

British Association for Sexual Health and HIV
Recommendations for Core Service Provision in
Genitourinary Medicine

With notes for commissioners and clinical governance leads

SECTION A

1. Introduction

- 1.1 Genitourinary Medicine (preferred short title GU Medicine) is the medical specialty concerned with the screening, diagnosis and management of sexually transmissible infections (STIs) and related genital medical conditions.
- 1.2 In the past 20 years the scope of clinical work has broadened to include HIV diagnosis and management. GU Medicine departments may also provide a range of other specialised services (see Section 14).
- 1.3 This document is intended to offer a concise overview of those elements of the physical and staffing needs for the provision of basic core services in GU Medicine at any site.

2. Essential service features

- 2.1 Service provision requires facilities distinct from generic Outpatient medical clinics (see Section 4).
- 2.2 Open access to services must be available to anyone requiring care; formal referrals from doctors (and other health workers) are usually a small proportion of the total workload.
- 2.3 Clinics should aim to provide access within 48 hours (2 working days).
- 2.4 Emergencies must be seen on that day, or at the next available clinic.
- 2.5 GU Medicine units usually include an outpatient HIV service and always offer HIV testing and advice for clinic attenders.
- 2.6 Services are led by consultants with specialist training in genitourinary medicine. Nurses, health advisers and doctors work together as a multidisciplinary team.
- 2.7 Specimen analysis (including microscopy), venepuncture and dispensing of medication are performed on site.
- 2.8 The service must be supported by a comprehensive diagnostic laboratory service, which may be off-site.
- 2.9 Clinic attenders can expect free STI treatment, and may be eligible for travel expenses (Schedule 12, NHS Act 1977; see HC11 - *Help with health costs*, DH, 2004).
- 2.10 Out of hours advice should be provided for GU Medicine and HIV services; arrangements may vary from informal access to on-call rotas depending on local need.

- 2.11 Notes (kept separately from general hospital records) and computer systems require strict security measures, resourced support and maintenance contracts. These principles will continue to apply within developments relating to the National Programme for IT and NHS Care Records Service (Connecting for Health).
- 2.12 All patients have the right to a chaperone; they should be available in all clinics (often these will be female staff members). Chaperones can identify and raise concerns if appropriate to do so.

3. Basic services required for all clinics

- 3.1 Screening and therapy for bacterial and viral STIs, infestations and common genital skin conditions.
- 3.2 Partner notification, health promotion advice and specialised counselling about STIs (supported by a range of relevant written advice, in appropriate languages).
- 3.3 HIV testing and advice; post-exposure prophylaxis for HIV and hepatitis B (with policies on sexual and occupational exposure and liaison with occupational health services).
- 3.4 Prompt access and advice following sexual assault.
- 3.5 Cervical cytology.
- 3.6 Hepatitis A and B vaccination, and hepatitis C testing, for selected client groups.
- 3.7 Sexual health advice and information on STI prevention for men and women, reflecting local needs (young people, drug users, gay men).
- 3.8 Pregnancy testing and advice on antenatal/termination services.
- 3.9 Emergency contraceptive pills, provision of condoms and information/advice on contraception.
- 3.10 Provision of, or onward referral for, counselling, psychology input or mental health problems.
- 3.11 Advertising and public relations activity appropriate to the local community.

4. Considerations of site

[See also *Health Services Building Note 12, supplement 1 – sexual health clinics*]

- 4.1 Dedicated area will be within an acute hospital, community trust/PCT or other suitable site; the site must allow ready access to all related clinical and diagnostic services.
- 4.2 Signposting of the clinic should be clear.
- 4.3 Shared facilities (eg with other outpatient clinics) should offer the appropriate level of privacy for patients.
- 4.4 Child-friendly and disabled access and facilities are required within the clinic area.
- 4.5 Highest standards of confidentiality maintained at all times (see Section 11).
- 4.6 Security measures to protect staff working in remote sites or out of hours.

4.7 Specific areas

- a. Clinical rooms and interview areas should be well sound-proofed.
- b. Suitable rooms for partner notification, psychological support from health adviser, etc.
- c. Reception. Welcoming ambience, with scope for patients to give personal information in privacy.
- d. Secure notes storage area. Ideally should be close to, or combined with, reception area.
- e. Waiting area(s). Provision of information leaflets and magazines.
- f. Consultation/exam room(s) - may be separate or combined (see 5.1).
- g. Nurse treatment area (venepuncture/dispensing/review clinic).
- h. Laboratory area (see 5.2), in separate area but within easy access by staff.
- i. Offices for consultants/doctors, senior nurse/nurses, health adviser(s), secretarial and administrative staff; with adequate privacy.
- j. Male and female toilets - within clinic or close by; ideally with connections to the laboratory so patients do not need to carry urine samples outside the toilet by hand.
- k. Staff room/seminar room, with audiovisual equipment for education and training (separate rooms should be provided in larger clinics).
- l. Staff toilets and changing facilities.
- m. Dirty utility.
- n. Storage/sterile supplies disposal/pharmacy stock areas.
- o. Access to (and storage space for) relevant textbooks, journals and guidelines.

5. Facilities

Departments and equipment must comply with COSHH (Control of Substances Harmful to Health) and Health & Safety regulations; eg safe storage and use of liquid nitrogen.

5.1 Clinical area

- a. Couches appropriate for male and female general and genital examination; couches for female examination should have variable geometry, facilitating internal examination.
- b. Lighting, including 'deep cavity' rating for female examination.
- c. Sterile / clean equipment for genital examination and specimen collection, including swabs, vaginal speculums, proctoscopes, etc.
- d. Appropriate storage and supply for sterile equipment, depending on site considerations; a steriliser may be needed in clinic.
- e. Skin biopsy and equipment for minor surgery.

- f. Equipment for venepuncture, and safe disposal of sharps.
- g. Equipment for therapeutic procedures e.g. electrocautery (hyfrecator) and cryotherapy.
- h. Suitable drugs storage areas.
- i. Urine dipstick and pregnancy testing equipment, with disposal facilities.
- j. Resuscitation equipment; a full crash trolley may be needed in isolated clinics. Anaphylaxis pack.
- k. Display and storage of up to date health promotion materials, and condoms.

5.2 Laboratory

- a. Microscope(s), including dark ground condenser and teaching attachments. Related equipment and disposal/storage areas. If not provided within clinic, results to be available without undue delay (ideally within 15 minutes).
- b. Staining and disposal of slides needs a sink and 'burn'-bin system.
- c. Slide drier.
- d. Adequate ventilation/extraction for laboratory area.
- e. System of transfer for pathological samples to main laboratory area(s) - may need CO₂ incubator in the clinic to maintain in good condition.
- f. Refrigerators - one for drugs, one for pathology specimens.
- g. Centrifuge may be needed if clinic remote from main site.

5.3 Office equipment

- a. Confidential data handling and notes storage. GU clinic notes should be kept securely within the unit, and separate from main hospital notes.
- b. IT systems to provide diagnosing and database management with adequate backup facilities and due regard to confidentiality of data.
- c. Electronic access to laboratory results; access to external email and internet.
- d. Secretarial equipment and supplies.
- e. Photocopier/shredder easily available or within clinic.
- f. Telephone equipment, with at least three direct phone lines (one to health adviser), fax facility and at least one 24 hour 'ansaphone' linked to lines.
- g. Secure working areas for staff - panic buzzers/code doors as needed.

6. Personnel

- 6.1 Workforce numbers depend on size of clinic, which in turn is linked to population served (see Section 12).
- 6.2 Consultant-led service; non-consultant career grades and trainees, and nurse practitioners should have access to consultant advice. Consultants should be regarded as

the team leader for day to day clinical matters for medical, nursing and health advising staff of all grades.

6.3 Professional leadership and accountability should follow established local and professional structures.

6.4 All staff members should have annual appraisal/review and personal development planning.

6.5 For each clinic session:

- Doctor (or access to medical opinion if nurse-delivered clinic session)
- Nurse(s) (may be supported by support worker/health care assistant)
- Health adviser (role may be undertaken by trained nurse)
- Personnel for slide interpretation and lab work – nurse or laboratory technician
- Receptionist/admin support; access to manager/senior administrator
- Secretarial support
- Interpreter service may be required (training may be required in sensitive and confidential nature of the work)

Sessions must be supported by access to an experienced GU/HIV consultant for advice (see 6.2 above).

6.6 Minimum qualifications for GU Medicine clinic work:

- Medical staff
 - a. Consultants should be fully accredited in genitourinary medicine/CCST holders or equivalent (ie listed in the GMC's Specialist Register).
 - b. Non-consultant career grades - Diploma in GU Med desirable.
 - c. Clinical assistants - appropriate induction and refresher sessions in GU Medicine; attendance at STI foundation (STIF) course (essential).
 - d. All medical staff - Diploma of the Faculty of Family Planning desirable.
 - e. Regular STI/GU Medicine updates and, if appropriate, HIV updates (eg via BASHH and BHIVA meetings).
- Nurses
 - a. Nurse roles vary in knowledge and competence required; roles and responsibilities will be reflected in the Knowledge and Skills Framework (KSF) of Agenda for Change, and guidance in *The competency framework for nurses working in the specialty of sexual and reproductive health across the UK* (2004).
 - b. Nurse consultants and senior registered practitioners represent the senior nursing clinical expertise within departments; these nurses will work collaboratively with senior medical practitioners in developing services, and

actively participate in the strategic planning and development of local sexual health services.

- c. Nurse consultants and senior registered practitioners will be responsible for negotiating the development of nursing roles and responsibilities within the organisation, and will remain clinically responsible for leading the training, development, assessment and evaluation of training programmes established to support the development process.
 - d. Registered practitioners should ideally hold a teaching qualification, for example *Teaching and assessing in clinical practice* (formerly ENB 997/998), or the more recent equivalent *Facilitating Education in the Workplace (FEW)*. Other equivalent teaching qualifications do exist and will locally be considered as part of the recruitment process. It is also desirable that nurses in charge and other senior registered practitioners possess the Diploma in Sexual and Reproductive Healthcare (formerly ENB 8103) or have attended an equivalent diploma level course; with progression to degree level recommended. Established senior registered practitioners in post for many years may have commensurate experience and knowledge, and should hold or be working towards degree and masters degree levels of study. For operational clinic managers, a management certificate is desirable.
 - e. It is also desirable that senior staff nurses hold other sexual health specific qualifications/certificates, for example *Care and management of people with HIV disease* (formerly ENB 934) or *Contraception and Family Planning* (formerly ENB 901) or equivalent. (Scotland, Wales and Northern Ireland nursing board equivalents to be substituted as appropriate). Other equivalent qualifications/certificates do exist and will locally be considered as part of the recruitment process.
 - f. All registered practitioners should receive organisational support to access both formal and informal training opportunities, and should have access to clinical supervision regarding their nursing practice from nurse consultants or senior registered practitioners.
- Health advisers

- a. Should be regarded as specialist practitioners.
 - b. Degree level entry, Certificate in Social Work, or RGN; at least 12 months training with experienced health advisers is recommended.
 - c. A recognised qualification in counselling or demonstrable equivalent experience is recommended.
 - d. On a day to day basis the health adviser is clinically responsible to a lead clinician, but remains professionally accountable for their own individual practice.
 - e. At present the Nursing and Midwifery Council (NMC) is exploring the provision of professional support to all health advisers, irrespective of whether their qualification is in nursing or social work; this is in recognition of the multi-professional nature of health advising.
 - f. Health advisers' work should be supported by agreed guidelines including those developed by the Society of Sexual Health Advisers (SSHA).
 - g. Health advisers may work alone or in senior positions; roles and responsibilities may vary and will be reflected in the KSF of Agenda for Change.
- Receptionists
Should be wordprocessing/computer literate, and experienced in office work. They should have a good understanding of the sensitive and confidential nature of STI work. Customer care skills training recommended. Roles and responsibilities will be reflected in the KSF of Agenda for Change.
 - Secretary/PA
There is a level of complexity to the work and discretion is required. Roles and responsibilities will be reflected in the KSF of Agenda for Change.

7. Working Partnerships

- 7.1 Clinical - urgent and routine referral pathways to and from related specialties (primary care, family planning, pregnancy counselling and abortion, urology, A&E, gynaecology, paediatrics) should be clearly defined. These may include general medicine /ID for inpatient HIV care.
- 7.2 Microbiology and pathology - for rapid transfer of specimens and results between laboratories and clinic and advice from pathologists. Support/advice for quality assurance of on-site laboratory.
- 7.3 Pharmacy
- 7.4 Imaging - ultrasound/X ray should be easily accessible; HIV patients may also require CT/MRI scans.

- 7.5 Management - consultants (and other senior staff members) should develop management skills to negotiate with and appropriately influence colleagues and managers in their trust.
- 7.6 Public health – Health Protection Agency, regional public health and epidemiology, for specialist services and regional planning.
- 7.7 Local sexual health commissioners. Strategic planning for the catchment population requires GU/HIV expertise in collaboration with Health Promotion and sexual health leads in PCTs and strategic health authorities.
- 7.8 Child protection services, and vulnerable adults support services.
- 7.9 Local mental health services including psychiatry.
- 7.10 Voluntary and community groups.
- 7.11 Police, prison and local authorities.
- 7.12 Higher education institutions and deaneries.

SECTION B

Additional information for commissioners and clinical governance leads

8. Introduction

- 8.1 Genitourinary (GU) Medicine deals with communicable diseases, some of which are potentially life-threatening (HIV, hepatitis B) and/or acutely painful (first attack genital herpes, pelvic infection). Many patients see these sexually transmitted infections (STIs), or the threat of having them, as life crises requiring prompt attention.
- 8.2 STIs affect all sections of the population; however case finding by screening at-risk groups and the identification of sexual partners of persons with STIs are necessary components to control spread of infection.
- 8.3 The interval from infection to treatment is a crucial factor in determining spread of infection within a community, so timely access to diagnosis and therapeutic intervention are necessary.
- 8.4 Specialist services in GU Medicine provide primary level STI management, particularly in urban areas and to those without easy access to health services. They also provide secondary and tertiary level referral and reference services to other primary level care providers (general practice, family planning) and training facilities for healthcare workers.
- 8.5 These functions require accessible, confidential services staffed by multidisciplinary healthcare teams with appropriate training.
- 8.6 A distinctive feature and strength of GU Medicine clinics (which provide basic and more specialised sexual health services ie at levels 1, 2 and 3) is the holistic approach whereby STI and HIV diagnosis and management, contraceptive advice/emergency contraception,

health promotion/risk reduction advice and partner notification, are all provided in the same clinic.

- 8.7 GU Medicine services are central to local networks of STI service providers, and essential for setting the clinical governance framework, for care pathways, and for providing training to other services in the network.
- 8.8 This document offers standards for GU Medicine provision in the UK, and should be read in conjunction with the *Recommendations for Core Service Provision in Genitourinary Medicine* (Section A above).

9. Fundamental service principles

- 9.1 Open access without need for referral.
- 9.2 Free treatment for STIs at point of access.
- 9.3 Highest standards of confidentiality (see Section 11).
- 9.4 On-site diagnosis of common conditions.
- 9.5 Partner notification and health promotion available to all attenders.

10. Access to services

- 10.1 Genitourinary medicine services should be provided at a level such that any person requesting an appointment should be seen within 48 hours (2 working days).
- 10.2 For emergency conditions, patients should be seen on the same day or on the next occasion the clinic is open.
- 10.3 The interval between clinic sessions should be no longer than 2 working days.
- 10.4 Triage systems may be needed to determine level of need; however, such systems may give undue low priority to symptomless carriage of important infections, or to patients with significant psychological distress (which should be assessed as part of the triage process).
- 10.5 Appointment systems should not be designed simply to control patient access; restrictive booking systems (such as those limited to booking only 2 days ahead and not beyond) may obscure true level of demand.
- 10.6 Appointment systems should offer patients the option to see a practitioner of the gender of their choice, ideally at a time of their choice.
- 10.7 Immediate access for patients presenting without appointments should be maintained as far as possible.
- 10.8 A great deal of routine clinic work is conducted by telephone, including provision of advice and information, symptom assessment and triage, and psychological support. The importance of this activity (a form of access to support/advice within 48 hours) and the work load involved should be recognised by commissioners.

- 10.9 Review or return systems can include timed appointments, and should be used when clinically required. In general, the follow up : new episode ratio should not exceed 1 to optimise service capacity for new episodes (this does not apply to HIV patients).
- 10.10 Access to results of investigations should be available without the need to return to clinic (by telephone or text messaging).
- 10.11 For most GU Medicine clinics, achieving the 48 hour access target and above objectives will require considerable expansion in staff numbers (including additional consultants, see Section 12), recruitment of experienced nurses, staff training and redesign of service delivery (see 13.5).

11. Confidentiality

- 11.1 All staff involved in service provision are subject to the NHS (Venereal Diseases) Regulations 1974 and the NHS trust and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000.
- 11.2 Patient confidentiality must be maintained in accordance with these and other statutory requirements and the common law.
- 11.3 Communication with the GP, for instance to convey key results, may be medically appropriate but should only be done with patient's knowledge and consent.

12. Staffing and clinical leadership

- 12.1 Each GU Medicine/sexual health service providing diagnostic and therapeutic services for STI and HIV should be led by specialists in genitourinary medicine (CCST holders, or equivalent, in GU Medicine).
- 12.2 As a multidisciplinary team, the day to day management leadership should devolve to a lead GU Medicine consultant; s/he would have a managerial relationship to the general management structure of the provider trust.
- 12.3 The staffing level of the clinic should be such as to provide as a minimum
- 2 consultants per 250,000 population (RCP, 2005)
 - At least 3 days' clinic sessions per working week
 - Ideally, at least one session out of normal working hours
- 12.4 The staff profile for each clinic session should conform to national standards, as detailed in Section 6 above. These should also apply to outreach services, satellite clinics and sexual health clinics providing combined family planning/GU Medicine services.
- 12.5 Nurse and health adviser development, with expansion of their roles within clinical teams, requires a structured framework and is to be encouraged. This will increasingly be guided by the KSF within Agenda for Change.

13. Clinical governance and service development

- 13.1 The clinical governance framework for GU Medicine services should include sections that relate to
- a. policies and procedures
 - b. standards and clinical guidelines
 - c. clinical audit
 - d. risk management, including a robust incident reporting system
 - e. complaints and other feedback from users
 - f. staff training, appraisal and CPD
- 13.2 GU Medicine clinics see patients <18 years, and may see patients <16 years; and are subject to the Children Act (1989 and 2004) and child protection policies.
- 13.3 GU Medicine clinics should participate in the business planning process, which takes into account changing local needs and disease incidence/prevalence.
- 13.4. Estate issues should be reviewed in the light of changing local needs, with consideration of how clinic infrastructure should be improved.
- 13.5. Services should continuously evolve in line with changing demands, and embrace opportunities for service redesign and modernisation.

14. Commissioning GU Medicine: core and specialist services

- 14.1 There should be a transparent service level agreement (SLA) for all GU Medicine services which specifies the different elements of the service to be provided locally, together with details of baseline numbers of each element of the service.
- 14.2 The financial elements of the SLA should be specified.
- 14.3 Outside the basic provision of GU Medicine, a range of specialist services has been developed in clinics;
- 14.4 These services may include colposcopy, vulva clinics/genital dermatology, erectile dysfunction and psychosexual dysfunction.
- 14.5 Such specialist services should be commissioned in response to local needs assessments and incorporated into SLAs, ideally as a separate SLA from the core service.
- 14.6 Specialist services should comply with relevant published national standards and guidelines.

15. Inpatient services

- 15.1 The GU Medicine service may require inpatient access for the management of complex infections (such as HIV-related complications, severe pelvic infection and severe primary herpes).

- 15.2 A range of inpatient specialties may require access to clinical opinion from GU consultant physicians, who should be available to give opinion on the wards to fellow consultants and to other healthcare providers on request.
- 15.3 Those GU physicians who act as sole consultant for inpatients should have current, demonstrable knowledge of HIV/AIDS medicine to an acceptable level.
- 15.4 Levels of junior medical staffing should be sufficient to support GU Medicine admissions.
- 15.5 Access to GU Medicine/HIV opinion out of hours should be available to every acute service in trusts, and to primary care services. Such cover arrangements should be appropriate to local need, may be provided on a network basis, and should be explicit.

16. Links to other providers

- 16.1 Access to contraception services, pregnancy counselling, substance misuse and psychiatric services are examples of cross referral from GU Medicine to other providers.
- 16.2 Providers of GU Medicine services should ensure that service level agreements for services provided outside their trust are in place and reviewed regularly.

17. Indicators

- 17.1 A range of indicators are available to measure service delivery; indirect measures of sexual health provision as well as data from the clinic should be considered.
- 17.2 Indicators include
 - Service activity KH09
 - Diagnoses KC60
 - Colposcopy KC65
 - HIV workload AIDS Control Act Report
 - HIV prevalence SOPHID
 - Complications ICD/Read coding
 - STIs Laboratory reports
- 17.3 Additional indicators arising from the *National Strategy for Sexual Health and HIV* (2001) include
 - HIV testing - offers and uptake
 - Hepatitis B vaccination in gay men - offers and uptake
- 17.4 Additional indicators required for monitoring in relation to *Choosing Health* (2005) include
 - Access to GU clinic appointment within 48 hours

18. Reference documents

- 1. Department of Health (1988). *Report of a working group to examine the workload of genito-urinary medicine clinics (the Monks report)*.

2. Department of Health (2001). *The national strategy for sexual health and HIV*.
3. Department of Health (2005). *Health Services Building Note (HBN) 12, supplement 1 – sexual health clinics*.
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6. Department of Health (2004). *The competency framework for nurses working in the specialty of sexual and reproductive health across the UK*.
7. Consultants working with patients. *The duties, responsibilities and practice of physicians in general medicine and the specialties* (2005). 3rd edition. Royal College of Physicians. London.

19. Acknowledgements

We gratefully acknowledge receiving helpful comments from:

Immy Ahmed, Ian Alexander, Mary Alston, Camden PCT Multidisciplinary Genito-Urinary Implementation Group, Rima Chowdhury-Hawkins, Anne Edwards, Alyson Elliman, fpa (Family Planning Association), George Kinghorn, Susan Lindsay, London NHS Network for Nurses and Midwives working in Sexual Health, Raymond Maw, Danielle Mercey, Richard Pattman, Katia Prime, Angela Robinson, Jackie Sherrard, Martin Talbot, Conrad White, Alison Wright, Susan Young.

20. Authors & process

Section A Core service provision – AGUM Working party (2001)

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Sections A & B Core service provision and notes for commissioners

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Process (2005)

1. A working subgroup of the BASHH Clinical Governance Committee (CGC) was appointed to steer the work.
2. Dr Angela Robinson, President of BASHH, and Prof George Kinghorn provided additional input.
3. The draft was circulated to members of CGC and cascaded to members of BASHH.
4. The draft for consultation was posted on the BASHH website for 6 weeks (2.8.05-12.9.05); a final draft was prepared for BASHH Board.
5. The final document was ratified by BASHH Board on 16.12.05.
6. Proposed review date: 2007

Recommendations for core service provision in genitourinary medicine. British Association for Sexual Health & HIV, 2005. www.bashh.org