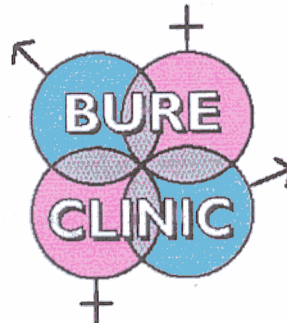


# ANNUAL REPORT 2005



Department of  
Genito-Urinary Medicine



Compiled by  
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7<sup>th</sup> Edition

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## Foreword

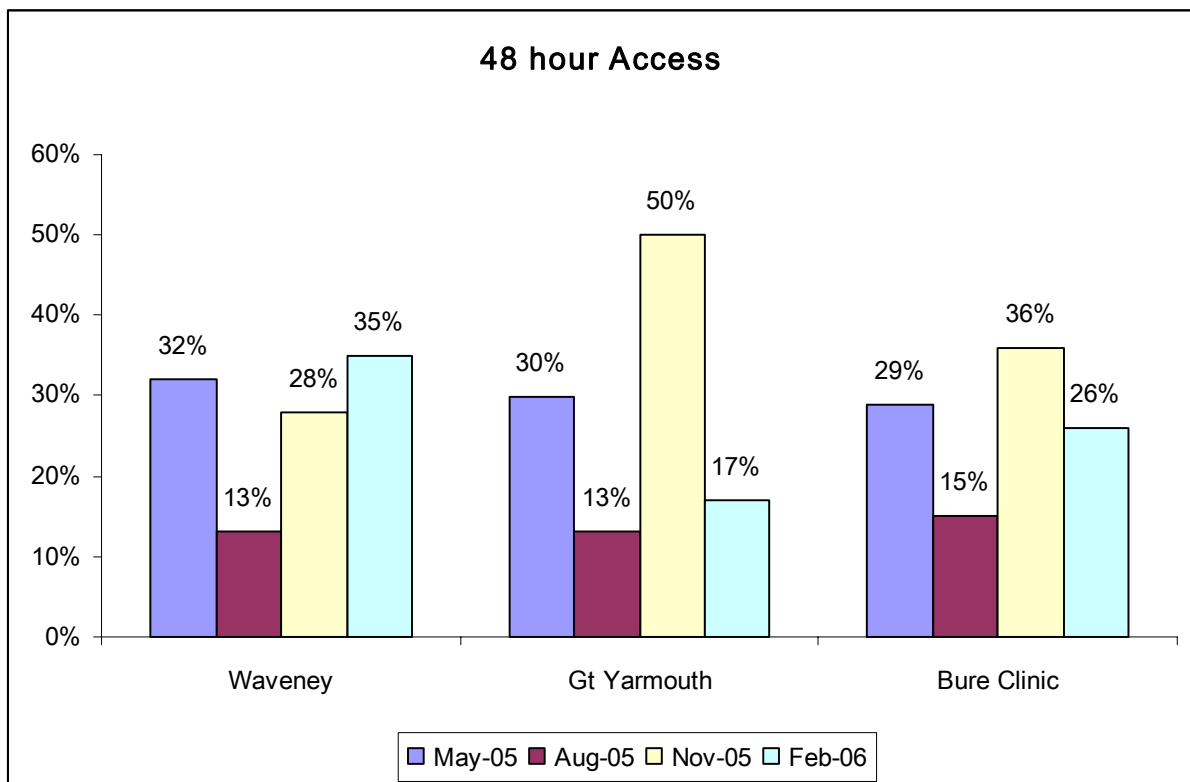
This seventh annual report is written after a 3 year gap. During the last three years following the sixth edition considerable changes had occurred and sexual health services have been given the much needed priority by the department of health.

Local needs are often centrally driven. The standard of the Monk Report has now finally found currency in contractual and commissioning of sexual health services.

The much needed review of sexual health services have now been undertaken under the aegis of MedFash. Our unit was reviewed in July 2005. The report is available at [www.bureclinic.com/annualreports.htm](http://www.bureclinic.com/annualreports.htm) including the Strategic Health Authority review report of September 2005.

The National target is to offer open-access to attendees within 48 hours. The challenge of this target embodied in the Monk's Report is dependent in recruitment of essential Medical and supporting services after a period of considerable under-investment.

The challenge is achieving 48 hours for all attendees by 2008.



## RESOURCES

### Staffing:

1 Full time Consultant  
1 Full time Locum Staff Grade from 1<sup>st</sup> March 2006 for 6 months  
2 vacant Hospital Practitioners  
1 Part time Sister (30 hours)– G grade  
1 Full time Health Advisor – G grade  
1 Part time Health Advisor - F grade  
3.35 W.T.E Nurses – E grade  
2.07 W.T.E Secretarial and Reception staff – Grade 4  
Sessional Social Worker, Dietician and Clinical Psychologist  
Bank nurses with Staff Nurse & Nursing Health assistants for holiday and sickness cover.

### Department profile:

The siting of the clinic and the standard of accommodation confirms to the Monks Report recommendations. There are dedicated facilities for counselling and treatment. The department is clearly signposted from all patients' entrances to the hospital.

### Categories of referral

1. Self referral
2. Referred by contact
3. Health advisor initiated referrals
4. Referrals from GP's
5. Referrals from other Consultants/Department
6. Transferred from other GUM departments

### Clinic Access Times

	AM	PM
Monday	9.00 – 12.30	14.00 – 1700
Tuesday	9.00 – 12.30	
Wednesday	9.00 – 12.30	14.00 – 1700
Thursday	9.00 – 12.30	14.00 – 1700
Friday	9.00 – 12.30	

## APPOINTMENT SYSTEM

### 1.GENERAL CLINICS

Monday (AM session)	Mixed male & female clinic
Monday (PM session)	Mixed male & female clinic
Tuesday (AM session)	Mixed male & female clinic
Wednesday (AM session)	Mixed male & female clinic
Wednesday (PM session)	Mixed male & female clinic
Thursday (AM session)	Mixed male & female clinic
Thursday (PM session)	Mixed male & female clinic
Friday (AM session)	Mixed male & female clinic

### 2.SPECIALIST CLINICS

Monday (AM session)(males & females)	HIV/AIDS follow up
Thursday (PM session) males & females	Genital-Dermatosis Clinic

### **SERVICES PROVIDED BY THE BURE CLINIC**

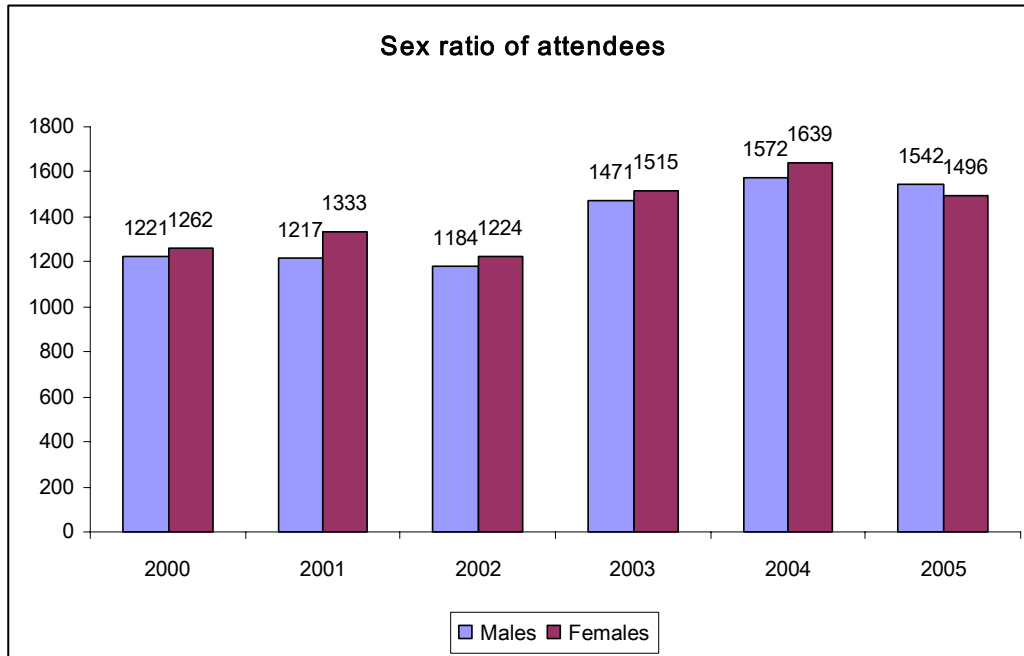
1. Comprehensive screening and treatment for sexually transmissible infections.
2. Partner notification and provider referral
3. HIV antibody tests with pre and post test counselling
4. Clinical, virological and immunological monitoring of HIV antibody positive/AIDS patients.
5. Support for HIV positive patients, family and friends
6. Sexual Health Education for patients schools medical and paramedical staff and other agencies.
7. Genital Dermatoses Clinic run jointly with Consultant Dermatologist Dr I Salvary, FRCP
8. Hepatitis B immunisation programme for “at risk patients”
9. Provision of inpatient care to HIV/AIDS patients
10. Provision of care to patients admitted with sexually transmitted infections in other wards in the hospital
11. Psychosexual services by Clinical Psychologist
12. Collaborative research with other agencies involved in the enhancement of sexual health

### **THE BURE CLINIC PHILOSOPHY STATEMENT**

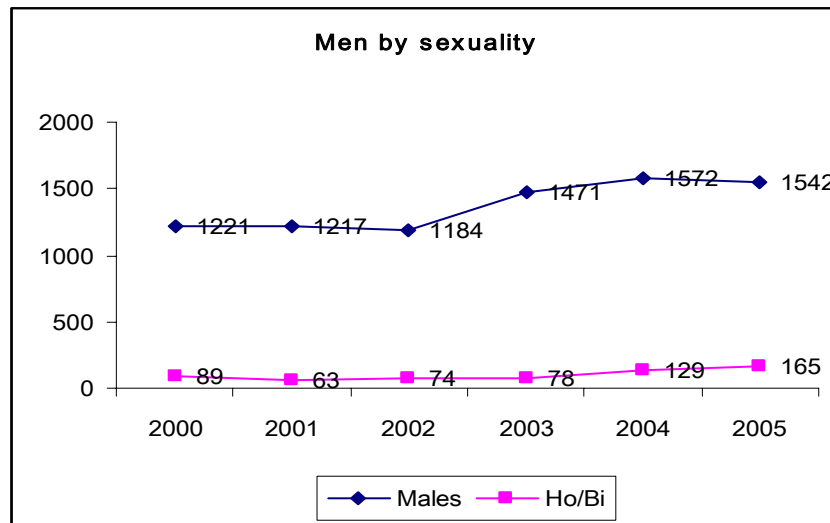
- The department believes that the patients’ confidentiality is of the utmost importance and is assured by the Venereal Disease Act.
- Morality of the patient will never be questioned and to achieve this a holistic approach is adopted in treatment with full patient participation.
- The department is run on democratic principles.
- Opinions and suggestions are welcomed and encouraged from both service providers and patients in adopting best practice.
- All staff knows they have an important role to play and they are aware of their responsibilities.
- We assure patients of their rights and encourage a civic discharge of their responsibilities.

## TRENDS IN ATTENDANCE & SUMMARY

In this annual report we have set out the sex differentials in the common infections seen. From the 2001 census our catchment population is drawn from Waveney (112,342) made up of 48% males and 52% females and Great Yarmouth (90,810) also made up of 48% males and 52% females. This is reflected in our having more female attendants than males. The sex ratios continue to be skewed towards more female attendance (see graph).



This is reassuring as women more acutely feel most of the morbidity associated with STD's. However in 2005 we had a slight excess of men. This is encouraging as we now have a substantial increase in attendance amongst men who have sex with men (See graph)



In Great Yarmouth & Waveney 14.5% of the population are aged between 16 – 29 years. And this age group represent 70.4% of the total attendees to the clinic and bear the greatest burden of the acute STI's but not HIV.

HIV is commoner amongst men aged 40 – 64 who make up 32.3% of the total population served.

About 25 % of the catchment population aged 16 and above are single, and 98.7% of the population are white and 0.3% of the population are black.

Unemployment amongst those aged 16 and above is 5.3% and those retired represent 17.2 % of the population. About 37% of those aged 16 – 74 have no formal educational qualification.

These sociological factors contribute to the significant burden of infections in our local population.

For instance 70% of all cases of *Chlamydia trachomatis* were detected in those aged 16 – 24 who make up 43.5% of the total attendees. We have also seen significant increase in the incidence of chlamydial infection to 313 cases.

The increases seen are of concern, as both infections contribute to significant morbidity and are surrogate markers of unsafe sexual practices.

The Vulval clinic run jointly with a Consultant Dermatologist has now been re-established and continues to be over subscribed.

The Colposcopy Service in the Bure Clinic has now been decommissioned and we rarely perform cervical smears.

The acceptability of HIV antibody testing within the department continues to increase in momentum, especially for heterosexual males and females. Greater collaboration continues with the Women and Child directorate in seeking to minimise fetomaternal transmission by offering opportunistic HIV antibody testing and providing antiretroviral treatment to those infected. Post exposure prophylaxis to healthcare workers exposed to HIV infection is led from the department in collaboration with the Occupational Health department, Accident & Emergency and Ward 17. The Department of Health guideline for routine screening for HIV and Hepatitis B in pregnancy has now been implemented in the Trust from April 2000. We have so far from April 2000 - March 2001 screened 1754 pregnant mothers with 1 positive case representing a prevalence rate of 57 per 100,000. An uptake rate of 87% was achieved during this period, well within the expected Department of Health targets. 90% of Attendees had HIV test in 2005

We need to ensure continuity in providing a fully responsive service for all aspects of Genito-urinary Medicine in the District by assuring adequate staffing level, a mandate for the Organisation.

### **Research & Audit publications 1996 - 2005**

Participation in the *Roche* International phase 111b open label safety study of Saquinavir (Ro 31-8959; HIV – proteinase inhibitor) in-patients with proven HIV infection

Harry TC. Are the *Health of the Nation's* targets attainable. *Int J STD AIDS* 1998; **9**: 185 – 6

Audit of the outcome of inflammatory smears managed in the Bure Clinic. Oral presentation at the British Colposcopy and Cervical Pathology Meeting, Cheltenham, UK 23rd - 26<sup>th</sup> April 1998. Published as: Harry TC, Cozens C. Outcome of inflammatory smears in women seen in the Bure Clinic. *Int J STD AIDS* 1998; **9**: 299-300.

Partner notification and provider referral differences across the Atlantic. Presented at the MSSVD Spring meeting in Athens. May 1998

Participation in Dupont open label safety study of Efavirenz (DMP 89421 Sustiva) non-nucleoside analogue in patients failing on therapy.

Patient-led survey evaluating responsiveness of the service. Harry TC. Quality and resource management in GUM service delivery. *Int J STD AIDS* 2000; **11**: 751-4.

Audit on the impact of pre-test HIV counselling upon knowledge about HIV and the motivation to change behaviour. Presented as a poster at the 4<sup>th</sup> International Conference on the Biopsychosocial Aspects of HIV Infection, Ottawa, Canada 15<sup>th</sup> -18<sup>th</sup> July 1999.

Evaluation of sexual health knowledge of adolescents in a Great Yarmouth High School. Presented as a poster at the 6<sup>th</sup> World Congress, Sun City, South Africa 21<sup>st</sup> - 24<sup>th</sup> November 1999.

13<sup>th</sup> International AIDS Conference Durban, **South Africa**, 9<sup>th</sup> - 14<sup>th</sup> July 2000. *Ophthalmic manifestations in HIV/AIDS patients on highly active antiretroviral therapy*. (Abstract No. **ThPeB5257**: Poster).

Harry TC. Management of Genital *Chlamydia trachomatis* infection. *CME BULLETIN STI & HIV* 1998; **2**: 4-5

Harry TC, Clark SL. Are race and ethnicity in STD analysis still of relevance? *Sex Transm Infect*. 1998; **74**: 231.

Harry TC. Sexual ill-health among blacks in the UK. *Lancet* 1998; **351**:1363-4

Harry TC. Sexually transmitted diseases. *Lancet* 1998; **352**:650

Harry TC, Snobl H. Website as a tool for patient education in sexually transmitted diseases. *Int J STD AIDS* 1998; **9**: 779-8

Harry TC HIV/AIDS in Zambia. *eBMJ* 9th August 1999.

Harry TC. Information Technology for postgraduate education. *Br J Obstet Gynaecol* 2000; **107**: 144

Harry TC. Sexual health knowledge of adolescents in a Great Yarmouth High School. *Int J STD AIDS* 2000; **11**: 129-31

Harry TC, Matthews M, Salvary I. Indinavir use: Associated reversible hair loss and mood disturbance. *Int J STD AIDS* 2000; **11**: 474-6

Harry TC Induced Abortion. *The Obstetrician & Gynaecologist* 2000; **2**:52-3

Harry TC Impact of adequate medical manpower in genitourinary medicine service delivery. *Int J STD AIDS* 2001; **12**: 131-2

Harry TC Infectious syphilis and importance of travel history. *Lancet* 2002; 359: 447 - 8. 8<sup>th</sup>

European Conference on Clinical Aspects & Treatment of HIV-Infection. Athens, **Greece** 28<sup>th</sup> - 31<sup>st</sup> October 2001. *To test or not to test: Implications for late diagnosis of HIV/AIDS.* (Poster). Abstract No: **P382**

14<sup>th</sup> International AIDS Conference Barcelona, Spain, 7<sup>th</sup> - 12<sup>th</sup> July 2002. *"Outcome of baseline viral resistance testing in newly diagnosed HIV patients"* (Abstract No **B10406**)

2<sup>nd</sup> Joint BASHH/ASTDA Spring Meeting Bath, **England** 19<sup>th</sup> -21<sup>st</sup> May 2004  
*"Should tests of cure for gonococcal infection still be routine in patients attending genitourinary medicine clinics"*(Abstract No **P77**)

15<sup>th</sup> International AIDS Conference, Bangkok, **Thailand**, 11<sup>th</sup> – 16<sup>th</sup> July 2004. *"Efficacy of T-20 (Enfuvirtide) in a patient recovered from nucleoside-induced lactic acidosis with virological failure"*(Abstract No **B10268**)

3<sup>rd</sup> International AIDS Society (IAS) Conference on HIV Pathogenesis and Treatment, Rio de Janeiro, **Brazil**, 24<sup>th</sup> – 27<sup>th</sup> July 2005. *"Outcome of partner notification in a provincial clinic in East Anglia, United Kingdom"* (Poster) (Abstract No **MoPe10.2P03**)

Harry TC The management of uncomplicated adult gonococcal infection: Should test of cure still be routine in patients attending genitourinary medicine clinics? *Int J STD AIDS* 2004; **15**: 453 – 8.

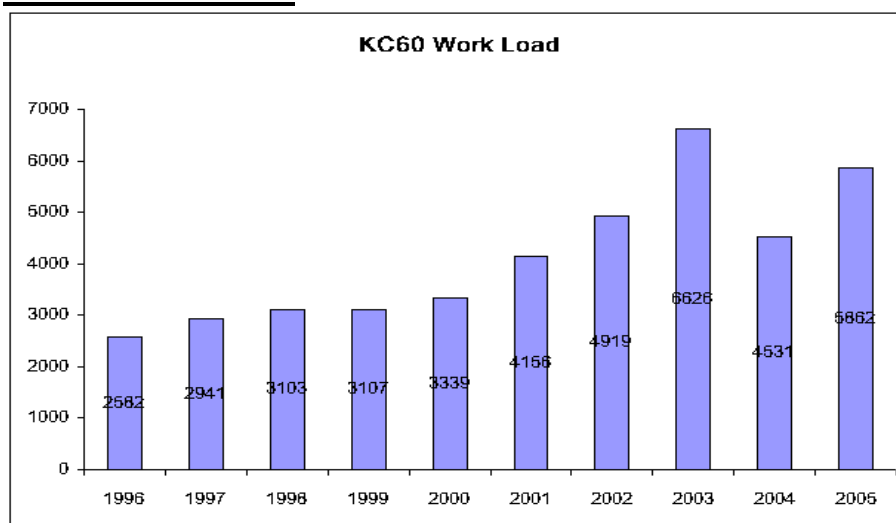
Jaiyesimi RA, Harry TC. Men's sexual health: behaviour, infections and consequences. *J R Soc Health* 2004; **124**:212-3.

Harry TC, Black P. Unilateral gonococcal ophthalmia without genital infection: an unusual presentation in an adult. *Int J STD AIDS* 2005; **16**: 78-9.

Harry TC. The outcome of oropharyngeal gonorrhoea treatment with different regimens. *Int J STD AIDS* 2005; **16**: 520

Harry TC. RE: Ciprofloxacin resistance in Great Yarmouth and Waveney district. *J Eur Acad Dermatol Venereol* 2006;**20**:216-7.

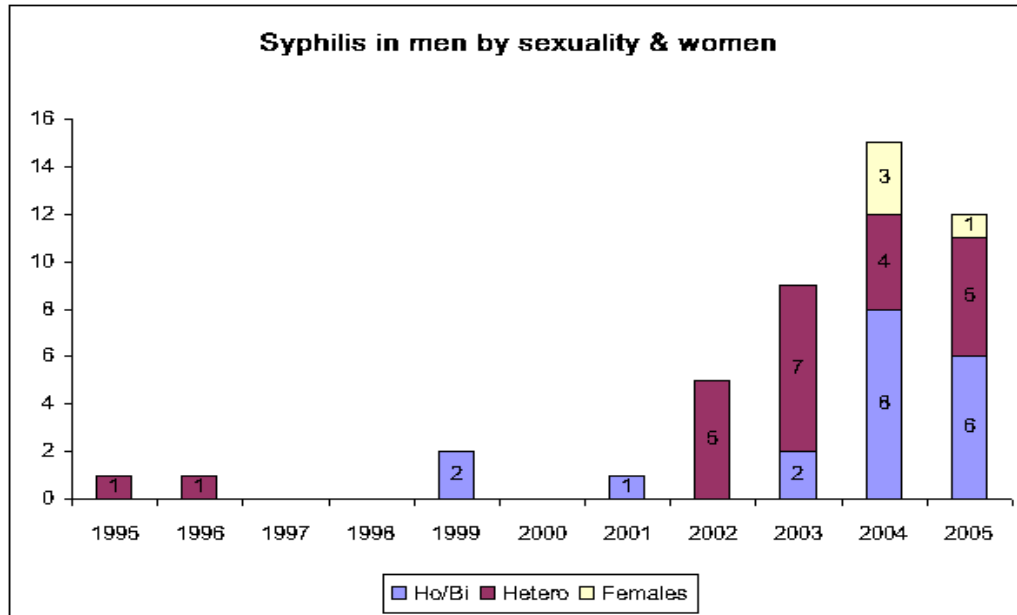
### **Total clinic workload**



Since 1996 we had a doubling in activity undertaken in the clinic, manifest from the considerable increase in a new diagnosis of various STI's seen.

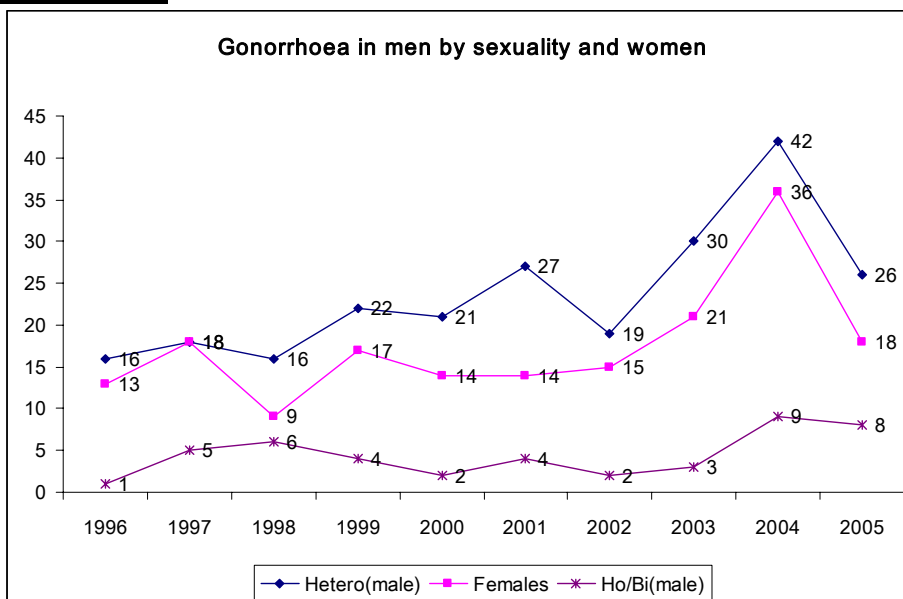
The relevant aspects are that with increase in the numbers of patients attending so also, the complexity, diversity and the STD related problems. These have led to significant increase in the workload of the medical staff. This in turn has increased the resource and manpower demands on supporting diagnostic services. The year 2005 was particularly marred by clinic closures from due to unfilled medical staff vacancies with closure of clinics following the holidays of the incumbent single-handed GUM consultant.

### Syphilis



Since 2002 we have had substantial increase in the cases of syphilis. Unlike national trend where the increase is more marked in men who have sex with men our local epidemic have been mostly fuelled by heterosexual males. In 2004 & 2005 we had 4 cases in females, all Caucasians living locally with no successful contact tracing. Partners have been itinerant and casual.

### Gonorrhoea

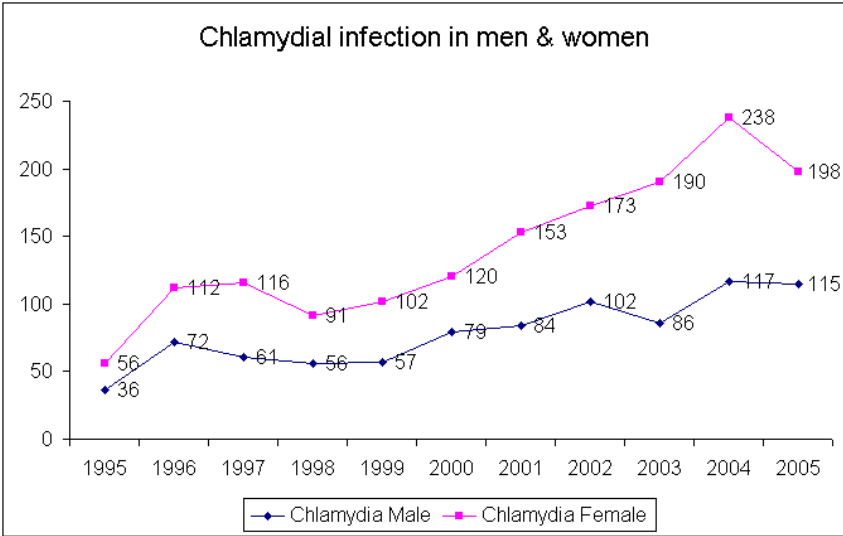


The rise in incidences of gonorrhoea remains sustained from 1996 to 2005. There was a three fold increase from 1996 to 2004 in the Bure Clinic (see graph). We have reached 68.8 cases per 100,000 population aged 16 -64 in Great Yarmouth & Waveney. This is the highest incidence seen in the district since 1990 when the incidence was 25 per 100,000 cases. The rise is most marked amongst heterosexual males and closely followed by females. The males are exclusively local with little ethnic minority population amongst them. Paradoxically men who have sex with men did not contribute much to the rise in the district when compared to national trend.

In east Norfolk, Great Yarmouth has the highest unemployment rate and deprivation index which is manifested in the sexual ill-health markers of high teenage pregnancy and gonorrheal infections. The sustained rise in females is clearly shown from 1996 to 2004 with a mild drop in 2005. The trend in the first quarter of 2006 suggests that this fall may be sustained.

Contributory factors will be explored in next years report.

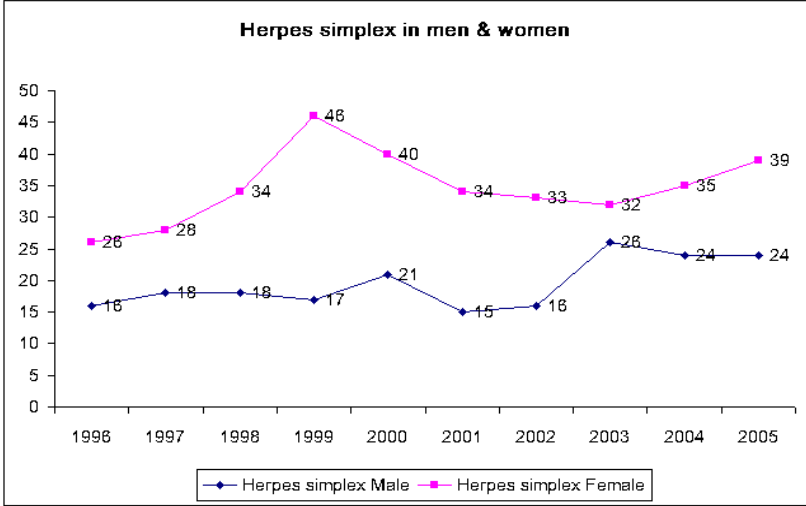
**Chlamydia trachomatis**



The greatest burden of chlamydia in our catchment population are females aged 16 – 29 years who are also at greatest risk of the complications of chlamydia notably infertility and ectopic pregnancy. New case detection has been due mostly to increase screening of chlamydia in the primary care sector and the chlamydia screening programme. The advent of nucleic acid amplification tests (NAATs) is diagnosis has also aided the high pick up rate.

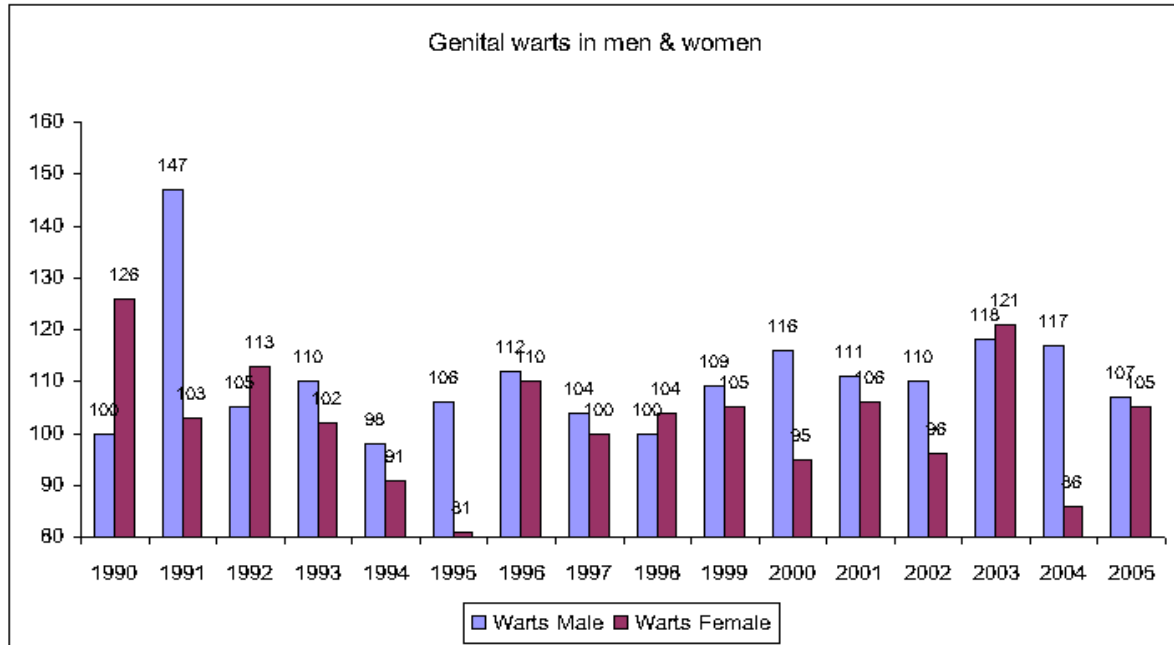
Nevertheless more needs to be done. The sex ratio of attendees indicates not all contacts are seen. The greatest challenge will be increasing the partner notification index.

**Herpes simplex infection**



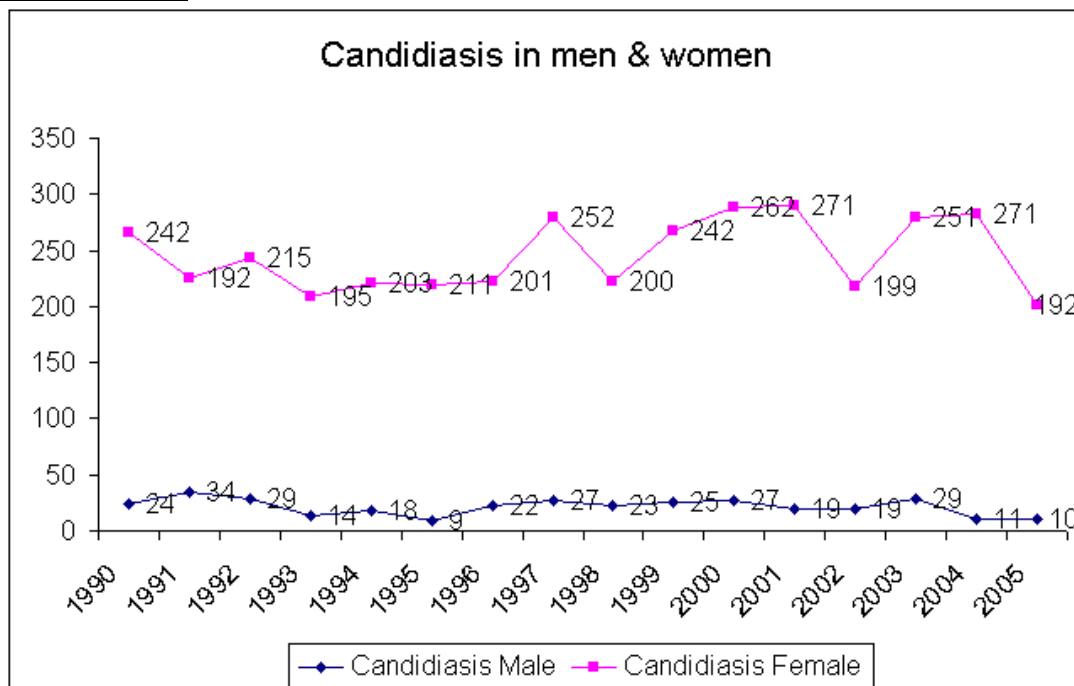
The greatest burden of first attack herpes is in women in our catchment population in tandem with other published series. Analysis of viral subtype will be undertaken. Timely access is crucial to culture diagnosis of herpes simplex. Interestingly we have had co-infection with syphilis particularly in men who have sex with men.

### Genital warts



The prevalence of genital warts has remained fairly stable in the catchment population, more marked in men than women.

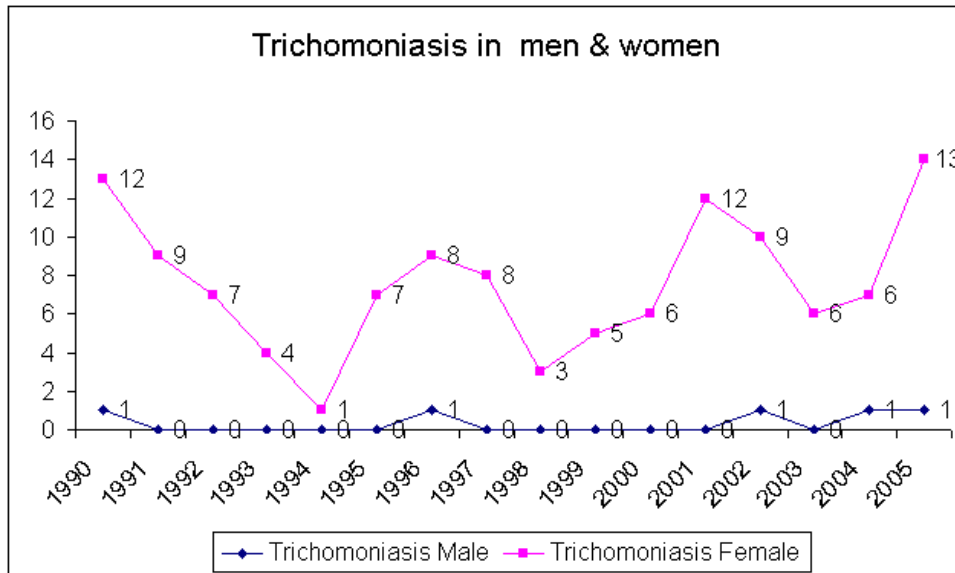
### Candidiasis



The incidence has remained stable over the last 15 years. Most women with vaginal discharge and vulval pruritus see their primary care physician or Practice nurse either of who initiate referral. Most magazines read by women similarly provide advice to patients to attend the

clinic, if symptoms of intractable vulval pruritus are discerned. This would also account for the skewed sex ratio in favour of female noted amongst attendants. It is exclusively a problem acutely felt by women. In the men it is usually a marker of diabetes mellitus.

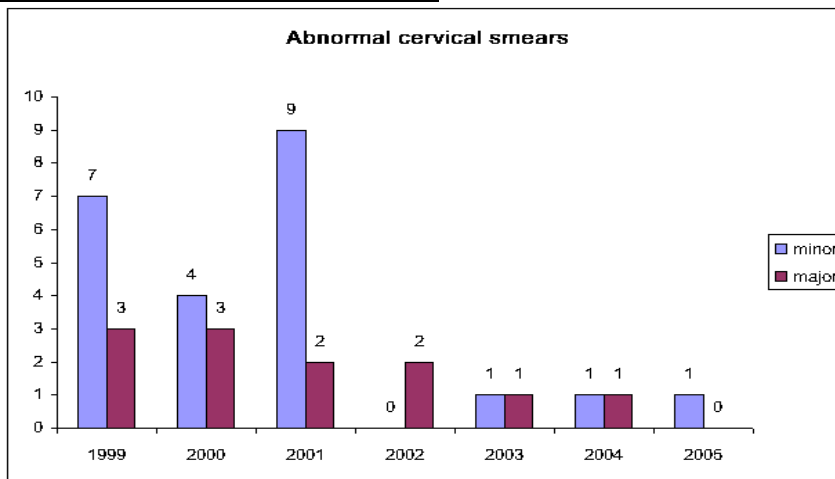
**Trichomoniasis**



The prevalence has remained low with an initial fall and slight rise as shown in the graph in the annex. We have now discontinued routine culture in women.

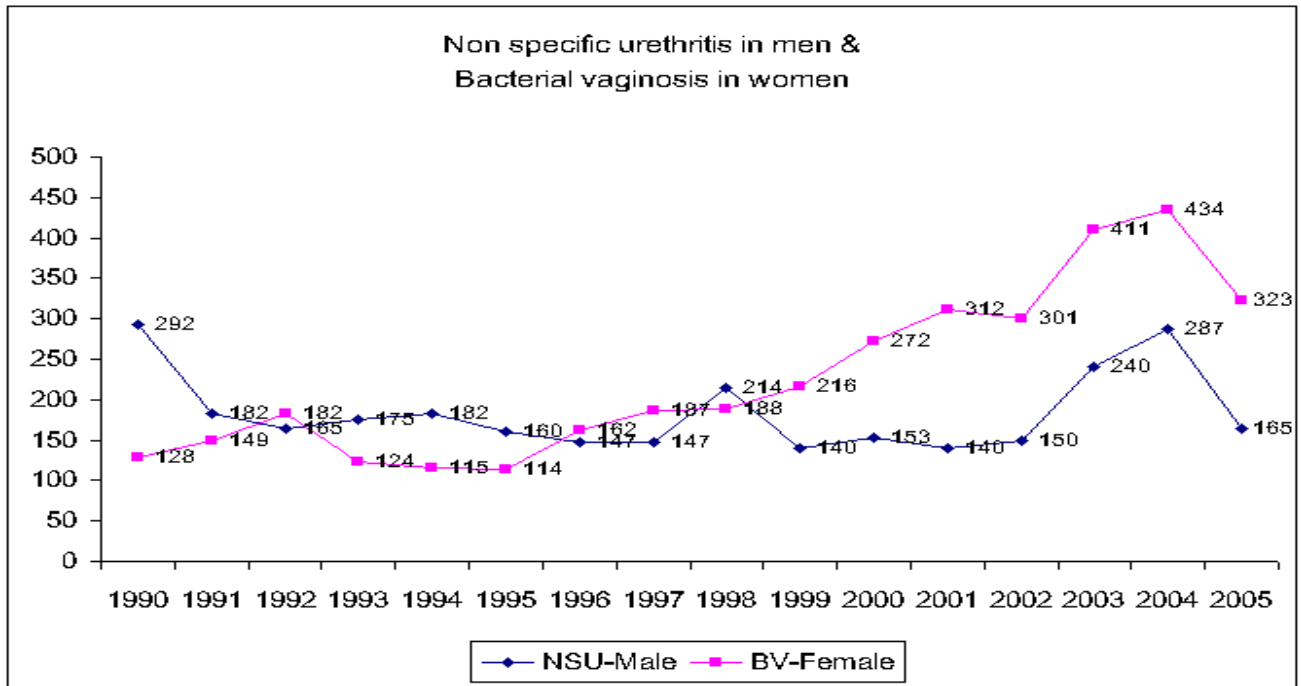
The routine cervical cytology screen in women three yearly in the district and the increased use of Metronidazole in treating bacterial vaginosis has all contributed to a steady decline. Nevertheless we still pick it up mostly in women with intractable vaginal discharge who have been using self-prescribed antifungal pessaries bought over the counter. It is exclusively a problem noted in women in our catchment population and most patients are referred from the cervical screening programme.

**Cervical cytology & Colposcopy**



We have now decommissioned the Colposcopy service and we only perform the occasional cervical cytology in the unit in consonance with the national guideline. From 2002 to 2005 there were only 4 cases of minor and 1 major cervical dyskariosis seen in the unit..

**Non specific urethritis in men & Bacterial vaginosis in women**



Non specific urethritis represents the cause of attendance of about 10 -20% of all new and rebooked males seen from 1990 to 2005. With introduction of NAATs testing for chlamydia those attributable to Chlamydia but not identified because of the relative insensitivity of the ELISA assay will reduce.

Bacterial vaginosis diagnosis has increased three-fold from 1990 to 2005. Females with intractable vaginal discharge unresponsive to over the counter antifungal medications now self-refer or attend following referral form their GP.

**HIV antibody test**

Between 15 - 35% of attendees to the Bure Clinic in 2000 to 2002 had HIV test at their consultation for sexual health care.

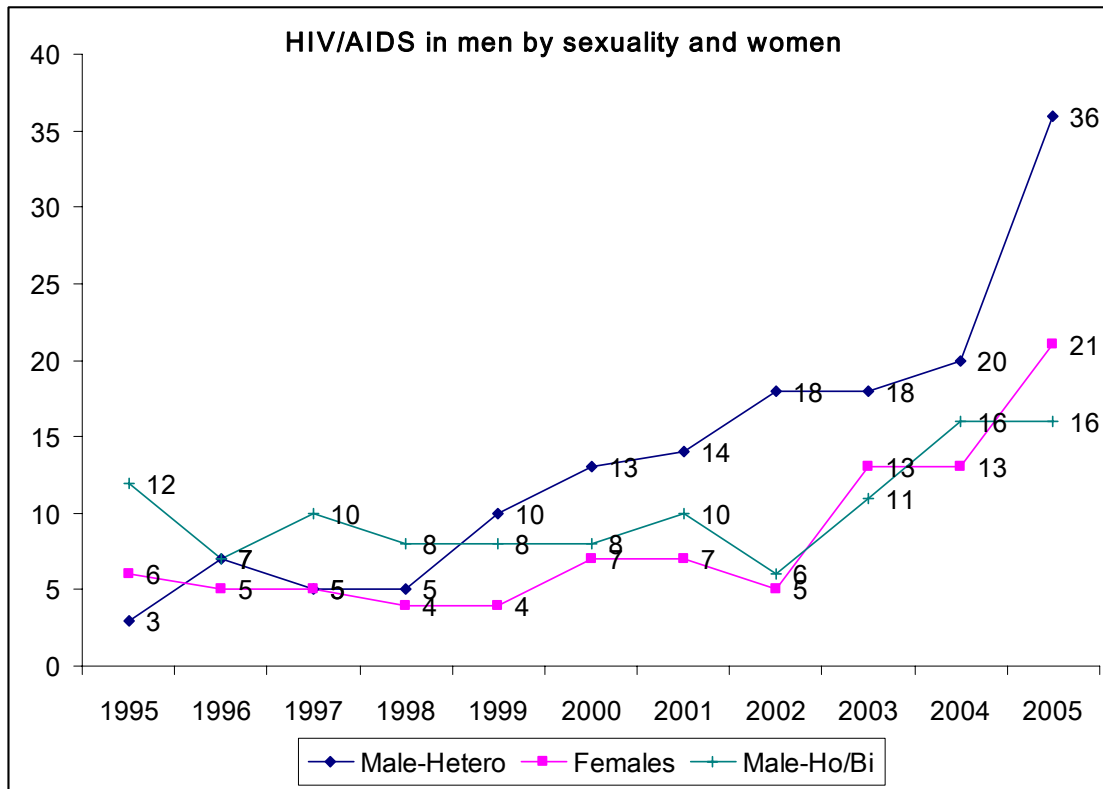
<u>Year</u>	<u>Total HIV Tests (%)</u>	<u>Total Attendees</u>	<u>Heterosexuals Tested (%)</u>	<u>Homosexuals Tested (%)</u>	<u>New HIV Positives</u>
2000	367 (15.3%)	2393	14.1%	35.9%	2 (Hetero)
2001	551 (21.1%)	2488	21.5%	28.6%	3 (Hetero)
2002	808 (34.3%)	2323	34.3%	40.5%	3 (Hetero)

During 2000-2002 only 8 cases were identified from a total of 7204 patients. All cases acquired their infection heterosexually.

From 2003 we introduced an opt-out policy for HIV antibody testing. We achieved 95.8% testing of all attendees from 2003 – 2005.

The greatest burden of HIV/AIDS in our cohort is amongst heterosexual white males who acquire their infections outside the region mostly in sub-Saharan Africa and Asia (notably Thailand). See accompanying graph for sero-prevalence in the district from 1995 – 2005.

In 1995 in our unit the highest risk was in homosexual but in 2005 the highest incidence is in heterosexual acquisition in men. Worrying is the local heterosexual acquisition of HIV amongst our local female population. In 2005 there were new HIV cases seen amongst 9 females (1 antenatal case) and 12 males of which only 3 were homosexuals. It is of concern; as in our district heterosexual acquisition is now the dominant mode of new infections.



We had 5 new cases diagnosed with acute opportunistic infection and HIV. Inpatient period of care varied from 10 – 60 days. All were transferred for respite care in All Hallows for convalescence before discharge home. This facility is proving useful as newly diagnosed patients have a chance to self-medicate, come to terms with their diagnosis with support from weekly ward-round during the course of their admission. Input from both Health advisors and Clinical Psychologist have been useful. This nevertheless poses considerable work-load for the single-handed consultant as we are now seeing increase in the overall number of new patients from graph above.

### **Medical School:**

The department is involved with the activities of the medical school, from the selection process (participation at interviews), examination, teaching and supervision of research. I participate in Feedback sessions with Unit 1 in conjunction with Chris Cowley at UEA. Unit 4 medical students have formal lectures in HIV and respiratory diseases details of which are available in a password protected area at <http://www.bureclinic.com/students/> Unit 9, Fourth year medical students rotate through the department as part of the reproduction module and I deliver didactic lectures available at <http://www.bureclinic.com/students/>

The current challenge is identification of SIFT funding as the clinical teaching during clinic sessions limit the through put of patients, particularly with meeting the 48 hour target open-access. The level of service commitment interference will be a subject of review.

The informal feedback of students during their sessions in the clinic has been encouraging.

### **Recommendations from the peer-review in June 2005.**

1. We would strongly suggest that a review of existing contracts for this GUM service be undertaken. In the future national tariffs for GUM services under the 'payment by result' scheme should clarify potential income for the STI element of the service. In the interim period, we recommend that current and projected attendance patterns be mapped against Healthcare Resource Groups (HRGs) to inform service business plans. It should be noted under "payment by results", PCTs cannot determine, nor can Trusts bid for a specific level of funding. Allocations will be based on out-turn activity.
2. PCT spending plans should demonstrate how the additional DH revenue would be utilised to support the 'White Paper' sexual health targets. These plans should be shared with relevant stakeholders including the GUM clinical team.
3. NAAT technology should be available in the GUM clinic from October 2005 for all chlamydia samples. Implementation plans should be monitored to ensure there is no further delay. The introduction of dual gonorrhoea and chlamydia testing should be considered as a longer term service development. The Trust should ensure that this capacity is reflected in the ongoing modernisation of pathology services within Norfolk.
4. We recommend that the GUM take up the offer of Great Yarmouth PCT to work with their data and information analysts to see how GUM data can best be utilised in shaping service configuration and development within the local communities.
5. We recommend that MDT should review all current formal and informal processes of communication with a view to improve information flow to all members of staff. Given the number of changes that are happening in the service we suggest that the MDT meetings be held on a more frequent basis. We would suggest that rotating the chair for the team meetings might be a way to help all staff to engage with and have ownership of the agenda for this meeting. This also provides an opportunity for different members of the team to develop skills in managing and leading meetings.
6. Recruitment plans for the additional consultant need to be expedited as soon as possible.
7. We recommend that the job description and TORs for the new consultant be reviewed. This is a good opportunity to use this development to develop capacity in Primary Care and therefore we recommend that the responsibilities of this post should be to oversee the implementation of local enhanced services, develop training for primary care clinicians to enable them to execute this service. The local enhanced services should be linked with the GUM services as part of a clinical network to ensure consistency of the quality of care and clinical governance framework.
8. a review of the existing workloads and an assessment of additional nursing resource that may be required to backfill work carried out by the registered nurses,
9. a training plan to ensure practitioners meet the required competencies,
10. introduction of a wide range of PGDs to support nursing practice,
11. regular clinical supervision for registered nursing staff,
12. regular protected time with a senior nursing professional for lead nurse.
13. As many health advisers are also trained nurses, there will be overlap of functions and responsibilities between the two teams. We would recommend that the review of workload and resource assessment for the nursing team should also include the health adviser team.

14. The diversity of responsibilities for admin teams in GUM services are not always recognised and we recommend additional support under the agenda for change process to ensure their remit is appropriately recognised.
15. The clinic should develop a strategy to increase patient involvement and feedback in the service. This could include developing links with the Trust patient forum, and seeking feedback from voluntary groups that may represent service users. There should also be stronger links between the clinic and the health promotion services that are in contact with service users in outreach programmes.
16. With external support from the PCT modernisation team the current operational practices should be analysed with a view to rationalise and improve efficiency in the current systems.
17. It is clear that a great deal of activity is already happening to assist this service to reduce waiting times. In order to ensure that this progress is maintained at the required pace we recommend that this service develop a strategic plan including a timetable of milestones of achievement and a realistic outline on how to meet the 48 hr GUM access target as outlined in the Public Health White Paper.<sup>1</sup>
18. External sign posting to the clinic should make it clear that the Bure clinic is a GUM service.
19. A formal review of the current space should be undertaken by the Trust. The barriers to modernisation and to further development of the multidisciplinary team, and the potential to increase capacity by changing service hours should be assessed as part of the review.
20. Membership of the sexual health forum should be expanded to include patient or voluntary sector participation.
21. We would recommend that the GUM service is closely involved in the theoretical and practical training for primary care to support community based services to provide level 1 and if appropriate level 2 STI services. Robust patient pathways between services need to be outlined and joint protocols to ensure equity of treatment and care between services should be developed. The potential resources and costs required to implement the strategy should be assessed and taken into account when developing implementation plans.

### **Recommendations from Strategic Health Authority Review September 2005**

1. The Clinic should use the date of referral data and date first seen to better understand actual demand and waiting times. This information should then be used to undertake a demand and capacity exercise in order to ensure that appointment variation is reduced.
2. Given the statement underpinning High Impact Change Number Five, review the reasons behind the decline in follow-up performance during the latter part of 2004.
3. Review the utilisation of the nurse treatment clinics with a view to reconfiguring the available slots to better match demand. This may include a review of referral

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<sup>1</sup> Department of Health (November 2004) Public Health White Paper, *Choosing Health: making healthier choices easier*

criteria for nurse treatment clinics to extend the types of patients seen by nursing staff.

4. Consider opportunities for providing clinics or appointments to reflect the lifestyles of patients, for example providing evening clinics, or extending the working day to late afternoon.
5. Ensure that where changes are made to clinic templates or processes, patients are made aware of this in order to avoid any confusion in the future.
6. The Clinic should consider how it will be able to achieve the 48-hour appointment recommendation, set out by the Health Select Committee and supported by the Department of Health through pump-priming funding for PCTs during 2005/06.

### **Conclusion:**

The National Sexual Health Strategy, amongst its aims include:

- *"Setting a national standard that all GUM services should offer an HIV test to clinic attendees on their first screening for STIs".*
- *"Reduce the transmission of HIV & STIs with a national goal of achieving a 25% reduction in the number of newly acquired HIV infections and gonorrhoea infections by 2007.*

This target is to rise to 90% or more by the end of 2003 and 100% by the end of 2004.

The Bure Clinic achieved the target of offering HIV test to all clinic attendees at the time of screening for STI's. Challenges ahead will be filling the existing Medical Staff vacancies with funding now available. A permanent middle-grade staff additional to the second consultant will be ideal to absorb the service shortfalls and teaching commitments occurring with the Unit 9; 4<sup>th</sup> Year Medical students undertaking their posting through the clinic and Foundation Year 2 Senior House officers commence in August 2006.

We have also introduced Nurse-led clinics working to Patient group Directives (PGD's). The clinic templates now start at 9.00 am. We now use nursing health assistants.

We are starting the Sexually Transmitted Infections (STIF) Course from 19<sup>th</sup> – 20<sup>th</sup> October 2006.

We remain cautiously optimistic about the future and we recognise that we still need a considerable amount of investment in sexual health services to be fully responsive and achieve all the recommendations of the two recent peer-reviews.

The partnership we are fostering must recognise the limitations and capabilities of a single-handed service until adequately staffed.

## **Sister's Report**

The year 2005-2006 has seen an upward trend in the increase of STD's. More worrying is the increase seen in syphilis and HIV. Much emphasis is put on teenage pregnancy and the use of contraception with the safe sex message being missed. I feel the hard hitting media messages of the late 80's and early 90's should be reintroduced as during this period a decrease was seen in STD's.

In May 2005 a peer review of the clinic was undertaken by MEDFASH. Recommendations were made for the implementation of Nurse Led Clinics which is in keeping with the National Sexual Health Strategy and the 10 Year NHS Plan. We have now introduced a twice weekly Nurse Led Clinic with myself working two PGD's offering appointments to asymptomatic clients. We are hoping to extend this service by obtaining funding for a development role to run alongside this service offering another two sessions a week and additional nursing administrative support to myself. Another observation noted by the peer review was that the clinic employed no Health Care Assistants. We have now rectified this and have employed two bank Health Care Assistants; this has proved to be very cost effective and I hope in the future we will be able to offer them permanent posts.

The Government sets the target of 48 hours for an appointment but I do find this is a very unrealistic target to meet. Even with the increase in nursing staff and an additional full time staff grade doctor the clinic we can still not meet this demand due to lack of space and capacity.

My Health Advisor is on an extended hour's contract and so is one Medical Secretary. The Health Care Assistants need to be offered more permanent posts with more bank staff being employed. Until these posts are filled I feel staff moral will be decreased.

Sister Chris Souter  
Manager, Bure Clinic