

Measuring access to genitourinary medicine clinic services

Report to the Sexual Health Services Data Group

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INTRODUCTION AND BACKGROUND

Demand for genitourinary medicine (GUM) services has increased over recent years. Consequently, patients have had difficulty accessing GUM clinics.¹ Currently waiting times in GUM clinics are not measured but a large proportion of patients are not seen within 48 hours, which is the accepted gold standard.² A routinely collected waiting time indicator would provide a standard measure of access on a regular basis, and could be used to resource and plan services.

Patients access GUM clinics in different ways according to the type of clinic:

- Drop-in clinics – no appointment necessary
- Closed appointment clinics – appointments made over a restricted period of time only
- Open appointment – appointments made over an unrestricted period

OBJECTIVE

To develop a waiting time indicator as part of routine surveillance which measures access to GUM clinics.

METHOD

A literature review and semi-structured interviews with GUM consultants and statistical and surveillance experts were carried out.¹

RESULTS

1 Literature review

No national or international literature on existing GUM clinic waiting time indicators was found. Few countries have specific GUM clinics and none measure their waiting times.

2 What should be measured?

Waiting times in the different types of clinic cannot be compared and each would require their own indicator. In addition, this would allow monitoring trends over time by clinic type. For example, in recent years many clinics have changed from drop-in to appointment only to manage demand better.

Based on the interviews, proposed waiting time measurements are shown in table 1. A summary of the main points raised during the interviews is given in the Appendix.

¹ List of interviewees: Dr Angela Robinson, Dr Keith Radcliffe, Dr Caroline Bradbeer, Dr George Kinghorn, Mr Lesz Lancucki, Dr Gwenda Hughes

Table 1

Waiting time indicators (at end of quarter for new attendances only):			
Open appointment clinics:	Days till next available routine appointment		
Closed appointment clinics:	Booking period in days		
	Days till next available routine appointment		
Drop-in clinics:	Numbers seen within 1 hour	Numbers seen between 1 hour and 2 hours	Numbers seen after 2 hours

Descriptions of the measurements shown in table 1 are given in table 2.

Start of waiting time	Patient registration with reception
End of waiting time	Patient seen by clinician, i.e. doctor or nurse practitioner but <i>excluding triage</i>
End of quarter	On any given day during the last two weeks after the end of quarter
Next available routine appointment	Next free appointment slot patient could have had for those who do not need to be seen on same day on clinical grounds (exclude emergencies)
New attendances	Any new episodes of patient care
Booking period	The period for which appointments are booked
Hours till seen by clinician	Total time spent in clinic from patient registration until consultation with the clinician.

3 How should it be measured?

Collection method

QMOP (previously KH09) returns from all NHS Trusts and PCTs record first and subsequent attendances, and DNAs (did not attend) for each specialty. It is a standard form and including specific questions for one specialty only is not an option.

Form KC60 is a quarterly statutory return from all GUM clinics, which records aggregated counts of all conditions seen and episodes of care delivered. Currently, the form is undergoing a review and a small number of questions on waiting times could be included in the revised form. In the longer term, it is hoped that KC60 surveillance will be replaced with an individual patient-based data collection system, the Programme of Enhanced STI Surveillance (ProgrESS). Therefore it is proposed to incorporate the waiting time indicators in form KC60 until the new system is operational in two to three years.

Most KC60 returns are collected by CDSC as paper records. In some clinics the data are generated automatically by the GUM clinic information system, in others the data are collated manually by clinic staff. The capability of the six major computerised information systems used in GUM clinics varies. Only some could routinely produce information on waiting times and at present no differentiation between available and actual appointments could be made. Altering the software to automatically provide the

proposed waiting time indicators would require considerable programming input, and should be deferred until major revisions to GUM clinic data collection systems are undertaken as part of ProgrESS. Consequently, waiting time indicators would need to be collated manually by receptionist or administrative staff.

Calculation method

Because waiting time indicators would need to be collated manually by receptionist or administrative staff it should be simple and quick to record the raw data with which to calculate them. Clinics would be responsible for collecting the raw data on form KC60; any further calculations would be done by CDSC, where appropriate. Waiting times indicators will be calculated as follows:

Appointment clinics	Days until the next routine appointment for a new attendance on a given day at the end of the quarter. The median time for routine appointments for all open appointment clinics would be calculated annually. Clinics with closed appointment booking systems would be grouped separately and according to booking periods, and estimates calculated independently.
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Drop-in clinics	The proportion of patients seen in each time category i.e. the number of patients seen in each time category divided by the total number of patients seen on a given day at the end of the quarter.
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4 What should be done with the data?

Standards will have to be set against which waiting times can be compared. The following are proposed:

Appointment clinics:	All new patients should be offered routine appointments within 48 hours
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Drop-in clinics:	No patient should have to wait more than 2 hours to be seen by a clinician (excluding triage)
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CONCLUSION

Separate waiting time indicators are necessary for drop-in, closed and open appointment clinics but these could be easily collected through KC60 returns.

RECOMMENDATIONS

The proposed waiting time indicators, definitions and standards should be adopted. Waiting time indicators should be collected through the revised form KC60, thereby incorporating waiting time indicators as part of statutory routine surveillance.

Appendix What should be measured to monitor access? Summary of interviews.

Category	Options (those chosen in bold)	Justification for choice	Comment
Patient group	<ul style="list-style-type: none"> • First attendances • Subsequent attendances • All 	For follow-ups diagnoses and patient risk factors determine when they need to be seen again	Waiting for follow-ups influenced by waiting for tests and results
Appointment count	<ul style="list-style-type: none"> • Available appointment • Actual appointment 	Large number of patients do not take up first available appointment because date or time do not suit them, resulting in artificially increased waiting times using actual appointments	For available appointments electronic data collection not possible at present
Type of appointment	<ul style="list-style-type: none"> • Routine • Emergency (urgent) • All 	Easier to define and better standardisation than emergency appointments	<ul style="list-style-type: none"> • No agreed definition of emergency appointments amongst clinicians and patients • Large variety of systems to deal with emergencies • Patients' insistence to be seen and clinicians willingness to work longer can influence waiting times for emergency appointments thus making standardisation difficult
Start of waiting time	<ul style="list-style-type: none"> • Patient registration • Patient contact 	Patient registration easy to measure	Patient registration excludes those turned away or not able to get through on telephone but this would be very difficult to measure
End of waiting time	<ul style="list-style-type: none"> • Seen by clinician dealing with reason for attendance • Seen by clinician 	Clinician dealing with reason for attendance excludes triage, and would be relevant to patients	Introduction of triage could influence waiting times
Time measurement	<ul style="list-style-type: none"> • Fixed time categories (e.g. numbers seen within 1 hour) • Actual time 	Easier to measure and set standard	Setting standard for average waiting time much more difficult than for proportion of patients seen within a certain time

REFERENCES

1. Djuretic T, Catchpole M, Bingham JS, Robinson A, Hughes G, Kinghorn G. Genitourinary medicine services in the United Kingdom are failing to meet current demand. *Int J of STD & AIDS* 2001;12:571-2.
2. Foley E, Patel R, Green N, Rowen D. Access to genitourinary medicine clinics in the United Kingdom. *Sex Transm Infect* 2001;77(1):12-4.