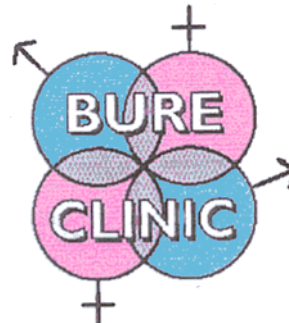


# ANNUAL REPORT 2001



Department of  
Genito-Urinary Medicine



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

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## **Foreword**

This fifth annual report is written at a time of anticipated changes in the way sexual health services will be delivered. Consultation document on the National Sexual Health Strategy is ongoing. Concerns raised about inequity in service provision remains, as our temporary 4 sessional locum consultant post has not been sustained beyond May 2002.

The Bure Clinic website sponsored and commissioned on the 3<sup>rd</sup> July 1998 by the Great Yarmouth Haven Rotary Club now subscribes to the HONcode principles. Sexual health education and healthy sexual behaviour remains the dominant theme for 2000 - 2001.

The Bure Clinic will continue to work within Regional and National guidelines, adopt strategies that are in line with good practice and be sensitive and responsive to locally defined needs.

## **RESOURCES**

### **Staffing:**

- 1 Full time Consultant
- 1 Full time Locum Consultant (till 31<sup>st</sup> May 2002)
- 2 Hospital Practitioners (from 1<sup>st</sup> July 2001)
- 1 Full time Acting Sister – 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 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	9.30 – 12.30	14.00 – 1700
Tuesday	9.30 – 12.30	
Wednesday	9.30 – 12.30	14.00 – 1700
Thursday	9.30 – 12.30	14.00 – 1700
Friday	9.30 – 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. 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 concentrated on total new patient attendance. In 2001, there were 2442 new/re-registered patients representing 6.63% growth compared to 1999. There was an increase of 3.4% attendance of new/re-registered patients in 1999 (total: 2,290). In 1998 (total: 2215) we had a growth of 5.5% increase in attendance compared to 1997 and 1996. In 1996 (total: 2047) and 1997 (total: 2098), there was only an increase of 2.8 and 2.5% respectively.

This increase was in part due to client responsiveness from our open access service, from the additional part-time 4 sessional consultant post and continuing confidence in the quality care provided. The appointment of the 4 sessional consultant posts has created a continuum of high quality consultant-based service<sup>1</sup>.

We now see all patients within 2 working days of requesting an appointment is consonance with the recommendations of the Monk's report.

The sex ratios continue to be skewed towards more female attendance. This is reassuring as women more acutely feel most of the morbidity associated with STD's (see table).

1998/99 was characterised by maintaining specialist clinic services in tandem with maintaining consultant based mixed clinics.

The incidence of gonorrhoea increased 4-fold from 1995 to 1996 in the Bure Clinic<sup>2</sup>, and that increase was sustained in 1997, a deviation from the "Health of the Nation" targets. The trend continued in 1998 and 1999 respectively. There were 44 cases in 1999, representing an increase of 37.5% over 1998 figures (see annexe) and remained at 44 cases in 2000.

*Chlamydia trachomatis* also increased 2 fold from 1995 to 1996, and that increase was sustained in 1997 and 1998. Nationally a 12% rise was seen in the incidence of chlamydia. The increase seen in the Bure Clinic is a function of more case detection in the district as more women are now screened, prompting referral for contact tracing and partner notification.

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<sup>1</sup> Harry TC Impact of adequate medical manpower in genitourinary medicine service delivery. *Int J STD AIDS* 2001; **12**: 131-2

<sup>2</sup> Harry T C Are the Health of the Nation targets attainable? *Int J STD AIDS* 1998; **9**: 185-6

The increases seen are of concern, as both infections contribute to significant morbidity and are surrogate markers of unsafe sexual practices. In 2000, there were 199 cases identified, the highest in the district.

The fall in incidence of first attack *Herpes Simplex* has been due to the revised method of recording. Only culture positive cases are recorded after 1995. We have however noted a 14.2% increase between 1996 and 1997. This rise is still sustained in 1998 with an increase of 10.4%. In 1999 (total no: 63) there was an increase of 19% in new cases. In 2000 we detected 61 cases.

An initial 18.7 % increase in incidence of first attack genital warts was noted between 1995 and 1996. The decrease of 8.1% between 1996 and 1997 has been due to the waiting list that had built up with the decrease in medical staffing alluded to earlier. In 1998 the reported numbers remain the same. In 1999 (total no: 209), represented an increase of 5% in new cases. In 2000, we had 211 cases. The district prevalence of first attack warts seen in the clinic is 86 per 1000 attendees in 2000.

Greater collaboration continues to be fostered with other departments in the hospital and agencies providing sexual health related services. All child sex abuse cases are reviewed jointly with a Consultant Paediatrician. There were two cases of statutory venereal infection seen in 1998. In 1999 we had only one case of gonorrhoeal infection isolated from the eyes of an 8 year-old boy. The source remains a mystery. In 2000, we had gonococcal ophthalmia neonatorum in a 5days old infant girl from a mother with postpartum sepsis from gonorrhoeal infection. We are currently jointly managing 2 children born to mothers with HIV infection who are on antiretroviral treatment.

The Vulval clinic run jointly with a Consultant Dermatologist has now been re-established.

The Colposcopy Service in the Bure Clinic remains under-utilised, because of reduced cervical cytology screening undertaken in the clinic in conformance with National Cytology Screening Policy.

HIV/AIDS care continues to be multidisciplinary, and led from the Bure Clinic with full participation of the other departments and relevant services. The Bure Clinic was enrolled into the Phase 111b of the Roche (Saquinavir) proteinase inhibitor trial in August 1996, including the Haemophilia cohort following my participation in the 11<sup>th</sup> World AIDS Conference held in Vancouver. In 1998 we participated in the expanded access of the Du Pont (Efavirenz) a non-nucleoside analogue for the use of patients failing on triple therapy. The benefit of triple therapy became manifest early in our cohorts with continual improvement.

There has been a substantial reduction in inpatient episodes and disease progression. For the first time we have seen a sharp decrease in mortality in our cohort. However this has not been sustained in 1997/98. Virological failures were manifest despite HAART (highly active antiretroviral therapy), including side effects of these potent regimes.

In 1999 we were able to procure Phase IV medications, Glaxo-Wellcome (Amprenavir & Abacavir). We enrolled a pregnant mother in RCOG Cohort of AZT use in pregnancy to reduce maternal reduction. Baby remains uninfected 18 months after delivery. Disease progression from treatment failure occurred in 2 patient in this period. We now routinely utilize viral resistance assay and therapeutic drug level monitoring when necessary.

In 2000 we have now seen a trend representing more heterosexual acquisition in our cohort.<sup>3</sup> The value of routine viral resistance and therapeutic drug level monitoring has manifested as reduced virological failure and adherence to treatment.

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.

**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 - 2000**

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

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<sup>3</sup> Harry TC. To test or not to test: Implications for late diagnosis of HIV/AIDS. Accepted poster presentation at 8<sup>th</sup> ECCATH, Athens, Greece 27<sup>th</sup> - 31<sup>st</sup> October 2001.

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 23<sup>rd</sup> - 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

### **Total clinic workload**

In 1998 we had a growth of 5.5% increase in attendance compared to 1997 and 1996. In 1996 and 1997 there was only an increase of 2.8 and 2.5% respectively. There was an increase of 3.4% attendance of new/re-registered patients in 1999 from 2215 to 2290 cases in 2000.

What has significantly varied over the last three years has been the increase in the number of KC60 returns, reportable diagnoses which, which have increased from 2535 in 1995 to 2941 in 1997, 3103 in 1998, 3107 in 1999 and 3339 in 2000. 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.

### **Syphilis**

In 2000 there were no cases of syphilis. There were 2 cases of syphilis seen in 1999 in our clinic. They were in 2 men who declared themselves homosexuals and are partners. The index had secondary syphilis probably acquired in London from an itinerant homosexual from Israel with a co-existing peri-anal herpes simplex infection. The contact had a primary syphilitic chancre on presentation.

### **Gonorrhoea**

The incidences of gonorrhoea remain sustained in 1998/99 respectively. There was a four-fold increase from 1995 to 1996 in the Bure Clinic (see annexe). The national goal was to reduce the incidence of gonorrhoea among men and women aged 15 - 64 by at least 20% in 1995 (from 61 new cases per 100,000 population in 1990 to no more than 49 new cases per 100,000 in 1995). There were 31 cases of gonorrhoea seen in Great Yarmouth & Waveney in 1990. Against a total local population of men and women aged 15- 64 of 122,007, this translates into 25 per 100,000. This level of prevalence is still maintained in Great Yarmouth & Waveney. In 1999 there were 51 cases of gonorrhoea including epidemiological treatment, the greatest rise seen in the district. There were 44 cases of gonorrhoea confirmed by culture. Great Yarmouth has the highest incidence of teenage pregnancy in the region, a surrogate marker for unsafe sex. In 2000 there were 44 cases confirmed by culture.

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 gonorrhoeal infections.

## **Chlamydia trachomatis**

The outcome targets of the Association of Genitourinary Medicine Physicians goals and indicators for the management of sexually transmitted diseases guidelines for purchasers of services is to reduce uncomplicated chlamydial infection from GUM Clinics to 100 cases per 100,000 of the population aged 15 - 64 years in 3 years. We have seen a changing paradigm in the incidence of chlamydia over the last 3 years. The prevalence has increased from 3.6% in 1995, 6.8% in 1996 to 8.4% in 1997. In 1995 there were 75 cases per 100,000. This increased to 149 per 100,000 in 1997. In 1998 a slight decrease was seen which is not of any statistical significance. In 1999 this has increased to 160 cases. This is of concern as during the same period we have seen an increase in the incidence of gonorrhoea. In 2000, we had 199 cases, the highest in the district since we started keeping records.

This is one of the reasons we have launched our website, to supplement sexual health education among adolescents in our catchment population, as 30% of all cases of chlamydia in our district is amongst those aged under 20.

## **Herpes simplex infection**

The apparent fall in incidence of first attack herpes simplex has been due to a revised method of recording this data after 1995. Only culture positive cases were required to be recorded. Genuine interpretation of this data indicates a 14.2% increase between 1996 and 1997. Viral typing was introduced in April 1997. In 1998, we had 53 cases. In 1999, an increase of 19% in culture positive cases was noted (63 cases). In 2000 we had 61 cases.

## **Genital warts**

Between 1995 and 1996 an increase of 18.8% of first attack genital warts was noted. The subsequent fall of 8.8% noted between 1996 and 1997 has been due to implementation of a waiting list scenario and reduced clinical prioritisation of this patient group due to shortage of medical manpower. In 1999 there was a 4% rise noted in new diagnosed cases. There were 205 cases in 1998, 209 cases in 1999 and presently 211 cases attended in 2000.

## **Candidiasis**

The attendance has remained stable over the last 7 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. In 1999 there were 266 cases.

### **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. In 1998 there were 3 cases and 5 cases in 1999. In 2000 we had only 6 cases.

### **Cervical cytology & Colposcopy**

There were 44 cases of minor and 6 cases of major cytological abnormalities seen in 1995. In 1996, 31 cases of minor and 3 cases of major cervical abnormalities were seen. In 1997, 40 cases of minor and 8 cases of major cervical cytological abnormalities were seen. In 1998, 38 cases of minor and 3 cases of major cervical abnormalities were seen. In 1999, we had 7 cases of minor and 3 cases of major cervical abnormalities seen. This reduction may be attributable to changes in the guidelines for cervical cytology screening, and the increased threshold for routine screening in the community. In 2000 there were only 4 minor and 3 major cases.

In 1995, 66 colposcopies were performed whereas in 1996 only 26 colposcopies were performed. In 1997 only 21 colposcopies were performed. This reduced numbers of colposcopy performed in 1996/97 was largely due to revised criteria for colposcopy following changes in National Guidelines.

In 1997/98, the reduced numbers is still reflective of the reduced threshold in colposcoping females with genital warts as a sole criterion.

### **HIV antibody test**

Although principally done in the Bure Clinic, there are a number of other test sites in the district. The local drug rehabilitation centres, the remand and prisons, the renal dialysis centre, the infertility unit and the antenatal clinic. These alternative sites follow the pre and posttest counselling inherent in HIV antibody testing.

In the Bure Clinic in **1996** there were 222 HIV antibody tests carried out amongst 106 females age range 15 - 53 years and 116 males aged 19 - 65 years.

In **1997** there were 282 HIV antibody tests done on 135 females aged 15 - 66 years and 147 males aged 12 - 61 years.

In **1998** there were 380 HIV antibody tests carried out amongst 177 females aged 13-60 years and 203 males aged 15-74 years.

In **1999** there were 351 HIV antibody tests carried out amongst 177 females aged 14 – 55 and 174 males aged 16 – 61 years. Of the males 5 declared themselves homosexual.

In **2000** there were 364 HIV antibody tests carried out in the department amongst 164 females median age 27 years, mean age  $28 \pm 10.81$  years, range 1 - 71 and 200 males median age 30 years, mean age  $32.22 \pm 11.73$  years, range 1 - 68 years.

Total cohort of HIV positive patients in 1999 was 20. The cumulative total incidence in our local population is (0.016%) or 17 per 100,000 population amongst those aged 15 - 64.

Total cohort of HIV/AIDS patients in 2000 was 25. The prevalence in our catchment population is about 1 in 1754 (antenatal attendees).

The risk categories of the present cohort in 2000 are 23% homosexual/bisexual, 67% heterosexually acquired of which - 89% acquired from sub-Saharan Africa, & Thailand, 11% intravenous drug use and 10% was a combination of bisexuality and in some cases undetermined. The median age of men in our cohort is 56 years and in women 38 years. The ratio of men to women is 5:1.

### **Health Advisor Report**

The last year (April 2000 – March 2001) has seen an increased Health Promotion and teaching initiative from the Bure Clinic. We have visited local schools and colleges advertising our services and hopefully have increased their sexual health awareness. We have also encouraged small groups of young people to visit the clinic for a tour, slide show and discussion about sexual infections, all of which have proved very effective in raising sexual health issues and building bridges with local voluntary sector organisations as well as the young people themselves. Alison Jennings has also had an active role in the development of the young people's sexual health website in Suffolk.

Despite increased patient numbers, we continue to provide an high standard of contact tracing and our community HIV work continues, this is despite the fact that since May 2000 I have had to take on the additional role of acting Clinic Manager due to sickness.

However, I have become increasingly aware of the lack of sexual Health Promotion given to local Oil Industry workers travelling abroad, especially to sub Saharan Africa. We continue to see regularly, young to middle-aged men who have unprotected sex abroad and this has been highlighted during the last year by HIV positive diagnosis at this clinic.

Hopefully the forthcoming year will see an improved attitude from oil companies to their employee's health, we will continue to promote sexual health and advocate our services, within the constraints of the limited resources we have.

Paul Nicholls, Health Advisor/Acting Clinic Manager

### **Business Managers Report**

In many areas of the James Paget Healthcare NHS Trust staff have again, over the last twelve months, experienced significant clinical, operational, managerial and personal challenges. Public and professional reflection of the causes of a District General Hospital's pressures would probably take account of the reality of rising numbers of medical emergency admissions, winter pressures and meeting inpatient and outpatient waiting list targets.

The media interest, subsequent public interest and the consequential impact of the Health Service within the political arena can lead to minds being concentrated on the clinical areas, which are more prominently placed within the public domain. In reflective moments how many members of the public, or indeed health professionals, would consider the tribulations of providing a service within Genito-Urinary Medicine! Unless experienced at first hand, services such as those provided within the Bure Clinic, will remain unobtrusive and a well hidden local secret.

The Bure Clinic, and the dynamic multi-disciplinary team which serve its clients, has had its share of issues and pressures in 2000 / 2001. Each of which has been confronted and addressed with an air of professionalism that has grown to be expected from the team. Many of these issues have allowed new horizons to be pursued and personal journeys of development of individuals and the team are under way.

The coming financial year of 2001 / 2002 we know will be a time of development and growth for the service and will see the advent of a stronger and more wide reaching service being available from the Bure Clinic. This is an exciting prospect and a positive local starting position in a year when outcomes from the work undertaken nationally is expected in the form of a "Sexual Health Strategy". I remain confident that within the Bure Clinic we have adopted a strong position already for the challenges that this strategy will bring and this will enable us to attain the high standards and expectations that will be promoted within its text.

The year 2001 / 2002 is an exciting prospect and it is only the knowledge of the strength of the multi-disciplinary team within the Bure Clinic that makes it an exciting prospect and not a daunting one!

Andrew Fox, Clinical Services Manager for the Medical Directorate

### **SISTER'S REPORT**

Since May 2000, due to long-term sickness, the Nursing Staff has been below establishment. No increase in funding has been made available to cover this shortfall.

The Monks Report states that clients contacting the Clinic should be seen either the same day, or at the next session. These targets are currently being met but not without it taking it's toll on Nursing Staff and quality time given to clients.

This year the Clinic has seen an upward trend in the incidence of Gonorrhoea. This is worrying, as the "Safer sex" message is not filtering through, especially to the younger population.

Because of this, the Health Advisers and myself have recently taken part in Great Yarmouth College's "Lifestyles" week, showing slides and speaking on STDs to students. This is something that Alison Jennings (Health Adviser) and myself hope to set up involving contacting Schools/Colleges and offering our services. I envisage if there is a high uptake for this service extra funding will be required.

Chris Soutter Deputy Sister

### **Quality Standard Indicators**

1. Any persons presenting with a new clinical problem suggestive of a sexually transmissible disease or who considers him/her self to have been in contact with such a disease should be seen on the day of presentation or failing that on the next occasion the clinic is open (This was recommended by the CMO in his letter of 30<sup>th</sup> July 1986 to Regional General Managers)
2. In accordance with the recommendation of the Monks report, arrangements should be made for some evening clinic sessions to be held after 5pm
3. Twenty minutes consultation for new patients recommended by the Royal College of Physicians.
4. Ensure adequate staffing level of Health Advisors to provide their traditional role of contact tracing, partner notification, provider referral, pre and post test counselling for HIV antibody test and opportunistic sexual health education to all attendee and the community from sexual health promotion activities with voluntary and statutory bodies.
5. Regions should be required to review the distribution of their main GUM services and make improvements where necessary

**Recommendations for improvement of  
Bure Clinic Service delivery in 2000/2001**

- 1. Full-time Locum Consultant post.**
- 2. Increase additional nursing support.**
- 3. Increase additional secretarial support.**