BASHH CSU MEETING WITH MEDFASH
REVISION OF
STANDARDS FOR THE MANAGEMENT OF STIs
Held on 16 April 2013 from 10 -2 pm

Held at BMA House, Tavistock Square, London, WC1H 9JP

<table>
<thead>
<tr>
<th>Members present</th>
<th>Initials</th>
<th>By Teleconference</th>
<th>Apologies noted</th>
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<tr>
<td>Janet Wilson</td>
<td>JW</td>
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<tr>
<td>Alan Tang</td>
<td>AT</td>
<td>Immy Ahmed (IA)</td>
<td>Colm O’Mahoney (COM)</td>
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<td>Ruth Lowbury</td>
<td>RL</td>
<td>Jane Dickson (JD)</td>
<td>Killian Quinn (KQ)</td>
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<td>Ceri Evans</td>
<td>CE</td>
<td>Danielle Mercey 12-2pm (DM)</td>
<td>Antony Chuter (AC)</td>
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<td>Jan Clarke</td>
<td>JC</td>
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<td>Richard Lau (RL)</td>
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<td>Jyoti Dhar</td>
<td>JD</td>
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<td>Kate Folkard (KF)</td>
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<td>Tosh Lynch</td>
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<td>Hugo McLean (HM)</td>
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<td>Erna Buitendam</td>
<td>EB</td>
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<td>Steve Baguley (SB)</td>
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<td>Ann Sullivan</td>
<td>AS</td>
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<td>Martin Murchie</td>
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<td>Claudia Estcourt 10-12</td>
<td>CSE</td>
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<td>Claire Tyler</td>
<td>CT</td>
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<td>Liz Rodrigo</td>
<td>LR</td>
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<td>Cathy Ison</td>
<td>CI</td>
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<td>Gwenda Hughes 10-1</td>
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STIMS=Standards for the management of sexually transmitted infections 2010.

1. PURPOSE OF THE MEETING

RL introduced the meeting and thanked co-opted members for agreeing to take part in this project. IA outlined the purpose of the meeting – to review and revalidate the STIMS to reflect current environment and increased number of commissioning organisations. A business case had been put to the BASHH Board, and was approved on the basis that STIMS would be reviewed and updated and not be started afresh. He added that the final look of the revised standards should be in a form commissioners were used to reading. The project will keep previous stakeholders engaged and as there will not be a massive change in content, this could be done by email. He explained the system of chapter leads was to facilitate delivery of the revision within a tight time frame, allowing CT to finalise all issues of content by the summer holidays.
2. PROJECT OUTLINE AND PROCESS

Paper – Standards for the management of sexually transmitted infections (STIs): proposal for updating and revision.

2.1 RL described the role of MedFASH in managing the project and the CSU (including co-optees) as the ‘engine room’ for this project supporting CT, who would work closely with the Chapter Leads. The Project Advisory Group (PAG) of 2009 will be re-established as virtual group of organisations (Project Stakeholder Group – PSG). Stakeholder organisations would be asked to nominate a representative and flag up at an early stage any issues they thought should be considered in the review. These representatives would also be invited to comment on the consultation draft and secure the endorsement of their organisations for the final publication. Keeping a diverse range of organisations as stakeholders was a strength of the STIMS 2010 and we will maintain this in the Review.

**ACTION:** New stakeholder organisations since 2009, such as the Faculty of Public Health, would be invited into the virtual group by IA or RL.

2.2 Patient and public engagement would be enhanced for this revision through the BASHH Public Panel, chaired by JC, and inclusion of AC as a co-optee on the CSU.

2.3 The **Outline timeline** was discussed, the tight timescale and risks noted and holding two further meetings of this STIMS Review Group agreed.

**ACTION:** Meeting dates to be circulated by AT.

2.4 AS enquired on method of the Consultation on draft standards in August and RL explained it would be on BASHH and MEDFASH websites and also a wider audience included by direct invitation. CT highlighted the short turnaround for comments from the Review Group on the draft in June, as it would be only 2 weeks, to be in time for the July Review Group meeting.

**ACTION:** Chapter groups to read and comment on whole draft and not just own chapter when circulated rewrite of Standards 1-9 in June.

3. IDENTIFIED STANDARD LEADS AND MEMBERS

3.1 AT outlined the Leads and Members for each chapter and appendices C, D and E. The table below shows what was agreed:

<table>
<thead>
<tr>
<th>Chapter/Standard no.</th>
<th>Title</th>
<th>Lead</th>
<th>Members</th>
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<tbody>
<tr>
<td>1</td>
<td>Principles of STI care</td>
<td>Immy Ahmed</td>
<td>Steve Baguley, Tosh Lynch</td>
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<tr>
<td>2</td>
<td>Appropriately trained staff</td>
<td>Claudia Estcourt</td>
<td>Nick Theobald, Steve Baguley</td>
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<tr>
<td>3</td>
<td>Clinical Assessment</td>
<td>Janet Wilson</td>
<td>Jyoti Dhar</td>
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<td>4</td>
<td>Diagnostics</td>
<td>Cathy Ison</td>
<td>Virologist</td>
</tr>
<tr>
<td>5</td>
<td>Clinical Management</td>
<td>Colm O’Mahoney</td>
<td>Martin Murchie, Ann</td>
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3.2 There was much discussion on the merits of retention of service Levels 1-3 based on the sexual health strategy of 2001.

3.2.1 JD commented that the FSRH had redefined the levels of SRH service provision. JW said it was important to be consistent with the terminology used in the Framework for sexual health improvement in England (March 2013), and CSE pointed out that prescribing or badging providers to certain levels may be unhelpful. On the other hand, LR explained that commissioners found Levels 1-3 descriptions useful, and pointed out that the Framework recommended integration of services, therefore the SRH levels would be relevant in integrated services. RL, CT and JD emphasised STIMS would be on the STI element of integrated services only. It was agreed to use a descriptive term for each level followed by the number in brackets: Asymptomatic (level 1), Symptomatic (level 2) and Complex/specialist (level 3).

3.2.2 IA clarified, as debated in 2009, that the STIMS should not prescribe what services are delivered in certain premises but that anyone can provide a service if they are competent, are contracted by commissioners to do so and can deliver to the standards.

RESOLVED: CT agreed she would amend Appendix B as agreed and will review/revise the project definitions for levels of STI services flagging up if any elements appeared to be in the wrong level. Services such as postal testing, internet testing and self testing should be covered in Level 1 and explicitly discussed. The levels could be more specifically explained in the Introduction.

4. ROLES AND RESPONSIBILITIES

CT described the Leads and Groups as experts that would feed information to her for writing, in a staggered manner, and therefore she would agree individual deadlines with each Lead. The timescale meant she would not chase up missed deadlines and would escalate them to IA immediately. Leads and members would review literature from 2009 onwards, provide new references and remove irrelevant ones from the 2010 sections. Members would feed work in via the leads. If there are overlaps between chapters, leads would liaise to ensure consistency and
non-duplication. It was agreed that email addresses would be freely shared within the Review Group.

5. STRUCTURE FOR EACH STANDARD

5.1 CT explained the rationale for hybridising the 2010 structure with that of NICE quality standards. She suggested dealing with Equality and Diversity within the Introduction instead of each Standard to avoid repetition. CSE advocated gathering all the references and bibliography in one section. As regards where the definitions should be, CT suggested we decide at a later phase.

5.2 There was much discussion on the KPIs. IA explained that the audit measures should capture the essence of the standards, but there ought to be balance in the number of measures to ensure that they captured the key elements of the standard. Whilst outcome measures would be preferable, we currently have mainly structure and process based measurements. This is in common with many medical specialties and the process of developing new outcome based measurements would be too long and complex to include in this short-term project. GH suggested being more explicit about how to measure each indicator.

5.3 CT noted that coherent terminology was needed for describing these measures and that they must fit with the Quality Statements also. CSE agreed that it would be too big a piece of work to gain consensus for each condition and JC noted that this process took a year in the HQIP project. However, there may be some outcome measures which are evident and AS urged that for each standard we should seek to identify a quality outcome where possible. It was helpful that HM had already aligned the outcomes to CQC criteria.

6. Standard 1

LR proposed ‘You’re Welcome’ criteria for this standard. Achieving ‘You’re Welcome’ accreditation would be a process quality measure and percentage of Young People accessing the service could be an outcome quality measure. However, it was noted that this would not be a relevant measure for all services (e.g. if targeting a different population group).

7. Standard 2

It was agreed that ‘people at risk of STI’ should be replaced with ‘people concerned about STIs’ or people with STI concerns. CSE said she would consult with others on how to measure competence of staff.

RESOLVED: The Review Group unanimously agreed that the format was workable after discussing Standards 1 and 2.

8. DM joined by teleconference and the discussion moved to Standard 6.

8.1 DM made the important point that all CQC-Registered services would already be complying with Information Governance requirements. She confirmed that all providers of clinical services had to be registered with the CQC and report on compliance with its information governance standards. IA said the focus should be on the STI-specific mandatory dataset. Requirements for CQC data should be mentioned but a single measure could be included (e.g. ‘met CQC requirements’) rather than itemising each one.

8.2 JC added the Public Panel perspective that records should be secure as well as confidential and suggested including retention and storage of records in the standards. DM reported that the
integrated BASHH/BHIVA Information Group was now established and comments on the Review would be from this integrated group. AS suggested a measure could be included about patients’ receipt and understanding of service confidentiality statements.

**ACTION:** CT to provide a Word version of each chapter, instructions for the review and a structured feedback form for all leads.

9. **Standard 3**

9.1 There was discussion on the increasingly minimalist services such as ‘pee and go’ and self-taken swabs. JW acknowledged that whilst face to face contact may be minimal, as long as a minimal sexual history was also taken, such services should still meet minimum standards. CT suggested acknowledging this explicitly, in the Introduction or elsewhere. IA agreed that we should not lower standards to the lowest common denominator and instead stretch some services to meet standards – we should maintain quality services without stifling innovation.

9.2 LR pointed out that safeguarding, sexual exploitation and domestic violence concerns should be included, and that the link should be made with other issues also of relevance to local authorities including alcohol and drugs. FGM was also suggested. Wording in the ‘rationale’ could refer to ‘other risk factors’ and ‘assessing vulnerability’.

9.3 JC discussed ways of feeding back PPE issues, for example service user experiences of intimate examination.

9.4 JW discussed the KPI level for sexual history taking. AS acknowledged that KPI have to allow for reporting and entry errors. JW accepted that 2 errors per 40 patients audited was not suggestive of a systemic problem and it was agreed to set the ‘target’ for compliance at 95%. It was agreed that the HIV testing offer and uptake levels could be increased in line with current achievement levels e.g. 80% minimum.. GH suggested ‘HIV test coverage’.

9.5 JW discussed extra-genital tests in MSM. CE shared the experience in C & W that anal infections in heterosexual women were detected more when history of anal sex was obtained and the tests done. CI cautioned that anal swabs for those at risk of anal infection would be fine, but screening all patients for anal infections would result in significantly more specimens. AS confirmed that the revised sexual history taking guidelines advocated asking about extra-genital sites more and the standards should be in line with these.

9.6 EB explained that there were some discrepancies with the recommendations in NCSP core guidance e.g. time for results and time to treatment, and it was agreed that this needed consideration in the Review.

9.7 The potential discrepancy between KPIs in the DH’s forthcoming model sexual health service specification and the revised STI standards was identified as a cause of concern. LR and RL offered to investigate this.

10. **Standard 4**

10.1 CI noted that the time taken to get results had moved on since 2009. Following discussion of Standard 5 (below) it was agreed the KPI for results to reach testing providers from the lab should go down to 5 working days. The recently rewritten antenatal screening standards should be checked in this regard. CI said she would take advice from a clinical scientist on a realistic compliance ‘target’ for the KPI, 100% or even 95% being too high. The quality statement should include the word ‘timely’.
10.2 Web-based systems and text messaging have transformed patients’ access to results (relevant to Std 5). Supplementary testing for complex cases e.g. LGV would be allowed longer turnaround times – an audit measure for supplementary testing was therefore needed.

10.3 Timeliness of sending specimens to Pathology was important. CI gave an example that batching of specimens over a period of time before sending to the reference laboratory caused undue delay. IA stated we could not condone such delays and this standard should drive providers and commissioners to improve specimen postage times and reduce delays in data entry into IT systems. Lab to lab communication was also significant. It was suggested more should be included in the standard on the commissioning and monitoring of labs.

10.4 CI would add something on the importance of maintaining GC culture. She also noted the omission of medico-legal work standards and agreed to look into this aspect, with reference to the BASHH sexual assault guidelines. It was noted that SARCs were excluded from the standards for reasons of complexity.

10.5 In ‘implications for service users’ it was suggested replacing ‘best available’ with ‘in line with BASHH testing guidelines’.

11. Standard 5

11.1 The appropriate standard for partner notification (PN) was discussed and would be updated in line with revised BASHH PN statement. Further KPI were discussed including adherence to/meeting auditable outcomes of BASHH guidelines, and adding more about management of Chlamydia and gonorrhoea. Compliance with current NICE guidelines was discussed but JW pointed out that local authorities are not obliged to comply with NICE, but ‘compliance with all relevant NICE guidance’ could be ‘recommended’. LR confirmed that discrepancies between BASHH and NCSP standards for service users to get results were much debated by commissioners. It was agreed the standard for results to patients should now be 10 days (excluding supplementary tests). The lab KPI (Standard 4) should go down to 5 working days.

11.2 AS pointed out that KPI were based on Chlamydia because of the STIMS audit, but now KPI were more generalizable.

12. Standard 7

12.1 Services should be keen to network with others, rather than work in complete isolation. There was a fear that networks in the new environment are under threat and discussion as to what was realistic or desirable for the standards to recommend in relation to networks. LR said that commissioners were keen to see networking occur, and IA suggested this was not necessarily a formal Network. IA suggested ‘Care pathways’ and CT ‘Wider linkages’ as change in title. LR emphasised the uniqueness of sexual health in crossing boundaries, in contrast to the traditional focus of LAs on their local population. The standard should specify ‘sexual health’ in relation to services/networks.

12.2 The standard should include signposting as well as referral and self-directed care.

13. Standard 8

Patient safety will be of key importance. The KPI would include audit. There should be a better KPI linking to CQC outcomes as evidence and one on serious untoward incidents. ‘Complaints’ should be added to implications for patients.

14. Standard 9

14.1 New guidance is available from NICE and much other work has been published. JC noted that PROMs were not validated yet. Patient Reported Experience Measures were therefore important, and 360 degree appraisal/Multi-Source Feedback would include these. Evidence of appraisals and
360 degrees could go in Standard 2 KPIs. Both Public and Patient engagement were important standards and an extra phrase should be included in the Quality Statement re public consultation on design and development. CT mentioned inclusion of learning from the Francis Report.

14.2 JC agreed to take the draft Quality Statement to the BASHH Public Panel for comment.

**15. Overview of the 9 Standards**
Standard 1 may be too complex but the others were thought to be reasonably straightforward.

**15.1 Introduction**
CT to draft and run this by one or two key people (JW, LR).

**16. STAKEHOLDER FEEDBACK**

16.1 LR proposed including the Local Government Association (LGA).
16.2 JW suggested the Association of Directors of Public Health (ADPH) and Public Health England.
16.3 RL proposed the Faculty of Public Health and suggested as the professional body this might be more appropriate for formally endorsing the standards than ADPH. It was suggested ADPH might asked for a letter of support and specifically targeted for consultation.
16.4 CT discussed possible authors for the Foreword.
16.5 CI suggested the Royal College of Pathologists and offered to help with liaison.
16.6 CT wondered about the Royal Pharmaceutical Society or the National Pharmacy Association.

**17. NEXT STEPS**
CT will tweak the first draft outline with comments from this meeting, and send each chapter in MS Word (to enable tracking of changes) to the leads with instructions.

**18. NEXT MEETINGS**
Early July and early September.