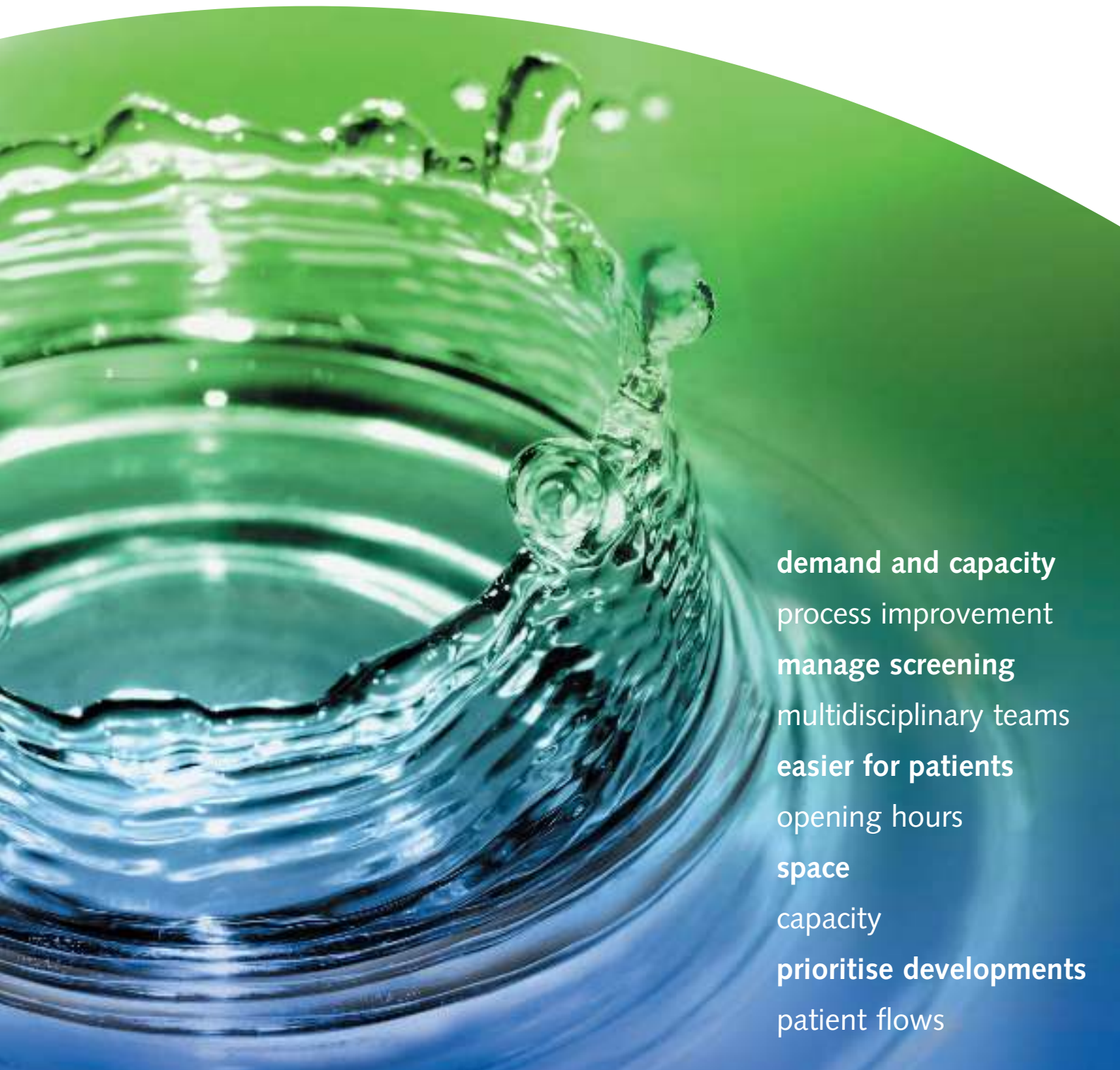


10 High Impact Changes

For Genitourinary Medicine 48-hour Access



demand and capacity
process improvement
manage screening
multidisciplinary teams
easier for patients
opening hours
space
capacity
prioritise developments
patient flows

DH INFORMATION READER BOX

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INTRODUCTION

The implementation of strategies for integrated local sexual health service development takes time, and progress varies around the country. In the future, sexual health services will be provided in a range of hospital and community settings and people will be able to choose where to go for treatment.

This document recognises that aspects of sexual health service development involve a broader focus and that the use of alternative settings will help to reduce demand upon genitourinary medicine (GUM) clinics. Case studies within the High Impact Changes highlight the importance of making better use of community contraceptive services. The document recognises that, in order to alleviate pressure, Level 2 GUM should be developed to support the testing and treating of existing patients. Such an approach demonstrates the role of other sexual health services in the community as a stepping stone to achieving this strategy in addition to preventing further unnecessary demand for GUM.

Some of this may demand a wider approach for long-term improvements to sexual health, such as the introduction of the National Chlamydia Screening Programme¹ and reducing Teenage Pregnancies.^{2,3} However, the focus of this document is upon the rapid improvement of access to GUM services.

These High Impact Changes provide measures that can be implemented quickly and on a scale that will enable 48-hour access to a local GUM service by March 2008.

For many primary care trusts (PCTs), the changes likely to have the greatest and quickest impact on achieving the target will be within existing GUM services. The measures included in this document reflect good practice. They are not mandatory but where trusts implement them, they will both increase efficiency and enable progress towards the GUM access target.

SEXUALLY TRANSMITTED INFECTIONS – A PUBLIC HEALTH CHALLENGE

- STI diagnoses and other GUM workload more than doubled in the five years to 2004.⁴
- Syphilis diagnoses increased by 23% in one year (2004/05).⁵
- More than 750,000 cases of STI were diagnosed in GUM clinics in 2005.⁶
- The number of people receiving care for HIV doubled in the five years to 2004.⁷
- A third of HIV infections in the UK are undiagnosed.⁸
- Over one in ten young people screened for chlamydia test positive.⁹

SUMMARY OF HIGH IMPACT CHANGES

Theme: Identify how much capacity you need to meet the access target

High Impact Change 1: *Measure demand and capacity across the local health economy*

By understanding the gap between demand and capacity, services can then plan how to address it through implementing the other High Impact Changes.

Theme: Maximise use of existing resources to increase capacity

High Impact Change 2: *Begin a process improvement project to inform service redesign*

Optimising patient flow through service bottlenecks, through service redesign, can deliver shorter patient journeys, release existing resources and increase capacity.

High Impact Change 3: *Analyse and improve utilisation of the multidisciplinary teams in GUM*

In many cases multidisciplinary team roles, particularly nursing, have been extended to increase capacity to see new patients, but there is scope to take this work further.

High Impact Change 4: *Develop a separate pathway to manage screening of patients at low risk for STIs*

Change from triage to streaming, so lower risk patients can be seen quickly by more junior staff, while more senior members of the multidisciplinary team see complex cases and higher risk patients.

High Impact Change 5: *Review current access system and make it easier for patients to access the service*

Centralised booking systems make better use of capacity across an area and enable patients to make an appointment through one phone call, which is particularly useful for satellite or part-time services.

High Impact Change 6: *Reorganise clinic opening hours to improve access*

Matching the timing of services and staffing levels to the times when people want to be seen should ensure that capacity is fully utilised.

High Impact Change 7: *Reorganise the physical environment to maximise the space available for seeing Patients*

Identify any times when existing space is under-utilised and adapt patient journeys to minimise these bottlenecks.

Theme: Improve efficiency (and eliminate waste)

High Impact Change 8: *Reduce unnecessary clinical activity to increase capacity for new patients*

Reviewing traditional practice and reducing unnecessary clinical activity such as follow-up patient attendances, sending results by text, and changing the type and volume of tasks traditionally undertaken by staff, can free up capacity to see more new patients.

Theme: Ensure effective commissioning and contracting

High Impact Change 9: *Assess the state of readiness of service providers outside GUM, and prioritise developments that will help meet and sustain the GUM access target*

Other local sexual services can enhance and supplement current GUM capacity and provide more choice for patients.

High Impact Change 10: *Make costs of GUM services transparent and develop appropriate commissioning consortia which reflect patient flows*

HIV outpatients represent low volume but high cost for GUM services, and they do not attract Payment by Results (PbR) at present. Separate commissioning arrangements will ensure that adequate services are provided for HIV patients without compromising care for other STI patients.

THEME: Identify how much capacity you need to meet the access target

High Impact Change 1 focuses on measuring the gap between demand and capacity in the local health economy. By understanding the gap between demand and capacity, services can then plan how to address it through implementing the other High Impact Changes.

HIGH IMPACT CHANGE 1

Measure demand and capacity across the local health economy

WHAT DO WE MEAN? Many services are struggling to plan effectively for demand. The principle for a public health, open access service such as GUM should be that demand is not 'managed' by being restricted in order to fit current activity (limiting the number of patients seen in line with a clinic's current working practice) but instead capacity is developed in order to meet real demand.

In some cases, this means that services may need a significant increase in capacity. This section aims to provide some simple initial guidance on how to measure demand effectively. The subsequent nine High Impact Changes will then assist services to create additional capacity through new ways of working. The Department of Health policy team and the Department of Health National Support Team are developing more detailed guidance on how to measure demand and capacity in sexual health services. This will be distributed as soon as possible but, in the interim, PCTs and GUM providers can start to undertake an assessment of current demand on individual GUM services.

The majority of queues in the NHS are caused by a mismatch between variations in daily (or hourly) demand, ie requests for the service, and variations in capacity, ie when the staff are actually available to see patients. In the presence of such a mismatch, a queue will result, even if the average capacity is equal to the average demand. This is because when demand exceeds capacity, the excess demand will be carried forward as a queue, but when capacity exceeds demand, the excess is lost and cannot be retrieved in the future. Services are advised to avoid the 'flaw of averages' when planning the capacity of their clinic.

In most services, there will be natural peaks and troughs in demand. The key to resolving persistent waiting times is for staff to measure the demand and understand the pattern and causes of variation. The service capacity then needs to be designed to meet the peaks. Waiting times will inevitably build up if capacity plans are not sufficient to meet demand peaks.

There are different types of demand that may present to a service. In simple terms, the demand can be broken down and described as three different types:

1. real demand, ie patients who are seeking a service;
2. failure demand, ie patients who are presenting to the service because they have failed to have their needs met elsewhere;
3. institutional demand, ie demand created in the system through the process, such as follow-up.

It is best practice for services to monitor **all** demand. Ideally, monitoring should be continuous. Over time, as the impact of service redesign, reduced waiting times and increased capacity is felt, real demand may increase. Where waiting times are excessive, it may be necessary to eliminate a waiting list backlog by providing additional services for a time-limited period. Thereafter the service may need to provide sufficient capacity to meet demand peaks in order to sustain required waiting times.

Activity is a crude measure of the capacity within the system; it is not a measure of demand. The activity is governed by the actual capacity, ie numbers of staff present at a given time and when the patients are booked in to be seen. It is imperative that activity and demand are not confused. The access plan to meet the 48-hour target will be informed by demand, and it is advisable to include measures that provide sufficient capacity to meet demand peaks.

WHAT ARE THE BENEFITS? Armed with an understanding of the scale and nature of the gap between demand and capacity, services can develop realistic and concrete plans for eliminating it. This information will also support commissioners undertaking needs assessment and developing broader implementation plans for their local sexual health strategy.

WHAT DO YOU NEED TO DO?

While opinions vary regarding how best to undertake demand and capacity planning in GUM, there are a number of tasks that can be undertaken by local health economies.

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Capture all requests for a service. The tool for this can be very simple (such as a five-bar gate), if it cannot be done through an electronic booking system. Separate calls into simple categories: <ul style="list-style-type: none"> • calls received; • appointments required; • appointments given. 		✓	
Capture the number of patients who actually turn up for the service, to calculate the did not attend (DNA) rate.		✓	
Ensure sufficient staff and phone line capacity to take and record all requests for a service. A crude measure of adequate phone capacity is when reasonable intervals between phone calls are established. A phone that is constantly ringing indicates there are patients who are not able to get through on the line. (See High Impact Change 5.)		✓	
Remove any other restrictions on how patients might access the service. (See High Impact Change 5.)			✓

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Monitor demand continuously if possible, but never for less than a six-week period.		✓	
Over time (three months) identify trends and peaks in demand on a daily basis.		✓	
For services with persistently long waiting times, consider running additional services for a time-limited period to eliminate the backlog.			✓
Use information gathered to calculate service demand, to inform the overall 48-hour access plan.			✓

Case study

Demand and capacity mapping – Sexual Health Modernisation Initiative, Lambeth and Southwark, South East London

The Sexual Health Modernisation Initiative in Lambeth and Southwark gathered data on demand as the first step in understanding how people accessed services and where potential improvements could be made. All services agreed to record the number of people accessing the service, the reasons people visited the service, the

number who were turned away and the number who left without being seen. In addition, telephone demand was monitored.

A data collection tool was developed and piloted in one service. After adjustments, the tool was used to collect demand data for a week in all GUM clinics and sexual and reproductive health services in Lambeth and Southwark, plus a sample of GP practices and

Case study – continued

community pharmacies from one area. A service lead and lead clinician were involved from each service. The data were analysed based on time of day and reason for visit.

The outcome was a deeper understanding of demand for services and the capacity required to meet it. For example, it was discovered that over 50% of people accessing a GUM service arrived within the first hour of the clinic opening. This explained the long queues, crowded waiting rooms, staff feeling under pressure, harassment of reception staff by frustrated clients and adverse incidents.

A number of initiatives were implemented to control the flow of clients into the clinic, including a slot booking system (similar to museum queuing whereby visitors get a timed ticket to return and enter the exhibition); a triage system so that nurses' and doctors' time and skills could be used more effectively; and a change to answer machine messages so they did not suggest that people wanting to access the clinic should arrive early.

Ongoing measurement of the total time spent in the clinic per visit found that the slot booking system reduced the average

from over four hours to under two. Staff reported feeling more in control and not operating in a 'fire-fighting' mode.

It was recognised that there was enough capacity to meet demand but that it had not been supplied in the right configuration. For example, for less than one hour face to face with a clinician, clients could have spent up to five hours waiting. The data also showed that community pharmacy and general practice were significant providers of sexual health services and should not be excluded from any improvement work.

Measuring demand and capacity takes planning. It is essential that all services are signed up to the exercise, especially clinicians. Lack of engagement can result in poor data quality and resentment of 'yet another' monitoring activity. As it is easy to collect much more data than it is possible to analyse, it is important to keep the exercise simple and be very clear at the outset about the purpose for which the data are being collected.

Contact: Vikki Pearce, Programme Manager, Sexual Health Modernisation Initiative, Lambeth and Southwark, South East London. Email: vikki.pearce@nhs.net

Resources and further guidance

- 1 Department of Health. Forthcoming guidance on how to measure demand and capacity in sexual health services (early 2007)
- 2 Improvement Foundation (incorporating the National Primary Care Development Team) *Advanced Access – Handling Common Questions*, www.improvementfoundation.org/View.aspx?page=/topics/health/advanced_access/aa_material.html
- 3 Murray M (2000) Patient care: access. *BMJ*, **320**:1594–6
- 4 NHS Institute for Innovation and Improvement (2005) *Improvement Leaders' Guides – Matching capacity and demand*, www.institute.nhs.uk/Products/ImprovementLeadersGuidesProcessandSystemsThinking.htm
- 5 Oldham J (2001) *Advanced Access in Primary Care* (National Primary Care Development Team) www.npdt.org/1626/advancedaccess.pdf
- 6 Silvester K, Lendon R, Bevan H et al (2004) Reducing waiting times in the NHS: is lack of capacity the problem? *Clinician in Management*, **12**, www.wise.nhs.uk/NR/rdonlyres/5EF9230C-34D6-4094-A3BC-520A40B42823/1092/CIM12_3_Silvester.pdf

THEME: Maximise use of existing resources to increase capacity

High Impact Changes 2–7 focus on reviewing existing resources to ensure that they are being best utilised in order to maximise the available capacity to see patients.

HIGH IMPACT CHANGE 2

Begin a process improvement project to inform service redesign

WHAT DO WE MEAN? A process improvement review, which defines, measures and analyses all processes used in the service, can highlight factors that support or hinder the service's ability to meet patient demand. This process can enable teams to prioritise changes they may want to make and will also allow them to test and control the impact of any change. The process is cyclical with regular repetition to review and refine changes.

Process improvement methodologies have been widely tried and tested within the NHS, but may be relatively new to GUM teams. Individual services will need to decide on the scope of their process improvement project. It is possible to focus on a particular process, eg clinic registration. However, a whole-system approach provides an opportunity to understand the entirety of a service and to review the impact of clinical practice on team members' time and thus their capacity to see patients. For example, mapping and measuring time spent on triage, and considering how else patients could have had their needs met, can

give teams the information they need to redesign this element of service.

The complexity of the process improvement task, and the time that will be required to carry it out, may prohibit many GUM services from undertaking this work without extra support. Securing external expertise to work alongside clinical teams will maximise the benefits. This knowledge is often found within acute trusts, many of which have developed expertise in process redesign over recent years.

WHAT ARE THE BENEFITS? This process can provide accurate insight into factors within a service that are restricting its capacity in ways which may not be immediately obvious. It can also clearly identify bottlenecks in the patient pathway, where redesign or removal of barriers could improve patient flow in the clinic. It may not always be possible to remove

completely an identified bottleneck, in which case everything possible may need to be done to minimise its impact by working at 100% capacity. For example, if the main constraint is clinic rooms, then it would be beneficial to ensure that these are in full use all the time and that staffing is rearranged in accordance with this. With detailed information, teams can make effective choices about what to change or redesign, and how. The process will also allow teams to test change in a controlled manner and therefore to minimise any undesirable consequences.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Identify where in the provider organisation, or elsewhere in the local health economy, there is the expertise to carry out a process improvement project.		✓	
Ensure that working within the GUM service is made a priority for those with expertise in process improvement.		✓	

Case study

How process improvement methodology was applied to the development of capacity and demand measurement – West Midlands Strategic Health Authority/National Primary Care Development Team

Members of the multidisciplinary teams from the majority of clinics across West Midlands SHA attended National Quality Improvement Skills Programme (NQISP) workshops to focus on the psychology of change, process improvement, analysis of information and data measurement, and process mapping. The aim was to help support and sustain change by applying improvement skills learnt to clinical and organisational problems, particularly focusing on 48-hour access. The programme reviewed the methodology to measure capacity and demand.

Capacity and demand were measured by each team for at least four weeks prior to the first workshop, and the baseline data

used to identify areas of work to focus on in order to identify problems and possible solutions, including improving access across all sites. Areas considered included analysis of existing services to identify possible gaps in service provision; analysis and understanding of existing demand and capacity for each site; streamlining of some administrative and appointment processes; further development of nurse-led clinics; and raising awareness of existing, utilised services available.

The overall impact of the workshops was to improve awareness of all members of the multidisciplinary team regarding existing financial, resource and staffing constraints on access and improvement initiatives. Capacity and demand have continued to be measured at regular intervals.

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Resources and further guidance

- 1 Emergency Services Collaborative, NHS Modernisation Agency (2004) *Making See and Treat Work for Patients and Staff*. www.wise.nhs.uk/sites/serviceimprovementcollab/emergency/Emergency%20Services%20Documents/1/See%20and%20Treat/Making%20See%20and%20Treat%20Work%20for%20Patients%20and%20Staff.pdf
- 2 NHS Institute for Innovation and Improvement (2005) *Improvement Leaders' Guides – Process mapping, analysis and redesign*, www.institute.nhs.uk/Products/ImprovementLeadersGuidesGeneralImprovementSkills.htm

HIGH IMPACT CHANGE 3

Analyse and improve utilisation of the multidisciplinary teams in GUM

WHAT DO WE MEAN? Arguably, the untapped resource with the most potential to impact on waiting times in GUM is the multidisciplinary staff team (MDT). It can be used to maximise capacity and capability. Eliminating under-utilisation of skills in the MDT resource is crucial and this may involve significant changes to the workforce, capitalising on existing skills and enabling staff to develop new skills and new roles in the service.

The staffing resource in GUM services is very varied. There are still significant numbers of single-handed consultant services, and difficulties filling consultant vacancies is a problem. In many cases MDT roles, particularly nursing, have been extended to increase capacity to see new patients, but there is scope to take this work further. Although experienced GUM nurses and health advisers are difficult to recruit, services often have existing experienced and dedicated staff whose skills and potential are under-utilised. The reasons for this are varied but all too frequently it is because the contribution of healthcare assistants (HCAs) may not have been recognised and subsequently fully harnessed.

An ideal model for GUM is one where clinical staff with different roles practise at different levels on the novice-to-expert continuum. Small groups are required to work closely and communicate effectively together. This can allow patients to be streamed easily to see the most appropriate clinical practitioner for their needs. The whole clinical team will require high-level clinical leadership but, at the other end of the continuum, it is essential that there are sufficient GUM technicians or HCAs to ensure the expertise of each team member is used as productively as possible.

The concept of streaming patients to an appropriate practitioner is preferable to triaging. Triage is a system for ranking all patients according to an assessment of priority, and in GUM its application has tended to focus on preventing high-risk patients from being turned away from services. However, this uses up valuable staff time while leaving patients' needs unmet. Adopting the principle of streaming patients, ie not sending anyone away but directing them to the appropriate level of practitioner, can ensure best utilisation of the clinical team resource (see also High Impact Change 4).

To achieve this there may be a need for some additional investment. However, extending the roles and responsibilities of the wider MDT to manage new patients (both symptomatic and asymptomatic) is an extremely cost-effective way to increase capacity and reduce waiting times in GUM clinics.

Whole-team development may be more difficult for smaller or isolated services with limited numbers of practitioners, but evidence suggests that realising the potential of the MDT and utilising skills appropriately is equally important in smaller services. An MDT clinical network to share and support practice development may be particularly beneficial for

such services. Formal links with colleagues in neighbouring services can significantly support the learning and implementation aspects of a practice development plan.

WHAT ARE THE BENEFITS? Developing the MDT can have a significant impact on improving access and achieving the 48-hour target. In many cases, the expertise and skill is already within the existing team and therefore considerable improvement can be achieved in a short timescale. Such developments have been shown to boost team morale, improve retention rates and provide a long-term and sustainable solution to improving access.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Carry out a skill mix review examining the roles and functions of the whole MDT to identify the most appropriate skill mix, tailored to the needs of the individual service, and to ensure staff are best utilised at all levels.		✓	
Initiate recruitment planning to implement the desired skill mix. Consider using temporary staff to release existing team members for intensive training.		✓	
Plan training and download/implement patient group directions (PGDs) to maximise utilisation of the existing workforce. The main focus is on developing practitioner roles, to manage new symptomatic patient clinics autonomously.		✓	

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Develop HCA and/or technician roles to work in partnership and support the practice of the wider MDT.		✓	
Identify space in the clinic for new roles to practise (see also High Impact Change 7).		✓	
Explore the potential for patient 'streaming' in both large and small services. This involves patients being clinically assessed (not triaged) and then directed to the most appropriate member of the MDT to meet their level of need.		✓	
Develop a robust clinical governance framework to support advanced clinical practice for the MDT. This should include professional line management, regular clinical supervision, regular audit of clinical practice, individual performance review (IPR), an ongoing programme of educational activities and close liaison with the clinical lead.			✓
Identify potential for an external MDT clinical network to share and support practice development.		✓	

Case study

Sexual Health Service – Salford PCT

In 2004, Salford PCT decided to review its GUM and community contraceptive services. Specifically, it wanted:

- to reduce the transmission and prevalence of HIV and STIs by focusing HIV prevention and sexual health promotion that also prevents unintended pregnancy on local need;
- to provide high-quality, comprehensive integrated sexual health services for people in Salford which reduce stigma and are supportive to sexual well-being;
- to link to the Teenage Pregnancy Strategy to ensure that sexual health services are accessible to young people and dedicated teenage sexual health services are networked into the whole;
- to commission appropriate specialist HIV services;
- to provide adequate and equitable access to NHS termination of pregnancy (TOP) services.

The PCT redesigned existing services to implement a primary-care-based integrated sexual health service delivering family planning, GUM and sexual health, young people's, HIV and erectile dysfunction/psychosexual services in Salford. The modernisation increases access to sexual health services (both GUM and family planning) for the population of Salford.

As a result of the changes, the former GUM clinic has now become a Level 3 sexual

health service, offering specialist services for GUM and contraception. Meanwhile, the family planning clinics in outlying health centres have become Level 2 sexual health services, providing access to most types of contraception while offering testing and treatment for low-risk STI patients. All staff have contracts for a minimum of three sessions (two clinical sessions per week plus one session for continuing professional development/administration).

All patients are channelled through a centralised number, from where they are directed either to their nearest Level 2 service for non-complex STI patients or contraception, or Level 3 for higher risk STI patients, HIV care and complex contraception. The Level 3 hub also provides a base for training and other specialist services. Opportunities will be sought via PMS and GMS to develop robust Level 1 services in primary care, which will be the foundation for Salford Sexual Health Service.

The additional flexibility provided by a centralised number, and the use of streaming, means that the service expects to offer over 85% access within 48 hours for all patients requiring STI testing and treatment from 1 December 2006.

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Case study

Development of Level 3 nurse-delivered GUM services – Barts and The London NHS Trust and the North East London Clinical Network

Level 3 nurse-delivered GUM services were implemented at Barts and The London NHS Trust from 2003 at two sites. A new nursing model was developed that significantly changed the structure and role of the nursing team with the aim of improving the efficiency and quality of service delivery, patient access and experience.

Key actions included:

- reviewing nursing establishments and skill mix;
- redesigning the nursing team, including the development of new nursing posts for nurse practitioners and sexual health technicians (unregistered nursing staff);
- reviewing resources such as clinical space and budget (all changes were made within existing budgets);
- reviewing nursing models within and outside GUM and developing a multidisciplinary teams vision for future service delivery.

The sexual health technicians have liberated registered nurses from roles including chaperoning, venepuncture and the preparation of slides for microscopy, allowing them to develop competence in managing defined cohorts of new asymptomatic and symptomatic patients.

The nursing establishment also reflects the career and skills escalator (*Making a Difference*, 1999) with nurses of different bands managing patients via integrated pathways, clinical guidelines, patient group directions and independent prescribing. Increasing nurse-led provision has allowed reallocation of medical staff, improving whole-team working.

Patients self-triage on entry to the service which allows nurses to 'stream' patients, signposting them to the most appropriate healthcare professional according to case complexity.

Job satisfaction, recruitment and retention of nursing staff have improved, as has the patient experience because of reduced transit times through the services and a smaller number of different health professionals being seen on each patient visit. Clinical audits demonstrated that nurse-managed care was equivalent to junior doctor-managed care.

The new service model has supported the nurse management of increasing numbers of new patients (from 30% to 50% in one year at Barts). It has enabled the maintenance of an open access walk-in service, an increase in opening hours and a reduction in late clinic closures. Overall, the initiative has supported performance against 48-hour access targets, as monitored by real-time data collection on the clinic IT system (Clinisys).

Case study – continued

The amount of time and investment in education, training and assessment of competence required for such initiatives should not be underestimated. In this case, implementation has taken three years and is still ongoing. The support of the whole multidisciplinary teams, particularly medical colleagues, has been crucial for challenging

traditional ways of working and finding effective solutions for improved access.

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Case study

Development of nurse practitioners and establishment of Level 3 nurse-led GUM clinics serving dispersed rural populations – Bishop Auckland and Durham GUM clinics

On 1 November 2003, existing GUM nurses began working as nurse practitioners in the GUM clinics of Durham and Bishop Auckland, after working towards nurse practitioner competencies over the previous year. This had a significant impact on the way patients were seen in the GUM setting and meant the nurses were using their skills more appropriately and managing a wide range of patients. The use of nurse practitioners had a significant impact on the number of patients seen within GUM, with a 25% increase in new and rebook episodes.

Other initiatives in the service were a review of the skill mix in the team, the development of the sexual health team assistant role, a review of the appointments system and the development of nurse-led clinics.

These resulted in:

- involvement of the whole MDT in flexible assessment of patients, who are streamed to the most appropriate team member;
- a freeing up of nursing staff time as sexual health team assistants were trained to perform microscopy, venepuncture and chaperoning;
- improved patient access through the creation of more emergency appointments, made possible by nurse-led clinics;

Case study – continued

- improved staff efficiency, morale and job satisfaction, as skills were used more effectively and roles and responsibilities extended.

Working in this way has maximised the ability of the MDT to manage all patients. New challenges arise regularly and the support of the MDT is fundamental to the

continued success of the GUM service across the two sites of Bishop Auckland and University Hospital of North Durham.

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Resources and further guidance

- 1 British Association for Sexual Health and HIV (BASHH) sample patient group directions (from Nottingham and Isle of Wight), www.bashh.org/committees/cgc/#patientgroupdirections
- 2 Department of Health (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process*, www.dh.gov.uk/assetRoot/04/09/08/61/04090861.pdf
- 3 NHS Institute for Innovation and Improvement (2005) *Improvement Leaders' guides – Redesigning roles*, www.institute.nhs.uk/Products/ImprovementLeadersGuidesPersonalandOrganisationalDevelopment.htm
- 4 Robinson AJ, Rogstad K, Genitourinary Medicine Modernisation Group (2003) Modernisation in GUM/HIV services: what does it mean? *Int J STD AIDS*, **14**(2): 89–98. (Erratum in: *Int J STD AIDS*, 2003 Apr; 14(4): 292).
- 5 Royal College of Nursing (2004) *Sexual health competencies: an integrated career and competency framework for sexual and reproductive health nursing*, www.rcn.org.uk/publications/pdf/sexual_health_competencies.pdf
- 6 Skills for Health *Service Redesign Tools*, www.skillsforhealth.org.uk/careerframework/tools.php

HIGH IMPACT CHANGE 4

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

WHAT DO WE MEAN? New approaches to managing patients assessed as being at low risk of STIs or asymptomatic have been tested and are being used in many GUM and community services across England. Currently there is no clear consensus on the scope or inclusion criteria for this kind of screening. Services may need to design a pathway that is appropriate for their local circumstances. Generally, patients at low risk are seen by junior nursing staff or HCAs/technicians. They may be identified for this level of service in a number of ways, including self-assessment. They may not undergo a fully comprehensive STI screen and clinical examination, but will receive an adapted screen depending on their level of need. In some cases new non-invasive STI diagnostic tests (eg self-taken genital or urine specimens by NAATs) are used. It is not uncommon for a patient to present with an apparent low risk but other issues then come to light during the course of the consultation. Clear protocols are required and a pathway that will allow the patient to pass quickly and easily to a higher level practitioner is essential.

This type of service can operate as a separate session or it may be part of a team package whereby lower risk patients are 'streamed' to junior staff. This approach works very well

within GUM services but, where rapid patient pathways to higher level practitioners are established, it can also be an effective outreach or community-based service.

Triage – seeing the most clinically urgent patients first; low-risk and asymptomatic patients tend to wait.

Streaming – urgent and non-urgent cases are seen at the same time by being streamed to the most appropriate member of the multidisciplinary team

It should be recognised that developing this separate pathway may not be operationally feasible for some services. This is particularly true for small services, especially if they are delivered across multiple sites, or those led single-handedly by a consultant.

WHAT ARE THE BENEFITS? Streaming low-risk patients to appropriate staff in GUM can free up capacity for senior staff to focus on patients with more complex problems. There is also potential to design this kind of service outside GUM, which may reduce overall demand on the clinic.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
<p>Develop a protocol for streaming to the appropriate staff member in the multidisciplinary teams:</p> <ul style="list-style-type: none"> • Agree in the protocol how patients will self-identify or be identified as at low risk of an STI (eg self-completion questionnaire and proforma completed by HCA); • Ensure the protocol enables a clear patient pathway to a more experienced staff member if risk factors or symptoms emerge at any stage. • Agree an appropriate clinical protocol to provide the desired level of STI screening. 		✓	
<p>Explore the feasibility of providing this level of service outside the standard hours in GUM (to improve utilisation of clinic space, improve patient choice for access and increase overall capacity).</p>		✓	
<p>Consider developing this kind of service in additional primary care and community settings such as general practice, walk-in centres, voluntary organisations and pharmacies. Explore the feasibility of using outreach GUM staff to operate the service, or alternatively use them to implement the service initially and then train community-based staff to take over.</p>			✓

Case study

Fast-track asymptomatic screenings for STIs and HIV – Sheffield Teaching Hospitals NHS Foundation Trust

Fast-track asymptomatic screening has now been implemented in the GUM clinics in Sheffield and Rotherham. The initiative required the development of a clinic protocol, a screening pathway, patient selection and exclusion criteria and guidance for reception staff to provide an explanatory script for patients booking by phone. Written patient information was also developed to explain which infections would and would not be screened for, and why. The initiative was developed by a multidisciplinary project team including representatives from all professional groups within GUM. Strong clinical leadership at consultant level was important for keeping the project on course, modifying protocols as appropriate to local need and preventing slippage into just another extra GUM session.

The clinic was developed purely to be applied to asymptomatic individuals because no clinical examination is performed. Bloods were taken for syphilis and HIV serology. Screening for chlamydia and gonorrhoea was through NAAT (BDProbe Tec-SDA assay) on first catch urine for men and self-taken vaginal swabs for women. The aim of the pilot was to increase patient access to

appropriate high-quality sexual healthcare by separating off relatively straightforward asymptomatic cases from the main stream of patients with symptoms and issues requiring greater expertise.

The impact of the new service was an increase in the total number of booked appointments by 7.8% from May 2005 to November 2005. During the same period, the percentage of new patients seen within 48 hours increased from 24% to 40%. The number of patients defaulting from their booked appointments decreased from 24% to 17%. Real-time monitoring showed that in November 2005, 42.5% of new patients were offered, and 30% accepted appointments within 48 hours of contacting the clinic. By June 2006, 74.5% of the patients were offered and 52.3% of patients accepted an appointment within 48 hours of contacting the clinic. Patient satisfaction with the service has also been audited and reported as being high. The service was assessed through routine collection of data and waiting times, demographics, attendance rates, and diagnoses of patients who attended.

There have been many lessons learned, including problems with patients and non-clinical staff understanding when patients have or do not have symptoms, and a

Case study – continued

number of inappropriate patients booked in with symptoms or conditions that require full consultations and additional tests. There were problems with void samples from women using self-taken vaginal swabs that required a change in practice to cervical swabs taken by a clinician. The protocol was also amended to take account of the needs

of men who have sex with men for whom urine NAAT testing may not be sufficient.

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Case study

'eTriage' in GUM – John Hunter Clinic, Chelsea and Westminster Hospital NHS Foundation Trust

A web-based GUM patient prioritisation system (eTriage) has been developed to allow patients to go online and request an appointment. They are asked a series of clinical questions to prioritise their appointment request. Used via the internet or the web capability of mobile telephones, it enables a response within one working day with notification of an appointment in the most appropriate clinic to see an appropriate member of the MDT. If a case is categorised as a potential emergency or clinically time-sensitive it directs the individual immediately to an appropriate service.

The system serves three clinics, enhancing the ability to offer appointments within 48 hours, while maintaining patient choice. It has the capability for patients to decline the offered appointment. An administrative clerk supports the service by allocating the appointments.

A survey revealed extremely high satisfaction levels, with 95% of patients saying they would use the system again. 65% of requests were categorised as being for 'routine' appointments (with 6% of these for specific clinics such as rapid HIV testing or contraception). Some 35% were symptomatic, of whom almost half were categorised as urgent and offered an appointment to be seen within 24 hours.

Case study – continued

Additional advantages include: out-of-hours access to the booking system at patients' convenience, easier streaming to appropriate appointments, more flexible to run than phone appointment systems, provision of accurate monitoring information on waiting times and savings in the valuable time of experienced staff previously used for phone triage within the clinic.

The system came second at the London NHS Innovations Awards 2006.

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Resources and further guidance

- 1 Department of Health (2006) *Specialist Provider Medical Services (SPMS). Questions and answers*, www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/PrimaryCareContracting/PMS/PMSArticle/fs/en?CONTENT_ID=4125644&chk=1YPbQD
- 2 Griffiths V, Butler S and Ahmed-Jushuf I (2005) Recognising the potential of non-registered nurses to increase capacity – another phase in modernising GUM services. *Sex Transm Infect*, **81** (suppl): P2A.

HIGH IMPACT CHANGE 5

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

WHAT DO WE MEAN? GUM clinics operate a variety of different access systems. Commonly, patients may phone the clinic and be offered the next available appointment. Other clinics may operate a walk-in service whereby patients turn up without an appointment and wait in turn to be seen. There are numerous variations on the above systems and in recent years a number of restrictions have been placed on access in order to help staff cope with large numbers of patients. Such restrictions include limiting times when patients can call and capping the number of slots a service will give out. This practice can seriously distort understanding of real demand and skew performance monitoring data to give a misleading picture of good performance, and it provides an unacceptable level of service to patients. It is important that all services review the arrangements for patients to access their service.

In delivering the 48-hour access target, it will be important to make sure that no new restrictions are placed on access and current arrangements are tested to ensure that none exist, so that the patient experience is one of significant and rapid improvement.

Not only must current restrictions be removed, but other barriers to obtaining the service should also be considered. Across the country, large numbers of patients struggle just to get through on the phone. The availability of sufficient phone lines and administrative staff to answer them should not be overlooked as aspects of the access system. In principle, a patient should be able to make an appointment within one phone call, without having to repeatedly redial, call the following day or be diverted to other clinics.

Many local areas have a number of GUM services in different locations, each with different clinic days and hours, and with different access systems. Service users attempting to get an appointment may not contact all the relevant local services or have information on all available appointments within the next 48 hours. A centralised booking system implemented across all GUM services in a local health economy would allow access through a single route and a more flexible use of capacity. This is particularly useful for ensuring that patients' phone calls to part-time or smaller, satellite GUM services are always answered. Including all local clinics in the centralised booking system enables

appointments at these services to be offered as available capacity for all patients.

Electronic booking systems allowing real-time access and monitoring enable services to assess their current performance in meeting the target, on a daily basis if required, and also to track peaks and troughs of demand and capacity.

WHAT ARE THE BENEFITS? Removing restrictions to access systems will improve the patient experience and will also help the service to understand current patient demand. This is vital information for demand and

capacity planning (see High Impact Change 1). Centralised booking systems can enable all local capacity to be accessed equitably, so that peaks and troughs of demand are better managed between the services. They can be implemented relatively quickly by contracting with external partners, thus potentially having a rapid impact on access figures for part-time or satellite clinics.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Identify problems with current access systems. As part of this consider: <ul style="list-style-type: none"> • what restrictions are placed on the appointment or walk-in services and what it would take to remove them; • whether it would be feasible to provide walk-in services and what resources this would require. 		✓	
Have sufficient phone lines and staff to answer all external calls. Map peak times for patient calls and staff accordingly.		✓	
Assess how much time is spent doing telephone triage. Where feasible (using actions from High Impact Change 3), phase out telephone triage and use time gained to see patients.		✓	

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
<p>Undertake local research and patient consultation including:</p> <ul style="list-style-type: none"> • 'mystery shopper' reviews of services and access systems; • audit of telephone calls for a fixed period to find out why and when people are calling (eg for advice and/or to book appointments); • review of any existing research on patient and public preferences regarding access; • surveys, focus groups or in-depth interviews with service users on experiences of accessing the service and attitudes to access systems; • surveys, focus groups or in-depth interviews with non-users to explore knowledge of local GUM services and how to access them. <p>It is important to tie in this research with any undertaken for High Impact Change 6 and adopt a systematic approach to surveys across the local health economy to allow meaningful comparison of data.</p>			✓
<p>Define and agree a patient access system to best meet local needs (based on information and intelligence from the above research). Develop phased implementation milestones for this.</p>		✓	
<p>Explore the viability of implementing a centralised booking system. If considering this, lessons can be learnt from other such systems already in place (eg GPs' out-of-hours arrangements). Any publicity would benefit from explaining which geographical area or clinics are covered by this system. This means patients will know they are still able to book into a local clinic even if the number is not 'local' to their area.</p>			✓

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Operate electronic booking systems to allow real-time access and monitoring, the registration of all referrals from all sources and the recording for each patient of the time to first appointment offered.		✓	

Case study

Introducing a new access system – Central Middlesex Hospital GUM, North West London Hospitals NHS Trust

Central Middlesex Hospital GUM service introduced a new access system combining walk-in and appointment slots, and researched the effects of this change.

The clinic had had an unrestricted walk-in service, where all patients were seen if they arrived during opening hours, but throughput was erratic, with periods of high and low activity. Often several patients arrived just before closing time and staff missed their lunch break or went home late. Patients would become upset if they arrived to find a long queue and many said they needed the certainty of an appointment so

as to make childcare or work arrangements. The system was inefficient and was damaging staff morale and patient confidence.

The service calculated the maximum number of patients that could be seen per clinic session with the prevalent staffing level and allocated this number of slots. Eighty per cent of slots were retained as walk-in and 20% became able to be booked in advance. The walk-in service was 'first come, first served' through allocation of numbered tickets at the start of each clinic session. Anyone not getting a ticket was invited to return to the next session with instructions on how to be sure of getting a ticket. Those identified as requiring urgent access

Case study – continued

(eg the very young, or those with severe symptoms) were triaged and added as 'extras' if necessary.

Following the change, the service achieved a 10% increase in patient numbers with no increase in staffing levels. Clinics were finishing on time. Detailed research of clinical outcomes showed that identical numbers of STIs were being diagnosed.

A patient questionnaire distributed prior to the change, and again two months after, found high satisfaction ratings with the new system. Responses confirmed that certain high STI prevalence groups (eg young black men) required continuation of a walk-in service. Staff morale, as measured by

anonymous questionnaire, improved greatly following the change. Fine-tuning of the system continued, and when it was found that men required fewer appointments booked in advance, these were reduced to 10% of the total.

The service benefited not only from planning the change, but also from researching its effects, so that the impact could be measured and continuing adjustments made.

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Case study

Centralised telephone booking – Directorate of Sexual Health and HIV Medicine, Chelsea and Westminster Hospital

In March 2006, a centralised telephone service was established in the Directorate of Sexual Health and HIV Medicine at the Chelsea and Westminster Hospital. It deals with appointment requests for three GUM clinics, HIV outpatients, four results lines and health adviser advice and information lines.

Callers are taken through an options tree to direct them to the correct service and all appointment requests are dealt with centrally by a team of call centre operators. These operators are former telephone receptionists from the individual GUM clinics, brought together into one central booking system and still employed by the trust. The system provides real-time data on calls waiting as well as detailed information about the calls, including numbers, time spent in the queue, length of call and abandoned calls.

The system has been dealing with 8,000–9,000 calls per month, of which 5,000–6,000 have been for appointments. Set-up costs were relatively low (and mainly

for infrastructure at under £2,500). Concern about the cost of calling the 0845 number, provided by the network operator, from some mobiles has led to a decision to bring the system in house and enhance the service further. The cost implications of this should be mitigated by sharing the automatic call distribution (ACD) functionality across a large number of departments and, potentially, with other trusts.

The centralised telephone service has significantly reduced the time spent on calls by staff on the clinic floor and has freed reception staff to deal uninterrupted with patients attending the clinic. It has also improved patient access, helping to meet the 48-hour target, as patients can be offered the next available appointment in any of the three clinics, while maintaining choice if they wish to attend a specific one. Following implementation of the new system, the clinics received positive reports in the London SHA mystery shopper exercise and waiting times improved.

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Resources and further guidance

- 1 Emergency Services Collaborative, NHS Modernisation Agency (2004) *Making See and Treat Work for Patients and Staff*, www.wise.nhs.uk/sites/serviceimprovementcollab/emergency/Emergency%20Services%20Documents/1/See%20and%20Treat/Making%20See%20and%20Treat%20Work%20for%20Patients%20and%20Staff.pdf
- 2 Improvement Foundation (incorporating the National Primary Care Development Team) *Advanced Access – Handling Common Questions*, www.improvementfoundation.org/View.aspx?page=/topics/health/advanced_access/aa_material.html
- 3 Oldham J (2001) *Advanced Access in Primary Care* (National Primary Care Development Team), www.npdt.org/1626/advancedaccess.pdf
- 4 *Improving patient flow* (modelling waiting list management in other specialties – also applicable to GUM), www.steyn.org.uk

HIGH IMPACT CHANGE 6

Reorganise clinic opening hours to improve access

WHAT DO WE MEAN? The length of time a GUM service is open each week is an important factor which can affect the number of new patients it is able to see. If opening hours can be extended overall with sufficient staffing, capacity to see new patients could be significantly increased.

The choice of hours and days a service is open can also affect capacity. Matching the timing of services and staffing levels to the times when people want to be seen should ensure that capacity is fully utilised. This applies to all patients but also to those population groups for whom dedicated services may be provided. For example, if the need for a young people's clinic has been identified, it is likely to be much better attended if scheduled at school going-home time rather than between 10.00am and 12.00pm.

Reviewing all current opening hours and clinics provided, and identifying the times that are convenient and preferable for patients, will help services reorganise their opening hours in line with demand.

WHAT ARE THE BENEFITS? Extending opening hours can directly increase capacity, helping to achieve the 48-hour access target. In addition, organising opening hours in line with demand means not only better care for patients but also more effective use of GUM resources, thus also increasing capacity.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Review existing research on patients' preferred opening hours, including population groups at higher risk. If not already available, undertake research with service users and potential users to provide local information on preferences. Tie this in with the research suggested in High Impact Change 5.			✓
Appraise current opening hours and days, including any time-related patterns in attendance levels or demand, and assess whether they reflect the needs of GUM service users (and potential users).		✓	
Define what opening hours and clinics best meet local needs, including those of particular at-risk groups, such as young people.			✓
Adapt working patients and move clinic sessions if they are needed at specific times or on certain days. Consider the feasibility of sessions out of normal working hours.		✓	
Introducing 'staggered' breaks for staff could enable clinics to stay open throughout the day. This is more patient friendly, and can significantly reduce set-up time. For walk-in clinics, this also reduces the influx of patients at the start of sessions.		✓	
Consider whether it would be possible to see more patients if opening hours were extended.		✓	

Case study

Changing clinic times, increasing sessions and moving to a part walk-in service – Southport GUM, Southport and Ormskirk Hospital NHS Trust

Southport GUM service had a long waiting time for appointments. More sessions were needed to increase capacity. A survey of service users had given a clear message in favour of more evening clinics, as well as a mixture of walk-in and appointment clinics.

Sessions were increased by the employment of healthcare assistants to help both nurses and doctors to conduct their own clinics (the most affordable means of freeing up trained nurses). Sessions (defined as one trained clinician undertaking a clinic) increased from 21 to 30 per week, of which 4 were in the evening and 12 were walk-in.

As a small GUM clinic in a semi-rural setting, the Southport service struggled to maintain telephone access when walk-in was introduced, because the receptionist was often busy processing new case notes. However, use of an answerphone at busy times put patients off. The problem was solved by staggering arrival as far as possible for open access while maintaining direct telephone access to reception.

The service now offers to see all potential users within 48 hours of their telephone contact – either by appointment, which most people prefer, or by walk-in. The appointment system is entirely unrestricted.

The percentage of attendees seen in Southport GUM within 48 hours of contacting the service increased steadily from 6% in May 2005 to 49% in August 2006. The figure for November 2006 will be above 90% [SP1]. The major improvement from August to November has been achieved through changing clinic times, increasing sessions and moving to a part walk-in system.

The improvement came about by implementing suggestions made by MedFASH on its visit to the service as part of the national review of GUM services. Support from Cheshire and Merseyside SHA and Trust management was instrumental in facilitating the changes.

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HIGH IMPACT CHANGE 7

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

WHAT DO WE MEAN? The patient pathway through a GUM service is often dependent on available clinical rooms as well as the staffing resource. It is strongly advised that the clinical environment is fit for purpose in a way that does not hinder the capacity to use staff and other resources efficiently.

WHAT ARE THE BENEFITS? Ensuring the available estate is utilised for clinical activity as far as possible will mean that the maximum number of patient lists and clinics can operate at any given time, queues for available rooms will be minimised, and additional space can be identified within which to run additional clinics.

Assessing the physical environment in GUM services will identify if it prevents the most effective use of current (and any additional future) capacity and staff resources.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Assess the internal clinical environment with a view to adapting the use of space, if necessary, to accommodate new roles in the MDT. (See High Impact Change 3.)		✓	
Review all clinical space and identify non-clinical areas that may be suitable for conversion to clinical use.		✓	
Draw on information gathered from process improvement to identify and address bottlenecks associated with use of clinical space, for example patients having to queue for the phlebotomy room.		✓	
Develop plans for redesigning the space if necessary so that it permits the best use of the staff resources available.		✓	

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Identify any times when existing space is under-utilised and consider adapting clinic times to address this (in conjunction with High Impact Change 6).		✓	
Where space for the GUM clinic is shared with other unrelated services and this is a restraining factor to developing capacity, negotiate with the provider organisation to explore alternative solutions.			✓
Undertake capital planning for redevelopment of additional space or redesign, in cases where the environment is significantly below acceptable standards or where layout represents a significant constraint.		✓	

Case study

Maximising space in GUM – Hastings and Rother PCT

The community clinic that housed the GUM service in Hastings was extended in 2000 to provide a dedicated area for sexual health. Although the clinic space was planned well, with the involvement of the whole MDT, it was evident that demand on this part-time service would soon outstrip capacity.

Small modifications to practice were made, which enabled space to be used more flexibly. Each consulting room doubled as an examination room, and was suitably equipped to be used by the clinical staff for seeing either male or female patients. In addition, each of these rooms was equipped with a phlebotomy tray, enabling blood to be

taken at the time of examination, avoiding a bottleneck at the phlebotomy room.

A successful bid to the SHA for capital funds will enable an extension to the clinical area to be built in the near future.

Creating additional space was not in itself enough to cope with the pressure of demand. Eventually recruiting additional staff and increasing working hours were necessary, but the space created allowed the staff to work more efficiently and improve capacity to achieve the 48-hour access target.

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Resources and further guidance

- 1 Department of Health, forthcoming (December 2006) *Health Building Note 12 Out-patients department – Supplement 1 Sexual health clinics*. (This will be available to those in the NHS upon application for a free password at <http://estatesknowledge.dh.gov.uk/>. The print version will be available from The Stationery Office from spring 2007.)

THEME: Improve efficiency (and eliminate waste)

High Impact Change 8 focuses on reviewing all activities currently undertaken in GUM clinics and identifying those which are unnecessary. This can be informed by any process improvement project undertaken as outlined in High Impact Change 2.

HIGH IMPACT CHANGE 8

Reduce unnecessary clinical activity to increase capacity for new patients

WHAT DO WE MEAN? In all clinical services, the way we do things and the staff we use can be traced back to historical custom and practice. Originally the practice was designed because it was thought this would provide the best quality of service, but new ways of working and using staff differently can provide a quality service in a different but less resource-intensive way. In this section we aim to challenge the reasons why we do things and explore the potential for new ways of working. A good example of this is the work GUM services have done to reduce follow-up activity. BASHH recommends that the 'new episode' to 'follow-up' ratio should be no less than 1:1 (ie a clinic's total follow-up visits should not exceed the total new first episodes). In practice, significant numbers of GUM services have already addressed this issue and have managed to reduce follow-up activity further, so that the national **average** is now 1:0.75 (new episodes to follow-ups).

Another example of historical practice is the difference in length of appointment slots between practitioners in the MDT. Traditionally, nurses have often had longer appointment slots than medical staff, but with equivalent support staff there is no longer a good reason for this difference. Where the MDT is being fully utilised, average slots are 10 minutes for a follow-up and 20 minutes for a new patient, regardless of which MDT member sees the patient.¹⁰

In challenging unnecessary clinical activity in GUM, some difficult decisions may need to be made. There is a risk that 'specialist' services (such as colposcopy) that are provided in some GUM clinics may be offered at the expense of capacity which would otherwise be used for the core GUM activity of STI testing and treatment. If this is the case, it may be less

likely that the 48-hour access target can be achieved. Teams may wish to review current arrangements for such specialist services in GUM, especially if they are duplicating services provided elsewhere in the provider organisation or PCT, in order to free up space and resources for GUM general clinics.

WHAT ARE THE BENEFITS? Reviewing traditional practice and reducing unnecessary clinical activity such as follow-up patient attendances, and changing the type and volume of tasks traditionally undertaken by staff, can free up capacity to see more new patients. One GUM service discovered through audit that by using text messages, more patients received their results than when they had been asked to call the clinic. Research has highlighted that most patients dislike the 'no news is good news' approach often used in GUM services.¹¹

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Clearly agree and define what the GUM service is there to achieve. Aim to stop anything that takes the service away from that goal, and seek to increase aspects that take it closer.			✓
Measure levels of current new and follow-up activity with a view to reducing the new episode to follow-up ratio if appropriate.		✓	
Challenge the reasons why patients are asked to return for follow-up (for treatment or results) and review existing clinical protocols.		✓	

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Review how patients are informed of results. Texting has been proven to be an effective and popular method of giving negative results.		✓	
When follow-up activity has been reduced, make sure the clinic profile is adjusted to make more slots available for new patients.		✓	
Review whether staff in the MDT are being utilised effectively. See High Impact Change 3.		✓	
Review the clinic policy regarding microscopy. Is there potential to do less microscopy on patients who have no demonstrable symptoms?		✓	
If patients are attending the clinic on a regular basis for a course of treatment, consider whether this is something for which the patient could either self-treat at home or attend their GP.		✓	
Review the length of appointment slots. Are they longer for nurses than doctors, and if so why? Use support from all levels in the MDT to equalise them.		✓	
Consider developing a separate pathway for patients at low risk. See High Impact Change 4.		✓	
Review and agree arrangements for 'specialist' services provided by GUM (eg colposcopy).			✓

Case study

Introduction of SMS text messaging services within GUM at Leeds General Infirmary Centre for Sexual Health.

An initial patient questionnaire indicated that 85% of attendees had access to a text phone, so a results service with text messaging as the first option was developed. New patients were encouraged to book a text message for results, and two message options were offered – a negative text or a request to call the clinic. Patients were offered three further options: receiving their results from a nurse by telephone; visiting the clinic to discuss their results with a nurse; or receiving their results by letter.

The texting service was approved by the Data Protection Officer, provided by the company supplying telephone communications to the Trust and supported by installation of the appropriate software and staff training (eg reception staff had to be trained and spend more time explaining the new system and issuing text cards).

The impact was a reduction in demand for the nurse-led telephone results by 60%, which freed up 30 hours of nurse time per month to support other screening clinics and activities. Additionally, fewer DNAs were recorded in the nurse-run clinics. There was also a reduction in secretarial workload – it was estimated that 10 text messages could be generated in the time required to produce one standard results letter. A patient questionnaire revealed that 80% of respondents felt the service was the best option available.

Text messaging has now expanded to become one of the main means of contacting patients for health advisers, as a secure and confidential means of communicating directly with a person. It is also very acceptable to young adult patients.

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Case study

Reducing follow-up rates – Central Middlesex Hospital GU Medicine, North West London Hospitals NHS Trust

The Central Middlesex GUM clinic implemented a raft of improvements over a number of years, arising out of continuous assessment of performance. The ratio of new to follow-up activity was reduced to 1:0.4, and the overall aim was for patients to attend only once wherever possible.

These initiatives included limiting patients returning for test of cures to those with continuing symptoms/resistant gonorrhoea; patients undertaking their own treatment at home for genital warts; development of protocols that reduced the number of patients returning for results (including HIV) by 80% through a telephone results service and texting for teenagers; elimination of

health advisers' pre-test discussions, except in high-risk patients; changing the sensitivity of asymptomatic NSU (>10 pmn/hpf) to eliminate unnecessary treatment; maximising walk-in clinics wherever possible, supported by appointments for 10% of men and 20% of women; use of a triage system to manage any queues of patients waiting for walk-in clinics; nurse-led asymptomatic screening; nurse practitioners undertaking 80% of female vaginal examinations that would normally be carried out by doctors; and nurse-led discharge for most patients.

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Resources and further guidance

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THEME: Ensure effective commissioning and contracting

High Impact Changes 9 and 10 focus on ensuring that quality commissioning and contracting arrangements are in place in the local health economy in order to maximise resources and capacity for GUM services. They sit within the context of developing a wider local sexual health strategy which will address diagnostic and treatment requirements that would otherwise need to be dealt with in GUM, impacting on the GUM access target.

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 target

WHAT DO WE MEAN? There is a need to bring specialist GUM clinics into a network of delivery with sexual health services in community and primary care settings. GUM clinics can be an effective hub supporting the development of a range of STI services in these different settings. Such services can meet needs which would otherwise have to be dealt with in GUM. Therefore, their development will help to reduce workload in GUM and will make it easier to achieve and sustain the GUM access target.

The development of additional providers of STI services can enhance and supplement current GUM capacity and provide more choice for patients. However, the ability of such providers to have an impact by March 2008 on local achievement of the GUM 48-hour access target will depend on their current stage of development. Some areas have potential additional providers close to 'readiness', and these could have an impact on the target within the required timescale. In other areas, a longer time will be needed to develop new providers to the point where they can make a significant difference, and in these cases plans for meeting the target will need to focus on action within the GUM service. Therefore, in order to decide what actions to prioritise locally so that services can meet the access target, it will be necessary to assess the state of readiness of additional providers outside GUM. This assessment should be explored as part of the commissioning strategy for the local area.

For the strategy of developing new providers to be effective, a strong collaborative partnership with the GUM hub is essential. Commissioners will need to ensure that the GUM service is fit to play its role in developing the wider strategy. In order to achieve this, it may be appropriate to consider a parallel effort by investing in both GUM and community-based services that offer provision at Levels 1

and 2.¹² Furthermore, by adopting a combined approach, positive short-term improvements may prove easier to reach. It should be noted that as overall sexual health service provision is increased through the development of providers outside GUM, this may uncover previously unmet and hidden demand in communities.

WHAT ARE THE BENEFITS? The appointment of additional providers outside traditional GUM clinic settings will augment current local capacity and support improved access, in some cases within the timeframe for impacting on achieving the access target by 2008. Their development will also improve patient choice and provide additional access routes, particularly for groups at highest risk of STIs – for example young people – who are less likely to use mainstream services.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Assess the stage of development and readiness of additional providers of STI services outside GUM	✓		
In particular, assess community contraceptive services, as there is potential to build on their existing infrastructure and skill base to achieve new or additional STI service capacity relatively quickly.	✓		
Use these assessments to inform the level of effort and investment that should be made immediately to develop new STI providers. Where there are providers capable of offering quality services, support them to start or gear up provision as soon as possible, in order to have a significant impact before 2008.	✓		
Encourage development of additional STI service provision through initiatives such as incentivising general practice and the development of the National Chlamydia Screening Programme (NCSP) in primary care.	✓		
Develop local network arrangements, with appropriate training and clinical leadership to support the development of additional STI service providers, and with patient pathways in place between services at different levels.			✓
Define governance, clinical safety and risk management arrangements for both GUM and other STI service providers, and include the identification of an accountable clinical governance lead.			✓

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Create clear, outcome-focused links between prevention strategies, such as condom distribution schemes, and sexual health service providers.			✓
Assess the links with the clinic's chlamydia screening programme and ensure as many sites as possible see and treat in line with NCSP Core Requirements, to minimise the impact on Level 3 provision.			✓
Implement and expand outreach where appropriate, and build partnerships to overcome any space limitations in GUM clinics.		✓	

Case study

Development of community GUM services – West Dorset General Hospitals NHS Trust and South West and North Dorset PCTs

The GUM service in Weymouth had already undergone modernisation and a significant increase in activity, and it had reached full capacity. Department of Health funding for pilot sites (2003) enabled the development of community GUM services. The Weymouth GUM service became the hub, with satellite GUM clinics in Dorchester and Blandford to improve access for rural areas and army camps. A general practice local enhanced service was developed in Weymouth, and a young persons' walk-in sexual health one-stop shop was created through joint working with local contraceptive services. The development was supported by a multi-agency sexual health commissioning group with representatives from GUM, microbiology, contraceptive services, health promotion, teenage pregnancy, PCTs and the army.

The nurse practitioner training programme was expanded and additional nurse-led clinics were introduced, including weekly

early morning and late evening clinics within existing resources. Nurses undertake asymptomatic screening, and nurse practitioners also see and manage patients with complicated problems. Adequate capacity of the other involved services, especially pathology, was a key requirement for service expansion.

The outcome was a significant increase in activity, from 5,142 new patients in 2004–05 to 6,420 in 2005–06. Access improved from 10% seen within 48 hours in May 2005 to 73% in May 2006.

The increase in capacity was due to a combination of developments and changes in practice, and no single factor could be identified. Engagement and support of all the agencies, especially the Director of Public Health, were crucial to success.

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Case study

Managing uncomplicated STIs outside GUM – Contraception and Sexual Health Service (CASH), Manchester PCT

A nurse-led STI service, based in community contraception clinics, was launched in Manchester in December 2003.

High rates of STIs and long GUM waiting times provided motivation for a bid to manage uncomplicated chlamydia, including partner notification and treatment, diagnosed in the community Contraception and Sexual Health Service (CASH). The increasing success of this service enabled its scope to expand to include management of other uncomplicated STIs diagnosed in the contraceptive service. CASH is provided from the service headquarters and 12 community clinics across central and south Manchester. Walk-in sexual health screening was introduced in August 2005, and is run at the headquarters and a specialist young people's clinic.

The original bid provided funding for one full-time clinical nurse specialist (CNS). Additional funding was secured, and a second CNS was appointed in 2006. The CNSs are employed and managed by the PCT CASH services but hold honorary contracts for weekly clinical sessions in GUM. They are supported by a trainee assistant practitioner. The service adheres to PGDs and clinical protocols developed in collaboration with the community pharmacy lead and the local GUM services.

In a two-week survey (June 2005), 34% of clients accessing the headquarters for sexual health advice/screening had tried unsuccessfully in the previous month to get an appointment at a GUM clinic in central and south Manchester. The remaining 66% had chosen to access the community walk-in service, and 12% of these made comments about the difficulty getting through to GUM on other occasions.

It has been difficult to demonstrate a direct effect on the GUM 48-hour access target at this stage, as the demand for local GUM services continues to outstrip service capacity. However, the monitoring data indicate that a large volume of clients has been treated and managed in the community. Over the last 12 months, approximately 5,000 patients were screened; 583 with positive results were referred to a CNS.

There is scope, with additional resources, for further expansion of the service. Its success has been underpinned by dual training of existing CASH staff.

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Case study

Using a Local Area Agreement as a lever to implement satellite clinical sessions for lower level STI screening and treatment within the community – Strategic Planning and Joint Commissioning, Camden (including Camden PCT Sexual Health Services, Mortimer Market Clinic and Terrence Higgins Trust)

Camden PCT is increasing sexual health capacity in community settings in partnership with the GUM clinic, the Mortimer Market Centre, one of the largest in London. It prioritised sexual health and a 48-hour GUM access target within the Camden Local Area Agreement (LAA) with Camden Council. This enabled £230,000 to be levered into supporting increased sexual health capacity in community settings which targeted young people, and supported the GUM clinic to recruit healthcare technicians in order to release GUM nursing staff to carry out clinics in linked community contraceptive services and the voluntary sector.

The Camden LAA has two overarching priorities – to reduce inequalities and build social cohesion. Sexual health outcomes were included within the LAA blocks in order to be able to seek funding for both 'Healthier Communities' and 'Children/Young People'. The proposed health outcomes and impacts were to increase access to sexual health services for young people; to increase chlamydia and

gonorrhoea screening and treatment for young people between the ages of 15 and 24; and to increase the number of young people given contraceptive advice and the number of women screened for STIs at selected community contraceptive services.

Three targeted services were proposed to be delivered within the community:

1. Delivering satellite sessions at community contraceptive services through the recruitment of healthcare technicians.
2. Targeted community-based outreach sessions in King's Cross.
3. Cross-cutting interventions with a sexual health outreach worker.

The employment of healthcare technicians in the main GUM clinics is generating extra capacity by freeing up nursing staff who are able to carry out screening and treatment of lower-risk young people in the community, as well as within GUM clinics.

'Rapid low-touch' STI screening and emergency contraception are provided in conjunction with Terrence Higgins Trust at King's Cross for young people below 23 years of age. An integrated approach was developed with service provision from both community sexual health and health promotion teams, and a new model of sexual health services with a strong focus on self-management is being developed.

Case study – continued

A sexual health outreach worker for children and young people was employed to set up a virtual outreach and training team, to increase access to services for young people most at risk of teenage pregnancy, early parenthood and poor sexual health. This role will also encourage young people to use new interventions, and will raise their awareness of all contraceptive and GUM services in the area.

Lessons learned include the following:

- The cheapest and quickest way of starting a nurse-led initiative is to recruit healthcare technicians for the main GUM clinic to free up nursing time and transfer this to provide extra capacity within existing community clinical settings;

- Existing clinic space within the community can be easily utilised to deliver GUM satellite sessions with little extra resource input.
- Development of extended GUM capacity in the community requires effective partnership working across all agencies.

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Resources and further guidance

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HIGH IMPACT CHANGE 10

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

WHAT DO WE MEAN? Historically the majority of GUM services were commissioned using block contracts with providers, often as part of a range of outpatient services. These historical arrangements may not have been updated for many years. It is not uncommon to find that no information about value for money, no data for benchmarking and no definable breakdown of service costs are requested by PCTs. In spite of increases in patient demand, and evident problems within the teams to manage increased activity, the overall contract may not have been re-negotiated for many years.

GUM outpatient activity is funded through PbR. Current and projected GUM attendance patterns should be mapped to inform service business planning which prioritises 48-hour access. The PCTs are strongly advised to negotiate robust Service Level Agreements (SLAs) with GUM providers which include activity and quality indicators. It is also strongly advised that SLAs be negotiated for Level 1

and 2 services commissioned in the community, as they help to reduce workload in GUM and therefore assist with meeting and sustaining GUM access target. These services do not attract a mandatory tariff.

PCTs may enter into a voluntary agreement to put in place cross-charging mechanisms with neighbouring PCTs to ensure funding will accurately reflect the patient flow into GUM services.* To enable this, GUM services will need to provide accurate data to demonstrate where patients have come from.

Most GUM services provide outpatient treatment and care for people living with HIV. The number of people with HIV receiving care doubled in the five years to 2004,¹⁴ and this growth was not distributed evenly around the country, with some services experiencing much bigger increases. The impact on the capacity of many services to manage both HIV- and STI-related demand has been severe. HIV work is characterised as a low-volume but high-cost activity, whereas the GUM work is generally a

* Future revisions to the *Establishing the responsible commissioner* guidance¹³ will clarify this further. Existing data collections to meet the 48-hour access target will facilitate such cross-charging.

high-volume, low-cost service. There should be an understanding of separate HIV specialist costs and income from the mainstream GUM. In particular, HIV costs and activity breakdowns should be shared with HIV specialist commissioners to inform discussions around contracts. There may be a need to renegotiate the HIV outpatient contract (particularly for clinical services, not just drug costs) to ensure there is a realistic income for this aspect of the service which can keep pace with HIV patient activity. Where there are HIV inpatients, these should be funded through the PbR scheme, using the HIV inpatient tariff. (There is currently no PbR tariff for HIV outpatient activity, and this is not covered by the GUM tariff.)

WHAT ARE THE BENEFITS? Effective and discrete commissioning of GUM and HIV services respectively, securing the appropriate PbR income for both GUM outpatient and HIV inpatient activity, will ensure existing GUM resources are maintained and will harness additional funding. This will facilitate implementation of the High Impact Changes in this document and achievement of the 48-hour target. Regular review and updating of HIV contracts to reflect increasing HIV workload should ensure that the pressures of managing HIV do not restrict the capacity of GUM services to manage STIs and meet the 48-hour access target.

WHAT DO YOU NEED TO DO?

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Implement PbR for all relevant clinical activity, notably GUM outpatient and HIV inpatient care.			✓
Develop a GUM commissioning consortium involving local providers, to ensure effective commissioning and PbR implementation are addressed.	✓		
Provide accurate activity data to the consortium to enable effective cross-charging between services and across PCT boundaries where locally agreed.		✓	

	WHO'S RESPONSIBLE?		
	PCT	PROVIDER	SHARED
Develop appropriate SLAs between PCTs and GUM providers which reflect patient demand, activity and other relevant indicators, such as follow-up to new ratio (see High Impact Change 8).			✓
Make explicit in SLAs the role and expectations of the GUM service to support other sexual health services that provide STI services (eg training and clinical leadership), taking account of the time and investment needed for this from the GUM team.			✓
Segregate budgets between work on STIs and HIV respectively, including allocation of staff time.		✓	
Understand the real costs of the different elements of the GUM service, including reviewing the degree to which funding flows for HIV are commensurate with HIV workload.			✓
Negotiate local tariffs for any STI services outside GUM, and ensure these have clear SLAs, specifying activity and quality indicators.			✓
Involve service users in the commissioning process and development of performance frameworks for SLAs to reflect needs appropriately.			✓

Case study

How the development of a sexual health network supports consortium commissioning: North East London HIV and Sexual Health Clinical Network – Barts and The London NHS Trust and North East London SHA providers.

The North East London HIV and Sexual Health Clinical Network was established in 2003 and evolved out of an HIV commissioner/SHA-led working group for finance and activity management of the HIV SLAs with provider trusts. The network involves all HIV and GUM provider units in five acute trusts and seven PCTs, as well as public health, contraceptive services and specialised HIV and GUM commissioning. Its structure was developed by MDTs at stakeholder events.

An executive group was established with a clinical lead, and relevant sub-groups were also created to facilitate the development of services and staff for local GUM services, monitored by the executive group. The annual work plan is performance-managed by the SHA. The network is able to represent North East London SHA on pan-London forums, advise and support the SHA on the allocation of GUM capital monies

and act as a conduit for communication. There is a teaching/audit and research programme, a website, a common data set, a common IT system, a programme of workshops focusing on supporting key government policy drivers, and specific clinical training to support patient group directions and the development of new roles. The network has dedicated management support and administration.

The overall impact has been an improvement in healthcare governance structures, the development of shared protocols and care pathways, expanded education and training, improved MDT working and better patient and public involvement.

Most importantly, NE London SHA has been the best performing and improving SHA on 48-hour access in the country.

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Resources and further guidance

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