Integrating family planning with genitourinary medicine: Developing an holistic sexual health clinic in Eastbourne

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Summary
The idea of providing family planning and genitourinary medicine under one roof has attracted much interest. The development of an integrated sexual health clinic in Eastbourne is described, from initial discussions between disparate parties to the emergence of a one-stop-shop, with a look to the future.

Key words
family planning, genitourinary medicine, sexual health

Key message points
• Family planning (FP) and genitourinary medicine (GUM) have been successfully integrated into a sexual health clinic in Eastbourne.
• To enable successful integration it is essential to secure the support of senior management, and to involve staff and users.
• Prior to integration, cross referral between FP and GUM clinics was unsuccessful.
• During the period of integration of sexual health services in Eastbourne, there has been a rise in activity in all areas, including attendances by people in target populations: under 20s, men who have sex with men, people living with HIV.

Introduction
The 1990s saw an increasing interest in, and debate about, sexual health clinics. Practical constraints in many health authorities have been described as a barrier to the integration of family planning (FP) with genitourinary medicine (GUM), although, as a minimum, collaboration and co-ordination between the two services has been advocated.1 Searle identified the need for FP clinics to ‘adapt or perish’, listing a number of potential routes for the speciality to secure its future, including the possibility of combining with GUM.2 The Ipswich GUM Clinic broadened its provision to include FP, drawing attention to the advantages of an holistic approach for women’s sexual health.3,4 Since gaining trust status, Eastbourne and County Healthcare NHS Trust had managed FP and GUM as fragmented parts of its community health services. Fortuitous historical circumstances meant that, in Eastbourne, these were held in the same building but at different times of the week. Both FP and GUM held four sessions per week, each staffed by one or two doctors with two staff nurses, plus a health adviser in the GUM sessions.

In 1994, local commissioners increased the level of funding so that a GUM consultant, shared with the neighbouring trust in Hastings, and a full-time clinical nurse specialist / co-ordinator could be appointed. A strategic review identified the disparate parts of the service, and the opportunity to bring the services more closely together was identified. This led to their integration as a sexual health service 4 years later, in July 1998. The process of achieving these changes is presented in order to encourage debate and discussion amongst colleagues within the speciality. We acknowledge that we are not the first or only sexual health clinic in the UK.

Table 1 SWOT Analysis 1995

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<tr>
<th>Strengths</th>
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<tr>
<td>• FP and GUM share premises</td>
<td>• Patients who present in FP and who also need GUM (and vice versa) are required to re-attend, and often do not</td>
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<td>• FP and GUM are managed by the same trust</td>
<td>• Knowledge and role of nurses in GUM under-developed</td>
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<td>• Some medical and nursing staff work in both FP and GUM</td>
<td>• Activity above contract level</td>
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<td>• Service users favour an holistic approach to sexual health</td>
<td>• Overspending in several budget areas</td>
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<td>• Staff are committed to developing an holistic sexual health clinic</td>
<td>• No budget for newer contraceptive methods such as Mirena</td>
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<td>• Commissioners are supportive</td>
<td>• Reliance on volunteers, bank and sessional staff</td>
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<td>• High level of training and role development in FP nursing</td>
<td>• No telephone access for the public out of clinic times</td>
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<td>• Provision of specialist training for doctors and nurses</td>
<td>• Lack of publicity about the clinics</td>
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<td>• Location in town centre</td>
<td>• Premises unsuited to clinical work</td>
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<td>• Partnerships with school nursing, drugs team, youth services, etc.</td>
<td>• Doctors practising psychosexual medicine isolated from other psychosexual practitioners</td>
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Opportunities
• Potential for integrating FP with GUM
• Trust plans to redevelop premises
• Developing links with other professionals, e.g.: obstetricians and gynaecologists
• Pathology
• Health promotion specialists
• Health adviser in drugs team

Threats
• Budgetary uncertainty
• The potential removal of GUM to the hospital
• Potential failure to seize the existing opportunity through lack of vision

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Getting started

Medical, nursing and administrative staff participated in a series of meetings which included analyses of strengths, weaknesses, opportunities and threats (SWOT analysis) and political, economic, social and technological factors (PEST analysis) (Tables 1 and 2). The potential for integrating FP with GUM was obvious as the services were already ‘under one roof’. This enabled us to agree upon the shared goal of creating an holistic sexual health department.

Management involvement and strategic planning

Senior management commitment was secured by a presentation about sexual health to a joint meeting of the Trust Board with the Senior Management Team. A sexual health strategy was developed and was adopted by the Trust in 1996. Local commissioners did not have a sexual health standard was not met and patients’ identified sexual health needs were not being fully addressed. An audit of such cross clinic referrals was required to re-attend during a GUM assessment were required to re-attend during a GUM clinic. The majority of nurses are now qualified and skilled in both FP and GUM nursing, and skill mix review has introduced the post of nursing auxiliary to all combined sessions. However, there has been no increase in the budget and therefore the basic establishment remains part-time.

One difficulty for the emerging speciality of sexual health is that the training of doctors in FP and GUM is organised via different career routes, through separate Royal Colleges. It is difficult to identify the career path for a doctor aspiring to a future post as a consultant in sexual health. This contrasts with the situation for nurses who can obtain ENB-equivalent training in FP, GUM and HIV and AIDS as part of a diploma or degree in nursing studies.

A number of in-house training events were held, covering such topics as child protection, cervical cytology, nurse issuing of hormonal contraception under protocol, taking a sexual history, etc. The sexual-history-taking training was instrumental in helping us to agree on a common approach to holistic sexual health assessment. New clinic notes were designed in order to document this. A sexual health lunch club was started and now meets regularly, its programme including audit, journal club, case presentations and a variety of invited speakers.

Staff involvement and training

Staff appraisal was introduced, enabling individuals to identify their personal development needs for working in an integrated department. Visits to the already-established sexual health clinic in Slough were arranged for medical, nursing and administrative staff, enabling them to discuss experiences of change and to see an integrated service in action. There were already a few nurses and one doctor working in both FP and GUM. Our aim was to increase this proportion and to ensure that staff were appropriately trained in both specialities.

During the period of transition, two FP doctors have attended the Diploma in Genitourinary Medicine course, and several nurses have completed ENB courses in GUM and/or FP. Clinical leadership in FP and GUM has remained unchanged and is provided by a senior clinical medical officer (SCMO) and a consultant, respectively. We have changed the rest of our medical staffing structure from sessional clinical medical officers in FP and clinical assistants in GUM by establishing two part-time staff grade posts in sexual health. The staff grade doctors work in both FP and GUM, as does the SCMO in FP. The majority of nurses are now qualified and skilled in both FP and GUM nursing, and skill mix review has introduced the post of...
Concerns

Anecdotal evidence from Slough and Ipswich, where this was experienced, suggested that there might be a temporary fall in attendances of patients in target populations. Another concern was that, only 2 weeks after integration, we moved from our usual clinic building near the town centre to temporary accommodation, half-a-mile up the road. Most of our first 8 months as an integrated sexual health clinic were therefore spent waiting to move back to purpose-designed clinic rooms at our normal community health centre base. Posters and leaflets describing the temporary move were widely distributed, key referrers were informed and the clinic’s direct telephone number was retained during the period.

There was a reduction in the numbers attending the young people’s walk-in clinic which have recovered since moving back. This has been interpreted as being related to the temporary move away from a convenient town centre location rather than dissatisfaction with integrated sexual health services. In the waiting room survey, users of the Eastbourne Youth Walk-in were the most enthusiastic about integration. Activity levels amongst key target populations have risen during the period of planning and since integration (Table 3).

Table 3 Changing activity since integration

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<tr>
<td>Total FP attendances</td>
<td>5388</td>
<td>5547</td>
</tr>
<tr>
<td>Proportion of FP patients under 20 years</td>
<td>24%</td>
<td>29%</td>
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<tr>
<td>Total GUM attendances</td>
<td>4501</td>
<td>5157</td>
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<tr>
<td>Proportion of male GUM activity: men having sex with men</td>
<td>13%</td>
<td>19%</td>
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<tr>
<td>Total HIV+ cases</td>
<td>24</td>
<td>31</td>
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Doctors and nurses who have worked in the department since before 1994 state that the nature of the FP work has changed, with a greater bias towards complex cases which cannot be easily handled in general practice: an appropriate shift for a specialist service. In order to cope with the increase in demand for the service, we have reviewed our systems for re-booking appointments. Women using oral contraception are now asked to contact the clinic when they move back. This has been interpreted as being related to integration. Activity levels amongst key target populations have risen during the period of planning and since integration (Table 3).

Financial implications

The trust made a considerable capital investment in excess of £1 million in the building in order to create the purpose designed health centre which houses the sexual health clinic. Since the 1994 investments in GUM, however, the core budgets for sexual health services have been merely ‘rolled over’ from 1 year to the next, while the HIV budget has risen to reflect the introduction of highly active anti-retroviral therapy. The changes described, with the exception of a new psychosexual therapy service, have therefore been achieved within existing resources and not through new investment in the service. The increase in activity has caused considerable budget pressures.

Clinic organisation

The sexual health clinic now opens for seven combined FP and GUM sessions per week. These are appointment-only clinics with two lists: one for FP and one for GUM. Two doctors staff each session, one taking a lead in FP, the other in GUM. There are two trained nurses, a health adviser and a nursing auxiliary employed in each session. In addition there is a young people’s walk-in and an IUD clinic each week, and two vasectomy operating lists per month. The focus of the young people’s walk-in clinic is contraception, as this is the predominant reason for attendance. Extra funding has been secured for a weekly psychosexual therapy session, jointly run with Relate, after the earlier demise of a psychosexual medicine service due to retirement and a lack of suitable local supervision.

The clinic is advertised in local directories, via leaflets and posters, and on the Trust’s website as a ‘Sexual Health Clinic’ dealing with ‘contraception, genital infections, family planning, sexually transmitted infections, HIV and AIDS, hepatitis B vaccination, emergency contraception, pregnancy testing and Youth Walk-in Clinic’.

Next steps

Improving data collection

FP data are still collected manually, while GUM is computerised. It is our belief that some activity, particularly for patients with both FP and GUM needs, is not included in current activity returns, despite our best efforts to capture it. All-through computerisation, with the creation of a single database of sexual health clinic patients, is envisaged.

Further audit

Re-auditing the work on patients with identified sexual health needs in both FP and GUM is planned.

We believe we are now in an enhanced position to effectively respond to ‘The New NHS’ and the plethora of new strategic initiatives, including: the Social Exclusion Unit Report on teenage pregnancy, the BMA Foundation for AIDS standards for HIV care, the Chlamydia pilot and strategy (as yet unpublished), the health authority’s recently launched sexual health strategy and the government’s anticipated sexual health strategy.

Conclusion

The establishment of an integrated, one-stop-shop for sexual health in central Eastbourne has taken 5 years. We have moved from inadequate first floor rooms to a purpose designed, ground floor clinic, retaining our town centre address, which is well-known in the community. The process of evolution rather than revolution has meant that
staff have been involved in deciding the direction and the pace of change throughout.

We hope that the publication of this account will provoke a discussion amongst colleagues who have taken, who are considering taking or who have decided against taking this route.

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Competing interest. None declared.

References