

Genitourinary Medicine 48-hour Access:

Getting to target and staying there

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INTRODUCTION

This good practice guide provides primary care trusts (PCTs) with a number of key recommendations to help support clinics to reach the Genitourinary Medicine (GUM) 48-hour access target by March 2008, reduce the gap between offered and seen and maintain that level of access.

These measures build on the *10 High Impact Changes for Genitourinary Medicine 48-hour Access (HIC)*¹ published by the Department of Health (DH) in December 2006. It should be used in conjunction with the HIC where PCT commissioners and their providers have considered and implemented, as appropriate, changes but are still looking to improve services.

In reviewing 48-hour access action plans, consideration should be given to:

- the improved use of resources to enable clinics to be run in the evenings, early mornings and at weekends
- ensuring choice of access by offering a choice of both walk-in and appointment

- promoting 'informed choice' to balance the public health risks of delayed attendance with patient choice, by encouraging patients to attend at the appropriate time for their particular concern
- making use of outreach facilities to reduce the travelling time or barriers to attending which are experienced in specific communities
- the appropriate delivery of a service across a sexual health network, bearing in mind the importance of ensuring that the needs of all sectors of the community are met.

In addition, to sustain comprehensive delivery of Levels 1, 2 and 3 (L1,2,3) in the most efficient manner for the level of complexity within your GUM clinic, run through *The national strategy for sexual health and HIV*² and the *MedFASH Recommended standards for sexual health services*³ which outline how NHS-funded sexual health services can be comprehensively delivered through L1,2,3 models of care and define what services should be expected to provide regardless of setting.

PROGRESS

The Operating Frameworks for the NHS in England identified 48-hour access to GUM clinics as a priority in 2006/07 and 2007/08. The target is that 100% of patients attending

Resources and further guidance

- 1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074104
- 2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006374
- 3 http://www.medfash.org.uk/publications/documents/Recommended_standards_for_sexual_health_services.pdf

GUM services are offered an appointment to be seen within 48 hours of contacting a service by March 2008. Strategic health authorities (SHAs) were also asked to plan for 95% of patients to be seen within 48 hours by March 2008.

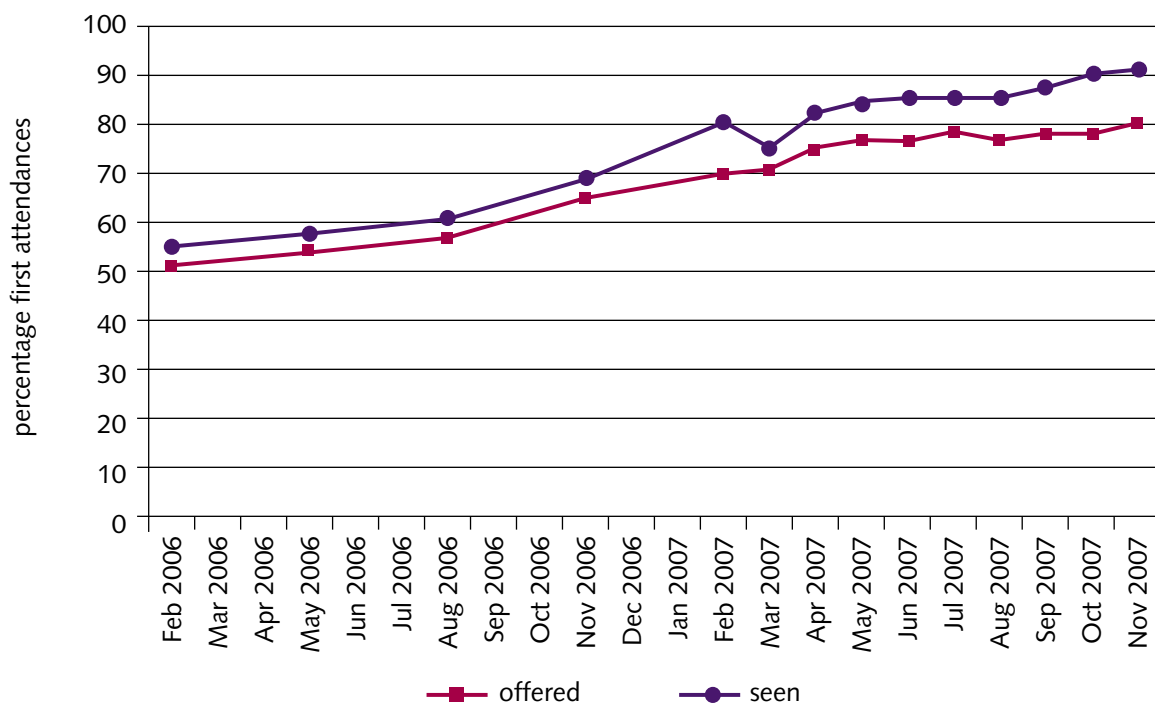
The latest national data from the GUM access monthly monitoring (GUMAMM) data for November 2007 shows that 92% of patients were offered an appointment to be seen within 48 hours and that 80% were seen within 48 hours. The gap between percentage offered and percentage seen is therefore 12%

across England. Great progress has been made towards achieving the GUM 48-hour access target and ensuring that patients are seen quickly within services.

EXTRA SUPPORT FROM THE NATIONAL SUPPORT TEAM

The National Support Team (NST) continues to facilitate visioning and strategic planning events in support of areas reviewing existing or developing new sexual health strategies and monitor progress against target both on offered and seen, and will continue to provide support as required beyond March 2008.

Figure 1: National performance against GUM 48-hour Access Target – February 2006 to November 2007



HIGH IMPACT CHANGE 1

Measure demand and capacity across the local health economy⁴

SEXUAL HEALTH NEEDS ASSESSMENT

Further recommendations:

- Doing a comprehensive Sexual Health Needs Assessment (SHNA) will enable commissioners to identify services

appropriate to local population needs and to reduce health inequalities. For help in developing a SHNA to specifically assist in planning, commissioning and delivery, please refer to the DH-sponsored *Sexual Health Needs Assessments (SHNA) – A 'How To Guide'* by Design Options.⁵

- Where possible, avoid commitment to long-term contractual arrangements with providers prior to the completion of a SHNA, as this will allow for flexibility while emergent need is assessed.

RACHEL PAYLING – WAKEFIELD PCT

"We have had an excellent experience in relation to our SHNA for Wakefield. The independent organisation, Design Options, who authored the *Sexual Health Needs Assessments (SHNA) – A 'How To Guide'* helped us to improve our understanding of the successes and barriers to providing appropriate sexual health services.

The report (still in draft format) is the first full SHNA to be carried out in Wakefield. It has provided us with some very useful data especially in relation to some of our vulnerable groups. The findings have

allowed us to target some 'hot-spot' areas and develop campaigns in relation to gonorrhoea and other local needs.

Having undertaken this SHNA has provided us with the appropriate evidence to direct funding to areas of specific need. It will assist us in the process of modernising our sexual health services and ensure we are increasing accessibility to vulnerable groups in and around Wakefield PCT."

Rachel Payling
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Resources and further guidance

4 *10 High Impact Changes for Genitourinary Medicine 48-hour Access*, Pages 6 to 11

5 <http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/index.htm>

THIS WILL HELP:

Achieve the GUM 48-hour access target	Narrow the gap between offered and seen	Sustain the GUM 48-hour access target ✓
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Provider is responsible	Primary care trust and provider are jointly responsible ✓
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VISION AND STRATEGIC PLANNING**Further recommendations:**

- Review existing strategic plans, ensuring they are driven by the needs of patients (and potential patients) and informed by the experiences of all stakeholders.
- Pay particular attention to the overlap between strategic planning for both adults and children/youth (e.g. teenage pregnancy).
- Ensure commissioning reflects the robust evidence from local SHNAs and matches the demand of local populations so that service provision and service improvement have the capacity to meet identified needs.

SUKHI MAHIL – DERBY CITY PCT AND DERBYSHIRE COUNTY PCT

“The NST visits in Derby and Chesterfield were the catalysts to improve the structures required to deliver the sexual health agenda. A Sexual Health Commissioning Board (SHCB) now has responsibility for overseeing the agenda whilst maintaining a strategic focus. Supporting the strategic direction and priority areas are time-limited ‘task and finish groups’ established to actually deliver on actions.

Derby City PCT acts as the ‘lead commissioner’ on behalf of the City and County PCTs, with input and direction from Public Health. The strengthening of the commissioning function has improved strategic planning and service delivery considerably as the work programme now focuses on the commissioning cycle and uses the process to ensure continuous review, design and implementation. As commissioning covers all aspects, e.g. primary care, secondary care and voluntary sector organisations, this has facilitated and

therefore supports a holistic model and vision for Derbyshire.

The PCT reorganisations, supported by the new commissioning structure for sexual health, gave the opportunity to create a clear vision to ‘deliver high quality, holistic and integrated sexual health services across Derbyshire, working in partnership with all key stakeholders’. Agreement and sign up to this vision has been facilitated through two stakeholder events; the first was to agree the vision and the second was to progress understanding of local needs. The stakeholder forums have improved engagement with stakeholders and ensure everyone is working towards a common goal. The next steps will be to complete the SHNA to ensure priority areas are evidence based and develop the strategy, which will need all stakeholders to be involved and engaged for successful implementation.”

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THIS WILL HELP:

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DEMAND AND CAPACITY (AND HIC 8⁶)

Further recommendations:

- Accurate assessment and review of demand to ensure adequate clinic capacity is fundamental to meeting and sustaining the 48-hour access target. The Department of Health is developing a Demand and Capacity Toolkit to help GUM services measure demand for appointments and match this demand to clinic capacity. This toolkit will provide support for clinic managers, service developers, receptionists, clinical staff and commissioners who need a practical guide to correctly measure demand and identify gaps in capacity at services. This toolkit is based on a pilot project carried out in North Central London in 2007, covering five GUM clinics. The

project helped identify fluctuations in demand across the working week and over a six-week period, including shortfall in capacity and overlap in demand across services. The toolkit is due to be published in March 2008. It incorporates a Capacity Model which is currently being piloted in some areas. In the meantime, to increase capacity for new patients, consider reducing follow-up attendances in favour of more new attendances (British Association for Sexual Health and HIV (BASHH) guideline ratio for new to follow-ups being 1:0.7) and scale down follow-up appointments when senior medical staff are on leave or have other commitments to ensure that first attendances are not compromised.

BECKY MAHLUNGE – HASTINGS AND ROTHER PCT

“In Hastings and Rother PCT area it was clear that the demand for services outweighed the capacity to deliver services.

The GUM clinic team was composed of part-time staff both in terms of administration and clinicians, including the GUM consultant. In addition the skill mix was inappropriate

for the level of demand for service, with only one Band 6 GUM nurse and the rest Band 5. This meant all symptomatic patients and complex cases were given an appointment with either the Band 6 nurse or the consultant. The Band 6 nurse worked 24-hours/week and 0.5wte of the GUM consultant's time was to cover another GUM clinic in a neighbouring PCT. In addition, there was no cover for sickness and annual

Resources and further guidance

6 *10 High Impact Changes for Genitourinary Medicine 48-hour Access*, pages 40 to 44

leave, which meant services were significantly reduced during peak holiday time.

On examining performance which was at 8% in June 2006, the team agreed to explore doing things differently. Firstly, we secured investment from the PCT which meant skilling up the Band 5 nurses who were then able to work with symptomatic as well as asymptomatic patients. Secondly, the neighbouring PCT secured funding for their own GUM consultant, releasing time to facilitate a full-time consultant for the H & R services. Thirdly, the team agreed to a minimum staffing level throughout the year to avoid seasonal trends in service delivery. The minimum level of staff were three clinicians at every session. Fourthly, we worked on fully integrating all areas of service and multi-skilling nurses, thus maximising use of available skill and resource base. In addition, we opted for nurse-trained Health Advisers (full time) who undertook GUM work on an agreed

sessional basis. We moved the emergency appointments and booked appointments throughout the clinic sessions. The GUM clinic sessions were increased from 2.5 hour to 4 hour sessions and all clinicians were required to remain in clinic for the entire duration to accommodate walk-in clients, and any emergency requests for appointment.

The above was achieved through teamwork, ownership of the problem and willingness to address it. The service increased their performance from 8% of people being offered an appointment within 48 hours in June 2006 to 86% in June 2007. Today the service offers appointments within 24 hours of contacting the service and we have retained the skill mix and the minimum staffing level structure."

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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
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Provider is responsible	Primary care trust and provider are jointly responsible ✓
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HIGH IMPACT CHANGE 2

Begin a process improvement project to inform service redesign⁷

PATHOLOGY SERVICES

Further recommendations relating specifically to the provision of pathology services:

- Services need to understand the cost base for pathology Service Level Agreements (SLAs) and whether this is value for money.
- Ensure that SLAs have flexibility built into them to cover the transportation of samples or include additional clinics (evening, early morning and weekends).
- Consider revising contracts with the pathology services and invest in a fridge/incubator for overnight storage.
- Ensure the contract includes Friday night pick up and delivery and depending on the number of samples stored each day include an allowance for alternate day collection.
- In addition to the above, work with local laboratory teams to introduce advanced screening and diagnostic technology, such as combined gonorrhoea and chlamydia Nucleic Acid Amplification Tests (NAATs), which can reduce the need for clinical examination in those without symptoms.

THIS WILL HELP:

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Resources and further guidance

⁷ 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 12 to 14

HIGH IMPACT CHANGE 3

Analyse and improve utilisation of the multidisciplinary teams in GUM⁸

MULTIDISCIPLINARY TEAMS (AND HIC 8⁹)

Further recommendations:

- Multidisciplinary teamwork or collaboration is designed to guide thinking and practice within sexual health services. Multidisciplinary approaches to healthcare are dependent on a high level of co-operation between members of different professions within multidisciplinary teams (MDTs). Inherent in the concept of such a team is the assumption that each team member has a clear understanding of the role of all other members.
- Promote the development of clinics delivered by competent nurse members of the MDT. Many nurses are capable of working at a higher level, depending on education and supervised practice, and can perform examinations and manage chronic conditions such as herpes, warts and dermatological problems.
- Review the use of Health Care Assistants (HCAs) who can support nurses at busy times and can undertake asymptomatic screening, chaperoning, venepuncture, phlebotomy and microscopy providing the HCAs are skilled and supervised until they are able to work independently. And include Health Advisers and nurses being triple trained (health advising, sexual health nursing and contraception).
- Designated staff should review clinical sessions daily to ensure that all appointments are used and additional clinics introduced opportunistically to respond to local needs at short notice.
- Generally, Medical Laboratory Scientific Officers (MLSOs) are recruited to provide microscopy in a proportion of clinic settings. While MLSOs free up nursing time during the day, providing microscopy cover during the evening, early morning and weekend clinics can be challenging and expensive.
- Nurses and HCAs are able to undertake microscopy to create flexibility for additional clinics according to patient needs. In order for nurses and HCAs to be fully skilled in microscopy, it is imperative that they gain experience during each clinic period to allow for supervision within an adequate clinical governance framework. BASHH offer microscopy training courses for skilling up nurses.
- In order to provide nursing staff with the option for flexible working hours, explore utilising the existing resource of full-time

Resources and further guidance

8 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 15 to 21

9 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 40 to 44

nursing contract hours (37.5 hours per week), to offer the option of four instead of five-day working arrangements. This will facilitate the availability of nurses to allow for the introduction of extended clinic opening times as well as potentially increasing personal time for staff involved.

Consider introducing 'annualised hours' contracts for staff in clinics to allow for significant seasonal fluctuations, such as those services close to universities.

ANGELA HILLS – ROYAL CORNWALL HOSPITALS NHS TRUST

"Within the GU Medicine service of Royal Cornwall Hospitals NHS Trust Band 7 nurses carry out un-triaged assessment of new and follow-up patients and manage uncomplicated sexually transmitted infections (STIs) according to Patient Group Directions (PGDs). The increasing demands on the service regarding meeting and sustaining the 48-hour access target have led us to redefine and develop the role of the Band 5 nurse.

A skill mix review has enabled the successful introduction of Band 3 Health Care Assistants to provide chaperoning and phlebotomy. With the aim of holding dedicated nurse-delivered clinics for screening asymptomatic patients, an in-house training programme has been devised for the Band 5 staff nurses. The training incorporates taking a sexual

history, male and female genital sampling, HIV/syphilis and hepatitis B pre-test discussion, hepatitis B vaccination, HPV management and patient support and education. Relevant PGDs have been approved.

Benefit for patients – The early morning nurse-led asymptomatic screening clinics extend the choice of attendance times.

Benefit for staff – Enhanced professional role for GU nurses and better career satisfaction.

Benefit for the service – The nurse-delivered clinics contribute to meeting and sustaining the 48-hour access target. In addition opportunistic nurse-delivered clinics are established at times when there is a risk of 48-hour breach."

Angela Hills

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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
Provider is responsible ✓	Primary care trust and provider are jointly responsible	

HIGH IMPACT CHANGE 4

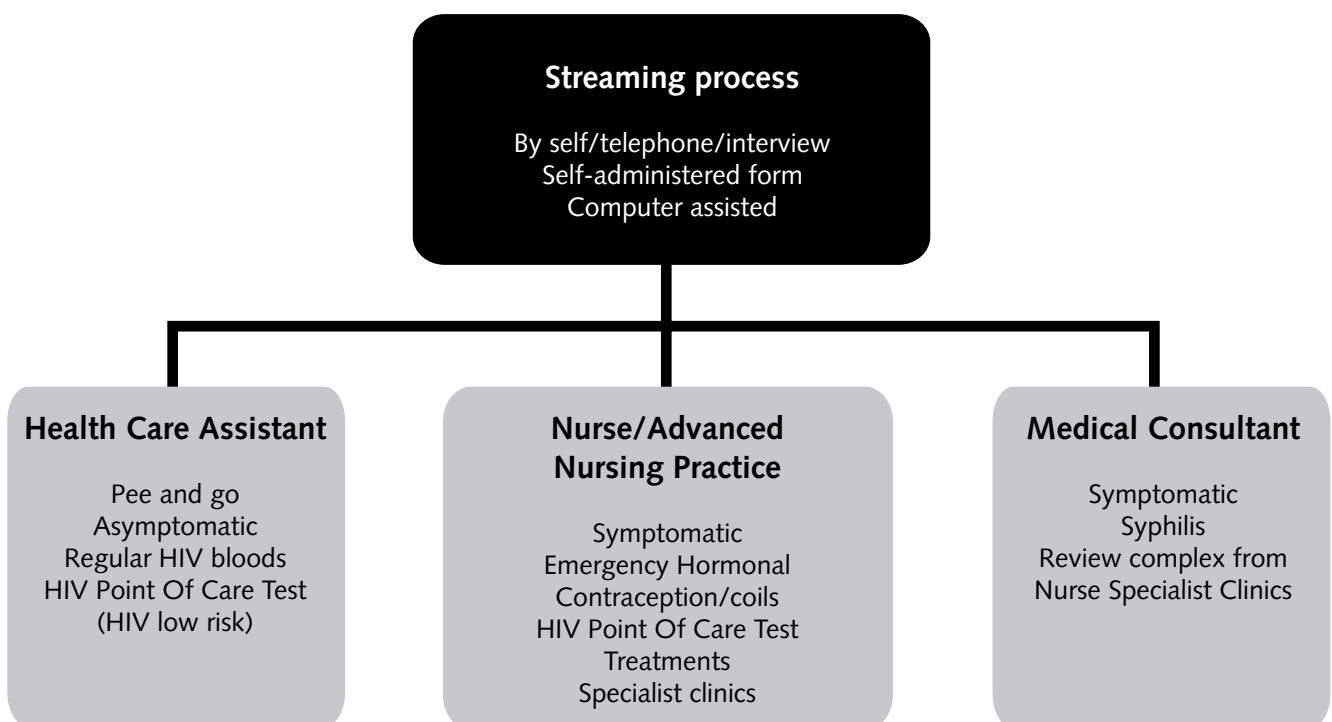
Develop a separate pathway to manage screening of patients at low risk for STIs¹⁰

STREAMING

Further recommendation:

- Update reception staff training and explore different telephone scripts to allow for streaming at the point of contact.

Figure 2: Streaming process allows for streaming to appropriate clinic staff¹¹



Resources and further guidance

10 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 22 to 26

11 Figure 2: Courtesy of Colin Roberts, Imperial College Healthcare NHS Trust London

JACKIE REES – WARWICKSHIRE PCT

“We looked at the way in which reception staff respond to telephone calls.

With a scripted response, reception staff now re-direct callers who initially refuse the appointment offered within 48 hours to the nurse. This enables the nurse to discuss more fully with them the possibility of asymptomatic infections alongside symptoms that may not be apparent. This enables a frank discussion about the need to be seen sooner rather than later. They will then be offered an initial appointment

within 48 hours with a further follow-up appointment if appropriate.

This has resulted in an upward trend of the number of people seen within 48 hours.

Previously, reception staff would simply accept that the caller didn't want the offered appointment and would offer a later one.”

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THIS WILL HELP:

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HIGH IMPACT CHANGE 5

Review current access system and make it easier for patients to access the service¹²

IMPLEMENTING A CENTRALISED BOOKING SYSTEM

Further recommendations:

- Centralised Booking (CB) takes different forms and can be applied differently in urban and rural settings.
- It can be used for signposting patients to an appropriate service and/or can be used as a booking system in itself which allows for multiple option phone lines so that patients are clear about clinic opening times, availability and what to expect, and access to appointments/information and walk-in provision.
- When considering introducing a CB system it has proved essential to review IT system connectivity. Many areas have completed this successfully and the NST can recommend areas prepared to share their experiences.
- Introduction of such a system that is fit for purpose requires investment in the staff who will deliver it. In its most simplistic form, this could entail diverting phone calls from one or more clinics, to a central point or principal local clinic, where reception staff have access to booking facilities for more than one site. With a longer lead-in time, more sophisticated call-centre arrangements are also possible.
- CB systems need to be staffed by appropriately trained operators with scripts that offer a choice to patients and do not automatically book a patient into another clinic without their agreement to attend that clinic (see Appendix A for an example of a GUM reception script template and Appendix B for an example of a sexual health clinic confidential assessment sheet).

DR HELEN LACEY AND STEPHANIE TARPEY – PENNINE ACUTE HOSPITALS NHS TRUST

“The Centralised Booking Service for the Pennine Acute Hospitals NHS Trust went live on Monday 19th February 2007. The service provides improved and quicker

access to GUM services for patients across Bury, Heywood, Middleton, North Manchester, Oldham and Rochdale.

Centralised Booking (CB) has improved the working lives of the receptionists, allowing them to focus on booking-in patients

Resources and further guidance

12 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 27 to 33

on arrival at the clinic. Patients' calls are answered promptly by an appointment booking service with extended opening from 8.30am–6.00pm Monday–Friday. Access to appropriate services is much improved by the offer of appointments at clinics on four sites and at a range of times including various evenings and one Saturday morning. Asymptomatic patients appreciate the offer of non-invasive testing, avoiding the embarrassment and discomfort of an unnecessary examination. The self-assessment and non-invasive testing in the screening clinics have reduced the waiting time in the screening clinics with patients completing their visit within 10 minutes.

There has been a sustained improvement in the availability of appointments within 48-hours which has risen from 39% in December 2006 to 99% by July 2007. The national target to be met was 70% by March 2007 and this was achieved within one month of starting the new screening clinics and implementing the CB team. The CB across the four trust sites offers patients a choice of clinic site and maximises the

capacity of the different sites especially during times of staffing shortages and holidays, enabling access to be maintained. The streaming of patients has improved efficiency at the doctor-led clinics which now see a case mix more appropriate for the staff skill mix in those clinics.

Funded by the local primary care trusts (Bury; Heywood, Middleton and Rochdale; North Manchester; and Oldham), the scheme plays a key role in helping the service to meet the Department of Health access time that by 2008 no patient will wait more than 48 hours for GUM services."

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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
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MARKETING SEXUAL HEALTH SERVICES

Further recommendations:

- Marketing sexual health services can improve the way in which patients access services. Think about appropriately targeted advertising that uses a range of locations such as pub toilets, websites, buses and taxis and consider the diversity of local target groups to publicise opening times and access to where appropriate services are available. Include community magazines, pharmacies, GPs and voluntary organisations.
- Most young people use the web for information. If your service operates a website, ensure it is 'youth friendly', up to date and robust with dynamic links to other sources of information.

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HIGH IMPACT CHANGE 6

Reorganise clinic opening hours to improve access¹³

CLINIC TEMPLATES

Further recommendations:

- Whether walk-in, appointment or both, clinic templates will vary between rural areas and urban locations. The NST feels it is reasonable to expect that extended clinic opening times be targeted to suit service users and therefore consideration be given to accommodate evening, early morning and weekend clinics where appropriate. Clinic times should be determined by local needs assessment and demand and capacity analysis, and care should be taken to ensure that appointments are offered throughout and including advertised opening times. A note of caution, however, was made in October 2007 in the joint DH/BASHH statement on achieving the target and narrowing the gap between offered and seen, saying that PCTs and providers should "... ensure that there are no unintended adverse consequences of hitting targets by reducing access, for

example, by reverting to only walk-in models of service. A mixed economy of service provision through a range of opening hours is most appropriate to meeting patients' needs and the appropriate delivery of a service across a sexual health network."¹⁴

- Should a clinic become overwhelmed with too many patients at one particular point, consider introducing a managed slot system to help stagger walk-ins and match available staff capacity to patient demand.
- Demand and capacity can fluctuate in university towns and cities where patient flow is directly affected by term-time attendance of students. Clinics may wish to consider factoring this into the clinic template and making better use of annualised hours when considering staff contracts.
- Piloting as 'appointment only' can allow the template to be assessed in six months' time, and further refinements made. If 'walk-in' sessions are created, it will be harder to change patterns of attendance, and therefore these should be focused on established sessions, or where a service is committed to a long-term extension of opening hours.
- Some services may find a quick solution in running a nurse-delivered STI

Resources and further guidance

¹³ *10 High Impact Changes for Genitourinary Medicine 48-hour Access*, pages 34 to 36

¹⁴ 'Genito-Urinary Medicine Clinics and the 48 Hour Access Target', DH and BASHH joint statement, October 2007

service alongside an existing evening Contraception and Sexual Health service (CASH). Appointments could be offered through a Centralised booking service

within the main GUM service. Consider contracting CASH to run this service if key staff already work in a GUM service.

COLIN ROBERTS – IMPERIAL COLLEGE HEALTHCARE NHS TRUST

“The Jefferiss Wing Centre for Sexual Health, St Mary’s Hospital currently operates a managed slot system, with 15 slots per hour, within the walk-in clinic across a five-day week. To assess patient demand and identify if the opening hours were appropriate, it was decided to carry out a survey of patients attending the service.

We gave a questionnaire to over 5,000 patients over a 12-week period asking them their preferred day of the week to visit the clinic, their preferred time of day, if they would attend a weekend clinic (Saturdays or Sundays) and if they had attended the clinic on that specific day because it was convenient to them or if they were told it was a good time to come.

The results have been very useful and showed that over 60% of patients would prefer to be seen before midday with 28% stating that Monday was the preferred day. Only 4% of those surveyed said that Sunday was acceptable, with a further 14% indicating that Saturday was their preferred day. The patients surveyed also showed that only 7% wanted to be seen after 6pm.

This survey, undertaken by Caroline Hart, has been extremely useful for measuring the preferred opening hours of our current users.”

Colin Roberts
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MICK TRAFFORD – CENTRAL AND EASTERN CHESHIRE PCT

“Following advice from the National Support Team for Sexual Health on achievement of the access target for GUM services, we as a team of commissioners and providers (clinicians and managers) focused our attention on the operation of the two GUM departments within the PCT area (Crewe and Macclesfield). More specifically, this centred upon the types of clinics available (booked appointments versus drop-in) and the times the clinics were open to the public.

After a specific workshop on these issues was held (involving a range of staff from both departments and facilitated by the NST), key changes were introduced and a decision made to trial a different service at each of our GUM departments. These included a mix of appointments and drop-in out of Crewe, as well as running

only drop-in clinics for new patients with booked appointments for those requiring follow-up treatment/monitoring in Macclesfield. After evaluating the services at both sites the PCT is now looking to operate a mix of appointments and drop-in out of both locations.

At the same time as these changes were introduced, a weekly performance monitoring system was established to assess the impact of the changes. As a consequence of these interventions the PCT as a whole has moved within six weeks from ‘failing’ against both elements of the target (55% offered and 53% seen) to being able to offer 100% of patients an appointment within 48 hours, and ‘seeing’ 99% of patients within 48 hours (as at 21st January 2008).”

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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
Provider is responsible ✓	Primary care trust and provider are jointly responsible	

HIGH IMPACT CHANGE 7

Reorganise the physical environment to maximise the space available for seeing patients¹⁵

INTEGRATED SERVICES (AND HIC 3¹⁶)

Further recommendation:

- There are various forms of integration. One example could be a fully integrated

one-stop-shop; another might be the collaboration with contraception services to provide a GUM clinic alongside an existing contraception clinic. Partnerships that can involve separate services (with some joint working) sharing space, integrating departments and clinical care, can provide a more flexible and responsive service. Further information will be available shortly when the DH publishes *The National Evaluation of One-Stop-Shops*.

KATHIE HARPER – WESTON AREA HEALTH NHS TRUST

“Weston Integrated Sexual Health (WISH) Centre, based at Weston Area Health NHS Trust, opened in September 2005 to provide an One-Stop-Shop for patients. It brought together two services – sexual health and contraception – and allowed a totally integrated service to develop. The aim was to manage a wider range of sexual health issues more appropriately, using combined skills, and to make the service much more convenient for the patient.

Planning prior to opening was paramount and consultations with staff and client

groups took place. Staff at all levels offered commitment to the service, and undertook substantial training to become nurse practitioners with the ability to offer sexual health, contraception and partner notification skills at any consultation. Alongside the training, with strong clinical leadership from the consultant, all aspects of the clinic were reviewed. This resulted in the development of new combined notes, a new appointment system, increased nurse-delivered sessions at different times of the day, review of the skill mix in the clinic, development of patient group directives, new protocols and a review of the patient pathway throughout the clinic.

Resources and further guidance

15 10 *High Impact Changes for Genitourinary Medicine 48-hour Access*, pages 37 to 39

16 10 *High Impact Changes for Genitourinary Medicine 48-hour Access*, pages 15 to 21

When booking an appointment, patients do not usually differentiate between the services they require. But all patients are offered both sexual health and contraception during their consultation if appropriate. Self-triage on arrival supports this system.

Staff commitment to training has been huge, but it is important that staff feel supported, especially when there are difficulties with their changing roles. The biggest transition was for the evening contraceptive staff who found it hard to access daytime training. This was overcome by the senior nurse agreeing to work on a one-to-one basis with individual staff. This allowed those staff to learn and be supported as they developed their practice.

Multi-skilled Health Care Assistants, trained in reception, phlebotomy and microscopy, support the nurses and doctors in their roles.

Since our initial opening, some staff also work within the community at PCT-led 'No Worries' young people's clinics. This provides an invaluable link and allows young people to access sexual health check-ups in the community. Any subsequent problems mean that the nurses can facilitate a visit to the WISH Centre and arrange to meet the patient there, so more specialist care can be carried out.

The WISH Centre is now established as a quality service, valued by patients, staff and the Trust as an efficient, effective department, with patients as its focus, as well as meeting the 48-hour access target."

Kathie Harper
WISH Centre Manager
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DR MIKE BRADY – KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

"In June 2007 we opened an integrated sexual health and contraception service in Camberwell, South London, which is a collaboration between the local GUM and Reproductive and Sexual Health (RSH) services. The RSH service was already providing an open-access, walk-in

contraception and STI service. However, there was limited capacity to cope with the high demand. A radical re-design of the service was necessary. The work was funded by the Guy's and St Thomas' Charitable Trust. The new service has a number of key features: it is highly visible on a local high street with long opening hours, including evenings and Saturday mornings; it has a large open plan

reception/waiting area with computer touch screens so clients can self-triage and self-register without seeing a receptionist; it allows self-management from vending machines for simple sexual health needs (pregnancy test and asymptomatic chlamydia and gonorrhoea testing) and we developed a new role, the Client Support Worker, to meet and greet, signpost clients round the department and undertake simple clinical tasks.

Since opening the service has seen a 30% rise in activity with considerable increases in the number of STI tests performed and the number of diagnoses made. The provision of contraception, including long-acting reversible methods (LARC) and emergency contraception increased as well. Self-registration is hugely popular with clients. 81% prefer it to the traditional receptionist, 98% find it easy to use and 81% find it confidential. Computerised triage has made patient flow more efficient. 96% of clients now have their healthcare needs met by one healthcare professional compared with 71% prior to any triage system. Average transit

time through the service has dropped by 29 minutes. A patient satisfaction survey and mystery shoppers have shown the Client Support Workers to be very popular and they currently independently facilitate about 10% of total activity, releasing capacity for the nurses and doctors. 95% of users would recommend the service to a friend.

We have successfully implemented a fully integrated sexual and reproductive health service that was designed with considerable input and guidance from service users. Early evaluation is positive in terms of overall activity, uptake of LARC, STI diagnoses, patient satisfaction and transit times. Highly motivated staff, most of whom are dual trained to provide contraception and STI services, computerised self-triage and registration, self-management and the Client Support Workers have all contributed to this success."

Dr Mike Brady
Consultant GUM/HIV
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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
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Provider is responsible	Primary care trust and provider are jointly responsible ✓
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HIGH IMPACT CHANGE 8

Reduce unnecessary clinical activity to increase capacity for new patients¹⁷

RESULTS BY TEXT

Further recommendation:

GUM services should review existing result notification policy/practice and consider the benefits of implementing a result by text service.

DR MIKE ABBOTT – SOUTHPORT AND ORMSKIRK NHS HOSPITAL TRUST

“In an attempt to improve access, our service had a brief flirtation with a ‘no news is good news’ policy. We found this policy unsatisfactory. We therefore established a facility to send results by SMS messaging (i.e. text).

Texting of results proved very popular for service users and staff alike. The main advantages of texting are that:

1. Every service user gets a result – unlike the ‘no news is good news’ policy where the ‘worried well’ still rang for results (and at a time that we could not control).
2. There is a record of delivery as well as sending.
3. Notes that require no action can be immediately filed on sending a negative text.

Resources and further guidance

17 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 40 to 44

4. Incoming phone lines are not blocked by patients ringing for negative results. Also, we found we had more control over when patients ring for results (often shortly after sending the text).
5. Time is saved particularly for health advisers and clerical staff.
6. It is extremely cost-effective.

Many GUM services now send results by text, but those that do not might wish to consider the option. We obtain consent for this means of communication and there are other safeguards in line with our Trust policy. Where it is felt to be in the patient's interest to receive a

result by other means, or where s/he expresses another preference, alternative arrangements are made. However, the vast majority opt for texting of results. Texting has significantly improved our 48 hour-seen figures, although the effect is difficult to quantify because other service changes were occurring at the same time. I would be happy to email a short guidance pack for those who would find it helpful."

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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
Provider is responsible ✓	Primary care trust and provider are jointly responsible	

HIGH IMPACT CHANGE 9

Assess the state of readiness of STI service providers outside GUM, and prioritise developments that will help meet and sustain the GUM access target¹⁸

ROBUST MANAGEMENT STRUCTURES

Further recommendation:

- Clearly the impact of strong leadership and ownership within robust management structures has proved integral in progressing to target.

DALLAS POUNDS, ANGIE BLACKMORE AND PAULA DOHERTY – BUCKINGHAMSHIRE PCT

“The Buckinghamshire PCT provide a range of Contraceptive and Sexual Health Services (CASH). Following the formation of the PCT in October 2006 these services were brought together under one Service Manager to form an integrated CASH service. This post gave the necessary senior leadership within provider services to begin to drive the service agendas forward, and in particular address the failure to meet the GUM 48-hour access targets.

It became clear that the service had become inadequately resourced and lacked operational management but, almost more importantly, staff lacked a sense of being involved with the PCT and had no clear understanding of what was expected. The honest communication of this vision and the shared formulation of an agreed action plan, coupled with the recruitment of the necessary staff, including operational and clinical leads, have resulted in a dramatic improvement in both team working and target attainment. On the ground staff now feel they have some ownership of

Resources and further guidance

18 10 *High Impact Changes for Genitourinary Medicine 48-hour Access*, pages 45 to 53

the service, its delivery and consequential success. There is also strong representation, and an identified lead, for the service within the provider arm, which has promoted recognition and integration of the service into the PCT.

To support these developments in provider services strong relationships with identified individuals in PCT Commissioning and Public Health were needed. We were lucky enough to establish these quite quickly, again through enthusiasm, determination, and open communication of the vision and target achievement. We agreed our action plan and how each 'lead' would contribute to achieving it. There is now a shared understanding of the services, the challenges they face, and plans for the future.

Ownership and accountability at all levels within the service and the organisation is the key to this success, and will support further improvements in the near future."

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Angie Blackmore
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THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen ✓	Sustain the GUM 48-hour access target ✓
Provider is responsible	Primary care trust and provider are jointly responsible ✓	

PRACTICE BASED COMMISSIONING

Further recommendations:

- Practice Based Commissioning (PBC) is a key part of improving the NHS. It is also central to sustaining the GUM 48-hour access target, as provision of L1 and L2 services in pharmacies, General Practitioners and voluntary organisations can help free up capacity at GUM clinics to provide more complex L3 treatment and care.
- GUM clinics, as specialised providers of L1,2,3 do not lose out from the Payment by Results tariff and therefore L1 and L2 provided outside of GUM clinics support greater choice for patients.
- PBC business cases need to ensure that provision of L1 and L2 sexual health services is developed and delivered in primary care within the quality markers and outcomes agreed across the district.
- To assist with local approval use generic templates to support practices that do not have the skills/resources to write this kind of document themselves.

CLAIRE WHITLEY – BRADFORD PCT

"The Information Shop for Young People is a city centre based location which is part of Bradford Youth Service. It offers drop-in services and information and advice for any young person under 25.

The Information Shop has offered contraception services for over 10 years and has recently offered full CASH services in response to young people's needs. This includes STI screening on site, without having to refer young people on to other settings.

The Information Shop continues to provide a comprehensive sexual health service in a partnership approach between the Youth Service and both Primary and Secondary Care. Three CASH services and three young people GUM services are complemented by two sessions of the Lads' Room (specifically for young men), enabling young people to access a discreet and confidential service for all under 25s."

Claire Whitley
Young People's Sexual Health Strategy
Manager
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THIS WILL HELP:

Achieve the GUM 48-hour access target	Narrow the gap between offered and seen	Sustain the GUM 48-hour access target ✓
Provider is responsible	Primary care trust and provider are jointly responsible ✓	

HIGH IMPACT CHANGE 10

Make costs of GUM services transparent and develop commissioning consortia which reflect patient flows¹⁹

unit costs. Increasingly Trusts (and Foundation Trusts in particular) will need to ensure that Payment by Results income will cover any new expenditure. With the widespread introduction of de-hosting for GUM and cross-charging to a patient's PCT of residence, financial plans should allow for a variety of scenarios to replicate anticipated patient flows.

ACTION PLANS

Further recommendations:

- All existing 48-hour access action and productivity plans need to be reviewed regularly between commissioner and provider to look at how services become more efficient in delivering and reducing

Resources and further guidance

19 10 High Impact Changes for Genitourinary Medicine 48-hour Access, pages 54 to 58

ANDREW RIX – LINCOLNSHIRE PCT

“The sexual health service in Lincolnshire has been subject to a number of external reviews which have resulted in a series of recommendations for action.

These recommendations have informed the development of business plans, with associated costs that have enabled funding to be secured via the Choosing Health allocation.

Lincolnshire was visited in June 2007 by the NST and a comprehensive action plan was subsequently formulated.

The action plan is formally reviewed at the monthly Sexual Health Programme Board meetings. All items are traffic light colour coded to enable rapid identification

of those that require specific attention. Updates are made to the plan in ‘real time’ by the authors of the plan which entails reviewing the effectiveness of the actions and associated costs.

This simple, but effective, approach has enabled appropriate status of priority to be given and the associated costs to be easily tracked to the allocated budget, ensuring that all developments are accounted for. This, along with other local changes, has impacted in a positive way to Lincolnshire achieving the target.”

Andrew Rix
Lead Manager for Specialised
Commissioning
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THIS WILL HELP:

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Provider is responsible	Primary care trust and provider are jointly responsible ✓	

ADDITIONAL HIGH IMPACT CHANGES

SOME QUICK WINS

It is important for relevant information to be sought and scrutinised locally to understand why individuals are not being seen within 48 hours. Local clinical audits can be undertaken to examine the reasons for the gap and to enable commissioners and providers to work to understand it.

We should also see swift implementation of phase 2/3 (enhanced) GUMAMM data²⁰ which will provide better information on why patients are not accepting appointments within 48 hours. Once available, data can be shared in a constructive dialogue between GUM clinicians in provider units and expert sexual health commissioners to formulate appropriate plans to:

- support the monitoring and performance management of the 48-hour access target (to be achieved by March 2008) and its ongoing management once achieved
- validate and assure that the target is being met, expose restrictive booking

practices and ensure that the patient perspective is taken into account

- assess any unmet demand for services
- improve the number of patients 'seen' within 48-hour access.

DATA, PERFORMANCE AND IT

The collection of data and the monitoring of performance are intrinsically linked to accessible and effective IT systems and reporting. However effective systems may be human error with regard to data entry is a risk to be managed closely.

Further recommendations:

- PCTs working with providers should support the implementation of effective IT systems, collection of data and reporting to monitor performance
- Consider modifying monthly reviews to weekly data reporting and monitoring. Clinical managers need to understand their data thoroughly to ensure that local GUM 48-hour access reports correctly reflect reality. Errors made by staff entering data can be identified by either running local reports on a weekly basis or by reviewing raw datasets. Training can then be targeted towards individuals who repeatedly make mistakes when answering GUM 48-hour access checklist

Resources and further guidance

²⁰ <http://www.isb.nhs.uk/docs/48-hour-genito>

questions. Other programme reporting errors may also be identified when the data is reduced to smaller datasets. Where access reports do not seem to reflect reality, further investigations can be made, including manual data counts.

- Create a 'Breach Log' and check appointment availability on a daily basis to identify when breaches might happen, e.g. if service runs low on female appointments, move staff resources to put up an extra clinic before breach occurs.

THIS WILL HELP:

Achieve the GUM 48-hour access target ✓	Narrow the gap between offered and seen	Sustain the GUM 48-hour access target ✓
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THIS APPLIES TO:

Provider is responsible	Primary care trust and provider are jointly responsible ✓
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SEXUAL HEALTH NETWORKS

Sexual health networks can enable the co-ordinated provision of services across a geographical area configured to reflect patterns of need, with equity of access, shared standards and clearly defined care pathways. By planning services across a network, duplication can be avoided and gaps in provision filled, thus making the best use of available resources. Refer to the MedFASH *Recommended standards for sexual health services*²¹ which includes a standard for networks.

Recommendation:

- It is important to support the development and maintenance of networks in order to foster a collaborative approach between local services to the achievement and maintenance of GUM 48-hour access.

THIS WILL HELP:

Achieve the GUM 48-hour access target	Narrow the gap between offered and seen	Sustain the GUM 48-hour access target ✓
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THIS APPLIES TO:

Provider is responsible	Primary care trust and provider are jointly responsible ✓
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Resources and further guidance

21 http://www.medfash.org.uk/publications/documents/Recommended_standards_for_sexual_health_services.pdf

CONCLUSION AND SUSTAINABILITY

One of the original targets of the sexual health and HIV strategy was a reduction in gonorrhoea (GC) rates. This was chosen because it was felt that its short incubation period and ready diagnosis made GC a good early indicator of the effect of sexual health interventions. The latest annual report from the HPA²² shows – in heterosexuals – that there has been a significant decline in GC since 2003, which they state “may reflect recent improvement in patient waiting times, increase in the number of sexual health screens being done and evidence of improved partner notification within the GUM clinic setting”.²³ Over this same period, however, there have been increasing levels of all STIs in Men who have Sex with Men (MSM) including GC. Other factors may be in operation here such as changes in sexual behaviour associated with treatment optimism related to effective HIV antiretroviral therapy. This is not to negate the benefit of the interventions but indicates some of the complexities and the need for additional targeted interventions in groups at higher risk of infection such as MSM.

Clearly there is an ongoing need for Chief Executives to ensure the GUM 48-hour access target is monitored and sustained. Public Health too must maintain up-to-date SHNAs while guaranteeing that robust data and epidemiological evidence is used to inform/ guide any decisions made as to future funding and provision. In particular, clinicians need to provide strong governance assurance to all levels of service development, modernisation and planning. Alongside this, commissioners, providers, the voluntary sector and patients must create opportunities to review progress in relation to local sexual health strategies and planning in support of clear commissioning intentions and to monitor that any changes to services meet the needs of all sectors of the community.

The NST will continue to provide support beyond March 2008 and looks forward to working with all stakeholders to make certain that appropriate resources are available to support sexual health service provision nationally.

Resources and further guidance

²² Health Protection Agency, *Testing Times*, November 2007: http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/default.htm

²³ *Testing Times*, section 2.2, page 43

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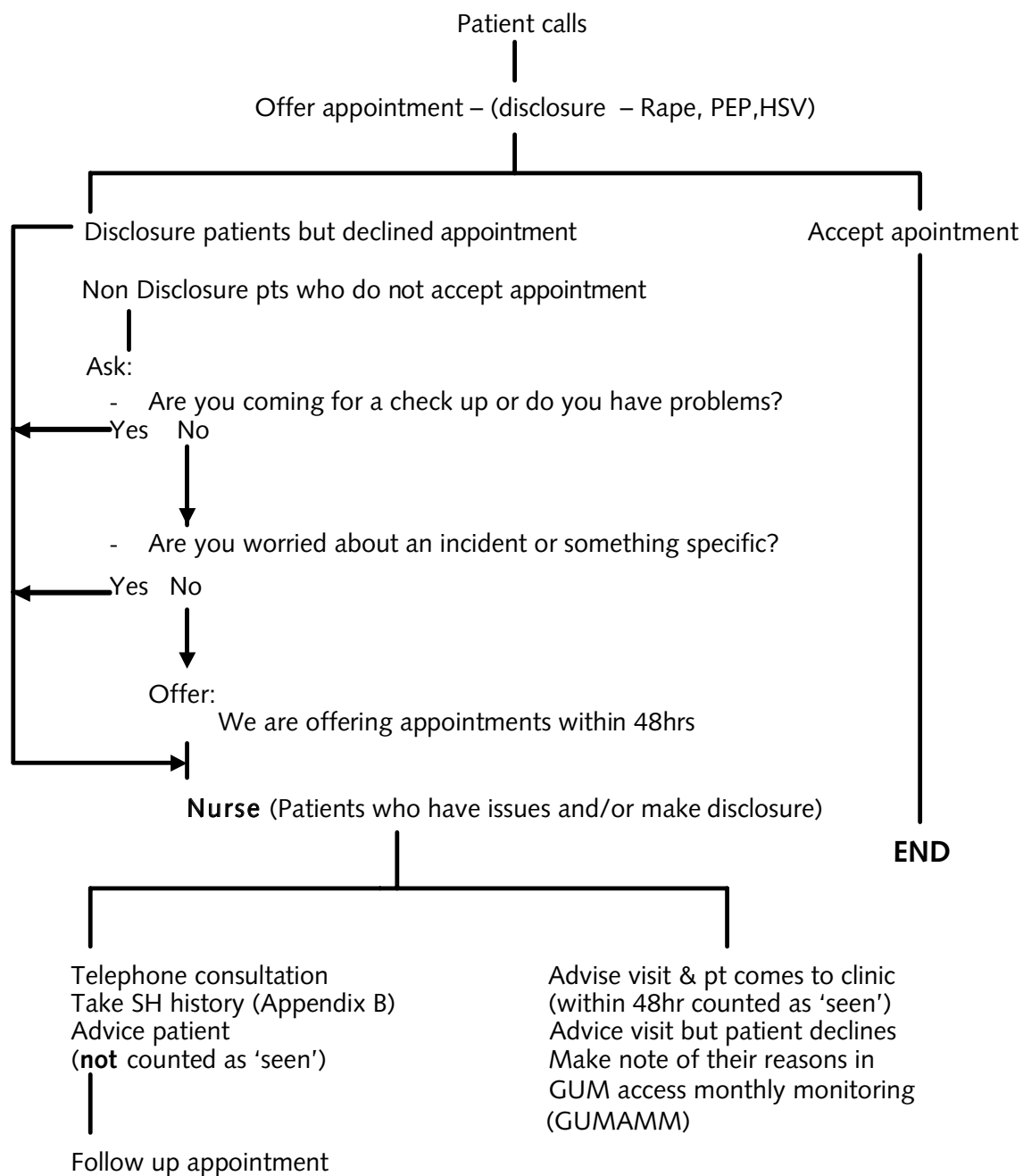
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APPENDIX A

GUM Reception Script Template

The following example of a frontline GUM Staff script template suggests how to engage patients that ring up to make an appointment but do not accept an appointment offered within 48 hours



APPENDIX B

South Manchester Sexual Health Clinic Confidential Assessment Sheet

DATE:

ID LABEL:

Who referred you to this clinic? (Please tick box)

- Family Planning Clinic
- GP (letter/advised)
- Given contact slip
- Own accord
- Other (please state)

.....

When did you first try to contact the clinic to book this appointment?

- | | | | |
|----------------|--------------------------|----------------|--------------------------|
| • Today | <input type="checkbox"/> | 5–6 days ago | <input type="checkbox"/> |
| • Yesterday | <input type="checkbox"/> | 7–13 days ago | <input type="checkbox"/> |
| • 2 days ago | <input type="checkbox"/> | 14–27 days ago | <input type="checkbox"/> |
| • 3–4 days ago | <input type="checkbox"/> | 28+ days ago | <input type="checkbox"/> |

If you waited more than 2 days (since you first tried to contact this clinic to be seen or make an appointment) was this because:

- You decided to wait until you were free
- There was no appointment/slot available/the clinic was too busy
- You were offered or had an earlier time/appointment but could not attend
- You were advised by staff to wait (for clinical reasons)
- Other (please specify)

Would you be happy for us to contact you? (Please tick box(es))

By letter By phone By text message

How would you define your sexuality? (Please tick box)

- Heterosexual (straight)
- Gay
- Bisexual
- Lesbian

Have you had a new sexual partner in the last 3 months?

- Yes (if yes, was the new partner male or female)
- No

How many partners have you had in the last 3 months?

- Male Female

How many partners have you had in the last 12 months?

- Male Female

Have you had sex abroad (with a non-UK resident) in the last year?

- Yes (if yes, were they male or female or both)
and in which country/countries
- No

Have you ever accepted or paid money for sex?

- Yes No

Have you ever had sex with an intra-venous drug user?

- Yes No

Have you ever injected drugs?

- Yes No

Have you ever been treated for any sexually transmitted infection(s)?

- Yes (if yes, please state where, when and the infection)

.....
.....
.....

- No

Have you previously had an HIV test?

- Yes (if yes, please state where, when and the test result)

.....
.....
.....

- No

Do you have any of the following? (Please tick box(es))

FEMALES ONLY

MALES ONLY

- | | | | |
|--------------------------------|--------------------------|----------------------------|--------------------------|
| Lower abdominal/tummy pain | <input type="checkbox"/> | Pain or lumps in testicles | <input type="checkbox"/> |
| Pain/bleeding during/after sex | <input type="checkbox"/> | Discharge from penis | <input type="checkbox"/> |
| Bleeding between periods | <input type="checkbox"/> | Pain on passing urine | <input type="checkbox"/> |

FEMALES ONLY

What date was your last menstrual period?

Are your periods regular/how often?

What date was your last cervical smear (over 25s only)?

NAME:

ADDRESS:

.....

.....

POST CODE:

TELEPHONE NUMBER:

Mobile

Home

Work

DATE OF BIRTH:

MARITAL STATUS:

NATIONALITY: PLACE OF BIRTH:

OCCUPATION:

GP NAME & ADDRESS

.....

.....

Supplied by: Debra Hough, Administration Manager, Manchester PCT



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