

**ACCESS  
TO GENITO-URINARY MEDICINE CLINICS  
IN THE UNITED KINGDOM**

**AN AGUM-MSSVD REPORT**

**13<sup>th</sup> JULY 2001**

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## **ACCESS GROUP REPORT**

**13<sup>th</sup> July 2001**

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### **INTRODUCTION**

The huge increase in the numbers attending GU Medicine Clinics is obvious to all of those working in the field. There has been a doubling in the number of patients attending Genito-Urinary Medicine services in the past ten years. The advent of highly active anti-retroviral therapy for HIV patients has also meant that patients who previously would have died, are surviving on complicated triple therapies that require extensive monitoring and multiple outpatient attendances. With little or no expansion in the service over the last few years, it is inevitable that demand would begin to outstrip supply, and many clinics couldn't maintain "open access" systems, and services deteriorated <sup>1</sup>. Two studies – one from Southampton <sup>2</sup>, and one done by the PHLS, AGUM and MSSVD (submitted for publication), both showed a deteriorating system, with even patients describing urgent symptoms, not being able to seen within 24-48 hours. The Southampton study also highlighted a discrepancy between the Consultant's perception of when urgent patients could be seen, and the actual reality of a pretend patient phoning the clinic looking for an urgent appointment. The two Societies representing the specialty, ie. AGUM and the MSSVD, set up a working group to look at why access is so poor, why it varies throughout the country and suggest possible options that might help.

It's ten years since the Monks Report<sup>3</sup> was published. This report did go into great detail about what was needed and, indeed, some clinics in the country did manage to upgrade to meet the current demand at the time. However, the doubling of attenders has overtaken those improvements and new initiatives are needed. A further report published in 1993 by Isobel Allen and Debra Hogg, entitled "Work Roles in Genito-Urinary Medicine Clinics"<sup>4</sup> had some key recommendations which have not been implemented. That report even then highlighted the "lack of clarity about work roles and responsibilities, and a lack of appreciation over the extent and nature of the overlap, and duplication between individuals and types of staff".

### **DISCUSSION**

This report looks at the current situation and reports on discussions with various individual clinics around the country. It also reviews the results of a snapshot of 120 clinics done over a one week period in July 2001. It also attempts to look at work load calculations and number of Doctor sessions needed to address the current situation.

### **CORE WORK**

There was some discussion regarding whether the specialty should concentrate on core work and stop development in so-called fringe areas in Genito-Urinary Medicine, ie. colposcopy, vulval/dermatology clinics, erectile dysfunction, psychosexual medicine, forensic work related to sexual assault, etc. This specialty has been at the forefront in developing services for sexual health and many of these innovative services are doing their absolute utmost to fulfil an NHS need in previously neglected areas. In reality only a small

percentage of staffing is spent on these services and stopping them would have virtually no impact on access. It would be undermining both the scientific value of the specialty and the morale of people working in it if the small amount of specialist services in various clinics throughout the country were stopped. Also, many patients have come to depend on these services and again, as it's largely a disenfranchised group of society that use them, it would only compound the problem. For example, a recent report by Dr Kell indicates why GU Clinics are ideally suited for the practice of psychosexual medicine <sup>5</sup>.

### **CURRENT PRACTICE**

The enormous pressure on the routine clinics had the effect of, for the first time, generating a waiting list. It is disheartening that twenty years ago all GU Clinics were open access and the concept of "appointment only" was considered untenable. Patients who actually turned up at a clinic were seen as doing society a favour in getting their communicable disease treated, and therefore every effort was made to make it as easy as possible. However, in many parts of the country the system just simply cannot cope with the demand, and appointment systems have been established. The survey showed that 34% of clinics are now appointment. Some centres have tried to introduce some logic to a waiting list by trying to develop a triage system. However, there has been some disquiet about triage and, indeed, at recent AGUM meetings regional representatives had reservations about its feasibility. The idea of taking a highly skilled worker out of the system to conduct triage is obviously just compounding the problem of reducing the staff available for the clinic work. Also, in some cases, triage is simply a matter of persuading somebody who wants to be seen then that the condition is not urgent enough and can be seen at a later date. This is a very difficult and unpleasant job, and goes against medical and nursing aspirations which aim to relieve distress as quickly as possible. There is also the danger that although triage is conducted sensibly, mistakes can occur, and even our patients are quick to sue. There are many anecdotes of missed conditions, and particularly something like ectopic pregnancy can be missed at triage with awkward consequences. It also emerged from the Southampton study, indeed, the editorial<sup>1</sup> where Dr Kinghorn highlights this, that "Reception staff alone invariably performed triage. This is unacceptable. Only suitably trained qualified staff should perform triage". Some centres feel they can provide a successful system under these circumstances <sup>6</sup>.

One outer London DGH Consultant commented – "In the last three years we have gone from an almost entirely appointment system to one of which Monday, Wednesday and Friday mornings are walk-in clinics. This was largely by done by an audit which showed that almost all GC and most chlamydia was being seen during times when patients just turned up the Nurse drop-in sessions, and not in booked clinics. Some patients wait four hours to be seen in our clinics. The nurses do triage sessions on Tuesdays and Thursday mornings, and these have become almost identical to the doctor sessions on the other days, as patients just turn up and demand to be seen. I do think we need to formalise and recognise senior nurse involvement in a more structured way, ie. Nurse Practitioners or Nurse Consultants".

Another system is to "*shut the door*" after a certain number policy. This simply involves working out the accepted work load for the clinic staff available, and then when that number has been reached no further patients are seen after that, and the doors are simply locked, and a note is put up saying, "*go to Casualty or see your own GP*". With this system, at least the patients have no interaction with a health service personnel, and there would be nobody to sue.

At St Mary's Hospital (London), there is in theory an "open access" system. However, this can lead to huge waiting times and, indeed, the policy there is, that when the waiting time to be booked in reaches 4 hours the clinic doors are locked until the pressure eases off again. This just indicates how desperate some patients are to be seen, that they will even wait up to 4 hours in a clinic before being booked in to get their problem seen to.

Other clinics in London have adopted appointment systems for new patients and, in many cases, these appointments stretch to three or four weeks. Inevitably, some of the patients end up going elsewhere out of desperation and then, of course, DNA from the appointment without giving any notice. Some clinics have DNA rates as high as 40% for new patients where appointment times are given two or three weeks delay.

Speaking to other Consultants from various clinics throughout the country, it's obvious that clinics have tried their utmost to be as efficient as possible. To quote one DGH single-handed Consultant in the mid regions – “Clinical work patterns have changed to attempt to adapt. I think it's really important to emphasise this, as it shows we have all tried to cope. For example, we're using home-based treatments whenever possible and telephone results for a majority of patients, which means that very few patients need to actually return. However, this increases the proportion of new to return visits, and makes the clinic work load far more intensive, needing highly trained staff to cope with the increasing complexity of new patient attendances every time”.

A Consultant in Scotland commented that “accessing an existing clinic can be difficult enough, but some parts of the UK have no service at all. Patients living in the Scottish Borders, Dumfries and Galloway, Outer Isles, Orkney and Shetland have no access to a Consultant-led genitourinary clinic. Provision in Ayrshire remains poor with no Consultant in post at present, although clinics are running under the auspices of a sexual health Consultant. The lack of services in these parts of Scotland has knock-on effects for the over-stretched urban clinics who see patients who can go nowhere else. Consultants in these centres are also involved in the political negotiations to implement services outside their Health Board area, which in turn means less time for their core local responsibility”.

In reply to a letter, a Senior Medical Officer in the NHSiS Health Department said in February 2001 that the executive was not in a position to deliver increased Consultants, as this is up to Health Boards.

### **APPOINTMENTS AND WALK-IN**

Many clinics, however, still operate with a system that allows them to see walk-ins on the day they attend. This is usually a mixture of appointments and there is usually enough space to slot in anyone who happens to turn up – emergency or not. This is obviously the ideal, but staffing levels need to be able to take care of peaks and troughs to be able to cope with this type of system.

### **WORK LOAD DATA**

Attempts have been made to try and assess the staffing needed for various areas and, as a rough guide, the Royal College of Physicians Working for Patients document use a figure of about 1 GU Consultant per 113,000 population. Of course, it is expected that a Consultant has an adequate supporting team. If we look at the recent AGUM Survey<sup>7</sup>, it shows that between them Clinical Assistants and Hospital Practitioners contribute to 1366 clinic sessions per week. The soon to be published Royal College of Physicians Working for Patients document has a section related to Genito-Urinary Medicine contract and work load, and using these calculations there is a doubling of Consultant posts needed (Appendix 1). A pilot work load survey was also sent out in July 2001 to look at actual work load and staffing in a random selection of clinics, mainly via the Regional Representatives. This simple questionnaire just looked at catchment population, number of new attendances, and number of actual Doctor sessions within each unit (Appendix 2). A sample calculation was given for the Chester Clinic which has reasonable access. Twenty clinics were selected and the ratio of Doctor sessions per week per 1000 patients varied from a low of 2.1 to a high of 6.7; the average was 3.8 Doctor sessions per week per 1000. Most of these clinics had access problems, apart from the ones with higher Doctor sessions. This particular work load calculation is highly relevant, as it actually looks at the real life situation, ie. simply select a clinic that has adequate access, look at the actual number of Doctor sessions in that clinic and the total of new attendances. As well as the Chester clinic as an example, I

have included in Appendix 2 the results from Sheffield and Slough. Sheffield is a highly regarded Genito-Urinary Medicine service, which is just about coping with the huge number of patients it currently sees. Despite having very high attendances of over 10,000 per year, there are 60 Doctor sessions to cope with this, giving a ratio of 5.5 Doctor sessions per week per 1000 new patients. In contrast, Slough is a service under extreme pressure and has a ratio of only 2.4 per 1000. It is no surprise that clinics that have ratios of 5 and 6 Doctor sessions per 1000 patients can maintain open access. This is the level of service that should be strived for. Many of these increased sessions should be Consultant provided, in keeping with the new NHS aspirations.

### **CLINICAL EFFECTIVENESS GUIDELINES AND RECOMMENDATIONS**

It also became obvious that practice varies greatly throughout the country and this can influence attendances, particularly follow-up numbers. For example, some clinics spend more money from the drugs budget purchasing home therapies, ie. podophyllotoxin or imiquimod, so that patients can treat themselves at home without attending for follow-up visits for genital warts. Other clinics continue to use podophyllin with the attendant follow-ups that are necessary. Some clinics still do tests of cures for chlamydia, some clinics don't, some clinics insist on re-attendance for HIV results – even in low risk patients, other clinics accept phone calls for results, and some clinics don't give any results over the phone, and some clinics do. Somewhere in amongst this variation of practice there must be a best practice that actually focuses on cutting down the number of attendances.

It was suggested that the British Co-operative Clinical Group could help in establishing what the actual variation in practice is, and what the reasons are behind it. For example, if the British Co-operative Clinical Group could do a questionnaire, specifically relating to practices on follow-up patients, and also seeing which of these clinics have easy access or difficult access, and see if there's a correlation between the two. As one member had put it. "it seems inappropriate for a clinic to have a 2-week waiting time for a man with symptoms and urethral discharge, and yet be doing chlamydia test of cure follow-ups, where the benefit would be miniscule". It was also suggested that such a BCCG study could ask the simple question, "What's the current waiting time for a routine appointment" on an ongoing basis to establish what's actually happening, and if the situation is deteriorating. It was also proposed that perhaps that simple question could be added to the KC60 Returns which are done every quarter from every clinic in the country ?

From the Southampton study, there is information regarding which are the clinics that do not have a problem with access. These clinics could be sent a detailed questionnaire to establish practice, ie. policy for follow-up, number of personnel, number of nurses, etc.

### **NON MEDICAL STAFFING**

There is considerable interest in the concept of Nurse Consultants, and some clinics already are using nurses in the frontline, ie. seeing new patients, and doing the basic tests, and only requiring doctor consultation if there is an unusual or difficult problem. Other clinics use nurses for follow-up cases, and for giving results. These posts have been discussed both at the MSSVD in Baltimore in open forum and at the recent AGUM AGM. It's obvious there are major differences of opinion, and the whole concept of Nurse Consultant has not been fully thought through by either the Department of Health or GUM Clinics. The idea of simply getting the current nursing staff to do more is not realistic, as all GU Clinics have nurse staffing problems as it is, without expecting the current nursing staff to take on the extra role, particularly as there is little training in sight.

### **INVOLVEMENT OF WIDER MEDICAL COMMUNITY**

The new Sexual Health Strategy is likely to emphasise the role of general practice and other agencies in the management and treatment of sexually transmitted infections. We really have no idea how this is going to impact on the services. Certainly there will be extra chlamydia testing being done in the Community, probably urine. It is expected that a large

amount of this will actually be referred on to GUM Clinics, as opposed to being treated in general practice, so the work load can be expected to increase, at least initially. One can see the Sexual Health Strategy having minimal impact in inner London areas where the general practitioners are already under enormous pressure, with many practices offering patients appointments for two or three weeks, even though the patients perceive they have an acute problem. As one member commented, even more resources might not be the answer for inner London, as with this area there is an almost unlimited demand for GUM services, with patients attending with a wide variety of problems and issues, many unrelated to the core work of genito-urinary medicine. "Perhaps the Sexual Health Strategy gives us an opportunity to change the model of care where unselected patients are screened in the Community, and the more complicated cases are seen in GUM. Perhaps we should just act as a screening service in these areas, ie. just offer urine and chlamydia, and GC tests. Don't do microscopy and give syndromic treatment at first visit, and only follow-up if symptomatic".

A single-handed Consultant in a DGH outside of London commented about the aspirations of the Sexual Health Strategy, and worried whether in fact General Practice has any real interest in Sexual Health. If I could just quote - "General Practitioners in..... also have two to three week waiting lists and Sexual Health is well down their agenda. Few have an interest in GU, and the increasing referrals / attendance rates indicate that they expect us to sort it out. Without a national service framework, as with diabetes and heart disease, Trusts and Health Services will not have a political need to do anything at all. GP's won't welcome more work without more resources and training. It would seem a shame to divert money from improving GU Medicine services which **have** the expertise and are trying to cope and directing some of that to provide a financial incentive to General Practice to do work they really don't have an interest in".

#### **ACCESS SURVEY FINDINGS OF JULY 2001**

At the AGUM Committee Meeting of the 29<sup>th</sup> June, it was suggested that another snapshot of access was actually needed to see if the situation had worsened or improved in the last year, and therefore a questionnaire similar to the MSSVD, AGUM, PHLs questionnaire of 2000 was sent out (Appendix 3). 120 clinics replied within 10 days and it is obvious that access is worsening by the month.

- **34% of clinics are now appointment only**
- **61% will see urgent cases within 24 hours**
- **23% never turn away patients**
- **68% have routine appointment delay of 1-week or more**
- **81% indicate the waiting times have increased**

The fact that so many clinics have such excessive routine appointment waiting times means that acute and urgent care is also compromised. In some cases, the waiting times ran to 3-4 weeks, but most of those clinics had adopted the protocol of refusing to give appointments once the appointment time exceeded two weeks. Despite the obvious pressure that all of the clinics are under there is still a strong willingness to try and see urgent cases, as soon as possible, and it's a reflection of the dedication of the staff that despite the pressures 61% of clinics to their utmost to see urgent cases within 24 hours. The replies to the questionnaire also included many personal comments, indicating the frustration and pressure of GUM services unable to cope.

## COMMENTS

- *Increased numbers of attendances, particularly more complicated cases means clinics are working well beyond safe capacity, and we frequently have to shut the doors even before the official closing time.*
- *At our busy walk-in sessions patients wait up to three hours to be seen..*
- *We opened a walk-in service in January 2001 which has proved extremely popular. We are at times overwhelmed, with 30+ men and 20+ women attending to see 3-4 doctors in a single morning session. Each doctor is thus seeing about 12 new cases in 3.5 – 4 hours, and clinics often run into the afternoon session. We have given access to those able to sit and wait each morning, but are concerned about sustaining quality and staff health in this highly pressured environment. Less staff time is now, however, taken with triage. GP referrals by letter now inevitably have less priority, as we have reduced booked clinics.*
- *The Welsh Assembly has embarked on a chlamydia public awareness campaign without even putting the infrastructure in place to cope with the inevitable increased demand.*
- *A half-time Consultant for a population of 160,000 including about 50 HIV Positives is woefully inadequate. We have all walk-in clinics, except one appointment clinic for GUM patients. HIV attendances are by appointment only, but patients can occasionally walk in. The number of new and total attendances have risen by 20% each year. The increase in staffing has not been commensurate with this. Staff stress has been extremely bad over the last two years particularly. The demand on our service has been increasing rapidly and is overwhelming us, so withholding appointments and telling patients to go elsewhere was the only way to control clinics, and to decrease the DNA rate.*
- *Excess attendances finally, reluctantly, led us to commencing an appointment only system in September 2000. Disappointing, but there was no other way.*
- *We are the only clinic in the area that still has walk-in sessions. This means a 3 hour walk-in clinic usually takes up to 5.5 hours to clear out all the patients.*
- *We see far too many patients from a neighbouring district where the waiting time is always very long.*
- *Access to our routine clinics remains reasonable and urgent cases are seen quickly. However, the development of other recognised clinical services, eg. Erectile Dysfunction and Genital Dermatology are just not happening. There is also an increase in paper work load to get through with the NHS reforms, re-validation, etc., etc.*
- *Access is worse due to an increase in attendances, especially in HIV patients, without a parallel increase in resources. Health advisers are over burdened, so contact-tracing is poor. There is also the problem of a high DNA rate amongst patients with appointments. We would dearly love to be open-access, but if only we had the resources, ie. money, staff and clinical space.*
- *Single-handed clinic, total attendances 12,000 plus per annum. Impossible now to obtain Clinical Assistants, no Staff Grade, no Associate Specialist.....*
- *We have at last managed to cut down waiting times by 50% since the introduction of Nurse Clinics through introduction of competency based work practises. Access varies according to circumstances. We had to close the clinic entirely for a week because of lack of support staff early in the year. August will be a difficult month, as there is no doctor cover available for annual leave.*
- *Our clinics are under pressure and the time for appointments have increased, especially when the adjacent clinic was closed temporarily.*

- *Increase in staffing has made a considerable difference.*
- *No time available, no personnel, no available premises, no finance, but every reason to wish to increase the number of sessions. Doctor..... says that the premises are worse than in Africa ! The managerial structure is inappropriate and in the hands of a ..... not even on the Consultant register. The Chief Executive does not reply to letters, clinic moving round temporarily from site to site.....*
- *The service is under relentless pressure and patients are having to wait an increasing amount of time.*
- *Clinics are overwhelmed. Enforced shorter consultations, patient and doctor dissatisfaction, urgent need for service expansion, situation worsening over the last 12 months.*
- *Severe under provision is impacting on access to surrounding clinics. Increasing waiting times is a consequence.*
- *Judging on the last three months, we have increased the number of patients being turned away from our clinics by 19%. Our waiting times are now ridiculous – up to 3-4 hours with at least 2 hours the average. The late night walk-in clinics – vastly oversubscribed.*
- *Point about telephone access. I can't believe how poorly the clinics advertise their services in local phone books, etc. We have a system whereby someone clinical is available from Monday to Friday 9-5pm, so that if patients cannot be seen straight away, they will have a chat with a Nurse of Health Adviser to suss out the problem. We often then simply add them on to the clinic. I think a lot of people find it reassuring to speak to somebody who knows what's what before they attend the clinic.*
- *Problem fitting people in, can't accommodate patients, problem getting locum cover.*
- *More and more patients have tried most of the other local clinics when they phone and have been unable to get appointments.*
- *Impact of syphilis outbreaks in Manchester on outlying areas of Greater Manchester. We desperately need a full time service at Salford.*
- *This service is woefully inadequate. We need a big expansion of services, in view of the local population.*
- *So many patients DNA'd. The waiting times are so long. These are significant missed opportunities.*
- *We have had to close early frequently in the last three months.*
- *Extreme lack of manpower.*
- *Hugely difficult. There is a desperate amount of emergency patients, especially women, and they often end up waiting for hours. Our work load has trebled since we opened this service 8 years ago. It obviously will continue to increase and we have no more capacity. We need more clinics, but no funding. We have every intention of increasing the number of sessions, but funding is a major problem. We are now considering an appointment only system. The sessions are over-running and the length of time we can spend with a patient has to decrease.*
- *We are just about coping at present. The open clinic is increasingly busy. We have to reduce Nurse Clinics, due to staff shortages.*

- *In the last three years, we have seen 150% increase in chlamydia. 206% increase in PID and 40% increase in primary herpes. 100% increase in secondary herpes, etc. All with the Trust reducing our budget.*
- *Would like to increase the number of evening appointments, but no money for extra staff.*
- *Planning to open throughout lunchtime in the Autumn, as soon as more staff can be appointed.*
- *We currently have unfilled 8 clinic sessions. No recurrent funding to fill vacancies.*
- *Walk-in clinics are essential, but staff don't like their unpredictability.*
- *The walk-in clinic is becoming increasingly busy and unmanageable. We are seeing many patients from adjacent areas where there's no walk-in service and are being referred to us. We can no longer cope with this and feel it could compromise patient care, and we could lose staff. We are in the process of discussing how we could continue to provide a walk-in service, and we will just have to reduce the numbers attending our clinic. New patient work load has increased markedly. We have accommodated this by establishing a new Staff Grade post, increasing the number of Clinical Doctor sessions weekly, reducing follow-ups, and prevailing upon the goodwill of all staff. Our waiting times for new patients have been in excess of 7 working days on some occasions. However, with the above plan in place we have managed to reduce this. None the less, we still feel that the service we are able to give is sub-optimal. For those patients who ring for an appointment, it is possible for those who are young, socially disadvantaged, from ethnic minorities and are less assertive may have delays being seen, despite having urgent conditions. Surrounding DGH clinics have less capacity to meet increased work load, and because their waiting times for non urgent cases has increased this partially accounts for an increase in demand in our clinic.*
- *There is a clear need to increase the number of sessions, but still awaiting additional funding and resources.*
- *Patient numbers have more than doubled in the last five years. There is very little increase in resources. The clinic has to close sometimes as early as 30 minutes after opening, due to large number of patients.*
- *The numbers attending our service has been increasing rapidly, so withholding appointments are the only way to control the clinics.*
- *Excessive attendances have led us to commencing an appointment system in September 2000. Access for urgent problems still maintained with difficulty. These patients, however, do have a long time to wait. Booked appointments are restricted and patient choice limited, due to demand exceeding availability.*
- *This clinic cannot cope indefinitely with the chronic under-funding and lack of staff. The main problem is the fact this clinic is still run by a single-handed DGH Consultant. Clinical governance indicates it is highly inappropriate that single-handed posts in acute specialties like this should be doubled up immediately or else the unit shut down. Leave is a major issue. I am so fed up, burnt out and generally disillusioned with the service, and the difficulty in getting cover. The local..... area is obviously a major problem with high levels of teenage pregnancies and chlamydia, and indeed HIV. I have been pleading for an Outreach Clinic there, combined with Family Planning, for three years now, with hardly a response ! This service needs a second full time Consultant immediately, with 2-3 sessions devoted to setting up a proper satellite service in ..... area.*

### **Summary of the access survey:**

The statistics indicated above, and the strength of feeling expressed in comments received, indicate a service under undue pressure. It is extraordinary that there is still extreme determination to implement a satisfactory service, but the chronic lack of staffing is an issue, and one wonders how much longer the goodwill of the overworked staff can be relied upon.

### **CONCLUSIONS**

Access to Genito-Urinary Medicine services is now difficult in most areas of the country and the situation is deteriorating. Attempts at triage or “close the door” policy is simply a reflection of the demand outstripping the supply, and at best can only be stop-gap. The key to adequately performing service is the Doctor↔Patient interaction and access will continue to be poor until funding is available to increase the number of doctors actually seeing patients in GUM clinics.

Our work load survey has shown that clinics that can achieve a ratio of at least 5 Doctor sessions per week per 1000 new patients should have the ability to maintain easy access. The survey showed that very few clinics are actually achieving this level, and unless the staffing issues are seriously looked at with extra funding, there is no possibility of improving access and this situation will continue as it is.

### **WORK NEEDED TO CLARIFY THE METHOD OF MAXIMISING ACCESS WITH CURRENT WORK FORCE**

1. British Co-operative Clinical Group to conduct a survey of specific clinical procedures, to try and highlight practices that require the minimum follow-up. Where appropriate, these practices may be indicated in the Clinical Effectiveness Guidelines.
2. Data from the Southampton study could be used to compare a random selection of clinics that have good access, and clinics that don't, and establish the practices and procedures in these clinics, to establish if it's simply staffing issues or clinic practice that determines lack of access.
3. Using calculations similar to Appendix 1 & 2. Clinics can establish the number of Doctor sessions needed per catchment area of population in various locations, ie. inner city of London, outer London, out of London City Hospital and District General Hospital. These are the levels of staffing that should be strived for if access is to be reasonable.
4. Through AGUM establish which clinics are using Senior Nursing personnel as frontline staff or as Nurse Consultants, and see if it's having an effect on access.
5. Continue to monitor access by having a simple question added to the KC60 or in Scotland the ISD(D)5. One simple question asking – *How long is it before the next routine appointment can be given ?* - would be enough to indicate the pressure clinics are under. This request has already been made to the PHLS and Department of Health.

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## ACCESS REPORT – APPENDIX 1

### CONSULTANT WORKFORCE DATA FOR GENITOURINARY MEDICINE RCP WORKFORCE UNIT (Dr Karen Rogstad 29/11/00)

#### Number of Consultants by country

	<b>Number</b>	<b>Whole time equivalent (WTE)</b>
England	244	221
Wales	8	7
Northern Ireland	3	3
<b>TOTAL</b>	<b>255</b>	<b>231</b>

#### Distribution of Consultants

NHS	228
NHS/Academic	21
Academic/Research	1
NHS / Private	3
HM Forces	0
Other / Private	2

#### Number of Consultants by year

	<b>Number</b>
1993	198
1994	220
1995	228
1996	241
1997	254
1998	255
1999	255

#### Consultant expansion

	<b>GUM</b>	<b>All medical specialties</b>
over 3 years	0.30%	11%
over 7 years	29%	38%

#### Distribution of Consultants by teaching and non-teaching hospitals

<b>Non-teaching</b>		<b>Teaching</b>	
<b>Number</b>	<b>WTE</b>	<b>Number</b>	<b>WTE</b>
172	158	83	73
67.50%	68.40%	32.50%	31.60%

**APPENDIX 1 ..... continued**

CONSULTANT WORKFORCE DATA FOR GENITOURINARY MEDICINE  
RCP WORKFORCE UNIT  
(Dr Karen Rogstad 29/11/00)

**Gender of Consultants**

	<b>GUM</b>	<b>All medical specialties</b>
Male	180 (70.6%)	4458 (83.2%)
Female	75 (29.4%)	902 (16.8%)

**Gender of SpRs**

Male	43 (42.2%)	1810 (62.6%)
Female	59 (57.8%)	1082 (37.4%)

**Retirement**

	<b>GUM</b>	<b>All medical specialties</b>
Average retirement age plan to retire early		61
1997		27.50%
1998		30.90%
1999	25.50%	32.10%
Number reaching 60 in next 10 years.	89 (35%)	1816 (34%)

**Workload**

**Excess workload**

**GUM**

**Gender of Consultants**

	<b>GUM</b>	<b>All medical specialties</b>
Male	180 (70.6%)	4458 (83.2%)
Female	75 (29.4%)	902 (16.8%)

Average excess hours in 48hr week 2.5

Excess NHDs worked 4.4

**Increase in Consultant workforce needed**

	<b>GUM</b>
to satisfy EU directive on working times	14
based on excess NHDs worked	102
based on 1 per 113,000 of population	227

**95% increase**

**APPENDIX 2**

**WORK LOAD CALCULATIONS FOR ACCESS  
JULY 2001**

In an attempt to calculate number of Doctor sessions needed per 1000 new attendances, I am looking at clinics that have 'open access' and are managing. I am also looking at clinics that have several weeks waiting times. It looks like clinics that have at least 5.3 Doctor sessions per 1000 new attendances are able to cope. Would you please fill in the figures for your clinic. I am enclosing copy of the calculations for the Chester Clinic as an example.

Adequate access is the equivalent of 'open access' or the ability to give routine appointments for the next clinic, ie. no waiting list.

**CLINIC:**

**CONSULTANT:**

**ACCESS:**

**Catchment area population:** \_\_\_\_\_

**GUM**

- New & Re-booked attendances per year (NOT follow-up): \_\_\_\_\_

therefore % of population attending = \_\_\_\_\_

**HIV**

- Number of HIV Positive patients attending = \_\_\_\_\_

on average, 10 visits per year. Therefore, it's the equivalent of 10 x visits = \_\_\_\_\_

This figure is added to the total New and re-booked attendances, giving therefore total new attendances, including HIV = \_\_\_\_\_

Number of Doctor clinic sessions per week \_\_\_\_\_

**Please return to:**

Dr Colm O'Mahony  
Hon. Secretary – AGUM  
Consultant in Genito-Urinary Medicine  
Dept Genito-Urinary Medicine  
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**APPENDIX 2 ..... continued**

**WORK LOAD CALCULATIONS FOR ACCESS  
JULY 2001**

Adequate access is the equivalent of 'open access' or the ability to give routine appointments for the next clinic, ie. no waiting list.

**CLINIC: CHESTER**

**CONSULTANT: Dr Colm O'Mahony**

**ACCESS: Open / Adequate**

**Catchment area population:** 250,000

**GUM**

- New & Re-booked attendances per year (NOT follow-up): 3,500

therefore % of population attending = 1.4%

**HIV**

- Number of HIV Positive patients attending = 40

on average, 10 visits per year. Therefore, it's the equivalent of 10 x 40 visits = 400

This figure is added to the total New attendances, giving total new attendances, including HIV = 3,900

Number of Doctor clinic sessions (3 x 3 and 3 x 4) 21

21 Doctor sessions needed for 3900 new attendances per year.

or

**5.3 Doctor sessions per week for 1000 new attendances per year.**

**APPENDIX 2 ..... continued**

**WORK LOAD CALCULATIONS FOR ACCESS  
JULY 2001**

Adequate access is the equivalent of 'open access' or the ability to give routine appointments for the next clinic, ie. no waiting list.

**CLINIC: SHEFFIELD**

**CONSULTANT: Dr G R Kinghorn**

**ACCESS: Mixed appointment / open. Barely adequate !**

**Catchment area population:** 525,000

**GUM**

- New & Re-booked attendances per year (NOT follow-up): 10,800

therefore % of population attending = 2.0%

**HIV**

- Number of HIV Positive patients attending = 80

on average, 10 visits per year. Therefore, it's the equivalent of 10 x 80 visits = 800

This figure is added to the total New attendances, giving total new attendances, including HIV = 10,964

Number of Doctor clinic sessions per week 60

**5.5 Doctor sessions per week per 1000 patients**

**APPENDIX 2 ..... continued**

**WORK LOAD CALCULATIONS FOR ACCESS  
JULY 2001**

Adequate access is the equivalent of 'open access' or the ability to give routine appointments for the next clinic, ie. no waiting list.

**CLINIC: Garden Clinic, Upton Hospital, SLOUGH.**

**CONSULTANT: Dr N Desmond**

**ACCESS: Appointment and walk-in, but service is overwhelmed.**

**Catchment area population:** 350,000

**GUM**

- New & Re-booked attendances per year (NOT follow-up): 7,200  
therefore % of population attending = 2.05%

**HIV**

- Number of HIV Positive patients attending = 100

on average, 10 visits per year. Therefore, it's the  
equivalent of 10 x 100 visits = 1,000

This figure is added to the total New attendances,  
giving total new attendances, including HIV = 8,200

Number of Doctor clinic sessions per week 20

**ie. 2.4 sessions per 1000 new attendances per year**

**APPENDIX 3**

**SURVEY OF PATIENT ACCESS TO GENITO-URINARY MEDICINE – JULY 2001**

**CLINIC:**

**LEAD CONSULTANT:**

**TELEPHONE:**

**FAX:**

**E-MAIL:**

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**ROUTINE APPOINTMENTS**

1. Does your clinic operate (tick one of the following):

(a) an appointment service only

(b) walk in service only

(c) appointment and walk in

2. For your routine appointment services, what is the current waiting time for: (Please check with your reception before you complete this questionnaire).

(a) Female appointment \_\_\_\_\_(working days)

(b) Heterosexual male appointment \_\_\_\_\_(working days)

(c) Homosexual male appointment \_\_\_\_\_(working days)

3. How quickly are patients seen for urgent problems:

♦ within 24 hours

♦ 1-2 working days

♦ 3-4 working days

♦ 5-7 working days

♦ >1 week

♦ other

4. What is the longest time between your clinic opening times:

\_\_\_\_\_ (working days)

5. If you have a walk-in service, do you have to turn patients away ?

Always  Frequently  Sometimes  Never

6. Have you had a reason over the past 12 months to:

(a) Increase the number of sessions YES  NO

(b) Decrease the number of sessions YES  NO

7. Has the time 'waiting to be seen' increased in the last year ? YES  NO

Any further comments about access \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE RETURN YOUR QUESTIONNAIRE TO:  
REGIONAL AGUM REPRESENTATIVE**

**and to**

**Dr Colm O'Mahony**

**Hon. Secretary – AGUM**

**Telephone: (01244) 363097**

**Fax: (01244) 363095**

**E-mail: [dr.o'mahony@coch-tr.nwest.nhs.uk](mailto:dr.o'mahony@coch-tr.nwest.nhs.uk)**

## ACCESS REPORT

JULY 2001

### EXECUTIVE SUMMARY

#### Introduction

There has been a doubling of attendances at Genito-Urinary Medicine services over the last ten years. Over the last few years it became obvious that access was becoming difficult, with clinics developing waiting lists and many clinics being unable to see urgent cases within 24 hours. This has coincided with a significant increase in the incidence of all sexually transmitted infections, particularly chlamydia, gonorrhoea, syphilis and HIV. For control of these infectious conditions to be effective, immediate access to care and treatment is an absolute necessity. Previous studies in the year 2000: one from Southampton – *Foley et al*, and one by the combined PHLS / AGUM / MSSVD – both showed problems with access. Small increases in staffing levels in the early 90's have not kept pace with the demand for the service. The two specialty Societies, AGUM and MSSVD, have done further work, looking at access and work load, and this is summarised in this report.

#### SUMMARY

A 2-page questionnaire was sent to a random selection of clinics, via the Regional Representatives, when 120 clinics responded within ten days and the results are summarised:

- **34% of clinics are now appointment only**
- **61% will see urgent cases within 24 hours**
- **23% never turn away patients**
- **68% have routine appointment delay of 1-week or more**
- **81% indicate the waiting times have increased**

The full report published on the AGUM website at <http://www.agum.org.uk/index.html> also contains three pages of collated comments that were returned with the questionnaires. There is no doubt that the situation has deteriorated dramatically, even in the last year, many clinics stretched well beyond safe practice. The comments indicated the depth of frustration at the lack of funding that is needed to provide a responsive service.

A further questionnaire was also sent out to establish what Doctor staffing levels were needed to run an open access service and work load figures indicate that at least 5-6 Doctor sessions per 1000 new attendances is what is required to keep this service open access. Most clinics fell well below this, the average being 3.8, but some clinics being as low as 2.1 Doctor sessions per 1000 patients. General clinic practice has changed with the development of the Clinical Effectiveness Guidelines, and better use of skill mixtures within clinics, but despite operating at maximum efficiency, most areas of the country have insufficient services to meet the overwhelming demand.

#### CONCLUSION

The Genito-Urinary Medicine services are desperately trying to cope with major public health issues of HIV / AIDS and sexually transmitted infections within the United Kingdom. The demand for service far outstrips the provision and long waiting lists, and lack of access are a clear sign of this deterioration. To restore reasonable access will require significant funding for improved premises, so that the service can physically cope with the numbers, and increase staffing levels of the appropriate skill mix to run an efficient system. To allow the current situation to continue will simply lead to increased prevalence and morbidity, and a disillusionment of the dedicated, but already overwhelmed work force who desperately want to provide a first class service to their patients.

#### ACCESS REPORT GROUP

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Dr Philip Kell  
Dr Sue Mitchell  
Dr Elizabeth Foley

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