

BASHH



Standards for the management of sexually transmitted infections (STIs)

April 2019

Contents

Acknowledgements	3
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Foreword	4
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Executive summary	5
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Introduction	8
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The Standards	15
Standard 1 – Access	15
Standard 2 – Clinical assessment	21
Standard 3 – Diagnostics	29
Standard 4 – Clinical management	36
Standard 5 – Information governance	44
Standard 6 – Clinical Governance	50
Standard 7 – Appropriately trained staff	57
Standard 8 – Links to other services	61
Standard 9 – Patient and public engagement	65

Appendices	70
Appendix A – Project Group members and representatives	70
Appendix B – Project definitions for elements of STI management	72
Appendix C – Summary of mandatory sexual health, reproductive health and HIV datasets	75
Appendix D – Education and training matrix	76
Appendix E – Recommended tests for STIs	79
Glossary of abbreviations	81

Acknowledgements

The British Association for Sexual Health and HIV (BASHH) are delighted to share this revised and updated standards document. It has been made possible thanks to the hard work and expertise of members and co-optees on the BASHH Clinical Standards Unit (see Appendix A). Particular thanks are due to those who took lead responsibility for shaping sections of the new document.

Thanks are also due to those individuals and organisations who took the time to respond to the consultation, and thus shape the standards document, and those who provided additional expert advice.

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

Foreword

Everyone has the right to expect the highest attainable standard of sexual health. In the UK, high-quality sexual health services are the cornerstone of ensuring good population health and we should rightly be proud of the history we have of delivering these. The introduction of the Venereal Disease Act in 1917 helped to standardise the principles and specifications that services were expected to meet and significantly, provided a foundation from which remarkable advances have since been made. The services are amongst the most innovative and forward-looking parts of the health system and have a truly vibrant and world-leading workforce.

The publication of these new BASHH *Standards for the management of sexually transmitted infections (STIs)* build on the principles of the 2014 standards but also reflect the changing climate we deliver services in, the varying landscape of commissioning across the UK and the advances in technology and diagnostics in the field. They also recognise the emergence in recent years of a number of considerable new challenges for those involved in the commissioning and delivery of sexual health services, as well as changing attitudes and behaviors from those they serve. Digital technologies and apps that are transforming the way in which people access sexual encounters similarly provide important considerations that we need to be responsive to.

New interventions such as HPV vaccination for girls and men who have sex with men and PrEP (pre-exposure prophylaxis) for HIV prevention are welcome tools for primary prevention and have played a role in the reduction of genital warts and HIV respectively. However, sustained increases in the diagnoses of several sexually transmitted infections (STIs) – most notably gonorrhoea and syphilis – are of real concern. The continued spread of antimicrobial -resistant infections also poses a grave threat, which we must meet head on through ensuring services providing STI diagnosis and management meet the standards set out in this document.

It is through co-production with our communities and close collaboration between all agencies, including statutory and third sector, that we will achieve a collective response to commissioning cohesive and integrated sexual health services, the delivery of which is essential to securing patient-centered care and reductions in the incidence of STIs and HIV.

It therefore gives me great pleasure to present these vital new BASHH Standards, which represent the very best of recommended practice and when implemented successfully, will help to ensure the best possible sexual health outcomes for all parts of society for years to come.



Dr Olwen Williams OBE
President of the British Association for Sexual Health and HIV

Executive summary

Improving the sexual health of the population remains an important public health outcome. Yet the UK continues to have high rates of sexual ill health with some population groups disproportionately affected. Effective commissioning of services and the delivery of high-quality care are therefore key to improving health outcomes.

In recognition of this the British Association for Sexual Health and HIV (BASHH) has updated the *Standards for the management of sexually transmitted infections (STIs)* in order to support commissioners and providers in achieving high quality sexual health services for the populations they serve. The standards also, importantly, specify what the public can expect of the services they access.

Representing current best practice, they are intended for use in all services commissioned by local authorities or the NHS including those provided by the independent and third sectors. The standards are also strongly recommended for use in independent services not commissioned by the public sector. While they 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 and contextualise current guidance and cover all aspects of the management of STIs. In order to achieve alignment with NICE quality standards each one contains: a quality statement; quality measures; quality standards; implications for commissioners, service providers, healthcare professionals and non-registered healthcare workers and people with needs relating to STIs; supporting information and references.

Since publication of the 2014 version of these standards there have been a number of developments including: publication of the NICE Sexual Health Quality Standard; the availability of HIV pre-exposure prophylaxis (PrEP); a growth in the commissioning and delivery of online STI services; improvements in laboratory turnaround times and changes to the commissioning and delivery of education and training for staff working in STI services. These, and other developments are addressed within individual standards.

Standard statements and key updates to the previous document are outlined below:

Standard 1 – Access

People with needs relating to STIs, whether they have symptoms or not, should have rapid and open access to a range of local confidential services for STI testing and treatment. Rapid access means within two working days. Those with clinically urgent needs should have access within four hours.

Updates include:

- A new quality measure and standard for people with clinically urgent need to be seen within four hours of first contacting the service.
- A new quality measure and standard for people seen or assessed as a walk-in having a waiting time of less than two hours.
- A new quality measure and standard for an effective triage system operating on each working day.
- Responsibilities in relation to access and online services (where commissioned).

Standard 2 – Clinical assessment

People with needs relating to STIs should have an appropriate medical and sexual history taken regardless of how, or where, they access services e.g. face-to-face, telephone, online. This should include questions about sexual behaviour and other risk factors. Those with symptoms should be recommended a genital examination. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV and should include samples from extra-genital sites if indicated by the sexual history.

Updates include:

- A new quality measure and standard for drug and alcohol risk assessment.
- A new quality measure and standard for repeat screening in people at risk of re-infection.
- Responsibilities in relation to PrEP.

Standard 3 – Diagnostics

People being tested for STIs should have the most accurate diagnostic test (chosen according to national guidelines) for each infection for which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately.

Updates include:

- Reduced turnaround times in the quality measures and standards for issuing of laboratory reports.
- An updated list of recommended tests for STIs (Appendix E).

Standard 4 – Clinical management

People using a service for STI testing should have access to their results both positive and negative within eight working days. Those diagnosed with an infection should receive treatment as quickly as possible, within three weeks, and be managed according to current BASHH national guidelines, including the provision of partner notification (PN).

Updates include:

- The quality measure and standard for receipt of test results is reduced to eight working days.
- A new quality measure and standard for effective partner notification (PN) of early syphilis.
- A new quality measure and standard for evidence of PN discussion at the time of HIV diagnosis.
- A new quality measure and standard for HIV test of contactable contacts of index cases of HIV.
- Responsibilities in relation to PrEP.

Standard 5 – Information governance

Services managing STIs must ensure information collected about service users remains secure and is only shared for legitimate reasons: in the service user's or public's best interest or, suitably anonymised, for mandatory reporting purposes.

Updates include:

- Responsibilities in relation to the General Data Protection Regulation (GDPR).
- New legislation and guidance.

Executive summary

- An updated summary of sexual health, reproductive health and HIV datasets for England, Scotland, Wales and Northern Ireland (Appendix C).

Standard 6 – Clinical governance

People should receive their STI care from high quality services that are safe, well-managed and accountable regardless of how and where the service is accessed.

Updates include:

- Expanded guidance on the use of information technology.
- New legislation and guidance.

Standard 7 – Appropriately trained staff

People with needs relating to STIs should have their care managed by an appropriately skilled healthcare professional.

Updates include:

- Responsibilities for developing a skilled future workforce.
- An updated list of nationally recognised postgraduate STI courses (Appendix D).

Standard 8 – Links to other services

People needing to be referred to another service for ongoing STI management should have this arranged for them quickly and easily. Similarly, people with any other sexual health needs that the service is unable to meet (e.g. HIV treatment and care, contraception, abortion, psychology or sexual assault) should experience easy and timely referral (appropriate to circumstances) to a suitable service.

Updates include:

- Responsibilities for effective partner notification.

Standard 9 – Patient and public engagement

People who use STI services, the public, staff and external partners should all be consulted about the delivery of services both face-to-face and online. Those using services should be encouraged to give feedback about them.

Updates include:

- Responsibilities for engagement with all equality groups in particular gender and sexual minorities.

Introduction

- i. The British Association for Sexual Health and HIV (BASHH) *Standards for the management of sexually transmitted infections (STIs)* are written to support local authorities in commissioning and monitoring services and to support service providers in the delivery of high-quality care.
- ii. This 2019 edition of the *Standards for the management of STIs* supersedes previous versions and supports local authorities in their sexual health commissioning role and complements the Department of Health and Social Care (DHSC) *Framework for Sexual Health Improvement in England*¹.
- iii. The standards are intended for use in all healthcare settings where STIs are managed, including when some or all of a person's care may be online. While written to be applicable to the commissioning and legal system in England, their clinical recommendations on STI management also apply across the other nations in the United Kingdom (Scotland, Wales and Northern Ireland). Separate standards for sexual health services in Scotland were produced by NHS Quality Improvement Scotland and informed the original version of these standards². Variations exist in each nation with respect to sexual health services including: the legal / governance frameworks; commissioning; health care priorities; and systems for data collection. The standards in this document, particularly in overlapping areas, should not supersede any existing standards in, Scotland, Wales or Northern Ireland. However, in areas unaddressed, they may be regarded as national standards.
- iv. Since 1 April 2013 local authorities in England have been legally required to commission open access sexual health services for everyone 'present' in their area covering: free STI testing and treatment; and the notification of sexual partners of people with an infection^{3,4}.

Reviewing and updating the standards

Background

- v. The first national standards for the management of STIs were published in 2010. Since then they have been regularly updated to ensure they continue to reflect current best practice in STI management, as well as new policies and structures arising from the implementation of evolving legislation.
- vi. Recent years have seen a considerable shift in sexual health service provision in line with advances in eHealth / online care across the NHS and specifically within sexual health services. In this edition of the *Standards for the management of sexually transmitted infections (STIs)* we highlight how the standards apply to the online care environment. Commissioners and service providers are also supported by two additional standards documents: BASHH *Standards for the management of sexually transmitted infections (STIs)* in outreach services⁵; and the Faculty of Sexual and Reproductive Healthcare (FSRH) and *BASHH Standards for Remote and Online Providers of Sexual and Reproductive Health Services*⁶.

Standards review process

- vii. As the largest multi-professional organisation within the field of STIs, BASHH commissioned its Clinical Standards Unit (CSU) to manage the review and updating.
- viii. A number of relevant professional bodies, many of which had endorsed previous editions, as well as Public Health England (PHE), were invited to work in partnership by nominating a representative to contribute advice on their behalf to the review and updating. The support of all these individuals was vital in ensuring the delivery of this standards document and its endorsement by key professional organisations.
- ix. The names of CSU members and co-optees are listed in Appendix A.

Consultation

x. Following development of the draft the updated 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 from late January to mid-February 2019. All feedback from the consultation was considered by the CSU and informed final revisions.

Future updating of the standards

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

xii. It should be noted that some of the legislation and documents cited within these standards are either in the process of being updated, or 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 STIs

Context

xiii. In recent years commissioners have worked with providers of STI care to improve access to services. Many local authorities now commission a variety of STI services from different providers across primary and secondary healthcare based on their local needs; most services now include elements of online provision.

xiv. However, the UK continues to have high rates of sexual ill health. The Government's ambition is to improve the sexual health and wellbeing of the whole population by reducing health inequalities and improving sexual health outcomes, fostering a culture where everyone is able to make informed and responsible choices, and recognising that sexual ill health can affect all parts of society³.

Public health outcomes

xv. Services managing STIs have a strong public health role. Reflecting this the Public Health Outcomes Framework⁷ contains two indicators to measure progress in the effective management of STIs:

- a. chlamydia diagnoses (15-24 year olds).
- b. people presenting with HIV at a late stage of infection.

Sexual health indicators are likely to be updated in the Public Health Outcomes Framework for 2019-2022 (this is yet to be published).

Elements of STI management

xvi. These standards build on a number of earlier documents that describe three levels of care for the management of STIs – Level 1 (asymptomatic), 2 (symptomatic) and 3 (complex / specialist). Appendix B proposes a list of the elements of STI management which should be included at each of the three levels. The list was produced with consensus from all professional groups managing STIs, as part of the development of the original standards. It was amended as part of the 2014 review process and has been updated in this version to include the provision and follow up of HIV pre-exposure prophylaxis (PrEP).

xvii. Local authorities may commission providers to deliver elements of care at any of the three levels, based on findings from a local sexual health needs assessment. However, **all** elements of care in **all** three levels should be available within the commissioned area.

xviii. 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.

xix. 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 services (SRH) and genitourinary medicine services (GUM), as well as education, youth and the voluntary sector. The relative importance of these sectors in ensuring equity of access and service provision should not be underestimated. In some areas the voluntary and third sector are key to ensuring that the specific needs of certain communities are addressed.

xx. In many areas SRH and GUM services are integrated. In addition, some primary care providers are commissioned to provide some elements of STI management at Levels 1 and 2.

Specialist services (Level 3)

xxi. 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 GUM service (Level 3) for the management of STIs. Specialist GUM services should provide clinical leadership, including training, clinical expertise and clinical governance, for the management of STIs within commissioned areas. Similarly, clinical leadership for the management of contraceptive care across the commissioned area should be provided by services led by consultants in Community SRH (CSRH).

xxii. However, the competencies acquired through completing the current medical training curriculum for CSRH mean that STI services at Level 1 and 2 may be provided by consultants in SRH, while most doctors completing GUM specialist training will have fulfilled the requirements to provide contraceptive services at Levels 1 and 2. This facilitates an integrated approach to sexual health service provision including the integration of Level 3 specialist GUM services with Level 3 specialist SRH services.

Equality and Diversity

xxiii. Following publication of the *Equality Act* in 2010 the Public Sector Equality Duty came into force in 2011⁸. 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.

xxiv. The Public Sector Equality Duty requires local authorities 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.

xxv. Providers should ensure the service they provide meets their equality duty, paying particular attention to sensitivities relating to culture, sexuality and disability when taking a sexual history and performing an examination. All services should be able to meet special communication needs, such as providing translators or interpreting services, where requested or necessary. For some there will be considerable barriers to accessing online services and for this reason providers need to ensure that face-to-face service provision is available.

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

The standards

xxvii. The standards cover all the key principles of STI service provision. They bring together and contextualise existing guidance and are therefore derived from the best available evidence.

xxviii. Representing current best practice, the standards are intended for use in all publicly funded services managing STIs, including those provided by the third and independent sectors (although it is recognised that some of the quality measures may only be auditable in services specifically commissioned to manage STIs or across services in a commissioned area). They are strongly recommended for use in the private healthcare sector. The standards also recognise that some elements of care may need to be approached differently depending on the care setting i.e. online versus face-to-face, this is highlighted in each individual standard.

xxix. Different service models exist for the delivery of care, with some STI services integrated with those providing sexual and reproductive healthcare while others are not. These standards are meant to apply to all services managing STIs regardless of the model of delivery.

Scope of the standards

xxx. The standards cover all aspects of the management of STIs including the diagnosis and treatment of individuals and the broader public health role of infection control. They cover issues for commissioners, service providers, healthcare professionals and the public, including people with needs relating to STIs.

xxxi. The management of chlamydia is included for services commissioned to manage STIs. Asymptomatic chlamydia is frequently identified through the National Chlamydia Screening Programme (NCSP) which has the objective of controlling chlamydia related harms through increasing the detection of chlamydia in sexually active 15 to 24 year olds. *NCSP Standards*⁹ cover all aspects of this opportunistic screening programme. In recent years BASHH and the NCSP have worked closely to align standards in chlamydia testing and treatment so that there is now greater convergence between the *Standards for the management of STIs* and the *NCSP Standards* on laboratory turnaround times, conveyance of results (both positive and negative) and the re-testing of all under 25 year olds following a positive result.

xxxii. The management of STIs 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 STI management and HIV treatment and care to ensure that people living with HIV have timely access to high quality STI services.

xxxiii. Similarly, the management of STIs in individuals in population groups most at risk of STIs, such as men who have sex with men (MSM), young people and some black and minority ethnic groups, is a key public health priority and within the scope of the standards. Where clinical management differs for specific groups, this is set out in Appendices B and E.

xxxiv. 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 BASHH¹⁰.

xxxv. The following are outside the scope of the standards:

- a. Other aspects of sexual healthcare which are equally important but beyond the remit of this document, such as contraception and reproductive healthcare, and related service issues including child protection. The FSRH published updated *Service Standards for Sexual and Reproductive Healthcare* in 2016¹¹. It is anticipated that commissioners of integrated services will use this document as well as the FSRH service standards when commissioning integrated sexual health services.
- b. HIV treatment and care, which is covered by the British HIV Association (BHIVA) *Standards of care for people living with HIV* 2018¹². However, STI service providers play an important role in the prevention and detection of HIV infection. The standards 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 after sexual exposure to HIV (PEPSE).

- c. Domestic violence and abuse. Relevant guidance is available from NICE¹³.
- d. Female Genital Mutilation (FGM) is illegal in the UK. Relevant guidance is available from the Department of Health and Social Care¹⁴ and the Royal College of Gynaecologists and Obstetricians¹⁵. Further information is available from the Foundation for Women's Health, Research and Development (FORWARD): www.forwarduk.org.uk.
- e. Where the management of STIs should be delivered. These standards should be applicable regardless of the setting or provider.
- f. Different models of service provision. Although these standards focus on the management of STIs, this does not imply that other aspects of sexual healthcare should not be provided within the same service or integrated locally as appropriate. The DHSC's national service specification for integrated sexual health services states expectations as to the conditions that must be diagnosed and treated in the STI element of an integrated sexual health service¹⁶.

Structure of each standard

xxxvi. In order to achieve greater alignment with NICE quality standards¹⁷ each standard contains:

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

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

xxxviii. *The quality measures* and *quality standards* aim to improve care outcomes and where possible are based on existing national standards. They will assist commissioners and 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).

xxxix. 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.

xl. 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.

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

Language

xlii. The language used throughout the document reflects suggestions made by consumer forums responding to the public consultation in 2010.

xliii. 'People with needs relating to STIs' are defined as those who have needs or concerns about STIs which are either expressed spontaneously; or on a triage form; or elicited verbally during a consultation; or on a self-completed history pro forma either in person or via an online portal. The term is analogous with, and includes, the term 'people contacting a sexual health service about an STI', which is used in the NICE Sexual Health Quality Standard¹⁹.

xliv. To refer to people using STI services, the term 'service user' is generally adopted. 'Patient' is used instead where it is embedded in phrases and terminology in everyday use.

xlv. 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

xlvi. 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** receiving care and the **public** can use the standards to find information about the type of services and the care they should receive.

xlvii. 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 2016-19⁷
- NICE Sexual Health Quality Standard¹⁹

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STANDARD 1

Access

1.1 Quality statement

People with needs relating to STIs, whether they have symptoms or not, should have rapid and open access to a range of local confidential services for STI testing and treatment. Rapid access means within two working days. Those with clinically urgent needs should have access within four hours.

1.2 Quality measures

1.2.1 The percentage of people with needs relating to STIs who are offered to be seen or assessed with an appointment within two working days of first contacting the service. A walk-in option within two working days may be offered to provide choice where available.

1.2.2 The percentage of people with needs relating to STIs who are seen or assessed by a healthcare professional within two working days of first contacting the service.

1.2.3 The percentage of people with clinically urgent needs relating to STIs who are offered to be seen or assessed with an appointment or as a walk-in within four hours of first contacting the service. For example, for post-exposure prophylaxis after sexual exposure to HIV (PEPSE). Where this runs into time outside of normal service hours people should be referred to appropriate out-of-hours services.

1.2.4 The percentage of people with clinically urgent needs relating to STIs who are seen or assessed by a healthcare professional within four hours of first contacting the service.

1.2.5 The percentage of people with needs relating to STIs who attend as a walk-in with a waiting time of less than two hours.

1.2.6 Providers of STI care should have in place an effective triage system to identify those who need to be seen within four hours, those who are suitable for online services, and those who require face-to-face services so that they can be streamed appropriately. Where demand peaks and exceeds capacity the system should be used to identify those who are symptomatic, vulnerable or at higher risk of passing on an infection so that they have priority for being seen within two working days.

1.3 Quality standard

1.3.1 Offered an appointment or walk-in option (where available) within two working days:
Standard: 98%

1.3.2 Seen or assessed by a healthcare professional within two working days:
Standard: 80%

1.3.3 Offered an appointment or walk-in option within four hours:
Standard: 98%

1.3.4 Seen or assessed by a healthcare professional within four hours:
Standard: 80%

1.3.5 Seen or assessed as a walk-in with a waiting time of less than two hours:
Standard: 80%

1.3.6 Effective triage system operating on each working day:
Standard: 100%

1.4 What the quality statement means for each audience

Responsibilities of commissioners

1.4.1 Service specifications and contracts for services commissioned to manage STIs should be explicit in their expectations in relation to:

- a. rapid and open access (within two working days of contacting the service), urgent access (within four hours of contacting the service for those with clinically urgent needs) and for the provision of online services.
- b. the provision of pre-booked appointments, which should be flexible and pragmatic to accommodate people needing regular appointments (such as those with conditions where regular screening is recommended or those who need appointments for review, e.g. PrEP), and should not be limited to booking forty-eight hours ahead.
- c. the requirement for routine monitoring of access data (see 1.5.6).

1.4.2. Commissioning of services should be informed by an up-to-date sexual health needs assessment which includes assessment of needs in relation to STIs, health inequalities and gaps in services, to ensure that the location and opening times of face-to-face services and online facilities are appropriate to the needs of the local population.

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

1.4.4 Commissioners should ensure that within the commissioned area people with needs relating to STIs have a choice of pre-booked appointment and walk-in services.

1.4.5 As an adjunct to face-to-face clinical services, the provision of an online STI service within each local authority area should be considered, in order to extend choice and empower those with needs relating to STIs who are appropriate for online care. Commissioners and providers need to be clear about where online services fit within the commissioning framework and when they are, and are not appropriate. They should ensure that access to treatment and partner notification for those using online STI services is seamless, timely and meets national guidelines.

Responsibilities of service providers

1.4.6 All providers of services commissioned to manage STIs should:

- a. make their face-to-face services available through self-referral for all people regardless of where they live (open access).
- b. provide rapid access, by appointment (or walk-in if available) within two working days of contacting the service.
- c. provide urgent access for those who clinically require it e.g. PEPSE, within four hours of contacting the service. Where this runs into time outside of normal service hours people should be referred to appropriate out-of-hours services.
- d. consider providing an online STI portal for those where self-sampling is appropriate and for signposting to other appropriate services.
- e. provide pre-booked appointments which are flexible and pragmatic to accommodate people needing regular appointments (such as those with conditions where regular screening is recommended or those who need appointments for review, e.g. PrEP), and which should not be limited to booking forty-eight hours ahead.
- f. use a triage system so that people are directed to the most appropriate STI service for their needs and to maintain access for those who are most at risk and / or vulnerable.
- g. have mechanisms to routinely record access data.

Responsibilities of healthcare professionals and non-registered healthcare workers

1.4.7 All healthcare professionals and non-registered healthcare workers working in services commissioned to manage STIs should:

- a. understand the public health rationale underpinning a rapid and open access model of care.
- b. ensure that people contacting the service are directed to the most appropriate service for them so that:
 - i. people are either offered an appointment within two working days of contacting the service or advised of walk-in options available within two working days.
 - ii. people who require urgent access are offered an appointment or advised of walk-in options available within four hours, or referred to out-of-hours provision as appropriate.
 - iii. if available, people who are appropriate for online services are advised of this and are offered them.
- c. deliver services that are flexible and capable of responding to people with urgent healthcare needs.
- d. have mechanisms to routinely record access data.

People with needs relating to STIs:

1.4.8 Must be able to go to any face-to-face sexual health service, in or out of their local area, without needing to see their GP first.

1.4.9 Should be offered an appointment or walk-in options within two working days of contacting a service commissioned to manage STIs. The appointment or walk-in time should be within four hours for those requiring clinically urgent access. If this runs into time outside of normal service hours, they should be referred to appropriate out-of-hours services.

1.4.10 Should be able to access online services if these are appropriate and available within the commissioned area.

1.4.11 Should be able to access a service offering pre-booked appointments within their local authority area and advance booking should not be limited to a timeframe of two working days. This is particularly important for those where regular screening is recommended or for those who need appointments for review e.g. PrEP.

1.5 Supporting information

Rapid open and urgent access

1.5.1. *The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations*¹ state that 'each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area'.

1.5.2 Open access is the ability of an individual to use any commissioned provider of STI management regardless of the location of the service or their area of residence. This is a long-established principle of STI care and is important, as it offers service users ease of access and for some the level of anonymity and confidentiality they require.

1.5.3 Rapid access, defined as access within two working days of contacting a service, remains a key quality measure and should be available regardless of where people access services^{2,3}. This is because early access to STI testing and, where applicable, treatment breaks the chain of onward transmission. For this reason, rapid and open access services are recommended within *A Framework for Sexual Health Improvement in England*⁴.

1.5.4 Urgent access is access within four hours of contacting a service and is for people with clinically urgent needs e.g. PEPSE who should be seen or assessed within four hours of first contacting the service. Where this runs into time outside of normal service hours people should be referred to appropriate out-of-hours services.

1.5.5 If services are unable to offer an appointment within two working days, or urgent access within four hours for those who require it, then commissioners and service providers should ensure that care pathways are in place to direct people to alternative services that can provide it within the local authority area. In accordance with national guidance, clear pathways for those needing urgent access for PEPSE should be in place and similarly pathways need to be in place for those needing sexual assault services.

1.5.6 In monitoring access, commissioners should ensure the following data is recorded:

- a. the proportion offered an appointment within two working days and the proportion who walk-in.
- b. the proportion requiring clinically urgent access who are offered an appointment within four hours and the proportion who walk-in.
- c. the proportion who are seen or assessed within two working days.

Standard 1 – Access

- d. the proportion who require clinically urgent access who are seen or assessed within four hours.
- e. the proportion attending as a walk-in who are seen within two hours.

This will reduce the risks of inaccurate or distorted recording of activity data by providers. See Appendix C for guidance on surveillance data.

Triage

1.5.7 Triage plays an essential part in identifying the urgency of clinical need and the type of service that is most appropriate for those requiring STI services. A triage system should be used whenever individuals choose to make contact with STI services including on the telephone, face-to-face and online.

1.5.8 The triage system should be effective in identifying those who need to be seen within four hours, those who need to be seen face-to-face and those who are suitable for online services. The system should be intensified when demand exceeds capacity to identify those who are most in need so that they have priority for being seen within two working days. This includes those who are symptomatic, vulnerable or at higher risk of passing on an infection.

1.5.9 By using an effective triage system people can be directed to the most appropriate service for them, thus providing individualised care, optimising resources and maximising efficiency.

Online services

1.5.10 Where online services are commissioned as an adjunct to clinical services, they should be advised for people only where it is appropriate and they are willing to use them (see table below). Processes to ensure this and detect safeguarding concerns must be used. If people who are not appropriate for online services attempt to access them there must be straightforward mechanisms in place to direct them to face-to-face services.

The following table is suggestive and not necessarily comprehensive or exhaustive:

Appropriate for online services	Not appropriate for online services
People who do not have symptoms of sexual infection	People with genital symptoms or symptoms of sexual infection
People who do not require PEPSE	People requiring PEPSE
At least 16 years old	Under 16 years old
People who are able to understand the online information and process	People where IT, reading / written literacy or understanding is limited
Those where there are no safeguarding concerns	Those where there are safeguarding concerns

Sexual health needs assessment

1.5.11 A local sexual health needs assessment should inform commissioners as to the services providers should offer, when they should operate and where they should be located⁶. People accessing online, non-specialist or outreach services should receive the same standard of care as those accessing any other service for the testing and treatment of STIs^{6,7}. If a service is unable to offer any element of Levels 1, 2, and 3 STI testing and treatment, people accessing that service should be informed which elements of care are available so that they can make choices about where to seek care. Care pathways should be in place to support onward referral.

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STANDARD 2

Clinical assessment

2.1 Quality statement

People with needs relating to STIs should have an appropriate medical and sexual history taken regardless of how, or where, they access services e.g. face-to-face, telephone, online. This should include questions about sexual behaviour and other risk factors. Those with symptoms should be recommended a genital examination. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV and should include samples from extra-genital sites if indicated by the sexual history.

2.2 Quality measures

2.2.1 Sexual history taking:

The percentage of people accessing services with needs relating to STIs, who have a relevant sexual history documented, as defined by BASHH national guidelines¹.

2.2.2 STI screening / testing:

- a. The percentage of people with needs relating to STIs who are offered screening for chlamydia, gonorrhoea, syphilis and HIV at first attendance.
- b. The percentage of people with needs relating to STIs who have a documented HIV test at first attendance.
- c. The percentage of people at risk of reinfection who are offered repeat screening for chlamydia, gonorrhoea, syphilis and HIV according to best practice guidelines e.g. young people, some men who have sex with men (MSM)^{2,3}.

2.2.3 Drug and alcohol risk assessment:

The percentage of people, with needs relating to STIs, attending face-to-face services who are assessed for drug and alcohol use⁴.

2.2.4 Competence to deliver services:

Compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*⁵:

- 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 taking:
Standard: 97%*

2.3.2 STI testing:

- a. Offered screening for chlamydia, gonorrhoea, syphilis and HIV at first attendance.
Standard: 97%*
- b. Have a documented HIV test at first attendance.
Standard 85%
- c. Offered repeat screening according to best practice guidelines.
Standard: 85%

2.3.3 Drug and alcohol risk assessment:
Evidence of drug and alcohol risk assessment in face-to-face services.
Standard: 97%*

2.3.4 Competence to deliver services:
Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*⁵ for regulations 9, 10, 11,12, 13 and 15.

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 STIs:

- a. have clinical premises that are fit for purpose and which offer privacy.
- b. deliver optimal standards of clinical care in accordance with BASHH guidelines⁶, the NICE Quality Standard for Sexual Health⁷ and relevant public health guidance.
- c. have relevant accreditation, or meet appropriate standards for the services provided e.g. young people.
- d. 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 twenty-four-hour access to:

- a. emergency contraception.
- b. HIV post-exposure prophylaxis after sexual exposure (PEPSE).
- c. referral pathways into a Sexual Assault Referral Centre (SARC).

*This translates to 1 error per 40 audited cases.

Standard 2 – Clinical assessment

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

- a. contraception.
- b. PEPSE.
- c. sexual assault and the 'chain of evidence' process.
- d. pre-exposure prophylaxis for HIV infection (PrEP).
- e. specialist support beyond that offered in the service. This includes but is not limited to:
drug and alcohol use; domestic abuse; female genital mutilation (FGM); child sexual exploitation; sex work;
homelessness; mental health and social care.

2.4.4 Commissioning of services should aim to reduce health inequalities with a focus on prevention e.g. using educational and behavioural change interventions.

Responsibilities of service providers

2.4.5 All providers of services commissioned to manage STIs should ensure that they have appropriate mechanisms in place for:

- a. recording of a medical and sexual 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 PEPSE is indicated and the use of PrEP.
- e. performing a genital examination in patients with symptoms, with the offer of a chaperone.
- f. collecting specimens for STI testing including as a minimum those for chlamydia, gonorrhoea, syphilis and HIV from all relevant exposed sites. 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 encouragement of safer sex behaviour and condom 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.

Responsibilities of healthcare professionals and non-registered healthcare workers

2.4.6 All healthcare professionals and non-registered healthcare workers working in services commissioned to manage STIs should be fully competent (appropriate to role, see Standard 7) in:

- a. obtaining a minimum of two methods of contact, with people accessing the service, to allow result giving and recall for repeat testing and / or treatment as indicated. If only one point of contact e.g. a mobile phone number is obtainable then agreement needs to be reached with the individual about how they will access their results in the event of the service not being able to contact them. Additionally, consent should be sought for GP communication (for use if all other forms of contact are unsuccessful).
- b. recording a medical and sexual history including risk assessment.
- c. managing issues relating to confidentiality, safeguarding and vulnerable adults and acting on concerns as appropriate.
- d. performing genital examination and STI testing.
- e. explaining to people which STI tests have been taken, and how and when the results will be available.
- f. assessing the need for further STI testing and vaccination as appropriate.
- g. onward referral to other services within the commissioned area.

People with needs relating to STIs:

2.4.7 Should expect to be asked about their medical and sexual history which will include questions about their sexual partners, sexual behaviour and other risk factors.

2.4.8 Should be offered appropriate STI testing and vaccination (if indicated). As a minimum this should include tests for chlamydia, gonorrhoea, syphilis and HIV. This may involve having blood taken and an examination or self-taken swabs or urine test. If experiencing symptoms, a genital examination should be recommended and a chaperone offered. If care is being sought online, people who report symptoms should be advised to seek examination in a face-to-face service and assisted to do so.

2.4.9 Should be informed which infections they have been tested for, and how and when they will get their results.

2.4.10 Should be advised what will happen if they get a positive result.

2.5 Supporting information

Clinical premises

2.5.1 In order to provide service users with privacy, and to ensure that consultations are confidential the premises in which STI examinations are performed should comply with relevant national guidance⁵ and all local infection control and Health and Safety policies. Online services should comply with BASHH / FSRH *Standards for Online and Remote Providers of Sexual and Reproductive Health Services*⁸.

Medical and sexual history

2.5.2 A medical and sexual history may be taken by a healthcare professional or may be a self-completed assessment either in a face-to-face service or online. The medical and sexual history should be in line with current BASHH national guidelines and include questions about sexual partners (including any suspected infection, infection risk or symptoms), sexual exposure at extra-genital sites, contraception and risk of pregnancy, and questions about time since exposure¹. It should also include a risk assessment for STIs, HIV and other blood-borne viruses, including whether people are from the groups most at risk of these infections, and identify whether PEPSE is indicated^{9,10} and whether the use of PrEP should be considered¹¹.

2.5.3 In face-to-face services assessment should also include: a history of alcohol and recreational drug use; and consideration of psychological wellbeing, as this can affect individuals' behaviour and responses to receiving a diagnosis or treatment, including adherence to medication and engagement in partner notification. Where needs are identified that cannot be met by the service, onward referral to other appropriate services should take place. This particularly applies to people who have accessed care online for whom it becomes clear that face-to-face assessment is needed.

2.5.4 PEPSE is a key preventative intervention to reduce HIV acquisition in people who have been at high risk of infection. Treatment needs to start as soon as possible within seventy-two hours, so twenty-four-hour access to PEPSE should be available. Emergency departments may initiate PEPSE and refer on to sexual health providers for completion of the four-week course of treatment. DHSC guidance gives advice about where the funding responsibilities for this service lie¹².

2.5.5 PrEP prevents HIV acquisition by taking anti-retroviral drugs prior to high risk sexual exposure. PrEP should be considered for individuals who report previous significant risk of HIV exposure and who have ongoing risk. Currently access and commissioning remains inequitable across the UK. If PrEP is not available locally, services should signpost individuals to alternative sources of PrEP (clinical trials or web-based resources) and provide PrEP monitoring for those sourcing PrEP elsewhere¹¹.

Assessing vulnerability

2.5.6 Staff providing care for under-18s should follow local and national guidance on safeguarding children¹³. All sexually active young people under the age of 16 years should be assessed for competency according to Fraser guidelines^{13,14}. A risk assessment for sexual abuse or exploitation should be performed using a standardised proforma at each new presentation at the service, and there should be documentation on whether or not a referral to child protection services is made¹⁴.

The management of children under 13 years must be discussed with the service's nominated safeguarding lead.

2.5.7 Compliance with the Mental Capacity Act¹⁵ is essential where healthcare professionals have contact with adults (and young people aged 16-17 years) with learning difficulties or where there is impairment of decision-making.

Examination

2.5.8 It should be normal clinical practice for people with genital symptoms to be examined irrespective of how they access care. Those who are asymptomatic and request examination should also be examined, but routine examination of those with no symptoms yields few additional diagnoses¹⁶. Abnormal findings should be documented.

2.5.9 The most frequent causes of a change in vaginal discharge in non-specialist settings are not sexually transmitted. In women over 25 years of age with a history suggesting a low risk of an STI, and where there are no symptoms indicative of upper genital tract infection, empirical treatment for candidiasis or bacterial vaginosis based on the reported symptoms may be given. However, if after empirical treatment the symptoms do not resolve, or if they recur, examination and microbiological testing should be performed¹⁷. Surveillance figures show higher rates of all STIs in women aged under 25 years therefore empirical treatment of vaginal discharge in this age group is not appropriate.

2.5.10 Women with evidence of female genital mutilation (FGM), should be referred to appropriate gynaecological services, if needed. An assessment must be made to identify any safeguarding risk to children in their family, living in the UK^{18,19}.

Testing

2.5.11 All people requesting a sexual health check should be offered and encouraged to accept HIV testing, in order to reduce the proportion of individuals with undiagnosed HIV infection, with the aim of benefiting both individual and public health^{9,20,21}.

2.5.12 The STI tests offered to individuals should be explained clearly, including what they are for, how samples are taken, the limits of each test i.e. window periods and when and how test results will be communicated.

2.5.13 It is the responsibility of the person taking the history / test to ensure appropriate contact methods are obtained. Ideally two methods of contact should be obtained, but in the event that this is not possible an agreed plan should be in place for how the service user will access results in the event they are not contactable e.g. if a mobile phone is lost. If possible, consent for GP communication should be obtained for use if all other methods are unsuccessful.

2.5.14 The choice of specimens will depend on the sexual history, symptoms and signs. Knowledge of the range of tests offered by the microbiology laboratory and the correct transport medium, storage and transport of specimens is essential before specimens are collected. If services are unable to offer all appropriate tests, e.g. gonorrhoea cultures, care pathways should be in place for onward referral to a local Level 3 service.

2.5.15 Specimens for microbiological testing obtained during the examination should be in line with national guidance and are shown in Appendix E. This should include samples from extra-genital sites if indicated in the sexual history.

2.5.16 Facilities for the correct transport medium, storage and transport of specimens should be in place. Specimens should be transported to the laboratory without unnecessary delay and enable compliance with the turnaround times in Standard 4.

2.5.17 If home sampling or testing kits are provided, it is the providers' responsibility to ensure there are clear and comprehensive written instructions on how to use the kit and how to access follow up and support if necessary.

Chain of evidence

2.5.18 Where the results of microbiological tests are likely to be used as admissible evidence in court, e.g. in relation to child protection issues or some cases of sexual assault, advice should be sought from a Sexual Assault Referral Centre (SARC) and a 'chain of evidence' process used, as detailed in national guidelines²². Taking specimens for 'chain of evidence' does not need to be available in all settings however there must be procedures and care pathways in place for onward referral when needed.

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Standard 2 – Clinical assessment

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STANDARD 3

Diagnostics

3.1 Quality statement

People being tested for STIs should have the most accurate diagnostic test (chosen according to national guidelines) for each infection for which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately.

3.2 Quality measures

3.2.1 Diagnostic tests: The percentage of people who have symptoms suggestive of gonorrhoea or are Nucleic Acid Amplification Test (NAAT) positive for *Neisseria gonorrhoeae* who have a culture performed.

3.2.2 Laboratory turnaround times:

- a. The percentage of reports (or preliminary reports) issued by the laboratory 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 within nine working days of the specimen being received by the laboratory.

3.3 Quality standard

3.3.1 Diagnostic tests:
Standard: 97%*

3.3.2 Laboratory turnaround times:

- a. Reports issued by the laboratory within four working days.
Standard: 97%*
- b. Final reports on supplementary testing or following referral issued by the laboratory within nine working days.
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, in consultation with colleagues commissioning laboratory services, should ensure that all laboratories commissioned to perform STI diagnostic testing are appropriately accredited and deliver optimal standards of laboratory services including specimen turnaround times. They should be United Kingdom Accreditation Services (UKAS) accredited and have evidence of External Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality Assurance (IQA). Laboratory procedures should be consistent with advice from the Royal College of Pathologists.

3.4.2 Commissioners should ensure that commissioned laboratories are using the 'gold standard' test wherever possible, 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) with twenty-four-hour access to HIV screening assays in every commissioned area.
- b. the use of HIV point-of-care tests (POCT) or near patient tests (NPT), for screening only, when validation data are available. Confirmation of a reactive POCT by an established laboratory test is mandatory.
- c. 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. This is likely to require effective care pathways between services.
- d. ensuring that NAAT testing is available for gonorrhoea and chlamydia diagnosis for all genital and extra-genital site testing, including specialist tests for detection of Lymphogranuloma venereum (LGV), and used in accordance with national guidance.
- e. ensuring the availability of culture, point of care or NAAT test for the diagnosis of *Trichomonas vaginalis* (see 3.5.8).
- f. ensuring the availability of serological testing for syphilis and HIV, hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV).
- g. ensuring the availability of herpes simplex virus (HSV) polymerase chain reaction (PCR) and *Treponema pallidum* PCR.
- h. ensuring the availability of *Mycoplasma genitalium* testing, and resistance testing, as per BASHH guidelines¹.

3.4.3 Commissioners should monitor the performance of all commissioned laboratories including for the samples sent to reference laboratories.

3.4.4 Commissioners should consider the commissioning of postal self-sampling services. Sample type should be chosen so as to provide the greatest accuracy for the conditions being tested for. Where appropriate, the use of dried blood spot tests may be necessary e.g. for screening populations who would not access other services. These have been particularly helpful for HIV case finding in high risk groups e.g. people who inject drugs.

3.4.5 Commissioners should ensure there is continuity planning provision should the contracted laboratory be unable to provide the service.

3.4.6 Economies of scale may be identified through regional commissioning of services. However, this should be balanced against the needs of local populations where specific demographics may have different diagnostic testing needs. All clinicians who use laboratory tests should have access to a medical microbiologist or senior scientist advice to help interpret and manage complex results.

3.4.7 Commissioners should ensure that all commissioned Level 3 (specialist) services have real time microscopy available.

Responsibilities of service providers

3.4.8 All providers of services commissioned to manage STIs should:

- a. use the 'gold standard' test for the infection they are screening for including gonococcal cultures when indicated.
- b. have systems in place to monitor the time from when the specimen is received by the laboratory to the time the report is issued, as the turnaround time for laboratory testing should be four working days or less for standard screening tests. If supplementary testing or referral to the reference laboratory is necessary, then a preliminary report should be issued and the final report issued within nine working days. Electronic requesting and reporting should be encouraged to minimise turnaround times.
- c. ensure that all staff performing microscopy are appropriately trained and undergo regular assessment for quality assurance.

Responsibilities of healthcare professionals and non-registered healthcare workers

3.4.9 All healthcare professionals and non-registered healthcare workers who perform microscopy in services managing STIs, should be competent to do so and undertake regular continuous professional development (CPD) and assessment.

People with needs relating to STIs:

3.4.10 Should receive tests for STIs that are in keeping with national BASHH Clinical Effectiveness Group guidelines. See www.bashh.org/guidelines.

3.4.11 Should have their specimens processed within the recommended timescales.

3.5 Supporting information

Diagnostic tests

3.5.1 Appendix E summarises recommended tests for STIs.

3.5.2 NAATs are recognised as the most sensitive diagnostic tests for many STIs and are recommended for screening and testing^{2,3,4,5,6} but false positive results can occur. In areas of low disease prevalence, the positive predictive value (PPV) is low even if the test has high sensitivity and specificity so the proportion of false positives results will be greater⁷. The reporting of false positive results should be avoided. This is a particular problem for gonorrhoea as the prevalence varies by population group and so it is recommended that any gonorrhoea NAAT is confirmed with a supplementary test (using an alternative target) if the PPV of the single test is under 90%^{4,5,6}. The prevalence of chlamydia is more evenly distributed and confirmation is not recommended.

3.5.3 Gonorrhoea and chlamydia NAATs are also recommended for extra-genital samples and are known to be more sensitive than culture testing^{3,6}. Confirmation of any gonorrhoea NAAT positive from an extra-genital site is recommended because of the possibility of a false positive reaction with other *Neisseria* spp. Currently there is no NAAT approved for use on extra-genital samples for either *Chlamydia trachomatis* or *Neisseria gonorrhoeae* but extensive validation data now exist. In the UK diagnostic microbiology laboratories are able to use CE-marked tests to process specimens for which they are not approved, provided they have sufficient evidence-based validation data to justify their use and validation files have been completed⁸. If appropriate, tests for LGV caused by *C. trachomatis* belonging to the L serovars should be performed either in a local or regional laboratory where specialist tests are established or at the national reference laboratory.

3.5.4 Outreach and home testing services for HIV should use CE-marked tests. However, not all CE-marked tests perform satisfactorily. Tests should have been validated for the populations they are being used in (See BASHH *Standards for the management of STIs in outreach services*⁹, Standard 3: 3.5.4). Ideally fourth and fifth generation HIV tests should be used, but in some circumstances a third generation POCT may be used with a parallel sample sent for fourth and fifth generation laboratory testing. Some third generation tests have the added advantage of being relatively fast, require little sample preparation, and allow for the testing of multiple pathogens e.g. HIV and syphilis. Tests marketed for home testing of bacterial STIs should be used with extreme caution as their performance may be poor¹⁰. One CE-marked point of care test for chlamydia gave more false positives than true positive results¹¹.

3.5.5 Twenty-four-hour availability of HIV testing, is needed to support urgent clinical decision making e.g. acutely unwell medical admissions where rapid diagnosis is required for management decisions and when a pregnant woman at high risk of HIV is in labour. Such availability may be provided through the laboratory or POCT depending on local facilities and timing, but laboratory confirmation of POCT results should be available, including over weekends.

3.5.6 Serological testing for syphilis¹², HBV¹³, HCV^{14,15}, HAV¹⁶ and HIV¹⁷ should be provided in line with national guidelines^{18,19,20,21,22,23}. See Appendix E.

Microscopy

3.5.7 Direct microscopy of genital samples is a near patient, rapid method for diagnosis of several genital infections. Microscopy of urethral smears from men with symptoms of dysuria and / or urethral discharge is a sensitive test for the diagnosis of urethritis. It enables immediate differentiation, before any laboratory testing, between gonorrhoea (>95% sensitivity) and non-gonococcal urethritis and is the only method of diagnosing non-gonococcal, non-chlamydial urethritis. An immediate diagnosis allows for the administration of the correct treatment, reducing the risk of inappropriate antimicrobial therapy and the development of resistant organisms. The immediate provision of treatment reduces the period of infectivity and the risk of complications, and the onward transmission of infection. Diagnosing non-gonococcal, non-chlamydial urethritis in men with urethral symptoms allows for partner notification and the epidemiological treatment of female contacts (see Standard 4) who are at risk of cervicitis and consequent reproductive tract complications.

3.5.8 Immediate microscopy of smears from women with symptoms of abnormal discharge can potentially identify bacterial vaginosis (BV) (sensitivity >95%), candidiasis (sensitivity 50%), *Trichomonas vaginalis* (TV) (sensitivity <50%) and gonorrhoea (sensitivity 30-50%). For the diagnosis of BV, the sensitivity of microscopy is far superior to that of a high vaginal swab processed in a microbiology laboratory (sensitivity 37% compared with immediate microscopy). Immediate diagnosis allows administration of the correct treatment at initial visit, resulting in quicker resolution of symptoms and reducing the need for further follow up. For TV microscopy is now accepted as the least sensitive method and TV NAAT should be used where possible²⁴.

Antimicrobial resistance

3.5.9 In England and Wales, the Gonococcal Resistance to Antimicrobials Programme (GRASP) has launched an action plan to raise awareness of the threat of antimicrobial resistant gonorrhoea and has highlighted that maintaining culture to provide a viable organism for susceptibility testing, for individual patient management purposes, is essential²⁵. Scotland and Northern Ireland have similar surveillance programmes^{26,27}.

Laboratory standards

3.5.10 UKAS accreditation, ensures that laboratories have an adequate quality and audit system in place and is the standard against which UK diagnostic laboratories are assessed. A list of accredited laboratories and their current status can be obtained from www.ukas.com.

3.5.11 The UK Standards for Microbiology Investigations are a comprehensive referenced collection of microbiology standard operating procedures, algorithms and guidance notes. They are designed to ensure that laboratories provide a good clinical and public health microbiology service and help standardisation of methods across laboratories. See <https://www.gov.uk/government/collections/standards-for-microbiology-investigations-smi>.

3.5.12 External quality assurance, such as UK National External Quality Assessment Service (www.ukneqas.org.uk) or Quality Control for Molecular Diagnostics (www.qcmd.org), is a requirement of UKAS accreditation. It is used to give external quality assessment in laboratory medicine, promote best practice and ensure results of investigations are reliable and comparable.

3.5.13 The Health and Care Professions Council regulates health professionals using a series of standards for their training, professional skills, behaviour and health. Registration is mandatory for laboratory personnel involved in the validation and authorisation of test reports. A list of registrants is available at www.hcpc-uk.org.

Turnaround times

3.5.14 The turnaround time in this standard is the time taken in the laboratory. This does not take into account the time taken for the specimen to reach the laboratory (see Standard 2). There is no evidence base for laboratory turnaround times; those recommended are based on expert opinion. Laboratory turnaround times for positive results can contribute significantly to the total time to treatment for an infection. Laboratories should ensure they have the ability to rapidly review results, confirm positive results where necessary and to communicate results to clinicians. It is accepted that referral for further testing and confirmation at reference laboratories and antibiotic sensitivity testing by culture is likely to take longer than four working days.

Cost / cost effectiveness

3.5.15 In laboratories where there is a small throughput of specimens it may be more cost effective to transport the specimens to a larger centralised laboratory for analysis. Diagnostic tests, particularly those commercially available, are often expensive but this cost can be reduced when large numbers of tests are performed in one laboratory or a contract for several laboratories exists. The reduced cost of combining tests in one platform, such as *Chlamydia trachomatis* and *Neisseria gonorrhoeae*, should be considered with the knowledge of the limitations of the test and the population being tested, including the prevalence of the infection (see 3.5.2).

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Standard 3 – Diagnostics

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STANDARD 4

Clinical management

4.1 Quality statement

People using a service for STI testing should have access to their results both positive and negative within eight working days. Those diagnosed with an infection should receive treatment as quickly as possible, within three weeks, and be managed according to current BASHH national guidelines, including the provision of partner notification (PN).

4.2 Quality measures

4.2.1 Timely provision of test results:

The percentage of people having STI tests who have their results (both positive or negative) within eight working days of the date of the sample (excluding those requiring supplementary tests).

4.2.2 Clinical management:

Adherence to the current BASHH Clinical Effectiveness Group (CEG) guidelines¹ and NICE Sexual Health Quality Standard².

4.2.3 Effective partner notification (PN)*:

- a. The ratio of all contacts of index cases of gonorrhoea who access a service commissioned to manage STIs within four weeks of the date of first PN discussion.
- b. The ratio of all contacts of index cases of chlamydia who access a service commissioned to manage STIs within four weeks of the date of first PN discussion.
- c. The ratio of all contacts of index cases of early syphilis who access a service commissioned to manage STIs within four weeks of the date of first PN discussion.
- d. The percentage of people with documented evidence of PN discussion at the time of HIV diagnosis, including HIV point-of-care tests (POCT), to determine if any at risk contact has occurred within the previous 72 hours to identify and refer partners potentially eligible for post-exposure prophylaxis following possible sexual exposure to HIV (PEPSE).
- e. The ratio of contactable contacts of index cases of HIV who have had an HIV test, as verified by a healthcare professional, within three months of the date of first PN discussion.

* This is an area of current BASHH development and the ratios stated are likely to change in the near future. For any amended guidance see <https://www.bashhguidelines.org/current-guidelines>

4.3 Quality standard

4.3.1 Provision of test results within eight working days:
Standard: 95%

4.3.2 Clinical management

- a. Treatment of an STI within 3 weeks:
Standard: 85%
- b. Evidence of use of the specific audit measures in the current BASHH Clinical Effectiveness Group (CEG) guidelines¹.
- c. Review of people who are diagnosed HIV positive by specialist HIV care within fourteen days³:
Standard: 95%

4.3.3 Effective partner notification (PN):

- a. gonorrhoea at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks⁴.
- b. chlamydia at least 0.6 contacts per index case within four weeks⁴.
- c. syphilis at least 0.4 contacts per index case within four weeks⁵.
- d. 97% index cases with documented PEPSE assessment at diagnosis⁶.
- e. HIV at least 0.6 contacts per index case within three months⁶.

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 STIs:

- a. utilise guidance on *Making every contact count* regarding smoking cessation, improving diet, increasing physical activity, losing weight and reducing alcohol consumption⁷.
- b. follow NICE guidance on one-to-one interventions within *Prevention of sexually transmitted infections and under 18 conceptions*⁸.
- c. 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 sample and receipt of results.
- d. provide treatment according to current BASHH CEG guidelines.
- e. instigate PN as a core requirement either by patient referral (in which the person informs their sexual partners of the need for testing and treatment), or by provider referral (in which the service provider contacts sexual partners on behalf of the person to advise on the need for testing and treatment). This could include the use of online / web-based PN tools. The form of PN utilised should be the choice of the person diagnosed with a STI.
- f. have clear agreed care pathways in place to ensure people have access to appropriate care based on their need.

4.4.2. Commissioners should make provision for 24-hour availability of PEPSE and access to a Sexual Assault Referral Centre (SARC) within their commissioned area.

4.4.3 Commissioners should not commission services to offer syndromic management of STIs (see 4.5.9). Services should be commissioned to manage antibiotic use appropriately and responsively in line with real-time national guidance.

4.4.4 Commissioners should ensure that for services commissioned to manage STIs appropriate arrangements are made for treatment free of prescription charge in compliance with legislation, and to ensure equity in services to which the legislation currently does not apply (see 4.5.10 – 4.5.12).

4.4.5 Commissioning of services should aim to reduce health inequalities with a focus on prevention, such as through educational and behaviour change approaches.

Responsibilities of service providers

4.4.6 Results must be reviewed and actioned in a timely manner by a healthcare professional or non-registered healthcare worker competent in their interpretation.

4.4.7 All providers of services commissioned to manage STIs should ensure that they have appropriate mechanisms in place for people to have access to their results, both positive and negative, in no more than eight working days from the time of initial consultation. Technology should support this.

4.4.8 Following positive results, if services are unable to provide additional tests as needed, care pathways should be in place for onward referral to a service which is able to provide these. The current BASHH guideline for the management of gonorrhoea should be followed regarding gonococcal culture and test of cure in those with confirmed GC NAAT test. All people aged under 25 years diagnosed with chlamydia and other high-risk people e.g. some MSM should be advised to be re-tested according to current National Chlamydia Screening Programme (NCSP) and BASHH CEG guidelines.

4.4.9 It is the responsibility of the service taking the specimens to ensure that systems are in place to identify which tests have been taken, to ensure the results are identified, and that abnormal results are acted on appropriately. Policies must be in place for the management of abnormal or positive results when there is difficulty in contacting the person tested. Ideally consent for contact via at least two different means should be sought as well as consent to contact the GP in the event of not being able to contact the individual. If only one point of contact is obtainable e.g. a mobile number, then agreement needs to be reached with the individual about how they will access their results in the event of the service not being able to contact them.

4.4.10 All providers of services commissioned to manage STIs should ensure that they have appropriate mechanisms in place to provide treatment to people diagnosed with an STI:

- a. within three weeks of the tests being taken. If a service is unable to provide treatment, care pathways should be in place to refer people to another service for ongoing management within that timeframe.
- b. according to current BASHH CEG guidelines and free of prescription charge. Where services cannot provide a free prescription, patients should be informed of alternative services who are able to do so (see 4.5.10 – 4.5.12).
- c. including epidemiological treatment of sexual partners, i.e. prior to confirmation of infection, provided appropriate tests have been offered to identify infection and according to current BASHH CEG guidelines.
- d. arranging follow up, at the time of treatment, in accordance with current BASHH CEG guidelines.
- e. having recall systems for those advised to be re-tested according to current NCSP and BASHH CEG guidelines.
- f. referring those newly diagnosed with HIV to specialist HIV services to support their retention into care.

Standard 4 – Clinical management

4.4.11 All providers of services commissioned to manage STIs 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.
- c. offer people diagnosed with an STI a choice of PN by either patient referral (in which the person informs their sexual partners of the need for testing and treatment), or by provider referral (in which the service provider contacts sexual partners on behalf of the person to advise on the need for testing and treatment), or by online / web-based PN tools.
- d. adhere to the current BASHH PN statement in relation to look-back periods for each infection.
- e. monitor PN outcomes for gonorrhoea, chlamydia, syphilis and HIV against national standards. For gonorrhoea these are a minimum of 0.4 contacts per index case in large conurbations, or 0.6 contacts per index case elsewhere, within four weeks; for chlamydia 0.6 contacts per index case within four weeks; for syphilis 0.4 contacts per index case within four weeks and for HIV 0.6 contacts per index case within three months.

4.4.12 All providers of services commissioned to manage STIs 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 or weblinks where available, ensuring that comparable information is available in different languages and in non-written formats. Translators or interpreting services (face-to-face or telephone) should be available where requested or necessary.
- c. providing condoms free of charge, supporting this by demonstration of correct usage as appropriate.
- d. by ensuring that appropriate vaccinations for HAV, HBV and human papilloma virus (HPV) are offered to people in high risk groups in accordance with current BASHH CEG guidelines. For those accessing services online there should be provision for referral into face-to-face services to enable vaccination.
- e. by ensuring that appropriate advice is given about effective preventative interventions such as PEPSE and PrEP for HIV e.g. people starting PEPSE should be advised about PrEP if their risks are likely to continue.
- f. including one-to-one interventions to support behavioural change in line with NICE guidance or using appropriate referral pathways to support this.
- g. utilise guidance *Making every contact count* regarding smoking cessation, improving diet, increasing physical activity, losing weight and reducing alcohol consumption⁸.

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 STIs should ensure that:

- a. they are fully competent to manage STIs in accordance with current BASHH CEG guidelines. Empirical and epidemiological treatment while awaiting results are acceptable practices; syndromic management, with few exceptions is not (see 4.5.9).

- b. if not competent or able to provide appropriate management for particular conditions, they have clear referral pathways to appropriate services in place, with systems to confirm effective transfer of care.
- c. they report identified notifiable infections in accordance with PHE guidance.

People with needs relating to STIs:

4.4.14 Should receive sexual health advice and information in a sensitive and non-judgemental way and be offered free condoms.

4.4.15 Should have access to their test results, negative or positive, within eight working days of having the tests taken. The service should agree with them how they will receive their results.

4.4.16 Should receive the best available treatment according to current BASHH CEG guidelines if diagnosed with an STI. If, in the service they have accessed, prescription charges apply for treatment they should be informed of other local services where they could get treatment free of charge.

4.4.17 Should receive support from services if diagnosed with an STI to let recent sexual partners know that they are at risk of infection, as they will need testing for STIs and treatment.

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. It is therefore essential that results are reviewed by a healthcare professional or non-registered worker who is competent to interpret them correctly. Some online services may have automated results systems which are appropriate providing the people using them have no clinical symptoms.

4.5.2 Registered medical practitioners in England and Wales, and Northern Ireland, have a statutory duty to report notifiable diseases⁹. BASHH provides guidance of how this notification can be done if a person is unhappy about disclosure of their name or address¹⁰.

Provision of results

4.5.3 Provision of access to results whether positive or negative, is important both for effective clinical management of infection and for user satisfaction. The exact turnaround time in different settings will vary but a period of eight working days from having the test taken to provision of test results represents a maximum, agreed by consensus in the development of these standards.

4.5.4 It is not acceptable for people with a negative result not to be informed of these ('no news is good news'). It is for commissioners and providers to determine which of the various mechanisms for conveying results is most appropriate for the services they commission^{11,12}.

Treatment

4.5.5 For both public and individual health reasons, treatment regimens should follow current BASHH CEG guidelines and the NICE Sexual Health Quality Standard^{1,2}.

4.5.6 In England and Wales, the national Gonococcal Resistance to Antimicrobials Surveillance programme (GRASP) monitors antibiotic resistance to gonorrhoea annually¹³. Scotland and Northern Ireland have similar programmes^{14,15}. The results of this are used to inform any changes in first line treatments for gonorrhoea. Treatment for gonorrhoea should be in line with the current national guidance. Effective therapy, and partner notification, is essential for public health control of gonorrhoea and affected individuals diagnosed in primary care should be referred to a specialist service for treatment management.

4.5.7 Epidemiological treatment, i.e. treatment of sexual partners of an infected individual prior to confirmation of infection in the partner, may be appropriate. This reduces duration of infectivity and onward transmission rates for non-viral STIs. This should be undertaken in line with current BASHH CEG guidelines. Testing partners is necessary for identification of infection and for managing subsequent partner notification for those partners identified as positive.

4.5.8 All people aged under 25 years diagnosed with chlamydia¹⁶, and other high-risk people e.g. some MSM¹⁷, should be advised to be re-tested according to current NCSP and BASHH CEG guidelines.

Syndromic management

4.5.9 Syndromic management of STIs, is the prescribing of antimicrobial regimens chosen to cover the major pathogens responsible for a syndrome, e.g. urethral discharge and genital ulcer disease, without taking appropriate swabs for laboratory investigation; it was developed for resource poor settings where diagnostic laboratory tests are not available¹⁸. In the UK it is considered sub-optimal care and may contribute to antimicrobial resistance, and such management should only be used in exceptional circumstances by a senior clinician.

Prescription charges

4.5.10 Current legislation dictates that STI treatment is provided free of charge with the exception of provision of primary medical services and certain pilot and Local Pharmaceutical Services schemes¹⁹.

4.5.11 There are different methods of supplying free NHS medicines for STI treatment in primary care which include Patient Group Directions (PGDs)^{20,21}. All methods need to be explicitly commissioned, including the procurement of the drugs to be dispensed, in order to allow free treatment. The NCSP has published guidance on the legal framework for provision of free treatments in the programme. This resource is equally relevant for the provision of all treatments for STIs in primary care.

4.5.12 Expecting individuals accessing care from non-GUM services to pay for prescriptions is inequitable and may undermine public health outcomes. In the absence of legislation and / or changes in NHS regulations to allow free treatment, primary care providers may need to offer the option of referral to a service with exemption from prescription charges for STI treatments.

Partner notification

4.5.13 All services managing STIs should be expected to instigate PN as part of the management of STIs including HIV^{4,6}. PN is vital in assisting in the control of infection as it offers sexual contacts the opportunity for screening, assessment and treatment and thus can break the chain of transmission. It can also prevent long-term complications of infections, reduce reinfection, offer health education opportunities and encourage behaviour change.

4.5.14 Partner notification is a fundamental and skilled aspect of STI management. Those undertaking PN should be suitably trained and skilled in this aspect of STI management. BASHH guidance and outcome measures should be followed to ensure optimal management^{4,22}.

Health promotion and prevention

4.5.15 Health promotion and prevention is important 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^{7,8,23,24}. For some people referral for psychology review and / or one-to-one behavioural interventions may be appropriate to reduce the subsequent risk of STIs.

4.5.16 Pre-exposure prophylaxis for HIV (PrEP) should be provided and monitored according to current guidelines²⁵. Individuals with a history of drug use should be identified, assessed and managed according to current guidelines^{26,27}.

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Standard 4 – Clinical management

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STANDARD 5

Information governance

5.1 Quality statement

Services managing STIs must ensure information collected about service users remains secure and is only shared for legitimate reasons: in the service user'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 Toolkit*².

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 services commissioned to manage STIs comply with current UK law and regulations pertaining to information governance. This includes that they:

Standard 5 – Information governance

- a. comply with the *Data Protection Act 2018*³ and *General Data Protection Regulation (GDPR)*⁴ and any amending or replacement legislation.
- b. safeguard service user confidentiality as set out in the *NHS Code of Practice*⁵.
- c. have measures in place to guarantee secure record management in accordance with the *Records Management Code of Practice for Health and Social Care 2016*⁶.
- 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*⁷ and *Care Quality Commission: Safe data, safe care 2016*⁸.
- e. have measures in place to transmit datasets securely.

5.4.2. Commissioners should follow the DHSC guidance regarding transfer of records when there is a change of service provider⁹.

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 5.5.10 and 5.5.11). This should be written into contracts and service specifications as it is a mandatory obligation and applies equally to face-to-face, online and outreach services.

Responsibilities of service providers

5.4.4 All providers of services commissioned to manage STIs, including online and outreach services, 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 PHE 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*¹⁰, the *Data Protection Act 2018* and *GDPR*⁴ and any amending or replacement legislation and the *NHS Code of Practice*^{5,6}. Where information about service users is held electronically, it must be held and managed in accordance with the *Data Security and Protection Requirements*¹¹ 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 scope that is clearly defined in written consent taken from the patient.

5.4.7 All providers of services commissioned to manage STIs, including online and outreach services, 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. PHE or DHSC.
- b. DHSC data retention and destruction requirements⁶.

5.4.8 Service providers must ensure that all staff complete annual information governance 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 manage STIs, including online and outreach services, 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^{12,13}.
- c. compliance with mandatory information governance requirements.

People with needs relating to STIs:

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

5.5.1 Information governance ensures safe handling and appropriate use of information from service users.

Confidentiality

5.5.2 People with needs relating to STIs have a right to confidentiality in their consultations with a health professionals or non-registered healthcare workers, regardless of how or where the service is accessed^{10,14,15,16}. Historically, users of GUM services have been assured of anonymity if required and there has been an acknowledgement that GUM offers a higher level of confidentiality than other healthcare providers. With more STI care now being provided in other settings, the public need to be able to understand, and be confident in the level of confidentiality they can expect from different services in order to make informed choices about where to access care.

5.5.3 The rights of people to access care for needs relating to STIs without referral from, or sharing information with, other healthcare professionals has been recognised in UK law since 1916. This assurance of confidentiality encourages people to use sexual health services safe in the knowledge that their sensitive information will not be shared with their GP or other NHS services. Despite major changes to legislation in England*, the DHSC^{17,18,19} and BASHH still consider it best practice that sexual health services maintain their own patient record systems separate from other healthcare services and, do not share identifiable information relating to an individual's STI care without their consent.

* The National Health Services (Venereal Diseases) Regulations 1974 (SI 1974/29) are still in force in Wales.

5.5.4 To ensure people living with HIV are treated safely and appropriately across the NHS, information about people receiving HIV treatment and care services is, with their consent, routinely shared with other healthcare professionals including their GP. However, information about a person living with HIV and their use of NHS sexual health clinics for STI testing and treatment should not be routinely disclosed.

5.5.5 In exceptional circumstances information may need to be shared in the interests of the service user or the public, as set out in the relevant guidance documents e.g. for safeguarding purposes^{14,15}.

Collecting and recording information

5.5.6 Information on people attending health services is usually collected at registration and subsequently throughout the episode of care to enable clinical management. This information must be recorded in accordance with NHS information standards. However, there is no obligation to use the NHS number as the consistent identifier where services are provided anonymously e.g. sexual health services^{20,21}.

5.5.7 NHS information standards specified in the *NHS Data Model and Dictionary*²² are assured by the NHS Digital Data Coordination Board (DCB) who review and approve the assurance information standards and data collections (including extractions)²³. The DCB publish Information Standard Notices which introduce new or changes to information standards. Information Technology (IT) systems must have the facility to meet the requirements of data reporting and have the versatility to incorporate updates to the datasets within acceptable timescales as laid out by the statutory bodies e.g. PHE and NHS Digital.

Data reporting

5.5.8 There are a number of mandatory data collections for sexual health surveillance^{24,25,26,27}. All data extracts must be reported according to the timelines specified by the agency collecting them e.g. the GUMCAD schedule is specified by PHE. Extracts must be received within six weeks of the end of the calendar period they cover. For a summary of current mandatory reporting datasets see Appendix C.

5.5.9 Commissioners and service providers should be aware that when extracts of patient level sexual health data are reported to government or health bodies to inform national audits, plan health services, inform infection control plans and improve public health they must, as a requirement, be in an anonymised or pseudo-anonymised form.

Data sharing and publication

5.5.10 The use and sharing of patient information must strictly follow Caldicott Guidance¹⁰, the Data Protection Act 2018³, GDPR⁴, PHE guidance²⁸, the NHS Act 2006²⁹, DHSC guidance³⁰, GMC guidance^{15,31} and the Health and Social Care Act 2012³².

5.5.11 Concerns have been raised over publication of data with small cell sizes which could possibly be used to identify individuals indirectly, even when personal identifiers are not given. PHE has produced guidance for publishing sexual health data containing small cell sizes (usually counts between 1 and 4) and sharing patient-level datasets for analysis by healthcare professionals²⁸. The aim of the policy is to reduce the risk of inadvertent disclosure and therefore protect service user confidentiality.

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STANDARD 6

Clinical Governance

6.1 Quality statement

People should receive their STI care from high quality services that are safe, well-managed and accountable regardless of how and where the service is accessed.

6.2 Quality measures

6.2.1 Clinical Governance arrangements:

- a. Compliance with the standards relating to record keeping as set out in *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 2009²:
 - Regulation 12: Statement of purpose
 - Regulation 18: Notification of other incidents

6.2.2 Audit and quality improvement:

- a. Participation in relevant annual regional or national audits.
- b. Actions taken as a result of audit and quality improvement findings.

6.3 Quality standard

6.3.1 Clinical Governance measures:

- a. Meets 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, regulations² 12 and 18

6.3.2 Audit and quality improvement measures:

- a. Evidence of participation in relevant annual regional or national audits.
- 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 STI management regardless of setting i.e. including face-to face, online and outreach services.

6.4.2 Service specifications should enable the development of effective integrated governance systems that are reflected within individual service specifications.

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

6.4.4 The role of specialist GUM providers (Level 3) in providing clinical leadership and governance in relation to the management of STIs across the commissioned area needs to be explicitly commissioned and form part of the service specification.

6.4.5 Commissioners must make it a requirement that services engage in regular and relevant clinical audit. This should be evidenced by an annual audit plan that includes national and regional audit activities and assures compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulations: 12, 16, 17 and 20. As well as the Care Quality Commission (Registration) Regulations 2009 regulations: 12 and 18^{1,2}.

Responsibilities of service providers

6.4.6 Level 3 specialist GUM services should provide clinical leadership, including training, clinical expertise and clinical governance in the management of STIs, within the commissioned area according to their service specification (see 6.4.3).

6.4.7 All providers of services managing STIs, including online and outreach services must ensure that they are registered with the appropriate healthcare regulatory authority.

6.4.8 All providers of services commissioned to manage STIs should ensure that effective clinical governance arrangements are in place. This includes but is not limited to:

- a. having a nominated clinical governance lead with responsibility for overseeing the clinical quality of the service delivered and establishing robust links between all local services, including the specialist GUM service (Level 3).
- b. compliance with evidence-based guidelines and policies informed by the most up to date guidance from national bodies including NICE, BASHH, BHIVA and FSRH and best evidence in peer reviewed literature.
- c. using IT to support all aspects of clinical governance including service development to improve quality, safety, efficiency and clinical effectiveness taking into account the required information governance standards (see Standard 5).

Standard 6 – Clinical governance

- 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.
- e. having an audit plan which includes participation in regional and national audits as well as 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 service users and staff.
- i. promoting a culture of vigilance to risk and empowerment of all staff to report risks and concerns.
- j. having clear mechanisms in place to report, review and respond formally to all clinical incidents and complaints in line with Duty of Candour¹.
- k. having regular, e.g. monthly, clinical governance meetings to share learning outcomes from audits or investigations of incidents and complaints.

6.4.9 All providers of services commissioned to manage STIs should have any complaints they receive handled according to accepted practices³ 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.

Responsibilities of healthcare professionals and non- registered healthcare workers

6.4.10 All healthcare professionals and non-registered healthcare workers working in services commissioned to manage STIs must understand and comply with all 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 control and the appropriate level of safeguarding of children and 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 including familiarity of local incident reporting systems.

People with needs relating to STIs:

6.4.11 Should find the services they attend for STI care to be safe and of a high quality.

6.4.12 Should receive a response to any concerns, or complaints they make about the service.

6.4.13 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 and / or the advice of expert bodies.

6.5 Supporting information

Clinical governance

6.5.1 The Local Authority as commissioner of services, to manage STIs, is responsible for commissioning clinically safe services. *A Framework for Sexual Health Improvement in England* (DHSC, 2013)⁴ identifies the importance of services having clinical governance arrangements, professional guidelines and NICE quality standards in place, and that services are commissioned around patient need and best value.

6.5.2 The DHSC defines clinical governance as ‘the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish’⁵.

As the regulator of health and adult social care in England, the Care Quality Commission’s (CQC) registration system for health and adult social care provides a framework to ensure that all services meet the essential standard of quality and safety. All providers of services managing STIs have a responsibility to demonstrate effective clinical governance arrangements^{6,7,8}.

Clinical leadership

6.5.3 Clinical leadership is fundamental to any governance structure as it provides a framework through which providers endeavour continuously to improve the quality of their services to safeguard standards of care by creating an environment in which clinical excellence can flourish.

6.5.4 Clinical leadership is distinct from service leadership. Service leadership refers to the operational management of a service and may be provided by any appropriately qualified individual. This standard however, emphasises clinical leadership which should be provided by an accredited GUM specialist within a commissioned area, comprising multiple local services, in order to oversee clinical governance and patient safety with regards to STI management.

6.5.5 Clinical leadership provides a framework for the development of shared protocols, care pathways, resources, audit and training, whilst assuring adherence to best practice guidance as laid out by professional bodies such as BASHH. Within a commissioned area, clinical leadership should empower and drive transformational change across organisational boundaries and ensure safe, equitable delivery of services regardless of who provides them.

Information technology

6.5.6 Information technology is a powerful resource which can help services to achieve and maintain high standards across all strands of governance including: systems for managing and recording clinical care. See Standard 5 (5.4.7); systems for reporting and investigating clinical incidents and risk; tools for learning and development (see Appendix D); processes for capturing and analysing data for audit and research; innovations that enhance clinical effectiveness, efficiency and / or experience of those with needs relating to STIs e.g. telemedicine or online tools that improve access or engagement particularly in hard to reach groups.

6.5.7 Integrated IT systems across branches of a service or between a network of services, have the potential to enhance care for those with needs relating to STIs because it gives healthcare professionals easy access to accurate and up to date information which can assure continuity of care and effective safeguarding. However, services should be aware of, and averse to, the inherent risks to data security and data protection. Strict adherence to all information governance requirements would mitigate these risks⁹. See Standard 5.

6.5.8 An electronic care record, also termed electronic patient record (EPR), can support good clinical governance in many ways. It can: ensure high standards of record keeping; ensure standardisation and consistency of data collection used for mandatory datasets; and facilitate data collection and analysis for audit and research. In addition, EPR software can enhance care e.g. integration with laboratory results, telecommunications, recall and alert systems. All of which can improve time to treatment and partner notification and improve safeguarding. For these reasons, but particularly because mandatory datasets are going to increasingly rely on behavioural and clinical information collected during a consultation, services should adopt an EPR in preference to paper records.

6.5.9 In 2017, new EU medical device regulations (MDR)¹⁰ were published which included an update on, and clarification of, the definition and classification of software as a medical device. ‘Medical device’ is defined as ‘any [...], software, [...] intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes: - diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease’.

Software that falls within this definition needs to be registered with the Medicines and Healthcare products Regulatory Agency (MHRA) and CE-marked. Although published in 2017, the provisions within the MDR are being implemented over a period of time and only come fully into force in 2020. At time of writing this document, there is uncertainty as to what will happen with such provisions that have not been fully implemented if Britain leaves the EU without a transition period. Should that be the case, software should still comply with current MHRA standards.

6.5.10 Services 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.

Teaching and training

4.5.11 All people accessing services should have their care managed by an appropriately trained healthcare professional; teaching and training are central to any governance structure. A variety of allied professionals and other staff, e.g. youth workers or receptionists, may be involved in elements of healthcare, and they too should be trained and competent.

6.5.12 Services managing STIs often employ a workforce with a diverse range of competencies and experience, who may all be at different stages of learning and development. It is therefore essential that services integrate appropriate supervision into their practice. This should involve reflective practice including clinical and safeguarding supervision. Appropriately trained and supervised staff will ensure services are delivered in a safe and high-quality manner. Further guidance can be found in *Supporting effective clinical supervision* (CQC, 2013)¹¹.

6.5.13 The role of specialist GUM services (Level 3) in supporting teaching and training on STI management is vital, although they do not necessarily have to provide the training themselves. See Standard 7.

Audit and research

6.5.14 Audit is an essential component of clinical governance. It is a process that seeks to improve clinical care and outcomes through systematic review and the implementation of change. Participation in audit is considered part of the objectives of all integrated sexual health services (Levels 1, 2 and 3), and is included in the quality outcomes indicators of the suggested national service specification¹².

6.5.15 Research in sexual health should be promoted and supported to further knowledge and improve outcomes for people accessing STI services^{13,14}. Sexual health has seen significant developments in diagnostic technology and self and near patient testing. Many digital technologies are being trialled that have the potential to improve access, enhance patient pathways and improve care outcomes.

Risk management

6.5.16 Sexual health services, due to the nature of their work, do carry clinical risk. Robust organisational arrangements for managing risk including critical incidents and complaints are therefore essential⁶. Transparency, sharing awareness, and learning from incidents within the commissioned areas should be promoted.

Quality improvement

6.5.17 Effective clinical governance should support continuous quality improvement. Regulation 17 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*¹ relates to assessing and monitoring the quality of the service provision¹⁵. Providers who comply with the regulations will improve their services by learning from adverse events, incidents, errors and near misses, as well as the outcomes from comments and complaints, and the advice of other expert bodies. Public Health England has developed a toolkit to assist services in evaluating interventions in sexual health, reproductive health and HIV services¹⁶.

6.5.18 Services should make use of public health data in order to identify local trends and for benchmarking. Examples include the Public Health England *Sexual and Reproductive Health Profiles*^{17,18}: rate of chlamydia diagnoses in 15 to 24-year olds, and proportion of people presenting with HIV at a late stage of infection. This intelligence can direct engagement activities and inform service developments thereby improving the effectiveness of local services. See Standard 9.

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STANDARD 7

Appropriately trained staff

7.1 Quality statement

People with needs relating to STIs should have their care managed by an appropriately skilled healthcare professional.

7.2 Quality measures

7.2.1 Competence to deliver services:

Compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*¹:

- Regulation 12: Safe care and treatment
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed

7.3 Quality statement

7.3.1 Competence to deliver services:

Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*¹ for regulations 12, 18 and 19.

7.4 What the quality statement means for each audience

Responsibilities of commissioners

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

7.4.2 All providers of Level 1 and 2 services should have access to senior clinical support and advice from a commissioned Level 3 service, and access to on-going education and training for staff that reflects national standards and local needs.

7.4.3 The clinical leadership role of specialist GUM providers (Level 3) in the delivery of training in STI management, across the commissioned area, should form part of service specifications.

7.4.4 Commissioners should ensure that the education and training of future healthcare professionals and non-registered healthcare workers is supported by commissioning decisions and arrangements to avoid compromising or undermining standards.

7.4.5 Commissioners should ensure that all service providers can demonstrate a workforce development and continuity strategy.

Responsibilities of service providers

7.4.6 All providers of services commissioned to manage STIs have a responsibility to provide and support education and training for their own staff, including trainees. This should include access to nationally recognised training programmes. See Appendix D.

7.4.7 Adequate provision should be made to support the maintenance of competencies in the management of STIs, e.g. through continued professional development, education and appropriate assessment.

7.4.8 Wherever possible, nationally recognised training and assessment tools should be used and, where appropriate, these should be common across all professional groups. Those assessing competence should be qualified trainers with the appropriate skills.

7.4.9 All services should be able to provide assurance that employees delivering care are competent and remain competent to do so. Staff numbers and skill mix should be appropriate to the workload and clinical complexity.

Responsibilities of healthcare professionals and non-registered healthcare workers

7.4.10 All clinical staff, regardless of discipline, should be assessed and able to demonstrate clinical competence at an appropriate level to their role. 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.

People with needs relating to STIs:

7.4.11 Should have their care managed by an appropriately skilled individual.

7.5 Supporting information

Competence

7.5.1 Competence is: the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance. Competencies should be relevant to the service that is being delivered. Disciplines may have different professional guidance and requirements for certain competencies e.g. in relation to prescribing or the authority to use patient group directions (PGDs) but the standards needed to achieve competence should be the same.

7.5.2 Knowledge is: the facts, information and skills acquired through experience or education. The theoretical or practical understanding of the subject.

7.5.3 A skill is: an ability to perform a task well which has been acquired by education, training and / or experience.

Maintaining competence

7.5.4 All healthcare professionals and non-registered healthcare workers providing elements of STI care, have a responsibility to maintain their own clinical competence. This should be demonstrated through local mandatory training programs, annual appraisal and revalidation processes relevant to the professional discipline. Regular audit of practice by a clinical supervisor or self-audit should take place to monitor practice. Maintenance of competencies must also form part of a robust local governance framework for both commissioners and service providers^{1,2}.

Training

7.5.5 Services managing STIs will often be responsible for providing a variety of locally agreed training programmes. Different disciplines are educated and develop clinical competence in STI management in a variety of ways^{3,4,5,6,7,8} at both pre and postgraduate level. Wherever possible staff of all disciplines should complete nationally recognised accredited training programs (for further information see Appendix D).

7.5.6 Although the responsibility to develop a skilled future NHS workforce lies with Health Education England (HEE), service providers and commissioners need to accept their role in developing trained staff to ensure the sustainability of current and future specialist services. Service providers should work in collaboration with commissioners and the relevant deaneries to provide placements for specialist trainees in GUM, SRH and other undergraduate and postgraduate trainees including those in allied healthcare professions. Wherever possible the training provided should support services.

7.5.7 Appendix D provides a list of nationally recognised postgraduate STI courses which BASHH has developed and / or endorsed, and courses to which BASHH has contributed. It is not exhaustive and a number of other high-quality courses that relate to the management of STIs are available including some which have been locally or regionally developed. Appendix D is intended to support individuals and organisations in determining which training programmes most appropriately meet their needs.

BASHH qualifications of clinical competence

7.5.8 The BASHH portfolio of clinical competency learning and assessment qualifications aimed at multidisciplinary healthcare professionals and non-registered healthcare workers⁹ provides a national standardised training and assessment pathway. This ranges from testing for asymptomatic STIs, risk assessment and offering health promotion (STIF Fundamental Competency) to the management of symptomatic uncomplicated STIs (STIF Intermediate Competency) and more advanced practice in the management of STIs (STIF Advanced Competency). The qualifications are aimed at staff delivering STI care in both specialist and non-specialist settings, including health care assistants (HCAs) / clinical support workers (CSW), pharmacists, nurses, midwives, sexual health advisers and doctors not undertaking formal training for Certificate of Completion of Training (CCT). They provide a portable passport of clinical competence. There are also competency training and assessment pathways specifically designed for those working in sexual health adviser roles and for nurses working in HIV medicine (many of whom will also be working in sexual health).

7.5.9 To remain on the BASHH Competency register, BASHH Competency qualifications require re-certification every 5 years¹⁰.

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

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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 for them quickly and easily. Similarly, people with any other sexual health needs that the service is unable to meet (e.g. HIV treatment and care, contraception, abortion, psychology or sexual assault) should experience easy and timely referral (appropriate to circumstances) to a suitable service.

8.2 Quality measures

8.2.1 Care Pathways:

Clear and up to date care pathways linking all providers of STI management, within a commissioned area, with a Level 3 specialist GUM service.

8.2.2 Competence to deliver services:

Compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*¹:

- Regulation 12: Safe care and treatment

8.3 Quality statement

8.3.1 Evidence of documented local care pathways for the management of people with needs relating to STIs.

8.3.2 Competence to deliver services:

Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*¹ for regulation 12.

8.4 What the quality statement means for each audience

Responsibilities of commissioners

8.4.1 Commissioners should work with service providers and clinicians to ensure that care pathways are transparent and integrated across the commissioned area.

8.4.2. Commissioners should be explicit about the clinical leadership role of the specialist GUM provider (Level 3).

8.4.3 Commissioners should consider how to encourage and support service providers to ensure effective patient-centred collaborative working.

Standard 8 – Links to other services

8.4.4 Commissioners should ensure appropriate linkages between providers of services commissioned to manage STIs and services providing HIV treatment and care. In order to ensure those newly diagnosed with HIV can rapidly and smoothly access HIV care, and those living with HIV can easily access STI testing and treatment.

8.4.5 Commissioners should contribute to robust and ongoing joint strategic needs assessments across all services within the commissioned area.

Responsibilities of service providers

8.4.6 All providers of services commissioned to manage STIs should ensure that effective links to other clinical services are in place. This includes but is not limited to the following:

- a. having formal links and clear referral pathways in place to the local specialist GUM service (Level 3) and other closely allied specialties e.g. Sexual and Reproductive Health services (SRH), abortion services, psychosexual services and a Sexual Assault Referral Centre (SARC).
- b. having formal links and clear referral pathways in place to HIV treatment and care providers that include provision for the continuation and completion of HIV partner notification as per the latest BHIVA / BASHH standards^{2,3}.
- c. having formal links and clear referral pathways in place to other relevant organisations within the commissioned area including those relating to safeguarding, social services, young people's services, domestic abuse services, substance abuse services and mental health services.
- d. actively liaising with other local providers to share best clinical practice, trends in infection presentation and other clinical developments.
- e. working with other services to develop and share local clinical guidelines and protocols.
- f. delivering or participating in education and training across the commissioned area.
- g. ensuring that service users have a range of ways to access their results (e.g. telephone, text, email, online portal) in the event that they attend an alternative service for treatment.
- h. ensuring that there are clear lines of communication between services for continuity of care and so that partner notification can be completed in accordance with the latest BASHH Clinical Effectiveness Group (CEG) guidelines.

Responsibilities of healthcare professionals and non-registered healthcare workers

8.4.7 All healthcare professionals and non-registered healthcare workers working in services commissioned to manage STIs should have a clear understanding of local care pathways, in order to facilitate appropriate referrals and know-how to access specialist advice.

People with needs relating to STIs:

8.4.8 Should find that quick and convenient referral to other sexual health services or organisations is facilitated in accordance with their needs.

8.5 Supporting information

Clinical links

8.5.1. All providers of STI management have a responsibility to collaborate and cooperate in delivering services that are responsive to the needs of the people who access them and that offer high quality, safe and effective patient centred care^{1,4}.

Care pathways

8.5.2 The Department of Health's *Framework for Sexual Health Improvement in England*⁶ identifies collaboration and integration between services as essential. This is because different groups of people often have varying and complex health needs e.g. women who believe they are at risk of an STI may also be at risk of an unintended pregnancy or vice versa. If the provider accessed is not an integrated sexual and reproductive health service, it is vital that clear referral pathways to relevant services are in place to ensure timely access to advice and care that meets individual need^{6,7,8,9}.

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 pathway development should always involve the local specialist GUM provider (Level 3) as well as other partners with a role in STI management. Pathways are likely to cover referral criteria, triage criteria, out-of-hours advice, diagnostics advice, two-way communication, clinical guidelines, management options and training and education of staff. All providers should be aware of, and adhere to, agreed care pathways which should be monitored for effectiveness.

Working collaboratively

8.5.4 There are a number of different models which provide a framework for collaborative working and a more integrated delivery of sexual healthcare including local or regional clinical advisory groups, transformation bodies or traditional sexual health networks. Establishing good professional relationships between services and other organisations working locally, and regionally, will help to ensure that the care people receive is holistic and person centred.

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Standard 8 – Links to other services

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STANDARD 9

Patient and public engagement

9.1 Quality statement

People who use STI services, the public, staff and external partners should all be consulted about the delivery of services both face-to-face and online. Those using services should be encouraged to give feedback about them.

9.2 Quality measures

9.2.1 Evidence that a patient and public engagement (PPE) plan is in place, detailing how PPE is incorporated into service design 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 and sexual minorities, black and minority ethnic groups and young people^{1,2}.

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 including the Friends and Family Test³.

9.2.3 Competence to deliver services:

Compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*⁴:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect

9.3 Quality standard

9.3.1 Evidence of a current Patient and Public Engagement plan which affords public consultation and feedback.

9.3.2 Evidence from service providers of effectiveness of care from the patients' perspective and the patient experience of the humanity of their care via annual reporting. Measurement tools can include Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMS) and the Friends and Family Test³.

9.3.3 Competence to deliver services:

Meets in full the requirements of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*⁴ for regulations 9 and 10.

9.4 What the quality statement means for each audience

Responsibilities of commissioners

9.4.1 Commissioners should develop an STI and Public Engagement Strategy for their commissioned area.

9.4.2. Commissioners, working with providers and service users, should develop local quality measurement frameworks utilising nationally validated tools.

9.4.3 Commissioners should proactively engage with users and non-users of services, including those most at risk of STIs, from all equality groups in particular gender and sexual minorities. Lay* representation on both commissioning and community groups should be encouraged from key target age groups using and requiring access to sexual health services.

9.4.4 Commissioners should ensure that there is evidence of PPE in service providers annual reports.

9.4.5 Commissioners should agree with services what appropriate methodologies are used to deliver robust PPE within the commissioned area.

Responsibilities of service providers

9.4.6 All providers of services commissioned to manage STIs should ensure that effective PPE arrangements are in place. This includes but is not limited to the following:

- a. identifying named individuals in each service with responsibility for leading PPE.
- b. promoting equality and diversity by seeking and respecting different beliefs and opinions during service development and delivery.
- c. proactively seeking participation from people who experience health inequalities and poor health outcomes.
- d. engaging with service users, to assess their experience of the STI services they have used and to seek their opinion about other services they may require.
- e. routinely engaging with the public, including non-users of STI services e.g. by having a regular PPE Forum.
- f. assessing potential access issues and why population groups may not be using services.
- g. providing clear information and seeking to facilitate involvement by all. This may require the involvement of advocacy services and other partners e.g. Healthwatch and other third sector providers.
- h. providing evidence of how the service has responded to feedback and how PROMS and PREMS are monitored.
- i. evidence of the development of staff engagement and training in PPE.
- j. the use of appraisal processes to obtain patient feedback for all staff interacting with people using services.

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

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 PPE and actively participate in PPE when opportunities arise.
- b. encourage patient involvement and feedback, both positive and negative.
- c. respond to feedback in an open and honest fashion by using appropriate methods of communication which may include web-based, telephone, written or verbal means of contact.
- d. review relevant information (e.g. from reports of Friends and Family Test responses) to understand patient's experiences, both positive and negative, and learn how to improve on them.

People with needs relating to STIs:

9.4.8 Should be encouraged to provide feedback on their personal experience of care and to offer opinions about services managing STIs, 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: 6.4.9).

9.5 Supporting information

Patient and public engagement

9.5.1 Putting people first, adopting a mindset that places the interests of patients before those of the service and tailoring what the service does to meet the needs of the people using it is imperative. Strengthening engagement and participation with patients and the public may lead to more sustainable and effective services.

9.5.2 There is a legal obligation to make provision for public involvement in health and social care matters^{3,5} across the UK and this forms the basis of care quality standards in the NHS Constitution¹, NHS Outcomes Frameworks^{6,7} and NICE Guidance⁸. STIs remain a source of stigma and achieving engagement with many populations who use services is challenging⁹.

Yet consultation with service users has many benefits both, in refining commissioning strategies to help provide cost effective and relevant services and, in encouraging people to take an active part in the development of services through immediate feedback of experience and through monitoring outcomes^{2,3}.

9.5.3 The NHS Constitution¹ includes a right for people to expect the NHS to assess the health requirements of their community and to commission and put in place the services to meet those needs as considered necessary. In England, Clinical Commissioning Groups (CCGs), local authorities and national commissioning and engagement mechanisms for specialised services, all carry a legal duty for public consultation as integral to their functioning, not just where changes in service provision are proposed¹⁰. Similar duties apply to NHS Scotland, Wales and Northern Ireland^{11,12,13}. Therefore engagement of the public, including non-users of services, should be a routine feature of commissioning and provider organisations and not just sought when any major redesign or development is planned. Consultation frameworks to engage with patients and the public should be developed across the commissioned area and may well include using local organisations such as patient groups and charities and direct public engagement through social media and web-based consultations.

Patient Reported Outcome Measures

9.5.4 The quality of care from the patient's perspective has two facets: its effectiveness (outcome); and its humanity (experience)¹⁴. Asking patients directly about the impact of treatment on symptoms and quality of life is the basis of Patient Reported Outcome Measures (PROMS). The use of PROMS in national clinical audits is complementary to clinician reported outcomes.

9.5.5 PROMS are typically short, self-completed questionnaires which measure the patient's health status at a single point in time. They are usually administered before and after health interventions.

Patient Reported Experience Measures

9.5.6 The means of recording the feelings of patients immediately after a clinical encounter are known as PREMS. They focus on the comfort / discomfort / pain of a physical process and personal perceptions of privacy, dignity and communication with staff. PREMs may be captured by a variety of tools^{7,8} many of which, such as simple visual analogue scales, can be developed and offered electronically. Immediate feedback to staff about experiential factors is a strong driver to changes in practice and improved clinical care. Furthermore, patient questionnaires validated for use in outpatient settings can be used as part of staff 360-degree appraisal, capturing metrics in a standardised manner.

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Standard 9 – Patient and public engagement

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APPENDIX A

Project Group members and representatives

BASHH Clinical standards Unit plus co-optees

NAME	DESIGNATION	ORGANISATION
Dr Raj Patel	Chair of BASHH Standards Group, Chair of BASHH Clinical Standards Unit, Consultant Physician in Genitourinary Medicine (Solent NHS Trust)	BASHH
Dr Emily Clarke	Secretary for the BASHH Standards Group, Consultant Physician in Genitourinary Medicine and HIV (Liverpool and Broadgreen University Hospitals NHS Trust)	BASHH
Dr Vanessa Apea	BASHH National Audit Group Representative, Consultant Physician in Genitourinary Medicine and HIV (Barts Health NHS Trust)	BASHH
Dr Daniela Brawley	BASHH Scottish Branch Chair, Consultant Physician in Genitourinary Medicine and HIV (NHS Grampian)	BASHH
Dr Savita Brito-Mutunayagam	Specialist registrar in Sexual and Reproductive Health (NHS Grampian)	Faculty of Sexual and Reproductive Healthcare
Erna Buitendam	Head of Quality assurance and Standards, National Chlamydia Screening Programme	Public Health England
Dr Elizabeth Carlin	Consultant Physician in Genitourinary Medicine and HIV (Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust)	BASHH
Robbie Currie	Executive member of the English HIV and Sexual Health Commissioners' Group, Sexual and Reproductive Health Programme Lead (London Borough of Bexley)	English HIV and Sexual Health Commissioners' Group
Professor Claudia Estcourt	Professor of Genitourinary Medicine and HIV (Glasgow Caledonian University)	BASHH
Ceri Evans	Sexual Health Advisor (Chelsea and Westminster Hospital NHS Foundation Trust)	BASHH
Dr Helen Fifer	Consultant Microbiologist	Public Health England
Kate Folkard	Interim Head, National Chlamydia Screening Programme	Public Health England
Dr Ashini Fox	Chair of the BASHH Education Committee Consultant Physician in Genitourinary Medicine and HIV (Nottingham University Hospitals NHS Trust)	BASHH

Appendices

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Dr Richard Ma	GP	Royal College of General Practitioners
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Jonathan O'Sullivan	Director of Sexual Health for London	Association of Directors of Public Health
Dr Say Quah	Consultant in Sexual Health and HIV (Belfast Health and Social Care Trust)	BASHH
Dr David Phillips	Co-chair BASHH – FSRH Information Group Consultant Physician in Genitourinary Medicine and HIV (Croydon Health Services NHS Trust)	BASHH
Professor Jonathan Ross	Vice President of BASHH, Professor in Genitourinary Medicine and HIV (University of Birmingham)	BASHH
Dr John Saunders	Clinical Champion National Chlamydia Screening Programme Honorary Consultant in Sexual Health and HIV	Central and North West London NHS Foundation Trust
Dr Craig Tipple	Chair of the BASHH Public Panel, Honorary Consultant Physician in Genitourinary Medicine and HIV (Imperial College Healthcare NHS Trust)	BASHH
Claire Tyler	Project Consultant	Wensum Consulting Ltd
Dr Olwen Williams	President of BASHH, Consultant Physician in Genitourinary Medicine and HIV (Betsi Cadwaladr University Health Board)	BASHH
Dr Janet Wilson	Consultant Physician in Genitourinary Medicine and HIV (Leeds Teaching Hospitals NHS Trust)	BASHH

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. See also Appendix E. 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 following sexual exposure (PEPSE)
- sexual assault with referral as appropriate

Signposting to appropriate sexual health services

Chlamydia screening

Opportunistic screening for genital chlamydia in sexually active asymptomatic males and females 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 men with dysuria and genital discharge**

Testing and treatment of STIs at extra-genital sites

STIs with complications

STIs in pregnant women

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 following sexual exposure (PEPSE)****

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^{1,2} (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 'starter packs' are often available in other settings such as Accident and Emergency or Occupational Health, but referral to a specialist GUM (Level 3) service is required for ongoing management and provision of antiretroviral drugs.

***** PrEP may be provided via the PrEP Impact Trial (England), NHS (Scotland, Wales, Northern Ireland) or self-funded but a specialist GUM (Level 3) service or HIV service is required for ongoing management and provision of antiretroviral drugs.

APPENDIX C

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

INFORMATION COLLECTED	SERVICES AFFECTED	DATASET	RESPONSIBLE ORGANISATION			
			ENGLAND	WALES	SCOTLAND	NORTHERN IRELAND
STI and HIV tests, diagnoses and services	Level 2 and 3 Sexual Health Services Also diagnostic and reference laboratories in Scotland	GUMCAD STI Surveillance System in England, Wales and Northern Ireland Electronic Communication of Surveillance in Scotland System (ECOSS) for laboratories and Sexual Service data from the National Sexual Health IT system (NaSH) in Scotland	Public Health England	Public Health Wales	Health Protection Scotland	Public Health Agency NI
HIV diagnoses and clinical outcomes of people accessing care	HIV diagnosing sites and HIV outpatient services	HIV and AIDS Reporting System (HARS) in England SOPHID, and HIV new diagnoses and deaths in Wales and Northern Ireland Electronic Communication of Surveillance in Scotland System (ECOSS) for HIV diagnoses and HIV care/attendance data by each health board for Scotland	Public Health England	Public Health Wales	Health Protection Scotland	Public Health Agency NI
Chlamydia tests and diagnoses	All laboratories commissioned to provide chlamydia testing	CTAD Chlamydia Surveillance System in England Electronic Communication of Surveillance in Scotland System (ECOSS) in Scotland	Public Health England	—	Health Protection Scotland	—
Contraception data	Settings (excluding General Practice except in Scotland) offering contraceptive services	Sexual and Reproductive Health Activity Dataset (SHRAD) in England and Wales. 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	Public Health England (data submitted via NHS Digital)	Public Health Wales	Information Services Division Scotland (part of NHS National Services Scotland)	—

* Correct as of March 2019

APPENDIX D

Education and training matrix

The following are learning resources which BASHH has developed and / or endorsed and courses to which BASHH has contributed. This matrix is not exhaustive and it is acknowledged that there are a number of other high-quality courses in existence, some locally developed, which relate to the management of STIs.

LEVEL 0/1									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge-based	Skills-based	Doctor	Nurse	Sexual health advisor	Pharmacist	
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
Centre for Postgraduate Pharmacy Education (CPPE) 1. Chlamydia testing and treatment 2. Sexual health in pharmacies (workshop, e-learning and assessment)	Yes	No	Yes	No	No	No	No	Yes	Certificate on completion

LEVEL 1									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge-based	Skills-based	Doctor	Nurse	Sexual health advisor	Pharmacist	
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
Centre for Postgraduate Pharmacy Education (CPPE) 1. Chlamydia testing and treatment 2. Sexual health in pharmacies (workshop, e-learning and e-assessment)	Yes	No	Yes	No	No	No	No	Yes	Certificate on completion
BASHH STIF - Plus 1 day course	Yes	Yes**	No	No	Yes	Yes	Yes	Yes	Certificate on completion and registration on BASHH database
BASHH STIF Fundamental Competency	No (STIF Core is designed to deliver this)	No Local clinic based training advised	Yes	Yes	Yes	Yes	Yes	Yes	Certificate on completion and registration on BASHH database
Faculty of Sexual and Reproductive Healthcare (FSRH) Diploma Course (DFSRH)	Yes	Yes	Yes	Yes	Yes	No	No	No	Diploma awarded after full competency assessment for contraceptive provision and Level 1 STI management***
BASHH Web-based STI knowledge assessment	No	No	Yes	No	Yes	Yes	Yes	Yes	Certificate awarded if successful

LEVEL 2									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge-based	Skills-based	Doctor	Nurse	Sexual health advisor	Pharmacist	
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	Some elements	No	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
BASHH STIF Intermediate Competency	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
BASHH STIF Integrated Competency	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
BASHH STIF Advanced Competency	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
Certificate of Completion of Training (CCT) in SRH	Yes	Yes	Yes	Yes	Yes	No	No	No	CCT

LEVEL 3									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge-based	Skills-based	Doctor	Nurse	Sexual health advisor	Pharmacist	
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	Some elements	No	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
BASHH STI course	Yes	Yes	No	No	Yes	Yes	No	No	Certificate on completion
Society of Apothecaries Diploma in GU Medicine (DipGUMed)****	No	No	Yes	Yes	Yes	No	No	No	DipGUM
Certificate of Completion of Training (CCT) in GUM	Yes	Yes	Yes	Yes	Yes	No	No	No	CCT

* Includes learning by interactive case-based discussion

** Developed through role-play.

*** BASHH STIF-Core Study Day is highly recommended to complement STI training in DSFRH.

**** BASHH STI Course and Society of Apothecaries Diploma in GU Medicine: the Course has no assessment and the Diploma no course. However, the BASHH STI Course is the best way to prepare for the Diploma.

APPENDIX E

Recommended tests for STIs

For details of exact specimens and diagnostic methods see either the summary tables for testing or the national guideline for patient management of the individual conditions at www.bashh.org/guidelines

Asymptomatic individuals

- Urine in men or self-taken vulvo-vaginal swab (VVS) in women for gonorrhoea and chlamydia NAAT
- If no VVS or cervical specimen, urine in women for gonorrhoea and chlamydia NAAT
- Serology for HIV and syphilis
- Serology for hepatitis B HBsAg, HBcAb and HCV Ab in those from endemic regions and in HIV positive individuals

If MSM or if indicated by sexual history

- Rectal sample for gonorrhoea and chlamydia NAAT
- Pharyngeal sample for gonorrhoea and chlamydia NAAT
- Serology for hepatitis A Ab, hepatitis B HBsAg and HBcAb in MSM with no history of immunisation, and HCV Ab in individuals living with HIV and MSM involved in group sex and chemsex

Men with symptoms of urethritis

- First void urine (FVU) or urethral sample for gonorrhoea and chlamydia NAAT
- FVU or urethral sample for *Mycoplasma genitalium* with resistance testing
- Urethral microscopy and culture for *Neisseria gonorrhoeae* (*N. gonorrhoeae*)
- Serology for HIV and syphilis
- Serology for hepatitis B HBsAg, HBcAb and HCV Ab in those from endemic regions and in individuals living with HIV

If MSM or if indicated by sexual history

- Rectal and FVU samples for gonorrhoea and chlamydia NAAT
- Microscopy and culture for *N. gonorrhoeae* if symptomatic at the rectum
- Pharyngeal sample for gonorrhoea and chlamydia NAAT
- Culture for *N. gonorrhoeae* if symptomatic at the pharynx
- Serology for hepatitis A Ab, hepatitis B HBsAg and HBcAb in MSM with no history of immunisation and HCV Ab in individuals living with HIV and MSM involved in group sex and chemsex

Women with symptoms of vaginal discharge

- VVS for gonorrhoea and chlamydia NAAT
- Endocervical microscopy and culture for *N. gonorrhoeae*
- If no VVS or cervical specimen collection not possible, urine or gonorrhoea and chlamydia NAAT
- Smear from the lateral vaginal wall for microscopy for bacterial vaginosis and candida, smear from the posterior fornix for *Trichomonas vaginalis* (*T. vaginalis*) for in clinic results and if more sensitive tests are not available

- Vaginal swab for culture, NAAT (preferred) or POCT for *T. vaginalis*
- Rectal samples for gonorrhoea and chlamydia NAAT plus culture for *N. gonorrhoeae* if indicated by sexual history
- Pharyngeal samples for gonorrhoea and chlamydia NAAT plus culture for *N. gonorrhoeae* if indicated by sexual history
- Serology for HIV and syphilis
- Serology for hepatitis B HBsAg, HBcAb and HCV Ab in those from endemic regions and in individuals living with HIV

If evidence of genital ulceration in men or women, additional specimens

- Ulcer specimen for *Treponema pallidum* (*T. pallidum*) for dark ground microscopy and / or ulcer specimen for NAAT for *T. pallidum* as a single or multiplexed test
- HSV NAAT from ulcer as a single or multiplexed test
- Other specimens for chancroid, donovanosis and LGV if indicated by sexual history and / or local symptoms and signs
- Ensure syphilis serology includes RPR and (if available) EIA IgM

GLOSSARY OF ABBREVIATIONS

BASHH	British Association for Sexual Health and HIV
BASHH CEG	BASHH Clinical Effectiveness Group
BASHH CSU	BASHH Clinical Standards Unit
BHIVA	British HIV Association
BV	Bacterial vaginosis
CCGs	Clinical Commissioning Groups
CCT	Certificate of Completion of Training
CE	Conformité Européenne
CPD	Continuing Professional Development
CPPE	Centre for Pharmacy Postgraduate Education
CQC	Care Quality commission
CSRH	Community Sexual and Reproductive Healthcare
CSW	Clinical Support Worker
CTAD	Chlamydia Testing Activity Dataset
DCB	NHS Digital Data Coordination Board
DHSC	Department of Health and Social Care
ECOSS	Electronic Communication of Surveillance in Scotland
EPR	Electronic Patient Record
EQA	External Quality Assessment
EU	European Union
FGM	Female Genital Mutilation
FORWARD	Foundation for Women's Health, Research and Development
FSRH	Faculty of Sexual & Reproductive Healthcare
GC	Gonorrhoea / Gonococcal
GDPR	General Data Protection Regulation
GMC	General Medical Council
GP	General Practitioner
GRASP	Gonococcal Resistance to Antimicrobials Surveillance Programme
GUM	Genito Urinary Medicine
GUMCAD	GUM Activity Dataset
HARS	HIV and AIDS Reporting System
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCA	Healthcare Assistant
HCV	Hepatitis C virus

Appendices

HEE	Health Education England
HIV	Human Immunodeficiency Virus
HPV	Human papilloma virus
HSV	Herpes simplex virus
IQA	Internal Quality Assurance
IQC	Internal Quality Control
IT	Information Technology
LGV	Lymphogranuloma venereum
MDR	Medical Devices Regulation
MHRA	Medicines & Healthcare products Regulatory Agency
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
NPT	Near patient test
PCR	Polymerase chain reaction
PEPSE	Post-exposure prophylaxis after sexual exposure
PGD	Patient Group Direction
PHE	Public Health England
PN	Partner Notification
POCT	Point of care test
PPE	Patient and public engagement
PREM	Patient reported experience measure
PrEP	Pre-exposure prophylaxis
PPV	Positive predictive value
PROM	Patient reported outcome measure
RCGP	Royal College of General Practitioners
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
SARC	Sexual Assault Referral Centre
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SRH	Sexual and Reproductive Healthcare
SHRAD	Sexual and Reproductive Health Activity Dataset
STI	Sexually Transmitted Infections
STIF	Sexually Transmitted Infections Foundation (courses)
TV	Trichomonas Vaginalis
UKAS	United Kingdom Accreditation Service

BASHH



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