



# Genitourinary Medicine Clinic Activity Dataset: GUMCAD (previously known as KC60 central return)

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## Guidance to clinic staff

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Health Protection Agency Centre for Infections

British Association for Sexual Health and HIV

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# 1 Document control

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Document control topic	Details		
<b>Current version</b>	Document intended to provide guidance to front line staff responsible for capturing and entering GUMCAD data into systems and reporting to the HPA.		
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## 2 Introduction

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- 2.1 This document is intended for front line NHS staff responsible for the collection and recording of data used to generate the KC60 Central Return in England (now known as Genitourinary Medicine Clinic Activity Dataset - GUMCAD) and to those responsible for reporting the data to the Health Protection Agency.
- 2.2 The GUMCAD return includes patient demographic details collected at patient registration at their first attendance, and clinical and risk factor data collected during the patient consultation. Collection of patient registration details is usually led by data entry clerks, front desk staff including receptionists, information technology, administrative or secretarial staff. Clinical coding and the collection of risk factor information is usually led by clinical staff supported by the above staff. Running and transmitting reports for the Health Protection Agency is usually led by administrative staff supported by information technology staff.
- 2.3 The GUMCAD data support the monitoring and reporting of STIs including historical trend data. From April 2008, the structure of the return has been revised to include additional data items which will improve the public health utility of the data and will facilitate robust assessment of local service needs. This enables informed planning and allocation of resources at national, regional and local levels and is important in the drive to reduce the level of Sexually Transmitted Infections (STIs) nationally. The more informed the planning and decision-making process, the better the allocation of limited resource to effective treatment of STIs.
- 2.4 This document will provide staff with a guidance explaining how to collect and record each data item. It also provides detailed instructions on how and when to report the return to the Health Protection Agency.
- 2.5 This guidance focuses on the items needed only for GUMCAD reporting. For reporting of other data-sets, such as GUM Access Monthly Monitoring, please refer to the appropriate guidance (DSCN 39/2007; [www.isb.nhs.uk](http://www.isb.nhs.uk)).
- 2.6 The GUMCAD return is electronic rather than paper-based. The data items collected on the GUMCAD return are shown in Appendix 1. The required format and coding options for these data items is given in Appendix 2.

## 3 Collection and recording guidance

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- 3.1 This section covers what to record when and deals with some of the common problems which may be encountered. Local systems and processes vary so the application of this guidance should be checked with your manager, software provider or with staff at the Health Protection Agency if any issues arise.
- 3.2 The guidance covers the collection and recording of data relevant to the GUMCAD return, and includes:
- Patient registration details at the patient's first attendance
  - Attendance type when the booking is made
  - Attendance date when the patient attends for the appointment
  - Clinical details and KC60 coding during and after the clinical consultation
- 3.3 The remainder of this section details what needs to be collected and recorded at each of these points.

### Patient registration details at first attendance

- 3.4 When a patient attends the clinic for a booked appointment or to a walk-in service, the patient should be registered and standard demographic details collected. Some patients may already have provided some basic registration information when calling to make the appointment.
- 3.5 Patient information to be collected at registration (and at appointment booking) has been specified for GUM Access Monthly Monitoring (GUMAMM). All staff recording and entering patient registration details should therefore refer to this specific guidance (DSCN 39/2007; [www.isb.nhs.uk](http://www.isb.nhs.uk)).
- 3.6 Some of the registration details are also required for the GUMCAD return. This section provides some additional guidance on recording the GUMCAD specific registration details.
- 3.7 To generate the GUMCAD return, the following items need to be collected from, or created for, all patients during patient registration at their first attendance:
- **Postcode of residence**
  - **Date of Birth**
  - **Gender**
  - **Ethnicity**
  - **Country of Birth**

- **Unique Patient Identifier number**

The various options that can be recorded for each of these data items are summarised in Appendix 2.

- 3.8 **Postcode of residence:** The postcode of residence enables most systems to generate Primary Care Trust and Lower Super Output area of residence, both of which are required for the GUMCAD return. If the patient does not provide their postcode, the patient should be asked to provide their PCT or borough of residence. Otherwise, the post code should be recorded as 'Not known' (however this is recorded on your clinic system) or left blank. *The post code of the clinic should not be entered.*
- 3.9 **Date of birth:** Date of birth allows the system to generate the age of the patient at the date of attendance. Age at the date of attendance is required for the GUMCAD return.
- 3.10 **Gender:** Gender should be specified by the patient. 'Not Specified' should be recorded where gender cannot be classified as either male or female and 'Not Known' where the patient does not provide the information.
- 3.11 **Ethnicity:** Ethnicity should be specified by the patient from the standard list. 'Not stated' should be recorded where the patient does not provide the information.
- 3.12 **Country of Birth:** Country of birth should be selected from the standard list.
- 3.13 **Unique Patient Identifier:** Most systems will automatically generate a unique Patient Identifier number at patient registration.
- 3.14 Some patients may not provide all these details. This should not prevent them being registered and accessing the service. If not all these details are collected at the first attendance, it may be possible to collect some further information at subsequent patient attendances.

## Attendance type

- 3.15 When the booking is made the attendance type must be recorded. The GUMCAD return requires information on the type of the appointment to distinguish new and follow-up patient attendances, and whether these are face-to-face or telephone/telemedicine consultations. The national categories, as defined by the NHS Data Dictionary, are as follows:
- First attendance face-to-face
  - Follow-up attendance face-to-face
  - First telephone or telemedicine consultation
  - Follow-up telephone or telemedicine consultation.

A first face-to-face attendance refers to a patient at the start of any new episode of care. A follow-up face-to-face attendance refers to a patient attending a follow-up

appointment for a pre-existing condition. The same definitions apply to telephone or telemedicine consultations.

- 3.16 In most clinic software systems, first patient attendances are further distinguished as either new or re-book attendances. A new patient attendance refers to patients at the start of a new episode who are being registered and seen at the clinic for the first time, and a re-book patient attendance to patients at the start of a new episode who were registered at the clinic during a previous episode. Criteria for booking new or re-book appointments are as follows: (1) The patient has never before attended the service (2) the reason for attendance is not related to any previous visit by that patient, and (3) the patient was discharged following their last visit or was not required to attend for a follow-up visit. New and re-book attendances are not distinguished on the GUMCAD return. However, for local patient management purposes it is advisable to continue to record attendance information in this way on your clinic system if possible.
- 3.17 Please note the recording of first and follow-up attendances may be automated in your system. Attendances by a patient within 26 weeks of their last attendance will usually be classified as a follow-up attendance by clinic software. Attendances by a patient 26 weeks or more after their last attendance will usually be classified as a first or re-book attendance by clinic software. However, patients will frequently return to the clinic within 26 weeks with a new episode or problem and these patients should be re-registered and coded as a first (re-book) attendance. In order to invoke a re-book attendance you must close the previous episode by discharging the patient or make it very clear in the case records that no further follow up is planned. Consequently, you should manually change the attendance type details in the clinic software if an episode is closed within, or should extend beyond, the 26 week default interval. If you are unsure, please check with clinical staff to determine exactly how these items are to be recorded.
- 3.18 Information from patients with a booked appointment but who did not attend (DNAs) is not included in the GUMCAD return.

### **Attendance date**

- 3.19 When the patient attends for the appointment the **Attendance Date** must be recorded.

## Clinical details and KC60 coding

- 3.20 During the clinical consultation, the following items need to be recorded for all patients:
- **Sexual orientation**
  - **KC60 code**
- 3.21 Data may be recorded directly onto the system by the clinician during the consultation or written in the clinical notes. The data entry process may therefore vary by clinic i.e. it may be entered by the clinician or transcribed later from clinical notes by administrative or other staff.
- 3.22 **Sexual Orientation:** Patients will have a sexual history taken during the clinical consultation. Detailed guidelines on taking a sexual history have been developed by BASHH and should be followed closely ('National Guideline for Consultations requiring Sexual History Taking', BASHH 2005). For the GUMCAD return, it is necessary to determine and record the Sexual Orientation of the patient<sup>1</sup>. The system default should be set as 'Unknown' but it is important to record specific and accurate information whenever possible. Sexual orientation should be collected for both males and females.
- 3.23 **KC60 code:** Each item of service provided or diagnosis made in a GUM clinic is described by a KC60 code. At least one KC60 code must be recorded for each first patient attendance. A KC60 code may also be appropriate at certain follow-up attendances. Where possible, the KC60 code should be recorded on the system or in the clinical notes during or immediately after the consultation. For those situations where this is not possible e.g. where the results from tests are awaited, codes should be recorded as soon as this is possible.
- 3.24 KC60 codes with descriptions and guidance on how they should be used are given in Table 1.

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<sup>1</sup> Sexual orientation is collected because route of transmission ('How acquired') is not appropriate for service provision codes such as 'sexual health screen'.

**Table 1. KC60 code descriptions and guidance for use**

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
<b>Diagnosis and/or treatment of infection or disease</b>		
A1	Primary syphilis	This refers to primary infectious syphilis. Laboratory confirmation is required.
A2	Secondary syphilis	This refers to secondary infectious syphilis. Laboratory confirmation is required.
A3	Early latent syphilis	This refers to latent syphilis in the first two years of infection.
A4	Cardiovascular syphilis	This refers to cardiovascular syphilis
A5	Neurosyphilis	This refers to syphilis of the nervous system.
A6	All other late and latent syphilis	This refers to latent syphilis after the first two years of infection and all other latent syphilis.
		For codes A4-A5, the patient is only coded once in each of these categories in the UK, i.e. the patient is not given this code again unless there is a new complication. For example, a diagnosis of cardiovascular syphilis after having been diagnosed as a case of late latent syphilis.  Therefore patients attending for routine follow up of say, latent syphilis, are not re-coded in this category; and if they attend another clinic elsewhere in the country they are not coded as A4, A5, A6.
A7	Congenital syphilis, aged under 2 years	
A8	Congenital syphilis, aged 2 years or over	
A9	Epidemiological treatment of suspected syphilis	This should include all cases where syphilis has not been confirmed, but epidemiological treatment is prescribed because the index patient (the partner) was found to be syphilis positive.
B1	Uncomplicated post-pubertal gonorrhoea	This includes all cases of uncomplicated gonorrhoea of the lower genitourinary tract, anorectum, mouth, throat, and adult conjunctivitis.  Persistent/recurrent gonorrhoea:  Treatment failures should not be given a new diagnosis  Patients who are thought to be re-infected should be regarded as new cases, and investigated, treated and diagnosed/coded accordingly
B2	Uncomplicated Pre-pubertal gonorrhoea	This includes all cases of uncomplicated gonorrhoea of the lower genitourinary tract, anorectum, mouth, throat, and conjunctivitis (except ophthalmia neonatorum which should be coded B3).  Persistent/recurrent gonorrhoea:  Treatment failures should not be given a new diagnosis  Patients who are thought to be re-infected should be regarded as new cases, and investigated, treated and diagnosed/coded accordingly
B3	Gonococcal ophthalmia neonatorum	
B4	Epidemiological treatment of suspected gonorrhoea	This should include all cases where gonorrhoea has not been confirmed, but where epidemiological treatment has been prescribed because the index patient (the partner) was found to be infected with gonorrhoea.

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
B5	Complicated gonococcal infection – including PID and epididymitis	This includes all cases of complicated gonorrhoea e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), and systemic complications.  Where a patient has complications that are associated with both gonococcal and chlamydial infections, the patient should be included as B5 and as C4B.
C1	Chancroid	Specific confirmation is advisable for this condition.
C2	Lymphogranuloma venereum	Specific confirmation is advisable for this condition.
C3	Donovanosis	Specific confirmation is advisable for this condition.
C4A	Uncomplicated chlamydial infection of the lower genital tract	This includes all cases of uncomplicated chlamydial infections (diagnosed by culture or antigen detection) involving the lower genitourinary tract.  Persistent/recurrent chlamydia:  Treatment failures should not be given a new diagnosis  Patients who are thought to be re-infected should be regarded as new cases, and investigated, treated and diagnosed/coded accordingly.
C4B	Complicated chlamydial infection – including PID and epididymitis	This includes all cases of complicated chlamydial infections e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), perihepatitis and arthritis. Diagnosis may be based on culture, antigen detection or high MIF titre.  Where a patient has complications that are associated with both gonococcal and chlamydial infections, the patient should be included as B5 and as C4B.
C4C	Uncomplicated chlamydial infection, other sites	This includes all cases of uncomplicated chlamydial infections (diagnosed by culture or antigen detection) involving all other sites and including adult conjunctivitis.  Persistent/recurrent chlamydia:  Treatment failures should not be given a new diagnosis  Patients who are thought to be re-infected should be regarded as new cases, and investigated, treated and diagnosed/coded accordingly.
C4D	Chlamydial ophthalmia neonatorum	
C4E	Epidemiological treatment of suspected chlamydia	This should include all cases where chlamydia has not been confirmed, but where epidemiological treatment has been prescribed because the index patient (the partner) was found to be chlamydia positive. If a male partner presents as a contact of C4A and has non-specific urethritis, he should be coded as C4H only and not C4E.
C4H	Uncomplicated non-gonococcal/non-specific urethritis in males, or treatment of mucopurulent cervicitis in females	In males, this is diagnosed in the absence of gonorrhoea and laboratory confirmed chlamydia and the presence of polymorphonuclear leucocytes at >5 per high power field. Also, if a male partner presents as a contact of C4A and has non-specific urethritis, he should be coded as C4H only and not C4E.  Females being treated for non-specific mucopurulent cervicitis are also to be coded C4H.  Persistent/recurrent urethritis:  Treatment failures should not be given a new diagnosis  Patients who are thought to be re-infected should be regarded as new cases, and

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
		investigated, treated and diagnosed/coded accordingly.
C4I	Epidemiological treatment of non-specific genital infection	This diagnosis is used for either males or females; e.g. the female would be diagnosed as C4I if she tested negative for gonorrhoea and chlamydia and is treated because her partner had been diagnosed with uncomplicated or complicated non-specific infection (C4H or C5).  Similarly, the male partner is diagnosed as C4I if he tested negative for gonorrhoea and chlamydia and is treated because the female partner has been diagnosed as C4H or C5.
C5	Complicated infection (non-chlamydial/non-gonococcal) – including PID and epididymitis	This includes all cases of complicated non-specific infections requiring treatment and negative tests for gonorrhoea and chlamydia e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), prostatitis and arthritis.
C6A	Trichomoniasis	If associated with bacterial vaginosis then code C6A only should be used.
C6B	Anaerobic/Bacterial vaginosis and anaerobic balanitis	Diagnosis of bacterial vaginosis is generally based on microscopy, pH vaginal fluid and the amine test. This diagnosis is very rarely appropriate in males and used only if the patient has confirmed anaerobic balanitis. Other and non-confirmed anaerobic balanitis should be coded as C6C. Asymptomatic patients who do not require treatment should not be coded C6B.
C6C	Other vaginosis/vaginitis/ balanitis	
C7A	Anogenital candidosis	This is diagnosed only when there is microscopic or culture evidence of Candida infection. Asymptomatic patients who do not require treatment should not be coded C7A.
C7B	Epidemiological treatment of C6 and C7	This should include all cases where C6 and C7 have not been confirmed, but where epidemiological treatment has been prescribed.
C8	Scabies	This includes cases treated on either a clinical or epidemiological basis.
C9	Pediculosis pubis	This includes cases treated on either a clinical or epidemiological basis.
C10A	Anogenital Herpes simplex: first attack	An episode should be recorded here only if the patient has never (as far as can be ascertained) been previously diagnosed with anogenital herpes at any Genitourinary Medicine (GUM) clinic. Laboratory confirmation is essential.
C10B	Anogenital Herpes simplex: recurrence	This should include all other episodes of anogenital herpes. If there has been previous confirmation, then clinical judgement is enough for this diagnosis.
C11A	Anogenital warts infection: first attack	An episode should be recorded here only if the patient has never (as far as can be ascertained) been previously treated for anogenital warts at any GUM clinic.  C11A diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.
C11B	Anogenital warts infection: recurrence	This should include patients in whom warts reappeared after a wart-free interval of at least 3 months.  C11B diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
C11C	Anogenital warts: Re-registered cases	<p>This is to be used for a patient previously diagnosed as C11A or C11B in whom warts persist and treatment continues for longer than three months, or which recur within 3 months of apparent eradication.</p> <p>This code is not to be re-entered for the same patient more than once every 3 months.</p> <p>C11C diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.</p>
C12	Molluscum contagiosum	
C13A	Viral hepatitis B (HbsAg positive): First diagnosis	C13A records a first diagnosis of antigen positive hepatitis B.
C13B	Viral hepatitis B (HbsAg positive): Acute viral hepatitis B at first diagnosis	C13B is a subset of C13A, so that a patient coded C13B must also be coded C13A. C13B records the number of first diagnoses of hepatitis B infections that were acute, where this is known. The definition of acute hepatitis B is newly identified HBsAg positive with anti-HBc IgM positive (>200 iu/l) <u>or</u> discrete onset of jaundice or anicteric illness accompanied by deranged LFTs (AST / ALT > 2x normal range) accompanied by HBsAg and anti-HBc IgM positive.
C13C	Viral hepatitis B: subsequent presentation	All subsequent presentations of hepatitis B that require management, or known carriers of hepatitis B who present at a clinic for the first time, should be coded as C13C. Subsequent attendances by carriers that are unrelated to hepatitis B management should not be coded as C13C.
C14	Viral hepatitis C: first diagnosis	This code records the first diagnosis of hepatitis C, defined as anti-HCV positive or HCV RNA positive. All other hepatitis diagnoses should be coded as D2B/D3.
D2A	Urinary tract infection	
D2B	Other conditions requiring treatment at GUM clinic	
E1A	New HIV diagnosis: asymptomatic	This is a new HIV diagnosis in a patient without symptoms who is not known to have been diagnosed previously at any GUM clinic. It includes patients with seroconversion illness. A patient can receive this code only once and it is mutually exclusive of E2A and E3A1.
E2A	New HIV diagnosis: symptomatic (not AIDS)	This is a new HIV diagnosis in a patient with symptoms who is not known to have been diagnosed previously at any GUM clinic. It excludes patients with seroconversion illness (see code E1A). A patient can receive E2A only once and it is mutually exclusive of E1A and E3A1.
E1B	Subsequent asymptomatic HIV presentation (not AIDS)	Includes all subsequent presentations by an asymptomatic patient who has been diagnosed with HIV previously (and therefore excludes those with AIDS). The patient should be given this code only once during any quarterly period.
E2B	Subsequent symptomatic HIV presentation (not AIDS)	Includes all subsequent presentations by a symptomatic patient who has been diagnosed with HIV previously, but excludes those with AIDS. The patient should be given this code only once during any quarterly period.

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
E3A1	AIDS: first presentation - new HIV diagnosis	An AIDS diagnosis is used for HIV infected patients with one or more AIDS indicator diseases. It is necessary to discriminate between first AIDS presentations that are also the first HIV diagnosis and those for which HIV was diagnosed previously.  E3A1 is a first presentation of AIDS where HIV has not been diagnosed previously. The patient (as far as can be ascertained) should not have been given an HIV or AIDS diagnosis at any clinic in the United Kingdom. This patient cannot be coded E1 or E2 ever again. E3A1 is mutually exclusive of E3A2.
E3A2	AIDS: first presentation - HIV diagnosed previously	E3A2 is a first presentation of AIDS where HIV has been diagnosed previously. The patient (as far as can be ascertained) should not have been given an AIDS diagnosis at any clinic in the United Kingdom. This patient cannot be coded E1 or E2 ever again. E3A2 is mutually exclusive of E3A1.
E3B	AIDS: subsequent presentation	The patient who has had an AIDS diagnosis at any time in the past should be given this code only once during any quarterly period and cannot be coded E1, E2 or E3A ever again.
P4A	Cervical cytology: minor abnormality	This includes inflammatory smears, warts virus infection only, borderline changes and mild dyskaryosis.
P4B	Cervical cytology: major abnormality	This includes moderate or severe dyskaryosis, or worse.

<b>KC60 code (2003 onwards)</b>	<b>Description</b>	<b>Definition and guidance</b>
<p><b>Services provided</b></p> <p>The 'Services provided' codes are used to code patients receiving services or undergoing tests. For example, if a patient is offered a sexual health screen he/she would be coded S1 or S2. If, as a result of that screen, a chlamydial infection was found, he/she would also be coded C4A or C4C. If, following the screen, no infections were found, the patient would be coded S1 or S2 and D3.</p>		
S1	Sexual health screen (no HIV antibody test)	S1 should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis etc. It will be used to count all patients who are given a sexual health screen excluding an HIV test. (This may be because the patient refuses or is not offered an HIV test. However, if the patient is known to be HIV antibody positive, he/she can be coded S1 and one of E1B/E2B/E3A2/E3B). S1 is mutually exclusive of S2 and P1A.
S2	HIV antibody test and sexual health screen	S2 is used to count all patients who are given a sexual health screen including an HIV test. It should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis etc. If the patient tests positive for HIV antibody then they would be coded S2, E1A. S2 is mutually exclusive of S1, P1A and P1B.
P1A	HIV antibody test (no sexual health screen)	This code refers to all HIV antibody testing done in patients who refuse or who are not offered a general sexual health screen (regardless of whether counselling was given). This code is mutually exclusive of S1, S2 and P1B.
P1B	HIV antibody test offered and refused	This code refers to all patients who are offered an HIV test and who refuse the test (regardless of whether counselling was given). This code is mutually exclusive of S2 and P1A.
P2	Hepatitis B vaccination (1 <sup>st</sup> dose only)	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.
P3	Contraception (excluding condom provision)	This code will be used to record contraception (females only), including prescribing and family planning advice, and excluding condom provision. Condom provision should not be included.
D3	Other episodes not requiring treatment	<p>D3 is used to code any new patient episode where no treatment is given, whether or not a sexual health screen and/or an HIV test are/is performed. D3 can therefore be used to record an episode where a patient tests negative for all tests done, or where testing the patient is not indicated and otherwise no treatment is given.</p> <p>D3 may also be used to record any other contact with a patient for clinical purposes but which does not result in treatment. Patients who do not attend appointments may be coded D3 if a) they have already been triaged, or b) they have had contact with a health advisor. Otherwise patients who do not attend should not be coded D3.</p> <p>D3 can be used only once per patient episode.</p>

## **Other guidance**

- 3.1 Supportive arrangements should be made where necessary for patients who do not have English as a first language, or who are visually impaired or have other disabilities that may affect their ability to complete the form e.g. literacy.
- 3.2 Patients should be made aware that the questions on the registration form and at sexual history taking are designed to help manage their care.
- 3.3 Clinics should be aware that some patients will have questions regarding these items.

## 4 Reporting and transmitting data to the HPA

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### Description

- 4.1 Each GUM clinic is required by law to produce a quarterly electronic data extract of all patient attendances and diagnoses at GUM clinics with associated patient information for the GUMCAD statistical return. These extracts are submitted to the Health Protection Agency (HPA) Centre for Infections for processing and analysis. The GUMCAD return from 2008 onwards is electronic rather than paper-based. The data items collected on the GUMCAD return are shown in Appendix 1. All specified fields are mandatory and must be reported<sup>1</sup>.

### Running extracts

- 4.2 In the majority of cases, the clinic's computer software will have a routine query tool to run the GUMCAD extract. This process is likely to vary according to the software your clinic uses, so please refer to your software provider's training material for specific guidance where necessary.

### Extract format

- 4.3 Once you have run the query, the GUMCAD extract report should be formatted into a single comma delimited CSV file or in Microsoft Excel format. The format of the CSV/Excel file is presented in Appendix 1. An example of the field content for one row of data is shown below and is used to illustrate how the data should appear in the CSV file. The field content and field order should be identical for files in Excel format. If you think the format of your extract differs from the one below, please contact your software provider for further advice. Files that do not match this format cannot be uploaded into the database at the HPA.

#### EXAMPLE OF CSV FORMAT FOR THE GUMCAD EXTRACT (FOR ONE ROW OF DATA)

```
ClinicID,PatientID,KC60,Gender,Age,Sex_Ori,Ethnicity,Country_Birth,PCT,LSOA,First_Attendance,AttendanceDate  
RCC25,PAT123,C10A,1,16,1,A0,GBR,5K9,E01000001,1,2007-10-31
```

### Reporting time period

- 4.4 Each GUMCAD extract should cover one calendar quarter.

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<sup>1</sup> The only exception is that a KC60 code need not be supplied for follow-up attendances.

## Frequency of reporting

- 4.5 Reports should be run quarterly, no later than **six weeks after the end of the calendar quarter**. You must therefore ensure that patient records have been updated with the appropriate KC60 codes (except in the minority of cases where results are delayed) and that these have been entered onto your computer system within 6 weeks of the end of the quarter. The GUMCAD Team at the HPA will send you a reminder two weeks before the deadline. Failure to meet the deadline will result in a null return for your clinic's data in quarterly feedback reports to the Department of Health and Trust managers. If you have concerns that you are unlikely to be able to meet this deadline please contact the GUMCAD Team at the HPA for advice as soon as possible.

## Transmission of the data extract to the HPA

- 4.6 GUMCAD data extracts should wherever possible be returned to the HPA through the secure document gateway in the HPA website. This gateway enables organisations to distribute any type of files to previously identified users in a secure manner across the Internet. The document gateway can be found at: <https://www.hpa.org.uk/login.spl>. Connection to the gateway requires a login account name and password, which will be provided to you by the GUMCAD Team at the HPA Centre for Infections.
- 4.7 If data transmission through the secure document gateway is not possible at your clinic, the GUMCAD team will discuss alternative arrangements with you. Encrypted data can also be transmitted using a portable device such as a CD or flashdrive. **Data transmitted on such portable devices must be sent by registered post**. It is important to alert the HPA as soon as you have sent data on a portable device so that any lost devices can be reported and investigated immediately.
- 4.8 Where data is transferred electronically, this must be encrypted to industry standard (128 bit). Please get in touch with your software supplier, local IT staff or the GUMCAD Team at the HPA for further advice if you are unsure about this.

## 5 How the HPA uses the data

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### Purpose of the GUMCAD return

5.1 The GUMCAD data are collected and analysed to monitor trends in new diagnoses of sexually transmitted infections (STI) and other sexual health problems and to determine which specific groups are at particular risk. For example, the data can be used to identify (1) emerging syphilis outbreaks in particular localities, (2) increasing gonorrhoea transmission among certain ethnic groups, or (3) HIV or other STI risk in specific immigrant populations.

This information is used to inform the public health response by:

- Improving the planning and management of services.
- Developing, adapting and refining interventions.
- Monitoring the effectiveness of sexual health policies.

### Types of output

5.2 In addition to the HPA's main annual publication on HIV and Sexually Transmitted Infections, the agency aims to produce timely routine outputs of data at the local, regional and national level. These will cover the following main areas:

#### *Data completeness and quality*

- Clinics reporting a valid return by 6 weeks of the end of the quarter by Primary Care Trust (PCT) and Strategic Health Authority (SHA).
- For those data items with a 'Not known' option, the proportion of entries containing 'Not known' information, by clinic, PCT and SHA.
- For selected STIs, counts by each demographic variable (e.g. gender, age group, sexual orientation etc.) to check that these fall within expected ranges.
- Distribution of all patients by PCT of residence, gender and age group.

#### *Service provision*

- Rate of sexual health screens for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth and age group.
- Number of chlamydia tests undertaken in the sexually active population by PCT of residence. This report would combine data on tests undertaken as part of the National Chlamydia Screening Programme (NCSP) with those from GUM clinics in the GUMCAD extract.
- HIV test uptake (including numerators and denominators) for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth, age group and clinic.

- Hepatitis B vaccine uptake (first dose - including numerators and denominators) for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth, age group and clinic.

### ***Epidemiological analyses***

- Rates and numbers of new diagnoses of gonorrhoea, chlamydia, syphilis, LGV, acute hepatitis B, genital herpes and genital warts for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth and age group.
- Rates of new diagnoses of gonorrhoea, chlamydia, genital herpes and genital warts by level of deprivation (calculated using LSOA of residence).
- Rates and numbers of new diagnoses of chlamydia in the sexually active population by PCT of residence. This report would combine data on diagnoses made as part of the NCSP with those made in GUM clinics in the GUMCAD extract.
- Rates and numbers of new diagnoses of complicated infection (including PID and epididymitis) for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth and age group.
- Rates and numbers of total STI diagnoses for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth and age group.
- Numbers and percentages of new diagnoses of gonorrhoea, chlamydia, syphilis, LGV, acute hepatitis B, genital herpes and genital warts for each calendar quarter and PCT of residence, stratified by PCT of clinic attended, and vice versa.
- Positivity of chlamydia and gonorrhoea (including numerators and denominators) among those screened in GUM clinics for each calendar quarter and PCT of residence, stratified by gender, sexual orientation, ethnic group, country of birth and age group.
- Positivity of chlamydia (including numerators and denominators) in the sexually active population by PCT of residence. This report would combine data on diagnoses made as part of the NCSP with those made in GUM clinics in the GUMCAD extract.

## **Reporting time period**

5.3 HPA output reports will cover quarterly and annual periods.

## **Frequency of reporting**

5.4 The HPA will run reports quarterly and annually. Data from clinics should be received by HPA within 6 weeks after the calendar quarter. HPA aims to distribute reports 4 weeks thereafter. Annual reports will summarise each full calendar year's data.

## **Report format**

- 5.5 Automated reports will be produced in pdf and Microsoft Excel format.

## **Presentation of local area data**

- 5.6 Following recent guidance issued by the Office of National Statistics on the risk of deductive disclosure in small area statistics, the HPA has agreed with the Department of Health (DH) that clinic, LSOA and PCT level STI data tables will not be published by the HPA, in hard copy or on the website. However, clinic, PCT and Local Authority level data tables will be distributed in confidence to relevant organisations within the NHS, DH, local government and HPA. When PCT or clinic level data are requested by other organisations (such as for Freedom of Information requests or Parliamentary Questions), then all cell sizes with counts of between 1 and 4 inclusive, and any associated 'Totals' columns that would allow these cells to be deduced, will be blanked out.
- 5.7 Maps of STI rates by PCT of residence, where rates are grouped into categories, will be published in reports and on the HPA website.

## **Recipients of routine reports**

- 5.8 Reports will be distributed to all clinics, PCTs, SHAs, Local Authorities and government offices via regional HPA Sexual Health Leads and copied to the Department of Health.

## **Distribution of reports**

- 5.9 Where possible, reports will be distributed electronically through the secure document gateway on the HPA website or, if not possible, via email.

## 6 Confidentiality and anonymity

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6.1 Some patients may express concern regarding supplying their data and it being reported to the HPA. If so, the following approached should be taken:

- Explain the uses to be made of the data i.e. what they are consenting to, which is to allow information to be recorded and reported to improve the service and to protect public health. This will reassure the vast majority of patients. When necessary, patients should be reassured that their personal data are held in strict confidence and that no personally identifiable information will be reported to the HPA. Patients can also be provided with the HPA leaflet “Safeguarding the confidentiality of information about patients while also protecting public health” for further information. These leaflets have been distributed to your clinic but please contact the HPA if you require more.
- If there are still on-going concerns, some systems allow for the use of aliases. Whilst this is not ideal it is preferable to not recording the data at all. This should then allow for the reporting of data for these patients.
- If neither of the two approaches above satisfies or the system does not allow for the use of aliases, then the patient’s data may not be recorded in a system at all. In most cases this will mean that data cannot be recorded and reported for these patients. If a patient’s data has been submitted to the HPA and the patient later objects, you should contact the GUMCAD Team at HPA with the patient’s unique ID number so that HPA staff can delete the relevant patient’s records on the database.

6.2 The HPA secure document gateway in the HPA website enables organisations to distribute any type of files to previously identified users in a secure manner across the Internet. Connection to the gateway requires a login account name and password. The browser supports the Secure Sockets Layers (SSL) method of communication and passwords are changed every 3 months.

6.2 All staff within the HPA have a legal duty to keep patient information confidential. All records are kept securely in compliance with the Caldicott Guidelines. The HPA stores personal health information on secure servers and all databases are password protected. Access to the data is strictly controlled and limited to those directly involved in the collation of the data. Data are retained for a maximum of 8 years from the date of patients’ last attendance.

6.3 Following recent guidance issued by the Office of National Statistics on the risk of deductive disclosure in small area statistics, the HPA has agreed with the Department of Health (DH) that clinic, LSOA and PCT level STI data tables will not be published by the HPA, in hard copy or on the website. However, clinic, PCT and Local Authority level data tables will be distributed in confidence to relevant organisations within the NHS, DH, local government and HPA. When PCT or clinic level data are requested by other organisations (such as for Freedom of Information requests or Parliamentary Questions), then all cell sizes with counts of between 1 and 4 inclusive, and any associated ‘Totals’ columns that would allow these cells to be deduced, will be blanked out.

## **7 Contact information for support and guidance**

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- 7.1 Further guidance on collecting, recording and reporting data for the GUMCAD return is available from:

GUMCAD Reporting Team, STI Section  
Department of STIs and Sexual Health  
Health Protection Agency Centre for Infections  
61 Colindale Avenue  
London  
NW9 5EQ

Tel: 020 8327 7469

Fax: 020 8200 7868

<http://www.hpa.org.uk/>

## 8 Appendix 1: Data items collected on the GUMCAD return

Position *	Field Name	Description	NHS Data Dictionary Data Element	Variable Length <sup>‡</sup>	Example <sup>±</sup>
1	ClinicID	Clinic ID code	<a href="#">SITE CODE (OF TREATMENT)</a>	AN(5)	RCC25
2	PatientID	Local patient identifier number	<a href="#">LOCAL PATIENT IDENTIFIER</a>	AN(10)	PAT123
3	KC60	KC60 code	<a href="#">GENITOURINARY EPISODE TYPE</a>	AN(4)	C10A
4	Gender	Gender	<a href="#">PERSON GENDER CURRENT</a>	N(1)	1
5	Age	Age at attendance date in years	AGE AT ATTENDANCE DATE	N(3)	16
6	Sex_Ori	Sexual orientation	SEXUAL ORIENTATION (CURRENT)	N(1)	1
7	Ethnicity	Patient's ethnic category	<a href="#">ETHNIC CATEGORY</a>	AN(2)	A0
8	Country_Birth	Patient's country of birth	COUNTRY CODE (BIRTH)	A(3)	GBR
9	PCT	PCT of residence code	<a href="#">ORGANISATION CODE (PCT OF RESIDENCE)</a>	AN(3)	5K9
10	LSOA	Lower Super Output Area of residence code	LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)	AN(9)	E01000001
11	First_Attendance	Attendance type	<a href="#">FIRST ATTENDANCE</a>	N(1)	1
12	AttendanceDate	Date of attendance	<a href="#">ATTENDANCE DATE</a>	N(10) CCYY-MM-DD	2007-10-31

\*Refers to the horizontal position of the field within CSV format

<sup>‡</sup>AN = Alpha-numeric, N = Numeric, A = Character. Number in brackets denotes the string length.

<sup>±</sup>Example of field content, also used to illustrate extract format expected

## 9 Appendix 2: Summary of format and available coding options for data items collected on the GUMCAD return

Data item	Format and coding options
Clinic ID	Format/length: an5
PatientID	Format/length: an10 Note: This is a number used to identify a <a href="#">PATIENT</a> uniquely within a <a href="#">Health Care Provider</a> . It may be different from the Patient's case note number and may be assigned automatically by the computer system.
KC60	Format/length: an4 <u>National Codes</u> : The national KC60 codes and their definitions are given in table 1 of section 3.
Gender	Format/length: n1 <u>National Codes</u> : 0 Not Known - means that the gender of the person has not been recorded. 1 Male 2 Female 9 Not Specified – means indeterminate, i.e. unable to be classified as either male or female
Age	Format/length: n3 This is usually derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the ATTENDANCE DATE . However, age can be manually entered in the absence of patient date of birth. Not known = 999, i.e. date of birth not known and age cannot be estimated
Sex_Ori	Format/length: n1 <u>National Codes</u> : 1 Heterosexual 2 Homosexual 3 Bi Sexual 9 Not known / Not stated
Ethnicity	Format/length: an2 <u>National Codes</u> : White A British B Irish C Any other White background  Mixed D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background  Asian or Asian British H Indian J Pakistani K Bangladeshi L Any other Asian background

Data item	Format and coding options
	<p>Black or Black British M Caribbean N African P Any other Black background</p> <p>Other Ethnic Groups R Chinese S Any other ethnic group</p> <p>Z Not stated</p>
Country_Birth	<p>Format/length: A(3) Refer to the International Standard of Organisation (ISO) 3166-1 standard for actual list of alphabetic codes and countries. Where country of birth in unknown please record this as <b>ZZZ</b> <b>Note:</b> The 2-char alphabetic code <b>must not be used</b>. Max 3 Characters <b>Reference:</b> <a href="http://www.iso.org/iso/home.htm">http://www.iso.org/iso/home.htm</a></p>
PCT	<p>Format/length: an3 <b>Notes:</b> <a href="#">PCT OF RESIDENCE</a> is the same as the attribute <a href="#">ORGANISATION CODE</a>. Derived from <a href="#">POSTCODE</a> using mapping from the National Administrative Codes Service (NACS). Records where the patient's postcode has not been provided to generate PCT of residence should be allocated to 'not known' and coded "Q99". Postcodes outside of England (overseas visitors, Wales, Scotland or Northern Ireland) should be allocated to 'not applicable' and coded as "X98". <a href="http://www.connectingforhealth.nhs.uk/technical/standards/nacs">http://www.connectingforhealth.nhs.uk/technical/standards/nacs</a></p>
LSOA	<p>Format/length: an9 List of English Lower Super Output Area codes available at <a href="http://www.statistics.gov.uk/geography/soa.asp">http://www.statistics.gov.uk/geography/soa.asp</a> <a href="http://neighbourhood.statistics.gov.uk/dissemination/Info.do?page=SOAConstitutions.htm">http://neighbourhood.statistics.gov.uk/dissemination/Info.do?page=SOAConstitutions.htm</a> There is a Lower Layer Super Output Area for each postcode in England and Wales. Postcodes in Scotland, Northern Ireland, Channel Islands or Isle of Man should be coded "Z99999999". Records where the patient's postcode has not been provided to generate LSOA of residence should be allocated to 'not known' and coded "X99999999". Postcodes outside the United Kingdom should be allocated to 'not applicable' and coded "X99999998".</p>
Attend_type	<p>Format/length: n1 The National Codes for 'FIRST ATTENDANCE' in the NHS Data Dictionary are: 1 First attendance face to face 2 Follow-up attendance face to face 3 First telephone or telemedicine consultation 4 Follow up telephone or telemedicine consultation</p>
AttendanceDate	Format/length: n10 – ccyy-mm-dd