

Pump-Priming funding to improve access to GUM clinics

During the past week, all lead consultants of GUM clinics should have received a letter from the Department of Health notifying them of an additional pump-priming funding allocation. The accompanying letter provides guidance for the use of this resource and asks for an invoice to be raised and details of the nominated account into which the allocation should be paid.

This note, which gives a specialty view, is intended to make suggestions as to how the use of this resource can be optimised in accordance with the purpose of improving access to GUM clinics and reducing sexual health inequalities.

1. Size of allocation

Specialty representatives persuaded DH that virtually all clinics would need to receive some additional funding if the immediate objective of increasing service capacity was to be achieved throughout England. The size of each clinic's allocation has been based on their KC60 caseload return in 2001, or on the 2000 return where later data was not available.

DH is very keen to see the development of STI service networks, in which larger, usually teaching hospital, clinics support their surrounding DGH clinics by developing shared consultant posts. There has been some weighting of allocations for this reason, which also acknowledges that the major workload pressures have usually been within large urban areas.

2. The Period of Funding

The additional allocation is intended to cover the period 1 October 2001 to 31 March 2003. Improved capacity in GUM clinics is essential because of

- a) the elongating waiting lists and/or waiting times for newly presenting patients
- b) the effect of the national education campaign, that is likely to emphasize the high prevalence of asymptomatic infections and encourage the public to seek sexual health screening.

We estimate that clinic capacity will need to increase by a minimum of 15%, equivalent to around 150,000 new patient episodes per annum, to accommodate the increased demand.

In order to meet this requirement, clinics will probably need to consider an increase in clinical sessions. The additional funding can then be used to support additional medical, nursing, health adviser, or clerical time.

Thus, the priority should be to support staffing infrastructure and other measures that support the recommendations for GUM services contained within the national strategy implementation plan.

The additional funding is expressly not intended to prop-up HIV drug budgets that are under pressure.

3. The nominated account

It is strongly recommended that the allocation should not be paid into General Trust accounts because, should all of the allocation not be spent within the current NHS year, it will be lost. It is suggested that a special GUM pump-priming account be established that would then allow any unspent monies to be carried forward after March 31 and used subsequently in support of the purposes outlined in the DH letter.

It is highly likely that use of this additional allocation will be subject to detailed audit. For this reason, it is recommended that detailed accounts be kept of expenditure and its purposes. It should be able to demonstrate how patient capacity and throughput have benefited as a consequence.

4. Making the funding recurrent

Although the pump-priming allocation has not, as yet, been made recurrent revenue, DH is intending to write shortly to clarify the situation regarding recurring money.

Specialty representatives are continuing to lobby hard with Ministers and DH officials for this to occur. We have advised that, at an average cost for a completed new patient episode of £150 to £200, the total revenue commitment required for the additional 150,000 episodes p.a. requires a revenue commitment of £22-30 millions.

DH has informed us of its current view that the additional NHS funding announced in the Chancellor's Budget statement has been given to PCTs and that securing increased funding for 2003/4 and beyond should be negotiated locally.

Nevertheless, it is recommended that every lead GUM consultant should identify their PCT Sexual Health lead and then initiate discussions about how expanded capacity can be maintained in 2003/4 and beyond. Each clinic should be able to calculate the patient numbers for its own capacity increase on the above basis. It is important that additional revenue be sought on a full-cost rather than marginal-cost basis because maintenance of staffing infrastructure is paramount.

The existence of this new allocation and the expected further upsurge in patient demand should be useful starting point for these discussions.

5. Monitoring Patient Access Times

The government has stated that Sexual Health is a national priority and expressed its determination to reduce inequalities in service access.

The speciality is monitoring GUM access. It is vital that all clinics should respond promptly to the current AGUM survey form so that we can draw the attention of politicians, DH officials, and commissioners to the results and give further emphasis to the case for continuation of the additional allocation.

In addition, to provide evidence on the impact of education campaigns on service use, it would be useful for clinics to measure what happens to access following the targeted national campaign.

Although there may be some anxieties and uncertainties about future revenue allocations and meeting further demand for GUM services, we believe that the pump-priming funding provides all GUM consultants with the impetus to be proactive in local negotiations within their Trusts and with their commissioners.

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