Implementing integrated sexual and reproductive healthcare in a large sexual health service in England: challenges and opportunities for the provider

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INTRODUCTION

This quality improvement project reports a provider perspective of service-level challenges associated with implementing integrated sexual and reproductive healthcare (SRH) services. Funding constraints and competitive tendering have led to rapid remodelling of sexual health services (SHS) in England,[1 2] with multiple contractual changes causing integration and splitting of many components of SRH care, as well as changes to service management and delivery.[2 3]

In January 2014, an integrated SHS was launched in Leicestershire, UK, providing Levels 1–3 contraception and genitourinary medicine (GUM) services and SRH promotion and prevention. The SHS serves a population of 1.1 million over 900 square miles, seeing approximately 50 000 patients per year. Leicester City, Leicestershire County and Rutland County Councils co-commissioned the service and the contract was awarded to Staffordshire & Stoke on Trent Partnership NHS Trust. This saw the transfer of GUM services from an acute hospital setting to join community contraceptive services, merging staff from both departments. HIV treatment, abortion care and vasectomies were no longer provided within the SHS.[4]

WHAT WERE THE REQUIREMENTS OF THE NEW CONTRACT?

- Patients to receive comprehensive integrated SRH (previously attended separate services for different aspects of SRH).
- Introduction of 'hub and spoke' service model:
  - Two 'hubs' (Leicester City and Loughborough)
  - Twelve 'spokes' (across Leicestershire and Rutland)
  - Eighteen outreach clinics (prison, barracks, male saunas, sex workers, LGBT (lesbian, gay, bisexual and trans) services, educational facilities).
- Two additional key performance indicators (KPIs):
  - 98% of symptomatic patients to be offered an appointment within 48 hours of contacting SHS
  - 80% of walk-in (WI) patients to be seen within 2 hours of arrival.
- Extended opening hours – 9.00am to 8.00pm Monday to Friday, Saturday morning clinics (previously only one evening clinic/week).

PHASE 1 – WALK-IN SYSTEM

The new amalgamated service adopted a WI system for all patients. Reception staff asked patients their reason for attendance and placed notes in time order in one tray for all clinicians (doctors and nurses). The expectation was that clinicians would select the top notes from the tray.

Phase 1 - What were the issues with this system?

Staff had to adapt to working in a new service with new colleagues and most were not dual-trained, having previously provided either contraception or GUM services. They attempted to provide more holistic healthcare, but lack of dual-training and clinicians' efforts to address multiple issues led to prolonged consultations. The resultant long waiting times caused complaints, with some patients

choosing to leave the SHS without being seen. Additionally, staff felt pressurised to catch up time, often missing breaks with no time for training/development.

The random allocation based on arrival times meant staff without appropriate skills could end up trying to manage patients with complex needs, such as post-exposure prophylaxis following sexual exposure (PEPSE), emergency contraception and sexual assault care. There were concerns that this could result in misdiagnosis and patients not receiving appropriate care. GUM specialty registrar training was affected as the unpredictable case-load could not guarantee adequate training. Patients attending for intrauterine contraception often occupied senior clinicians' time, resulting in other patients with complex problems being seen by junior staff. Additionally, many clinicians were not confident managing both contraception and GUM, and selected patients based on their presentation rather than time order, leading to longer waiting times.

There were many practical challenges of merging services, including staff working in different geographical areas, having to adapt clinic spaces to accommodate new SRH activities (eg, microscopy and hyfrecation) and administrative changes associated with changing Trust. Extended opening hours were not coupled with increased staffing, therefore staff workload increased, and unfortunately some staff left.

Table 1 Summary of the three phases in the implementation of the new integrated sexual and reproductive healthcare service

Phase 1: January 2014 – May 2015	Phase 2: May 2015 – March 2017	Phase 3: March 2017 – present
▶ One tray of walk-in patient notes for doctors and nurses of all grades to see ▶ Walk-in IUD procedures ▶ Walk-in complex GU patients ▶ Online chlamydia testing available (16–25-year-olds) ▶ No appointment clinics ▶ No separate 'Screen & Go' clinic list ▶ No protected lunchtime teaching for staff ▶ Worsening of financial situation	▶ One tray of walk-in patient notes for nurses and junior doctors to see ▶ Additional tray of patients for senior doctor only review ▶ Booked IUD clinics (routine and emergency IUDs) ▶ Booked complex GU clinics ▶ Separate 'Screen & Go' lists ▶ Walk-in implant procedures ▶ Separate clinics for high-risk groups (eg, young people, MSM) ▶ Online chlamydia testing available (16–25-year-olds) ▶ No protected lunchtime teaching for staff ▶ Improvement in financial situation	▶ Zone A/B/C trays ▶ Named lists for individual doctors/nurses ▶ Booked complex GU clinics ▶ Separate implant lists ▶ Booked IUD clinics (routine and emergency IUDs) ▶ Separate 'Screen & Go' lists ▶ Online chlamydia, gonorrhoea, HIV and syphilis testing for over-16s ▶ Separate clinics for high-risk groups (eg, young people, MSM) ▶ Protected lunchtime teaching programme for staff education ▶ Improvement in financial situation
Staff satisfaction score: 2.5/10	Staff satisfaction score: 5.0/10	Staff satisfaction score: 8.1/10

Phase 1 - What changes were required to address the issues identified?

1. Ensure an adequate skill mix in clinic, so patient needs were fully met in an appropriate timeframe.
2. Patients to be seen by an appropriately trained clinician,[5] based on their presentation rather than arrival time.
3. Introduction of protected educational time for clinicians.
4. Senior contraception and GUM clinicians to be present in each clinic to see patients and provide advice to colleagues.

Patient feedback forms were reviewed, staff were consulted on these issues, and ideas were gathered for Phase 2.

PHASE 2 – IMPLEMENTING CHANGES AFTER PHASE 1

Clinical skills and training needs for each clinician were identified and mapped in Excel. This was used to create a rota that ensured sufficient skill mix and presence of lead GUM and contraception clinicians in every clinic.[5] Staff were encouraged to seek support from lead clinicians and colleagues in the clinic, sharing skills/expertise. Healthcare assistants (HCAs) were trained in pregnancy testing and asymptomatic sexually transmitted infection screening. As a result of the skill-mix review, more HCAs and Band 5 nurses were recruited, and a retiring GUM consultant was replaced with a dual-trained SRH consultant.

A self-triage form was drafted to identify reasons for attendance, and reception staff were trained to allocate patients to one of four workstream trays within the WI clinic (table 1):

1. Suitable for nurses and junior doctors
2. For senior doctors
3. Implant procedures
4. Asymptomatic screening/pregnancy testing.

Patients identified on the triage form as not being suitable for the WI streams (eg, intrauterine device fit) were booked an appointment in the relevant clinic, as were patients who telephoned requesting an appointment. Pilots were carried out and outcomes presented at a team meeting. Feedback was sought from patients and clinicians.

PHASE 3 – IMPLEMENTING SUGGESTIONS AFTER PHASE 2

A retrospective survey was completed, asking staff for feedback and their own satisfaction scores for each phase. This revealed that clinicians found the unpredictable nature of the clinic prevented them from managing their time efficiently. Teaching and training was a concern as heavy workloads took priority over training and development.

To address concerns around time management, clinicians were allocated their own patient list, according to their expertise, to encourage ownership and allow

Table 2 Patient workstreams within the new integrated sexual and reproductive healthcare service

Zone/ clinic	Time (min)	Presentation/ procedure	Staff requirements
Zone A	40	Cases of severe pain, PEPSE, sexual assault, herpes, rash, lump/pain in testicles, rectal discharge/pain, pain with IUD in situ	Consultants or senior clinicians holding Dip GUM or Advanced STIF Competency
Zone B1	20	For GUM and contraception (excluding above presentations) with two clinicians working from the same stream	Clinicians with DFSRH/ Intermediate STIF competency
Zone B2	(20 min/ appointment)	A second workstream as above	As above
Zone B: implants	30	Walk-in implant procedures	LOC SDI
Zone C	20	'Screen & Go' for patients who are asymptomatic (includes triple-site testing if necessary), or require pregnancy testing/advice	Suitable for an HCA STIF Fundamental competency
Booked clinics	30–40	IUD clinics including emergency IUDs, complex contraception clinics, complex GUM clinics and training IUD/ implant clinics	Consultants or senior clinicians with appropriate training and qualifications (eg, LOC IUT for IUD, FSRH-registered Trainer qualification for training clinics, etc.)

DFSRH, Diploma of the Faculty of Sexual & Reproductive Healthcare; Dip, Diploma; GUM, genitourinary medicine; HCA, healthcare assistant; IUD, intrauterine device; IUT, intrauterine technique; LOC, Letter of Competence; SDI, subdermal implant; STIF, Sexually Transmitted Infections Foundation; PEPSE, post-exposure prophylaxis following sexual exposure.

clinicians to better manage their time. This helped reception staff allocate a set number of patients to each clinician and better inform patients about expected waiting times. This new system divided workstreams into Zones A, B and C (table 2), with patients assigned to a zone under the responsibility of a named clinician. The self-triage form was amended to reflect the zones (online Appendix 1). Staff met 10 min before the clinic started and were allocated to an appropriate zone.

The service produced an Education and Training Strategy, setting time lines and targets to address training needs. Additionally, a buddy system was introduced to support junior staff in enhancing their skills, whereby two clinicians with skills either in contraception or GUM shared the same workstream. Thirty minutes of protected teaching time for all clinicians was introduced every day between the morning and afternoon clinics, and a rota was developed that allocated senior clinicians to lead sessions in their area of expertise.

WHAT ARE THE OUTCOMES/IMPROVEMENTS SINCE IMPLEMENTING THE CHANGE?

The triaging system has resulted in the majority of patients being allocated to a suitably skilled clinician in an appropriate clinic. With senior clinicians available for supervision, colleagues can be supported to deal with suitably complex cases, thus furthering professional development.

The introduction of protected educational time has prioritised training and development. As a result, competence and confidence in providing fully integrated SRH continues to improve across all grades of staff.

Despite administrative changes, there has been a modest increase in SHS activity and the new KPIs are being met: 97% of patients are seen within 2 hours and 100% of symptomatic patients are offered an appropriate appointment within 48 hours. Allocation to appropriate clinicians has reduced the need for patients to return to the SHS or see multiple clinicians during one appointment. Patient surveys were issued throughout the three phases and the data continue to be reviewed on a monthly basis. These data show high levels of satisfaction, with >90% of service users reporting recommendation to a friend and >95% satisfied with their care.

Remarkably, staff satisfaction scores have rocketed from 2.5/10 to 8.1/10 across the three phases with significant improvements in staff morale. For information, current staff levels are:

- Band 7&8 nurses: 4.25 whole-time equivalents (WTE)
- Band 5&6 nurses: 18 WTE
- Band 2&3 HCAs: 17 WTE
- Consultants: 6 WTE
- Specialty and Associate Specialist (SAS) doctors: 2.6 WTE
- Trainees: 5 WTE.

WHAT ADVICE WOULD YOU GIVE OTHER CLINICAL DEPARTMENTS SEEKING TO MAKE SIMILAR CHANGES?

Despite the many difficulties associated with such dramatic changes, including loss of some aspects of the service, obstacles in patient workstreams, staff workload and training have been overcome. Our approach encompassed three elements:

- Communication and respect
- Flexibility
- Staff development.

Multiple changes in quick succession can cause unrest and dissatisfaction, and therefore it is important to communicate the rationale and positive

implications for change. A flexible approach, adapting to feedback from staff and patients, has encouraged ownership and improved organisation of clinic workload. Additionally, prioritising staff training and ensuring a supportive learning environment for clinicians has improved both staff satisfaction and patient experience.

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