

**Please refer to accompanying guidance notes****PART A INITIAL CONTACTS IN THE QUARTER**

| Code       | Condition/episode  |    | Male total * | * of which were homo/bisexual | Female total |
|------------|--|----|--------------|-------------------------------|--------------|
| A1, A2     | Primary and Secondary Infectious syphilis  | 1  |              |                               |              |
| A3         | Early Latent syphilis (first 2 years)  | 2  |              |                               |              |
| A4, A5, A6 | Other acquired syphilis  | 3  |              |                               |              |
| A7         | Congenital syphilis, aged under 2  | 4  |              | XXXXXXXXXX                    |              |
| A8         | Congenital syphilis, aged 2 or over  | 5  |              | XXXXXXXXXX                    |              |
| A9         | Epidemiological treatment of suspected syphilis  | 6  |              |                               |              |
| B1, B2     | Uncomplicated gonorrhoea   | 7  |              |                               |              |
| B3         | Gonococcal ophthalmia neonatorum   | 8  |              | XXXXXXXXXX                    |              |
| B4         | Epidemiological treatment of suspected gonorrhoea  | 9  |              |                               |              |
| B5         | Complicated gonococcal infection – including PID and epididymitis  | 10 |              |                               |              |
| C1, C2,C3  | Chancroid/LGV/Donovanosis  | 11 |              | XXXXXXXXXX                    |              |
| C4A, C4C   | Uncomplicated Chlamydia infection  | 12 |              |                               |              |
| C4B        | Complicated Chlamydial infection – including PID and epididymitis  | 13 |              |                               |              |
| C4D        | Chlamydia ophthalmia neonatorum  | 14 |              | XXXXXXXXXX                    |              |
| C4E        | Epidemiological treatment of suspected Chlamydia   | 15 |              |                               |              |
| C4H        | Uncomplicated non-gonococcal/non-specific urethritis in males or treatment of mucopurulent cervicitis in females | 16 |              |                               |              |
| C4I        | Epidemiological treatment of NSGI  | 17 |              |                               |              |
| C5         | Complicated infection (non-chlamydial/non-gonococcal) – including PID and epididymitis                           | 18 |              |                               |              |
| C6A        | Trichomoniasis   | 19 |              | XXXXXXXXXX                    |              |
| C6B        | Anaerobic/Bacterial vaginosis & anaerobic balanitis  | 20 |              | XXXXXXXXXX                    |              |
| C6C        | Other vaginosis/vaginitis/balanitis  | 21 |              | XXXXXXXXXX                    |              |
| C7A        | Anogenital candidosis  | 22 |              | XXXXXXXXXX                    |              |
| C7B        | Epidemiological treatment of C6 & C7   | 23 |              | XXXXXXXXXX                    |              |
| C8, C9     | Scabies/pediculosis pubis  | 24 |              |                               |              |
| C10A       | Anogenital herpes simplex: first attack  | 25 |              |                               |              |
| C10B       | Anogenital herpes simplex: recurrence  | 26 |              |                               |              |
| C11A       | Anogenital warts: first attack   | 27 |              |                               |              |
| C11B       | Anogenital warts: recurrence   | 28 |              |                               |              |
| C11C       | Anogenital warts: re-registered cases  | 29 |              | XXXXXXXXXX                    |              |
| C12        | Molluscum contagiosum  | 30 |              |                               |              |
| C13A       | Viral hepatitis B (HbsAg positive): first diagnosis**  | 31 |              |                               |              |
| C13B       | **of which were acute viral hepatitis B  | 32 |              |                               |              |

**NB. If information is not available, please enter “Nil” in the appropriate box(es) above.**

## Please refer to accompanying guidance notes

**PART A INITIAL CONTACTS IN THE QUARTER (Continued)**

| Code    | Condition/episode                                   |    | Male total * | * of which were homo/bisexual | Female total |
|---------|---|----|--------------|-------------------------------|--------------|
| C14     | Viral hepatitis C: first diagnosis                  | 33 |              |                               |              |
| D2A     | Urinary tract infection                             | 34 |              | XXXXXXXXXX                    |              |
| D2B     | Other conditions requiring treatment at GUM clinic  | 35 |              | XXXXXXXXXX                    |              |
| D3      | Other episodes not requiring treatment              | 36 |              | XXXXXXXXXX                    |              |
| E1A     | New HIV diagnosis: asymptomatic                     | 37 |              |                               |              |
| E2A     | New HIV diagnosis: symptomatic (not AIDS)           | 38 |              |                               |              |
| E1B,E2B | Subsequent HIV presentation (not AIDS)              | 39 |              | XXXXXXXXXX                    |              |
| E3A1    | AIDS: first presentation - new HIV diagnosis        | 40 |              |                               |              |
| E3A2    | AIDS: first presentation - HIV diagnosed previously | 41 |              |                               |              |
| E3B     | AIDS: subsequent presentation                       | 42 |              | XXXXXXXXXX                    |              |
| S1      | Sexual health screen (no HIV antibody test)         | 43 |              |                               |              |
| P1A     | HIV antibody test (no sexual health screen)         | 44 |              |                               |              |
| SP2     | HIV antibody test and sexual health screen          | 46 |              |                               |              |
| P1B     | HIV antibody test offered and refused               | 45 |              |                               |              |
| P2      | Hepatitis B vaccination (1 <sup>st</sup> dose only) | 47 |              |                               |              |
| P3      | Contraception (excluding condom provision)          | 48 | XXX          | XXXXXXXXXX                    |              |
| P4A     | Cervical cytology: minor abnormality                | 49 | XXX          | XXXXXXXXXX                    |              |
| P4B     | Cervical cytology: major abnormality                | 50 | XXX          | XXXXXXXXXX                    |              |
|         | <b>Total: all conditions</b>                        |    |              |                               |              |

**NB. If information is not available, please enter "Nil" in the appropriate box(es) above.**

**Please refer to accompanying guidance notes**

**PART B**

| Code and Condition   | Sex | Under 15   | 15         | 16-19      | 20-24      | 25-34      | 35-44      | 45-64      | 65 & over  | Total      |
|--|-----|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| A1, A2 -<br>Primary and secondary<br>infectious syphilis           | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |
| B1, B2 -<br>Uncomplicated<br>gonorrhoea                            | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |
| B1, B2 -<br>Uncomplicated<br>gonorrhoea - homosexually<br>acquired | M   |            |            |            |            |            |            |            |            |            |
|  | F   | XXX<br>XXX | XXX<br>XXX | XXXX<br>XX | XXXX<br>XX | XXXX<br>XX | XXXX<br>XX | XXXX<br>XX | XXX<br>XXX | XXXX<br>XX |
| C4A, C4C -<br>Uncomplicated<br>chlamydial infection                | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |
| C10A -<br>Anogenital herpes simplex<br>- first attack              | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |
| C11A -<br>Anogenital warts -<br>first attack                       | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |
| P1<br>HIV antibody<br>test   | M   |            |            |            |            |            |            |            |            |            |
|  | F   |            |            |            |            |            |            |            |            |            |

**PART C**

|   | Sex                 | First attendances** | **of which new patients | Subsequent attendances |
|---|---------------------|---------------------|-------------------------|------------------------|
| Total attendances<br>in the quarter                     | Male                |                     |                         |                        |
|   | Homo/ bisexual male |                     |                         |                        |
|   | Female              |                     |                         |                        |
| Incoming telephone calls for clinical advice or results |                     |                     |                         |                        |

**NB. If information is not available, please enter "Nil" in the appropriate box(es) above.**

**Please refer to accompanying guidance notes**

**PART D**

| <b>Waiting time indicators (at end of quarter<sup>1</sup> for new attendances only):</b> |  |  |
|--|--|--|
| <b>Open appointment clinics</b>  | <b>Days till next available routine appointment</b>  |  |
| <b>Closed appointment clinics</b>  | <b>Booking period (days)</b>                         |  |
|  | <b>Days till next available routine appointment</b>  |  |
| <b>Drop-in clinics:</b>  | <b>Number of patients seen within 1 hour</b>         |  |
|  | <b>Number of patients seen between 1 and 2 hours</b> |  |
|  | <b>Number of patients seen after 2 hours</b>         |  |

**NB. Please complete only those sections which apply. If not available or not applicable, please enter “Nil” in the appropriate box(es) above.**

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<sup>1</sup> **End of quarter:** On any given day during the last two weeks after the end of quarter.

## Notes on changes to form KC60

### Part A

1. **B5/C4B/C5.** These definitions have been made more specific (to indicate how PID should be coded).
2. **C4H.** Females being treated for non-specific muco-purulent cervicitis are now to be included.
3. **C6B.** Male infection will become anaerobic balanitis. Other and non-confirmed anaerobic balanitis should be coded as C6C.
4. **C13.** Currently antigen positive viral hepatitis B. This code has now been divided into 2 codes: C13A and C13B. C13A is similar to the old C13 code i.e. antigen positive hepatitis B but it should include **first diagnoses only**. C13B will be used to record the number of first diagnosis of hepatitis B infection which were **acute**, where this is known. The definition of acute hepatitis B will be “Newly identified HBsAg positive with anti-HBc IgM positive (>200 iu/l) (MR)” or “Discrete onset of jaundice or anicteric illness accompanied by deranged LFTs (AST / ALT > 2x normal range) accompanied by HBsAg and anti-HBc IgM positive”. These definitions will be given in the revised guidelines for completing form KC60. All subsequent hepatitis B diagnoses are to be coded as D2B/D3.
5. **C14.** This code will be changed from recording any other viral hepatitis to **first diagnosis of Hepatitis C** only. The definition given in the revised guidelines will be “Hepatitis C: anti-HCV positive or HCV RNA positive”. All other hepatitis diagnoses are now to be coded as D2B/D3.
6. **E codes.** These codes are re-structured and re-defined to get better information on the stage of infection at which people are presenting with new HIV diagnoses. E1A, E2A and E3A1 will reflect new HIV diagnoses at different symptomatic levels (asymptomatic HIV, symptomatic HIV and AIDS). A patient can receive only one of these codes and on only one occasion. It is necessary to discriminate between first AIDS presentations which are new HIV diagnoses and those for which HIV was diagnosed previously. Therefore, E3A is divided into E3A1 and E3A2; E3A1 is a first presentation of AIDS where HIV **has not** been diagnosed previously and E3A2 is a first presentation of AIDS where HIV **has** been diagnosed previously. E1B and E2B merge to become E1B/E2B (all subsequent HIV presentation, not AIDS). E3B (AIDS (subsequent presentation)) is unchanged.
7. **P1A and P1B.** Codes on HIV testing are being substantially revised and new codes on sexual health screening are being introduced to help monitor the targets set in the Sexual Health and HIV Strategy. The Clinical Effectiveness Group have asked the Bacterial Special Interest Group to review and report on precisely what a sexual health screen should involve for different populations. Once this group have reported, a full definition will be given in the accompanying guidance notes. The codes are as follows:
  - a S1: Sexual health screen only. This is a completely new code. This code will be used to count all patients who are given a sexual screen **excluding** an HIV test (either because they refuse or because they are not offered an HIV test). A patient can be coded S1 no more than once per quarter.
  - b P1A: HIV testing only. This code will be re-defined to mean all HIV antibody testing done, regardless of whether counselling was given, in patients who refuse or who are not offered a general sexual health screen.
  - c SP2: Sexual health screen and HIV test. This is a completely new code. This code will be used to count all patients who are given a sexual screen **including** an HIV test. A patient can be coded SP2 no more than once per quarter.
  - d P1B: HIV test refused. This code will be redefined to mean all patients who are offered an HIV test, regardless of whether counselling was given, and who refuse the test.
8. **P2.** Only the 1<sup>st</sup> dose of any new Hepatitis B vaccination course should be included. This would include those patients who may have been vaccinated some time in the past but are now receiving the first dose of a new course of vaccination. Subsequent doses and boosters should be coded as D2B.

9. **P3.** Becomes contraception (females only) and excludes condom provision.

## Part B

10. **B3.** Gonococcal ophthalmia neonatorum. This field is being removed as it provides no further information to that collected in Part A.

## Part C

11. **First and subsequent attendances in the quarter.** All attendances are now to be stratified by sex and male sexual orientation. The number of first attendances which were new patients i.e. patients which were newly registered at the clinic as opposed to a new episode in a previously registered patient, should also be given.

**Part D:** This is a new section being introduced to help monitor access to GUM clinics. This section would be completed by the appointments clerk or receptionist.

12. **Open appointment clinics: Days till next available routine appointment (at end of quarter).** This section is to be completed by clinics which use an 'open book' appointments system i.e. where appointments can be made over an unrestricted period. The number of days till the next available routine appointment, as at the end of the quarter (or on any given day during the last two weeks after the end of quarter), should be recorded in this field.
13. **Closed appointment clinics.** This section should be completed by clinics which use a 'closed book' appointments system i.e. where appointments can be made over a restricted period only. There are two fields to complete:
- a **Booking period (days).** The period for which appointments are booked.
  - b **Days till next available routine appointment (at end of quarter).** The number of days till the next available routine appointment, as at the end of the quarter (or on any given day during the last two weeks after the end of quarter).
14. **Drop-in clinics:** This section should be completed by clinics where a drop-in service is provided i.e. no appointments are made. The number of patients seen in the different time categories as at the end of the quarter (or on any given day during the last two weeks after the end of quarter) should be recorded here. (Hours till patient seen = time in hours from the patient being registered till the patient being seen by the clinician, excluding triage).

## Changes to table headings

15. 'Condition' becomes 'Condition/episode'.
16. 'Of which were homosexually acquired' becomes 'Of which were homo/bisexual'. This change has been introduced because 'Of which were homosexually acquired' is inappropriate for codes referring to epidemiological treatment, HIV testing, hepatitis B vaccination and sexual health screening. There is evidence that this field is poorly completed for these codes using the current definition. It is recognised that the meaning of this field has now changed.

## Revisions to form KC60

### Questions and Answers

#### *Why do we need to revise form KC60?*

There have been no revisions to form KC60 since 1995. Some revisions to the form are now considered necessary because:

1. The Department of Health's Sexual Health and HIV strategy proposed the monitoring of specific targets in sexual health<sup>1</sup>. Currently we are unable to monitor many of these targets with existing surveillance systems. Some targets will require to be monitored through bespoke surveys (e.g. Hepatitis B vaccination uptake in homo/bisexual men) but some can be adequately monitored by making minor revisions to form KC60 (e.g. HIV testing uptake targets).
2. Large increases in the numbers of patients attending GUM clinics has meant that access to GUM clinics is becoming an increasing problem. We want to include a new section which will allow us to monitor patient waiting times.
3. Certain codes are considered to be particularly confusing or inappropriate, and some are often used incorrectly e.g. codes P1A and P1B. Those codes considered to be most problematic are being revised.

#### *Who will implement the changes to the software?*

CDSC will co-ordinate the implementation of the necessary changes to your clinic software by liaising directly with all the relevant software providers on your behalf. If you use an 'in house' system we will liaise directly with your trust's software support staff.

#### *What will it cost my clinic?*

Because form KC60 is a statutory obligation, software providers will not charge to make the necessary changes to your clinic's software.

#### *When should I start using the new form?*

All clinics will need to start using the form at exactly the same time to enable consistent data collection. After this current consultation process (which ends 30<sup>th</sup> September 2002), the final changes to form KC60 need to be agreed

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<sup>1</sup> *Sexual health and HIV Strategy Targets*

##### *Infections*

- 25% reduction in newly acquired HIV infections by 2007
- 25% reduction in gonorrhoea infections by 2007

##### *HIV testing*

- All GUM clinic attendees offered an HIV test on first screening for STI (and subsequently according to risk) by the end 2004
- Uptake of HIV test (in those offered) to 40% by the end of 2004 and 60% by the end of 2007
- Reduce previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by 50% by the end of 2007

##### *Hepatitis B vaccination*

- All homo/bisexual men attending GUM clinics should be offered immunisation at their first visit by the end of 2003
- Uptake of first dose to reach 80% by the end of 2004
- Uptake of first dose to reach 90% by the end of 2006
- Uptake of 3 doses to reach 50% by 2004
- Uptake of 3 doses to reach 70% by 2006

by the relevant ministers through the Department of Health. However, we hope to be using the revised form from the beginning of January 2003.

***Will there be guidance notes for completing the new form?***

New guidance notes for the completion of form KC60 are currently being developed. These will be distributed with the new KC60 forms to all clinics.

***Many of the codes could be substantially improved and new and better ones added. Why are the changes not more substantial?***

It was agreed that only those revisions required to help monitor the Sexual Health and HIV Strategy targets and patient waiting times, and to revise particularly problematic codes, should be made to form KC60 this time around. These revisions involve changes to the definitions of existing codes and minor structural changes. As you should be aware, the Programme for Enhanced STI Surveillance (ProgrESS) is aiming to collect more detailed, attendance-based information from GUM clinics in England over the next few years, in order to significantly enhance the quality and usefulness of GUM-clinic-based surveillance data. Your clinic may be providing data for this project already. It is intended that more radical changes to diagnostic codes will be undertaken as this project develops and this is likely to involve considerable programming input from software providers in the medium term. Consequently, it was felt that short-term changes should involve minimal programming input.

***Why can't you monitor the hepatitis B vaccination targets for homo/bisexual men using form KC60 rather than developing a separate survey?***

For effective monitoring of a vaccination programme it is necessary to know numbers of patients receiving full, partial or no courses of vaccination, and the reasons why vaccination may be incomplete or not done. Because form KC60 is not patient-based it is not possible to link patient records which prohibits follow-up of individual vaccination courses.

***I think the new S1 and P codes are confusing – what do they mean and why do we need them?***

According to latest guidance from the expert groups involved in developing the Sexual Health and HIV Strategy, all new attenders and all 'at risk' reattenders (i.e. first attendances for a new episode) should be offered a sexual health (SH) screen, including an HIV test<sup>1</sup>. Most patients are likely to accept the SH screen with the HIV test but it is recognised that some will accept only the SH screen, some only the HIV test, and some, neither. In addition, some patients may not be offered the SH screen, the HIV test, or either of the two. If we want to monitor the targets on HIV testing uptake and offering, we need to be able to record all of these various combinations on form KC60, so that appropriate numerators and denominators can be generated. Knowing the number of SH screens done will also allow us to estimate positivity of infections which are screened for, such as chlamydia and gonorrhoea.

The S1 code is just a count of the number of SH screens done which did not include an HIV test. Code P1A is a count of the number of HIV tests done (regardless of whether counselling was given) without an SH screen. The SP2 code will reflect the most usual scenario, where patients receive both an SH screen and an HIV test. Code P1B counts the number of HIV tests that were offered but not taken.

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<sup>1</sup> The Clinical Effectiveness Group have asked the Bacterial Special Interest Group to review and report on precisely what a sexual health screen should involve for different populations. Once this group have reported, a full definition will be given in the accompanying guidance notes.

***These revisions will allow you to monitor whether or not sexual health screens are being offered.***

This is correct. The offering of sexual health screens will need to be monitored through clinical audit.

***Why is it necessary to further stratify data on patient attendances in part C?***

These changes are being introduced to get better information on patient demand for GUM clinic services and how these may alter as a result of the Sexual Health and HIV Strategy. Information on new attendances by homo/bisexual men can also be used in conjunction with data collected for the hepatitis B vaccination survey to monitor whether vaccine is being offered. It is recognised that a proportion of patients may fail to disclose previous attendances so that numbers of 'new' patient attendances may be slightly overestimated.

***How were the indicators of patient waiting times developed and why are they being included on form KC60?***

A consultation group comprising consultants in genitourinary medicine and representatives from CDSC and the Department of Health looked at various ways of measuring waiting times at GUM clinics. A short report outlining the deliberations of this group is available from CDSC and is also being posted on the AGUM website. It was felt that it would be simpler and more agreeable to clinic staff if indicators of patient waiting times were collected on form KC60 rather than developing a new form. This approach will also simplify data collection and provide more comprehensive data than *ad hoc* surveys can achieve.

***I have some comments on the proposed changes to form KC60 and/or the patient waiting times indicators. Who should I contact?***

If you have any comments on the proposed revisions to form KC60 please contact Dr Gwenda Hughes at CDSC ([ghughes@phls.org.uk](mailto:ghughes@phls.org.uk); tel: 020 8200 6868 ext 3423) to discuss these further. If you would specifically like to discuss issues around the proposed patient waiting time indicators please contact Dr Evdokia Dardamissis at CDSC ([edardamissis@phls.org.uk](mailto:edardamissis@phls.org.uk); tel: 020 8200 6868 ext 3441).