Standards for Online and Remote Providers of Sexual and Reproductive Health Services

Joint BASHH/FSRH Standard

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Standards for Online and Remote Providers of Sexual and Reproductive Health Services.

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Executive Summary

The rapid expansion in the number of providers of online Sexual Health/Sexual and Reproductive Healthcare (SH/SRH) services has enabled and empowered users to access their healthcare in more ways than through a face-to-face consultation with the health care professional.

The FSRH and BASHH support these innovations and recognise that these services have enormous potential. They are seeking, however, key assurances in the standards of care and quality of services provided.

The FSRH and BASHH have co-authored this set of standards to be used as a benchmark for all providers of online SH/SRH services, and as a tool for commissioning of services. It will also enable service users to understand what to expect from their provider.

The five standards mirror the key lines of enquiry followed by the Care Quality Commission (CQC) and are summarised below:

Standard 1. Safe:

> Providers must satisfy themselves that they can make an adequate and reliable assessment which does not compromise on service user care; have safety nets in place to manage and limit risks associated with remote consultations; ensure all staff receive appropriate training and maintain their skills; and have a system in place which enables a comprehensive approach to risk identification, assessment analysis and response in remote consultations.

Standard 2. Effective:

> Providers shall ensure that valid consent is obtained from service users by providing them with adequate information to make an informed decision, free from duress; ensure all staff are adequately trained to obtain valid consent by assessing for capacity in line with current UK legislation and General Medical Council (GMC) Guidance; consider how permission to share information is recorded and conducted; ensure appropriate and secure management of service user information in line with current guidance; and adhere to the UK Code of Non-broadcast Advertising and Direct & Promotional Marketing code (CAP code), with regard to relationships with pharmaceutical companies and advertising of their products.

Standard 3. Treating People with Kindness, Respect and Compassion:

> Providers shall ensure that: their services are accessible and inclusive for all those who need to use them; staff delivering online consultations understand and promote compassionate, respectful and empathetic behaviour; that the tests they utilise meet all UK standards and that processes are in place for monitoring and evaluating their workload; that any user interface is easy to navigate with regular review and input from the service user; and adhere to national guidance and standards regarding the use of service user information and demonstrate how confidentiality is maintained.

Standard 4. Responsive:

> Providers must be able to demonstrate how they promote equality within their services and fulfil the Equality Act 2010; how they collect, manage and respond to suggestions, concerns and complaints from service users; as well as how user and public involvement is encouraged and developed.

Standard 5. Governance and Leadership:

> Providers should ensure that a clear strategy is in place to deliver a high quality and sustainable care plan. The provider must be registered with the appropriate regulatory body and processes in place to continually review and improve services.

Current research and evidence regarding SH/SRH provision through online services is still in its infancy. It is imperative that the level of clinical excellence, governance, safety and care delivered through these new modalities is not compromised.

Asha Kasliwal

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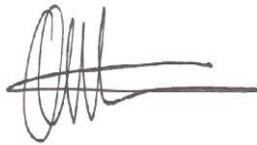
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Introduction

In 2018 the CQC published a report following the first full programme of inspections of online providers of primary health care.[1] Many of these providers offer management of sexual infections and provide contraception. The report highlighted specific concerns around safe prescribing practices, consent and capacity, proof of identity and safeguarding of children and vulnerable adults.

FSRH and BASHH recognise and welcome the rapid expansion in providers of online Sexual Health/Sexual and Reproductive Healthcare (SH/SRH) services which has allowed both public and private providers (NHS and non-NHS) to engage with the challenges of health provision in the twenty-first century. Innovative technology has enabled service users to access health care in more ways than the primary provision of care through a face-to-face consultation with a health care professional.

The FSRH and BASHH support these improvements which benefit their service users and the public more widely and recognise that these services have enormous potential. However, they strongly believe that, irrespective of consultation modality best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care.

Therefore, in response to the findings from the CQC the FSRH and BASHH have collaborated on writing and collating a set of 'best practice' standards of care for those providing SH/SRH services through avenues other than traditional face-to-face services. These could include a range of modalities from real-time interactive health care via a video link, to web-based questionnaires.

The working group was made up of members from BASHH and FSRH. Views and experiences were initially sought from other providers and stakeholders of SH/ SRH care including RCN, RCGP, CQC, LloydsPharmacy™ Online Doctor and SH:24. The initial draft was made available for a public consultation period inviting feedback which then shaped the final draft.

The working group recognises that there are soon to be published key national documents which may further define the provision of SH/ SRH care in this area, and therefore this document should not be used in isolation. Similarly, current research and evidence around SH/ SRH provision through online services is still in its infancy, though quickly growing, and as this becomes available will shape future versions of this document. For this reason, and at this time, each standard begins with a set of 'key statements' but does not contain 'key performance indicators (KPIs)'. The group recognises that this will, and should, change as evidence becomes available to support the creation of quantifiable measures and targets but did not feel it did at the time of publication.

One of the main themes highlighted by the CQC was regarding the need for proof of identity (including age) for users of non-face-to-face services. The FSRH and BASHH feel it is imperative that the level of clinical excellence, safety and care delivered through remote services is not compromised. They do not support the creation of obstacles which may prevent users from accessing these services and which do not currently exist in terrestrial services i.e. proof of identification or UK residence.

Regarding access to online services for individuals who are aged under 16 years, the group has consulted widely. While it is recognised there are many benefits to a young person accessing SH/ SRH services through a non-face-to-face environment, which create, as one study has found, a less pressured space for asking safeguarding questions,[2] new GDPR and data protection laws expect services to demonstrate that individuals who are aged under 16 years have the capacity to consent to their data being collected and processed remotely (see Section 3.5). Legally this would be difficult to show through an online service without confirming age and identification, and for this

reason we recommend individuals who are aged under 16 years are signposted to face-to-face services.

While we recognise the changing landscape of SH/ SRH clinically and politically within the UK and the need for 'smarter' ways of working which are future proofed for every eventuality, we fundamentally believe as health care professionals, that the service accessed by the user needs to be safe and of the same quality and standard that would be expected irrespective of the provider, or mode of contact, and that is the main driver for this piece of work.

1 Standard 1. Safe

1.1 Standard Statement on remote prescribing[3] (This refers to both medical and independent prescribers)

> When prescribing remotely, prescribers must satisfy themselves that they can make an adequate and reliable assessment which does not compromise service user care.

1.1.1 All services providing remote prescribing should have policies in place to ensure that any software products used for consulting remotely are secure, provide a robust audit trail and comply with clinical and information governance standards.

1.1.2 Before prescribing for a service user via telephone, video-link or online, the prescriber must satisfy themselves that they can make an adequate assessment, establish a dialogue and obtain the service user's consent.[4]

1.1.3 The GMC guidance on consent in prescribing should be adhered to including the ability to assess the service user's condition before deciding to prescribe a medicine.[5] If the prescriber does not feel able to do this remotely, pathways should be in place for the service user to be seen "face-to-face".

1.1.4 In line with 1.1.3 the prescriber may prescribe only when they have adequate knowledge of the service user's health and is satisfied that the medicines serve the service user's needs. Therefore the prescriber must consider:

    a. The limitations of the medium through which they are communicating with the service user.

    b. The need for physical examination or other assessments. Pathways should be in place for redirection, if the service provider does not offer this.

    c. Whether they have or need access to the service user's medical records relevant to the situation (e.g. past medical history, allergies etc.). Online service providers would be expected to follow the same guidance for accessing user records as a face-to-face service.

1.1.5 When prescribing remotely the prescriber must consider whether and how they can identify safeguarding concerns and vulnerable service users. There should be demonstrable systems in place to identify potentially "at-risk" persons e.g. by flagging multiple accounts or frequent requests or by assessing concerns regarding capacity to consent.

1.1.6 The prescriber must adhere to national and local policy on safeguarding children and vulnerable adults and have procedures in place for the escalation of safeguarding concerns when they become known (see Section 1.2).

1.1.7 Service users should be given the opportunity at any time in the process to ask questions and clarify any concerns that they may have regarding their prescription. This should include contact details which can be used after the initial consultation is complete.

1.1.8 Service users should be provided with information about the medication and alternative options in a form they understand and tailored to their needs. Patient information leaflets are a useful supplement and should be available in a choice of formats i.e. electronic and hard copy.

1.1.9   Service users requiring contraception provision should have supplies with an
expiry date that is beyond the duration of provision and be provided with
recommendations on their choices for future contraception and provision,
including when a face-to-face consultation would be required. All women should
be advised about the contraceptive effectiveness and side effects of the method
they have chosen and about long acting reversible contraception (LARC).

1.1.10   It is the online provider's responsibility to have processes in place to collect
feedback from service users on their experiences.

1.1.11   Service users should be afforded the same level of confidentiality that they would
receive at a face-to-face consultation within a SH/ SRH service. It is the
prescriber's responsibility to make this explicit and consent should be sought as to
how the service user would like to receive results (i.e. letter, SMS, email) and with
whom information can be shared (e.g. the GP). This should be checked and
confirmed at each contact and not presumed to be static.

1.1.12   Prescribers should adhere to national guidelines on prescribing (i.e. BASHH,
FSRH) while recognising their limitations. The mode of consultation should not
interfere with best practice prescribing, and where this cannot be achieved online,
pathways must be in place for timely referral (e.g. administration of intramuscular
or subcutaneous treatments or provision of emergency contraception).

1.1.13   Prescribers should follow the most up to date guidance on epidemiological
treatment pathways recognising their duty as stewards of antibiotics.[6]

1.1.14   Prescribers have a responsibility to maintain their skills in line with guidance from
their regulating bodies (see Section 1.3).

1.2   Safeguarding

Services should have safety nets in place to manage and limit risks associated with remote consultations.

1.2.1   Services should be aware there are obstacles to consulting via remote methods. For example, with a telephone consultation, physical symptoms or demeanour cannot be assessed. Similarly, an online questionnaire is not a two-way process meaning that uncertainties cannot be clarified and follow-up questions cannot be asked.[7]

1.2.2   Services should assess, and review regularly, the limitations and risks of communicating with service users via any none face-to-face means.[7]

1.2.3   Staff should be aware of the difficulties in assessing service users with vulnerabilities. This includes young people, people with mental health problems, adults who lack capacity, those with complex medical histories, and those who require polypharmacy. They should also be alert to circumstances where there may be a need to break bad news or complex ethical issues.[7] In these circumstances services users should be clearly signposted to clinics for face-to-face consultation.

1.2.4   Staff who consult with service users, either directly or indirectly should be adequately trained in the safeguarding of adults and young people, with this kept up-to-date. Any staff involved in direct clinical contact, e.g. in telephone consultations, should be trained to level 3 safeguarding.[1]

1.2.5   It is recommended that individuals who are aged under 16 years should be offered face-to-face consultations and that clear pathways are in place to signpost them appropriately.

1.2.6   It is recommended that all sexually active young people (16 to 18 years) should have a risk assessment performed for Child Sexual Exploitation (CSE) such as 'Spotting the Signs' (Appendix 2) by an appropriately trained health professional.[8]

1.2.7   Services should have mechanisms for risk assessment of recreational drug and alcohol abuse and domestic violence. The limitations associated with remote consultations should be acknowledged and, where appropriate, service users should be referred for face-to-face consultations.[9,10]

1.2.8   In any given presentation, the likelihood of a physical examination being required should be assessed and arrangements made for face-to-face consultation, either for initial appointment or for further follow-up. Pathways should be in place for redirection, if the service provider does not offer this.[7,11]

1.2.9   Providers of services should ensure policies for safeguarding are available to all staff. There should be a designated Safeguarding Lead within the service.[23]

1.3 Staffing and Training

> All staff providing remote and online services in SH/ SRH services should receive appropriate training and must maintain their skills. Training needs will vary, between clinical and non-clinical staff, and should be tailored to meet their individual needs.

1.3.1 Providers should ensure that staff are trained to deliver remote and online consultations, in line with the skills they would need for a similar face-to-face consultation. The level of contact that individual staff members have with service users and access to confidential information will determine which training is appropriate for their role.[7]

1.3.2 Staff providing contraception or sexual infection treatment should hold a relevant qualification in SH/ SRH. Holding a current Diploma in Sexual and Reproductive Healthcare (DFSRH), STIF foundation or be trained to equivalent competencies, as stipulated by their educational and professional bodies. They should be able to show evidence of current accreditation.[12] Nurses and pharmacists should be supported in the use of patient group directions (PGDs) or an independent prescribing qualification.[13]

1.3.3 Providers of SH/ SRH services should ensure staff receive regular education and training relevant to their specific role.[14]

1.3.4 All health professionals, including pharmacists and health care technicians working in SH/ SRH services should be trained to the competencies laid down by their educational body.[12]

1.3.5 Health professionals should be aware of their skills and limitations, and only work within their competencies. They must seek advice from experienced colleagues appropriately.

1.3.6 Where a health care professional is working with young people, they should have an understanding of adolescent development and experience of working with young and vulnerable people. This should include training in CSE and safeguarding.[12]

1.4   Management of risk and performance

> SH/SRH Services should have a system which enables a comprehensive approach to risk identification, assessment analysis and response in remote consultations. This should apply to all aspects of service provision i.e. both clinical and non-clinical. Service user safety and security of patient identifiable information should not be compromised by the modality of consultation.

1.4.1   There are potential safety risks to consulting remotely and services should identify and manage those risks and recognise that remote consultations are not always the right choice (see Appendix 1).

1.4.2   Where providers of online services have responsibility for patient management and clinical oversight in England, they are required to be registered with the CQC and are subject to inspection, monitoring and regulation.[1,15] Providers should check with the CQC whether their online or remote activities need to be registered. In Scotland, services independent of the NHS must be registered with Health Improvement Scotland (HIS). The equivalent bodies in Wales and Northern Ireland are the Care Inspectorate Wales (CIW) and the Regulation and Quality Improvement Authority (RQIA) respectively.

1.4.3   When using digital systems, triaging tools and symptom checkers, it is important to recognise the risks associated with the use of these systems. Where a provider accesses NHS patient data the Data Security and Protection Toolkit (an online self-assessment tool) must be completed.[16]

1.4.4   Inappropriate triaging of service users, wrong decisions from using symptom checkers, or failures in the electronic transfer of clinical data to the clinician, could all result in harm to the service user. Providers should be accountable for the performance of their systems and continue to improve their quality in response to these potential issues.[17]

1.4.5   A register should be established with a process in place to monitor and review risks and incidents regularly. For example, monitoring of inappropriate triage.

1.4.6   Services should have a system which enables a comprehensive approach to risk identification and which should include both prospective and retrospective indicators.[18]

1.4.7   Risk assessment should be carried out routinely, to establish the level of risk associated with a particular activity. For example, access to service user records and current medication.[18]

1.4.8   There should be a clear process in place to analyse the cause of any incident.[18]

1.4.9   Risk and response to risk should be monitored by a designated team within a service provider and a risk register should be maintained.[18]

1.4.10 There should be a systematic programme of internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The provider should take part in appropriate local and national audit programmes working in collaboration with the relevant Colleges, Faculties and Specialist Societies. Systems should be in place to regularly review performance against all relevant NICE Standards and CQC guidance.

1.4.11 Potential risks should be considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. Contingencies for the supply of key laboratory, IT and pharmacy resources must be realistic and regularly updated. Any planned or unplanned limitation of service and the subsequent consequences to other providers must be considered and discussed, with partner organisations and the relevant commissioners for those services.

1.4.12 Any applications and software qualifying as a medical device must be Conformité Européenne (CE) marked and hold a cyber essentials certificate, in line with the EU medical devices directive. Such applications and software should also be registered with the Medicines and Healthcare products Regulatory Agency (MRHA).[19] EU regulations state that a 'medical device' means any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes: diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease. Services should check with the MHRA whether their software qualifies as a medical device. The MHRA have a useful flowchart for aiding this decision.[20]

1.4.13 Services selling medicines to the public via a website must be registered with the MHRA and display the 'Distance Selling Logo' on every page of the website offering medicines for sale.[21]

1.4.14 Services should check that their websites are secure and have the necessary cyber essential certification to protect from malware, hacks and cyber-attacks. NHS service providers should have completed a NHS digital data security and protection toolkit.[16] NHS Digital offers guidance on protecting data and handling information securely.[22]

1.4.15 When procuring these systems, services should check with the system supplier how service user data is used, for what purpose and what they are requiring service users to consent to.

1.4.16 Services should ensure there are appropriate processes and systems of support in place to facilitate debriefs following difficult consultations as well as peer support for clinical dilemmas.[23]

1.4.17 When considering developments to services or efficiency changes, the impact on quality and sustainability must be assessed and monitored. An impact assessment should be conducted, addressing how any changes will impact the vulnerable and disadvantaged.

2   Standard 2. Effective

2.1   Obtaining Valid Consent

> SH/SRH Services should ensure that valid consent is obtained from service users by providing them with adequate information to make an informed decision, free from duress.

2.1.1   Informed consent is obtained following the process of shared understanding and decision making between service user and health professional. Online service providers should adhere to this process diligently and robustly.[24]

2.1.2   Health professionals seeking to obtain valid consent must be sure that the person giving consent can understand, retain and weigh the information relating to the decision. (See Appendix 3).

2.1.3   Adults (persons aged 18 years and over in England or aged 16 and over in Scotland) are assumed to be competent to give or withhold consent unless there is reason to believe otherwise.

2.1.4   Consent can be withdrawn at any time and providers must be able to document a change in individuals' wishes at any stage of the services they offer.

2.1.5   The GMC's guidance on consent outlines an expectation of two-way communication of tailored information between the patient and health professional. The 2015 judgment in the case of Montgomery expects that information must be tailored to the patient. Online service providers should note that consultations which rely only on transmission of standardised, generic information to the patient for the purpose of consent does not meet the standard expected in guidance for consent and shared decision-making.[5,25,26]

2.1.6   When seeking consent for a test, service users must be fully informed on the nature of the test being carried out and the implications of results. Providers must ascertain how users would like to receive their results.[5]

2.1.7   When seeking consent for treatment, service users should be fully informed of the potential side effects and interactions with other medications. They should also be advised it the medicine is being used for an off-license purpose, as well as any reasonable or accepted alternative treatments and where these can be accessed.[5]

2.1.8   In order to obtain valid consent, an adequate assessment must be carried out and the health professional must be satisfied that the service user is provided with enough information and time to make the decision, has mental capacity, and is free from duress.[5]

2.1.9   Patients should be given information in additional languages, where necessary, to help them understand and consider information in their own time.[27] Provision should be made for those with disabilities.

2.1.10 Obtaining valid consent using remote services may not be possible in some circumstances. Service providers must check the suitability of the remote service for the service user (Appendix 1). Face-to-face consultations, or referral to another service, should be arranged if an online consultation is deemed inappropriate.[23]

2.1.11 Where service users have consented to carers, parents or relatives communicating with providers using online consultations, a separate verification process must be taken prior to granting authorisation by proxy.

2.1.12 Where concerns regarding consent and capacity have been highlighted, these should be clearly documented in the user records.

2.2   Assessing Capacity

Online service providers should ensure all staff who have contact with service users are adequately trained to assess for capacity in line with current UK legislation and General Medical Council Guidance.

2.2.1   Online service providers who have contact with service users should conduct robust assessments, ideally with the aid of valid consent and capacity assessment tools, such as the two stage functional test, that enable a thorough evaluation of a service user's mental capacity during a consultation.[25] This should not be limited to the ability to complete a registration process or agreement to the terms and conditions of use on a website.

2.2.2   Capacity is decision-specific and can change. Where there are concerns about a potential lack of capacity, an assessment should be made in line with established good practice. Providers must be able to outline both how they can identify where there may be concerns about capacity, and how staff are able to carry out an assessment if required.

2.2.3   Where mental capacity cannot be confirmed, clear pathways for face-to-face consultation or referral to another service must be in place. This should clearly be recorded in the service user's notes.

2.2.4   GDPR requires consent to the collection and storage of data (see Section 3.5) and proof of capacity could be difficult to prove remotely for individuals under 16 years of age. Therefore it is recommended that they are signposted to face-to-face services.

2.2.5   Health professionals should take all reasonable steps to facilitate communication with the service user to assess capacity. This may require using interpreters or communication aids as appropriate.

2.2.6   Equality and diversity factors, such as a service user's ethnic background or disability, should also be considered in capacity assessment. This may help to eliminate the risk of misinterpreting indicators of cultural difference as incapacity and reduced cognitive function.[28]

2.2.7   Where family members, carers or relatives use online consultations on behalf of the service user, practices must have robust assessments to verify authorisation by proxy while being alert to the possibility that pressure or undue influence can come from these parties.[29]

2.3   Management of Information

> Appropriate sharing of information between providers in the management of a service
> user is an important part of good medical practice. Where there is a clinical indication,
> online providers should consider how permission to share information is recorded and
> conducted.

2.3.1   Online service providers must recognise that appropriate sharing of information between providers involved in a service user's care is an important part of good practice as outlined in guidance from the General Medical Council.[30]

2.3.2   Online service providers should routinely ask service users if details of their consultation could be shared with their own GP. Providers should encourage service users to provide their GP's details to support safe and effective care.

2.3.3   Where there is a clinical indication and, on the service user's request, a decision is taken to prescribe without sharing this information with the service user's GP, it is good practice for this to be clearly documented in the service user's records as outlined in the GMC guidance on remote prescribing.[4]

2.3.4   If health professionals are prescribing for service users who are overseas, they should consider how they can safely share information with local healthcare care providers, including any necessary follow-up or review.

2.3.5   Online service providers must make provisions for safe transfer of service user information within their team when handing over care.

2.3.6   Providers should ensure easy access to service user records (with consent) when required during emergency care.

2.3.7   The consent of a service user is required before any disclosure of information obtained during their engagement with the service. Disclosure of information without the individual's permission may be considered in exceptional circumstances to protect the individual from serious harm or in the public interest. Every effort should be made to inform the individual where disclosure against their wishes is made.[30]

2.3.8   All communication and information transfer methods should be secure and ensure confidentiality.

2.3.9   Providers should be aware that they may be liable for the actions of their staff if these principles of information sharing are not respected.

2.3.10 Online service providers should aim to record all service activity accurately and appropriately for quality assurance and surveillance purposes.[14]

2.3.11 Incidents that occur in the course of providing online and remote services, for example, breaches of data confidentiality (in relation to Data Protection Act 2018) should be investigated and reported to the relevant stakeholders, such as Commissioners, the CQC when it concerns a registered activity, the Information Commissioners' Office, or PHE as appropriate.

2.4   Record Keeping

> Policies and practices should be in place to ensure appropriate and secure
> management of service user information in line with current guidance.

2.4.1   Providers should be aware that good record keeping ensures that health
professionals can readily access information to provide efficient and high quality
care. It facilitates continuity of care whilst informing and justifying decisions made
in a manner that it is clear to all.

2.4.2   All providers of online services require robust procedures for their records
management to meet the requirements set out under the Data Protection Act 2018
(which is the UK's implementation of the European Union's General Data
Protection Regulation) and the Freedom of Information Act 2000.[43,44]

2.4.3   The storage, retrieval, disclosure, transfer, archiving and disposal of health
records must comply with Records Management: NHS Code of Practice.[31]

2.4.4   Consent can be recorded in writing or by electronic methods. The healthcare
professional making the record should be clearly identifiable and information
should be recorded in a manner that accurately reflects the consultation.[32]

2.4.5   The assessment of capacity, and any vulnerability, should be recorded in the
service user's notes, including the management plan and any actions taken. The
use of a standardised pro-forma is encouraged, e.g. 'Spotting the Signs' (see
Appendix 2).[8]

2.4.6   Multimedia images exchanged between service users and providers are
increasingly part of the service user record and must be stored securely. If it is
proposed that the image may be used for education or teaching, then consent
must be obtained and recorded, and the use must not be wider than that to which
consent has been given.[33]

2.4.7   Good clinical records support audit, management, planning and research.
Providers are encouraged to monitor the process of record-keeping in order to aid
these activities.

2.5   Marketing and Advertising Standards

Providers of Online and Remote Services must adhere to the UK Code of Non-broadcast Advertising and Direct & Promotional Marketing code (CAP code), with regard to relationships with pharmaceutical companies and advertising of their products.

2.5.1   In accordance with the UK Code of Non-broadcast Advertising and Direct & Promotional Marketing code (CAP code), online SH/SRH service providers should adhere to the following measures:[34]

   a)   Marketing communications must be obviously identifiable as such.

   b)   Marketing communications must make clear their commercial intent with clear labelling of any advertising.

   c)   Unsolicited e-mail marketing communications must be obviously identifiable as marketing communications without the need to open them.

2.5.2   If the online service provider is providing a health advice and either exclusively features or gives greater prominence to a brand with which the providers have a commercial relationship, the commercial nature of their relationship should be clearly conveyed to the user.

2.5.3   Although it is designed to reflect the law, the CAP code does not cover marketers' legal or other obligations, which remain their responsibility.

3   Standard 3. Treating people with kindness, respect and compassion

3.1   Access to Services

> It is the provider's responsibility to ensure their services are accessible and inclusive for all those who need to use them.

3.1.1   Online services need to be accessible to as wide a range of individuals as possible and be easily accessible using modern browsers or applications. They should satisfy the checkpoints developed by the World Wide Web Consortium (W3C) in order to maximise access by people with disabilities.[35] There should be options available to direct service users to digital support if they require this.

3.1.2   The provider should make it clear what SH/ SRH care and treatment is available via the online service. This may include tests for sexually transmitted infections (STI) and HIV and/ or contraception provision. They should also be explicit about what is not available via the online service such as contraceptive injections, implants and intrauterine contraception. The provider needs to explain to the individual if the online service is not suitable for them.

3.1.3   The provider must signpost appropriately for emergency situations where rapid access to face-to-face services is required, for example where HIV post-exposure prophylaxis following sexual exposure (PEPSE) is needed, or where emergency intrauterine contraception is required.

3.1.4   Additional support should be available for those who require information to be provided in a language other than English. The provider should detail which languages are available to meet the needs of the people using the service.[7]

3.1.5   The provider must work within the requirements of the Mental Capacity Act 2005[36] (Adults with Incapacity Act [Scotland] 2000[37]). An assessment must be made to ensure that the service user has the capacity and ability to consent to using the service and to be involved in planning their care, treatment and management (see Section 2.2).

3.2   Consultations

Staff delivering online consultations should understand and promote compassionate, respectful and empathetic behaviour.

3.2.1   Online specialist SH/ SRH services should provide individualised care using appropriate and clear language so that service users receive person-centred care and treatment based on an assessment of their needs and preferences.

3.2.2   Health professionals with the appropriate skills and knowledge should be available to discuss care and treatment choices with the service user, if this is required. The discussion should include health, social and emotional needs as well as partner notification. They should provide support to make sure the person understands the risks and benefits associated with their choices, and to enable them to make informed decisions about their care and treatment.

3.2.3   The provider should take an appropriate sexual and reproductive health history in line with local and national guidance.[9,38,39,40]

3.2.4   For those who have protected or other characteristics defined under the Equality Act, and where there are language difficulties, communication needs should be addressed as detailed in 3.1.4 and 3.1.5.[41]

3.2.5   The provider should have a system of processes, validated by national standards with clinical support from a specialist (Consultant level or equivalent) trained in SH/ SRH. These processes must recommend care, treatment and management of the service user, dependent on the information provided.

3.2.6   Treatment options must be made clear to the service user. The implications of not undertaking any, or only a part, of the care must be documented.

3.2.7   Provision must be made to inform the service user how their self-sampling/ test kits/ treatment/ contraception will be delivered and the time frame in which it will arrive. They should also be advised how to obtain their results, how to use the test kits/ treatment/ contraception that has been provided and whether any other management, partner notification or follow-up will be required. It is best practice to provide the service user with written information.

3.2.8   Signposting to other services is an important part of the consultation process and should be made available where necessary.

3.3 Workload

Service providers must ensure that the tests they utilise meet all UK standards and
that processes are in place for monitoring and evaluating their work.

3.3.1   All laboratories providing STI diagnostic testing must be appropriately accredited,
registered with the CQC and deliver optimal standards of services including
specimen turnaround times. They should be Clinical Pathology Association (CPA)
/ UK Accreditation Services (UKAS) accredited and have evidence of External
Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality
Assurance (IQA).[39] It is important to ensure that the Point of Care (POC)/ self-test
kits that are procured and provided are Conformité Européenne (CE) marked (see
Section 1.4.12).

3.3.2   Individuals being tested for STIs should be tested for relevant pathogens only, as
per national guidance, using highly performing tests that are endorsed and
recommended by the relevant governing body. It is important that the correct
samples are taken from appropriate sites and that the samples are transported to
the laboratory in a safe and correct manner.

3.3.3   Service users should be advised about the sensitivity of the assays for detecting
infection and about 'window periods' when infection may not be reliably identified.

3.3.4   Providers should audit the return rates of any home sampling kits.

3.3.5   Results (both positive and negative) must be received by the service user within
time frames specified within national and local policy. Those diagnosed with an
infection must be offered treatment and receive this promptly if accepted, following
UK national standards.[42] Other management and partner notification
arrangements must be initiated as detailed in 3.5.6.[39]

3.3.6   The provider needs to have in place contingency plans for the seamless provision
of care if there is an unexpected rise in demand or failure of supplies so that the
service user is protected.

3.4   Supporting service user involvement

Providers should ensure that the site is easy to navigate with regular review and input from the service user.

3.4.1   Digital support must be available on the website for service users to obtain additional explanation or information. Help buttons must be easily identifiable clear and consistent. The provider must have a mechanism for reviewing their use to enable them to identify areas requiring revision, and must ensure the information is kept updated to meet service users' needs.

3.4.2   Information, including contact information, must be provided on an appropriate section of the website regarding external bodies, community organisations and advocacy services which can provide independent support and advice for service users.

3.4.3   All policies must have an Equality Impact Assessment performed and any actions required must be completed.

3.4.4   The provider must actively seek the views of service users about their experience of using online services, how care and treatment has met their needs and their suggestions for improvement. The provider must consider these and be able to demonstrate that they responded to any feedback. (See Section 4.2).

3.5   Respecting and promoting privacy, dignity and confidentiality

> Providers must adhere to national guidance and standards regarding the use of
> service user information and demonstrate how confidentiality is maintained.

3.5.1   Information about individuals must be held confidentially and comply with the 2018 Data Protection Act (DPA), the General Data Protection Regulation (GDPR) and any regulations pertinent to STIs.[43,44, 45,46] Providers of services must ensure they have a designated lead person for GDPR.

3.5.2   Individuals must be informed, and consent sought, concerning the data that will be collected and how this will be stored. Service users must be advised that their data will be treated confidentially within the terms of the DPA, GDPR and SH/ SRH requirements. Staff will be required to undergo training in data protection and information governance as well as adhering to all legislation and requirements. This includes adhering to the Caldicott principles[47].

3.5.3   The provider must ensure that all records relating to the service user (including assessments, care, treatment plans, correspondence and referrals) are kept securely for the required retention periods.[48,49,50,51]

3.5.4   Products sent by post must be sent in a discreet, non-identifiable package so that no one but the recipient will know what the package contains.

3.5.5   Results must be provided in a way that enables the service user to maintain privacy and confidentiality.

3.5.6   Clear pathways with choices for individuals to obtain care, treatment and further management must be available if an STI is identified. Service users must be given information on the need for partner notification, re-testing as appropriate, and advised that this is part of STI management. It must be managed in a respectful and sensitive manner and service users must be offered ways to arrange partner notification.

4   Standard 4. Responsive

4.1   Equality

> Providers must be able to demonstrate how they promote equality within their services
> and fulfil the Equality Act 2010.

4.1.1   Providers of online or remote SH/ SRH services may or may not be the same organisation which provides the face-to-face SH/ SRH service for any specific location. It is the online service provider's responsibility to ensure that the pathway between the face-to-face and online and remote services is well supported and does not put the service user at a disadvantage if they need to move between the two types of service.

4.1.2   SH/ SRH services must be accessible to everyone who may need to use them. If not, this may be a breach of the Equality Act 2010. (See Section 3.1).[41]

4.1.3   The content and layout of the user interface should promote diversity and not discriminate against any protected characteristic. This includes recognition of diverse sexual orientation and gender identities.

4.1.4   Websites and applications should be easy to use and neither directly or indirectly discriminates against those with poor digital literacy; safeguards include the use of clear English, clear site structure and unambiguous site navigation.[52]

4.1.5   Provision should be made to accommodate service users who have a limited understanding of English or a disability: this may include redirecting users who require access to digital support or to mainstream face-to-face services.

4.1.6   Services should abide by UK government recommendations. (See Section 3.1.1).

4.2   Responding to suggestions, concerns and complaints

Providers must be able to demonstrate how they collect, manage and respond to suggestions, concerns and complaints from service users.[53]

4.2.1   Services should establish and operate an accessible and effective system for receiving, recording, handling and responding to concerns or complaints by service users.

4.2.2   Information and guidance about how to complain must be available and accessible to everyone who uses the service: this would be through clear signposting on websites' or applications' main menus and homepages. It should be available in appropriate languages and formats to meet the needs of those using the service.

4.2.3   Service users should be able to log complaints including online, by post or via telephone, and be given a choice for how they wish to be contacted with the response.

4.2.4   Services must tell people how to complain: they must offer support and provide the level of support needed to help users make a complaint. This may be through advocates, interpreter services and any other support identified or requested.

4.2.5   Complainants must not be discriminated against or victimised. In particular, a service user's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf.

4.2.6   Appropriate action must be taken without delay to respond to any failures identified by a complaint or by the investigation of a complaint.

4.2.7   Information must be available to a complainant about how to act if they are not satisfied with how the service manages and/ or responds to their complaint. Information should include the internal procedures that the service must follow and should explain when complaints should/will be escalated to other appropriate bodies.

4.2.8   Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the service should cooperate with any independent review or process.

4.2.9   Services must have effective systems to make sure that all complaints are investigated without delay.

4.2.10 The complainant should expect to receive both an acknowledgement of the complaint and a formal response to their complaint within an acceptable time periods in keeping with local and national guidance. (The NHS standard is 28 days).

4.2.11 Services should monitor complaints over time, looking for trends and areas of risk that may be addressed.

4.2.12 Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding.

4.2.13 Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result.

4.2.14 Services must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. A summary response for each complaint must be made available even when the complainant cannot be reached.

4.2.15 Services must act in accordance with the CQC Regulation 20: 'Duty of Candour' (under the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014) in respect of complaints about care and treatment that have resulted in a notifiable safety incident.[54,55]

4.3   Service User and Public Engagement

> The provider must be able to demonstrate how service user and public involvement is encouraged and developed.[39]

4.3.1   Services should be able to demonstrate service user involvement in service design.

4.3.2   A service user and public involvement plan should be developed and supported by the service.

4.3.3   Service user engagement should be encouraged as part of the routine process of using the service. This would encompass a variety of media including: online feedback forms, email, telephone or postal responses.

4.3.4   Services should have a mechanism for recording and reporting service user outcomes and experiences including both quantitative metrics and qualitative feedback.

4.3.5   Service users and their partners, the public, staff and external partners should be engaged and involved to support high-quality sustainable services. Efforts should be made to canvass the opinions of people from a diverse range of protected characteristics including populations who are less easily reached, with a view to improve equality of access.

4.3.6   There should be positive and collaborative relationships with external partners to: build a shared understanding of the challenges within the system and the needs of the relevant populations; and to deliver services to meet those needs.

4.3.7   There should be transparency and openness with all stakeholders about performance.

5 Standard 5. Governance and Leadership

5.1 Leadership

> It should be clear to staff and users whom the leaders are within a service, their relevant qualifications and how to communicate with them.

5.1.1 Online specialist services in SH/ SRH should be clinically supported by those with specialist training (Consultant level or equivalent) in SH/ SRH. This will ensure that they have the expertise to deliver best care in line with national standards.

5.1.2 There should be a program of training and professional development to ensure that clinical leaders maintain and develop their skills.

5.1.3 Leaders should understand the challenges to the quality and sustainability of service provision, how these differ in the online environment, and the mechanisms to identify the actions needed to address any concerns.

5.1.4 Service leaders need to be accountable, approachable, and available to their staff. Their roles and responsibilities need to be clearly described along with clear lines of communication.

5.2   Vision and strategy

Services should have a clear vision and credible strategy to deliver high-quality
sustainable care, and robust plans to deliver this care.

5.2.1   Organisations should collaborate with staff, external partners and service users to
develop their vision, values and strategy.

5.2.2   Care must be taken when planning the capacity of the service and service user
pathways so that they appropriately reflect the needs of service users. The
capacity of other relevant NHS providers to respond to these needs should be
considered to ensure appropriate support can be continued.

5.2.3   Online services may see rapid rises in demand in response to restructuring of
other SH/ SRH services. Services should anticipate service user flow particularly
through any periods of transition.

5.3 Culture of the organisation

> All staff should have had initial orientation, yearly appraisal and have awareness of the whistle-blowing policy.

5.3.1 There should be a culture of high-quality, sustainable care where staff feel supported, respected and valued. Relationships between staff should be cooperative, supportive and appreciative. Staff and teams should work collaboratively, share responsibility and resolve conflict quickly and constructively.

5.3.2 The service provider should have a culture centred around the needs of the service users. This should encourage openness and honesty at all levels in response to incidents.

5.3.3 Staff practice should be reflective. There should be mechanisms to learn and take action as a result of any concerns raised. The organisation must comply with the statutory requirements for duty of candour.

5.3.4 There should be mechanism for providing all staff at every level with the development they need, including high-quality appraisal and career development opportunities, where appropriate.

5.3.5 There should be an emphasis on the safety and wellbeing of staff. Staff should be aware of the policy for whistle-blowing within the organisation and who they should contact to raise concerns about service user safety, or colleague performance.

5.3.6 The organisation should promote equality and diversity within and beyond the organisation. Training should be offered in this area.

5.4   Governance and management

Providers of online SH/SRH services must be registered with the appropriate
regulatory body.

5.4.1   Organisations should have clear responsibilities, roles and systems of
accountability to support good governance and management. These systems
should be regularly reviewed.

5.4.2   There should be clarity for all staff in relation to their roles and responsibilities.

5.4.3   Arrangements with partners and third-party providers should be governed and
managed effectively to encourage appropriate interaction and promote
coordinated, person-centred care.

5.5 Learning, improvement and innovation

> The organisation should be able to demonstrate performance improvement and
> conduct audit loops to show quality improvement.

5.5.1 The service should have robust systems and processes for learning, continuous improvement and innovation. Learning should be effectively shared across the organisation. Services should participate in appropriate research projects and recognised accreditation schemes. Where standardised improvement tools for service improvement exist, they should be adopted.

5.5.2 Systems should exist to support improvement and innovation work. The organisation must have robust audit and service evaluation programmes in place to identify performance against benchmark standards and to demonstrate improvement.

5.5.3 Providers conducting clinical research should be able to demonstrate that they comply with guidance from the NHS Good Clinical Practice (GCP) and registered with the Integrated Research Application System (IRAF) where necessary.[56,57]

6   About this guideline

6.1   Editorial Independence

This set of standards was written, edited and endorsed by the FSRH and BASHH without
external funding being sought or obtained.

6.2   Declarations of interest

Following due consideration, the Working Group does not have any relevant declarations of
interest to declare.

6.3   Steering Committee

The steering committee was comprised of members and representatives from the following
organisations:

Royal College of Nursing (RCN)

Royal College of General Practitioners (RCGP)

Care Quality Commission (CQC)

LloydsPharmacy™ Online Doctor

SH:24

British Association for Sexual Health and HIV (BASHH)

Faculty of Sexual and Reproductive Healthcare (FSRH)

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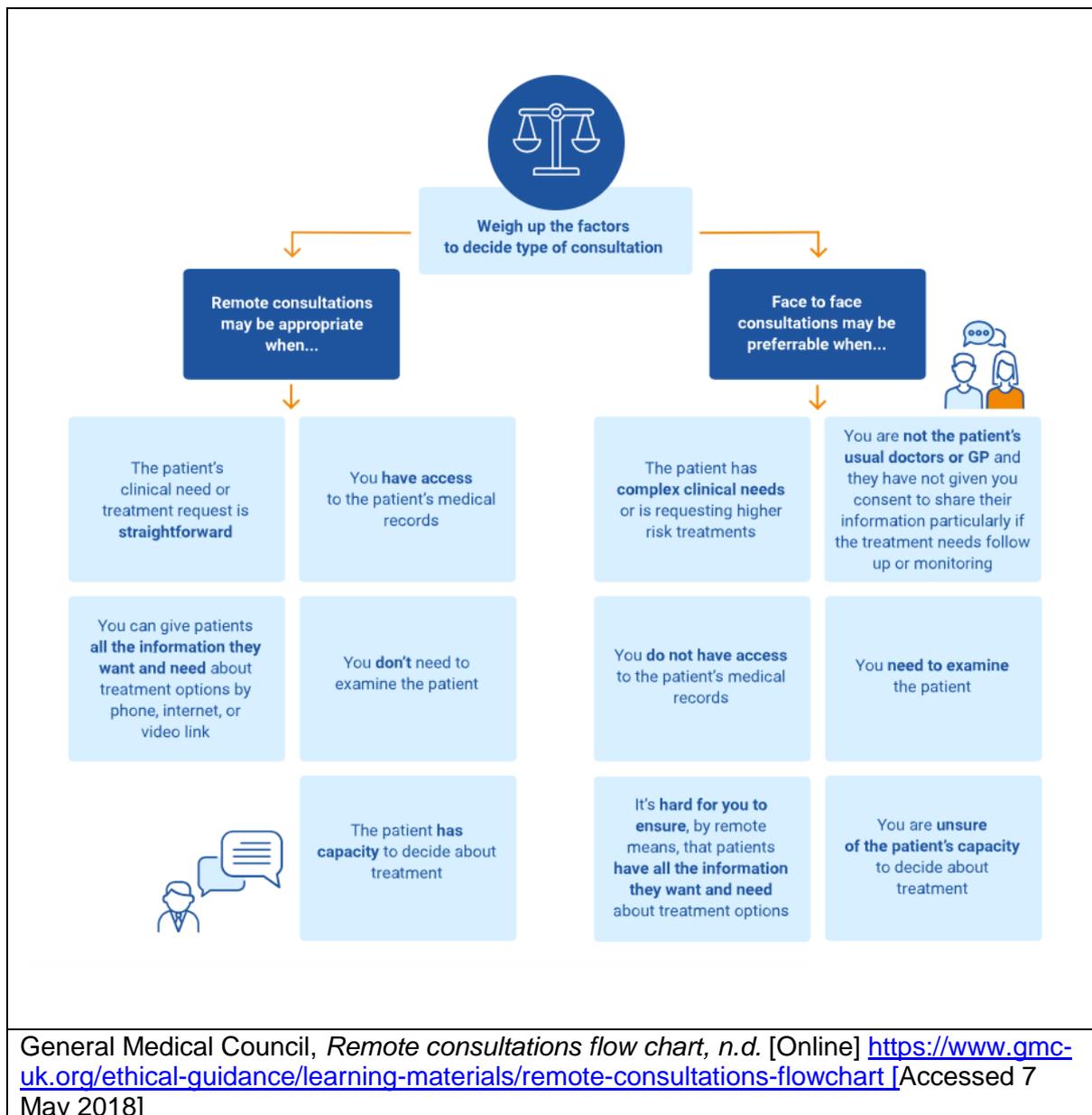
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Standards for Online and Remote providers of Sexual and Reproductive Health Services.

Appendices

Appendices

Appendix 1: Remote consultations flow chart

Weigh up the factors to decide type of consultation

Remote consultations may be appropriate when...

The patient's clinical need or treatment request is **straightforward**

You **have access** to the patient's medical records

You can give patients **all the information they want and need** about treatment options by phone, internet, or video link

You **don't** need to examine the patient

The patient **has capacity** to decide about treatment

Face to face consultations may be preferrable when...

The patient has **complex clinical needs** or is requesting higher risk treatments

You are **not the patient's usual doctors or GP** and they have not given you consent to share their information particularly if the treatment needs follow up or monitoring

You **do not have access** to the patient's medical records

You **need to examine** the patient

It's **hard for you to ensure**, by remote means, that patients **have all the information they want and need** about treatment options

You are **unsure of the patient's capacity** to decide about treatment

General Medical Council, *Remote consultations flow chart, n.d.* [Online] https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-consultations-flowchart [Accessed 7 May 2018]

Standards for Online and Remote providers of Sexual and
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Appendix 2: Spotting the Signs. A national proforma for identifying risk of child sexual exploitation in sexual health services

SPOTTING THE SIGNS: CHILD SEXUAL EXPLOITATION

Visit number:

Confidentiality discussed and understood:

Age:	Gender:	Ethnicity:

Education

Do you attend school/ education other than school/pupil referral unit/ college/training/ employment?	Do you attend regularly?	Do you enjoy it?	Is there anyone there who you can talk to?

Family Relationships

Who do you live with?	How are things at home?	Do you feel like you can talk to someone at home about sex and relationships?	Young carer: Looked after child: Homeless: Runaway: Family bereavement: Learning or physical disability:

Are you involved with any other agencies or professionals such as social workers or mental health services?

If so, would you be happy for us to contact them if we feel we need to?

Friendships

Do you have friends your own age who you can talk to?	Do your friends like and know the person you have sex with (if you are involved with or having sex with anyone)?

Relationships

Are you having sexual contact with anyone? (If no) When was the last time you did?	(If yes) Are you happy with the person you're going out with/the person you have sex with?	How old is the person you are having sex with?	How many people have you had sexual contact with in the past three months? In the past 12 months?
Where do you spend time together?		Where did you meet the person you have sex with?	

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Consent

Have you ever been made to feel scared or uncomfortable by the person/s you have been having sexual contact with?	Have you ever been made to do something sexual that you didn't want to do, or been intimidated?	Do you feel you could say no to sex?
Has anyone ever given you something like gifts, money, drugs, alcohol or protection for sex?	Where do you have sex?	Who else is or was there when you have sex (or any other form of sexual contact)?

Sexual Health

What contraception do you use?	Do you feel like you can talk to the person you have sex with about using condoms or other forms of contraception?
Have you ever had an STI test?	Have you ever had an STI? If yes, which, and how many times?

Do you ever use drugs and/or alcohol?

Do you often drink or take drugs before having sex?

Do you suffer from feeling down/depression?	Have you ever tried to hurt yourself or self-harm?	Have you ever been involved in sending or receiving messages of a sexual nature? Does anyone have pictures of you of a sexual nature?

Professional analysis

Is there evidence of any of these within their relationship?

Coercion:
Overt aggression (physical or verbal):
Suspicion of sexual exploitation/grooming:
Sexual abuse:
Power imbalance:
Other vulnerabilities (please give details):

If you have identified risks or concerns please discuss with your CSE or Safeguarding Lead by _____ (date) and follow your own child protection policy and procedure.

Standards for Online and Remote providers of Sexual and Reproductive Health Services.

Appendices

Any additional information:

Signed:	Printed:		
Fraser Guidelines		**Yes**	**No**
The young person understands the health professional's advice.			
The young person is aware that the health professional cannot inform his/her parents that he/she is seeking sexual health advice without consent, nor persuade the young person to inform his/her parents.			
The young person is very likely to begin having, or continue to have, intercourse with or without contraceptive/sexual health treatment.			
Unless he/she receives contraceptive advice or treatment the young person's physical or mental health, or both, are likely to suffer.			
The young person's best interests require the health professional to give contraceptive advice, treatment, or both without parental consent.			

BASHH charity number: 1148196. Brook charity number: 703015.

BASHH/ Brook, *Spotting the Signs. A national proforma for identifying risk of child sexual exploitation in sexual health services*, April 2014 [Online] https://www.brook.org.uk/our-work/spotting-the-signs-cse-national-proforma [Accessed 25 June 2018]

Appendix 3: Assessment Tools for Capacity

Mental Capacity Act 2005

The Mental Capacity Act 2005 details a two-stage test of capacity:

- Does the person have an impairment, or a disturbance in the functioning, of their mind or brain?

- Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? You should offer all appropriate and practical support to achieve this before applying this stage of the test.

The second stage of the test (or functional test) dictates that the person is unable to make a decision if they cannot:

- Understand the information about the decision to be made.

- Retain that information in their mind.

- Use or weigh –up the information as part of the decision process.

- Communicate their decision.

Mental Capacity Act 2005 (c9). [Online]
https://www.legislation.gov.uk/ukpga/2005/9/contents [Accessed 27 May 2018]

Gillick competency/ Fraser guidelines

Gillick competency and Fraser guidelines refers to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Since then they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgment of the Gillick case in the House of Lords Lord Fraser stated that a doctor could proceed to give advice and treatment:

Provided they are satisfied that:

- The young person will understand the professional's advice.

- The young person cannot be persuaded to inform their parents.

- The young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment.

- Unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer.

- The young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

Gillick v West Norfolk and Wisbech AHA [1986] AC112, [1985] 3 WLR830, [1985] 3 All ER 402, HL [Online] http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm [Accessed 12 January 18]