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Access to genitourinary medicine clinics in the United Kingdom

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Objectives: To assess the variability in time taken for a patient to be seen in a genitourinary (GUM) clinic in the United Kingdom having contacted that clinic by telephone and compare this with GUM physicians' expectations.

Methods: A postal questionnaire was sent to lead GUM physicians asking when they thought patients with two specific clinical scenarios would be seen in their clinics. Following this, health-care personnel contacted individual units posing as patients with the same clinical scenarios and asked to be seen as soon as possible.

Results: 202/258 (78%) lead clinicians responded to the postal questionnaire. All clinics claimed to have procedures allowing patients with acute symptoms to be assessed urgently and estimated that such patients would be seen within 48 hours of the initial telephone contact. In 243 of 311 (78%) clinic contacts, the patient was invited to attend the clinic within 48 hours. For the remaining 68 contacts (22%) the patient could not be accommodated within 48 hours and, of these, 49 could not be seen for more than 1 week.

Conclusions: No clinician estimated that patients with acute severe symptoms would be seen more than 48 hours after the initial telephone contact, but in reality, for 22% of the patient contacts this was the case. This study may well underestimate the difficulties the general public may have in accessing GUM services. We hypothesise that this situation could be ameliorated by establishing process standards and addressing issues of resource allocation.

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Keywords: accessibility; genitourinary medicine clinics

Introduction

A national network of genitourinary medicine (GUM) clinics was established in the United Kingdom in response to the epidemics of syphilis and gonorrhoea in the early part of the 20th century. The importance of open access to GUM facilities has been recognised as essential since the inception of the service¹ and this has been reiterated in recent years.^{2–5} In 1986, the chief medical officer in his letter to regional general managers recommended that “any persons presenting with a new clinical problem suggestive of a sexually transmissible disease or who considers himself/herself to have been in contact with such a disease should be seen on the day of presenting or failing that on the next occasion the clinic was open.”⁴ There has been a year on year increase in the number of patients attending GUM clinics and clinics now see a variety of acute and chronic conditions. There were more than one million attendances at UK GUM clinics last year.⁵ This represents a doubling in the numbers over the past decade. In the light of this, it is a matter of concern whether this government recommendation is still appropriate, whether it is in line with GUM physicians' expectations, and whether it can still be achieved.

Aim

The aim of this study was to attempt to identify specific barriers that may exist for a patient seeking a consultation in a GUM clinic in the United Kingdom. A study was set up to determine the variability in time taken for a patient

with acute symptoms to be seen in a GUM clinic having contacted that clinic by telephone. This was compared with the estimate of the time that lead clinicians in GUM clinics thought such patients would wait before being seen in their clinic.

Method

This was a two part prospective study. In January 2000 a postal questionnaire was sent to all lead clinicians of GUM clinics in the United Kingdom. They were asked details of their clinic including the number of doctor sessions available and clinic type. In addition, they were asked when they thought patients with the two following clinical scenarios who contacted their clinic by telephone would be seen.

Scenario one was a female patient complaining of symptoms suggestive of acute primary herpes; scenario two was a male patient with a 1 day history of acute, painful purulent urethral discharge. The clinicians were also asked if they would be willing to participate in an anonymous audit concerning patient access to clinics; clinics where the lead clinician declined to participate were excluded from the second part of the audit. A stamped addressed envelope was enclosed for the response but no follow up reminder letters were sent.

In the second part of the study, healthcare personnel familiar with the running of a GUM clinic contacted individual units posing as patients. They telephoned during appropriate clinic hours—that is, when the clinic was open to see patients of the sex of the caller. Calls

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Table 1 Number of patients offered consultations (appointment/"walk-in"/extra) (%)

	<24 hours	<48 hours	>48 hours but <1 week	>1 week
Female patients (n=157)	105 (67)	24 (15)	6 (4)	22 (14)
Male patients (n=154)	106 (69)	8 (5)	13 (8)	27 (18)
All patients (n=311)	211 (68)	32 (10)	19 (6)	49 (16)

were made during February and March 2000. The male and female callers complained of the clinical symptoms described in the scenarios above and they asked to be seen as soon as possible. The female "patient" complained of acute vulval pain, dysuria, of feeling generally unwell, and having difficulty walking or sitting. They specifically did not mention that they thought they might have herpes, but added that they had previously had thrush and the symptoms were completely different. The male "patient" complained of a 1 day history of pus discharging from the penis, dysuria, and pain. If an appointment was not offered within the next 2 working days, the caller requested to be seen sooner. The callers were instructed to ask as firmly as possible to be seen, emphasising the acute painful symptoms. No actual appointments or arrangements were made with the clinic staff. The response from each individual clinic was noted. To minimise the impact of our contacts sensitising reception staff to subsequent calls, no clinic was telephoned by both "male" and "female" patients on the same day.

Results

The response rate to the postal questionnaire was 78% (202/258). All clinics claimed to have procedures in place to allow patients with acute symptoms to be assessed urgently. Clinics which were "appointment only" had mechanisms by which such patients could bypass the usual booking procedure. All lead clinicians estimated that patients with these test scenarios would be seen in their clinic within 48 hours of the initial telephone contact. The majority (94%) thought that patients would be offered an appointment within 24 hours and the remainder (6%) thought that they would be seen within 48 hours. There was no difference for male or female patients. Of the 202 respondents, 15 (7%) GUM physicians declined to have their clinics audited anonymously. Clinics where the GUM physician did not reply to the questionnaire or declined were not audited; this left 178 clinics in the study.

In total, more than 600 attempts at contact were made to clinics. For the purpose of the study, a single attempt was defined as three telephone calls to a department in the first hour in which the clinic was thought to be running. This resulted in 311 actual telephone contacts with the clinics. The data collected were only from those clinics with whom telephone contact could be made during actual clinic opening hours for that unit. We were able to make 140 of the 311 contacts (45%) at the first attempt; the remaining 171 were considerably harder to contact and we were not able to contact five clinics in spite of at least four attempts. Overall, both a male and a female "patient"

Table 2 Waiting time by region*

Region	<48 hours (%)	>48 hours, <1 week (%)	>1 week (%)
North	75	6	19
North West	62	0	38
North East	77	3	20
West Midlands	70	6	24
East Midlands	94	0	6
East Anglia	79	7	14
Home Counties North	100	0	0
Home Counties West	82	9	9
South and South West	81	9.5	9.5
South and South East	78	3	19
London	79.4	11.2	9.4
Scotland	86.7	6.7	6.7
Wales	75	0	25

*For the purpose of anonymity Northern Ireland, the Channel Islands and the Isle of Man have been excluded.

contacted 129 GUM clinics, although 25 clinics were only contacted by a male "patient" and 28 clinics only by a female "patient." The results are shown in table 1. In 243 of 311 clinic contacts (78%), the patient was invited to attend the clinic within 48 hours.¹ There was some regional variation in the ability of patients to be seen within this time limit (table 2).

For the remaining 68 contacts (22%), the patient could not be accommodated within 48 hours, with 49 (72%) of these patients not able to be seen within 1 week. Of those clinics unable to offer an appointment for more than 1 week, 18 clinics could not offer a male appointment, 19 clinics were unable to offer a female appointment, and six were unable to see either a male or a female patient. Of these clinics, 23 were part time clinics and 26 were full time clinics, of which five were teaching hospital clinics. Almost all of the patients in this subgroup (96%) had been triaged by reception staff alone.

Discussion

Although no lead clinician estimated that patients with acute severe symptoms would be seen more than 48 hours after the initial telephone contact, in reality 22% of "patients" in the study could not be accommodated within this time frame. It is likely that this study underestimates the difficulties the general public may have in accessing GUM services. The "patients" in this study were experienced healthcare personnel who were insistent in their request to be seen and were able to talk openly on the telephone about their symptoms. Our "patients" requested to be seen as soon as possible but this was seldom picked up by the clinic staff and in most clinics the appointments were made by reception staff without initial assessment of the presenting complaint. When the study "patients" were offered an appointment more than 48 hours after their telephone call they asked to be seen more urgently. In only half of the initial telephone contacts with clinics were the callers actually able to get through immediately to the unit. The purpose of this study was to see what happened once contact was made with the clinics; however, this is an indication of the difficulty real patients may face in arranging a consultation. We suspect that the general population may be less persistent.⁶ This study is only a

“snapshot” of clinic procedures and it may not reflect an individual clinic’s performance; however, we believe that it is a balanced reflection of the current access to GUM clinics in the United Kingdom.

The majority of clinics were able to see patients with acute symptoms within 48 hours of a patient making contact; however, a substantial minority were unable to accommodate patients within the 48 hour recommendation. In this study, unless the clinic had a “walk-in” service we found that the majority of clinics were not in a position to offer a new patient an appointment on the same day as the patient contacted the clinic. In most cases the patient was either double booked on to a clinic list that was already full or asked to come and wait to be seen. This is consistent with a previous study, which demonstrated that the majority of patients attending an individual clinic in a district general hospital waited more than 1 week for an appointment.⁷ When patients were triaged by health advisers or nurses, they were more likely to be offered an urgent consultation. For the patients who were not offered an appointment within 48 hours, 96% were triaged by reception staff alone. This highlights the important role of health advisers and nurses in ensuring that patients with urgent symptoms are seen appropriately and the necessity for reception staff to refer patients to them for triage. More importantly, it identifies that when non-clinical staff triage patients there is a limited quality service to the individual patient and a potential area of clinical risk. This problem was not confined to small clinics; it also affects larger centres and teaching hospitals. All clinics claimed to have protocols in place to deal with patients with acute symptoms but our study shows that they are often not applied or do not achieve their objectives. If a clinic is unable to provide appointments within 48 hours, then triaging becomes inevitable. Our study would suggest that currently many receptionists are ill equipped to provide this service. In these circumstances clinicians may wish to consider whether it is appropriate for non-clinical staff to provide a triaging service. There is a move within genitourinary medicine to working towards nationally agreed standards and protocols⁸ and these could be extended to encompass areas of clinical practice. Process standards could be set for triage and the requirement for clinics to work to agreed written protocols for the management of urgent clinical problems agreed with local commissioners.

The white paper, “A First Class Service; Quality in the New NHS”, placed great emphasis on improving and maintaining quality within a framework of clinical governance.⁹ A responsive sexual health service is focused on accessibility so that sexually transmitted infections can be detected, treated appropriately, and contacts can be traced in a timely fashion thus controlling the rates of infection in the community. In the past, studies looking at accessibility to GUM clinics have concentrated on issues such as the geographical location of

clinics and their opening hours,^{10 11} and considerable effort has been made to implement changes in these areas so that patients can access clinics easily. Our study demonstrates a further barrier for some patients that clinicians are unaware of, and may be able to impact upon by reconsidering their triaging protocols. GUM physicians still consider their primary role to be for the diagnosis and management of sexually transmitted infections including HIV infection¹² and consider themselves best placed to fulfil this role compared with doctors in other settings.¹³ The results from this study suggest that GUM physicians still think that the government recommendation for seeing patients with sexually transmitted infections is appropriate and can be achieved; no lead clinician thought that patients with these two clinical scenarios would wait more than 48 hours to be seen in their clinics. It is of concern then that clinicians’ perceptions of what happens in their clinic and what actually does happen is at such variance. The inconsistency between the lead clinicians’ perspective and the reality of the situation in their clinic could be a reflection of the difficulty clinicians may have in performing audits in this area.

In addition to the ever increasing numbers of patients seen in GUM clinics and the rise in the rates of sexually transmitted infections, there is increasing pressure upon GUM clinics which is the consequence of transfer of resources to combination antiretroviral treatments and other aspects of HIV/AIDS management. In the face of this, to maintain an appropriate level of GUM services, clinics must set process standards and address problems regarding staffing levels, training, and resource allocation.

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