Inequalities in access to genitourinary medicine clinics in the UK: results from a mystery shopper survey

Elizabeth Foley, Martina Furegato, Gwenda Hughes, Christopher Board, Vanessa Hayden, Timothy Prescott, Eleanor Shone, Rajul Patel

ABSTRACT
Study design This study investigated whether access to genitourinary medicine (GUM) clinics meets UK-recommended standards.

Methods In January 2014 and 2015, postal questionnaires about appointment and service characteristics were sent to lead clinicians of UK GUM clinics. In February 2014 and 2015, researchers posing as symptomatic and asymptomatic ‘patients’ contacted clinics by telephone, requesting to be seen. Clinic and patient characteristics associated with the offer of an appointment within 48 hours were examined using unadjusted and UK country and patient gender adjusted multivariable logistic regression analyses. In March 2015, a convenience sample (one in four) of clinics was visited by researchers with the same clinical symptoms. Ability to achieve a same-day consultation and waiting time were assessed.

Results In 2015, 90.8% of clinics offered symptomatic ‘patients’ an appointment within 48 hours when contacted by telephone, compared with 95.5% in 2014 (aOR=0.46 (0.26 to 0.83); p<0.01). The decline was greatest in women (96.0% to 90.1%; p<0.05), and clinics in England (96.2% to 90.7%; p<0.01). For asymptomatic patients, the proportion offered an appointment within 48 hours increased from 50.7% in 2014 to 74.5% in 2015 (aOR=3.06 (2.23 to 4.22); p<0.001), and in both men (58.2% to 90.8%; p<0.001) and women (49.0% to 59.6%; p<0.01). In adjusted analysis, asymptomatic women were significantly less likely to be offered an appointment than asymptomatic men (aOR=0.33 (0.23 to 0.45); p value<0.001). 95% of clinics were able to see symptomatic patients offered an appointment within 48 hours.95% of clinics were able to see symptomatic patients offered an appointment within 48 hours (aOR=0.33 (0.23 to 0.45); p value<0.001).

Conclusions Access to GUM services has worsened for those with symptoms suggestive of an acute STI and is significantly poorer for asymptomatic women. This evidence may support the reintroduction of process targets.

INTRODUCTION

Good sexual health is important to individuals and to society, and as such genitourinary medicine (GUM) services in the UK play a key role in public health. Delays in the diagnosis and treatment of STIs may result in undesired consequences such as onward transmission and further complications. Since their inception a century ago, it is deemed that services should be free, confidential and accessible.1 2

A previous study using ‘mystery shopping’ to assess access to GUM clinics demonstrated a disparity between clinician expectations of the ability for a patient with symptoms suggestive of an acute STI to be seen and the actual situation.3 Following this, in 2004, the government introduced a mandatory target that 98% of patients in England should be offered an appointment to be seen within 48 hours of contact, with the devolved nations having similar recommendations.4-7 This was highly successful, and in 2010, a similar study demonstrated nearly all patients seeking an appointment by telephone were offered an appointment within 48 hours.8 In January 2010, BASHH released the standards of management of STIs recommending that 98% of people with needs relating to STIs should be offered an appointment within 48 hours of contact.9 Since 2010, the target in England is no longer mandatory, and from 2013 local authorities have become responsible for commissioning sexual health services in England. There is a growing culture of market testing (referred to as tendering from this point) where private and alternative National Health Service (NHS) providers are invited to bid for sexual health services to drive efficiencies, innovation and improved cost effectiveness. With increasing patient numbers and the absence of targets, there is concern that accessibility to services may be compromised.10 11 This study aimed to assess whether 48-hour access recommendations were being met by GUM services and whether accessibility of clinics across all four countries of the UK varied by patient characteristics, geography, service commissioning arrangements and over time.

METHODS

This was a three-part prospective study including (1) a postal questionnaire to all 248 clinics in the UK, (2) mystery shoppers contacting all clinics in the UK by telephone and (3) mystery shoppers visiting a sample of clinics in the UK.

Data collection Postal questionnaire to lead clinicians

Using a postal questionnaire sent in January 2014 and January 2015, lead clinicians of GUM clinics in the UK that are open for more than 2 days/week were asked their expectations of how quickly patients would be seen in their clinics after making telephone contact. Four scenarios were assessed:
the first two presented patients with symptoms suggestive of an acute STI—the female patient having symptoms indicative of primary genital herpes, and the male with symptoms suggestive of gonorrhoeal infection; the other two scenarios were a male and a female patient requesting an asymptomatic screen. In 2015, the questionnaire also included a question about the service’s tendering history.

Telephone calls by mystery shoppers
In February 2014 and February 2015, trained male and female researchers, posing as patients, contacted eligible GUM clinics by telephone on two separate occasions each, initially as a patient with the symptoms of an acute STI as in the postal questionnaire, and second requesting a fixed appointment for an asymptomatic screen. Telephone calls were only made during the times the clinic was known to be open, and clinics were contacted on different days in order to prevent researcher sensitisation. To prevent possible bias, researchers used set case studies and were trained to ensure consistent language. Researchers who were not immediately offered an appointment within 48 hours asked if there was a possibility of being seen sooner as they were experiencing pain. In some cases their calls were transferred to clinical staff for further discussion. Once a time for an appointment had been offered by the clinic, the researcher advised the clinic that they would check they could get transport at that time and call back immediately to confirm; no actual appointments were made. Up to a maximum of eight attempts were made to contact the clinics, and data were recorded onto standardised proformas.

Clinic visits by mystery shoppers
In March 2015, a subset of walk-in clinics was visited by researchers posing as patients with the same symptoms suggestive of an acute STI. The ability to be seen and waiting times were recorded.

Data analysis
Telephone calls by mystery shoppers
The percentage of appointments offered within 48 hours was calculated for each region/country, gender, year, clinical scenario and tendering history, for phone contacts and visits by the ‘patients’. In order to be compatible with all UK 48-hour access recommendations and to avoid bias towards clinics open for more than 5 days/week, 48 hour access was defined as been offered an appointment ≤48 hours after the initial point of contact, excluding weekends.

Pearson’s \( \chi^2 \) and Fisher’s exact tests were used to compare 48 hour access between 2014 and 2015 for asymptomatic and symptomatic ‘patients’, stratified by ‘patient’ gender and UK country. Multivariable logistic regression determined whether 48 hour access for asymptomatic and symptomatic patients changed between 2014 and 2015, adjusting for UK country and patient gender. In a subanalysis of GUM clinics in England in 2015, a multivariable logistic regression analysis investigated the effect of a recent history of service tendering on 48 hour access, adjusting for patient gender and symptom presentation.

All associations with \( p \leq 0.05 \) were considered to be statistically significant, and all analyses were carried out using STATA V13.1.

Although ethics approval is not required for a service evaluation, due to the use of ‘mystery shoppers’, approval was sought for each year from BASHH (obtained by BASHH board in September 2013 and June 2014, and Public Health England (PHE) (approved in October 2013 and September 2014).

RESULTS
Postal questionnaire to lead clinicians
There was a 51% (126/248) response rate in 2014 and 47.9% (119/248) in 2015 to the lead clinician questionnaire. Between 2014 and 2015, the proportion of clinicians reporting that all patients in their clinic were offered an appointment within 48 hours fell from 76.1% (85/112) to 67.2% (80/119) overall. However, 96.4% (106/110) of clinicians in 2015 reported that they expected symptomatic patients (both male and female) in their clinic to be offered an appointment within 48 hours; this was similar in 2014 (96.6% (113/117) for male and 95.7% (112/117) for female symptomatic patients). In 2015, 47.8% (43/90) of clinics in England reported their service had been tendered, of which 62.8% (27/43) were tendered within the last year.

Telephone calls by mystery shoppers
Of the 248 GUM clinics in the UK, 15 were excluded for being open fewer than 2 days/week, and 13 were not contactable by telephone. For the remaining 220 clinics in the UK, it was not always possible to establish contact at first attempt: the total number of attempted telephone calls required to make contact with the clinics was 1025 in 2014 and 1056 in 2016.

In 2015, 82.7% of the 220 UK clinics offered ‘patients’ contacting by telephone an appointment within 48 hours, compared with 74.4% in 2014. For patients with symptoms suggestive of an acute STI, the proportion of appointments offered within 48 hours fell from 95.5% in 2014 to 90.8% in 2015 (\( p < 0.01 \); table 1); however, this was primarily associated with a decline in women (96.0% to 90.1%, \( p < 0.05 \)), and clinics in England (96.2% to 90.7%, \( p < 0.01 \); table 1). When adjusted for gender and UK country, symptomatic ‘patients’ in 2015 were significantly less likely to be offered 48 hour access compared with those in 2014 (aOR=0.46 (0.26 to 0.83); \( p < 0.01 \); table 2).

For asymptomatic patients, the proportion of appointments offered within 48 hours increased from 50.7% in 2014 to 74.5% in 2015 (\( p < 0.001 \); table 1); the increase was observed for both men (58.2% to 90.8%; \( p < 0.001 \)) and women (49.0% to 59.6%; \( p < 0.01 \)) and for all UK countries (table 1). However, 50.6% of the asymptomatic patients in 2015 were not fixed appointments but an invitation to attend the walk-in service, and 18% of asymptomatic patients were unable to book any fixed appointment. In adjusted analysis, asymptomatic patients in 2015 were more likely to be offered an appointment within 48 hours compared with those in 2014 (aOR=3.06 (2.23 to 4.22); \( p < 0.001 \); table 2). However, although the overall proportion of asymptomatic patients offered an appointment within 48 hours increased, women (aOR=0.33 (0.23 to 0.45) compared with men; \( p < 0.001 \)) and those attending clinics outside England (compared with those attending English clinics) were significantly less likely to be offered an appointment within 48 hours (table 2).

In 2015 in England, there was no significant difference in the offer of 48 hour access between those services which had been tendered in the preceding year compared with those that had not (aOR 0.90 (0.45 to 1.78); \( p > 0.05 \)).

Clinic visits by mystery shoppers
In 2015, to assess waiting times in clinics for patients presenting with symptoms of an acute STI, 25.9% (57/220) clinics across the UK were visited in person. Of these, 95% offered the patient an appointment on the same day with a mean waiting
DISCUSSION

This large study based on four separate telephone contacts in both 2014 and 2015, with each NHS GUM clinic in the UK, provides an evaluation of over 1600 clinic contacts and identifies different patterns of service availability and incongruities among staff expectations and the actuality of service provision. The study shows that, while the majority of UK clinics can offer a consultation within two working days, there has been a significant decline in access for patients presenting with urgent symptoms. Of particular concern, and in contrast to clinicians’ perceptions, women have greater difficulty accessing services than men, which is surprising given that many GUM services are integrated with contraceptive services which traditionally see mainly women. Ensuring gender equity in service access is a clear priority.

One of the limitations of this study is that it only represents a snapshot for each of the years, which limits generalisability. Nevertheless, the use of a ‘mystery shopping’ survey provides insight into the difficulties that real patients may encounter when trying to arrange an appointment at a GUM clinic.

A further limitation is that the demand on service may alter during the week, and the contacts were made on random days when the clinic was known to be open. This single contact may only reflect on a clinic’s ability to offer an appointment on a busy rather than typical day. Having confirmed the opening times, the researchers only telephoned clinics when they were known to be open and at the beginning of service, and likewise the researchers only attended in person at the beginning of a walk-in clinic session; this was to allow the clinics a full opportunity to offer an appointment. This may not reflect a real patient’s expectation of being seen during stated opening times.

Despite the fears of the impact of tendering on GUM services in England, to date there has been no discernible difference in the ability to offer appointments immediately post tender. A limitation of this study is that data were not collected on the stage of tendering. It is acknowledged that tendering can be a long process from development of the service specification to implementation, and services may be affected both before and during this process. With the change in emphasis towards outcome measures rather than process targets, a key STI control

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Frequency and proportion of appointments offered within 48 hours for asymptomatic and symptomatic patients by UK country, gender and year</th>
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<tbody>
<tr>
<td>Appointment offered within 48 hours</td>
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<tr>
<td></td>
<td>Asymptomatic patients</td>
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<tr>
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<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
<td>89/153</td>
</tr>
<tr>
<td>Female</td>
<td>91/202</td>
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Data from telephone calls by mystery shoppers to GUM clinics in the UK, 2014 and 2015.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>ORs for ‘Appointment offered within 48 hours’ for asymptomatic and symptomatic patients unadjusted and adjusted for UK country, gender and year</th>
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<tbody>
<tr>
<td>Appointment offered within 48 hours</td>
<td></td>
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<td></td>
<td>Asymptomatic patients</td>
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<td></td>
<td>N (%)</td>
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<tr>
<td>Country</td>
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<td>Wales</td>
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<tr>
<td>Gender</td>
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<tr>
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<td>276 (76.9%)</td>
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<tr>
<td>Female</td>
<td>225 (52.7%)</td>
</tr>
<tr>
<td>Year</td>
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<tr>
<td>2014</td>
<td>180 (50.7%)</td>
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<tr>
<td>2015</td>
<td>321 (74.5%)</td>
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</table>

Data from telephone calls by mystery shoppers to GUM clinics in the UK, 2014 and 2015.

GUM, genitourinary medicine.


Table 1 Frequency and proportion of appointments offered within 48 hours for asymptomatic and symptomatic patients by UK country, gender and year

Table 2 ORs for ‘Appointment offered within 48 hours’ for asymptomatic and symptomatic patients unadjusted and adjusted for UK country, gender and year

Clinical
measure of rapid, open access to clinics for diagnosis and treatment may be lost. In our study, the majority of patients were advised to attend a walk-in clinic rather than being given a fixed appointment, although, encouragingly, few patients with symptoms were turned away when they visited in person. Access to a GUM service also appears to be more difficult for patients without specific symptoms. To reduce the rates of STIs in the community, it is imperative that clinics remain freely accessible to diagnoses and treat those with symptoms and that the ability of those at risk to be screened for undiagnosed infection is not lost in future service planning. To meet the demand for asymptomatic screening, an increasing number of clinics have introduced on-line testing, thereby freeing clinic capacity for symptomatic patients and patients with complex needs. The maintenance of outcome measures and the reintroduction of access targets should be considered in future planning of services.

Key messages

► With increasing patient numbers and the absence of targets, there is concern that accessibility to genitourinary medicine (GUM) services may be compromised.

► For patients contacting clinics with urgent symptoms, the proportion of appointments offered within 48 hours fell from 95.5% in 2014 to 90.8% in 2015, both below the BASHH recommendation of 98%.

► Asymptomatic women were significantly less likely to be offered an appointment within 48 hours than asymptomatic men.

► The use of a ‘mystery shopping’ survey provides insight into the difficulties that real patients may encounter when trying to arrange an appointment at a GUM clinic.

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Contributors EF—designed study and questionnaire and drafted first manuscript and revisions. MF and GH—contributed to questionnaire design, performed statistical analysis and contributed to preliminary drafts and final draft of manuscript and revision. CB, VH, TP and ES—undertook mystery shopping element of study. RP—contributed to study design, manuscript drafting and final revisions.

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Competing interests None declared.

Provenance and peer review Not commissioned; externally peer reviewed.

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