BASHH

# Standards for the Management of Sexual Health in UK Prisons

British Association of Sexual Health and HIV

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# Contents

# Acknowledgements

The British Association for Sexual Health and HIV (BASHH) are delighted to publish these new BASHH Standards for the Management of Sexual Health in UK Prisons. Their development has been made possible thanks to the hard work and expertise of members and co-optees of the BASHH Clinical Standards Unit, the BASHH Prison Special Interest Group, and others (see Appendix A).

It is testament to the importance of these standards that individuals representing professional bodies directly involved in providing sexual healthcare in prisons, and those with strategic responsibilities for ensuring its delivery, were involved in their development.

Particular thanks are due to those who took lead responsibility for shaping sections of the new document, including Dr Sophie Ross and Dr Jesal Gohil, both higher specialty trainees in genitourinary medicine, who were supported by BASHH Educational Fellowships. Thanks are also due to those who provided additional expert advice and the individuals and organisations who took the time to respond to the consultation thus shaping this standards document.

Dr Emily Clarke, Chair BASHH clinical standards unit and Dr Katia Prime, BASHH prison special interest group representative and co-chairs for the BASHH Standards for the Management of Sexual Health in UK Prisons.

# Foreword

## Everyone has a right to healthcare. Those in prison should be able to access the same quality and range of healthcare as would be available in the community. Improving the health of those in prison is a valuable and cost-effective endeavour.

The Standards for the Management of Sexual Health in UK Prisons have been created to promote and support the equity of sexual healthcare for those in UK prisons. Those in prison should have rapid access to sexual health care; appropriate assessment of their sexual health needs with the most appropriate tests and timely results; their confidentiality should be maintained; they should receive good quality services from adequately trained staff; and where needed, be referred on to other specialities. To fully understand the barriers faced and the needs of those affected, people in prison need to be included in the development of sexual healthcare services in prisons.

The standards will support commissioners, healthcare providers and those in prison to ensure sexual health care provision in prison settings mirrors that of the community. Additional measures are outlined in the standards to promote equity of care, such as opt-out screening for blood borne viruses on arrival and further discussion at 14 days. Screening on arrival at each secure unit will help overcome the rapid turnover and sometimes frequent movement of those in prison.

We are delighted to present the BASHH standards which will enable and promote the very best sexual health care within UK prisons to ensure there is limited morbidity, mortality and transmission of sexually transmitted infections in prison settings.

**Dr Claire Dewsnap**
**President of the British Association for Sexual Health and HIV (BASHH)**

**Dr Susanna Currie**
**Chair of the BASHH Prison Special Interest Group**

# Executive summary

**People in prison experience a disproportionate burden of ill health, which is often compounded by social deprivation. Information on the sexual health needs of people in prison is not consistently collected, however people in prison frequently experience risk factors for poorer sexual health, such as substance misuse and mental health conditions. Improving the sexual health of this vulnerable population requires effective commissioning of services and access to high quality care, equitable to that provided to the general population.**

In recognition of this, the British Association of Sexual Health and HIV (BASHH) developed these *Standards for the management of sexual health in UK prisons,* adapted from the BASHH *Standards for the management of sexually transmitted infections (STIs)*, to support commissioners and providers in achieving high quality sexual health services for people in prison.

Representing current best practice, they are intended for use by all services who provide sexual healthcare in prisons, whether by sexual health specialist services, or primary care services. Sexual health primarily concerns the management of simple and complex sexually transmitted infections (see Appendix B) and blood-borne viruses. However other aspects, for example simple contraception, genital dermatoses, genital pain syndromes and psychosexual issues, are also addressed. Whilst the standards are written to be applicable to the commissioning system in England, their clinical recommendations are relevant for Scotland, Wales and Northern Ireland.

The nine standards bring together current guidance and contextualise these to the prison setting, taking into account the unique challenges and opportunities posed by providing sexual healthcare for people in prison. In order to achieve alignment with National Institute for Health and Care Excellence (NICE) and other BASHH quality standards, each standard contains: a quality statement; quality measures; quality standards and implications for commissioners, service providers, healthcare professionals, non-registered healthcare workers and people in prison.

The nine standard statements are outlined below:

**Standard 1 – Access**

People in prison with needs relating to sexual health, whether they have symptoms or not, should have rapid access to confidential services. It is accepted that, within most prison settings, walk-in services are unlikely to be appropriate. However, people in prison should be able to access sexual healthcare, without the need for a referral from primary care.

Routine STI screening in sexual health services should be rapidly available to all people in prison, through self-referral, or referral from another healthcare worker. People requiring specialist sexual health input should have access to an appropriate service, either delivered in-house or externally. People with a clinically urgent need should be seen as soon as possible, or should have access to specialist advice, using out of hours services where necessary. Consultations should be private and confidential. Except in exceptional circumstances, people in prison should expect a consultation to take place without a prison service escort present in the room.

All people in prison should have access to:

a. condoms, dental dams and water -based lubricants in line with national policies[1] and local practice.

b. pregnancy testing, contraception and emergency contraception according to their needs.

c. information and advice about safer sex.

d. STI testing and treatment including for HIV and hepatitis.

e. the National Chlamydia Screening Programme where eligible.

f. the National Cervical Screening Programme where eligible.

g. HIV prevention strategies including post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP).

h. Sexual Assault Referral Centres (SARCs).

i. specialist genitourinary medicine services, either in-house or externally.

j. associated specialist care when required (e.g. dermatology, gynaecology, antenatal, abortion services, urology).

k. vaccination against hepatitis A, B, Human Papilloma Virus (HPV) where indicated, and any appropriate infection containment vaccination programmes equal to community populations.

Access routes should make provision for people in prison who may experience barriers to access, including, but not limited to, people who experience low literacy skills, physical or learning disabilities, sensory impairment, neurodiversity, or for whom English is not their first language.

**Standard 2 – Clinical assessment**

The medical assessment of people in prison should include appropriate assessment of sexual health. Opt-out testing for HIV, hepatitis B and hepatitis C should be offered to all at first or second stage assessments, with those who decline followed up with a discussion about risks and benefits at 14 days. For those that continue to decline the offer of a test, any subsequent contact with prison healthcare services should be considered an opportunity to re-offer sexual health screening. Assessment of pregnancy risk should form part of first stage health assessment with emergency contraception available. Pregnancy testing should be offered at both first and second stage health assessment, as appropriate.

People in prison with needs relating to sexual health should have an appropriate medical and sexual history taken, and those with genital symptoms should be recommended a genital examination. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV. Assessment should include: HIV risk, and where required HIV prevention methods, such as PrEP, PEP and condoms, should be available in a timely manner; a vaccination history, with assessment of risk for viral hepatitis and human papilloma virus (HPV) infection, with vaccination offered where eligible. Re-screening should be recommended at intervals based on ongoing risk, in according with relevant BASHH guidelines.

Where applicable, people in prison should be asked about participation in the National Cervical Screening and National Chlamydia Screening programmes and should be able to access these in prison. Assessment should include routine enquiry into gender-based violence and people who disclose sexual assault, recent or historic, should be supported to access appropriate services including a Sexual Assault Referral Centre (SARC). People with the potential for pregnancy should be offered a contraception consultation and supply of any chosen contraceptive method prior to leaving prison.

**Standard 3 – Diagnostics in prison services**

People in prison being tested for STIs should have access to the most appropriate diagnostic tests. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately. Robust processes should be in place to ensure timely transit of samples to the laboratory. Governance pathways should be developed to ensure all results are appropriately acted on. People in prisons should have recourse to access their own results.

**Standard 4 – Clinical management**

People in prison who undertake sexual health testing should result receive their results, both positive and negative, within eight working days, unless supplementary testing is needed. Those diagnosed with an infection or requiring vaccination should receive prompt treatment (within three weeks of a test being taken), and be managed according to BASHH national guidelines, including the provision of partner notification (PN). If treatment cannot be provided in the prison service, a robust pathway should be in place to ensure timely transfer to an appropriate service for management. Providers have a responsibility to ensure that the results of tests taken in prison are communicated to people who subsequently move facilities or are released, to ensure continuity of care.

**Standard 5 – Information governance**

Providers of sexual health services in prison must ensure information collected about service users remains secure and is only shared for legitimate reasons: in the individual's or public's best interest or, suitably anonymised, for mandatory reporting purposes.

**Standard 6 – Clinical governance**

People in prison should receive sexual healthcare from high quality services that are safe, well-managed and equitable to services in the community.

**Standard 7 – Appropriately trained staff**

People in prison with needs relating to sexual health should have their care managed by individuals with appropriate knowledge, skills and attitudes. Ideally this should be healthcare professionals who regularly work in a specialist Level 3 GUM service, with experience in managing sexual health, complex sexually transmitted infections, blood borne viruses, genital dermatoses, contraception, genital pain syndromes and psychosexual issues. If this is not the case then explicit links to the local specialist Level 3 GUM service should be in place to ensure access to, advice or timely review by, suitably experienced individuals.

**Standard 8 – Links to other services**

People needing to be referred to another service for ongoing STI management should have this arranged promptly. Similarly, people with any other sexual health needs that the prison is unable to meet should experience easy and timely referral to a suitable service in line with national standards (e.g. HIV treatment and care within 14 days, emergency IUD insertion within 5 days), including for interventions to promote good health (e.g. peer support services). Before release from prison, arrangements for an individual's ongoing care and support should be in place to ensure continuity of service provision.

**Standard 9 – Patient and public engagement**

People in prison need to be consulted about the development and delivery of sexual health services in prisons. Those using services should be asked to provide feedback to promote patient centred care, with feedback regularly reviewed and acted on to improve services.

# Introduction

## The British Association for Sexual Health and HIV (BASHH) is the professional body which represents the medical specialty of genitourinary medicine. This document sets out the *Standards for the management of Sexual Health in UK Prisons*. It complements the 2019 publication of the *BASHH Standards for the management of sexually transmitted infections (STIs)*[1].

The standards are intended for use in all United Kingdom (UK) prisons where sexual health is provided. While written to be applicable to the commissioning and legal system in England, their clinical recommendations also apply across the other nations in the UK (Scotland, Wales and Northern Ireland). Separate standards for sexual health services in Scotland were produced by NHS Quality Improvement Scotland[2] and were informed by the BASHH *Standards for the management of sexually transmitted infections (STIs)*[1].

Variations exist in each nation with respect to sexual health services including: the legal/governance frameworks; commissioning; healthcare priorities; and systems for data collection. The standards in this document, particularly in overlapping areas, should not supersede any existing standards or equivalent legislation/guidance in other legal jurisdictions particularly in the devolved nations. However, in areas unaddressed, they may be regarded as national standards.

### Standards for the management of sexual health in UK prisons

#### Background

People in prison have the right to healthcare services that are equivalent to those available for the rest of the population. It is recognised that differences and variations exist in the provision of sexual health within UK prisons. Therefore, the British Association for Sexual Health and HIV (BASHH) identified the need for the development of sexual health standards to ensure consistent and high-quality care is provided.

These are the first national standards specifically for the management of sexual health in UK prisons and reflect current best practice.

#### Standards review process

The BASHH Clinical Standards Unit (CSU) and Prison Special Interest Group (SIG) established a writing group for each standard and a strategic group to develop these. Each writing group comprised a BASHH educational fellow, members of the CSU and SIG, along with additional individuals with specific expertise in that area who provided on-going consultation and feedback. The strategic group comprised relevant stakeholders and included multidisciplinary membership across the 4 UK Nations with service user representation. Once the standards were drafted by the writing group, the strategic group met three times during the year and all members were given an opportunity to comment on subsequent drafts. See Appendix A for the names and designations of strategic group members.

#### Consultation

Following development of the draft, the standards underwent a period of consultation. They were made available on the BASHH website with a feedback form open to all for completion. Relevant stakeholders were invited to respond. The consultation process lasted for three weeks in September 2022. All feedback from the consultation was considered by the strategic group and informed final revisions.

### Future updating of the standards

To ensure its content remains applicable and up to date, a review and updating of this document is intended within five years of publication.

It should be noted that some of the legislation may be updated in the near future. When legislation or guideline or policy documents are revised, or new legislation or guidance or policy is published, the latest version should be used.

## The management of sexual health in UK prisons

### Context

Currently in the United Kingdom, NHS England commissions sexual health services in England. In Wales and Scotland, prison health services, including sexual health, are commissioned by regional Health Boards. The Department of Health in Northern Ireland conducts this role.

Healthcare services in prison should be equivalent to those available to the wider community. People in prisons are more likely to experience multiple risk factors for sexual ill-health[3]. However, information relating to the sexual health needs of people in prison is not consistently collected. BASHH advocates consistent data collection and reporting in order to inform the planning and commissioning of sexual health services.

NICE guidelines for the *Physical health of people in prisons*, which apply to England, Wales and Northern Ireland, recommend a first stage health assessment for each person on reception into prison[3]. These first assessments identify immediate health needs. People should be asked about HIV, hepatitis B and C and other sexually transmitted infections (STIs), to allow initiation or continuation of any required treatments, as well as an assessment of pregnancy risk.

Within the first seven days, a second stage health assessment should be undertaken. At this assessment, information should be collected including the date of previous sexual health screening and individuals should receive tailored sexual health advice. In Scotland an immediate health needs assessment is also undertaken on reception into prison. The schedule of subsequent health assessments may differ between facilities. NICE recommend that people identified as at high risk of STIs should have further discussions with a trained sexual health practitioner[3].

These standards will support commissioning of sexual healthcare in UK prisons by providing a framework for delivery of consistent, evidence based, safe and high-quality care. Commissioners and service providers are urged to disseminate the standards widely and work closely with prison services to ensure their implementation.

### Public health outcomes

Sexual health services have a strong public health role. Prompt detection and management of STIs reduces morbidity, including the development of long-term complications as well as breaking the cycle of onwards transmission. Reflecting this, the *Public Health Outcomes Framework*[4] contains three indicators to measure progress in the effective management of STIs:

a. New STI diagnoses (excluding chlamydia in people under the age of 25)

b. chlamydia diagnoses in 15-24 year olds

c. people presenting with HIV at a late stage of infection.

### Elements of STI management

The *Standards for the management of sexually transmitted infections (STIs)*[1] describes three levels of care for the management of STIs – Levels 1 (asymptomatic), 2 (symptomatic) and 3 (complex/specialist). All elements of care in all three levels should be commissioned and available to people in all UK prisons. Appendix B proposes a list of the elements of STI management which should be included at each of the three levels. The list was updated with consensus from all professional groups as part of the development of the 2019 *Standards for the management of sexually transmitted infections (STIs)*[1].

Sexual health services in prison should complement local community sexual health services. They may also provide specific elements of care tailored to prison populations.

The standards are not prescriptive regarding who can deliver which elements of care as this will be dependent on:

- the local needs assessment
- the clinical competence of clinicians delivering the service
- the service being provided
- the specific contract arrangements.

It is likely that across the commissioned area, different elements of care will be delivered by a range of staff from different professional backgrounds based on individual competency levels. Staff will work in a range of settings including primary care, hospital and community-based specialist services, sexual and reproductive health (SRH) services and genitourinary medicine services (GUM), as well as education, youth and the voluntary sector. Primary care providers may be commissioned to provide some elements of STI management at Levels 1 and 2.

### Specialist sexual health services (Level 3)

Only a service led by a consultant on the specialist register of the General Medical Council (GMC) for Genitourinary Medicine (GUM) and offering a comprehensive range of STI services spanning all three levels, can be defined as being a specialist Level 3 GUM service. This also includes services led by consultants who have gained a Certificate of Eligibility for Specialist Registration (CESR) in GUM, who also appear on the specialist register of the GMC for GUM.

Ideally a healthcare professional who regularly works in a Level 3 GUM service, should provide care for people in prisons. If this cannot be provided, explicit pathways and links should exist with local Level 3 GUM services. Similarly, clinical leadership for the management of contraceptive care across the commissioned area should ideally be provided by services led by consultants in Community Sexual and Reproductive Health (CSRH).

### Equality, diversity and inclusion

Following publication of the *Equality Act* in 2010 the Public Sector Equality Duty came into force in 2011[5].This identifies protected characteristics requiring commissioners and service providers to ensure that each and every individual receives a comprehensive and equal service regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Equivalent legislation exists in the devolved nations.

The Public Sector Equality Duty requires public bodies to fulfil their wider social duty to promote equality through the services they commission, paying particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. Prison populations are one such group.

Providers should ensure the sexual health services in prisons meet their equality duty, paying particular attention to sensitivities relating to culture, sexuality and disability, when taking a sexual history and performing an examination.

All prison sexual health services should be able to meet special communication needs for those who experience barriers to access, including, but not limited to, people who experience low literacy skills, physical or learning disabilities, sensory impairment, neurodiversity, or those for whom English is not their first language. For example, by providing translators or interpreting services and information in non-written formats.

Issues relating to equality, diversity and inclusion are relevant to all the standards: specific reference is therefore not made in each individual standard.

## The Standards

The standards cover all the key principles of sexual health provision in UK prisons. They bring together and contextualise existing guidance and are therefore derived from the best available evidence. Representing current best practice, the standards are intended for use in all UK prisons.

### Scope of the standards

The standards cover all aspects of the management of sexual health including the diagnosis and management of STIs in prisons and the broader public health role of infection prevention and control. Some aspects of reproductive health such as contraception, emergency contraception and pregnancy testing are also included, and standards are aligned to those produced by the Faculty of Sexual and Reproductive Health (FSRH)[6].

The standards cover issues for commissioners, service providers, healthcare professionals, non-registered healthcare workers and people in prisons. Whilst BASHH recommends these Standards as best practice, their implementation is reliant on joint working by commissioners, service providers and healthcare workers.

The management of sexual health in people living with HIV is within the scope of the standards and is critical for the maintenance of both individual and public health. Collaboration will be needed between the respective commissioners of sexual health and HIV treatment and care, to ensure that people in prisons living with HIV have timely access to high quality sexual health services.

Sexual assault is included only in relation to HIV infection prophylaxis and specimen transport. However, standards relating to the management of sexual assault are available from BASHH[7].

The standards apply to all categories of prison and should apply to all people in prison, including those released on temporary licence. They are not intended to cover wider places of detention such as immigration removal centres but, many of the standards may be applicable to these locations.

The standards were not written considering children under the age of 18 resident in the children and young people secure estate, including Young Offenders Institutions (YOIs), Secure Training Centres and Secure Children's Homes, but many of the standards will be applicable to these groups. The Royal College of Paediatrics and Child Health have published *Healthcare Standards for Children and Young People in Secure Settings*[8], and BASHH would recommend that settings consider the applicability of both documents to these settings.

The following are outside the scope of the prison standards:

a. Complex contraception and reproductive healthcare, and related service issues including child protection. The FSRH published updated *Service Standards for Sexual and Reproductive Healthcare* in 2016[9]. It is anticipated that commissioners of prison sexual health services will use this document as well as the FSRH service standards[6] when commissioning sexual health services in prisons.

b. Issues relating to reproductive health such as pregnancy, abortion and menopause. Relevant guidance is available from the Royal College of Obstetricians & Gynaecologists (RCOG)[10] and NICE[11].

c. HIV treatment and care, which is covered by the British HIV Association (BHIVA) Standards of care for people living with HIV 2018[12]. However, sexual health providers play an important role in the prevention and detection of HIV infection. The standards therefore include a range of interventions such as condom promotion and distribution, widespread HIV testing and provision of accurate information on risk reduction for all STIs, including HIV, as well as the provision of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) after sexual exposure to HIV.

d. Mental health, drug and alcohol care, except identification as part of routine sexual history taking.

e. Management of gender based violence (GBV) and intimate partner violence (IPV) except identification as part of routine sexual history taking. Relevant guidance is available from NICE[13], BASHH[14] and the Home Office[15].

f. Female Genital mutilation (FGM) which is illegal in the UK. Relevant guidance is available from the RCOG[16].

g. Health considerations for transgender people, beyond their sexual health needs.

**Structure of each standard**

In order to achieve greater alignment with the National Institute for Health and Care Excellence (NICE) quality standards[17], each standard contains:

- A quality statement
- Quality measures
- Quality standards
- Implications for different audiences
- Supporting information
- References

The *quality statement* describes key markers of high-quality care and where appropriate promotes an integrated approach to improving quality.

The *quality measures* and *quality standards* aim to improve care outcomes and where possible are based on existing national standards (most are the same as those included in the BASHH *Standards for the management of sexually transmitted infections*[1]). They will assist commissioners and providers of outreach services to measure performance against key indicators and thereby benchmark standards of care. Many of these measures can be collected via existing mandatory reporting datasets (see Appendix C), proof of compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[18] or established audit templates (see www.bashh.org).

What the *quality statement* means for each audience describes the responsibilities of commissioners, service providers, healthcare professionals and non-registered healthcare workers and the implications for people with needs relating to STIs.

The *supporting information* contains important facts, evidence and currently accepted best practice in relation to the content of the quality statement and implications for different audiences.

The supporting *references* are listed at the end of each standard.

### Language

The language used throughout the document reflects suggestions made by consumer forums responding to consultation for the S*tandards for the management of sexually transmitted infections (STIs)*[1].

Sexual health primarily concerns the management of simple and complex sexually transmitted infections (see Appendix B) and blood-borne viruses. However other aspects, for example simple contraception, genital dermatoses, genital pain syndromes and psychosexual issues, are also included. These mirror the curriculum requirements which enable GMC registration as a physician in Genitourinary medicine[19].

'Healthcare professional' is defined as an individual with a registered healthcare qualification e.g. doctor, nurse or pharmacist.

'Non-registered healthcare worker' is defined as an individual without a registered healthcare qualification involved in the delivery of healthcare.

The term 'must' and 'should' indicate how much flexibility commissioners, service providers, healthcare professionals and staff working in services, have in following the guidance. 'Must' is used for an overriding duty or principle. This means it is a legal requirement or a fundamental standard of ethical conduct applying in all situations. 'Should' is used where there is no legal requirement, but it is strongly recommended as best practice within this document.

### How the standards can be used

As with NICE quality standards, these standards can be used for a wide range of purposes both locally and nationally. For example:

a. commissioners can use the standards to ensure that high quality services and care are commissioned through the contracting process or to incentivise provider performance.

b. service providers can quickly and easily examine the performance of their service and, where appropriate, highlight areas for improvement.

c. Healthcare professionals and non-registered healthcare workers will be assisted in making decisions about care based on the latest evidence and best practice.

d. People in prisons receiving care can use the standards to find information about the type of services and the care they should receive.

The standards, in conjunction with the guidance on which they are based, should contribute to the outcomes outlined in the following frameworks:

- *NHS Public Health Outcomes Framework*[4]
- *NICE Sexual Health Quality Standard*[20]
- *NICE physical health of people in prisons Quality Standard*[3]

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# STANDARD 1

# Access

## 1.1 Quality statement

People in prison with needs relating to sexual health, whether they have symptoms or not, should have access to People in prison with needs relating to sexual health, whether they have symptoms or not, should have access to confidential services. It is accepted that, within most prison settings, walk-in services are unlikely to be appropriate, however people in prison should be able to access sexual healthcare, without the need for a referral from primary care. Ideally access to services should be rapid, especially for those with symptoms. BASHH define rapid access as within 2 working days, and urgent access as within 4 hours.

Routine STI screening in sexual health services should be rapidly available to all people in prison, through self-referral, or referral from another healthcare worker. People requiring specialist sexual health input should have access to an appropriate service, either delivered in-house or externally.

People with a clinically urgent need should be seen as soon as possible, or should have access to specialist advice, using out of hours services where necessary. Consultations should be private and confidential. Except in exceptional circumstances, people in prison should expect a consultation to take place without a prison service escort present in the room.

All people in prison should have access to:

a. condoms, dental dams and water -based lubricants in line with national policies[1] and local practice.
b. pregnancy testing, contraception and emergency contraception according to their needs.
c. information and advice about safer sex.
d. STI testing[2] and treatment including for HIV and hepatitis.
e. the National Chlamydia Screening Programme where eligible.
f. the National Cervical Screening Programme where eligible.
g. HIV prevention strategies including post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP).
h. Sexual Assault Referral Centres (SARCs).
i. specialist genitourinary medicine services, either in-house or externally.
j. associated specialist care when required (e.g. dermatology, gynaecology, urology).
k. antenatal services when required.
l. abortion services when required.
m. vaccination against hepatitis A, B, Human Papilloma Virus (HPV) where indicated, and access to any appropriate infection containment vaccination programmes equal to those in the community.

Provision should be made for people in prison who experience barriers to access, including but not limited to, people who experience low literacy skills, physical or learning disabilities, sensory impairment, neurodiversity, or those for whom English is not their first language.

## 1.2 Quality measures

**1.2.1** People in prison should have access to healthcare professionals or non-registered healthcare workers who are appropriately trained in sexual health. Prison healthcare services are expected to deliver aspects of routine sexual health in line with their contractual requirements. The model of service should also ensure that access to appropriate levels of service (as defined in national standards[1,3]) are available and accessible to all people in prison. There should be clear and accessible pathways from prison healthcare services to the local specialist Level 3 GUM services.

**1.2.2** Providers should have in place an effective triage system to identify those whose needs are clinically urgent, those who can be managed by non-specialist healthcare professionals in-house and those who require specialist sexual healthcare.

**1.2.3** People in prison requesting PEP should be seen within four hours of making their request, by someone able to make an assessment as to the need for PEP and provide it via prescription or Patient Group Direction (PGD). This includes requests made out of hours.

**1.2.4** People in prison should be informed of how they can request access to sexual health services following the first stage assessment on reception into prison.

**1.2.5** The prison sexual health service should be linked to a specialist Level 3 GUM service for ongoing management or advice within two working days of first presentation. If the Level 3 service is not local, then a referral pathway with the nearest Level 3 GUM service should be agreed and in place.

## 1.3 Quality standards

**1.3.1** Healthcare professional or non-registered healthcare worker trained in sexual health available on each working day.
Standard 100%

**1.3.2** Effective triage system operating on each working day.
Standard 100%

**1.3.3** Seen within four hours of requesting PEP.
Standard 98%*

**1.3.4** Informed of how to access sexual health services at first stage health assessment following reception into prison:
Standard 98%*

**1.3.5** Evidence of a referral pathway for ongoing management or advice with a local specialist Level 3 GUM service within two working days of first presentation.

*This translates to 1 error per 40 audited cases

## 1.4 What the quality statement means for each audience

### Responsibilities for commissioners

**1.4.1** Service specifications and contracts for services commissioned to provide sexual health services in prisons should be explicit in their expectations in relation to:

a. rapid and open access.

b. the requirement for routine monitoring of performance data including access data.

**1.4.2** Commissioning of services should be informed by an up-to-date sexual health needs assessment to ensure services are appropriate to the needs of the prison population.

**1.4.3** Commissioners should be clear about which clinical services are provided by each healthcare provider to ensure comprehensive coverage at Levels 1 (asymptomatic), 2 (Level 1 and symptomatic) and 3 (Levels 1, 2 and complex/specialist). See Appendix B for definitions of the elements of care at each of the three levels.

**1.4.4** Commissioners should ensure that people in prison have equitable access to:

a. condoms, dental dams and water-based lubricants in line with local policies[1].

b. pregnancy testing, contraception and emergency contraception according to their needs.

c. information and advice about safer sex.

d. HIV[2], hepatitis and STI testing and treatment.

e. the National Chlamydia Screening Programme where eligible.

f. the National Cervical Screening Programme where eligible.

g. HIV prevention strategies including PEP and PrEP for all genders.

h. Sexual Assault Referral Centres (SARCs).

i. specialist GUM services, either in-house or externally.

j. associated specialist care when required (e.g. dermatology, gynaecology, urology).

k. antenatal services when required.

l. abortion services when required.

m. vaccination against hepatitis A, B, Human Papilloma Virus (HPV) where indicated, and access to any appropriate infection containment vaccination programmes equal to those in the community.

**1.4.5** Commissioners should ensure that all prison sexual health services are linked with a local specialist Level 3 GUM service for appropriate further management. This should include provision of specialist advice and in person review as required.

**1.4.6** Commissioners with the service provider should review performance data on a regular basis, for assurance that the service is meeting the needs of patients and so that opportunities for service improvement can be identified. This should include the utilisation and effectiveness of referral pathways to Level 3 GUM services.

**Responsibilities of service providers**

**1.4.7** All providers of services commissioned to manage sexual health in prisons should:

a. following reception into prison, inform people of how to access sexual health services at the first stage assessment.

b. clearly advertise the opening times, procedure for requesting an appointment and range of services that can be accessed in the prison sexual health service in places relevant to people in prison.

c. make face-to-face services available through self-referral (open access).

d. provide appropriate opening hours, which take into account times at which movement of people in prison is restricted.

e. provide urgent access for those who clinically require it. Where this runs into times outside of normal service hours, people should be referred to appropriate out-of-hours services.

f. use a triage system to maintain access for those who are most at risk, and/or vulnerable.

g. have mechanisms to record, monitor and report performance data, including access data.

h. establish clear referral pathways to other relevant services including local specialist Level 3 GUM services.

i. regularly review demand for services and be prepared to respond to changing health needs of people in prison.

j. work with prison teams to ensure transport and escort arrangements are in place, if needed. To prevent delay in access to specialist care.

k. provide access to condoms in way that ensures privacy for the person in prison.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**1.4.8** All healthcare professionals and non-registered healthcare workers working in services commissioned to manage sexual health in prisons should:

a. understand the public health rationale underpinning a rapid and open access model of care.

b. clearly inform people in prison of the range of services that can be accessed in each setting and signpost them to the most appropriate service to meet their needs.

c. understand and utilise referral pathways when emerging needs are identified and cannot be met within the existing service.

d. have mechanisms to record, monitor and report performance data, including access data.

**People in prison**

**1.4.9** Should be made aware of how to access sexual health services at the first stage health assessment following reception into prison and the scope of these services.

**1.4.10** Should be able to request a sexual health appointment without needing to access a General Practitioner (GP) first.

**1.4.11** Should have access to:

a. condoms, dental dams and water-based lubricants in line with national policies and local practice[1].

b. pregnancy testing, contraception and emergency contraception according to their needs.

c. information and advice about safer sex.

d. HIV[2], hepatitis and STI testing and treatment.

e. the National Chlamydia Screening Programme where eligible.

f. the National Cervical Screening Programme where eligible.

g. HIV prevention strategies including PEP and PrEP for all genders.

h. Sexual Assault Referral Centres (SARCs).

i. specialist genitourinary medicine, either in-house or externally.

j. associated specialist care when required (e.g. dermatology, gynaecology, urology).

k. antenatal services as required.

l. abortion services as required.

m. vaccination against hepatitis A, B, Human Papilloma Virus (HPV) where indicated, and appropriate infection containment vaccination programmes equal to those in the community.

**Supporting information**

**1.5.1** In England, prison sexual health services are commissioned by NHS England. In Wales and Scotland, prison health services, including sexual health, are commissioned and delivered by the Health Board local to the prison. This role is fulfilled by the Department of Health in Northern Ireland. Commissioning guidance states that healthcare services in prison should be equivalent to those available to the wider community[4]. It is acknowledged that although services may not be provided in exactly the same way, the principles of open and rapid access remain fundamental[4]. Information on the sexual health needs of people in prison is not consistently collected. However, as a population who are more likely to experience multiple risk factors for sexual ill-health[5], this information is essential for the planning of sexual health services and up-to-date assessments of need.

**1.5.2** Open access is the ability of any individual to directly access sexual healthcare without the need for a referral. This is a fundamental principle of sexual health provision as it offers people ease of access and some level of confidentiality. The application system may provide an appropriate way for people in prison to request direct access to sexual health services, however confidentiality may not be assured. Therefore, a person should not be required to specify their reason for requesting a sexual health appointment when using this system.

**1.5.3** Rapid access is a key quality measure in sexual health[6,7] as early access to STI testing and treatment breaks the chain of onwards transmission. It is acknowledged that not all prisons will have in-reach provided by specialist Level 3 GUM services and therefore the need for clear and accessible referral pathways to specialist sexual healthcare services are essential. Some patients will have clinically urgent needs, for example for PEP. These situations require rapid assessment and management, and it may not be practicable to transfer the patient to an external service in a timely manner. Prison healthcare services must therefore have the appropriate knowledge, skills and access to medications to manage these urgent presentations in-house, including out-of-hours, with advice sought from specialist services as required.

**1.5.4** The sooner PEP is started following HIV exposure, the greater its efficacy. BHIVA guidelines state that PEP should be initiated as soon as possible and recommend that PEP is available via a 24-hour service to achieve this[8]. Training of all prison healthcare staff on PEP and robust pathways for seeking specialist advice out-of-hours, as well as keeping PEP drugs on site and being able to provide them via PGD, will ensure that people in prison have timely access to PEP within 4 hours of presentation even when presenting out of hours. The Specialist Pharmacy Service (SPS), BASHH and BHIVA have created a PEP PGD template which may be adapted by services[9] (see Appendix D).

**1.5.5** People in prison have lower levels of literacy than the general population[10] which may present an additional barrier in accessing healthcare and providing health information.

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# STANDARD 2

# Clinical assessment

## 2.1 Quality statement

The medical assessment of people in prison should include appropriate assessment of sexual health. Opt-out testing for HIV, hepatitis B and hepatitis C should be offered to all at first or second stage health assessments with those who decline followed up with a discussion about risks and benefits at 14 days. For those that continue to decline the offer of a test, any subsequent contact with the prison healthcare services should be considered an opportunity to re-offer sexual health screening. Assessment of pregnancy risk should form part of the first stage health assessment with emergency contraception available. Pregnancy testing should be offered at both first and second stage health assessments with onward referral to antenatal and abortion services made as appropriate.

People in prison with needs relating to sexual health should have an appropriate medical and sexual history taken, and those with genital symptoms should be recommended a genital examination. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV. Assessment should include: HIV risk, and where required HIV prevention methods, such as PrEP, PEP and condoms, should be available in a timely manner. An immunisation history, with assessment of risk for viral hepatitis and human papilloma virus (HPV) infection should take place and vaccination offered where eligible. Re-screening should be recommended at intervals based on ongoing risk, in accordance with relevant BASHH guidelines[1].

Where applicable, people in prison should be asked about participation in the National Cervical Screening Programme and National Chlamydia Screening Programme and should be able to access these whilst in prison. Assessment should include routine enquiry into gender-based violence and people who disclose sexual assault, recent or historic, should be supported to access appropriate services including a Sexual Assault Referral Centre (SARC). People with the potential for pregnancy should be offered a contraception consultation and supply of any chosen contraceptive method prior to leaving prison.

## 2.2 Quality measures

**2.2.1** The percentage of people in prison who have a relevant sexual history documented, as defined by BASHH guidelines[2], at first or second stage health assessment on reception into prison.

**2.2.2** The percentage of people who are asked specifically about current hepatitis B or C, HIV, syphilis and other sexually transmitted infections at the first stage health assessment on reception into prison.

**2.2.3** The percentage of people who are offered opt-out testing for HIV, hepatitis B and C on first reception into prison (with the exception of those already known to be living with these conditions).

**2.2.4** The percentage of people who decline blood borne virus testing who attend a follow up appointment at 14 days at which they are re-offered blood borne virus testing.

**2.2.5** The percentage of people who have an immunisation history, including history of hepatitis B and, where eligible, hepatitis A and human papilloma virus immunisation, documented at first or second stage health assessment.

**2.2.6** The percentage of people with the potential for pregnancy who are assessed for pregnancy risk and other reproductive needs (sexual, menstrual, contraceptive) at first stage health assessment, on reception into prison, and appropriately offered emergency contraception with pregnancy testing at 21 days.

**2.2.7** The percentage of people with the potential for pregnancy who are offered a pregnancy test at first and second stage health assessment.

**2.2.8** The percentage of eligible people who are offered cervical screening following the second stage health assessment.

**2.2.9** The percentage of eligible people who are offered chlamydia screening following the second stage health assessment.

**2.2.10** The percentage of people in prison with needs relating to sexual health who are offered screening for chlamydia, gonorrhoea, syphilis and HIV at first attendance.

**2.2.11** The percentage of people in prison with needs relating to sexual health who are asked about gender-based violence.

**2.2.12** The percentage of women and other people of childbearing potential who are offered a contraception consultation prior to leaving prison.

**2.2.13** Competence to deliver services:

Compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[3] or equivalent legislation in the devolved nations:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 15: Premises and equipment

## 2.3 Quality standard

**2.3.1** Sexual history documented.
Standard 97%*

**2.3.2** Asking about HIV, syphilis, hepatitis B and C and current STIs at first stage health assessment.
Standard 97%*

**2.3.3** Offered opt-out testing for HIV, hepatitis B and hepatitis C at first stage health assessment.
Standard 97%*

**2.3.4** Attend a follow up appointment at 14 days, if eligible.
Standard 80%

**2.3.5** Immunisation history documented.
Standard 97%

**2.3.6** Assessed for pregnancy risk (sexual, menstrual and contraceptive history) and offered emergency contraception if eligible.
Standard 97%*

**2.3.7** Offered pregnancy test if clinically indicated.
Standard 97%*

**2.3.8** Offered cervical screening if eligible.
Standard 97%*

**2.3.9** Offered chlamydia screening if eligible.
Standard 97%*

**2.3.10** Offered screening for chlamydia, gonorrhoea, HIV and syphilis at first attendance with needs relating to sexual health.
Standard 97%*

**2.3.11** Asked about gender-based violence.
Standard 97%

**2.3.12** Offered a contraception consultation if the person is of childbearing potential.
Standard 97%*

**2.3.13** Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[3] for regulations 9, 10, 11, 12, 13 and 15 (or equivalent legislation in devolved nations).

*This translates to 1 error per 40 audited cases.

## 2.4 What the quality statement means for each audience

### Responsibilities of commissioners

**2.4.1** Commissioners should ensure that all providers of services commissioned to manage sexual health in prisons:

a. have clinical premises that are fit for purpose, and which offer privacy.

b. deliver optimal standards of clinical care in accordance with BASHH guidelines[1], FSRH standards[4], BHIVA guidelines[5] NICE quality standards for sexual health[6] and NICE guidelines for physical health of people in prisons[7].

c. can provide evidence of confidentiality, safeguarding and vulnerable adults' policies and the training of staff to support these.

**2.4.2** Commissioners should make provision within their commissioned area for 24-hour access to:

a. emergency contraception.

b. PEP.

c. referral pathways into a SARC.

**2.4.3** Commissioners should ensure that all providers of services commissioned to manage sexual health in prisons are able to provide, or have clear onward referral pathways in place for:

a. contraception, including emergency contraception and long-acting reversible contraception (LARC).

b. PEP.

c. PrEP.

d. sexual assault and the 'chain of evidence' process.

e. immunisation against Hepatitis A, Hepatitis B and Human Papilloma Virus (HPV).

f. antenatal care.

g. abortion care.

h. other services/specialties as clinically indicated.

**Responsibilities of service providers**

**2.4.4** All providers of services commissioned to manage sexual health in prisons should ensure that they have appropriate mechanisms in place for:

a. recording of a medical, sexual and immunisation history, including use of contraception and drug and alcohol risk assessment, whether taken by a healthcare professional or self-completed.

b. providing interpreting services where requested or required.

c. identifying people at risk of infection. Incubation periods for STIs should always be considered and indications for re-testing explained.

d. determining when the use of PEP or PrEP is required or should be recommended.

e. performing a genital examination in patients with symptoms, with the offer of an appropriately trained chaperone.

f. collecting specimens for STI testing. Clear instructions should be provided where people self-sample.

g. safe storage and timely transport of specimens to the laboratories.

h. health promotion and prevention interventions including immunisation, encouragement of safer sex behaviour, condom and dental dam usage.

i. onward referral of individuals who require specialist support, beyond that offered in the service, to other services within the commissioned area.

j. implementing confidentiality, safeguarding and vulnerable adults' policies and the training of staff to support these.

k. offering testing for HIV, hepatitis B and C on an opt-out basis[8,9] at the first, and if declined, the second stage health assessment.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**2.4.5** All healthcare professionals and non-registered healthcare workers working in services commissioned to manage STIs should be fully competent (appropriate to role) in:

a. recording a medical, sexual and immunisation history including risk assessment.

b. managing issues relating to confidentiality, safeguarding and vulnerable adults and acting on concerns as appropriate.

c. performing genital examination and STI testing.

d. explaining to people which STI tests have been taken, and how the results will be made available.

e. assessing the need for further STI testing and vaccination as appropriate.

f. onward referral to other services within the commissioned area.

**People in prison**

**2.4.6** Should expect to be asked about their medical, sexual and immunisation history, including history of blood borne viruses and STIs at first stage health assessment on reception into prison. People with the potential for pregnancy should also expect to be asked about their menstrual, contraceptive and pregnancy history and be assessed for pregnancy risk and if appropriate emergency contraception at the first stage health assessment on admission to prison. These questions should be addressed in a sensitive and confidential manner.

**2.4.7** Should expect to be offered testing for HIV, hepatitis B and C on an opt-out basis[8,9].

**2.4.8** Should expect to receive tailored advice about sexual health at their second stage health assessment, including the offer of a contraception consultation for people with the potential for pregnancy, and information about, and appropriate access to STI and HIV prevention strategies including condoms, dental dams, PrEP and PEP.

**2.4.9** If eligible, should be offered cervical screening and chlamydia screening following the second stage health assessment.

**2.4.10** Should be offered appropriate STI testing and vaccination (if indicated). If experiencing symptoms, a genital examination should be recommended, and an appropriately trained chaperone offered.

**2.4.11** Should be informed which infections they have been tested for, and how the results will be made available.

**2.4.12** Should be advised what will happen if they get a positive result, paying attention to concerns they may have about confidentiality.

**2.4.13** Should be referred to other services/specialties as needed.

## 2.5 Supporting information

**2.5.1** NICE guidelines for the *Physical health of people in prisons* apply to England, Wales and Northern Ireland[7]. They make clear that on reception into prison each person should have a health assessment before being allocated to their cell. This is known as the first stage health assessment[7] and its purpose is to identify immediate health needs and health priorities to be addressed at subsequent contacts. The guidelines specify that people in prison should be asked about HIV, hepatitis B and C and other STIs, in order to allow continuation of any required treatments and where appropriate be assessed for pregnancy risk[7].

Following this, but within the first seven days, people in prison should then have a second stage health assessment, to include the date of their last sexual health screen and tailored sexual health advice[7]. HM Inspectorate of Prisons for Scotland's *Standard 9: Health and Wellbeing*[10] is the equivalent guidance for Scotland. This specifies the need for a health assessment on reception into prison, but the schedule of subsequent health assessments may differ between Scottish facilities.

It is essential that people in prison have a thorough assessment of sexual health needs, including an assessment of any time critical needs at the first health assessment on reception into prison e.g. for emergency contraception, PEP or forensic medical examination following sexual assault. It is acknowledged that the first stage health assessment may take place under stressful circumstances, and many people in prison have a significant history of trauma, however by the second stage health assessment the time window for many of these interventions will have passed. Therefore, people should be asked about recent sexual contacts on reception into prison, and where necessary, further questions should be asked about risk of pregnancy, risk of HIV and non-consensual sex, in order to identify individuals with urgent sexual health needs.

**2.5.2** The importance of a trauma-informed care is increasingly recognised in both healthcare and the criminal justice system and is shown to have a beneficial effect on outcomes. Practitioners need to be aware of how experiencing sexual trauma may have an impact on how an individual seeks support or is able to talk about their sexual health. The principles of safety, empowerment, choice, collaboration and trust are a framework to apply. NHS Scotland has produced a toolkit to support the development of trauma informed services[11].

**2.5.3** People in prison have the right to healthcare services that are equivalent to those available to the wider community, however it is acknowledged there may be differences and variations in the way sexual health is delivered in prisons[12]. Where services are not available in-house (e.g. for PrEP or certain contraceptive methods) there must be robust referral pathways in place to ensure people in prison are able to access appropriate services.

**2.5.4** Continuity of care is needed for those who need to start or continue long-term treatments including PrEP and treatments for blood borne viruses including antiretroviral therapy (ART) for HIV and treatments for hepatitis B and C. Other treatments which may require starting or continuing include contraceptive methods, antiviral suppression for herpes simplex virus, or other long-term medications for sexual healthcare. In addition to provision whilst in prison, these should be considered as part of the pre-release assessment.

**2.5.5** People in prison may be at increased risk of blood borne viruses, sexually transmitted infections and other infections which can be prevented with vaccination. Further information on risk factors and immunisation schedules is available in the *Green Book: Immunisation against infectious diseases*[13].

### Confidentiality

**2.5.6** People in prison are entitled to the same level of confidentiality in healthcare as the wider population. However, people in prison living with HIV frequently cite confidentiality as a major concern[14], and it is likely this extends to people with other blood borne viruses and sexually transmitted infections. Providers of sexual health services in prisons must take into account nuances in prison life that may impact on the confidentiality of health information, for example a reluctance to take patient information leaflets due to shared cells and the possibility of unannounced cell inspections. Any concerns should be sought out and managed accordingly, so that these do not act as a barrier to engagement with sexual healthcare services.

### Reproductive health in prison

**2.5.7** Evidence from the USA shows that women in prison are at high risk of unplanned pregnancy, that they desire access to contraception and that the provision of this prior to release may help prevent unplanned pregnancies[15]. The majority of women serve short sentences (<12 months) or are held on remand in prison[16] and therefore the second stage health assessment is an appropriate time to offer a contraceptive consultation to ensure that this can be implemented prior to release. Long-acting reversible contraceptives (LARCs) are highly effective methods with minimal user dependence, and may be useful for people in prison, who often experience intersecting vulnerabilities, therefore information about them and initiation should be available in the prison setting. Providers should take into account that some people in prison may have concerns about being coerced to use contraception, mindful of the history of forced sterilisation in prisons and other institutions[17]. Therefore, ensuring user autonomy should be central in discussions about reproductive health.

**2.5.8** It is essential that pregnancy is identified as soon as possible in order to link people to appropriate care. The report into the death of Baby B at HMP and YOI Styal recommended that pregnancy testing be offered to all premenopausal women at both first and second stage health assessments, as well as, at the second stage health assessment the taking of a comprehensive history including sexual, contraceptive and reproductive history[18]. The aim being to detect pregnancy and any unmet sexual health needs. Individuals who have had recent unprotected sexual intercourse, will require further testing to exclude pregnancy at least 21 days post intercourse, which may necessitate follow up beyond the second stage health assessment. The report raises concerns about asking these questions at the first stage health assessment, acknowledging that they are often conducted under very stressful circumstances. However, a significant proportion of people entering prison will have had recent unprotected sex and will be eligible for emergency contraception, with a significant proportion of those eligible accepting emergency contraception[19]. By the second stage health assessment the opportunity to use emergency contraception will have passed, and therefore assessment of unprotected sex needs to occur on first reception into prison.

**2.5.9** In England, the *Women's Health Strategy*[20] emphasises the importance of joined up care for reproductive health across the life course, and ensuring women's voices are heard, both in assessing their individual health, and in planning services. Reducing disparities in health outcomes and ensuring equity of access to health and social care for women in prison is a named goal in the strategy. Scotland has a *Women's Health Plan*[21] which focusses on reducing inequalities by raising awareness around women's health, improving access to healthcare and improving health outcomes for girls and women.

### Gender based violence

**2.5.10** People in prison, of all genders, have commonly experienced gender-based violence (GBV) both in childhood and as adults and/or intimate partner violence (IPV)[22, 23]. In addition, sexual violence does occur in prison, and is likely under-reported[24]. BASHH recommends routine enquiry about GBV and IBV in all sexual health consultations[2], and this is mandatory in Scotland[25]. Recognition allows support and access to specialist services for people who have experienced GBV and/or IPV. For women, IPV has been identified as a key driver for offending, and therefore recognition of IPV in prison presents a potential opportunity to intervene in the cycle of reoffending[26].

SARCs are specialist centres which can provide medical and psychosocial aftercare following sexual assault. They offer forensic medical examination and other evidence gathering by professionals trained in forensic medicine, which can often be performed even if the person does not wish for police involvement. It is not expected that forensic medical examination be performed outside of a specialist setting, but people in prison should be able to access SARCs if required. There are limits as to how long after the event forensic evidence can be collected[27] so it is essential that practitioners are aware of these timings.

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# STANDARD 3

# Diagnostics in prison services

## 3.1 Quality Statement

People in prisons being tested for STIs should have access to the most appropriate diagnostic tests, chosen according to national guidelines. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately. Robust processes should be in place to ensure timely transit of samples to the laboratory. Governance pathways should be developed to ensure all results are appropriately acted on. People in prisons should have recourse to access their own results.

## 3.2 Quality measures

**3.2.1** Diagnostic tests:

a. The percentage of people in prisons who have symptoms suggestive of gonorrhoea or are Nucleic Acid Amplification Test (NAAT) positive for *Neisseria gonorrhoeae* who have a culture performed from the appropriate sites.

b. The percentage of people in prisons who have a reactive HIV point-of-care test (POCT) that have a confirmatory sample sent to the laboratory.

**3.2.2** Laboratory turnaround times:

a. The percentage of preliminary reports issued by the laboratory to prison services within four working days of the specimen being received by the laboratory.

b. The percentage of final reports on supplementary testing, or following referral to the reference laboratory, which are issued by the laboratory to prison services within nine working days of the specimen being received by the laboratory.

## 3.3 Quality standards

**3.3.1** Diagnostic tests:
Standard: 100%

**3.3.2** Laboratory turnaround time:

a. Standard: 97%*

b. Standard: 97%*

*This translates to 1 error per 40 audited cases

## 3.4 What the quality statement means for each audience

### Responsibilities of commissioners

**3.4.1** Commissioners should ensure that all providers of services commissioned to manage sexual health in prisons:

a. have systems in place to store and transport diagnostic specimens in a safe and timely manner.

b. are enrolled in a suitable external quality assurance (EQA) scheme if HIV POCT are undertaken. Performance in such schemes should be monitored.

**3.4.2** Commissioners should ensure commissioned laboratories are using the 'gold standard' test wherever possible. Laboratories should have established pathways for reference referral for specialist tests and adhere to national standard operating procedures where these are available. This includes but is not limited to:

a. the use of fourth or fifth generation assays for HIV testing (combined antibody and antigen detection).

b. the in-clinic use of HIV POCTs for screening only, when validation data are available. Confirmation of a reactive POCT by an established laboratory test is mandatory.

c. serological testing for syphilis and HIV, hepatitis A virus (HAV), hepatitis B virus (HBV), hepatitis C virus (HCV), hepatitis D virus (HDV), hepatitis E virus (HEV).

d. quantitative or qualitative antigen detection tests for HBV and HCV as required.

e. NAATs for detection of gonorrhoea and chlamydia at genital and extra genital sites, including specialist tests for detection of Lymphogranuloma venereum (LGV) serovars.

f. ensuring the availability of gonococcal culture for anyone presenting with symptoms of gonorrhoea, or with a positive gonorrhoea NAAT, so that antimicrobial susceptibility testing can be performed and resistant strains identified.

g. type-specific herpes simplex virus (HSV) polymerase chain reaction (PCR).

h. HSV serology in exceptional circumstances.

i. *Treponema pallidum PCR*.

j. *Mycoplasma genitalium* testing, including genotypic macrolide-resistance testing.

k. NAATs for the optimal diagnosis of Trichomonas vaginalis.

l. Access to microscopy, culture and sensitivity swabs for cellulitis/abscess/superinfection/candida & bacterial vaginosis diagnosis where direct microscopy is not available.

m. urine dipstick, culture and susceptibility testing.

n. pregnancy testing.

o. screening for cervical cancer via the National Cervical Screening Programme.

p. screening for chlamydia via the National Chlamydia Screening Programme.

**3.4.3** Commissioners should ideally ensure there is access to direct microscopy including gram stain and dark ground microscopy via a specialist Level 3 GUM service. However, it is widely recognised that microscopy is not available in many prisons due to the lack of available space and/or the infrastructure needed to support it. In these cases, commissioners should support the use of expert-led presumptive treatment, based on recognised signs and symptoms of STIs, whilst results of confirmatory swab testing are awaited.

**3.4.4** All clinicians who use laboratory tests should have access to medical microbiologist and clinical virologist advice to help interpret and manage complex results.

**Responsibilities of service providers**

**3.4.5** All providers of services commissioned to manage sexual health in prisons should use the 'gold standard' test for the infection they are screening for.

**3.4.6** All providers of services commissioned to manage sexual health in prisons should ensure they have mechanisms in place for:

a. safe collection, storage and transport of diagnostic specimens.

b. safe disposal of clinical waste including HIV POCT cartridges.

c. monitoring of laboratory turnaround times, including monitoring the time taken for the specimen to be received by the laboratory.

d. quality assurance of staff performing microscopy.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**3.4.7** All healthcare professionals and non-registered healthcare workers in prisons should be fully competent in:

a. taking clinical specimens.

b. understanding the limitations of the diagnostic tests used.

c. the safe handling of diagnostic equipment, materials and diagnostic samples including the disposal of sharps.

d. correct completion of laboratory documentation.

**3.4.8** All healthcare professionals who conduct microscopy in prisons, should be competent to do so and undertake regular continuous professional development (CPD) and assessment.

**People in prison**

**3.4.9** Should receive tests for STIs that are in keeping with national BASHH guidelines[1].

**3.4.10** Should be made aware of the limitations of any diagnostic tests.

**3.4.11** Should have their specimens processed within the recommended timescale.

**3.4.12** Should have access to their test results, negative or positive, within eight working days of having the tests taken. The prison sexual health service should agree with them how they wish to receive their results e.g. in a written format or face to face discussion.

## 3.5 Supporting information

### Diagnostic tests

**3.5.1** Prison services should aspire to provide diagnostic tests as outlined by *the Standards for the management of sexually transmitted infections (STIs)*[1]. However, access to some diagnostic tests may be limited due to equipment, personnel and health and safety criteria in prisons. In this case robust pathways should be in place to either ensure swift transfer into appropriate services or to provide an alternative pathway for treatment of acute symptoms whilst confirmatory testing is awaited.

### Screening programmes

**3.5.2** There are differences in screening programmes across the UK including in age criteria for screening. Information can be found in the document *'Screening Programmes across the UK'*[2].

### Microscopy

**3.5.3** Microscopy should ideally be available. However, many prisons do not have the space or laboratory infrastructure to support this. Stains used for microscopy need to be stored in line with *Control of Substances Hazardous to Health (COSHH) regulations*[3].

**3.5.4** Direct microscopy of genital samples provides a rapid method for the diagnosis of several genital infections. In people with symptoms of penile dysuria and/or urethral discharge, microscopy of a gram-stained anterior urethral smear allows immediate differentiation between gonococcal urethritis (>95% sensitivity) and non-gonococcal urethritis. Microscopy of an anterior urethral smear is the optimal method of diagnosing non-gonococcal, non-chlamydial urethritis. The benefit of an immediate diagnosis ensures administration of correct treatment and reduces administration of inappropriate antimicrobial therapy and the development of resistant organisms.

**3.5.5** Immediate microscopy of smears from people with symptoms of abnormal vaginal discharge can potentially identify bacterial vaginosis (BV) (sensitivity >95%), candidiasis (sensitivity 50%), Trichomonas vaginalis (sensitivity <50%) and gonorrhoea (sensitivity 30-50%). Immediate diagnosis allows administration of the correct treatment at initial assessment, resulting in quicker resolution of symptoms.

**3.5.6** Gram stain and dark ground microscopy should be available if microscopy is offered.

### HIV POCT

**3.5.7** HIV POCT can facilitate early diagnosis leading to effective treatment of an individual, limiting progression of disease and facilitating a reduction in ongoing transmission.

**3.5.8** Ideally fourth and fifth generation HIV tests should be used, but in some circumstances a third generation POCT (HIV-1 and 2 antibody only), may be used with a parallel sample sent for fourth and fifth generation laboratory testing.

**3.5.9** Prison services that use HIV POCT should:

- involve the local laboratory who can advise on training, interpretation of results, trouble shooting, quality control and health and safety.
- in the case of a reactive POCT ensure confirmation by an established laboratory test.
- provide training and ensure that the competence of staff is established and recorded. Standard operating procedures must contain the manufacturer's instructions for use.
- keep results, recording the reagent lot numbers and member of staff performing the test.
- analyse quality control material to assure the system is working correctly.

### Laboratory standards

**3.5.10** Laboratories should be credited with Clinical Pathology Accreditation (CPA)/United Kingdom Accreditation Services (UKAS). Laboratories should also provide evidence of participation in External Quality Assurance (EQA), Internal Quality Assurance (IQA) and Internal Quality Control (IQC)4.

### Turnaround times

**3.5.11** In this standard the turnaround time is the time taken in the laboratory. This does not take into account the time taken for a specimen to reach the laboratory. Currently there is no evidence base for laboratory turnaround times. The turnaround time described in this standard is based upon the *Standards for the management of sexually transmitted infections*[1]. Turnaround times will be expedited by the use of electronic laboratory reporting.

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# STANDARD 4

# Clinical management

## 4.1 Quality statement

People in prison who have STI testing should receive their results, both positive and negative, within eight working days, unless supplementary tests are needed. Those diagnosed with an infection or requiring vaccination should receive prompt treatment (within three weeks of a test being taken), and be managed according to BASHH national guidelines, including the provision of partner notification (PN). If treatment cannot be provided in the prison service, a robust pathway should be in place to ensure timely transfer to an appropriate service for management. Providers have a responsibility to ensure that the results of tests taken in prison are communicated to people who subsequently move facilities or are released.

## 4.2 Quality measures

**4.2.1** The percentage of people having STI tests who can access their results (both positive and negative) within eight working days of the date of the sample (excluding those requiring supplementary tests).

**4.2.2** Clinical management:

a. Adherence to latest BASHH guidelines[2], NICE *Sexual Health Quality Standard*[3], NICE *Physical health of people in prison Quality Standard*[4] and Green Book: Immunisation against infectious diseases[5].

b. The review of people, with a reactive HIV point-of-care test (POCT) in a prison service, by a HIV specialist preferably within 48 hours, but definitely within 14 days[1].

**4.2.3** Partner notification:

a. The percentage of all contacts of index cases of gonorrhoea who attend a prison service commissioned to manage STIs within four weeks of the date of first PN discussion.

b. The percentage of all contacts of index cases of chlamydia who attend a prison service to manage STIs within four weeks of the date of first PN discussion.

c. The percentage of contactable contacts of index cases of HIV who have had an HIV test, as verified by a healthcare professional, within 3 months of first PN discussion.

d. The percentage of people with documented evidence of PN discussion at time of HIV diagnosis, including with HIV POCT, to determine if any at risk contact has occurred within the previous 72 hours, to identify and refer partners potentially eligible for PEP.

## 4.3 Quality standards

**4.3.1** Provision of written or face-to-face test results within eight working days (excluding supplementary testing). Standard: 95%

**4.3.2** Clinical management:

a. Treatment of an STI within 3 weeks of the test being taken.
Standard: 85%

b. Review of people who are diagnosed HIV positive by specialist HIV care preferably within 48 hrs but definitely within fourteen days[1].
Standard: 95%

c. Offered vaccination in accordance with the latest BASHH guidelines[2], *NICE Sexual Health Quality Standard*[3], *NICE Physical health of people in prison Quality Standard*[4] and Green Book: Immunisation against infectious diseases[5].

d. Evidence of use of the specific audit measures in the current BASHH guidelines[2].
Standard 100%

**4.3.3** Effective partner notification:

a. Gonorrhoea: at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks[6].

b. Chlamydia: at least 0.6 contacts per index case within four weeks[6].

c. Syphilis: at least 0.4 contacts per index case within four weeks[6].

c. HIV: 0.6 contacts per index case within three months[6].

d. HIV: 97% index cases with documented PEP assessment at diagnosis, to identify any contacts within the last seventy-two hours potentially eligible to receive PEP[6].

## 4.4 What the quality statement means for each audience

### Responsibilities of commissioners

**4.4.1** Commissioners should ensure that all providers of services commissioned to manage sexual health in prisons:

a. provide treatment and vaccination according to current BASHH guidelines[2].

b. have pathways in place to facilitate prompt review, of those receiving new diagnoses of HIV within the prison[1].

c. provide emergency contraception as required, follow up pregnancy testing and have pathways in place to support access for the fitting of emergency intrauterine devices (IUDS).

d. have pathways in place to appropriately manage positive pregnancy test results including onward referral to antenatal or abortion services and support as appropriate.

e. instigate or support PN. If this is not possible then commissioners should ensure robust pathways into an appropriate service for the management of PN.

f. are responsible for managing results, and providing the people tested with access to them, in a timely manner. There should be no more than eight working days between the date of the test and receipt of test results (excluding supplementary testing).

**4.4.2** Syndromic treatment for STIs should not be commissioned. However, it is widely accepted that as microscopy is not available in many UK prisons, presumptive treatment led by a Level 3 GUM service, based on recognised symptoms and signs of STIs may be initiated whilst awaiting results of confirmatory testing. This allows for immediate provision of treatment thus reducing the period of infectivity, risk of complications and onward transmission of infection.

All UK prisons should have the facility to confirm suspected STIs, wherever possible using gold standard confirmatory STI testing.

**4.4.3** Commissioners should make provision for 24-hour availability of PEP, via prescription or PGD[7]. PEP should be the full 28 day course and arrangements for follow-up for HIV testing should be available thereafter.

**4.4.4** Commissioners should ensure there is access to a SARC within their commissioned area.

**Responsibilities of service providers**

**4.4.5** Results should be reviewed and actioned in a timely manner by a healthcare professional who is competent in their interpretation, to ensure that people receive their results within eight working days of the test being taken[6].

**4.4.6** All providers of services commissioned to manage sexual health in prisons should ensure they have appropriate mechanisms in place to provide results, both positive and negative, in a timely manner and no more than eight working days from the initial consultation[6].

**4.4.7** It is the responsibility of the sexual health service taking the specimens to ensure that any abnormal results are acted upon, including if the patient is transferred to another facility or released.

**4.4.8** All providers of services commissioned to manage sexual health in prisons should ensure they have appropriate mechanisms in place to provide treatment to people diagnosed with an STI:

a. if treatment is needed and cannot be provided within three weeks of the test being taken, care pathways should be in place for people in prisons to be referred for ongoing management.

b. arranging follow-up and test of cure in accordance with current BASHH guidelines[2].

c. having recall systems for those advised to be re-tested according to the current National Chlamydia Screening Programme[8] and BASHH guidelines[2].

d. referring those newly diagnosed with HIV to be seen by a HIV specialist within 2 weeks[1].

e. referring those newly diagnosed with Hepatitis B or C to specialist services.

**4.4.9** All providers of services commissioned to manage sexual health in prisons should ensure that they have appropriate mechanisms in place to:

a. initiate PN for relevant infections. If the provider is unable to fully undertake PN, agreed pathways to another service should be utilised to ensure that it takes place in a timely fashion.

b. document the date of first PN discussion and record this in the person's record, following up in accordance with current national guidance[2,6].

c. adhere to the current BASHH guidelines in relation to look-back periods for each infection[2] sexual partners may be in prison and/or the community.

d. monitor PN outcomes for gonorrhoea, chlamydia, syphilis and HIV against national standards[2,6].

**4.4.10** All providers of services commissioned to manage sexual health in prisons should ensure that they have appropriate mechanisms in place to provide health promotion and prevention:

a. appropriate to the clinical condition and sexual history, in a sensitive and non-judgemental way.

b. using standard leaflets where available, ensuring that comparable information is available in different languages and in non-written formats. Translators, interpreting services and other support to access information about results should be available where requested or necessary.

c. providing vaccination for hepatitis B to all people in prisons[5,9]. The ultrarapid vaccination course should be used[4].

d. providing vaccination for HPV to all men who have sex with men (MSM) and transgender women under the age of forty-five[2].

e. providing vaccination for hepatitis A to people in high-risk groups in accordance with current BASHH guidelines[2].

f. engaging with appropriate infection containment vaccination programmes equal to those in the community.

g. providing discreet access to condoms, dental dams and water-based lubricants without the need for people to ask for them.

h. providing access to HIV prevention methods, including PrEP and PEP, ensuring that appropriate advice is given relating to these preventative interventions.

i. providing advice regarding contraception and that access (by referral if necessary) is facilitated to the chosen method.

**4.4.11** Treatments provided by sexual health services in prison should follow guidance for appropriate storage of medications, and their use be audited, in line with local policies and pharmacy guidelines.

**4.4.12** All providers of services commissioned to manage sexual health in prisons should ensure that they have appropriate mechanisms in place to:

a. provide oral emergency contraception as needed, follow up pregnancy testing and access for the fitting of emergency intrauterine devices (IUDS).

b. appropriately manage positive pregnancy test results facilitating onward referral to antenatal or abortion services and support as appropriate.

c. refer to other healthcare services as clinically indicated.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**4.4.13** All healthcare professionals and non-registered healthcare workers working in services commissioned to manage sexual health in prisons should ensure that:

a. they are fully competent to manage STIs in accordance with current BASHH treatment guidelines[2]. Expert-led, presumptive treatment, based on recognised signs and symptoms of STIs, while awaiting results of confirmatory testing, is an acceptable practice. Syndromic management is not.

b. if not competent or able to provide appropriate management for particular conditions, there are clear, agreed referral pathways to local specialist Level 3 GUM services, or other specialist services for effective transfer of care.

c. they are competent in the reporting of notifiable diseases in accordance with the UK Health Security Agency (UKHSA) guidance[10].

### People in prison

**4.4.14** Should receive sexual health advice and information in a sensitive and non-judgemental way.

**4.4.15** Should have access to their test results, positive or negative, within eight working days of having the tests taken, unless supplementary tests are needed. Should be able to choose how they receive their results, either in writing, or face-to-face. Unless requested, best practice is to inform people of their negative test results. 'No news is good news' is not acceptable practice[2].

**4.4.16** Should, if diagnosed with an STI, receive the best available treatment according to current BASHH guidelines[2]. If the prison service is unable to provide treatment, they should expect to be referred to a local specialist Level 3 GUM service. Expert led, presumptive treatment, based on recognised clinical signs and symptoms of STIs can be implemented, whilst awaiting results of confirmatory testing.

**4.4.17** Should, if diagnosed with an STI, have support to notify recent sexual partners they are at risk of infection and will need testing for STIs and treatment.

**4.4.18** Should have access to treatment for blood borne viruses. This includes infections that are diagnosed within the prison service or outside it. Systems and processes should be present to ensure continuity of care when people in prisons are transferred between prisons.

**4.4.19** Should be provided enough prescribed medication to complete their course of STI treatment when discharged or transferred from prison[3].

**4.4.20** Should be offered a hepatitis B vaccination[3].

**4.4.21** Should be offered an HPV Vaccine if they are MSM or a transgender woman below the age of 45[2,6].

**4.4.22** Should be offered a hepatitis A vaccine if they are in a high-risk group in accordance with current BASHH guidelines[2].

**4.4.23** Should have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them.

**4.4.24** Should have access to HIV prevention methods including PrEP and PEP and appropriate advice related to these preventative interventions.

**4.4.25** People with the potential for pregnancy should have access to contraceptive advice, emergency contraception and a chosen contraceptive method before release.

**4.4.26** People who are pregnant should have access to both abortion and antenatal services.

## 4.5 Supporting information

### Interpretation of results

**4.5.1** Test results both negative and positive should be interpreted in the light of the person's clinical presentation. Results should be reviewed by an individual who is competent to interpret them correctly. If this is carried out by a non-healthcare professional a mechanism should be in place to facilitate review of the results by a healthcare professional.

### Provision of results

**4.5.2** Provision of access to results whether positive or negative, is important for effective clinical management of infection. The turnaround time described in this standard is based upon those in the *Standards for the management of sexually transmitted infections (STIs)*[6]. This is eight working days, from having the test taken to the provision of test results, unless supplementary testing is required.

### Treatment

**4.5.3** For both public health and individual health reasons, treatment regimens should follow current BASHH treatment guidelines[2].

**4.5.4** Antibiotic resistance is of specific concern in the treatment of STIs, which informs treatment guidelines. In England and Wales, the national Gonococcal Resistance to Antimicrobials Surveillance programme (GRASP) monitors antibiotic resistance to gonorrhoea[11]. Scotland and Northern Ireland also have similar programmes[12,13]. Effective therapy, and PN is essential for public health control of gonorrhoea. Treatment for people in prisons should be in line with current national guidance, and people should be supported to complete full courses of medication and attend any required test of cure. If this cannot be facilitated in prisons, the individual should be referred to a specialist Level 3 GUM service for treatment management.

### Syndromic management

**4.5.5** Syndromic management of STIs involves making clinical decisions about diagnosis and treatment of STIs based on a patient's symptoms and signs (e.g. dysuria, dyspareunia, genital ulcers, urethral or vaginal discharge), without the use of microscopy or taking appropriate swabs for laboratory investigation. It was primarily developed for resource poor settings where diagnostic laboratory tests are not available. In the UK this is considered sub-optimal care and may contribute to antimicrobial resistance. As such, it should only be employed in exceptional circumstances and by a senior clinician.

### Vaccination

**4.5.6** The rates of blood borne viruses in people in prisons is generally high[9]. The UK Health Security Agency recommend people in prisons be offered vaccination for hepatitis B, utilising the ultrarapid vaccination course5, and that those in high-risk groups are vaccinated for HAV and HPV.

Prison services should engage with relevant infection containment vaccination programmes equal to those in the community.

### Partner notification

**4.5.7** Prison services testing and managing STIs should identify the need for partner notification as part of the management of STIs. People in prisons should be encouraged to contact relevant partners themselves. If this is not possible, then referral to the local specialist Level 3 GUM service should be instigated. It is acknowledged that partners may be in the community and liaison with community sexual health services may be required to ensure PN takes place.

### Health promotion

**4.5.8** Health promotion and prevention is essential in supporting lifestyle change and risk minimisation. People accessing services should receive health promotion interventions appropriate to their sexual history and lifestyle in a format that suits their individual needs. This should include access to peer-led programmes and one-to-one support. Sexual health services in prison should consider how they can provide support to wider sexual wellbeing programmes within prison.

**4.5.9** PrEP and PEP for HIV should be provided and monitored according to current guidelines[14,15].

**4.5.10** Individuals with a history of drug use should be identified, assessed and managed according to current guidelines[5].

### Continuity of care

**4.5.11** Continuity of care is needed for those who need to start or continue long-term treatments including PrEP and treatments for blood borne viruses including antiretroviral therapy (ART) for HIV, hepatitis B and C. Other long-term treatments which may require starting or continuing include contraceptive methods, antiviral suppression for herpes simplex virus, or other long-term medications for sexual healthcare. In addition to ongoing provision whilst in prison, these should be considered as part of the pre-release assessment.

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# STANDARD 5

# Information governance

## 5.1 Quality statement

Providers of sexual health services in prisons must ensure information collected about service users remains secure and is only shared for legitimate reasons: in the individual's or public's best interest or, suitably anonymised, for mandatory reporting purposes.

## 5.2 Quality measures

**5.2.1** Record keeping:

Compliance with the standard relating to record keeping as set out in *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[1]:

- Regulation 17: Good governance

**5.2.2** Information governance:

Completion of the *NHS Data Security and Protection Toolkit2*.

**5.2.3** Data reporting:

Compliance with national data reporting requirements, within six weeks after the end of the period being reported. See Appendix C.

## 5.3 Quality standard

**5.3.1** Record keeping:

Meets in full the standard relating to record keeping as set out in *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[1] for regulation 17.

**5.3.2** Information governance:

Meets in full the requirements of the *NHS data security and protection toolkit*[2].

**5.3.3** Data reporting:

Compliant with all national data reporting requirements.
Standard: 100%

## 5.4 What the quality statement means for each audience

### Responsibilities of commissioners

**5.4.1** Commissioners must ensure that all providers of sexual health services in prisons comply with current UK law and regulations pertaining to information governance. This includes that they:

a. comply with the *Data Protection Act 2018*[3] and any amending or replacement legislation.

b. safeguard service user confidentiality as set out in the *NHS code of practice.*[4]

c. have measures in place to guarantee secure record management in accordance with the *Records Management Code of Practice for Health and Social Care 2021*[5].

d. comply with recommendations to ensure data security as set out by: *National Guardian for Health and Care, Review of Data Security, Consent and Opt-Outs 2016*[6]; and Care Quality Commission *Safe data, safe care 2016*[7].

e. have measures in place to transmit datasets securely.

**5.4.2** Commissioners should follow the Department of Health and Social Care (DHSC) guidance regarding transfer of records when there is a change of service provider[8].

**5.4.3** Commissioners should have a clear understanding of the core requirements of national data reporting and any supplementary local data recording requirements, including what can legally be shared for commissioning purposes (see Appendix C). This should be written into contract and service specifications as it is a mandatory obligation.

### Responsibilities of service providers

**5.4.4** All providers of services commissioned to manage sexual health in prisons should have clear and transparent information available to people using services. This includes but is not limited to information about:

a. confidentiality.

b. how the service, local authority, DHSC and UKHSA use their data and the safeguards that are in place in order to protect patient confidentiality.

c. how to access their own health record.

**5.4.5** Information regarding people accessing services, and information about their sexual contacts, must be held securely and strictly in accordance with Caldicott guidance[9], the *Data Protection Act 2018*[3], and any amending or replacement legislation and the *NHS Code of Practice*[4,5]. Where information about service users is held electronically, it must be held and managed in accordance with the Data Security and Protection Requirements[10] including storage on secure password protected systems with restricted access.

**5.4.6** If digital images of patients are to be obtained, they must be stored securely and can only be shared: with other healthcare professionals caring for that patient; for educational purposes and research within a scope that is clearly defined in written consent taken from the patient.

**5.4.7** All providers of services commissioned to manage sexual health in prisons must comply with:

a. national data reporting requirements and ensure that adequate security measures are in place when transmitting datasets to a third party e.g. UKHSA or DHSC.

b. DHSC data retention and destruction requirements[5].

**5.4.8** Service providers must ensure that all staff complete annual information governance and data security training.

**5.4.9** All service providers should have an easily accessible business continuity plan which lays out clear and safe procedures for operating the service in the event of an IT failure.

### Responsibilities of healthcare professionals and non-registered healthcare workers

**5.4.10** All healthcare professionals and non-registered healthcare workers working in services commissioned to provide sexual health in prisons should understand their own responsibilities in relation to information governance requirements. This includes, but is not limited to:

a. patient confidentiality, including a clear understanding of the circumstances where sharing of patient identifiable information is necessary.

b. best practice in record keeping[11,12].

c. compliance with mandatory information governance requirements.

### People in prison

**5.4.11** Should receive clear information on:

a. the level of confidentiality they can expect from the service accessed.

b. how the service collects, processes, stores and shares their data.

c. how to request access to their health records.

## 5.5 Supporting information

### Data reporting

**5.5.1** Data reporting in sexual health is used to identify and target high risk groups, for service planning, surveillance and control of infectious disease, and for the monitoring and evaluation of initiatives designed to improve sexual health[13] and is considered mandatory in mainstream services. Currently prisons do not report data on sexual health, which compounds the lack of information relating to the sexual health needs of people in prison. Given that people in prison have multiple risk factors for sexual ill health[14], collecting and reporting this information will help to build a more accurate picture of the sexual health needs of people in prison and assist in the design of services.

Current mandatory reporting datasets are summarised in Appendix C. BASHH advocates that the same data be collected in prison and the UKHSA is currently exploring the best mechanism for this. Shared data must be suitably anonymised. As prison sexual health services may see low numbers of patients as compared to mainstream sexual health services, there may be concern over the publication of data with small numbers, due to the risk of the information being used inadvertently identifying people, even if anonymised. Public Health England produced guidance for publishing sexual health data with small patient numbers whilst protecting confidentiality.[15]

### Confidentiality and patient records

**5.5.2** People in prison have a right to confidentiality in sexual health consultations and the assurance of confidentiality is a key principle in sexual health, with an acknowledgement that sexual health services offer a higher level of confidentiality. The right to access sexual healthcare without referral from, or sharing of information with, other health services has been recognised in UK law since 1916.[16] However, sexual healthcare is increasingly provided in other settings, and it is acknowledged that not all prison sexual healthcare will be provided separately from general healthcare. People in prison need to feel confident that services offer an appropriately high standard of confidentiality, in order to make informed choices about their care.

The Department of Health and Social Care[17,18] and BASHH[19] consider it best practice for sexual health services to maintain their own separate patient records, and not to share identifiable information relating to an individual's sexual healthcare without their consent. Sexual health information should not, routinely, be shared with non-sexual healthcare workers without the consent of the patient and therefore physical and electronic records should be stored securely, and ideally separately from general health records, so that confidentiality can be maintained. Any electronic patient records system for sexual health should have the ability to easily extract the information required for mandatory sexual health data reporting (see 5.5.1). Where sexual health is provided on an in-reach basis, mechanisms must be in place for the secure transfer of patient information.

In order to keep people in prison safe, it may be necessary to share some information about sexual healthcare with general prison healthcare services, for example, details of current antibiotic treatments. Wherever possible, this should be done with the patient's consent. Only in exceptional circumstances, in the best interests of the patient or the public, can confidential sexual health information be shared without consent.[11,12] This includes the disclosure of HIV or hepatitis status to prison staff, other than healthcare staff involved in the patient's care, as this information is not necessary to protect prison staff or other people in prison. Where information does need to be shared (e.g. to inform a decision about PEP following significant occupational exposure), only the minimum information required should be disclosed.

**5.5.3** There will be situations in which sharing information between sexual health services is clearly beneficial to the patient to ensure continuity of care between prisons. People in prison may sometimes need to move facility, at short notice, which may make gaining consent more difficult. Discussions around sharing information and documentation of consent should therefore occur at the time of sexual health appointments. A patient health record which travels with the person, containing minimum information required for continuity (for example current STI treatment), may prevent disruption of care caused by transfer between facilities.

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# STANDARD 6

# Clinical governance

## 6.1 Quality statement

People in prison should receive sexual healthcare from high quality services that are safe, well-managed and equitable to services in the community.

## 6.2 Quality measures

**6.2.1** Clinical governance arrangements:

a. Compliance with the standards relating to record keeping set out in the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[1]:

- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 20: Duty of candour

b. *The Care Quality Commission (Registration) Regulations 2009*[2]*:*

- Regulation 12: Statement of purpose
- Regulation 18: Notification of other incidents

**6.2.2** Audit and quality improvement:

a. Participation in relevant local, regional and national audits and quality improvement projects.

b. Actions taken as a result of audit and quality improvement findings.

**6.2.3** Referral pathways:

a. Evidence that effective referral pathways and necessary clinical governance arrangements are in place with specialist Level 3 GUM providers and other appropriate services (see Standard 8).

## 6.3 Quality standard

**6.3.1** Clinical governance measures:

a. Meet in full the requirements of the *Health and Social Care Act 2008 (Regulated activities) Regulations 2014*[1], regulations 12, 13, 16, 17 and 20.

b. Meets in full the *Care Quality Commission (Registration) Regulations 2009*[2], regulations 12 and 18.

**6.3.2** Audit and quality improvement measures:

a. Evidence of participation in relevant local, regional and national audits and quality improvement projects.

b. Evidence of actions taken as a result of audit and quality improvement findings.

## 6.4 What the quality statement means for each audience

### Responsibilities of commissioners

**6.4.1** Commissioners should ensure that requirements for governance and accountability are explicit in all contracts with commissioned providers of sexual health services in prisons.

**6.4.2** Service specifications should enable the development of effective integrated governance systems.

**6.4.3** Key performance indicators should include metrics that monitor quality and compliance with clinical governance practice and processes.

**6.4.4** The role of specialist Level 3 GUM providers in providing clinical leadership and governance should be explicitly commissioned and form part of service specifications.

**6.4.5** Commissioners should ensure that audit and quality improvement requirements relating to sexual health are specific in all contracts and that audit activity is monitored via an annual audit plan. This should include arrangements for collection, collation and reporting of prison specific data on sexually transmitted infections and blood borne virus infections.

### Responsibilities of service providers

**6.4.6** All providers of services commissioned to manage sexual health in prisons must ensure that they are registered with the appropriate healthcare regulatory authority.

**6.4.7** All providers of services commissioned to manage sexual health in prisons should be able to demonstrate that effective clinical governance arrangements are in place. This includes, but is not limited to, the following areas:

a. having a nominated clinical governance lead with responsibility for overseeing the clinical quality of the service delivered and establishing robust links to relevant services, including specialist Level 3 GUM services.

b. compliance with evidence-based guidelines and policies informed by the most up to date guidance from national bodies including NICE, BASHH, BHIVA, FSRH and best evidence in peer reviewed literature.

c. using information technology (IT) to support all aspects of clinical governance within and across organisations, taking into account the required information governance standards (see Standard 5), and using IT and IT equipment securely when transferring data collected in prisons to other computer systems.

d. having a clear framework to support education and training that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of ongoing competence according to the service provided (see Standard 7).

e. having a clear audit plan which includes meaningful local audits to assess clinical practice against current national and local guidelines and evidence-based practice.

f. demonstrating action taken based on audit findings.

g. fostering and encouraging participation in clinical research and development.

h. having procedures in place to minimise risk to both patients and staff. Working with prison staff to ensure that people in prison can continue to access sexual healthcare in a way that is safe and dignified for both patients and staff.

i. promoting a culture where staff are both empowered and trained to report risks and raise concerns.

j. having clear mechanisms in place to report, review and respond formally to all clinical incidents and complaints in line with Duty of Candour[1].

k. having regular clinical governance meetings to share learning outcomes from audits or investigations of incidents and complaints. Findings should be shared with prison staff and other prison healthcare services where appropriate.

**6.4.8** All providers of services commissioned to provide sexual health in prisons should have any written complaints they receive handled according to accepted practices[3], including:

a. an acknowledgement of receipt of the complaint within three working days of receiving it.

b. an initial response outlining an approximate timescale for a formal response.

c. updates if the timescale lengthens.

In addition, the procedure for dealing with complaints should take into account the potential for people in prison to be moved between facilities or released from prison at short notice. Initial responses should include a named complaint handler who can continue to provide a point of contact even after the person has moved on from that facility. People in prison should be asked how they want to be contacted with the outcome of their complaint.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**6.4.9** All healthcare professionals and non-registered healthcare workers working in services commissioned to manage sexual health in prisons must understand and comply with clinical governance requirements and demonstrate a commitment to patient safety, quality improvement and clinical efficiency. This includes:

a. being up to date with mandatory training. This includes but is not limited to: information governance, infection prevention and control and safeguarding of vulnerable adults.

b. regular attendance at clinical governance meetings.

c. participation in local and national audits as appropriate.

d. vigilance towards clinical and non-clinical risks, and familiarity with local incident reporting systems.

e. ensuring safe transport of clinical samples (adhering to HSE standards)[4].

**People in prison**

**6.4.10** Should find sexual health services to be safe, high quality and equitable to local community services.

**6.4.11** Should receive clear information about the prison complaints procedure, in addition to a response to any concerns or complaints they make about the service, even if they move on from the facility.

**6.4.12** Should receive services from providers that continually improve as a result of learning from:

a. adverse events.

b. incidents, errors and near misses.

c. comments and complaints.

d. reviews of practice including audit and quality improvement projects and/or the advice of expert bodies.

## 6.5 Supporting information

**6.5.1** Sexual health services delivered in prison should operate to the same standards of safety and quality as those delivered in the community.

**6.5.2** Clinical governance, for prison sexual health services, can either be provided by the organisation commissioned to deliver the service or via contractual arrangements with another organisation e.g. a local specialist Level 3 GUM service. However, all providers of prison sexual health services should have a nominated lead for clinical governance and, if the service is not provided by a specialist Level 3 GUM provider, robust links with the local service should be established.

### Research

**6.5.3** Research on sexual health may further enhance knowledge and improve outcomes for people in prison. Due to the increasing number of people incarcerated worldwide, participation in research to improve health in this setting should be encouraged. All research in prisons must apply for the relevant permissions from HMPPS, the Scottish Prison Service or the equivalent body in the other devolved nations. This should include ethical approval and relevant data sharing agreements with the partner healthcare organisation[5]. International standards state that people in prison should be allowed to engage in health research, where they give free and informed consent[6], ensuring that all relevant ethical standards relating to human experimentation are respected[7].

### Complaints

**6.5.4** The average custodial sentence length in the UK is 24.8 months[8] which may not all be served in the same facility. Therefore, people in prison who have made a complaint may have moved on from the facility before the complaint is resolved. Prison health services have the same responsibility to effectively manage and resolve complaints as any other health service, and therefore this should be taken into account when designing a complaints procedure. Prison healthcare services run by the NHS are held to the same standards as community healthcare providers and hence follow similar complaints procedures and governance arrangements as their community counterparts. A named complaint handler can provide a point of contact if the person leaves the facility, but this places the onus to follow up on the complainant, unlike in other healthcare services. When a person remains in the prison service, responses should be communicated to the person themselves and significant attempts made to determine their current prison location. Correspondence could be sent to a home address following release, however people leaving prison are at increased risk of insecure housing[9] and there is the potential for breaches in confidentiality should correspondence be sent to an old or unsecure address. Where a complainant is in agreement and a follow up address is unknown, information could be forwarded to an appropriate next of kin.

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# STANDARD 7

# Appropriately trained staff

## 7.1 Quality statement

People in prison with needs relating to sexual health should have their care managed by individuals with appropriate knowledge, skills and attitudes. Ideally this should be healthcare professionals who regularly work in a specialist Level 3 GUM service, with experience in managing sexual health, complex sexually transmitted infections, blood borne viruses, contraception, genital dermatoses, genital pain syndromes and psychosexual issues. If this is not the case then explicit links to the local specialist Level 3 GUM service should be in place to ensure access to, advice or timely review by, suitably experienced individuals.

## 7.2 Quality measures

**7.2.1** Competence to deliver services:

Self-assessment against the *Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3),* Fundamental standards[1] for:

- Regulation 4: Requirements where the service provider is an individual or partnership
- Regulation 6: Requirement where the service provider is a body other than a partnership
- Regulation 12: Safe care and treatment
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed

## 7.3 Quality standards

**7.3.1** Competence to deliver services:

Meets *the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3)*, Fundamental standards[1] for Regulations 4, 6, 12, 18 and 19.

## 7.4 What the quality statement means for each audience

### Responsibilities of commissioners

**7.4.1** All providers of services commissioned to manage sexual health services in prisons should have an appropriate contract that explicitly states requirements in relation to clinical governance including education and training, assessment of competencies and ongoing maintenance of skills (see Standard 6).

**7.4.2** Commissioners should ensure that if sexual healthcare in prisons is only commissioned at Level 1 and 2 (see Appendix B) service providers have access to senior clinical support and advice from a commissioned specialist Level 3 GUM service and access to on-going education and training for staff that reflects national standards[2].

### Responsibilities of service providers

**7.4.3** All providers of services commissioned to manage sexual health in prisons should ensure that staff have training and experience in providing sexual healthcare away from a clinic/main service site. Access to clinical advice from either a senior member of staff in the service or a local specialist Level 3 GUM service should always be available.

**7.4.4** All providers of services commissioned to manage sexual health in prisons should:

a. support the ongoing education and training of their own staff.

b. provide assurance that healthcare professionals and non-registered healthcare workers delivering sexual healthcare can demonstrate that they are competent and remain competent, to do so.

c. provide training and awareness programmes on sexual health and blood borne viruses for prison staff to promote stigma reduction.

d. provide access for their staff to specific competency-based training according to the needs of the prison. This may include: drugs, alcohol, gender-based violence, safeguarding, equality, diversity and inclusion, and health inequalities training.

e. provide access to training on PEP for prison staff, to facilitate out of hours provision. This could be facilitated by use of a PGD[3] (see Appendix D)

f. provide access to training on emergency contraception for prison staff, to facilitate out of hours provision. This could be facilitated by use of a PGD

### Responsibilities of healthcare professionals and non-registered healthcare professionals

**7.4.5** All staff should identify themselves, their role and level of knowledge/expertise so that people in prisons accessing sexual health services are aware of each individual's employing organisation and professional background/expertise.

**7.4.6** All staff should be aware of limitations in their own knowledge and when to access senior support. Clear referral pathways should exist to discuss complex cases with relevant specialists.

**7.4.7** All clinical staff have a responsibility to maintain a record of their training, and work within the boundaries of their competence, in line with their relevant professional bodies.

**7.4.8** All clinical staff should attend training on non-discrimination, inclusivity, and health rights. This should cover equality, diversity and health inequalities training.

### People in prison

**7.4.9** People in prisons with needs relating to sexual health should have their care managed by individuals with appropriate knowledge, skills and attitudes.

## 7.5 Supporting information

### Competence

**7.5.1** Competence may be defined as: the knowledge, skills, abilities and behaviours that a practitioner needs to perform their work to a professional standard[2]. Competencies should be relevant to the service that is commissioned. Sexual healthcare services in prisons should be delivered by healthcare professionals who regularly work in a specialist Level 3 GUM service. If this is not the case, then healthcare professionals providing sexual healthcare should complete training as described below (7.5.8).

**7.5.2** Commissioners should ensure that specialist Level 3 GUM services are engaged in providing relevant training to prison sexual healthcare providers who do not work regularly in specialist Level 3 GUM services.

**7.5.3** The standards needed to achieve competence should be the same regardless of professional background or employing organisation.

### Maintaining competence

**7.5.4** All healthcare professionals providing elements of sexual healthcare in prison services, have a responsibility to maintain their own clinical competence. This can be demonstrated through routine annual appraisal and revalidation processes. Commissioners and providers of sexual health services within prisons need to work together to ensure that maintenance of competencies forms part of a robust local governance framework.

### Training

**7.5.5** Specialist Level 3 GUM services are responsible for providing different types of training relating to STI management across local sexual health economies. Commissioners should ensure that specialist Level 3 GUM services are engaged in providing relevant training to healthcare providers who do not work regularly in a Level 3 GUM services.

**7.5.6** Service providers should work in collaboration with commissioners and the relevant deaneries to provide placements for specialist trainees in GUM, SRH and other postgraduate trainees including those in allied healthcare professions. Wherever possible the training provided should support services.

### BASHH qualifications of clinical competence

**7.5.7** Doctors who have undertaken formal training for the Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) in GUM will have attained the required competencies to provide sexual healthcare to the standard expected of a specialist Level 3 GUM service.

**7.5.8** The BASHH portfolio of clinical competency learning assessment qualifications provide a standardised training and assessment pathway for healthcare professionals. Staff who have not undertaken formal training through CCT or CESR in GUM, and who provide sexual health services in prisons, such as GPs, infectious disease doctors, nurses and sexual health advisers, should as a minimum complete the Sexually Transmitted Infections Foundation (STIF) theory course[4].

**7.5.9** To remain on the BASHH competency register, BASHH competency qualifications require re-certification every 5 years.

**7.5.10** BASHH also runs microscopy courses for STIs designed for nurses, healthcare assistants, trainee doctors and others needing the skills necessary to perform microscopy for STIs.

### Other key sexual health educators

**7.5.11** The FSRH has a number of qualifications and courses relevant to professionals providing sexual healthcare in prisons. Information regarding these can be found on their website[5].

**7.5.12** The Royal College of Nursing has a framework for postgraduate nursing education in sexual healthcare[6].

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# STANDARD 8

# Links to other services

## 8.1 Quality statement

People needing to be referred to another service for ongoing STI management should have this arranged promptly. Similarly, people with any other sexual health needs that the prison is unable to meet should experience easy and timely referral to a suitable service in line with national standards (e.g. HIV treatment and care within 14 days, emergency IUD insertion within 5 days), including for interventions to promote good health (e.g. peer support services). Before release from prison, arrangements for an individual's ongoing care and support should be in place to ensure continuity of service provision.

## 8.2 Quality measures

**8.2.1** Care pathways:

Clear and up to date care pathways that link all providers of sexual health services in prisons to a specialist Level 3 GUM service.

**8.2.2** Self-assessment against:

- the *Health and Social Care Act 2008 (Regulated Activities) 2014 (part 3)*, Fundamental standards[1] for:
- Regulation 12: Safe care and treatment

## 8.3 Quality Standards

**8.3.1** Evidence of up-to-date local care pathways for the management of people with needs relating to sexual health.

**8.3.2** Meets the *Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3),* Fundamental standards for Regulation 12 (England)[1].

## 8.4 What the quality statement means for each audience

**Responsibilities of commissioners.**

**8.4.1** Commissioners should work with other commissioners, public bodies, organisations, service providers and clinicians to ensure referral pathways between prison health services and the local specialist Level 3 GUM services are established and functioning effectively.

**8.4.2** Commissioners should ensure that all referral pathways from prisons to sexual health and other services, are explicit and negotiated with the support of all the services involved. This should be supported by local sexual health networks, where they exist.

### Responsibilities of service providers

**8.4.3** All providers of services commissioned to manage sexual health in prisons should ensure that effective links to other clinical services are in place. This includes but is not limited to, the following areas:

a. having formal links and clear referral pathways to the local specialist Level 3 GUM service.

b. having formal links and clear referral pathways to the local HIV and hepatitis services.

c. having formal links and clear referral pathways to other closely allied specialities and services, including but not limited to: sexual and reproductive health; gynaecology; obstetrics; abortion care; dermatology; urology; psychosexual; SARCs; gender-based violence; substance abuse; peer support; safeguarding and mental health.

d. ensuring staff are trained to use referral pathways.

e. having clear lines of communication between prisons to ensure continuity of care by the provision and receipt of a formal handover when prison transfers occur. A patient health record which travels with the person would help facilitate this.

f. working closely with other services to develop and share local policies and guidelines.

### Responsibilities of healthcare professionals and non-registered healthcare workers.

**8.4.4** All healthcare professionals and non-registered healthcare workers working in services commissioned to manage sexual health in prisons should ensure that:

a. they understand how to access specialist advice and understand all local referral pathways, in order to facilitate appropriate referrals.

b. referrals are timely and appropriate. All referrals should be accompanied by clear documentation citing the reasons for referral.

c. they understand how to raise concerns when a referral pathway does not work effectively.

### People in prison

**8.4.5** Should be informed in an accessible way of where they are being referred to and why.

**8.4.6** Should have continuity of care if transferred to another prison.

## 8.5 Supporting information

### Clinical links

**8.5.1** All providers of sexual health services in prisons have a responsibility to establish links with local specialist Level 3 GUM services and other closely allied specialities to provide high quality, safe and effective services that meet the needs of people in prisons[1].

### Care pathways

**8.5.2** Collaboration and integration between services is essential. This is especially important in the prison setting, where people can have a variety of complex health needs.

**8.5.3** Care pathways describe a seamless patient journey across a range of health and social care services, using evidence-based guidelines and multidisciplinary working. Care pathways from a prison sexual health service to specialist Level 3 GUM services and other closely allied specialties will likely cover referral criteria, triage criteria, out-of-hours advice, diagnostics advice, two-way communication, clinical guidelines, management options, training and education of staff. All providers of sexual health services in prisons should be aware of, and adhere to, agreed care pathways which should be monitored for effectiveness.

### Sexual health networks

**8.5.4** Providers of sexual health services in prisons should integrate into the local sexual health network where these exist. Building links with the local Level 3 Specialist GUM service has the benefit of sharing intelligence and good practice, whilst providing opportunity to access training and further support.

### Peer support

**8.5.5** Peer support is *'a range of approaches through which people with similar long-term conditions or health experiences support each other to better understand the conditions and aid recovery or self-mangement'*[2]. Peer support utilises a relationship in which people see each other as equal partners with a focus on mutual learning and growth. At the roots of peer support there is a hope and a belief that sharing and support can transform lives and the lives of communities for the better. Peer support provision is specifically recommended by commissioning guidelines within the justice system[3] and by the NHS five year forward view as an intervention to promote self-management of health[4]. All prisons have a duty of care to provide access to peer support programmes, using those with lived experiences, to deliver safe, high-quality interventions that meet the needs of people in prisons.

## References


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# STANDARD 9

# Patient and public engagement

## 9.1 Quality statement

People in prison need to be consulted about the development and delivery of sexual health services in prison. Those using services should be asked to provide feedback to promote patient centred care, with feedback regularly reviewed and acted on to improve services.

## 9.2 Quality measures

**9.2.1** Evidence that a patient and public engagement plan is in place, detailing how this is incorporated into service development and delivery. The plan should include a description of how the views and experiences of people in a range of equality groups are sought e.g. gender minorities; sexual minorities; groups that are racially minoritised; people with visible and less visible disabilities; people for whom English is not a first language. It should also demonstrate mechanisms are in place to assure patient confidentiality in collecting and distributing feedback.

**9.2.2** The use of measurement tools to collect information from patients. These can include Patient Reported Outcome Measures (PROMs) and Patient Reported Experience measures (PREMs) or other similar tools.

**9.2.3** Compliance with *the Health and Social Care Act 2008 (Regulated Activities) regulations 2014*[1]*:*

- Regulation 9: person-centred care
- Regulation 10: dignity and respect

**9.2.4** Compliance with the *Equality Act 2010*[2].

## 9.3 Quality standards

**9.3.1** Evidence of a patient and public engagement plan which affords public consultation and feedback, including engagement of equality groups and confidentiality measures.

**9.3.2** Evidence from service providers of effectiveness of care from the patients' perspective and the patient experience of their care via annual reporting. Measurement tools can include Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMS).

**9.3.3** Competence to deliver services: Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*[1] for regulations 9 and 10.

## 9.4 What the quality statement means for each audience

### Responsibilities of commissioners

**9.4.1** Commissioners should develop a sexual health patient and public engagement strategy for their commissioned area.

**9.4.2** Commissioners, working with providers and people in prison, should develop local quality measurement frameworks utilising nationally validated tools.

**9.4.3** Commissioners should proactively engage with users and non-users of services from all equality groups. Lay* representation on commissioning groups should be encouraged.

**9.4.4** Commissioners should ensure that there is evidence of patient and public engagement in service providers' annual reports.

**9.4.5** Commissioners should agree with individual services the methodologies used to undertake robust patient and public engagement, with attention to patient confidentiality, within the commissioned area.

* Lay users are people who are not clinically trained and have not worked in a profession or role allied to healthcare provision.

### Responsibilities of service providers

**9.4.6** All providers of services commissioned to manage sexual health in prisons should ensure that effective patient and public engagement arrangements are in place. This includes but is not limited to the following:

a. identifying named individuals in each service with responsibility for leading patient and public engagement.

b. promoting equality, diversity and inclusion by seeking and respecting different beliefs and opinions during service development and delivery and adapting processes where necessary to ensure equity of participation.

c. engagement with people in prison, people with history of incarceration and others within the criminal justice system should be sought.

d. the private nature of sexual health, and associated confidentiality concerns, should be taken into account as these may present barriers to participation. Innovative methods to overcome this, including the ability to provide anonymous feedback should be available.

e. proactively seeking participation from people who experience health inequalities and poor health outcomes.

f. engaging with people in prison, to assess their experience of the sexual health services they have used and to seek their opinion about other services they may require.

g. routinely engaging with people in prison, including non-users of sexual health services e.g. by having a regular patient and public engagement forum.

h. assessing potential access issues and why population groups may not be using services, taking into account security considerations, and how these may impact on service utilisation.

i. providing clear information and seeking to facilitate involvement by all. This may require the involvement of advocacy services and peer support.

j. providing evidence of how the service has responded to feedback and how PROMS and PREMS are monitored.

k. evidence of the development of staff engagement and training in patient and public engagement.

l. the use of appraisal processes to obtain patient feedback for all staff interacting with people using services.

m. ensuring robust governance procedures to maintain confidentiality in patient and public engagement, including the option for feedback to be given anonymously.

**Responsibilities of healthcare professionals and non-registered healthcare workers**

**9.4.7** All healthcare professionals and non-registered healthcare workers should:

a. be aware of the importance of patient and public engagement and actively engage in it when opportunities arise.

b. encourage patient involvement and feedback, both positive and negative, taking into account the barriers to participation that may exist for people in prison, acknowledging that providing feedback in this circumstance may include the disclosure of personal medical information.

c. respond to feedback in an open and honest fashion by using appropriate methods of communication.

d. review relevant information to understand patients' experiences, both positive and negative, and learn how to improve on them.

**People in prison**

**9.4.8** Should be made aware that their feedback is valued, and be encouraged to provide feedback on their personal experience of care and to offer opinions about sexual health services, both current and future.

**9.4.9** Should always receive a response to any concerns, or complaints they make about the service (see Standard 6).

**9.4.10** Must be assured that any individual feedback will be treated confidentially, recognising that if feedback is given in a group setting that this may not be possible.

**9.4.11** Should be made aware of the option to give anonymous feedback.

## 9.5 Supporting information

**9.5.1** In England, commissioners have a statutory duty to undertake patient and public engagement in all stages of the commissioning process, with an emphasis on those who experience health inequalities[3]. Similar legal requirements exist in Scotland[4], Wales[5] and Northern Ireland[6]. People in prison experience a higher burden of overall ill health, and there is high prevalence of risk factors for poor sexual health for example mental health conditions, substance misuse and social deprivation[7]. People in prison are known to be disproportionately affected by blood borne viruses[8].

**9.5.2** People in prison may experience unique barriers to engagement with feedback processes, including lack of digital access, language barriers when English is not spoken as a first language, low literacy skills, restriction of movement and frequent movement due to short sentences and being on remand. Feedback mechanisms need to take this into account to assure effective participation. The inherent restrictions on freedom for people in prison result in power inequity. Mistrust may also be a significant barrier to patient and public engagement, necessitating clear explanation of the confidentiality of engagement at the outset[8].

**9.5.3** People in prison are a diverse group, with people from racially minoritised groups, people with mental health conditions and people with learning disabilities, being overrepresented[9]. Commissioners have a responsibility to ensure that a wide range of people in prison take part in patient and public engagement, including those with protected characteristics under the *Equality Act* (2010)[2]. The Women's Health Strategy for England specifically states the need to involve women accessing the criminal justice system in the development of health services for them[10], Patient and public engagement is expected to come from a population representative of the general prison population. Groups who may face additional challenges to participation in patient and public engagement may therefore require significant support to ensure patient and public engagement is fully representative.

## References


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10. Department of Health and Social Care (2022) Women's Health Strategy for England. Available at: https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#ministerial-foreword

# APPENDIX A

## Writing and strategic group members and representatives

| NAME | DESIGNATION | ORGANISATION |
|---|---|---|
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| **Dr Daniella Brawley** | Consultant in Sexual Health and HIV (NHS Grampian) | BASHH Scotland |
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| **Dr Christie Craddock** | Public Health Wales | NHS Wales |
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| **Dr Sophie Forsyth** | BASHH Education Committee Chair, Consultant Physician in Sexual Health and HIV (Great Western Hospital NHS Foundation Trust) | BASHH |
| **Dr Patrick French** | BASHH Patient/Public Group Chair Consultant Physician in Sexual Health and HIV (CNWL NHS Foundation Trust) | BASHH |
| **Dr Catherine Glover** | RCGP Secure Environments Group Southwest Representative, GP Partner (Hanham Health) | Royal College of General Practitioners |
| **Dr Jake Hard** | Clinical Lead, Health & Justice Information System, NHS England Improvement, Clinical Director HMP Cardiff (Cardiff and Vale Health Board) | NHS England Improvement |
| **Dr Linda Harris** | Chair Health and Justice Clinical Reference Group NHS England, Chief Executive Officer & Chief Medical Officer (Spectrum Community Health CIC) | NHS England, Health and Justice Clinical Reference Group |
| **Danielle Holden** | Project Manager, Health and Justice, Children and Young People (NHS England) | NHS England |
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| | | |
|---|---|---|
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| **Jonathan van der Veen** | Health and Wellbeing Services Manager, Rehabilitation and Support Services Group | HM Prison and Probation Service |
| **Dr Javier Vilar** | Consultant in Infectious Diseases (Pennine Acute Hospitals NHS Trust) | British HIV Association |
| **Rachel Wilson** | Co-Commissioner OPD Pathway | HM Prison and Probation Service |
| **Felicity Young** | Nurse Consultant, Sexual health and HIV (Solent NHS Trust) | BASHH Prison SIG |

# APPENDIX B

## Project definitions for elements of STI management

The following lists comprise elements of STI management that are appropriate at various levels of service provision. They are drawn from the three Levels (1, 2 and 3) originally defined in 'the National Strategy for Sexual Health and HIV' (2001) and have been updated by this project to take account of the descriptor of specialist services in 'A Framework for Sexual Health Improvement in England' (DHSC, 2013). They specifically consider STIs and related conditions and do not include elements of contraceptive and reproductive healthcare that may also be provided at these levels. The FSRH has developed descriptors of specialist contraceptive and reproductive healthcare.

The elements of care listed below are the maximum specifications for each service level, not the minimum requirements. Care pathways should be in place for onward referral if the clinical condition is beyond the scope or competence of the original service. To ensure optimum care for service users, it is recommended that there should be formal links between services providing STI management at Levels 1 or 2 and those at Level 3 as set out in Standard 8. Clinical guidance on STI management relevant to the elements of care listed below can be found at www.bashh.org.uk. It should be noted that the elements of care do not suggest where these can be delivered as this will be a commissioning decision based on the services commissioned and individual competence of the clinicians.

### Level 1 – Asymptomatic

**Sexual history taking and risk assessment**

Including identifying:

- safeguarding issues in under 18s and vulnerable adults with referral as appropriate
- the need for emergency contraception
- the need for HIV post-exposure prophylaxis (PEP) following sexual exposure
- sexual assault with referral as appropriate

**Signposting to appropriate sexual health services**

**Chlamydia screening**

Opportunistic screening for genital chlamydia in asymptomatic women and other people with a womb or ovaries under the age of 25 in line with the National Chlamydia Screening Programme policy

**STI screening and treatment of asymptomatic infections (except treatment for gonorrhoea and syphilis) in women and men (except MSM)***

**Partner notification of STIs or onward referral for partner notification**

**HIV testing**

Including pre-test discussion and giving results

**Point of care HIV testing**

Rapid HIV testing using a validated test (with confirmation of positive results or referral for confirmation)

**Screening for hepatitis B and hepatitis C and vaccination for hepatitis B**

Appropriate screening and vaccination in at-risk groups

**Sexual health promotion**

Provision of verbal and written sexual health promotion information

**Condom distribution**

Provision of condoms for safer sex

**Assessment and referral for psychosexual problems**

## Level 2 – Symptomatic

**Incorporates Level 1 plus:**

**STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)* and women including:**

- gonorrhoea if able to perform gonorrhoea cultures with rapid transport to the laboratory

**The following should be referred to Level 3:**

- men with dysuria and/or genital discharge**
- symptoms at extra-genital sites e.g. rectal or pharyngeal
- pregnant women
- genital ulceration other than uncomplicated genital herpes
- gonorrhoea if unable to perform gonorrhoea cultures with rapid transport to the laboratory

## Level 3 – Complex/Specialist

**Incorporates Level 1 and 2 plus:**

**STI testing and treatment of MSM***

**STI testing and treatment of transgender people**

**STI testing and treatment of men with dysuria and genital discharge****

**Testing and treatment of STIs at extra-genital sites**

**STIs with complications**

**STIs in pregnant women and people**

**Gonorrhoea cultures and treatment of gonorrhoea*****

**Recurrent conditions**

Recurrent or recalcitrant STIs and related conditions

**Management of syphilis and blood borne viruses**

Including the management of syphilis at all stages of infection

Tropical STIs

**Specialist HIV treatment and care**

**Provision and follow up of HIV post-exposure prophylaxis (PEP) following sexual exposure******

**Provision and follow up of HIV pre-exposure prophylaxis (PrEP)*******

**STI service co-ordination across a network including:**

- Clinical leadership of STI management
- Co-ordination of clinical governance
- Co-ordination of STI training
- Co-ordination of partner notification

* The testing and management of men who have sex with men (MSM) has been defined as an element of specialist care at Level 3 because the majority of infections in this group are in the rectum and/or pharynx rather than the urethra and the management of these infections is more complex and requires specialist provision (see Standard 3). However, for asymptomatic MSM there may be some Level 2 services which have the full range of investigations available, and the necessary clinical and prevention skills, to effectively manage care.

** The appropriate management of men with dysuria and/or urethral discharge requires immediate microscopy (see Standard 3). This is usually only available at specialist GUM (Level 3) services so the testing and treatment of such men has been defined as an element of care at Level 3. However, some services, at Level 2, may be able to provide immediate microscopy (with the appropriate training and quality assurance) and management of such men would then be appropriate at these services.

*** Gonorrhoea culture is an essential test before treating gonorrhoea or giving empirical antibiotics to people with symptoms (see Standard 3).

**** PEPSE is often available in other settings such as Accident and Emergency, but referral to a specialist GUM (Level 3) service is required for ongoing management.

***** A specialist GUM (Level 3) service or HIV service is required for ongoing management.

# APPENDIX C

## Summary of the mandatory sexual health, reproductive health and HIV datasets*

| | | | RESPONSIBLE ORGANISATION | | | |
|---|---|---|---|---|---|---|
| INFORMATION COLLECTED | SERVICES AFFECTED | DATASET | ENGLAND | WALES | SCOTLAND | NORTHERN IRELAND |
| **STI and HIV diagnoses, tests and services** | Level 2 and 3 GUM services<br><br>Diagnostic and reference laboratories in Scotland | GUMCAD STI Surveillance System in England, Wales and Northern Ireland<br><br>Electronic Communication of Surveillance in Scotland System (ECOSS) for laboratories and Sexual Service data from the National Sexual Health IT system (NaSH) in Scotland | UKHSA | Public Health Wales | Public Health Scotland | Public Health Agency NI |
| **HIV diagnoses and clinical outcomes of people accessing care** | HIV diagnosing sites and outpatient services | HIV and AIDS Reporting System (HARS) in England<br><br>SOPHID, and HIV new diagnoses and deaths in Wales and Northern Ireland<br><br>Electronic Communication of Surveillance in Scotland System (ECOSS) for HIV diagnoses and HIV care/attendance data by each health board for Scotland | UKHSA | Public Health Wales | Public Health Scotland | Public Health Agency NI |
| **Chlamydia tests and diagnoses** | All laboratories commissioned to provide chlamydia testing | CTAD Chlamydia Surveillance System in England<br><br>Electronic Communication of Surveillance in Scotland System (ECOSS) in Scotland | UKHSA | — | Public Health Scotland | — |
| **Contraception data** | Settings (excluding general practice in Scotland) offering contraceptive services | Sexual and Reproductive Health Activity Dataset (SRHAD) in England and Wales.<br><br>Data on Long Acting Reversible Contraception prescribing for primary care from Prescribing Information System (PIS) and from Sexual health using National Sexual Health IT System (NaSH) in Scotland | NHS Digital** | Public Health Wales | Information Services Division Scotland (part of NHS National Services Scotland) | — |

* Correct as of August 2022

** NHS Digital is expected to merge with NHS England in 2023 and the NHS Digital brand to be retired.

# APPENDIX D

This PGD is produced by the Specialist Pharmacy Service, BASHH and BHIVA. Please ensure the most up to date version is used (https://www.sps.nhs.uk/articles/emtricitabine-tenofovir-and-raltegravir-tablets-for-hiv-pep/).

## Patient Group Direction for the supply of HIV Post Exposure Prophylaxis

Insert logo of authorising body

This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practice under it. The most recent and in date final signed version of the PGD should be used.

# PATIENT GROUP DIRECTION (PGD)

## Supply of emtricitabine/tenofovir disoproxil and raltegravir tablets for HIV Post Exposure Prophylaxis (HIV PEP) location/service/organisation

Version Number 1.1

| CHANGE HISTORY | |
|---|---|
| **Version and Date** | **Change details** |
| **Version 1.0 August 2021** | New template |
| **Version 1.1 August 2022** | Updated to included advice on interaction between PEP and antacids/multi vitamin and mineral preparations and management of this interaction. |

Each organisation using this PGD must ensure that it is formally signed by a senior pharmacist, a senior doctor and any other professional group representatives involved in its review and that it is reviewed in line with the organisations' PGD governance system. The organisation's governance lead must sign to authorise the PGD on behalf of the authorising organisation to ensure that this document meets legal requirements for a PGD.

This Patient Group Direction (PGD) must only be used by registered professionals who have been named and authorised by their organisation to practise under it (See Appendix A). The most recent and in date final signed version of the PGD must be used

**PGD DEVELOPMENT GROUP**

| | |
|---|---|
| Date PGD template comes into effect: | 01/08/2021 |
| Review date | February 2024 |
| Expiry date: | 31/07/2024 |

This PGD template has been peer reviewed by the PEP for SARCs PGDs Short Life Working Group in accordance with their Terms of Reference. It has been approved by the British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH) in July 2021.

**This section MUST REMAIN when a PGD is adopted by an organisation.**

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The PGD has also been reviewed by members of the Sexual Health PGDs Short Life Working Group in accordance with their Terms of Reference.

| Name | Designation |
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| Ali Grant | Highly Specialist Clinical Pharmacist: HIV, Sexual and Reproductive Health |
| Chetna Parmar | Pharmacist Adviser, Umbrella |
| Dr Cindy Farmer | Chair General Training Committee<br><br>Faculty of Sexual and Reproductive Healthcare (FSRH) |
| Dr John Saunders | Consultant in Sexual Health and HIV |
| Dr Rachael Jones | Consultant in HIV and Sexual Health, Chelsea and Westminster NHS Foundation Trust |
| Dr Rita Browne | Consultant in Sexual Health and HIV |
| Jodie Crossman | Specialist Nurse. BASHH SHAN SIG Chair |
| Belinda Loftus | Specialist Nurse, BASHH Board Nurse Representative, BASHH SHAN SIG Secretary |
| Michelle Jenkins | Advanced Nurse Practitioner, Clinical Standards Committee<br><br>Faculty of Sexual and Reproductive Healthcare (FSRH) |
| Portia Jackson | Pharmacist, Cambridgeshire Community Services |

**The PGD template is not legally valid until it has had the relevant organisational approvalsee below.**

| Glossary | |
|---|---|
| **ART** | Anti-Retroviral Therapy |
| **BASHH** | British Association for Sexual Health and HIV |
| **BHIVA** | British HIV Association |
| **eGFR** | Estimated Glomerular Filtration Rate |
| **GUM** | Genitourinary Medicine |
| **HIV** | Human Immunodeficiency Virus |
| **PEP** | Post Exposure Prophylaxis |
| **RCN** | Royal College of Nursing |
| **STI** | Sexually Transmitted Infection |

## ORGANISATIONAL AUTHORISATIONS AND OTHER LEGAL REQUIREMENTS

**This page may be deleted if replaced with a format agreed according to local PGD policy with relevant approvals and authorisation.**

The PGD is not legally valid until it has had the relevant organisational authorisations.

To ensure compliance with the law, organisations must add local authorisation details i.e. clinical authorisations and the person signing on behalf of the authorising organisation. You may either complete details below or delete and use a format agreed according to local PGD policy which complies with PGD legislation and NICE MPG2 PGD 2017.

| Name | Job title and organisation | Signature | Date |
|---|---|---|---|
| **Senior doctor** | | | |
| **Senior pharmacist** | | | |
| **Senior representative of professional group using the PGD** | | | |
| **Person signing on behalf of authorising body** | | | |

It is the responsibility of the provider organisation to ensure that all legal and governance requirements for using the PGD are met.

To meet legal requirements, authorising organisations must add an Individual Practitioner Authorisation sheet or List of Authorised Practitioners. This varies according to local policy and how the service is managed but this should be a signature list or an individual agreement.

PGDs do not remove inherent professional obligations or accountability. It is the responsibility of each professional to practice only within the bounds of their own competence and in accordance with their own Code of Professional Conduct. Individual practitioners must declare that they have read and understood the Patient Group Direction and agree to supply/administer medication(s) listed only in accordance with the PGD.

**ORGANISATIONS MAY ALSO ADD:**

- Local training and competency assessment documentation
- Other supporting local guidance or information
- Links to local PGD Policy and other supporting guidance
- Audit requirements

Any reference to a Trust protocol (either clinical to be followed as part of the administration of a medication with the PGD or for any other purpose) must be referenced and hyperlinked to ensure the practitioner acting under the PGD has direct access to the protocol for reference.

| 1. Characteristics of staff | |
|---|---|
| **Qualifications and professional registration** | Current contract of employment within a Local Authority or NHS commissioned service or an NHS Trust/organisation.<br><br>Registered healthcare professional listed in the legislation as able to practice under Patient Group Directions. |
| **Initial training** | The registered healthcare professional authorised to operate under this PGD must have undertaken appropriate education and training and successfully completed the competencies to undertake clinical assessment of individuals leading to an assessment of risk of infection of the condition listed.<br><br>The registered healthcare professional authorised to operate under this PGD must have experience in the delivery of emergency or unplanned care in primary/secondary including, as relevant occupational health, sexual health medicine and/or the pre-hospital care setting, including forensic medicine.<br><br>Recommended requirement for training would be successful completion of a HIV PEP specific relevant module/course accredited or endorsed by BHIVA, BASHH, RCN or a university or advised in the RCN Sexual Health Education directory.<br><br>The healthcare professional has completed locally required training (including updates) in safeguarding children and vulnerable adults. |
| **Competency assessment** | • Individuals operating under this PGD must be assessed as competent or complete a self-declaration of competence to operate under this PGD.<br>• Staff operating under this PGD are encouraged to review their competency using the NICE Competency Framework for health professionals using patient group directions |
| **Ongoing training and competency** | • Individuals operating under this PGD are personally responsible for ensuring they remain up to date with the use of all medicines and guidance included in the PGDif any training needs are identified these should be discussed with the senior individual responsible for authorising individuals to act under the PGD and further training provided as required.<br>• Organisational PGD and/or medication training as required by employing Trust/organisation. |
| The decision to supply any medication rests with the individual registered health professional who must abide by the PGD and any associated organisational policies. | |

| 2. Clinical condition or situation to which this PGD applies | |
|---|---|
| **Clinical condition or situation to which this PGD applies** | • HIV Post-Exposure Prophylaxis (HIV PEP) |
| **Criteria for inclusion** | • Individuals 40kg or greater in weight, presenting within 72 hours of potential HIV exposure risk as per BASHH UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021<br>• Individual able and willing to attend either a face to face or telephone follow up appointment with relevant GUM/Sexual Health/HIV clinic within 3 days of PEP being started. In exceptional circumstances where access to a clinic follow up may be delayed due to bank holiday etc. this must be within 5 days.<br>• ***Noteif locally required add details for supply during a pandemic in line with local policy/SOPalso review 'Duration of treatment' and 'Quantity to be supplied' section.*** |

| | |
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| **Criteria for exclusion** | • Consent not given.<br>• Individuals under 16 years old and assessed as lacking capacity to consent using the Fraser Guidelines.<br>• Individuals 16 years of age and over and assessed as lacking capacity to consent.<br>• Individuals under 40kg in weight.<br>• Individuals presenting following potential HIV exposure more than 72 hours ago<br>• Known hypersensitivity or allergy to emtricitabine, tenofovir disoproxil, raltegravir or to any component of the productSee current product Summary of Product Characteristics (SPC) for active ingredients and excipients<br>• Individuals are excluded if they are:<br>➢ known to be HIV positive<br>➢ already being treated with anti-retroviral medication<br>➢ known renal impairment where eGFR less than 50ml/minute<br>➢ known hepatitis B infection, liver impairment or disease<br>➢ immunocompromised<br>➢ known pregnancy<br>➢ breastfeeding<br>➢ known to have hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption<br>➢ already receiving medication which interacts with anti-retroviral medication and defined as a rating of 'Red' when assessed on Interaction charts produced by the Liverpool HIV Pharmacology Group http://www.hiv-druginteractions.org See 'Drug Interactions' section<br>➢ currently taking antacids containing aluminium, calcium carbonate and magnesium either regularly or as requiredPEP may be supplied if individual advised and willing/able not to take these products for duration of PEP course (28 days)<br>➢ taking multivitamins/other supplements containing iron, aluminium, calcium, magnesium and zinc either regularly or otherwisePEP may be supplied if individual advised and willing/able not to take these products for duration of PEP course (28 days) |

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| **Cautions including any relevant action to be taken** | • Individuals with significant psychiatric illness:<br>➢ Consider contact with mental health team/GP if possible<br>➢ Advise individual of risks and also get consent to discuss with their GP/mental health team that they have been given PEP and will need to be monitored to ensure mental health does not deteriorate.<br>➢ For individuals who are not monitored, recommend that they should see their GP within next few days to discuss mental health<br>➢ Highlight to the referral team that the individual has a pre-existing mental health condition<br>• Individual already receiving medication which interacts with anti-retroviral medication defined as an 'Amber' or 'Red' rating when assessed on Interaction charts produced by the Liverpool HIV Pharmacology Group http://www.hiv-druginteractions.org or where an interaction check is not available via this resource. See 'Drug Interactions' section.<br>• Discuss with an Independent Prescriber regarding conditions/ medicines/side effects of which the healthcare professional is unsure. |
| **Action to be taken if the individual is excluded or declines treatment** | • If declined, ensure individual is aware of the reasons this medication has been offered and the potential consequences of not receiving it. Record reason for declining in record.<br>• Weight under 40kg does not preclude the use of HIV PEP but the individual should be referred to a prescriber for consideration of suitability/an alternative regime.<br>• PEP is generally not recommended beyond 72 hours post-exposure. Any decision on initiation of PEP more than 72 hours after the exposure should be left to the discretion of clinicians in discussion with the exposure recipient, in full knowledge of the lack of evidence of efficacy after this time point. In this circumstance PEP would need to be prescribedit cannot be supplied under this PGD.<br>• If eGFR known to be less than 50ml/minuterefer to a prescriber for further investigation and consideration of PEP.<br>• Known hepatitis B does not preclude the use of HIV PEP but the individual should be referred to a prescriber.<br>• Pregnancy does not preclude the use of HIV PEP but the individual should be referred to a prescriber.<br>• Breast feeding does not preclude the use of HIV PEP but the individual should be referred to a prescriber.<br>• If excluded, explain the reasons for exclusion to the individual and document in the consultation record.<br>• Where required refer the individual to a suitable health service provider if appropriate and/or provide them with information about further options. |

| 3. Description of treatment | | |
|---|---|---|
| **Name, strength & formulation of drug** | Emtricitabine 200mg/tenofovir disoproxil 245mg tablet (e.g. Truvada®) | Raltegravir 600mg tablet (e.g. Isentress®) |
| **Legal category** | POM | POM |
| **Route of administration** | Oral | Oral |
| **Dose and frequency of administration** | One tablet once daily | 1200mg once daily |
| **Duration of treatment** | 28 days.<br><br>Individual should be advised that total course length is 28 days but the original containers contain 30 days of medicationall remaining tablets should be returned to a pharmacy for disposal.<br><br>***Note this wording reflects a full course supplyif a starter pack is being supplied the regime should be amended in line with BASHH guidance/in line with local supply and commissioning agreements.***<br><br>***Also if locally required add details for supply during a pandemic in line with local policy/SOPalso review 'Criteria for inclusion' and 'Quantity to be supplied' sections.*** | |
| **Quantity to be supplied (NOTE both emtricitabine/ tenofovir disoproxil and raltegravir tablets must be supplied)** | Appropriately labelled pack of 30 x emtricitabine 200mg/tenofovir disoproxil 245mg tablets<br><br>***Note this wording reflects a full course supplyif a starter pack is being supplied the regime should be amended in line with BASHH guidance/in line with local supply and commissioning agreements.***<br><br>***Also if locally required add details for supply during a pandemic in line with local policy/SOPalso review 'Criteria for inclusion' and 'Duration of treatment' sections.*** | Appropriately labelled pack of 60 x raltegravir 600mg tablets<br><br>***Note this regime reflects a full course supplyif a starter pack is being supplied the regime should be amended in line with BASHH guidance/in line with local supply and commissioning agreements.***<br><br>***Also if locally required add details for supply during a pandemic in line with local policy/SOPalso review 'Criteria for inclusion' and 'Duration of treatment' sections.*** |

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| **Identification of adverse reactions** | A detailed list of adverse reactions is available in BNF or the product SPC. The following side effects are reported as common with emtricitabine/ tenofovir disoproxil:<br>• diarrhoea, vomiting, nausea<br>• dizziness, headache<br>• feeling weak<br>• pain, stomach pain<br>• difficulty sleeping, abnormal dreams<br>• problems with digestion resulting in discomfort after meals, feeling bloated, flatulence<br>• rashes (including red spots/ blotches sometimes with blistering and swelling of the skin) which may be allergic<br>• itching, changes in skin colour including darkening of the skin in patches<br>• other allergic reactions, such as wheezing, swelling or feeling light-headed<br>• swelling of the face, lips, tongue or throat | A detailed list of adverse reactions is available in BNF or the product SPC. The following side effects are reported as common with raltegravir:<br>• decreased appetite<br>• abnormal dreams, insomnia, nightmare<br>• abnormal behaviour<br>• depression<br>• dizziness, headache<br>• psychomotor hyperactivity<br>• vertigo<br>• abdominal distention, abdominal pain, diarrhoea, flatulence, nausea, vomiting, dyspepsia<br>• rash<br>• asthenia<br>• fatigue,<br>• pyrexia |

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| **Drug interactions** | All concurrent medications should be reviewed for interactions.<br><br>Interactions which mean the named medicines **must not be supplied under this PGD** are defined as 'Red' rating when assessed on the interaction charts produced by the Liverpool HIV Pharmacology Group http://www.hiv-druginteractions.org Refer individual to a prescriber.<br><br>Where an interaction is defined as 'Amber' rating when assessed on the interaction charts produced by the Liverpool HIV Pharmacology Group http://www.hiv-druginteractions.org discuss with a relevant prescriber or pharmacist to confirm suitability of supply. Refer individual to a prescriber where supply not suitable within parameters of this PGD.<br><br>• N.B. The following are exclusions to supply under this PGD due to risk of compromisation of raltegravir absorption:<br>➢ Antacids containing aluminium, calcium carbonate and magnesium<br>➢ Multivitamins/other supplements containing iron, aluminium, calcium, magnesium and zinc<br><br>Discuss with a relevant prescriber or pharmacist to confirm suitability of supply in all cases where an interaction is not available on the interaction charts produced by the Liverpool HIV Pharmacology Group http://www.hiv-druginteractions.org.<br><br>Refer individual to a prescriber where supply not suitable within parameters of this PGD. |
| **Off label use** | Best practice advice is given by BHIVA/BASHH and the Faculty of Forensic and Legal Medicine (FFLM) is used as the reference guidance in this PGD and may vary from the Summary of Product Characteristics (SPC).<br><br>**Off label use included within this PGD:**<br><br>• The named medicines within the PGD do not include PEP within their licenced indicationsguidance supports its use.<br><br>Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected drugs for use lies with pharmacy/Medicines Management.<br><br>Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/carer that the drug is being offered in accordance with national guidance but that this is outside the product licence. |
| **Storage** | Medicines must be stored securely according to national guidelines and in accordance with the product SPC. |

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| **Management of and reporting procedure for adverse reactions** | • Healthcare professionals and individuals/carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme<br>• Record all adverse drug reactions (ADRs) in the patient's medical record.<br>• Report via organisation incident policy. |
| **Written information and further advice to be given to individual** | • original containers contain 30 days of medicationall remaining tablets should be returned to a pharmacy for disposal. ***Note this wording reflects a full course supplyif a starter pack is being supplied the regime should be amended in line with BASHH guidance/in line with local supply and commissioning agreements***<br>• Advise that a patient information leaflet (PIL) is provided with the original pack. Note that the regime being taken may not reflect that detailed in the PILit is therefore advisable that the HIVPA information leaflet is also offered or the link provided (https://hivpa.org/wp-content/uploads/2021/04/HIVPA-PEP-PIL-April-2021-generic-TDF-FTC-RAL-OD-Final.pdf)<br>• Explain mode of action, side effects, and benefits of the medicine.<br>• PEP should be commenced as soon as possible after exposure, allowing for careful risk assessment, ideally within an hour.<br>• Ensure individual is counselled as to dosage regimen.<br>• Advise if individual is concerned about any side effects they experience they should contact their clinic as soon as possible.<br>• Advise individuals that PEP medicines may interact with other medicines, including medicines purchased over-the-counter and some supplements and herbal remedies. These include:<br>➢ Calcium, iron, magnesium, aluminium and zinc which can be found in indigestion remedies, vitamins and mineral tablets. These can prevent raltegravir from being absorbed so should not be taken.<br>➢ **Advise individual that these must not be taken for the duration of the PEP course (28 days)**<br>• Advise individuals to seek advice on any new medicines commenced whilst taking PEP (including over the counter medicines) from a prescriber/pharmacist to check for interactions.<br>• Advise that PEP is not a contraceptive.<br>• Advise on use of condoms until result of final HIV test known (minimum of 73 days/10.5 weeks after exposure assuming full 28 PEP course is completed). |

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| **Written information and further advice to be given to individual (continued)** | • **Emtricitabine/tenofovir disoproxil tablets only**<br>• If needed, the tablets can be dispersed in approximately 100ml of water, orange juice or grape juice and taken immediately.<br>• It is preferable that these tablets are taken with food.<br>• If a dose is missed within 12 hours of the time it is usually taken, the dose should be taken as soon as possible and the normal dosing schedule should be resumed. If a dose is missed by more than 12 hours and it is almost time for the next dose, the missed dose should not be taken and the usual dosing schedule should be resumed.<br>• If vomiting occurs within 1 hour of taking the tablet, another tablet should be taken. If vomiting occurs more than 1 hour after taking the tablet a second dose should not be taken<br><br>**Raltegravir tablets only**<br>• Tablets can be administered with or without food. The tablets should not be chewed, crushed or split due to anticipated changes in the pharmacokinetic profile. |
| **Follow up treatment** | • Individuals must be referred to a relevant HIV, GUM, Sexual Health or infectious disease departments for regular clinical follow-up during the period of PEP, to monitor possible toxicity and adherence to the antiretroviral regimen.<br>• Individuals exposed to HIV should have follow-up counselling, post-exposure testing and medical evaluation whether or not they have received PEP under this PGD.<br>• Final HIV testing is recommended at a minimum of 45 days after the PEP course is completed. If the 28 day course is completed, this is a minimum of 73 days (10.5 weeks) after exposure. For sexual exposures this can be performed at 12 weeks to align with syphilis testingadvise individual on appropriate appointment schedule/s.<br>• Advise that it may take 14 days for a chlamydia test to show a positive result after infection and 3 months for hepatitis B, C, or syphilis tests to show positive resultsadvise individual on appropriate testing appointment schedule/s.<br>• Individuals should be advised of signs of infection with any STI and if symptoms of infection develop they should seek medical advice.<br><br>**Follow up appointments with the individual should be arranged in line with local care pathway** |

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| **Records** | **Record:**<br>• The consent of the individual and/or<br>➢ If individual is under 16 years of age document capacity using Fraser guidelines.<br>➢ If individual is under 13 years of age and not competent, record action taken<br>➢ If individual is under 16 years and not competent, record action taken<br>➢ If individual over 16 years of age and not competent, record action taken<br>• Name of individual, address, date of birth<br>• GP contact details where available/appropriate<br>• Relevant past and present medical history<br>• Relevant medication history (to include over the counter, herbal medications, supplements and recreational drug use).<br>• Examination or microbiology finding/s where relevant.<br>• Any known allergies<br>• Name of registered health professional<br>• Name of medication supplied<br>• Date of supply<br>• Dose supplied<br>• Quantity supplied<br>• Advice given, including advice given if excluded or declines treatment<br>• Details of any adverse drug reactions and actions taken<br>• Advice given about the medication including, dosing regimen, side effects, benefits, and when and what to do if any concerns<br>• Any referral arrangements made<br>• Any supply outside the terms of the product marketing authorisation<br>• Recorded that supplied via Patient Group Direction (PGD)<br>Records should be signed and dated (or a password controlled e-records) and securely kept for a defined period in line with local policy.<br>All records should be clear, legible and contemporaneous.<br>A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy. |

| 4. Key references | |
|---|---|
| **Key references (accessed July 2021)** | • Electronic Medicines Compendium http://www.medicines.org.uk/<br>• Electronic BNF https://bnf.nice.org.uk/<br>• NICE Medicines practice guideline "Patient Group Directions" https://www.nice.org.uk/guidance/mpg2<br>• Royal Pharmaceutical Society Safe and Secure Handling of Medicines December 2018 https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines<br>• BASHH UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021 https://www.bashhguidelines.org/current-guidelines/hiv/post-exposure-prophylaxis/ |

**Appendix A – Registered health professional authorisation sheet (examplelocal versions/electronic systems may be used)**

**PGD Name/Version** **Valid from:** **Expiry:**

Before signing this PGD, check that the document has had the necessary authorisations. Without these, this PGD is not lawfully valid.

**Registered health professional**

By signing this patient group direction you are indicating that you agree to its contents and that you will work within it.

Patient group directions do not remove inherent professional obligations or accountability.

It is the responsibility of each professional to practise only within the bounds of their own competence and professional code of conduct.

| I confirm that I have read and understood the content of this Patient Group Direction and that I am willing and competent to work to it within my professional code of conduct. | | | |
|---|---|---|---|
| **Name** | **Designation** | **Signature** | **Date** |
| | | | |
| | | | |
| | | | |
| | | | |

**Authorising manager**

| I confirm that the registered health professionals named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of insert name of organisation for the above named healthcare professionals who have signed the PGD to work under it. | | | |
|---|---|---|---|
| **Name** | **Designation** | **Signature** | **Date** |
| | | | |

**Note to authorising manager**

Score through unused rows in the list of registered health professionals to prevent additions post managerial authorisation.

This authorisation sheet should be retained to serve as a record of those registered health professionals authorised to work under this PGD.

Add details on how this information is to be retained according to organisation PGD policy.

# GLOSSARY OF ABBREVIATIONS

| | |
|---|---|
| AART | Anti Retroviral Therapy |
| BASHH | The British Association for Sexual Health and HIV |
| BHIVA | The British HIV Association |
| BV | Bacterial vaginosis |
| CCT | Certificate of Completion of Training |
| CESR | Certificate of Eligibility for Specialist Registration |
| COSHH | Control of Substances Hazardous to Health |
| CPA | Clinical Pathology Accreditation |
| CQC | Care Quality Commission |
| CSRH | Community Sexual and Reproductive Healthcare |
| CTAD | Chlamydia Testing activity Dataset |
| EQA | External Quality Assurance |
| DHSC | Department of Health and Social Care |
| ECOSS | Electronic Communication of Surveillance in Scotland |
| EU | European Union |
| EQA | External Quality Assessment |
| FGM | Female genital Mutilation |
| FSRH | The Faculty of Sexual and Reproductive Health |
| GBV | Gender Based Violence |
| GC | Gonorrhoea/Gonococcal |
| GDPR | General Data Protection Regulation |
| GMC | General Medical Council |
| GP | General Practitioner |
| GRASP | Gonococcal Resistance to Antimicrobials Surveillance |
| GUM | Genito Urinary Medicine |
| GUMCAD | – Genito Urinary Medicine Activity Dataset |
| HARS | HIV and AIDS Reporting System |
| HAV | Hepatitis A virus |
| HBV | Hepatitis B virus |
| HCV | Hepatitis C virus |
| HDV | Hepatitis D virus |
| HEV | Hepatitis E virus |
| HIV | Human Immunodeficiency Virus |
| HMPPS | Her Majesty's Prison and Probation Service |
| HPV | Human papilloma virus |
| HSE | Health and Safety Executive |

| | |
|---|---|
| HSV | Herpes simplex virus |
| IPV | Intimate Partner Violence |
| IT | Information Technology |
| IQA | Internal Quality Assurance |
| IQC | Internal Quality Control |
| IUD | Intrauterine device |
| LARC | Long Acting Reversible Contraception |
| LGV | Lymphogranuloma venereum |
| MSM | Men who have sex with Men |
| NAAT | Nucleic acid amplification test |
| NCSP | National Chlamydia Screening Programme |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| PCR | Polymerase chain reaction |
| PEP | Post exposure prophylaxis for HIV |
| PGD | Patient Group Direction |
| PN | Partner Notification |
| POCT | Point of care test |
| PPE | Patient and public engagement |
| PREM | Patient reported experience measure |
| PrEP | Pre exposure prophylaxis for HIV |
| PROM | Patient reported outcome measure |
| RCOG | Royal College of Obstetricians & Gynaecologists |
| RCN | Royal College of Nursing |
| RCP | Royal College of Physicians |
| RCPCH | Royal college of Paediatrics and Child Health |
| SARC | Sexual Assault Referral Centre |
| SHRAD | Sexual and Reproductive Health Activity Dataset |
| SPC | Summary of product characteristics |
| SPS | Specialist Pharmacy Service |
| SRH | Sexual and Reproductive Healthcare |
| STI | Sexually Transmitted Infection |
| STIF | Sexually Transmitted Infection Foundation (courses) |
| UKAS | United Kingdom Accreditation Services |
| UKHSA | UK Health Security Agency |
| YOIs | Youth Offender Institutions |

BASHH

**BASHH**
British Association for Sexual Health and HIV

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