people be supportive of it?

P Patients definitely would. The patients love it. They come in and they still ask for the instant HIV-syphilis test and we need to say, well actually we’re not doing that one anymore. And people want the results same day. I think that’s why one of the central London clinics, so most people will know, was so popular, was because they had same-day results. So you went in, you did everything and within an hour or so you’d have a text with your results.

So patients would be very keen.

Reference 5 - 6.71% Coverage

R Right, and what about the four pathogenic tests, so CT, NG, MG, TV, how would that benefit the clinic, if at all?

00:28:49

P You can give them the right treatment.

R Right.

P So we, the population we have here, we have a high amount of TV. Nearly always symptomatic in women, but we can’t test men without being really cruel. So actually even just for the TV portion of the module, then when people come in as a contact or they’ve got, or men have urethritis symptoms, we don’t treat with metronidazole, which is the TV treatment. So we treat them with something else, but then they end up coming back with symptoms.

So it could improve the care quite a bit if we know those two additional results. Because they do have an impact on what antibiotics we can use. Particularly with the Mgen antimicrobial resistance and things. So I think that would potentially get taken up easier than just the chlamydia-gonorrhoea, because that’s a relative, chlamydia-gonorrhoea is something we can do relatively quickly through the lab. The results are normally back within a week.

And there’s less concerns about, and normally if there’s gonorrhoea you’re going to want to culture as well, which needs to be done quickly. But to have the TV, which is, particularly in the community, because we only have a microscope at this one site, would potentially solve a whole load of problems, a whole load spread of infections.

00:30:00

Because we treat TV as, we treat it as BV. So same treatment. Symptoms go, and then they keep coming back because partners aren’t treated. So I think that would be a good thing, particularly in this demographic area, we have a lot of trichomoniasis, I think it goes under-diagnosed. I think at one stage we did a pilot on doing it as a PCR-TV, well that’s what our business case is for at the moment, is to get that as a permanent test for us.

R Oh, I see.

P And obviously that’s being done by the lead.

Reference 1 - 9.24% Coverage

R And do you think that technology is not being good enough, is a common reason why they don’t get adopted?

P Technology not being good enough?

R Yes. Or maybe there is, maybe even if they are good enough there is some distrust.

P I’m not sure. I think technology, when it’s used well, is really good. You know, the online testing here is great. If you haven’t got any symptoms, that’s really good. You would just get your test and go or have it sent home. I think that people are really happy with that, but they want to know that that’s actually going to be as good as a test that they would do here.

So I think, I don’t think people have a problem with that, as long as they know it’s a good test. I think the issue we might have here is that we, people are used to seeing a clinician. They’re used to seeing somebody to say, I just want this done or that done and they look for the other questions as well. They don’t necessarily need to see anybody, but they’re used to doing that, so it’s moving people away from perhaps seeing a human being and just relying on the online testing.

00:07:28

So some people are really happy just to come in and pick up a test. Some people want to see somebody. If they haven’t, they’ve got nothing wrong, they just want the reassurance of seeing somebody. Other people get a bit anxious about having to do a test themselves. But I think with the point-of-care testing that we’re thinking about doing, it’s, we would be doing it anyway, wouldn’t we? So we’re not asking them to do the test there on their own. Is that right? We would be doing…

R Well, it depends really because patients can take their own swabs and urine samples.

P But they wouldn’t then be using the machine to run it, would they? No. So, yes. They do that now, even if they come and see us for a chlamydia and gonorrhoea test, they’ll do the swab themselves, but we’d send it off to the lab. But we haven’t got so far as them doing the swab and running the machine have we?

Reference 2 - 7.07% Coverage

You’ve got to balance those up really, I think. Is the outcome of doing it going to be better. Is it worth the money we’re going to spend on it actually. I actually think that’s what’s going to be the [overtalking].

00:10:05

R By better, do you mean improving patient experience…

P Yes. So if you can do a chlamydia and gonorrhoea, the TV would be really good as well because I think we’re giving the people a lot of medication. And I think in our outline, because we’re going to be doing the microscopy here for TV, so the outline can link. So if you can run it, run a TV test, because I think we’re giving antibiotics maybe for a BV that might be TV. And then, obviously, that’s just never going to go, because that’s the partners treated

So if that could be done, there’s room to be a cost saving there, for the patient and for the service as well, if they’re managing to treat that. So I think the quicker you can get a test result to somebody, obviously it’s the better, really. So, but obviously if you’ve got a 30-minute wait, that’s an additional 30 minutes on top of your consultation as well.

Here people sometimes do wait that anyway, for the result of the microscopy so I don’t know if that would make any difference, but I think in the peripheral clinics it’s going to be an additional waiting time, I think. Yes, I don’t know. It might change the way that we run the consultation. So, we know sooner whether we’re going to do that test or not. So we get that started and then do other things afterwards.

Reference 3 - 7.83% Coverage

R So the best would be if you could choose which patients…

P Possibly, yes.

R A selection of tests.

P Yes. And then we’ve also then got HIV and syphilis. So would we be just sending those off as we would do normally. I don’t know.

R That could potentially be…

P So they’ve still got to wait for that, haven’t they?

R Yes.

P I guess it’s, at least you’ve got the chlamydia and gonorrhoea you can do. I think, certainly for people who have come in as a contact of chlamydia and gonorrhoea, they have the option, at the moment, of testing and seeing, and testing and treating. Where I think, with the rate of potential resistance to medication, I think if you can do a test there and then for chlamydia and gonorrhoea for a contact, I think that would be really good. Because you can say, well actually you don’t need treatment now.

00:24:22

So, if you look at the cost of medication for treating people who actually don’t have the infection, but because they’re a contact we treat anyway. That might outweigh, I don’t know what the finances are, but there are certain benefits there, I think. Being able to assure somebody straightaway that they don’t have an infection at that point, as long as it’s not sort of in the window period, that, for the patient I think certainly that would be a great thing to do.

I think if that was me and I’d been in contact with somebody and they told me they had gonorrhoea, and I could come and and say, yes, well no, actually you don’t have it, and you can say that’s safe because you’re, it was more than two weeks ago, then you haven’t got any treatment, potential side effects, potential anaphylaxis. That’s probably is a good thing, yes.

Reference 1 - 3.85% Coverage

PA Very good idea.

00:12:18

RE Right okay, why?

PA Because we have a lot of patients with… Well TV we only can diagnose here on the microscopy and that's only females mycoplasma we don't diagnose and we know patients have it and treat symptomatically. But of course, we can't do [unclear] identification, we don't know, we can't actually get a full diagnosis. It would be very, very advantageous.

RE Right.

PA Those people with the symptoms that we're treating and they're not kind of completely clearing. Yes.

Reference 1 - 0.76% Coverage

Quality of patient care is a big one still; we still need to be doing that but a lot of this will be down to whether we can actually afford to do that.

Reference 2 - 3.85% Coverage

Usability, obviously, from our practitioners will be a huge issue if there are issues around reliability or if it’s fiddly or too time consuming will have a negative effect. If it’s something that works really well that will go a long way to that. Also patients, what they think about it, if it’s what they want. I think with point of care testing and new ways of working that often is what patients want but they probably don’t realise it at the time because nobody tends to ask them that.

So, I think, probably all the way around, at the end of the day, it will come down to finances but actually we can prove that we can be more efficient, see more patients, bring more income into the Trust as a result of new technologies that will also go a long way towards approval.

Financial considerations

Reference 1 - 0.25% Coverage

The financial drivers are seeing you and patients, and then delivering everything in one go are all there in terms of integrated sexual health tariff.

Reference 2 - 0.21% Coverage

The trust was very keen that we move forward with that, you know, as in our directorate, because they could see clear savings.

Reference 1 - 0.51% Coverage

We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

Reference 2 - 6.33% Coverage

We're also looking at how can you make something work. Because what most people try to do is, how do I get this new thing to work in this current way of working, but actually saying, can we change the way we work to make this a feasible thing, rather than saying, how does this affect the clinic, how does this affect the patient, can we improve patient journey by changing everything around that? And then say that we can deploy different new technologies in different scenarios in a cost-effective manner by changing pathways by which the patients know where patients are tested.

For example, if you have a rapid test that you would be using in paper who don't have any symptoms, there's no reason why you can’t have a sample first to people. So, say, you have a test that takes, I don't know, an hour to get the result, and you know your waiting time in clinic is about an hour to two hours. And these are people who are, at the end of the day, just going to give samples anyway.

You can get them to do the samples when they check in, and then collect all the information that you want. And then at the end of the consultation, you might do your part in, which the result is there so you actually don't have to... and then you can basically, in your business plan, look at how many infections you would have detected that you have treated on that day, which means that you are not going to spend near a thousand pounds and personal time recalling those people.

00:16:34

So just looking at what your investment savings are going to be would be a good business plan. Basically saying that investing here means you can save in that [unclear] job out there, and then added to that are the public health benefits. And then trying to see that the best way in which you would be able to implement something is if you can show a cost-neutral way. So you don't have to show a saving, but you need to say that I don't need extra money. And basically, within my budget, I can say I can move this from here to there.

It may not be in your power to move budgets, but it might be that you can expand roles. You can do other things and basically make savings on other things. So it may not be that your books are going to be balanced right away, but you can basically show that you can deliver a whole lot of things that you would have to get funding for. But basically by changing this, you're basically freeing this person up to do other things.

But it's actually saying that I know how much this is work, and if you don't do this, you would need to find this. But you're basically saying, this new pathway allows this to happen. This technology allows this to happen. So it would be a case for making that investment and projecting what your savings is going to be. It would be good to have a management team that is able to look at things in the long term to say that I want to not just make a saving in this quarter, which is what you hit with commissioning. It's like you only commission for your commission period.

00:18:17

I think that's the hurdle that you have at the national level and at the regional level. But at the local level, you can actually have a team that, if you have a forward-thinking team, they can say, fine, we'll keep an eye on how things are, and we'll see how you perform. Give yourselves stage targets and not just say that it's a five-year plan and look at how things are in five years, but show how you're going to be giving a monthly target. Have the ability to measure what you're doing. Be confident in what you're measuring and basically having a contingency plan.

Reference 3 - 1.47% Coverage

But get research funding to allow implementation, and then show to people that if you can actually get good quality data, that shows that you can actually save money by showing a research project that actually looks at that rather than saying, oh, I'm going to do a model, and then you go, well, it’s just a model, and say that I'm going to do a health technology assessment study.

I'm going to do an implementation science that's going to look at what are the cost implications of this change and say that we get this properly funded as a study. You get the device or the new technology through the study, and then you put it into a real world scenario. And then they have a real time look at what the exact, say, changes in work time because you're going to measure everything. And I think that's probably one of the way forward.

Reference 4 - 1.67% Coverage

And it's usually the lack of ability to deliver on this because you're not able to get results quickly but what is currently available. New technologies are looking at faster results. You're looking at tests, which don't require a lab that has 15-meter square and a whole lot of things. You're talking about things that might be logging in to have something the size of a refrigerator that you could have in the OptiMix.

Or you could have something that's a desktop that you can have in the rooms and then saying, how do you do that? And then it's looking at you've gone [unclear], saying that if I have... so far, our patient, we see about 1,700 patients a week. Those 1,700 patients a week, how do we manage to do them on different models? And you can look and say that how many do you need and then seeing that in having that negotiation to go, what is going to be cost-effective, what can we actually afford to do, and which model we can go for.

Reference 5 - 0.72% Coverage

Obviously, if the technology is super expensive, and they're saying that we need to improve development cost and we want to get our bonuses, then it looks like, well, it’s not affordable. You probably need to look at a different market. But it's a thing. And National Health will need to have good quality affordable care, because the service that we provide needs to be accessible, equitable, and sustainable.

Reference 6 - 0.22% Coverage

Obviously, there are the constraints of finances and what's commissioned and what's not. But what's commissioned is services.

Reference 7 - 3.96% Coverage

But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

00:28:04

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

And so that's where you're having a higher management team throughout the structure, which is looking at the longer picture, saying that you have all these things, you have contingency plans for the [unclear] of the system where things change. But you know that your commissioning is not going to change dramatically. So you only know that you're considered at risk because we are an at-risk department financially because we have a lot of performance targets, which are unrealistic.

And it’s unguaranteed money, which can change at any time, which basically means that you need to look at how you can get with things, but they're always [unclear]. And if you can get research to take on a large proportion of your routine work, it's paid for by research. It basically means that you make your target. At least that's a good mix, good [unclear] sense to look at that. But it also means that you have real world implementation science, I think, is the way forward, especially with new technologies.

00:29:46

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it.

Reference 8 - 2.39% Coverage

And being through quite a few service development implementations, we don’t get extra money. If you ask commissioners for extra money, it's always no. And you can generate it. And again, the other thing is to look at your business services management [unclear]. Just look at how do you make a business plan. The income-generating methods that you can use to... you could provide private services that can support these changes.

You can get research funding, as in funds generated through research, because research brings in money to the department. You could take part in commercial studies that allows you to get a budget that allows you to make the changes you want in exchange. So you have that power. So how do you empower yourself to get that? So it's saying that who are your stakeholders? Who are the people who are going to be affected, and who are the people who can make it happen?

00:45:28

The people who can make it happen are your management teams, your business managers, your research teams, and your private services teams. You want support from your general managers, who are managing the service and the directorate. And then you want to buy in from the lab because you're talking about testing. You are either going to say the lab is going to adopt it, or the lab is going to lose that. And either way, you need them to be on board.

Reference 9 - 1.87% Coverage

So if you talk to people, they talk about financial problems. And of course, they're going to be a [unclear] on the part of money, smaller and smaller. The demands are [unclear]. You need to be creative about how you navigate that. People will say money is the metric. Now, what do you do about it? If they're just going to say, financial considerations are the biggest barrier, what do you do about it?

The stakeholders are going to be different. You need to be able to say that think creatively about how we're going to do things. Diversify your activity to basically say, now you have income generation. And so basically having the ethos, that you're going to do more than what is asked of you, because that's the only way you're going to generating income. You're only going to do the bare minimum. You're not going to generate any income. You're not going to be able to make any changes.

00:47:26

So it's basically having a forward-thinking department is always going to be... having a problem solving approach is going to be key to adopting something.

Reference 10 - 4.04% Coverage

People, if they don't apply for these, don't get this. And it's basically being aware of what is out there, trying to say that you're applying for them responsibly, having those relationships. You talked about having a business development team. They're your key stakeholders usually. So people always talk about commissioner [unclear] and then talking to people [unclear]. Commissioners want lab test. And commissioners won't agree to pay to it.

00:49:18

But if you're going to do it on your own and you can deliver your key commission targets, nobody cares how you do it. Nobody cares what tests you use as long as you're able to do it within the resources that you have. So if you can move resources and implement something, it's possible. And the other side of the [unclear], you have less control because the people who develop how marketing the diagnostic and basically saying that you need to meet halfway and make it affordable.

And I think that you have the real-world examples that this has happened. So [clinic] have the Cepheid GeneXpert that they've implemented in two of their clinics. It's a very expensive piece of kit. But they have it [unclear] the service. And the understanding is that they would buy a certain number of tests, and that fits in [unclear]. As long as that is cost-effective, basically they had a cost neutral plan saying that this is how much it cost the lab to charging them.

They do it in-house, same costs. And that can happen. And we're trying to do the same, but it's looking at every situation in our service. Our lab is a company called [Unclear], which basically means that every time I come up with something that is cost-saving, does it then go... no, no, no, no, no. This is income loss for us. And they're like, yes. Everything that I'm going to suggest to you is going to be income loss to you.

00:51:09

It's looking at, if you had that, your stakeholder then, it's for as our fit for the future team, which the change management is in the trust. They're basically saying that they're going to be using different schemes, which is branded by the trust saying, this is what our organization expects. So you need to provide this. And it's saying, how do you get better bargaining power? So that’s having organizational support.

Reference 11 - 0.87% Coverage

No, I don't think. But I think I've talked about lots of the key things. I think the things to reiterate is that actually looking at avenues to service implementation studies and to make them as studies rather than say just make cost to things basically, then would make it attractive for companies to say that you have that implementation thing funded by research. And then you have all the data to make a business case. That's probably the strongest thing. And then getting organization leads.

Reference 1 - 6.68% Coverage

P Well, so the money… So I’ll talk about the money first, so financial… Areas of financial importance create uncertainty and the NHS isn’t blessed with loads of cash, okay. You’ll have known that over the last five years the government prevented a new funding scheme for the NHS for the last couple of years. It was a tiny investment. The year just gone it stayed static and over the next two years we’re going to see a decrease in funding.

So it’s more important than ever that we’re managing our services effectively from a financial point of view. And you, as a manager particularly, you’ll need to understand what are the cost implications of trying something new? So you need to understand the quality aspect, the safety aspect, the benefits to the patient of course, but actually sometimes in NHS you need to make a decision around is what we’ve got good enough or is there something we need to do differently?

Or the flipside of that is, is this a way of making us much more efficient which means we can generate income from a different means? So if we have a… If we adopt a process that means we could see patients more quickly or reduce the need for follow-up etc. we can then see more patients who need our help.

00:04:47

So the financial side is one thing. You have to understand the numbers because you’re not going to ever get support if you just make a decision with no clue what’s going to happen next financially. Because that would be very risky, I would suggest for any managers just making a decision based on something they do not understand.

Reference 1 - 5.33% Coverage

P That’s an interesting… Yes, it’s a… I think it’s a bit of both. So, you know, when we were talking about decisions around what tests to do. Is it a finger prick or a traditional blood test? That’s… The final decision always comes down to what costs more, or less, really.

00:16:23

And I find that a bit unfortunate. That it’s all about cost. That it’s, you know, we can say that it’s about patient choice and about patient experience, and everything. But the most important thing in this current state of the NHS is that it costs less. And that’s a bit frustrating sometimes, really.

But we have to kind of… We have to roll with it at the moment. So, it’s always exciting though, to try and find ways to do things that are going to save some money and actually improve the experience as well. So, if you can hit on that combination, that’s pretty exciting.

So, for instance, when we switched… This was before I was here. But when we switched to taking chlamydia, gonorrhoea swabs from all sites instead of doing them in one sample. That saved a massive amount of money. And it’s one sample. And it’s, you know, the patients.

And I suppose, that took away patient information a little bit. And that they don’t know immediately what site an infection, a positive result is from. So, that can be… Patients get a little bit annoyed with that sometimes. But it doesn’t matter. It doesn’t impact the treatment that they are getting. Because the treatment is the same, regardless of the site, really.

So, for us to be able to do something… To use technology in that way and save money is good. I wish it didn’t have to come down to money all the time though. It’d be nice if we could, like, you know, having an onsite panther machine.

Reference 1 - 0.62% Coverage

The thing… With the reception registering the patients, and because it was a new… It was really important for them to tick the enabled box for the patient's address, because it's all about funding. So when they're capturing data, and these things are being missed, then you know, that is a budget knock on effect.

Reference 2 - 4.51% Coverage

P Yes. And every single time we have a meeting, do you think we're going to get anymore more? No, we're not going to get any more money. So we just have to work with what we've got. And little things, like, affect patient turn away as well. If you don't have the staff, you know, staff might be on sick, staff might be on annual leave. So there's less numbers. So we had to get stricter with looking at how many staff we allow for annual leave. So, you're meant to have, like, some sort of, like, local policy within the department to run a service.

And then, you know, we started to explain to patients, well we did have six sites, and now we've gone down to three. And then the patients start to appreciate that, you know, it's… We've had cuts, because everybody listens to the news, or reads the papers. So they are well aware, because then they… The patients that are coming in saying, oh yes, the clinic in our area's closed down. It's because you have patients coming from all over. So once the word gets out, I mean you still get the few that don't understand, you know, why they're waiting so long.

But, you just still be told… We're still told there's no money, no funding. So you still have to work with what you've got. So we can do little things like do time slots for LARC patients, so the patients that have implants. Try and… So, those time slots are guaranteed to be seen in an hour. But they're… You only get six of those a day. And then patients who are coming in for just a general check with no concerns, you can give them a card, are you interested in a self-testing kit? Oh, I didn't know that. So, you know, little things you can do to take the pressure off.

00:27:01

R Right.

P Yes. But even though there's no funding, it's trying to weed these patients out of the clinic.

R Right.

P And then, you know, everything is reviewed. And then they say, right, okay, we can take… Because we weren't allowed to take patients who were just coming general check. We had to, people booked a time slot, because we weren't getting paid for it. So it was having to be monitored. And then eventually, they say right, you know, decision is made. And then we can take these patients. So even though we have time slots, we can take extra, so that's good. So that's… Weeding out.

Reference 3 - 0.46% Coverage

R So, it could be the case that all the cuts, and closure of clinics, that they may actually encourage adoption of certain technologies that would help the clinics.

P Yes, exactly. But we already had the self-testing kits in place.

Reference 1 - 10.27% Coverage

P There is research money, which the person who previously led on research, who left last year, he had managed to accrue a certain amount of money. It took him a while, because it was in different places, to put it into one place and sort of claw it back, as it were. And he made a point when he left, of saying that he wanted that money to be used in the whole team, and not just on certain parts of the team, and so that’s opened up a lot of options, actually.

00:11:53

Because, particularly for the nurses, sort of going to conferences or courses is very difficult, because there isn’t really any money, and the trust, over the last five years, every year they reduce the budget for courses, and only very, very essential courses. So, once you’ve done your essential courses, you’re not really a candidate for anything, and there’s always somebody new who does need a course, so you’re always overlooked – which is fair enough, if people are new, they need to get the basics in.

So, that’s been very good, because that money has actually now been opened up, and the person who now is in charge of that pot of money, as it were, is quite keen to open it up, and to approach nurses and see what they need, and what they need for their development. So, that’s been very good, and I think that will open up other doors that we have that. And knowing the directorate, because we ended the year favourably, we were given some money, additional money, so that can now be used to put back into the service, so that might be used on something for this clinic.

00:13:10

So, money’s always tight, but I think as a service we’re quite good at using, and there’s been a lot of focus particularly last year on, well, what we have, how can we make the service better, so what small changes can we make. Which I think was quite good, there was a lot of focus on that last year, with kind of quality improvement projects, and looking at time and motion studies, of how the service works, looking at what they call the barriers, so what are the barriers to people being more productive or more efficient in their work.

So, not having to actually spend any money, but say, okay, what can we change that would make you more efficient, you more productive, and looking for themes. So, if lots of staff are saying the same thing, and it’s something easy that we can change, it’s a quick win, you know? So, I think there’s been a lot of change that hasn’t had to cost money, but I think when we do need to spend the money, there is some reserve, and it’s fairly… And again, because we have three clinics, it’s trying to be equitable, so that one service, one side isn’t favoured over another, that’s another challenge.

Reference 1 - 2.61% Coverage

So the main things that I would like to know if you introduce the point-of-care testing is obviously the first thing is, is it costly, right? So what is the cost difference between the standard laboratory test and a point-of-care testing, and what is the procedure involved? Because this may include staff getting trained, right? So it has to be a consistent training, because we have different types of staffs working in the clinics basically. So we have doctors, we have nurses and we have healthcare assistants.

Reference 1 - 14.41% Coverage

R In the current political climate or financial climate, I think they’re both quite interlinked issues, do you feel like they encourage or discourage adopting new technologies?

P It depends. It’s a mix because there are new technologies that are more cost effective compared to what was traditionally being offered and able to have [?] some efficient in terms of how the whole system is run. So the current difficult or stressing financial climate gives an opportunity for things to be reviewed also so that you don’t look at doing the same thing. You’re under pressure to ask yourself, is there is a better way? Is there a more cost-effective way?

So this gives an opportunity to every new technology that comes into the market to be looked into in its own unique way. So you may come with something but it may not completely replace what you’ve been doing, but it would take a chunk of what you've been doing and then do it in a different way, so you have a mix of both. Or it could come and completely replace.

00:16:12

So I think it’s both directions, new technologies, financial climate, then our pros and cons. The only challenge we tend to face within new technology at the moment is... Especially when you’re talking to most managers, they look at the up-start cost of putting it in place and mostly we just look at that. This is what it's going to cost you to get it on the board and that puts most budget holders off. They don’t look at the long term, they don’t look at the next four years, five years to see how it's going to help. We’ve seen a lot of that happening across the board in many areas, with many decision makers. They look at the initial up-start cost, but they don’t look at the next five years, what impact it would have and how it would be more cost effective. So the same with the new technologies.

R Do you have any idea why that is?

P I think ignorance a lot of it, and also I think we just look at the main up-start cost of starting up something. That’s why you need somebody who can also sit with the budget holder, the financials, to convince and to help them look at the wider picture in the long term. When you’re coming with a new technology and you want to get it implemented, you have to have that initial cost and how you’re going to have people overcome that fear of that start-up cost by looking at the long-term benefits and how that would... Spreading it would make it look more cost effective than what is currently in place.

00:18:00

That is the biggest barrier that if you want to start up anything you want to try and overcome because that is the main thing that people always look at the first initial cost and that is a barrier because they say, no that’s too much money. We cannot do that. And that's it.

R Would those people be commissioners or someone else...?

P Yes. Generally a lot depends on the commissioner and some of the people who hold the financial budget strings, the senior managers, the budget holders, generally they tend to be the ones who you really need to convince that whatever you’re trying to bring into place is cost effective. It's something even we did experience when we were rolling out the new testing that I was telling you about when I started working here. There were some initial costs and... Not much but it’s there. It will bump up. And everybody was dancing around saying, who is going to pay for that? We don’t have that money, blah, blah, blah. But when you think in the long term, the benefit makes a huge big difference.

R So you would say that the biggest barrier is the initial cost of the product that is [overtalking]?

P At the moment that’s one of the main barriers, the initial start-up cost.

Reference 1 - 10.65% Coverage

But in terms of influencing key people around… In terms of decision-making, if there was an introduction of technology that cost X amount of pounds and provided this outcome…

Say, e.g., we introduced a technology that would improve the management of results, meaning that people had their test results within two hours and, basically, we could demonstrate that a financial saving would be there, the quality would be maintained, and the satisfaction of people using the service would be the same or improved, then we would be then just talking to our commissioners about this, and our commissioners are very much behind piloting new technologies to try and achieve the outcomes that we’re commissioned to do.

But within our partnership, it is very much dependent on what we are commissioned to provide, e.g., if there was a technology that improved turnaround times for results by 50%, that actually that would add an additional cost of £100,000 a year to no real additional satisfaction or quality, it’s unlikely that our commissioners would support it. Even if a clinical lead said, but we must have this because it would improve our turnaround rates, if there was no clear public health outcome associated with that other than people got their results quicker, it’s unlikely it would be supported.

00:17:01

And that is a tension, especially for me. You’ve got to remember, it’s clinical as well. It is a tension because I’d like, in the nicest possible… I’d like the ideal world scenario where everyone who has a problem, if we’ve got a solution to it, we can do it. But the reality is it’s within a price, and we’re stuck in a position whereby we’re not like these big hospital trusts with blank cheques, too big to fail, we’re a social enterprise that are working on a commercial basis like every other business in the country except for big government institutions like hospitals.

And we just don’t have the luxury of being able to say, oh, we’ll just add that on and someone will pick up the bill, or we’ll just get our knuckles rapped and we’re £4 billion overspent at the end of the financial year. If that happens to us, we go bust, we close. Equally, the message is, if we introduce new technologies and we don’t get support from our commissioners and we feel that it’s important to introduce, we have to find the money from somewhere else.

R And is it possible to do that?

P I think everything’s possible with a broad mind, but what people have got to realise, it might mean one less doctor, it might mean one less nurse, it might mean one less clinical building.

R Cuts need to happen somewhere else, obviously?

00:18:32

P Yes, absolutely. It could be there are other efficiencies that could be made, but it’s about looking at things with a broad mind, but it’s also understanding that there’s just not a new… And this is where we have to be really careful with other pressures that come onto us from other areas, and it’s very easy to say yes to everything because people don’t come to us with requests that aren’t valid, but they’ve still got to be affordable. Because it’s a bit like taking passengers on a boat. Every passenger’s got a reason to take that journey, but if you overbook the boat, the boat sinks.

Reference 1 - 5.48% Coverage

R And what about the finances, can they [overtalking]?

P Well, I was just coming to it.

R In a way?

P Yes. There’s always potential for that but it’s a case for them being able to look at finances and deciding whether it’s, how much of a difference is it going to make compared to the costings. Is it going to be cost effective after having all the facts, all the figures, all the outgoings and then being able to look at it and deciding how much is actually really needed, whether it’s just a nice a little extra and the benefit it will bring back home, benefits it will bring the patients.

R So I can hear that there are key things that drive implementations. So that’s patient needs?

00:13:11

P Yes.

R And also the new technology being cost effective?

P Cost effective, patient needs, I would say. So definitely patient needs have got to come first. It’s not going to make any impact really on the patients and there’s no improvement to their service or their care, then there’s not much just bringing something in. It’s got to be a key driver with an improvement there.

Reference 1 - 0.85% Coverage

You actually need to be able to see what the benefit is and explain that to the people seeing the patients. And if you can't do that, then you probably shouldn’t be... unless there's a cost saving in this.

Reference 2 - 2.01% Coverage

R It is a lengthy process.

P Yes. I mean, it depends how much you're asking for. I mean, some business cases I've had through were actually invest to save. So moving to a fully electronic patient record removes all the cost of papers. So it's actually cost improvement as well as a business case. So that will get through much more quickly than something that wants money attached to it. Something that wants new money will take much longer than something that actually saves money.

Reference 3 - 1.30% Coverage

P Yes. That would be... I mean, because if you're just asking for money to do something which adds cost with no receivable benefit, then it's very likely to be turned down, unless there's a benefit of it being more specific and more sensitive. But there needs to be some value added if you're looking for finance.

Reference 4 - 2.96% Coverage

R And what about the political climate, I'm thinking, is it encouraging to think about new technologies, changes?

00:15:28

P Only if it makes us more cost-efficient. Politics, it’s all about the cost. So anything that saves money is where, in terms of tendering and everything, they want things to be as sensitive-specific as the current test, but anything that saves money, so like the home testing, it needs to compare with infinite testing, got to be cheap. So anything that drives down cost, the politics. And there is the whole thing of closer to home.

Care closer to home is the other big driver, so anything that fits with those national bandwagons is keeping people out of hospitals, and cheaper.

Reference 5 - 0.72% Coverage

P No. I mean, I think in such a cost-driven organization, it has to come in at a price that’s comparable to existing technology. And I think cost is one of the big barriers

Reference 1 - 1.36% Coverage

financially you have to decide whether this test is something that can or cannot happen. There’s lots of tests that we’d love to have, but it just depends on money and funding and everything else, to see if there’s money in play for that. And, yes, you have to decide which ones are the best ones to have for the clinic, and the reasons that you’d like to have that.

Reference 2 - 0.67% Coverage

P Yes. But it, as I say, it largely also depends on money. That is the main thing, I think, because there are lots of tests out there, but it just depends on how it might work. Yes.

Reference 3 - 1.67% Coverage

P I’d quite like for that to happen. And then we can go through all the sort of finances and the funding and the budget and everything else and say, okay, well, this is the data that we have on this, and this is why it would be best. Or these are the couple of options, and bring it to the table and we can all discuss it, knowing that actually at the end of the day the money is there and we just need to pick one and that will be much easier for us!

Reference 1 - 2.68% Coverage

R And would you say that there’s anything that hinders adoption of new tests?

P That’s usually finance.

R Finance?

P Yes.

R That’s the main one?

P Yes.

00:12:36

R And how would you… Are there anyways of improving that? Of negotiating the finances?

P I don’t know, that depends on the NHS budget and all that. I don’t know how to answer that question.

Reference 1 - 1.16% Coverage

P I think obviously finance is probably a massive barrier, because you need the money to be able to put the resources in to allow, yes, adaption within the service.

Reference 1 - 13.89% Coverage

challenge.

00:01:50

R Is this something recent? Those changes?

P Well, we had a contract offer that was offered for sexual health services for an integrated service. We put a contract offer out for that which recently failed. We had absolutely no bids for that contract at all. And that means now we have direct award with our current provider. Which isn’t a problem because they provide really adequate services. More than adequate, they provide excellent services.

But we are in financial constraints because obviously everybody has to save money, and the council, in particular, has to save money, and we can’t afford what we used to afford. So, anything that means that we’re reducing or saving money and stopping unnecessary or unneeded attendance to expensive clinics is welcome within our services and our service redesign.

R What does that mean for people working with patients in clinics, and for patients?

P Well, for patients it means, hopefully, that they don’t actually see very much difference. It might mean that they may be seen by a different person in their GP practice. Because we’re in a situation at the moment with our GPs that many don’t have sexual health practitioners who are qualified to fit coils, for example, or implants. So, some are contracting with our specialist service, so they may go in and do that. But patients should not see any difference.

00:03:44

We’ve got community pharmacies who offer emergency hormonal contraception and chlamydia treatments. We’ve got a good community service.

It just means that behind the scenes things are done slightly different. So, we’ve really got the patient going to the right place at the right time to see the right person. Rather than everybody just going to the Sexual Health Service for absolutely everything, so it could be delivered somewhere else.

An example of that is, repeat prescriptions for the pill, which actually, GPs are paid to do that in their core funding that they receive from government. We’re actually double paying for that because the Sexual Health Service were actually picking the whole tab up nearly for that. So, they were getting a bit of a freebie on that one. So, we’ve stopped that. Ladies are having to go back to their GP for initial and repeat prescriptions.

So, behind the scenes, lots of things have been changing but hopefully the patient isn’t seeing too much disruption at all. We haven’t, at any time, stopped any services at all. We’ve just made them delivered in a different way.

Reference 2 - 2.88% Coverage

So, yes, collaboratively, we do work across the board, but decision making is done… I suppose the decision making comes eventually from our finances. So, if we know we can’t afford something we say, okay, we can’t afford that, we can’t do it.

But our Director of Public Health and Associate Director of Public Health will support the decisions that are then made, or not, if they don’t want to make it. But I would say that the decisions are made collaboratively. And it’s always in the best interests of the patient.

Reference 3 - 7.03% Coverage

But as you can understand, it’s the money that sits behind it all. If say, for example, a million pounds is needed to set up a new system. Well, that would fail immediately because we haven’t got a million pounds. Even if we could see further down the line that we could save ten million, it’s that initial funding that is a real problem.

Just as an example, the Health Check Programme uses quite basic technology where they have to use a desk top, similar to point-of-care, testing things, like a finger prick thing for cholesterol, etcetera. The cost of the cartridges, etcetera, is prohibitive, so we’ve got some practices who just say, I can’t afford to keep paying for those.

Even though we pay them monthly for however many health checks they do, they haven’t got the funding to adopt the bits and the sundries, maybe, sometimes, that support the technology. Especially with testing. It’s very complicated. And they won’t see that. Sorry.

R Is that then the money that you have to put up front?

P Yes. That is a real barrier. And it’s sustaining that money as well. I struggle now to fund the online testing. I really do. And I’ve got meetings with the actual provider tomorrow to see if we can negotiate better prices per volume. Because it becomes expensive.

Reference 4 - 4.51% Coverage

R And would you say that the political climate is in any way hopeful, or quite the opposite?

P It goes from one thing to the other. Sometimes, yes, yes, you can have as much funding as you need for public health, and then it’s no, let’s have all your money back, please. So, yes, there’s never enough funding and we have had huge cuts to our budgets. Huge, huge cuts, yes. Which have been quite devastating.

We had a whole article in the BMJ last year about how the [name] service was one of the biggest, if not the largest, cutter of finances to Sexual Health Services. But we have worked so hard to not cut any services. We don’t put any caps on the age for chlamydia treatment or for emergency hormonal contraception. But how long we can sustain that for, I don’t know, to be perfectly honest. I really don’t know.

Reference 5 - 4.60% Coverage

R Of course. This may be a more difficult question, but I was wondering, because you identify finances as the main barrier. Is there anything that can be done in that area?

P In finances?

R Yes.

P Probably not, no. I think as long as I have enough money to provide the statutory requirements of our public health grant, of which I do have just about enough money, then there’s very little chance of having any extra funding for additional, they would be classed as, sadly, ‘nice to do things’. Because they would say, you’ve got a lab at your hospital, you’ve got your online staff, why would you want any more? There would have to be an extremely, huge, robust business case behind getting any more money.

I’ve just had to argue to have enough money to provide Year 3 of contract with Sexual Health, anyway, and that was hard.

Reference 6 - 3.98% Coverage

R So, do you think there are other ways? Obviously, you don’t work in the clinic, on the ground, but do you have any idea how the test would impact the workload in any other area?

P Within the clinic?

R Yes.

P I don’t think so. I think it would make the clinic run easier because the person would get their result quickly, and they could probably have their treatment there and then if it was appropriate. And again, it might save yet another trip back, another appointment, another need to come to the clinic. Maybe that could be done remotely again, any follow-ups, etcetera, if that was appropriate for that.

It could reduce activity, which is obviously costly. Every time someone visits the clinic it’s a cost.

Reference 1 - 3.52% Coverage

And cheaper doesn’t necessarily mean the unit, for example using your own like the [unclear] unit, but even cheaper on the NHS as a whole, healthcare as a whole. And population of course under WHO. That all counts. And we know what’s happening with gonorrhoea at the moment, and syphilis. We’re seeing pockets of syphilis. So we know that we are able to access those areas or access those people. Get to know the results quickly. It’s got to be a win-win situation. It’s great for the consumer, the person coming through the door, and it’s good for us at the Health Service to be able to look after them.

00:07:08

And keep those costs, both monetary and the health costs, down. I might have gone around and round, but it’s so important. It’s not just about the money here. It’s about everything else going on as well, because of course one infection can lead to something else and it does have its effects on health. It’s not just about clearing a chlamydia infection. That’s all fine. But It’s also the damage that can also be done by that. Or indeed anything else. To be able to have something convenient is a good thing.

Reference 2 - 8.52% Coverage

I can’t remember the rep’s company, but we had a rep come around with a cartridge. I think it might have been to do with placentae. They had a cartridge machine, just showing what it was basically. And it was amazing. And they were saying that it could do all of them, basically your routine testing. And it was a no-brainer in my eyes, and some other people’s eyes. To have something like this in-clinic.

00:11:18

And I think the unit was a couple of thousand pounds, which, out of our budget, is a large amount. But the actual technology to have it there was brilliant. To know that this was no available to people, and you could see how beneficial this would be. But, sadly, we couldn’t do that.

R So the barrier was finances?

P Well, the barrier, from what I could gather, and I don’t know whether or not it would be… They say this is what’s about to be available, and this is the cost. I can remember… I’m sure it was about £2,000. And they were telling us… And I think the cost of the cartridges… And what we were concerned about… Because we were saying about doing it almost like if an HIV came in and we could do the INSTI testing, that type of thing. And the cost of the cartridges compared to the expiry date on them, we couldn’t justify the cost, because we couldn’t see, if we were going to be using it as an INSTI test, which is how it was being sold for some time.

We knew that we couldn’t do it. Because I think the cartridges are sold in packs of 50 or something. But it wasn’t going to be for us because of those reasons. Again that was back then, and I imagine things have changed now. But the way that it was being done. Because across [name] area, we do have that barrier. A lot of people sail well. People go across to different counties. And so it’s a grey, fuzzy area. And I can remember the lead on the National Committee screening programme saying that.

And I just sat in the room, and I said no. Our barrier is wet. It’s very real. We don’t have [name] County people coming in to use the service. So it’s not like we could have shared with somewhere else. Like [location] have got a combined Sexual Health service, which is fantastic, but we aren’t part of that. We are own entity. So money does come into it, yes.

00:13:48

R So, in a way, the fact that [name] Trust is somehow isolated from that… That can be a potential barrier?

P A potential barrier, yes. Only when it comes to… Where other people can see it as well, we can purchase this, then actually between our budgets we can cover that cost. We only have our budget. We can’t be looking anywhere else. What we have is what we get to spend. So, we can’t say to [location], can we tap into you? Or how about we share this? That’s not possible.

Reference 1 - 2.89% Coverage

So we were actually providing the kits to them and then they would be sending them off direct to… It was the doctors laboratory [unclear] that was being used at that point. And then we would be managing all the results, so any positives we would see but they would be able to get their medication either through us or through pharmacies or GPs. So that was happening via the chlamydia screening program up until October last year. The commissioners, because of the funding situation, decided that we would no longer run the chlamydia screening program but what we would do is actually operate an online testing service.

Reference 2 - 2.57% Coverage

And obviously it’s cost effective, so we are very much involved in introducing any changes to the service and it’s actually almost that nothing is done without our say so, where at all possible.

00:09:50

I mean, budgets unfortunately don’t… We can’t influence them but if there are any changes to the way that we work then we are very instrumental in actually making sure that it’s something that can be delivered. And also that it is actually going to be something that’s needed and also that is going to offer the quality of service that we want.

Reference 3 - 1.97% Coverage

P No I can’t see any barriers, finances are always something to be considered and I think even… I would suggest… I mean obviously we don’t know until we do it but I will suggest it either be cost neutral or hopefully some savings. I can’t actually see it costing more from what my understanding is so far.

R I see. Yes, so the project has to be cost neutral or in the long term it should save some money for this?

P Yes.

Reference 4 - 11.22% Coverage

Yes I mean, in my opinion, I can only speak for how it is managed here so I mean, it’s… You see, we’re very I suppose, unique, in as much as we negotiate directly with the commissioners to a certain extent so clearly obviously our execs have the final word in everything but they will be very much, not dictated, but will listen to the opinion of the services. So if I give you an example, we recently had our budget cut. We’re a very small service, our budget directly from public health up until April this year was £950,000 so it’s not a big budget. They chose to cut the budget because of the local authority pressures to £800,000 so we lost £150,000 overnight. Which has obviously, on a small service you know, that’s equivalent to three Band 6 nurses, and I’ve only got six to begin with.

So you know, if you’re thinking into real money terms and into staffing levels, that’s the way it works. What we negotiated with the commissioners is that they had a separate contract with the GPs to provide LARC which is contraceptive services which is fitting and the removal of implants, contraceptive implants and the fitting of copper coils and intrauterine systems, the Mirena coils. We were already doing that but we weren’t being paid any extra so what I negotiated with the commissioners, we became a chosen provider along with any GPs who still wanted to provide that service. But we, like all the GPs on the island, were being paid.

00:22:01

So we now get paid for every implant we fit, every implant we remove and every coil that we fit. That will income generate probably topping up about 800 by 50 per cent of the shortfall. So I am confidentially looking at ways with the commissioners that we can actually income generate through different contracts. It’s the same pot of money, I mean it’s a bit daft, but it’s the same pot of money but it’s another way of getting some money out of the pot, if you see what I mean.

R Yes [overtalking].

P Yes, so we… So I think we’re pretty, I don’t know, we may not be unique but I think we have got that relationship and we’re able to negotiate those sorts of things. So financially we are you know, at the beck and call of the commissioners and the local authority but we have got the means to negotiate around things. So if we wanted to introduce something and everybody felt it was worth doing, then we would obviously try to find the money to do so.

Reference 1 - 2.46% Coverage

But, again, there is… there is input from other departments because, obviously, if we want to choose the most expensive one we have to justify why. So it isn’t… although a lot of it depends on what money is available, the decision isn’t made purely on the basis of cost but if you do choose the most expensive, and, on paper, all the other pieces of equipment look exactly the same and deliver the same results, there would have to be good justification for why we’d made that decision.

Reference 2 - 1.82% Coverage

The rest of it, really, is around how expensive is it to use it on a regular basis because you can write a business case to purchase the equipment, but that doesn’t cover the ongoing costs for consumables and the agents. So you would have to look at how expensive those are going to be, and, again, what staff resource are you going to need to actually use it

Reference 3 - 5.63% Coverage

R I see. What about the political climate at the moment? And I think what’s related to it is obviously finances. Is it more difficult or easier, like, when you think about, you know, 17 years of your experience of this particular …?

P It’s more difficult, much more difficult and that isn’t going to get any easier.

R Right. And is this something that has already hindered some things?

P Yes. Because if you’re putting a business case in and you are asking for capital, there is a finite pot and everybody across the Trust will be bidding for capital and if yours isn’t considered the highest priority, it won’t be funded.

R Right, so you would have to actually show that this is the highest priority?

P Yes. What happens at the moment is that within business unit, things get scored. So if it’s a capital purchase and it’s expensive, it goes onto a list of things we need and we score them. And if it doesn’t score highly, you know it won’t get considered.

R Right. I see. And how does the scoring system work?

00:15:18

P It’s sort of risk based scoring. So what would be the risk of not implementing this?

Reference 1 - 2.17% Coverage

P Generally, the biggest in… The biggest barrier to anything is the finances. If you're trying to introduce something that may be a better way of doing it, but if it costs more, then it's very, very hard to introduce that. So, I think that would be the main barrier. I think busy staff that don't necessarily have time to consider things well is a barrier.

Reference 2 - 5.49% Coverage

P Well the political climate is there's no money. I don't think there's much more to the political climate than that. And I think what that's unfortunately doing is leading to a lack of investment in prevention care, because that's not seen as acute, or essential. And I think that's a real shame, particularly when you would talk about sexually transmitted infections. Funding has been cut from the sort of prevention side of things. And I don't think there're much political issues with regards to anything else to do with sexual health care.

00:11:04

There are… I suppose the change in the health and social care acts, the way that sexual health was commissioned has caused some issues. The way that sexual health is being tendered out to the lowest bidder. Again, that comes down to finances, but causes a lot of challenges. Time and effort put into submitting tenders, tender bids is challenging.

Reference 1 - 2.59% Coverage

And then obviously we need to work with our microbiology lab colleagues to make sure they’ve got capacity there. I think the bottom line is it comes down to commissioning. So we’re obviously all in financially squeezed situations and at the moment we’re not commissioned to test mycoplasma and so that’s negotiating with our commissioners about how that would happen. So I guess, the ultimate thing comes down to finances.

As I said it’s about, we’re partly helped by guidelines so if guidelines say something has to happen, it’s easier to get commissioners to accept that. But sometimes it’s about if you can demonstrate a cost saving. So, for example, if you could reduce workload and chasing somebody up, for example, and you could demonstrate that it was actually going to cost less money to do it in this way, then you avoid the commissioner issue and then you can get your own trust to approve it and fund it.

Reference 2 - 0.17% Coverage

But I guess I feel like the barrier is mostly financial.

Reference 3 - 5.62% Coverage

R I see. And so you mentioned there is always a lot of training required, especially if there is something new happening, but is this also quite expensive? Does it require additional funds?

P Yes. So, it really depends on what training is involved, really. So, we already have an educational programme running within our clinic, so we have time set aside for that. So that, for example, quarterly, we have a clinical governance meeting which I organise, which is clinical governance and education. And basically I can put into that whatever I want. So whatever I feel is educationally appropriate for the clinic. So lecture based teaching is easy to deliver.

00:17:26

We also have a journal club which runs, although it’s harder to get staff to attend that. That tends to be attended by fewer staff, whereas for the quarterly session we actually close the clinic for a morning. And then it needs more face to face training, on an individual basis, that obviously does come with a cost. So, for example, for our HIV point-of-care test, there’s a training session which is run by the lab and that lasts and hour and staff have to be released from clinics to attend that.

So that obviously has an impact. So, I mean, we put that in people’s induction so they’re not actually in clinic at that stage. So obviously if a test was to change, we’d need to train, depending on who was going to operate that test. If it was just the lab staff, that would be relatively straight forward, because there’s a much smaller number. But if the tests are going to be operated by all our clinical staff or, for example, by a healthcare assistant, there’d be more training.

And that would be more difficult but not unachievable. It would depend a bit on how long. You know it’s relatively easy to fit in an hour or two of training. If staff need two days’ worth of training, that becomes increasingly challenging. So it really turns on how long the training is, and how many staff need to be trained.

Reference 1 - 0.97% Coverage

And funding, I think, there’s lots of stuff that we could do, but quite often, you’ll always be given the excuse of no, there’s no money to do this. Just carry on doing what you’re doing already.

Sexual health tends to be a very underfunded service.

Reference 2 - 14.71% Coverage

However good it is, quite often they’ll say no, there’s not enough money this financial year.

R Right.

P We look at oh, can you get some… a drug company to pay for it etc, and that’s… those days are kind of gone, really.

R So, what about if a technology seems to be cost-effective, or has the potential to reduce costs in the future?

00:10:41

P I think it’s using that argument, it has to be a very well kind of reasoned argument. Because quite often, especially in… we’re part of an acute trust. So, where we say our efficiencies and money-saving, it actually might be a financial load to another bit of the trust.

So, we have the laboratory as part of this trust, so if we say we’re not going to do this test any more, we’re going to do this test, and it’s going to save us this amount of money… that’s great for us, but actually, at a kind of trust level, the micro lab might be saying, well, actually, we’ve just lost x amount of income, and we can’t afford to do this particular test.

So, there’s quite a lot of balances. So even… so it has to be very well thought out across the whole organisation, and actually has to save money for the entire organisation rather than just one chunk. Because by the time it gets to the top-level balance sheet, quite often inefficiencies in one side is actually a loss in another side. Especially when tests are concerned.

So, pardon me… so, a really good example is trichomonas testing again. So, we do in-house culture, because we’ve always done that. That comes out sort of quite cheap, because we use… but the laboratory time is dependent on that. The lab gets a discount on reagents and stuff. But actually, if we switched over to the more… what would be considered more cost-effected TMA type methods, actually, you’d probably see the lab costs go up.

00:12:27

So, it’s… it has to be a whole system approach, really, so… and quite often, that’s what kills something, in that… so, yes, we can do this extra test, this will cause efficiencies. So, talking about your committee on gonorrhoea platform, yes, we can do tests half an hour in the clinic, which is great, it increases our efficiency, makes a potential cost saving for us.

But the chlamydia lab is also part of this trust, so they’re going to be losing work. And actually, by the time it gets to the top, it might be that you’re losing more because we’ve made an efficiency, rather than the other way around. So, kind of issues like that.

R Right, so there are a few issues that you have to consider. So, there’s a financial consideration. That’s not just… yes?

P I think that… I think anything in the NHS, it’s primarily financial considerations at the moment. In kind of the information governance, getting people to adopt sort of newer, innovative technology, you meet obstructions, but if you keep on persevering and not going away, quite often, you will get there in the end.

But the thing that kills… probably a good proportion of innovation type projects is the funding, and kind of the local trust funding.

R I see. And is there any way in which you would think that there’s a… it is possible to improve that state of affairs?

00:14:09

P It’s very difficult in big organisations. Because quite often the people that will be objecting… that can object to something and sort of kill a project, you don’t deal with on a day-to-day basis. So, it’s not a small team that you have to kind of convince, it’s a big organisation with lots of vested interests, really. Lots of interconnected systems.

So, I think it… it has to come… it’s almost having somebody with an overview of the whole trust dedicated to… well this project has this effect here, here and here, so rather than trying to push it up, it’s almost that you give… they’ve got the project and they push it down. But where would that… where we’re at with that, I don't know.

Reference 3 - 9.32% Coverage

P I think data. I think you have to have a clinical case for doing anything. So, the status quo will always be the status quo, because it works. So, why do you need to do something different?

So, you need audit data, financial data and mostly clinical data to say, well, if we did this, it potentially would do this. So… and it’s kind of a funny circle, because you almost have to have that data… well, you have to have that data really to institute the thing that you want to institute.

00:15:43

And sometimes you don’t… you’re not going to have that data until you institute the thing. And that’s why… pretty much in the NHS you have to pilot everything to get some initial data, to actually say, well, this… look, this scaled up this many times will probably do this.

So, it’s having the data to back up why you want to do that, so that… and that’s mainly clinical data. But you also have to, if anything, you have to show nearly everything now has to be shown to make a cost saving. If it’s going to cost more, it’s dead in the water, in the current climate.

R Yes. And it has to save money for everyone.

P I think it has to save… probably save money across the unit and the trust as a whole. So, same example there, there are people whose entire job is to look at quality efficiencies, basically. Now, they will go and say, yes, this is great, but potentially this impacts on this department over here, meaning we don’t do it.

And… so it all has to equal out. So, our best… if you can show it improves quality of care, at best it has to be cost neutral. But if it makes an efficiency, it’s more likely to go through if it improves quality of care or efficiency of care probably, but also cost saving as well. It’s almost certainly going to go through at that point.

00:17:19

If it’s cost-neutral, then if it’s got a clinical champion or a group that really pushes it through, then you probably will get through. But if it’s going to cost significantly more to what you’re already doing, it’s very unlikely to be pushed through, unless what you’re doing is sub-standard.

And nearly all… the current level of care is that, it’s the level of care. So, anything above it is an improvement, but… I think people will say well, if it costs more, so, the current level of care is adequate. So, carry on doing what you’re doing.

And that’s essentially the default position of the entire NHS at the moment, not just sexual health.

Reference 1 - 2.60% Coverage

R And what about finances?

P Finances, that is from the management team. How they roll it out and what is to expect.

R But could there be a potential barrier there, or you think that…?

P If it’s funded… I think we come under Public Health, so, it is between management discussing it, to roll it out with Public Health, whoever’s in charge of pay for us, yes. [inaudible]. But If it’s something that is cheaper, convenient, easier, I’m sure they’ll be all for it. If it’s within the budget.

Reference 1 - 4.26% Coverage

P I mean, I think the current political climate is making us save more and wanting us to save which I always think is very short sighted. Because I think sometimes if you invest a large amount of money in something that will save you in the long run it’s worth it. But the problem is people are looking at the financial situation this year say and then they’ll look at it for next year and then for next year. They’re not looking at it five years on because there’s a lot of money they need to save.

And the other thing is, it’s not... so, maybe your department might be saving but if you’ve got another department within in your, you know, service that’s overrunning you have to bear that brunt. So, whatever money you could have said, look, I’ve saved this amount of money can I get this device, can I get that they’ll say no we have to give it to them.

So, the money side of things is making it very difficult and it’s making people blinkered and not thinking long term. Because actually if you invest in something that’s a lot of money now it will save you in the end, it really will. So, it’s actually being brave enough to... and having people enough to agree with you. But I think the biggest thing is the financial pressures, yes.

Reference 2 - 2.26% Coverage

P Yes, absolutely if something came up then I would say okay fine that will be a big capital investment now but my God in the long run it will be much, much cheaper for us, absolutely, yes. No, definitely I mean it’s like, you know, taking on a digital technology if I could find a way to, you know, make things easier for patients who need repeat, you know, pills or something it might cost me a bit more now but that would be something I’d want to invest in. So, within our department we are forward thinking but obviously we are just, you know, a group within an organisation that’s got a lot of financial pressures. So, we have to appreciate that as well.

Reference 1 - 1.11% Coverage

P Yes. There’s still this thing between doctors and nurses that doctors get a lot of training, and they get particular leave for training whereas we have to fight a little bit more for training. So I’ve paid for a few things myself. Because it’s just easier. Unfortunately. So there’s bringing up money and study leave.

Reference 2 - 4.61% Coverage

P We’re encouraged to save as much money as possible. We’re trying to, as I think with every NHS trust, we’ve got to cut a certain amount of the budget. So it’s quite, that would be a barrier to new technologies because unless it was being seen as something to correct something that was wrong, they might say, but why we going to introduce that, because that’s going to cost more in the short term.

One example is we were having computer issues with our results coming through, so we switched to doing instant HIV-syphilis tests. So that was, even though they were more expensive than the lab, because the lab’s on a bolt contract, it was seen as essential until we got the computer system sorted because we did not want to miss an HIV positive or a syphilis positive result. So that was seen as an essential, and therefore a justifiable cause.

00:16:49

But as soon as the lab was fixed we had to stop using them and go back to venous bloods. So finance is a very big thing. And it’s also the training of the people, what staff would be, because that would take staff out of clinic, and what staff are actually going to do the testing and things, because we don’t’ want nurses to be stood next to a machine for half and hour because that’s not the best use of their time. So that what would also have to be considered as well.

Reference 3 - 2.51% Coverage

But actually thinking about new technologies, and I know this is about point-of-care testing, is it can save a lot of time and therefore resources on calling people back, because if we know a result within half an hour that will take out the three weeks of recall we have to do when we have a positive that’s not being treated. And that takes a lot of time trying to write to people, call to people, voicemails, everything. So that’s another way to look at the financial things, is time. Not just the money but the time things take.

And that the problem in the NHS at the moment, there’s a lot of save, save, save. Cutting budgets, and I don’t think it’s just sexual health, I think it’s every department unfortunately.

Reference 4 - 0.25% Coverage

08

R So, technology would have to be proven to be cost saving.

P Yes.

Reference 5 - 2.57% Coverage

Would having the recall save in the short-term or in the long-term. Is that enough, is it…

P I don’t know enough about how much budget we need to cut this year. I think if it was, short term would probably be what they’re looking at at the moment, because they’ve been told within the next couple of years they have to cut so much of the budget. And, but long term would be something that potentially all of us would see, as clinicians, see the benefits. But it may not look as good on paper and therefore might mean that the commissioners don’t approve it.

It’s that word of commissioners. All of the directors of the trust as well, they may not, they might say, why’re we doing this then. So money would be a big factor on cost saving.

Reference 1 - 0.61% Coverage

And probably the decisions going to be made on financial, what’s it going to cost to run. And the cost as opposed to the benefits.

Reference 2 - 3.79% Coverage

P Well we had a TV testing on our NAATs swab, we had a pilot for that, which was really good. It was much better than… I mean, we were doing just high vaginal swabs that aren’t’ really very good for TV. So, that worked really well. And we were doing it on men, I think we were doing it on men as well. Anyway, it was a pilot and now we’ve got to write a business case to try and see if we can do that as well. So I think, financially, there’s always going to be a barrier to new things.

R So even if people are supportive of it, and the patient experiences improve.

P It doesn’t always happen.

R Because it’s not…

P Yes.

R There are no savings there.

P I’m not sure if that’s been, you know, I haven’t seen the result of that and it’s not something I would probably be involved in. It could be, I don’t know.

Reference 1 - 3.36% Coverage

We've got less and less money, we're constantly being told you've got to savings of money that we haven't even spent. So we're thinking, well okay, so we're trying to cut the service, while trying to run an efficient service. So no, the finances are not helping at all. The lack of finances is not helping at all.

RE So that, kind of, potentially can then stop introducing technology that is good.

PA Well if it is expensive then yes, yes it will.

Reference 1 - 1.98% Coverage

P Yes, the financial side that would have to run through the consultant within GUM and costings would have to be provided by the Point to Care team. I’m not heavily involved with that sort of thing at all but that’s the way I envisage it working.

Reference 1 - 0.80% Coverage

P It’s probably one of the biggest things at the minute will be around finances, and it’s proving that actually bringing something in will be of financial benefit.

Reference 2 - 0.76% Coverage

Quality of patient care is a big one still; we still need to be doing that but a lot of this will be down to whether we can actually afford to do that.

Reference 3 - 1.53% Coverage

We can have really good ideas which will help us do the right thing, but actually some of the blocks, I should imagine because this is a new role to me in this sense, would be around just making sure that we can balance the books and generate extra income for the trust. That would probably be a key thing.

Reference 4 - 4.82% Coverage

P No, finances is probably the biggest one at the minute because I should be aware the NHS is in a pretty bad state. Having said that, we’re part of a big Trust which has a huge deficit so every penny that we spend is being looked at. We have to be very clear that we’ve got very demonstrable outcomes for what we’re doing and why we’re doing them.

00:14:13

At the end of the day finances do play a huge part in that and we’re a department that actually makes a fair bit of money if we’re still on tariff with our commissioners. The more patients we see the better for our hospital, and that’s for the patients too, obviously, as well and that would be the way we’d think of it first. The Trust might have a different view, and, I think, if something that’s a big borderline then it might not be as well received as something that we can clearly make it obvious that that is going to be the right thing to do because it will allow us to increase our profits or whatever.

Reference 1 - 5.74% Coverage

P Yes, okay, I think that does... is an important factor. And if, I think and I don’t know, but I think that if it’s cheaper than what we’re currently using then... and we can save money then I think that would be seen as advantageous. If it costs more then obviously there’d need to be a very good case for us changing our existing, you know, supply so. And I know that point of care from a public health perspective would...

So, if we were to have a 30 minute result for chlamydia and gonorrhoea, you know, instead of waiting the week to two weeks we would very much have to, you know, use the public health factor there. That, you know, whilst they’re in clinic they can be treated, you know, so, therefore it stops the spread of onwards infection. So, I think there’s, you know, back up for using a point of care test but I think if it’s more expensive I don’t know how the Trust or our business managers would see that. And I think we’d really have to sell that to them.

Attitudes towards change

Reference 1 - 0.27% Coverage

It's all plan, do, study, act. And just getting people to think about what was in research type mentality, which I think a lot of healthcare workers don't have.

Reference 2 - 0.62% Coverage

Yes, and it takes a while to get, you know, people up to speed. And I think a lot of people in healthcare just think, you know, healthcare is an art, and it's all about, you know, all the soft stuff. But it isn't, you know, it is that, but it's not just that. You know, there's a lot of objective, you know, training, and objective measures that we can bring into that.

Reference 3 - 1.87% Coverage

That's another thing, it's about, you know, everybody seems to want to contribute something, and you know, there's the problem about, you know, being in the sort of perpetual sort of revolving door of… Of asking people too, you know, what's their opinion, and you know, can they think of any barriers? You know, people always can. The answer is they always can. So there's someone who can say no, or maybe, and then it puts it… The project on hold for yet another week, month, year.

So unfortunately we tend to… We're a bit paralysed by the sort of consensual process, you know. And at times it's just a case of saying to people, look, I know it's not perfect, we're just going to do it, and we're going to do it for this time period, and then we're going to evaluate it. And we can either say yes or no going forward.

00:15:45

And then I… It kind of upsets people, that approach. But the reality is, nothing happens otherwise, you know. You end up surrounded by people who want to get the perfect, you know, the perfect scenario before you launch into a new project, or… And then what happens is, nothing happens.

Reference 4 - 0.41% Coverage

So, the perfect is the enemy of the good. So you need, you just have to make good. And set it up, run it, evaluate it, and say, yes, no, maybe. And if the maybe, then what do we do to test it definitively before we either adopt it or drop it? Yes.

Reference 5 - 0.96% Coverage

Well, yes, that is the challenge of any projects. This, you know… You won't take everybody on board with you. You know there's always the laggards who have got, you know… Usually vociferous laggards are the enemy of any development, to be honest. But they exist, and you just have to deal with them. But there, the thing is, the frame that we've put around all the changes that we've brought in the last five years is that we need to keep on developing things. We don't know what's… What, what's going to work, but we all give everything a go, you know, as safely as possible.

Reference 6 - 1.77% Coverage

So when it comes to adopting something brand new, it's like the syphilis tests. So we sort of brought that in as alongside herpes, because we thought we'll swab every ulcer to find out how much comes out. But now we realise, after having it in for a few years, and embedding the test that we're wasting a lot of money by testing everybody. So we're now going to decouple that as I said. So actually turning things off can be harder than turning things on.

R Oh interesting.

P Stopping things is, you know, is sometimes harder. But, yes, it's, it's just, it's just because people get…

R Used to [overtalking].

P Used to things working like that, and uncoupling things can be difficult. So it took a while for us to uncouple, for example. So we still do order separate pharyngeal, rectal, and urine samples and cultures. But we just had to… I did it in another test, three and one, and that was fine to run that. But when you want to then have… When you have two things together, and you want to uncouple it, it's just a bit more, more tricky. But it's doable.

Reference 7 - 2.67% Coverage

You know, so, you know, it's like all… It's like even policy changes, you know, you've got to get a lot of people on board. So you got to sort of get people thinking about the problem, articulating it clearly, rearticulating it in another format.

R Yes.

P But you know, things like electronic rostering. You know like two years ago I had… I got some money to work with a company called Rotageek, beautiful name, great company. The idea was that we'd just move everything to more the rostering online, because there's so many more efficiencies we could get, if we could roster effectively. It's good for staff, it's good for patients. And it allows you to have those sort of conversations that you don't normally have also with staff, which is, you know, maybe you should work a few more evenings, or you know, contribute to X, Y, Z rostering problems when the new juniors start. All those things.

00:47:50

And that got stymied by colleagues who created all sorts of, you know, false objections really. Just because they just didn't like the idea of it. And then luckily the trust came along, and said oh, we've got this, we want to do electronic rostering, and we found another provider. It wasn't Rotageek, it was called Medi Rota [?]. And so low and behold, we quickly adopted it, because you know, it came along. So you can be an early adopter and hit a wall. And it's usually people with all sorts of other agendas. You know, they're usually ill-founded, you know. Or they're usually easily surmountable, it's just you need to be able to unpick why they're saying now, or why they're blocking it.

Reference 8 - 1.10% Coverage

But there's a lot of people who can say no in the NHS, or in any organisation. Risk averse negative responses, or no responses are the default of big organisations. That's just normal. So you just have to realise that. You have to work it. And I think Kim Kardashian's mother was… My partner quoted her, I have no idea what her name is. But she apparently said, if I'm hearing a no, I'm not speaking to the right person. Which I think says it all. You know, the idea of, you know, if you get… If you hit barriers, you know, you just need to talk to other people. Because you usually you can get over them. So yes, so mama Kardashian is clearly a force for good.

Reference 9 - 0.89% Coverage

We need to get feedback, and yet people block it. Or there is other agendas that people say well, we've got something else in the pipeline that can do that.

00:51:05

You know, so I've been involved in a number of projects where people have… You know, they don't understand what you're trying to do, or there's something that's close to it. And I don't know, I think people don't like doing things in parallel. They'll… They… You know, there's a serial mentality to doing things.

R Yes.

P But that's, that's a blocker, big blocker.

Reference 1 - 0.14% Coverage

And getting staff engaged onto that process, which is probably the hardest.

Reference 2 - 2.09% Coverage

also thinking about how do we navigate the changes that we need to make, developing our communications, how do we communicate, how do we get people feel involved into these decisions.

So it's pretty much having the same approach to service delivery that we have to... things that we do with patients. So in sexual health research, one of the things that we say is no decision made about [unclear]. We talk to patient groups and even doing something for them. We need to involve them. Similarly with staff, you can say that your working conditions are going to change, get that. How does that affect you? If you had to get it with this, how would you do that?

00:09:29

It's easy to say, but it's very difficult to deliver on, because part of it is getting engagement from staff, but why those changes need to happen? Because obviously, everybody is like, I don't want anything to change. I want things to be the way they are. But we have a duty to provide great care, and great care is more than... care basically means being up-to-date with everything and being able to deliver the best we can that is available now, which basically means that it won't be the same as it was last year.

Reference 3 - 0.98% Coverage

People don't want to be just working in a place that's okay. They want to work in a place that's the best. And the best places are able to use the best tools. And I think that the ability to implement new technologies would be the best. And there are different ways in which you can do service implementations. You can make it a health technology assessment as a research project, saying that I'm going to study and I'm going to have partners, and you're going to say that we're going to do this in different settings so that you can show others how to do this.

Reference 4 - 0.76% Coverage

I think that you have a management team that is receptive to change, which allows quite a lot. We are talking about a model that we have testing in-house, in-clinic testing. And we're just working out how we can implement that. So from that point of view, yes, I would say, in a very supportive environment. Obviously, there are the constraints of finances and what's commissioned and what's not. But what's commissioned is services.

Reference 5 - 1.91% Coverage

So I think that I'm lucky that in the department I work, we have a commitment to research. And we're looking at how can we... the research improving clinical performance, clinical morale, and also adoption.

So we are quite interested in... I think that evolving science of implementation science, I think that's the way to success. It's become very trendy at the moment, but there's still very little that's happening as to implementation science. But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

Reference 1 - 1.25% Coverage

And what you find, the first thing you tend to find in the NHS, is when you want to try and do something different there are a lot of people telling you you can’t do it. And there’s this immediate fear factor about what does it mean if we do something differently? What are the implications?

Reference 2 - 8.20% Coverage

P Yes, I think so. So the most difficult thing is probably people, okay. So sounds quite obvious, but the normal reaction to hearing about a change or a development in technology is what does that mean to me personally? That’s a normal thing to think about. So for instance, if I heard about somewhere in America that developed a machine that could do most of my job, my initial response would probably be: Oh, what does that mean for me?

Because that’s very interesting, it’s very impressive, and that’s something that we should be looking at, but actually what does it mean for me as an individual? And if you don’t get the initial engagement bit right, which I spoke about earlier… You have to go in and discuss with everybody involved what are the benefits? What are the downsides?

00:15:13

If you don’t do that you won’t achieve what you want to achieve as quickly as you would have first liked because people find reasons to resist. It’s very easy to do. I’m hoping that’s a drill. Wednesday is going to be fire alarm day. We’ll carry on for now, it’s not going through here.

So yes, you’ve got to get the culture side of things right. People have got to feel like they’re part of that journey. You can’t just tell someone they’re doing something because if you get that wrong you are going to be facing an uphill battle.

R So that’s a lot about interpersonal relationships.

P Very much so and I’d say that applies whether it’s a big or a small change. That’s probably the one thing I’d say is transferrable.

R Right, and those interpersonal relationships, do you mean those in the clinic or also between you and the clinic and just…?

P I think all over. So basically, it’s very important that even if it’s with people you’ve not engaged and worked with before… So it could be a supplier for instance. It’s important that you have the ability to build relationships very quickly and manage expectations early.

Reference 1 - 5.11% Coverage

I think there is always… With some members of staff, there is always a bit of resistance around doing this. Things in general, in a new way. New technology. If we can present it in a way that shows to the staff that it’s going to help. Let them do their jobs better and actually make the patients more happy. I don’t think anybody would be complaining about that at all.

I think there is… So, as an example, the giving HIV results on the day to someone. It’s something that it makes some of the nursing staff quite nervous. Because it’s not something that they would expect to have to do in their job. It’s not really part of their job description. But if they were to do a rapid test, there is always going to be that possibility that, even though someone has been assessed as low risk, they are still going to have a reactive result. And that nurse will need to be able to give that result.

00:13:45

Now here, there has been a lot of resistance to that thought. The thought that, I might have to give someone this positive result. That. That’s a health advisor thing. I shouldn’t have to do that. That’s outside of my remit. So, there is some resistance from some people.

And it’s interesting to see the ones that are up on, you know? The people… There are members of the nursing staff who want to do it all. And then other people who are like, nope, nope. Not my isle. It’s not my department. Not doing it.

R Yes. So, quite clear about their boundaries.

P Yes. Well, here’s… I do this. But I don’t do that. For sure. So, that… And that’s about the individual, really.

R Yes. So, that could be a barrier, potentially, to new things.

P Yes, it could. Yes.

Reference 2 - 2.65% Coverage

P Yes, I don’t… I suppose, in the other clinics, there is a smaller staff group. So, they are not as well staffed. And a lot of how busy people get depends on how many people are walking through the door. So, on super busy days, you’re going to be less likely to have the capacity to kind of think about using new this or new that. Because you just need to kind of get on with what you need to get on with, really.

So, the stress of the day to day job, I think, can get in the way of properly adapting to new things, sometimes. But then a lot of using new technology is just about repetition, really, isn’t it? It’s like new ID systems. You just have to kind of… It’s everybody hates it at first, but then you get used to it after a while. And then it’s like you can do it in your sleep.

R Then you even forget about the previous one completely.

P Yes, exactly.

Reference 3 - 7.69% Coverage

And how quickly people change and adapt is an individual thing. That’s about that person. Sometimes, that can be an age element. It’s, you know? But not always. Not always. Some of the older people, older staff, they can roll right with it. Pick things up quite quickly. And it will be the younger ones that struggle.

R And do you find yourself sometimes supporting other members of staff who may be struggling with new ideas?

P I try to. Yes. I mean kind of like an emotional level, if they are, like, frustrated or something. Yes. So, we use a website to help identify with partner identification. Which is another clinic lead’s initiative. And I have to be the biggest cheerleader for that, aside from him. And I am. And I am happy to be. Because, really, I believe in it. Very much so.

But there are people on my team who are less enthusiastic about it. Because it involves asking a few more questions of the patient. Pushing them a little bit harder about how many partners have you had? Can we contact them? Do you have numbers for this one? Do you have numbers for that one? Blah, blah, blah. So, I have to kind of motivate. Keep the enthusiasm up for it when it’s not something that people are just naturally going to be, like, yay, about.

R How do you do that? Do you have any, like, techniques? Because [Overtalking].

00:23:02

P Not necessarily. I mean I like… I like the challenge of trying to figure out a way to get the information I need from the patient in a good way. So, can I use the questions that I am asking, and my personality, to kind of win them over enough so that they are going to be cooperative, really? And so, I will… I’ve gotten like a little, I suppose, a speech in my mind that I use when I am explaining that website, for instance.

And I can see when people are buying into it and when they are not. I can see when I need to be, maybe, changing what I am saying a bit, or pushing a little bit harder to explain why it’s important. But I like that challenge. But I don’t think everybody necessarily gets that excited about that particular thing.

But then it could be. You never know what’s going to get people excited about things. So, we have one member of my team who sees himself as a point of care. HIV tests. Like, the lead for that. He was never point to that. But it’s just he loves doing it. And he loves showing the members of staff how to do it. It’s just kind of, he takes it and says his little thing that he likes to be the volunteer to show everybody.

Reference 1 - 0.71% Coverage

P So you know when you get relaxed with just the system that you use. I didn't really like EMIS, oh sorry, IMS. I was a bit in denial, I thought to myself, right, you're in this new role, get yourself… Said my name. Sorry.

R This is going to be deleted.

P Oh, okay.

R Yes.

P So I said, you know, right I need to get my act together, learn this system quick.

Reference 2 - 9.07% Coverage

Views of individuals on, like, new technologies. So like attitude to new ideas.

P Not good.

R How that… Not good?

P Not good.

R Not good.

P No.

R Okay.

P No, there's no… No, it's nice for me.

R Yes.

P And I think it's how you sell it, because no one likes change. Well, not everybody. Some… Some do, and some don't. But I think it's how you come… If you just say, right, we're getting a new system, and it's going to be on such and such a date, and we're going to be using it, and everybody is going to be trained up on such and such a date. I think it's how you deliver the message.

00:36:39

So, for example when the reception realised that there's all these other processes that we use, because before they were just working at other sites, but then they were going to be having to work at this site. Somebody's using IMS, weekend working. And they were horrified at the fact that all these patients, and how do you hand out the registration forms? And can't we give them all a number in advance, and…? I said what I'll do is, I said let me test the waters, I will go there and work, and see how it is. Because the… Everyone was like worried that, you know, hundreds of people are coming at the weekend… Well it's every day, but the weekend working, and they were quite scared.

So I came, worked at reception, because there was three of us. I said right, we all had a plan, so I will hand out the registration forms, you'll take back the registration forms, and in the meantime you've logged onto all these systems, right. You'll add the patients onto Qudini. So that's the… Do you know Qudini? It [unclear].

R Yes.

00:37:47

P Yes. You'll add the patients on the Qudini. So you have a system going. And some would, right, time to go to the sync meeting. So the person that was handing out, me, I'll go to the sync meeting. Come back, right, this is what we're doing for the day. How many staff have got… So it's about communicating, making sure the paperwork is also kept tidy, because there's nothing… Oh, what's this? Or what's that? I said everything that was handed back… So once you've handed out all the registration forms, the queues, everybody's completing the forms. And then it's the hand back. You're communicating to the patient.

R Yes.

P They've either gone off, or… Depending what the stream, take a seat in the waiting area. Right, you put those ones and twos, and let's get some on the system, so they can start taking the patients. And then say about midday, it was all calm. And I was thinking, this is, this is… It's about organisation. Communicating, and having a little system going. And it works.

R Yes.

P So I was able to feedback to them, and say, there's no need to panic. It's about having a system in place, and communicating with each other. I said I've done it, and they believed me. And when they all experienced it, it was just nothing to worry about. Because you know, they were all told, right, you're rota'd on to work on the Saturday. And they were like panicking. And so I said I'll go first, because… We were going live with our new rotas. The whole department was going live with their new rotas.

00:39:13

R Yes.

P And they hadn't… Oh that's what I did actually. Before we went live, I said we're all going to have a taster session. So they weren't just thrown in the deep end. And they were all happy to go along, and have the taster session. I said just go for the first… Just baby steps, the first few hours just to observe. And then the next time they went, actually go on reception, and work. And then it was fine. So when they went, go live day, to do their weekend working, it was fine. So…

R Right.

P It's about how you deliver the message, and reassure them, and… I said I'll even come in to… For support as well. You know, so I'm giving up my weekends as well, so they can see that, you know, I care. And…

R Yes.

00:39:57

P I'm there for them to support them as well. Because it's, it's all very well and good saying, well you know, you… This is your job, and you have to. You've worked at reception, you have to do it. You can't be like that to…

R Yes.

P You know, you have to… We're a team, and you know, we're all equal, even though I'm obviously in a different role. And then, you know, you get the respect. So anything that you ask them to do, I mean, they will do it for you. I mean, if I said to them, oh we're a bit… We're short staffed. Oh, do you want me to stay on for the extra hour? You know, they jump, and… So they're really supportive in that sense. So it's good, you know, because you know, you win both ways. So…

Reference 3 - 3.67% Coverage

Apart from that, I think it’s a very good department to work for. I joined in 1998, so you can imagine all the changes that I’ve been through. It’s, you know, I can honestly say that all the changes are good. But, I’m not a negative person, I always on the positives. And even if I don’t agree with something, I’ll work with it.

I’ll voice my opinion, just to my manager. Which I don’t think I have, because over the years, I’ve not agreed with something. But like, if you get staff that don’t agree with a change, then you have to explain to them, you have to talk to them in certain way, why it has to happen. You know, and then they accept it. I’ve always said, it’s about how you come across, when you change. As I say, there have been so many changes, you know, some staff can’t handle it and then they just leave.

Or some just stay, and just be angry. Eventually, if someone’s coming to complain about something they’re not happy about, like with the changes. You need to just smile, and you know, you have to say something to cheer them up and just get them out of this mind set. Otherwise, they’re going to be constantly like that, and they’re going to be negative, and then it can get wearing for the team. So, because, sometimes, you always have that one person. But if someone comes to me with something negative, I’m like, you know what I’m going to say. I’m always positive, I can never be negative. Even if I don’t agree with something that’s been put in place, I will still be positive. Because, you have to be, what’s the word? You have to be shown to be working as a team, and you can’t be seen to be negative about not agreeing with something.

00:07:38

P Because then, the minute they get a waft of that, and then they say, oh, she agrees. And then it’s, you know, they will keep that mind set. So, I think it’s always about being positive.

Reference 1 - 18.80% Coverage

R And what about interpersonal relationships, and views on the idea of change, how that plays a part in the process of evaluating new ideas and adopting new technology?

P Yes, I think that does play a big part. I think when there’s a change it probably depends who announces it, like whose idea is it, and I think because there has been so much change, particularly in the last two years, there’s probably a bit of change fatigue. And I think there is still a particular sort of environment, because of what people went through in 2016.

00:15:25

My opinion is that, day to day, people are fine, generally speaking, but if you sort of poke them with something, or want to change something, you do sometimes get that snap back from people, where actually, under the surface they’re not completely okay still, and they haven’t completely moved on and made their peace with that. And in my opinion, I think that will take a few years to go, and I think some staff will just naturally leave, and you’ll get new people, and the kind of dynamic of the team will change, and I think that will help facilitate change.

Because new people, this is what they know, they don’t know what it used to be like, or what it used to be like before that, so they’re not tired of change, this is normal. So, a change is, it’s not an extra thing, it’s just a new thing, where I think for some staff it always feels like an extra thing being put on them, and another expectation of what they need to do. So, I think the workforce changing over time will help facilitate that.

But as I said, I think it maybe depends where the ideas come from, because I think some staff possibly have an issue with a certain manager maybe more than another, so if an idea comes from a particular person, they might take umbrage with it just because of the person it’s come from, and they don’t like this person, or they don’t trust this person, or this person’s always having all these ideas, and… you know. So, I think that probably has a bearing on how successful things are.

00:17:00

And I think even within the operational team, I think it happens on a smaller scale, because there’ll be certain people who maybe hold certain opinions. And so, if an idea comes from someone, it’s maybe not taken seriously, because they’re maybe not as important, or it might be, oh, this person always has all these ideas, and always wants to do things, you know, and they don’t understand this, and they don’t appreciate that, and so they sort of don’t want to adopt that idea.

So, I think it’s difficult if someone wants to bring out a change, and the team, the management team isn’t united in it, because obviously then people will tell over time that you’re not united on it. So, I think you can’t really be, what’s the word, you’re not really going to be taken seriously, unless everybody is… and I think during the consultation there was a lot more unity, there was a very clear line what had to happen, and why it had to happen.

So, even though it was very difficult, and I think the management team found it very challenging, I think they had to stick together, because they were a small group leading this massive change, and so if they hadn’t stuck together, you know, it wouldn’t have worked. But probably on more day-to-day things, maybe that doesn’t always happen quite as much, and I think people don’t always say what they really think, so they’ll sort of say nothing, or imply that they’re happy with something, but maybe they’re not, and so they don’t then really get behind it and support it.

00:18:38

So, ideas that maybe could have taken off, don’t, because people weren’t really behind it. So, I think you need maybe a bit more honesty among the team, or actually just say, it’s okay if you don’t agree with this, it’s okay if you’re not happy with it – we might still go ahead with it, but you’re not going to get in trouble for saying that you didn’t agree. And I think, maybe making people feel like all of your opinions count.

I mean, in the management team, and in everyone, I think people feel like, my opinion doesn’t really count for anything, or like in the consultation, we said what we thought, but not that they’d make the changes anyway, so what difference did it make. So, I think there needs to be a bit of wound-healing still, and acknowledging, because I think some people feel like, well, that was two years ago, we need to move on – and we do in a way, but I think you can’t drag people with you, you have to bring them with you.

00:19:31

So, you have to then meet them where they are, and say, fine, you’re still in that place, okay, I acknowledge that, how do we move forward together – you might be still back here, somebody else might be here, this new person is completely fine. So, it’s quite a complex thing to navigate, I think, where people are, but I think a bit more okay to be honest about how you actually feel about things, would help.

Reference 2 - 9.32% Coverage

I think, with the idea, you’ve got to get buy-in from the start, so people know what the change is exactly, and exactly what the benefits are. And I think maybe getting people to kind of reflect a little bit, so sort of say, okay, well, what do we do – this is what we do right now, what’s good about what we do right now, what’s not so good about what we do right now. Because obviously, right now we’re happy, because this is what we know is status quo, but let’s explore what’s not so good at the moment – okay, so what can we do about that.

So, I think try and get people to think about it a bit more, that just because something is how it’s been done, it doesn’t mean it’s the best way, or the only way. I think as a team changes it helps, because some people have worked here for a very long time, or they’ve only worked here, so this is all they know. So, when people come from other clinics and you hear about how they do things in other places, you think, okay, that sounds better, that doesn’t sound as good, or it sounds different, it’s no better or worse, it’s just different, so it makes you aware that actually things can…

00:21:29

So, I think kind of having more of an idea of what’s going on in the wider context of the area that we work in, the field that we work in, I think would be useful. But as I said, I think getting buy-in from people, and kind of showing, tangibly, how the idea would help. So, say if we had this test, or we had this piece of technology, it would enable us to do this, this would release capacity, or it would make this part of the workforce, their job more interesting, because they might be able to run with that independently – that wouldn’t diversify their role, that will help with retention, because people won’t be leaving all the time.

So, the knock-on effect is that you won’t have to always be training up new staff, you won’t have to always be interviewing, and getting people through a recruitment process. So, kind of trying to really join all the dots up, and for each staff group, say okay, look, you will be benefited because of this, your staff group will benefit because of that, and then you’ll benefit, because normally if you work in a team, you’re always connected to the people. And I guess, maybe telling people that actually what affects the doctors does affect the nurses, what affects the admin team does affect the recall team, you know, it’s like, maybe a bit more connectivity.

Reference 1 - 5.23% Coverage

P So I think with changes, I think some of these changes actually we see as negative at the beginning, but when you go through the changes then you realise later on, okay, it's positive and it has good outcomes. But it’s the same way around, I think you see something positively but then you realise later on that it doesn't work out really well though we expected that. I think so, I would like to see any changes as a positive change initially until proven otherwise.

00:09:36

R So this is the approach that you take?

P Yes, especially when you're working in the NHS because it's always money pressure, isn't it? So you have to expect something getting changed every day on a daily basis. So I think it's mostly living with it. If something is not working properly… If you can't change something then what else you can do, probably you have to leave at the end. So if you're not happy and if nothing is getting changed according to your requirements, I think people tend to leave, that’s the final thing but the service continues.

Reference 2 - 5.83% Coverage

And also you said an interesting thing that some of the changes are seen as negative or they tend to be seen as negative at the beginning, but then they become this positive thing about the care. So how do you think that happens? What makes it possible that suddenly implemented change is being seen as something positive?

00:11:10

R I think because it's something new that you haven't experienced before. So you may not be seeing the positive side of it initially, but then later on it might work out positively. For example, integration, I don't think personally I saw it as a positive thing, but later on realised that for the patient it's a good thing if you think about the patient care because patient can get the service within the same clinic time.

So that's something positive, although staff training and losing more experienced staff are the initial negative things that we thought about but later on realised, okay, that patients… When you think about the quality of the patient care, it improves the quality of the patient care so then you ultimately see it as a positive moment. So that is one of the examples that I have come across.

Reference 1 - 7.60% Coverage

R What would be the other barriers?

00:19:38

P The other barriers would be the confidence in anything new, if it’s been... Also adopting it, adopting anything new also needs a lot of convincing people because naturally you will work with the people within a big organisation, some who do not like change. And so when you come up with something new there is always the question of why do you have to change something that is working? What are the...? So you have to have that ability to convince people to see the benefit of that and how it’s going to improve the service and where it can fit in the service. And that makes it easy to implement it safely.

R Why do you feel people don’t feel like getting involved in trying new things?

P Because, number one, I think... Okay, there could be an explained reason, but I think learning something new sometimes can also be challenging for some people. I’m looking at this in the context of even, let’s say for example, IT, we’ve gone through a lot of transformation from even our record keeping using IT, new pathology system. And every time you come with this proposal of we have to start a new system and there’ll be training, and you have to... It's an uphill task. Or when you want people to learn new skills or procedure, there will be people who are very quick and they can adapt, but also... So that bit has to be handled well. You don’t assume it that people will just jump in and be happy.

00:21:29

So they will need a lot of support during that stage. And once they also start seeing the benefit, the way it fits in and how it’s working well, then they own it and then it makes it easy to implement it. So if it’s something new, you have to involve everybody, all the people who’ll be doing it, the staff, the patient, and there has to be that sort of support in the background. In case of any problems, any queries they know it can be addressed and it makes it easy for them to adopt it.

Reference 1 - 3.02% Coverage

R There is a resistance?

P There can be.

R There can be, that is related to fear about one’s position?

P Yes, one’s position, one’s status, paying the rent, I suppose. There’s a whole range of things. What we’ve always used to counter that is we’ve had a very ambitious development programme for staff. Once upon a time, nurses in GUM services were really there to fetch and carry for doctors in managed care. Nurses in sexual health services now manage the care.

We’ve always been very much looking to be clear to all levels of staff, this isn’t about making you redundant, this is about training you up so you’ve got the opportunity to learn new things, and the challenge then becomes if you’re dealing with staff that don’t want to learn or they feel that they’re too old in their career to learn or they feel that they’re being exploited if they’re expected to learn in these areas, and that is a challenge.

Reference 1 - 4.70% Coverage

So what were the main challenges in that process?

P First of all, I think, the installation that’s been done by IT. So it’s liaison with the third party to get them to do it, then they weren’t installed correctly so it’s going back again to do it again. And then just with the training of staff who are clinical that whereas maybe something like IT isn’t there, isn’t their main thing so it’s getting them to understand the processes, have they got their computers to work and stuff with them.

But we’re all there and we’re all using them, we’ve cracked it. Some people are quicker than others but we all get there in our own time, don’t we?

R Yes.

P We all get there in our own time.

00:04:43

R Well, those processes turn to be time consuming and energy consuming, right?

P That’s it. They’ll be time consuming and sometimes you have to go back over a few steps a few different times, but we’ve got there in the end.

Reference 2 - 3.31% Coverage

R Having so many different perspectives of people coming from different departments, do you think it helps or it may actually?

P Not always.

R So why is that?

P Just because everybody has got different ideas as to what’s going on. Some people don’t understand an awful lot about the actual clinical processes or about patient journey. So for them something from... It’s harder for them to get to groups with what we’re talking about because they don’t have that knowledge base and stuff that goes with it. So it’s just a case of trying to help people to understand what the processes are and how maybe something new is going to improve that process.

Reference 3 - 2.85% Coverage

R And would you say that there is overall support from people working with the service?

P Definitely, obviously I can only comment about the team that we’ve got here. I would definitely say yes, and the contract manager in that kind of thing, then definitely there’s definitely support there and support for driving things forward. And here within clinic, definitely and I would say the teams. The team are onboard with new stuff that’s, like I said, going to improve patient journey, improve their working practices. The two things together, then definitely.

Reference 4 - 4.50% Coverage

P No, we’re pretty up for new technology and we’ll give it a go. I think we’re quite positive and we’re quite proactive into about moving things forward. We can’t go back, we need to step forwards and obviously patients do want things as quick as possible and as easy as possible, but obviously it’s got to be as accurate as possible. We don’t want to be it to be quick but it’s got to be accurate as well. We don’t want to be sending people off with false information and stuff.

Like I said, we’re pretty... The service changes that we’ve actually made with the new contracts and stuff, I think have made people be prepared to change their practices. Because people had maybe got a bit stale in the past and having new contracts and stuff and moving forward has made people change their practices and look at things in a different way, and just what we’re doing and how we do things.

Reference 1 - 5.40% Coverage

You can normally pick out the people who have more resistance, and then actually work out what their issues are and why they're challenged by it. And especially if you've got enough lead in time, actually, you can usually work around what the barriers are, particularly if you got a well-developed referral pathway and why you're doing something is quite clear and is to an advantage to the patient or the clinic, then actually I would be very surprised if you can get people to actually buy into it in terms of...

R So they would be working with individuals and spending time...

P Well, people who may find it less easy to understand the advantages, yes.

R Would you be the person to do this?

00:19:39

P It would depend on who they were, and if it was a doctor, then probably yes. If it was, for example, a health care assistant, then I would probably get one of the nurses who was closer to them, so a less threatening person, someone who already sees the value of it to talk them through to it. And with introducing the order comms, we've done a cascade thing. So myself and [name] sorted out the doctors and the senior nurses, and then the nurses sorted out their more junior nurses.

So there's been very much a team approach and everybody helping each other to do it, working through it.

Reference 1 - 1.65% Coverage

P It depends on why we are adopting it and how it’d impact on the service, I guess. So our commissioner’s very keen for us to be, you know, being sort of part of innovation and, you know, and bringing on innovation. I don’t think that being a problem at all, I don’t think that will be a barrier, and she would certainly support that, but it just depends on what it means in terms of our numbers, our, you know, our service that we’re providing.

Reference 1 - 0.99% Coverage

So in a way, the patients' needs, that as well can make a case for a new technology.

00:08:00

P That can, yes. But I think it's a combination of patients' needs and staff willingness as well to embrace it.

Reference 2 - 12.99% Coverage

R And I don't know, is your feeling that if you were in the large clinic and had more space available for waiting areas and for lab work, do you think your team will be more keen on adopting new tests or doing service evaluations for more technologies?

P I think with my team, it's a combination of both. Because within my team, I do have some people who look at change as an opportunity, and then I look at some members who look at change as, oh, my God, what now? So sometimes, it's hard to strike a balance. But what I see is that things have to improve. They cannot be always where they've been. And change sometimes, it's a good thing. But it's just to make people feel that it is. So yes, I find that in teams, it's always a combination of both, people who want to embrace change of work style and people who just want it to be as it is.

00:14:21

R And would you say that you are the one who's comfortable with the change?

P I think I look at change as an opportunity, but that's probably me as an individual. But I appreciate that not everyone is like that.

R And do you try and then maybe change how others feel about or you just leave them to see for themselves?

P To be honest, that is part of my day-to-day work. Yes.

R That's challenging.

P It is, it is. But that's part of my work, I find. Because things are changing a lot even within our service. So I just feel like if I don't embrace it, how am I going to motivate my team towards what we think would be the best way of working? So yes, that is part of my day-to-day work.

R So you're the example to...

P I wouldn't say it that way, but yes, I try my best to be. Yes.

R But you know what I'm thinking, that if you're embracing this new technology, then the nurses that you work with are more likely to also follow you.

00:15:46

P I think so. I think so. But it's not easy. It's a challenge. Yes, it's a challenge. Because even with these simple ways of working, it's always hard to introduce something new. But if that something new comes with an incentive of, say, getting results quicker, then I find it's easier for people to say, oh, so we are benefitting from this. So, probably, my day-to-day way of looking at it would be analyse something new that's coming up and highlighting the benefits of why it's done against the negatives.

Because there would be negatives, there would be. Probably, people would need to go on training or people would need to change the way they work. So it's things like that. But focusing on the benefits, sometimes emphasizing on why we are introducing the change in the first place, I find, works better. But you always get, oh, you see, it's not working. When you hit a problem you get, see, this is it, it's not working. But, yes.

Reference 3 - 8.18% Coverage

R So in practice, how do you do or how would you do it ideally if you had all the time and money in terms of convincing people, like there's a new way of doing things or there's a new technology? So how then do you introduce it to everyone in the clinic?

P I think it's giving people time. I think proper explanation of whatever it is that we are changing. And go through it with them because they need to take it in and analyse it in their own time before actually introducing it. So I find, if people are given much notice, it works better because then they have time to think about it, talk about it, and bring their worries forward and then get them addressed before it's then introduced.

And with certain changes, you don’t actually look at how... when, realistically, you're implementing it, sometimes it's not possible to see how it would be in due time when it's being introduced. And it's also looking at and learning every single day and keep evaluating how it is. But I find that if people are given more time to think about it and analyse it in their heads, it helps a bit. Because it's amazing how people would come back and say, oh, I was thinking about that change, and what if this, that, that, the other happened?

00:21:30

And if people talk about it, it's much easier than when you introduce it. So from experience, I find that if people are given more time, it's amazing what they can come up with. They can probably come up with things that probably you were not even thinking about them, because they are the people who are working in this environment. They are the people who are actually supposed to implement it at the end of the day. So, yes. I find, if people are given more time, then it works better.

Reference 1 - 1.70% Coverage

I'd be the one who would teach the other members of staff how to use something. Give them their reassurance, because a lot of new changes can cause a bit of anxiety within the team, and just support them through using the new technologies.

Reference 1 - 4.95% Coverage

And who would you say are the key decision makers? I’m thinking about introducing new ideas. Who would that be? Is it you or [overtalking]?

P Yes, we work collaboratively. Myself, the Clinical Lead from our Sexual Health Service, GP Leads. After we had our failed procurement, we set up quite a few different task and finish groups to look at various different elements that we were working on.

And from that we’ve got, I suppose you could call it friends, with different elements. So, say if I was looking at the LARC, the Long-Acting Reversible Contraception pathway. We had a specialist GP who was very interested in it, who wrote the specifications, etcetera. We had an active manager who explained who could and who couldn’t do it. And we also had a really good, robust procurement team as well, who also support us to make sure that we’ve procured the services in the best way as well.

Reference 2 - 1.74% Coverage

The specification that sits with the contract states quite clearly that the outcomes are to deliver sexual health services that contribute towards the Public Health Outcome Framework. And also, to work collaboratively with other partners, which they do. And also, to adopt new technology as and when it’s approved.

Reference 3 - 3.89% Coverage

R What about inter-personal relationships and individual’s views on new technologies? Do you think they support them or they can be a potential barrier?

P I think they support. Anything that speeds up the process. Anything that prevents a GP appointment or an appointment at a clinic somewhere is very welcome. Self-care is very good here, yes. Among younger residents.

R Does it mean that then there’s less workload for the practitioners?

P Yes. Anything that can reduce workload. Someone can do the test themselves, get the answer remotely, and have a good, clear pathway to how they then access treatment. Again, this is where our community pharmacies are very useful. That stops a GP appointment.

Reference 1 - 8.11% Coverage

My responsibility will be making sure that I’ve got all that information first, so that it makes sense to the rest of the team. Remember, there’s a varying level of experience, knowledge and responsibility. Some people are going to go okay, we do whatever we’re told, and others are going to be saying tell me a bit more about that, what’s the science behind this, what’s the motivation for doing this differently, why are we doing this? My responsibility is making sure other people understand and other people are signed-up to it.

00:05:18

R Can that be sometimes challenging to get everyone on board?

P Absolutely, I think the challenges come with… I try to anticipate that by thinking about who am I talking to? How am I going to be selling this new idea to them? And what will work with my team and the individuals within my team? Because lots of people come at it in different ways and when you’ve got a team that’s quite a small team and it’s been together for quite a long time, you do know what’s the best way of addressing. You can sort of anticipate where you may run into trouble, where you might find people resistant to change and who those people might be and what’s the best way of managing that.

R The key, would you say, is to know your staff?

P Yes, for me, that’s one of the advantages of being in a small team for a long period of time, a small, stable team that hasn’t changed a lot. One advantage is that you know people well and you can anticipate where there may be sticking points, or where they may be concerns, you know how to pitch it. Like when you’re a kid and you talk to your mum, you’d do it differently to how you’d do with your dad, if you want something.

Reference 1 - 1.60% Coverage

Well, there’s more than just me on board with new technology. Like I’ve brought Twitter and Facebook in to. I’ve been running it years for Sexual Health, even before I came to this setting. There’s also… The consultant nurse is really interested in technology. And I’m not sure if you’re going to talk to her. I’ve got a feeling. And she’s also the HIV specialist that we’ve got here in the clinic. She’s very interested in new technologies. As well as a couple of… Our data analyst. She’s very interested in it.

Reference 2 - 0.66% Coverage

And it’s very frustrating when you know things are out there and we can’t put our hands on them. I’m chompy [unclear] if I’m allowed to say that. I’ve got to wait and see, but actually I think it’s marvellous.

Reference 3 - 1.13% Coverage

Is there something within the service that is encouraging getting new things?

P I imagine… I can’t remember what the groups are called, but we’ve got something under CCG now which is to do with people contacting their GPs and then they… It’s almost like a buddying up system, and that’s for weight loss and things like that. But I’m not sure about other things.

Reference 1 - 2.92% Coverage

P I think introducing anything can cause some concern to people, I think it can cause a bit of anxiety but I think if it’s actually introduced in the correct way and people are given the training so they feel comfortable doing it then I don’t think there’s a problem.

I think we would, from the staffing point of view, we would manage the time so nobody felt that they were not… You know, that they were having to work extra. So we would make sure that the times are correct for people to be able to do the job and I think if the training is given to people then they are more than happy to actually embrace new technology.

Reference 1 - 4.83% Coverage

P Yes, and as you say, invested in the idea is hugely variable. So some people are resistant to change, and very anti anything being different. Whereas some are very proactive, and keen, and positive, forward thinking.

R And why do you think that difference, do you think it's just a personal…

P I think there was a personal element to it. I think in general, people are resistant to change. Perhaps feel threatened by it. And so it's important that we make sure that people are aware, and understand the benefits of doing so. I think the trouble is, some of the benefits involve saving money for the department, which individual staff members don't necessarily appreciate. Particularly the more junior staff have obviously less understanding and appreciation of the financial sides of things.

Reference 2 - 1.00% Coverage

So some people are less maybe in support of new technologies. Are there any ways of [overtalking]…

P Not necessarily new technologies, but in terms of any change.

Reference 3 - 7.07% Coverage

P I suppose you've got to make it as easy as possible for them, but the change, sort of training is kind of fundamental to that isn't it? Making sure people aren't frustrated by the system, or whatever it is that's being implemented. They don't… It needs to be perceived to be easier and better. So, it's so hard to get people to change from what they're used to and comfortable with, and they can do easily, with something that's hard, and difficult, and takes more time.

So anything that can smooth that process over is going to be better. I mean take change of computer system, or move to electronic patient records. You can see a patient, and document their notes on a piece of paper in 30 seconds. To do the same thing on an IT system could take you five minutes, and therefore there's a frustration, particularly those who are less IT savvy to have to invest that extra time for every patient to do so. Even though that's the right thing moving forward to move to electronic records that can be shared across regions.

00:13:10

While there's clear benefit for that individual in clinic at the time, you can appreciate the frustration of having to change.

Reference 1 - 0.55% Coverage

I think it’s more about getting staff on board as an early start so they appreciate the importance of what you’re doing, so that they prioritise it happening along with standard clinical care.

Reference 2 - 1.36% Coverage

You’re always going to get some people who complain about the process, but we certainly successfully introduced changes on a clinical governance base, which has definitely increased workload. And I think it’s also about listening to staff when you introduce a process. So, you know, if there are any issues, making sure that you hear about them early, and then staff can come to you about them. And that you can troubleshoot those things early before they turn into a big problem.

Reference 3 - 2.09% Coverage

And then I guess there’s always change. Change is always challenging to a degree in that you need to train all your staff and make sure they’re up to date with the required education and monitoring, and all that kind of thing. But I see those challenges as less insurmountable, really, because although we don’t have new technology introduced frequently, we do have lots of change happening on an ongoing basis and actually clinic and lab staff are used to training and updating.

And clinical guidelines change and we have to update staff and ensure that’s ongoing. So, I see those challenges as less of a problem than financial, really. I think, particularly if new technologies don’t take up much room, you can generally fit things in.

Reference 1 - 7.40% Coverage

R Yes, and would you describe those processes as smooth?

P Not in any way at all.

R Oh, right.

P I think, because we’re… sexual health tends to be quite self-contained, and it tends to use its own IT, so our own electronic patient records, which means that there’s no… when you’re implementing something, you have to have the approval of the trust, and normally the trust IT department.

00:04:35

Now, on a day-to-day basis, they don’t actually have any involvement with the system at all. So, what you tend to have to do is educate a whole load of people about what you actually do before you make any changes, the reason for making the changes, and then quite often you’re trying to fit changes which are completely appropriate for sexual health into a general kind of NHS structure. And it… quite often it doesn’t fit.

The NHS is incredibly conservative about information governance. So actually, just an example, trying to get negative text messaging, which… text messaging is an old technology now, so everywhere does it, but to sort of an NHS organisation it’s seen as a big risk, there might be a problem.

You meet lots of… I would call it obstruction actually. You do meet a lot of obstruction from people that you get the impression that they’d prefer it if you were just on paper notes doing everything on paper, because that’s secure, you can lock it away again.

So, yes, I don't… there’s never been a drive to develop… nearly all kind of IT technology type development has come from the clinical team, or the group, to say, actually, we want to improve this. This is really old-fashioned. A trust would quite happily, or the NHS kind of hierarchy in general, would quite happily just let you carry on doing the same old things, because it’s tried and tested and safe in their eyes.

00:06:16

So, we still use fax machines here. So, I think that’s a really good example of where the NHS generally is at, at the moment.

Reference 2 - 5.45% Coverage

And would you say that there were instances where actually the adoption process of something of value in your opinion, and in the opinions of your colleagues, was stopped?

P Let me think. It would be… probably not stopped, but delayed to the point where people moved on. Which is effectively stopping it. Nothing… no one said no in the NHS, they just sort of… it’s obstructed until it’s kicked into the long grass really. So, a lot of our projects that we’ve wanted to do here, there’s not been any IT time, or development time. And basically, it’s, everything’s just sort of timed out.

That’s a reasonably common scenario, in that, normally we try and run everything as a pilot project, and quite often, if we have a small amount of funding for the pilot project, but we need other things on board. And it’s the other things coming on board which don’t happen, and then actually that… the funding times out and you don’t do it.

So, I think we had a small amount of funding for trichomonas vaginalis testing which allowed us to do a pilot in our population. But it never happened, purely because the laboratory didn’t have capacity, or they didn’t have time to do it. So, they almost obstructed it to the point where that funding ran out and we stopped doing it.

00:08:09

So, that’s a big… that’s how the NHS stops things. It just doesn’t resource the approvals around it, and then you can’t really progress any further.

Reference 1 - 2.65% Coverage

If I can understand what we’re doing and how working well and how it can work and how we can roll it out, then that means what I can bring to the rest of the staff, the reception staff, and say, yes this will work better. This will make our jobs much easier. We can cope with it. It’s not as difficult as you think. Because a lot of people do not like change. But once it comes into play, it comes into place. They’re all for it. But you’ve got to actually convince everyone that everything’s working.

Reference 2 - 2.68% Coverage

And you said that it’s actually that the clinic seems to be really ready. And the communication is...

P Yes. Once something’s going to be rolled out, we are informed. If we need training, we need training. And if... We normally do examples for the staff so they know what they are to expect when it comes in and how easy it is to process, or how difficult it is. Some people find it easier than others. And once they know what they have to do, they’re fine about it. But we all have to accept changes. Yes.

Reference 1 - 3.97% Coverage

P I mean, I think essentially if you ever want to adopt anything in any service you’ve got to have people who are champions that’s one thing I’ve learned. And if you’ve got people who are into innovative projects and are ready to follow them say they’ll have set guidelines, okay, fine, by the this and this date we’re going to do this and this and this. If you get champions involved and interested parties then it works.

00:13:48

So, if you’ve got some people who don’t like to adopt technology then it becomes very difficult because within your department you’re struggling because you’ve already got conflicts. So, that becomes difficult. But that’s within the departments but I think it’s also working with other, say, other like I’m doing something with a GP surgery trying to adopt something new to increase HIV testing.

And actually it was identifying a GP, a senior GP from the practice who’s interested in this and, you know, has background in IT. So, together we’re working on a project but, you know, if I came in and said, oh, how about that it probably wouldn’t work because you need someone from within that area who’s interested as well.

Reference 2 - 6.40% Coverage

P I mean, I think if there is resistance to meeting the first thing you do is, you know, if it’s a resistance and it’s come down via an email I think the first thing one has to do is have a conversation with the stakeholders in a room. Because this email is just ridiculous I just think that there are a lot of emails that can fly around and nothing ever gets solved. And I think if there is particular... if someone says, oh, I don’t like the idea I think it’s always best to actually meet the person and say, well, what is the problem with the idea is it the idea itself, is it... have you tried it before and it’s not worked etc.

So, they have conversations flowing but I think I personally believe in face to face conversations if things are not working and things are not pushing and not moving forward. Because there’s sometimes too many people involved and everybody loses sight of who’s involved. And then someone says, oh, no, I don’t like it and then they say, oh, well, why don’t you like it and they say, oh.

And then actually if you sit down everyone’s like actually do you know what it’s a good idea, it’s actually fine I don’t know why I said I didn’t like it. And actually also when you have emailed there’s a lot of people that don’t know, you know, the person, you know. And then when you meet it’s like, oh, it’s nice to put a face to a name, you know, an email address and stuff like that. And I think, you know, things are solved much better.

00:16:27

So, I think if there’s ever any pushback I’d be like the first thing I would say is can we have a meeting in person to discuss what the issues are. Because actually you might be right and I was just barking down the wrong tree and actually you’ve done it before and it hasn’t worked. So, you know, yes, I don’t mind being told I’m wrong but I’d rather have that conversation face to face.

Reference 1 - 0.54% Coverage

Some staff are technophobes. So wouldn’t like the idea of having to even, to use the equipment, we’d have to get people who were happy to use the equipment.

Reference 2 - 6.62% Coverage

And some staff would be more than happy to do everything, they’d be like, yes, lets do it, straight away, let’s get the machines here, let’s get it done now.

Others would be more reluctant because they’re more traditional. And yes, we’ve got quite a wide age range of people working here. So sometimes technology is not taken up as easily.

R So would you have to think about certain strategies, how to approach those people and get them on board?

P Yes. I won’t mention names, but there is certain, I know certain people who are very reluctant to change and anything, even if it is in the best interest of patients, may be, have to be put in slowly. But it is always in the patients’ best interest and that’s why we’re here in the long run. Most of our patients would be ecstatic if they could get a result within an hour.

R And who would be responsible for then getting those people on board.

P Probably their line managers, or the project leads. So, there was some of us who are a bit more willing to have a bit more information, a bit more about the technology, and be almost the leads for it, so, or the local champions. And that’s a term they like a lot with things, is champions. And then we will just go and talk through and be the person to answer questions to. Because they may approach us, not as their managers, it would be easier as a champion, than they would a manager.

00:23:12

Because they don’t want to be seen to be making problems with the managers, but they want to ask questions. It’s what’s happening with this consultation at the moment. I’m not actually involved in the consultation, but because I seem to know, and I know a lot of the information because I’ve listened, people come to me to ask me questions. And that’s just because I happened to have listened and taken note of everything. Mainly with how it’s relevant to me, but luckily their questions were the same thing.

Reference 1 - 2.59% Coverage

PA I suppose it's the philosophy of the doctors and the nurses being willing to do that. So we have a lesson, we have a meeting and if this is going to be advantageous to our service, so we do it. Obviously we have arguments and people might think I don't want to do that or whatever, but on the whole, we think it's a good idea we will adopt it.

Reference 2 - 3.62% Coverage

PA And think about the ideas that we've had, on the whole, they're reasonably good ideas. They're there to reduce waiting time, reduce stress, so we would adopt that.

RE Right, so it has to show that it [overtalking].

PA Has to show it's advantageous to us and to the patients and not too complicated. Anything complicated people are just not going to… It's going to be too confusing, I think. That's my personal opinion, but it's quite straightforward, it should be absolutely fine.

Reference 3 - 14.42% Coverage

PA Obviously you're dealing with lots of different members of staff who've probably got together for a long time and it is some people are more reluctant to change than others. So you're dealing with those people who always the ones that at the meetings, who always have a problem with whatever and are reluctant. And that is a problem.

00:07:36

But it's just a matter of, we have a Take Five every, before every clinical session, so we have a… We bat out what's happening… And that's when people can… But there'll always be certain people who say, I can't do it. I can't do it. I won't do it, I can't do it. And you just have to support them.

RE And how do you do that?

PA Well you just encourage them and you say right, well okay, let's see I'll do this with you or I'll work with you this morning, or let's see how that can go or take your time over that patient or… Do you know what I mean? Because we have a time limit for patients, so if we don't see them in half an hour. Some people take ten minutes to see patients, some people take an hour and it's difficult to support those ones who take longer to, kind of, get them to speed up a bit. So sometimes we work with them, we talk to their manager about it, it's just difficult.

RE Right.

PA But there are people who are reluctant to change and complain about the change and say well, it was better in the old days… In the old days people just do this.

RE And do you think that can actually stop, that process?

PA I think they can, well they can make it difficult.

00:08:44

RE Right.

PA But the senior management, so for people that are running the clinic really, you have to be on it and if they're on it they'll be workers who just have to fall in. Yes, it's not usually the management that are reluctant, it's usually the workers. Do you know what I mean?

RE And that's because they tend to be just used, it's a habit of using something else that…

PA Yes, yes.

Reference 4 - 6.87% Coverage

PA And I think this clinic… This service is a good service and we do embrace change well. There are… People are reluctant, people do find it stressful but with good support it can be done. I think it will be okay.

RE So when you say that this clinic is particularly good because it embraces, how do you think, why do you think that is?

PA Calibre of staff, staff that have been here a long time, a lot of staff been trained to do a lot of things, they're professionally well-developed. Kind of interested in the subject, you know, we don’t have agency staff, we have permanent staff it's all just permanent staff who work here all the time. I think that's an advantage. A lot of us have worked here a long, long time. That's a group dynamic thing. We're quite happy to support each other. Obviously there are issues but not as many issues as perhaps there could be.

RE Right.

PA So we're pretty good embracing change.

Reference 1 - 8.61% Coverage

R Yes, so the resistance.

P That could be a barrier possibly, yes. People don’t like change, as I’m finding out. I’m somebody who thrives on change, I like new ways of doing things, that’s what interests me about the role. I like to embrace new ways of doing things, but not everybody is the same.

R Why do you think that is happening, that there is resistance?

00:10:31

P Well, I’m also trying to look at our opening hours and that’s probably a bit of my own experience here over the last two years. I’m looking at trying to modernise the service, look at new ways, our opening hours, the offer that we have to our patients. On the whole it’s probably featured with the appropriate blend of enthusiasm, but there are some quarters that do find it very difficult and find it threatening when we look at new ways of doing things.

They take that very personally because it’s different from what they’ve experienced before, depending on the individual but can be easily sorted or not. Then there’s a whole another story which I shouldn’t go into.

R But they are strategies of communicating the need for change.

P Yes, sure; indeed there are and most of them work, but some people are very dead set against things and that is a problem.

R Has that ever happened that something was not adopted or was adopted with a delay because of certain resistance amongst staff?

00:11:51

P Certainly some things are delayed for that reason, but they’re more organisational ones, not about new technologies. I think, most of that probably would be okay. Yes, we certainly have some staff groups that every time we have to do something new or different that should mean that they get a pay rise, but it doesn’t often go in that direction.

Reference 2 - 2.76% Coverage

P Well, that’s part of the communication as well, in a sense, it’s just about being aware of what the benefits are and actually trialling things. Personally, I think, when there is something new we do have to look at it, and, hopefully, if we think it’s a good idea and think it will benefit up we then need to trial that to make sure that it does what we think it does and learn by that, then you adapt things accordingly based on how well it’s going or otherwise.

00:13:12

That’s part of the team response to new technologies, I suppose, then change.

Reference 1 - 4.31% Coverage

P No, I would say certainly the... our current leadership are very interested in new technologies. We’ve also got... we’ve recently appointed some new younger consultants who have... who are very interested as well. So, I’d say the climate at the moment within the department is quite exciting and people are willing to try new things. And there’s, you know, there’s an eagerness and an enthusiasm within the senior doctor team to start to move things forward definitely. And as I say our lead nurse is very proactive in new technologies and bringing us, you know, wanting to lead us forward.

00:10:27

However, we do have a lot of... some staff who have been here a long time, you know, and some people don’t like, you know, change.

Reference 2 - 3.12% Coverage

The other obstacles are, you know, I did say before that, you know, people... that the environment is supportive of change but you do have some people within the department who don’t like change. And that potentially... you know, and some of these people are quite strong characters and, you know, have influence over maybe more junior staff. So, you know, so, that would need to be managed appropriately as any change needs to be managed appropriately regardless of what that could be. So, that could potentially be an obstacle.

Reference 3 - 3.25% Coverage

P Absolutely, absolutely, you know, and I’m, you know, I am a person who sees the glass always half full rather than half empty. You know, so, I do try in any situations where there’s negative I try and pull it round to the positives. So, you know, so, if I hear discussions like that I’ll, you know, sit back listen and then give my view point so people can see both sides of the equation. You know, so, I wouldn’t sit back and just let people moan about it, you know. So, but then again I wouldn’t shoot them down either because that’s their opinion.

Communication

Reference 1 - 3.01% Coverage

So the main time my staff come together is a Wednesday morning. Okay, and the Wednesday mornings I ran teaching and training, but also a chance to talk about new things.

R Yes.

P Okay. And they are important times, because people get to see the department's moving forward, it gives a chance for people to air, you know, their gripes. You know, some people, you know, are very articulate about that. Other people, you know, they tell you quietly, and then you raise it on their behalf. But it's a good opportunity for people to sort of thrash out problems.

00:26:03

We have… So that's all the department. We have all the senior doctors meeting at least once a month on a Wednesday. We have a research meeting every two weeks now, myself and the tutor. We… But before every clinic, we also have a synchronisation meeting where everybody turns up, we talk about how many people are there, how many patients we can see, what research studies we're doing, what stock issues we have, what training needs we have. And that happens before every single clinic. And that's been the case for the last six years.

And the beauty of that is you, you know, everybody's on the same page at the beginning of the clinic. Instead of, you know, strolling in, and you know, not really understanding what the focus is. And so yes, we… That's just a straight rip and burn from a talk of one day's checklist manifesto, you know. Just making sure you know what your aim is, and what you're trying to see. So you know, it's no surprise then that we got so many trial patients coming through the door, or so many women for an IUD, or whatever. So that's the purpose of those meetings. But they also become good places for people to articulate problems, and then we can then collectively come to the Wednesday morning meetings.

Reference 1 - 2.09% Coverage

also thinking about how do we navigate the changes that we need to make, developing our communications, how do we communicate, how do we get people feel involved into these decisions.

So it's pretty much having the same approach to service delivery that we have to... things that we do with patients. So in sexual health research, one of the things that we say is no decision made about [unclear]. We talk to patient groups and even doing something for them. We need to involve them. Similarly with staff, you can say that your working conditions are going to change, get that. How does that affect you? If you had to get it with this, how would you do that?

00:09:29

It's easy to say, but it's very difficult to deliver on, because part of it is getting engagement from staff, but why those changes need to happen? Because obviously, everybody is like, I don't want anything to change. I want things to be the way they are. But we have a duty to provide great care, and great care is more than... care basically means being up-to-date with everything and being able to deliver the best we can that is available now, which basically means that it won't be the same as it was last year.

Reference 2 - 0.53% Coverage

Nobody actually tells you that you will deliver it in this way. They'll tell you what you need to deliver. And it's up to you how you are going to deliver that. It is a lot of work to implement change, to look at new technologies and how you're going to implement them and nobody else has done it before.

Reference 3 - 0.76% Coverage

Whether I think you should do this in and somebody [unclear] do it this other way. And sometimes, people come up with things that you don't think of. So it's kind of getting that. Talking to the people who have to implement it to see how they will look at it, see what training is required, what resources are required. If you're asking patients to wait for another 20 minutes, do you have the space for all these people to wait?

Reference 1 - 1.98% Coverage

If you’re changing a part of the pathway it’s going to affect lots of people, not least patients, and I believe you have to have that conversation in an inclusive way where you say: This is what we would like to do. What do you think are the benefits and the cons compared to our list of pros and cons? And I think you should do that with all staff involved, all patients because they will also bring up things that you weren’t considering that’s really important.

Reference 2 - 2.52% Coverage

R So that’s a lot about interpersonal relationships.

P Very much so and I’d say that applies whether it’s a big or a small change. That’s probably the one thing I’d say is transferrable.

R Right, and those interpersonal relationships, do you mean those in the clinic or also between you and the clinic and just…?

P I think all over. So basically, it’s very important that even if it’s with people you’ve not engaged and worked with before… So it could be a supplier for instance. It’s important that you have the ability to build relationships very quickly and manage expectations early.

Reference 1 - 2.89% Coverage

So, I feel I am very much a part of the process that’s kind of thinking of the ideas. But, also, I suppose mainly implementing them. And thinking about pathways. And who does what and how is it going to be used, and with who? That kind of thing.

R Right. So, I presume you have a lot of meetings around those issues?

P Yes. So, you know, operations meetings and other ad hoc meetings related specifically to new initiatives.

00:04:53

R And that’s where you share your opinions on the new ideas?

P Yes. There is quite a good environment here about just sharing ideas and so on. So, if you, you know, just want to grab the clinic lead or one of our other consultants, and have a chat about what do you think about this idea? Let’s debate it. We can just have that any time, really. It’s nice.

R Oh, right. Okay. So, it doesn’t have to be structured, really.

P Yes. No, there is a lot of just us, kind of, talking off the cuff about things.

Reference 2 - 2.65% Coverage

P I don’t know. I don’t know if I have any ideas about that. I think communication is probably the most important thing. So, to… And this is something we do fall down on sometimes. Like, I think, sometimes, we can be so quick to make changes to even just, like, how test or, you know, samples are processed or something.

But does the whole service know that we talked about it in a training session for everyone? And we emailed the service. Sometimes it happens. Sometimes it doesn’t. So, I think it’s difficult to kind of make sure that the message is being communicated to everyone.

R And what about these two other settings that you mentioned that are more traditional?

P Oh, the other clinic sites. Well, we… So, we… It’s all the same staff that are rotating throughout.

00:20:19

So, everybody... So, we know each other regardless of what the location is.

Reference 1 - 1.87% Coverage

And thing is as well, everything falls on your shoulders, but then you're still liaising with your managers to see where you are. And then they're feeding back to, like, their managers, because there's a chain isn't there? So… But on the ground level, everything's fine, and they're confident, no problems.

R Right.

00:07:38

P And I'm always fed back, there's no problems. Or if there was a problem with, like, the printing, and then you've got, like, IT, they will come out and try to fix what's… Because I'm not technical, so I don't know that side of things. So that circumstance is beyond my control. But at least I'm liaising, and having these telephone calls, testing there and then, running from room to room. It was, like, a lot of work, but I enjoyed it. And it was a learning process as well. So I think when you get something else, you remember what you did previously, and then it makes it even more easier. That's how I find things. So…

Reference 2 - 1.10% Coverage

So, obviously we can't, like, be turning the admin off because it's something that they're getting used to. But we're just supporting them, and just… Telling them… Giving them the reasons why it's important. Because it's no good you just saying to them, oh you have to make sure you tick that box. You have to give them an explanation why, and then things started to improve, because we got the data for probably, like, two days after. When it went live. And then they noticed that that was one of the things that wasn't being done. It was being done ad hoc.

Reference 3 - 2.92% Coverage

This was to do with opening times. There was a site that was opening at 11 o'clock, and the other sites were open at nine o'clock. So two hours productivity was being lost in the morning, and patients were queuing up. As soon as you open the doors, you had the mad rush. And we were trying to say if that clinic opened a little bit earlier, it would… You know, it would be in line with everything else. But there's always sometimes you have resistance. Didn't affect the… They looked at the rota, staff were already in at that time anyway, but just down to start clinic at 11.

So what we did was, you have first of all staff meetings. And it's, like, discussed, so everybody's aware. And then you have a team of people, like, you call it a little project. And say, right you, I want you to be involved in this project. Again informing the staff what… The department, we're going to start doing a survey for the patients to see what they… Times they prefer. And it came back that they all wanted early.

00:15:21

Collected the data, so that it was clear for the department to see, so to make sure that they're all involved. Everybody has their comments. And even though you will still get somebody who's still not happy, but the overall majority, and the data will speak for itself, because you know, you have to have the proof. And then we say from this day, we're going to go live with the time, the opening times, with the change. So that's the way to address things as well.

Reference 4 - 2.16% Coverage

But you do… It's good to, like… We have an ops team, and if something new is coming in, we all discuss it. Work out the pros and the cons. I also cover reception, we're short staffed, so I know everything that goes on at reception. So they will say, well, do you think that this can work? And I will say, well, no, I don't think it can work. And then I give my reasons. And then they're quite good, the team, because they do respect what I say. And they won't, like, go with it. Or we try and come up with another solution, or can we just trial it? Because we know that the reception have got so many steps, and so many systems that they need to log onto.

R Yes.

P Have to be careful about giving them yet something else. So, I just make sure that I think, well, can this be done? Or can this new thing be added? You know. So it's all about teamwork, and communication is key. I don't think it's good to make a decision… There are some decisions outside of everyone's control that have to be made. And you know, you're always going to get somebody that's not happy with a decision that's made.

Reference 5 - 2.64% Coverage

We all get together as a team to discuss it. But the deputy general manager, service manager, obviously the general manager, but the service manager will lead on it. And then will feedback to the deputy general manager. But we all get together as a team, and discuss what's our business planning for the year. And it goes… Goes quite well, because I think the service manager shares the office with the other service managers within the, like, directorate. And then obviously they can all bounce off each other, and see where they're at. But, you know, I think they have little competitions going. So it's quite good to know that, you know, what… You obviously like your plan is the best, and like… Because when it's sent up…

R Yes.

P To be evaluated, or checked, or whatever. And then, you know, if there's a few comments, then it's good. But if there's lots of comments, then, you know, if there's less then it means you're on the right path. So… And then obviously it's got to get signed off. So, yes. And there, again there's a deadline for that. So it's important that everybody… You know, because we have a set agenda to discuss certain things. And then if that's on it, you know, we might spend a bit more extra time on that for that day, so that it's signed off. So… I think we've got a really good team, actually, quite supportive.

Reference 6 - 1.41% Coverage

So it's about communicating, making sure the paperwork is also kept tidy, because there's nothing… Oh, what's this? Or what's that? I said everything that was handed back… So once you've handed out all the registration forms, the queues, everybody's completing the forms. And then it's the hand back. You're communicating to the patient.

R Yes.

P They've either gone off, or… Depending what the stream, take a seat in the waiting area. Right, you put those ones and twos, and let's get some on the system, so they can start taking the patients. And then say about midday, it was all calm. And I was thinking, this is, this is… It's about organisation. Communicating, and having a little system going. And it works.

Reference 1 - 3.55% Coverage

Probably when we moved to [name] clinic, that was a big change, closing down the old clinic and coming here, because the way that we worked completely changed. It changed mostly for the nurses, because our role expanded a lot clinically, and we became a lot more autonomous in our clinical work. So, that was a big change that we went through, which would have been about five years ago, five or six years ago now, and there was about a year of work that led up to that.

So, there was kind of an evaluation during that time, and people sort of asking the nurses, you know, like things that would affect us, what our opinion was on that. I don’t remember it being very formalised, like I don’t think we did feed back specifically, but I think there were a lot of meetings at the time, there was a lot of discussion that went on, it was more informal, it felt. But there was certainly a lot of conversation, because it was a big project.

Reference 2 - 5.97% Coverage

But during the consultation, it certainly affected us in terms of the hours that we worked, the weekend opening hours, the clinics that we worked in, and that was when we were going to become properly one merged service. So, there was lots of kind of formal evaluation in that process. I feel like, for me, that didn’t really… because it wasn’t specifically my job that was at risk, and I wasn’t interviewing for my role, which other teams were, and because it was expected that we were going to have our own consultation, I was sort of outside of it.

So, even though actually a lot of things affected me, I wasn’t actually properly consulted. So, my weekend hours changed, but I wasn’t actually ever consulted about having my hours changed, which I think technically I should have been. And if I’d been very awkward, I probably could have refused to change my working hours on a Sunday, because nobody ever consulted me about changing my working hours on a Sunday. It was just expected that, as a sister, obviously you’re helping to lead the change, you’re just going to do it, but it wasn’t actually ever put to me like that, ever.

00:05:10

So, I thought like there was more of an expectation that I would just obviously go along with it, because of my role, you know. But yes, there were a lot of team meetings then, a lot of communication via email, there was a folder of communication and information that you could access. So yes, I think they’re probably the two biggest things that I can think of, in terms of evaluating the service, and things changing a lot.

Reference 3 - 2.90% Coverage

If it’s a very big change, it probably does involve the directorate management team as well, but I suppose that’s a bit more in the background to most staff, they maybe don’t know that actually that has gone through the directorate management team, they have signed that off, and now that’s why it’s being implemented. I don’t think people always understand that, or they’re not told that that’s the process.

00:08:37

Like, I know the clinical lead wants to bring in a change to appointments, so he’s already written a business case, which has already been read by the DMT, so there is a process. But I think if it’s just kind of, not such a big change, it doesn’t have to involve them all the time, so then I think it probably would just be those three people.

Reference 4 - 4.16% Coverage

P Yes, and we have an operational group that meets every, sort of bi-monthly, so any sort of operational idea will be discussed there. And I guess that’s meant to be where you sort of thrash out ideas, and you have your say if you think something… and it might be, this is a good idea, but we haven’t thought about this and that.

00:09:59

And also, I think it depends who brings the idea, because people know their own team, or their own… you know, if you’re a doctor, or if you’re a nurse, there’s always going to be that slight breakdown where, you’re not a nurse, you don’t understand fully what it is to be a nurse, and how they work.

So, that’s where we’d come in and say, actually, that wouldn’t work for our team, because of this – so, it’s not that it’s a bad idea, but at the moment, in that format, it won’t work, we need to look at something else. I think it’s quite a good meeting, because there’s a representative of every sort of staff group in this department, so the nurses, the doctors, the health providers, and the admin, are all represented in that meeting, which is good.

Reference 5 - 2.72% Coverage

And I guess, maybe telling people that actually what affects the doctors does affect the nurses, what affects the admin team does affect the recall team, you know, it’s like, maybe a bit more connectivity.

00:22:43

R Yes, connectivity and communication.

P Yes. So, say you’re thinking, okay, well, this piece of technology, that’s clinical, I’m admin, it’s not going to make any difference to me, you know. But say, well actually, if they did this, then it would release capacity there, so therefore actually that would help you, because maybe when you’re struggling on the reception desk we’d be able to send someone to help you – trying to find a way of making it relevant to everybody, to maybe get that buy-in.

Reference 1 - 3.68% Coverage

And every time you come with this proposal of we have to start a new system and there’ll be training, and you have to... It's an uphill task. Or when you want people to learn new skills or procedure, there will be people who are very quick and they can adapt, but also... So that bit has to be handled well. You don’t assume it that people will just jump in and be happy.

00:21:29

So they will need a lot of support during that stage. And once they also start seeing the benefit, the way it fits in and how it’s working well, then they own it and then it makes it easy to implement it. So if it’s something new, you have to involve everybody, all the people who’ll be doing it, the staff, the patient, and there has to be that sort of support in the background. In case of any problems, any queries they know it can be addressed and it makes it easy for them to adopt it.

R So there is a lot of internal communications and meetings?

P Yes.

Reference 1 - 11.91% Coverage

R And in your opinion, who are the key stakeholders? Who’s more likely to introduce a new idea and then who’s more likely to take charge of adopting it?

P So probably our contract managers ultimately, which would probably be the keepers or the drivers for these obviously came from him. So that was from, he’s the contract manager and he’d set up the contracts with the lab and this is what was needed to be able to work with the lab and stuff. So he would definitely be one of the key drivers.

But I think equally if some of the heads, some think that they wanted to bring to the table for everybody, then we would take it to our strategy group meeting and we would present it and then everybody would be able to give their opinion as to what they thought. We’re quite democratic as a whole.

R So who’s a part of those meetings?

P Who is?

R Yes. Who can come to those meetings?

00:06:21

P So it’s obviously quality assurance from [company], there’s contract leads and all the integrated sexual health team leads, practice and development team, safeguarding and sexual preventions, there’s the medicines management, the consultants and our partners as well, so [name], [name] and stuff like that. So our partners come through as well.

R Well, that’s a lot of people coming from different potential perspectives, right?

P Yes, different perspectives and stuff. So it may be that if it’s not relevant to everybody then you would have a sub-meeting afterwards or just, but it would be introduced. If it was something that needed to be introduced to majority of people, that would be the first forum for introducing it to people and get people’s thoughts and feedbacks and ideas.

R Having so many different perspectives of people coming from different departments, do you think it helps or it may actually?

P Not always.

R So why is that?

P Just because everybody has got different ideas as to what’s going on. Some people don’t understand an awful lot about the actual clinical processes or about patient journey. So for them something from... It’s harder for them to get to groups with what we’re talking about because they don’t have that knowledge base and stuff that goes with it. So it’s just a case of trying to help people to understand what the processes are and how maybe something new is going to improve that process.

Reference 1 - 2.72% Coverage

P I mean, I think it depends where you sell it to. If you can see an advantage or something, and you can then convey that to the staff, then yes. Then I think everybody becomes very invested in it. And I think if it's something you're told you must do from the top-down, then there's usually... unless they can see the really good... I think at the end of the day, the people who should be most interested are the people at the shop floor dealing with the patients if they can see the benefit of it. And that's why I always feel quite strongly.

You actually need to be able to see what the benefit is and explain that to the people seeing the patients.

Reference 2 - 1.87% Coverage

P And the communication within the services. And we've implemented the impact really effectively, and we fully recruited within two months of going live, our evaluation of BD, point-of-care HIV test. And there have been a lot of things we've implemented, which everybody has bought into. We’ve reconfigured all the rooms in the last six months, so there's been changes. But as long as people understand why you could see the benefits of it, they...

Reference 3 - 0.90% Coverage

P And we're a relatively small team. Across the two sites, there's less than 50 people, so...

00:11:41

R It's easy to manage the communication, the exchange, yes.

P It's easy to manage the communications, yes.

Reference 1 - 4.71% Coverage

R So if there is a disagreement during meeting and people, then you would consider, for example…

P I think we would discuss it just to make sure what the issues were. Yes. And I think even when we brought out the previous point-of-care tests there were still a few concerns about that, which I think is good. Because it means that we are considering it and are thinking about it. And you bring it to the table and discuss it and say actually, is that a real concern or is that not a real concern? Or is that a misinterpretation of something, or the concerns that they have, how large would that actually be in reality? So I think that’s one of the things…

And with this particular test it is going to be just like our HIV point-of-care test that we select a population of patients that have it, rather than everybody having it. So, yes, it is important to hear what people’s concerns are about, you know, either the group that you’re selecting or otherwise. And there’s always going to be a group of people who ask for it, that you don’t think necessarily would be suitable perhaps or that you think not necessarily will be able to have it. So that’s always an issue about how you deal with that as well, within the clinics, so that’s always good to discuss that beforehand.

Reference 1 - 4.82% Coverage

P Yes. So obviously, all staff can't attend the meetings, and so whatever is discussed at the meetings then get discussed at more general meetings, like we hold regular nurses' meetings. So if anything particular that's discussed at the SDU meeting, then that's a good opportunity to discuss it then and just keep people updated. And also, the SDU leader's very good at communicating via email. She does a monthly newsletter, which she pings out to all members of staff, including reception, just to keep them updated on what's going on, what's being discussed, what we're looking at, you know, the future plans, that kind of thing. So everyone is kept up to date with what's going on.

Reference 1 - 4.66% Coverage

R I assume that the process of evaluation and giving feedback also happens in collaboration?

P It does, yes.

R Are there meetings designed for that?

P With the contracts that we have with the trust we have meetings monthly, or bi-monthly to discuss the contracts and how that’s working, etcetera. And they have key performance indicators within that, so we’re constantly evaluating what they’re doing and are they meeting the outcomes of the contract that’s offered to them.

00:10:47

And that’s exactly the same with our primary care providers, which is a bit harder to get meetings with them because they are so stretched. But yes, all the KPIs have to be met and the quality standards are met for the evaluation.

It is ongoing, actually, we’re constantly looking at how we do things and what’s the better way to deliver these things.

Reference 1 - 8.11% Coverage

My responsibility will be making sure that I’ve got all that information first, so that it makes sense to the rest of the team. Remember, there’s a varying level of experience, knowledge and responsibility. Some people are going to go okay, we do whatever we’re told, and others are going to be saying tell me a bit more about that, what’s the science behind this, what’s the motivation for doing this differently, why are we doing this? My responsibility is making sure other people understand and other people are signed-up to it.

00:05:18

R Can that be sometimes challenging to get everyone on board?

P Absolutely, I think the challenges come with… I try to anticipate that by thinking about who am I talking to? How am I going to be selling this new idea to them? And what will work with my team and the individuals within my team? Because lots of people come at it in different ways and when you’ve got a team that’s quite a small team and it’s been together for quite a long time, you do know what’s the best way of addressing. You can sort of anticipate where you may run into trouble, where you might find people resistant to change and who those people might be and what’s the best way of managing that.

R The key, would you say, is to know your staff?

P Yes, for me, that’s one of the advantages of being in a small team for a long period of time, a small, stable team that hasn’t changed a lot. One advantage is that you know people well and you can anticipate where there may be sticking points, or where they may be concerns, you know how to pitch it. Like when you’re a kid and you talk to your mum, you’d do it differently to how you’d do with your dad, if you want something.

Reference 2 - 5.03% Coverage

Are there any people within the clinics that are likely to introduce new ideas?

00:07:33

P We have the sort of team where we welcome new ideas and creative thinking. We would, in the clinical staff, if any of the staff at whatever grade level comes up and says hey everybody look at this or I went to a conference and I saw that or I was at study day and I’ve taken home this information. There’s a very free forum for discussion and it’s a supportive one and it’s very equal opportunity, everyone has the opportunity to share their advice or information or their interest in something new.

It wouldn’t always be head-down. Some things are, that’s the nature of stuff, a senior nurse in the hospital says we’re going to be doing this and this is the new policy on that and that’s what we’re doing. When it comes to the local service, what we’re doing, how we work, changing hours, changing clinic times, something as simple as that, then it could be any member of staff that says I’m thinking we might want to try this, what does everyone else think?

Reference 1 - 2.92% Coverage

P I think introducing anything can cause some concern to people, I think it can cause a bit of anxiety but I think if it’s actually introduced in the correct way and people are given the training so they feel comfortable doing it then I don’t think there’s a problem.

I think we would, from the staffing point of view, we would manage the time so nobody felt that they were not… You know, that they were having to work extra. So we would make sure that the times are correct for people to be able to do the job and I think if the training is given to people then they are more than happy to actually embrace new technology.

Reference 1 - 2.35% Coverage

R I see. And what about social facilitators? Would you say that the social relationship within the services help or create barriers?

P We don’t have any involvement in that because we are purely contracted to provide a service. How we choose to provide it is a decision within this organisation. Provided we deliver on the quality of the results and the turnaround time, we wouldn’t… that wouldn’t be something that we would have that much engagement with outside.

Reference 2 - 5.11% Coverage

So we would inform our users that we were looking to change and inform them if was going to affect anything in terms of what’s already in place. So, again, turnaround time or if they’re going to have to take a slightly different sample type.   
The only time I think it would make a difference would be if what you’re moving to is a process that requires an invasive sample being taken where it might require clinical input for that sample to be taken, because obviously that then puts a pressure onto the clinicians taking the samples.

But apart from that, unless it changes what they have to do, so provided, say, for the clinical one, provided we could still receive a swab or a urine, we would notify them if the swab they need to take changes, but as long as how they take doesn’t change, they would be quite receptive to that change. It doesn’t normally make any difference to them. It’s only if what they have to do at their end changes that then they need to have more involvement with the process change.

Reference 3 - 6.56% Coverage

R So would you say that overall, in your experience, people have been quite receptive to new ideas?

P Yes. Yes.

R Okay. And that’s because it doesn’t… it’s not too disruptive?

P Yes, provided what you’re going to change isn’t going to hugely impact on their workload and how they work, usually it’s fine.

R Yes. Is there something that you think about? So, for example, when you think about new technologies, new equipment, is there something that you consider that, you know, it shouldn’t be too disruptive?

P Yes, because they will be, in the business case, they will be one of the stakeholders that we list. So we have to consider what is the impact of the change we implement going to have on service users. And certainly we implemented something about 18 months ago that was quite a big change from what the doctors within the Trust did. So before we implemented it we made sure that there were meetings where they could discuss it, that they were fully informed, that there was adequate notification. We explained what the changes were going to be and we explained what we needed from them.

00:13:47

And there was an opportunity for feedback from them before we made a decision to implement. So they do have to be… if it is a change for them, they do have to be involved in the process.

Reference 1 - 4.93% Coverage

P So I think, adding at all to staff workload can be seen as a challenging task, but I think it’s, I think there’s a degree about how you approach it really. So, I’m the clinical governance lead so I’ve had to introduce changes based on incidents we’ve had to improve our safe practise, and that sometimes involves increasing workload.

And I think it’s really about making sure staff are fully aware of why you’re doing something, and why it’s important, and how it’s going to improve patient care, at the encouragement. And I think that the degree of… I guess it’s all with the degree of personal involvement whereby you try to be nice to your staff all the time so that when you need them to do something, there’s a degree of goodwill and they’re happy to go through with that because you’ve built up some emotional goodwill there.

I think it’s about, rather than just imposing it on people, really saying to people, this is going to improve patient care, this is how. Or this is going to improve research knowledge and this is how this will benefit our patients. And actually staff come to work to do a good job for their patients, so I think it’s just about making sure they understand why it’s being done and how it’s going to be a benefit.

00:10:13

You’re always going to get some people who complain about the process, but we certainly successfully introduced changes on a clinical governance base, which has definitely increased workload. And I think it’s also about listening to staff when you introduce a process. So, you know, if there are any issues, making sure that you hear about them early, and then staff can come to you about them. And that you can troubleshoot those things early before they turn into a big problem.

Reference 2 - 5.62% Coverage

R I see. And so you mentioned there is always a lot of training required, especially if there is something new happening, but is this also quite expensive? Does it require additional funds?

P Yes. So, it really depends on what training is involved, really. So, we already have an educational programme running within our clinic, so we have time set aside for that. So that, for example, quarterly, we have a clinical governance meeting which I organise, which is clinical governance and education. And basically I can put into that whatever I want. So whatever I feel is educationally appropriate for the clinic. So lecture based teaching is easy to deliver.

00:17:26

We also have a journal club which runs, although it’s harder to get staff to attend that. That tends to be attended by fewer staff, whereas for the quarterly session we actually close the clinic for a morning. And then it needs more face to face training, on an individual basis, that obviously does come with a cost. So, for example, for our HIV point-of-care test, there’s a training session which is run by the lab and that lasts and hour and staff have to be released from clinics to attend that.

So that obviously has an impact. So, I mean, we put that in people’s induction so they’re not actually in clinic at that stage. So obviously if a test was to change, we’d need to train, depending on who was going to operate that test. If it was just the lab staff, that would be relatively straight forward, because there’s a much smaller number. But if the tests are going to be operated by all our clinical staff or, for example, by a healthcare assistant, there’d be more training.

And that would be more difficult but not unachievable. It would depend a bit on how long. You know it’s relatively easy to fit in an hour or two of training. If staff need two days’ worth of training, that becomes increasingly challenging. So it really turns on how long the training is, and how many staff need to be trained.

Reference 1 - 3.90% Coverage

And what about interpersonal relations within the clinic? Do you think they have a role in the process?

P Probably not within the clinic, because quite often kind of an advance in technology, changing processes will kind of come from the senior leadership team and kind of filter down, really. I think interpersonal relationships with other departments that you use, and particularly microbiology labs, your executive team, I think that’s quite important, and the IT kind of development team as well.

00:18:43

I think if you’ve got a name of a person that you can say, well, actually, we’re looking to do this in this way. It’s a key into getting things moving. I think that’s where relationships come into play. You’re less likely to meet obstruction if you’ve kind of already talked it through with somebody in each one of the key teams, really.

I think if you go completely fresh and say, we want to do this. Somebody’s assigned it, then quite often, they… you’re more likely to find something that’s obstructive.

Reference 1 - 2.65% Coverage

If I can understand what we’re doing and how working well and how it can work and how we can roll it out, then that means what I can bring to the rest of the staff, the reception staff, and say, yes this will work better. This will make our jobs much easier. We can cope with it. It’s not as difficult as you think. Because a lot of people do not like change. But once it comes into play, it comes into place. They’re all for it. But you’ve got to actually convince everyone that everything’s working.

Reference 2 - 2.68% Coverage

And you said that it’s actually that the clinic seems to be really ready. And the communication is...

P Yes. Once something’s going to be rolled out, we are informed. If we need training, we need training. And if... We normally do examples for the staff so they know what they are to expect when it comes in and how easy it is to process, or how difficult it is. Some people find it easier than others. And once they know what they have to do, they’re fine about it. But we all have to accept changes. Yes.

Reference 3 - 5.64% Coverage

R Yes. And it’s... Do you sometimes have to work with other people who maybe they’re less for new technologies?

00:01:16

P Yes. I will sit with them. I will, as the patient come in and we’re telling them about it, my colleagues are there with me. So they know exactly what I’m saying. So they can actually say it to them. And when I’m actually doing it with the patient and they see how simple it is, they start taking it on board. Because they realise; oh, I don’t have to do it this way anymore which is more, not as convenient. But this one’s much... But it’s re-educating people and letting them see that... They understand by example. Rather than just telling them; you have to do this. If they can see it for themselves they understand better.

R So is it you have a way of approaching them that works?

P Yes. We, I believe that you have to sit down with all staff member. Be at the forefront with them. So they’re not in the deep end of what’s happening. They can see you’re there supporting them as well. And they realise how simple and straightforward it is.

Reference 1 - 3.42% Coverage

P I mean, I think one of the biggest hindrances to getting new technology in is the various meetings that you have to go to, to say that you need something. So, right now we’re looking to get, you know, there’s a machine that can do blood pressure, weight and height all in one. And that would cut down on clinicians’ time because we give a lot of the contraceptive pill. And we’re thinking that actually if you got this machine that does this then, you know, the patient will come in with all their, you know, vitals done.

It’s already in another department but and you’ve said, no, you’ve got to do... you know, do this, this, this, get us this quote. So, there’s a lot of... and it tends to be from, not from the department, it tends to be from the finance side of things where they add in all these extra things that you’re supposed to do. That actually we’re actually being offered this machine for free and, you know, we still haven’t got it because there’s, yes, a lot of other stuff that...

Reference 2 - 11.01% Coverage

P I mean, I think if there is resistance to meeting the first thing you do is, you know, if it’s a resistance and it’s come down via an email I think the first thing one has to do is have a conversation with the stakeholders in a room. Because this email is just ridiculous I just think that there are a lot of emails that can fly around and nothing ever gets solved. And I think if there is particular... if someone says, oh, I don’t like the idea I think it’s always best to actually meet the person and say, well, what is the problem with the idea is it the idea itself, is it... have you tried it before and it’s not worked etc.

So, they have conversations flowing but I think I personally believe in face to face conversations if things are not working and things are not pushing and not moving forward. Because there’s sometimes too many people involved and everybody loses sight of who’s involved. And then someone says, oh, no, I don’t like it and then they say, oh, well, why don’t you like it and they say, oh.

And then actually if you sit down everyone’s like actually do you know what it’s a good idea, it’s actually fine I don’t know why I said I didn’t like it. And actually also when you have emailed there’s a lot of people that don’t know, you know, the person, you know. And then when you meet it’s like, oh, it’s nice to put a face to a name, you know, an email address and stuff like that. And I think, you know, things are solved much better.

00:16:27

So, I think if there’s ever any pushback I’d be like the first thing I would say is can we have a meeting in person to discuss what the issues are. Because actually you might be right and I was just barking down the wrong tree and actually you’ve done it before and it hasn’t worked. So, you know, yes, I don’t mind being told I’m wrong but I’d rather have that conversation face to face.

R Yes, and when it comes to bureaucracy that you said that it can actually hinder the whole process. Are there any ways of improving it do you think?

P I mean I think it’s actually making people realise... the perfect example is when we do an audit we have to fill an audit form. It’s difficult to find out who the person is to email. The audit form is clunky, it’s difficult, it’s actually then letting the... you know, because we’ve got an audit lead letting her know actually the reason we’re not filling in these audit forms is because it’s really difficult to get held of, really difficult to fill is there any way they can simplify it. Actually giving feedback and saying you’ve made this a really difficult process is there a reason for this.

This, you know, this is our feedback would you mind like maybe revising it or something. Because sometimes people don’t realise actually because they’ve told you to click here, click there, click there, you know, and you’re like, oh, forget it I’m not going to bother, you know. It’s like having a 20 page survey no one’s going to fill it. And then it’s like why didn’t anyone fill it, it’s 20 pages. Make it one page and you’ll get like probably 70% success rate. But 20 pages after page two you’re like, no, I’m not doing this particularly if you’re not going to get anything out of it, so.

Reference 1 - 3.16% Coverage

R Right. I see. And who’s most likely to introduce ideas? Is it, does it happen that, does it always, is it always someone from the senior staff members or could it be anyone?

P It depends what people have heard of. So, we’ve had people come in recently and try to introduce certain, there’s a website that does provider, partner notification, so getting the quotes and things for that, that was somebody quite senior but because they knew of it. Whereas I’ve come in and I’ve used other computer software. So therefore I’m very much, why can’t we use this software instead. So it depends on your background and what you know.

00:06:22

So I came back from a conference, and well there’s a new type of coil. So it’s that sort of feeding back from conferences and education. But as nurses we have to be quite proactive in going to conferences. So we have to ask and we have to be quite insistent to go on them.

Reference 2 - 8.52% Coverage

R Yes. And then who’s involved in the service evaluation process? I guess it depends on technology, really.

P Yes, so developments with what’s, when we’ve implemented things, how they’ve been working?

R Yes.

P So we all do individual audits, so within the team that we get allocated to look at things. So I’ve just looked at the uptake of the SAYANA PRESS injection. Other people are doing audits on other things and we all have our little lead, with [unclear] we’ve all got our own little leads so we’ve got somebody who’s in charge of friends and family. So that’s one of our biggest feedbacks from patient groups, is from friends and family.

00:07:43

Because that’s where we get most comments. So there will be someone who’s in charge of that, and they’ll feed that back. We do do all staff meetings and newsletters and things where people can raise concerns. I think we can all approach our bosses if we have any questions about things that are being implemented.

R And this feedback from patients, have you see it having a real impact in terms of that it actually led to a change?

P So we had a, very broad example, but a transgender patient who wasn’t very happy that we had a male and female form and that at the reception he had to register as one or the other. When in theory he would have liked to… I think he was born female, so had female genitalia but presented as a man and wanted to be treated as a man.

But the question didn’t apply because actually what they were about was a female problem. And it was, so we got this comment on the feedback and then the matron sat down with me, because I’d had the experience with more different genders, different varying backgrounds, and we went through and we just changed the form completely, and within a week that was implemented.

00:08:54

So that changed quite a lot. So that was one bit of feedback that’s changed our complete registration form and allows people to put, other. So we haven’t put transgender, intersex, anything like that because it would get too confusing. So it’s, male, female, other. And we can put other on our computer system.

Because the previous barrier was on our system. If we put male, we couldn’t order vaginal swabs, and if we put female we couldn’t order some of the tests that we need for men like urethral swabs. So, but it was good that we’ve come up with that.

R So now you can put other and then you can order.

P Then you can order everything, yes.

Reference 3 - 4.75% Coverage

P Just trying to think. So I mean, we do have a, within the top, there’s always ways to feed back. So there’s always an on-list to your, not an on-list, to your matron, there’s feedback. We’re doing a consultation at the moment, so we’re all being asked to email in our views and then that’s being taken further up. But that’s already gone through commissioners and has come back to us to then go back to commissioners.

It, yes, I’m just trying to think. Yes. I’m just want to think what’s actually in place. We do our, we try and do monthly staff meetings. So, and anything urgent, they put in an urgent, all-staff meeting which is where everyone can share.

00:12:16

R So everyone goes to those meetings.

P Yes, everyone should. Everyone’s invited. So we’re all invited, whether people go or not, that’s their own decision. And we have had them before when it’s just been for nurses, just for healthcare assistants because it’s about them. And then, when you’re talking about the actual way the clinic runs on a daily basis, at the beginning of the clinic we have what we call a take-five.

So if something has changed we can feed that back. Such as if we’re changing our first line UTI treatment, we can feed that back at that meeting, that little collection of people as well as updating all the guidance on the shared drive. So that’s a daily thing that happens.

Reference 4 - 8.49% Coverage

P It can do. But it can also be, because we’ve got the three satellite sites, there can also be a breakdown in communication between the sites. So if somebody never works here, they might not come to these meetings, therefore they don’t know about the changes and they don’t read their emails. So we’re relying on people to come to meetings, to be there at the take-five, to read their emails, to look at the guidance, which I suppose happens anywhere.

00:13:37

But because some people are not here, you can’t actually say, well this is not what we’re doing anymore, we need to do this. And if people, we can’t force people to come here for training, we can’t force people to come here for a meeting. So that’s one of the most recent consultation, there’s been a separate one or two with the satellite services as well, to try and capture everyone.

Because not everyone will come here. I think that’s, and not everyone reads emails. I don’t think that’s possible to overcome though really, is it?

R Well yes, so now I wanted actually to ask you, do you think that those problems could be dealt with in any way, the communication breakdowns.

P I think it’s difficult. Because if it’s just that people aren’t reading their emails, and they don’t want to come here, and there’s no facilities at the other places to have meetings, so there’s no big enough rooms within. And because those are all private, we rent the rooms at the other places, we don’t have access to, like the seminar room we’ve got upstairs which can sit everyone.

So the two hospital sites of course have their own seminar room, but if local changes would not involve those other two clinics, but there’s just no capacity at the other places to actually do those meetings. Because even the waiting, because one of our clinics, in the morning, is used by Phlebotomy. So we can’t even use the waiting room because there’s people in the waiting room all day.

00:15:04

And it’s the same with one of the other service centres. There’s no rooms there unless we have to hire them, and that’s financial constraints, where I think we can hire these rooms for free, I think. And we can’t make everyone read their emails. We can prioritise, and we can make things important, must read, put in particular subject headers, but they still may not get read. And I don’t know how to overcome that. We shouldn’t have to chase everyone to say, have you read your emails. We don’t want to either.

Reference 1 - 11.31% Coverage

R But what was there that helped introducing that? Was there anything?

P Well, making sure that we all knew what we were doing, really, I think. Which, yes.

R Communication.

P Yes, definitely. It’s a bit of a stumbling block at times because it’s a little bit knee-jerky at times, so it’s like we’re going to introduce this and then, oh no, we need some, we’d better put something in place that everyone knows what they’re doing. I’m a little bit the other way around. I like to know what I’m doing in advance. So I think if we decided to go ahead with, we’re doing this now aren’t we? Are we doing it?

R Well…

P Potentially.

R Potentially, yes.

00:15:04

P You know, that stuff needs to be there in advance so people know exactly what’s happening. And the people that are going to be responsible for making sure the kits in the right place, with the right stuff, at the right time. You know that sort of thing rather than, we’re doing this on Monday but we haven’t got a machine and we haven’t, which sometimes that sort of thing does happen.

So yes, making sure everything is in place, make sure everyone knows what they’re doing, making sure we know whatever paperwork forward needs to be filled in. Yes, so communication is key.

R Yes, so that should be improved in a way.

P Yes, I think so. Yes.

R Ahead of action.

P Yes, it’s like, with this online testing we’re doing now, I’d say we still haven’t got the compliance sorted out. And we’re already treating people. So it’s kind of catching up when things have already been put in place. So, yes, it needs to be put in place first, I would say. And then sort of also like, this is plan A, but if this happens then we go to this plan B, and so that people know what they’re doing, I think.

00:16:19

There’s nothing worse than when you’re in a clinic and your machine’s making funny, giving you different results, and then no-one said to you, well this is what... I think we could, it needs to be robust.

R Right, so investing in preparation time.

P I would say.

R And involving everyone.

P Definitely.

R Yes.

P Yes. Most people would, are happy to do things that improve patient outcomes, that improve the patients’ journey, that might be cost-saving. It might not be cost-saving but there’s an improvement in another way. If they’ve been informed of what’s happening and involved in the process so that they know what’s expected of them, I think that’s important.

Reference 2 - 2.76% Coverage

Who’s responsible for ordering stock, the kits so we don’t run out, making sure that’s all in date, making sure that the quality control’s done so that the machines effective. Yes, there will be responsibilities that people might have to take on board that they might think, oh Lord, I’m doing enough already, you know, give me more things to do. So I think that all needs to be thought through and I think that’s where communication comes in as well.

That people are aware of, what’s the benefit of doing this. You know, look if the benefit’s worth the extra responsibilities and things.

Reference 1 - 8.46% Coverage

R And in terms of inter-personal relationships, is there something that helps or maybe speeds up?

P I think so. Because we don’t meet as often as we used to. The Point of Care team used to have a monthly meeting and since we’ve had a new manager, I’ve not been able to attend those meeting. But certainly I think we all work well together so I wouldn’t have thought that would be difficult, it’s just again, it’s timeframes you need to plan this. And often, and then previous with the last thing I implemented, we had a project manager involved too.

So of course the more people you involve, the longer this can take to implement, it seems to get a lot more drawn out and there’s all the paperwork involved with that as well that has to be inputted on too. We’ve got a cue pull system in place now. So it needs a lot of planning, put it that way. So maybe there’s somebody that I can point you towards. I’m trying to think of the name. Perhaps I’ll ask and then scribble down some names and I’ll forward your email and I’m going to CC you in, if that’s okay?

Reference 2 - 6.66% Coverage

R Yes, but this is important what you’re saying. So in a way there’s a lot of bureaucracy or there’s so many steps that you have to take but at the same time they’re already in place.

P Oh yes, we have these things in place.

R So it can make actually things easier in a way, that’s interesting.

P Yes. We have got these things in place within the various departments and it’s easier now because I suppose, we’re all working together under one roof now. So the project managers will not just be for bacteriology, they’ll work with virology, clinical, chemistry. So everybody, I suppose they know each other, know those conversations to be had which are always easier face to face, aren’t they?

R Right.

P So break down those barriers, really.

R So in a way there would be a way to do it face-to-face meetings?

P Yes, I think so.

Reference 1 - 4.38% Coverage

P It depends how something is sold and probably what we’re try and do with the things I’ve been involved in over the last two years, because I’ve just been in post coming up two years now, we’re looking at doing something differently. It could be anything really, I suppose. I’ve tried to make sure that we’ve got the right people involved and that they’ve actually able to contribute to it once they understand how it’s going to work. That’s a big part of that, and, I suppose, when that doesn’t happen people don’t get to find out about things and then things are just introduced and that could be a problem. So communication, I think, is probably key right from the word go and just getting people involved in new ways of working because that could be a threat.

00:09:41

People might think they’re going to do this and that means they won’t need me and my job, whatever it is.

Reference 2 - 2.76% Coverage

P Well, that’s part of the communication as well, in a sense, it’s just about being aware of what the benefits are and actually trialling things. Personally, I think, when there is something new we do have to look at it, and, hopefully, if we think it’s a good idea and think it will benefit up we then need to trial that to make sure that it does what we think it does and learn by that, then you adapt things accordingly based on how well it’s going or otherwise.

00:13:12

That’s part of the team response to new technologies, I suppose, then change.

Reference 1 - 2.40% Coverage

P I mean, communication is always an issue and sometimes things don’t get communicated down, you know, so... and there’s that miscommunication. So, I’m not sure whether that’s what you’re asking. I mean, anywhere there’s always room for improvement, always, because we... or we should always be striving for, you know, for better quality, you know. So, I think there’s always room for improvement, you know.

Reference 2 - 3.25% Coverage

P Absolutely, absolutely, you know, and I’m, you know, I am a person who sees the glass always half full rather than half empty. You know, so, I do try in any situations where there’s negative I try and pull it round to the positives. So, you know, so, if I hear discussions like that I’ll, you know, sit back listen and then give my view point so people can see both sides of the equation. You know, so, I wouldn’t sit back and just let people moan about it, you know. So, but then again I wouldn’t shoot them down either because that’s their opinion.

Current climate of SHS

Reference 1 - 0.27% Coverage

And I think the move, globally, in all industries is a sort of dematerialisation, a decentralisation. It's just that's the way things are. More digitalisation.

Reference 2 - 1.16% Coverage

So we're part of that. But I think we're still the only clinic that's really doing it in [city], three in one. Surprisingly. Even though there's a published aid as showing it's not inferior. Except there was some loss around the pharynx, so we just said to patients that you swab yourself, we'll swab you too in the pharynx. And then, you know, rectal swab was fine, and urine is urine.

So, that's not inferior where it's acceptable we thought oh, patients going to really worry about where's the infection? Is it in my… Is it in my throat, is it in my bum, is it in my penis? Where is it, right? And so we… But we realise that most patients don't give a monkey's about that. You know, very few.

Reference 1 - 1.19% Coverage

And having an accessible health care service will improve the outcome, sexual health outcomes. We can see that within England and definitely within London, there is increases in STIs and some STI, sexually transmitted infections, are disproportionately increasing.

00:01:49

So syphilis is a good example. Gonorrhoea, we see pockets of increase. And they're trying to increase the number of people with STIs that we see, which basically means that these are the people, if we can get to test and treat people in a timely manner, reduce on the transmission of infections. And the overall aim of our department is to reduce the burden of STIs in the community that we cater to.

Reference 2 - 1.17% Coverage

We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

So you're basically trying to do it with a goal post that’s changing all the time. So what you need to do and what you are expected to do, it's what was an extra last year might be an expected basic minimum next year, and then say, how do you do that, and looking at what priorities are, looking at what priorities are within our control to adopt and what are imposed on us.

Reference 3 - 0.72% Coverage

There's a lot of exciting things go through research. You see papers about all these exciting tests, but you never see them available to you to use in clinic.

It happens in quite a lot of things. It's basically what you call the research graveyard. So there's a lot of support from research to develop these things once they're developed. Your intended users don't have the purchasing power to use these things.

Reference 4 - 2.40% Coverage

And it's usually the lack of ability to deliver on this because you're not able to get results quickly but what is currently available. New technologies are looking at faster results. You're looking at tests, which don't require a lab that has 15-meter square and a whole lot of things. You're talking about things that might be logging in to have something the size of a refrigerator that you could have in the OptiMix.

Or you could have something that's a desktop that you can have in the rooms and then saying, how do you do that? And then it's looking at you've gone [unclear], saying that if I have... so far, our patient, we see about 1,700 patients a week. Those 1,700 patients a week, how do we manage to do them on different models? And you can look and say that how many do you need and then seeing that in having that negotiation to go, what is going to be cost-effective, what can we actually afford to do, and which model we can go for.

Obviously, if the technology is super expensive, and they're saying that we need to improve development cost and we want to get our bonuses, then it looks like, well, it’s not affordable. You probably need to look at a different market. But it's a thing. And National Health will need to have good quality affordable care, because the service that we provide needs to be accessible, equitable, and sustainable.

Reference 5 - 0.42% Coverage

So we are quite interested in... I think that evolving science of implementation science, I think that's the way to success. It's become very trendy at the moment, but there's still very little that's happening as to implementation science.

Reference 6 - 7.38% Coverage

If you're basically saying that you have to process... there's a lot sample processing steps that's basically... so one of those, which is [unclear]. Basically, it only takes 90 minutes to get the result and scan it in. And what you actually have to do is that the samples come in, they're meant to have stayed in the buffer medium for a certain length of time, then you have to shake it, you have to [unclear] on that into the thing.

00:59:12

Then you're basically going to tell the computer that this sample belongs to this cartridge, which basically means that if you're having too many steps in between, A, it's going to be finicky, B, mistakes can be made. I'm going to stand this in this and then it's just on the wrong cartridge. That can happen, which means that somebody will get the result, they have gonorrhoea, somebody will get the result, they have nothing. And then actually, it's the other way around.

So it's making sure that the more processes there are in this... that’s one of the probably the limitations of more to the point-of-care test is that they don’t really look at what people in the clinic come in to do. And most of them are designed by lab people, who think that [unclear] is basic. But if somebody is not prepared and therefore not used to it, it's not basic. Getting the right amount and people either get lazy and don’t put enough or they get so finicky that it's like super stressful.

So it's looking at how finicky the process is. The other ones has brought all these things about, oh, you tap this, you shake this, then you add something else and shake it, leave it for ten minutes. All of that, if you're doing one or two samples, it's fine. If you're going to be doing [unclear] see about in the weekends, you see about a hundred and eight patients a day and about a hundred and thirty during the week. That’s a lot of samples that are coming through.

01:00:45

I mean, just sitting there, doing this into the tube that are okay [unclear]. It could be a hundred thirty, it's not. What you want is, I've got the sample, I want to basically put it into something, maybe just transfer it into something and then plug. That would work. But basically, the thing is that you need to be... it's also learning how does the machine know whose sample that is. It's thinking about that, bearing in mind in the clinic, we just put a label, transfer the sample into that and you're done.

There are extra steps you're asking people. You need to make sure that that process is a bust. That’s a lot of work. And it's usually the bit that people think about the least. Because most of the time, people go, which has to happen? But it has to happen without mistakes. And that means that that might be the bottom. And then it might be that you haven't tested [unclear] in 15 minutes. But if you're going to spend half an hour [unclear] about the samples and then scanning it and then rechecking things, you're going to have a pile up, and then you're sitting there looking at the experience of people who've testing in-house.

The [clinic] GeneXpert experience is that though the clinic is [unclear] open from 7:00 to 7:00, people are loading samples until midnight. So that’s a huge workload. So if you're not finishing it real time and you're having samples piling up, you need to think about what or how you're going to do it. Because if you're seeing a lot of patients and you have a machine that can do one sample at a time, and even though it's super quick, sometimes they [unclear] see patients. Eight sets of samples come in at the same time, and then you say 15 minutes each, 15 minutes times eight is two hours.

01:02:59

And in that two hours, you got another three lots of 15. So two hours later, you're now waiting four hours. So that sitting is where you need to have. The ideal thing is that you say that every examination room has this device, which should be ideal, but that would be expensive. So it's looking at what is feasible, how do you change your pathway? And if you're having... are you going to have a backlog, how are you going to deal with that? So those are the things that would concern me if I was implementing something.

Reference 1 - 1.88% Coverage

P Well, so the money… So I’ll talk about the money first, so financial… Areas of financial importance create uncertainty and the NHS isn’t blessed with loads of cash, okay. You’ll have known that over the last five years the government prevented a new funding scheme for the NHS for the last couple of years. It was a tiny investment. The year just gone it stayed static and over the next two years we’re going to see a decrease in funding.

Reference 1 - 5.33% Coverage

P That’s an interesting… Yes, it’s a… I think it’s a bit of both. So, you know, when we were talking about decisions around what tests to do. Is it a finger prick or a traditional blood test? That’s… The final decision always comes down to what costs more, or less, really.

00:16:23

And I find that a bit unfortunate. That it’s all about cost. That it’s, you know, we can say that it’s about patient choice and about patient experience, and everything. But the most important thing in this current state of the NHS is that it costs less. And that’s a bit frustrating sometimes, really.

But we have to kind of… We have to roll with it at the moment. So, it’s always exciting though, to try and find ways to do things that are going to save some money and actually improve the experience as well. So, if you can hit on that combination, that’s pretty exciting.

So, for instance, when we switched… This was before I was here. But when we switched to taking chlamydia, gonorrhoea swabs from all sites instead of doing them in one sample. That saved a massive amount of money. And it’s one sample. And it’s, you know, the patients.

And I suppose, that took away patient information a little bit. And that they don’t know immediately what site an infection, a positive result is from. So, that can be… Patients get a little bit annoyed with that sometimes. But it doesn’t matter. It doesn’t impact the treatment that they are getting. Because the treatment is the same, regardless of the site, really.

So, for us to be able to do something… To use technology in that way and save money is good. I wish it didn’t have to come down to money all the time though. It’d be nice if we could, like, you know, having an onsite panther machine.

Reference 1 - 5.35% Coverage

P Well the thing is… I don't know if you know the history, that we had six sites…

00:22:41

R Right.

P Originally. And that's where I was talking about the consultation, and I was closing down sites responsible for…

R Yes.

P Because we were going with a new way of working, cross site working, just a few staff. Unfortunately though, they had to re-interview to get their jobs. But we had a clinic in [name], clinic in [name], and then the HIV clinic in the hospital.

R Yes.

P So… Those three. So there were deadlines for each one of them to be closed. So, you know, you have to do consultation with the patients. They have to have, like… And surveys, and then you had some of the clinicians having to meet with them, like, to, you know, to get their opinion, because it was like a public thing as well. And you had to have like a big sign up. Like, so, at least warning the patients that… So that they can see that this was going to happen.

I mean obviously you're not going to target every single patient, because like, somebody might have a procedure where they don't need to come to the clinic. Or they might have had their year's supply worth of pills. So they're not going to know that all these things are happening. And then you know, you have to update websites, and you know, try… In the GPs, you have to try and target as many people as possible, to say well, this is going to be happening.

00:24:00

And then the clinics close, and then the impact is more and more patients were coming to the clinic. We had our budget cut. So, you just have to work with what you've got. There's nothing that you can do. And then when we realised we were having a lot of turn aways, because once you reach full capacity, because you know, we have a matrix, and how many clinicians are working for the day. And we work out with the hours, and how many patients you can take.

And then once you've reached that, can't see any more patients, obviously… If the patients are being seen, then you can review the matrix, and you can add more patients. But we… There's a cut-off point. Patients that complete the registration forms being told if… No guarantee that you can be seen, but if we can see you, we'll give you a call. They're asking is there anywhere else? But everywhere else is the same, you know. But you can still suggest something to the patient, or ask them to Google something in that area.

And when they realise that, you know, there was… We were getting a lot of turn aways, then we started to collect the data. Well I started to have to, I was asked to collect the data, so that they could compare what was happening. And I mean, it does, I think, gets escalated up, but there's still no money, because this…

Reference 2 - 0.46% Coverage

R So, it could be the case that all the cuts, and closure of clinics, that they may actually encourage adoption of certain technologies that would help the clinics.

P Yes, exactly. But we already had the self-testing kits in place.

Reference 1 - 1.17% Coverage

R So you just said that it is very important to think about how new things can be implemented because of the financial situation. So it's something that we cannot avoid, is that…?

P Yes, basically I think that is the bottom line.

Reference 1 - 2.99% Coverage

Yes, I think absolutely. I think there’s a lot of uncertainty at the moment, there’s a lot of uncertainty around investment. Scientifically and medically, I’ve always been very, very proud of the massive varied inputs in our medical and scientific community in Britain, and I think there is additional instability that the current political climate brings, and it makes me quite sad, because it’s only through bringing different people from different backgrounds, different parts of the world together you get a richness of result, I think.

This is what’s always wound me up about going back to isolated services. How can services in isolation think they’re going to do much good? The world is changing, ideas need to be circulated. I’m not saying reinvent the wheel, I’m not saying all new ideas are great ideas, but you can bet yourself you’ll be walking around with a blindfold if you’re too isolated.

Reference 2 - 4.65% Coverage

P I don’t think so. I probably will. I just think it’s just to say that in terms of my role, technology in all healthcare, I think, is going to come more and more to the forefront just based on technology advances so quickly, medicine moving on so quickly, and, at the end of the day, we are what, by comparison, sometimes feels like limited human beings. Whether we like or not, we’re going to have to approach, get involved with, technology, because I don’t think our brains can hold the information.

R That’s true.

P I just think realistically, we can’t. You’re never going to get away from the need to talk to people, and I talk about all of this, as it’s about… I’m the first one that likes to pick up the phone or see someone directly when it comes to trying to get something done. I don’t like emails, I don’t like these other things, but I have to use them because it’s what people use and it’s a good tool. Preference isn’t coming into it for me, it’s more about practicalities. I think if people just understood that as well.

00:43:26

Unfortunately, healthcare is a very proud and personality-driven area of work, I would suggest. And I don’t think that’s a bad thing. You need personality and you need character and you need individuals, because I think sometimes that’s a massive part of all therapeutic work, but, in the same sense as well, I think we have got to be practical in healthcare.

Reference 1 - 2.96% Coverage

R And what about the political climate, I'm thinking, is it encouraging to think about new technologies, changes?

00:15:28

P Only if it makes us more cost-efficient. Politics, it’s all about the cost. So anything that saves money is where, in terms of tendering and everything, they want things to be as sensitive-specific as the current test, but anything that saves money, so like the home testing, it needs to compare with infinite testing, got to be cheap. So anything that drives down cost, the politics. And there is the whole thing of closer to home.

Care closer to home is the other big driver, so anything that fits with those national bandwagons is keeping people out of hospitals, and cheaper.

Reference 1 - 0.67% Coverage

R Yes. And in terms of political climate. So any other changes to the NHS? Does that affect the way you discuss adopting new technologies?

P Not currently.

R Not currently.

P No.

Reference 1 - 2.87% Coverage

P I think it can work. Space is always an issue in most places. And I think at the moment, in sexual health, we probably, because of awareness, so most clinics are much busier probably than they were initially planned for. So we are probably ending up seeing more people in a limited space. So space is a big issue. But that does not mean it cannot work because, sometimes, introducing something new helps with the flow. So, hopefully, it might work, but space is always an issue, I find.

R So what you're saying is that the people, they are more aware of STIs and then they test more frequently?

P Yes.

Reference 2 - 0.91% Coverage

P Of course, in health care, there will always be changes depending on new evidence that’s coming up. And then that involves us to change in practice depending on new studies that have come up.

Reference 1 - 4.51% Coverage

R And would you say that the political climate is in any way hopeful, or quite the opposite?

P It goes from one thing to the other. Sometimes, yes, yes, you can have as much funding as you need for public health, and then it’s no, let’s have all your money back, please. So, yes, there’s never enough funding and we have had huge cuts to our budgets. Huge, huge cuts, yes. Which have been quite devastating.

We had a whole article in the BMJ last year about how the [name] service was one of the biggest, if not the largest, cutter of finances to Sexual Health Services. But we have worked so hard to not cut any services. We don’t put any caps on the age for chlamydia treatment or for emergency hormonal contraception. But how long we can sustain that for, I don’t know, to be perfectly honest. I really don’t know.

Reference 1 - 13.85% Coverage

It is, I would say that, we don’t just run the service for the sake of it, these days services are commissioned business deals. So the commissioners need to be sure that we’re delivering what they want us to deliver. And we need to be sure that we’re doing what they want us to do. It’s not like it was ten years ago when you could say… Hey, I’ve got this great new idea, let’s just run with it. And you’re only limited by your own imagination, or your manager or the immediate structures. It’s not like that anymore, it’s quite limiting really.

Fortuitously I would say we have really positive and responsive commissioners. But I don’t take that for granted, I don’t think that those people are going to be in post forever and I don’t think the funding is going to be there forever. And I don’t think that this current philosophy is going to last forever.

R When you say it’s different than ten years ago, it’s because of financial constraints that weren’t maybe there?

00:16:19

P No, not the financial constraint at all, that’s the least of the issue. It’s the philosophical underpinning of how sexual health services are delivered now. Sexual health services used to be part of the health service, they’re now part of the local council, commissioned by the local authority. It’s a completely different mindset, for want of a better word. That in itself is also underpinned by a government that does not fund public health services by saying, public health is really important, we need to protect public health. No, the government does not fund that.

So, that has changed massively. That’s what’s changed, it is the philosophical, the political will and the underpinning theory behind what we’re doing. Not the actual, here’s the money, go and do what you need to do, it’s the other stuff.

R The way in which the whole of sexual health is structured?

P Yes, sexual health is completely different now, to what it was ten, 15 years ago. It’s been chunked-up, divided-up, it’s been split-up, a lot of sexual health services are now community-based. And not run by the health service, or the public health service are run by private companies that are creaming off a layer of money. The whole thing is completely different to when I first started a long time ago.

00:18:13

R And that creates barriers rather than facilitates?

P Oh, absolutely. This isn’t seen as… It just so happens here we’re based locally within a hospital. And the services being delivered by a hospital team. But it’s not like that everywhere in the country. And there are people who are commissioning. For a start, commissioners, why do you need to commission a service? It’s just that’s a layer of political bureaucracy that’s just… Anyway, don’t get me started. I think it’s muddle-headed and foolish. And it’s trying to create this false, internal market, it’s not what I understand a national health service to be.

Reference 1 - 2.89% Coverage

So we were actually providing the kits to them and then they would be sending them off direct to… It was the doctors laboratory [unclear] that was being used at that point. And then we would be managing all the results, so any positives we would see but they would be able to get their medication either through us or through pharmacies or GPs. So that was happening via the chlamydia screening program up until October last year. The commissioners, because of the funding situation, decided that we would no longer run the chlamydia screening program but what we would do is actually operate an online testing service.

Reference 1 - 5.49% Coverage

P Well the political climate is there's no money. I don't think there's much more to the political climate than that. And I think what that's unfortunately doing is leading to a lack of investment in prevention care, because that's not seen as acute, or essential. And I think that's a real shame, particularly when you would talk about sexually transmitted infections. Funding has been cut from the sort of prevention side of things. And I don't think there're much political issues with regards to anything else to do with sexual health care.

00:11:04

There are… I suppose the change in the health and social care acts, the way that sexual health was commissioned has caused some issues. The way that sexual health is being tendered out to the lowest bidder. Again, that comes down to finances, but causes a lot of challenges. Time and effort put into submitting tenders, tender bids is challenging.

Reference 1 - 0.97% Coverage

And funding, I think, there’s lots of stuff that we could do, but quite often, you’ll always be given the excuse of no, there’s no money to do this. Just carry on doing what you’re doing already.

Sexual health tends to be a very underfunded service.

Reference 1 - 4.26% Coverage

P I mean, I think the current political climate is making us save more and wanting us to save which I always think is very short sighted. Because I think sometimes if you invest a large amount of money in something that will save you in the long run it’s worth it. But the problem is people are looking at the financial situation this year say and then they’ll look at it for next year and then for next year. They’re not looking at it five years on because there’s a lot of money they need to save.

And the other thing is, it’s not... so, maybe your department might be saving but if you’ve got another department within in your, you know, service that’s overrunning you have to bear that brunt. So, whatever money you could have said, look, I’ve saved this amount of money can I get this device, can I get that they’ll say no we have to give it to them.

So, the money side of things is making it very difficult and it’s making people blinkered and not thinking long term. Because actually if you invest in something that’s a lot of money now it will save you in the end, it really will. So, it’s actually being brave enough to... and having people enough to agree with you. But I think the biggest thing is the financial pressures, yes.

Red tape

Reference 1 - 1.06% Coverage

So unfortunately we tend to… We're a bit paralysed by the sort of consensual process, you know. And at times it's just a case of saying to people, look, I know it's not perfect, we're just going to do it, and we're going to do it for this time period, and then we're going to evaluate it. And we can either say yes or no going forward.

00:15:45

And then I… It kind of upsets people, that approach. But the reality is, nothing happens otherwise, you know. You end up surrounded by people who want to get the perfect, you know, the perfect scenario before you launch into a new project, or… And then what happens is, nothing happens.

Reference 2 - 0.41% Coverage

So, the perfect is the enemy of the good. So you need, you just have to make good. And set it up, run it, evaluate it, and say, yes, no, maybe. And if the maybe, then what do we do to test it definitively before we either adopt it or drop it? Yes.

Reference 1 - 3.00% Coverage

Because the usual thing that kills everything is... there are two things that kill new diagnostics. One is that they make it so expensive, nobody can afford it.

Or it can be afforded only by private clinics, which don't have enough of a footprint to make it worthwhile to progress with the device. And the other thing is that people have a new technology and they are in competition with other people, and they [unclear] these. But you have all the research people spending a lot of research money on this, and then you've basically have a big company that buys them up and then stops its development to reduce competition.

So, obviously, competition in diagnostics or in any kind of new technology basically would make things... it drives progress to also make sure that people make... they're competing with each other. So the other thing [unclear] basically think that I can do whatever I want. You have no other options. There are other options, then you basically have market prices, pressures driving prices down and making them attainable.

00:31:14

So the other thing that should be important is to have a lot of things in the pipeline and people committed to actually who are developing it and make sure to having implementable things rather than aiming to be bought out by the next big company. So you have start-up companies that come up with an idea. And what they want is to come under notice off a big company, get bought out, and then move on to the next thing.

It's actually saying that companies at the public health angle or interest or public health hook, so they have some financial incentive or a mission statement to say that this is what we want. We want this to become a thing.

Reference 1 - 1.25% Coverage

And what you find, the first thing you tend to find in the NHS, is when you want to try and do something different there are a lot of people telling you you can’t do it. And there’s this immediate fear factor about what does it mean if we do something differently? What are the implications?

Reference 1 - 2.04% Coverage

what are the challenges?

P IT, I would say.

R Right.

00:08:35

P Yes, because in the community, the IT, you know, it's all about money as well, because it's not a really good IT system. You know, the servers, if the system's slow, and you're like… The knock on effect is the consultations are slow, because they're having to type the information on. And then it freezes, and then it crashes, and then you have to go to paper. So there's things outside our control. So I always… I know people say it's easy to blame IT, but there are problems with the IT. And they've called in companies to try and speed it up, and add in whatever they need to add in to the… What was it? They have this, like, the server. You know, that sometimes they can add in extra gigabytes, or whatever to speed it up. And then it changes for say probably a couple of days. And it goes back to normal. So I think that's the frustrating thing, I would say, out of everything, it's IT.

R Right.

P We have the good systems, but then it's the back end of things.

Reference 2 - 1.65% Coverage

P No, I think as I said, the barriers, the decisions take sometimes too long to be made. And then, by the time they say, oh, you can go ahead with it. And then we have to do our planning, and then you’re like oh, because you remember when it was fresh in everybody’s minds. And then it has to be approved, and, you know, you’re just waiting. Oh, I have to put that on the agenda. Oh, it was missed off. And then the delays, you know, I just think things need to be, what’s the word, it has to be, like, managed a little bit better, when they say, we’re interested in this. It needs to be discussed, and it’s either yes or no.

00:05:30

P Or go back and, if they’re thinking about then, go back and see if we can do it. Otherwise people just get fed up and then they don’t want to be involved in planning something. So that’s what I think.

Reference 1 - 1.08% Coverage

That is the biggest barrier that if you want to start up anything you want to try and overcome because that is the main thing that people always look at the first initial cost and that is a barrier because they say, no that’s too much money. We cannot do that. And that's it.

Reference 1 - 2.75% Coverage

Even if a clinical lead said, but we must have this because it would improve our turnaround rates, if there was no clear public health outcome associated with that other than people got their results quicker, it’s unlikely it would be supported.

00:17:01

And that is a tension, especially for me. You’ve got to remember, it’s clinical as well. It is a tension because I’d like, in the nicest possible… I’d like the ideal world scenario where everyone who has a problem, if we’ve got a solution to it, we can do it. But the reality is it’s within a price, and we’re stuck in a position whereby we’re not like these big hospital trusts with blank cheques, too big to fail, we’re a social enterprise that are working on a commercial basis like every other business in the country except for big government institutions like hospitals.

Reference 1 - 5.88% Coverage

P No. I mean, I think in such a cost-driven organization, it has to come in at a price that’s comparable to existing technology. And I think cost is one of the big barriers in terms of... and having something that’s reliable, because what you don’t want is a technology... one of the things about IT projects and everything is... they have a problem. They're not reliable... they come in and people don’t know how to work it. People don’t know how to integrate it. And so people get pissed off of it and then don’t want to use it.

So it has to be reliable so that people actually from the start don’t mind using it because they know it's going to do what it says on the tin as opposed to struggling to get it to work and then finding, press this button, it doesn’t happen, and you do this, and it doesn’t happen. And then they get disenfranchised. And then when you do get it working, you've lost the buy-in that you have from them in the beginning.

00:26:48

On the staff level, you need something that’s reliable and easy to use. On organizational level, you need something that’s cheap. Ideally cheaper than what you've already got to get their buy-in or has some other big added value, like patients coming. But it becomes cheaper if patients don’t have to come back, then that’s cheaper. But however it is, it needs to be at least as the similar costing and ideally cheaper at an organizational level.

Reference 1 - 2.68% Coverage

R And would you say that there’s anything that hinders adoption of new tests?

P That’s usually finance.

R Finance?

P Yes.

R That’s the main one?

P Yes.

00:12:36

R And how would you… Are there anyways of improving that? Of negotiating the finances?

P I don’t know, that depends on the NHS budget and all that. I don’t know how to answer that question.

Reference 1 - 5.37% Coverage

P I think obviously finance is probably a massive barrier, because you need the money to be able to put the resources in to allow, yes, adaption within the service. And then it's time as well. That's a big thing with our clinics, always busy. People don't have enough time just to do admin as it is, but they also… You know, but you're also expected to bring in something different for them to learn working a different way. So time, money and the support as well. If you're teaching someone something different, then that would impact on how many patients we see as well. We couldn't see the number of people we have done coming through the doors without having that extra support just to backfill [?] the person who is learning or being trained on something.

Reference 1 - 7.03% Coverage

But as you can understand, it’s the money that sits behind it all. If say, for example, a million pounds is needed to set up a new system. Well, that would fail immediately because we haven’t got a million pounds. Even if we could see further down the line that we could save ten million, it’s that initial funding that is a real problem.

Just as an example, the Health Check Programme uses quite basic technology where they have to use a desk top, similar to point-of-care, testing things, like a finger prick thing for cholesterol, etcetera. The cost of the cartridges, etcetera, is prohibitive, so we’ve got some practices who just say, I can’t afford to keep paying for those.

Even though we pay them monthly for however many health checks they do, they haven’t got the funding to adopt the bits and the sundries, maybe, sometimes, that support the technology. Especially with testing. It’s very complicated. And they won’t see that. Sorry.

R Is that then the money that you have to put up front?

P Yes. That is a real barrier. And it’s sustaining that money as well. I struggle now to fund the online testing. I really do. And I’ve got meetings with the actual provider tomorrow to see if we can negotiate better prices per volume. Because it becomes expensive.

Reference 1 - 8.52% Coverage

I can’t remember the rep’s company, but we had a rep come around with a cartridge. I think it might have been to do with placentae. They had a cartridge machine, just showing what it was basically. And it was amazing. And they were saying that it could do all of them, basically your routine testing. And it was a no-brainer in my eyes, and some other people’s eyes. To have something like this in-clinic.

00:11:18

And I think the unit was a couple of thousand pounds, which, out of our budget, is a large amount. But the actual technology to have it there was brilliant. To know that this was no available to people, and you could see how beneficial this would be. But, sadly, we couldn’t do that.

R So the barrier was finances?

P Well, the barrier, from what I could gather, and I don’t know whether or not it would be… They say this is what’s about to be available, and this is the cost. I can remember… I’m sure it was about £2,000. And they were telling us… And I think the cost of the cartridges… And what we were concerned about… Because we were saying about doing it almost like if an HIV came in and we could do the INSTI testing, that type of thing. And the cost of the cartridges compared to the expiry date on them, we couldn’t justify the cost, because we couldn’t see, if we were going to be using it as an INSTI test, which is how it was being sold for some time.

We knew that we couldn’t do it. Because I think the cartridges are sold in packs of 50 or something. But it wasn’t going to be for us because of those reasons. Again that was back then, and I imagine things have changed now. But the way that it was being done. Because across [name] area, we do have that barrier. A lot of people sail well. People go across to different counties. And so it’s a grey, fuzzy area. And I can remember the lead on the National Committee screening programme saying that.

And I just sat in the room, and I said no. Our barrier is wet. It’s very real. We don’t have [name] County people coming in to use the service. So it’s not like we could have shared with somewhere else. Like [location] have got a combined Sexual Health service, which is fantastic, but we aren’t part of that. We are own entity. So money does come into it, yes.

00:13:48

R So, in a way, the fact that [name] Trust is somehow isolated from that… That can be a potential barrier?

P A potential barrier, yes. Only when it comes to… Where other people can see it as well, we can purchase this, then actually between our budgets we can cover that cost. We only have our budget. We can’t be looking anywhere else. What we have is what we get to spend. So, we can’t say to [clinic], can we tap into you? Or how about we share this? That’s not possible.

Reference 1 - 4.25% Coverage

P Generally, the biggest in… The biggest barrier to anything is the finances. If you're trying to introduce something that may be a better way of doing it, but if it costs more, then it's very, very hard to introduce that. So, I think that would be the main barrier. I think busy staff that don't necessarily have time to consider things well is a barrier.

Asking for change, does that involve people investing time in doing that? So, thinking about laboratory staff, laboratory structures in terms of if we were to ask for a new way of testing, then that involves them having to go through the process, evaluation of it, of the test. Potentially that would then be a barrier for introducing it.

Reference 1 - 2.59% Coverage

And then obviously we need to work with our microbiology lab colleagues to make sure they’ve got capacity there. I think the bottom line is it comes down to commissioning. So we’re obviously all in financially squeezed situations and at the moment we’re not commissioned to test mycoplasma and so that’s negotiating with our commissioners about how that would happen. So I guess, the ultimate thing comes down to finances.

As I said it’s about, we’re partly helped by guidelines so if guidelines say something has to happen, it’s easier to get commissioners to accept that. But sometimes it’s about if you can demonstrate a cost saving. So, for example, if you could reduce workload and chasing somebody up, for example, and you could demonstrate that it was actually going to cost less money to do it in this way, then you avoid the commissioner issue and then you can get your own trust to approve it and fund it.

Reference 2 - 0.17% Coverage

But I guess I feel like the barrier is mostly financial.

Reference 3 - 0.47% Coverage

I think our lab is cooperative and helpful when it comes to changes that happen, but it’s all down to money at the end of the day. That’s what it feels like anyway.

Reference 4 - 0.49% Coverage

So, I see those challenges as less of a problem than financial, really. I think, particularly if new technologies don’t take up much room, you can generally fit things in.

Reference 1 - 5.48% Coverage

R Yes. And would you say that there were instances where actually the adoption process of something of value in your opinion, and in the opinions of your colleagues, was stopped?

P Let me think. It would be… probably not stopped, but delayed to the point where people moved on. Which is effectively stopping it. Nothing… no one said no in the NHS, they just sort of… it’s obstructed until it’s kicked into the long grass really. So, a lot of our projects that we’ve wanted to do here, there’s not been any IT time, or development time. And basically, it’s, everything’s just sort of timed out.

That’s a reasonably common scenario, in that, normally we try and run everything as a pilot project, and quite often, if we have a small amount of funding for the pilot project, but we need other things on board. And it’s the other things coming on board which don’t happen, and then actually that… the funding times out and you don’t do it.

So, I think we had a small amount of funding for trichomonas vaginalis testing which allowed us to do a pilot in our population. But it never happened, purely because the laboratory didn’t have capacity, or they didn’t have time to do it. So, they almost obstructed it to the point where that funding ran out and we stopped doing it.

00:08:09

So, that’s a big… that’s how the NHS stops things. It just doesn’t resource the approvals around it, and then you can’t really progress any further.

Reference 2 - 14.71% Coverage

However good it is, quite often they’ll say no, there’s not enough money this financial year.

R Right.

P We look at oh, can you get some… a drug company to pay for it etc, and that’s… those days are kind of gone, really.

R So, what about if a technology seems to be cost-effective, or has the potential to reduce costs in the future?

00:10:41

P I think it’s using that argument, it has to be a very well kind of reasoned argument. Because quite often, especially in… we’re part of an acute trust. So, where we say our efficiencies and money-saving, it actually might be a financial load to another bit of the trust.

So, we have the laboratory as part of this trust, so if we say we’re not going to do this test any more, we’re going to do this test, and it’s going to save us this amount of money… that’s great for us, but actually, at a kind of trust level, the micro lab might be saying, well, actually, we’ve just lost x amount of income, and we can’t afford to do this particular test.

So, there’s quite a lot of balances. So even… so it has to be very well thought out across the whole organisation, and actually has to save money for the entire organisation rather than just one chunk. Because by the time it gets to the top-level balance sheet, quite often inefficiencies in one side is actually a loss in another side. Especially when tests are concerned.

So, pardon me… so, a really good example is trichomonas testing again. So, we do in-house culture, because we’ve always done that. That comes out sort of quite cheap, because we use… but the laboratory time is dependent on that. The lab gets a discount on reagents and stuff. But actually, if we switched over to the more… what would be considered more cost-effected TMA type methods, actually, you’d probably see the lab costs go up.

00:12:27

So, it’s… it has to be a whole system approach, really, so… and quite often, that’s what kills something, in that… so, yes, we can do this extra test, this will cause efficiencies. So, talking about your committee on gonorrhoea platform, yes, we can do tests half an hour in the clinic, which is great, it increases our efficiency, makes a potential cost saving for us.

But the chlamydia lab is also part of this trust, so they’re going to be losing work. And actually, by the time it gets to the top, it might be that you’re losing more because we’ve made an efficiency, rather than the other way around. So, kind of issues like that.

R Right, so there are a few issues that you have to consider. So, there’s a financial consideration. That’s not just… yes?

P I think that… I think anything in the NHS, it’s primarily financial considerations at the moment. In kind of the information governance, getting people to adopt sort of newer, innovative technology, you meet obstructions, but if you keep on persevering and not going away, quite often, you will get there in the end.

But the thing that kills… probably a good proportion of innovation type projects is the funding, and kind of the local trust funding.

R I see. And is there any way in which you would think that there’s a… it is possible to improve that state of affairs?

00:14:09

P It’s very difficult in big organisations. Because quite often the people that will be objecting… that can object to something and sort of kill a project, you don’t deal with on a day-to-day basis. So, it’s not a small team that you have to kind of convince, it’s a big organisation with lots of vested interests, really. Lots of interconnected systems.

So, I think it… it has to come… it’s almost having somebody with an overview of the whole trust dedicated to… well this project has this effect here, here and here, so rather than trying to push it up, it’s almost that you give… they’ve got the project and they push it down. But where would that… where we’re at with that, I don't know.

Reference 1 - 3.42% Coverage

P I mean, I think one of the biggest hindrances to getting new technology in is the various meetings that you have to go to, to say that you need something. So, right now we’re looking to get, you know, there’s a machine that can do blood pressure, weight and height all in one. And that would cut down on clinicians’ time because we give a lot of the contraceptive pill. And we’re thinking that actually if you got this machine that does this then, you know, the patient will come in with all their, you know, vitals done.

It’s already in another department but and you’ve said, no, you’ve got to do... you know, do this, this, this, get us this quote. So, there’s a lot of... and it tends to be from, not from the department, it tends to be from the finance side of things where they add in all these extra things that you’re supposed to do. That actually we’re actually being offered this machine for free and, you know, we still haven’t got it because there’s, yes, a lot of other stuff that...

Reference 2 - 2.94% Coverage

P No, I think most of the NHS framework within and between within different Trusts are fundamentally I think essentially the same. They all have the same red tape and the same bureaucracy and the same issues. So, everybody will be battling the same problems, yes. So, I worked in another Trust and we were introducing, you know, an amazing testing strategy but it was, you know, still problematic.

And actually there’s... I actually asked about... this was also... this was partner notification and I found out they never adopted it because information governance said no. So, you know, it’s, you know, it’s all the same principles that are guide... that particularly for sexual health it’s always about confidentiality, who’s the information going to etc, etc. So, all those channels I’ve found within... between, yes, very similar in different Trusts.

Reference 1 - 4.61% Coverage

P We’re encouraged to save as much money as possible. We’re trying to, as I think with every NHS trust, we’ve got to cut a certain amount of the budget. So it’s quite, that would be a barrier to new technologies because unless it was being seen as something to correct something that was wrong, they might say, but why we going to introduce that, because that’s going to cost more in the short term.

One example is we were having computer issues with our results coming through, so we switched to doing instant HIV-syphilis tests. So that was, even though they were more expensive than the lab, because the lab’s on a bolt contract, it was seen as essential until we got the computer system sorted because we did not want to miss an HIV positive or a syphilis positive result. So that was seen as an essential, and therefore a justifiable cause.

00:16:49

But as soon as the lab was fixed we had to stop using them and go back to venous bloods. So finance is a very big thing. And it’s also the training of the people, what staff would be, because that would take staff out of clinic, and what staff are actually going to do the testing and things, because we don’t’ want nurses to be stood next to a machine for half and hour because that’s not the best use of their time. So that what would also have to be considered as well.

Reference 1 - 3.79% Coverage

P Well we had a TV testing on our NAATs swab, we had a pilot for that, which was really good. It was much better than… I mean, we were doing just high vaginal swabs that aren’t’ really very good for TV. So, that worked really well. And we were doing it on men, I think we were doing it on men as well. Anyway, it was a pilot and now we’ve got to write a business case to try and see if we can do that as well. So I think, financially, there’s always going to be a barrier to new things.

R So even if people are supportive of it, and the patient experiences improve.

P It doesn’t always happen.

R Because it’s not…

P Yes.

R There are no savings there.

P I’m not sure if that’s been, you know, I haven’t seen the result of that and it’s not something I would probably be involved in. It could be, I don’t know.

Reference 1 - 3.36% Coverage

We've got less and less money, we're constantly being told you've got to savings of money that we haven't even spent. So we're thinking, well okay, so we're trying to cut the service, while trying to run an efficient service. So no, the finances are not helping at all. The lack of finances is not helping at all.

RE So that, kind of, potentially can then stop introducing technology that is good.

PA Well if it is expensive then yes, yes it will.

Collaborations

Reference 1 - 1.93% Coverage

Well we have close links to HIV Service. We have close links to Women's services, so the Colposcopy unit, the unit which does, you know, have medical gyne. The early pregnancy advisory units, urology departments. We have links with SH:24, because we look after a lot of patients who test at home. Have a reactive test, and need to be managed, all those sort of positive for gonorrhoea need to be treated.

We are… Yes, we… Those are the main links. You know, we, in terms of research, we are starting to, you know, build relationships with the rest of the other trust. So Professor [name], for example, is you know, realises that we're, you know, a big recruiter in special and [unclear] services. Yes, as a directorate, we're linked to the HIV department, the infection department, rheumatology, genetics, dermatology, so those are all within our directorate. So there are, you know, there are some links, referrals to dermatology. Rarely do we have links to, you know, or need to send patients to rheumatology. But every now and then, we do have reactive arthritis. It's not common. But the biggest pathways to HIV, we diagnose five a month at least with HIV.

Reference 1 - 1.86% Coverage

So the core body of the work is with the clinic staff. So that's the doctors, nurses, and health care assistants and health advisers on the floor and reception and administrative teams. And that's when we collaborate with working together for daily running. But we also have people who have other supportive roles within the team.

So I work with the practice development nurse, looking at training needs, looking at training doctors, look at their training needs, and how can we have a system in place where we can have a training program that allows people to identify what their learning needs are to deliver on the roles that's expected of them, and how we can provide that to them so that they can be supported in providing great quality care.

We work with a management team which is, basically, we call it our operational team, which basically has got the service leads, the heads of the various staff groups with the service manager connection, the head of nursing, and just looking at both processes, which have day-to-day running of the service, but

Reference 1 - 1.73% Coverage

But in terms of how I interact with the team, I work very closely with the clinical lead, I work closely with the matron and a big part of what I’ve been dealing with so far… You may or may not be aware about the pan-London contract changes which have meant significant reduction in funding for the next four years.

So I’ve been working quite closely with the team from a financial point of view so far.

Reference 2 - 2.57% Coverage

P Yes. So I think my role within that… So ultimately as I said, I’m a general manager of the directorate. I work very closely alongside a head of nursing and the clinical director, so I’m the management arm. The clinical director looks after the medical team and the nursing looks after the nurses.

We have to make decisions together and ultimately any significant change within the service would have to come through us from a governance point of view. And the reason it would have to come through us from a governance point of view is because we’re accountable to other managers in the organisation.

Reference 1 - 1.90% Coverage

P Yes. So, within the clinic, we, you know, there is… The model is that you would have, you know, a couple of doctors. A couple of senior nurses. A couple of junior nurses. At least one health advisor. And a healthcare assistant. So, everybody kind of doing their own things in the context of the clinic, but there to do our own specialities, really. So, we do work quite closely alongside all of them. Yes.

We also are very much connected to the results administration team. So, the team that does all the calling people with their results and sending out text messages. So, we do… We help with that quite a bit. Yes.

Reference 1 - 0.17% Coverage

I liaise with the matron, clinic sisters, the lead clinician, and the service manager.

Reference 2 - 1.18% Coverage

we have a service manager's meeting that I attend, and it's from all disciplines. So you might have somebody that works for surgical department theatres, dermatology.

00:01:41

R Right.

P So, because they're based in a hospital…

R Yes.

P And we're obviously based out in the community.

R Yes.

P So it's good to all get together and see what's happening.

R Right.

P So it's quite a large network.

R Yes. Any…

P I also, you know, sexual reproductive health, the service manager also manages [clinic], and the staff cross site work.

R Yes. And that's the HIV clinic?

P Yes, that's HIV clinics, yes.

Reference 3 - 1.87% Coverage

And thing is as well, everything falls on your shoulders, but then you're still liaising with your managers to see where you are. And then they're feeding back to, like, their managers, because there's a chain isn't there? So… But on the ground level, everything's fine, and they're confident, no problems.

R Right.

00:07:38

P And I'm always fed back, there's no problems. Or if there was a problem with, like, the printing, and then you've got, like, IT, they will come out and try to fix what's… Because I'm not technical, so I don't know that side of things. So that circumstance is beyond my control. But at least I'm liaising, and having these telephone calls, testing there and then, running from room to room. It was, like, a lot of work, but I enjoyed it. And it was a learning process as well. So I think when you get something else, you remember what you did previously, and then it makes it even more easier. That's how I find things. So…

Reference 1 - 2.62% Coverage

who do you work closely with?

P Most closely with [name], who is one of the other sisters, and she works in [name] clinic. So, in terms of jobs, she’s the only other person that does my exact role, and there will be somebody starting in a month, who will be the other sister, so they will be the two people I work most closely with. After her, I would say it’s [name], who’s my direct line manager, and she’s the matron.

00:01:40

But also, I work quite closely with the nursing team, because as I said, half of my role is clinical, so if I’m on clinic, then I’m on clinic with my colleagues. And a lot of the nurses I have known for a long time, so I’d say we have fairly good working relationships.

Reference 1 - 3.43% Coverage

I’m the [service] health team lead for [region], so it’s part of the [name] Sexual Health Service. So I have a mixture of roles. So it’s sometimes clinical and other parts of general management and service management, results management and just general clinic management, stock services, budget management, all that kind of stuff.

R And who do you collaborate with?

P So here in [region] it’s part of the general [name] Sexual Health Service as the quadrants there and the overall contract managerialists, [company]. But we work close with [charity] and [clinic] based with us for HIV Services and our lab that’s up in [location], so we collaborate with those.

Reference 1 - 2.66% Coverage

P So the team within this, it is the whole [name] Sexual Health service. So it's the doctors, nurses, and administration and health advisers across both clinics.

R And are there any other unit services that you collaborate with [overtalking]?

P Yes, in terms of the sexual health. So we have a level two provision in the county, which is run by [charity], who have a series of little clinics that they run once a week, two or three hours in peripheral clinics, mostly in general practices.

R HIV testing?

P Yes, mainly provision of contraception and screening asymptomatic patients. And they also run the committee screening for the county.

Reference 1 - 1.14% Coverage

P So we also have the nurses, the health advisors, healthcare assistants as well, and obviously the sort of admin staff as well. So that’s at each site we have our team, and then obviously we work with the labs, local labs as well for all of our tests to be done, so… And other clinicians across the Trust.

Reference 1 - 2.52% Coverage

R Right, okay. So, who would you say are the people that you collaborate with most?

00:03:46

P That would be the nurses, so the nurses on the wards, and the doctors, and the HCAs, so that’s the health care team. Sometimes, our staff, because sometimes our staff may need to use the point of care equipment. And, sometimes some managers.

Reference 1 - 1.11% Coverage

P Okay. So we do work with nurses and health advisers within the clinic. And we also work with other nurses from other departments if they want our input. So in terms of other departments, it would be occupational health or maternity.

Reference 1 - 0.79% Coverage

R And who do you work with closely in the clinic?

P So the other members of the staff and the doctors as well.

Reference 1 - 1.67% Coverage

I work with, obviously, our Trust as provision for sexual health services there. I also work with Community Pharmacy. And I work with GPs. We get to provide various different elements of contraception that they are not commissioned for. And that’s mainly around long-acting, reversible contraception.

Reference 2 - 4.99% Coverage

R Would you be able to identify the structures that are already in place that are supporting adoption of new technologies? You’re describing those collaborative processes.

P I think, across the STP… Has anyone talked to you about the STP, Sustainable Transformation Partnership?

R No.

P Maybe go and have a look at the STP for this area. There is a whole element about new technology. If we come up and say, actually, this sits with STP design, etcetera. I also work very closely with my colleagues in [name] and [name] and [name] too.

00:12:13

R So, there is a specific programme design?

P Yes. And actually, you would look for the STP.

R And these are the main things that help?

P Yes, I would be working towards that. And obviously if we decided something individually, I would then obviously, like you say, make a business case and take that to our senior management team here for a yes or a no [unclear].

Reference 1 - 2.31% Coverage

My collaboration is very multi-disciplinary, it’s across the team here within the integrated sexual health service, it’s also across the trust, across the hospital, with other healthcare professionals related to clinical matters, but also to general healthcare matters within the hospital and across the island, in relation to working with practice nurses and GPs. And then regionally and nationally with organisations like BASHH and the Faculty of Sexual and Reproductive Healthcare.

Reference 1 - 0.58% Coverage

Within the clinic it would be… I work very closely with the nurses anyway. But also with our HIV specialist. Would be with the HIV specialist and with the nurses. Yes. Senior nursing.

Reference 1 - 0.71% Coverage

I liaise with the consultants if… and we review the tests we use, the samples we test, to make sure that the service performs as it should.

Reference 1 - 2.85% Coverage

So we have five consultants, myself included. And a selection of other doctors, and then a large nursing team, nurse practitioners. And health care assistants that deliver the care to patients in the clinic. We also work in the hospital with the infectious diseases department to deliver outpatient HIV care. Outside of the hospital, we work closely with our community sexual health colleagues, who deliver community sexual health, sexual and reproductive health care.

Reference 1 - 1.52% Coverage

P So I’m quite new to my clinic. I’ve moved here from another part of the country, in November. So at the moment I’m looking at setting up some local collaboration with close-by clinics. But previously I was involved, when I was working down south, I was collaborating with, I was working in [clinic] and we had regional studies running there at the university. I’m looking to set something similar up, up here, in this area.

00:03:01

But that’s not, that’s part of the STI champion role really. But that’s not running yet, so that’s my plan.

Reference 1 - 2.13% Coverage

R Right. So, it seems like you really work quite closely with everyone in the clinic?

P Yes. I do.

R There’s training, there’s collaboration.

P Yes. I think most consultants do. We have an over… kind of an overarching kind of responsibility for the whole clinic, right, from admin to microbiology lab staff, to nursing and junior doctors. So, we do have a general overview of everything that’s going on, or we should do, anyway.

Obviously, my key colleagues, I have four consultants, colleagues here, and I have two consultant colleagues over in the X.

Reference 1 - 1.42% Coverage

I work mainly with my colleague who’s the Contraception Lead and is also Lead for the service. And I lead for the genitourinary medicine side of things.

So, he leads for the contraception sexual health and I lead for the genitourinary medicine side of things. We work with a big team of nurses and doctors as well as other support staff. So, there’s a massive big admin staff and health care assistants as well.

Reference 1 - 1.90% Coverage

Okay. I’m a Senior BMS in the bacteriology and GUM laboratory. And the sections I look after are the urine section, GUM bends, reading TCs within GUM laboratory. Within the GUM location, I liaise with the consultant at the GUM department.

Day to day responsibilities

Reference 1 - 2.51% Coverage

Okay. I'm the clinical lead for sexual reproductive health. We have three clinics that see about 1600 patients a week. We diagnose about 1400 infections a month, and that's my main role. I do HIV clinic once a week. And what else do I do locally? Oh yes, I'm involved in SH:24 which is a home sampling service. And I'm involved with all set up SXT which is a partner notification tool. And this afternoon we're going to go through the final bits before we go live with the appointment module.

So partners are getting told they’ve been potentially exposed to an STI, and then they'll be able to book an appointment. Which means they have a full digital journey from being told to getting tested. So it's kind of exciting. So those are the things I do. In the clinic, my role is… The clinical lead role is only eight hours a week, but that's… It takes a bit more time than that, just trying to help obviously move the service forward.

00:01:20

The day to day is delivering an integrated sexual reproductive health service. And training as many staff as we can, and trying to make sure that we can get through the volume that we need to do. The clinic's run seven days a week. And we start off with a group hug in the lab at 8:20. We start seeing patients at 8:30. And then we have three clinics over the day, and we're seeing patients until seven PM every day of the week. And then on the weekend it's an 8:00 and… Two eight hour shifts on Saturday and the Sunday. So that's the service. That's what I do.

Reference 1 - 0.56% Coverage

I work in a HIV clinic for follow-up of HIV patients. It's one session a week. And the rest of the time, I work in a sexual health clinic. It's a walk-in service that caters to people with symptoms of sexually transmitted infections or the physical sexually transmitted infections or requiring contraception or advice.

Reference 2 - 0.89% Coverage

And I do a referral clinic for people with genital skin problems as well as complicated infections. So that’s basically all aspects of sexual health that we manage.

R So your main responsibilities are providing care to patients.

P Providing care to patients. Part of it is making sure that we provide good quality care when it comes to sexual health care, and also making sure that our services are accessible, making sure that we have the capacity to see the patients that want to be seen in our service.

Reference 1 - 6.83% Coverage

So, we do… Should I kind of explain about what health advisors do in a sexual health context?

R Yes, please. Yes.

P So, we are… We sit alongside, clinically, the nurses and the doctors as people who are kind of the experts in the emotional and psychological side of things. So, we help manage positive results, in the first instance. So, when people are… Come in for a check-up. And then they’ve got chlamydia or something. They come back and see a health advisor. And we are the ones that supposedly have the skills to explain what the infection is. How it’s transmitted. What the potential complications are if it’s untreated.

00:00:59

We talk about… It’s partly notifications. That’s probably one of the core roles that we play. It’s the taking responsibility for having that conversation. Making the patient feel comfortable enough that they are actually sharing the details with you. And then coming up with a plan for how to contact patient with our partners. So, we do that.

We do a lot of path assessment as well. So, we see patients, or gay men who have had unprotected sex in the last 72 hours who think they might need PEP. And we get the story from them and find out whether, kind of, do the assessment on whether they actually need it or not. And if they do need it, we do the tests. So, we have a clinical role in some of the testing.

So, we do blood. We do a lot of asymptomatic screens on people as well Like. when the rest of the nurses are busy, we can jump in and help out with that kind of thing.

And we do all kinds… Like the anxiety. People coming in that are crying or upset about something. Or nervous. And just need more time and space and information.

00:02:01

They come through to us. And then we run our own counselling service as well. So, people that want to have ongoing sessions to explore the fact that they are having lots of risk in their sexual lives and they don’t exactly know how to stop it. Or if they are using drugs or a lot of alcohol and that’s related to sex. And they want to look at the connection between the two and try and understand things a bit better. That’s another thing that we can see people for. So, yes. So, I manage that team that does all of that work.

Reference 1 - 0.73% Coverage

So I am the assistant service manager. Of which I'm currently acting up in the role. I'm responsible for operational, and overall management of the team leaders and the reception staff. And just the general managing of the clinic, and overseeing any new processes that need to be implemented.

R Right.

P And just the everyday, you know, hustle and bustle of the clinic.

Reference 2 - 0.18% Coverage

But I'm also on the shop floor, so to speak.

R And do you…

P And attend a lot of meetings.

Reference 1 - 2.60% Coverage

So, I am one of the sisters in the service, there are three – or there will be three, there’s been two for about six months now – and I cover [name] Clinic, so I specifically work here, I don’t really rotate around as much as the other staff do. I’m responsible for line management of nursing and healthcare assistant staff, I am responsible for the running of the clinic here, sort of day-to-day, sort of operational type things, responsible for recruitment, that sort of thing, the rota.

And I work clinically, as well. So, 50% of my role is to work clinically, so in that respect I sort of work in the capacity of a nurse, you know, so clinical nurse specialist, at that sort of level.

Reference 1 - 1.40% Coverage

I'm a speciality doctor working in contraception and sexual health in the [name] Sexual Health Service. So I work in different clinics across [name] Sexual Health Service. So I work in [name of the trust], I work in [name of the clinic] and I work in [name of the clinic].

Reference 1 - 2.85% Coverage

P My main role is clinical lead in [location] Sexual Health, basically I provide both clinical services, seeing patients and also management responsibility. I provide care to broad range patients with HIV infection and patients requiring sexual health services including STI screening, take referrals from other specialities. I’m also involved in the day-to-day management activity of the service within [location] Sexual Health covering the mid, the north and the west. That’s like a big summary.

R Yes, it is a combination of the clinical and management. So does it mean that you have to juggle both parts of work every day?

P Yes. So basically my calendar features both clinic, features meetings, features the admin stuff.

Reference 1 - 1.19% Coverage

P My role is to manage the contract and the partnership. Basically, [name] Sexual Health Service is commissioned by our local authority, [name] County Council, and we’re commissioned to provide integrated sexual health services. That’s a broad range of contraception interventions and sexually transmitted infection management and education associated with those areas.

Reference 2 - 1.87% Coverage

Hopefully, that describes my role. I’m still clinically involved, and from the point of managing a contract, it’s a double-edged sword.

00:04:13

My clinical background means that I stick my nose into things where perhaps traditional contract managers wouldn’t, but the advantage to that is I have a view that’s got additional validity when it comes to discussing things with my clinical colleagues. Not that any clinician would use clinical information to take advantage in terms of a position, but that’s probably a little bit more difficult when dealing with me.

Reference 1 - 3.43% Coverage

I’m the [service] health team lead for [region], so it’s part of the [name] Sexual Health Service. So I have a mixture of roles. So it’s sometimes clinical and other parts of general management and service management, results management and just general clinic management, stock services, budget management, all that kind of stuff.

R And who do you collaborate with?

P So here in [region] it’s part of the general [name] Sexual Health Service as the quadrants there and the overall contract managerialists, [company]. But we work close with [charity] and [clinic] based with us for HIV Services and our lab that’s up in [location], so we collaborate with those.

[<Files\\HWcons&sdu\_clean>](1f388b2f-7a03-43e7-87d5-c6d5b8fa4126) - § 1 reference coded [2.02% Coverage]

Reference 1 - 2.02% Coverage

R And if you could talk to me about your main responsibilities.

P What, clinically or managerially?

R Both.

P Okay. So clinically, I do four-five sexual health clinics a week, which are mostly integrated sexual health clinics. So contraception, and then I also see HIV patients separately, so we have the HIV service. And then as the manager, I am responsible for the whole management of the service, including the finances and how the service operates within the organization.

Reference 1 - 3.65% Coverage

R And in terms of this process that might occur, what would be your role in the process of adoption of a point-of-care test, the Atlas point-of-care test?

P Yes, well, I guess because I’m one of the consultants here, so as part of the senior management team that’s something that falls onto all of us to sort of, A, disseminate the information out to the rest of the team; be part of who we decide will need the training and who will be part of the core group that uses it as well.

So, yes, I guess that’s how I see things going. And because I’m primarily based at the other clinics, so I’m the main consultant at the other clinics, so I guess my role over there will be slightly different as well, but… In terms of being probably the only consultant at that site. Yes.

00:04:04

R Right. So you probably, you have more responsibilities there or…?

P Yes. As opposed to here, because usually the other two consultants are mainly based here, whereas I’m mainly based at the other site.

Reference 1 - 16.44% Coverage

And, what I do on a day to day basis is, just, make sure that individual staff, doctors, HCAs are using it properly, that they are running their internal QCs and external QCs. That they have been trained to use the various equipment, and that they have knowledge of the results that the equipment are producing. In addition to that, because some of these [unclear] analysers require a barcode, so they require individuals to have unique barcodes to access it.

So, when I’m getting new staff into the trust, they will get trained and request a barcode from myself. Or if for instance, with the blood gas analysers, they have a barcode already; but they need access to another area, so maybe their working in IT and they need access to A&E, I would activate that. Also, we have point of care equipment in the community, so, we have district staff nurses who use glucose meters. So, if they’re faulty I would replace them, if they require, if they’re just coming newly in the trust and they’re not sure how to acquire one, I would advise them.

00:01:52

P I send out the external QCs, so that they all instantly put it on and send me back the results. The results of all internal QCs, I input them into the various external QCs scheme, whether it’s Worth Works or Networks. And I, when the results are all in and analysed, I have a look and just make sure that we are within the confines, and if there are any outliers, or if there are any results that are outside of the consensus range, then I will investigate them. So, whether it’s an individual error, or whether it’s an error of the actual meter content, or whether it’s something I have to take back to the company. So, I do that.

Any new point of care kit that comes into the trust, I make sure I examine it and make sure that it compares with the results that we produce in our lab, before it goes live on any ward, or in the community. So that’s, kind of, my role, and I coordinate the point of care meetings, which happen every quarter. So, my role is making sure that different stake holders through out the trust attend the meeting and keep their opinions. So that it’s not just a point of care team led by the lab, it’s involving the stake holders as well.

Reference 1 - 2.99% Coverage

So I manage the nurses and the healthcare assistants on a daily basis. I do clinics regularly. So I take histories from symptomatic and asymptomatic patients. I'm a prescriber as well, so I can prescribe medication to patients. And then, it's all about supporting and the teaching role as well that comes with being a sister of the clinic.

R So you provide, I guess, a lot of support to junior staff members.

P Yes, I do.

Reference 1 - 4.14% Coverage

Well, my role is as Local Authority Commissioner for Sexual Health Services. My role is to purchase and facilitate provision of the core elements of sexual health provision that the local authority is responsible for. And that is contraception, STI testing, psychosexual and HIV testing. And that fits in with the public health outcomes framework indicators that we then have to reach. Such as, we don’t want high late diagnosis of HIV, etcetera.

I work with, obviously, our Trust as provision for sexual health services there. I also work with Community Pharmacy. And I work with GPs. We get to provide various different elements of contraception that they are not commissioned for. And that’s mainly around long-acting, reversible contraception.

Reference 1 - 6.80% Coverage

P I’m a consultant nurse in sexual reproductive healthcare, which means I cover all aspects of sexual healthcare, from provision of contraception, management of STIs and HIV care. And then the related things. My collaboration is very multi-disciplinary, it’s across the team here within the integrated sexual health service, it’s also across the trust, across the hospital, with other healthcare professionals related to clinical matters, but also to general healthcare matters within the hospital and across the island, in relation to working with practice nurses and GPs. And then regionally and nationally with organisations like BASHH and the Faculty of Sexual and Reproductive Healthcare. Just a little outline of what I do.

R That’s quite a wide range.

P Yes, you bet.

R Your day must be really busy.

00:01:29

P It’s busy and it’s also very variable, I try to chunk-up the week, I tend to have four clinical sessions on Thursday and Friday, essentially Thursdays and Fridays are all clinical. I have one clinical session on a Monday morning and one clinical session on a Tuesday evening, then the times in-between are more to do with research and development, and service-designed delivery and the matters that support the clinical activity. It’s busy, there’s always a lot going on, it’s not the sort of job where you can kick your heels. If you’re not busy, you can always find something to make yourself busy.

Reference 1 - 1.71% Coverage

I’m the health advisor at the [name] Sexual Health Service. So I talk to anybody who’s got an infection to get them treated. Anybody with any concerns about anything, they would be put through to me. I’m the point of contact for anyone that comes through to the clinic. Reception will put them through to me. Or if nurses need anyone contacting and anything talked about, it would be me that does that whether or not professionally or with patients. And it’ll be partly notifications as well and get everyone tested, so that’s what I do in the clinic.

Reference 1 - 3.55% Coverage

P Okay. I’m the head of service for microbiology in the laboratory here. So it’s my responsibility to make sure that we provide the clinical service. So I oversee the work that’s done in the laboratory. I liaise with the consultants if… and we review the tests we use, the samples we test, to make sure that the service performs as it should.

I’m responsible for our accreditation but I have a quality officer who does the bulk of the work. I’m responsible for health and safety within the department and I’m responsible for our financial budget. So I’m the one who makes decisions about what equipment we buy, what consumables we buy, if we’re going to change our methodology, all that sort of thing.

Reference 1 - 1.12% Coverage

P So I look after the C test, treat people for sexually transmitted infections and HIV. I'm also involved in the management leadership side of running the clinic, service development.

Reference 1 - 4.35% Coverage

So I’m a consultant in genitourinary medicine and HIV. And then I also have some additional roles within the department from the leads for clinical governance and that includes a degree of overseeing of our testing strategies. And then, within research, within the National Institute for Health Research, the NIHR, within our local area, in the local clinical research networks, I’m both a research scholar, which is a two-year programme looking at developing individuals into becoming future principal and chief investigators.

And then I’m also the local clinical research network sexually transmitted infection research champion. So that’s a role basically looking at increasing the quantity and quality of portfolio studies within GUM in the local area. So that’s not just my trust, but a number of other local trusts as well.

R Alright, so do you commute also between different locations?

00:01:27

P No. So I work at my main clinic, clinically, but I’m in communication with consultants at other clinics. That’s a very new role as I’ve only just been appointed to that, about three weeks ago, they’ve only just invented the role. But they’re really trying to promote STI research.

R Right.

P So that’s why I’ve got that role. And then although, sorry, although I’m not the research leader in the department because I have that role, I have a significant role of encouraging research in the department. I think, ultimately, I probably will become the local research lead, but at the moment that’s covered by a different consultant.

Reference 1 - 2.72% Coverage

So, I work across sites. So, they’re… where I’m a consultant in sexual health and HIV.

I also… we have arrangements with other trusts, so I’m also sort of the [name] Trust, which provides another sexual health service in [location], I… a day and a half of my consultant time every week. I also do a locum session every two weeks at [name] Trust, which is another trust which hold sexual health services.

So, my main role in this clinic is really sort of standard NHS dumb consultant really. So, it’s assessment of patients, it’s management of results, it’s training of staff and supervision of clinic, really. So, I’m… my clinic, so I would ultimately be responsible for the care of the patients coming through the doors.

Reference 1 - 3.31% Coverage

Things that need to be... We need for the clinic, make sure that we got everything here. So, just to make sure there’s smooth running of the clinic per session. Yes. Okay. I do enjoy the job, and no two days are the same. Sometime I plan my day out, and then next you know I'm actually on the front desk because some sort of emergency's come up. So I'm all over, yes.

R Only in this clinic or in two others as well?

P Currently, I'm based here, but sometime I do have to interact with the other clinics from here. Order their stuff for them, clinical stuff, if the person who’s there is on annual leave, or sick or something.

Reference 1 - 1.07% Coverage

P Okay, so, I am currently working as a locum consultant in the... basically the role is called Integrated Sexual Health HIV and Research. So, it’s kind of... it has facets of all of those contraception, sexual health, GU medicine, HIV as well as research in it. I’ve been in post since end of October last year.

Reference 2 - 1.45% Coverage

And my other hat is I do an HIV clinic in another clinic. So, I do one clinic there a week and, yes.

So, and the other bit is I do research work with our head of research as well. So, we’re looking to get our clinic involved more in sexual health research essentially because there’s a lot of focus on HIV research but little focus on sexual health research. So, we’re looking to develop that side of our portfolio.

Reference 1 - 3.76% Coverage

P I’m a clinical nurse specialist, so when we work with everyone’s, we’ve got a range.... Staff-wise we’ve got doctors, we’ve got nurses or healthcare assistants and apart from the results team we mostly do a lot of coordinating with the lab about getting results and processing them. Patient-wise we have all ages, all demographics, all genders including the list which is about twenty genders long now. But we see everyone, pretty much.

R And what are your main responsibilities within that role?

P So, I’m here as a, more of a specialist towards GUM, so the more infection side. So I’ve come from a very GUM background, but I’ve worked in quite a few clinics, which are a bit more high-level GUM. I know we’re all Level 3, but they have a bit more acute stuff. So I do a lot of the syphilis follow-ups, the GUM follow-ups and more complicated infections and resistant infections and dealing with that. That’s my speciality.

00:01:22

But then we all have the responsibility for the negative results, the other positive results and seeing patients. So I suppose that’s my thing.

Reference 1 - 3.55% Coverage

P Okay, so my role at the moment is a clinical specialist. So I’m a balance of a nurse. So, my role is part clinical and also managerial, line management role as well. Personally I have a bit more responsibility for the [name] clinic in as much as overseeing medicines management, there’s been an issue with temp, which is just things like that that occur within the [name] Clinic which just need a bit more finer managing and dealing with. But clinical as well.

R Right. So that’s busy.

P It’s busy, yes. Busy. And at the moment the online testing, you know the new Sexual Health London online testing has been rolled out from the [name] clinic, here, so, yes. So patients are using the point-of-care testing, well no actually it’s not point-of-care, it’s home testing isn’t it.

Reference 1 - 6.70% Coverage

PA Okay, so I'm one of the clinical nurse leads in the clinic and we run a clinic. I'm here everyday and my responsibilities are to oversee the admin, to ensure the patient numbers are correct, to see that the appropriate patient goes to the appropriate clinician. We offer all services and I do all the services, so I can do all the contraception, the STI work etc. I also manage staff and oversee their performances, yes.

RE So it's managerial but also clinical?

PA Yes.

RE Right you must be busy.

00:00:54

PA Not really.

RE No.

PA No it's totally easy, it's fine, it's absolutely fine. It is just getting into the routine, it's fine.

RE Alright.

PA It's busy and you have to be really, know what's going to, how the clinic is running to help it to run smoothly. I don't know, who, what staff are working, how they work, calibre of patient and what we can offer and what we can't offer.

Reference 1 - 1.90% Coverage

Okay. I’m a Senior BMS in the bacteriology and GUM laboratory. And the sections I look after are the urine section, GUM bends, reading TCs within GUM laboratory. Within the GUM location, I liaise with the consultant at the GUM department.

Reference 1 - 0.80% Coverage

My role is Lead Nurse in Sexual Health.

00:00:16

I don’t work in a clinical capacity, but more in the leadership and strategic capacity within the department.

Reference 1 - 16.54% Coverage

Yes, okay, so, my job title is Health Advisor, Nurse Practitioner. I see patients from a clinic list alongside my other nurse practitioner colleagues and health advisor colleagues and also my doctor colleagues. We don’t stream patients, we pick the patients up and I will do the... take them in and do a clinical assessment, a medical assessment.

And it’s really dependent on the outcome of that. I will then decide what tests to do. So, I’ll...all the tests send them potentially if they’re a symptomatic we’ve got onsite microscopy so we’ll send tests to the onsite laboratory. And I’ll also do cultures and NAT tests for sexual transmitted infections. If they are asymptomatic I’ll advise the results process and then send patients then are free to leave the department.

00:01:48

If they’re symptomatic I’ll send say screening test to the laboratory. I’ll wait for the results of those and then on receipt of those I’ll make a clinical decision as to whether treatment is required. If treatment’s required I’m a nurse prescriber and I will prescribe the treatment. And we have set guidance that we follow with regards to that. So, that’s my role as a nurse practitioner. I also do a split role so I work in the Health Advisor Team.

So, as part of that we manage the positive results and the recalling patients accordingly. I will then see those patients and give advice and treatment and do the partner notification. Also as part of that role we’ll see any distress patients, any patients who are presented for the department who’ve been sexually assaulted. We’ll see them and offer support and onwards referral if required. We also offer any crisis intervention. So, that part of the role is very much a supportive role for the patient.

I’m also involved in the Impact PrEPTrial. So, I actually offer a clinical week for patients who are on the impact trial. I also do an implant clinic as well, contraceptive subdermal implant clinic as well. So, my role is quite a diverse role. I also do one session a week where I go into the local, our local [name] which is our local male prison and I mainly offer... I can’t offer microscopy there but I offer STI screening and BBV screening and treatment in that service as well. Is that what you were...?

00:04:09

R Yes, so, I can see that you work across different sites and you have different roles even which is interesting and challenging I guess.

P Yes, I suppose sometimes it can be challenging certainly when you’re working in the prison, when you’re working on your own. You know, you have to make some decisions, you know, when you’re in the clinic environment you’ve always got colleagues around, doctors around more specifically. You know, and I am an independent practitioner but at times I do need support from doctors, from our doctor colleagues.

Experience with SE and adoption and role in the processes

Reference 1 - 1.48% Coverage

And what is your role, exactly, in the process of service evaluation?

00:14:18

P Well it depends on which projects I'm in. But you know a minimum is to make sure that people present them clearly, and that we can critique them. I think that's, yes, the most important thing is that, you know, that the data is, you know, we understand what the baseline is, we understand what the study is. So my role would be to make sure that we're being a bit, you know, we're being scientific about it…

R Right.

P As much as we can be.

R Yes.

P And that we, you know, and that we just get going. That's another thing, it's about, you know, everybody seems to want to contribute something, and you know, there's the problem about, you know, being in the sort of perpetual sort of revolving door of… Of asking people too, you know, what's their opinion, and you know, can they think of any barriers?

Reference 1 - 0.76% Coverage

I think all departments need to evaluate their services. We look at various aspects of it. And part of my role as quality improvement is looking at how can we improve our services to make it in line with the best standards of care that are published nationally, but also to incorporate advances within the field. So there's a lot that is happening. And how we manage STIs, how we test for STIs, how we interact with our patients.

Reference 2 - 1.91% Coverage

So I think that I'm lucky that in the department I work, we have a commitment to research. And we're looking at how can we... the research improving clinical performance, clinical morale, and also adoption.

So we are quite interested in... I think that evolving science of implementation science, I think that's the way to success. It's become very trendy at the moment, but there's still very little that's happening as to implementation science. But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

Reference 1 - 5.90% Coverage

And what you find, the first thing you tend to find in the NHS, is when you want to try and do something different there are a lot of people telling you you can’t do it. And there’s this immediate fear factor about what does it mean if we do something differently? What are the implications?

So my job is to assess all of those important subjects I need to assess and what’s the financial impact of doing this? What does this actually mean for our patients? What does this mean for our support services like our pathology provider etc.? What does it mean for our workforce? How are we going to quantify the benefit?

We need to make sure that if we’re going to be investing in something we get clear outcomes and vice versa. If it doesn’t require initial investment we still need to know what we’re looking to achieve. My job is to make that as minimal as possible for the service, so I think that we’re an organisation that likes to adopt change comparatively. We like to try new things.

I think sexual health is probably our most innovative service. I think some of that comes from the fact that they’ve learnt to not ask for permission for a lot of things. Because I think if you ask for permission you’re essentially making it someone else’s responsibility, of which when that person needs to understand everything about it to say yes or no.

So does that answer your question?

Reference 2 - 0.84% Coverage

It’s then my job once we’ve understood that to go and break through some of the bureaucratic barriers and to show that we’ve done our due diligence if you like, to say this is a safe thing to do.

Reference 3 - 1.12% Coverage

So what you’re trying to do as a manager is find out who’s done something else like this? And you’ll talk to them about what are the things that you considered? What are the things you didn’t consider? And what are the things you would do differently next time?

Reference 1 - 3.21% Coverage

P Yes. I think I have a pretty active role in that process. I think, as a department, we are quite open about trying to find new ways to do things. And if there is an easier way to do something, or a more efficient or a more accurate way to do something, then we are really quick to jump onboard that. And the clinic lead is really, as our clinical lead, is all up on the technologies. So, he is always looking for us to adopt new things.

And he would come to me and the matron. That would be the head of nursing. And talk about, hey guys, I want to… I hear we have this idea to improve our service and get results faster. Or get people, you know… Have to stick a needle in someone less. Blah, blah, blah. And then we think about doing it. Come up with a plan in order to put it into effect. Yes.

So, I feel I am very much a part of the process that’s kind of thinking of the ideas. But, also, I suppose mainly implementing them. And thinking about pathways. And who does what and how is it going to be used, and with who? That kind of thing.

Reference 2 - 6.01% Coverage

R Oh, right. Okay. So, it doesn’t have to be structured, really.

P Yes. No, there is a lot of just us, kind of, talking off the cuff about things. Do you want an example of that or is that something you are going to ask about?

R Yes. Well, yes, if you have something that will illustrate that.

P Yes, so there is a… We’ve been thinking a lot about the… With HIV testing, for instance. The difference between using a rapid test and the laboratory test. And I had to kind of shake my own mindset when I started here, two years ago, about the benefits of the rapid test. So, the rapid test is generally more expensive than the laboratory test. And it’s nice, because it gives people the result on the day.

But with most people who are low risk, who we know are going to be negative, it would make more sense just to take blood from their arm and do it that way. So, that’s been kind of a shift in mindset. But there is rapid test that does HIV and syphilis combined. It doesn’t really cost that much more than an HIV rapid test alone.

00:06:15

And if we were to use that for patients who are low risk, you could… We wouldn’t even have to stick a needle into someone’s arm at all when they come in for a check-up. So, one little finger prick with four drops of blood will give us an HIV and syphilis result for someone who is low risk for those things. And that’s a great example of trying to… Of using something that is out there now to make the… To give the patients a better service, and to make clinic work a little bit quicker.

R So, in a way, it was you seeing that, you know, those tests can be combined. They are combined here.

P Yes. So, I mean, usually… Look, we… Cost usually something that is looked at first, really. But the fact that people could leave with that result on the day is a great benefit. So, it makes sense clinically, and people are getting a better, faster result. Great, that’s a win.

R And that’s what matters, right?

P Yes.

Reference 3 - 1.64% Coverage

R Yes. And does it sometimes mean that you have to work extra hours? Or do some work outside of your regular working hours. When there is a new, you know, new process, new technology in the clinic.

P I suppose on very rare occasions, maybe. Yes. Well, I mean, generally speaking, I think most of us try to stick to our hours. And I think that’s… You’ve got this number of hours in the day. That’s what you are contracted for. And you try to stick to it. Although, you know, some people work a lot more hours than they should, really.

Reference 4 - 7.69% Coverage

And how quickly people change and adapt is an individual thing. That’s about that person. Sometimes, that can be an age element. It’s, you know? But not always. Not always. Some of the older people, older staff, they can roll right with it. Pick things up quite quickly. And it will be the younger ones that struggle.

R And do you find yourself sometimes supporting other members of staff who may be struggling with new ideas?

P I try to. Yes. I mean kind of like an emotional level, if they are, like, frustrated or something. Yes. So, we use a website to help identify with partner identification. Which is another clinic lead’s initiative. And I have to be the biggest cheerleader for that, aside from him. And I am. And I am happy to be. Because, really, I believe in it. Very much so.

But there are people on my team who are less enthusiastic about it. Because it involves asking a few more questions of the patient. Pushing them a little bit harder about how many partners have you had? Can we contact them? Do you have numbers for this one? Do you have numbers for that one? Blah, blah, blah. So, I have to kind of motivate. Keep the enthusiasm up for it when it’s not something that people are just naturally going to be, like, yay, about.

R How do you do that? Do you have any, like, techniques? Because [Overtalking].

00:23:02

P Not necessarily. I mean I like… I like the challenge of trying to figure out a way to get the information I need from the patient in a good way. So, can I use the questions that I am asking, and my personality, to kind of win them over enough so that they are going to be cooperative, really? And so, I will… I’ve gotten like a little, I suppose, a speech in my mind that I use when I am explaining that website, for instance.

And I can see when people are buying into it and when they are not. I can see when I need to be, maybe, changing what I am saying a bit, or pushing a little bit harder to explain why it’s important. But I like that challenge. But I don’t think everybody necessarily gets that excited about that particular thing.

But then it could be. You never know what’s going to get people excited about things. So, we have one member of my team who sees himself as a point of care. HIV tests. Like, the lead for that. He was never point to that. But it’s just he loves doing it. And he loves showing the members of staff how to do it. It’s just kind of, he takes it and says his little thing that he likes to be the volunteer to show everybody.

Reference 1 - 3.30% Coverage

Yes. And do you have any experience of participating in adoption process within the NHS, of like new technologies?

00:02:26

P Yes, I do, because I occasionally will attend something on behalf of the clinic lead.

R Right.

P Like at the moment, like we've got SH:24.

R Yes.

P Certainly be aware of that, and…

R Yes.

P But there's a new company that's taken over, so I attended a few of those meetings to see, you know, the new process for that company. Little things like Qudini, we have, like, a queuing system for the patients.

R Yes.

P I brought that in into the… We got two other sites, it was currently only here. I introduced that into the other sites.

R Oh right.

P Yes. IMS, that's the…

00:03:10

R Yes.

P Dentist that we use. We had a consultation before. But in the community we were always using EMIS [?] Web that the GPs use. Have to bring that in over on those two sites. Because it was important that everything was in place before the first of April, because all the staff had to cross site work. And so I am involved in quite a lot of processes and getting things up and running.

R So you're involved in introducing the idea?

P Yes. As well. Yes. So we have meetings about clinical work. I mean it was… EMIS, they were already using it at this site. But to get it to work in the community, so you know, you have to liaise with so… Like IT, and, you know, then you have to do the testing, and then you have to, like, liaise what's wrong, and then coming in the morning so… Because it's about, like, clinic, and you have to do it when there's no clinic. So it was a lot involved. But I like doing things like that, and I like working to deadline, so…

Reference 2 - 6.15% Coverage

P So, I really enjoy that part of the role actually, because then it sees that you, like, got good service, and the service is efficient, because you know we can if we have a deadline to work to. Then I make sure that we definitely meet that deadline.

00:04:33

R But it sounds quite challenging as well.

P Yes, it can be challenging, but then you just have to have your plan. So, like, when I took on this role. And that was two of… One of the most important things that I was told that this need to be rolled out.

R Yes.

P So… Because there was… Having like a lot of, like, problems, so what I did was, I, myself, I started from scratch. I thought, right, let me see what the problems are. So I checked all the… Because it wasn't printing the labels, and they've got for the samples.

R Oh yes.

P So, and I wasn't really used to using IMS, because I was used to using EMIS Web.

R Yes.

00:05:16

P So you know when you get relaxed with just the system that you use. I didn't really like EMIS, oh sorry, IMS. I was a bit in denial, I thought to myself, right, you're in this new role, get yourself… Said my name. Sorry.

R This is going to be deleted.

P Oh, okay.

R Yes.

P So I said, you know, right I need to get my act together, learn this system quick. Because I was given full rights for everything, so I needed to know how to request test results, because I was testing the labels. And that's how I kind of like, it was trial and error, getting used to, you know, using the clinician side of it. I'd already known… Obviously had to do the registration, the reception side of it. But I needed to know the other side of it. So I quickly learnt. And then found out what the problems were, working with IT, printing, doing last minute tests. But that meant running from site to site.

So I'd go to one site in the morning, it was working fine, then go to another site, sending e-mails, yes, that's fine, I'll be good to go live on that day. Making sure all the reception were trained up, because we're moving to another system. Make sure the paperwork was in place. Taking a certain amount of patients for that day, and it… We went live.

00:06:30

And it's like a good feeling to know that you've met the target, because… And also while I was doing that, I was also closing down sites, so you can imagine that the… Well I don't get pressured, and I don't get stressed, and… Or anything like that, because I kind of like thrive on it. Because I like to do things like that. And say show me what we need. It's so funny. We need to do this, and we need to do… We need to do this and we need to do that. And we've got a deadline. So, no, it can be done.

R Okay.

P Yes, so… And it all works well because we went live, the deadline, do all cross site work, because they'd already done the rotas. So, I mean… And thing is as well, everything falls on your shoulders, but then you're still liaising with your managers to see where you are. And then they're feeding back to, like, their managers, because there's a chain isn't there? So… But on the ground level, everything's fine, and they're confident, no problems.

Reference 3 - 3.88% Coverage

The thing is, when… For example, switching from EMIS Web to IMS, something with EMIS Web was… I don't know if you're familiar with that type of system. Well GPs use it.

R No. Right.

P And it was so quick and easy. Just a few clicks, patient's registered. Moving to this system, it was a lot of more clicks, a lot of more ticks. You go into this, you go into that. So, that was a bit challenging, because you think, oh my gosh, you know, from moving from something so simple, to moving to something else that's a bit more difficult. But I… The way that I supported the staff, was I said, it's a change, take your time, we will get used to it. Because they were getting fed up, they were getting frustrated, forgetting where to… That… You know, they hadn't ticked a box. And I said, that's fine, we're all learning. I said we can go back and check over what… If we've missed something.

And then eventually, that perseverance, and they got there. It's just about supporting the team, because it's not good to put something in place, and then leave them to get on with it, or not have somebody there, like, shadowing, or somebody to call on to assist. I think it's important, because what we did was when we went live, I mean obviously, it was fine at this site, because it was already being used. But, we had staff in place to assist everybody, so we had staff in place to assist the nurses, and the doctors, and the admin team, to make it work.

00:11:31

And to also cut the amount of patients that were going to be seen, because we had a go live day, so everybody was prepared. Everybody had a dummy patient that they could play with on the system, to familiarise themselves with it. There was training, you know, because there's no point in having the training, like, months ago and then we're going to go live a couple months later. It needs to be fresh in everybody's mind. So they were doing, like, refreshers. And everybody was quite nervous. But it did go fine.

Reference 4 - 2.92% Coverage

This was to do with opening times. There was a site that was opening at 11 o'clock, and the other sites were open at nine o'clock. So two hours productivity was being lost in the morning, and patients were queuing up. As soon as you open the doors, you had the mad rush. And we were trying to say if that clinic opened a little bit earlier, it would… You know, it would be in line with everything else. But there's always sometimes you have resistance. Didn't affect the… They looked at the rota, staff were already in at that time anyway, but just down to start clinic at 11.

So what we did was, you have first of all staff meetings. And it's, like, discussed, so everybody's aware. And then you have a team of people, like, you call it a little project. And say, right you, I want you to be involved in this project. Again informing the staff what… The department, we're going to start doing a survey for the patients to see what they… Times they prefer. And it came back that they all wanted early.

00:15:21

Collected the data, so that it was clear for the department to see, so to make sure that they're all involved. Everybody has their comments. And even though you will still get somebody who's still not happy, but the overall majority, and the data will speak for itself, because you know, you have to have the proof. And then we say from this day, we're going to go live with the time, the opening times, with the change. So that's the way to address things as well.

Reference 1 - 11.77% Coverage

R Do you have experience of being a part of an evaluation or adoption process?

P I think, a few things. Probably when we moved to [name] clinic, that was a big change, closing down the old clinic and coming here, because the way that we worked completely changed. It changed mostly for the nurses, because our role expanded a lot clinically, and we became a lot more autonomous in our clinical work. So, that was a big change that we went through, which would have been about five years ago, five or six years ago now, and there was about a year of work that led up to that.

So, there was kind of an evaluation during that time, and people sort of asking the nurses, you know, like things that would affect us, what our opinion was on that. I don’t remember it being very formalised, like I don’t think we did feed back specifically, but I think there were a lot of meetings at the time, there was a lot of discussion that went on, it was more informal, it felt. But there was certainly a lot of conversation, because it was a big project.

00:03:25

The other thing probably would be the consultation that happened in 2016, here in the service. I was sort of not specifically a part of that consultation – I was in some respects, but I wasn’t in terms of my job specifically – because at the time, the plan was that once they’d done that consultation there’d be another consultation, which would involve my role, maybe it was only going to involve about 11 people, who were more management, and that ended up not happening.

But during the consultation, it certainly affected us in terms of the hours that we worked, the weekend opening hours, the clinics that we worked in, and that was when we were going to become properly one merged service. So, there was lots of kind of formal evaluation in that process. I feel like, for me, that didn’t really… because it wasn’t specifically my job that was at risk, and I wasn’t interviewing for my role, which other teams were, and because it was expected that we were going to have our own consultation, I was sort of outside of it.

So, even though actually a lot of things affected me, I wasn’t actually properly consulted. So, my weekend hours changed, but I wasn’t actually ever consulted about having my hours changed, which I think technically I should have been. And if I’d been very awkward, I probably could have refused to change my working hours on a Sunday, because nobody ever consulted me about changing my working hours on a Sunday. It was just expected that, as a sister, obviously you’re helping to lead the change, you’re just going to do it, but it wasn’t actually ever put to me like that, ever.

00:05:10

So, I thought like there was more of an expectation that I would just obviously go along with it, because of my role, you know. But yes, there were a lot of team meetings then, a lot of communication via email, there was a folder of communication and information that you could access. So yes, I think they’re probably the two biggest things that I can think of, in terms of evaluating the service, and things changing a lot.

Reference 2 - 0.30% Coverage

R Are you ever a part of a business case writing?

P I have not been yet, no.

Reference 1 - 6.34% Coverage

R Yes. And have you been involved in any changes to care? Implementing new ideas in terms of how care is being provided, it doesn't have to be around point-of-care testing. Was there anything new that's been implemented that you were witnessing perhaps or even that you were involved in?

P The only thing I can recollect is actually I was working in the public health side a while ago and I was sitting on the commissioner’s side of the sexual health. Yes, so I think I have seen dramatic changes because of the changes to the funding distribution, and then everyone is going now to tender and then new services are coming up, and looking at the service specifications and things like that… There was lot of new things coming up from different providers.

So that is the only time I can actually… I have not been involved with any of this laboratory stuff, but it's like changing the services basically. So I have done most of the service health needs assessments and then suggest service changes required. And I think the integration is a new thing for sexual health because earlier the sexual health and the contraception was two separate services, isn’t it? So they’re amalgamated and I don't know whether it’s relevant to what you're talking about.

Reference 1 - 2.77% Coverage

R With regards to adopting new technologies, what is your role in that process? How would you describe that?

P My role would be to oversee the whole project in terms of implementing it and making sure that during the clinical trials, it’s run within the established protocols, and also to make sure that there is adequate supervision and supporting any queries regarding that particular study and also being like a link between the sponsor and ourselves, what I mean the study, whatever issue it wants to resolve. And also help in formulating policies that once we started at least with a clear understanding on what needs to be done at what stage. So it’s making sure that everyone understands this protocol.

Reference 2 - 7.45% Coverage

P The experience I’ve had is when I started working in this particular service we were initially not using, what you call, a NAAT test, PCR test, specially for infections like gonorrhoea. So when I joined the service I did work very closely with our local microbiology to be able to adopt a NAAT test, PCR test for testing for gonorrhoea. And we worked on a protocol of making sure that the system was robust enough to be able to provide a safe and reliable result and be able to manage it.

00:04:07

So that saw us transition from our previous service where we were only offering culture and microscopy, to a step whereby we were able to now start offering both PCR and a culture for gonorrhoea testing. So that was more like a study but it was a lot about adopting a new way of testing for a particular pathogen, in this particular case gonorrhoea within our service and also developing care pathways to address any sort of issues and making sure that there’s governance [unclear] within the whole new system.

That’s basically the role I’ve played in sort of a near similar scenario whereby we are having a new sort of a platform for testing of patients within the service and seeing how we can adopt it for our service and I’ve seen it developed [unclear] by now it’s become part of our standard of care in our testing.

R That sounds like a big change because it also involved coming up with new pathways...

P Yes.

R So that affected probably everyone?

P Yes. So, of course, it has to involve training, it has to involve working closely with the microbiology department and also with regards to patient care pathways and making sure that the system is robust to be able to generate reliable results. So it was a multidisciplinary work, especially together with the microbiology department once we had a strong business case for it and why it was important and can be able roll it safely and successfully.

Reference 1 - 3.44% Coverage

R Let’s go back for a second to the example, because you said that you recently introduced a home testing system. What was your role in that? Were you overseeing it, was it you who introduced that to the service?

00:08:39

P We actually started working with a company before we won the contract to develop a self-testing platform, and that was back in, oh, probably the end of 2014. We were always looking to develop online services. It just so happened that we worked with a subcontractor, because we weren’t as far as developed as they were. We recognised the need.

And always within our model of service was the idea of, if we could get somebody to do it themselves safely and appropriately, then we should be making that happen, and technology was a way we could do that, technology in terms of the sampling technology which was already there, but also using the Internet to record information and allow us to process the information in a way that sorted people out, who were appropriate and who weren’t appropriate for self-management.

Reference 1 - 6.78% Coverage

R So what is your role when it comes to adopting new technologies? Are you a part of that?

P Yes. Ultimately if it’s on a service and even across the whole of the [name] Sexual Health Service then yes, that would be part of it to ensure that it’s rolled out across the team that we’ve got here and staff. Or if it was something just local to us, then that would be for me to decide whereas we were going to adopt it and then if we are to roll it out and to support everybody and promote, ensure that we’re all doing it.

R And do you find it challenging?

P It depends. I’ve got clinical background so it depends on what we’re doing. My IT skills probably aren’t the same as somebody who’s got an IT background but I’m prepared to give it all a good go, give anything a go and stuff and some of this clear pathways that go with it, then we’ll give things a try. Some of it are going to be of benefit to patients or just speed up processes then we’re prepared to give things a go.

00:03:29

It’s a recent thing but we got a label print which is a very small step, but for the clinic it was a very big step because we were having to hand write labels. But we’ve got them installed, then a little bit temperamental but we’ve got there in the end and it speeded up the process and obviously for quality and stuff it’s definitely a lot better.

Reference 1 - 3.54% Coverage

P I mean, I've been working as a consultant for over 20 years, so yes, I've done quite a lot of evaluation of new technologies. And, for example, in [location], where I was previously evaluated, nucleic acid, when they were first introduced initially for Chlamydia and then for gonorrhoea, and then the triple NAATs for TV as well, which we've published on all three of those. The most recent one was the evaluation of the TV NAAT there.

00:02:28

And then we've just recently here done an evaluation of the BD Vaginal Panel, which is the first UK service evaluation of that, which we're just analysing the results now, which was the triple NAATs for candida, BV, and TV. And then we'll look at it. So I'd say we've just done... well, we say, it's the first UK evaluation of that. We then look at what its place, if any, is in sexual health services.

Reference 1 - 5.50% Coverage

P The, we have, we do have a point-of-care test that we use, which is the HIV point-of-care test, so that we rolled out last year. It wasn’t sort of a formal adoption process really, because this is something that’s been around for quite a long time and lots of clinics used it. And I used it at my previous trust before I came here, as did all of the other consultants as well.

So in terms of that, that wasn’t really a formal adoption thing that we went through. We really needed an SOP for the test, and that was about it, about proving the test to be used, rather than anything else.

R Were you in training for this?

P Yes, so that also happened. They came to each site once just to go through how to use the test. Because a lot of us have been using them or had been using them for a long time, it wasn’t really a major issue at all.

R Right. So did you have a specific role in that process? Were you training, for example, other members of your staff?

00:02:34

P Yes. So in… Yes. Because I had used it before and then those who had missed out on the training as well. Yes. A lot of us are encouraged to use and then I help them use the test as well, to show them how you use it, so, yes.

R How long was that ago?

P It was probably about a year ago or maybe a year and… I think we put it out… Yes, probably January last year actually.

R So recently?

P Yes, fairly recently, yes, that we brought that out. Yes. It was some time last year. I can’t remember when exactly. Yes.

Reference 2 - 4.60% Coverage

And do you have any experience of being a part of service evaluation within NHS?

P Not formally, no.

R Not formally.

P No.

R And informally?

P I guess you sort of get… You’re going through the process as being part of it with everybody else. Yes, so, yes, we did… I used to work at Imperial, so there’s lots of bits that we had to evaluate anyway, but it was all very informally in terms of internally rather than an external thing that happened. And always, you know, using or auditing our services and making sure that it’s all better, so not done formally for that.

00:05:00

R So it’s kind of, it was always continuous alongside everything else?

P Yes. And we still sort of do that here, just to make sure that our service is running as sufficiently as it can be. Yes, so we do have our… Every six weeks we have a meeting called service delivery meetings, which obviously I attend. And again we are always constantly reviewing our service as a whole during that meeting anyway.

We each go through how much money we spend, how much money we’ve got coming in, how much drugs are costing, so all of that gets reviewed there. As I said, it’s all an internal thing that our unit does, and that happens every six weeks.

R Ongoing?

P Yes.

Reference 1 - 5.67% Coverage

R And do you have any experience of being a part of the process of adopting new technologies within the NHS or being a part of service evaluations?

00:01:36

P I have, but I cannot remember when. It's been a while. I have, but I cannot really remember when. I think the first one that I did take part was the HIV point-of-care test.

R Was it here?

P No, it was at another trust.

R Right.

P I haven't done anything here apart from probably changing the way we work from using paper notes to electronic notes. So I thought there was a difference in using technology to all the tests. So that, I have done here. So the transition of writing requests for the lab on a form to requesting online on the system.

R Was it a huge change to...

P It was. It was. Because, previously, we would send a request in paper form, but now, we would send a request online.

R Just click it.

00:02:50

P Yes. So I would say in terms of something different to practice that I have done here was that changing from paper to request tests online.

R And was it a smooth process?

P Well, interesting. I like that. I would love it to be smooth, but no, not really, a little bit of hiccups but, otherwise, okay.

Reference 2 - 2.23% Coverage

P I think when it comes to evaluation, everyone is involved. It might not be all coming together at once, but it might be various teams getting feedback from various people. So, say, if we start using a new system, say, a clinic, then I'll be responsible for getting feedback from the nursing team and then bring it forward. So whether it's good or bad, I will have to say based on what my team has said. So I think when it comes to evaluation, everyone's input is valid.

Reference 3 - 1.72% Coverage

P I've never been involved in writing a business case. I joined this trust in July last year, so I haven't really participating in any of that. So I've never been involved.

R And do you know who would be involved here if there was a business case needed?

P I'm not sure who would write it. Probably my line manager would know, but I'm not sure at the moment.

Reference 4 - 7.94% Coverage

R And do you try and then maybe change how others feel about or you just leave them to see for themselves?

P To be honest, that is part of my day-to-day work. Yes.

R That's challenging.

P It is, it is. But that's part of my work, I find. Because things are changing a lot even within our service. So I just feel like if I don't embrace it, how am I going to motivate my team towards what we think would be the best way of working? So yes, that is part of my day-to-day work.

R So you're the example to...

P I wouldn't say it that way, but yes, I try my best to be. Yes.

R But you know what I'm thinking, that if you're embracing this new technology, then the nurses that you work with are more likely to also follow you.

00:15:46

P I think so. I think so. But it's not easy. It's a challenge. Yes, it's a challenge. Because even with these simple ways of working, it's always hard to introduce something new. But if that something new comes with an incentive of, say, getting results quicker, then I find it's easier for people to say, oh, so we are benefitting from this. So, probably, my day-to-day way of looking at it would be analyse something new that's coming up and highlighting the benefits of why it's done against the negatives.

Because there would be negatives, there would be. Probably, people would need to go on training or people would need to change the way they work. So it's things like that. But focusing on the benefits, sometimes emphasizing on why we are introducing the change in the first place, I find, works better. But you always get, oh, you see, it's not working. When you hit a problem you get, see, this is it, it's not working. But, yes.

Reference 1 - 11.57% Coverage

I'd be the one who would teach the other members of staff how to use something. Give them their reassurance, because a lot of new changes can cause a bit of anxiety within the team, and just support them through using the new technologies.

R Right, so that, again, it's a teaching responsibility.

P Yes, and supporting. Leadership, I suppose.

R Yes. And could you talk to me a bit more about your experience of adoption processes within the NHS? So like service evaluations and being a part of meetings where decisions are being made.

P Okay. So I suppose we could look right back to when I worked in A&E and I was a deputy sister in A&E. And so there was lots of changes going on in departments with targets, making decisions, using new technologies as [unclear] goes along. And so I started then. But within sexual health, the most recent ones, I suppose, is us starting on Ordercom. So that's asking for tests via an order process on the computer, which is very new to us. And so I've been able to help implement that and support the other members of staff in using it, because it's something that we hadn't been used to doing. And so change is, as I said, can be quite different.

00:03:06

R And how did it go in the end?

P Yes, it's going okay now. A few glitches to start with, but everyone takes to technology differently. Sometimes, some need more support than others with it.

R So the glitches could… you know, it was possible to provide easy solution?

P Yes. A lot of it is just lack of confidence with the technology, not using it as frequently or as often as some people, and so it's just gaining their confidence in it.

Reference 2 - 0.96% Coverage

R Right. And were you ever a part of the service evaluation of a technology that was not adopted in the end.

P No, I haven't been, no.

Reference 1 - 3.59% Coverage

R What was your role in those processes of adoption?

P My role, obviously, is commissioning research to get better value for money. Also, with the technicalities behind it I’m responsible for making sure that the patient group direction for treatment is in place, such as, azithromycin treatment for chlamydia. We have a patient group direction with our community pharmacies to enable them to deliver and also get paid for doing that work. And also, making sure that the pathways are in place and communicated, etcetera, in the best way that patients know.

00:07:28

But I facilitate all of that, especially around the payment and the PGD element.

Reference 2 - 4.99% Coverage

R Would you be able to identify the structures that are already in place that are supporting adoption of new technologies? You’re describing those collaborative processes.

P I think, across the STP… Has anyone talked to you about the STP, Sustainable Transformation Partnership?

R No.

P Maybe go and have a look at the STP for this area. There is a whole element about new technology. If we come up and say, actually, this sits with STP design, etcetera. I also work very closely with my colleagues in [clinic] and [clinic] and [clinic] too.

00:12:13

R So, there is a specific programme design?

P Yes. And actually, you would look for the STP.

R And these are the main things that help?

P Yes, I would be working towards that. And obviously if we decided something individually, I would then obviously, like you say, make a business case and take that to our senior management team here for a yes or a no [unclear].

Reference 1 - 3.47% Coverage

R And what is your role within the adoption process?

P If somebody comes up with an idea, in terms of a new idea and using that, then my role would be to look at the evidence to support implementing a new practice or a new way of delivering patient care. It may be me that comes up with the idea of let’s do something differently, let’s try this or I might have picked up some information from other colleagues or at a conference, or maybe the other people come up with something. My role would be to make sure that the evidence based for implementing a change is robust and that it goes through the appropriate authorities within the hospital, within the trust, to be able to implement a new way of delivering patient care.

Reference 2 - 2.55% Coverage

My responsibility will be making sure that I’ve got all that information first, so that it makes sense to the rest of the team. Remember, there’s a varying level of experience, knowledge and responsibility. Some people are going to go okay, we do whatever we’re told, and others are going to be saying tell me a bit more about that, what’s the science behind this, what’s the motivation for doing this differently, why are we doing this? My responsibility is making sure other people understand and other people are signed-up to it.

Reference 1 - 2.96% Coverage

R And when it comes to adoption process or a service evaluation, what is your role within that?

P I don’t have any budget. So, although we may have a discussion about it and your views will be taken into account, but when the service manager received the email from you and showed it to me… Actually, I don’t know if you’d be interested in it, or do you want to talk about it? So I know that the thoughts are valued with what will be said. But there’s no monetary value with what I can do.

R So it’s about providing feedback about how those technologies…?

P Yes. And I think also… My degree is in public health, health education, health promotion. So I’m grateful that my line manager does see that as a good thing to use. I’m aware of costs. I look at things differently than a clinician. I’m not a clinician. So I do look at things very differently. And the bigger picture. How is sex… The Public Health themselves, and the cost to the public.

Reference 2 - 8.18% Coverage

I have to the point. When I took on my role 11 years ago I took it on working with the community screening program. I knew from Day 1, at interview, because it was going to be working in the community, I needed to know more about sexual health. I was coming from an education background. So I needed to know more about sexual health, so that I could make sure that they weren’t just peeing in a pot. But actually they would have questions that they needed answering. And I felt very duty-bound to be able to answer those questions and get them the correct report, and make sure they were testing for the correct things.

And guiding them in that way. And promoting good health. In whatever sense that was. That wasn’t just to do with sexual health, but you can use the opportunity for so many other things. Like smoking and alcohol. It’s important you do that, but… When we started, we then… I went on to a training course because that’s what I wanted to do. And I met the people that run the company Freetest.me. We didn’t have it here at the time. They were very new back then. I think this was about nine, ten years ago. Preventex I think it’s called nationally.

00:09:47

And brought that idea back here. I also wanted to bring back the idea of the vending machine because I thought that was great. Just because of the way our population is again on the island, that was too expensive, the vending machine. But the Freetest.me really was a win-win for us. People could be anywhere on the island and they could access this testing. So we took it on board, and we’ve been using it ever since. We’re pushing it more and more now. I’ve moved out of Public Health, and I now sit in Sexual Health, doing the job that I do.

But we are still very much running the Freetest.me as part of our enhancing of our service. And it’s very good. But I know that there are other ways. Now we did about 4.5 years ago, we did have… I can’t remember the rep’s company, but we had a rep come around with a cartridge. I think it might have been to do with placentae. They had a cartridge machine, just showing what it was basically. And it was amazing. And they were saying that it could do all of them, basically your routine testing. And it was a no-brainer in my eyes, and some other people’s eyes. To have something like this in-clinic.

00:11:18

And I think the unit was a couple of thousand pounds, which, out of our budget, is a large amount. But the actual technology to have it there was brilliant. To know that this was no available to people, and you could see how beneficial this would be. But, sadly, we couldn’t do that.

Reference 1 - 2.53% Coverage

I liaise with the consultants if… and we review the tests we use, the samples we test, to make sure that the service performs as it should.

I’m responsible for our accreditation but I have a quality officer who does the bulk of the work. I’m responsible for health and safety within the department and I’m responsible for our financial budget. So I’m the one who makes decisions about what equipment we buy, what consumables we buy, if we’re going to change our methodology, all that sort of thing.

Reference 2 - 2.44% Coverage

R Right. How would you describe your role when it comes to introducing new technologies? Is it about assessing them?

P It’s the whole thing. So we will make an investment if we need to change something and we will look at what technology is available. So what do we want to change? How do we want to do that test? We will assess what technology is available and depending on what kind of thing we’re implementing, we will then go to procurement and say this is what we want to do.

Reference 3 - 7.11% Coverage

So we’ll draw up a specification for what we want and we get them to go out and test the market for us to look at what companies are out there who can provide equipment that does what we want it to do.

And I will then put a business case together so it will have the reasons why we want to implement the change; what the change is; what the impact will be clinically; what the impact will be in terms of service delivery; who would be affected by that change; and then finance draw up the financial side in conjunction with procurement. And we then go to the Trust and we request the money and if it’s successful we will then go through the procurement process.

So, depending how much it is, if it’s a very expensive piece of equipment they will look to see how many companies there are who could provide that equipment and then we go through a procurement process of how we would score them and how we would ultimately make the decision about which one we’re going to go with.

R Right. So it’s checking all angles?

P Yes.

R And making sure that the technology is the best for [overtalking].

P It’s fit for purpose, yes. And obviously it’s got to be good value for money as well.

R I see. How long have you been in that role for?

P 17 years.

00:03:59

R And that was… that’s been always the same Trust?

P Yes. I’ve worked in a similar role other Trusts before that but I’ve been here for 17 years.

Reference 1 - 4.13% Coverage

R Yes, so let’s say that, I don’t know if you’ve already had an experience of going through the adoption process within that clinic.

P No, not within this clinic, no. I mean, I think what would happen is we would, we’d certainly, there’s five consultants in the clinic, so that would include me as clinical governance lead, the research lead, the clinical lead, and we would certainly be involved in that process along with our lab colleagues, and other colleagues as part of that. But I’m not sure what the process would involve, because I’ve not been involved in anything like that up here.

R And previously, did you take part in any adoption processes, service evaluations…

00:04:18

P Yes, my previous job I was training as a registrar, so I had no direct responsibilities. But I was part of service evaluations, looking at, we did a Roche study for a new herpes test, comparing it to our in-house PCR, basically. So I was part of the, I was one of the lead supervisors for that study. And I recruited patients for that, and supervised one of our research students who was conducting our study. I think that’s it when it comes to adoption.

We did, when I was in [clinic], we also did a service evaluation looking at how long patients were prepared to wait for point-of-care test results, but that was based on a 90-minute point-of-care test. That was the number of, that would have been a few years ago, where the only thing on the market was 90 minutes.

Reference 2 - 2.48% Coverage

P I think it’s more about trying to integrate it into the common clinical practice. So, for example, for the herpes test, we had to run additional swabs alongside our standard, so it was about making sure that that wasn’t being missed by staff. Obviously in GU clinics, we had large numbers of different staff, nurse, practitioners, doctors, seeing patients. And it was about finding ways to make sure that all the patients had the additional swabs for that.

So we ended up packaging the swabs together so you couldn’t pick up a standard swab without also picking up the research study swab. They came together. And that helped. So it was more about introducing it as routine. But actually, the study itself ran easily and the patients agreed to the additional test. I don’t think we had any refusal that which, you know, was just an ulcer swab, so it’s very straightforward.

Reference 3 - 2.04% Coverage

So the challenges were all really about getting staff to remember to conduct the double test. And it was just about finding ways to do that. So we packaged the swabs together and then we had, certainly when we started the study, we had quite careful… So we would pull all the codes, so people with herpes, and check that to make sure everyone had been included in the study, and those that hadn’t, we contacted the staff members. And we did this on a weekly basis to really keep it in everybody’s mind.

I guess it depends on whether additional tests are required or whether you can use some of the standard tests. But I mean, it ran well. It was, we managed it in a few months. It was fast and successfully performed.

Reference 4 - 2.65% Coverage

Yes, they can, but I don’t think it needs to be a significant barrier. I guess if you’re taking additional swabs you obviously have to discuss that with patients, and then depending on how the study is conducted, sometimes you might need, you know, consent for that. It depends a bit on how you’re doing it. It’s obviously a bit different to doing a clinical evaluation. What we were doing was a research study, so we had to get written consent from patients and go through the formal consent process.

00:08:13

And that definitely added to the workload. But if you’re doing it as a service evaluation, I don’t think it’s a significant, there’ll be a small increase to workload, but it really depends on how, what the additional test involves. I think it’s more about getting staff on board as an early start so they appreciate the importance of what you’re doing, so that they prioritise it happening along with standard clinical care.

Reference 1 - 4.38% Coverage

And do you have an experience of the adoption process within the NHS, service evaluation as well?

P So, yes, so, I’ve been a consultant a long time now, so… and probably in terms of technology, we’ve done a few things really, going right the way back to probably 2012, we implemented, when I was a consultant elsewhere, but it’s still NHS, we implemented full electronic patient records, so that was probably a big… that was a big implementation process from a… from being paperless.

00:03:06

Most recently, what have we done? We’ve implemented a… we didn’t take over, but we acquired the contract for an HIV service remote from the main hospital site in [location]. So, a lot of implementation is actually getting the IT to work and getting remote links and things which perhaps have been somewhat problematic.

So, that would be another kind of implementation process for quite a big change in the service. And then in between, lots of little things, really. So, texting, setting up automatic results text messaging, emailing patients projects, online booking, those types of things. So, sort of little things compared to the bigger things I’ve mentioned.

Reference 1 - 15.35% Coverage

R So what would be your role in the adoption process? So, for example, when you mentioned that SH:24,,,?

00:01:00

P When it came in?

R Yes. What was your role?

P My role is actually, basically selling it to the patients that come in, to say this is the best way forward. It’s a good, new service, and how wonderful, how quick the service is. It was just so… We had to be that good selling point to get the patients to do it. And the advantage of working this way… And we thought it wouldn’t have taken off, but it went from down here straight up. Because it was a quick turnaround and had quick results. Was sent to the patients by text on their phone. So I think that once we know what we have to do and how it helps the patient, we can work with any new product.

But we’ve got to know the ins and outs, teething problems. But the best selling point to get a service across… Yes, I’m all for changes if it makes life easier and convenient for the patient, because I think the basic thing with the patient is the long waiting time to be seen. And if we can persuade them that this is the best way forward and, if it’s something that they’re here for, and how quick it can be rolled out and how quick they can get their results, I’m sure it would take off.

R Right. And how did it go with SH:24? With convincing patients that that’s an improvement?

00:02:37

P It went very well. Very well. Within the first week, we thought we may do… Saying there’d be ten a week, I think we saw like 10, 20 per day per section. Recently changed over from SH:24 to Preventx. We’re still persuading patients that it’s just as good as the previous SH:24 and it just worked just as well. Then we haven’t had any negative feedback from the patients. And once they’ve done it on their mobile smartphones, and they see how quick and easy it is, they’re happy with it. So, I think once we know, as reception staff, the selling points to the patient, we can sort of roll it out to them. And I believe it’s something that works, why not roll it out? I do believe in that technology. Yes, I’m all for technology.

Reference 2 - 5.38% Coverage

P From the reception point of view, we give feedback if we’ve got teething problems, if it’s re-occurring problems. We give feedbacks to say… We’re front line. We’re the ones that act on patients, so we have to give feedbacks, and we make a list of things, teething … Anything that’s new, always there’s teething problems, so we have to give feedback. It gets signed out, anything that’s over us, once we know what the problems are, and it gets handled. Like the Preventx, the service teams, we just email them every time there’s a query from a patient.

For example, it wasn’t accepting patients from [name] area, even though on the board are all from [name] area, but it wouldn’t accept them because of their post code. So, it’s little teething problems. We just to have to put the patient through to CESOL because they usually come under [name] area which is not part of Preventx. London-wide scheme, so… Things like that, but we always get around it. How we can deal with a situation which is not an inconvenience to the patient.

Reference 3 - 5.23% Coverage

P I haven’t come across anything that we rolled out that has been to say we’re not doing it anymore. The only thing we had was SH:24, but then we moved to a different company that was agreed, that was in the pipeline, but it wasn’t up and running at the time. That’s why we used SH:24, but now we use Preventx, which is London-wide. So that was the new technology that came in recently. I haven’t come across any barriers of new technology being rolled out to our ground that’s been taken away from us.

R Okay, so once it’s here…

P It’s here, yes. We may just move to a different company, but it’s best if we do the same thing.

R And does it involve a lot of work? Does it take a lot of work to actually get it running, or does it tend to be smooth? The process?

P Once we know what we’re doing, it is smooth running. It has to be very… Because the way the clinic is, it has to be convenient for us, being the reception staff, being in the front line, and how we offer it to the patients.

Reference 1 - 4.76% Coverage

P I’m essentially, if we’re going to be adopting a new policy or... sorry, a new kit or a new set of guidelines etc we have to... My role would be to review the evidence and also to just see how does the kit work, what other services have used it, how this worked with the other services. And basically look to see how it would fit in within our service because obviously different services are different. It could be doing really well in a service where they see 10 people but absolutely collapse in a service where you see 40 people.

So, you’ve got to be aware of actually where was this study done and evaluate all the evidence that has been given to you. So, that would be my role I would look at the evidence and I would think, okay, this is a good idea and then I would put it forward within the senior management team. That would include the other consultants of the Trust rather within our department.

But also our business manager and general manager and service manager because they’re obviously going to be involved in terms of cost, in terms of how we can we adopt the product and in terms of how it can fit in with our service. So, it would probably be more in the preliminary stages that I would probably get involved as well as with my other consultant colleagues. And then also, you know, finding out how other people have found the product etc and how they’ve used it.

Reference 1 - 2.97% Coverage

P So if we, all of our opinions are respected, so if we found something and we proposed it, we could always have a role within that. So I know the most recent thing, no, I can’t even think now. So we do, if we did need to change anything, like we’ve recently taken on the online testing, the Pan-London online testing, we all had a role in getting the training, the posters, how we advertise it. That was something that we’ve recently changed.

Since I’ve changed I’ve made them, I’ve expressed my concerns about certain things, and things have been changed after that, such as the storage of liquid nitrogen and things. Because I’ve worked in a clinic where it had to be outside and here it was inside and… But with the right oxygen meters and everything else. So it was just about raising concerns and then acting on them and following up, at the moment.

Reference 2 - 6.24% Coverage

P So a lot of it was already decided by commissioners and then we didn’t get, the posters were designed by the trustees hosting the service. And we just had to put them in place. We did have some training about it, so we knew. And I was doing the course at the time, so when our previous provider, I actually went and spent a day with them to see what they did at the other end as well.

And that was something I’d organised myself, I don’t know if anyone else did that. Just to see what actually happened when they got a positive result, how they actioned it and what they did with it and what they followed up. And that’s something I did for myself because of a course I was doing.

R Right. So you can also take initiative and try and be a part of something even more, then it’s effective maybe

P Yes. Because if you know, if you express and interest they will jump, which is good, because if you have an interest in something they will jump on you and get you to do some work towards that. Such as when we wanted a new microscope. Then I was looking at models and brands and putting in my input there because I was one of the more senior microscopists.

00:04:00

And when we think about changing our EPR, because I’ve worked with three other systems before, my opinions have been taken into account. So I think if you know enough and you do use your initiative, they will use it.

R Right. And that, when we say they will use it, it’s clinical leads or commissioners?

P So it would be the matrons, the lead nurse, the lead consultants and the people involved in that. So, the higher up nurses as well.

R Right.

P So they do look at that and think, who can, not who can we get to do the work, but who’s got an interest enough to do the work properly, to make it a bit more evenly distributed.

Reference 1 - 20.63% Coverage

R Right, so did you have part in adopting that?

P Just a small bit really about how it’s going to run in the clinic. And at the moment we’re also looking at a department of education and compliance for patients that come in to the [name] clinic having had an online testing kit done. Because we don’t have a pathway for that at the moment. So that’s just a thing that we just need to consider. Just to make sure that they’ve completed the treatment and haven’t had any problems with the treatment and haven’t had sex and that kind of thing.

So we have, when we have results that come in, that we do here, we have a point of reference to contact patients. But when they’re done through Sexual Health London, we don’t have that result to trigger the partner notification compliance. So we’re looking at a pathway to do that.

R Right.

P That’s another thing.

R Yes, so what is your role in the adoption process or what your role was in those adoption processes that you been through in…

P What’s my role…

R Previously, in adoption process of a new technology or new pathway…

00:02:42

P I think it’s been meeting with the providers and looking at how the setup would work physically, with where we’re going to put, because previously we used Preventx, which was using a computer to log in. So it’s looking at the physicality of where we’re going to do it, how we’re going to issue packs, what’s the process for when they return to the clinic with a positive result, how would we process that. It’s slightly different with Sexual Health London, because people do it on their own devices.

So the physicality part of that has changed, but it’s, you know the packs where we’re going to… There’s physical procedures that need to be in place to do that. Yes, I mean, previously we used INSTI kits for HIV and syphilis and then they’ve been looking at how do we ensure the quality control on that, do we make sure quality control’s done with each batch?

That’s going to be an issues with point-of-care testing, I think, because I’ve used point-of-care testing previously with cholesterol testing. So, this was in another role. I’ve set up the monthly quality control for that within GP practices. So I presume there’ll be some issue with doing quality control on point-of-care testing, which obviously takes time. Needs to be monitored. People need to know what to do if there’s an issue with quality control, that kind of thing. I don’t know if that’s information that you want to know.

00:04:16

R Oh no, that’s great. So potentially you would be the person involved in that process.

P I might be, I don’t know. I’m not going to volunteer, necessarily. But I think having had some experience in that before, I kind of know that’s where the difficulties can lie with making sure that… I mean, with cholesterol testing you’ll send a sample of a range of cholesterol HDL levels, things like that. So, you’ll send that with, every month, to test. Whether that’ll be the same with machines that they use for chlamydia and gonorrhoea, I don’t know.

I don’t know how the quality control will be done, but I know usually, with point-of-care testing, in order to be equal to a lab testing, there’s got to be some quality control in the machines that you’re using. So, I imagine that there will have to be some process in place to do that, which can be time-consuming. You’ve got to make sure people know where to record the information, what to do with the information, to make sure that it’s being done each month.

So that would be a process of setting that up, I would imagine. But I don’t know if this is being used. Is it being used already? No. Okay. So, that’s, it’s quite nice if it’s already being used in the area and you can see what they’re doing, but obviously that’s something that will have to be developed then for introduction. But, then you have the issue of who pays for that. Who pays for quality control. So there are issues with that as well.

But I think part of that is, one, knowing that your machines are working to a certain level that you can reassure your clients that coming in that that test you’re doing with them at that time is the equivalent to one that they’re doing in a lab. Because sometimes when people come in with the online testing, we say, you can have it done online. They’re a bit concerned that that test isn’t going to be as good as the one we send to the lab. So, that might be a barrier to people doing it.

Reference 1 - 3.31% Coverage

PA Yes, I mean I'm just one of the nurses that will get the training and then help to implement it. We've had lots of changes, we always have lots of changes, we have the computer system, we have lots of different things around prescribing. We've not got Preventx so we have lots of new ways of working which we're constantly being told to adapt to. And my role will be to learn and then support the other staff to do it.

00:01:54

RE Right.

Reference 1 - 5.54% Coverage

R Do you play a part in service evaluation or adoption processes within the clinic?

P Not so much within the clinic, I do in the main bacteriology lab. So I’ve implemented one of the machines which is the Mast Uri System, which is a semi-automated way of reading the urine cultures. I haven’t been involved in implementing anything within the GUM laboratory, that would be the Point to Care manager for [name] clinic.

00:01:49

They would liaise with the consultant there and introduce new technologies within the location. And like I said previously, they would perform all the validation, verification exercises which should be involved and I’d help out with that and be directed by the manager.

Reference 2 - 4.94% Coverage

So I think you’re probably best speaking with her first to see how we go about doing this. Because we’ll have to run tests side by side and then you’ll have to go and get, you’re aware of all this, you’ve done all this previously. You’ll have to go and pay because you may need possibly two swabs.

00:06:34

The urine wouldn’t be a problem, would it, because that would just be one part so we could then test it on this Point to Care and the same urine can go up to the virology lab for the lab test. But with swabs, you’d have to ask the patients permission but the clinic lead has gone through this already with you?

Reference 1 - 1.97% Coverage

The point of care testing, I suppose, from my perspective, would be from a theoretical one. It’s also about re-designing patient pathways, looking at how we can do things more efficiently, how we can actually use some of the technologies that are out there to take services out to patients.

My role, I suppose, is a little bit different from your average lead nurse, if there is such a thing.

Reference 2 - 7.07% Coverage

P Yes, I’ve worked for Sexual Health for many years, but 20 years ago I was the commissioner for the service I’m now providing. From that I set up what was the Sexual Health Network, I was the director of that. In that role I worked with the commissioners but, also, with clinical leads from all aspects of Sexual Health to look at patient pathways, what was new, what was going on, what we could learn from elsewhere and how we’d actually bring that home and try out in our own clinics.

So it is quite a strategic post but it was all about getting things better for patients, but, also, tightening up on communication, you name it, with the people I was working with as well. When I first came into post in that role we had a lot of single handed consultants that were quite isolated and a lot of nurses that were too. Part of the role of that was to bring them in and keep them updated, keep them contributing and that side of things.

00:05:17

I’ve worked in Sexual Health in probably very different ways, an prior to all of that I was a the Sexual Health Promotion Lead as well, so trying to make sure that we got services to those that needed it the most, so targeting the most vulnerable groups. Part of that, even at the early stages, would be how we could take clinic services out of the hospital settings into more community settings. I come from it with a lot of experience, just different experience, I suppose.

Reference 1 - 4.85% Coverage

P I mean, I’m not a decision maker in that respect. However, my... I was the lead nurse for the service up until three years ago. So, at that point I was very involved in those decisions. However, I chose that I wanted to come back to my clinical roots.

So, obviously I’ve had that authority previously but now if I’m ever asked for my input I’m more than willing to actually participate with that. I take the lead... I’m just in the process of writing a PGD. So, I take the lead in writing patient group directions for medicines. So, I have some authority with regards to that but if I’m asked to participate and for my views I’m more than happy to do that.

00:06:12

R Right, so, you have an experience of that but you’re not necessarily key decision maker at the moment in your current role?

P Yes, that’s right, yes.

Reference 2 - 3.25% Coverage

P Absolutely, absolutely, you know, and I’m, you know, I am a person who sees the glass always half full rather than half empty. You know, so, I do try in any situations where there’s negative I try and pull it round to the positives. So, you know, so, if I hear discussions like that I’ll, you know, sit back listen and then give my view point so people can see both sides of the equation. You know, so, I wouldn’t sit back and just let people moan about it, you know. So, but then again I wouldn’t shoot them down either because that’s their opinion.

Personal motivation

Reference 1 - 1.53% Coverage

So there's lots with digital healthcare that we could do, which can make it more efficient and basically make it more patient-centred but not dependent on the service but actually to empower patients to look after themselves. So when you talk about service evaluations, as part of NHS clinic, what we are expected to do is to review how we run our services against national standards of care and make sure that we are meeting the standards.

But actually, we want to do more than that, so we've moved away from what we used to do as audits, which is kind of saying, how do you do next to a national standard. We actually say, how can we give the best care that we can and making sure that we are above the minimum standard? So rather than aspiring to the national standards, we want to say, we want to outperform those and basically have a service that is sustainable.

Reference 2 - 0.28% Coverage

There's a lot of exciting things go through research. You see papers about all these exciting tests, but you never see them available to you to use in clinic.

Reference 3 - 0.62% Coverage

That's a service people would want to go to. And that's what you want to be. You want to be the best.

00:20:02

People don't want to be just working in a place that's okay. They want to work in a place that's the best. And the best places are able to use the best tools. And I think that the ability to implement new technologies would be the best.

Reference 4 - 2.41% Coverage

And it's one of the things that I look at my role, which puts in together quality improvement and research, is that you can actually bring the two together and then have this culture of evaluation. Because if you can evaluate yourself and show that you are good at evaluating yourself, you know that you can be trusted to make changes because you get to measure it. You'll know very early on that the things are going the way you expect them to go or not.

And you have the ability to assess whether you need to change your intervention, you need to go to something different, or just make some tweaks, saying, oh, this is not going because of this, so we factor that in. And then you can actually have a fully-fledged plan that you can implement, and then you make the jobs for your staff more interesting. It's actually more stressful because it involves a lot of change.

But once you get changes really in things, stuff, you basically say that your job is not going to be this, you come into clinic, and you're going to go through and do these tick boxes and go. But you actually have this very exciting job, which is the forefront of what is available. You have the best possible care that is possible to give to patients, part of giving that. Patients would love to get that because you are able to say that you're making that experience the heart of what you do.

Reference 1 - 0.79% Coverage

So, we use a website to help identify with partner identification. Which is another clinic lead’s initiative. And I have to be the biggest cheerleader for that, aside from him. And I am. And I am happy to be. Because, really, I believe in it. Very much so.

Reference 1 - 0.49% Coverage

So, I really enjoy that part of the role actually, because then it sees that you, like, got good service, and the service is efficient, because you know we can if we have a deadline to work to. Then I make sure that we definitely meet that deadline.

Reference 2 - 0.99% Coverage

And it's like a good feeling to know that you've met the target, because… And also while I was doing that, I was also closing down sites, so you can imagine that the… Well I don't get pressured, and I don't get stressed, and… Or anything like that, because I kind of like thrive on it. Because I like to do things like that. And say show me what we need. It's so funny. We need to do this, and we need to do… We need to do this and we need to do that. And we've got a deadline. So, no, it can be done.

Reference 3 - 3.67% Coverage

Apart from that, I think it’s a very good department to work for. I joined in 1998, so you can imagine all the changes that I’ve been through. It’s, you know, I can honestly say that all the changes are good. But, I’m not a negative person, I always on the positives. And even if I don’t agree with something, I’ll work with it.

I’ll voice my opinion, just to my manager. Which I don’t think I have, because over the years, I’ve not agreed with something. But like, if you get staff that don’t agree with a change, then you have to explain to them, you have to talk to them in certain way, why it has to happen. You know, and then they accept it. I’ve always said, it’s about how you come across, when you change. As I say, there have been so many changes, you know, some staff can’t handle it and then they just leave.

Or some just stay, and just be angry. Eventually, if someone’s coming to complain about something they’re not happy about, like with the changes. You need to just smile, and you know, you have to say something to cheer them up and just get them out of this mind set. Otherwise, they’re going to be constantly like that, and they’re going to be negative, and then it can get wearing for the team. So, because, sometimes, you always have that one person. But if someone comes to me with something negative, I’m like, you know what I’m going to say. I’m always positive, I can never be negative. Even if I don’t agree with something that’s been put in place, I will still be positive. Because, you have to be, what’s the word? You have to be shown to be working as a team, and you can’t be seen to be negative about not agreeing with something.

00:07:38

P Because then, the minute they get a waft of that, and then they say, oh, she agrees. And then it’s, you know, they will keep that mind set. So, I think it’s always about being positive.

Reference 1 - 1.52% Coverage

You must know the myths about sexual health services. Some people describe them almost like entering in for voluntary torture, and if you’ve got that hanging over your head, then I don’t know, I couldn’t live with myself as a service if the average person said, well, when you go to that service you get an inverted umbrella pushed down your penis. And I’m not exaggerating by saying that that’s a common myth. Albeit it’s a myth, it still needs transforming.

Reference 1 - 2.73% Coverage

P Well, I think you have to keep the service modern. I don't introduce everything just for the sake of it, but if they can see an added value to it, yes. It's like when the national guidelines come out, you look and you say, what is in it for us? In terms of where you are, I'm probably an early adopter, but I like to know that things work before I adopt them. So I will critically evaluate something, but I will look at new things and actually see if there is some added value.

00:05:49

So I won't be someone who puts everything in right up front without the evidence. But I do like to be an early adopter rather than dragged to the gate as it were.

Reference 1 - 2.69% Coverage

I have to the point. When I took on my role 11 years ago I took it on working with the community screening program. I knew from Day 1, at interview, because it was going to be working in the community, I needed to know more about sexual health. I was coming from an education background. So I needed to know more about sexual health, so that I could make sure that they weren’t just peeing in a pot. But actually they would have questions that they needed answering. And I felt very duty-bound to be able to answer those questions and get them the correct report, and make sure they were testing for the correct things.

And guiding them in that way. And promoting good health. In whatever sense that was. That wasn’t just to do with sexual health, but you can use the opportunity for so many other things. Like smoking and alcohol. It’s important you do that

Reference 2 - 1.76% Coverage

In Australia, the TTANGO they call it, don’t they? I don’t know if you know that. And it’s T T A N G O. And I think it’s Take the Test And Go. And just think that’s’ fantastic. It’s just amazing. And I said to service manager, I said, can you imagine just saying let’s TTANGO, or when was the last time you took the TTANGO? Or you can see the straplines. I know it belongs to Australia, but it’s brilliant. These little things. And it’s just bouncing these ideas off. She said, you’re doing your homework then? I said yes, because I’m interested in it.

00:026:07

Reference 1 - 0.66% Coverage

And I believe it’s something that works, why not roll it out? I do believe in that technology. Yes, I’m all for technology.

Reference 2 - 0.58% Coverage

You have to move forward.

R What if there…?

00:06:03

P We can’t go back. We have to keep moving forward.

Reference 3 - 1.25% Coverage

I’m all for it. Because I’m always keen if it makes our job easier. I’ll support any changes to help us through to get... And because of the way we are and how busy all the clinics are getting everywhere. Yes, I think it’s a good idea.

Reference 1 - 0.99% Coverage

I do very much enjoy new ways of doing things and if we can get things better for patients then that’s great. This sounds like an opportunity to do just that, so, for me, it would be very welcome. I’m

Role

Reference 1 - 0.10% Coverage

Okay. I'm the clinical lead for sexual reproductive health.

Reference 2 - 0.30% Coverage

In the clinic, my role is… The clinical lead role is only eight hours a week, but that's… It takes a bit more time than that, just trying to help obviously move the service forward.

Reference 1 - 0.07% Coverage

I'm a sexual health and HIV consultant.

Reference 2 - 0.15% Coverage

And I'm also the lead for quality improvement and for research within the department.

Reference 3 - 0.76% Coverage

I think all departments need to evaluate their services. We look at various aspects of it. And part of my role as quality improvement is looking at how can we improve our services to make it in line with the best standards of care that are published nationally, but also to incorporate advances within the field. So there's a lot that is happening. And how we manage STIs, how we test for STIs, how we interact with our patients.

Reference 4 - 2.86% Coverage

And there are different ways in which you can do service implementations. You can make it a health technology assessment as a research project, saying that I'm going to study and I'm going to have partners, and you're going to say that we're going to do this in different settings so that you can show others how to do this.

But get research funding to allow implementation, and then show to people that if you can actually get good quality data, that shows that you can actually save money by showing a research project that actually looks at that rather than saying, oh, I'm going to do a model, and then you go, well, it’s just a model, and say that I'm going to do a health technology assessment study.

I'm going to do an implementation science that's going to look at what are the cost implications of this change and say that we get this properly funded as a study. You get the device or the new technology through the study, and then you put it into a real world scenario. And then they have a real time look at what the exact, say, changes in work time because you're going to measure everything. And I think that's probably one of the way forward.

00:21:34

And it's one of the things that I look at my role, which puts in together quality improvement and research, is that you can actually bring the two together and then have this culture of evaluation. Because if you can evaluate yourself and show that you are good at evaluating yourself, you know that you can be trusted to make changes because you get to measure it. You'll know very early on that the things are going the way you expect them to go or not.

Reference 1 - 1.40% Coverage

Okay. So my role in the organisation is a general manager role, so I manage a large specialist outpatient directorate. Sexual health is one of nine services within that. My relationship with sexual health services is quite new, so I’ve been doing this job since late September. So just over six months from that point of view.

Reference 2 - 1.27% Coverage

So I’ve been working quite closely with the team from a financial point of view so far. Am I allowed to refer to names as well? You can delete all that out [overtalking]. Rather than just titles?

00:01:10

R Yes.

P Okay.

R Of course. Right, so it must be challenging?

P It’s very challenging.

Reference 3 - 0.84% Coverage

It’s then my job once we’ve understood that to go and break through some of the bureaucratic barriers and to show that we’ve done our due diligence if you like, to say this is a safe thing to do.

Reference 4 - 1.12% Coverage

So what you’re trying to do as a manager is find out who’s done something else like this? And you’ll talk to them about what are the things that you considered? What are the things you didn’t consider? And what are the things you would do differently next time?

Reference 1 - 0.54% Coverage

P So, I am the lead health advisor. So, I manage the team of the health advisors within the SRH department. And HIV clinic as well. So, one health advisor that works up there.

Reference 1 - 0.58% Coverage

So I am the assistant service manager. Of which I'm currently acting up in the role. I'm responsible for operational, and overall management of the team leaders and the reception staff. And just the general managing of the clinic, and overseeing any new processes that need to be implemented.

Reference 1 - 0.16% Coverage

So, I am one of the sisters in the service

Reference 2 - 4.00% Coverage

P Yes. I feel like, at the sister role, you’re that gatepost between, so you’ve got the people on the floor, who are just getting on and doing the job, you’re not high up in management, you’re not actually making the key decisions. And actually, during the consultation, the three sisters, we weren’t a part of the consultation, it was the people above us who actually planned it, implemented it, went to the meetings.

00:06:26

So, it was quite difficult, because all the staff assumed that we knew exactly what was going on, but actually we weren’t in any of the meetings at all, we weren’t part of any of the decision-making, and often we were told things not particularly long before the staff were told things. But yes, I think generally as a sister you’re in that role between… like, you’re sort of on the floor still, more than any other manager, but then obviously you do go to some meetings, and know about things, and you do line-manning stuff, so you’re sort of that channel, I think, between the two. So, it’s an interesting role, I think.

Reference 1 - 0.53% Coverage

I'm a speciality doctor working in contraception and sexual health in the [name] Sexual Health Service.

Reference 1 - 0.62% Coverage

P My main role is clinical lead in [location] Sexual Health, basically I provide both clinical services, seeing patients and also management responsibility.

Reference 1 - 0.18% Coverage

My role is to manage the contract and the partnership.

Reference 2 - 1.49% Coverage

As I said, my job is to make sure that all of these various elements work together in a way that forms a partnership rather than what would be a traditional subcontract, even though it is a subcontract, because what we hope to achieve is a transformation of sexual health services so we move from dependency on services, dependency on clinicians, to more of a model that promotes independence and self-management, a model which actively removes stigma.

Reference 1 - 0.27% Coverage

P I’m the [service] health team lead for [region]

Reference 1 - 0.45% Coverage

P So I'm a consultant in sexual health, and I'm also the service lead for sexual health here in the trust.

Reference 1 - 0.56% Coverage

P So I’m one of the consultants in sexual health and HIV in the Trust, so there’s three of us. I’m also the contraception lead for the Trust as well.

Reference 2 - 0.14% Coverage

P Yes. So it’s a clinical role, yes.

Reference 3 - 3.65% Coverage

R And in terms of this process that might occur, what would be your role in the process of adoption of a point-of-care test, the Atlas point-of-care test?

P Yes, well, I guess because I’m one of the consultants here, so as part of the senior management team that’s something that falls onto all of us to sort of, A, disseminate the information out to the rest of the team; be part of who we decide will need the training and who will be part of the core group that uses it as well.

So, yes, I guess that’s how I see things going. And because I’m primarily based at the other clinics, so I’m the main consultant at the other clinics, so I guess my role over there will be slightly different as well, but… In terms of being probably the only consultant at that site. Yes.

00:04:04

R Right. So you probably, you have more responsibilities there or…?

P Yes. As opposed to here, because usually the other two consultants are mainly based here, whereas I’m mainly based at the other site.

Reference 1 - 1.33% Coverage

P Okay, so my main role is being the point of care lead. So, I’m in charge of all the point of care equipment. So, your glucose meters, pregnancy tests, etcetera, around the trust.

Reference 2 - 1.49% Coverage

My role is mainly point of care, so if, for instance, they needed a new test in the lab, then the lab staff, there would be a [unclear] in the lab would be involved in the introducing it into the lab.

Reference 1 - 1.27% Coverage

P Okay. So I am a specialist nurse practitioner in sexual health, gyno medicine, and contraception. I am a lead nurse, so I'm a nursing sister leading a team of nurses. I do run nurse-led clinics under the supervision of the consultant. Yes, that's about it, I think.

Reference 1 - 0.39% Coverage

P Okay, so I'm the sister of the sexual health clinic.

Reference 1 - 0.41% Coverage

Well, my role is as Local Authority Commissioner for Sexual Health Services

Reference 1 - 0.27% Coverage

I’m a consultant nurse in sexual reproductive healthcare

Reference 1 - 0.17% Coverage

I’m the health advisor at the [name] Sexual Health Service

Reference 1 - 0.37% Coverage

So my role is Clinical Service Manager for the Integrated Sexual Health Service.

Reference 1 - 0.36% Coverage

Okay. I’m the head of service for microbiology in the laboratory here.

Reference 1 - 0.50% Coverage

P So I'm a consultant in sexual health and HIV, but I'm also the clinical lead.

Reference 1 - 0.15% Coverage

So I’m a consultant in genitourinary medicine and HIV.

Reference 2 - 1.52% Coverage

P So I’m quite new to my clinic. I’ve moved here from another part of the country, in November. So at the moment I’m looking at setting up some local collaboration with close-by clinics. But previously I was involved, when I was working down south, I was collaborating with, I was working in [clinic] and we had regional studies running there at the university. I’m looking to set something similar up, up here, in this area.

00:03:01

But that’s not, that’s part of the STI champion role really. But that’s not running yet, so that’s my plan.

Reference 1 - 0.34% Coverage

So, I work across sites. So, they’re… where I’m a consultant in sexual health and HIV.

Reference 1 - 0.47% Coverage

P Okay, so, I am currently working as a locum consultant in the... basically the role

Reference 1 - 0.11% Coverage

I’m a clinical nurse specialist

Reference 1 - 0.26% Coverage

Okay, so my role at the moment is a clinical specialist.

Reference 1 - 0.61% Coverage

PA Okay, so I'm one of the clinical nurse leads in the clinic and we run a clinic.

Reference 1 - 0.45% Coverage

I’m a Senior BMS in the bacteriology and GUM laboratory.

Reference 1 - 0.80% Coverage

My role is Lead Nurse in Sexual Health.

00:00:16

I don’t work in a clinical capacity, but more in the leadership and strategic capacity within the department.

Reference 2 - 2.29% Coverage

Yes, I am probably the strangest Lead Nurse in the country really; my background was very different from the role I’m in now. I’m the Lead Nurse for a very large team of nursing staff who are all very experienced. But what they were lacking, and it’s my assumption which I think is probably right, was around leadership structure, somebody that could come in and ask questions of why you do stuff like that and look for different ways in which we could do things.

Reference 3 - 1.97% Coverage

The point of care testing, I suppose, from my perspective, would be from a theoretical one. It’s also about re-designing patient pathways, looking at how we can do things more efficiently, how we can actually use some of the technologies that are out there to take services out to patients.

My role, I suppose, is a little bit different from your average lead nurse, if there is such a thing.

Reference 1 - 0.39% Coverage

Yes, okay, so, my job title is Health Advisor, Nurse Practitioner.

Accuracy

Reference 1 - 3.45% Coverage

Because obviously you may be doing your point-of-care testing as well as standard laboratory testing on the same patient just to mean the quality assurance. So I mean the evidence, what is the evidence and what is the outcome of your pilot studies? That would be interesting to see.

And also with any healthcare facilities already using this point-of-care testing then I would like to know the practicalities of it, who is using it, how it's being done and the issues related that I mean, sometimes we don't think about these problems as issues but sometimes we can learn from others. So I would like to know anyone else who is practically doing it and how do they feel about it.

Reference 2 - 3.00% Coverage

P I don't think that the structure of the clinic really matters. I think I would like to encourage a point-of-care test which really works to be on honest. Pretty sensitive, specific and I don't know whether it’s useful to use it on everyone, I don't think it's useful but patients who really need quick test results… Because sometimes we do see patients who are coming for a test today and they talk about going away tomorrow so they would like to know the results as soon as possible, which makes sense sometimes. So for a particular group of patients, point-of-care testing is quite useful.

Reference 3 - 2.67% Coverage

P I think it could improve with a certain group of people as I said before, so they can get their results within half an hour. So they can probably wait in the clinic and then get the results and go away. So in that sense it's quite useful provided that the accuracy is the same as a standard laboratory test then we don't have to repeat the test. But initially, I think probably we have to have a standard lab test and then do the point-of-care testing, isn't it, to see how it goes probably kind of a quality assurance step.

Reference 1 - 7.61% Coverage

P If it’s a test I guess our lab would have to be on board with this anyway, just to make sure that this is a test that, you know, has been verified and validated, to make sure that they would be happy for us to bring on. It’d obviously have to go through the Trust anyway if it’s, yes, something new that we’re bringing in. And, as I said, in terms of our senior management meeting, just to make sure that everybody’s on board with this, and then our commissioners as well. All of those things would be important.

00:17:09

I don’t think they’d be necessarily a barrier to it, but, yes, just to making sure… Well, I think the may be, because they’d have more… If it’s a lab test, then I think they may definitely… we’d definitely want to talk to them to make sure that they would, they’d known about it and things as well.

R Yes. So if the lab is not happy with a new test and that kind of stops the adoption…

P I think you’d be… I think we’d be quite worried then if they’d said actually, you know, we have concerns about this. I think we would be quite concerned then.

R Would you be able to adopt anyway or absolutely not? So is it more…?

P It just depends on what their concerns were. I think that would a thing, and exactly what was specifically an issue with it. Yes. And in terms of results, what kind of staff and sensitivity and specificity for the test really. I think that would be key to it. Yes.

R The quality of the product.

P Yes, I think so. It just depends exactly what was wrong.

R Yes.

00:18:15

P And how important that thing that was wrong would be then implicated on the rest of the Trust. I mean, it could be something… I mean, who knows? It could be something like the machine, something to do with the machine, but not actually with the results or something. Like, say, for example, we use it three days and the fourth day every so often it just doesn’t work or something. It just depends on exactly what they, what the issue is with it. Yes. And what results it gives really. I think that would be the most important thing.

Reference 1 - 3.38% Coverage

Again, at the moment, I have no idea about sensitivities. I think we need to sort of have some understanding about the differences in sensitivities of the assay compared with a standard laboratory assay, and the impact that that might have on the wider public health. You know, if we're missing infections because it's not as accurate, is it still better because we test more people?

R Right, yes.

P Do you make more diagnoses overall with a less sensitive test, because you're testing more people?

R I see. Thank you. I'll switch off the recorder now.

Reference 1 - 2.58% Coverage

P I guess important things for clinicians would be, the only other thing would be how the swab will be taken. So would it be first for urine for men, would it be vulvovaginal NAPs for women? If there are changes in the kinds of swabs that are needed, that would also be a consideration. But that’s all, really. I suppose the only other thing would be sensitivities and specificities of tests. So I’m sure that the platform will be comparable but it would need to be comparable to current availability of NAPs.

I’m not sure, personally. We’d have to make a decision clinically, but if we were going to be losing sensitivity to get quicker time, I’m not sure we’d accept that. So, I think you’re probably better to wait for a result that is more accurate, if that was the case. So certainly the quality of the test would be important, not just the time to get a result. Yes, I can’t think of anything else, really.

Cost

Reference 1 - 0.28% Coverage

And new technologies tend to be expensive generally. So it's a question of how do you make things accessible, how do you make a business case that involves that?

Reference 2 - 0.72% Coverage

Obviously, if the technology is super expensive, and they're saying that we need to improve development cost and we want to get our bonuses, then it looks like, well, it’s not affordable. You probably need to look at a different market. But it's a thing. And National Health will need to have good quality affordable care, because the service that we provide needs to be accessible, equitable, and sustainable.

Reference 3 - 0.82% Coverage

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

Reference 4 - 3.00% Coverage

Because the usual thing that kills everything is... there are two things that kill new diagnostics. One is that they make it so expensive, nobody can afford it.

Or it can be afforded only by private clinics, which don't have enough of a footprint to make it worthwhile to progress with the device. And the other thing is that people have a new technology and they are in competition with other people, and they [unclear] these. But you have all the research people spending a lot of research money on this, and then you've basically have a big company that buys them up and then stops its development to reduce competition.

So, obviously, competition in diagnostics or in any kind of new technology basically would make things... it drives progress to also make sure that people make... they're competing with each other. So the other thing [unclear] basically think that I can do whatever I want. You have no other options. There are other options, then you basically have market prices, pressures driving prices down and making them attainable.

00:31:14

So the other thing that should be important is to have a lot of things in the pipeline and people committed to actually who are developing it and make sure to having implementable things rather than aiming to be bought out by the next big company. So you have start-up companies that come up with an idea. And what they want is to come under notice off a big company, get bought out, and then move on to the next thing.

It's actually saying that companies at the public health angle or interest or public health hook, so they have some financial incentive or a mission statement to say that this is what we want. We want this to become a thing.

Reference 1 - 0.74% Coverage

Cost usually something that is looked at first, really. But the fact that people could leave with that result on the day is a great benefit. So, it makes sense clinically, and people are getting a better, faster result. Great, that’s a win.

Reference 2 - 5.33% Coverage

P That’s an interesting… Yes, it’s a… I think it’s a bit of both. So, you know, when we were talking about decisions around what tests to do. Is it a finger prick or a traditional blood test? That’s… The final decision always comes down to what costs more, or less, really.

00:16:23

And I find that a bit unfortunate. That it’s all about cost. That it’s, you know, we can say that it’s about patient choice and about patient experience, and everything. But the most important thing in this current state of the NHS is that it costs less. And that’s a bit frustrating sometimes, really.

But we have to kind of… We have to roll with it at the moment. So, it’s always exciting though, to try and find ways to do things that are going to save some money and actually improve the experience as well. So, if you can hit on that combination, that’s pretty exciting.

So, for instance, when we switched… This was before I was here. But when we switched to taking chlamydia, gonorrhoea swabs from all sites instead of doing them in one sample. That saved a massive amount of money. And it’s one sample. And it’s, you know, the patients.

And I suppose, that took away patient information a little bit. And that they don’t know immediately what site an infection, a positive result is from. So, that can be… Patients get a little bit annoyed with that sometimes. But it doesn’t matter. It doesn’t impact the treatment that they are getting. Because the treatment is the same, regardless of the site, really.

So, for us to be able to do something… To use technology in that way and save money is good. I wish it didn’t have to come down to money all the time though. It’d be nice if we could, like, you know, having an onsite panther machine.

Reference 1 - 5.12% Coverage

P I think we’re, because sometimes, obviously, you can put in business case for things, and I don’t know if they can also apply to the charity. We’ve recently got a charity box put in place, well, it’s not put in place yet, they’re just finalising a few things, for people to donate. But if they looked into it and saw that it would be, it would benefit patients and the patient’s journey, then it would be a good investment.

00:01:48

P But at the moment, I believe that it would definitely be a good investment because the patients would be getting their results then and there, instead of having to wait. And then also, more partner notifications… It would have a knock-on effect, actually. Because if someone was positive then you could give them partner notifications, what do they call them, PN?

R Yes.

P So, they could hand those out, get those patients back. So, I think it could do some good, and then if they could do, like, data to see the impact, because they always do data on partner notification, don’t they? So, I think there’s things they could look at, as well, to see how it’s benefitted the department. But I see a lot of that as very positive, I know they can always find, if they need to put something in place that will benefit the department, that’s what I believe.

Because, like, you know, they said we’ve got an under-spend on staffing, because they’ve got a lot of staff, quite a few staff leave, and vacancies and we’ve managed to still tick the surplus over. And they could take something from that money and use that. So, it’s not as if we’re, sort of, in debt, as such. And I’ve saved them quite a bit of money as well, with redesigning my little team upstairs, because there was a patient access team, and like, a secretary. But some staff left from that department, well, not that department, from that, what do you call it, team. Team within the department. So, I just looked at it and I thought, well, we don’t really need the staff. We don’t need to recruit, perhaps we could give this person to do, even though they’re doing it already. But, just tweaking some things, because if something’s removed from her job description, because have a complex specialist service anymore.

00:03:57

P Because that went through the consultation, so that’s been removed from their work load, so you give them something else to replace it with. So, I save money by just having a team of two, rather than having a team of four. So, that was cost saving, and at the time the trust was working hard, every area was having to save money. So, and we met our target, which is good.

Reference 1 - 2.61% Coverage

So the main things that I would like to know if you introduce the point-of-care testing is obviously the first thing is, is it costly, right? So what is the cost difference between the standard laboratory test and a point-of-care testing, and what is the procedure involved? Because this may include staff getting trained, right? So it has to be a consistent training, because we have different types of staffs working in the clinics basically. So we have doctors, we have nurses and we have healthcare assistants.

Reference 2 - 3.00% Coverage

P I don't think that the structure of the clinic really matters. I think I would like to encourage a point-of-care test which really works to be on honest. Pretty sensitive, specific and I don't know whether it’s useful to use it on everyone, I don't think it's useful but patients who really need quick test results… Because sometimes we do see patients who are coming for a test today and they talk about going away tomorrow so they would like to know the results as soon as possible, which makes sense sometimes. So for a particular group of patients, point-of-care testing is quite useful.

Reference 1 - 9.57% Coverage

R What would be needed if it was a new technology? What would be needed, what kind of structures or what kind of data would be needed for that, to encourage people to...?

P If it’s not popular?

R Yes, if it’s not commonly used.

P I think the first thing would be to understand why that particular technology has not been widely adopted. So maybe something new and there is no confidence. And the question is if there is no confidence, what can you do to build confidence? You can find the other partners who are already using it and what challenges they’re going through and what sort of safety, quality assurance they’ve got in place. So you have to understand why something that is new but has not been quickly adopted, what has happened?

00:13:48

It could be that cost may be compared with what is already been available there, being used, might be cheaper than this new technology. So this new technology is not going to have a huge impact in any change. Or it could be the fact that maybe the new technology is a bit clumsy in how you do the whole process. There is no... You need to really reset, you need to put a lot of other extra resources to get it running and that can put people off especially during this time when there’s a lot of financial stress.

So I think the key thing would be find out if anybody’s adopted it, what sort of advantages, challenges and benefits and then you can decide to do a case for it. So yes.

R In the current political climate or financial climate, I think they’re both quite interlinked issues, do you feel like they encourage or discourage adopting new technologies?

P It depends. It’s a mix because there are new technologies that are more cost effective compared to what was traditionally being offered and able to have [?] some efficient in terms of how the whole system is run. So the current difficult or stressing financial climate gives an opportunity for things to be reviewed also so that you don’t look at doing the same thing. You’re under pressure to ask yourself, is there is a better way? Is there a more cost-effective way?

So this gives an opportunity to every new technology that comes into the market to be looked into in its own unique way. So you may come with something but it may not completely replace what you’ve been doing, but it would take a chunk of what you've been doing and then do it in a different way, so you have a mix of both. Or it could come and completely replace.

Reference 1 - 2.47% Coverage

R So I can hear that there are key things that drive implementations. So that’s patient needs?

00:13:11

P Yes.

R And also the new technology being cost effective?

P Cost effective, patient needs, I would say. So definitely patient needs have got to come first. It’s not going to make any impact really on the patients and there’s no improvement to their service or their care, then there’s not much just bringing something in. It’s got to be a key driver with an improvement there.

Reference 1 - 2.46% Coverage

P I think we need to know what it's going to cost. I mean, it's part of the trial with free cartridges and free machines. That’s fine. Then it has to be competitive with the lab-based test. It has to be able to replace the lab-based test at a similar cost to ever be thought of. If it's going to be three or four times the cost of sending off to the lab when you can get the result in two or three days, that may be less advantage for most patients.

But in some situations, then it's cheaper to treat epidemiologically and still wait the test than if it's going to be an expensive test.

Reference 2 - 0.72% Coverage

P No. I mean, I think in such a cost-driven organization, it has to come in at a price that’s comparable to existing technology. And I think cost is one of the big barriers

Reference 1 - 1.82% Coverage

The rest of it, really, is around how expensive is it to use it on a regular basis because you can write a business case to purchase the equipment, but that doesn’t cover the ongoing costs for consumables and the agents. So you would have to look at how expensive those are going to be, and, again, what staff resource are you going to need to actually use it

Reference 2 - 1.67% Coverage

P I think point of care testing will be fully removed to wards. At the moment, the issue is that point of care testing is usually much more expensive than conventional testing. So to get point of care testing through, there would need to be quite a good reason why the tests couldn’t be done in a conventional way in a laboratory.

Reference 3 - 1.42% Coverage

P And, potentially, that means that if they do want to screen their patients for GC, are we going to be in a situation where they’re sending one test to the urine analyser, but we’re still referring a test off for GC? So that could end up at twice the cost that we currently have.

Reference 1 - 4.68% Coverage

P Well, yes, so the difficulties are that if the platform itself costs more, then there's going to be an initial outlay of additional funding to run the tests. And as yet, an unknown cost saving from the benefits of it that we just talked about. And I think the difficulty also is if a lot of that cost saving that would be realised from introducing the point of care test, is staff.

Then you're then talking about making staff redundant. Which itself has cost, creates great ill feeling, and anxiety amongst staff groups. And potentially could minimise the body of staff that allows you to deal with fluctuations in service activity, outbreaks of infections, and also sort of an organisational memory of people who are experienced and knowledgeable leaving a service.

Reference 1 - 5.62% Coverage

R I see. And so you mentioned there is always a lot of training required, especially if there is something new happening, but is this also quite expensive? Does it require additional funds?

P Yes. So, it really depends on what training is involved, really. So, we already have an educational programme running within our clinic, so we have time set aside for that. So that, for example, quarterly, we have a clinical governance meeting which I organise, which is clinical governance and education. And basically I can put into that whatever I want. So whatever I feel is educationally appropriate for the clinic. So lecture based teaching is easy to deliver.

00:17:26

We also have a journal club which runs, although it’s harder to get staff to attend that. That tends to be attended by fewer staff, whereas for the quarterly session we actually close the clinic for a morning. And then it needs more face to face training, on an individual basis, that obviously does come with a cost. So, for example, for our HIV point-of-care test, there’s a training session which is run by the lab and that lasts and hour and staff have to be released from clinics to attend that.

So that obviously has an impact. So, I mean, we put that in people’s induction so they’re not actually in clinic at that stage. So obviously if a test was to change, we’d need to train, depending on who was going to operate that test. If it was just the lab staff, that would be relatively straight forward, because there’s a much smaller number. But if the tests are going to be operated by all our clinical staff or, for example, by a healthcare assistant, there’d be more training.

And that would be more difficult but not unachievable. It would depend a bit on how long. You know it’s relatively easy to fit in an hour or two of training. If staff need two days’ worth of training, that becomes increasingly challenging. So it really turns on how long the training is, and how many staff need to be trained.

Reference 2 - 3.08% Coverage

I guess the other thing is cost. So, at the moment we have a combined chlamydia, gonorrhoea NAP. Then we have a separate TV culture which we also do candida culture on, although it’s a substandard candida culture. So we’d need to do a separate candida culture which would increase costs for those that needed it. But at the moment I feel that we’re indiscriminately culturing anyone, any women with symptoms for candida which is not really appropriate.

00:37:31

So we could certainly reduce our candida testing. And we’ve got the two separate tests, the two separate swabs, as we’re doing TV separately. And if we streamline that, it could potentially increase costs a small amount without causing problems. At the moment we’re not offering mycoplasma, mainly due to cost and delay. So we have to send it off to [location] and it’s a three-week wait to get the result back, which isn’t massively clinically helpful.

So I think from a clinical point of view it would be absolutely amazing to have the four-pathogens in a 30-minute test. But we need to think about clinic processes with that.

Reference 1 - 4.90% Coverage

R Yes, right, and what about the costs of the tests, how important that is?

00:27:07

P God in this climate it’s very important, yes, it is very important. I think for a test that’s reasonably priced is one that will...

R Would it have to be cheaper or priced the same?

P Because the thing is I wouldn’t see why it’s more expensive when it’s less labour intensive. Do you know what I mean you don’t have a lab, it’s a small thing, you know. You don’t need a biotechnician to do it etc. So, you know, these are the things that if I... the other people, sorry, the other stakeholders will be the lab that’s, you know, that’s a big... So, if I was telling the lab, oh, we want to do this machine, you know, we want to go with this machine they’ll be like it’s going to cost this much and they’re like actually we’re cheaper because we can do X amount, you know, of tests in a... you know...

And, yes, you may miss a couple of people because they haven’t come back for the results but you’ll get your results in within seven days or a positive result within, you know, 48 hours or whatever it is they’ll be turning it round in. So, I mean, I think if it was priced more nobody would touch it because you’ve already got, you know, a well set up machine that’s already doing that, yes.

R And contracts with labs.

P Yes, we’ve got contracts with labs, yes, we do, yes. So, it’s, yes, if it’s priced cheaper how... yes, it would, yes.

Reference 1 - 3.44% Coverage

I guess the more tests you can do, the better. My guess, there’s a cost implication in doing more tests. So, I don’t know. I don’t think I would be at a level to say we should, well I could probably say yes, it would be a good idea to do that but whether funding would allow it, I think that’s probably…

00:22:42

R So they would be better to do it for the…

P I think with... Could you do the TV without the mycoplasma?

R I don’t know because I think development is…

P I think mycoplasma, I don’t think we need to do it for everybody. I think you’d have to thing about the protocol and who would you need to do certain tests on… And again, the TV might not, if someone’s asymptomatic, they’d be doing online testing and they won’t know.

Reference 1 - 0.80% Coverage

P It’s probably one of the biggest things at the minute will be around finances, and it’s proving that actually bringing something in will be of financial benefit.

Reference 2 - 0.76% Coverage

Quality of patient care is a big one still; we still need to be doing that but a lot of this will be down to whether we can actually afford to do that.

Reference 3 - 1.53% Coverage

We can have really good ideas which will help us do the right thing, but actually some of the blocks, I should imagine because this is a new role to me in this sense, would be around just making sure that we can balance the books and generate extra income for the trust. That would probably be a key thing.

Reference 1 - 5.74% Coverage

P Yes, okay, I think that does... is an important factor. And if, I think and I don’t know, but I think that if it’s cheaper than what we’re currently using then... and we can save money then I think that would be seen as advantageous. If it costs more then obviously there’d need to be a very good case for us changing our existing, you know, supply so. And I know that point of care from a public health perspective would...

So, if we were to have a 30 minute result for chlamydia and gonorrhoea, you know, instead of waiting the week to two weeks we would very much have to, you know, use the public health factor there. That, you know, whilst they’re in clinic they can be treated, you know, so, therefore it stops the spread of onwards infection. So, I think there’s, you know, back up for using a point of care test but I think if it’s more expensive I don’t know how the Trust or our business managers would see that. And I think we’d really have to sell that to them.

Design and development

Reference 1 - 0.81% Coverage

So we brought in a company called Zesty, which is a for profit company doing appointments. And just as a quick way of providing some appointments to some patients. And that's, you know, that's worked well for us for some years. We're going to move to a more intelligent appointment system very soon. But that's been helpful. And, you know, we'll have evaluated DNA rights related to that, and showed that, you know, it's certainly better than nothing. But obviously it could be better.

Reference 2 - 0.68% Coverage

The Qudini was a queue management system, but using SMS. Seen in the commercial sector, brought from restaurants to our service, and we had loads of complaints from patients, how long they were waiting. Complaints from reception team about the behaviour of patients who were frustrated at waiting. And as soon as we brought in that system, the complaints disappeared. So we evaluated it in that respect.

Reference 3 - 0.41% Coverage

So, the perfect is the enemy of the good. So you need, you just have to make good. And set it up, run it, evaluate it, and say, yes, no, maybe. And if the maybe, then what do we do to test it definitively before we either adopt it or drop it? Yes.

Reference 4 - 0.62% Coverage

So if we were to bring in other point of care tests, and we could show where they fit in the pathway, then we would just send less samples, if we could show it's non-inferior. You know, ideally it would be superior. But usually to prove something's superior, is harder than proving it's non-inferior. You know, that’s just the way it is with pharmaceuticals and diagnostics.

Reference 5 - 4.35% Coverage

So if we knew that this person was a partner of gonorrhoea, and yes they did have gonorrhoea, but yes it also could be treated with Ciprofloxacin, then we can do partner notification and get their partners in, and see if their partners also have the same gonorrhoea that's sensitive to Ciprofloxacin. So we can start doing all those really interesting things. But you know, going forward, you know, mycoplasma is obviously something that we could test more effectively for, and there's a lot of resistance, and yes. So, there's lots of really good things.

So point of care testing is key for that group. And I want us to spend more and more time focusing on partners, because that's where we are standing out. That's a definitely… You know, we have a number of USPs, but that's a big one. Yes, and just being a magnet for these people, and just show that we're, you know, testing as many people in the network as possible. You know, the online testing, I'm a great fan of, you know. [Unclear] working like [clinic] I'm a great fan of.

All these things are great. But they're all focusing on volume, and then people in a high risk group and volume means you make diagnosis. But in terms of bringing the cost down to make diagnoses around getting in partners is about focusing on the sexual networks. And it's not good enough to say, oh yes, let's just get a load of gay men in. You know, you'll find maybe 15% are positive. But if you get all the partners in, you'll get twice as many infections, so you'll half the cost to make a diagnosis. Yes. So… And that's, that's obviously good. And you need to do both, but yes.

00:58:54

R So considering that the point of care test would be used for specific groups of patients, and not for everyone, right?

P Well to start with…

R To start with.

P It would be, yes. Like, we'd focus on the patients that clearly we can make, you know, important decisions around, you know. If you test 100 people coming through the door, and you find only, you know, ten are positive from that background rates. You know, you don't see immediate value. But if it's, you know, four out of ten, you know, 40 out 100, you know, you can then see it quickly making a difference in terms of patient flow, and management. The business case is so much easier to articulate. I think then we can start looking at, you know, what does… What would the test do for regular patients?

But certainly focusing on those who are more likely to have an STI is, yes, it's a no brainer. I'm looking at the time because I have a date at high noon, so sorry about me looking at the watch.

Reference 6 - 0.91% Coverage

So, you know, our provider, it doesn't necessarily… It can go straight through into the machine, it doesn't necessarily have to go through disc talk or whatever they use in the, you know, in the Bio-Path [?]. So that will be an issue.

R Okay.

P The logistics.

R Yes.

P And then what it comes down to is, yes, how clunky is it to run? And how many can run at the same time? You know, it's just the logistics. But really, I think to start with, we just need to get the right patients in front of the machine, and testing it, and see how it works.

Reference 1 - 0.72% Coverage

There's a lot of exciting things go through research. You see papers about all these exciting tests, but you never see them available to you to use in clinic.

It happens in quite a lot of things. It's basically what you call the research graveyard. So there's a lot of support from research to develop these things once they're developed. Your intended users don't have the purchasing power to use these things.

Reference 2 - 2.40% Coverage

And it's usually the lack of ability to deliver on this because you're not able to get results quickly but what is currently available. New technologies are looking at faster results. You're looking at tests, which don't require a lab that has 15-meter square and a whole lot of things. You're talking about things that might be logging in to have something the size of a refrigerator that you could have in the OptiMix.

Or you could have something that's a desktop that you can have in the rooms and then saying, how do you do that? And then it's looking at you've gone [unclear], saying that if I have... so far, our patient, we see about 1,700 patients a week. Those 1,700 patients a week, how do we manage to do them on different models? And you can look and say that how many do you need and then seeing that in having that negotiation to go, what is going to be cost-effective, what can we actually afford to do, and which model we can go for.

Obviously, if the technology is super expensive, and they're saying that we need to improve development cost and we want to get our bonuses, then it looks like, well, it’s not affordable. You probably need to look at a different market. But it's a thing. And National Health will need to have good quality affordable care, because the service that we provide needs to be accessible, equitable, and sustainable.

Reference 3 - 0.82% Coverage

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

Reference 4 - 8.95% Coverage

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it. But again, it's having dialogues with these people who develop these new technologies and getting them not to be greedy when it comes to this. Because the usual thing that kills everything is... there are two things that kill new diagnostics. One is that they make it so expensive, nobody can afford it.

Or it can be afforded only by private clinics, which don't have enough of a footprint to make it worthwhile to progress with the device. And the other thing is that people have a new technology and they are in competition with other people, and they [unclear] these. But you have all the research people spending a lot of research money on this, and then you've basically have a big company that buys them up and then stops its development to reduce competition.

So, obviously, competition in diagnostics or in any kind of new technology basically would make things... it drives progress to also make sure that people make... they're competing with each other. So the other thing [unclear] basically think that I can do whatever I want. You have no other options. There are other options, then you basically have market prices, pressures driving prices down and making them attainable.

00:31:14

So the other thing that should be important is to have a lot of things in the pipeline and people committed to actually who are developing it and make sure to having implementable things rather than aiming to be bought out by the next big company. So you have start-up companies that come up with an idea. And what they want is to come under notice off a big company, get bought out, and then move on to the next thing.

It's actually saying that companies at the public health angle or interest or public health hook, so they have some financial incentive or a mission statement to say that this is what we want. We want this to become a thing. And a lot of that would be looking at, not just what you can deliver here but looking at resource limited settings, which are more dependent upon having a point of care test, because access to health care is a huge problem for the guy who trained in India.

Follow-ups in a government hospital is unheard of. You need to test and treat, otherwise, you lose a patient. So how do you get that and how do you get those type of diagnostics to those settings, which basically barely have the funding to treat patients? So it's basically saying, make that [unclear] supporting to do that. What is useable in a resource-limited setting can be used in a resource-less-limited setting. And then basically having some ethical framework of delivery, of how you can cost it.

00:33:17

There's nothing wrong with having a resource-limited pricing and less resource-limited pricing. But then the less resource-limited pricing also needs to be realistic. And it's not about saying, how do you make your millions? Of course, you need to be able to offset your development cost because, otherwise, you're not going to be able to develop anything. But the thing is that you need to have the vision of being able to say that this is the change that you want to make, and it shouldn't be just about the money.

R Yes. So it's having companies who are change-oriented and who have the ethics that allow them to get to deliver objectives set by public health, really.

P So it's basically companies that are ethical and are interested in making a difference rather than [unclear] this is about the money. And it's usually when you work with them, you can make... often, people want to take shortcuts and say, we need to... of course, you need to satisfy investors, but then thinks that if you're willing to take shortcuts, I wouldn't trust them to stay with it. Because the thing is that anything is worthwhile doing is difficult to do. It's going to involve a lot of patience, a lot of time.

And if you're not willing to invest in the time, you're not willing to... if you're going to say that you're going to play people against each other, it's really unlikely that you're going to see it through. So it’s a good look at [unclear] companies as well before entrusting my patient's wellbeing to something. Because any company that does its evaluation in our service is using our patient's time, which they're getting free.

00:35:28

And it's that trust that it's really important that's not betrayed, that they're not taking advantage of people. And you find that quite a lot of companies basically are about, you need to progress this and don't look at the patient experience through that development process. And if you're not going to look at it through the development process, I don't really think that there's near ready product suddenly become altruistic about it.

If it's always been about the money, then you know that that's what it's going to be. So it's choosing the right ones. So some people might have a great technology, but if they don't have what it takes to translate that, that wouldn't be so much of a priority.

Reference 5 - 1.64% Coverage

What's important is to take in account experience of patients, also of the researchers and health care providers? Should there be more involved?

00:36:32

P I think so, because I think the researchers are probably at the best place to know how the ethical approach of a company that’s producing a diagnostic test, because they are the ones who know about what shortcuts that they've been asked to make. Because that doesn't get translated in the clinic. You don't get to know about that. So if you had a lot of backers in getting your study to where people say, oh, we have this, let's do it. You don't need to get ethics.

You just need to think about long term. What is this company going to do? Are they committed to getting that? Because if they're not committed to translating this into a working solution, and for them, it's all about the money, you're not going to make any difference. And is that really your best priority?

Reference 6 - 8.37% Coverage

And how the point-of-care has impact the clinic?

P Depending on the point-of-care test.

R Let's say the half an hour CT/NG for now.

P You need to be creative on how you use it. If you have a traditional model and if you think about this patient is sitting in the waiting room, has waited two or three hours to see somebody, then they have a 20-minute consultation, and they're examined, samples are taken, and say, at this point, just go to the lab, you have your point-of-care test. Your half an hour starts there. You only have another 20 minutes that you're spending with this patient to finish off discussing the results, treating, and send them off, or we have to wait half an hour for your result, what do you do?

00:52:47

So if you wanted two point-of-care tests, you're probably looking at something that if you want people not to change the way they work, that you just want to implement it, it probably needs to be less than ten minutes, 15 minutes max. Beyond that, it's going to stretch the consultations out. But there's no reason why you can't change your pathways and then do a sample first or something else. People check and get their samples. You test them, then you basically tell them, you have a time slot in, I don’t know, two hours.

And they get to see a doctor, talk about their symptoms. If they need to do... they sample you at that point. You know that it's going to be two hours. You can do a sample first. You know that if the tests are negative, you can swab them again. Basically you told them you passed urine. Don’t pass urine until you're seeing the doctor again. There are ways [unclear] that basically means changing the way you implement them. Being smart about whom you would... that basically depends on what the point-of-care test is.

00:54:04

You have a half an hour, and you could go for a sample first. There are some situations where it doesn't matter, but that's half an hour. And again, it depends on whether you are doing the test one by one, or we're going to be doing a batch testing, because somebody is coming in and they're just coming for a check-up. They're not going to wait. They've given the samples, they're going to leave. So whether you're going to take half an hour or you're going to take three hours, they still have left the clinic. We still have to recall them.

So any of your benefits that you're going to get, you're basically saying, we have a same day results model. And then what you can do is you can basically... there are different ways in which you need to be smart about how you arrange your things. So you can say that, fine, we'll have a, on your way to work, test, on your way back, come and get treated. So throughout the day, we'll send you timeslots if you have anything. Otherwise, we'll send you a message saying, everything's fine.

So we've talked about, say, that if you can get same day results in the batch testing, there's no reason why you can't do different things for different people. So, say, that you have your half an hour Chlamydia-gonorrhoea testing, you would say that I'm going to use that only in people who have ticked symptoms of urethritis or pelvic infection, so abdominal pain, bleeding, pain on parts [unclear]. If they tick any of these, you tell them probably means swab yourself and then pee.

00:55:49

We want the samples. And because your half an hour basically means that you have 20 people, and it depends on how many machines you have, you basically can say that, by this time, this patient's timeslot comes up, the result is back. If something's already there, then you can go where we need to send the [unclear]. Or we know what you have. We can test you. You don't need to do anything else. Or you can say, Chlamydia and gonorrhoea is negative. We need to do additional sample testing now to look for things, other things.

It could be Trichomonas. It could Mycoplasma genitalia. The fact that you know that the Chlamydia-gonorrhoea is negative basically means that you can go down the nonspecific urethritis rules and then give very specific treatment. So you basically can go in the sample first. So off the top of my head, I mean, having worked in the sample first model, there are different ways in which you can work. But you're not going to get one model fits all.

So unless you can get a device that you can have in your room, somebody gives you a sample, you plug it in, you get the result while you're... from the time that it takes you to do the [unclear]. And it works. Because I take ten to 15 minutes because that's how long it takes to get microscopy, because that’s what you're used to. And you know that if anything that takes longer than that is going to be a knock-on effect on the number of patients you can see.

Reference 7 - 15.64% Coverage

If you're basically saying that you have to process... there's a lot sample processing steps that's basically... so one of those, which is [unclear]. Basically, it only takes 90 minutes to get the result and scan it in. And what you actually have to do is that the samples come in, they're meant to have stayed in the buffer medium for a certain length of time, then you have to shake it, you have to [unclear] on that into the thing.

00:59:12

Then you're basically going to tell the computer that this sample belongs to this cartridge, which basically means that if you're having too many steps in between, A, it's going to be finicky, B, mistakes can be made. I'm going to stand this in this and then it's just on the wrong cartridge. That can happen, which means that somebody will get the result, they have gonorrhoea, somebody will get the result, they have nothing. And then actually, it's the other way around.

So it's making sure that the more processes there are in this... that’s one of the probably the limitations of more to the point-of-care test is that they don’t really look at what people in the clinic come in to do. And most of them are designed by lab people, who think that [unclear] is basic. But if somebody is not prepared and therefore not used to it, it's not basic. Getting the right amount and people either get lazy and don’t put enough or they get so finicky that it's like super stressful.

So it's looking at how finicky the process is. The other ones has brought all these things about, oh, you tap this, you shake this, then you add something else and shake it, leave it for ten minutes. All of that, if you're doing one or two samples, it's fine. If you're going to be doing [unclear] see about in the weekends, you see about a hundred and eight patients a day and about a hundred and thirty during the week. That’s a lot of samples that are coming through.

01:00:45

I mean, just sitting there, doing this into the tube that are okay [unclear]. It could be a hundred thirty, it's not. What you want is, I've got the sample, I want to basically put it into something, maybe just transfer it into something and then plug. That would work. But basically, the thing is that you need to be... it's also learning how does the machine know whose sample that is. It's thinking about that, bearing in mind in the clinic, we just put a label, transfer the sample into that and you're done.

There are extra steps you're asking people. You need to make sure that that process is a bust. That’s a lot of work. And it's usually the bit that people think about the least. Because most of the time, people go, which has to happen? But it has to happen without mistakes. And that means that that might be the bottom. And then it might be that you haven't tested [unclear] in 15 minutes. But if you're going to spend half an hour [unclear] about the samples and then scanning it and then rechecking things, you're going to have a pile up, and then you're sitting there looking at the experience of people who've testing in-house.

The [clinic] GeneXpert experience is that though the clinic is [unclear] open from 7:00 to 7:00, people are loading samples until midnight. So that’s a huge workload. So if you're not finishing it real time and you're having samples piling up, you need to think about what or how you're going to do it. Because if you're seeing a lot of patients and you have a machine that can do one sample at a time, and even though it's super quick, sometimes they [unclear] see patients. Eight sets of samples come in at the same time, and then you say 15 minutes each, 15 minutes times eight is two hours.

01:02:59

And in that two hours, you got another three lots of 15. So two hours later, you're now waiting four hours. So that sitting is where you need to have. The ideal thing is that you say that every examination room has this device, which should be ideal, but that would be expensive. So it's looking at what is feasible, how do you change your pathway? And if you're having... are you going to have a backlog, how are you going to deal with that? So those are the things that would concern me if I was implementing something.

R And my last question here would be, if I ask you to compare the CT/NG tests versus the four pathogen tests, CT/NG/MG/TV, how do you see their usefulness in the clinic?

P Again, they're different populations, so you do both. The problem with Mycoplasma genitalium testing is that there are lots of beliefs about it. If you look at people and say, don’t do a symptomatic testing because it's transient. How transient is it? At the end of the day, I think you need to think about it as like it’s an STI, then you treat it like any other STI. You find it [unclear] Chlamydia is transient, gonorrhoea is transient. Do you want to test? Do you want to reduce burdens, you have to test into it.

01:04:49

So actually, having the full pathogen one is more attractive to me. If it was going to cost the same as to pathogens, at the moment, we have two [unclear] testing. So we have Trichomonas testing for certain populations because that’s all we can afford to test. Ideally, I would want to test everyone. But not everybody would want to tell us that their partners are high-risked ethnicities. And it's super awkward asking people what ethnicity are your sexual partners.

Whichever way you face it, that’s just like, why? And you're basically making judgment in what's most common with patterns that can change. So actually, if you have the ability to test everybody, I would do that. If it's [unclear] you to, that's what you would do. So the four pathogen tests would be useful, and then you have a separate one, which allows you to test for resistance. And then you basically make sure that you have residual sample to do that.

And you know that you're going to be doing the resistance ones in a smaller proportion of patients. And it might be that you want to have the resistance ones as separate. So you have a gonorrhoea resistance cartridge, your Mycoplasma resistance cartridge. We don’t know enough about Chlamydia and Trichomonas to do any resistance testing. But these two, where you make a treatment decision. And then you can again change your pathways.

01:06:29

Somebody has got Chlamydia infection. You pop them off to a health advisor to talk about their partner notification and do that while you find out what is the best antibiotic to give them with your cartridge number two. And that’s going to be a small proportion of patients. So we're going to say it's going to be about a third to a quarter of your patients, depending on the population, who would need that, which means that the bulk of them would test and go, ta da, you don’t have anything.

So the fourth testing one is attractive form of testing, and then you say that for gonorrhoea, you have the resistance one as your confirmatory asset. That also tells you about what they think is [unclear]. And if you can actually make it more savvy and increase your antibiotic susceptibility prediction to other antibiotics, it had to be that. If you can tell, tell me that this gonorrhoea is resistant to azithromycin, we won't waste time adding azithromycin to the treatment.

If I know that this has got [unclear] resistance, I would make sure that I get at least one of the antibiotic with it. So then you can personalize the treatment. And it's especially important for Mycoplasma at the moment, because quite often, you end up treating and retreating them. Because by the time you find out azithromycin doesn’t work, you already given them azithromycin and go, actually, you have to come back, we have to give you [unclear].

01:08:22

So actually having that could be better. So I would go for four pathogen first, followed by resistance would be my preferred one. I know that you guys have done work with patient groups, but I'm not quite sure if that’s... we need to be informed about what actually that means before you can just say, if you're able to present the scenario to patients saying that this is... but we're also looking at how does having the two pathogens versus the resistance together versus four pathogens affect the clinical pathways.

R So is there anything else in terms of adoption of new technologies that you think that you haven't had a chance to mention? Because I've ran out of questions.

P No, I don't think. But I think I've talked about lots of the key things. I think the things to reiterate is that actually looking at avenues to service implementation studies and to make them as studies rather than say just make cost to things basically, then would make it attractive for companies to say that you have that implementation thing funded by research. And then you have all the data to make a business case. That's probably the strongest thing. And then getting organization leads.

Reference 1 - 7.29% Coverage

R Right. And what about existing contracts? So between for example, clinic and a lab and all those. How do they fit into that picture?

P So they will have to be considered. That all falls under the evaluation process. So the first thing to do is, say you’ve got a contract with a supplier to do X amount of activity for X amount of years. Somebody else comes along, can do it better, cheaper, faster, whatever, you need to have a very good understanding of where you sit from a legal perspective because of your previous contract.

So do you have a good termination clause in place? Because sometimes it can be like yes, that’s definitely the best idea in the world. We should do it, but we can’t do it for four years. And you need to understand that that… Your existing arrangements if you like.

I think when you’re negotiating with companies it’s really important to have a good termination clause, so one where you can walk away at a certain point of time, ideally with no cost. Because the technology… Well, you only need to read the BBC every morning to see how much things are evolving. That’s exactly the same for healthcare. It’s an evolution and you’d be mad to agree to something today if you think that’s going to be the pinnacle of testing for example in two years because it’s not going to be. Things are going to change.

So I think we need to be quite prospective about the way we reach an arrangement with a company and most companies are quite open to this now. It’s quite a normal way of living for them at the moment.

00:14:02

But there are some things that we have to consider. Historic arrangements, what have you got in place and what does it mean to us if we’re going to change this?

Reference 2 - 5.19% Coverage

P Yes, absolutely. So when I was talking earlier about the pan-London changes to sexual health services we've seen, we're now commissioned very differently. So I mean, point of care testing is a clear benefit to the patient, okay. So I think if you can reduce the amount of unnecessary investigations because you can diagnose a particular thing earlier, you will also have a big reduction in your prescribing. So you don't want to be prescribing drugs unnecessarily or general antibiotics, where you could target treatment per se.

You will also make a big dent in capacity as well, because if you're bringing patients back unnecessarily, or necessarily, for results, when you could've dealt with that within, I think you said 30 minutes, I think you said, that is a game changer for sexual health services. Where we are managed so tightly on our budgets, it's important we're as effective as possible. And bringing somebody in, taking their history, testing them, to then send their results off to a lab to be processed, a number of days later to call them back. You have troubles getting hold of people. It's a walk-in service. There's no guarantee they'll be seen. The benefits here are absolutely massive, huge.

Reference 3 - 1.23% Coverage

So it wouldn't surprise me if these did significantly change the way we're managing our service over time. I don't think it would be an immediate thing. This maybe seems like you need to see the results, prove that it works first.

R Yes. Do the local validation as well, yes.

P Exactly.

Reference 1 - 4.68% Coverage

P I think, for certain patients it would definitely improve the service. So, I can see us using the chlamydia, gonorrhoea rapid tests as a way of testing partners coming in. Who otherwise come in as a partner. And we say, oh, you had sex three weeks ago? Okay. Well, we are just going to take samples of you and wait two, a minimum of two days. Maybe up to a week for that result to come back.

And then, if it’s positive, then call you. Book you an appointment to come back in. Give you treatment then. And all in that time, they could have… They still have the infection. Could potentially pass it on to someone else.

So, having something where we can tell them, 30 minutes later, yes, your result is positive, or your result is negative. That’s awesome. That’s brilliant. Are we going to want everybody to be sticking around the clinic for 30 minutes to wait for that kind of results? And what is the cap… Like, how many machines would we have in order to use it on, you know.? Say, we have someone coming in as a contact. But we’ve got two machines, and they are both in use for lower risk samples. That would be frustrating. Yes.

So, I think we have to make… I don’t… Unless we had loads of machines to do it for everyone. And there are patients who are… I would probably be interested to see how many patients would actually be willing to, right, you’ve come in for a check-up. You want to be out the door in ten minutes. I could give you all your results in 30 minutes if you just wait. Would people actually do it?

Reference 2 - 2.23% Coverage

P Well, I think… I mean we’re still just getting our heads around the microplasma thing. I mean people are still not quite comfortable explaining it and talking about it. Let alone doing partner notifications and stuff for it. So, I think we… It would be good. I think the sooner we get into talking about it on a regular basis. And this could be something that helps us make that part of the routine.

But if we can offer the test that has more results on it, to be able to rule out mycoplasma, and not have to give people ten courses of antibiotics. Try and find the one that’s going to work. That would be brilliant. That would be really good. Yes. So, the more we can use that test for, the better, really, I think. Yes.

Reference 3 - 2.43% Coverage

P Yes. Chlamydia, gonorrhoea, HIV, syphilis. And, occasionally, TV. But not all clinics do it.

00:34:04

R Yes. But how do you talk to the patients about it?

P Yes. Well, it changes the dialogue, doesn’t it?

R Yes. And then how do they notify their partners? With new… Supposedly new. It’s strange, yes.

P I think… A new STI. I think the more we have an opportunity to talk about it, the better. And using something that is going to test for microplasma in the clinic gives us something to talk about. And it’s not something that’s widely done as well, at the moment. So, that would be quite a nice feature, as a way of kind of, you know, patients would come here specifically because we test for that. But it shows how robust the service that we offer is. I am well in favour of it. Yes.

Reference 4 - 1.74% Coverage

P Yes. Okay. Because, you know, it would be nice just to be able to start trying something like this. And kind of doing a trial and error thing around what is, you know? Because I think we would have to experiment with who are the patients seeing. And who is doing the tests, and all of this. And change things up if it is stressing out the nurses too much. Or if it is creating too much work for the health advisors. Got to be thinking about all of that stuff. But I think it’s a brilliant thing for the patients, at the end of the day, really. So, I am excited. Yes.

Reference 1 - 3.26% Coverage

R And… So I told, like, I explained a little bit about the point of care test. But I don't know how confident, well I don't know how well I explain, I don't know how confident that you would be to maybe tell me what you think… Well, I guess we can just talk about a rapid point of care test that would allow patients to receive… To be diagnosed, and receive treatment within the same clinic visit.

00:44:09

P Yes.

R How would it impact the clinic?

P Well, I would say…

R Yes.

P It wouldn't have an impact, because at the moment we have the labs in place.

R Yes.

P Because when… before the… We all did the cross site working, we didn't have a lab at [name] site, and we didn't have a lab at [name] site. So that was one of the business planning, to introduce labs into the… These clinics. So that when patients, because you know they can be diagnosed for certain…

R Yes.

P Things.

R Yes.

P So… And they're waiting for their results.

00:44:47

R Yes.

P So, it doesn't delay… Obviously the patient's happy to wait, and be treated. So I think it would be really good for…

R For the patients?

P For the patients.

R That will be the main impact.

P Yes, that…

R Patient's experience?

P Yes, patient's experience, I think, because you know, they come in a… You get quite a few patients that say, oh would I get the results the same day? So, I think this would be good if they got it on the same day, because we say no, two to… It's seven to ten working days. And I know they don't want to hear that.

R Yes.

00:45:17

P But, if they say, yes, we give the results on the same day. I think definitely it would be a good thing. And also, I think the patient…

Reference 2 - 0.85% Coverage

R And what about the work load in the clinic? So, you know, it would be additional test.

P Because we have, like, the healthcare assistants, so we have more than what we had previously. And obviously about five nurses, so I don’t think that it would make that much of an impact. It might, if we’re moving the ASIMS to the kits, and for this to replace it, then it’s not taking any extra burden as such. That’s what I really think.

Reference 1 - 5.74% Coverage

R And what about four pathogen test, so CT/NG, MG, TV, how would you see that benefiting, or maybe not?

P Personally, I think it would. Me personally, I’m seeing more and more patients who have been tested for Mycoplasma, or Ureaplasma, in another country. I had one yesterday, she’d been tested in Hong Kong, positive for Ureaplasma and Mycoplasma, and had had treatment, and still had symptoms, and had abdominal pain.

00:29:16

And I had another one a few weeks ago, it was a similar thing, they had been tested somewhere in Eastern Europe, and had come back, and they have an expectation that because these things are tested for routinely in other countries, of course it’s tested for routinely here. Or the woman I saw yesterday had been to her GP, who said, I can’t test you for these, but go to this clinic, they’ll test you for it. So, then they’re always completely surprised and shocked, or upset, that we don’t routinely test for it, or we don’t test for Ureaplasma, at least – we do have the ability to test for Mycoplasma, if we send the test off to the reference lab.

So yes, I think that would help, because it’s becoming more and more routine, so I feel like if we don’t start introducing it, it kind of already feels like we’re falling behind slightly. Because patients just automatically assume we test for it, and then you tell them, well, we can test you just for this one bacteria, and it will have to go off to this lab, and it may take two weeks. So, it’s not really a great service.

Reference 1 - 7.60% Coverage

P I don't think that the structure of the clinic really matters. I think I would like to encourage a point-of-care test which really works to be on honest. Pretty sensitive, specific and I don't know whether it’s useful to use it on everyone, I don't think it's useful but patients who really need quick test results… Because sometimes we do see patients who are coming for a test today and they talk about going away tomorrow so they would like to know the results as soon as possible, which makes sense sometimes. So for a particular group of patients, point-of-care testing is quite useful.

R So in terms of adopting new technologies, you mentioned that what can facilitate a process like that is that if the technology is cost-effective, if the training is provided to all the staff involved if there is a strong evidence. And you also said that it’s helpful if there are other services already using the technology and obviously if it's seen that it improves patient care, then also that helps to adopt new technology.

00:17:06

P Yes, and also if you have a proper method of recording system results, recording and… The other thing that I was concerned about was what is the process in place for ongoing daily quality control testing and any troubleshooting issues and what are the instruments that we need to use. And if there is any particular instrument that we need to use, so what is the instrument maintenance requirements and things like that, those technical stuff more than clinical stuff.

Reference 2 - 5.53% Coverage

R So this is interesting because my next question is about… Well, the long-term plans for Atlas or Binx Health as they call now, is to produce a point-of-care test that will also give results for Mycoplasma and TV. So that would be a four pathogen test. So how do you think, would that be useful?

00:26:34

P That would be useful, certainly, because we don't test for Mycoplasma at the moment. So that would be something that we would be interested in. Yes, certainly. If you can have four tests in the same platform that would be better, I think.

R Maybe not because patients would be anxious about their result, but it's more about not having those tests available at the moment at all?

P Yes, because Mycoplasma and TV, I don't think even half of the patients that we see do not know about the TV actually. We need to talk about it before we test them. And I don't think from patients’ point of view they are bothered about TV or Mycoplasma, but obviously as clinicians we know that it's important testing for Mycoplasma. It’s recommended for some people. So yes, I think it will be useful.

Reference 1 - 6.54% Coverage

You said that evidence is important, I’m thinking it has to be data coming from a robust research...

00:10:13

P Yes.

R I assume? Yes.

P So the evidence was there in terms of the robustness of using a PCR testing for NAAT. It was now a question of deciding what platform we were going to use for our specific set up. So the key thing was not about doing another study, it was about just implementing what is already, has become a part of a standard practice elsewhere in most clinics. So we were evaluating the platforms we have within the laboratory. Can they run a similar test? Can we get their reassurance about the quality? Is there an in-house system for us to check to reassure ourselves that the quality is okay?

And that was set up with the laboratory. I think in the initial stage all the samples tested here using the platform PCR were counterchecked in our reference lab. So that was like a quality assurance process to make sure that this new system we’re going to use is going to give us reliable results. And once we had that reassurance that our machine in the pathology is generating reliable results, after a period of time sending test samples we then started working on a process of how to roll it out and what to do during the transition phase?

So the first step is to make sure that we have the right machine to do the testing, we have the right kits to get the samples. And once we had that reassurance then we know that we can now safely move to the next step. So it was just testing that machine that was in the lab already there to make sure that whatever result it’s going to generate is reproducible by another independent pathology laboratory.

Reference 2 - 5.61% Coverage

R What would be needed if it was a new technology? What would be needed, what kind of structures or what kind of data would be needed for that, to encourage people to...?

P If it’s not popular?

R Yes, if it’s not commonly used.

P I think the first thing would be to understand why that particular technology has not been widely adopted. So maybe something new and there is no confidence. And the question is if there is no confidence, what can you do to build confidence? You can find the other partners who are already using it and what challenges they’re going through and what sort of safety, quality assurance they’ve got in place. So you have to understand why something that is new but has not been quickly adopted, what has happened?

00:13:48

It could be that cost may be compared with what is already been available there, being used, might be cheaper than this new technology. So this new technology is not going to have a huge impact in any change. Or it could be the fact that maybe the new technology is a bit clumsy in how you do the whole process. There is no... You need to really reset, you need to put a lot of other extra resources to get it running and that can put people off especially during this time when there’s a lot of financial stress.

So I think the key thing would be find out if anybody’s adopted it, what sort of advantages, challenges and benefits and then you can decide to do a case for it. So yes.

Reference 3 - 1.87% Coverage

P Yes, point of care within the clinical will mainly be for HIV and syphilis tests predominantly. So that’s been used for a long time, not in my clinic here but I know in the clinics I’ve worked in [location] and I know [location]. So the point of care we’ve used it in that context of the testing for HIV and syphilis, but mainly HIV.

R And do you feel like there is support for that testing?

P Yes. The testing with proper clear pathways and training, it works very well.

Reference 1 - 15.92% Coverage

R Apart from the finances, is there anything else that can be a barrier too?

P Well, if it’s physically viable. So it’s no good having a piece of kit that won’t actually fit anywhere, but it could be the best thing in the world. But if you can’t physically get it into the room then we can’t use it.

R Well, that makes sense.

P So that would be a decider as well. We’re talking about patients, because actually it is something that would benefit the majority of the patients rather than be paying for something that’s only for the minority, because that would be a driver as well.

R So maybe it shouldn’t be just for certain groups of people but rather for as many patients as possible?

00:15:05

P Benefit to as many patients as possible, yes.

R So now I’m wondering, what is your opinion on point-of-care tests and what in your opinion is the general approach to those point-of-care tests in the service?

P I think they’ve got massive benefits for patients. I think they’ve got massive benefits for groups of patients. It’s a case of also using them but being able to remind the patients about the need to follow up their testing as well. So if it is a case of they still need to come back in X amount of week’s time or whatever, it’s making sure that we’ve given all the right information because sometimes patients just want the results right now.

They don’t always listen to the rest of the information when you’re saying to them yes, but you still need to be tested in X amount of weeks. They can’t just stand to that bit so they’ve got their results now and that’s it, that they’re off. So I think it’s a whole this massive benefits but it’s also about making sure that we’re not sending them all off with, not forcing information but reminding them about the need to come back if they need to. Does that make sense?

R Yes, definitely.

P Because I know sometimes with HIV, we don’t do point-of-care testing for HIV but Terrence Higgins do and they were saying the same. That was brilliant but as soon as they’ve got their results that’s it, everything else you said to them, they’ll just forget. They say, no, yes, we’ve done this or that but you still need to come back and have another one done, but they don’t always listen to that bit.

00:17:27

It’s about the here and now. But like I said, I think for those who could have chlamydia and gonorrhoea point-of-care testing, especially for those young people that maybe are going to struggle to get back into clinic again, then it’s brilliant. For the high risk patients, maybe those who have been assaulted and actually having the trauma of coming back into clinic and pre-coil fix, all those ones that potentially you do need your results right here, right now. Then yes, I think there are actually benefits to it.

R So are you familiar with the Atlas point-of-care test that’s currently being CE-marked?

P No, I’m not.

R So this the test that would give results for chlamydia and gonorrhoea within half an hour. It’s quite easy to use and after half an hour, results are being printed: positive, negative or can’t read. So it’s simple.

P We like simple, yes.

Reference 2 - 5.27% Coverage

R So long-term plans for Atlas is to develop a four pathogen test, so there would be chlamydia, gonorrhoea, mycoplasma, TV. What is your opinion on a test like that comparing to just chlamydia, gonorrhoea?

P There’s potential of patients, they’re obviously going to be getting tested for the four rather than two. Currently we only do chlamydia and gonorrhoea and we do TV if it’s clinically indicated, we don’t do TV on everybody and stuff. So it just depends on... I think upping it even up to four I think it’s going to look at, obviously that’s going to come in more instances. So costings would be implicated to be looked at as well, definitely finances. Not so out of the question but we would have to, finances will be a big draw on that one.

R Compared to just the CT/NG because those tests they’re already being performed in the clinic.

P Yes. We do TV but obviously we don’t do it on everybody and we don’t test for Mycoplasma, that would be a new test. We don’t currently test for that and our lab test doesn’t test for that.

Reference 1 - 4.74% Coverage

So if there's something about the test that has a unique selling point that's better or... not necessarily better but compliments or adds to what you've currently got, then I think that very rapidly can get buy-in of a whole service. So what I would normally do as a service lead is if someone comes to me with an idea either from within the department or an external person saying we've got this test, you look and say, actually, is there a niche or is there any potential in the service? And then talk to anyone who may be affected by it.

00:04:33

So for a lab test, actually talking to the consultants in the lab and the people who do test because you need to know if they've got the results to evaluate it, the inclination to do it. Talk to the people on the shop floor in the service here. So if we bought in, what's the label, what's the change in work pattern, and can they see any advantages? So starting with the senior team, so the senior nurse or the consultants.

And if they can see some value in it, then actually talking to whole service about what it might be before them developing the process for implementing it.

Reference 2 - 2.90% Coverage

P I mean, I think looking at your population, particularly hard-to-reach... if you got something that performs better for hard-to-reach groups, people who have a high DNA rate, people who are vulnerable for whatever reason, difficult to get to clinic, difficult to come back for follow-up, then if you can have anything that makes access for them easier, more of a one-stop shop, then that is always an advantage in terms of adoption.

It may not be something that fits the mainstream, low-risk population, but something for the high-risk and vulnerable population, then that would always be a selling point in terms of... or something that would weigh quite strongly in favour of those people.

Reference 3 - 4.86% Coverage

R So in terms of the way the services structures, can you see any points within the service that actually hinder adopting?

P Not really. I mean, I think if something... if you can identify a clear purpose or place for something, then you can get the whole service to buy in. I mean, some of them are physical things, like something that takes up a lot of space. The physical space is not huge. So something that needs a lot of physical space would be a problem. And that would probably be one of the biggest things, something that involves a lot of time, because everybody is very busy.

So something that’s difficult to operate, difficult to put in place and difficult... so something that's just taking an extra swab, pushing an extra button, those type of things are straightforward. If something has a lot of time commitment attached to it, then I think that would be just because people are... nobody has in lot of extra stuff, and say that takes a lot of personal time or takes up a lot of physical space. Something that adds a lot to the cleaning, just the day-to-day chores that people already having to do would be more difficult to persuade them to do.

Reference 4 - 1.03% Coverage

P I think the current test as being designed by Atlas would have added value for a small sub-group of patients. I think one has to recognize that it is a low-volume test and that it is a 30-minute test per machine, so you cannot run a lot of tests.

Reference 5 - 1.28% Coverage

I don’t think it would necessarily speed things up in-clinic or anything else. I think it would just give added value for a particular sub-group of patients.

00:22:35

R For their experience.

P For their experience, yes. And it would make it their follow-up and just easier for that group of patients.

Reference 6 - 3.60% Coverage

P I mean, the CT/NG/MG would be the ideal and TV would be a real added bonus. TV would be less critical, I think, but it would be nice to have, because, obviously, for TV, for men in particular, is less. But if you had cartridges where you could interchange, so if it was a woman who's got symptoms, then sticking in the TV one whereas...

R Right. Would they have actually significantly more impact on the clinic even if it was still the half an hour...

P I think probably because then as we don’t have those tests routinely available in the laboratory at the moment. But, obviously, if the laboratory switched to quadruple panel, then it would be less so. But particularly having a TV, so a woman, if you do microscopy and it's negative, but you think she's got TV, then being able to run a 30-minute test, actually, in a sub-group of patients would be helpful.

Reference 1 - 1.04% Coverage

P I mean, we’ve seen the machine, so it’s really not very big. So in terms of the lab, because certainly it’s locked in the lab quite easily, yes, because it doesn’t take up much space anyway, so that’s not going to be an issue. And both sites, that would be absolutely fine. Yes.

Reference 2 - 3.05% Coverage

P If it’s a test I guess our lab would have to be on board with this anyway, just to make sure that this is a test that, you know, has been verified and validated, to make sure that they would be happy for us to bring on. It’d obviously have to go through the Trust anyway if it’s, yes, something new that we’re bringing in. And, as I said, in terms of our senior management meeting, just to make sure that everybody’s on board with this, and then our commissioners as well. All of those things would be important.

00:17:09

I don’t think they’d be necessarily a barrier to it, but, yes, just to making sure… Well, I think the may be, because they’d have more… If it’s a lab test, then I think they may definitely… we’d definitely want to talk to them to make sure that they would, they’d known about it and things as well.

Reference 3 - 2.27% Coverage

P Yes, I think so. It just depends exactly what was wrong.

R Yes.

00:18:15

P And how important that thing that was wrong would be then implicated on the rest of the Trust. I mean, it could be something… I mean, who knows? It could be something like the machine, something to do with the machine, but not actually with the results or something. Like, say, for example, we use it three days and the fourth day every so often it just doesn’t work or something. It just depends on exactly what they, what the issue is with it. Yes. And what results it gives really. I think that would be the most important thing.

Reference 4 - 2.00% Coverage

P Yes. Because a lot of people will come up asking for the HIV point-of-care test, but actually we know that it is much better to have it in a highly population for HIV rather than a low population. That actually does change your results quite a lot. So it’s again about doing the same thing here. I don’t think necessarily that would impact on the results, but it is just making sure that the right people have the tests, because, you know, 30 minutes, that’s only four in there, so you can do the maths and see that it takes quite a while.

Reference 5 - 0.55% Coverage

So definitely in terms of that, in terms of public health, I can see that being definitely something that would be beneficial to our service, yes.

Reference 6 - 2.54% Coverage

P Well, potentially I think it could be beneficial, yes, but it just depends on how much things come at afterwards and what it can do. As the consultant/SDU lead was saying, and as we were saying before, it’d be quite nice to have four testing in one… It just depends on what that works out to be, I think, in the end. I think if it could do that, that would be really nice. If it could just test for STIs at the same time, I think, actually, potentially, that would be very good. But if not, it still would be… I can still see the benefit of having it anyway. Yes. I can still see the benefit of having it anyway, but it just depends on how much everything comes down to when it’s done.

Reference 7 - 2.79% Coverage

P Because it’s so quick, as in half-an-hour, I don’t really… It would be very much… I think for the patient experience, patients actually like knowing their results. Some do, and especially those that come in with symptoms, they would prefer to know what it is and get treatment before they leave, so I think that would be a positive thing. Some people may say half-an-hour is quite a long time, but actually in the general scheme of things, it’s…

You spend more than that in the clinic anyway, so, you know, you could do various bits beforehand, so I really don’t think that’s actually going to be very much at all in terms of time. So, yes, I think overall it would be a very positive thing to have, and I’m sure they would appreciate that as well, yes.

Reference 1 - 1.74% Coverage

P Yes, you see I’m not a microbiologist, so I wouldn’t be able to tell you yes or no. Honestly, from that meeting, and from the lab manager, who has a microbiology background, they felt it was. So, yes, I couldn’t tell you yes or no.

Reference 2 - 3.61% Coverage

P That’s an idea, it should definitely improve the pathway. So, it would mean that, you know, instead of having to wait a week or two weeks, I’m not sure how long they have to wait for their results now, they get it within half an hour. That’s definitely good, but obviously, we’ve got to be careful with a test like that. To make sure that, you know, the people that are giving those results out are trained and they are doing the tests properly. Because that’s quite an important test.

Reference 1 - 4.27% Coverage

P I'm not very much involved with the lab. But having said that from a clinician's perspective, what you want is a result. So how you get it, it's interesting. With the lab, at the moment, it takes a bit longer to get results, so that's why it gets to patients' needs. So what I find now, because of technology, the expectations of patients are high from health services. So if they want a test, they want a result now. I find that in clinic a lot, that the demand for wanting to get the result now is much higher than it was probably years back.

So it might be possible that it might help in terms of that, but I don't know how that would work with the lab. That's a political one. I think that's for the lab. But for me, if I can get a result, that's my own interest, I think.

00:12:15

R And the sooner, the better.

P The sooner, the better. If it's reliable and you get the result, that's good.

Reference 2 - 0.98% Coverage

The only concern for me personally is the 30 minutes.

R Yes. It's too long.

P Yes, I think so.

R Which means that you can't test as many patients?

P Yes. Because in one hour, you are looking at two.

Reference 3 - 7.76% Coverage

P I think for patients, they would love it. I'm saying it's longer time. But for them, they are having to wait two weeks to get their result. So for them, that would be amazing to get the result when they visit. But it depends on what time we've done the test, because even now, some patients complain that they are waiting longer within the clinic for their appointments. So if we have to make them wait even longer, I'm looking at some patients going, I'm going home, so ring me up.

00:28:26

So that would mean more time with the same patient ringing them up, telling them the result that they could have got in the clinic. So, yes. In that way, it might. For some people, it might be all right. But for some, they would think that being in clinic for another 30 minutes would not work.

R And what about those patients who are aware of the test but then find out that they can't have it?

P I think that will always happen. That will always happen, because even now, you'd be surprise that people come in and ask for the test. Because if some people have travelled to some country that, this test I used at United States, they'll come back and say, could I have my result now then? And with technology, they are reading a lot. People would sometimes, oh, you do in-clinic, it's clarifying what people have already read on the internet. So, yes.

R I could imagine, yes.

P So they know I'm a practitioner in the United Kingdom. We are not using this test here yet, blah, blah, blah. But some people would ask for them and would have to see and manage the expectations accordingly, because people do ask.

R Already?

P Yes, people ask.

Reference 4 - 2.34% Coverage

P I think with TV, we can diagnose TV on the microscope. So probably it might be all right, but it might also not be all right, because someone with TV symptoms, some of them is so obvious clinically when you examine them. And it's so obvious on the microscope, on the live sample. So probably for that, it would be fine. But for MG and the other tests, we very rarely see those anyway. But if we can have a benefit of having them, too, that would help. But I don’t think that would change much.

Reference 1 - 3.26% Coverage

P Okay. So adopting new technology, initially it does impact the service users, because everyone's a little bit slower at what they're doing. But over time when people get used to it, it's probably benefit the patient, say a point-of-care test instead of having to wait for the results and having the anxiety around waiting the results. They could possibly get a test result very quickly within a certain time frame, which then is good for patient satisfaction.

Reference 2 - 3.10% Coverage

so you already suggested that the point-of-care test could improve the service.

P Yes.

R And in what way, if you could…? So it would improve patient experience, you said.

P Patient experience.

R Any other ways?

00:14:33

P Staff experience, the flow of patients through the department, the number of patients we could potentially see. Yes, I think mostly it's that patient satisfaction, patient experience that is the most important.

Reference 1 - 5.15% Coverage

R So, would you say that a point-of-care test in the Sexual Health Clinic would improve the service?

00:19:35

P Personally, I think it would because I know that they struggle with the laboratory. I know the laboratory is criticized for being slow. And I often think that the online testing is used to circumnavigate the internal laboratory anyway.

When we had our committee screening programme, we used exactly the same online testing practice rather than the local laboratory for the urine sample testing, purely because the turnaround time was so slow, it was unworkable. Whereas an online test, everything was posted off, and the answer, a positive or a negative, was back within 48 hours, 72 at the most.

So, yes, I think it would help patient pathway. Yes, it certainly would speed up the process. But we would probably then be criticized for reducing the need for our laboratory. But they are slow, they are pretty slow.

Reference 1 - 2.66% Coverage

P I think, as you’ve already said, that cost-effectiveness is important. But also I think, the practicalities of it. How easy is it to use? That would definitely be a factor. Because if it’s just as easy to get a patient to do a urine sample and send it off to a lab. Or if it’s easier to do that, then I think you’re going to have preference for staff to go with what they already know. But if you give them a straight… The test is equally as easy to use as the current test then that would definitely be a positive aspect. I can’t think of anything else.

Reference 1 - 3.01% Coverage

R That’s okay. So, at the beginning you said that you’re quite… that you like the idea of a point of test?

P Yes.

R And that’s because you can give those results on the same day, and therefore you can treat people within the same visit, and obviously stop infections?

P Yes. Stop forward transmissions. Reduce all of that. Lower clinic costs, lower costs to the NHS, and further costs outside of that. Things that could happen later on their lives. Ectopial pregnancies for example. All of that going on. And fertility. But it doesn’t matter how many times you talk about it on the phone to a young person. They still aren’t going to believe it until it happens to them. To be mobile, or to be able to have that ease of use, the aesthetic unit. Just saying we’ve got this new technology in our clinic and being better prepared to improve their access.

Prompt diagnoses. It’s good. It’s great for the public health purse. It’s hugely beneficial for everyone.

Reference 1 - 4.10% Coverage

P Well again, we don’t actually have any real... We can test for NG here but it’s not something we can do routinely so to have that would be a bonus but having said that we’d probably find more infections so therefore there would need to be more treatments available.

00:29:24

TV at the moment we mainly rely on microscopy for that so again that would actually be a real benefit from the point of view of maybe cutting out some microscopy time. So both of which at the moment we don’t see a great deal of, but that’s probably because we haven’t got the facilities to look for it.

So I can see that it would have an impact inasmuch that we potentially pick up more infection but then obviously the impact of picking up more infection is the work that would generate around having to obviously give out treatments and the partner notifications. But that’s what we’re here for.

Reference 1 - 1.36% Coverage

However, facilities, it depends how big the piece of equipment is because if we’ve got to make adjustments to the environment, that cost has to be factored in, and if it’s going to be disruptive, how we’re going to continue to provide a service has to be factored in.

Reference 2 - 6.56% Coverage

R So would you say that overall, in your experience, people have been quite receptive to new ideas?

P Yes. Yes.

R Okay. And that’s because it doesn’t… it’s not too disruptive?

P Yes, provided what you’re going to change isn’t going to hugely impact on their workload and how they work, usually it’s fine.

R Yes. Is there something that you think about? So, for example, when you think about new technologies, new equipment, is there something that you consider that, you know, it shouldn’t be too disruptive?

P Yes, because they will be, in the business case, they will be one of the stakeholders that we list. So we have to consider what is the impact of the change we implement going to have on service users. And certainly we implemented something about 18 months ago that was quite a big change from what the doctors within the Trust did. So before we implemented it we made sure that there were meetings where they could discuss it, that they were fully informed, that there was adequate notification. We explained what the changes were going to be and we explained what we needed from them.

00:13:47

And there was an opportunity for feedback from them before we made a decision to implement. So they do have to be… if it is a change for them, they do have to be involved in the process.

Reference 3 - 3.39% Coverage

P Well, the TV would be useful because at the moment we do microscopy and it’s not particularly sensitive and with patients in the clinic, they don’t send swabs to us for a routine genital investigation unless they suspect bacterial or a parasistic infection. So a lot of those patients potentially aren’t even being screened. So I think there would be some benefit there.

But, again, it would depend how the test was going to be used. I mean we do a combined… that test we do at the moment is combined chlamydia and GC. So if what you’re going to implement is just a chlamydia test that is actually giving less… a less accurate result than what we’re currently doing.

Reference 1 - 1.12% Coverage

P I think a rapid test that gave results to allow immediate treatment of Chlamydia and Gonorrhoea would improve patient flow. Yes.

R So that would be generally a good thing?

P Yes.

Reference 2 - 2.83% Coverage

Potentially there may be a delay in those results. But that means it doesn’t work as well, and if I remember rightly, the proposed platform is a 30 minute assay. Well, given the number of people that we might see in a day, 30 minutes might be fine for the actual test to run. But they might wait three hours for a machine to be available for that test to run. So, all of what I've just said ceases to become, well not all of it, but it's not necessarily as relevant.

Reference 3 - 4.72% Coverage

R So do you think it would still have the potential to impact patient experience in a positive way?

P I still think that absolutely it does have the potential to. It's just a question of, again if a… Slightly hypothetical situation, because I don't know how many tests can be run simultaneously, I don't know in a physical day to day average clinic, would there always be a machine available to run a 30 minute test? Or would there be five or six in a queue for each machine? That would mean that there would be a three, four hour delay in those results.

00:17:54

Because people would be probably happy to wait for 30 minutes for the test result, but may not be happy to wait for three or four hours for the machine to be available to give them their 30 minute test result.

Reference 4 - 5.19% Coverage

P Yes. So I think that the benefit potentially of MGen being included means that you… So at the moment, so symptomatic, let's take symptomatic male patients. Currently have microscopy done to identify Urethritis. And that largely to facilitate rapid treatment, which point of care tests would potentially overcome. But also to identify Urethritis in people who are non-Chlamydia, non-Gonococcal Urethritis, of which the most significant pathogens are probably MGen and Trichomonas.

00:19:19

So if you could exclude Mycoplasma, and Trichomonas, and Chlamydia, and Gonorrhoea people, then I think that would potentially negate the need for routine microscopy. Which then allows you to deal with symptomatic patients in more community based clinic settings, and potentially hours and days of delivery that you don't routinely have microscopy available.

Reference 1 - 0.30% Coverage

P Yes, I think that will be brilliant. So I think having just chlamydia and gonorrhoea is slightly limiting.

Reference 2 - 3.08% Coverage

I guess the other thing is cost. So, at the moment we have a combined chlamydia, gonorrhoea NAP. Then we have a separate TV culture which we also do candida culture on, although it’s a substandard candida culture. So we’d need to do a separate candida culture which would increase costs for those that needed it. But at the moment I feel that we’re indiscriminately culturing anyone, any women with symptoms for candida which is not really appropriate.

00:37:31

So we could certainly reduce our candida testing. And we’ve got the two separate tests, the two separate swabs, as we’re doing TV separately. And if we streamline that, it could potentially increase costs a small amount without causing problems. At the moment we’re not offering mycoplasma, mainly due to cost and delay. So we have to send it off to lab and it’s a three-week wait to get the result back, which isn’t massively clinically helpful.

So I think from a clinical point of view it would be absolutely amazing to have the four-pathogens in a 30-minute test. But we need to think about clinic processes with that.

Reference 3 - 3.11% Coverage

I think the other thing that will be really useful, and I don’t know if this is something they’re thinking of, it would be to have a rapid PCR-Ulcer platform. So your patient comes in with an ulcer and it might be syphilis, you do dark-ground microscopy, well we offer that in our clinic, but lots of clinics don’t have either the expertise or the staff to offer dark-ground microscopy. So they don’t have any way of offering instant syphilis diagnosis.

And even then, with dark-ground, sensitivity varies with the site of the ulcer and the person doing the microscopy. And we’re taking herpes PCR from ulcers as well, which would type it to type-1 and type-2, but again, the delay there is approximately a week. So again you’re treating patients syndromically, based on your best guess that this is herpes rather than something else.

00:39:13

We do have syphilis PCR available, but we’re not using it commonly, because we have dark-ground. And actually, if you could have an ulcer platform that did, say, syphilis, HSV-1 and HSV-2, I think that also has real capacity to transform patient care.

Reference 4 - 1.67% Coverage

P Sure, because I think, certainly within our clinic, if we were to offer the point-of-care test, we’d definitely want to be able to do rectal and pharyngeal samples because I think our MSM cohorts have one of the greatest potential benefits from this system. And we see a lot of, some pharyngeal infection there.

So, certainly locally, our gonorrhoea rate is rising, has risen far more than that we see nationally. And we think a lot of that’s been driven by pharyngeal spread. So we’d certainly want to be able to offer those samples, and we should validate that locally to achieve that.

Reference 1 - 6.84% Coverage

would you say that a rapid point of care test, such as Atlas CT/NG test would improve the service?

00:23:22

P I think so, I think it probably would. I wouldn’t use it in everybody, because clinic flows couldn’t handle everybody who was coming for kind of five minutes seeing an HCA, getting a urine test and a blood test, to send off waiting 30 minutes for results. We don’t have capacity for that.

So, where I’d see it fitting in would be symptomatic patients. So, you could redesign the clinic flows, really, so if somebody came in, kind of do a triage, so in men, it’s I’ve got dysuria or I’ve got urethral discharge.

Well, actually, their triage would be that they do a urine sample… or whatever sample… urine sample first, that goes on the analyser, and then they go back and wait, then the chlamydia/gonorrhoea test comes through, so you know, and then you call them through and do the assessment.

So, you know that they’re chlamydia and gonorrhoea negative before you do the assessment, so… that’s probably where I see it fitting in, in use for symptomatic patients within the clinic, or very high-risk patients that you think there’s a… or contacts with chlamydia, something like that.

So… where you’ve… actually having a chlamydia and gonorrhoea result would make a difference to the management you do on the day. So, for example, if you would… you would give a different type of antibiotic.

00:24:52

Certainly, I’d see that fitting in. So, if somebody came in with urethral discharge, their chlamydia and gonorrhoea was negative on the rapid test, you’d do a swab and confirm, you would treat them for mycoplasma and other NSU organisms, rather than concentrating on the chlamydia and the gonorrhoea. So those… that’s how I’d see that fitting in with kind of our pathways.

Reference 2 - 14.28% Coverage

And how would it impact patient experiences, if at all?

P So, probably in terms of time in the clinic, would increase. As the payoff, so that time, say, if they’re in a rush or something, then that might be perceived as a negative impact, but, I suppose a positive impact would be they’re far more likely to find out what the cause of their symptoms is earlier rather… earlier on the attendance, rather than waiting for a text message or a phone call.

00:27:51

So, yes, normally, when we find urethritis or any [unclear], say well, it could be this, we’re going to treat you for this, because it covers this. Actually, with a point of care… a rapid test, you would say, well, actually, yes, your symptoms are caused by this organism. Or, it’s not chlamydia, it’s not gonorrhoea, which means that it’s either going to be one of these things. We will send some extra tests for that.

It would certainly help in terms of mycoplasma testing, rather than… while we can’t afford to blanket mycoplasma test everybody, but it would be useful for people with symptoms that they come in and have their rapid chlamydia and gonorrhoea test, it’s negative, you treat them for mycoplasma, and you send off their mycoplasma test. Just to see that if it is mycoplasma, you can do then resistance and things on it.

So, it would improve clinical pathways from that point of view.

R Yes. And my last question is about the difference between CT/NG test versus full pathogen test that would also include TV and MG.

P Okay.

00:29:01

R What do you think about that difference, and how significant it would be for the service?

P In terms of if there’s a rapid test?

R Yes, so having CT/NG point of care test, versus having CT/NG/TV/MG point of care test.

P I think… I think… again, trying to compartmentalise that into one attendance where everybody gets kind of a diagnosis when they come in one attendance, so, again, in looking at the pathways, symptomatic people could have a chlamydia and gonorrhoea.

If it’s negative, then that sample is automatically then redone, the patient probably sent away to come back in half an hour, but to treat… it’s another pathogen as the cause of their symptoms.

So, if it could potentially… if you’re assuming it takes half an hour, we wouldn’t want… if the costs of the reagents and things wasn’t particularly high, then we’d probably do them all at the same time. If there was an additional cost, or significant additional cost of doing mycoplasma or TV, we would probably do that as a test after you’ve excluded more common pathogens, CT and GC.

00:30:29

And then, sort of, the patient waited like an hour, so potentially the efficiencies at that point, certainly in terms of time and being able to diagnose and treat in the clinic are probably a bit different.

So, potentially, if it wasn’t… if it was economically viable, you’d do them all at the same time, rather than doing them sequentially. I think if the cost of CT… the cost of TV and MG testing was significant additional work, probably the clinic pathway would be more suited to, you’ve not chlamydia, you’ve not got gonorrhoea, here’s a treatment which covers most other things. We’ve sent some extra tests off, and then we’ll contact you if there’s a problem, or we find something.

So, it kind of reduces the need for a rapid test as such. They don’t necessarily, they don’t need that result in 30 minutes. Just a standard five-day result is probably enough. But… if actually it was a more kind of multiplex… it’s the same reagents, it tests all of them at the same time, it doesn’t actually make massive cost difference, or no cost difference between testing for CT/GC and… or CT/GC/TV and MG, then yes, definitely, you’d do them all at the same time.

Reference 1 - 6.86% Coverage

What about individuals views of point-of-care testing?

P I mean, No. 1 I think the first thing we need to think about is, you know, the point-of-care test that is like... in sexual health we’ve had point-of-care tests for a long time. Microscopy is a point-of-care test, urine dip is a point-of-care test. Everybody uses it, adopts it, loves it, it actually gives you an answer straight away and gives you something to give to a patient. You know, you can say, oh, you’ve got BV, you’ve got thrush, you’ve got trichomoniasis.

So, you know, I think in terms of point-of-care tests we love them because... And I think one of the things we love is they’re quick. So, the INSTI test so when I think about HIV testing there was one test I remember that you had to do and it took 20 minutes to give a result. And, you know, I think I did one actually when I was in A&E in [hospital] and the man was positive. But, you know, luckily I was in A&E in [hospital] and I was on call but if I was a clinic situation that’s a bit longer isn’t it, it takes a bit of time.

But point-of-care tests are definitely adopted and people love them. INSTI is the one minute, I mean, in Uganda they have the 20 minute test because I’ve worked in Uganda. And actually it’s amazing because you give the person an answer there and then they don’t have to come back because unlike this country travel for a lot of people in the developing world is a big, big thing. They’ll travel to go and get their test and then they’re going to travel to come back and get the results.

00:19:34

That’s a challenge and that’s actually where, you know, the beauty of giving someone an answer, you know, at the point of doing the test is really good. So, I think, you know, because everyone when anybody thinks of point-of-care tests they think of just the INSTI but actually I always remind the clinicians I work with actually the urine dip, microscopy these are all point-of-care tests that we use and have adopted and work really well within our service.

Reference 2 - 5.17% Coverage

R And so the long term plans for Atlas is to develop four pathogen tests, so, CT NG, Mycoplasma and TV. How do you think that would impact the clinic, can you see benefits, can you think of benefits of that?

P Absolutely because I think we did the pilot here with TV NAAT and we picked up quite a lot of asymptomatic TV because at the moment the only way we can actually diagnose TV is microscopy. And I think they also picked up a few in men and you never see it in men. So, I think something has... a test that has an addition to chlamydia and gonorrhoea is definitely a benefit for yourselves because at the moment we just have gonorrhoea and chlamydia.

Some clinics have TV but a lot of clinics don’t have TV. So, and MG is... that would just be in symptomatic men at the moment. But, yes, that would be... I mean, I think having all the four tests would be useful. But again I think it’s great that you have the four tests but it’s... I don’t know how but a technology in such a way to maybe batch five at one go or even 10 that would just make it so much...

Because you can... so essentially what could you do is get, you know, run 10 people’s specimens and then 20 minutes later see... do you know what I mean, see the patients with the results or get someone started in the morning doing the specimens and then... do you know what I mean. But it’s just doing one at a time is just, you know, literally, you know, when you’re in a clinic that sees 60 patients a day it’s difficult, very difficult.

Reference 3 - 4.82% Coverage

But I mean it definitely has a use. I think another place, I mean, if you’re looking at non sexual health settings where, you know, people are a little bit, oh, I’m a little bit worried about this pregnant woman, do you know what I mean. I mean, there’s, you know, pregnancy, young people and pregnancy, you know, they test for HIV, syphilis and hepatitis B but they don’t test for chlamydia and gonorrhoea.

00:29:08

And we know there’s a lot of chlamydia and gonorrhoea in the under 25s. And there have been pushes to make, you know, testing universal with HIV and syphilis in this age group. But it hasn’t really happened because the midwives haven’t adopted it. But, you know, maybe having something like this because it wouldn’t be, like, a massively big, like, sexual health unit it might be there’s one 25 year old or one 21 year old amongst a... you know.

That’s another interesting setting there, you know, put it in terms of... Because there actually it’s quite useful particularly if a woman books at 30 weeks or 37 weeks and you find she’s got chlamydia, you know, you’ve saved that baby’s eyes potentially. So, that, you know, and you’ve given her the answer and you just give her the treatment straight away because that’s where I think it’s quite a nice... It’s got, I mean, where it’s not a massive footfall of patients unless they increase the number of tests they can do at the same time.

Reference 4 - 1.54% Coverage

55

But, no, definitely I think, you know, we would work with it and see how it’ll work in our clinics. But I know we’ve already felt that it’s something that’s not in a very busy clinic it’ll be difficult to manage. Yes, but the good thing is it’s simple to do and if any... you know, if anybody can do it then you don’t need like a trained nurse or a trained doctor running the test. You can get, you know, the health care assistant doing that.

Reference 1 - 6.71% Coverage

R Right, and what about the four pathogenic tests, so CT, NG, MG, TV, how would that benefit the clinic, if at all?

00:28:49

P You can give them the right treatment.

R Right.

P So we, the population we have here, we have a high amount of TV. Nearly always symptomatic in women, but we can’t test men without being really cruel. So actually even just for the TV portion of the module, then when people come in as a contact or they’ve got, or men have urethritis symptoms, we don’t treat with metronidazole, which is the TV treatment. So we treat them with something else, but then they end up coming back with symptoms.

So it could improve the care quite a bit if we know those two additional results. Because they do have an impact on what antibiotics we can use. Particularly with the Mgen antimicrobial resistance and things. So I think that would potentially get taken up easier than just the chlamydia-gonorrhoea, because that’s a relative, chlamydia-gonorrhoea is something we can do relatively quickly through the lab. The results are normally back within a week.

And there’s less concerns about, and normally if there’s gonorrhoea you’re going to want to culture as well, which needs to be done quickly. But to have the TV, which is, particularly in the community, because we only have a microscope at this one site, would potentially solve a whole load of problems, a whole load spread of infections.

00:30:00

Because we treat TV as, we treat it as BV. So same treatment. Symptoms go, and then they keep coming back because partners aren’t treated. So I think that would be a good thing, particularly in this demographic area, we have a lot of trichomoniasis, I think it goes under-diagnosed. I think at one stage we did a pilot on doing it as a PCR-TV, well that’s what our business case is for at the moment, is to get that as a permanent test for us.

R Oh, I see.

P And obviously that’s being done by the lead.

Reference 1 - 9.24% Coverage

R And do you think that technology is not being good enough, is a common reason why they don’t get adopted?

P Technology not being good enough?

R Yes. Or maybe there is, maybe even if they are good enough there is some distrust.

P I’m not sure. I think technology, when it’s used well, is really good. You know, the online testing here is great. If you haven’t got any symptoms, that’s really good. You would just get your test and go or have it sent home. I think that people are really happy with that, but they want to know that that’s actually going to be as good as a test that they would do here.

So I think, I don’t think people have a problem with that, as long as they know it’s a good test. I think the issue we might have here is that we, people are used to seeing a clinician. They’re used to seeing somebody to say, I just want this done or that done and they look for the other questions as well. They don’t necessarily need to see anybody, but they’re used to doing that, so it’s moving people away from perhaps seeing a human being and just relying on the online testing.

00:07:28

So some people are really happy just to come in and pick up a test. Some people want to see somebody. If they haven’t, they’ve got nothing wrong, they just want the reassurance of seeing somebody. Other people get a bit anxious about having to do a test themselves. But I think with the point-of-care testing that we’re thinking about doing, it’s, we would be doing it anyway, wouldn’t we? So we’re not asking them to do the test there on their own. Is that right? We would be doing…

R Well, it depends really because patients can take their own swabs and urine samples.

P But they wouldn’t then be using the machine to run it, would they? No. So, yes. They do that now, even if they come and see us for a chlamydia and gonorrhoea test, they’ll do the swab themselves, but we’d send it off to the lab. But we haven’t got so far as them doing the swab and running the machine have we?

Reference 2 - 4.97% Coverage

R And what would your say are individuals’ views of point-of-care testing within the clinic? Would there be heat resistance towards them or would it be just welcomed?

P I’m not sure. I haven’t really, we haven’t really talked about it since that meeting, to be honest. There hasn’t been a lot of discussion about it. Yes, I couldn’t really say. I’m not sure. My own view is, I think point-of-care testing is, or near patient testing is a really good idea. I think the equipment needs to be robust. I think the result needs to be the equivalent or more of what you would expect, it can’t be a lesser test.

But I think it needs to work, I don’t think it’s, you can’t shoe-horn a point-of-care test into a service where it doesn’t fit. It’s got, you know, it can’t affect the clinic and people waiting and things like that, I think. So that’s why I think you need to think through the steps of how it will be used to ensure that it makes a positive difference. But I think, like I say, anything that provides you with a diagnosis there and then, is a really good thing.

Reference 3 - 3.38% Coverage

P I think to work, if whoever’s providing the machines and the information, you know, if we can work really closely together and put in place what needs to be done. Obviously the running of the machine, the upkeep of the machine, what to do if the machine… All those things in place, a really sturdy protocol so that when we do run it out, everyone is aware of the situation. There’s nothing worse than trying to run something that’s sort of a bit half-hearted and not quite, and nobody knows quite what happens, if this happens nobody knows what to do. And I think that’s pretty frustrating. Its frustrating for a clinician, it’s frustrating for a patient, as well, and that happens all the time. So yes, that would be my… Yes.

Reference 1 - 9.09% Coverage

PA It fails to work.

RE Right so technologies are…

00:04:03

PA Yes, so we sometimes have a system we're online and we have online testing, pathology testing, and we… If that goes down for whatever reason, we have to stop doing pathology so we stop doing screening and then make a decision on an hour to hour basis. So that's one example, so the computer might go down or the path links might go down. From now on until it's up again, we can't do any testing, so we make that decision. Yes, so that would be, so it's day to day, it's clinical day-to-day.

RE Right. So it has to not only just work as in terms of like, provide good results.

PA Yes.

RE But it has to fit in within the clinic?

PA Yes. Yes I mean like the Preventx, for us that's beneficial because it means we don't have to see those patients. So for us it's advantageous and we would want to make sure that works on patients. So today I'm doing triage, so that means I start the clinic and I see every patient and I decide whether we're seeing them or not.

RE Yes.

PA So it's my decision so not seeing… That's my decision. But I'm pro Preventx so I'm going to go right, we can't see you as a clinician but we would do this online testing for you.

Reference 2 - 3.62% Coverage

PA And think about the ideas that we've had, on the whole, they're reasonably good ideas. They're there to reduce waiting time, reduce stress, so we would adopt that.

RE Right, so it has to show that it [overtalking].

PA Has to show it's advantageous to us and to the patients and not too complicated. Anything complicated people are just not going to… It's going to be too confusing, I think. That's my personal opinion, but it's quite straightforward, it should be absolutely fine.

Reference 3 - 11.52% Coverage

RE And you put a cartridge in the machine, it locks, it's locked for half an hour and then the print out of results saying CT/NG positive, negative or can't read.

PA Do you want my personal opinion, I think it's excellent. Absolutely do it.

RE Right.

PA Yes, I know other services do it and I think it was cut down. The last time has been getting results out, getting results, processing results, it's not there. We can see the person and process them completely.

RE And what about the half an hour?

00:10:21

PA Well that'll be fine because we would have more staff because they wouldn't have people sitting up there, ringing people, telling them they've got chlamydia, after waiting two weeks for the result to come back. They'd be here, see the patients and processing the patient at the same time.

RE Right.

PA I think it's an excellent idea, I mean, I can't see what the problem would be. If the patient has to keep coming back, they get treated quicker, cuts down the cross infection, it's a no brainer.

RE So potentially they would benefit everyone?

PA Yes.

RE The clinic and patients.

PA Totally benefit the patient but also benefit the clinic and the staff because you have lots of staff are doing things that aren't actually seeing the patients. You need them to be on the shop floor, see the patient. So you might have three or four more staff then you could wait half an hour with a patient. Or send them out into the waiting room, you call them back.

RE Yes, yes.

00:11:10

PA I think it would be totally advantageous.

Reference 1 - 5.77% Coverage

R And what is your view on Point of Care testing?

P My view is again just quick and easy results and readings and the pregnancy testing reader. So we’re used to that which sounds like it’s a similar thing that you’re proposing that we use for the Chlamydia and GC test. That’s simple to use, easy to clean, we got quick results and we’re not putting any bias on it because of the reader reading bad.

So we’re not limited as to someone’s eye sight or they’re worried is there a line or isn’t the line and having those conversations. Yes, I’m quite happy with them. And for the IQA and IQC, that always works very well. And we subscribe to the various EQA schemes as well and there doesn’t seem to be a problem with those.

Reference 2 - 4.07% Coverage

P I couldn’t tell you anything about mycoplasma at all, I’m not involved in that at all. I don’t know about any numbers that go up to the virology lab.

00:17:57

For the TV, yes, I think that would be excellent. We’re currently using the broths and it takes a long time to read those broths from the clinic, 48 hours previously and then to import those results into the Melcare System, it’s quite an arduous task. So certainly that would be an improvement to the service. Yes, we’d welcome that, absolutely.

Reference 1 - 3.65% Coverage

R At the moment is there any particular type of technology that is easier to adopt because it would just help the clinic and the Trust?

P Yes, we are actively looking at things like chlamydia and gonorrhoea testing where we get results back very quickly. We’ve have between half and hour and an hour for results to come back for some tests and HIV as well, which we do on point of care testing anyway. Things we can actually then market as a very fast… we have a stream for asymptomatic patients called Rapid Access and we can actually market that as something very fast or very rapid. That’s a good thing and patients would like that. I’ve forgotten what the question was, I do beg your pardon but I was halfway through answering it.

Reference 2 - 2.97% Coverage

R No, it’s all good. I was just kind of asking about what types of technologies would have a good chance to be adopted, what would they have to do?

P Yes, if we can shorten the patient journey and get reliable test results to patients very quickly then that’s a really very good and powerful thing to do. Those would be the kinds of things I’d probably be most interested in myself. It just means that we can see more patients, we can get patients through the system much more quickly, it means using our resources better, and, hopefully, increasing patient satisfaction as well at the same time.

Reference 3 - 6.29% Coverage

P Yes, I think, the problem that we would have with it is, and I’m now thinking back to what I think was at that meeting, so if it wasn’t forgive me. The thing that we realised would be a problem for us would be who… Actually it’s all coming back to me now, sorry, yes, I was at that meeting. It was who we would offer this to and it would be really good, in a sense, to offer it to everybody but because we see so many patients here, there’s a constant flow of patients through the system, we felt that we would actually have to rationalise who we offered the rapid testing to and those being the most vulnerable really.

The problem that we would have then is that we actually need separate machines because if it takes half an hour to do one, and we’ve got a whole load of samples, you can see there would be a backlog there and a bottleneck really in terms of the flow of samples being tested.

00:24:16

The difficulty there is if we’re selling this as a very quick and rapid way of getting SDI results but we’re creating a backlog and it’s not going to be that. It will certainly be a lot quicker than the two weeks that we currently have to wait, or our patients have to wait for some of the results. Yes, I must have been at that meeting, I do beg your pardon.

Reference 4 - 2.83% Coverage

P Well, as I said before, I think, the more tests that we can do and get the results back to patients more quickly, particularly for those that are perhaps the most vulnerable, then that’s going to be a good thing. If we can provide results quickly that makes sense for patients. It’s the right public health thing to do because we can tell them straight away and treat them. I can’t see a problem with that. Some of it might just come down to costs really at the end of the day.

R Right, I see.

P I can’t see a negative side for why it wouldn’t be a good thing.

Reference 1 - 8.53% Coverage

would you say that a rapid point of care test for chlamydia and gonorrhoea would improve the service?

00:20:36

P Yes, I think it would. I think from... again as I said before from a public health perspective I think if we’re able to treat on the day, you know, that we see someone. Because often, you know, I mentioned before as part of my health advisor role I do the recalls of the positive patients and, you know, sometimes people fail to come back. So, we’ve got a known positive diagnosis and we’re unable to get them back for treatment.

So, there’s a person out there that it is, you know, is passing their infection on to others. So, if we had a point of care test and they were able, the patients, wait we would then be able to treat on the same day. So, that would be really, really helpful. So, yes, I would see it as a benefit. I think if we could have the four, you know, infections tested for that would even be better. You know, because you.... because at the moment we do Trichomonas testing on all our female patients.

So, that would, you know, that would be really helpful. So, if it was just the dual test we would have to do the vaginal swabs for Trichomonas as well. Currently we don’t test for mycoplasma I know that’s very much in... It’s coming our way; I can imagine it’s coming our way. I think the issue is funding so funding for the infection. So, if that was in there as well that would be really, really helpful.

Reference 2 - 4.74% Coverage

And the other issue is the potential patient having to wait the 30 minutes. And then that could then potentially cause problems in the waiting area because obviously all patients will then have to wait the 30 minutes where at the moment they don’t. So, I suppose the concern there would be that if a new patient walks through the door sees the waiting room absolutely chocker then they’re just going to turn round and not even book in. So, that’s I suppose that’s another issue I think.

R Right so it can actually potentially discourage patients from...?

P Potentially if you’ve got a waiting room full, I’ll use an example, if you need to go into the Walk-In Centre and the waiting room is full you think, oh, I’ll come back later. You know, so that’s what I’m thinking potentially that could be a negative.

Fit with existing pathways and services

Reference 1 - 0.68% Coverage

The Qudini was a queue management system, but using SMS. Seen in the commercial sector, brought from restaurants to our service, and we had loads of complaints from patients, how long they were waiting. Complaints from reception team about the behaviour of patients who were frustrated at waiting. And as soon as we brought in that system, the complaints disappeared. So we evaluated it in that respect.

Reference 2 - 2.65% Coverage

But, you know, if we can show that, then we're onto something. But when it comes to diagnosing, you know, for… Your partner have chlamydia or gonorrhoea, you got a one in three chance, one in four, you know, you know one in three chance of having an STI. When you're outside the window period, from national data, it's probably higher in reality but that's from national data. You know, two out of three people, you can tell them you don't have it. You know, and that's it, that would be great. The one in three, you can tell them, yes, you have it. And let's do partner notification for you to get their partners in.

00:36:56

So, clearly if we had a test that allow us to make… Have that conversation, then we're onto something, because then we can start really acting, you know, in a real time, next to real time sort of fashion. And that's going to make it just so much easier. You know, the patient, you know, especially if you can get the partner. You know, the… Obviously soon they'll be coming in straight for appointments, and they won't be waiting for a long time.

So, you know, these people have been told the not so good news. They then see a local clinic, they then book an appointment, so they turn up at that time. We know that they're coming at that time, we know their partner have syphilis, chlamydia, gonorrhoea. So we can obviously get everything ready, and we can test them, and we can say based on the clinical history, you know, we're going to test and treat because you're inside the window period, or we can just test and give you the results, and act on that.

Reference 3 - 0.38% Coverage

It's going to be really exciting. Seeing how that's… And… But you know, what will happen is that… What will the lab see? The lab see less samples coming their way if we find another way of getting a non-inferior result earlier.

Reference 4 - 4.35% Coverage

So if we knew that this person was a partner of gonorrhoea, and yes they did have gonorrhoea, but yes it also could be treated with Ciprofloxacin, then we can do partner notification and get their partners in, and see if their partners also have the same gonorrhoea that's sensitive to Ciprofloxacin. So we can start doing all those really interesting things. But you know, going forward, you know, mycoplasma is obviously something that we could test more effectively for, and there's a lot of resistance, and yes. So, there's lots of really good things.

So point of care testing is key for that group. And I want us to spend more and more time focusing on partners, because that's where we are standing out. That's a definitely… You know, we have a number of USPs, but that's a big one. Yes, and just being a magnet for these people, and just show that we're, you know, testing as many people in the network as possible. You know, the online testing, I'm a great fan of, you know. [Unclear] working like [clinic] I'm a great fan of.

All these things are great. But they're all focusing on volume, and then people in a high risk group and volume means you make diagnosis. But in terms of bringing the cost down to make diagnoses around getting in partners is about focusing on the sexual networks. And it's not good enough to say, oh yes, let's just get a load of gay men in. You know, you'll find maybe 15% are positive. But if you get all the partners in, you'll get twice as many infections, so you'll half the cost to make a diagnosis. Yes. So… And that's, that's obviously good. And you need to do both, but yes.

00:58:54

R So considering that the point of care test would be used for specific groups of patients, and not for everyone, right?

P Well to start with…

R To start with.

P It would be, yes. Like, we'd focus on the patients that clearly we can make, you know, important decisions around, you know. If you test 100 people coming through the door, and you find only, you know, ten are positive from that background rates. You know, you don't see immediate value. But if it's, you know, four out of ten, you know, 40 out 100, you know, you can then see it quickly making a difference in terms of patient flow, and management. The business case is so much easier to articulate. I think then we can start looking at, you know, what does… What would the test do for regular patients?

But certainly focusing on those who are more likely to have an STI is, yes, it's a no brainer. I'm looking at the time because I have a date at high noon, so sorry about me looking at the watch.

Reference 5 - 2.90% Coverage

So, I suppose the issue comes up is, you know, who's going to run these tests? Where are they going to sit if they're not going to run in, you know… The reason why the Alea [?] 20 minute HIV test lost out to the INSTI™ one minute HIV test is because you had the test sitting in the lab running alongside, you know, other tests running. You had to make sure you got the labels right, and people ready at the right time. And it just became very difficult to manage in the, you know, when you had lots of kits up.

But that was in the time when we were in a clinic where patients were walking in through the lab area, and you know, there's the sort of, you know, the disclosure issue there, if you got, you know, samples on the side. So, you know, the logistics of the clinic just weren't right for the Alea test. But certainly, compared to the one minute test, it fell far short.

But, if we had, you know, a 90 minute test that enabled us to say to two thirds of people, you don't have this infection, relax, job done. You know, especially if we were testing with the point of care system for syphilis and HIV at the same time, and they were outside the window period, and we can say you are negative for all four infections at 90 minutes, then it's worth thinking about the pathway.

01:01:49

But the issue we have with the 90 minute, and I'm assuming it's going to be a 90 minute test. But if it is, the issue we have is, you know, when do we get all these patients in, when are we going to run it, when will be the last person to run it? So, you know, if it's a five 30 patient, you know, or five o'clock patient, then we'd get it done by six 30. If we're closing away seven. So we'd have all those logistics. But we can manage that.

Reference 6 - 1.97% Coverage

Potentially. Just with testing partners. They would notice that, of course they would. But because we don't have to get those patients back, then that releases at least another 20 minutes for staff members downstream. And it also means that patient doesn't have to come back on another day. Which of course nobody ever factors in the patient's time. But, you know, they have jobs and lives to live. So, you know, they, they're key to this. But if they've taken the day off, and then they know they're going to come back, then you know, it's much easier for them to just get it all managed in a day, than it is to come back on another day.

Yes, so the… I suppose the issue is accommodating people coming back as well, you know. How do you… You know, if you're… If you suddenly get a lot of people with reactive tests, and they need to come back for treatment, then you know. But we can work on that, and it won't, you know… It will balance out over time. But you know, initially there'll be those logistical issues. But it'll be fun, it'll be fun to have in place. You know, obviously two thirds will have a negative, and it will just be a case of communicating that effectively.

Reference 7 - 1.82% Coverage

Yes, so we don't really know what our point prevalence is of MG coming through, you know. But if we did run that test on everybody, we'd end up not seeing much, I don't think, initially. Certainly we'd use it in people who have a negative chlamydia, gonorrhoea, NGU, you know.

01:05:02

R Yes.

P But the… But, yes, be interesting to see how that test fits in. I'm not sure what the, the prevalence is going to be for us to… But you know, it'd be nice to have it in place and test it. Certainly we know it's a, you know, it is an important organism. We're… We don't give Azithromycin to anybody, unless they can't take Doxycycline, because they're allergic or they're pregnant, you know. So we give doxy to everybody, so in terms of, you know, the sequence of antibiotics, I think we're one of the better clinics in terms of not dishing out azithro. But yes, it would be nice to see how that'd… Yes, but we just, like, just don't have enough data, and don't know what we're missing at the moment. But yes, if we then show that we were missing a lot, then clearly it becomes an important test.

Reference 8 - 0.89% Coverage

Yes, so the issue for any of point of care test is how do we make sure that we do the quality controls, quality assurance stuff? How do we document that? How do we… And then how do we get the results from point of care tests into our electronic patient record? I think, you know, that's one thing, you know, once you start, you know, if you start small, you can put those in manually. But as you start scaling it up, it needs to start feeding in pretty promptly into the electronic patient record. Otherwise it just becomes onerous.

Reference 9 - 0.30% Coverage

Yes, and then we can start measuring the actual time they're in clinic. The time to acting on a positive diagnosis, the time to getting their partners in. Yes. So I think I'm done.

Reference 1 - 2.58% Coverage

We're also looking at how can you make something work. Because what most people try to do is, how do I get this new thing to work in this current way of working, but actually saying, can we change the way we work to make this a feasible thing, rather than saying, how does this affect the clinic, how does this affect the patient, can we improve patient journey by changing everything around that? And then say that we can deploy different new technologies in different scenarios in a cost-effective manner by changing pathways by which the patients know where patients are tested.

For example, if you have a rapid test that you would be using in paper who don't have any symptoms, there's no reason why you can’t have a sample first to people. So, say, you have a test that takes, I don't know, an hour to get the result, and you know your waiting time in clinic is about an hour to two hours. And these are people who are, at the end of the day, just going to give samples anyway.

You can get them to do the samples when they check in, and then collect all the information that you want. And then at the end of the consultation, you might do your part in, which the result is there so you actually don't have to... and then you can basically, in your business plan, look at how many infections you would have detected that you have treated on that day, which means that you are not going to spend near a thousand pounds and personal time recalling those people.

Reference 2 - 7.08% Coverage

So if you wanted two point-of-care tests, you're probably looking at something that if you want people not to change the way they work, that you just want to implement it, it probably needs to be less than ten minutes, 15 minutes max. Beyond that, it's going to stretch the consultations out. But there's no reason why you can't change your pathways and then do a sample first or something else. People check and get their samples. You test them, then you basically tell them, you have a time slot in, I don’t know, two hours.

And they get to see a doctor, talk about their symptoms. If they need to do... they sample you at that point. You know that it's going to be two hours. You can do a sample first. You know that if the tests are negative, you can swab them again. Basically you told them you passed urine. Don’t pass urine until you're seeing the doctor again. There are ways [unclear] that basically means changing the way you implement them. Being smart about whom you would... that basically depends on what the point-of-care test is.

00:54:04

You have a half an hour, and you could go for a sample first. There are some situations where it doesn't matter, but that's half an hour. And again, it depends on whether you are doing the test one by one, or we're going to be doing a batch testing, because somebody is coming in and they're just coming for a check-up. They're not going to wait. They've given the samples, they're going to leave. So whether you're going to take half an hour or you're going to take three hours, they still have left the clinic. We still have to recall them.

So any of your benefits that you're going to get, you're basically saying, we have a same day results model. And then what you can do is you can basically... there are different ways in which you need to be smart about how you arrange your things. So you can say that, fine, we'll have a, on your way to work, test, on your way back, come and get treated. So throughout the day, we'll send you timeslots if you have anything. Otherwise, we'll send you a message saying, everything's fine.

So we've talked about, say, that if you can get same day results in the batch testing, there's no reason why you can't do different things for different people. So, say, that you have your half an hour Chlamydia-gonorrhoea testing, you would say that I'm going to use that only in people who have ticked symptoms of urethritis or pelvic infection, so abdominal pain, bleeding, pain on parts [unclear]. If they tick any of these, you tell them probably means swab yourself and then pee.

00:55:49

We want the samples. And because your half an hour basically means that you have 20 people, and it depends on how many machines you have, you basically can say that, by this time, this patient's timeslot comes up, the result is back. If something's already there, then you can go where we need to send the [unclear]. Or we know what you have. We can test you. You don't need to do anything else. Or you can say, Chlamydia and gonorrhoea is negative. We need to do additional sample testing now to look for things, other things.

It could be Trichomonas. It could Mycoplasma genitalia. The fact that you know that the Chlamydia-gonorrhoea is negative basically means that you can go down the nonspecific urethritis rules and then give very specific treatment. So you basically can go in the sample first. So off the top of my head, I mean, having worked in the sample first model, there are different ways in which you can work. But you're not going to get one model fits all.

So unless you can get a device that you can have in your room, somebody gives you a sample, you plug it in, you get the result while you're... from the time that it takes you to do the [unclear]. And it works. Because I take ten to 15 minutes because that's how long it takes to get microscopy, because that’s what you're used to. And you know that if anything that takes longer than that is going to be a knock-on effect on the number of patients you can see.

Reference 3 - 0.20% Coverage

Right. So this is going to change patients experience and lab contract if there is a high volume of patients?

P

Reference 4 - 2.15% Coverage

R And how would that form of purchase impact workload in the clinic?

P You're going to hate me for this. Depends on the point-of-care clinics. Depends on [unclear]. There are some tests, of the ones that I have experienced it, so there are two in the research environment and one in clinical practice. If you're basically saying that you have to process... there's a lot sample processing steps that's basically... so one of those, which is [unclear]. Basically, it only takes 90 minutes to get the result and scan it in. And what you actually have to do is that the samples come in, they're meant to have stayed in the buffer medium for a certain length of time, then you have to shake it, you have to [unclear] on that into the thing.

00:59:12

Then you're basically going to tell the computer that this sample belongs to this cartridge, which basically means that if you're having too many steps in between, A, it's going to be finicky, B, mistakes can be made. I'm going to stand this in this and then it's just on the wrong cartridge. That can happen, which means that somebody will get the result, they have gonorrhoea, somebody will get the result, they have nothing. And then actually, it's the other way around.

Reference 5 - 2.01% Coverage

The [clinic] GeneXpert experience is that though the clinic is [unclear] open from 7:00 to 7:00, people are loading samples until midnight. So that’s a huge workload. So if you're not finishing it real time and you're having samples piling up, you need to think about what or how you're going to do it. Because if you're seeing a lot of patients and you have a machine that can do one sample at a time, and even though it's super quick, sometimes they [unclear] see patients. Eight sets of samples come in at the same time, and then you say 15 minutes each, 15 minutes times eight is two hours.

01:02:59

And in that two hours, you got another three lots of 15. So two hours later, you're now waiting four hours. So that sitting is where you need to have. The ideal thing is that you say that every examination room has this device, which should be ideal, but that would be expensive. So it's looking at what is feasible, how do you change your pathway? And if you're having... are you going to have a backlog, how are you going to deal with that? So those are the things that would concern me if I was implementing something.

Reference 6 - 2.46% Coverage

Whichever way you face it, that’s just like, why? And you're basically making judgment in what's most common with patterns that can change. So actually, if you have the ability to test everybody, I would do that. If it's [unclear] you to, that's what you would do. So the four pathogen tests would be useful, and then you have a separate one, which allows you to test for resistance. And then you basically make sure that you have residual sample to do that.

And you know that you're going to be doing the resistance ones in a smaller proportion of patients. And it might be that you want to have the resistance ones as separate. So you have a gonorrhoea resistance cartridge, your Mycoplasma resistance cartridge. We don’t know enough about Chlamydia and Trichomonas to do any resistance testing. But these two, where you make a treatment decision. And then you can again change your pathways.

01:06:29

Somebody has got Chlamydia infection. You pop them off to a health advisor to talk about their partner notification and do that while you find out what is the best antibiotic to give them with your cartridge number two. And that’s going to be a small proportion of patients. So we're going to say it's going to be about a third to a quarter of your patients, depending on the population, who would need that, which means that the bulk of them would test and go, ta da, you don’t have anything.

Reference 1 - 1.66% Coverage

And that in itself can take a long time. There are various structures around us internally. We have governance structures. For example, we’re buying equipment, it depends who we’re buying the equipment from and how that’s governed internally by organisation. Because that wouldn’t be governed by me as a manager, like a new pathology machine. But it would be managed by our suppliers etc.

Reference 2 - 13.62% Coverage

P Okay. So I think the first thing is it would have a significant impact. So first of all, I'm going to talk about the patient. So we know that across London for sexual health services, demand outstrips supply massively. So there is a problem. We know a large number of patients are being turned away from walk-in centres every single day, because they're at capacity. So that's the first problem. The second problem is once a patient gets through, they have a test. Their results are available within a number of days, sometimes weeks, and if they are called in for their results to discuss treatment, etc., they have to attend the clinic again.

Now, we know we're bouncing patients away all the time in London, but we don't know how many times we're doing that and we don't know where they're ending up. And if we give someone the result that says, you need to come in for X treatment, they'll come in. If they're not able to attend the clinic that day, they might try again, but they might try and go somewhere else. If they go somewhere else, they're likely to be told you're going to have to be tested with us before we prescribe anything you need.

00:02:40

So I think the immediate benefit to the patient is it's far more effective. It almost becomes a one-stop shop for some of our conditions, which if you look at what surgical services across the country are doing to impress surgical units, I think they've really changed the way they deliver care and it's a much better experience for the patient. It manages that anxiety in a different way to what we're doing now. It's clearly cost effective, because you're not having to send results off to the labs to be processed. You're not then paying your staff to process those results. You are, in theory, bringing more capacity into your service.

So if I were to attend, traditionally speaking, I'd be given a follow up in two weeks' time for my results. That could now go to somebody else who's coming for the first time. So there's a big financial benefit that is mainly through additional income of filling that slot. But also, there will be some stuff around the whole process now. So if it's not going off centrally to a lab, you know, you don't need couriers. You don't need lab staff, etc.

R So does it mean then some contracts will have to be altered or people may lose jobs?

00:03:44

P It depends. So I always like to think of these things as never that drastic. It never needs to be a case of people need to lose jobs, but actually, maybe what they're doing needs to change. So they could take on a different responsibility, if you like. But again, I think, you know, from what you've described here, it sounds like, you know, potentially there is a huge benefit of doing this, but I don't know enough about the scale to say whether it would or would not impact on people's jobs. My gut feeling is this probably is something that could change the way we manage care, because you said [unclear] chlamydia and gonorrhoea.

R Yes.

P So a significant amount of our cohort. So it wouldn't surprise me if these did significantly change the way we're managing our service over time. I don't think it would be an immediate thing.

Reference 1 - 4.68% Coverage

P I think, for certain patients it would definitely improve the service. So, I can see us using the chlamydia, gonorrhoea rapid tests as a way of testing partners coming in. Who otherwise come in as a partner. And we say, oh, you had sex three weeks ago? Okay. Well, we are just going to take samples of you and wait two, a minimum of two days. Maybe up to a week for that result to come back.

And then, if it’s positive, then call you. Book you an appointment to come back in. Give you treatment then. And all in that time, they could have… They still have the infection. Could potentially pass it on to someone else.

So, having something where we can tell them, 30 minutes later, yes, your result is positive, or your result is negative. That’s awesome. That’s brilliant. Are we going to want everybody to be sticking around the clinic for 30 minutes to wait for that kind of results? And what is the cap… Like, how many machines would we have in order to use it on, you know.? Say, we have someone coming in as a contact. But we’ve got two machines, and they are both in use for lower risk samples. That would be frustrating. Yes.

So, I think we have to make… I don’t… Unless we had loads of machines to do it for everyone. And there are patients who are… I would probably be interested to see how many patients would actually be willing to, right, you’ve come in for a check-up. You want to be out the door in ten minutes. I could give you all your results in 30 minutes if you just wait. Would people actually do it?

Reference 2 - 12.99% Coverage

P I don’t know that it would affect contracts at all. I think… You mean, like, in terms of with the laboratory and stuff?

00:28:30

R For example.

P That is a good question. I am not kind of… I suppose the business managers no more about what kind of financial implication that would have. Yes. What was… The first part of the question was about the?

R Workload?

P About? Yes. Okay. So, it would… So, say, it’s like… Talking about the context of infections. They see a Band Six nurse, or a Band Five nurse. Usually it is, right, do you have symptoms or not? No? Okay, when was the last sex with that partner that had the infection? Within the last two weeks or not? In the last two weeks. Let’s do all your tests.

If it was within the last two weeks, we are giving you treatment. Getting it sorted right now. If it’s not, test away and out the door. Right. So, those patients could be, if it’s tested weight, then they are out the door in less than ten minutes. So, it would potentially mean a kind of, like… Who is going to manage the results there, waiting for 30 minutes? Does that nurse wait while the tests processes? And that would slow us down, massively. That’s going to stop us from seeing a number. Unless we thought of it in a different way.

00:29:45

Like, maybe there is with the… Yes. How would we do that? I mean, literally, would you have, like, a healthcare assistant that would be, like, in the lab, that pulls the results when they are finished? And goes, oh, it’s negative. And they can… They are the ones that just go grab the patients off of a list online. Could work that way, I suppose.

If the result was positive, then they need to see a health advisor, really. So, we’d have to think about the flow with that. And do we have the right staff? So, I could see kind of a negative given to the healthcare assistant. Positive, give it to a health advisor. And then that person will already be back in the clinic, anyway.

It can be a little bit frustrating to kind of manage. Like, if we are basically… If you, say, you’ve got someone on the wait list for the health advisors. And it says, chlamydia contact. Waiting for a point-of-care result. And you’re like... And then you might take another patient.

But then you have to go back. Somebody needs to put that result on the system, so that we can… Or, you know, say it comes back as positive. And then it goes on the health advisor list. That person might end up having to wait, still, another 30 to 45 minutes, depending on what staffing levels we have. Is that good? Or would it be better if we’re… Obviously, staff-wise, the nurse who would have done the test would have moved on. Yes. So, we would have to iron out all of those details about who is going to do what.

00:31:21

R Yes. It could be a potentially huge change too.

P Yes. It could have… I mean it could mean, like, if we are using it for contacts, that the health advisor starts seeing those contacts. But then the contacts. Like, the contacts, like, we can’t give the medication right now. So, if they needed medication, they would have to go and see a nurse anyways.

But then we are the ones that do the partner notification. So, you receive, like, if, a positive results on the day means… So, we will have had to wait 30 minutes for the results. Which is not… Obviously, it’s not a long time. But, like, wait for that result. Patient is out in the waiting room. And if it is positive, they still need to see two members of staff after that. That doesn’t feel right.

But it’s how… That’s how we would work if the patient had tested and waited. And had a positive result and was returning to clinic. They would be… They would have an appointment with the health advisor. They’d be waiting to see us first. We will pass them on to the nurses if they need to have a jab.

So, it would… But then, the benefit of having it all done on that day. I think that still outweighs any… Because it means that we would have less positive results coming back on the tests to wait, doesn’t it?

00:32:37

So, we’d have less recall appointments. So, that helps, we’d have a little bit less appointments booked. So, that would be the trade-off. So, it all sort of swings in roundabouts, really. Yes.

Reference 3 - 1.74% Coverage

P Yes. Okay. Because, you know, it would be nice just to be able to start trying something like this. And kind of doing a trial and error thing around what is, you know? Because I think we would have to experiment with who are the patients seeing. And who is doing the tests, and all of this. And change things up if it is stressing out the nurses too much. Or if it is creating too much work for the health advisors. Got to be thinking about all of that stuff. But I think it’s a brilliant thing for the patients, at the end of the day, really. So, I am excited. Yes.

Reference 1 - 3.26% Coverage

R And… So I told, like, I explained a little bit about the point of care test. But I don't know how confident, well I don't know how well I explain, I don't know how confident that you would be to maybe tell me what you think… Well, I guess we can just talk about a rapid point of care test that would allow patients to receive… To be diagnosed, and receive treatment within the same clinic visit.

00:44:09

P Yes.

R How would it impact the clinic?

P Well, I would say…

R Yes.

P It wouldn't have an impact, because at the moment we have the labs in place.

R Yes.

P Because when… before the… We all did the cross site working, we didn't have a lab at [name] site, and we didn't have a lab at [name] site. So that was one of the business planning, to introduce labs into the… These clinics. So that when patients, because you know they can be diagnosed for certain…

R Yes.

P Things.

R Yes.

P So… And they're waiting for their results.

00:44:47

R Yes.

P So, it doesn't delay… Obviously the patient's happy to wait, and be treated. So I think it would be really good for…

R For the patients?

P For the patients.

R That will be the main impact.

P Yes, that…

R Patient's experience?

P Yes, patient's experience, I think, because you know, they come in a… You get quite a few patients that say, oh would I get the results the same day? So, I think this would be good if they got it on the same day, because we say no, two to… It's seven to ten working days. And I know they don't want to hear that.

R Yes.

00:45:17

P But, if they say, yes, we give the results on the same day. I think definitely it would be a good thing. And also, I think the patient…

Reference 1 - 7.65% Coverage

And, just a couple of questions about the point-of-care testing, so do you think that it would improve the service?

P I think it would have the potential to, because obviously a same-day test would definitely change the way that we work, particularly if we have partners coming in, I guess you’d have to change it. If we were going to adopt that, you’d have to change your clinic, because of the 30-minute wait you’d have to kind of build that time in somehow, so that it’s not always… But yes, you could maybe make a clinic for partners, so people can come in, and we can say, well, we’ll just use this test on this particular group of patient, and then if they are a partner, or if they’re a contact on infection, they’ll get this test, we’ll prioritise just those people.

If the test is positive, then we’ll treat them, and do PN, and everything’s done on the day, so then recall admin won’t have to recall as many patients, the positive results. We won’t have to recall people back in to see the health adviser first, to then be transferred to the nurse, which adds to the nursing workload, and all that that entails. Because at the end of the day, when the health adviser’s with a patient, and then they transfer the patient, and it’s late, and then the nurses maybe leave late because a patient needs treatment, and… etc, etc.

00:24:40

But yes, I do think this, because it’s a point-of-care test, it definitely would benefit the clinic. It would be nice if it was a quicker test than 30 minutes, that’s probably the biggest negative of it, and because it’s not extragenital, so a lot of our patients will be MSM, but it would have some benefit. Maybe say we’ll use it on heterosexual partners who just need a urine or a vaginal swab, you know, we’ll put something on the triage form, we’ll siphon those people off. And, you know, maybe we’ll get the healthcare assistants to see them, run the test, take the history, etc, and then if they need treatment, then they can see the nurse, see the health adviser.

Reference 2 - 10.02% Coverage

P It would affect the workload, because particularly like partners, you could see a contact in, depending if they need treatment or not, ten minutes, and you’d maybe have to introduce… So, it would, A, lengthen the consultation considerably, but then you have to off-set that with, well, if it is positive, then think about it, we’re not bringing this person back. So, the extra 30 minutes you spend here, or 20 minutes you spend here, is maybe 30 minutes saved another day, where the patient would have come in, waited, seen a health adviser, waited, seen a nurse.

So, you’d have to kind of think, okay, it does feel slower today, but we are going to save time on another day, so I think kind of making that very clear to people, in trying to keep that in mind. It will change the way we work, I think we may have to have appointments for that, maybe, because of the time it will take. You can’t have somebody coming in at 6:00, who then, if it was positive, they’re not going to know until after 6:00. So, there’d have to be practical things put in place, maybe a late limit, you can’t do them after five o’clock, or 5:30, or let’s do appointments for it.

But I think the healthcare assistants could do it, if they had training on how to do the test, because they do those, they collect those samples anyway, it wouldn’t be a particularly different history from what they already take. They often already get contacts in the clinic that they do anyway, and they will just transfer it as appropriate to the nurse, and sometimes they don’t need to, because they know the person’s out of the window period, and so they just test them and wait.

00:27:32

So, it wouldn’t really change their workload, it wouldn’t change how they work, as in the history that they take, the test that they do, it would just be kind of maybe saying, okay, well, you’ll have appointments in your stream, and so you’ll know these people are coming in to have this test done, and you’ll know what to do if it’s negative, if it’s positive. So, a little bit of training would be involved, there’d be a bit of a time investment in terms of training, and the time which would add into their clinic.

I think it depends on your workforce. At the moment, I think the workforce we have in the healthcare assistants is very good, there are a lot of very good members of staff, they work really hard, they see quite a high volume of patients, and I think there’s people in that team who are quite keen to do new things, and they’d be quite interested in this. But obviously workforces always change, people leave, so you don’t know who you might have in a year’s time.

Reference 1 - 6.03% Coverage

So I think all of our clinical staff needs to get trained to the same standard and then you can minimise obviously the [unclear] to observe a variation when you are doing a test. So training issue is the next one. So costs, training issues, how you are going to train our staff and obviously I need to know about the test. I would like to know more details about the test. So how long will it take and when are we going to read the results and how it's going to affect the timing in the clinic basically, because if you have a test that gives instant results probably within a minute or two, then that wouldn't affect our clinic times.

But if it is going to give the results maybe two, three hours after, then obviously [unclear] day around because we then need to ask the patient to wait or we need to ask the patient to ring back or whatever. So those are the key things. And obviously when you talk about point-of-care testing, I think the first thing that comes across is actually how do you do quality assurance and what is the sensitivity and the specificity of the test in comparison to the standard laboratory test, and obviously what is your kind of pilot that you have been doing.

Reference 2 - 4.60% Coverage

R So in terms of adopting new technologies, you mentioned that what can facilitate a process like that is that if the technology is cost-effective, if the training is provided to all the staff involved if there is a strong evidence. And you also said that it’s helpful if there are other services already using the technology and obviously if it's seen that it improves patient care, then also that helps to adopt new technology.

00:17:06

P Yes, and also if you have a proper method of recording system results, recording and… The other thing that I was concerned about was what is the process in place for ongoing daily quality control testing and any troubleshooting issues and what are the instruments that we need to use. And if there is any particular instrument that we need to use, so what is the instrument maintenance requirements and things like that, those technical stuff more than clinical stuff.

Reference 3 - 13.31% Coverage

So yes, it certainly improves the patient care because they get the results quite quickly. On the other hand then we have to think about, so what are we going to tell the patient? Are we going to tell the patient to wait half an hour? And who is going to give the results to the patient? Is that the receptionist or is it the clinical person who’ll need to see the patient again and give the results? For example, if the patient becomes positive for chlamydia or gonorrhoea after half an hour, who is going to see him again?

Because we have about 20 minutes or half an hour appointments, so we have normally patients one after the other. So that is another one that I think we need to seriously think about. Because if this patient becomes positive for gonorrhoea in half an hour's time, who is going to see him? Because we have all appointments, we don't have any drop-ins at the moment. So our service is purely appointment-based service. Do you see the problem?

R Yes.

P So if we have a positive test then you’re happy to see him or whether he needs to be rebooked next day or I don't know. So we need to answer that question.

R So there will be potential changes to patients pathways but also redistribution of care responsibilities, maybe it is [overtalking]. And would a test like that, would you say that you would offer it to all of the patients coming through or some of them?

00:24:34

P I don't see a particular point or a particular advantage offering it to everyone to be honest, but it's something that the [name of the company] can make the decision. So if they want to implement this uniformly for every patient, and then I think they need to make the decision. Because sometimes there may be some practical issues if we just offer this test to certain number of people, because then the others might ask, so why can't I get the point-of-car test and then finish this off? So I don’t know.

It doesn’t happen for the HIV and syphilis at the moment. I don't think everyone knows about the point-of-care testing, but if it is something like gonorrhoea and chlamydia, probably. I don't know, it’s something that we need to think about whether we should offer it to everyone so it is uniform for everyone, no discrepancy or whether we should limit it to those who really need it.

I can understand HIV and syphilis, because the HIV is more important because people are scared about it still so they would like to know their results as early as possible. But I don't think that they have the same feeling for chlamydia and gonorrhoea to be honest.

R So they’re not in a rush to get their results.

P Exactly, yes.

Reference 1 - 32.47% Coverage

R At the workshop we discussed Atlas point of care test that provides results for CT/NG within half an hour. So it’s not as rapid as rapid HIV test, but it can be still potentially used as a point of care test. And so how do you think such test would improve the service, if at all?

00:25:53

P It will help especially, the way I look at it, especially for the point of care, because for chlamydia and gonorrhoea you may have cases where getting the results sooner would help you make a division. So we have cases whereby we are forced to treat somebody empirically. You know empirically means that we assume they’ve got infection for clinical reasons, so we cannot wait for the results. So this sort of situation you can have the option of saying, maybe waiting for a few hours and we get the results back, will take away that and that could also occur to be cost effective so you don’t have to give unnecessary treatment and it cuts down your cost.

So we will have a selected group of patients who can benefit from that point of care test. And it’s something that we’ve discussed about where this would fit in different scenarios. So there will be a selected group of patients who can come to the clinic and we can say, yes, this group, this particular person would benefit from testing and if the results come back negative then at least we can be reassure them that we don’t have to give them unnecessary treatment.

Some patients may be due for a procedure and we want to that reassurance that they have no infection before the procedure. So that can be done and the results obtained quickly and the decision is made as to whether to treat them first before the procedure or there’s no infection so just go ahead. So it will help in a group of patients, selected patients in making quick decisions and avoiding unnecessary treatment.

00:28:03

R How would that test impact the way in which the clinic operates? Would it be a massive impact?

P Not a massive impact, but of course it would change some of our... It will probably lead to some change in our care pathway. To give you an example, maybe some staff that is normally with some patients who may want to make sure they’ve got no infection, before coil, of chlamydia and gonorrhoea and either we tell them to get tested before the appointment date and we get the results to be happy that they’re clear. So if, let’s say, the patient comes to the clinic and we’re not sure they can take the point-of-care test and wait for the results and then the procedure can be if there is no infection.

Or in the past it was a question of it you’re not sure then you can give them antibiotics just in case there’s something there, so before you do the procedure. So it’s like a blind treatment. So this sort of test would take away all these unknowns and make clinicians make a decision based on results as opposed to assumptions. And also it cuts down frequent trips for the patient back and forth, do this and that. They just come and they can get everything in one setting.

R Would it impact the way in which care responsibilities are distributed?

00:29:52

P It would because yes, if let’s say, you’re going to start providing the service, you will need somebody dedicated to carry out the test, reading it and recording it so that it’s there on the record what the result is and it’s acted on and raised in the system. So there will be somebody in the staff who makes sure that trained on a regular basis who receives the samples and runs the test. So it’s like having a mini laboratory with the technician there but one of the staff, one or two dedicated to that.

And again this can also be depending on the volumes. So if, let’s say, the testing is expanded to several patients or even to routine patients routinely, then you will need to review your capacity in terms of who does what in the clinic. And the advantage of this is that of course it will provide results there and you can deal with the results management immediately and the treatment and that takes away the other extra burden of always having somebody who may be allocated that job to check on the computer, check for results and call the patients back and bring them back for treatment and then the chain goes back home.

So you can have a lot done within the same day and it cuts down on the patient’s seen, they go, they come back. And again that involves a lot of visits and multiple patient contacts and you need more staff for that. So you can cut off all that pathway.

R How did it impact contracts with the lab?

P The impact would depend on the initial intention and the long-term intention of the performing of the tests. So if let’s say the initial rollout this system becomes well accepted, adopted, and there is also capacity to carry out more tests, then the impact would be that all the samples for patients coming for routine check for, let’s say, chlamydia, gonorrhoea, patients who are walking into the department, none of that sample would need to go to the lab.

00:32:38

So basically the lab will lose a lot of activity because then you could have maybe time dedicated, depending on how long the specimen can be kept before it's tested, you can have a dedicated time within your department where, even if the patient has gone home, all the samples are being tested internally. So you could have maybe, in a day you open the clinic and you had 50 patients who had a chlamydia, gonorrhoea swab test. Even though the patients are gone, you know that maybe it’s two or three people with the machine running slowly in the lab and you know that within this time you’ve tested all the samples, entered them on the system and texted the patient the results and that would cut off your main pathology.

So that potential is there depending on how quick the turnover is, how quick you can... And the resources involved and the cost. So that’s with [?] the cost of sending the sample to the lab. It depends on how much it costs you in the lab and how much this machine and the kits, everything, cost you to buy them and to maintain them and the quality assurance.

So that potential is there to be able to do your GC chlamydia test in-house without necessarily sending any specimens out and maybe having a very small number that you need to send because you need to do things like culture and sensitivity, you need to test for the lymphogranuloma venereum for those with complicated chlamydia-like infections. So there will be a small number that will be sent laboratory, but a big chunk will not.

00:34:39

R So potentially if the test was used for most of the patients then that would completely change the relationship between the clinic and the lab.

P Yes, absolutely.

R My last question is about your opinion on the difference between the CT/NG point-of-care test and the four pathogen point of care test that would also include TV and MG. How would you say those are more or less useful, one than the other? How does that...?

P Of course, getting the four tests CT/NG plus mycoplasma and TV would be superior to just getting the CT/NG test. But if it's going to be cost effective, given the fact that we’ve got a very low prevalence of TV generally, we know that form our diagnoses, and given the fact that... Okay we don’t... MG is becoming an increasing problem, but we want to test for MG in a selected group of patients, not on everybody. So it depends on the cost, it depends on how long it will take to generate the results in the department. It depends on the resources that are required to report these results.

So personally, I wouldn’t want to run all four tests at the same time on a routine basis. On a routine basis I would want to run CT/NG and then on a selected group of patients I would want to run the TV and MG. And I think that would be better because, unless the machine is very intelligent and very smart to quickly process the results at the same time as opposed to maybe the one particular batch of tests taking much longer than the other one and creating a lot of backlog and also generating a lot of administrative work for a big chunk of negative results.

00:37:12

So we don’t to be generating thousands on thousands of just negative results, we want to be testing a selected group of patients for some infection based on local epidemiology and prevalence.

Reference 1 - 5.47% Coverage

R Do you think that Atlas point-of-care test, where you have 30 minutes of a wait for your result, would that improve the service in those cases?

P Yes, I think so. It would.

R And how would it impact on the workload or distribution of care responsibilities? Would there be any impact felt by the staff?

P I think there’d be some initial training to work around, and there’s likely to be some reorganisation around appointment allocation. We’d have to screen those people out, but that’s all quite doable.

R There would be potentially new pathways?

00:39:01

P Yes, there would be some new pathways, but we’re lucky enough to be able to manage those pathways internally. We work on first point of contact being a triage process, whether that’s online, whether that’s ringing up, or whether that is walking in. We could manage that.

R I see. The last question would be, if we could maybe talk about the difference in potential impact of a point-of-care test for CT/NG and then CT/NG/TV/MG point-of-care test. Would it be useful?

P Yes.

R Do you routinely test for mycoplasma or TV?

P No, we don’t at the moment. We do test for TV. Mycoplasma we can test for, but we’re actually in discussions at the moment about how we move our internal clinical pathways on based on the new best guidance. I don’t think the guidance has actually been released. I know it’s been released under consultation at the moment. But certainly, mycoplasma genitalium would be something that would be very useful, it feels like it would be useful, given that there’s new guidance out at the moment. Again, it would be about how that compared to our routine laboratory costs.

Reference 1 - 10.35% Coverage

R So now I’m wondering, what is your opinion on point-of-care tests and what in your opinion is the general approach to those point-of-care tests in the service?

P I think they’ve got massive benefits for patients. I think they’ve got massive benefits for groups of patients. It’s a case of also using them but being able to remind the patients about the need to follow up their testing as well. So if it is a case of they still need to come back in X amount of week’s time or whatever, it’s making sure that we’ve given all the right information because sometimes patients just want the results right now.

They don’t always listen to the rest of the information when you’re saying to them yes, but you still need to be tested in X amount of weeks. They can’t just stand to that bit so they’ve got their results now and that’s it, that they’re off. So I think it’s a whole this massive benefits but it’s also about making sure that we’re not sending them all off with, not forcing information but reminding them about the need to come back if they need to. Does that make sense?

R Yes, definitely.

P Because I know sometimes with HIV, we don’t do point-of-care testing for HIV but Terrence Higgins do and they were saying the same. That was brilliant but as soon as they’ve got their results that’s it, everything else you said to them, they’ll just forget. They say, no, yes, we’ve done this or that but you still need to come back and have another one done, but they don’t always listen to that bit.

00:17:27

It’s about the here and now. But like I said, I think for those who could have chlamydia and gonorrhoea point-of-care testing, especially for those young people that maybe are going to struggle to get back into clinic again, then it’s brilliant. For the high risk patients, maybe those who have been assaulted and actually having the trauma of coming back into clinic and pre-coil fix, all those ones that potentially you do need your results right here, right now. Then yes, I think there are actually benefits to it.

Reference 2 - 15.47% Coverage

R But it takes half an hour to get those results. So I’m wondering, do you think that a test like that would benefit the clinic?

00:19:08

P I think so. I think from if you say like pre-coil fix, they’re going to be in the clinic for probably that length of time anyway. So they’re here. And I think for some people appreciate what you explain to them that actually if they wanted to wait around, they may have to be [unclear] for a little bit longer but actually we could give them a result now. But we’re saying like, people are essentially insulted, they don’t want to keep coming backwards and forwards for clinic and stuff.

Then I think they probably would stay for that extra bit now to benefit them keep having to come backwards and forwards. There are going to be those that would want to hang around and that’s fine. There are going to be those that some of them are looking at the clock before it even arrived and it’s certainly won’t be suitable for them. But I think once it’s explained to people then I think people would understand.

R And I’m wondering, so you identified that certain groups of patients that would benefit from the test, but that means that it won’t be everyone coming to the clinic obviously. So do you think that that is a barrier that part of the test wouldn’t be used for every patient?

P It would depend on cost-effectiveness. Not every single patient is going to want to hang around for 30 minutes, and the waiting room won’t hold everybody for 30 minutes. I think depending on costings and stuff, then yes, I think we’ve got a big enough need for the others to make it worthwhile.

00:21:07

R And how would such tests impact the clinic? So I’m thinking about the workload for everyone and maybe how responsibilities are being distributed, would there be anything that it’s going to impact?

P Yes. Nearly the impact is going to be people are going to call patients back again, so I guess sit around in the waiting rooms. So we may have a slower clinic because of actually having to call people back for their results rather than them leaving the clinic and just getting the text message saying that. That would have an impact. We have somebody in the lab anyways, the actual time took running the test even could have an impact. It’s going to be the time of people waiting around and being called back in again. That will have an impact.

So that may mean that we need to reduce then our appointments. If we notice that it was making a significant difference then we would have to adjust our appointments. Because currently our appointments, depending on what somebody’s coming in for, our only just wait it’d be 15 and 20 minutes long. Then somebody’s going to wait half an hour is going to have an impact on them coming back. Then obviously if they’re positive then we’ve got to treat them. So then does have an impact on time potentially.

R And I can assume that those patients will have to also wait in a waiting room, so that’s also space of the waiting room.

P Yes, like we said, the space as well.

Reference 1 - 4.73% Coverage

So if there's something about the test that has a unique selling point that's better or... not necessarily better but compliments or adds to what you've currently got, then I think that very rapidly can get buy-in of a whole service. So what I would normally do as a service lead is if someone comes to me with an idea either from within the department or an external person saying we've got this test, you look and say, actually, is there a niche or is there any potential in the service? And then talk to anyone who may be affected by it.

00:04:33

So for a lab test, actually talking to the consultants in the lab and the people who do test because you need to know if they've got the results to evaluate it, the inclination to do it. Talk to the people on the shop floor in the service here. So if we bought in, what's the label, what's the change in work pattern, and can they see any advantages? So starting with the senior team, so the senior nurse or the consultants.

And if they can see some value in it, then actually talking to whole service about what it might be before them developing the process for implementing it.

Reference 2 - 6.35% Coverage

So in a four-hour clinic, and most you can do is eight, and that’s assuming they're very slick and rapid to... you can turn everything around as quickly as you can. Realistically, there's going to be a five-minute time when people are taking out the cartridge, getting the results.

So you're probably only going to do seven in a four-hour clinic. So it has performance issues attached to it. So even working at its maximum, it's not going to turn around huge numbers of tests. I think there are sub-group of populations, so people coming for an emergency coil, young people who have already travelled a long distance to get to the clinic, those people with learning difficulties, vulnerable people with... to be able to give them their results today, particularly if you think they're at a high-risk at being positive would be really helpful.

I think it would be more helpful in the future if they have Mycoplasma as well. That would be really helpful. And ultimately, if you got approved for extra-genital samples as well, because some of the highest risk gay men, someone who it would be particularly helpful for. And again, if the turnaround time became a little bit quicker or you could have more slots, there are lot of things. But I think one has to start somewhere. And I think in a sub-group of patients at the moment, it would give them added value.

I don’t think it would necessarily speed things up in-clinic or anything else. I think it would just give added value for a particular sub-group of patients.

Reference 3 - 3.70% Coverage

P I think the main thing is the patients who were waiting for the test will have to stay in-clinic a bit longer. Because, obviously, if we normally do the test, we'll send them away whilst waiting for their results for two or three... and then they'll get a text. Obviously, these patients, we will need to keep in-clinic and just make sure we get their results. And I'd say for something like an emergency coil, that will be fine because they'll be waiting for someone to be able to do the fit anyway while we're waiting for the results.

Some of the others, it will just mean a bit more waiting room and someone just keeping an eye on the machine. So there'd be a small increase in workload and a slight decrease in throughput as patients are waiting. But I don’t think in terms of throughput, we're talking of these machines at the moment, I don’t think it will be a massive impact.

Reference 1 - 2.00% Coverage

P Yes. Because a lot of people will come up asking for the HIV point-of-care test, but actually we know that it is much better to have it in a highly population for HIV rather than a low population. That actually does change your results quite a lot. So it’s again about doing the same thing here. I don’t think necessarily that would impact on the results, but it is just making sure that the right people have the tests, because, you know, 30 minutes, that’s only four in there, so you can do the maths and see that it takes quite a while.

Reference 2 - 8.06% Coverage

R In terms of point-of-care testing, in your opinion, would it improve your service, and how?

P Would it improve our service?

R Yes.

00:23:38

P Well, I guess it just depends on how it performs, first of all, the test. I think a lot depends on that. So if we’re thinking of how it was done we’d have to know more about, yes, the quality of the test.

R But let’s assume the quality is great…

P That it was fine. Yes.

R And it gets adopted, so…

P Fine.

R Yes.

P Then how would it impact on our service really to improvement? So I would say, in a certain group of population, then, yes. In little micro groups and… It hopefully will. So, as I was saying before, that we do have sort of young women who have, go through coils, who have coils, and those that are, particularly those that are young will have very frequent change in partners. That may have, say, a cell phone conversation beforehand, but may not have had the testing beforehand. And actually having that result before you put the coil in is quite useful for them.

00:24:36

Travellers would be very, very useful because it is so difficult to get hold of them again, and actually them leaving with, A, the diagnosis, B, the right treatment, C, partner notification before they go off travelling is actually, I think, going to be very, very important. Because there’s lots and lots of patients that we just cannot contact, because they’re, you know, coming here for a day or two and then disappearing. And that will be somebody out there in the community, wherever the community is, who potentially will infect other people as well.

And then the third group that I think would definitely be very useful are high risk MSMs. So, as I say, we’re part of the PrEP trial and I think they are definitely quite a high-risk population that would be useful to do testing on as well. And again, that would be, these are people that have very frequent partners and it’d be really important to give them the diagnosis before they leave, and their treatment before they leave.

So definitely in terms of that, in terms of public health, I can see that being definitely something that would be beneficial to our service, yes.

Reference 3 - 5.42% Coverage

P I guess it depends how much work it takes to use it! I can’t see it being that much different. So it looks… From looking at it before, it really looks quite straightforward, so I can’t envisage…

00:26:08

R And so low volume.

P Yes. I can’t really envisage that it’s going to be a major, yes… I don’t think… And also if you identify a few key people, that can actually do what needs to be done. I don’t know. I don’t think it’s going to impact on the clinic much at all.

R So, yes…

P No.

R So will there be a slight redistribution of responsibilities here in the clinic?

P I would say so, I would say so.

R Is it something that you would notice?

P No. I think it’s because, you know, as I said, it’s not really… You know, in terms of how many patients we see in a day compared to… I don’t think it’s really going to impact on it that much really, because we’re going to be selecting patients that we do it on. So I envisage that we’ll probably use it every day, but you wouldn’t be able to use it for, you know, because it’s half-an-hour each time for a time, so, yes, I can’t say that we’d do more than 20 in a day anyway, no.

R And in the same way, I guess it wouldn’t have a huge impact along, for example, your contract with lab?

P No.

00:27:18

R No?

P No, because that still needs to happen, yes.

R And about cost? Would it have any impact, any significant impact on the cost?

P I guess not. Well, it’s doing the trial period, but afterwards, yes.

Reference 4 - 2.79% Coverage

P Because it’s so quick, as in half-an-hour, I don’t really… It would be very much… I think for the patient experience, patients actually like knowing their results. Some do, and especially those that come in with symptoms, they would prefer to know what it is and get treatment before they leave, so I think that would be a positive thing. Some people may say half-an-hour is quite a long time, but actually in the general scheme of things, it’s…

You spend more than that in the clinic anyway, so, you know, you could do various bits beforehand, so I really don’t think that’s actually going to be very much at all in terms of time. So, yes, I think overall it would be a very positive thing to have, and I’m sure they would appreciate that as well, yes.

Reference 5 - 2.95% Coverage

I mean, I don’t think anything is set in stone as to who you can and who you can’t do it on. It mainly is just the capacity for it, rather than anything else. So, you know, so it might not be the… So it may not be exactly who would fill in, but actually there’s space there and you can put in another one. I wouldn’t say no to that. Why not? Just do it anyway.

00:29:57

R So there would be a lot of negotiation maybe around it?

P Oh, yes. This isn’t going to be set in stone.

R Right.

P No.

R So that, for example, if someone comes and is very anxious, but doesn’t fit within the groups, then you would…

P Yes, I would say.

R Given that there was…

P Yes, and especially if we have the capability and the capacity for it, why not? And if that helps, yes, I think that would be a good thing.

Reference 6 - 0.52% Coverage

P Yes. And again, that would be a subsection of patients that we would do it on anyway, but that would definitely be very useful to have that.

Reference 7 - 2.62% Coverage

P Yes. So in particularly with the MGen ones. I guess women with PID I would definitely want to do an MGen on, and the TV, it would be very useful. And some of the male patients who come back with recurrent NSU, again, having an MGen test there would be quite good to have. Yes, and as the other consultant was saying, with those… The proportion of people who have urethritis, or what’s diagnosed as NSU and actually having the MGen test then at the same time would be very good. Because we know that a huge proportion of those have been to the MGen anyway, actually getting the antibiotics right and giving them the right treatment for them is better. So, yes, I can see a different population of this. Yes.

Reference 1 - 1.33% Coverage

P I think it would. The only concern I had, for me personally, is that probably there's no any other way at the moment, because I think it takes about 30 minutes to get a result out. So it would but for a specific patient, not for everyone, I would have thought. So, yes, it would.

Reference 2 - 2.19% Coverage

P So if we have patients that we want to rule out infection prior to another procedure, then that would be the best thing to do. Or if we have patients who are anxious that they have an infection, depending on what they've done as far as the incubation period is reliable, then that would work, because it would then at least reassure them or they would know on the day that they have an infection and get treated on the day. So I think in that way, it will work.

Reference 3 - 11.90% Coverage

R And would it impact the way in which clinic works? For example, think about the workload, will it impact the workload?

P It might. It might, simply because we would probably have the machine in the lab. And I'm thinking in terms of patients that we want to rule out infection, like patients who are coming in for coil, patients who are coming in to have a coil fitted, we can do the coil consultation over the phone. So that helps a lot because then it sets appointment, so you just have one clinician over the phone ringing patients at home.

But then, before the caller is put in, we need to make sure that they don’t have infection. So the only thing is that instead of them coming in for the appointment at, say, nine o'clock, they would have to be here by half past eight to have their test done, so that by nine o'clock, we have the result for their appointment. That’s about 30 minutes to get the result. So in that way, it might. But if we work it really well, probably it might not. Because as long as we have the first one in and get the second one while the other one is having the caller put in, then we're going to be doing the test.

00:25:22

In that way, it serves them coming in for Chlamydia and gonorrhoea test and coming back in for the coil. So that serves them time. And it's probably a win-win situation for both them and us because it saves some appointment time, and for them, it saves them two appointments or three.

R So there's less work actually.

P Yes.

R What about in terms of responsibilities, would there be any change in how they are distributed among the staff?

P I wouldn’t have thought so. Not really. In terms of staff, because there will always be a member of staff in the lab, so I would have thought that the person who is the lab would have the responsibility to run the test. But it will be on top of other things that they are doing in the lab. I've never used the machine, but I would have thought that if it's put in, then it's cooking. Put in extra minutes, hopefully. I don’t know.

So they could be doing other things in the lab. So there would be a member of staff in the lab. So in terms of staffing, I wouldn’t have thought it would have major, major impact. Probably at the beginning, it would because, like I said, always with new things, it would be like, oh, this machine, I need to do this and that, I don’t know. But afterwards, once people are comfortable with the way things work, it gets easier.

00:27:10

But in terms of workload, I don’t think so.

Reference 4 - 7.76% Coverage

P I think for patients, they would love it. I'm saying it's longer time. But for them, they are having to wait two weeks to get their result. So for them, that would be amazing to get the result when they visit. But it depends on what time we've done the test, because even now, some patients complain that they are waiting longer within the clinic for their appointments. So if we have to make them wait even longer, I'm looking at some patients going, I'm going home, so ring me up.

00:28:26

So that would mean more time with the same patient ringing them up, telling them the result that they could have got in the clinic. So, yes. In that way, it might. For some people, it might be all right. But for some, they would think that being in clinic for another 30 minutes would not work.

R And what about those patients who are aware of the test but then find out that they can't have it?

P I think that will always happen. That will always happen, because even now, you'd be surprise that people come in and ask for the test. Because if some people have travelled to some country that, this test I used at United States, they'll come back and say, could I have my result now then? And with technology, they are reading a lot. People would sometimes, oh, you do in-clinic, it's clarifying what people have already read on the internet. So, yes.

R I could imagine, yes.

P So they know I'm a practitioner in the United Kingdom. We are not using this test here yet, blah, blah, blah. But some people would ask for them and would have to see and manage the expectations accordingly, because people do ask.

R Already?

P Yes, people ask.

Reference 5 - 5.23% Coverage

P I think it's still useful in specific circumstances, like I said, very anxious patients would just want to know their result. And for emergency coils or for people we've consulted over the phone coming in that day for coil fitting, so they are specific patients that we can actually benefit using the point-of-care test. But I strongly feel it might not be of benefit to everyone. But there are specific patients that it would be really useful for.

R And what about the test that also has TV and MG, or no, CT/NG/TV/MG, would you see this as more useful or about the same given that they wouldn’t be quicker?

P I think with TV, we can diagnose TV on the microscope. So probably it might be all right, but it might also not be all right, because someone with TV symptoms, some of them is so obvious clinically when you examine them. And it's so obvious on the microscope, on the live sample. So probably for that, it would be fine. But for MG and the other tests, we very rarely see those anyway. But if we can have a benefit of having them, too, that would help. But I don’t think that would change much.

Reference 1 - 6.02% Coverage

R And how would a point-of-care test impact the work in the clinic? So I'm thinking about the workload, distribution of responsibilities.

P So I suppose it depends on who could actually do the point-of-care tests. Some medical staff would prefer another like a nurse or a healthcare assistant to do it, but then also, other members of the medical team would prefer to do it themselves. So it does really depend on an individual basis and depending on what is involved in the point-of-care depends on whether we allocate people differently, depending on how it works. And it's just about getting the best patient flow through quickly, Whether we allocate someone just to do the point-of-care to speed things along or get lots of members of staff trained up to do that particular test, I don't know, until I kind of know a little bit more about the test.

Reference 2 - 5.70% Coverage

It would just be finding out how we could manage. If each test takes 20 minutes, what would we do with the patient in the meantime? Do you send them away and get them to come back or do they sit and wait? All those kind of patient expectations as to what they do in that 20 minutes. And then if… So if we did take on the point-of-care, it would only be for… it would only have to be for the specific groups of patients, because if one test takes 20 minutes, you could have 30 patients waiting. They'll be waiting all day if that makes sense. So yes, it would have to… I think it would have to be quite a strict criterion who we use them for and we would have to say to the patient that it can take… or you could be waiting longer to get this result. It's just about those pathways on how we go about it, yes.

Reference 1 - 5.15% Coverage

R So, would you say that a point-of-care test in the Sexual Health Clinic would improve the service?

00:19:35

P Personally, I think it would because I know that they struggle with the laboratory. I know the laboratory is criticized for being slow. And I often think that the online testing is used to circumnavigate the internal laboratory anyway.

When we had our committee screening programme, we used exactly the same online testing practice rather than the local laboratory for the urine sample testing, purely because the turnaround time was so slow, it was unworkable. Whereas an online test, everything was posted off, and the answer, a positive or a negative, was back within 48 hours, 72 at the most.

So, yes, I think it would help patient pathway. Yes, it certainly would speed up the process. But we would probably then be criticized for reducing the need for our laboratory. But they are slow, they are pretty slow.

Reference 2 - 0.63% Coverage

R So, that test will definitely have an impact on patient experience because they’re waiting for results…

P Yes.

Reference 3 - 3.98% Coverage

R So, do you think there are other ways? Obviously, you don’t work in the clinic, on the ground, but do you have any idea how the test would impact the workload in any other area?

P Within the clinic?

R Yes.

P I don’t think so. I think it would make the clinic run easier because the person would get their result quickly, and they could probably have their treatment there and then if it was appropriate. And again, it might save yet another trip back, another appointment, another need to come to the clinic. Maybe that could be done remotely again, any follow-ups, etcetera, if that was appropriate for that.

It could reduce activity, which is obviously costly. Every time someone visits the clinic it’s a cost.

Reference 4 - 7.44% Coverage

P No. I mean, I think it’s a really good trial and it will be really interesting to see how laboratories accept and adopt. And whether they say, well, it’s actually really good that you can do your tests now because it’s saving us doctors time and we can go and do these tests more quickly. It will be good to see how the lab responds to the fact that it’s work not being done by their service.

00:24:47

Because I know everybody gets very protective about their area of work. And I know the laboratory is very criticised, so it will be very interesting to see how they respond and how they think, will actually be a really good thing.

You’re saying the barriers to adopting technology, I sometimes wonder, they’ve got an absolutely… Have you been to their lab at [name]?

R No.

P It’s lovely, I mean, it’s a good lab, but I think they struggle with staffing and funding, you know, clinical stuff, and everything. I don’t know, I’ll be very interested to see how they respond.

R It will be good to interview someone there, definitely.

P They’ may say, well actually, it’s a nail in our coffin if somebody else is doing that piece of work for us. We need as much work as we can to justify our position. Or, actually it’s really good that that work can be done there because then we can do this a lot quicker. Yes, it will be really interesting.

Reference 1 - 4.72% Coverage

P Most people like point-of-care testing when they improve the delivery of care for the patient. For example, a pregnancy test, being able to do that in front of a patient, with a patient means you’re getting alongside that patient at a time when they need additional support. Again, this morning, a little earlier I did a point-of-care HIV test. And that’s with a patient who was so worried and clearly, it had a great benefit to him, to be able to address his anxiety very quickly.

It then meant, again, with the patient having the pregnancy test, you can work with the patient, with what you’ve got in front of you. There isn’t that maybe, yes, but well let’s see what this result says, come back next week, come back in two days, come back later today. The point is, you’re able to be responsive immediately to the patient. And then make a plan of care that is useful and relevant to them.

R You think that the point-of-care test has the potential to improve the service?

P Yes.

Reference 2 - 13.77% Coverage

An Atlas point-of-care test, its design, its CT/NG and results can be achieved in half an hour. Do you think that a test like that would impact the way in which the clinic operates?

P No. Because it’s half an hour. If you said that I can give you results in three minutes, like a pregnancy test, or three minutes like an HIV test, yes. I think that would make a difference.

00:24:45

P But if it takes half an hour to do the test, I think, in a sexual health clinic, when you’ve got a patient with symptoms and you can do microscopy, you can do microscopy in less than half an hour. And be telling the patient, I’ve looked at this and this is what it looks like to me, I’m going to go ahead and give you treatment based on what I’ve seen and heard today. A point-of-care test, really how much is that going to advance?

I think, if you had patients doing their own point-of-care tests in the privacy of their own home, then coming to us with a positive result, then that would be helpful. Because they could say, oh look, I’ve done this test, it’s positive and I… Like with the pregnancy test, rather than going to your GP for a pregnancy test, you go to your GP and say I’ve done a pregnancy test, this is positive, what do we do next?

So, I think a half-hour result on a symptomatic patient is helpful. But doesn’t go above… I don’t know what advantages it has above microscopy. On an asymptomatic patient, I think it would be maybe an asymptomatic patient who was in contact with somebody with chlamydia or gonorrhoea. But then if they were in contact with somebody with chlamydia or gonorrhoea, you’d still go ahead and treat them. So I don’t know, I’m still trying to imagine where it would fit. Maybe in a community clinic?

00:26:35

R It would be a fraction of patients?

P Yes. I wouldn’t imagine it being used on all patients. And I’d be interested to think about, which patients would we use it on and why? How would we improve care? What difference would it, in terms of testing to treatment time, who would it help? Because the point-of-care test, I think, maybe… I don’t know. I’m just trying to think where it would fit, in terms of symptomatic, asymptomatic, contact of… Yes, that would be what I would need to think some more about.

R Sure and would it impact the patient experience?

P Yes, I think it would. I think there’s going to be those patients that come in and would be very keen to know what their diagnosis was as quickly as possible. If a point-care-test was as valid as a laboratory-based NAAT test, then that would be really, really, really helpful. And if you could do lots of point-of-care tests all at the same time and perhaps test everybody who attended the clinic in the morning. And then by the end of the afternoon be able to tell them, yay, your tests are negative, or your tests are positive. I think that would be really, really helpful.

Reference 1 - 8.59% Coverage

P I think it would make things really interesting actually. I think it would be really… Dare I say enriching? I think it would enhance people’s roles. Certain people that aren’t clinical. But I’d very much see something like this as have [unclear] come in. They could do the samples themselves. We don’t have that type of thing here, like [clinic] or something where they go in and do it. So clinicians or healthcare support workers can do that type of thing. Take samples from them of the person who fills in the form. It does bear their own information.

00:35:00

It will free up time so that more clinics can be added, so that there can be even better access for other types of clinics, because we are seeing a lot of outreach going on as well. And just to be able to make it more clean, more efficient in the way things are done, more streamlined… If somebody were to come in, and they come up to clinic, and whether or not it’s a healthcare support worker who’s doing that test with them, which doesn’t happen at the moment. So they run through it, and they can go off and they can do their test and bring it back, and the cartridge can go in. And then whether or not it’s myself or somebody else. It doesn’t have to be a nurse that reads those results.

And then either… I’m the only healthcare support worker here, so positives, I would be discussing that with that patient. And then the nurses, they’ll be sorting out the treatment for those people. But I just see that the biggest footfall could happen because of the time it’s allowing us to have more time to give better service, bigger service to people. Although we are a one-stop shop in [name] trust. They come here for everything. We even do vasectomies here. But should be able to be running every day.

00:36:45

Everyone has their role within this. People don’t need to be hanging around. Sometimes we can be having people waiting an hour, because you don’t know what’s going to happen once people get through the door. Somebody says, oh I’m just worried about this. A 20 minute appointment can be a 45 minute appointment. And then everyone of course is late. And it just changes those dynamics. I’m seeing this as a positive thing, and other people that maybe would like to have a hand in things. Having that opportunity with training to be able to do that.

And it wouldn’t take training to take the specimen, put it into… Obviously, you need to know how to do it. But then, they don’t need to know the ins and outs about the sexual health bit. Because that’s what I’d be here for, or someone else, and doing those bits of counselling. And it just frees up that time so that you don’t need to worry about it, whereas everyone is feeling more enhanced and hands on in their role.

Reference 1 - 7.72% Coverage

P Yes. I think the key thing for us… I mean the main thing is the fact that we can get results back to patients in a much more timely manner, that would be the first thing that I think would be a great plus. But I think also by using that we could also then be able to give treatment more appropriately so sometimes we start treatment thinking that maybe the results are going to come back as positive, maybe a contact or something like that. Whereas maybe we wouldn’t necessarily have to start the treatment you know, literally as they are with us, we could within a few hours have a result and then decide whether treatment is appropriate or not.

00:25:44

So maybe we would reduce the number of treatments we actually provide because we’d have more accurate information to go on. So I think it’s the time of the results from the patients experience is that we do less treatment than we are currently much more appropriately. And I think also from thinking about the onward transmission, again we would probably… Potentially I don’t know, we’d have to think about how to put it all into practice, there may be situations where we are waiting for results that patients are actually… Because they haven’t got a definite positive, maybe then they are going out and having unprotected sex and therefore the onward potential of transmission.

So there could be a little bit about actually controlling onward transmission by having those more or less you know, straight away results that would actually emphasise the need for abstinence or you know, that would help with the advising side of it as well. I think those are the three benefits that we would see.

Reference 2 - 4.80% Coverage

R I see. And how would it impact the services? I’m thinking about workloads and distribution of responsibilities and costs…

P I think we would need to factor in somebody… The time obviously, for somebody to do the testing which currently just gets decanted and sent to the lab.

00:27:31

Having looked at yesterday, yes that would mean that somebody would spend more time at the machine so to speak, however it would take away the administrative time that we spend looking up results, texting results or phoning results through to patients. So that’s why I think it potentially is going to be cost neutral. We have Band 3 support workers who support us with some of those aspects and I could see that their role would slightly change from more you know, less at the computer looking up results to more actually doing the actual tests through the machines on site. So I think it would be a sort of you know, a slightly different way of working but it’s something that wouldn’t cause any… Too much in the way of any problems.

Reference 1 - 6.56% Coverage

R So would you say that overall, in your experience, people have been quite receptive to new ideas?

P Yes. Yes.

R Okay. And that’s because it doesn’t… it’s not too disruptive?

P Yes, provided what you’re going to change isn’t going to hugely impact on their workload and how they work, usually it’s fine.

R Yes. Is there something that you think about? So, for example, when you think about new technologies, new equipment, is there something that you consider that, you know, it shouldn’t be too disruptive?

P Yes, because they will be, in the business case, they will be one of the stakeholders that we list. So we have to consider what is the impact of the change we implement going to have on service users. And certainly we implemented something about 18 months ago that was quite a big change from what the doctors within the Trust did. So before we implemented it we made sure that there were meetings where they could discuss it, that they were fully informed, that there was adequate notification. We explained what the changes were going to be and we explained what we needed from them.

00:13:47

And there was an opportunity for feedback from them before we made a decision to implement. So they do have to be… if it is a change for them, they do have to be involved in the process.

Reference 2 - 10.12% Coverage

R So I was just… I’m just interested in finding out what, in your opinion, how the test would impact the service.

P Probably that’s a difficult one for me to answer because I’m not the clinical service involved. That’s probably one that sexual health would need to answer because it would totally depend on the model they’re going to use for actually using these tests.

If we had one analyser in the laboratory and we had the same number of tests coming through for testing, it won’t be… it won’t be a real time result. We are having massive backlog of tests so whilst we might be able to turn them around faster than we do referring them off; we are not going to be turning them round inside an hour.

R Right. So then it wouldn’t necessarily mean that patients would get their results within half an hour?

00:19:27

P No. No. That certainly won’t happen from the laboratory’s perspective.

R And what about… so I’m thinking even if patients wouldn’t get the result within half an hour, potentially they would get them sooner?

P Well, the potentially would if there are several analysers and the clinic are using them as well. But we get a vast number of samples into the laboratory and if it takes an hour for the test result on the analyser, we’d start building up at the end of that first day, given that we’re open for eight and a half hours during the day, we would already have built up a backlog the first day we start testing. And that backlog would just get bigger and bigger.

But there might well come a point at which, actually, no, we’re not giving a better turnaround because we do so many. So we would have to look at who are these tests going to be performed on because as things stand we wouldn’t be able to do all the tests that come through the door with one analyser.

R I see. So there will have to be a bigger volume?

P Either a bigger volume or we would have to look at what criteria we can use. Are we going to test all patients or is it going to be a specific cohort?

Reference 3 - 1.42% Coverage

P And, potentially, that means that if they do want to screen their patients for GC, are we going to be in a situation where they’re sending one test to the urine analyser, but we’re still referring a test off for GC? So that could end up at twice the cost that we currently have.

Reference 1 - 1.12% Coverage

P I think a rapid test that gave results to allow immediate treatment of Chlamydia and Gonorrhoea would improve patient flow. Yes.

R So that would be generally a good thing?

P Yes.

Reference 2 - 7.90% Coverage

So, I think without knowing exactly how we, or which patient groups we introduced to. But if we talked about it being a universal thing, then you're talking about the lack of need for management of positive results at a later stage. And therefore that would reduce the staff input time chasing patients. It would improve patient convenience, because they're not having to return a second time in order to receive treatment.

00:14:47

It would potentially increase improved public health, because people are not going to be passing on infections whilst they're waiting for those results to come back. There was… And also the patients who then don't come back, they can't be bothered, or they never hear their results, because they've lost their mobile phone, or changed their number. So I think that's a positive thing I suppose.

Potentially there may be a delay in those results. But that means it doesn’t work as well, and if I remember rightly, the proposed platform is a 30 minute assay. Well, given the number of people that we might see in a day, 30 minutes might be fine for the actual test to run. But they might wait three hours for a machine to be available for that test to run. So, all of what I've just said ceases to become, well not all of it, but it's not necessarily as relevant.

Reference 1 - 2.48% Coverage

P I think it’s more about trying to integrate it into the common clinical practice. So, for example, for the herpes test, we had to run additional swabs alongside our standard, so it was about making sure that that wasn’t being missed by staff. Obviously in GU clinics, we had large numbers of different staff, nurse, practitioners, doctors, seeing patients. And it was about finding ways to make sure that all the patients had the additional swabs for that.

So we ended up packaging the swabs together so you couldn’t pick up a standard swab without also picking up the research study swab. They came together. And that helped. So it was more about introducing it as routine. But actually, the study itself ran easily and the patients agreed to the additional test. I don’t think we had any refusal that which, you know, was just an ulcer swab, so it’s very straightforward.

Reference 2 - 6.00% Coverage

P So I think it has real capacity to do that, slightly depending on how we use it. So, I think, so for some patients, for example our male patients with Non-Gonococcal Urethritis, being able to exclude or rule in Chlamydia is very helpful. You’ve got the microscopy for gonorrhoea as effect. But I think that, at the moment, we’re within this kind of limbo with mycoplasma testing.

If you could say, it’s not chlamydia and it’s not gonorrhoea, you would just treat them for mycoplasma from the start. I think that will be helpful. And then I think for other patients, so if for example for patients with pelvic inflammatory disease where we’re making a, we’re syndromically managing them, being able to rule in or out gonorrhoea, for example, would influence our antibiotic choice in clinic.

I think there’s also something about preventing onward spread of infection. So we see a number of high-risk patients. So, for example, we have an MSM clinic which runs twice a week, and those patients have a 20-minute HIV point-of-care test. So actually having a 30-minute test running alongside that would be no significant difference to their wait time, but actually be giving them a lot more results on the day.

Now I think the slight barrier is that our HIV and syphilis serology is slow. So, we wait for those results in the main lab. And although we can get an HIV test within 24 hours, it’s only for urgent tests. And certainly syphilis results, particularly if they’re the positive result, can be delayed for a good two weeks. And I think there is a slight issue about giving some results to patients and not giving others.

00:24:50

And I’m not saying we shouldn’t be giving as many results as we can, because I often think we should do that, but I think for it to be truly transformative, we’d need to look at speeding up our serology results. Now certainly, in previous clinics, I’ve used a dual point-of-care test for syphilis and HIV, and we’re looking at changing our point-of-care test for HIV, the one we’re using. We’ve gone for a fourth-generation test, but we don’t actually trust the antigen result anyway.

Reference 3 - 6.88% Coverage

So it might be better to go to the third-generation HIV antibody test, which also offers syphilis. So again, that would be able to give us some fast results for patients. Having said that, that would need to be confirmed with serology anyway. So we’d probably only be offering that to our high-risk patients. But I think to end that with the [clinic] model, we’d have to really sort out with the lab how we were going to streamline our HIV and syphilis testing.

So I think the point-of-care test has got real value for certain sections of patients, basically. So certainly people who we’re treating syndromically, it would be extremely useful in those patients. So I mean, in their eyes, so pelvic inflammatory disease, Non-Gonococcal Urethritis, Mucopurulent Cervicitis, so these syndromic management… I think it’s useful in cutting onwards infection and I think it also reduces workload.

00:26:22

So inevitably we get patients who test positive for chlamydia, and then we’re trying to recall them for treatment. And some patients take months to get back in and have treatment. And inevitably those are the patients who you consider to be the most vulnerable or who are not good answering a phone and you’re worried about who else they’re having sex with.

So, it’s always the patient who you can’t get hold of are always the ones you’re most worried about, with someone from a transmission or complication point of view. And it would certainly reduce that. All our clinics run as walk-in clinics, so patients basically turn up and wait. And generally waiting times are fairly short, so under an hour.

But it might be something we need to think about if there’s a, if we can give results in 30 minutes, do we need to have our women do a vulvovaginal swab on arrival? That can then be cooking in the machine and then when we see them, we can give them the results as well as do all the other things we do. And I think we’d need to just look at our clinic pathways and how that would work to try to speed up. Because you wouldn’t want to see them, I don’t think, and then wait the 30 minutes.

I mean, it’s only 30 minutes, but to try to speed-line the process if we’re able to do that. Having said that, you know patients who need microscopy, we can wait 20 minutes for our microscopy to be done in the lab. So, I think having a 30-minute test isn’t’ much of a problem as some of the previous tests which are much longer.

Reference 4 - 10.39% Coverage

R I see. And not having those pathways mapped out yet, but already knowing that this test would be for certain groups of patients, rather for everyone. So having that in mind, do you think that that test would actually impact the way in which the clinic operates? So the workload and the responsibilities, the way they’re distributed.

P So, it depends really. I think if you introduce the test for everybody, so that everyone can have their results in 30 minutes, we would definitely need to alter the clinic pathways, otherwise we’d be adding 30-minute time to every patient if they have to see a clinician first. And I guess then you’d need to think about whether your reception staff will be saying to the patient, here’s your swab, here’s the leaflet on how to do it, go and do it and then take it in to see the clinician.

Or whether we’d need to have the healthcare assistant on reception to assist patients with that. I think we’d need to think about, if male patients are giving a urine sample, and we then later want to do urethral microscopy on them, there’s a slight issue there. So, whether we have to do, how we’d do that, whether we’d have to get our men who we think will need microscopy to wait until they see a clinician before they can have the test done, knowing that they then have to wait 30 minutes for the result.

00:29:34

So I think we would need to, we would definitely need to look to our clinic stream. And it’s probably easier to introduce it for women than for men because women can take their own vulvovaginal swab without damaging any of your future samples taking, whereas you don’t want your men to have passed urine before you do microscopy, should they need that.

I mean it may that we need to have some men, we need a better triage system, so they’re being clinically triaged, but then again that would introduce a new role and potentially increase waiting time. I don’t think it’s impossible to achieve, but we’d certainly need to look at that. I think, so some patients it would be fairly easy to introduce.

So, symptomatic patients who are waiting for microscopy anyway, high risk patients who are waiting for an HIV point-of-care test, they’ve already got that wait-time after they’ve been seen, so you’re not really increasing their clinic-time experience. I guess the other thing is, do you let the patient leave the clinic and then ring them with their results? That’s, I think that removes some of the benefits of the tests.

So it obviously, patients get their results sooner which is good. And then hopefully, if they are positive, they come back for treating sooner. I think for your symptomatic patients where you’re looking to use the tests syndromically, actually you do need the results in clinic before they leave, otherwise there’s not particular benefit in having it.

00:31:02

I think for other, say asymptomatic patients, if they leave the clinic before they get their results, you do lose the benefit of being able to capture those hard-to-access patients where they’ve tested, now you can’t get them back in again. Because once they’ve left that’s then your problem. So I think the more you can streamline it so the patients get their results before they leave, the more benefits you get from the test.

But of course, even if they’ve left, knowing their diagnosis sooner, you would hope would reduce onward transmission and might make them come back for the treatment sooner. I think there is some data on that, but I’m not, I’ve not got it at the tip of my fingers. But I think there have been data showing that it does reduce time to treatment. I think that’s something we’d need to think about, loosely.

Reference 5 - 0.50% Coverage

So I think from a clinical point of view it would be absolutely amazing to have the four-pathogens in a 30-minute test. But we need to think about clinic processes with that.

Reference 1 - 6.84% Coverage

would you say that a rapid point of care test, such as Atlas CT/NG test would improve the service?

00:23:22

P I think so, I think it probably would. I wouldn’t use it in everybody, because clinic flows couldn’t handle everybody who was coming for kind of five minutes seeing an HCA, getting a urine test and a blood test, to send off waiting 30 minutes for results. We don’t have capacity for that.

So, where I’d see it fitting in would be symptomatic patients. So, you could redesign the clinic flows, really, so if somebody came in, kind of do a triage, so in men, it’s I’ve got dysuria or I’ve got urethral discharge.

Well, actually, their triage would be that they do a urine sample… or whatever sample… urine sample first, that goes on the analyser, and then they go back and wait, then the chlamydia/gonorrhoea test comes through, so you know, and then you call them through and do the assessment.

So, you know that they’re chlamydia and gonorrhoea negative before you do the assessment, so… that’s probably where I see it fitting in, in use for symptomatic patients within the clinic, or very high-risk patients that you think there’s a… or contacts with chlamydia, something like that.

So… where you’ve… actually having a chlamydia and gonorrhoea result would make a difference to the management you do on the day. So, for example, if you would… you would give a different type of antibiotic.

00:24:52

Certainly, I’d see that fitting in. So, if somebody came in with urethral discharge, their chlamydia and gonorrhoea was negative on the rapid test, you’d do a swab and confirm, you would treat them for mycoplasma and other NSU organisms, rather than concentrating on the chlamydia and the gonorrhoea. So those… that’s how I’d see that fitting in with kind of our pathways.

Reference 2 - 6.98% Coverage

Yes, so it’s probably wouldn’t affect the on-the-day clinical input too much. You just… you’re spending the same amount of time with the patient, but maybe in a slightly different way.

Where it would really impact, would probably be on results management. So, if somebody came in with discharge on the day, they had a rapid test and it was chlamydia positive, you’d treated them for chlamydia, and say, look, it’s chlamydia, we’ll contact you if there’s any other problems at all you’ll get a text message with everything else. Come back and see us for your test of cure, and then you send them away, and then that’s finished.

In our current pathway, you come in… people come in, you say, oh, you’ve probably got urethritis, it may be chlamydia, here’s some antibiotics, the chlamydia test goes off to the lab, the positive result comes down, it has to be reviewed by the nurse… the member of nursing staff doing results, that nursing member of staff then has to kind of check records to see have they been treated, have they not been treated? If they haven’t then they can spend a lot of time recalling them.

00:26:27

If they have been treated, they still have to contact them to tell them yes, it’s chlamydia, and you need to come back for your test of cure. If they’ve not been treated, they have to recall them for treatment, which means another attendance.

So, certainly for symptomatics, a rapid test would probably reduce follow up attendances and subsequent administration. So, it would make a clinic appointment quite… everything would happen in the clinic appointment. There wouldn’t really be any work beyond that, unless they’re… unless a blood test came back showing something.

So, that’s where the efficiency would come, it would be results management and decreased follow up clinic attendance for treatment.

Reference 1 - 24.78% Coverage

P Well if it’s just a... At the moment we’ve got the health care assistants that help the patient with their swabs and their bloods, to send off the test, when the results have come back. If it’s a case where they’re doing the same; would they need training, the health care assistants or the clinician? Because I don’t know at what level, because of the...

R Potentially. Well the test is supposed to be really easy to use. So it can be used by nurses or clinicians or health advisors.

00:03:48

P Right. Okay. So it could be anyone. So...

R Yes.

P Okay. So in my opinion; would the patient still have to see a clinicians for a consultation, or...?

R Well, yes, so they, so we run workshops in different clinics participating in this research. So there were different ideas. So the, for example, there was an idea that patients would take their swabs and their urine samples, and then that would be tested. So someone would then prepare the samples to put in the machine and run the machine. And then the consultations would be just taking history and talking about the treatment, if needed, and all that. Rather than also taking the swabs.

P Right. Okay. This is an example. Let me give you a blank copy, because that’s a patient’s one. This is the example of a health care assistant would do for a patient, because then they just come in for the routine checks. So they’re not seeing a clinician, doctor, nurse. It’s just a health care assistant. So they have to follow this. We give that to the health care assistants to say; go through that with the patient. The patient have to fill in this questionnaire.

R Right.

00:05:21

P Would it be along the same similar lines type of thing, for the health care assistant, in order to sort them? Because they cannot ask the patients questions, you see.

R Yes. So this is something the patients, I guess, does here.

P If they’re asymptomatics we give that to the patient and a health care assistant will see the patient. If they’ve got symptoms then we have to put them through to a clinician.

R Right.

P So if the patient’s say... Okay.

R Yes. Well, so the question is; is the point of care test, is it going to be used for all of the patients? Or is it going to be just used for contacts? Or for young people? Or for...? So but this is, this really depends on the clinic.

P Right. Okay.

R Yes. But I guess it’s very, it’s not easy to imagine without actually...

00:06:15

P Yes. So if... Okay. So to me there’d be two roles here. The health care assistant can do it for asym patients, if they’ve got no symptoms. If the patient has symptoms, they have to see a clinician to ask them all these additional questions or whatever, and then do the tests. So I see there’s two roles here. So asymptomatics; health care assistants can deal. Very straightforward. Symptoms... Yes. Okay.

R Right.

P Right.

R So I guess there could be different pathways for the same test.

P Yes.

R But depending on the symptoms, or the lack of symptoms.

P Yes. Because the HCAs cannot ask questions. Only the basic questions that’s on here. Follow it through their guidelines. Then they can actually do the asymptomatics. But if the patients do have symptoms, they have to see a clinician. And like you said; there is a different pathway for them as well. So it’s like... Yes.

R I see.

P I can see that. Yes. If it’s something that we can roll-out at reception, yes. But then, again, that might be a bit more guidelines. Because we’ve got to get someone, health care assistants, to actually do the tests for us.

00:07:36

R Right.

P Yes. Because we can’t literally take from the patients. As we give them the home test kit to take away, they can do them, put it in the post. If they, it’s going to be rolled-out here, it still has to be... I think a health care assistant will have to do it. Because reception staff cannot take themselves off and say; oh, we’re going to go round the back to do this. I can see, yes, two different pathways still. Yes.

R So they could potentially have an impact on, a bigger impact on the clinic. Maybe too, not too complicated, but it will be complicated.

P It’s not complicated. It’s just that we’ve, it’s still the pathway as if we’re going to give them the home test kit to take away. But we have to find out; can the health care assistant do it straight away, do it for us, are available to do it? As long as the patients do not having any questions. Because they’re not trained to answer medical questions. If there’s any complication, any concerns, then they would have to see a clinicians to do it. But it’d still be a quick test for them to get the results back from the same... So yes, there’s advantage. Yes.

Reference 2 - 12.60% Coverage

P What I’m trying to say is that; are we to be allocated, say, 50 per week, 50 cartridges per week? And then after that, that is it? Or would it be unlimited? Because it’d be difficult for us to roll something out and then say; oh, sorry, we’ve reached our limit for the week, or we’ve reached our limit for the day.

R Well, I think that really depends on the clinic and how much money the clinic has to spend. So in the service evaluation period, the cartridges will be provided free of charge by Atlas. And that’s, I can’t remember, I think it’s 18... I don’t know.

P Okay. That’s fine.

R I can’t remember the number.

P No. Numbers don’t mean nothing.

R But once it’s implemented, then it depends how much money the clinic wants to spend on that technology, really.

P Right. Because when we rolled things out, like I said; Preventx and SH:24. When it took off that originally was allocated to, say, 15 maximum per day or something. But then it didn’t get to that. They lift the ban and actually... It wasn’t a ban... But lift to say; yes, we will keep rolling it out. So we were never... Because it took off so quickly, I think that was taken away.

00:11:34

And we just got our orders in automatically in. If we ran low, they sent in more of the packs. Because it took off so well, extremely well. I was all for it. I loved it from day one. Yes. From the first time I saw how easy it was to do. Anything that’s easy... My problem I have with it is that if we start something, I don’t want to know to say; oh, we’ve reached our limit.

R Alright. Yes.

P Yes? And the next patient comes...

R And back to the...

P Yes. And then we just go back to the old ways because we have to wait for delivery or wait until the week to get more in. I just like to know that something is continuous. Yes? So all that is management-level strategy, whatever; they have to sort it out.

R Yes.

P So if we are rolling out something, I like to know that it will be continuous for a period of time. If we know we’re doing it for six month and then we’re stopping it; fair enough. It’d be the sixth month. But don’t say to us that we’ve reached our limit, we cannot have any more. Because that is... I find hard. When patients come back again, repeating patients, and say; what’s happened to the service? We start something then we stop it. Yes. I’m just looking at it from that point of view. Yes.

Reference 1 - 9.42% Coverage

P Then you get a CT/NG result and then you do another... So, apparently how I thought it would work would be in a young person’s clinic where you don’t have a large volume of patients. I don’t think it could work here in [clinic] but I don’t think it could work at the other clinic where there’s a large volume of patients that come along and, you know, you’ve got 30 people waiting. It’s very difficult it would probably work somewhere where you don’t have the huge volumes and people can wait for a result.

Because the thing is if you could do let’s say, you know, batch them up and do, I don’t know, five at a go then it’s a little bit easier because then you’ve got five people who get the result at the same time. But if it’s one test per run then that becomes a challenge in a very, very busy setting. I mean, because even when you talk about, like, you know, the 20 minute HIV test you can do five of them six of them because it’s all its own test isn’t it.

But if it relies on one machine and you’d have, you know, one person waiting 20 minutes and then the next person then that becomes very clunky and difficult. Because even I think even at [clinic] they run, they batch them and run them together. I think they can and I think you can batch up to 96. But it’s a batch, you know, that you can do and work with.

00:22:06

But single, single testing I would say it would have to be somewhere where it’s controlled and you don’t have a large, a huge footfall of patients, yes, because it’s just... And the reason we were thinking of our young people’s clinic because I remember when they came and talked. The results team sometimes struggled to get hold of, you know, patients to give them their results and say ‘oh numbers are wrong’ all this.

So, you’d actually be able to give the person their result there and then. But then you’d have to decide who to choose it would have to be probably someone who was symptomatic or a contact you wouldn’t choose every patient. No, because if they were asymptomatic and were walking in just for a test and then you’ve got someone who’s a contact I would go for the contact first because, you know, 30 minutes and then I have to wait for... do you see what I mean.

You’d have to think about who you would... say, okay, fine you’re our contact, yes, let’s see what your result is. The other utility is obviously we’re getting a huge issue with anti*-*microbial resistance*.* So, obviously you don’t want to willy-nilly treat people. So, if you are able to maybe just look at contacts and just, you know, test anyone you were thinking of giving empirical treatment to. But actually you’d just wait to have a diagnosis and tell them, okay, just go out and a have a coffee and come back or something.

Reference 2 - 3.95% Coverage

P So, I mean, essentially what would... you know, because it seems a very simple thing to do. So, you’d actually probably be getting a health care assistant to do the work with the samples, get the samples and put them in the machine and then wait. And the nurses, doctors would continue seeing the patients as is. So, in that way it shouldn’t impact. Essentially what you will have though is you’ll have... you’ll see a patient do the test, see another patient do the test, see another patient do the test, then call back the other patient in with the results, do you know what I mean?

R Right, yes.

P So, there will be that where now you’ll see a patient do everything, they leave you’re going to have to tell them to wait, so, you’ll have those patients that are waiting. Which used to be the model before you’d see a patient take the history, the nurse would take them get them ready. You’d see another patient maybe two then you’d go back and examine that patient and then you’d come back and give them the results. So, it would be going back to a model that a lot of clinics now have adopted not to do anymore, back and forth, back and forth.

Reference 1 - 5.78% Coverage

And it also comes down to when we’re going to know the result in about half an hour, what we do with the patient during that time.

00:20:07

So we don’t have a, there’s not really, within a five-minute walk, a cheap, affordable café here, because we don’t have one within the building. Whereas I know at some of the bigger trusts you’ve got, just across the road, you’ve got Costas and you’ve got a Friends Café, and you just say, go have a drink and then we will text you. And then that’s looking into what recall’s going to be for that. So, if we’ve taken the test, what’s our responsibility towards the patient as well.

But then there’re also going to be questions about the efficacy of the testing, but I know if it gets the CE-mark, then it’s been tested, and, yes.

R So what to do with the patient waiting for half and hour.

P Because we’ve only, we’ve got one small waiting room. We’ve got the big waiting room then we’ve got the little one, so we’d probably put people to recover if we’ve done coil fittings or… And that’s when they wait when they’re waiting for microscopy at the moment. Because we already do some, I think microscopy is a point-of-care test, so we do that, but that’s a five-minute thing, and normally we don’t have that many, because it’s not every patient who’s eligible for that, or needs that.

00:21:21

So we don’t get that much of a build up. I think the most I’ve seen waiting was three. Whereas if, with this if every patient was eligible, then we’d have to think how we’d manage that. We’d also have to think about who would be eligible. And whether we’d have to prioritise, particularly at first while we’re getting used to it.

Reference 2 - 5.87% Coverage

So you said that the point-of-care test would improve patients’ experience.

P Yes.

R Would there be any other advantages of that for the clinic?

P The time saved on positive results. So the amount of people who get lots to follow up, the amount of… Everyone who’s positive gets three recalls. So if they’ve got a, chlamydia, we would call them, we would text them, leave a week then call them, text them, voicemail, leave it a week, see if they’ve come in. Then we’ll do exactly the same again, and maybe write to them. So that takes a lot of staff time just to review the notes and check that.

00:24:18

And not everyone comes in with the first text message. And at least if we knew the result on the day, particularly in someone who is a contact, because that would get rid of some of the, that’s another thing to point out to managers is antimicrobial resistance. If we know that chlamydia’s negative here, then we don’t have to give them treatment as a contact. So that’s something of benefit. So if we think about, I’m getting completely distracted, I do this all the time.

But the amount of time we spend recalling positive patients will be saved so dramatically. When somebody’s here we can talk to them about partner notification, we can talk to them about test of cures when it comes to gonorrhoea, we can do all of that here and now, not over the phone where you don’t know if they’re listening properly or not. I mean, if we can actually start the process rolling.

It’s the whole point of microscopy, is to try and get them a result here and now, and treatment, appropriate treatment, here and now, to save that, to prevent further spread of infection. So that’s one thing.

Reference 3 - 9.19% Coverage

P Yes. And also think, even though it’s half and hour to process the test, we have ten clinical rooms. If we have ten people working simultaneously, we could end up with a massive backlog, so it might not be ten minutes, might not be half an hour because they’re waiting, there’s already a test in the machine.

00:26:10

So we’ve got to wait for that one to finish before we can put the next one in, so that might also be a backlog and a concern as well with that, actually. If you happen to be the first patient of the day, it’s half an hour, but if you’re near the end, it could be hours.

R Right.

P So that’s, it’s difficult to say half an hour when it’s not. They’re not like the insti- HIV test that we process in front of them, or the old insti ones which were like a mouth swab and you dip them in to 20 minutes. But you knew that that would be 20 minutes because as soon as you put it in, it was processing. Whereas this, you can do all the samples and then you’ve got to wait for the machine. And if the machine’s not free then, yes.

R Yes, what do you do with that sample. So would there be any redistribution of care responsibilities? Do you think? Would there be, for example, someone just to do the point-of-care test.

P If it’s got a big enough uptake it would be. And if it was something we implemented it would be something that would need someone who’s pretty much on that machine all day. We’d need a, space wise, we’d probably need a bigger lab as well, because our lab and sample preparation area is quite small. But that’s something that we’ll be thinking about based on the size of the actual machines and the number of them

00:27:34

But then that’d mean there’s somebody probably in that room most of the day. Unless we limit it, unless we have a policy that it was just limited to people who were contacts of infections, who had certain symptoms. But that would need to be discussed with everyone, I suppose, to decide who’s the most eligible for it.

Most of the people we see have symptoms, because all the asymptomatics are now directed to online testing. So it’s not, most of our patients would have symptoms. Yes, I suppose that would be something to think about.

R So it wouldn’t be for all of the patients, probably.

P It depends on the number of machines and the capacity of the machines. So if it was a machine that could do ten tests at a time, then that will be able to offer to more, whereas if it’s one at a time it takes half and hour, and there’s only one or two machines, that could lead to big backlogs. And they say you’ll get a result in half and hour but then they’re actually waiting for two hours.

Reference 1 - 2.75% Coverage

P Because I think we’re, at the workshop we did, I think one of the issues was that it takes 30 minutes to run, is that right?

R Yes.

00:08:39

P So, which is slightly different to running a three-minute or four-minute cholesterol test, when you’ve go somebody in the room and you can do other things. So I’m, that’s one of the things I’m, especially if we’ve only got one machine, how is that actually going to run in a clinic, when you’re waiting for a test to be run. But maybe if those things can be worked around, but yes. I mean, I don’t know if I’m answering you questions at all.

Reference 2 - 1.93% Coverage

Here people sometimes do wait that anyway, for the result of the microscopy so I don’t know if that would make any difference, but I think in the peripheral clinics it’s going to be an additional waiting time, I think. Yes, I don’t know. It might change the way that we run the consultation. So, we know sooner whether we’re going to do that test or not. So we get that started and then do other things afterwards.

Reference 3 - 1.31% Coverage

P I’m thinking at the workshop I think we thought about using this, not necessarily here but at the other clinics. I don’t really know what the layout of those, how the layout would facilitate those. But I don’t really work there. So if I don’t, not quite sure how that would work.

Reference 4 - 7.83% Coverage

R So the best would be if you could choose which patients…

P Possibly, yes.

R A selection of tests.

P Yes. And then we’ve also then got HIV and syphilis. So would we be just sending those off as we would do normally. I don’t know.

R That could potentially be…

P So they’ve still got to wait for that, haven’t they?

R Yes.

P I guess it’s, at least you’ve got the chlamydia and gonorrhoea you can do. I think, certainly for people who have come in as a contact of chlamydia and gonorrhoea, they have the option, at the moment, of testing and seeing, and testing and treating. Where I think, with the rate of potential resistance to medication, I think if you can do a test there and then for chlamydia and gonorrhoea for a contact, I think that would be really good. Because you can say, well actually you don’t need treatment now.

00:24:22

So, if you look at the cost of medication for treating people who actually don’t have the infection, but because they’re a contact we treat anyway. That might outweigh, I don’t know what the finances are, but there are certain benefits there, I think. Being able to assure somebody straightaway that they don’t have an infection at that point, as long as it’s not sort of in the window period, that, for the patient I think certainly that would be a great thing to do.

I think if that was me and I’d been in contact with somebody and they told me they had gonorrhoea, and I could come and and say, yes, well no, actually you don’t have it, and you can say that’s safe because you’re, it was more than two weeks ago, then you haven’t got any treatment, potential side effects, potential anaphylaxis. That’s probably is a good thing, yes.

Reference 1 - 9.09% Coverage

PA It fails to work.

RE Right so technologies are…

00:04:03

PA Yes, so we sometimes have a system we're online and we have online testing, pathology testing, and we… If that goes down for whatever reason, we have to stop doing pathology so we stop doing screening and then make a decision on an hour to hour basis. So that's one example, so the computer might go down or the path links might go down. From now on until it's up again, we can't do any testing, so we make that decision. Yes, so that would be, so it's day to day, it's clinical day-to-day.

RE Right. So it has to not only just work as in terms of like, provide good results.

PA Yes.

RE But it has to fit in within the clinic?

PA Yes. Yes I mean like the Preventx, for us that's beneficial because it means we don't have to see those patients. So for us it's advantageous and we would want to make sure that works on patients. So today I'm doing triage, so that means I start the clinic and I see every patient and I decide whether we're seeing them or not.

RE Yes.

PA So it's my decision so not seeing… That's my decision. But I'm pro Preventx so I'm going to go right, we can't see you as a clinician but we would do this online testing for you.

Reference 2 - 5.32% Coverage

RE But would it impact the way in which clinic operates in any major way?

PA Yes, I think because you will have more people milling around, wouldn't you. So that might be stressful, you might get people getting a bit… But otherwise not really, we need more staff at the start of clinic, because you're going to have more patients, you're going to have patients for a longer time, but if you're seeing them and then you're waiting, get them to take half an hour you can always see another patient in that time. I think it would be okay. I mean it would be change and people would have to work with that.

RE Right.

PA But we work with lots of change, I think we could do that.

RE Right.

PA I really, I'm on it.

Reference 1 - 13.06% Coverage

R And implementing a Point of Care test for Chlamydia and Gonorrhoea, will it impact the lab that you work in?

P It’s just another test, isn’t it, really. So I suppose once all the work has been done then we go ahead. We have two part-time members of staff who are quite longstanding in data and train staff from the bacteriology department. So I wouldn’t see that there would be a problem because we’re already using similar equipment and that because they’re there routinely throughout the week, they’re well versed with the training and performing the IQA, IQC and EQA. So I would think that would run very smoothly.

00:15:25

R And then what about the contracts existing between the clinic and the lab?

P I don’t really have an opinion on that because I don’t think whether for particular hours while the clinic is running, until we start to use it, I couldn’t give you any idea on how many samples we’ll putting through the machine. Because I suppose that would have to be a piece of work that the consultant does. Which you foresee that we’re testing every single swab and urine that comes in or they’re going to select out particular patients that they want that quick test, and then the other samples we may continue to use in that test.

So there could be an impact, could be that would you need one machine, two machines, I don’t know. But I usually have two people in the lab per day sometimes and then afternoon that can go to one person because I also have the outreach clinics to attend as well. So I don’t know what the impact would be. I don’t know whether we’ll be testing one sample a day [inaudible], I have no idea.

Reference 1 - 16.07% Coverage

P Yes, I think, the problem that we would have with it is, and I’m now thinking back to what I think was at that meeting, so if it wasn’t forgive me. The thing that we realised would be a problem for us would be who… Actually it’s all coming back to me now, sorry, yes, I was at that meeting. It was who we would offer this to and it would be really good, in a sense, to offer it to everybody but because we see so many patients here, there’s a constant flow of patients through the system, we felt that we would actually have to rationalise who we offered the rapid testing to and those being the most vulnerable really.

The problem that we would have then is that we actually need separate machines because if it takes half an hour to do one, and we’ve got a whole load of samples, you can see there would be a backlog there and a bottleneck really in terms of the flow of samples being tested.

00:24:16

The difficulty there is if we’re selling this as a very quick and rapid way of getting SDI results but we’re creating a backlog and it’s not going to be that. It will certainly be a lot quicker than the two weeks that we currently have to wait, or our patients have to wait for some of the results. Yes, I must have been at that meeting, I do beg your pardon.

R Right, so first of all it will have to be decided who’s going to be benefiting from those tests.

00:24:25

P Yes, indeed.

R Once that’s decided, assuming it’s only a certain group of patients that will be benefiting from this test, how do you think that’s going to impact the workload for analysis for healthcare advisers, consultants?

P I’m not sure whether it will actually add to it slightly because at the minute we collect samples from patients, take them down to the labs and that’s the end of what we do until the results come back. Whether it very much shortens the gap between patients coming back and being told the results maybe it will, maybe it won’t.

P That’s okay. I’m not sure, it’s quite hard to think how that would actually work. I presume if it’s half an hour then that’s really very quick and the samples were done first. A whole episode of care could happen in one visit which is great for the patient, so it’s very good. It depends on the numbers that were being done, I suppose, and whether there were any waits for the samples to be processed.

R What about the cost or existing contracts with the lab, for example? I also assume that depends on the volume.

P Yes, it would, and I don’t know the costs really. I remember something about the cartridges. I remember now going to this meeting because I didn’t know what the meeting was about in the first place, somebody just said, come along. It wasn’t explained and I was kind of picking up through the meeting, oh, that’s what this meeting’s about, that’s why I hadn’t registered.

00:27:20

Yes, I don’t know, I think it would be one of those things that we’d have to try to see. I dare say our own laboratory assistants, I’m not sure what the feeling would be from them, but I don’t think it would be much of a problem, particularly it would probably be just smaller select groups of patients for a good reason; and because they can’t currently do that I can’t see that being a problem.

Reference 1 - 5.19% Coverage

P I think there’s pros and cons to all things. We introduced a point of care test for HIV, oh, God, it was about now seven years ago. And there was a lot of interest in that however, you know, the test did throw off some false positives which then caused anxieties not only for our patients but also for staff. So, I think that experience has... that experience might have an impact moving forward if we introduce other point of care tests.

So, I think we’d need to be, you know, confident that the tests, you know, are good tests. We use microscopy which is a point of care test in its own right really. It’s a test that we do, you know, that is done not at the bedside but pretty much at the bedside which is something we’ve had for years and years and years. So, point of care isn’t a new thing for us or for, you know, the people in the department and we know it’s coming, so.

Reference 2 - 4.37% Coverage

P Right, so, you’re looking at what the obstacles could be. Okay, so, at the moment... and we had this... this was an issue when we introduced the point of care test for HIV, there was a 20 minute wait for that. So, there was an issue then around the waiting area not being big enough because some of our patients came and had their bloods done and then went straight away.

So, that was a real concern of ours that if everyone was having to wait that 20 minutes to have that blood test done then the waiting area wouldn’t be... there wouldn’t be enough room in the waiting area. That’s a practical thing but it’s a real thing. So, if this test is taking 30 minutes then that would be an issue. And so that potentially could be an obstacle.

Reference 3 - 10.78% Coverage

P Okay, so, currently our... we have onsite laboratory staff who deal with all our specimens. So, once the tests have been taken they’re then taken to our laboratory and they then either do the microscopy or sort out for it then to go off to distribution up to our laboratories which are onsite at the moment. So, if we were to change from doing... from that system we would still need the laboratory staff to deal with all the other tests that we do.

So, but I think that we would possibly require more people power to enable us to... for the clinical staff to be able to do the tests because obviously it’s going to take time for whoever to do that. So, I suppose that’s an issue. It will potentially take money out of the Trust because we send a lot of our specimens to our laboratories which I just said are in house. So, I don’t know how that would be viewed because they deal with... I know they deal... our business to our laboratories here is quite important.

00:25:40

So, I don’t know what impact that could have. And the other issue is the potential patient having to wait the 30 minutes. And then that could then potentially cause problems in the waiting area because obviously all patients will then have to wait the 30 minutes where at the moment they don’t. So, I suppose the concern there would be that if a new patient walks through the door sees the waiting room absolutely chocker then they’re just going to turn round and not even book in. So, that’s I suppose that’s another issue I think.

R Right so it can actually potentially discourage patients from...?

P Potentially if you’ve got a waiting room full, I’ll use an example, if you need to go into the Walk-In Centre and the waiting room is full you think, oh, I’ll come back later. You know, so that’s what I’m thinking potentially that could be a negative.

Key decision makers

Reference 1 - 0.82% Coverage

Well it depends on what the sort of clinics you have, but you need to get, you need to get everyone on board. Clearly there are, when it comes to, say, bringing in things, like diagnostics, the trust at the moment is just developing a point of care test committee, because they see point of care tests as becoming the, you know… More and more important. But at the same time, they are worried about quality assurance, and making sure it's done properly. And of course, we can do all that too.

Reference 2 - 0.61% Coverage

So in terms of introducing new ideas, it can be the trust, or it can be people working with patients on the ground?

P Well it can be… It can… Well it can come externally. But I think it really comes from, you know, us thinking about the whole service. So it's…

R Right.

P You know, it's all the people involved in the management team around the patient journey.

Reference 3 - 1.56% Coverage

who makes the final decisions that we'll stay with it, we'll be going back?

P So the way we… The way we've done it, so maybe if I'd use the… The two biggest examples I suppose.

R Yes.

P So the one big example was a three in one.

R Yes.

P So Dr [name], he's moved on sadly, but he was, you know, banging the drum around, you know, pooling samples. We see a lot of gay men, 40% of the men we see, and 48% of our punters are men. 40% of those are gay men, and they need sampling from the pharynx, and the rectum, as well as the urethra. Many of them are asymptomatic, and of course if we screen all three sites, and send off three samples, we end up paying, you know, just round numbers here, 90 quid for example. If we pool all of them, we only spend 30 Pounds, and we tended testing all three sites the same way. The trust was very keen that we move forward with that, you know, as in our directorate, because they could see clear savings.

Reference 4 - 1.44% Coverage

Right. And who's involved in writing business case?

P So, well we have a management team involved. So there's myself, [name], and there is a matron, there is service manager, and a sister. And we basically will put it together. Well people will contribute, but it will be… Main drivers will be one of the doctors and the service manager will then put it in front of the directorate management team. And say look, these are the numbers, this is, you know, the numbers of patients, this is the quality issue, this is the financial issue, this is, you know… We have patient input, etcetera. And then, yes, and then it gets thumbs up, thumbs down, or we need more information. Very rarely do we get things… You know, we get things pushed back every now and then, because they just need more information. But usually, you know, if it's a sound case, it just goes through.

Reference 1 - 4.69% Coverage

Again, it depends on what the effect is, and it depends on how you're implementing it. The key stakeholders are how we're talking about diagnostics. So diagnostics is the key stakeholders of the lab, because you're going to say, either you're going to do this new technology or we are going to use the new technology. So it's going to involve one or two things to the lab. It's going to be a change in the way they work. Or the other thing is that they're doing it, it means that there's going to be a change in their activity with us, which would transmit to income generated through our clinic to their [unclear].

00:39:08

So that's one key stakeholder. Service managers would be another stakeholder because that involves change both of our service and it's overseeing that. It's looking at what the changes are, who are going to likely be most affected by it, and that they are the people that I would be contacting early, get their opinions. If I'm going to say that, oh, this guest is going to be implemented in clinic, and I'm going to get their health care technicians to do this, this is a change in what the health care technicians do.

So how do they feel about that or what does this impact and [unclear] would get their involvement in that? If they're changing patient pathways, I would want to get an idea as to what do patients feel about that. Is that something that they think was worthwhile doing? Do they have a positive expectation or a negative expectation? That is the most difficult thing to do because, again, being an open-access clinic, we only can access people who access our services.

00:40:26

And as you change things, you change the population that comes to your clinics. So patient involvement would be key if you're changing patient pathways. It's probably not that... I mean, patients wouldn’t have that much of an opinion. If I'm going to say, I'm going from a DNA detection method to an RNA detection method, patients are unlikely to have that much of an opinion on that, because what they would want to know is that it worked. If it works, we're not telling them what the methods are.

Because people talk about patient involvement like it happened for everything, and it needs to be relevant. If the patients aren’t going to notice any changes, and when you change, you're going to have... some of this is going to be a cost saving. Patient involvement is probably not that. If you're saying that, say, it's a rapid test and you want to deploy it as a point-of-care test, and that might mean that patients wait 20 minutes more. I want to know whether they want to do that, they're willing to do that, they're happy to do that.

Reference 2 - 1.57% Coverage

Say, you have five people who are turning out patients or, say, you have two or three patients every hour, then say, per person, then you have five people. You're seeing 15 people waiting 20 minutes extra, which basically means that, very quickly, you could end up with 60 people in a waiting room that can hold 20 people. So it's kind of saying that working out your patient flow and seeing where do people go, how can you make sure that that's the least once a patient comes through the process.

They go through it, and they don't have to come out and [unclear] out the holding area and they get to... how do you streamline it? So that's working with your clinic staff, administrative staff to... so, yes, those are the key stakeholders for it to be your service needs. And then, obviously, the thing is that if it's going to affect your performance, then you need to involve commissioners.

Reference 3 - 2.39% Coverage

And being through quite a few service development implementations, we don’t get extra money. If you ask commissioners for extra money, it's always no. And you can generate it. And again, the other thing is to look at your business services management [unclear]. Just look at how do you make a business plan. The income-generating methods that you can use to... you could provide private services that can support these changes.

You can get research funding, as in funds generated through research, because research brings in money to the department. You could take part in commercial studies that allows you to get a budget that allows you to make the changes you want in exchange. So you have that power. So how do you empower yourself to get that? So it's saying that who are your stakeholders? Who are the people who are going to be affected, and who are the people who can make it happen?

00:45:28

The people who can make it happen are your management teams, your business managers, your research teams, and your private services teams. You want support from your general managers, who are managing the service and the directorate. And then you want to buy in from the lab because you're talking about testing. You are either going to say the lab is going to adopt it, or the lab is going to lose that. And either way, you need them to be on board.

Reference 4 - 1.77% Coverage

Say, personalized medicine, it's... the intervention is going to have a different... they're going to be broad. So if you talk to people, they talk about financial problems. And of course, they're going to be a [unclear] on the part of money, smaller and smaller. The demands are [unclear]. You need to be creative about how you navigate that. People will say money is the metric. Now, what do you do about it? If they're just going to say, financial considerations are the biggest barrier, what do you do about it?

The stakeholders are going to be different. You need to be able to say that think creatively about how we're going to do things. Diversify your activity to basically say, now you have income generation. And so basically having the ethos, that you're going to do more than what is asked of you, because that's the only way you're going to generating income. You're only going to do the bare minimum. You're not going to generate any income. You're not going to be able to make any changes.

Reference 5 - 1.65% Coverage

People, if they don't apply for these, don't get this. And it's basically being aware of what is out there, trying to say that you're applying for them responsibly, having those relationships. You talked about having a business development team. They're your key stakeholders usually. So people always talk about commissioner [unclear] and then talking to people [unclear]. Commissioners want lab test. And commissioners won't agree to pay to it.

00:49:18

But if you're going to do it on your own and you can deliver your key commission targets, nobody cares how you do it. Nobody cares what tests you use as long as you're able to do it within the resources that you have. So if you can move resources and implement something, it's possible. And the other side of the [unclear], you have less control because the people who develop how marketing the diagnostic and basically saying that you need to meet halfway and make it affordable.

Reference 6 - 1.09% Coverage

Yes. But also, the thing is that you can be creative about saying the lab has oversight of those testing. They are in charge of the ordering and everything. So basically, they could get the thing and charge us purchase. So basically then, they can get something that is doable, get a business plan. So it's basically seeing that we get a business plan that is feasible for both us and them. And you have support from the higher up, from the organization, which basically means that you have the power to basically tell the lab, if you don’t do this, the organization supports us in doing this and you're going to get that.

Reference 7 - 3.37% Coverage

No, I don't think. But I think I've talked about lots of the key things. I think the things to reiterate is that actually looking at avenues to service implementation studies and to make them as studies rather than say just make cost to things basically, then would make it attractive for companies to say that you have that implementation thing funded by research. And then you have all the data to make a business case. That's probably the strongest thing. And then getting organization leads.

01:09:52

I know there's a lot of interesting commissions, but I don't think they're that powerful. And it's looking at what labs think about this, what service managers think about this, what the finance people think about this, just [unclear] things and change would be the other kind of key stakeholders. But also to get key stakeholders is in Public Health, looking at, would they be interested in supporting a rapid diagnostic strategy nationally?

And once you have a national strategy that comes from Public Health England or NHS England, you have more buy-in. If you have a national body or you can [unclear] HIV saying has a standard supporting this, then you actually have somebody saying, look, this is a national standard, so actually campaigning for that and getting that voice and seeing what their concerns are, but mostly they're going to say there's nothing there.

But actually saying that how do you actually get national support for implementation of new technologies? Actually, to have something about that, some kind of guidance to services to say that this is best practice, this is what would be, this is what the future thinking service should be, would be a catalyst that allows people to do that. Because at the moment, you need a lot of local buy-in, which a lot of smaller services and even larger services with less interest would not have. So I think that’s probably all I have to add.

Reference 1 - 4.45% Coverage

P So I think first and foremost it’s the service team. So I think these ideas generally come from the frontline. So I would say whoever the staff member is who’s come up with the idea is obviously key. I think the clinical lead, the matron and the service manager, they’re like a trio that cover all areas of the service. They’re the ones that in the first instance should be deciding if this is something we want to progress.

And my assumption is by the time it gets to me and my colleagues at a directorate management team level, is that they’ve already done a lot of that work to say this is how much it’s going to cost. This is the risk to the patient. This is the benefit to the patient. This is what it means for staff and the way we work. And that’s where you’d expect that to happen, so I’d say they’re probably the key people initially.

It’s then my job once we’ve understood that to go and break through some of the bureaucratic barriers and to show that we’ve done our due diligence if you like, to say this is a safe thing to do.

Reference 2 - 1.90% Coverage

So I would say the frontline team are probably the most key individuals. It can depend what it is. So if for instance, if you were buying a specific piece of kit the clinical team will understand it to a point, but actually there’s probably somebody more appropriate in the organisation to make a decision about whether we should or should not be buying that device.

So it can depend, but generally speaking I’d say it’s the service team. Yes.

Reference 3 - 5.72% Coverage

R And the final yes or no, that also comes from the trio that you identified with the clinic?

P Yes, it depends on the scale, okay. So if it’s relatively low scale… So a really easy way of explaining it is for financial sign-off we have a sliding scale. So a service manager can sign off anything up to £5,000 and then a matron can do up to £10,000. The clinical lead’s the same, then it goes up to the directorate. It can up to £100,000 and beyond that it goes to a director and so on.

00:09:52

So and that’s for purchases and stuff like that. So you already have a framework you can work in, but that’s just an example how we do it here because it would be different across the board. But you would expect them to make a decision about whether we can or cannot do this.

When it comes to us it will be because it requires a more senior level of sign-off and there won’t… It won’t be as easy as they can just get on with it without us knowing about things. Because the way the organisation works, if you want to purchase something, if you want to invest in a staff group or whatever, it will always come back to does this have sign-off from your directorate management team?

So again, I think the answer can vary depending on the size of the change, but generally speaking decisions progress… Initially will be made by the service team.

Reference 1 - 3.21% Coverage

P Yes. I think I have a pretty active role in that process. I think, as a department, we are quite open about trying to find new ways to do things. And if there is an easier way to do something, or a more efficient or a more accurate way to do something, then we are really quick to jump onboard that. And the clinic lead is really, as our clinical lead, is all up on the technologies. So, he is always looking for us to adopt new things.

And he would come to me and the matron. That would be the head of nursing. And talk about, hey guys, I want to… I hear we have this idea to improve our service and get results faster. Or get people, you know… Have to stick a needle in someone less. Blah, blah, blah. And then we think about doing it. Come up with a plan in order to put it into effect. Yes.

So, I feel I am very much a part of the process that’s kind of thinking of the ideas. But, also, I suppose mainly implementing them. And thinking about pathways. And who does what and how is it going to be used, and with who? That kind of thing.

Reference 2 - 8.85% Coverage

You know, on my team we have team meetings every week. So, we are always… I try to keep the kind of environment where people would feel like they can make suggestions about. That… What usually comes out of that is new processes rather than new technology necessarily.

It would be nice to have people. You know, people who are kind of working at the clinic level, coming to us and saying, hey, I’ve got a great idea about a new test to use. But most people aren’t quite. They are just kind of doing the day to day work. Wouldn’t necessarily know about what technology is out there. But I like to think that there is a pretty open environment for encouraging people to come forward with, hey, here is an idea. So, yes.

R So, it’s really a very democratic process.

P Yes.

R And then who would be the key decision maker? So, someone who says, okay, let’s try it. And then who would be the people assessing that? The new process or the new technology. And, finally, who would be… Who is empowered to say the final yes or no to something?

P Well, I suppose it depends on what, which… What we are looking to do.

00:08:53

There are things in our service that can happen a little bit off the cuff, I suppose. Like, there will be some of the managers who will say, right, here is an idea about speeding this up now. So, let’s just go down and tell the nurses, and just start doing it today. Alright. So, there are some people that kind of operate on that kind of way.

And then some of the nursing managers who want to have a protocol for something. And they want it approved by the directorate. And it needs to be seen by this person, this person, this person or that person. You can probably see which side I kind of end or go on, really. I tend to think that… I know that there are processes that need to be followed. I think it’s important to follow protocol. But I think it’s important to try and not let it get in the way of starting something that could be beneficial for patient care.

R Right. And who is involved in writing the business case?

P So, there’s… The operations team that we have. There is a group of us that go to, like… So, there is business planning on a directorate level. And there is, kind of, four or five of us that go. That go on along to those meetings, every quarter or so. But yes, business case. It kind of depends on who has the most time, I suppose. And time is the biggest challenge with any of this kind of stuff.

00:10:19

It’s just finding time when you’re not in clinic. And you’re not doing day to day management of staff, to focus on things like this, really.

But yes, at the operations team. So, there would be lead consultant, deputy head of nursing, matron, me. A couple of the other sisters. There’s our service manager and our deputy service manager that are involved. So, it’s kind of a core group of maybe seven or eight people. Yes.

Reference 1 - 5.90% Coverage

R So you would say that there is a real democracy in a way, in terms of assessing new technologies…

P Yes.

R Or new way of delivering care?

P Yes.

R And who says the final… Who makes the final decision if something's implemented or not?

P The final decision will… I say will have to… Even though the lead clinician has his say as well. It has to go to the service manager, because there's a DMT. And they have meetings, so it has to be discussed, and they have to agree as well.

00:19:26

R And DMT is?

P District Management…

R Right.

P Team. So you have the…

R District manager.

P Deputy general manager, and the general manager, deputy head of nursing, and then they will, like, have to agree as well. To see if this can be done. Because it's good that we, like, have ideas, but they might be thinking, oh, there might be a cost, or there might be added, you know, burden to, you know… Can it be staffed, can… Whatever reasons, it has to be, you know, they have to be involved as well. And then once we get the go ahead, then we feed it back to the department.

R Yes.

00:20:03

P So…

R And who's involved in writing business cases?

P It… That would be… We all get together as a team to discuss it. But the deputy general manager, service manager, obviously the general manager, but the service manager will lead on it. And then will feedback to the deputy general manager. But we all get together as a team, and discuss what's our business planning for the year. And it goes… Goes quite well, because I think the service manager shares the office with the other service managers within the, like, directorate. And then obviously they can all bounce off each other, and see where they're at. But, you know, I think they have little competitions going. So it's quite good to know that, you know, what… You obviously like your plan is the best, and like… Because when it's sent up…

R Yes.

P To be evaluated, or checked, or whatever. And then, you know, if there's a few comments, then it's good. But if there's lots of comments, then, you know, if there's less then it means you're on the right path. So… And then obviously it's got to get signed off. So, yes. And there, again there's a deadline for that. So it's important that everybody… You know, because we have a set agenda to discuss certain things. And then if that's on it, you know, we might spend a bit more extra time on that for that day, so that it's signed off. So… I think we've got a really good team, actually, quite supportive.

00:21:42

R Right.

P Yes. They listen, because everyone takes turns in chairing it. I don't chair it.

R Right.

P But you just send up your items if you've got anything to discuss, or any other business. And everybody's listening too. And it's not to… And you know, and like, sometimes we, like, we have a laugh and a joke. It isn't… Nothing's ever taken, like, seriously. And so you can see everybody's quite like close knit, and you know, quite supportive of each other, which is good.

Reference 1 - 5.08% Coverage

P I think the key decision-makers are going to be the clinical lead, definitely, by his job and by his nature. Then I would say, to a lesser extent, the service manager, because he operationally supports change happening. And I think the matron as well, particularly changes that will affect the nursing workforce. So yes, I’d say those three people – there are others, but I’d say they are the three.

R And this is both for introducing ideas, and then saying yes or no to them, right?

P Yes, for the most part; I guess it depends how big the idea is, and how major it is. If it’s a very big change, it probably does involve the directorate management team as well, but I suppose that’s a bit more in the background to most staff, they maybe don’t know that actually that has gone through the directorate management team, they have signed that off, and now that’s why it’s being implemented. I don’t think people always understand that, or they’re not told that that’s the process.

00:08:37

Like, I know the clinical lead wants to bring in a change to appointments, so he’s already written a business case, which has already been read by the DMT, so there is a process. But I think if it’s just kind of, not such a big change, it doesn’t have to involve them all the time, so then I think it probably would just be those three people.

Reference 1 - 8.56% Coverage

R And so from your descriptions I'm getting this idea that all those implementations that involved everyone sort of, I just have this image. But who are the key decision makers would you say?

P What do you mean by key decision makers, in any changes or any…?

R So for example, if there was a new diagnostic test to be implemented in the clinic, who are the people that are likely to introduce an idea like that? And then who is more invested?

00:13:13

P I think that is, you have to come to the idea [?]. [Name of the company] actually, I work for [name of the company], not that I work for [name of the company] but [name of the company] is the organisation that provides sexual health service across [name of the area]. So I think you need to speak to those key people in [name of the company].

R So those people are more likely to introduce [overtalking].

P Yes, exactly. And I think you need to get involved with our clinical lead as well, and so clinical lead will give the input to the decision makers.

R And then the final decision whereas to implement it or not let's say after the period of a service evaluation, is it also [name of the company] and clinically…?

P Yes.

R But the collaboration with [name of the company], that's quite recent, relatively recent?

P Sorry?

R So what I'm saying is that your collaboration with [name of the company] that's relatively recent, is that right?

P No, not really because the service changed, so we were with the [name] Hospital. [name] Hospital is still part of it but then the service went out to tender [?] going on [?] three years ago and then [name of the company] took over, so we have been with [name of the company] for three years now.

Reference 1 - 6.71% Coverage

R Drawing on that experience... First of all who would you say are the key decision makers in a process like that? For example, who introduces the idea and then who evaluates it and who [overtalking]?

P I did introduce the idea because it was an idea which was being adopted by most clinics around the country. But when I, at least the first couple of years when I was here, it hadn’t been adopted yet. So I initiated the conversation with our pathology service, so our lead microbiologist about adopting this. And of course, the initial bits looks at some of the pros and the cons, the benefits and doing a business case around it and looking at the impact it would have on the service.

But overall there was a strong case for it because, number one, getting a better facility, the better, more reliable results and also more robust. So there’s a strong business case for it.

So with that we set up our small team of people to sit and see how it can be implemented. That involved also our local managers in the laboratory, in the department. And looking at the facilities we had, what resources we’ve already got that we can make use of to minimise any cost and what is required and what other extra cost might be required. And there was a costing done to all of this.

00:08:05

And then in terms of the implementation there was a grid process on how it was going to be done, in what stages and at what stage we evaluate it to see if it’s working well and before we then decide to take it as a standard practice. So those several steps we did, but of course the key stakeholders were myself and the clinical lead in the microbiology department working closely with their relevant managers so that we can adopt it.

Reference 2 - 4.02% Coverage

That is the biggest barrier that if you want to start up anything you want to try and overcome because that is the main thing that people always look at the first initial cost and that is a barrier because they say, no that’s too much money. We cannot do that. And that's it.

R Would those people be commissioners or someone else...?

P Yes. Generally a lot depends on the commissioner and some of the people who hold the financial budget strings, the senior managers, the budget holders, generally they tend to be the ones who you really need to convince that whatever you’re trying to bring into place is cost effective. It's something even we did experience when we were rolling out the new testing that I was telling you about when I started working here. There were some initial costs and... Not much but it’s there. It will bump up. And everybody was dancing around saying, who is going to pay for that? We don’t have that money, blah, blah, blah. But when you think in the long term, the benefit makes a huge big difference.

Reference 1 - 5.00% Coverage

P In terms of the introduction of new technologies, we’re commissioned to provide a service, and as lead provider, we would have the final say around introduction, because ultimately, we’re responsible for the contract. But in terms of influencing key people around… In terms of decision-making, if there was an introduction of technology that cost X amount of pounds and provided this outcome…

Say, e.g., we introduced a technology that would improve the management of results, meaning that people had their test results within two hours and, basically, we could demonstrate that a financial saving would be there, the quality would be maintained, and the satisfaction of people using the service would be the same or improved, then we would be then just talking to our commissioners about this, and our commissioners are very much behind piloting new technologies to try and achieve the outcomes that we’re commissioned to do.

But within our partnership, it is very much dependent on what we are commissioned to provide, e.g., if there was a technology that improved turnaround times for results by 50%, that actually that would add an additional cost of £100,000 a year to no real additional satisfaction or quality, it’s unlikely that our commissioners would support it. Even if a clinical lead said, but we must have this because it would improve our turnaround rates, if there was no clear public health outcome associated with that other than people got their results quicker, it’s unlikely it would be supported.

Reference 1 - 6.36% Coverage

R And in your opinion, who are the key stakeholders? Who’s more likely to introduce a new idea and then who’s more likely to take charge of adopting it?

P So probably our contract managers ultimately, which would probably be the keepers or the drivers for these obviously came from him. So that was from, he’s the contract manager and he’d set up the contracts with the lab and this is what was needed to be able to work with the lab and stuff. So he would definitely be one of the key drivers.

But I think equally if some of the heads, some think that they wanted to bring to the table for everybody, then we would take it to our strategy group meeting and we would present it and then everybody would be able to give their opinion as to what they thought. We’re quite democratic as a whole.

R So who’s a part of those meetings?

P Who is?

R Yes. Who can come to those meetings?

00:06:21

P So it’s obviously quality assurance from Xcompany], there’s contract leads and all the integrated sexual health team leads, practice and development team, safeguarding and sexual preventions, there’s the medicines management, the consultants and our partners as well, so [charity], [clinic] and stuff like that. So our partners come through as well.

Reference 2 - 1.50% Coverage

R So who then has the final say, who decides whereas to introduce something or not?

P So if it was going across the service then that would be down to the contract manager. If it was something that was just being put in a local level in just say, just in my clinic then it would be down to me.

Reference 1 - 2.72% Coverage

P I mean, I think it depends where you sell it to. If you can see an advantage or something, and you can then convey that to the staff, then yes. Then I think everybody becomes very invested in it. And I think if it's something you're told you must do from the top-down, then there's usually... unless they can see the really good... I think at the end of the day, the people who should be most interested are the people at the shop floor dealing with the patients if they can see the benefit of it. And that's why I always feel quite strongly.

You actually need to be able to see what the benefit is and explain that to the people seeing the patients.

Reference 2 - 6.16% Coverage

R So it doesn’t mean that everyone is involved in service evaluation.

P It depends on what they are. I mean, again, if it was the lab just changing the kit that they're doing a committed test on, I would just inform the service that that's what we're doing, and we're using different swabs. But if it's something that affects how we deliver care to patients at a more granulate, a more basic level, then everybody needs to be aware of what we're doing and why we're doing it and what these benefits might be.

00:08:38

R And who's involved in writing a business case?

P It's usually the senior management team. So myself, the senior nurse, our business manager, and anyone else. I mean, we would share it with the members of our STU team, so the senior nurses. We have consultants, but at the end of the day, it would be one of us three together who would be responsible for writing it.

R And who has the power to say the yes or no?

P It goes up through division and then to trust board.

R It is a lengthy process.

P Yes. I mean, it depends how much you're asking for. I mean, some business cases I've had through were actually invest to save. So moving to a fully electronic patient record removes all the cost of papers. So it's actually cost improvement as well as a business case. So that will get through much more quickly than something that wants money attached to it. Something that wants new money will take much longer than something that actually saves money.

Reference 1 - 1.25% Coverage

who would be the key decision makers when it comes to adopting new technologies?

P Well, I guess the key… Part of the key is the Department that needs to use it. They have, obviously must have a say in it. The Trust will do as well, and, yes, I mean, financially you have to decide whether this test is something that can or cannot happen.

Reference 2 - 0.98% Coverage

R And who would make those decisions?

P I guess as a unit, we… The ultimate responsibility will come down to X, who’s our service delivery unit lead, but as part of the senior management team, it all comes down to all of us to make that decision with her as well.

Reference 3 - 3.17% Coverage

I think all of us bring to the table different things as well. There’s three consultants plus anybody else in nursing and management roles, so I don’t think so. I think, because [name] and I come from different backgrounds, we’ve come from different clinics and started working here probably about 18 months ago, we do bring with us the experience from elsewhere, plus the things that we used to use elsewhere as well. And we’ve shared that across with everybody else. So are the things that [name] used. As I said, the point-of-care test for HIV, and I use that quite a lot.

You understand, both of us were very keen to introduce that, and it took quite a while – well, not quite a while – it took several months to get there, but that was one of the first things that we brought out. I don’t think anybody particularly has one role than anybody else in our clinic.

Reference 4 - 1.56% Coverage

But is there a person who has the final, who’s the decision-maker, so to say the final yes or no?

P Well, I guess that would be our service delivery unit lead, which is [name], as I said, and also as part of our division, it’ll be the person on top of her as well. So there is a sort of hierarchy that occurs.

00:09:05

R And writing business case, so is… Again, is everyone involved in that process?

P Yes, I would say so.

Reference 5 - 1.31% Coverage

P I can’t think of anything at the top of my head that would do. I guess if there’s major change within the leads of the service, that would definitely impact on it, because the new person coming in would have to go through the similar process, so that would be one of the things that would impact. But otherwise I can’t see any other potential barriers.

Reference 6 - 0.90% Coverage

P Or anyone in sort of the three lead consultants changing, because that would impact on, yes, making sure that everybody was happy with it before we roll it out. But otherwise I can’t think of anything within our unit that would impact on it.

Reference 1 - 3.50% Coverage

P It’s usually the area that requires the test that does most of the pushing. For instance, when the community required point of care analysers for FBC and CRP, they were the ones, well I mean, they got in touch with me. But they were more the ones who were pushing it forward, because they had deadlines. They had deadlines where they had to have it in place by. So, we worked together with them, but the relationship comes from the service user who wants the equipment.

Reference 2 - 5.86% Coverage

P Well, anything, any equipment, is passed through the point of care team. So, for instance, if we felt that the amount of workload warrants the equipment… because if someone wants the equipment, and they’re only doing two tests per week, then, obviously, we’re not going to authorise it. But the decision is by the point of care team, so that’s the consultant, the head DMS, and myself, as well as stakeholders. If stakeholders have any opinions about it, then obviously, they’re opinion would count.

R And those stakeholders would be people using the tests in the future?

P The stakeholders are people who attend the meeting, so, we would have a representative from IT, for instance. Or A&E, or from the diabetic team. So, they are the people that attend the meeting on a regular basis.

Reference 1 - 1.62% Coverage

P I think the key players would be the clinicians. But the clinicians are more swayed towards what the patients want. So I think the key players would be the clinicians. And by clinicians, I mean both doctors and nurses, I think, would be the key players. And I think most clinicians are persuaded on what works better for patients, I think.

Reference 2 - 3.15% Coverage

R So would you say that it's the clinicians and nurses... so everyone who deals with patients that they are the most interested as well in new technologies?

P I think so, but probably the commissioners as well.

R And that is because...

P Because of the patient needs.

R Yes, as well.

P Yes. I think most of it is more down to patient needs. But if it makes work much better for clinicians, both patient's needs and clinicians work, then it works better, I think. Well, I think it's a bit of both.

R Yes. And who has the power to make that final decision?

P I think the person who has power to make that final decision would be probably our lead consultant.

Reference 3 - 2.22% Coverage

P I think when it comes to evaluation, everyone is involved. It might not be all coming together at once, but it might be various teams getting feedback from various people. So, say, if we start using a new system, say, a clinic, then I'll be responsible for getting feedback from the nursing team and then bring it forward. So whether it's good or bad, I will have to say based on what my team has said. So I think when it comes to evaluation, everyone's input is valid.

Reference 4 - 1.72% Coverage

P I've never been involved in writing a business case. I joined this trust in July last year, so I haven't really participating in any of that. So I've never been involved.

R And do you know who would be involved here if there was a business case needed?

P I'm not sure who would write it. Probably my line manager would know, but I'm not sure at the moment.

Reference 5 - 1.41% Coverage

P That can, yes. But I think it's a combination of patients' needs and staff willingness as well to embrace it.

R And when you mean staff, does it have to be the managers or just everyone?

P I would like to say everyone, but it all comes down to managers depending on what they think is right.

Reference 1 - 11.85% Coverage

P Okay. So I think initially it would be the SDU lead and she would bring it then to the meetings, the SDU meetings, where there's all the senior members of the team there to decide on the right way to go about things. And then we make that decision at the SDU meetings.

R Right. And is the SDU leader, is it the person that tends to be most invested in finding out what's out there and what should be brought to the clinic?

P Yes, she seems to be finding out new innovations and bringing training and more research trials within the team, yes.

00:05:04

R And is she also the person who has the power to make the final decision?

P I think ultimately, yes. And also, unless it's someone who's the matron of the service, I think both of them ultimately have the ultimate say, yes or no, yes. But most of the time it is a team decision, rather than just one person.

R And that happens during meetings?

P Yes.

R Okay. And what about the…? So I guess there is a lot of feedback from the staff.

P Yes. So obviously, all staff can't attend the meetings, and so whatever is discussed at the meetings then get discussed at more general meetings, like we hold regular nurses' meetings. So if anything particular that's discussed at the SDU meeting, then that's a good opportunity to discuss it then and just keep people updated. And also, the SDU leader's very good at communicating via email. She does a monthly newsletter, which she pings out to all members of staff, including reception, just to keep them updated on what's going on, what's being discussed, what we're looking at, you know, the future plans, that kind of thing. So everyone is kept up to date with what's going on.

Reference 1 - 4.95% Coverage

And who would you say are the key decision makers? I’m thinking about introducing new ideas. Who would that be? Is it you or [overtalking]?

P Yes, we work collaboratively. Myself, the Clinical Lead from our Sexual Health Service, GP Leads. After we had our failed procurement, we set up quite a few different task and finish groups to look at various different elements that we were working on.

And from that we’ve got, I suppose you could call it friends, with different elements. So, say if I was looking at the LARC, the Long-Acting Reversible Contraception pathway. We had a specialist GP who was very interested in it, who wrote the specifications, etcetera. We had an active manager who explained who could and who couldn’t do it. And we also had a really good, robust procurement team as well, who also support us to make sure that we’ve procured the services in the best way as well.

Reference 2 - 7.53% Coverage

So, yes, collaboratively, we do work across the board, but decision making is done… I suppose the decision making comes eventually from our finances. So, if we know we can’t afford something we say, okay, we can’t afford that, we can’t do it.

But our Director of Public Health and Associate Director of Public Health will support the decisions that are then made, or not, if they don’t want to make it. But I would say that the decisions are made collaboratively. And it’s always in the best interests of the patient.

R I assume that the process of evaluation and giving feedback also happens in collaboration?

P It does, yes.

R Are there meetings designed for that?

P With the contracts that we have with the trust we have meetings monthly, or bi-monthly to discuss the contracts and how that’s working, etcetera. And they have key performance indicators within that, so we’re constantly evaluating what they’re doing and are they meeting the outcomes of the contract that’s offered to them.

00:10:47

And that’s exactly the same with our primary care providers, which is a bit harder to get meetings with them because they are so stretched. But yes, all the KPIs have to be met and the quality standards are met for the evaluation.

It is ongoing, actually, we’re constantly looking at how we do things and what’s the better way to deliver these things.

Reference 3 - 1.17% Coverage

R And who is participating in writing of business cases?

P I would do that, yes. I would do that initially and then our senior management team would then take that forward and comment, etcetera, and come back.

Reference 1 - 4.91% Coverage

R That’s great, who are the other key decision-makers?

00:09:10

P Then we would have [name] who’s the clinical services manager and the senior nurse. So, in terms of, say, clinic hours, we might have organisation in terms of when clinics are delivered, they might be key people coming up with that. We’ve got Dr [name] who has an important role in our contraception service delivery. She’ll often be saying, latest guidelines out of the faculty say we should be perhaps doing this, so what are we doing here, why are we doing it like that? And getting us to think about how we’re doing it and reflecting on our practice.

If it comes to clinical matters I would say it’s probably myself, somebody directly clinical as in we’re going to use this antibiotic rather than that, or we’re going to be doing this test rather than that test, or I think we should be offering this intervention to all our patients rather than that. But that’s coming from national guidelines, or national policy, it probably won’t be me just inventing something.

Reference 2 - 6.52% Coverage

R And who’s in charge of making the final decisions, thinking if there’s a new technology or new pathway we’re introducing to the clinic and it’s being evaluated. Who has the power to say yes or no?

P Well, depends what it was. Me or the clinical services manager might be the ones that say, that’s not going to work in the department because, or that would be ideal for the department, because. And then either way one of us, probably me, would be responsible for making sure that it was presented at the appropriate boards, like clinical governance or a clinical s standards group, or the drug advisory committee if we were going to be using a new drug.

So, if we’re going to be taking a new drug or a new therapy or a new treatment, then we would go through that. If it was say for example, we wanted to do a new test, then we’d probably be taking it to pathology and speaking to the senior people who run the pathology services and looking for, say, for example, first of all letting them know that’s what we’re doing and then looking for whether we’d need any support from them, the cost implication to the trust or to the service locally. That’s where we would take it.

00:12:27

R Are you also involved in writing business cases?

P That would be myself and the clinical services manager, who would be writing a business case if we needed to take one.

Reference 1 - 3.30% Coverage

But who is the power to make the final decision once the technology is evaluated?

00:19:26

P Well, I believe, and I could be wrong here, and we’re… There’s about to be a change in power, should we say? Service manager has come down to being semi-retired. I don’t know when it will actually finish. So there’s service manager, and there’s clinic lead, and clinic lead is doing what service manager used to do. But obviously we’ve also got CCG, which I suppose would have to look and say, yes this is ok, or no it’s not. Sexual Health lead is [name], for our CCG. And she’s at xxx.gov.co. Sorry .uk. You’ve got her information. But I know that she’s quite technology keen. When we came back with Freetest.me idea, we worked with her for 11 years.

She was very keen for that and could absolutely see the benefits of it. I’d like to think that these people… But some people are still scared of technology. But it was completely a thing to be… The cartridges and getting them used before they ran out of date. And then that was it. It was just thrown out, really.

Reference 1 - 11.64% Coverage

So my question now is, in your opinion, who would be the key decision makers? When you think about the people… I’m interested in people’s roles, so who are the key people who influence from the moment of introducing the idea, maybe suggesting there is something out there, up to the final yes or no?

P Okay. So I think if we’re looking specifically at this project then the people who are actually at that meeting, the initial meeting… So the Commissioner for Sexual Health who is part of the public health local authority, she would be part of that decision making process. Myself, and I think then mainly it would be… It would be my line manager who would really take the steer from me, so if we felt and the commissioners felt that it was something that needed to be adopted then the trust would adopt it. We may have to do a business case or what have you, but they would adopt it if we actually felt it was going to be a benefit.

The other people who may be involved and again, already are, is our pathology department. From this particular project they are the ones that would need to actually make sure that we are using something which is equally as good as what they can provide. So those would be the main decision makers.

00:12:07

R I see. And so I can hear that the commissioners have a very crucial role.

P Yes they do, but as I said they would take the… They would actually look to us to be advising them so they’re very open to you know… They often refer to us as a specialist so they won’t make the decision without actually having the evidence or what we can provide for them and us giving something a green light, so to speak.

R So you have those established styles of communication and the relationship with…

P Yes very much so, I meet with the commissioners on a regular basis to look at service development, usually at least once a month. And they would… Yes, so we have got very good communication levels with them. I suppose the other stakeholders ultimately if we wanted to roll this out wider, would be the GPs and even potentially the pharmacies. And we already have got those links to them through various mechanisms really, but there are pharmacies that we work really closely with in as much as that they already provide treatment for Chlamydia. And also we work closely with them through training and looking at sort of updating PTDs and things like that with them. So we’ve already got those channels in place to actually link with them in the event of needing to.

Reference 1 - 10.10% Coverage

R` Right. So, apart from you, who would you say are the key decision makers?

P So there will be clinical input. So depending what the test is, the consultant microbiologist would be involved. If it’s a test that we’re doing on behalf of another department, so if it’s a very specialised test, then obviously that service would be involved.

R` Right. So that really depends on the nature of the change?

P It does. So within the business case there’s a list of affected stakeholders. So you will make an assessment of all the potential service users, bodies that would be involved would be affected, and then you have to include them in the document and you include them in notification, making sure they’re kept informed.

00:05:04

If it’s something you’re doing for somebody else, they obviously will be quite a considerable stakeholder so they would be involved in the actual decision making.

R I see. And who’s in the power to make the final decision? Does it always depend on the technology?

P Usually, the final decision comes down to… it would be, depending what it was; it would be myself and the consultant microbiologist. We would hope to be able to do an evaluation in-house so you have equipment on a trial basis to see how it performs in our hands; how easy it is to use; how labour intensive it is; how long it takes to get a result. All those sorts of things we would assess and then we would be the ones who would make the ultimate decision.

But, again, there is… there is input from other departments because, obviously, if we want to choose the most expensive one we have to justify why. So it isn’t… although a lot of it depends on what money is available, the decision isn’t made purely on the basis of cost but if you do choose the most expensive, and, on paper, all the other pieces of equipment look exactly the same and deliver the same results, there would have to be good justification for why we’d made that decision.

But, ultimately, the decision does rest with us.

Reference 1 - 5.29% Coverage

P I think across the board really. It depends on the level of scope of the idea. So the consultant body will have perhaps a better awareness of different tests, diagnoses, or ways of testing for infections. But our lead nurse, and some of the senior nurses have led on ideas about changing patient flow, staff groups that see patients, and how they're seen. But also our health care assistants, so the sort of untrained nursing staff have also had suggestions, and contributed to those sort of developments along the way.

R I see. And I guess they're all interested and invested in those ideas, just depending on the context of the daily job?

00:04:28

P Yes, and as you say, invested in the idea is hugely variable. So some people are resistant to change, and very anti anything being different. Whereas some are very proactive, and keen, and positive, forward thinking.

Reference 2 - 6.02% Coverage

P You, I mean [unclear] who's led the project, so we do have data analyst, and an analyst who will analyse data for us. It's usually what the project lead that would feedback to the staff group, which is usually a senior member of staff.

00:06:01

R Right, and who is involved in writing a business case?

P So that would be done jointly between the senior clinicians and the management staff. We have a deputy general manager who is based in the clinic, who would be involved. But also our… The general manager for the care group that we sit in would obviously help that. The director accountant would be involved in terms of costing things. So their input's going to be useful as well.

R And who is in power to make the final decision?

P An ultimate decision would, I'm trying to think whether it needs executive signoff. There probably is an executive signoff for business case type issues. But the majority of that power, the decision making process will sit with the general manager.

Reference 1 - 5.01% Coverage

P So, there’s a couple of layers there. So, in terms of the drivers for saying this would be a really good idea, we want to do this, would probably come from the consultant body. And probably sort of a couple… so, I’ve got five colleagues here, probably the development would come from mainly from myself, my clinical lead, and another colleague.

00:09:28

So, it would probably come from the consultants, a little bit from the senior nursing team. So that the actual idea of we want to do this would come from us, really. The actual can we do this, quite often you have to do a lot of the process in terms of funding and business cases yourself, but the people that actually say yes, you can do this are probably our divisional general manager, who kind of ultimately holds the purse strings.

And quite often they’re not… they’re not in sexual health day to day, they’ve got a bigger portfolio, so that in terms of, if we went and said, we really want to do this, it’s going to cost this much, the person that will… it will happen or not happen from a finance divisional manager type level. However good it is, quite often they’ll say no, there’s not enough money this financial year.

R Right.

P We look at oh, can you get some… a drug company to pay for it etc, and that’s… those days are kind of gone, really.

Reference 2 - 2.10% Coverage

P Yes, so what I’d go with, senior management team would be consultants, lead nurse, a select senior experienced nurses who kind of are opinion leaders. So, where one goes, the others follow. And that tends to be quite a core team. The admin staff as well, and the analysts within the team. If it’s IT related, they have to manage different data, or…

But normally, it comes from the senior consultant leadership team to say, look, well, we want to do this, we want to move this forward. So that’s where the actual impetus for a project comes from.

Reference 1 - 3.25% Coverage

R Okay. Right. So, who are the key decision-makers in the clinic? When it comes to introducing the idea of what to adopt next, to evaluating it, and then to saying the final yes or no?

P This would normally come from the management team. If it’s something that works well and is the way forward, I’m sure they’re all keen to bring it on board, to get it up and running as soon as possible. If it’s straightforward and simple, I’m sure they will be all for the idea. And, yes, it’s the management team.

R And who introduces the idea? Is it also the management as well?

P Everything comes from the management, yes.

Reference 1 - 10.12% Coverage

P Okay, so, I found out that... so, say if we wanted to introduce a new product. So, it depends, so, if it’s a medicinal product you’re going to talking with pharmacy and the pharmacy research etc and I think the MHRA. So you’d have... so, it would depend on what the product is if the product’s medicinal, pharmacy. If it’s a device there is an innovation team that sit once every two, three months and we have to actually run the product by them and get their permission first actually to see if they want it. So, they’re going to be involved as well.

In addition it would be the procurement because they want to know is there something else out there. Can we get it for a cheaper price say if we had to pay for it. So, the procurement office is involved because we were actually recently trying to look at an alternative to Cryotherapy which is an alternative to liquid nitrogen which was in a can. And we’d seen a product but then they said okay is there another product cheaper than this and that was procurement are involved in that.

00:04:22

And then obviously, you know, to some extent, yes, patients as well getting, you know, patients feedback on the product as well. So, we’ve currently trialled this new product hydroxide it’s not new but it’s basically a can which freezes warts. And we’re looking to see whether we’ll replace that with liquid nitrogen. But obviously cost will be important but also how does it actually work with the patients does it actually treat the warts better than what we have or is it the same.

R And how do you get their feedback? Do you get individual feedback?

P So, essentially there is one nurse who’s running the wart clinic and she’s getting their feedback. So, she’s actually set out a standardised thing because if we’re going to adopt this we’ve got to actually tell our, you know, people who pay the money actually. It might be a bit more expensive but actually the patients like it.

So, we are actually doing a formal process where there is one nurse seeing all the Cryo... the wart patients and assessing actually not only just patient feedback but also does it look like the wart’s getting... You know, how many treatments does she need to do is it four or five and actually previously it might have been a bit more. So, that’s what we’re doing.

R I see, right and who’s in the power to make the final decision? I guess this also depends on the type of the product. So, who says the final yes or no? Is there one [overtalking].

00:05:55

P So, essentially... no, there’s never an individual, there’s never one individual. So, in our Trust at the moment as you can imagine in a lot of NHS Trusts there’s a huge financial cost pressure. There’s a big pressure on departments to save money. There’s pressure on departments to adopt technology that will save money. So, what we do is if we find that we like a product we will put a bid to get this product whether it’s a device or, you know.

Reference 2 - 4.32% Coverage

And then if it’s more than a certain amount of money it would go to the... they call it the S3 panel and that’s saving safely and something. But it’s that panel that will look at the evidence and you have to provide the evidence of why you want that over something else and why that would work. So, they essentially would be the ones that say it’s fine you can go ahead. But I think the onus will come from the clinicians if we give a very strong argument for why we need it but they’re the final say.

R And who’s involved in the business case? That also depends on the...?

P So, I guess it would depend on the product that you want, yes. It would depend on the product that you want, yes. But essentially I think the person who should potentially be leading the business case should be the service manager. So, if you’ve got a strong service manager then they can, you know, do all that and work on that.

00:07:14

But you’re service manager might not be as involved with your service because they’re busy with another service because a lot of them work cross specialities. It ends up being the onus would be on the consultants, the procure... well, not much the procurement but also maybe contracts and finance to help with the money side of things, yes.

Reference 1 - 0.37% Coverage

R And would you say that those senior people are the key decision makers?

P Yes. With the commissioners.

Reference 2 - 4.00% Coverage

R Great. Yes, that’s a good example. And whose involved in the writing of business codes?

P That would be much more senior than me. I think if it’s something to do with testing, it’s normally the lead consultant for the entire team for three services. I think our lead GUM consultant is involved, but I’m not sure to what extent. Because if it’s a business case it involves the lab or it will involve all three clinics. Because we’ve got the community arm in the hospital basis, so it’s normally the lead consultant for all of those who does most of those.

00:10:09

So I know she’s writing one at the moment for one particular test. But I think that’s… But yet we all put in a, when we wanted the microscope, that wasn’t a business plan, but it was an application for particular funding. There was a few of us who got involved in that, with people who knew how to use a microscope. Because we didn’t want people ordering a microscope that wasn’t going to be fit for purpose, as has happened before. Because they just ordered the box standard one when actually we needed separate light filters and things, which is, you didn’t know if you use it.

Reference 1 - 2.36% Coverage

R Oh, no, That’s all great. So, within the clinic, who would you say are the main key decision makers?

P I would say the two clinical leads, so the GUM consultant and your contraception consultant, and probably the lead nurse and the matron. And they might have some input from the rest of the nurses. But we wouldn’t have a decision in that, it’s going to be much higher up. And probably the decisions going to be made on financial, what’s it going to cost to run. And the cost as opposed to the benefits.

Reference 1 - 6.79% Coverage

RE Right who would you say are the key decision makers then?

PA It's usually the nurse or doctor in charge of each clinic. So we have a matron and we have a sort of senior nurse. But they're not often in the clinic at the time. They might make a decision generally about the service and what we're going to implement, but the day-to-day running is the actual person who is here at that time. So it could be someone like me or it could be one of the doctors, and we're called like a hub so we are running the clinic that shift.

RE Yes.

PA So we make the decisions that day of who's doing microscopy and the coils, what kind of patients we're going to see and that sort of thing.

00:02:54

RE Right. Yes, and so these are the people who introduce the ideas, people working on the ground with patients?

PA Yes, well no, I suppose the senior management introduce the ideas but we're the ones that implement it.

Reference 2 - 3.91% Coverage

RE Yes, yes. And who, who has the power to say yes or no?

PA Oh I would imagine the senior nurse. But it depends I mean I suppose it depends on what we're talking about. If it's something in the clinic that we can't do that day well the person in charge of the hub, myself or the doctor will say we can't do that. So we will rate as a day-to-day if the computer system goes down, close the clinic or whatever. So we make that decision on a day-to-day basis but sort of departmental decisions are made by senior management.

Reference 1 - 10.13% Coverage

So if you could maybe map those key stakeholders or do you think that there are any particular people within the service who are more likely to introduce new ideas?

00:04:01

P Let me think. I think it would be the consultant within the GUM, they will be exploring them and if it was involving Point to Care, speaking with the Point to Care team because they lead the service. We can’t adopt anything or implement anything without it going through the Point to Care management. We can’t just set this up on our own, it would have to go through that laboratory.

R So that would be in terms of adopting a Point of Care test?

P Yes.

R And if there was any other technology, do you think that there would probably be other people dealing with it depending on the?

P Let me see, possibly. If there was any sort of a PC, I’m just trying to think. Because mainly I’m involved in bacteriology lab with the culture readings, so you already have the technology if it’s for the lab test. And then on our side, we’re actually culturing the organisms and giving out susceptibility test results. So I would say yes. Again, we’re happy to go ahead and use this new technology but it’s something that as far as implementation would go, it would have to go through the Point of Care.

Reference 2 - 5.73% Coverage

And then I don’t know what would happen, whether virology would have any input because they would then be having a huge loss. Because there’s a huge volume of work for the virology department if it’s going to go to the quick Point of Care test as opposed to the lab test. I’m not entirely sure how long that actually takes to get the results on that analyser but there could be some issues with that.

And so it involves several people, wouldn’t it? It would involve also the laboratory manager who oversees bacteriology and virology and would have to speak with the Point to Care manager. So there would have to be several conversations but I’m not privy to those. So that all takes time so that’s another obstacle.

Reference 1 - 11.05% Coverage

R Who’s most likely to introduce new ideas?

P It will be our consultant lead, I would imagine. He has his finger on the pulse and from a clinical perspective it would be him definitely. He tends to have very good up to date information about all sorts of stuff that’s going on. He’s a man that likes new ways of doing things and new ideas.

R Who are the people who evaluate technology and provide feedback, does it depend on the technology itself?

P It might do. Some of our SDRs would perhaps take on the role of evaluation as part of their training, and we often find that. They’ll pick up on a particular thing that we’ve introduced and look back and see what the difference has been over a period of time in terms of patient uptake either speed through the clinic, satisfaction, all of that sort of stuff. That would often be the medical staff, but not absolutely the medical staff, it might be the nursing staff as well.

R Who’s in power to make the final decision?

P I suppose it will come down to if… Yes, finance will have a part to do with it. We have Directorate, we have a General Manager, so a lot of that will be down to them and convincing them that this is a good idea. Once we’ve got them on-board then if they have to take that further up in the Trust to get approval that would be the way that would happen. I presume, I’m not sure to be honest, but I would imagine if it’s something that we can easily display, one, it makes good financial sense and, two, it concludes in patient satisfaction and speed of care, all that sort of stuff, then you would think it would be a no brainer that it would be passed too easily.

I think, probably, the difficulty would be if it’s a new technology and we have to put in some money to start that up [unclear] that might be an issue. Again if we can produce a decent business plan that will spell out the benefits for doing so then that should be sortable.

00:20:42

R Right, and who’s involved in writing of business codes?

P That would probably be the clinical leads, I might have a role in that; but, also, the general managers will. We’d probably pull it together but certainly we’re in the right area with those clinical leads and the general management team.

Reference 1 - 9.16% Coverage

R So, who would you say is likely to introduce new ideas in the...?

P Usually it’s our clinical lead who I know you’ve.... I’m okay to use names aren’t I, sorry, who I know you’ve already spoken to and our lead nurse. So, and then if it’s around a funding issue it would then need to go higher again to our business managers. But certainly from a clinical perspective there would be input from the lead doctor and the lead nurse.

R Are those people also the most interested in getting new technologies?

P Absolutely, yes, our clinical lead and our lead nurse who we have in post presently are very interested in moving things forward and, you know, looking at really what’s best for our patients.

R I see, and who’s then involved in service evaluation process and feedback because I imagine there would be more people [overtalking]?

P Yes, I mean, we’ve recently had a staff health and wellbeing survey sent round. And that obviously asks your opinions. I mean, if there are any new... if there’s any further change then obviously there’s... they call meetings and our opinions are asked of at that point. You know, so, from that perspective we are involved.

00:08:19

We have a clinical governance meeting every three months where obviously we... all our audits are presented and obviously it’s an opportunity for the training as well. But also it’s an opportunity if there are any new, you know, new ideas, new thoughts that we’ll have those discussions at that, that is an arena where we can do that. And they will also call ad-hoc meetings if required.

Commissioners

Reference 1 - 0.51% Coverage

We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

Reference 2 - 0.22% Coverage

Obviously, there are the constraints of finances and what's commissioned and what's not. But what's commissioned is services.

Reference 3 - 1.87% Coverage

People here like to blame commissioners for a lot.

Commissioners don’t look at details. They say that they're commission services to provide sexual health testing for these groups. They might say things like, on London at the moment. The proposal for people without symptoms to be moved on to online testing, so things like that, which basically, I think, that actually having commission as a stakeholder is good for more executive raw decisions like that. If you're going to say, hey, symptomatic testing is going to move into online. Does everybody want to go online?

00:43:56

Are you going to marginalize people? Have the commissioners done any patient group involvement? Have they looked at community involvement? I think that's where the things are good. If I'm going to say I'm going to change how I do the test and it's not going to affect the number of people I can see if I can make my target and not exceed my target patients, I don’t think the commissioners really would care as long as you're not asking for money from them for the implementation.

Reference 1 - 4.02% Coverage

That is the biggest barrier that if you want to start up anything you want to try and overcome because that is the main thing that people always look at the first initial cost and that is a barrier because they say, no that’s too much money. We cannot do that. And that's it.

R Would those people be commissioners or someone else...?

P Yes. Generally a lot depends on the commissioner and some of the people who hold the financial budget strings, the senior managers, the budget holders, generally they tend to be the ones who you really need to convince that whatever you’re trying to bring into place is cost effective. It's something even we did experience when we were rolling out the new testing that I was telling you about when I started working here. There were some initial costs and... Not much but it’s there. It will bump up. And everybody was dancing around saying, who is going to pay for that? We don’t have that money, blah, blah, blah. But when you think in the long term, the benefit makes a huge big difference.

Reference 1 - 5.00% Coverage

P In terms of the introduction of new technologies, we’re commissioned to provide a service, and as lead provider, we would have the final say around introduction, because ultimately, we’re responsible for the contract. But in terms of influencing key people around… In terms of decision-making, if there was an introduction of technology that cost X amount of pounds and provided this outcome…

Say, e.g., we introduced a technology that would improve the management of results, meaning that people had their test results within two hours and, basically, we could demonstrate that a financial saving would be there, the quality would be maintained, and the satisfaction of people using the service would be the same or improved, then we would be then just talking to our commissioners about this, and our commissioners are very much behind piloting new technologies to try and achieve the outcomes that we’re commissioned to do.

But within our partnership, it is very much dependent on what we are commissioned to provide, e.g., if there was a technology that improved turnaround times for results by 50%, that actually that would add an additional cost of £100,000 a year to no real additional satisfaction or quality, it’s unlikely that our commissioners would support it. Even if a clinical lead said, but we must have this because it would improve our turnaround rates, if there was no clear public health outcome associated with that other than people got their results quicker, it’s unlikely it would be supported.

Reference 1 - 2.38% Coverage

R So would you say that it's the clinicians and nurses... so everyone who deals with patients that they are the most interested as well in new technologies?

P I think so, but probably the commissioners as well.

R And that is because...

P Because of the patient needs.

R Yes, as well.

P Yes. I think most of it is more down to patient needs. But if it makes work much better for clinicians, both patient's needs and clinicians work, then it works better, I think. Well, I think it's a bit of both.

Reference 1 - 4.11% Coverage

It is, I would say that, we don’t just run the service for the sake of it, these days services are commissioned business deals. So the commissioners need to be sure that we’re delivering what they want us to deliver. And we need to be sure that we’re doing what they want us to do. It’s not like it was ten years ago when you could say… Hey, I’ve got this great new idea, let’s just run with it. And you’re only limited by your own imagination, or your manager or the immediate structures. It’s not like that anymore, it’s quite limiting really.

Fortuitously I would say we have really positive and responsive commissioners. But I don’t take that for granted, I don’t think that those people are going to be in post forever and I don’t think the funding is going to be there forever. And I don’t think that this current philosophy is going to last forever.

Reference 2 - 2.36% Coverage

R There are certain structures, but I kind of have a feeling that while this is all happening and all the changes have happened throughout the past ten years, they create barriers. At the moment there are some interpersonal relationships within your service that kind of make it easier?

P Yes, I think so, absolutely. That’s a very good summary. And I think for us here, the relationship with public health, with the commissioners, is a very positive, respectful, mutually-understanding one.

Reference 1 - 1.08% Coverage

As I mentioned, we have a very good relationship with our commissioners who actually would look to us as the experts in the field, so to speak, to actually advise them what we think is going to make sure that it’s a quality service.

Reference 2 - 1.87% Coverage

I see. And so I can hear that the commissioners have a very crucial role.

P Yes they do, but as I said they would take the… They would actually look to us to be advising them so they’re very open to you know… They often refer to us as a specialist so they won’t make the decision without actually having the evidence or what we can provide for them and us giving something a green light, so to speak.

Reference 3 - 1.36% Coverage

So you have those established styles of communication and the relationship with…

P Yes very much so, I meet with the commissioners on a regular basis to look at service development, usually at least once a month. And they would… Yes, so we have got very good communication levels with them.

Reference 1 - 2.11% Coverage

There are… I suppose the change in the health and social care acts, the way that sexual health was commissioned has caused some issues. The way that sexual health is being tendered out to the lowest bidder. Again, that comes down to finances, but causes a lot of challenges. Time and effort put into submitting tenders, tender bids is challenging.

Reference 1 - 3.74% Coverage

R And would you say that those senior people are the key decision makers?

P Yes. With the commissioners.

R With the commissioners.

P It’s unfortunate, a lot of it is down to commissioners.

R Right.

P So, you know, a lot of it will be, we might want to do something, but it still has to go through the funding and the commissioners and see what they want us to do.

00:04:59

R Yes. And that could be a potential buy-in.

P Potentially, yes. With, I’m sure you know about commissioning in sexual health and we’re going through a consultation at the moment to change our opening hours. So the commissioners have a lot of power. And if they don’t want it, they’re just going to say, well, you’re not going to get any money for doing that. So they do have a lot of power. Particularly in a small clinic like this, it doesn’t have this big hospital to back them up.

R Right.

P So, because we not in the community, it’s slightly different to if you’re within a hospital base and you can actually say, well in that case, that falls under gynae, we can pay for that under gynae.

Reference 2 - 2.57% Coverage

Would having the recall save in the short-term or in the long-term. Is that enough, is it…

P I don’t know enough about how much budget we need to cut this year. I think if it was, short term would probably be what they’re looking at at the moment, because they’ve been told within the next couple of years they have to cut so much of the budget. And, but long term would be something that potentially all of us would see, as clinicians, see the benefits. But it may not look as good on paper and therefore might mean that the commissioners don’t approve it.

It’s that word of commissioners. All of the directors of the trust as well, they may not, they might say, why’re we doing this then. So money would be a big factor on cost saving.

Key to success

Reference 1 - 0.36% Coverage

Well the thing is making things happen is easier said than done. Obviously you need to have the right trained staff. You need to have the need for patients, and you need to have the environment that helps with that.

Reference 2 - 1.21% Coverage

The evaluation, it always, you know, it always relies on, you know, are you collecting good data in the first place?

00:09:02

R Right.

P And, you know, what is your baseline? So in terms of partner notification, we had no real baseline, because we had audits every once a year that showed that we're nowhere near hitting the targets. And then as soon as we had a tool with a real time KPI, we could see that, you know, there was nowhere to run or hide. You know, you could see how it was performing in different groups. So there, the trick is to really understand what your baseline is. So we know our baseline around diagnostics, for example. We know that 75% of our results are coming in at 72 hours, which is rubbish.

Reference 1 - 3.58% Coverage

But it's actually saying that I know how much this is work, and if you don't do this, you would need to find this. But you're basically saying, this new pathway allows this to happen. This technology allows this to happen. So it would be a case for making that investment and projecting what your savings is going to be. It would be good to have a management team that is able to look at things in the long term to say that I want to not just make a saving in this quarter, which is what you hit with commissioning. It's like you only commission for your commission period.

00:18:17

I think that's the hurdle that you have at the national level and at the regional level. But at the local level, you can actually have a team that, if you have a forward-thinking team, they can say, fine, we'll keep an eye on how things are, and we'll see how you perform. Give yourselves stage targets and not just say that it's a five-year plan and look at how things are in five years, but show how you're going to be giving a monthly target. Have the ability to measure what you're doing. Be confident in what you're measuring and basically having a contingency plan.

Say that if this doesn’t go, this is what we are going to do. How are we going to offset it? Make sure that you're not going to spiral out of control, making sure that you make small changes yearly. Obviously, that means that departments need to be able to show that they can deliver on that. It's very easy to say, we can do this. So it's adopting a change, basically showing that we can plan it properly.

It's basically having a very in-depth view of what that entails, looking at what the knock-on effect of the change is going to be, how it's going to change working, looking at how it improves patient experience, and also looking at, if you are going to have a service that can say that you are going to spend your usual time in the clinic, get the results right away. That's a service people would want to go to. And that's what you want to be. You want to be the best.

Reference 2 - 3.96% Coverage

But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

00:28:04

So we're looking at in-house testing, molecular testing for Chlamydia and gonorrhoea within the clinic. And we projected that, in two years, we'd be saving something like £2 million. And they're like, that's a no-brainer. We should buy the device. And then every two years, if you're going to save £2 million, you're going to spend £500,000 now on this. They didn't. Obviously, you're not going to make any of those savings in the first six months. But you're equipped.

And so that's where you're having a higher management team throughout the structure, which is looking at the longer picture, saying that you have all these things, you have contingency plans for the [unclear] of the system where things change. But you know that your commissioning is not going to change dramatically. So you only know that you're considered at risk because we are an at-risk department financially because we have a lot of performance targets, which are unrealistic.

And it’s unguaranteed money, which can change at any time, which basically means that you need to look at how you can get with things, but they're always [unclear]. And if you can get research to take on a large proportion of your routine work, it's paid for by research. It basically means that you make your target. At least that's a good mix, good [unclear] sense to look at that. But it also means that you have real world implementation science, I think, is the way forward, especially with new technologies.

00:29:46

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it.

Reference 3 - 8.65% Coverage

So diagnostics is the key stakeholders of the lab, because you're going to say, either you're going to do this new technology or we are going to use the new technology. So it's going to involve one or two things to the lab. It's going to be a change in the way they work. Or the other thing is that they're doing it, it means that there's going to be a change in their activity with us, which would transmit to income generated through our clinic to their [unclear].

00:39:08

So that's one key stakeholder. Service managers would be another stakeholder because that involves change both of our service and it's overseeing that. It's looking at what the changes are, who are going to likely be most affected by it, and that they are the people that I would be contacting early, get their opinions. If I'm going to say that, oh, this guest is going to be implemented in clinic, and I'm going to get their health care technicians to do this, this is a change in what the health care technicians do.

So how do they feel about that or what does this impact and [unclear] would get their involvement in that? If they're changing patient pathways, I would want to get an idea as to what do patients feel about that. Is that something that they think was worthwhile doing? Do they have a positive expectation or a negative expectation? That is the most difficult thing to do because, again, being an open-access clinic, we only can access people who access our services.

00:40:26

And as you change things, you change the population that comes to your clinics. So patient involvement would be key if you're changing patient pathways. It's probably not that... I mean, patients wouldn’t have that much of an opinion. If I'm going to say, I'm going from a DNA detection method to an RNA detection method, patients are unlikely to have that much of an opinion on that, because what they would want to know is that it worked. If it works, we're not telling them what the methods are.

Because people talk about patient involvement like it happened for everything, and it needs to be relevant. If the patients aren’t going to notice any changes, and when you change, you're going to have... some of this is going to be a cost saving. Patient involvement is probably not that. If you're saying that, say, it's a rapid test and you want to deploy it as a point-of-care test, and that might mean that patients wait 20 minutes more. I want to know whether they want to do that, they're willing to do that, they're happy to do that.

Whether I think you should do this in and somebody [unclear] do it this other way. And sometimes, people come up with things that you don't think of. So it's kind of getting that. Talking to the people who have to implement it to see how they will look at it, see what training is required, what resources are required. If you're asking patients to wait for another 20 minutes, do you have the space for all these people to wait?

00:42:09

Say, you have five people who are turning out patients or, say, you have two or three patients every hour, then say, per person, then you have five people. You're seeing 15 people waiting 20 minutes extra, which basically means that, very quickly, you could end up with 60 people in a waiting room that can hold 20 people. So it's kind of saying that working out your patient flow and seeing where do people go, how can you make sure that that's the least once a patient comes through the process.

They go through it, and they don't have to come out and [unclear] out the holding area and they get to... how do you streamline it? So that's working with your clinic staff, administrative staff to... so, yes, those are the key stakeholders for it to be your service needs. And then, obviously, the thing is that if it's going to affect your performance, then you need to involve commissioners. People here like to blame commissioners for a lot.

Commissioners don’t look at details. They say that they're commission services to provide sexual health testing for these groups. They might say things like, on London at the moment. The proposal for people without symptoms to be moved on to online testing, so things like that, which basically, I think, that actually having commission as a stakeholder is good for more executive raw decisions like that. If you're going to say, hey, symptomatic testing is going to move into online. Does everybody want to go online?

00:43:56

Are you going to marginalize people? Have the commissioners done any patient group involvement? Have they looked at community involvement? I think that's where the things are good. If I'm going to say I'm going to change how I do the test and it's not going to affect the number of people I can see if I can make my target and not exceed my target patients, I don’t think the commissioners really would care as long as you're not asking for money from them for the implementation.

Reference 4 - 2.37% Coverage

Again, your stakeholders is having good links with the lab, good links with the managers, having a very good business plan, looking at who's enrolled in that business plan. It's having a very clear vision, rather than saying, you test, how can we use it, to actually say, this is how we can use it. This is how it's going to affect A, B, and C.

Talk to A, B, and C and see, how do you think? What do you need to support? How do you feel about this? We're going to ask you to do this. What needs to give in your job plan for you to deliver this? How do you move things over? And the thing, that’s the change. Get it agreed. Have an evaluation process. Then say that these are the costs. These are the savings, which makes it worthwhile. Who or where can we get the funding to do that?

And now, all of this, you have charity funds. You're going to have research funds. You're going to have core funds. People, if they don't apply for these, don't get this. And it's basically being aware of what is out there, trying to say that you're applying for them responsibly, having those relationships. You talked about having a business development team. They're your key stakeholders usually. So people always talk about commissioner [unclear] and then talking to people [unclear]. Commissioners want lab test. And commissioners won't agree to pay to it.

Reference 5 - 3.37% Coverage

No, I don't think. But I think I've talked about lots of the key things. I think the things to reiterate is that actually looking at avenues to service implementation studies and to make them as studies rather than say just make cost to things basically, then would make it attractive for companies to say that you have that implementation thing funded by research. And then you have all the data to make a business case. That's probably the strongest thing. And then getting organization leads.

01:09:52

I know there's a lot of interesting commissions, but I don't think they're that powerful. And it's looking at what labs think about this, what service managers think about this, what the finance people think about this, just [unclear] things and change would be the other kind of key stakeholders. But also to get key stakeholders is in Public Health, looking at, would they be interested in supporting a rapid diagnostic strategy nationally?

And once you have a national strategy that comes from Public Health England or NHS England, you have more buy-in. If you have a national body or you can [unclear] HIV saying has a standard supporting this, then you actually have somebody saying, look, this is a national standard, so actually campaigning for that and getting that voice and seeing what their concerns are, but mostly they're going to say there's nothing there.

But actually saying that how do you actually get national support for implementation of new technologies? Actually, to have something about that, some kind of guidance to services to say that this is best practice, this is what would be, this is what the future thinking service should be, would be a catalyst that allows people to do that. Because at the moment, you need a lot of local buy-in, which a lot of smaller services and even larger services with less interest would not have. So I think that’s probably all I have to add.

Reference 1 - 1.25% Coverage

The way I understand it, it’s actually really dependent on individuals and the structure.

P Yes, my personal view is yes, it relies on those. I think we live in an environment where we’re very much encouraged to try new things, but like you say, you rely on those ideas for set individuals.

Reference 1 - 2.65% Coverage

P I don’t know. I don’t know if I have any ideas about that. I think communication is probably the most important thing. So, to… And this is something we do fall down on sometimes. Like, I think, sometimes, we can be so quick to make changes to even just, like, how test or, you know, samples are processed or something.

But does the whole service know that we talked about it in a training session for everyone? And we emailed the service. Sometimes it happens. Sometimes it doesn’t. So, I think it’s difficult to kind of make sure that the message is being communicated to everyone.

R And what about these two other settings that you mentioned that are more traditional?

P Oh, the other clinic sites. Well, we… So, we… It’s all the same staff that are rotating throughout.

00:20:19

So, everybody... So, we know each other regardless of what the location is.

Reference 1 - 1.79% Coverage

The way that I supported the staff, was I said, it's a change, take your time, we will get used to it. Because they were getting fed up, they were getting frustrated, forgetting where to… That… You know, they hadn't ticked a box. And I said, that's fine, we're all learning. I said we can go back and check over what… If we've missed something.

And then eventually, that perseverance, and they got there. It's just about supporting the team, because it's not good to put something in place, and then leave them to get on with it, or not have somebody there, like, shadowing, or somebody to call on to assist. I think it's important, because what we did was when we went live, I mean obviously, it was fine at this site, because it was already being used. But, we had staff in place to assist everybody, so we had staff in place to assist the nurses, and the doctors, and the admin team, to make it work.

Reference 1 - 6.40% Coverage

So yes, once again it comes back to the training thing. So we have to be trained properly to read the test and then interpret it and obviously the documenting thing. Because we normally use the online IT system to document everything, so then we have to think about how we document this. Because I looked at some of the stuff out there, I saw a Canadian study and they have found that 30% of these point-of-care testing results have not been documented correctly and about 12% have not been documented at all. So I think that that's something that we can learn.

R What does that mean that they weren’t documented properly?

P Maybe in the patients’ records, so it’s a human error, isn’t it?

R Right.

P So you do the test, you give out the results but you don't document it finally because when you have a standard laboratory test… Because everything is online at the moment, so we get the results online. So we normally attach the patients’ records so we don't have any problems. But if you are doing a point-of-care testing, then we have to have a separate place to document it, probably discuss with the IT system how to record this point-of-care testing. I mean, those all can be done but these are the things that we need to make sure that it happens, isn’t it?

Reference 1 - 2.34% Coverage

P Yes. The process was supported because there was a big strong case for it. And I think the fact that also there was a very close working relationship networking between the key drivers, myself and microbiologist, that was very supportive, so that if there’s a stumbling block in the microbiology department, like they would push it and get it sorted. If there was stumbling block on my side, I would get it sorted. So you need all the stakeholders to acknowledge and to accept that it’s an important thing and that we work on it. So I think that was the most important thing to get it on the ground.

Reference 2 - 3.41% Coverage

And every time you come with this proposal of we have to start a new system and there’ll be training, and you have to... It's an uphill task. Or when you want people to learn new skills or procedure, there will be people who are very quick and they can adapt, but also... So that bit has to be handled well. You don’t assume it that people will just jump in and be happy.

00:21:29

So they will need a lot of support during that stage. And once they also start seeing the benefit, the way it fits in and how it’s working well, then they own it and then it makes it easy to implement it. So if it’s something new, you have to involve everybody, all the people who’ll be doing it, the staff, the patient, and there has to be that sort of support in the background. In case of any problems, any queries they know it can be addressed and it makes it easy for them to adopt it.

Reference 1 - 3.66% Coverage

R Is there anything else that helps? You also mentioned data that supports.

P Yes, absolutely. A business case that’s driven by data and not egos and personalities helps. I think in the past it’s been, well, I’m clinical lead, I’m this, I’m that, I’m the hospital, I’ll demand, and quite often that’s worked. In the real commercial world, that’s not the way it would work. If there’s a justification for a new technology and that technology can make things safer, more cost-effective, and more satisfying and acceptable to people, then absolutely, it’s a no-brainer.

But if it just makes someone’s life a little bit easier, if it just makes their day job a bit more exciting, if it just adds a little bit of queue loss to their organisation, then these are reasons which probably aren’t going to hold weight anymore, oh, it’s great if… I think the clear things around new technologies are safety, cost-effectiveness, and acceptability.

00:21:06

R And acceptability in terms of patients or also…?

P Yes, patients and staff, I think I would [sound slip] the two together, but maybe they should be split off.

Reference 1 - 2.47% Coverage

R So I can hear that there are key things that drive implementations. So that’s patient needs?

00:13:11

P Yes.

R And also the new technology being cost effective?

P Cost effective, patient needs, I would say. So definitely patient needs have got to come first. It’s not going to make any impact really on the patients and there’s no improvement to their service or their care, then there’s not much just bringing something in. It’s got to be a key driver with an improvement there.

Reference 1 - 2.06% Coverage

can you think about any structures that already exist within the service that you know that they will support that process of adoption?

P No. And I think within our service, I think we’ve got quite a small and well-knit team with good communication. And so the structure is there that if we say we think this test is good and it works in these pathways, the staff... if the way we've structured it is sensible and people can see the logic of it, then the staff will buy into it quite quickly.

Reference 1 - 0.67% Coverage

P Yes. But it, as I say, it largely also depends on money. That is the main thing, I think, because there are lots of tests out there, but it just depends on how it might work. Yes.

Reference 1 - 0.99% Coverage

So in a way, the patients' needs, that as well can make a case for a new technology.

00:08:00

P That can, yes. But I think it's a combination of patients' needs and staff willingness as well to embrace it.

Reference 1 - 5.65% Coverage

Once all the equipment was installed, everyone had to be trained on the equipment. So it was started off that only certain people were allowed to do it and then from there, it then slowly more people got involved until everyone was able to do it.

R And do you think the clinic was ready for that?

P I think so. I think doing it slowly is better than just putting something new in and expecting everyone to be able to use it straightaway, because as I said previously, different people learn things quicker, pick up things quicker, take a little bit more time. So it's just about taking those baby steps to support each person individually on getting the best use out of the equipment. If it all just goes in all at once, then you're going to have more mistakes, more disasters at the end of the day.

Reference 1 - 1.77% Coverage

P There is the systems within the trust and the various or boards that you need to take things through. And if you can demonstrate there’s going to be a cost saving, the trust are more than happy to entertain new ideas. I think the other thing is, if we’re going to make a substantial change, we need to think about where it would fit in with our service specification.

Reference 2 - 0.40% Coverage

R So what is important, what I’ve just gathered, is that is cost-effective?

P Yes.

Reference 3 - 2.68% Coverage

R And is there anything else that you think that should be done, that is possible, that could improve on the structures and relationships, so it’s even easier to introduce new things?

P What I would like to see is sexual health in its widest sense, being removed from local authority’s responsibility. Either becoming part of the local council, the CCG, Clinical Commissioning Group. That seems to me, probably, quite a sensible way of doing things. So becoming part of the health service rather than the local council, with the roads and the bins, the trees.

Reference 1 - 2.48% Coverage

P I think it’s more about trying to integrate it into the common clinical practice. So, for example, for the herpes test, we had to run additional swabs alongside our standard, so it was about making sure that that wasn’t being missed by staff. Obviously in GU clinics, we had large numbers of different staff, nurse, practitioners, doctors, seeing patients. And it was about finding ways to make sure that all the patients had the additional swabs for that.

So we ended up packaging the swabs together so you couldn’t pick up a standard swab without also picking up the research study swab. They came together. And that helped. So it was more about introducing it as routine. But actually, the study itself ran easily and the patients agreed to the additional test. I don’t think we had any refusal that which, you know, was just an ulcer swab, so it’s very straightforward.

Reference 1 - 1.45% Coverage

P I mean, I think essentially if you ever want to adopt anything in any service you’ve got to have people who are champions that’s one thing I’ve learned. And if you’ve got people who are into innovative projects and are ready to follow them say they’ll have set guidelines, okay, fine, by the this and this date we’re going to do this and this and this. If you get champions involved and interested parties then it works.

Reference 1 - 0.80% Coverage

P It’s probably one of the biggest things at the minute will be around finances, and it’s proving that actually bringing something in will be of financial benefit.

Reference 2 - 0.76% Coverage

Quality of patient care is a big one still; we still need to be doing that but a lot of this will be down to whether we can actually afford to do that.

Reference 3 - 1.53% Coverage

We can have really good ideas which will help us do the right thing, but actually some of the blocks, I should imagine because this is a new role to me in this sense, would be around just making sure that we can balance the books and generate extra income for the trust. That would probably be a key thing.

Required

Reference 1 - 0.36% Coverage

Well the thing is making things happen is easier said than done. Obviously you need to have the right trained staff. You need to have the need for patients, and you need to have the environment that helps with that.

Reference 2 - 1.21% Coverage

The evaluation, it always, you know, it always relies on, you know, are you collecting good data in the first place?

00:09:02

R Right.

P And, you know, what is your baseline? So in terms of partner notification, we had no real baseline, because we had audits every once a year that showed that we're nowhere near hitting the targets. And then as soon as we had a tool with a real time KPI, we could see that, you know, there was nowhere to run or hide. You know, you could see how it was performing in different groups. So there, the trick is to really understand what your baseline is. So we know our baseline around diagnostics, for example. We know that 75% of our results are coming in at 72 hours, which is rubbish.

Reference 3 - 0.44% Coverage

But we had to wait for the study to be published, and as soon as it's published, we then adopted it. But we did all the preparatory work before that, and we were involved in the three in one study that was, you know, presented by [name] and others. So we're part of that.

Reference 4 - 1.28% Coverage

And obviously that's going to involve us, you know, doing a bit of work proving that it's as good as. And then it will… And, and, and obviously there are other trials that we can build on. So we don't have to do the whole trial ourselves. You know, we can say there are other trials showing this. And we can show that our results corroborate with that. But the issue is going to be a lot of people come in with STIs are men having sex with men, and a lot of the tests out there are only being evaluated is from vaginal and urethral samples, which of course is going to make it trickier.

And the reason why three in one took so long to get adopted, because we were ready to roll with that nine months before we did, is because we were waiting for the publication.

Reference 5 - 1.10% Coverage

But there's a lot of people who can say no in the NHS, or in any organisation. Risk averse negative responses, or no responses are the default of big organisations. That's just normal. So you just have to realise that. You have to work it. And I think Kim Kardashian's mother was… My partner quoted her, I have no idea what her name is. But she apparently said, if I'm hearing a no, I'm not speaking to the right person. Which I think says it all. You know, the idea of, you know, if you get… If you hit barriers, you know, you just need to talk to other people. Because you usually you can get over them. So yes, so mama Kardashian is clearly a force for good.

Reference 1 - 1.01% Coverage

So that's what we try to strive to do. It is difficult, but we do have a program that's looking at doing that, and basically looking at it as a long-term thing, a marathon, and not a race. So it's not just take something off and then say, look, we've done this and not sustain that. We want to maintain and build on improvements that we make, which is quite a difficult thing to do in the current environment where we're restricted by what we are able to do by constraints of funding and a very, very mobile commissioning landscape that seems to be changing all the time.

Reference 2 - 2.09% Coverage

also thinking about how do we navigate the changes that we need to make, developing our communications, how do we communicate, how do we get people feel involved into these decisions.

So it's pretty much having the same approach to service delivery that we have to... things that we do with patients. So in sexual health research, one of the things that we say is no decision made about [unclear]. We talk to patient groups and even doing something for them. We need to involve them. Similarly with staff, you can say that your working conditions are going to change, get that. How does that affect you? If you had to get it with this, how would you do that?

00:09:29

It's easy to say, but it's very difficult to deliver on, because part of it is getting engagement from staff, but why those changes need to happen? Because obviously, everybody is like, I don't want anything to change. I want things to be the way they are. But we have a duty to provide great care, and great care is more than... care basically means being up-to-date with everything and being able to deliver the best we can that is available now, which basically means that it won't be the same as it was last year.

Reference 3 - 1.02% Coverage

We're also looking at how can you make something work. Because what most people try to do is, how do I get this new thing to work in this current way of working, but actually saying, can we change the way we work to make this a feasible thing, rather than saying, how does this affect the clinic, how does this affect the patient, can we improve patient journey by changing everything around that? And then say that we can deploy different new technologies in different scenarios in a cost-effective manner by changing pathways by which the patients know where patients are tested.

Reference 4 - 1.46% Coverage

But get research funding to allow implementation, and then show to people that if you can actually get good quality data, that shows that you can actually save money by showing a research project that actually looks at that rather than saying, oh, I'm going to do a model, and then you go, well, it’s just a model, and say that I'm going to do a health technology assessment study.

I'm going to do an implementation science that's going to look at what are the cost implications of this change and say that we get this properly funded as a study. You get the device or the new technology through the study, and then you put it into a real world scenario. And then they have a real time look at what the exact, say, changes in work time because you're going to measure everything. And I think that's probably one of the way forward.

Reference 5 - 1.11% Coverage

But you can actually say that we do this as a study. We get it properly funded. That tells us exactly whether this implementation is cost-effective, feasible, sustainable.

Have clear measurement goals. Get it properly funded, so you get that for the service. It's going to be cost-effective to have the study because all of that is going to be taken care of by the research. And the research, then, if it shows that it is cost-effective, you have a very good case to make to adopt it. The trust I work with is towards support for developmental services. So if you can say that by having this, I'm going to reduce other expenditures.

Reference 6 - 2.00% Coverage

And so that's where you're having a higher management team throughout the structure, which is looking at the longer picture, saying that you have all these things, you have contingency plans for the [unclear] of the system where things change. But you know that your commissioning is not going to change dramatically. So you only know that you're considered at risk because we are an at-risk department financially because we have a lot of performance targets, which are unrealistic.

And it’s unguaranteed money, which can change at any time, which basically means that you need to look at how you can get with things, but they're always [unclear]. And if you can get research to take on a large proportion of your routine work, it's paid for by research. It basically means that you make your target. At least that's a good mix, good [unclear] sense to look at that. But it also means that you have real world implementation science, I think, is the way forward, especially with new technologies.

00:29:46

And it's saying that you may use research to pay for that. And then you make a good business case, then you can implement it.

Reference 7 - 1.77% Coverage

Say, personalized medicine, it's... the intervention is going to have a different... they're going to be broad. So if you talk to people, they talk about financial problems. And of course, they're going to be a [unclear] on the part of money, smaller and smaller. The demands are [unclear]. You need to be creative about how you navigate that. People will say money is the metric. Now, what do you do about it? If they're just going to say, financial considerations are the biggest barrier, what do you do about it?

The stakeholders are going to be different. You need to be able to say that think creatively about how we're going to do things. Diversify your activity to basically say, now you have income generation. And so basically having the ethos, that you're going to do more than what is asked of you, because that's the only way you're going to generating income. You're only going to do the bare minimum. You're not going to generate any income. You're not going to be able to make any changes.

Reference 8 - 5.90% Coverage

So it's basically having a forward-thinking department is always going to be... having a problem solving approach is going to be key to adopting something. Again, your stakeholders is having good links with the lab, good links with the managers, having a very good business plan, looking at who's enrolled in that business plan. It's having a very clear vision, rather than saying, you test, how can we use it, to actually say, this is how we can use it. This is how it's going to affect A, B, and C.

Talk to A, B, and C and see, how do you think? What do you need to support? How do you feel about this? We're going to ask you to do this. What needs to give in your job plan for you to deliver this? How do you move things over? And the thing, that’s the change. Get it agreed. Have an evaluation process. Then say that these are the costs. These are the savings, which makes it worthwhile. Who or where can we get the funding to do that?

And now, all of this, you have charity funds. You're going to have research funds. You're going to have core funds. People, if they don't apply for these, don't get this. And it's basically being aware of what is out there, trying to say that you're applying for them responsibly, having those relationships. You talked about having a business development team. They're your key stakeholders usually. So people always talk about commissioner [unclear] and then talking to people [unclear]. Commissioners want lab test. And commissioners won't agree to pay to it.

00:49:18

But if you're going to do it on your own and you can deliver your key commission targets, nobody cares how you do it. Nobody cares what tests you use as long as you're able to do it within the resources that you have. So if you can move resources and implement something, it's possible. And the other side of the [unclear], you have less control because the people who develop how marketing the diagnostic and basically saying that you need to meet halfway and make it affordable.

And I think that you have the real-world examples that this has happened. So [clinic] have the Cepheid GeneXpert that they've implemented in two of their clinics. It's a very expensive piece of kit. But they have it [unclear] the service. And the understanding is that they would buy a certain number of tests, and that fits in [unclear]. As long as that is cost-effective, basically they had a cost neutral plan saying that this is how much it cost the lab to charging them.

They do it in-house, same costs. And that can happen. And we're trying to do the same, but it's looking at every situation in our service. Our lab is a company called [Unclear], which basically means that every time I come up with something that is cost-saving, does it then go... no, no, no, no, no. This is income loss for us. And they're like, yes. Everything that I'm going to suggest to you is going to be income loss to you.

00:51:09

It's looking at, if you had that, your stakeholder then, it's for as our fit for the future team, which the change management is in the trust. They're basically saying that they're going to be using different schemes, which is branded by the trust saying, this is what our organization expects. So you need to provide this. And it's saying, how do you get better bargaining power? So that’s having organizational support.

Reference 9 - 2.47% Coverage

I know there's a lot of interesting commissions, but I don't think they're that powerful. And it's looking at what labs think about this, what service managers think about this, what the finance people think about this, just [unclear] things and change would be the other kind of key stakeholders. But also to get key stakeholders is in Public Health, looking at, would they be interested in supporting a rapid diagnostic strategy nationally?

And once you have a national strategy that comes from Public Health England or NHS England, you have more buy-in. If you have a national body or you can [unclear] HIV saying has a standard supporting this, then you actually have somebody saying, look, this is a national standard, so actually campaigning for that and getting that voice and seeing what their concerns are, but mostly they're going to say there's nothing there.

But actually saying that how do you actually get national support for implementation of new technologies? Actually, to have something about that, some kind of guidance to services to say that this is best practice, this is what would be, this is what the future thinking service should be, would be a catalyst that allows people to do that. Because at the moment, you need a lot of local buy-in, which a lot of smaller services and even larger services with less interest would not have. So I think that’s probably all I have to add.

Reference 1 - 1.52% Coverage

I think sexual health is probably our most innovative service. I think some of that comes from the fact that they’ve learnt to not ask for permission for a lot of things. Because I think if you ask for permission you’re essentially making it someone else’s responsibility, of which when that person needs to understand everything about it to say yes or no.

Reference 2 - 5.07% Coverage

The next side of it is you have to think about everything else that goes with the idea of implementing something new. So first and foremost is how does this affect the patient? Okay. What is the benefit and potential risk to that patient? And you have to assess that very carefully. Most cases are filled with benefits, very little risks, but when you do have risks you need to understand them. You need to understand the likelihood of those risks materialising and you need to develop a plan to mitigate them.

So that’s something that’s important as a manager. You then have to think about how politically sensitive you need to be about making a change because for instance, if you made a change to a patient pathway that reduced the amount of attendances by let’s say 50%. I’m making this up. 50%. You might think I’ve done a really good thing because I’m reducing the amount of follow-ups for a patient, I’m being more effective with my workforce. But what the team on the ground hear is: You’ve halved our workload. Therefore, is there personal risk in it for us?

So you need to think about that initial engagement process. So you don’t want to make decisions like this in isolation.

Reference 3 - 1.98% Coverage

If you’re changing a part of the pathway it’s going to affect lots of people, not least patients, and I believe you have to have that conversation in an inclusive way where you say: This is what we would like to do. What do you think are the benefits and the cons compared to our list of pros and cons? And I think you should do that with all staff involved, all patients because they will also bring up things that you weren’t considering that’s really important.

Reference 4 - 3.69% Coverage

And that process alone, everything I’ve just said, not just the last point, takes time. It takes time and I think ultimately, when you’re signing something off you need to know that it’s going to be safe. That’s probably the most important thing. And then after that you need to know that it’s going to be cost-effective and if it’s not cost-effective you need to know it’s addressing a significant risk. Because otherwise it just wouldn’t really make sense to be doing this.

And that in itself can take a long time. There are various structures around us internally. We have governance structures. For example, we’re buying equipment, it depends who we’re buying the equipment from and how that’s governed internally by organisation. Because that wouldn’t be governed by me as a manager, like a new pathology machine. But it would be managed by our suppliers etc.

Reference 5 - 2.95% Coverage

I think you find out about these things through normally clinicians on the frontline who have heard about someone else who’s doing something like this or have gone to a conference and witnessed something that’s happening somewhere else in the world that we could be doing differently, but we’re not.

00:11:25

And they’ll come to you and they’ll say: This is how we do it. And we figure out, okay, well who else has done something similar? So there’s always a process to procure new equipment and stuff like I said around assessing safety behind this; the evaluation process if you like. There’s a standard process for that, but what you need is people’s experience who’ve done similar things.

Reference 1 - 1.64% Coverage

R Yes. And does it sometimes mean that you have to work extra hours? Or do some work outside of your regular working hours. When there is a new, you know, new process, new technology in the clinic.

P I suppose on very rare occasions, maybe. Yes. Well, I mean, generally speaking, I think most of us try to stick to our hours. And I think that’s… You’ve got this number of hours in the day. That’s what you are contracted for. And you try to stick to it. Although, you know, some people work a lot more hours than they should, really.

Reference 2 - 2.65% Coverage

P I don’t know. I don’t know if I have any ideas about that. I think communication is probably the most important thing. So, to… And this is something we do fall down on sometimes. Like, I think, sometimes, we can be so quick to make changes to even just, like, how test or, you know, samples are processed or something.

But does the whole service know that we talked about it in a training session for everyone? And we emailed the service. Sometimes it happens. Sometimes it doesn’t. So, I think it’s difficult to kind of make sure that the message is being communicated to everyone.

R And what about these two other settings that you mentioned that are more traditional?

P Oh, the other clinic sites. Well, we… So, we… It’s all the same staff that are rotating throughout.

00:20:19

So, everybody... So, we know each other regardless of what the location is.

Reference 1 - 1.87% Coverage

And thing is as well, everything falls on your shoulders, but then you're still liaising with your managers to see where you are. And then they're feeding back to, like, their managers, because there's a chain isn't there? So… But on the ground level, everything's fine, and they're confident, no problems.

R Right.

00:07:38

P And I'm always fed back, there's no problems. Or if there was a problem with, like, the printing, and then you've got, like, IT, they will come out and try to fix what's… Because I'm not technical, so I don't know that side of things. So that circumstance is beyond my control. But at least I'm liaising, and having these telephone calls, testing there and then, running from room to room. It was, like, a lot of work, but I enjoyed it. And it was a learning process as well. So I think when you get something else, you remember what you did previously, and then it makes it even more easier. That's how I find things. So…

Reference 2 - 1.79% Coverage

The way that I supported the staff, was I said, it's a change, take your time, we will get used to it. Because they were getting fed up, they were getting frustrated, forgetting where to… That… You know, they hadn't ticked a box. And I said, that's fine, we're all learning. I said we can go back and check over what… If we've missed something.

And then eventually, that perseverance, and they got there. It's just about supporting the team, because it's not good to put something in place, and then leave them to get on with it, or not have somebody there, like, shadowing, or somebody to call on to assist. I think it's important, because what we did was when we went live, I mean obviously, it was fine at this site, because it was already being used. But, we had staff in place to assist everybody, so we had staff in place to assist the nurses, and the doctors, and the admin team, to make it work.

Reference 3 - 0.13% Coverage

R So you had to be very strategic about it.

P Yes, we did, yes.

Reference 4 - 2.64% Coverage

We all get together as a team to discuss it. But the deputy general manager, service manager, obviously the general manager, but the service manager will lead on it. And then will feedback to the deputy general manager. But we all get together as a team, and discuss what's our business planning for the year. And it goes… Goes quite well, because I think the service manager shares the office with the other service managers within the, like, directorate. And then obviously they can all bounce off each other, and see where they're at. But, you know, I think they have little competitions going. So it's quite good to know that, you know, what… You obviously like your plan is the best, and like… Because when it's sent up…

R Yes.

P To be evaluated, or checked, or whatever. And then, you know, if there's a few comments, then it's good. But if there's lots of comments, then, you know, if there's less then it means you're on the right path. So… And then obviously it's got to get signed off. So, yes. And there, again there's a deadline for that. So it's important that everybody… You know, because we have a set agenda to discuss certain things. And then if that's on it, you know, we might spend a bit more extra time on that for that day, so that it's signed off. So… I think we've got a really good team, actually, quite supportive.

Reference 5 - 5.90% Coverage

If you could improve something, then for the clinic to be more ready for new technologies, what would that be? IT?

P Yes, exactly.

R IT.

P That's the first thing I was going to say. IT, and have a system that didn't crash. I think sometimes when there's an idea, it's such a, like, a process before it's implemented, because you have to go through all these channels. And by the time it's ready to go live with your department, now you need to sort out when you're going to have your timeframe. You just, like… Because I'm, like as somebody has said, I like taking a… Right.

For example the lead clinician was saying the other day, in an ops meeting about [unclear] medicine, new vac systems, better than IMS. And it's already in another… It's already in Ireland. And I was thinking, you know, I was getting really excited, because I was thinking, I wish we could just have it the next month, and say right. But then there's processes, and there's training, and…

R Right.

00:33:49

P You know. So we can't just have something just like that. So, it's just like the speed of something that's going to happen.

R So you would improve that? Maybe minimise…

P Yes.

R The number of things…

P Yes.

R We need to do.

P Do you… Do we have to do this, or do we have to do that?

R Yes, right.

P Is it necessary?

R Right.

P You know. So, I… That's the only thing I don't like. Is things sometimes take too long. I mean I know I liked it if you give me a deadline. If they say, we want this done by next month, I'd have it done this month. Because I remember once I was asked to do… When we were tidying up the admin, and they didn't have many processes, and SOPs in place, and I was asked to do an SOP for reception, and the deadline was the end of the month. And I had it done the following day.

00:34:38

So, little things like that, I like to… You know, because they might… Because on the… In… With the mind set to say that, well, as a receptionist what would you need? What needs to go in this document? And all the sites need to be the same. So, a new person coming in will be reading this book, and it'll be easy for them, because they didn't have anything. So little things like that. But… So the general, for the whole department, if there's something, a new system that's coming in, and I notice it does take, you know… It's a discussion, and then where are we at with the discussion? And, you know, why is it taking so long? Or, where… Who is, who's leading on it? And you know, somebody says, oh I… Oh yes, I need to chase that. And I know everybody's busy, but if you keep on, like, on top of something, then it will…

R Right.

P You know, you… Or dedicate it to somebody to be responsible for it. Instead of just saying, oh yes, I need to chase that. And then the following week, it hasn't been done. So, that's why I think sometimes things slip.

R Yes.

00:35:43

P And then they say, oh we need to pick that up again. That's the only thing I would say. I don't like the delay.

Reference 6 - 1.65% Coverage

P No, I think as I said, the barriers, the decisions take sometimes too long to be made. And then, by the time they say, oh, you can go ahead with it. And then we have to do our planning, and then you’re like oh, because you remember when it was fresh in everybody’s minds. And then it has to be approved, and, you know, you’re just waiting. Oh, I have to put that on the agenda. Oh, it was missed off. And then the delays, you know, I just think things need to be, what’s the word, it has to be, like, managed a little bit better, when they say, we’re interested in this. It needs to be discussed, and it’s either yes or no.

00:05:30

P Or go back and, if they’re thinking about then, go back and see if we can do it. Otherwise people just get fed up and then they don’t want to be involved in planning something. So that’s what I think.

Reference 1 - 11.25% Coverage

I think, with the idea, you’ve got to get buy-in from the start, so people know what the change is exactly, and exactly what the benefits are. And I think maybe getting people to kind of reflect a little bit, so sort of say, okay, well, what do we do – this is what we do right now, what’s good about what we do right now, what’s not so good about what we do right now. Because obviously, right now we’re happy, because this is what we know is status quo, but let’s explore what’s not so good at the moment – okay, so what can we do about that.

So, I think try and get people to think about it a bit more, that just because something is how it’s been done, it doesn’t mean it’s the best way, or the only way. I think as a team changes it helps, because some people have worked here for a very long time, or they’ve only worked here, so this is all they know. So, when people come from other clinics and you hear about how they do things in other places, you think, okay, that sounds better, that doesn’t sound as good, or it sounds different, it’s no better or worse, it’s just different, so it makes you aware that actually things can…

00:21:29

So, I think kind of having more of an idea of what’s going on in the wider context of the area that we work in, the field that we work in, I think would be useful. But as I said, I think getting buy-in from people, and kind of showing, tangibly, how the idea would help. So, say if we had this test, or we had this piece of technology, it would enable us to do this, this would release capacity, or it would make this part of the workforce, their job more interesting, because they might be able to run with that independently – that wouldn’t diversify their role, that will help with retention, because people won’t be leaving all the time.

So, the knock-on effect is that you won’t have to always be training up new staff, you won’t have to always be interviewing, and getting people through a recruitment process. So, kind of trying to really join all the dots up, and for each staff group, say okay, look, you will be benefited because of this, your staff group will benefit because of that, and then you’ll benefit, because normally if you work in a team, you’re always connected to the people. And I guess, maybe telling people that actually what affects the doctors does affect the nurses, what affects the admin team does affect the recall team, you know, it’s like, maybe a bit more connectivity.

00:22:43

R Yes, connectivity and communication.

P Yes. So, say you’re thinking, okay, well, this piece of technology, that’s clinical, I’m admin, it’s not going to make any difference to me, you know. But say, well actually, if they did this, then it would release capacity there, so therefore actually that would help you, because maybe when you’re struggling on the reception desk we’d be able to send someone to help you – trying to find a way of making it relevant to everybody, to maybe get that buy-in.

Reference 1 - 6.40% Coverage

So yes, once again it comes back to the training thing. So we have to be trained properly to read the test and then interpret it and obviously the documenting thing. Because we normally use the online IT system to document everything, so then we have to think about how we document this. Because I looked at some of the stuff out there, I saw a Canadian study and they have found that 30% of these point-of-care testing results have not been documented correctly and about 12% have not been documented at all. So I think that that's something that we can learn.

R What does that mean that they weren’t documented properly?

P Maybe in the patients’ records, so it’s a human error, isn’t it?

R Right.

P So you do the test, you give out the results but you don't document it finally because when you have a standard laboratory test… Because everything is online at the moment, so we get the results online. So we normally attach the patients’ records so we don't have any problems. But if you are doing a point-of-care testing, then we have to have a separate place to document it, probably discuss with the IT system how to record this point-of-care testing. I mean, those all can be done but these are the things that we need to make sure that it happens, isn’t it?

Reference 2 - 9.72% Coverage

P I don't think that the structure of the clinic really matters. I think I would like to encourage a point-of-care test which really works to be on honest. Pretty sensitive, specific and I don't know whether it’s useful to use it on everyone, I don't think it's useful but patients who really need quick test results… Because sometimes we do see patients who are coming for a test today and they talk about going away tomorrow so they would like to know the results as soon as possible, which makes sense sometimes. So for a particular group of patients, point-of-care testing is quite useful.

R So in terms of adopting new technologies, you mentioned that what can facilitate a process like that is that if the technology is cost-effective, if the training is provided to all the staff involved if there is a strong evidence. And you also said that it’s helpful if there are other services already using the technology and obviously if it's seen that it improves patient care, then also that helps to adopt new technology.

00:17:06

P Yes, and also if you have a proper method of recording system results, recording and… The other thing that I was concerned about was what is the process in place for ongoing daily quality control testing and any troubleshooting issues and what are the instruments that we need to use. And if there is any particular instrument that we need to use, so what is the instrument maintenance requirements and things like that, those technical stuff more than clinical stuff.

R So would it be, for example, helpful to have someone from outside of the clinic to support that process, maybe someone from a company that designed the technology?

P Yes, at least we should have contact details to call or email and find out certain things. If we come across a problem, then there should be someone to help us. I don't know whether it should be in-house or outside, but someone that we can rely on.

Reference 3 - 2.67% Coverage

P I think it could improve with a certain group of people as I said before, so they can get their results within half an hour. So they can probably wait in the clinic and then get the results and go away. So in that sense it's quite useful provided that the accuracy is the same as a standard laboratory test then we don't have to repeat the test. But initially, I think probably we have to have a standard lab test and then do the point-of-care testing, isn't it, to see how it goes probably kind of a quality assurance step.

Reference 1 - 1.76% Coverage

P Yes. So, of course, it has to involve training, it has to involve working closely with the microbiology department and also with regards to patient care pathways and making sure that the system is robust to be able to generate reliable results. So it was a multidisciplinary work, especially together with the microbiology department once we had a strong business case for it and why it was important and can be able roll it safely and successfully.

Reference 2 - 2.27% Coverage

But overall there was a strong case for it because, number one, getting a better facility, the better, more reliable results and also more robust. So there’s a strong business case for it.

So with that we set up our small team of people to sit and see how it can be implemented. That involved also our local managers in the laboratory, in the department. And looking at the facilities we had, what resources we’ve already got that we can make use of to minimise any cost and what is required and what other extra cost might be required. And there was a costing done to all of this.

Reference 3 - 1.70% Coverage

And then in terms of the implementation there was a grid process on how it was going to be done, in what stages and at what stage we evaluate it to see if it’s working well and before we then decide to take it as a standard practice. So those several steps we did, but of course the key stakeholders were myself and the clinical lead in the microbiology department working closely with their relevant managers so that we can adopt it.

Reference 4 - 2.34% Coverage

P Yes. The process was supported because there was a big strong case for it. And I think the fact that also there was a very close working relationship networking between the key drivers, myself and microbiologist, that was very supportive, so that if there’s a stumbling block in the microbiology department, like they would push it and get it sorted. If there was stumbling block on my side, I would get it sorted. So you need all the stakeholders to acknowledge and to accept that it’s an important thing and that we work on it. So I think that was the most important thing to get it on the ground.

Reference 5 - 6.54% Coverage

You said that evidence is important, I’m thinking it has to be data coming from a robust research...

00:10:13

P Yes.

R I assume? Yes.

P So the evidence was there in terms of the robustness of using a PCR testing for NAAT. It was now a question of deciding what platform we were going to use for our specific set up. So the key thing was not about doing another study, it was about just implementing what is already, has become a part of a standard practice elsewhere in most clinics. So we were evaluating the platforms we have within the laboratory. Can they run a similar test? Can we get their reassurance about the quality? Is there an in-house system for us to check to reassure ourselves that the quality is okay?

And that was set up with the laboratory. I think in the initial stage all the samples tested here using the platform PCR were counterchecked in our reference lab. So that was like a quality assurance process to make sure that this new system we’re going to use is going to give us reliable results. And once we had that reassurance that our machine in the pathology is generating reliable results, after a period of time sending test samples we then started working on a process of how to roll it out and what to do during the transition phase?

So the first step is to make sure that we have the right machine to do the testing, we have the right kits to get the samples. And once we had that reassurance then we know that we can now safely move to the next step. So it was just testing that machine that was in the lab already there to make sure that whatever result it’s going to generate is reproducible by another independent pathology laboratory.

Reference 6 - 4.81% Coverage

P Yes. The other thing will be to have a good failsafe system. So you need to do something new which was maybe something differently, you have to think of when things can go wrong. And if things go wrong what backup have you got in place and how you’re going to investigate and address that. You also want to look at the support available within your system’s liability because again you don’t want adopt a new system and then you’re struggling to maybe get your results, you’re struggling to resolve something that’s not working. Maybe the machine has got some fault somewhere and you need some IT technician support and there’s no support available. So you have to think of all these issues that can make you feel frustrated.

So whatever new system that comes in place and especially, for example, if it's something that you’re going to run in-house in your day-to-day work you need that backup, reliable and supportive to make sure that if somebody’s experiencing some problems there is that support available instead of being left on your own, you don’t know what to do. People started saying, why this thing is not good, fit for purpose, let’s go back to the old system. So there has to be that robust support system available.

Reference 1 - 1.77% Coverage

What I would say is overall I think it was easier working, implementing new technologies with some sort of formal restructure, because you can make it happen, whereas trying to convince and bribe and flatter and threaten individual teams, you get yourself caught up in, for one team, the reason for this technology is this, for another team, the reason for this technology is that, and I don’t think that’s necessarily the best way to approach the implementation of technology, especially if you’re trying to achieve a consistent service.

Reference 2 - 3.40% Coverage

I know it sounds a roundabout way thing, but there’s lots of work that goes on in healthcare, not just sexual healthcare, where there are a lot of anecdotes, there’s a lot of expert opinion, and sometimes it has just been what everybody’s always done. Technology which can start verifying that, I think, in a sense, is its own justification. Again, this is where things like the use of technology to support clinical recording so that clinical recording can be brought together and looked at as a mass of data, I think all of these things support the introduction of technology.

I think again there is still a bit of an attitude sometimes that Big Brother’s looking at you, from individual clinicians, and I think there’s still professional pride that goes on as well: why should anybody be scrutinising what I do, I do a good job. It’s not about scrutinising what you do, it’s scrutinising the interplay and the relationship between what you do and what everyone else does, not only in [sound slip] but potentially in the country.

Reference 3 - 9.21% Coverage

R And are there any ways of improving things as well, are there any areas that you’re particularly keen on improving?

P Loads. I think testing technologies is a big area for improvement. At the moment, we’re still in the position where tests go off to big labs. Big labs, that involves a lot of transport, that involves time, it involves a lot of manpower. I’ve always dreamt of the day where we could use, I don’t know… Is it called mass spectrometry? I don’t know, some of these molecular analysis processes onsite, so basically labs could shrink to the size of, I don’t know, maybe small fridges or even smaller, and people could be tested for a whole variety of things with just one small sample with instant results on a molecular level as opposed to on…

And I’m sure that technology’s there and happening. That would always be, I think, something I’d always look at. Again, anything, technology which supports people’s ability to do things themselves and supports the reduction in process steps so that individual clinicians can better manage people, because what people don’t want to… I understand from working with people, being a patient myself, nobody likes to keep repeating their stories, nobody likes to be shifted from pillar to post.

Technology that supports recorded and secure information transfer so people didn’t have to keep on repeating their stories, I think would. Technology that supports virtual consultation, technology that supports telemedicine, those sorts of areas, you could effectively have one person supporting a number of other clinicians around certain symptomatic presentations by using telemedicine and systems that recorded that sort of intervention as well so we can all be completely accountable.

00:30:09

And we’ve taken some steps towards that. We have got the ability for a number of people to virtually review the same clinical record, but I’d love to get to the point where we can start using screens, where we can start using cameras, where we can start making… Because as I was saying, it would make a better use of clinical staff. I want the experts to be dealing with expert stuff, I want the people who are clinically appropriate to deal with the routine stuff, but we never know 100% when a routine thing is going to become complex. That’s when you do need the support.

But what you don’t need is somebody erring on the side of caution, a very highly paid expert just waiting for that odd moment when there’s going to be something complex coming in. I’m very keen on technology supporting individual health records as well, patients hold their own record. Rather than always clinicians holding the record, give the responsibility and the onus to the patient. Then the patient can go anywhere. I think that’s an area that’s unexplored.

Reference 4 - 2.28% Coverage

R And do you think that because the guidance like that exists, would it be easier, then, to write a business case?

00:41:04

P I think you’d still have to do both, because guidance is guidance, and at the end of it all, commissioners can make a decision based on their evaluation of the public health impacts of doing it or not doing it, and that’s the long and short of it all, but guidance still would be it’s additional evidence. If I didn’t add that to my list of things that could help, I do now, all right? Clinical guidance is certainly important, but again, there are other ways to do things and we have to look at the costs of those other ways in comparison to the new technologies.

Reference 1 - 6.27% Coverage

R So I can hear that there are key things that drive implementations. So that’s patient needs?

00:13:11

P Yes.

R And also the new technology being cost effective?

P Cost effective, patient needs, I would say. So definitely patient needs have got to come first. It’s not going to make any impact really on the patients and there’s no improvement to their service or their care, then there’s not much just bringing something in. It’s got to be a key driver with an improvement there.

R Apart from the finances, is there anything else that can be a barrier too?

P Well, if it’s physically viable. So it’s no good having a piece of kit that won’t actually fit anywhere, but it could be the best thing in the world. But if you can’t physically get it into the room then we can’t use it.

R Well, that makes sense.

P So that would be a decider as well. We’re talking about patients, because actually it is something that would benefit the majority of the patients rather than be paying for something that’s only for the minority, because that would be a driver as well.

R So maybe it shouldn’t be just for certain groups of people but rather for as many patients as possible?

00:15:05

P Benefit to as many patients as possible, yes.

Reference 1 - 4.74% Coverage

So if there's something about the test that has a unique selling point that's better or... not necessarily better but compliments or adds to what you've currently got, then I think that very rapidly can get buy-in of a whole service. So what I would normally do as a service lead is if someone comes to me with an idea either from within the department or an external person saying we've got this test, you look and say, actually, is there a niche or is there any potential in the service? And then talk to anyone who may be affected by it.

00:04:33

So for a lab test, actually talking to the consultants in the lab and the people who do test because you need to know if they've got the results to evaluate it, the inclination to do it. Talk to the people on the shop floor in the service here. So if we bought in, what's the label, what's the change in work pattern, and can they see any advantages? So starting with the senior team, so the senior nurse or the consultants.

And if they can see some value in it, then actually talking to whole service about what it might be before them developing the process for implementing it.

Reference 2 - 2.73% Coverage

P Well, I think you have to keep the service modern. I don't introduce everything just for the sake of it, but if they can see an added value to it, yes. It's like when the national guidelines come out, you look and you say, what is in it for us? In terms of where you are, I'm probably an early adopter, but I like to know that things work before I adopt them. So I will critically evaluate something, but I will look at new things and actually see if there is some added value.

00:05:49

So I won't be someone who puts everything in right up front without the evidence. But I do like to be an early adopter rather than dragged to the gate as it were.

Reference 3 - 2.72% Coverage

P I mean, I think it depends where you sell it to. If you can see an advantage or something, and you can then convey that to the staff, then yes. Then I think everybody becomes very invested in it. And I think if it's something you're told you must do from the top-down, then there's usually... unless they can see the really good... I think at the end of the day, the people who should be most interested are the people at the shop floor dealing with the patients if they can see the benefit of it. And that's why I always feel quite strongly.

You actually need to be able to see what the benefit is and explain that to the people seeing the patients.

Reference 4 - 1.96% Coverage

R So then to improve those structures, I guess you would need more space and possibly more staff.

P And more staff, yes, which is also more money. And the space is always more difficult because every NHS trust is struggling with space and pressures on space, and you're stuck with where you are. For example, to make our lab bigger, you'd have to relocate the... our lab is surrounded by toilets and things that you'd be having to look at moving the whole service too.

Reference 1 - 1.36% Coverage

financially you have to decide whether this test is something that can or cannot happen. There’s lots of tests that we’d love to have, but it just depends on money and funding and everything else, to see if there’s money in play for that. And, yes, you have to decide which ones are the best ones to have for the clinic, and the reasons that you’d like to have that.

Reference 2 - 0.67% Coverage

P Yes. But it, as I say, it largely also depends on money. That is the main thing, I think, because there are lots of tests out there, but it just depends on how it might work. Yes.

Reference 3 - 1.01% Coverage

P It’d be nice to have somebody to just evaluate it all, just give you all the data. That would be very nice! And engage with… So somebody specifically to do that. that would be very nice.

R So having a unit within the service just to do that?

P Yes, that would be nice.

Reference 4 - 1.67% Coverage

P I’d quite like for that to happen. And then we can go through all the sort of finances and the funding and the budget and everything else and say, okay, well, this is the data that we have on this, and this is why it would be best. Or these are the couple of options, and bring it to the table and we can all discuss it, knowing that actually at the end of the day the money is there and we just need to pick one and that will be much easier for us!

Reference 5 - 0.36% Coverage

R Right. So is it also the problem of not having enough time…

P Oh, there’s never enough time.

Reference 6 - 4.71% Coverage

R So if there is a disagreement during meeting and people, then you would consider, for example…

P I think we would discuss it just to make sure what the issues were. Yes. And I think even when we brought out the previous point-of-care tests there were still a few concerns about that, which I think is good. Because it means that we are considering it and are thinking about it. And you bring it to the table and discuss it and say actually, is that a real concern or is that not a real concern? Or is that a misinterpretation of something, or the concerns that they have, how large would that actually be in reality? So I think that’s one of the things…

And with this particular test it is going to be just like our HIV point-of-care test that we select a population of patients that have it, rather than everybody having it. So, yes, it is important to hear what people’s concerns are about, you know, either the group that you’re selecting or otherwise. And there’s always going to be a group of people who ask for it, that you don’t think necessarily would be suitable perhaps or that you think not necessarily will be able to have it. So that’s always an issue about how you deal with that as well, within the clinics, so that’s always good to discuss that beforehand.

Reference 1 - 3.50% Coverage

P It’s usually the area that requires the test that does most of the pushing. For instance, when the community required point of care analysers for FBC and CRP, they were the ones, well I mean, they got in touch with me. But they were more the ones who were pushing it forward, because they had deadlines. They had deadlines where they had to have it in place by. So, we worked together with them, but the relationship comes from the service user who wants the equipment.

Reference 2 - 10.61% Coverage

So, you know, within those question, we would have already, you know, assessed whether we are able to improve the service that we have already. Before we go to the evaluating by the point of team. And, also, the amount of samples that they do, that’s quite important, because there’s no point in having equipment that’s, it’s not going to be used often because these are nurses that will be using it, not trained staff. And if they’re not using it often, there’s a possibility that they might forget how to use it and may not use it properly.

R So, training is important in that process?

P Yes.

R I guess, is it that continuous…

P [Unclear]

00:11:17

R Yes.

P Yes, we do the initial training, which lasts a year. And then it’s up to the manager to decide, to make sure that the staff under them are sufficiently trained to continue using the equipment. So, if we look at our glucose meters, for instance, we activate their barcodes just for one year. When it’s after a year, they have to run control, to have it activated again.

If there’s an individual that has gone on to maternity leave, or has left the trust for a little while, when they phone up to say, can I activate my barcode? When I see that two years has elapsed, I would say, go and do the E-learning, because we have that system for the glucose meter. So, they would go and do the E-learning. But that’s not the case in all point of care equipment that we have.

Reference 3 - 4.68% Coverage

P Yes, obviously the staff that use equipment can sometimes be difficult, in that because they work a shift system they’re not usually all there when it’s time to train them for the equipment. And, so, sometimes, what you may have is a watered-down training for the equipment. Not only that, but sometimes, when they’re supposed to have their own unique passwords, and sometimes they tend to share, when no one’s around. And, you know, some of them may not have been trained at all, maybe because they’ve used it another trust, and they feel that they can use it. So those are sometimes the issues that we have to battle with here.

Reference 4 - 6.02% Coverage

P Yes, I think that most people like it, and if it were possible for, if there was no red tape, if there wasn’t such a long pathway; I think that most places would have point of care equipment. But the reason why we can’t just disperse them all over the place is one, because they’ve got to be managed, and they’ve got to be used properly.

Because the last thing you want is point of care equipment being used, either not they’re not being used properly, the wrong result going out, the wrong result being used for treatment. So, it’s all got to be managed properly. So, they like the idea of having it, they like the quickness of it, they like the, you know, that it’s right there next to the patients. But we are probably the ones that hinder them from having it, because we just want it to be used properly.

Reference 5 - 5.05% Coverage

P I think, what I’d prefer, because it would be difficult for me to be everywhere in the trust, at the same time. What I would want is the, is for more Head Nurses or sisters, those in charge of the wards, to be more, how can I put it? More stricter, or more compliant with the system for point of care. So, they should definitely not be encouraging sharing barcodes, they should make sure that all their staff are trained, they make sure that if the training lapses, quick on the ball to get them retrained.

You know, I would want them to be more proactive. And that’s how, if that happens then I’ll be confident to now, okay, this point of care analyser is being used properly.

Reference 6 - 4.47% Coverage

P I think one thing that would be good, is that because resources within the NHS are limited. One thing that would be useful, from the company’s point of view, when they need to introduce an equipment, they have some staff that can do the evaluation. Because that would make a big difference, so instead of having to pull your limited [unclear] staff to start evaluating the new point of care equipment, you would have a team in the company that can do it. That would be really useful, not just to do, not just to check the QCs, the patient samples, but also do the stats, that is required by Crest now.

Reference 1 - 2.23% Coverage

P I think when it comes to evaluation, everyone is involved. It might not be all coming together at once, but it might be various teams getting feedback from various people. So, say, if we start using a new system, say, a clinic, then I'll be responsible for getting feedback from the nursing team and then bring it forward. So whether it's good or bad, I will have to say based on what my team has said. So I think when it comes to evaluation, everyone's input is valid.

Reference 2 - 0.99% Coverage

So in a way, the patients' needs, that as well can make a case for a new technology.

00:08:00

P That can, yes. But I think it's a combination of patients' needs and staff willingness as well to embrace it.

Reference 3 - 1.54% Coverage

R So one thing is that the work that you do is trying to convince and talking about the benefits, another thing is the evidence.

P Because people want evidence. But like I said, everything will have a few hiccups here and there. And then you get people saying, you see, we said it's not going to work. But that is expected.

Reference 4 - 8.18% Coverage

R So in practice, how do you do or how would you do it ideally if you had all the time and money in terms of convincing people, like there's a new way of doing things or there's a new technology? So how then do you introduce it to everyone in the clinic?

P I think it's giving people time. I think proper explanation of whatever it is that we are changing. And go through it with them because they need to take it in and analyse it in their own time before actually introducing it. So I find, if people are given much notice, it works better because then they have time to think about it, talk about it, and bring their worries forward and then get them addressed before it's then introduced.

And with certain changes, you don’t actually look at how... when, realistically, you're implementing it, sometimes it's not possible to see how it would be in due time when it's being introduced. And it's also looking at and learning every single day and keep evaluating how it is. But I find that if people are given more time to think about it and analyse it in their heads, it helps a bit. Because it's amazing how people would come back and say, oh, I was thinking about that change, and what if this, that, that, the other happened?

00:21:30

And if people talk about it, it's much easier than when you introduce it. So from experience, I find that if people are given more time, it's amazing what they can come up with. They can probably come up with things that probably you were not even thinking about them, because they are the people who are working in this environment. They are the people who are actually supposed to implement it at the end of the day. So, yes. I find, if people are given more time, then it works better.

Reference 1 - 5.65% Coverage

Once all the equipment was installed, everyone had to be trained on the equipment. So it was started off that only certain people were allowed to do it and then from there, it then slowly more people got involved until everyone was able to do it.

R And do you think the clinic was ready for that?

P I think so. I think doing it slowly is better than just putting something new in and expecting everyone to be able to use it straightaway, because as I said previously, different people learn things quicker, pick up things quicker, take a little bit more time. So it's just about taking those baby steps to support each person individually on getting the best use out of the equipment. If it all just goes in all at once, then you're going to have more mistakes, more disasters at the end of the day.

Reference 2 - 7.60% Coverage

R So would you say that having an extra, a member of staff, for example, would speed up the process or help the process in any way?

P I think it would definitely help the process as if there was people on the shop floor to be there if someone has problems with a certain equipment, say for example, because as we are all busy and so if someone had a problem, it would be waiting for someone to be free in between patients. And then that would also impact the patient care and the patient flow through the departments.

R Do you imagine that the person would be a healthcare professional working in the clinic or a person from let's say the company that design the said technology.

P It would have to be someone who's familiar with the piece of equipment to allow to give that support. But I suppose they would have to be clinical or just be aware of confidentiality, which is very important in sexual health, especially if it's a piece of equipment that involves being in the room when there's patients in the room at the time. We'd have to consider the, yes, confidentiality.

Reference 3 - 2.89% Coverage

P Yes. So I think it would involve a lot of training around it and then again, on that individual support for each member of staff who is going to use it, unless you only allocate certain people to use it, then there's less people to train and less people to get it wrong, maybe.

R So it's… The efforts would be mainly around teaching, supporting, maybe troubleshooting as well?

P Yes, that's correct, yes.

Reference 1 - 4.47% Coverage

you say that technologies can be there, and it’s very frustrating. So what happens exactly that they don’t get to the clinic?

P I think we may not hear about them, which I know seems a bit daft, because obviously we’ve heard about you. Or it might not seem viable, or possibly the right people might not hear about it and want to carry it. I think the way that it gets sold in a meeting. If we have a team meeting to see something exciting, and new, and quick and how you get your results and what this means. It can very much sometimes just depend on the wording. As I’m sure you know. And you get that right and I think people will jump on board.

R So, it has to be good selling point?

P A good selling point.

R Has to be well-phrased?

00:16:49

P Yes. I think because the service manager, my line manager that gave you my name, she knows that I’m really keen on this, and she knows I’ve done homework on it. And those other people that I’ve mentioned, they’re all well aware of it. So we know that we can say, yes, but this is really good, because… And push it to be done, because I don’t see there being any pitfalls. I can’t see it. And I know before, when it was mentioned that there were concerns about the end of life and shelf dates and things on them. It was, well that’s really good, but what about…? So, actually, we’ve got to a point… And we can do this again. We can say, well, actually, we’ve got another chance.

Reference 2 - 3.89% Coverage

And when people… It’s again wording it. If I say to people, when I do the repeat testing and I want them to a peace of mind test for their chlamydia. If you say to them, how about you do a test, I can send you a text message and you do this, they’re not interested. But then if I were to word it and say something along the lines of okay, in that seven weeks’ time, for your piece of mind, we want to make sure this has gone, so that we know exactly where you stand. I can send you a text message out. Don’t do it before then, because you might get a false positive, or however I say it. Are you happy for me to send you a text? Yes. No problem.

And yet I know that the same person being asked that by somebody else, might have a no I don’t want to hear. I don’t want anything. I don’t want to know about it. It’s always about the message you give across, isn’t it? But I do believe, whether or not you’d want to work with us, I imagine that’s what you do, because nobody knows our population like we do. You have all your things you need to say. But most definitely getting the information out about the… What’s happening and the new technology. Why wouldn’t you? And I saw, I don’t know if… You must have seen it because of the job that you do.

Reference 1 - 2.90% Coverage

P We have to work with our procurement team. So it all comes under a set of standing financial instructions that the Trust adopts for purchasing things. We have financial rules that are in place so there are certain pathways that have to be followed depending on the cost of what you want to buy. And we have to follow European law as well in terms of very large contracts.

So there is a procedure that we follow for the purchase of everything, and what paperwork is involved and at what level it goes through the Trust is dependent on the value of what you’re purchasing.

Reference 2 - 12.77% Coverage

R Right, I see. And it’s also quite important, you said, that the equipment is tested where it’s going to be used?

P Yes, because, on paper, things can look the same and it can have performance criteria that’s the same, but in practice, I mean even with just very small tests we do, when you actually start using them, if one test has got two or three steps that somebody has to do and you can have a band three who does them, and another test has eight or nine complicated steps that you need a band six to perform, it might be the same on paper and it might cost the same to actually purchase it, but in terms of the resource to perform the test it’s very different and we may not have a staff resource to be able to do a more complicated test.

So you have to assess whether it’s going to put an additional pressure on the workforce, depending on what that piece of equipment is. So that is quite important, that we look at that when we do an evaluation.

If it’s a very big piece of equipment, what usually happens is you do a site visit somewhere else where it’s being used. And then you can talk to the staff who are using it. You can actually see it in operation. You can see exactly how big it is. You can talk to them about, you know, how it performs in terms of IQA and EQA, all that sort of thing, because obviously they don’t put big [unclear] in for trials but we would do it that way.

00:08:06

So you would either want to be able to see it in practice somewhere else or you would want to be able to look at it actually in practice in your own department.

R And would it have to be a similar service to yours?

P It depends what you’re looking at because if you’re just looking at how a piece of equipment performs, it doesn’t matter. You can make that assessment yourself. So if, for example, we were looking at just a small PCR analyser, we would be looking at how that analyser performs; what the staff resource to use it is; how easy it is to use; how quickly we would get a result from it; what the cost of all of the agents and things are. So you would make that assumption on the basis of the actual piece of equipment.

If you’re looking at, say, something for appliances, which have huge analysers, then you would need to look at a similar size service because there’s no point going and looking at an analyser that can throughput 20,000 samples in 24 hours if you’re only going to test 2,000 because you wouldn’t want to go for that anyway.

` So it totally depends on what you’re actually looking at.

Reference 3 - 5.63% Coverage

R I see. What about the political climate at the moment? And I think what’s related to it is obviously finances. Is it more difficult or easier, like, when you think about, you know, 17 years of your experience of this particular …?

P It’s more difficult, much more difficult and that isn’t going to get any easier.

R Right. And is this something that has already hindered some things?

P Yes. Because if you’re putting a business case in and you are asking for capital, there is a finite pot and everybody across the Trust will be bidding for capital and if yours isn’t considered the highest priority, it won’t be funded.

R Right, so you would have to actually show that this is the highest priority?

P Yes. What happens at the moment is that within business unit, things get scored. So if it’s a capital purchase and it’s expensive, it goes onto a list of things we need and we score them. And if it doesn’t score highly, you know it won’t get considered.

R Right. I see. And how does the scoring system work?

00:15:18

P It’s sort of risk based scoring. So what would be the risk of not implementing this?

Reference 4 - 2.72% Coverage

P I don’t think so, no. I mean I think probably from a clinical perspective, the answers from sexual health would be more useful to you because all I can give you is, sort of, from the laboratory perspective. We’re very happy to be involved in the trial but if it was something that was going to be adopted, we would have to look at how that’s going to work if there’s only one analyser based in the lab.

So it’s more the logistics of how it works in practice rather than any concerns about actually looking at changing our methodology.

Reference 1 - 0.79% Coverage

P I think that all depends on which technologies you're referring to. Are you referring specific to laboratory technologies, or?

Reference 2 - 3.05% Coverage

P I think it's so different, depending on what project you're talking about. It's very hard to answer that. I… So, if we were to take a laboratory, and assay, then staff time in order to evaluate, and validate that assay would be important. But that makes the case of funding, rather than necessarily people. I think probably quite difficult to have new people in a laboratory that's already established to do that. I think that would be a hard one to answer without having a specific project in mind.

Reference 3 - 7.07% Coverage

P I suppose you've got to make it as easy as possible for them, but the change, sort of training is kind of fundamental to that isn't it? Making sure people aren't frustrated by the system, or whatever it is that's being implemented. They don't… It needs to be perceived to be easier and better. So, it's so hard to get people to change from what they're used to and comfortable with, and they can do easily, with something that's hard, and difficult, and takes more time.

So anything that can smooth that process over is going to be better. I mean take change of computer system, or move to electronic patient records. You can see a patient, and document their notes on a piece of paper in 30 seconds. To do the same thing on an IT system could take you five minutes, and therefore there's a frustration, particularly those who are less IT savvy to have to invest that extra time for every patient to do so. Even though that's the right thing moving forward to move to electronic records that can be shared across regions.

00:13:10

While there's clear benefit for that individual in clinic at the time, you can appreciate the frustration of having to change.

Reference 4 - 3.10% Coverage

P I'm going to... So the things that I would like to see are some cost analysis modelling as to the potential savings beyond the cost of the test itself. And I think that is planned to be part of the study. So that will be useful to see. I think the future direction of more multiplex assays would be interesting to know, and see. I think the machine platform, and it's actual function, and how easy it is to use, and stuff, again, like that are unknown to me at the moment. Those things I would want to know.

Reference 1 - 9.87% Coverage

And then it’s the implementation, is getting people outside the department on board with it, especially if it’s seen as a threat to what they do already. And nearly every… if you’re kind of going down a different EPR routes to the trust, it’s seen as a threat to the people who ware instigating generally the [unclear] in the trust. If you’re going with a different test, that’s seen as a threat to people in the lab who are already doing the tests.

So, there’s lots of ways it can be sort of slowed down and blocked if you don’t have the right people onside. So, a really good example would be an HIV point of care test that we use. So, we use a fourth generation Alere test, which is fine, we’ve come to realise that all commercial point of care tests are actually, the way we use them, we could use any one of them really. So, it’s actually far better if we used something like an INSTI, which is cheaper, and you get the result quicker.

Now, for reasons unknown, they’re not here anymore, but there was a laboratory point of care test lead, who… so wasn’t in the department, but had overall responsibility in the trust. They just said, no, the clinicians wanted to go and change this point of care test, but they basically said no, and we were stuck with something that we… was fine, but it was more expensive and actually didn’t add any more benefits to what we could have done with a cheaper point of care test.

00:21:37

So, it’s kind of things like that. And quite often it’s personality driven. Somebody’s had a problem with somebody else previously and they wait until the next thing comes up and are purposely obstructive. It’s… the NHS is like a big school, I think, in some degrees.

Personalities, especially people can bear a grudge sometimes, and… but it’s… yes, it’s interesting, and nearly everything… key relationship… back to the key relationship question, it’s getting people outside the department on your side to advance things, will be the… that’s the key thing where projects fail.

Convincing people within the department is not such a problem, because it either, as a clinical team, clinical management team, you say we are doing this, accept it, move on, and it happens. Or everybody saying we really want to do this, we need to change this.

So, kind of at a clinic small team level, getting changes made aren’t that big of a problem. It’s when you try and involve people in the general management or ecosystem of the trust, where everyone’s got their kind of silo working and their set agendas, and that’s where things get obstructed in my experience.

Reference 1 - 0.61% Coverage

So, I think once we know, as reception staff, the selling points to the patient, we can sort of roll it out to them.

Reference 1 - 7.91% Coverage

P Okay, so, I found out that... so, say if we wanted to introduce a new product. So, it depends, so, if it’s a medicinal product you’re going to talking with pharmacy and the pharmacy research etc and I think the MHRA. So you’d have... so, it would depend on what the product is if the product’s medicinal, pharmacy. If it’s a device there is an innovation team that sit once every two, three months and we have to actually run the product by them and get their permission first actually to see if they want it. So, they’re going to be involved as well.

In addition it would be the procurement because they want to know is there something else out there. Can we get it for a cheaper price say if we had to pay for it. So, the procurement office is involved because we were actually recently trying to look at an alternative to Cryotherapy which is an alternative to liquid nitrogen which was in a can. And we’d seen a product but then they said okay is there another product cheaper than this and that was procurement are involved in that.

00:04:22

And then obviously, you know, to some extent, yes, patients as well getting, you know, patients feedback on the product as well. So, we’ve currently trialled this new product hydroxide it’s not new but it’s basically a can which freezes warts. And we’re looking to see whether we’ll replace that with liquid nitrogen. But obviously cost will be important but also how does it actually work with the patients does it actually treat the warts better than what we have or is it the same.

R And how do you get their feedback? Do you get individual feedback?

P So, essentially there is one nurse who’s running the wart clinic and she’s getting their feedback. So, she’s actually set out a standardised thing because if we’re going to adopt this we’ve got to actually tell our, you know, people who pay the money actually. It might be a bit more expensive but actually the patients like it.

So, we are actually doing a formal process where there is one nurse seeing all the Cryo... the wart patients and assessing actually not only just patient feedback but also does it look like the wart’s getting... You know, how many treatments does she need to do is it four or five and actually previously it might have been a bit more. So, that’s what we’re doing.

Reference 1 - 6.62% Coverage

And some staff would be more than happy to do everything, they’d be like, yes, lets do it, straight away, let’s get the machines here, let’s get it done now.

Others would be more reluctant because they’re more traditional. And yes, we’ve got quite a wide age range of people working here. So sometimes technology is not taken up as easily.

R So would you have to think about certain strategies, how to approach those people and get them on board?

P Yes. I won’t mention names, but there is certain, I know certain people who are very reluctant to change and anything, even if it is in the best interest of patients, may be, have to be put in slowly. But it is always in the patients’ best interest and that’s why we’re here in the long run. Most of our patients would be ecstatic if they could get a result within an hour.

R And who would be responsible for then getting those people on board.

P Probably their line managers, or the project leads. So, there was some of us who are a bit more willing to have a bit more information, a bit more about the technology, and be almost the leads for it, so, or the local champions. And that’s a term they like a lot with things, is champions. And then we will just go and talk through and be the person to answer questions to. Because they may approach us, not as their managers, it would be easier as a champion, than they would a manager.

00:23:12

Because they don’t want to be seen to be making problems with the managers, but they want to ask questions. It’s what’s happening with this consultation at the moment. I’m not actually involved in the consultation, but because I seem to know, and I know a lot of the information because I’ve listened, people come to me to ask me questions. And that’s just because I happened to have listened and taken note of everything. Mainly with how it’s relevant to me, but luckily their questions were the same thing.

Reference 1 - 6.52% Coverage

I don’t know how the quality control will be done, but I know usually, with point-of-care testing, in order to be equal to a lab testing, there’s got to be some quality control in the machines that you’re using. So, I imagine that there will have to be some process in place to do that, which can be time-consuming. You’ve got to make sure people know where to record the information, what to do with the information, to make sure that it’s being done each month.

So that would be a process of setting that up, I would imagine. But I don’t know if this is being used. Is it being used already? No. Okay. So, that’s, it’s quite nice if it’s already being used in the area and you can see what they’re doing, but obviously that’s something that will have to be developed then for introduction. But, then you have the issue of who pays for that. Who pays for quality control. So there are issues with that as well.

But I think part of that is, one, knowing that your machines are working to a certain level that you can reassure your clients that coming in that that test you’re doing with them at that time is the equivalent to one that they’re doing in a lab. Because sometimes when people come in with the online testing, we say, you can have it done online. They’re a bit concerned that that test isn’t going to be as good as the one we send to the lab. So, that might be a barrier to people doing it.

Reference 2 - 1.44% Coverage

P I think it’d have to be somebody that would be, kind of, overall involved in the roll-out of the service, this new service. And then I guess they would then be involved in looking at the audit. I guess data would come from the company providing the… Because they will get information back wouldn’t they on…?

Reference 3 - 1.02% Coverage

P Okay. Right. Well, who’s responsible for it? We’re all going to be responsible for making sure that we’re filling in whatever data we need so that we get accurate records, really. But who collects that, I’m not sure.

Reference 4 - 11.31% Coverage

R But what was there that helped introducing that? Was there anything?

P Well, making sure that we all knew what we were doing, really, I think. Which, yes.

R Communication.

P Yes, definitely. It’s a bit of a stumbling block at times because it’s a little bit knee-jerky at times, so it’s like we’re going to introduce this and then, oh no, we need some, we’d better put something in place that everyone knows what they’re doing. I’m a little bit the other way around. I like to know what I’m doing in advance. So I think if we decided to go ahead with, we’re doing this now aren’t we? Are we doing it?

R Well…

P Potentially.

R Potentially, yes.

00:15:04

P You know, that stuff needs to be there in advance so people know exactly what’s happening. And the people that are going to be responsible for making sure the kits in the right place, with the right stuff, at the right time. You know that sort of thing rather than, we’re doing this on Monday but we haven’t got a machine and we haven’t, which sometimes that sort of thing does happen.

So yes, making sure everything is in place, make sure everyone knows what they’re doing, making sure we know whatever paperwork forward needs to be filled in. Yes, so communication is key.

R Yes, so that should be improved in a way.

P Yes, I think so. Yes.

R Ahead of action.

P Yes, it’s like, with this online testing we’re doing now, I’d say we still haven’t got the compliance sorted out. And we’re already treating people. So it’s kind of catching up when things have already been put in place. So, yes, it needs to be put in place first, I would say. And then sort of also like, this is plan A, but if this happens then we go to this plan B, and so that people know what they’re doing, I think.

00:16:19

There’s nothing worse than when you’re in a clinic and your machine’s making funny, giving you different results, and then no-one said to you, well this is what... I think we could, it needs to be robust.

R Right, so investing in preparation time.

P I would say.

R And involving everyone.

P Definitely.

R Yes.

P Yes. Most people would, are happy to do things that improve patient outcomes, that improve the patients’ journey, that might be cost-saving. It might not be cost-saving but there’s an improvement in another way. If they’ve been informed of what’s happening and involved in the process so that they know what’s expected of them, I think that’s important.

Reference 5 - 3.30% Coverage

My own view is, I think point-of-care testing is, or near patient testing is a really good idea. I think the equipment needs to be robust. I think the result needs to be the equivalent or more of what you would expect, it can’t be a lesser test.

But I think it needs to work, I don’t think it’s, you can’t shoe-horn a point-of-care test into a service where it doesn’t fit. It’s got, you know, it can’t affect the clinic and people waiting and things like that, I think. So that’s why I think you need to think through the steps of how it will be used to ensure that it makes a positive difference. But I think, like I say, anything that provides you with a diagnosis there and then, is a really good thing.

Reference 6 - 4.99% Coverage

P Yes, could do. I mean, there are going to be people who are going to have to, I mean, there will be responsibilities for making sure, just like, if we are using another building that belongs to other people, just the thing of where we’re actually going to store it, where’s it going to be store safely. I mean, these machines aren’t going to be cheap, are they? They’re quite expensive pieces of machinery, so they need to be stored appropriately. So things like that.

00:21:17

Who’s responsible for ordering stock, the kits so we don’t run out, making sure that’s all in date, making sure that the quality control’s done so that the machines effective. Yes, there will be responsibilities that people might have to take on board that they might think, oh Lord, I’m doing enough already, you know, give me more things to do. So I think that all needs to be thought through and I think that’s where communication comes in as well.

That people are aware of, what’s the benefit of doing this. You know, look if the benefit’s worth the extra responsibilities and things.

Reference 7 - 3.38% Coverage

P I think to work, if whoever’s providing the machines and the information, you know, if we can work really closely together and put in place what needs to be done. Obviously the running of the machine, the upkeep of the machine, what to do if the machine… All those things in place, a really sturdy protocol so that when we do run it out, everyone is aware of the situation. There’s nothing worse than trying to run something that’s sort of a bit half-hearted and not quite, and nobody knows quite what happens, if this happens nobody knows what to do. And I think that’s pretty frustrating. Its frustrating for a clinician, it’s frustrating for a patient, as well, and that happens all the time. So yes, that would be my… Yes.

Reference 1 - 3.62% Coverage

PA And think about the ideas that we've had, on the whole, they're reasonably good ideas. They're there to reduce waiting time, reduce stress, so we would adopt that.

RE Right, so it has to show that it [overtalking].

PA Has to show it's advantageous to us and to the patients and not too complicated. Anything complicated people are just not going to… It's going to be too confusing, I think. That's my personal opinion, but it's quite straightforward, it should be absolutely fine.

Reference 1 - 8.09% Coverage

Because we’ll have to run tests side by side and then you’ll have to go and get, you’re aware of all this, you’ve done all this previously. You’ll have to go and pay because you may need possibly two swabs.

00:06:34

The urine wouldn’t be a problem, would it, because that would just be one part so we could then test it on this Point to Care and the same urine can go up to the virology lab for the lab test. But with swabs, you’d have to ask the patients permission but the clinic lead has gone through this already with you?

R Well, that wouldn’t be necessarily with me but with my colleagues who are responsible for the clinical studies so they would know more about that side of things. So there could be a potential, maybe not obstacle but something that has to be done.

P Yes, it’s an exercise that would have to be done. I don’t know how far it would go and it might have to be brought to the hospital board because potentially you’re asking for two swabs from one site. So I have to go through ethics.

Reference 2 - 5.73% Coverage

And then I don’t know what would happen, whether virology would have any input because they would then be having a huge loss. Because there’s a huge volume of work for the virology department if it’s going to go to the quick Point of Care test as opposed to the lab test. I’m not entirely sure how long that actually takes to get the results on that analyser but there could be some issues with that.

And so it involves several people, wouldn’t it? It would involve also the laboratory manager who oversees bacteriology and virology and would have to speak with the Point to Care manager. So there would have to be several conversations but I’m not privy to those. So that all takes time so that’s another obstacle.

Reference 3 - 3.20% Coverage

It might be nice to actually, if somebody could come in and show us the system how it works and first to give us an idea.

R Oh yes, definitely that will happen. So our plan is now to have another workshop where staff would be able to see how the tests are made [?] and familiarise themselves with the process of processing samples and so on and so forth.

P Okay, so workshop and then some training.

Reference 4 - 3.03% Coverage

You see we have EQA samples and more so external quality assessment and there’s the Welsh one as well and there’s an EQA specifically for Point of Care testing as well as, for example for the HIV. There’s a Point to Care test EQA and there’s also for the HIV serology so they’re two different tests. So I’m just wondering are there schemes out there that we would participate in?

Reference 1 - 3.85% Coverage

Usability, obviously, from our practitioners will be a huge issue if there are issues around reliability or if it’s fiddly or too time consuming will have a negative effect. If it’s something that works really well that will go a long way to that. Also patients, what they think about it, if it’s what they want. I think with point of care testing and new ways of working that often is what patients want but they probably don’t realise it at the time because nobody tends to ask them that.

So, I think, probably all the way around, at the end of the day, it will come down to finances but actually we can prove that we can be more efficient, see more patients, bring more income into the Trust as a result of new technologies that will also go a long way towards approval.

Reference 2 - 6.79% Coverage

P No, finances is probably the biggest one at the minute because I should be aware the NHS is in a pretty bad state. Having said that, we’re part of a big Trust which has a huge deficit so every penny that we spend is being looked at. We have to be very clear that we’ve got very demonstrable outcomes for what we’re doing and why we’re doing them.

00:14:13

At the end of the day finances do play a huge part in that and we’re a department that actually makes a fair bit of money if we’re still on tariff with our commissioners. The more patients we see the better for our hospital, and that’s for the patients too, obviously, as well and that would be the way we’d think of it first. The Trust might have a different view, and, I think, if something that’s a big borderline then it might not be as well received as something that we can clearly make it obvious that that is going to be the right thing to do because it will allow us to increase our profits or whatever.

R So it may be sometimes a matter of convincing the Trust?

P Yes, indeed, that would be a big part particularly if there’s any initial financial outlay that’s required by the services. The hoops that we would have to go through are considerable really; we have to go through a lot of red tape to get something agreed particularly if it’s going to cost quite a bit of initial outlay or whatever.

Reference 3 - 2.73% Coverage

P I don’t think so. I do very much enjoy new ways of doing things and if we can get things better for patients then that’s great. This sounds like an opportunity to do just that, so, for me, it would be very welcome. I’m sure with our clinical leads here it would be too, but probably, at the end of the day, it needs to stack up financially. Maybe that’s about us being very clear about who we [unclear], but that’s doable so that’s just protocol and we work that out, that’s okay. In answer to your question I don’t think there was anything else.

Reference 1 - 0.46% Coverage

So this clinic is our most flexible venue, because we have the most rooms. We have now just recruited a consultant substantively to take on the research portfolio. Which you'll be interviewing later, Doctor [name], the great [name]. So that's good that we have somebody in place for that.

Reference 2 - 3.08% Coverage

We got a huge lab, which, you know, we can do more with.

R Yes.

P We have 16 clinical rooms. Each clinical room can do everything. We have two counselling rooms. But… And we have a small waiting room that only seats 42. But we have this queue management system I was talking about earlier, so people don't have to hang around here.

R Yes.

P So yes, we have, we have the… Enough space to do things. To have run, you know, our own little labs. And certainly, we could even have them in clinical rooms, which would be possible. You know, we have a scanner, for example, in room one, which we do ultrasound scanning for medical gyne work. So there are rooms that we could repurpose. We have an observation room with two way mirrors. It looks in… Look into two clinical rooms, which you know, we could also… We do a dark ground for microscopy in there. So yes, there are other places where we could have other bits of kit.

And then we have rooms that are… For example, the results team are round at the back, behind the counselling area. They could in theory be moved to another location, because their work doesn't involve one position. So they could be working out of another location, and we could even put a whole lab in there. You know, a whole lab doing everything, you know.

00:40:48

And so what I'd like to do is, you know, explore, you know, how much of a lab could we bring in there. Because in theory, you know, in the whole back end we could have, you know, we could be doing blood, and you know, other parts, other sample analysis in that room, and not send anything anywhere. You know, we could just have every sample come to us. It certainly is a big enough space. So, you know, we have a lab that we could repurpose bits of it, but we also have another area which we could basically run diagnostics in. And that would be nice. Yes.

Reference 3 - 1.01% Coverage

Does it mean that it's also quite easy to introduce new pathways, and experiment with different pathways?

P Well yes, no, it certainly is. You know, we have five streams at the… Well actually we have six streams for patients. So stream one is very symptomatic patients, they see healthcare assistants. Stream two are for band six and five nurses, and they're for people returning with positive STIs, or partners with infections, or people for vaccinations. But we can easily move that to a, you know, we're going to soon have appointments for partners as I said. And they'll go straight to health advisors.

Reference 1 - 2.56% Coverage

Now would you say that some of those…? There are certain structures that support adopting new technologies that are already in place?

P I… My personal view is there aren’t any real formal structures for it. So I don’t think it’s necessarily something we’re encouraged to go off, absorb and implement. I think you find out about these things through normally clinicians on the frontline who have heard about someone else who’s doing something like this or have gone to a conference and witnessed something that’s happening somewhere else in the world that we could be doing differently, but we’re not.

Reference 2 - 0.73% Coverage

But I think as an organisation we’re very much encouraged to adopt new technologies. That’s what we’re about, but I wouldn’t say there’s a formal environment to do that.

Reference 1 - 2.35% Coverage

P Because I think the answer would be different depending on which location we are talking about. Because the other two clinic sites are much more traditional NHS environments. And, you know, a laboratory is kind of slammed into the corner of a closet, really. Right.

Whereas here, we’ve got this, sort of, a massive nursing station laboratory that is well… It’s a brilliant space for us to add any kind if new equipment to our machinery or anything like that. And it’s considered, like, a hub as well. So, all of the clinic rooms would have easy access to that. So, I think the facilities that we have here are really good for using something. Like if there is something communal that everybody needed access to, we would be able to accommodate that pretty easily.

Reference 1 - 4.06% Coverage

P One of our principles within our service development model and service delivery model is using technologies where possible to further our aspirations around self-management and around reducing process steps and creating simplicity in sexual health services. It does come down to we have got financial obligations to meet, such as making sure we’re… I said we wouldn’t get interrupted; apologies.

R It’s okay.

P I’ve said we’ve got our obligations around breaking even, and there are elements around how technology can streamline services, simplify services, and reduce process steps, which we feel, and people, service users we work with, have suggested as well that reducing steps in any process is desirable. We look to technology and the implementation of new technology to make things simpler and quicker and hopefully increase quality, and that’s one of our guiding principles.

00:06:24

We moved onto our online testing using online triage methods linking to test requests. Help for home sampling was very much linked to our principle of adopting technology to support with the pathway. The difficulty that we do experience with this is that quite often, the immediate response is, you’re taking my job away by doing that.

Reference 2 - 1.77% Coverage

What I would say is overall I think it was easier working, implementing new technologies with some sort of formal restructure, because you can make it happen, whereas trying to convince and bribe and flatter and threaten individual teams, you get yourself caught up in, for one team, the reason for this technology is this, for another team, the reason for this technology is that, and I don’t think that’s necessarily the best way to approach the implementation of technology, especially if you’re trying to achieve a consistent service.

Reference 3 - 0.55% Coverage

R I see. In terms of what supports introducing new technologies, you said that there is a restructuring of the service and making it more unified; that helped?

P Yes.

Reference 4 - 1.50% Coverage

P And this is where again I think there is an underutilisation of technology that brings information together, and this is one of the challenges that I’m finding now, two and a half years into the contract, is about how it feels like sometimes it would be great to have technology that supported the separation of data, that brought the data together so we could look at things more as a whole, but I think it’s improving as systems become more integrated.

Reference 1 - 9.91% Coverage

R You mentioned that you have quite democratic ways of discussing things. Are there any other structures or processes in place that you’d say help introducing new technologies?

P Not necessarily, it’s just a case of taking it... If it was something that we wanted to take to the whole of the service, it could be a case of just trying it in one small area and then be there to present that to everybody and saying, this is what we’ve found here. This is what we’ve done, this is what we understand, this is why we think it would be really a good idea to roll it out across all the services. Or it may be something you just want to keep in one or two particular quadrants depending on what type of patients they have coming through, maybe it’s not the same benefit in one particular area.

00:09:54

R So it seems like you need to have a plan and then focus on where it’s actually needed?

P Yes. All the quadrants have got slightly different clinics and facilities and I’m a senior staff but it’s a case of seeing what it is. Like it could be something that’s going to be useful to everybody or it could be something that’s only going to be useful to one particular service.

R Would you say that clinics welcome new technologies?

P Well, we certainly do. I’m not sure on everybody, but we’re certainly doing. We had Sandwell who were recently looking at a new piece of lab equipment which they came to show us here, which wouldn’t have been of benefit to us here now in our clinic. But we were able to redirect them to one of the other services who were struggling with I think facilities, and the new piece of equipment would certainly help them with their lack of facilities.

So while it wasn’t necessarily suitable for us, it was certainly another area and they’ve already purchased that piece of equipment. So while it might not be suitable for us, it was suitable for somebody else for definite.

R So that turned out okay in the end?

P Yes.

Reference 1 - 2.06% Coverage

can you think about any structures that already exist within the service that you know that they will support that process of adoption?

P No. And I think within our service, I think we’ve got quite a small and well-knit team with good communication. And so the structure is there that if we say we think this test is good and it works in these pathways, the staff... if the way we've structured it is sensible and people can see the logic of it, then the staff will buy into it quite quickly.

Reference 2 - 1.51% Coverage

R And you said that you have done changes to the actual physical spice of the clinic as well. So that is now prepared a bit more for the...

P Yes, it's increased the capacity, so yes.

R So there's more room for trying new pathways maybe.

P Yes. I mean, essentially, we've doubled the number of clinical rooms we have just by changing the way we're working.

Reference 3 - 1.96% Coverage

R So then to improve those structures, I guess you would need more space and possibly more staff.

P And more staff, yes, which is also more money. And the space is always more difficult because every NHS trust is struggling with space and pressures on space, and you're stuck with where you are. For example, to make our lab bigger, you'd have to relocate the... our lab is surrounded by toilets and things that you'd be having to look at moving the whole service too.

Reference 1 - 4.27% Coverage

For the data collection part of it, I don’t know. I think that will be sort of an… Yes. I’m not sure we have anything in place specifically for this. But, yes, I mean, in terms of our sort of management meetings, we have everybody on board who will be able to support. So we do have our business manager who has been through, and we’ve been through, part of the PrEP trials, because she’s very good at sort of taking on all the admin role and sort of stuff that needs to happen for that.

And our team sort of used to now, because we are part of another major national trial, in terms of how to actually select patients, particularly talk to them about trials and things. And they have all… Those that are involved in the trial have all gone through the good clinical practise as well. So that, I guess, gives us some sort of knowledge about entering a trial.

00:12:08

In terms of adopting a test, we’ve been… I guess we’ve been through it with the whole bucket thing anyway, although that was pretty much everybody that had to do it. Yes, I guess, it would be sort of similar again. I don’t know if we have anything specific that is in place to do it.

Reference 1 - 7.66% Coverage

P Yes, definitely. So, we have a point of care policy, so that’s on our internet here, in the trust. And it actually tells you what you need to do if you wanted the equipment. So, there’s a form to fill out and within the form, it’s asking you various questions; So, it’s asking you, who do you expect to use it? How are you going to get your funding for it? How many tests are you running? You know, so it’s asking you various questions, and then this form is handed to us. And we look at in the point of care meeting to decide whether or not we think it’s something that we can say okay to, or if it’s something we have to put on hold.

R And what about the facilities or the structure of the clinic? Space…

P I mean, most point of care equipment are quite small. But, we would look at that as well. We’ll look at the fact that, so, some analysers have to be on a stable worktop, they must have sufficient air around them. So, we look at things like that as well. But a lot of the equipment is so small that they can fit in anywhere.

Reference 1 - 2.31% Coverage

P I think it can work. Space is always an issue in most places. And I think at the moment, in sexual health, we probably, because of awareness, so most clinics are much busier probably than they were initially planned for. So we are probably ending up seeing more people in a limited space. So space is a big issue. But that does not mean it cannot work because, sometimes, introducing something new helps with the flow. So, hopefully, it might work, but space is always an issue, I find.

Reference 2 - 0.63% Coverage

R So is there an issue with space in terms of waiting areas or lab areas?

P It could be probably lab areas and waiting areas. Yes.

Reference 3 - 1.02% Coverage

P Yes, having a larger clinic will be nice because then you would have more space to work with, because the demand is there. So having more space would be ideal. But in the little ward, things don't work that way.

Reference 1 - 4.53% Coverage

So I'm thinking about facilities in the clinic, the structure, contracts that are in place, finances.

00:07:14

P That one I'm not really sure about, because those things I don't really get involved too much with, so I'm not sure I could answer your question.

R Right. Or maybe it would be easier if we, for example, if we're thinking about the recent process of adopting a new way of delivering the results, right.

P Yes.

R So was the clinic like… Were there any facilities that were needed for that to happen? Was something in…?

P Oh, okay. So I know we had to get new equipment in, which just took time, which then had to be installed.

Reference 1 - 5.41% Coverage

P There is the systems within the trust and the various or boards that you need to take things through. And if you can demonstrate there’s going to be a cost saving, the trust are more than happy to entertain new ideas. I think the other thing is, if we’re going to make a substantial change, we need to think about where it would fit in with our service specification.

00:13:38

P And if there were something that would impact on the delivery of the service, then it would be the sort of thing that needed to be discussed with commissioners. But if it meant a saving… I don’t know, it depends on what we wanted to do. I’m thinking about, we participated in a service… Well, a piece of research that had implications in the long-term for service delivery. And we needed to have approval from the commissioners. They were fine about it, very interested in what we do and taking part in. But it needed to have their input and their agreement that we could do it. Because at the end of the research there’s the potential that they would then be in a position to consider a business case for us being able to deliver that new technology.

Reference 2 - 2.36% Coverage

R There are certain structures, but I kind of have a feeling that while this is all happening and all the changes have happened throughout the past ten years, they create barriers. At the moment there are some interpersonal relationships within your service that kind of make it easier?

P Yes, I think so, absolutely. That’s a very good summary. And I think for us here, the relationship with public health, with the commissioners, is a very positive, respectful, mutually-understanding one.

Reference 3 - 2.52% Coverage

And I think the relationships within the team are useful and create a beneficial working environment. I know things constantly change but I think there’s… I think if you start with the mindset it’s changing, it’s all terrible, then you probably will find yourself becoming very miserable, very quickly. But if you can say, things will change, how can we respond in a useful way to these changes? How can we be creative with what we’ve been given? How can we make the most of what we’ve got? That, I think is a helpful mindset.

Reference 1 - 5.32% Coverage

Is there anything else that sometimes can be in the way?

P I don’t think so, because, as a population on the island, we are quite used to things being trialled here, whether or not that’s water meters, the community screening. Things happen, and they say, well we need a set population. Let’s do it there. Because our population is 160,000. So it’s quite a decent population to be having. We’ve got some elderly to very young. And from rich to the very poor. So it’s a good population to be with. And I think it’s just getting that information out.

I did notice on the info that you sent out with your email, and it was saying that you helped to basically advertise the service. So, and the way I read that is, this is what we’ve got going on, and how about giving it a go type of thing. Which I think is fantastic, because although we obviously advertise the service, to have someone aboard from the mainland, and you know what you’re doing, you know how to advertise, and you are going to be trying to get out there to those places and get people to use this. Because it’s pointless doing this if only two people are going to turn up and do it.

But to know that actually it will be used and the right people, which I fear any people, but people are going to be wanting to use it, can engage in using it, keen to get on with it. Yes, I do see the island as a fantastic opportunity to do that. We do have a mobile community in so much as being a holiday place. People come over, we have a rise in STIs, we see peaks and troughs. It’s just an interesting place to be doing it. Though I don’t really see it as being a negative outside. Let’s just get the information out there, tell people what we got.

Reference 2 - 3.73% Coverage

P What people see is… And by that I mean the companies like the Water Board Company. When they brought on water meters, many years ago, it was the trial for the testing. When they did the community screening program, although they used Portsmouth and [unclear] it then came down to the island. People just see it as a good place to be doing things for that. Because there’s a decent number of the population, and depending on how you want to test, and the age range that you want to be going through on that testing machine, we have a really good population for that.

I can’t tell you percentage wise what we have. I don’t know if you want to know that. I didn’t think to ask about the percentage of the island population we actually have in our clinic. I’m surprised that we’ve got so many people that are doing it. This afternoon we are going out to a different clinic elsewhere because we just say that we’re going to do a clinic here. We’re going to go into mental health and we’re going to do a clinic there. And we pick up a suitcase, fill it with whatever we need. And we sit in a mental health hospital, and these people come and test. Because if we don’t do that, they can’t come to us.

Reference 3 - 1.13% Coverage

Is there something within the service that is encouraging getting new things?

P I imagine… I can’t remember what the groups are called, but we’ve got something under CCG now which is to do with people contacting their GPs and then they… It’s almost like a buddying up system, and that’s for weight loss and things like that. But I’m not sure about other things.

Reference 1 - 2.63% Coverage

We don’t have electronic patient records and we don’t have the systems in place to be able to facilitate that, so I think we’re quite a long way off from actually introducing that. And I would suggest that if we already had that in place and we were getting results a lot quicker then maybe we wouldn’t be looking at something like point of care testing, if I’m honest. But actually because of the situation that we find ourselves in with those results, I think that would really help the quality of care that we could give to the patient and the patient experience.

Reference 2 - 2.95% Coverage

P Lack of IT system and delays in actually getting results is one of our… Well, is the original sort of emphasis for us to actually consider this. I mean, we had seen the equipment a couple of years ago, I think one of the gentlemen from Atlas came down and showed it to our local lab and it just seemed at that time quite a really good idea for us to be able to adopt because of the lack of IT and the slow response we get from the results. So when this project came along it was like, great so maybe we can move that on now, because before we weren’t able to do so. I don’t think it was at a point where we could have introduced it.

Reference 1 - 2.58% Coverage

However, facilities, it depends how big the piece of equipment is because if we’ve got to make adjustments to the environment, that cost has to be factored in, and if it’s going to be disruptive, how we’re going to continue to provide a service has to be factored in.

If we’re signed up to a contract with an existing supplier at present and we’re tied in for a fixed number of years, then we wouldn’t look to move that because to get out of a contract it’s usually quite expensive. So that would play a part.

Reference 2 - 3.49% Coverage

P Well, we don’t have any point of care testing in microbiology. So it’s not something that I have had much involvement in. There is a Trust point of care committee being pulled together and they will look at what point of care is being used. And they will make, you know, they will make assessment on what is the most appropriate point of care where we should be looking at putting point of care.

So there are some areas in the organisation where it makes a lot of sense to have point of care if they turn patients round very quickly. And there are other areas where, actually, it would be nice to have point of care but there’s no real, significant justification for why it should be in.

Reference 1 - 0.32% Coverage

And then obviously we need to work with our microbiology lab colleagues to make sure they’ve got capacity there.

Reference 2 - 4.59% Coverage

P Yes, so I mean we’re, I guess all clinics, you know you’re sort of stuck with your clinic building and we’re in a very old hospital. We’re supposed to be imminently moving into a new location but that’s on hold, basically, for the next couple of years. So it’s difficult to know what the new, when we move into the new clinic what the situation will be like. We’ll certainly have fewer clinic room. We do have a lab within our clinic which gives us the dedicated space.

But I guess if new technology was to require large machines, for example, that would be a problem, if we couldn’t fit into our own clinic. So if, for example, for a 30-minute point-of-care test we’d want, it would make sense to have that machine within our local clinic lab. So within the the be have BMSes who do microscopy for us and who make sure the samples are properly, appropriately labelled before they go up to the main lab. So it would make sense to have, we currently operate our HIV point-of-care test in that lab, and the HIV point-of-care test we currently use, have a 20-minute turn-around time.

So we’d want to have that within our local lab. So we’d need to ensure that the machine was, could fit in there. I guess it’s also about lab training, so we have a number of regular lab staff who work for us. But we also have some staff who were sent up to the main lab to have differing degrees of skill mix, basically. So we’d need to ensure that lab staff were properly trained.

And new technology adds an additional, they all have to train on the HIV point-of-care test, but I guess that adds another test they’d need to train on.

Reference 1 - 4.14% Coverage

And then that’s looking into what recall’s going to be for that. So, if we’ve taken the test, what’s our responsibility towards the patient as well.

But then there’re also going to be questions about the efficacy of the testing, but I know if it gets the CE-mark, then it’s been tested, and, yes.

R So what to do with the patient waiting for half and hour.

P Because we’ve only, we’ve got one small waiting room. We’ve got the big waiting room then we’ve got the little one, so we’d probably put people to recover if we’ve done coil fittings or… And that’s when they wait when they’re waiting for microscopy at the moment. Because we already do some, I think microscopy is a point-of-care test, so we do that, but that’s a five-minute thing, and normally we don’t have that many, because it’s not every patient who’s eligible for that, or needs that.

00:21:21

So we don’t get that much of a build up. I think the most I’ve seen waiting was three. Whereas if, with this if every patient was eligible, then we’d have to think how we’d manage that. We’d also have to think about who would be eligible. And whether we’d have to prioritise, particularly at first while we’re getting used to it.

Reference 1 - 4.34% Coverage

P Yes, could do. I mean, there are going to be people who are going to have to, I mean, there will be responsibilities for making sure, just like, if we are using another building that belongs to other people, just the thing of where we’re actually going to store it, where’s it going to be store safely. I mean, these machines aren’t going to be cheap, are they? They’re quite expensive pieces of machinery, so they need to be stored appropriately. So things like that.

00:21:17

Who’s responsible for ordering stock, the kits so we don’t run out, making sure that’s all in date, making sure that the quality control’s done so that the machines effective. Yes, there will be responsibilities that people might have to take on board that they might think, oh Lord, I’m doing enough already, you know, give me more things to do. So I think that all needs to be thought through and I think that’s where communication comes in as well.

Lab’s capacity and contracts

Reference 1 - 1.32% Coverage

So there's no reason why we can't, you know, have a lot of those kits that previously existed only in the lab in our service. And you know, that is threatening to the lab, who, you know, are a multimillion Pound business that rely heavily on the fact that everyone's tied in. And as soon as we start doing something else, then clearly that's a threat to, you know, their central role in the trust.

And you know, we're a very high volume service, so we send about a quarter of a million samples a year to, you know, to our lab. And we have consistently been disappointed about the turnaround times. So one of the big issues for us is around, you know, adopting things. We need to think about the patient journey. And the patient journey is clearly supported by having more immediate results.

Reference 2 - 0.90% Coverage

Well obviously it depends on what it is. But if you think about diagnostics, so three in one, we had non… We were delivering non-inferior care, and using less samples. So, we saved, you know, two lots of tests that we'd send to the lab for those. And initially, you know, the lab weren't happy because we sent them less samples. You know, after spending years value dating, you know the rectal and pharyngeal, or getting their approval. We then were sending them less. But that's just how it is, you know, we're sending them less, you know.

Reference 3 - 0.09% Coverage

We got a huge lab, which, you know, we can do more with.

Reference 4 - 0.28% Coverage

So, you know, we have a lab that we could repurpose bits of it, but we also have another area which we could basically run diagnostics in. And that would be nice. Yes.

Reference 5 - 1.15% Coverage

We can manage that. But that was, that'd be… The issue is making sure that it all fits, you know, and how do we, you know, how do we track the samples, and you know, you know, just the logistics of it. You know, we'll just be sending less samples to the lab. Maybe initially we wouldn't as we're testing it. But you know, eventually we'd be sending less samples to the lab. And certainly if we manage to double the number of partners we see. So if we did get, say 700 or 900 partners in a month through the system, then we're currently sending, was it 1400? We're sending about 5000 a month to them. So if we got more partners in, we'd… You know, they'd see a fifth and a drop of the line.

Reference 1 - 1.09% Coverage

Yes. But also, the thing is that you can be creative about saying the lab has oversight of those testing. They are in charge of the ordering and everything. So basically, they could get the thing and charge us purchase. So basically then, they can get something that is doable, get a business plan. So it's basically seeing that we get a business plan that is feasible for both us and them. And you have support from the higher up, from the organization, which basically means that you have the power to basically tell the lab, if you don’t do this, the organization supports us in doing this and you're going to get that.

Reference 1 - 3.02% Coverage

Which is for doing chlamydia, gonorrhoea, testing for everybody, is something that we have talked about. And we’re still kind of slowly edging our way forward with an idea about that.

But there are politics involved. You know, the laboratory. And the fact that they would not be getting the money, the business, from us. But yes, we need their support in overseeing any kind of equipment that we install here. That kind of thing.

R Yes, this is tricky, right. Because you need involvement from them during service evaluation of a new technology.

P Yes.

R But then, eventually, they may lose.

P So, we are trying to save money. I.E. we are trying to give them less business. But we need their help at the same time. And that’s such a tricky rope. Tightrope to walk.

R And, potentially, this could be a barrier as well. Sometimes, you just can’t. Because there is a contract that you have with them.

00:18:48

P Yes, If the lab says no, the lab says no. What do we do about that?

Reference 1 - 3.60% Coverage

R And you mentioned that you work closely with lab obviously to provide results to people and you mentioned that the capacity of lab that you’re quite happy with it. Are the contracts that you have with the lab, are they important? Is this something that has to be considered when implementing new technologies?

P Do you mean the existing contract with the lab?

R Sorry?

P You're talking about the existing contract in the lab?

R Yes.

P Yes, I think so. I'm not sure about the contract really, what does it include and whether they have agreed for certain number of tests and things like that, I'm not sure about. But if we are going to reduce the number of tests and things, probably that will be an issue.

Reference 1 - 2.43% Coverage

So for a lab test, actually talking to the consultants in the lab and the people who do test because you need to know if they've got the results to evaluate it, the inclination to do it. Talk to the people on the shop floor in the service here. So if we bought in, what's the label, what's the change in work pattern, and can they see any advantages? So starting with the senior team, so the senior nurse or the consultants.

And if they can see some value in it, then actually talking to whole service about what it might be before them developing the process for implementing it.

Reference 2 - 6.63% Coverage

P Yes, they do. I mean, it would also depend with this particular test that we're talking about. Because the volume that one can run on the current setup is so low that it actually won't make a significant impact. If one was looking at a higher volume thing, then yes, the impact on the lab would become very important. So, again, introducing HIV point-of-care test, we're only doing in a small sub-group of patients. So that again hasn't impacted on the lab.

If you were to adopt point-of-care test for everybody, it would have a very big impact on the workload of the lab and their finance stream. So yes, that would actually become very important.

R And a potential barrier to other options?

P Yes, because it could... if they were to lose a significant part of their income because of a change in... they were getting fewer tests, and so getting less remuneration. Potentially, they've been looking at having to staff... so a test that takes significant workload away and, therefore, money away from the lab could have big changes.

And the other thing for example, if it was a high-volume, low-cost test that was going to the lab, that suddenly stopped going to the lab, but they were renting the machine or using the machine to do high-cost tests, low-volume costs based on the savings made from the high-volume, low-cost test, then actually that could impact on their costing of those low-volume tests across the rest of the trust, so yes.

00:14:03

I mean, with this test, one is not looking at that kind of change in pattern because it hasn't got the throughput the moment.

Reference 1 - 5.59% Coverage

P If it’s a test I guess our lab would have to be on board with this anyway, just to make sure that this is a test that, you know, has been verified and validated, to make sure that they would be happy for us to bring on. It’d obviously have to go through the Trust anyway if it’s, yes, something new that we’re bringing in. And, as I said, in terms of our senior management meeting, just to make sure that everybody’s on board with this, and then our commissioners as well. All of those things would be important.

00:17:09

I don’t think they’d be necessarily a barrier to it, but, yes, just to making sure… Well, I think the may be, because they’d have more… If it’s a lab test, then I think they may definitely… we’d definitely want to talk to them to make sure that they would, they’d known about it and things as well.

R Yes. So if the lab is not happy with a new test and that kind of stops the adoption…

P I think you’d be… I think we’d be quite worried then if they’d said actually, you know, we have concerns about this. I think we would be quite concerned then.

R Would you be able to adopt anyway or absolutely not? So is it more…?

P It just depends on what their concerns were. I think that would a thing, and exactly what was specifically an issue with it. Yes. And in terms of results, what kind of staff and sensitivity and specificity for the test really. I think that would be key to it. Yes.

R The quality of the product.

P Yes, I think so. It just depends exactly what was wrong.

R Yes.

Reference 1 - 4.01% Coverage

Amongst the questions that they fill out on the form, one of the questions we ask is, is that a service that the lab is providing already? Is there an issue with that? So, whether it’s that they can’t get their results in a reasonable time, and before we actually even go through the point of care equipment, we ask, is there something that we can improve to get those results to you at a quicker time? So, whether it’s marking your sample as urgent, and you send this to the lab, and so w know that we need to turn this around in an hour.

Reference 1 - 0.63% Coverage

R So is there an issue with space in terms of waiting areas or lab areas?

P It could be probably lab areas and waiting areas. Yes.

Reference 1 - 5.53% Coverage

P Having discussed the project with our head of the lab, I don’t see that there are any barriers there, they are quite keen. Because of their constraints… If this was something that could be adopted then they would support it. So inasmuch that there’s an awful lot of work going on in the lab locally, there is talk of amalgamating labs, there’s sort of… At the moment it’s sort of I suppose, an interesting time inasmuch that I don’t think that they quite know what the future holds for them. So they are very supportive of any ways that we can alleviate some of their workload because they are extremely busy. And I suppose the only thing future wise that could potentially be an issue is…

We were talking about it yesterday actually, is that LabLink would… One of the difficulties that we have here is the time it takes for us to get results. Because it goes to our local lab then goes to [location], and [location] I think serve quite a large area and have issues themselves, that we find that some of those results are actually delayed quite significantly beyond what we would desire as a quality service. One of the things I think is being looked into is LabLink which could speed up that process.

Reference 1 - 2.58% Coverage

However, facilities, it depends how big the piece of equipment is because if we’ve got to make adjustments to the environment, that cost has to be factored in, and if it’s going to be disruptive, how we’re going to continue to provide a service has to be factored in.

If we’re signed up to a contract with an existing supplier at present and we’re tied in for a fixed number of years, then we wouldn’t look to move that because to get out of a contract it’s usually quite expensive. So that would play a part.

Reference 1 - 0.47% Coverage

I think our lab is cooperative and helpful when it comes to changes that happen, but it’s all down to money at the end of the day. That’s what it feels like anyway.

Reference 1 - 4.82% Coverage

R And so how would you describe your experience with service evaluation?

P It’s quite difficult within the bacteriology lab because at the moment, we’re quite short-staffed so it can take longer than you think really to implement new technologies. And quite often, we’re ill-prepared but I can only speak from the bacteriology side as opposed to within Point to Care. I think you’re better talking to someone within the Point to Care lab for implementing new technologies. Because we would be the service user so we would be performing the tests but we wouldn’t actually carry out the verification, etc.

Reference 2 - 13.06% Coverage

R And implementing a Point of Care test for Chlamydia and Gonorrhoea, will it impact the lab that you work in?

P It’s just another test, isn’t it, really. So I suppose once all the work has been done then we go ahead. We have two part-time members of staff who are quite longstanding in data and train staff from the bacteriology department. So I wouldn’t see that there would be a problem because we’re already using similar equipment and that because they’re there routinely throughout the week, they’re well versed with the training and performing the IQA, IQC and EQA. So I would think that would run very smoothly.

00:15:25

R And then what about the contracts existing between the clinic and the lab?

P I don’t really have an opinion on that because I don’t think whether for particular hours while the clinic is running, until we start to use it, I couldn’t give you any idea on how many samples we’ll putting through the machine. Because I suppose that would have to be a piece of work that the consultant does. Which you foresee that we’re testing every single swab and urine that comes in or they’re going to select out particular patients that they want that quick test, and then the other samples we may continue to use in that test.

So there could be an impact, could be that would you need one machine, two machines, I don’t know. But I usually have two people in the lab per day sometimes and then afternoon that can go to one person because I also have the outreach clinics to attend as well. So I don’t know what the impact would be. I don’t know whether we’ll be testing one sample a day [inaudible], I have no idea.