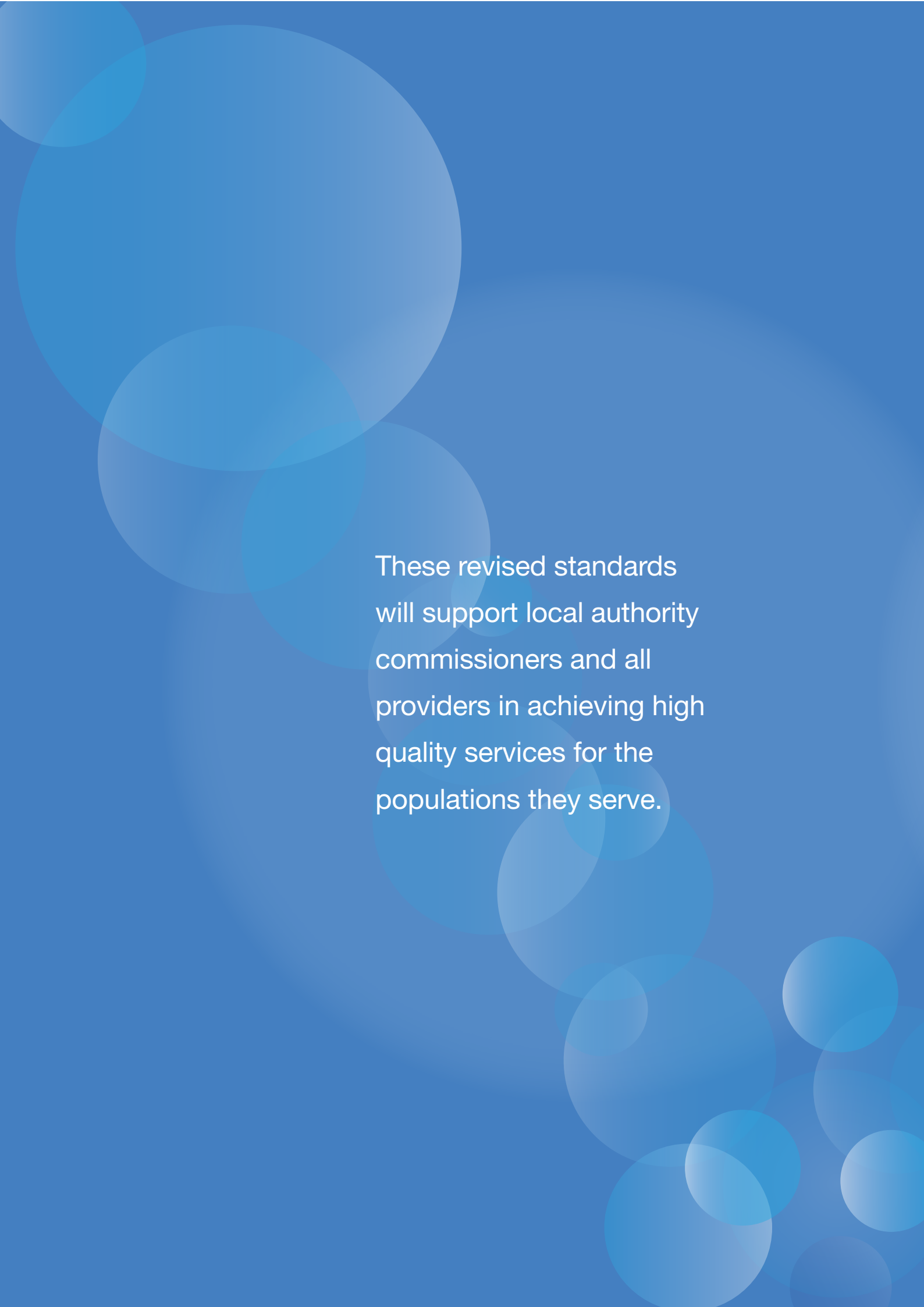




Standards for the management of sexually transmitted infections (STIs)

REVISED AND UPDATED JANUARY 2014





These revised standards
will support local authority
commissioners and all
providers in achieving high
quality services for the
populations they serve.

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Thanks are also due to those individuals and organisations who responded to the consultation and those who provided additional expert advice.

It is a testament to the importance of these standards that so many professional bodies either directly involved in providing sexual healthcare, or with strategic responsibilities for ensuring its delivery, have agreed to endorse this document. These bodies are listed below, with thanks to the individuals who facilitated their input.

Association of Directors of Public Health (ADPH)

Faculty of Public Health (FPH)

Faculty of Sexual & Reproductive Healthcare (FSRH)

Genito-Urinary Nurses Association (GUNA)

Local Government Association (LGA)

Public Health England (PHE)

Royal College of General Practitioners (RCGP)

Royal College of Nursing (RCN)

Royal College of Pathologists (RCPATH)

Royal Pharmaceutical Society (RPS)

Royal College of Physicians (RCP)

Society of Sexual Health Advisers (SSHA)

HIV Pharmacy Association (HIVPA)

Foreword

Good sexual health is both fundamental to the health and wellbeing of individuals and a cornerstone of good public health. It is underpinned by the provision of high-quality, safe and accessible sexual health services and interventions. We know that timely access to testing and treatment services can reduce the risk of onward transmission of sexually transmitted infections (STIs) as well as support people to stay healthy and to protect themselves.

This updated edition of *Standards for the management of sexually transmitted infections (STIs)* will be an invaluable resource to both commissioners and providers alike as they seek to deliver on the ambition to improve sexual health outcomes across the population.

Since these standards were first launched in 2010, there has been a momentous change across the health landscape, with local authorities assuming their new public health functions. Local authorities now commission a majority of sexual health services in England, with additional commissioning input from Clinical Commissioning Groups (CCGs) and NHS England.

These changes provide an opportunity to align the design and delivery of services more closely to the needs of local communities, through key bodies such as health and wellbeing boards. It is an opportunity to improve outcomes through local leadership. But it is vital that these changes do not lead to fragmentation of pathways of care. The *Standards for the management of sexually transmitted infections* can help to secure consistently excellent support and services to promote good sexual health across the system.

We need this now more than ever. For while we have undoubtedly made good progress in improving sexual health in England, important challenges remain. Today, just over one in five persons with HIV in the UK are unaware of their infection, a situation that drives late presentation as well as transmission and acquisition of HIV. This, in turn, has a negative impact on both individual and public health. A substantial increase in HIV testing is required to address this. In areas where diagnosed HIV prevalence is high (≥ 2 per 1,000 population), UK guidelines recommend expanding HIV testing into a wide variety of clinical settings, yet this is still slow to happen and needs to be accelerated if there is to be real progress.

We can be proud of the improved access to specialist genito-urinary medicine services as well as the expansion of services in the community and general practice. There have been significant improvements in screening and encouraging testing in recent years, particularly chlamydia screening in young adults and more widespread testing for gonorrhoea and chlamydia among young adults at risk and men who have sex with men. We are diagnosing and treating more infections than before. But the continuing high rates of STIs in England suggest that too many people are still putting themselves at risk through unsafe sex.

All the stakeholders across the new public health and healthcare system are committed to working together to ensure we improve sexual health outcomes for all. The Public Health Outcomes Framework, which includes sexual health among its indicators, will help us monitor progress towards these goals.

It is a complex endeavour, and one that requires innovation in how the most effective services and interventions are commissioned and delivered, without compromising on the high levels of quality and safety that people rightly expect. This has to be a collaborative exercise in learning from and contributing to a developing evidence base. Public Health England is delighted to endorse these updated standards, which form a crucial part of this effort.



Dr. Paul Cosford
Director for Health Protection and Medical Director
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Professor Kevin Fenton
Director for Health and Wellbeing
Public Health England

Executive summary

Despite progress in recent years the UK continues to have high rates of sexual ill health. Within the population sexual health needs vary according to factors including age, gender, sexuality and ethnicity, with some groups disproportionately at risk of poor sexual health. It is widely accepted that effective commissioning of services and interventions is key to improving health outcomes.

Recent structural changes mean that most sexual health services, including those managing sexually transmitted infections (STIs), are now commissioned by local authorities. Clinical Commissioning Groups (CCGs) and NHS England commission some other aspects of sexual healthcare.

These revised *Standards for the management of sexually transmitted infections (STIs)* update the original 2010 version, and have been developed with the aim of supporting commissioners and providers in achieving high quality services for the populations they serve. Importantly they also specify what the public can expect of the services they access.

The standards represent current best practice and are intended for use in all services commissioned by local authorities or the NHS including those provided by the independent and third sectors. They 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 on STI management also apply to Wales and Northern Ireland. Sexual health service standards for Scotland were published by NHS Quality Improvement Scotland in 2008 but these standards should be considered of relevance.

The nine standards bring together and contextualise existing guidance. They cover all aspects of the management of STIs including access to services, the diagnosis and treatment of individuals and the broader public health role of infection control.

In order to achieve greater alignment with NICE quality standards each one contains a quality statement, quality measures, quality standards, implications for commissioners, service providers, healthcare professionals and people with needs relating to STIs, supporting information and references.

Standard statements

STANDARD 1 - Access

People with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment.

STANDARD 2 - Clinical assessment

People with needs relating to STIs should have a medical and sexual history taken which includes questions about sexual behaviour and other risk factors. Those with symptoms should be offered 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.

STANDARD 3 - Diagnostics

People being tested for STIs should have the most accurate diagnostic test in its class (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.

STANDARD 4 - Clinical management

People using a service for STI testing should receive their results both positive and negative within 10 working days. Those diagnosed with an infection should receive prompt treatment and be managed according to current BASHH national guidelines, including the delivery of partner notification (PN).

STANDARD 5 - Information governance

Services managing STIs should ensure information collected about individual service users remains secure and is only shared with other professionals if it is in the service user's best interests or for public health reporting purposes.

STANDARD 6 - Clinical governance

People should receive their care from high quality services managing STIs that are safe, well-managed and accountable.

STANDARD 7 - Appropriately trained staff

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

STANDARD 8 - Links to other services

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

STANDARD 9 - Patient and public engagement

People should be consulted about the development and delivery of services managing STIs in their community. Those using services should be encouraged to give feedback about them.

Introduction

- i) 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 sexually transmitted infections (STI) testing and treatment, and notification of sexual partners of infected persons^{1,2}.
- ii) This 2014 edition of the *Standards for the management of sexually transmitted infections (STIs)* supersedes the original 2010 edition. It will support local authorities in their new sexual health commissioning role and complement the Department of Health (DH)'s *Framework for Sexual Health Improvement in England*³.
- iii) The standards are intended for use in all healthcare settings where STIs are managed, although it is recognised that some of the quality measures may only be auditable in services specifically commissioned to manage STIs or across a sexual health network. While written to be applicable to the commissioning system in England, their clinical recommendations on STI management also apply to Wales and Northern Ireland. Separate standards for sexual health services for Scotland were produced by NHS Quality Improvement Scotland and informed the development of the original version of these standards⁴.

Reviewing and updating the standards

Background

iv) The first national standards for the management of STIs were published in 2010. A comprehensive review and updating of the standards was undertaken during 2013, to ensure they would reflect current best practice in STI management as well as new policies and structures arising from implementation of the Health and Social Care Act 2012⁵. The revised standards will:

- support local authorities in commissioning and monitoring services to ensure consistently high standards of care regardless of provider
- support service providers in the delivery of high quality care.

Standards review process

v) As the largest multi-professional organisation within the field of STIs, the British Association for Sexual Health and HIV (BASHH) commissioned MEDFASH (Medical Foundation for HIV & Sexual Health) to manage the development and publication of the original standards. MEDFASH was again commissioned by BASHH to manage the review and updating.

vi) To support this process the BASHH Clinical Standards Unit (CSU), along with additional individuals co-opted for the purposes of the project, worked closely with MEDFASH on revising and updating the content of the standards.

vii) A number of relevant professional bodies, most of which had endorsed the first edition, 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.

viii) The names of CSU members and co-optees are listed in Appendix A.

Consultation

ix) Following development of the draft the updated standards underwent a period of consultation. They were made available on the MEDFASH and BASHH websites with a feedback form open to all for completion. Relevant stakeholders were invited to respond. The consultation process lasted for three weeks between mid October and early November 2013. All feedback from the consultation was considered by the CSU and informed final revisions.

Future updating of the standards

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

The management of STIs

Context

xi) 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.

xii) 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

xiii) Services managing STIs have a strong public health role. Reflecting this, the Public Health Outcomes Framework⁶ 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.

Elements of STI management

xiv) These standards build on a number of earlier documents that describe three levels of care for the management of STIs - Levels 1 (asymptomatic), 2 (symptomatic) and 3 (complex / specialist). The levels were originally proposed in *The national strategy for sexual health and HIV (2001)*⁷ to assist the commissioning process by indicating the elements of care which could be delivered by a range of providers in any setting. Appendix B proposes an updated 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 has been amended as part of the review process.

xv) Local authorities can 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 commissioned and available within all local authority areas.

xvi) 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.

xvii) It is likely that across the local authority area different elements of care will be delivered by a range of staff from different professional backgrounds based on individual competency levels.

xviii) In many areas primary care and community sexual and reproductive healthcare (SRH) services are already commissioned to provide some elements of STI management at Levels 1 and 2 and this could increase. In 2013 the Royal College of General Practitioners (RCGP), with BASHH endorsement, published updated guidance on managing STIs in primary care⁸. In addition to courses offered by BASHH, the RCGP specialist training and educational portfolio and the Diploma of the Faculty of Sexual & Reproductive Healthcare (FSRH) provide a sound basis upon which to develop competence in STI management.

Specialist services (Level 3)

xvix) 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 STIs⁹. Specialist GUM services should provide clinical leadership, including training, clinical expertise and clinical governance, for the management of STIs within local authority areas. (Similarly, clinical leadership for the management of contraceptive care across the local authority area should be provided by services led by consultants in Community SRH).

xx) However, the competencies acquired through completing the current medical training curriculum for CSRH mean that STI services at Levels 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

xxi) Following publication of the Equality Act in 2010 the public sector equality duty came into force in 2011¹⁰. 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, pregnancy, race (including ethnic or national origins, colour or nationality), religion or belief (including lack of belief), sex and sexual orientation.

xxii) Providers should ensure the services they provide meet their equality duty, paying particular attention to sensitivities relating to culture, sexuality and disability when taking a sexual history and performing an examination. All services should be able to meet special communication needs, such as providing translators or interpreting services, where requested or necessary.

xxiii) The NHS Constitution¹¹ 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.

xxiv) Because 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

xxv) 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.

xxvi) 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 a sexual health network). They are also strongly recommended for use in the private healthcare sector.

xxvii) Different service models exist for the delivery of care and some STI services are 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

xxviii) 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 service users.

xxix) 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 by the opportunistic screening of as many young people as possible. NCSP Standards¹² 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-screening of all under 25s three months after a positive chlamydia result.

xxx) 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 a pro-active approach is taken.

xxxi) Similarly, the management of STIs in individuals from population groups most at risk of STIs, such as

men who have sex with men, 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.

xxxii) 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 BASHH¹³.

xxxiii) 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 project, such as contraception and reproductive healthcare, and related service issues including child protection. The FSRH published its own service standards in January 2013¹⁴. 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 2013*¹⁵. However, STI service providers play an important role in the prevention and detection of HIV infection, and 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.
- c. Domestic violence and abuse. Relevant guidance is available from NICE¹⁶.
- d. Female Genital Mutilation (FGM), which is illegal in the UK. Relevant guidance is available from the Royal College of Obstetricians (RCOG)^{17,18}. 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 managing STIs.
- 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 as locally appropriate. The DH'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 service¹⁹.

Structure of each standard

xxxiv) In order to achieve greater alignment with NICE quality standards²⁰ each standard contains:

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

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

xxxvi) 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 Care Quality Commission's *Essential standards of quality and safety*²¹ or established audit templates (see www.bashh.org). Although the Care Quality Commission's remit is for England only, its Provider Compliance Assessment tools adopted in these standards will be useful in all parts of the UK.

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

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

xxxix) The supporting references for each standard are listed at the end of the document.

Language

xl) The language used throughout the document reflects suggestions made by consumer forums responding to public consultation on the 2010 edition.

xli) '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 the history or on a self-completed history pro-forma.

xlii) 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.

How the standards can be used

xliii) 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 **staff** 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.

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

- the Public Health Outcomes Framework 2013-2016²²
- the NHS Outcomes Framework 2013-2014²³
- the Framework for Sexual Health Improvement in England⁷
- the Care Quality Commission's Essential Standards of Quality and Safety²¹.

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STANDARD 1

Access

1.1 Quality statement

People with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment.

1.2 Quality measures

1.2.1 The percentage of people with needs relating to STIs contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service.

1.2.2 The percentage of people with needs relating to STIs contacting a service who are seen or assessed by a healthcare professional within 2 working days of first contacting the service.

1.3 Quality standards

1.3.1 Offered an appointment or walk-in: Standard: 98%

1.3.2 Seen or assessed by a healthcare professional: Standard: 80%

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 rapid and open access (within 2 working days of contacting the service) and should require routine monitoring of access data. See 1.5.2 and 1.5.3.

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 services 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 non-complex symptomatic) and 3 (Levels 1, 2 and complex / specialist) across the local authority area. See Appendix B. Where it is not possible to provide a Level 3 service in a given area, commissioners should commission

access to a Level 3 service in a neighbouring area to ensure local residents have access to specialist services when needed.

1.4.4 Commissioners should ensure that there is provision of an appointment service within each local authority area in order to give users a choice of walk-in or pre-booked appointment. They should require providers to monitor waiting times within the service for users of each option.

Responsibilities of service providers

1.4.5 All providers of services commissioned to manage STIs should:

- a. make their services available through self-referral for all people regardless of where they live (open access).
- b. provide rapid access (within 2 working days of contacting the service).
- c. have mechanisms to record access data routinely.

Responsibilities of healthcare professionals

1.4.6 All healthcare professionals and staff 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 either offered an appointment within 2 working days of contacting the service or advised of walk-in sessions available within two working days.
- c. deliver services that are flexible and capable of responding to people with urgent healthcare needs.

People with needs relating to STIs:

1.4.7 Can go to any sexual health service, in or out of their local area, without needing to see their GP first.

1.4.8 Should be able to either 'walk in' or be offered an appointment within 2 working days of contacting a service commissioned to manage STIs.

1.4.9 Should be able to access a service offering pre-booked appointments within their local authority area.

1.5 Supporting information

1.5.1 In order to better manage the public health implications of STIs, every Local Authority should offer access, ideally within the boundaries of their local area, to a comprehensive range of services managing STIs at Levels 1, 2 and 3. Appendix B lists definitions for the elements of care at each of the three levels.

Rapid open access

1.5.2 The Local Authorities Regulations 2013¹ state that ‘each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area’. Open access is defined as the ability of an individual to choose 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 anonymity and confidentiality they require.

1.5.3 Rapid access, defined as access within 2 working days of contacting a service, remains a key quality measure and should be available regardless of where people access services². 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* also published in 2013³. If services are unable to offer an appointment within 2 working days then commissioners should ensure that care pathways support the option of people being seen elsewhere within the local authority area. In addition, in accordance with national guidance, clear pathways for those needing to access HIV post-exposure prophylaxis (PEP) and sexual assault services should be in place to ensure timely and appropriate access.

1.5.4 In some cases it may be appropriate to assess asymptomatic individuals by telephone and arrange for self-taken samples.

1.5.5 In monitoring access, commissioners should ensure that both the proportion of individuals offered an appointment within two working days and the proportion who ‘walk in’ are recorded. The proportion ‘seen’ or assessed within 2 working days should also be recorded in order to avoid inaccurate or distorted recording of activity data by providers. See Standard 5 for guidance on surveillance data.

Sexual health needs assessment

1.5.6 A local sexual health needs assessment should inform commissioners as to the services providers should offer, when, and where these should be located^{3,4}. However people accessing 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. 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, and care pathways should be in place to support onward referral.

1.6 References

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STANDARD 2

Clinical assessment

2.1 Quality statement

People with needs relating to STIs should have a medical and sexual history taken which includes questions about sexual behaviour and other risk factors. Those with symptoms should be offered 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 taken (as defined by BASHH national guidelines for differing symptoms) by the STI service provider.

2.2.2 HIV testing:

- a. The percentage of people with needs relating to STIs who are offered an HIV test at first attendance (excluding those already diagnosed HIV positive).
- b. The percentage of people with needs relating to STIs who have a record of having an HIV test at first attendance (excluding those already diagnosed HIV positive).

2.2.3 Completion of the Care Quality Commission *Essential standards of quality and safety* 2010¹ Provider Compliance Assessment tool for:

- Outcome 4 (Care and welfare of people who use services)
- Outcome 10 (Safety and suitability of premises)

2.3 Quality standards

2.3.1 Sexual history taking: Standard: 97%*

2.3.2 HIV testing:

- a. Standard 97%*
- b. Standard 80%

* This translates to 1 error per 40 audited cases (RCP recommended number).

2.3.3 Meets in full the CQC Provider Compliance Assessment tool for Outcomes 4 and 10.

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 guidelines and NICE clinical and public health guidance.
- c. have relevant accreditation for the services provided eg young people.
- d. can provide evidence of safeguarding and vulnerable adults' policies and the training of staff to support these.
- e. have clear care pathways in place for onward referral including for the 'chain of evidence' process.

2.4.2 Commissioners should also ensure 24-hour access to HIV post-exposure prophylaxis after sexual exposure (PEPSE) for those who need it.

Responsibilities of service providers

2.4.3 All providers of services managing STIs should ensure that they have appropriate mechanisms in place for:

- a. taking and recording a medical and sexual history including a risk assessment for STIs, HIV and other blood-borne viruses, with provision of interpreting services where requested or required.
- b. in the assessment, identifying people from the population groups most at risk for these infections and determining when PEPSE would be indicated.
- c. performing a genital examination, with the offer of a chaperone, and collecting specimens for STI testing including for HIV.
- d. the storage and timely transport of specimens.
- e. onward referral to other services within the local area where necessary.
- f. implementing safeguarding and vulnerable adults' policies and the training of staff to support these.

Responsibilities of healthcare professionals

2.4.4 All healthcare professionals providing clinical care in services commissioned to manage STIs should be fully competent in:

- a. undertaking a clinical assessment.
- b. assessing vulnerability.
- c. performing STI testing.
- d. explaining which STI tests have been taken, and how and when the results will be available.

People with needs relating to STIs:

2.4.5 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.

2.4.6 If experiencing symptoms, should have a genital examination and be offered a chaperone for this examination. Those without symptoms do not need an examination but have the right to request one if it is not routinely offered. Those offered an examination have the right to refuse it.

2.4.7 Should as a minimum be offered tests for chlamydia, gonorrhoea, syphilis and HIV. This may involve having an examination or self-taken swabs or urine tests.

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

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 guidance^{1, 2} and all local infection control and Health and Safety policies.

Accreditation of services

2.5.2 Nationally a range of bespoke services for different populations and demographic groups exist, including those for young people. Where these are commissioned and there is relevant national guidance and accreditation, eg the DH *Quality criteria for young people - friendly health services* referred to as *You're Welcome*³, service providers should be encouraged to comply with them.

Medical and sexual history

2.5.3 As STIs are often asymptomatic and genital symptoms non-specific, localising the site of any infection may be difficult. Therefore a medical and sexual history in line with current BASHH national guidelines should be taken which includes asking about sexual exposure of extra-genital sites, and about sexual partners (including any suspected infection, infection risk or symptoms)^{4,5}. It should also include a risk assessment for STIs, HIV and other blood-borne viruses, including whether people are from the population groups most at risk of these infections, and identify whether PEPSE is indicated⁵. In addition, assessment should include consideration of psychological wellbeing, as this can affect individuals' behaviour and responses to diagnosis and treatment, including adherence to medication and engagement in partner notification. An alcohol history is recommended as part of the risk assessment for STIs, and the use of recreational drugs, history of sexual coercion and intimate partner violence could also be considered. For people with no symptoms a self-completed history pro-forma can be used to elicit this information provided the pro-forma complies with BASHH guidelines⁴.

2.5.4 Post-exposure prophylaxis after sexual exposure (PEPSE) is a key preventive intervention for people who may have been exposed to HIV to reduce the risk of them acquiring HIV. Treatment needs to start as soon as possible within 72 hours so 24-hour access to PEPSE should be available. Accident and emergency departments may initiate PEPSE where indicated and refer on to sexual health providers for completion of the four-week course of treatment. DH and Local Government Association (LGA) guidance gives advice about where the funding responsibilities for this service lie between local authorities, clinical commissioning groups and NHS England^{6,7}.

2.5.5 If symptoms are identified that the healthcare professional or service cannot manage, care pathways should be in place for onward referral of the individual.

Assessing vulnerability

2.5.6 Staff providing care of under-18s should follow local and national guidance on safeguarding children⁸. All sexually active young people under the age of 16 years (and those aged 16-17 years where there is cause for concern) should have a risk assessment for sexual abuse or exploitation performed using a standardised pro-forma at each new presentation at the service, and there should be documentation on whether or not a referral to child protection services is made⁹. All cases under 13 must be discussed with a nominated safeguarding lead. All under-16s should be assessed for competency according to Fraser guidelines^{8,9}.

2.5.7 Compliance with the Mental Capacity Act is essential where clinicians have contact with adults (and young people aged 16-17 years) with learning difficulties or where there is impairment of decision-making¹⁰.

Examination

2.5.8 It should be normal clinical practice for people with genital symptoms to be examined. Abnormal findings, including evidence of female genital mutilation (FGM), should be documented. Those with FGM should be referred to appropriate gynaecological services if needed and safeguarding issues of any female children of such women should be considered.

2.5.9 Those who are asymptomatic and request examination should also be examined, but routine examination of those with no symptoms yields few additional diagnoses^{11,12}. As the most frequent causes of a change in vaginal discharge are not sexually transmitted, if the history suggests low risk of STI and 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 in non-specialist settings¹³ (This would not be appropriate for women aged under 25 years who have ever been sexually active as statistically the greatest risk factor for having an STI is being under 25. Surveillance figures show higher rates of all STIs in this age group.) However, if after empirical treatment the symptoms do not resolve, or if they recur, examination and microbiological testing should be performed¹⁴.

Specimen collection

2.5.10 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^{5,15,16,17}.

2.5.11 Which specimens are appropriate will depend on the sexual history, symptoms and signs. Knowledge of the range of tests offered by the local microbiology laboratory and the correct transport medium, storage and transport of specimens is essential before specimens are collected. If clinical services are unable to offer all diagnostic tests, eg gonorrhoea cultures or herpes polymerase chain reaction (PCR), care pathways should be in place for onward referral of the individual.

2.5.12 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.

2.5.13 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 to enable compliance with the turnaround times in Standard 4.

2.5.14 It is the responsibility of the service taking specimens to ensure that the service user gets their results (see Standard 4). A method of contact, and correct contact details, should be agreed in advance.

Chain of evidence

2.5.15 Where the results of microbiological tests are likely to be used as admissible evidence in court, eg in relation to child protection issues or some cases of sexual assault, advice should be sought from a Sexual Assault Referral Centre (SARC) where possible and a 'chain of evidence' process should be used, as detailed in national guidelines¹⁸. This does not need to be available in all settings, but if not available there must be procedures and care pathways in place for onward referral when needed.

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STANDARD 3

Diagnostics

3.1 Quality statement

People being tested for STIs should have the most accurate diagnostic test in its class (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 are symptomatic or 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 five 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 10 working days of the specimen being received by the laboratory.

3.3 Quality standards

3.3.1 Diagnostic tests: Standard: 80%

3.3.2 Laboratory turnaround time:

- a. Standard: 97%*
- b. Standard: 97%*

* This translates to 1 error per 40 audited cases (RCP recommended number).

3.4 What the quality statement means for each audience

Responsibilities of commissioners

3.4.1 Sexual health 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 Clinical Pathology Association (CPA) / United Kingdom Accreditation Services (UKAS) accredited and have evidence of External Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality Assurance (IQA).

3.4.2 Commissioners should ensure that commissioned laboratories are using the 'gold standard' test wherever possible and adhere to national standard operating procedures where these are available. This includes, but is not limited to, the following areas:

- a. the use of fourth generation assays for HIV testing (combined antibody and antigen detection) with 24-hour access to HIV screening assays in every local 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 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 veneruem (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 B (HBV) and hepatitis C (HCV).
- g. ensuring the availability of herpes simplex virus (HSV) PCR and *Treponema pallidum* PCR for atypical ulcers.

3.4.3 Commissioners should consider, where appropriate, the use of dried blood spot tests in exceptional circumstances, eg for screening in hard to reach populations who would not access other services.

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

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.

3.4.7 Commissioners should ensure that all commissioned Level 3 (specialist) services have on-site 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 and reporting should be five working days or less. If supplementary testing or referral to the reference laboratory is necessary, then a preliminary report should be issued and the final report issued within ten 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

3.4.9 All healthcare professionals 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 BASHH STI testing guidelines.

3.4.11 Should be clear about the time expected for laboratories to process their diagnostic tests.

3.5 Supporting information

Diagnostic tests

3.5.1 Appendix E summarises recommended tests for sexually transmitted infections.

3.5.2 Gonorrhoea and chlamydia NAATs are recognised as the most sensitive diagnostic tests and are recommended for screening and testing^{1,2} 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 positive results will be greater. The reporting of a false positive result should be avoided. This is a particular problem for gonorrhoea as the prevalence varies across the country and so it is recommended that any gonorrhoea NAAT is confirmed with a supplementary test if the PPV of the single test is under 90%^{2,3,4}. The prevalence of chlamydial infection is more evenly distributed and confirmation is not recommended but it should be remembered that the prevalence in individuals over 35 years of age is low and confirmation should be considered if large numbers of people in this age group are tested.

3.5.3 Gonorrhoea and chlamydia NAATs are also recommended for extra-genital samples and, for gonorrhoea, are known to be more sensitive than culture^{5,6,7}. Confirmation of any gonorrhoea (GC) 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 at the national reference laboratory or a regional laboratory with specialist tests established.

3.5.4 Not all CE-marked tests perform satisfactorily. Point of care tests are manufactured for professional use and for home testing. Tests marketed for home testing should be used with extreme caution as their performance may be poor⁹. One CE-marked point of care test for chlamydia gave more false positive than true positive results¹⁰.

3.5.5 Twenty-four hour availability of HIV testing is needed to support urgent clinical decision-making, eg 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, having not already had an antenatal screen. 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 syphilis¹¹, HBV^{12,13}, HCV^{12,13} and HIV should be provided in line with national guidelines¹⁴. See Appendix E.

Microscopy

3.5.7 Direct microscopy of genital samples is a near patient, rapid method of diagnosis of several genital infections¹⁵. 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 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 partner notification and 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 either culture, point of care or TV NAAT should be used where possible¹⁶.

Antimicrobial resistance

3.5.9 The Gonococcal Resistance to Antimicrobials Surveillance 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

and surveillance purposes, is essential. See www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Gonorrhoea/AntimicrobialResistance/

Laboratory standards

3.5.10 Clinical Pathology Accreditation (CPA)/UKAS 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.cpa-uk.co.uk.

3.5.11 The UK Standards for Microbiology Investigations are a comprehensive referenced collection of clinical 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 www.hpa.org.uk/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 CPA/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.hpc-uk.org.

Turnaround times

3.5.14 The turnaround time in this standard is for the time taken in the laboratory. This does not take into account the time taken for a specimen to reach the laboratory (see Standard 2). There is no evidence base for laboratory turnaround times; those recommended in this standard are based on expert opinion.

Cost / cost effectiveness

3.5.15 In laboratories where there is a small throughput of some 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 will 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 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 4

Clinical management

4.1 Quality statement

People using a service for STI testing should receive their results both positive and negative within 10 working days. Those diagnosed with an infection should receive prompt treatment, and be managed according to current BASHH national guidelines, including the delivery of partner notification (PN).

4.2 Quality measures

4.2.1 Timely provision of test results:

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

4.2.2 Clinical management:

Adherence to all the latest BASHH Clinical Effectiveness Group (CEG) guidelines.

4.2.3 Partner notification (PN):

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

4.3 Quality standards

4.3.1 Timely provision of test results: Standard: 95%

4.3.2 Clinical management: Evidence of use of the specific audit measures in each BASHH Clinical Effectiveness Group (CEG) guideline.

4.3.3 Partner notification:

- a. gonorrhoea at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks
- b. chlamydia 0.6 contacts per index case

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:
- are responsible for managing results and communicating them to the service user in a timely manner. There should be no more than 10 working days between the date of the sample and receipt of results.
 - provide treatment according to BASHH CEG guidelines.
 - instigate PN as a core requirement either by patient referral (in which the service user informs their sexual partner(s) of the need for testing and treatment) or by provider referral (in which the service provider contacts sexual partner(s) on behalf of the service user to advise on the need for testing and treatment). The form of PN utilised should be the choice of the person diagnosed with an STI. (See 4.5.11.)
 - follow NICE guidance on one-to-one interventions within *Prevention of sexually transmitted infections and under 18 conceptions*.
 - 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 within their local authority area.
- 4.4.3** Commissioners should not commission services to offer syndromic management of STIs. (See 4.5.7.)
- 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 4.5.8.)
- 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 competent in their interpretation.
- 4.4.7** All providers of services commissioned to manage STIs should ensure that they have appropriate mechanisms in place to give results, both negative and positive, in a timely manner and no more than 10 working days from the time of initial consultation. Technology can 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. Gonococcal culture should be performed on anyone with a confirmed positive GC NAAT test. All people under 25 diagnosed with chlamydia should be re-tested for chlamydia three months after treatment.

4.4.9 It is the responsibility of the service taking the specimens to ensure that any 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.

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. in as short a timescale as possible. If a service is unable to provide treatment, care pathways should be in place to refer people to another service for ongoing management in a timely fashion.
- b. according to current BASHH CEG guidelines and free of prescription charge (see 4.5.8-4.5.10).
- c. and to be able to epidemiologically treat sexual partner(s) ie prior to confirmation of infection, provided appropriate tests have been offered to identify infection and according to the BASHH CEG guidelines.
- d. and to arrange follow up in accordance with BASHH CEG guidelines at the time of treatment.

4.4.11 All providers of services commissioned to manage STIs should provide appropriate vaccination for BBVs to people in high risk groups.

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

- a. instigate PN for relevant infections. If the provider is unable to fully undertake PN, agreed care 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 service user's record, following up in accordance with current national guidance.
- c. offer people diagnosed with an STI a choice of PN by patient referral (in which the service user informs their sexual partner(s) of the need for testing and treatment) or by provider referral (in which the service provider contacts sexual partner(s) on behalf of the service user to advise on the need for testing and treatment).
- d. adhere to the current BASHH PN statement in relation to the look-back periods for each infection.
- e. monitor PN outcomes for HIV, gonorrhoea and chlamydia against national standards. For gonorrhoea these are a minimum of 0.4 contacts per index case in large conurbations, or 0.6 contacts elsewhere, within four weeks and for chlamydia 0.6 contacts per index case.

4.4.13 All providers of services commissioned to manage STIs should ensure that they have appropriate mechanisms in place to provide health promotion:

- a. appropriate to the clinical condition and sexual history in a sensitive and non-judgemental way.
- b. using standard leaflets where available, ensuring that comparable information is available in different languages and in non written formats. Translators or interpreting services (face-to-face or telephone) should be available where requested or necessary.
- c. and condoms free of charge, supporting this by demonstration of correct usage as appropriate.

- d. including one-to-one interventions to support behavioural change in line with NICE guidance or using appropriate pathways to support this.

Responsibilities of healthcare professionals

4.4.14 Healthcare professionals working in services commissioned to manage STIs should ensure that:

- a. they are fully competent to manage STIs in accordance with current BASHH CEG treatment guidelines. Empirical and epidemiological treatment while awaiting results are acceptable practices; syndromic management, with few exceptions (see supporting information) is not.
- b. if not competent or able to provide appropriate management for particular conditions, they have clear agreed referral pathways to appropriate services in place, with systems to confirm effective transfer of care.

People with needs relating to STIs:

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

4.4.16 Should get their test results, negative or positive, within 10 working days of having the tests taken. The service should agree with them how they will receive the results.

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

4.4.18 If diagnosed with an STI requiring PN, should receive support from services to let recent sexual partner(s) know that they are at risk of infection, as they will need testing for STIs and treatment. This is called partner notification.

4.5 Supporting information

Interpretation of results

4.5.1 Test results both negative and positive should be interpreted in the light of the service user's clinical presentation. It is therefore essential that results are reviewed by a clinician who is competent to interpret them correctly.

Provision of results

4.5.2 Provision of 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 10 working days from consultation to provision of results represents a maximum, agreed by consensus in the development of these standards.

4.5.3 It is not acceptable for people with negative results not to be informed of these. It is for commissioners and providers to determine which of the various mechanisms for conveying results is most appropriate for their local services^{1,2}.

Treatment

4.5.4 For both public and individual health reasons, treatment regimens should follow current BASHH CEG treatment guidelines^{3,4}. Resistance profiles will be monitored and, in the case of resistance to first-line treatment, laboratories will advise on appropriate regimens.

4.5.5 In England and Wales, the national Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) has identified drifts towards decreased susceptibility to the third generation cephalosporins, particularly cefixime, the oral agent⁵. In 2011 the national guidelines were changed to recommend ceftriaxone, an injectable, at the increased dose of 500mgs in combination with azithromycin, 1g, given orally⁶. Effective therapy and partner notification is essential for public health control of gonorrhoea and infected individuals diagnosed in primary care should be referred to a specialist service for treatment management.

4.5.6 Epidemiological treatment, ie treatment of the sexual partner(s) of an infected individual prior to confirmation of infection in the partner, reduces time of infectivity and onward transmission rates for non-viral STIs. Testing partners is necessary for identification of infection and for managing subsequent partner notification for those partners identified as positive.

Syndromic management

4.5.7 Syndromic management of STIs, ie the prescribing of antimicrobial regimens chosen to cover the major pathogens responsible for a syndrome, eg urethral discharge and genital ulcer disease, without taking appropriate swabs for laboratory investigation, was developed for resource-poor settings where diagnostic laboratory tests are not available⁷. In the UK it is considered sub-optimal care and such management should only be used in exceptional circumstances by a senior clinician.

Prescription charges

4.5.8 Current legislation dictates that STI treatment is free of prescription charges in directly managed NHS services but this is not the case for other providers of STI care. This is because exemption stems from the NHS Act 1977 and applies to Part 1 NHS prescriptions only^{8,9}. It is often difficult to implement this in primary care for treatments using GP (FP10) prescriptions. Furthermore medicines supplied through general practice are subject to NHS regulations (which limit dispensing in non-dispensing practices).

4.5.9 It should however be noted that there are methods of supplying NHS medicines in primary care such as Patient Group Directions (PGDs)^{10,11}. These need to be explicitly commissioned, including 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 provision of all treatments for STIs in primary care.

4.5.10 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

4.5.11 All services managing STIs should be expected to instigate PN as part of the management of STIs including HIV¹². 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 re-infection, offer health education opportunities and encourage behaviour change.

4.5.12 Partner notification is a fundamental and skilled aspect of STI management. BASHH guidance and outcome measures should be followed to ensure optimal management^{13,14}.

Health promotion

4.5.13 Health promotion is important in supporting lifestyle change and risk minimisation. People accessing STI services should receive health promotion interventions appropriate to their sexual history and lifestyle in a format that suits their individual needs¹⁵. NICE guidance¹⁶ should be utilised and for some appropriate referral to psychology services can be beneficial in contributing towards one-to-one behavioural change in the reduction of contraction of further STIs.

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STANDARD 5

Information governance

5.1 Quality statement

Services managing STIs should ensure information collected about individual service users remains secure and is only shared with other professionals if it is in the service user's best interests or for public health reporting purposes.

5.2 Quality measures

5.2.1 Record keeping:

Completion of the Care Quality Commission *Essential standards of quality and safety 2010*¹ Provider Compliance Assessment tool for:

- Outcome 21 (Records)

5.2.2 Information governance:

Compliance with the requirements of the DH/HSCIC information governance assessment².

5.2.3 Data reporting:

Compliance with national data reporting requirements, within six weeks of the end of each quarter.

5.3 Quality standards

5.3.1 Record keeping: Meets in full the CQC Provider Compliance Assessment tool for Outcome 21.

5.3.2 Information governance: Meets annually in full the DH information governance assessment tool.

5.3.3 Data reporting: Standard: 100%

5.4 What the quality statement means for each audience

Responsibilities of commissioners

5.4.1 Commissioners should ensure that all providers of services commissioned to manage STIs:

- a. are registered under the Data Protection Act.
- b. have appropriate measures in place to comply with secure record management requirements, including the NHS Code of Practice.
- c. have appropriate security measures in place to transmit datasets securely.
- d. comply with all national data reporting requirements.

5.4.2 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 5.5.9 and 5.5.10.)

Responsibilities of service providers

5.4.3 All providers of services commissioned to manage STIs should have clear and transparent information available to people using services about:

- a. confidentiality.
- b. how the service, local authority, PHE and DH use their data and the safeguards that are in place in order to protect patient confidentiality.
- c. how to access their own health records.

5.4.4 Information on people attending services, and information about their sexual contacts, should be held securely and strictly in accordance with Caldicott Guidance, the Data Protection Act and the NHS Code of Practice. Where information about service users is held electronically, it must be held on secure password-protected systems with restricted access.

5.4.5 All providers of services commissioned to manage STIs must comply with:

- a. national data reporting requirements and ensure that adequate security measures are in place when transmitting datasets to a third party eg PHE or DH.
- b. DH data retention and destruction requirements.

5.4.6 Service providers should ensure that all staff attend annual information governance training.

Responsibilities of healthcare professionals

5.4.7 All healthcare professionals working in services commissioned to manage STIs 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. record keeping.

- c. compliance with mandatory information governance training requirements.

People with needs relating to STIs:

- 5.4.8** Should receive clear information on the level of confidentiality they can expect.
- 5.4.9** Should have access to clear information about how the service collects and shares confidential information.
- 5.4.10** Should receive clear information on how to request access to their health records.

5.5 Supporting information

- 5.5.1** Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information.

Confidentiality

5.5.2 People with needs relating to STIs have the right to confidentiality in their consultation with a health professional regardless of the location in which they are seen^{3,4,5,6}. Historically, users of GUM services have been assured of anonymity if required and there has been a perception 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 confidentiality they can expect from different services in order to make informed choices about where to access care.

5.5.3 The lapsed NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000⁷ imposed on PCTs an obligation not to disclose any information about STIs obtained by their officers, and capable of identifying an individual, except to a medical practitioner (or someone employed under their direction) for the purposes of treatment or prevention. Work is currently underway within the DH and the Health and Social Care Information Centre to publish a new statutory Code of Practice (CoP) on sharing patient identifiable information. Providers of health and social care services will be legally obliged to follow the CoP which will include separate guidance on confidentiality and disclosure of information on sexual health. The CoP will reaffirm the importance of keeping information about a person's use of NHS STI and other sexual health services separate from their other NHS care records. The Department of Health has issued guidance on clinical governance for commissioners and providers of sexual health services which includes statements on confidentiality⁸.

5.5.4 In exceptional circumstances information may need to be shared in the interests of the service user or public as set out in the relevant guidance documents, eg for safeguarding children.

Collecting and recording information

5.5.5 Information on people attending health services is usually collected at registration and subsequently throughout the episode of care to enable clinical management. This information should be recorded in accordance with NHS information standards^{9,10,11,12}.

5.5.6 NHS information standards specified in the NHS Data Model and Dictionary¹³ are assured by the NHS Information Standards Board for Health and Social Care (ISB HaSC) and published as Information Standards Notices (ISNs). These cover in detail requirements of commissioners and providers in relation to the collection and recording of data.

Data reporting

5.5.7 There are a number of mandatory national data collections for sexual health surveillance¹⁴. All data extracts are reported quarterly and should be received within six weeks of the end of the calendar quarter. For a summary of current mandatory reporting datasets see Appendix C.

5.5.8 Commissioners 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 pseudoanonymised form.

Data sharing and publication

5.5.9 The use and sharing of patient information must strictly follow Caldicott Guidance³, the Data Protection Act¹⁵, PHE guidance¹⁶, the NHS Act¹⁷, DH guidance¹⁸, GMC guidance^{5,19} and the Health and Social Care Act 2012²⁰.

5.5.10 Following an Office for National Statistics (ONS) review of health statistics²¹, Public Health England 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 professionals¹⁶. Recently, 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. The aim of the policy is to reduce the risk of inadvertent disclosure and thereby protect service user confidentiality.

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STANDARD 6

Clinical Governance

6.1 Quality statement

People should receive their care from high quality services managing STIs that are safe, well-managed and accountable.

6.2 Quality measures

6.2.1 Clinical Governance Arrangements:

Completion of the Care Quality Commission *Essential standards of quality and safety 2010*¹ Provider Compliance Assessment tool for:

- Outcome 15 (Statement of purpose)
- Outcome 16 (Assessing and monitoring the quality of service provision)
- Outcome 17 (Complaints)
- Outcome 20 (Notification of other incidents)
- Outcome 21 (Records)

6.2.2 Audit:

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

6.3 Quality standards

6.3.1 Meets in full the CQC Provider Compliance Assessment tool for Outcomes 15, 16, 17, 20 and 21.

- 6.3.2**
- a. Evidence of participation in relevant annual regional or national audits.
 - b. Evidence of actions based on audit 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.

6.4.2 Commissioning should enable the development of an effective integrated governance system that is reflected within individual service specifications.

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

6.4.4 Commissioners should ensure that audit requirements relating to STI management are specific in all contracts and that audit activity is monitored via an annual audit plan and compliance with CQC Outcomes 15, 16, 17, 20, 21.

Responsibilities of service providers

6.4.5 Level 3 specialist GUM services should provide clinical leadership, including training, clinical expertise and clinical governance in the management of STIs, within the local authority area.

6.4.6 All providers of services managing STIs should ensure that effective clinical governance arrangements are in place. This includes, but is not limited to, the following areas:

- a. Having a nominated clinical governance lead with responsibility for overseeing the clinical quality of the service delivered and establishing robust links between local services, including the local specialist GUM service (Level 3).
- b. Using information technology (IT) to support clinical governance within and between organisations, taking into account the required information governance standards (see Standard 5).
- c. Having a clear framework to support education and training that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of ongoing competence that fulfils the needs of the level of service provided (see Standard 7).
- d. Having an annual audit plan and, as a minimum, annually auditing elements of clinical practice to ensure adherence to current local and national guidelines and evidence-based procedures.
- e. Demonstrating action taken based on audit findings.
- f. Fostering and encouraging clinical research and development.
- g. Having procedures in place to minimise risk to both service users and staff.
- h. Having clear mechanisms in place to report, review and respond formally to all clinical incidents and complaints.

Responsibilities of healthcare professionals

6.4.7 All healthcare professionals working in services managing STIs should understand and comply with all clinical governance requirements and demonstrate a commitment to patient safety, quality improvement and clinical efficiency. This includes, but is not limited to, the following areas:

- a. Compliance with all mandatory training requirements including information governance, infection control and safeguarding children and vulnerable adults.
- b. Regular attendance at clinical governance meetings.
- c. Compliance with local and national audits as appropriate.

People with needs relating to STIs:

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

6.4.9 Should receive a response to any feedback they give including complaints.

6.4.10 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* (DH, 2013)² 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 DH 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’³. As the regulator of health and adult social care in England, the Care Quality Commission’s registration system for health and adult social care provides a framework to ensure that all services meet the essential standards of quality and safety. All providers of services managing STIs have a responsibility to demonstrate effective clinical governance arrangements^{2,4,5,6,7}.

Clinical leadership

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

6.5.4 Clinical leadership should be regarded as distinct from service leadership. In many services, both roles may be provided by the same individual. Service leadership refers to the managerial aspect of a service and may be provided by any appropriately qualified individual. This document emphasises clinical leadership which should be provided by an accredited GUM specialist within a local network in order to oversee clinical governance and patient safety as regards STI management.

6.5.5 Clinical leadership provides a framework for the development of shared protocols and audit and training. Within a network, clinical leadership can empower and drive transformational change across organisational boundaries.

Information technology

6.5.6 Standardisation of clinical governance requirements across providers will help to ensure safe, equitable delivery of services regardless of who provides them. Integrated IT systems which facilitate adherence to all information governance requirements and the sharing of data where appropriate would support this⁸ (see Standard 5).

Teaching and training

6.5.7 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, eg youth workers or receptionists, may be involved in elements of healthcare, and they too should be trained and competent. Appropriately trained and supervised staff will ensure services are delivered in a safe and high quality manner. 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

6.5.8 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 specification⁹.

6.5.9 In addition, research in STI management should be promoted to further knowledge and improve outcomes for people accessing STI services¹⁰.

Risk management

6.5.10 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 essential⁴. Much could be gained from transparency and sharing of incidents and learning within local sexual health networks.

Quality improvement

6.5.11 Effective clinical governance should lead to continuous quality improvement. Outcome 16 of the standards for all providers registered with the Care Quality Commission (CQC) relates to assessing and monitoring the quality of service provision. It states that 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 bodies¹. In addition, the two outcome indicators included in the Public Health Outcomes Framework relating to sexually transmitted infections (rate of chlamydia diagnoses in 15-24 year olds and proportion of people presenting with HIV at a late stage of infection) provide an opportunity to engage with local populations to benchmark and improve local services¹¹. (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:

Completion of the Care Quality Commission *Essential standards of quality and safety 2010*¹ Provider Compliance Assessment tool for:

- Outcome 12 (Requirements relating to workers)
- Outcome 13 (Staffing)
- Outcome 14 (Supporting workers)

7.3 Quality standards

7.3.1 Competence to deliver services: Meets in full the CQC Provider Compliance Assessment tool for Outcomes 12, 13, and 14.

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 Since providers of services at Levels 1 and 2 are likely to have education and training needs in relation to STI management, appropriate education and training should be commissioned to meet national standards and reflect local needs.

7.4.3 The clinical leadership role of specialist GUM providers (Level 3) in overseeing (and undertaking, if required) training in STI management across the local authority area needs to be explicitly commissioned and form part of the service specification.

7.4.4 Commissioners need to ensure that the education and training of future healthcare professionals eg doctors and nurses are not compromised or undermined by any commissioning decisions.

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 and other groups, including trainees, as commissioned and appropriate.

7.4.7 All services should be able to provide assurance that all employees delivering care are competent and remain competent to do so. Staffing numbers and skill mix should be appropriate to the workload and case complexity.

7.4.8 Adequate provision should be made to support the maintenance of competencies in the management of STIs, eg through continued professional development, education, and sexual health networks.

7.4.9 Agreed mechanisms should be in place for the assessment of clinical competence. Where appropriate these should be standardised and common across all professional groups and those assessing competence should be appropriately trained in the assessment of competence.

Responsibilities of healthcare professionals

7.4.10 All clinical staff, regardless of professional discipline, should be able to demonstrate clinical competence (at the level at which they are working) and maintenance of that competence in line with national and local standards.

People with needs relating to STIs:

7.4.11 Should have their care managed by an appropriately skilled healthcare professional.

7.5 Supporting information

Competence

7.5.1 Competence may be defined as²: the knowledge, skills, abilities and behaviours that a practitioner needs in order to perform their work to a professional standard. Competencies should be relevant to the service that is being commissioned and, while disciplines may have different professional guidance around the legalities and requirements for certain competencies and the steps required to ensure safe practice, eg in relation to prescribing or the authority to use patient group directions (PGDs), the standards needed to achieve competence should be the same regardless of professional group.

7.5.2 Knowledge is: the facts and information which underpin health conditions and their management.

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

Maintaining competence

7.5.4 All healthcare professionals have a responsibility to maintain their own clinical competence demonstrating this through routine annual appraisal and the appropriate revalidation processes relevant to the professional discipline. Commissioners and providers of services need to work together to ensure that maintenance of competencies forms part of a robust local governance framework which is commissioned and performance monitored^{1,3}.

Training

7.5.5 Services managing STIs will often be responsible for providing different types of training. Different professional disciplines are educated and develop clinical competence in relation to STI management in varying ways,^{4,5,6,7,8,9,10} at both a pre- and postgraduate level. Standardisation of the content and quality of specialist (postgraduate) education provision is important and the lack of standardisation is a risk. Not all courses designed to support skills development in the management of STIs are clinically assessed.

7.5.6 Appendix D brings together national postgraduate STI courses which BASHH has developed and/or endorsed and courses to which BASHH has contributed. It is not exhaustive: a number of other high quality courses are in existence, some locally developed, that relate to the management of STIs. However, it is hoped that Appendix D will aid individuals and organisations in determining which courses most appropriately meet their needs.

BASHH qualifications of clinical competence

7.5.7 The BASHH portfolio of clinical competency learning and assessment qualifications aimed at multidisciplinary healthcare professionals¹¹ provides a national standardised training and assessment pathway, ranging from testing for asymptomatic STIs and offering health promotion (STIF Level 1 Competency) to the management of symptomatic uncomplicated STIs (STIF Intermediate Competency) and more advanced practice in the management of STI (STIF Level 2 Competency). The qualifications are aimed at staff delivering STI care in specialist and non-specialist settings, including healthcare assistants (HCAs), pharmacists, nurses, midwives and doctors not undertaking formal training for CCT. They provide a portable 'passport' of clinical competence.

7.5.8 The BASHH Competency qualifications require revalidation every 5 years to remain on the register^{12,13}. They stipulate a minimum requirement of continued professional development related to sexual health over this timeframe.

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

7.6 References

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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 find this arranged for them quickly and easily. Similarly people with any other sexual health needs that the service is unable to meet (eg 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:

Care pathways, or a sexual health network, linking all providers of STI management with the local Level 3 specialist GUM service.

8.2.2 Completion of the Care Quality Commission *Essential standards of quality and safety* 2010¹ Provider Compliance Assessment tool for:

- Outcome 6 (Co operating with other providers)

8.3 Quality standards

8.3.1 Evidence of documented local care pathways or a sexual health network.

8.3.2 Meets in full the CQC Provider Compliance Assessment tool for Outcome 6.

8.4 What the quality statement means for each audience

Responsibilities of commissioners

8.4.1 Commissioners should work with providers, clinicians and sexual health networks to ensure that care pathways are transparent and integrated across the local authority area.

8.4.2 Commissioners can assist in the development, management and leadership of sexual health networks by being explicit about the clinical leadership role for STI management 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.

8.4.4 Commissioners should ensure appropriate linkages between providers of services commissioned to manage STIs and services providing HIV treatment and care.

8.4.5 Commissioners should contribute to robust and ongoing joint strategic needs assessment across all services within the local sexual health network.

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 areas:

- a. having formal links and clear referral pathways in place to the local specialist GUM service (Level 3) and other closely allied specialties including HIV treatment and care, SRH and abortion as well as any other relevant local organisations.
- b. actively engaging in a sexual health network if in place.
- c. working with other services to develop and share local clinical guidelines and protocols.
- d. delivering or participating in education and training across the local authority area.

Responsibilities of healthcare professionals

8.4.7 All healthcare professionals and other staff working in services commissioned to manage STIs should have a clear understanding of local care pathways in order to facilitate appropriate referrals and to know where 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 care¹.

Care pathways

8.5.2 The Department of Health's *Framework for Sexual Health Improvement in England*² identifies collaboration and integration between services as essential. This is because different groups of people often have varying and complex health needs eg 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 pathways to relevant services are in place to ensure timely access to advice and care that can meet individual needs^{3,4,5}.

8.5.3 Care pathways describe a seamless patient journey across a range of health and social care services, using evidence-based guidelines and multi-disciplinary working. Care pathway development should always involve the local specialist GUM provider (Level 3) as well as all 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.

Sexual health networks

8.5.4 There are a number of different sexual health and HIV networks established around the country, both local and regional, which build on the existing improvement and expansion of services and provide a framework for collaborative working and more integrated delivery of sexual healthcare⁶. Most people's sexual health needs are likely to be wider than the management of STIs and for this reason networks should be clinically broad and holistic in focus. The role of commissioners is vital in all of them, though varying in the extent to which networks are commissioner-led.

8.6 References

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STANDARD 9

Patient and Public Engagement

9.1 Quality statement

People should be consulted about the development and delivery of services managing STIs in their community. Those using services should be encouraged to give feedback about them.

9.2 Quality measures

9.2.1 A Patient and Public Engagement (PPE) plan which affords public consultation and feedback.

9.2.2 The use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to collect information from patients.

9.2.3 Completion of the Care Quality Commission *Essential standards of quality and safety* 2010¹ Provider Compliance Assessment tool for:

- Outcome 1 (Respecting and involving people who use services)

9.3 Quality standards

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

9.3.2 Evidence from providers of effectiveness of care from the patients' perspective and the patient experience of the humanity of their care via annually reporting validated PROMs and PREMs.

9.3.3 Meets in full the CQC Provider Compliance Assessment tool for Outcome 1.

9.4 What the quality statement means for each audience

Responsibilities of commissioners

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

9.4.2 Working with the local providers and users of healthcare services, commissioners should develop local quality measurement frameworks utilising nationally validated PROMs.

9.4.3 Commissioners should engage with users and non users of services, including those most at risk of STIs, and encourage lay representation on both commissioning and community groups from key target age groups using and requiring access to sexual health 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 service providers

9.4.4 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 areas:

- a. identifying named individuals in each service with responsibility for PPE.
- b. providing evidence of service responses to feedback and monitoring of PROMs and PREMs.
- c. engaging with service users about the STI services they have used as well as the services they would like to access.
- d. engaging with the public, including non-users of STI services, as routine, not just when any redesign or major service development is planned.
- e. assessing why services are not being used by some groups in the population.
- f. evidence of the development of staff engagement and training in PPE.
- g. utilising 360 degree appraisal processes for staff which include patient feedback.

Responsibilities of healthcare professionals

9.4.5 All healthcare professionals should:

- a. take individual responsibility for PPE viewing it as part of professional competence.
- b. encourage patient feedback, both positive and negative.
- c. respond to feedback in an open and honest fashion utilising appropriate communication methods which may include web-based, telephone, written or verbal means of contact.

People with needs relating to STIs:

9.4.6 Should be encouraged to provide feedback on their personal experience of care and to offer opinions about services managing STIs, both current and future.

9.4.7 Should always receive responses to their feedback and views.

9.5 Supporting information

Public and patient engagement

9.5.1 Public and patient engagement is a legal duty in the health service² and forms the basis of care quality standards in the NHS Constitution³, NHS Outcomes Frameworks^{4,5} and NICE Guidance⁶. Stigma about STIs remains and achieving engagement with many populations who use services is challenging⁷. Yet consultation with service users has many benefits, both in refining commissioning strategies to help provide cost-effective and relevant services and in encouraging patients to take an active part in development of services through immediate feedback of experience and through monitoring outcomes^{8,9}.

9.5.2 The NHS Constitution³ 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. Clinical Commissioning Groups, local authorities and national commissioning 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 proposed^{2,10}. 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 local area and may 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

9.5.3 The quality of care from the patient's perspective has two facets - its effectiveness (outcome) and its humanity (experience)². 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.

9.5.4 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. BASHH is developing tools for reporting PROMs as well as other quality indicator data which will be applicable for use across all services managing STIs.

Patient Reported Experience Measures

9.5.5 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 physical processes and personal perceptions of privacy, dignity and communication with staff. PREMs may be captured by a variety of tools^{11,12}, 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 care⁸. 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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APPENDIX A

Project group members and representatives

BASHH Clinical Standards Unit plus co-optees

NAME	DESIGNATION	ORGANISATION
Dr Immy Ahmed-Jushef	Chair of the Clinical Standards Unit, and Project Clinical Lead	BASHH
Dr Kate Armitage	GP	RCGP
Dr Steve Baguley	GUM Physician	BASHH
Erna Buitendam	Head of Quality Assurance and Standards, NCSP	PHE
Dr Jan Clarke	Chair of the Public Panel	BASHH
Dr Jyoti Dhar	GUM Physician	BASHH
Dr Jane Dickson	SRH Consultant	FSRH
Dr Claudia Estcourt	Reader in Sexual Health and HIV	BASHH
Ceri Evans	Sexual Health Adviser	BASHH
Kate Folkard	NCSP Programme Manager	PHE
Dr Gwenda Hughes	Head of STI Surveillance	PHE
Professor Cathy Ison	Head of Sexually Transmitted Bacteria Reference Unit	PHE
Ruth Lowbury	Chief Executive	MEDFASH
Tosh Lynch	GUM Nurse	BASHH
Dr Richard Ma	GP	RCGP
Dr Hugo McClean	Chair of the National Audit Group	BASHH
Dr Danielle Mercey	GUM Physician	BASHH
Martin Murchie	Sexual Health Adviser	SSHA
Dr Colm O'Mahony	GUM Physician	BASHH
Liz Rodrigo	Public Health Principal	Leicester City Council, HIV and Sexual Health Commissioners Group for England and Faculty of Public Health
Dr Ann Sullivan	Clinical Effectiveness Group Representative	BASHH
Dr Alan Tang	Acting Chair of the Clinical Governance Committee	BASHH
Dr Nick Theobald	STIF Lead	BASHH
Claire Tyler	Project Consultant	MEDFASH
Dr Janet Wilson	President	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* (DH, 2013). They look specifically at 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

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 eg 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 (PEP)****

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 other 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).

**** PEP '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.

References

1. Ota KV, Tamari IE, Smieja M et al (2009) Detection of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in pharyngeal and rectal specimens using the BD Probetec ET system, the Gen-Probe Aptima Combo 2 Assay and culture. *Sex Transm Infect* 85:182-6
2. Alexander S (2009) The challenges of detecting gonorrhoea and chlamydia in rectal and pharyngeal sites: could we, should we, be doing more? *Sex Transm Infect* 85:159-60

APPENDIX C

Summary of mandatory sexual and reproductive health datasets*

INFORMATION COLLECTED	DATASET	SERVICES AFFECTED	RESPONSIBLE ORGANISATION
STI diagnoses and services provided	Genitourinary Medicine Clinic Activity Dataset (GUMCADv2)	Level 2* and 3* Sexual Health Services	Public Health England
HIV diagnoses	HIV and AIDS Reporting System (HARS)	HIV outpatient services	Public Health England
Chlamydia tests and diagnoses	Chlamydia Testing Activity Dataset (CTAD)	All laboratories commissioned to provide chlamydia testing	Public Health England
Contraception data	Sexual and Reproductive Health Activity Dataset (SRHAD)	Settings (excluding General Practice) offering contraceptive services	Public Health England (Data submitted via the Health and Social Care Information Centre)

* Correct in January 2014

APPENDIX D

Education and Training Matrix

The following are courses 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 adviser	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
RCGP Introductory Certificate in Sexual Health (online and face-to-face training)	Yes	Yes*	Yes	No	Yes	Yes	Yes	Yes	Certificate on completion
Centre for Postgraduate Pharmacy Education (CPPE) (online) 1. Chlamydia screening and treatment: community pharmacy enhanced service 2. Sexual Health in Pharmacies	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 adviser	Pharmacist	
BASHH STIF Core: 1 day course*	Yes	Yes**	No	No	Yes	Yes	Yes	Yes	Certificate on completion
BASHH STIF-Plus: 1 day course	Yes	Yes**	No	No	Yes	Yes	Yes	Yes	Certificate on completion
Health Education England / BASHH / RCP / e- Learning for Healthcare: eHIV-STI	Yes	No	Some elements in respect of Level 1 and 2	No	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
BASHH STIF Level 1 Competency	No {STIF Core is a pre-requisite}	No {STIF Core is a pre-requisite}	Yes	Yes	Yes	Yes	Yes	Yes	Certificate on completion and registration on BASHH database
Faculty of Sexual & 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.***

APPENDIX D – Education and Training Matrix

LEVEL 2									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge-based	Skills-based	Doctor	Nurse	Sexual health adviser	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.
BASHH STIF Intermediate Competency (Entry Level)****	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
BASHH STIF Level 2 Competency (Advanced Level)	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 adviser	Pharmacist	
BASHH STI Course	Yes	Yes	No	No	Yes	Yes	No	No	Certificate on completion
Society of Apothecaries Diploma in GU Medicine (DipGUM) *****	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
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.

* Includes learning by interactive case-based discussion

** Developed through role play

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

**** The University of Greenwich will award 15 credits at Level 6 (Bachelor degree) or Level 7 (Masters degree) for successful completion of ‘STIF Intermediate Competency’ training and assessment with an academic component. This can be undertaken anywhere in the UK under the supervision of a sexual health specialist who is a BASHH registered trainer. The credits can be counted towards a related degree at any University using the CATS (Credit Accumulation and Transfer Scheme) system.

***** BASHH STI Course and Society of Apothecaries Diploma in GU Medicine: the Course has no assessment and the Diploma has 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 vaginal swab (SVS) in women for gonorrhoea and chlamydia NAAT
- If no SVS or cervical specimen, urine in women for gonorrhoea and chlamydia NAAT
- Serology for HIV and syphilis

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 B HBsAg and anti-HBcAb in MSM with no history of immunisation and individuals from endemic regions, HCV Ab in HIV positive individuals

Symptomatic men

- Urine or urethral sample for gonorrhoea and chlamydia NAAT
- Urethral microscopy and culture for *Neisseria gonorrhoeae*
- Serology for HIV, syphilis

If MSM or indicated by sexual history

- Rectal samples for gonorrhoea and chlamydia NAAT
- Microscopy and culture for *Neisseria 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 B HBsAg and anti-HBcAb in MSM with no history of immunisation and individuals from endemic regions, HCV Ab in HIV positive individuals

Symptomatic women

- Endocervical microscopy and culture for *N. gonorrhoeae*
- Self taken vaginal swab for gonorrhoea and chlamydia NAAT if endocervical swab not taken
- Smear from the lateral wall for microscopy for bacterial vaginosis, candida and *Trichomonas vaginalis* if more sensitive tests not available
- Vaginal swab for culture, NAAT or POCT for *T. vaginalis*
- Rectal samples for gonorrhoea and chlamydia NAAT plus culture for *N. gonorrhoeae* if indicated by sexual history
- Pharyngeal sample for gonorrhoea and chlamydia NAAT plus culture for *N. gonorrhoeae* if indicated by sexual history

- Serology for HIV and syphilis

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

- Ulcer specimen for *Treponema pallidum* for dark ground microscopy, if available
- Ulcer specimen for NAAT for *T. pallidum* as a single or multiplexed test, if available
- HSV NAAT from ulcer as a single or multiplexed test, serology only if NAAT not available
- 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
CATS	Credit Accumulation and Transfer Scheme
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CoP	Code of Practice
CPA	Clinical Pathology Accreditation
CPD	Continuing professional development
CPPE	Centre for Pharmacy Postgraduate Education
CQC	Care Quality Commission
CTAD	Chlamydia Testing Activity Dataset
DH	Department of Health
EQA	External Quality Assessment
EQAS	External Quality Assessment Scheme
FGM	Female genital mutilation
FORWARD	Foundation for Women's Health, Research and Development
FSRH	Faculty of Sexual & Reproductive Healthcare of the RCOG
GC	Gonorrhoea/Gonococcal
GMC	General Medical Council
GP	General Practitioner
GRASP	Gonococcal Resistance to Antimicrobials Surveillance Programme
GUM	Genitourinary Medicine
GUMCAD	GUM Clinic Activity Dataset
GUNA	Genito-Urinary Nurses Association
HARS	HIV and AIDS Reporting System
HCA	Healthcare Assistant
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency (now superseded by PHE)
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HSV	Herpes simplex virus
IQA	Internal Quality Assurance
IQC	Internal Quality Control
ISB	Information Standards Board
ISB HaSC	Information Standards Board for Health and Social Care
ISN	Information Standards Notices
IT	Information Technology
MEDFASH	Medical Foundation for HIV & Sexual Health
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

ONS	Office for National Statistics
PCR	Polymerase chain reaction
PEP	Post-exposure prophylaxis
PEPSE	Post-exposure prophylaxis following sexual exposure
PGD	Patient Group Direction
PHE	Public Health England
PN	Partner notification
POCT	Point of care test
PREM	Patient-reported experience measure
PPE	Patient and public engagement
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
SRH	Sexual and Reproductive Healthcare
SRHAD	Sexual and Reproductive Health Activity Dataset
SSHA	Society of Sexual Health Advisers
STI	Sexually Transmitted Infection
STIF	Sexually Transmitted Infections Foundation (course)
TV	Trichomonas vaginalis

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 service users.



Standards for the management of sexually transmitted infections (STIs)

Revised and updated edition, January 2014

As part of their public health responsibilities, local authorities now commission most services managing sexually transmitted infections (STIs) in England. Effective STI management not only improves health outcomes for individuals but also, by preventing new infections, plays a critical role in improving public health and containing costs to the public purse.

Comprehensively revised and updated since the original 2010 edition, these *Standards for the management of STIs* reflect changes arising from the Health and Social Care Act 2012 and new developments in clinical practice. They bring together the key elements of best practice in STI management and will be an indispensable resource for commissioners and providers alike. Applicable to all settings where STIs are managed, the standards will help ensure that people with STI-related needs receive safe and high quality care, whichever service they choose to use.

The updated standards were developed by MEDFASH with and for BASHH, supported by a multidisciplinary working group. The project was funded by BASHH.

About MEDFASH and BASHH

MEDFASH is an independent charity dedicated to improving the quality of HIV and sexual healthcare. It has a track record of managing major national projects to inform policy development and provide practical guidance for professionals.

BASHH is the lead professional representative body for those managing STIs and HIV in the UK. It seeks to innovate and deliver excellent tailored education and training to health care professionals, trainers and trainees in the UK and to determine, monitor and maintain standards of governance in the provision of sexual health and HIV care.

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