BASHH

MEDICAL FOUNDATION FOR AIDS & SEXUAL HEALTH

a charity supported by the British Medical Association

Standards for the management of sexually transmitted infections (STIs)

JANUARY 2010

Royal College of Physicians
Setting higher medical standards

RCGP Royal College of General Practitioners

Royal College of Nursing

Health Protection Agency

Faculty of Sexual & Reproductive Healthcare
Royal College of Obstetricians & Gynaecologists

Royal Pharmaceutical Society of Great Britain

SSHA
Society of Sexual Health Advisers

GU NA
GENITO-URINARY NURSES ASSOCIATION

The Department of Health has provided a supporting role in the development of these standards

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.

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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.

The *Sexual Health Services Standards* published by NHS Quality Improvement Scotland in March 2008 have proved an invaluable resource.

The Medical Foundation for AIDS & Sexual Health (MedFASH) and BASHH are particularly grateful to Claire Tyler who drafted these standards and whose energy, dedication and commitment to excellence were pivotal in ensuring their successful development and multi-agency endorsement.

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Foreword

Good sexual health is a vital aspect of health and wellbeing. It has been recognised as a Government public health priority since the publication in 2001 of the first ever national sexual health strategy, *Better prevention, better services, better sexual health. The national strategy for sexual health and HIV.*

Over the years the Government has built on this commitment through *Choosing Health* (2004), which announced new capital and revenue funding to tackle the high rate of sexually transmitted infections (STIs) and modernise sexual health services, and through *High Quality Care for All* (2008), which identified improving sexual health as one of the six key goals for which primary care trusts would commission comprehensive wellbeing and prevention services.

This drive for improvement has achieved notable successes, including a major reduction in waiting times resulting in the offer of an appointment within 48 hours for everyone wishing to be seen at a Genitourinary Medicine (GUM) clinic. The National Chlamydia Screening Programme, by encouraging the provision of screening in different primary and community healthcare settings, has helped increase the range of providers involved in tackling STIs.

Through increased financial investment and support for world class commissioning, the foundations have been laid for better NHS sexual health services. There is now increased patient choice and wider availability of testing and treatment for STIs, and the aim is to put patients at the centre of their care. However, as highlighted in the 2008 review of the sexual health strategy undertaken by MedFASH for the Independent Advisory Group on Sexual Health and HIV, local implementation of the strategy is very variable. Local leadership is required to ensure sexual health is adopted and maintained as a public health priority. So as PCT commissioners act to extend healthcare in the community and to embed quality throughout the NHS, as recommended in *High Quality Care for All* and the new NHS five-year plan, we must ensure sexual healthcare is an integral part of this improvement.

This is why I welcome these new *Standards for the management of sexually transmitted infections (STIs)*, produced by BASHH and MedFASH with the active involvement and endorsement of PCT commissioners and all professional groups involved in providing sexual healthcare.

The standards, designed to complement the Department of Health's forthcoming *Sexual Health Commissioning Framework and Toolkit*, will play a central role in maintaining consistent and high quality care for STIs across the spectrum of providers who manage them, whether in NHS acute, community or primary care settings, or commissioned from the independent or third sectors.

In these times of financial challenge, we need to use NHS resources wisely. By working with providers to implement the standards, commissioners can enable people to receive safe and effective care wherever they seek help for STIs. Not only will this cut out the waste arising from unnecessary referrals or suboptimal treatment, it will also bring enormous public health benefits and save further costs to the NHS by reducing the onward transmission of infection. These standards are a valuable tool for achieving these parallel goals.

Baroness Joyce Gould
Chair, Independent Advisory Group on Sexual Health and HIV

Executive summary

The UK has high rates of sexual ill health. In recent years, commissioners have worked with providers of STI care to improve access to services, and many PCTs now commission a variety of STI services from different providers based on their local needs. These new *Standards for the Management of Sexually Transmitted Infections (STIs)* have been developed with the aim of supporting both sexual health service providers and commissioners in achieving safe high quality services for the management of STIs. They complement the forthcoming *Sexual Health Commissioning Framework and Toolkit* to be published online by the Department of Health (DH).

The standards represent current best practice and are intended for use in all services commissioned by the NHS including those provided by the third and independent sectors. They are also strongly recommended for use in services not commissioned by the NHS. While they are written to be applicable to the NHS 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.

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 bring together and contextualise existing guidance as well as addressing relevant issues raised in *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV* (MedFASH, 2008) and proposals contained in Lord Darzi's final report of the *NHS Next Stage Review* (DH, 2008).

There are nine standards covering both clinical and commissioning issues and providing a framework for monitoring performance. Each one contains recommendations supported by a rationale, outcome-focussed implications for commissioning, key performance indicators, references and a list of further relevant supporting documents and guidance.

Core **Principles of STI care (Standard 1)** should underpin all STI service provision. All services should be 'open-access', ie available through self-referral, and all local health economies should provide people with a choice of where to access care. Needs assessment and service user feedback should inform the location and types of premises used, which should conform to NHS contract requirements. People have the right to confidentiality regardless of where they access STI care. A range of services for the management of STIs at Levels 1, 2 and 3 should be commissioned and available in every local health economy. Treatment for STIs should be in accordance with BASHH Clinical Effectiveness Group guidelines and free of any prescription charge. All services should instigate partner notification as part of STI management.

People at risk of STIs should have their care managed by **Appropriately trained staff (Standard 2)** with agreed mechanisms in place for the assessment of competence supported by assurance frameworks regarding its maintenance. Where possible, training courses at all levels should be multidisciplinary and standardised in content. The clinical leadership role of specialist Genitourinary Medicine (GUM) providers (Level 3) should be explicit and commissioned.

The **Clinical Assessment (Standard 3)** of all people with concerns or symptoms suggestive of an STI, including those who are asymptomatic, should include a risk assessment and appropriate medical and sexual

history. People reporting genital symptoms should be offered a genital examination and the appropriate specimens for microbiological testing should be taken, with facilities for their correct storage and transport in place. The minimum tests that in combination constitute an STI check (screen) are those for chlamydia, gonorrhoea, syphilis and HIV. The service taking the specimens is responsible for ensuring service users get their results and a method of contact should be agreed. All people tested for STIs should be informed which infections they have been tested for.

Diagnostics (Standard 4) should where possible use 'gold standard' tests, validated for the specimen type taken. On-site microscopy should be available in all specialist Level 3 GUM services. Near patient and point of care tests (POCT) should only be used for screening and when validation data are available. Confirmation of a reactive POCT by an established laboratory test is mandatory. Laboratories must be appropriately accredited and comply with international standards. Clinicians should receive laboratory reports within seven working days of specimen-taking, so laboratory turnaround times for testing and reporting should be no more than five working days unless supplementary testing or referral to the reference laboratory is necessary. 24-hour access to HIV screening assays should be ensured in every local area. Electronic requesting and reporting should be encouraged to minimise turnaround times. Expert advice on the management of clinical care arising from the test result must only be given by a medically qualified microbiologist or a clinical scientist.

The **Clinical Management (Standard 5)** of people with STIs should avoid syndromic management (treatment without tests), but empirical treatment (at the time of consultation before test results are available) is appropriate. All healthcare professionals interpreting results should be competent to do so. People having STI tests should receive their results, negative and positive, in a timely manner. People diagnosed with an STI should receive treatment according to current BASHH Clinical Effectiveness Group guidelines free of prescription charge and be offered a choice of partner notification by patient referral or provider referral. Partner notification outcomes should be monitored against national standards. Everyone accessing a service for STI testing should receive health advice and information in a sensitive and non-judgemental way, and one-to-one interventions to support behaviour change should be available in all health economies.

Systems to manage all **Information Governance (Standard 6)** requirements must be in place. Information about people attending services, and their sexual contacts, should be recorded in compliance with NHS information standards and held securely in accordance with national requirements. Any organisation collecting such information must be registered with the Information Commissioner's Office (ICO). Providers and commissioners should comply with national sexual health data reporting requirements. Transmission of datasets to third parties must comply with guidance on the use and sharing of patient information, with security measures in place to avoid unauthorised access. All people using services should have access to information about how their data will be used and the safeguards in place.

All services managing STIs should ensure that they have **Links to other services (Standard 7)** including formal links with the local (Level 3) specialist GUM service. Health economies should establish clear clinical care pathways between services, which are explicit, agreed and utilised by all STI providers. Sexual health networks should be developed in every health economy, with a membership inclusive of all sexual healthcare providers plus service users, public health and commissioners. The specialist GUM provider (Level 3) should have an explicit leadership role for the management of STIs within the network.

A framework for **Clinical Governance (Standard 8)** should be developed. The Level 3 specialist GUM service should provide clinical leadership for the management of STIs within local health economies. However all providers of STI services should have a nominated clinical governance lead with responsibility for overseeing the clinical quality of the service delivered and establishment of robust links with the local

specialist GUM service (Level 3). Information technology should be used to support clinical governance within and across organisations. Every provider of STI services should have a clear framework to support education and training, annually audit elements of clinical practice and have procedures in place to minimise risk to both service users and staff. The development of quality markers for the management of STIs, in the context of broader sexual health quality markers, should be undertaken in all health economies.

Patient and public engagement (Standard 9) should be used to inform service delivery and development. Frameworks to engage with patients should be developed across the local sexual health economy and the public, including non-users of STI services, should always be consulted when any major redesign or development is planned. Patient-reported outcome measures should be developed to capture both clinical outcomes and patient experience.

Some services and local health economies may already be meeting all the recommendations in this standards document but for many they will set the quality for future services. Commissioners and providers are likely to need to work closely together to enable effective implementation of the nine standards. This document is not exhaustive and it is intended to review and update it two years after publication.

Introduction

i) This document sets out standards for the management of sexually transmitted infections (STIs). While it is written to be applicable to the NHS commissioning system in England, its clinical recommendations on STI management also apply to Wales and Northern Ireland. NHS Quality Improvement Scotland has already published *Sexual Health Services Standards* for Scotland[1] which have been referred to in the development this document.

ii) The standards are intended for use in all healthcare settings where STIs are managed. Importantly they aim to support sexual health commissioning and complement the Department of Health (DH)'s *Sexual Health Commissioning Framework and Toolkit*[2].

Background

iii) The UK has high rates of sexual ill health. In recent years, commissioners have worked with providers of STI care to improve access to services, and this continues to be a priority in the National Health Service (NHS) Operating Framework. Many primary care trusts (PCTs) now commission a variety of STI services from different providers based on their local needs.

iv) STI services have a strong public health role and there is an increasing awareness that if the high rates of sexual ill health are to be tackled effectively, then this role needs to be a focus for both commissioners and providers of services.

Context

v) As the largest multi-professional organisation within the field of STIs, the British Association for Sexual Health and HIV (BASHH) recognised the challenges faced by both commissioners and service providers and identified the need for the development of standards to ensure consistent and high quality care. The standards should support PCTs in identifying gaps in their current commissioning and facilitate the world class commissioning of services for the management of STIs[3].

Standards development

vi) The Medical Foundation for AIDS & Sexual Health (MedFASH) was commissioned by BASHH to manage development of the standards. In order to support this process two groups were established, both with formal invited membership and agreed terms of reference. Membership of the groups is listed in Appendix A.

vii) The Project Working Group (PWG) comprised nominated members of BASHH, the Royal College of Physicians (RCP), the Royal College of General Practitioners (RCGP), the Faculty of Sexual and Reproductive Healthcare (FSRH), the Royal Pharmaceutical Society of Great Britain (RPSGB), the Health Protection Agency (HPA) and a PCT sexual health commissioner. The PWG's remit was to work closely with MedFASH on the content and development of the standards and provide support in managing the project.

viii) The Project Advisory Group (PAG) was a larger group of key stakeholders including the DH, relevant professional bodies, the HPA, a third sector service provider and an organisation representing potential service users. The PAG's remit was to offer stakeholder opinion on the content of the standards and to provide guidance on external consultation and broader project issues including formal endorsement of the published standards.

ix) The support of both the PWG and PAG was vital in ensuring the delivery of this standards document and its endorsement by key professional organisations.

Scoping and determining the content

x) The PWG worked with MedFASH to determine the appropriate standards for development. The PAG was approached for comment and approval and early consensus was reached. The content of each standard was decided upon with the advice and guidance of both groups.

xi) 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 both clinical and commissioning issues.

xii) The management of chlamydia is included within these standards. Asymptomatic chlamydia is frequently identified through opportunistic testing, and further guidance specifically in relation to this is covered in NCSP core guidance[4].

xiii) The management of sexual assault is mentioned in these standards. However, it should be noted that operational guidelines and standards relating to the management of sexual assault are referenced but not directly covered within this document.

xiv) The standards do not address:

- other aspects of sexual healthcare which are equally important but beyond the scope of this project, such as contraception and reproductive healthcare and other related service issues including child protection

- HIV treatment and care. The British HIV Association (BHIVA) in partnership with BASHH, the British Infection Society (BIS) and the Royal College of Physicians (RCP) published *Standards for HIV Clinical Care* in 2007[5]. The document does, however, recognise the role of STI service providers in the prevention and early detection of HIV infection, hence the inclusion of 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

- where the management of STIs should be delivered. The standards should be applicable regardless of the setting or provider managing STIs

- 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 assessment of cost effectiveness.

Elements of STI management

xv) These standards build on a number of earlier documents, notably *The national strategy for sexual health and HIV*[6], that describe three levels of care for the management of STIs (Levels 1, 2 and 3). The levels in the national strategy were proposed as a guide to indicate the type of services which could be delivered at these levels to assist in the commissioning process. Appendix B proposes an updated list of the elements of STI management which should be included at each of the three levels. This list was produced with stakeholder engagement as part of the development of the standards.

xvi) PCTs may commission providers to deliver elements of care at any of the three levels, based on findings from a local sexual health needs assessment. However all elements of care in all three levels should be commissioned and available within all local health economies.

xvii) Only a service led by a person on the specialist register of the General Medical Council (GMC) for Genitourinary Medicine and offering a comprehensive range of services spanning all three levels, can be defined as being a specialist GUM service (Level 3) for the management of STIs[7]. Specialist GUM services (those led by consultants on the specialist register of the GMC for GUM) should provide clinical leadership, including training, clinical expertise and clinical governance in the management of STIs, within local health economies. (Similarly, clinical leadership for the management of contraceptive care across the local health economy should be provided by services led by consultants in Community Sexual and Reproductive Health (SRH)).

xviii) The revised medical specialist training curriculum for GUM will result in individuals completing training with a certificate of completion of training (CCT) in GUM and competence to provide SRH services at Levels 1 and 2. Similarly, the new medical specialist training curriculum in Community Sexual and Reproductive Health will result in individuals acquiring a CCT in SRH and competence to provide STI services at Levels 1 and 2.

xix) All commissioned services must be able to demonstrate evidence of clinical competence. This could be maintained through participation in a local sexual health network whose governance framework would include the requirement to participate in audit and appropriate continuing professional development (CPD) activities.

xx) This document will not be 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.

It is likely that across the health economy different elements of care will be delivered by a range of staff from different professional backgrounds based on individual competency levels.

Consultation

xxi) Following development of the draft and approval of the PWG and PAG, the standards underwent a period of consultation. They were made available on the MedFASH and BASHH websites and relevant professional organisations, PCT commissioners, sexual health leads from PCTs and strategic health authorities (SHAs), third sector organisations and established service user groups were invited to submit comments. The consultation process lasted for six weeks between late August and early October 2009. All feedback from the consultation was considered by the PWG, and the PAG gave its approval to the final draft incorporating agreed amendments.

The standards

xxii) The standards cover all of the key principles of STI service provision. They bring together and contextualise existing guidance and address relevant issues raised in the recent review of the national strategy for sexual health and HIV[8] as well as the proposals contained in Lord Darzi's final report of the NHS Next Stage Review[9].

xxiii) There are nine standards, each one containing a number of recommendations supported by a rationale which explains why the recommendations are made. This is followed by implications for commissioning, key performance indicators, references and a list of further relevant supporting documents and guidance.

xxiv) Where possible, recommendations in each standard are referenced. Those without a reference represent currently accepted best practice as identified by the PWG. The supporting documents and guidance are all considered to be of current significance regardless of their date of publication.

xxv) The language used throughout the document reflects the suggestions made by consumer forums responding to the consultation. The term 'patient' is only used where it is embedded in nationally recognised phrases.

Application of the standards

xxvi) Since they represent current best practice, the nine standards are intended for use in all services commissioned by the NHS including those in the third and independent sectors. They are also strongly recommended for use in services not commissioned by the NHS.

xxvii) In different areas different service models exist for the delivery of care. Some services may be integrated while others will not be. These standards are meant to apply to all services managing STIs regardless of the model of delivery.

xxviii) Implications for commissioning are identified throughout the document. These implications are outcome-focussed and relevant for commissioners in the development and monitoring of detailed service specifications.

xxix) The aim of the standards is to support both sexual health providers and commissioners in achieving high quality sexual health services for the populations they serve and to provide a framework for monitoring performance.

xxx) Specific outcome measures relating to recommendations contained within each of the nine standards have not been developed as part of this document. However, in monitoring performance, commissioners are urged as a minimum to utilise:

- relevant national targets
- audit outcomes identified in all BASHH Clinical Effectiveness Group national guidelines
- all measurable quality benchmarks identified within this document
- all key performance indicators identified within this document.

Identification of further performance and quality indicators could be supported by local sexual health networks.

Review and updating of the standards

xxxi) To ensure its content remains applicable and up-to-date, it is intended to review and update this document two years after publication.

References

1. NHS Quality Improvement Scotland (2008) *Standards – Sexual Health Services*. Scotland: NHS Quality Improvement Scotland. (Available at www.nhshealthquality.org)

2. Department of Health (forthcoming) *Sexual Health Commissioning Framework and Toolkit*. London: Department of Health. (To be available at www.dh.gov.uk)

3. Department of Health (2007) *World class commissioning: competencies*. London: Department of Health. (Available at www.dh.gov.uk)

4. National Chlamydia Screening Programme guidance. (Available at www.chlamydiascreening.nhs.uk)

5. British HIV Association, Royal College of Physicians, British Association for Sexual Health and HIV and British Infection Society (2007) *Standards for HIV Clinical Care*. London: British HIV Association. (Available at www.bhiva.org)

6. Department of Health (2001) *Better prevention, better services, better sexual health. The national strategy for sexual health and HIV*. London: Department of Health. (Available at www.dh.gov.uk)

7. Statutory Instrument 1995 No. 3208 *The European Medical Specialists Qualifications Order 1995*. London: The Stationery Office. (Available at www.opsi.gov.uk)

8. Medical Foundation for AIDS & Sexual Health, for the Independent Advisory Group on Sexual Health and HIV (2008) *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV*. London: MedFASH. (Available at www.medfash.org.uk)

9. Department of Health (2008) *High quality care for all: NHS Next Stage Review final report*. London: The Stationery Office. (Available at www.dh.gov.uk)

Standards for the management of STIs

STANDARD 1: **Principles of STI care**

STANDARD 2: **Appropriately trained staff**

STANDARD 3: **The clinical assessment**

STANDARD 4: **Diagnostics**

STANDARD 5: **Clinical management**

STANDARD 6: **Information governance**

STANDARD 7: **Links to other services**

STANDARD 8: **Clinical governance**

STANDARD 9: **Patient and public engagement**

STANDARD 1

Principles of STI care

1.1 Recommendations

1.1.1 Access

Services managing STIs should be 'open access', ie available through self-referral, to all people regardless of where they live, in accordance with legislative requirements[1].

People should be offered an appointment, or walk-in, within 48 hours (two working days) of contacting a service of their choice with concerns about an STI[2]. Individuals with urgent problems, either real or perceived, should expect to receive appropriate advice and or management on the same day or at the next clinic session within the local sexual health network. Local care pathways should be in place to facilitate this.

The timing of available services should be appropriate to the needs of the local population and informed by a sexual health needs assessment[3] and by service user experience.

1.1.2 Patient choice

People should be supported in taking responsibility for their own sexual health and provided with accurate information regarding STIs, HIV and locally available services. They should be offered a choice of where to access services[4] and equitable standards of care in whichever setting they choose. If central booking services are in place these should not preclude people from choosing where to access care.

1.1.3 Location and premises

The location of services and the types of premises used to deliver services managing STIs should be informed by findings from a local sexual health needs assessment[3,5] and by service user experience. Premises for all services should conform to either the NHS building regulations for STI services or the NHS contract requirements for premises and consultation areas in pharmacy and general practice[5,6,7].

1.1.4 Elements of STI management at Levels 1, 2 and 3

A range of services for the management of STIs at Levels 1, 2 and 3 should be available in every local health economy[8]. Clear referral pathways should be in place, including those for access to HIV Post-Exposure Prophylaxis (PEP) within the appropriate timescale[9], and for access to sexual assault services.

1.1.5 Confidentiality

People seeking care for a suspected STI have the right to confidentiality in their consultation with a health professional regardless of the location in which they are seen[10,11,12]. Services should provide clear information regarding confidentiality.

1.1.6 Treatment

All treatment should be in accordance with current BASHH Clinical Effectiveness Group national guidelines[13].

People requiring treatment for STIs should receive this free of any prescription charge or, if this is not possible (eg where FP10 prescriptions are used and the service user is not exempt) they should be offered access to another provider if they wish. Medication for the treatment of STIs should ideally be dispensed at the time of diagnosis[11,14,15].

1.1.7 Partner notification

All services should instigate partner notification (PN) as part of the management of STIs[16,17].

1.1.8 Surveillance data

The national standards for collection of STI data must be met. Further guidance relating to information governance is contained in Standard 6.

1.2 Rationale

1.2.1 Access

A key principle of STI management is the 'open access' nature of services which allows people to use the service they choose, regardless of its location or their PCT of residence. STIs remain stigmatised and in order to encourage people at risk of STIs to access care, this open access provision needs to remain.

Open access is also required by legal statute: *National Health Service (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002* stipulate that certain functions are to be exercised for the benefit of all persons present in a PCT area (not just those who are resident), and these include: *…facilities and services for testing for, and preventing the spread of, genito-urinary infections and diseases and for treating and caring for persons with such infections or diseases* (regulation 3(7)(b)(iii)).

48-hour access to a GUM service (within 2 working days) remains a standard within the NHS Operating Framework. It was originally made a target in response to increasing rates of STIs and public health concerns that people were not able to access services quickly enough. Early access to STI testing and, where applicable, treatment breaks the onward chain of transmission. For this reason 48-hour access to STI testing

and treatment should be available regardless of where people access services. If services are unable to offer access within 48 hours then provision will need to be made for individuals to be offered the option of being seen elsewhere within the local sexual health network.

1.2.2 Patient choice

Commissioners need to ensure that people are provided with accurate information about STIs and HIV in all local health economies in order that individuals can be supported in taking responsibility for their own sexual health and wellbeing. In addition both commissioners and providers need to ensure that potential service users are aware of all local clinical services and where these are located so that they can make informed choices about where to access care. If central booking services are in place these should not preclude people choosing where to access care.

In offering people choice in where to access STI testing and treatment, commissioners must ensure there is consistency in the quality of care provided and in the experience of people using different services. There are concerns that not all STI service providers currently commissioned in England are able to offer equitable standards of care. In order to mitigate risk, PCTs must make this a priority.

1.2.3 Location and premises

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 and all local infection control and Health and Safety policies.

1.2.4 Elements of STI management at Levels 1, 2 and 3

In order to better manage the public health implications of STIs, every PCT should offer access within the boundaries of the local health economy to a comprehensive range of STI services offering care at Levels 1, 2 and 3. Appendix B lists project definitions for the elements of care at each of the three levels.

Which services providers should offer, when, and where these should be located will be informed by local sexual health needs assessment. 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 access care.

In addition, in accordance with national guidance, clear pathways for those needing to access HIV PEP and sexual assault services should be in place to ensure timely and appropriate access.

1.2.5 Confidentiality

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. The *NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000* impose on NHS Trusts and PCTs an obligation to secure that information about STIs obtained by their officers, and capable of identifying an individual, should be treated as confidential and not communicated except to a medical practitioner (or someone employed under their direction) for the purposes of treatment or prevention. 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.

1.2.6 Treatment

Current legislation dictates that STI treatment is free 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 services only. 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).

However it should be noted that there are methods of supplying NHS medicines in primary care such as Patient Group Directions (PGDs). These need to be explicitly commissioned, as well as the drugs to be dispensed, in order to allow free treatment. The National Chlamydia Screening Programme 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.

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.

1.2.7 Partner notification

All STI services should be expected to instigate partner notification (PN) as part of the management of STIs. PN is vital in assisting in the control of infection as it offers sexual contacts the opportunity for screening, assessment and treatment and thus can break the chain of transmission. It can also prevent long-term complications of infections, reduce reinfection, offer health education opportunities and encourage behaviour change.

1.2.8 Surveillance data

Due to the public health implications of STIs as communicable diseases, effective monitoring and surveillance are essential. These rely on comprehensive data collection and reporting by services in compliance with national standards and requirements.

1.3 Implications for commissioning

1.3.1 In their commissioning of services all PCTs should be informed by an up-to-date local sexual health needs assessment, including assessment of need in relation to STIs. Identifying health needs, inequalities and gaps in services as well as utilising service user feedback will inform the development of annual operating plans and the commissioning cycle.

1.3.2 Commissioners should be clear about which clinical services (elements of care) are provided by each service provider to ensure comprehensive coverage across the local sexual health economy.

1.3.3 Commissioners should ensure a local communication strategy is implemented that will support current and potential service users to access the appropriate level of service.

1.3.4 Commissioners should assess providers against their ability to deliver elements of STI management at Levels 1, 2 and 3 (Appendix B) and ensure that whole care pathways are seamlessly commissioned.

1.3.5 Service specifications and appropriate contracts for commissioned providers of STI care should be explicit in their expectations in relation to access, type and levels of service commissioned, the location of services, confidentiality, data collection and reporting requirements, partner notification and participation in the local sexual health network for clinical governance.

1.3.6 Commissioners should manage the local health economy and facilitate constructive performance conversations with partners in order to evaluate service delivery against contracts. Key performance indicators should be developed.

1.3.7 Commissioners should give careful consideration to how treatment for people with STIs can be exempt from prescription charges.

1.4 Key performance indicator

1.4.1 Access to STI services: percentage of people offered an appointment, or walk-in, within 48 hours of contacting an STI provider. (Standard: 98%)

1.5 References

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STANDARD 2

Appropriately trained staff

2.1 Recommendations

2.1.1 Competence to deliver services

People at risk of STIs should have their care managed by an appropriately skilled health professional. Individual practitioners are responsible for maintaining their own competence but should be supported in this by their employing organisation.

A variety of healthcare and allied professionals, and other staff, eg youth workers or receptionists, may be involved in elements of sexual healthcare such as health promotion. They too should be trained and competent for their roles.

2.1.2 Assessment

Agreed mechanisms should be in place for the assessment of clinical competence. These should be standardised and common across all professional groups. Those assessing competence should be appropriately trained in assessment of competence.

As the scope of practice extends for individual professions, the assessment in practice should extend in parallel.

2.1.3 Maintaining competence

Services should be able to provide assurance that, professionals delivering care for the management of STIs can demonstrate they are competent and remain competent to do so.

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

All practitioners, regardless of professional discipline, and services should be managed within a robust clinical governance framework that is able to demonstrate maintenance of national and local standards as well as clinical competence.

2.1.4 Clinical leadership

The leadership role of specialist GUM providers (Level 3) in supporting the education, training and ongoing clinical governance arrangements for all providers of STI care across their PCTs should be both explicit and commissioned[1].

2.1.5 Training

Training courses for the development of skills and competence to deliver STI services at all levels should be multidisciplinary and standardised in content across the professions where appropriate.

2.2 Rationale

2.2.1 Competence to deliver services

A range of healthcare professionals with varying levels of knowledge and a mix of skills deliver services relating to the management of STIs. Not all competencies for STI management are appropriate for all disciplines. Competencies should be relevant to the service that is being commissioned and individuals should work within the scope of their own competence. However the standards needed to achieve competence should be the same regardless of professional group.

Competence may be defined as:

- the knowledge, skills, abilities and behaviours that a practitioner needs in order to perform their work to a professional standard.

Knowledge is:

- the facts and information which underpin (medical conditions)

and a skill:

- an ability which has been acquired by training and/or experience[2].

There are often differences between professional groups in the way competence is assessed. 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).

2.2.2 Training and assessment

Currently the different disciplines are trained in relation to STI management in different ways. Standardisation of content and quality of education provision are 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. Appendix C brings together 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 C will aid individuals and organisations in determining which courses most appropriately meet their needs.

Particular challenges unique to the different professional groups include:

Doctors. Competency frameworks have been developed by many of the professional organisations supporting medical staff in different specialties such as general practice, sexual and reproductive health and GUM.

Nurses. Many universities offer courses which lead to university credits but there is not a nationally recognised and accredited training course for the management of STIs. Increasingly nurses are independently managing STIs and, in order to ensure provision which is safe and of consistent quality, this needs to be urgently addressed. In 2004 the Royal College of Nursing (RCN), in partnership with BASHH, the Faculty of Sexual and Reproductive Healthcare (FSRH) and the DH, published role-based sexual health competencies in an integrated career and competency framework for sexual and reproductive health nursing. Competencies could be assessed in accordance with this document which was updated in 2009.

Healthcare support workers/assistants. Increasingly healthcare support workers or assistants are being trained to support healthcare professionals and service users in STI management. Role competencies are usually developed by individual services and have not been allied to any national qualifications such as National Vocational Qualifications (NVQs).

Sexual health advisers. Sexual health advisers are a trained professional group, usually with a background in nursing, counselling or social work. Although there is no core qualification for health advising, role competencies are usually adequately developed by individual clinics with a focus on public health outcomes. Work is underway supported by the DH and Society of Sexual Health Advisers (SSHA) to look at regulation and training in the field of health advising. Currently, sexual health advisers are not on the DH list of approved professions authorised to manage patients under PGDs. However, those who are nurse-qualified and have current nursing registration would be eligible to do so.

Pharmacists. Current DH funding for continuing education is tied into the Centre for Pharmacy Postgraduate Education (CPPE) to offer learning programmes for practising pharmacists and pharmacy technicians in England. The centre offers open learning programmes within a sexual health portfolio which have been reviewed by BASHH in line with the DH *Competencies for providing more specialised STI services within primary care*. Additionally PCTs may commission local workshops to meet the needs of their own service criteria. CPPE also offers assessment of knowledge and application of knowledge through online methods, which can support local assessment of skills and attitudes to meet the competency standards. These and other methods of competency-based assessment such as supervised placements with specialist providers should be considered where pharmacists are extending their role in sexual health.

2.2.3 Maintaining competence

All healthcare professionals have a responsibility to maintain their own clinical competence. However there is often a lack of clarity about how organisations are required by commissioners to demonstrate their ongoing competence to manage STIs. Commissioners and providers of services therefore need to work together to ensure that maintenance of competencies forms part of a robust local governance framework which is commissioned and performance monitored.

2.2.4 Clinical leadership

Specialist GUM providers (Level 3) are not always identified by commissioners as having a key role in supporting the delivery of education, training and governance across the range of providers within a sexual health economy. Their expertise should be harnessed and commissioned to support local service development and provide leadership in all education, training and governance matters.

2.3 Implications for commissioning

2.3.1 All services in the sexual health economy that are commissioned to provide STI management should have an appropriate contract that explicitly states requirements in relation to education and training, assessment of competencies, ongoing maintenance of skills and clinical governance arrangements.

2.3.2 All service providers should demonstrate a workforce development and continuity strategy.

2.3.3 Providers of services at Levels 1 and 2 are likely to have education and training needs in relation to STI management. Appropriate education, training and governance structures should be commissioned to meet national standards and reflect local needs. Outcomes of training should meet the local needs and gaps in the workforce development plan and continuity strategy.

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

2.4 Key performance indicator

2.4.1 Competence to deliver services: percentage of staff delivering STI services who have successfully completed competency-based training, according to their scope of practice, and fulfilled relevant update requirements. (Standard: 100%)

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STANDARD 3

The clinical assessment

3.1 Recommendations

3.1.1 Medical and sexual history

All people with concerns about, or symptoms suggestive of, STIs, including those who are asymptomatic, should have a risk assessment for STIs, HIV and other blood-borne viruses[1] and an appropriate medical and sexual history taken[2]. For people with no symptoms a self-completed history pro forma could be used. The history should be taken in a sensitive manner and in a setting which affords privacy. Services should be able meet special communication needs, such as translators or interpreting services, where requested or necessary[3].

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

Staff undertaking care of under-18s should follow local and national guidance on safeguarding children[4]. 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 presentation as a new case, and there should be documentation on whether or not a referral to child protection services is required[5]. All cases under 13 must be discussed with a nominated professional. All under-16s should be assessed for competency according to Fraser guidelines[4,5].

The Mental Capacity Act should be followed for adults (and young people aged 16-17 years) with learning difficulties or where there is impairment of decision-making[6].

3.1.2 Examination and specimen collection

Following a sexual history, people reporting genital symptoms should be offered a genital examination except in specific circumstances (refer to section 3.2.2)[7]. When people who are asymptomatic request an examination, this should also be performed. In all circumstances people should be offered a chaperone and examined in a private and confidential setting where others cannot see or overhear. Sensitivities relating to culture and sexuality should be considered.

Specimens for microbiological testing should be obtained during the examination. Knowledge of the range of tests offered by the local microbiology laboratory is essential before specimens are collected. If services are unable to offer all diagnostic tests, eg herpes culture or polymerase chain reaction (PCR), care pathways should be in place for onward referral of those people in whom they are indicated to a service which can provide them.

The appropriate specimen should be taken and placed in the correct transport container used by the laboratory for the diagnostic test requested. The appropriate specimen can include

invasive (urethral, cervical), non-invasive (urine), self-taken (vulvo-vaginal), extra-genital (rectal or pharyngeal) and blood samples. Which specimens are appropriate will depend on the sexual history, symptoms and signs.

Facilities for the correct 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.

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

Where specimens are likely to be used as 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 guidelines[8].

3.1.3 STI testing

The minimum tests that in combination constitute an STI check (often called an STI screen) are those for chlamydia, gonorrhoea, syphilis and HIV[9].

All services offering STI testing should meet the standard of 100% offer of an HIV test, and the minimum standard of at least 60% uptake by those offered, at a person's first STI screen[1].

All people tested for STIs should be informed which infections they have been screened for and know how and when they will receive their results.

3.2 Rationale

3.2.1 Medical and sexual history

Genital symptoms are often non-specific and localising the site of any infection is often difficult so a risk assessment should be made for STIs, HIV and other blood-borne viruses and an appropriate medical and sexual history should be taken for all people presenting with genital symptoms.

Many STIs are asymptomatic. Moreover many people may not recognise symptoms which could be suggestive of an underlying STI.

To avoid failing to identify child protection or other issues of risk or vulnerability, all commissioners and providers need to ensure that local and national guidance on safeguarding children and the Mental Capacity Act are followed, and that all staff are appropriately trained.

3.2.2 Examination and specimen collection

It should be normal clinical practice for people with genital symptoms to be examined, as should those who are asymptomatic and requesting examination. The reluctance to perform an examination may come from

the healthcare provider rather than the service user. However, with a symptom such as a change in vaginal discharge (where the most frequent causes 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. 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. If such treatment is given and the symptoms do not resolve, or if they recur, examination should be performed.

Syndromic management of STIs is the prescribing of antimicrobial regimens chosen to cover the major pathogens responsible for a syndrome without taking appropriate swabs for laboratory investigation. With the exception of the syndromic management of vaginal discharge described above, microbiological tests should be performed before any treatment is given. Syndromic management is covered in full in Standard 5.

Where the results of microbiological tests are likely to be used as admissible evidence in court, a 'chain of evidence' process should be used. 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. Failure to comply with the 'chain of evidence' process could jeopardise the ability to prosecute.

3.2.3 STI testing

There should be consistency in which tests are performed in people requesting testing for STIs irrespective of the service they are accessing. The recommended tests are shown in Appendix D. The minimum tests should be for chlamydia, gonorrhoea, syphilis and HIV. HIV is now a treatable medical condition and the majority of those living with the virus remain well on treatment. Despite this, a significant number of people in the UK are unaware of their HIV infection and remain at risk to their own health and of transmitting the infection. All people requesting a sexual health check (screen) 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[10]. Chlamydia and gonorrhoea are the two most common bacterial sexually transmitted infections in the UK, which if untreated can lead to pelvic inflammatory disease and infertility in women and epididymitis in men.

This recommendation does not apply to the National Chlamydia Screening Programme (NCSP) in England which has the objective of controlling chlamydia by opportunistic screening of as many sexually active young people as possible. Within this setting there is no evidence base to support widespread unselected testing for gonorrhoea.

3.3 Implications for commissioning

3.3.1 Commissioners should ensure that services commissioned to deliver STI management have clinical space that is appropriate to the needs of people accessing the service and that all clinical rooms afford appropriate levels of privacy.

3.3.2 All services which manage STIs should be commissioned to deliver optimal standards of clinical care and be able to demonstrate adherence to national guidelines for the testing of STIs.

3.3.3 Commissioners should ensure that all providers can supply evidence that policies, training and staff checks for safeguarding children and vulnerable adults are in place and current.

3.3.4 Commissioners must ensure that local care pathways are in place to meet the needs of people needing microbiological specimens using the 'chain of evidence' process.

3.4 Key performance indicators

3.4.1 Sexual history: percentage of individuals accessing services with STI concerns who have a sexual history and STI/HIV risk assessment made by the STI service provider. (Standard: 100%) See BASHH guidelines for sexual history-taking[2].

3.4.2 STI testing: percentage offer and uptake of HIV testing for people having a first STI check (screen). (Standard: offer 100%, uptake by those offered 60%)

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STANDARD 4

Diagnostics

4.1 Recommendations

4.1.1 Diagnostic tests

On-site microscopy should be available in all specialist Level 3 GUM services[1].

Staff performing microscopy should be appropriately trained and undergo regular assessment for quality assurance[2].

Laboratories should use the 'gold standard' test wherever possible and adhere to national standard operating procedures where these are available[3,4].

In the population being tested, any nucleic acid amplification tests (NAAT) for bacterial STIs such as chlamydia and gonorrhoea should give a positive predictive value (PPV) of over 90%. In low prevalence populations it may be necessary to use a supplementary or confirmatory test to achieve an acceptable PPV[5,6].

A gonococcal culture should be performed on anyone with a positive gonorrhoea NAAT result so that susceptibility testing can be performed and resistant strains identified.[7]

The test requested should be validated for the specimen type taken. Tests that are CE-marked and approved for use with genital specimens may be used for other specimens such as self-taken or extra-genital specimens if the test has been validated and the validation files completed[8,9].

For HIV testing, fourth generation assays (combined antibody and antigen detection) are recommended for screening. 24-hour access to HIV screening assays should be ensured in every local area.

Point of care tests (POCT) or near patient tests (NPT) should only be used as screening tests and when validation data are available. Confirmation of a reactive POCT by an established laboratory test is mandatory[10].

CE-marked kits/tests should not be used unless supported by sufficient evidence-based validation data[10,11]

4.1.2 Laboratory standards

The laboratory must be appropriately accredited with a nationally approved accreditation scheme, such as Clinical Pathology Accreditation (UK) Ltd (now part of the United Kingdom Accreditation Service (UKAS)), and be seen to comply with the international standards for medical laboratory accreditation, ISO 15189.

The laboratory should use National Standard Methods where available[12].

The laboratory must participate in an accredited External Quality Assessment Scheme (EQAS) and be able to demonstrate satisfactory performance as defined by the criteria specified by the EQAS organisers.

4.1.3 Turnaround times

The time from specimen-taking to the clinician receiving the report should be seven working days or less and hence 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 received within 14 working days. Electronic requesting and reporting should be encouraged to minimise turnaround times.

4.1.4 Cost/cost effectiveness

The needs of the local population should be balanced against the costs of local service provision.

4.1.5 Reporting test results

Management and reporting of test results, including validating, authorising and relaying a result, must be performed by healthcare professionals (biomedical scientists and clinical scientists) who have a current Health Professional Council (HPC) registration.

Expert advice on the management of clinical care arising from the test result must only be given by a medically qualified microbiologist or a clinical scientist.

Results must never be given by the laboratory direct to the service user (except where arrangements are in place for automatic referral and onward support, such as in the context of the NCSP where automated test results may sometimes be sent from the laboratory to the service user).

4.2 Rationale

4.2.1 Diagnostic tests

Direct microscopy of genital samples is a near patient, rapid method of diagnosis of several genital infections. Microscopy of urethral smears from men with symptoms of dysuria and/or urethral discharge is a sensitive test for the diagnosis of urethritis. It enables immediate differentiation between gonorrhoea (>95% sensitivity)[13] and non-gonococcal urethritis and is the only method of diagnosing non-gonococcal, non-chlamydial urethritis[14]. 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 5) who are at risk of cervicitis and consequent reproductive tract complications[14].

Immediate microscopy of smears from women with symptoms of abnormal discharge can potentially identify gonorrhoea (sensitivity 30-50%), *Trichomonas vaginalis* (TV) (sensitivity 70%), candidiasis (sensitivity 50%) and bacterial vaginosis (BV) (sensitivity >95%). 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)[15]. 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.

It is well recognised that false positive results can occur with nucleic acid amplification tests (NAATs). In areas of low disease prevalence the positive predictive value (PPV) is low even if the test has high sensitivity and specificity. The reporting of a false positive result should be avoided and therefore any positive gonococcal NAAT result should be repeated in the first instance, as is also recommended for *Chlamydia trachomatis*, and confirmed with a supplementary test if the PPV of the single test is under 90%.

In England and Wales, the national Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) has identified continuing high levels of resistance to ciprofloxacin, the previous first-line treatment, and emergence of decreased susceptibility to cefixime and ceftriaxone, the third generation cephalosporins currently recommended for therapy. Antimicrobial susceptibility testing is therefore recommended as necessary both for clinical management and surveillance purposes, and is essential to guide appropriate therapy in order to interrupt transmission of resistant infection. Susceptibility testing for either purpose will require a viable organism and it is essential to retain culture facilities and expertise to enable this testing[7].

Currently, no NAAT is approved for use on extra-genital samples for either *Chlamydia trachomatis* or *Neisseria gonorrhoeae*. It is advisable to obtain validation data[9] particularly when the prevalence of infection in unknown. 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 completed.

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 poor. (One CE-marked point of care test for chlamydia gave more false positive than true positive results[10]).

24-hour availability of HIV testing is needed to support urgent clinical decision-making, such as 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.

4.2.2 Laboratory standards

Clinical Pathology Accreditation (CPA) ensures that laboratories have an adequate quality and audit system in place and is the standard by which UK diagnostic laboratories work. There are regular, rigorous and ongoing inspections to ensure this quality is maintained. A list of accredited laboratories and their current status can be obtained from www.cpa-uk.co.uk.

The National Standard Methods 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 (www.hpa-standardmethods.org.uk).

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 accreditation. It is used to give external quality assessment in laboratory medicine, promote best practice and ensure results of investigations are reliable and comparable.

4.2.3 Turnaround times

The turnaround time for a test result includes the time taken for the specimen to reach the laboratory, for performing and reporting the test and delivery of the result report to the clinician. Attention should be given to all aspects of this process to provide timely results for the service user. This is particularly important with diseases such as STIs, as early treatment reduces the risk of complications and the period of infectiousness. The turnaround time for the test result alone is often dependent on the workload in the laboratory. Evidence should be obtained that the workload is sufficient to ensure regular testing (more than once a week) but not too great to avoid backlog due to insufficient staffing or other resources.

4.2.4 Cost/cost effectiveness

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.

4.2.5 Reporting results

The Health 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.

4.3 Implications for commissioning

4.3.1 All laboratories commissioned to perform STI diagnostic testing should be appropriately accredited and deliver optimal standards of laboratory services. They should have evidence of External Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality Assurance (IQA).

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

4.3.3 Economies of scale may be identified through regional commissioning of services. However, when commissioning laboratory services, consideration should be given to the current and future needs of local sexual health services.

4.3.4 Commissioners must ensure that local care pathways are in place for onward referral for supplementary tests if needed.

4.4 Key performance indicators

4.4.1 Percentage of reports (or preliminary reports – see 4.4.2) which are received by clinicians within seven working days of a specimen being taken. (Standard: 100%)

4.4.2 Where supplementary testing or referral to the reference laboratory is necessary, percentage of preliminary reports issued within seven days and final reports received by clinicians within 14 working days of a specimen being taken. (Standard: 100%)

4.5 References

1. BASHH Clinical Effectiveness Group (2006) *Sexually Transmitted Infections: UK National Screening and Testing Guidelines.* (Available at www.bashh.org/guidelines)

2. BASHH Bacterial Special Interest Group (2008) *Microscopy for Sexually Transmitted Infections. An educational DVD for health care professionals.* (Available to order from www.bashh.org.uk)

3. Health Protection Agency (2008) Chlamydia Infection – Testing by Nucleic Acid Amplification Test (NAATs). National standard method VSOP 37 Issue 2.1. (Available at www.hpa-standardmethods.org.uk/documents/vsop/pdf/vsop37.pdf)

4. Health Protection Agency (2007) *Serological Diagnosis of Syphilis*. National standard method VSOP Issue 1. (Available at www.hpa-standardmethods.org.uk/documents/vsop/pdf/vsop44.pdf)

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8. 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

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12. Health Protection Agency. *National Standard Methods.* (Available at www.hpa-standardmethods.org.uk)

13. BASHH Clinical Effectiveness Group (2005) *National Guideline on the Diagnosis and Treatment of Gonorrohoea in Adults.* (Available at www.bashh.org.uk/guidelines)

14. BASHH Clinical Effectiveness Group (2007, updated 2008) *UK National Guideline on the Management of Non-gonococcal Urethritis.* (Available at www.bashh.org.uk/guidelines)

15. Crowley T, Berry J, Horner PJ et al (1998) Can a laboratory diagnosis of bacterial vaginosis be made from a transported high vaginal swab using anaerobic culture and microscopy of a wet preparation? *Sex Transm Infect* **74**:228

4.6 Further supporting documents and guidance

CPA accredited laboratories. (Available at www.cpa-uk.co.uk)

UK National External Quality Assurance Service (www.ukneqas.org.uk)

Quality Control for Molecular Diagnostics (www.qcmd.org)

Health Professions Council (www.hpc.org.uk)

STANDARD 5

Clinical management

5.1 Recommendations

5.1.1 Syndromic management (treatment without tests)

The syndromic management of STIs (treatment without tests) is sub-optimal clinical care and should not be used unless in exceptional circumstances by a senior clinician. In contrast, empirical treatment at the time of consultation and before laboratory test results are available is appropriate, as is epidemiological treatment of sexual partners of individuals diagnosed with an STI (see 5.1.4). Services should not be commissioned to provide routine syndromic management of STIs[1].

5.1.2 Interpretation of test results

All healthcare professionals interpreting results should be competent to do so.
Following positive results, if services are unable to provide supplementary tests as needed, or if healthcare professionals are not competent to interpret the results of such tests or to provide further testing and clinical management as required, care pathways should be in place for onward referral of people to a service which is able to provide these.

A gonococcal culture should be performed on anyone with a positive gonorrhoea nucleic acid amplification test (NAAT) result so that susceptibility testing can be performed and resistant strains identified[2]. (See also Standard 4.)

5.1.3 Results

People using a service for STI testing should receive their results, both negative and positive, in a timely manner. The period of time between consultation and receipt of results should be as short as possible and ideally no more than 14 working days, taking account of the recommended laboratory turnaround times in standard 4. Technology can support this[3]. A comprehensive failsafe mechanism for checking and acting on positive results needs to be in place.

5.1.4 Treatment

People diagnosed with an STI should receive treatment according to current BASHH Clinical Effectiveness Group national guidelines[4] and free of prescription charge[5,6] (see Standard 1 and note the current constraints described).

People should receive treatment 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.

Epidemiological treatment, ie treatment of the sexual partner(s) of an infected individual prior to confirmation of infection, can be provided after appropriate tests have been offered to identify infection and according to the BASHH Clinical Effectiveness Group national guidelines[4].

5.1.5 Partner notification

People diagnosed with an STI should be offered a choice of partner notification (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)[7].

Details of all PN should be documented in the service user's record and followed up in accordance with current national guidance. PN outcomes should be monitored against national standards[8,9,10]. For both chlamydia and gonorrhoea these are a minimum of 0.4 contacts per index case in large conurbations, or 0.6 contacts elsewhere, within four weeks.

If a provider is unable to fully undertake PN, they should at least instigate it, using appropriate care pathways to ensure that it takes place.

5.1.6 Health promotion

People accessing a service for STI testing should expect to receive health advice and information relevant to their clinical condition and sexual history in a sensitive and non-judgemental way. The use of standard national leaflets is recommended and information should also be available in different languages and in non written formats[11]. Services should be able to offer translators or interpreting services (face-to-face or telephone) where requested or necessary.

Condoms should be available free of charge in all settings providing NHS-funded STI management and their distribution supported by demonstration of correct usage as appropriate.

One-to-one interventions to support behavioural change in line with NICE guidance[12] should be provided in all health economies with appropriate pathways in place to support this.

5.2 Rationale

5.2.1 Syndromic management

Syndromic management of STIs is the prescribing of antimicrobial regimens chosen to cover the major pathogens responsible for a syndrome, eg urethral discharge, genital ulcer disease, without taking appropriate swabs for laboratory investigation. It was developed for resource-poor settings where diagnostic laboratory tests are not available. It is considered sub-optimal care in a country such as the UK with good diagnostic facilities for infections. Such management should only be used in exceptional circumstances by a senior clinician. The syndromic management of uncomplicated vaginal discharge is considered an exception

if the woman is over 25 and assessed as being at low risk for an STI or has never been sexually active (see Standard 3). In contrast, empirical treatment at the time of consultation and before laboratory test results are available is appropriate.

5.2.2 Interpretation of results

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

5.2.3 Results

Provision of results as quickly as possible to service users, whether positive or negative, is important both for effective clinical management of infection and for user satisfaction. While the exact turnaround time possible in different settings will vary, a period of 14 working days from consultation to provision of results represents an aspirational maximum, agreed by consensus in the development of these standards, which should be achievable by all.

There are currently discrepancies across many health economies in the way in which people accessing an STI service receive test results, and particularly in whether those with negative results are actively informed of these. This inequity is not acceptable. All people having chlamydia testing through the NCSP are notified of their test results, positive or negative, and this should be the standard expected of all STI service providers. It is for commissioners and providers to determine which of the various mechanisms for conveying results is most appropriate for their local services.

Furthermore 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 how to manage abnormal or positive results when there is difficulty in contacting people.

5.2.4 Treatment

For public health reasons, treatment regimens should follow current BASHH Clinical Effectiveness Group treatment guidelines. Resistance profiles will be monitored and, in the case of resistance to first-line treatment, laboratories will advise on appropriate regimens.

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

5.2.5 Partner notification

Partner notification is a fundamental part of STI management and an important public health intervention. Ideally all providers of STI services should be able to undertake basic PN. However, if they are unable to, then onward referral as appropriate must take place. National guidance should always be followed to ensure optimal management. The Society of Sexual Health Advisers' manual[7] provides guidance on all aspects of PN.

5.2.6 Health promotion

Health promotion is an often forgotten component of STI management yet it is important in supporting lifestyle change and risk minimisation. For this reason people accessing STI services should receive health promotion interventions appropriate to their sexual history and lifestyle in a format that suits their individual needs.

5.3 Implications for commissioning

5.3.1 Commissioners should not commission services to offer syndromic management of STIs.

5.3.2 Commissioners should ensure that providers of services managing STIs are responsible for the management of results and agree a communication route with the service user.

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

5.3.4 Partner notification should be a core requirement for all services providing treatment for STIs, with pathways in place where this cannot be provided on site.

5.3.5 Consideration should be given to making adherence to NICE guidance on one-to-one interventions a core requirement for services. Commissioners should ensure that this is resourced and that care pathways are in place to support their implementation.

5.4 Key performance indicators

5.4.1 Partner notification: rate of partner notification for chlamydia and gonorrhoea by each STI provider. (Standard: at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks)

5.4.2 Timely provision of test results: period of time from consultation to receipt of results by service user. (Standard: time period regularly monitored by service providers and findings used to set local standard)

5.5 References

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2. Department of Health, Health Protection Agency and BASHH (2009) *Draft Guidance for Gonorrhoea Testing in England and Wales.* (Available at www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1174555864747)

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4. BASHH Clinical Effectiveness Group national guidelines. (Available at www.bashh.org/guidelines)

5. *National Health Service Act 1977*. (Available at www.opsi.gov.uk)

6. National Chlamydia Screening Programme (2008) *The National Chlamydia Screening Programme in England. Core Requirements. Appendix 8: Current legal framework for the supply and administration of medicines used by the NCSP.* (Available at www.chlamydiascreening.nhs.uk/ps/core/docs.html)

7. Society of Sexual Health Advisers (2004) *The Manual for Sexual Health Advisers.* London: SSHA. (Available at www.ssha.info)

8. BASHH Clinical Effectiveness Group (2005) *National Guideline on the Diagnosis and Treatment of Gonorrhoea in Adults.* (Available at www.bashh.org/guidelines)

9. BASHH Clinical Effectiveness Group (2006) 2006 *UK National Guideline for the Management of Genital Tract Infection with Chlamydia trachomatis.* (Available at www.bashh.org/guidelines)

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5.6 Further supporting documents and guidance

Department of Health (2007) *Sexual Health Needs Assessments (SHNA). A 'How to Guide'*. (Available at www.dh.gov.uk)

Department of Health (2006) *10 High Impact Changes For Genitourinary Medicine 48-hour Access.* London: Department of Health. (Available at www.dh.gov.uk)

Medical Foundation for AIDS & Sexual Health (2005) *Recommended standards for sexual health services.* London: MedFASH. (Available at: www.medfash.org.uk)

Medical Foundation for AIDS & Sexual Health, for the Independent Advisory Group on Sexual Health and HIV (2008) *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV.* London: MedFASH. (Available at: www.medfash.org.uk)

Department of Health (2003) *Effective Sexual Health Promotion: a toolkit for Primary Care Trusts and others working in the field of promoting good sexual health and HIV prevention.* London: Department of Health. (Available at www.dh.gov.uk)

National Chlamydia Screening Programme (2009) *Partner Notification for Chlamydia in Community Settings. Recommendations on process and outcome standards in English practice.* Draft for consultation. (Available at www.chlamydiascreening.nhs.uk)

STANDARD 6

Information governance

6.1 Recommendations

6.1.1 Information and confidentiality

Information on people attending services, and information about their sexual contacts, should be held securely and strictly in accordance with Caldicott Guidance[1], the Data Protection Act[2], the NHS Code of Practice[3] and the Department of Health's NHS and Primary Care Trusts (Sexually Transmitted Disease) Directions 2000[4]. Any organisation collecting such information must be registered with the Information Commissioner's Office (ICO). Where information about service users is held electronically it must be held on secure password-protected systems with access restricted. Only anonymised or pseudonymised data may be shared for data reporting and commissioning purposes[5] although there may be exceptions[3,6]. However, non-anonymised data may need to be shared with others involved in clinical case management in accordance with the DH Directions[4].

6.1.2 Collecting and recording information

Information on people attending services should be recorded in compliance with NHS information standards. These have been defined in the NHS Data Model and Dictionary[7] and have been assured by the Information Standards Board for Health and Social Care (ISB HaSC)[8].

6.1.3 Data reporting requirements

Providers and commissioners should comply with national requirements for reporting sexual health data to the DH[9] and/or HPA[10]. In addition, there may also be locally defined reporting requirements.

6.1.4 Data sharing and publication

When transmitting datasets to third parties, eg the PCT, HPA or DH, adequate security measures must be in place to ensure these cannot be accessed by unintended parties.

The use and sharing of patient information must strictly follow Caldicott Guidance[1], the Data Protection Act[2], guidance on publishing sexual health data containing small cell sizes[11], HPA guidance on appropriate use, sharing and publication of sexual health patient data[5], provisions under section 251 of the NHS Act 2006[12], DH Directions[4] and GMC guidance[13].

6.1.5 Information for service users

All people using services should have access to information about how the service, PCT, the

Health Protection Agency (HPA) and DH use their data and the safeguards in place[14].

All service providers should have clear and transparent information available to people using services about how to request access to their own health records.

6.2 Rationale

6.2.1 Information and confidentiality

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. Information on people attending health services is usually collected at registration and subsequently throughout the episode of care to enable clinical management. Sharing of this information for clinical case management may need to occur and should be done in accordance with the provisions of the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000, which specify the restrictions on sharing identifiable patient information relating to the management of STIs (see 1.2.5). However, only anonymised or pseudonymised data should be shared for data reporting or commissioning purposes.

6.2.2 Collecting and recording information

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

6.2.3 Data reporting requirements

There is often also a requirement to report summaries of this information to government or health bodies to inform national audits, plan health services and inform public health action. Data reporting requirements for sexual health services are evolving. The Common Data Set for Sexual Health will collect electronic information from all main providers of sexual health services and is currently being phased in.

The initial phase has covered the rollout of two systems in GUM clinics. The GUM Clinic Access Monthly Monitoring (GUMAMM) introduced in 2006/07 monitors waiting times for people attending GUM services stratified by provider and commissioning PCT, and produces monthly updates which are submitted to the DH. The GUM Clinic Activity Dataset (GUMCAD) introduced in 2008/09 monitors on a quarterly basis all diagnoses made and services provided by GUM clinics, and it includes information on patient risk factors and area of residence. Both GUMAMM and GUMCAD have been approved by ISB HaSC and are mandatory. In addition, the National Chlamydia Screening Programme (NCSP) collects data on chlamydia testing done in services outside GUM clinics. GUMCAD and NCSP data are reported on a quarterly basis to the national team at the HPA, via local chlamydia screening offices in the case of NCSP data.

Subject to successful ISB submission, the next phase likely to commence in 2010 will broaden the scope of data collection to other sexual health service providers, such as sexual and reproductive health (SRH) services, integrated services and enhanced services in general practice. This has two aspects. Firstly,

GUMCAD is currently being piloted by Level 2 sexual health services and, at the time of writing, an application from the HPA to ISB HaSC to broaden its scope to cover these services is in progress. Secondly, the Sexual and Reproductive Health Activity Dataset (SRHAD) which collects information on contraceptive service provision, has recently been piloted by the DH in SRH services and enhanced services in general practice. Eventually, electronic data collection of GUMCAD and SRHAD will be integrated as a single data flow in those services which are required to provide both STI and contraceptive-related data. Current data flows as part of the NCSP will be reviewed in light of these developments to minimise duplication of reporting.

6.2.4 Data sharing and publication

For data reporting, data should be effectively anonymised so that it cannot reasonably be used by the recipient to identify an individual. Pseudonymisation differs in that the original provider of the information may retain a means of identifying individuals, by attaching codes or other unique references. Further details are provided in the NHS Code of Practice on Confidentiality.

Following an Office for National Statistics (ONS) review of health statistics, the HPA Caldicott Group is developing guidance for publishing sexual health data containing small cell sizes (usually counts between 1 and 4). 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. In addition, the HPA has produced a data-sharing policy for sexual health data which provides guidance on sharing patient-level datasets for analysis by healthcare professionals.

6.2.5 Information for service users

It is considered best practice for all providers of services managing STIs to ensure that information is available to service users about how their data will be managed, and to have clear and transparent policies about how they can request access to their health records.

6.3 Implications for commissioning

6.3.1 Commissioners must ensure that all providers of services managing STIs comply with national requirements in relation to the recording, collection, sharing and reporting of data.

6.3.2 Clear understanding of the core requirements for national data reporting will support commissioners in the development of a minimum data set and any supplementary local data recording requirements.

6.3.3 Commissioners need to ensure that all providers of services managing STIs can securely transmit datasets to relevant third parties and are able to provide adequate security measures to protect the anonymity of service users and comply with Data Protection and Caldicott requirements.

6.3.4 Commissioners should ensure that all providers of services managing STIs are registered under the Data Protection Act. Providers should have an information governance system in place to assess requests for research and audit data against the Data Protection Act, NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 and local information governance policy.

6.4 Key performance indicator

6.4.1 Data reporting: provision of data by all providers of services managing STIs complies with national and local data reporting requirements.

6.5 References

1. Department of Health, Caldicott Committee (1997) *Report on the Review of Patient-Identifiable Information (The Caldicott Report).* London: Department of Health. (Available at www.dh.gov.uk)

2. *The Data Protection Act 1998.* London: The Stationery Office. (Available at www.opsi.gov.uk)

3. Department of Health (2003) *Confidentiality: NHS Code of Practice.* London: Department of Health. (Available at www.dh.gov.uk)

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7. NHS Data Model and Dictionary Services. *NHS Data Model and Dictionary.* (Available at www.datadictionary.nhs.uk)

8. Information Standards Board for Health and Social Care (www.isb.nhs.uk)

9. Information Standards Board for Health and Social Care (2007) *Notification: 48 Hour Genitourinary Medicine Access Monthly Monitoring (GUMAMM).* DSC Notice: 32/2007. (Available at: www.connectingforhealth.nhs.uk/dscn)

10. Information Standards Board for Health and Social Care (2008) *Genitourinary Medicine Clinic Activity Data Set. Change to an Information Standard.* DSC Notice: 04/2008. (Available at: www.connectingforhealth.nhs.uk/dscn)

11. Office for National Statistics (2008) *Disclosure Review for Health statistics – Consultation on Guidance.* London: ONS. (Available at www.ons.gov.uk/about/consultations/closed-consultations)

12. *The National Health Service Act 2006.* (Available at www.dh.gov.uk)

13. General Medical Council (2009) *Confidentiality.* (Available at www.gmc-uk.org)

14. Health Protection Agency (2009). *Information and the Health Protection Agency.* London: Health Protection Agency. (Available at www.hpa.org.uk/HPA/ProductsServices/InfectiousDiseases/ServicesActivities/1200055707560 or for copies of the leaflet please email publication@hpa.org.uk)

6.6 Further supporting documents and guidance

NHS Connecting for Health *Information Governance*. (Available at www.connectingforhealth.nhs.uk/systemsandservices/infogov)

Information Standards Board for Health and Social Care (2007) *48 Hour Genito Urinary Medicine Access Monthly Monitoring (GUMAMM).* London: NHS. (Available at www.isb.nhs.uk/docs/48-hour-genito)

British Medical Association (2007) *Guidance on secondary uses of patient information*. (Available at www.bma.org.uk)

Information Standards Board for Health and Social Care (2009) *Sexual and Reproductive Health Dataset*. Materials relevant to standard submission for Sexual and Reproductive Health Activity Dataset. (Available at www.isb.nhs.uk/docs/srhealthdataset)

STANDARD 7

Links to other services

7.1 Recommendations

7.1.1 Clinical links

All services managing STIs should ensure that they have formal links with the local specialist GUM service (Level 3) for advice, support and referral[1,2].

7.1.2 Care pathways

All local health economies should establish clear clinical care pathways between services. These should focus on ensuring appropriate clinical management for people accessing services and support healthcare professionals in delivery of high quality care. Care pathways should be explicit, agreed and utilised by all STI service providers[3] both statutory and non-statutory. In addition, all local health economies should establish clear referral pathways with closely allied specialties and other relevant organisations including the local authority.

7.1.3 Sexual health networks

Sexual health networks should be developed in every health economy[1,4]. This will support the above recommendations in relation to clinical links and care pathways. The specialist GUM provider (Level 3) should have an explicit leadership role for the management of STIs within the network.

Greater gain may be achieved by the development of regional or sub regional sexual health networks. Their size and configuration will depend on the arrangement of local health services and on the flow of people accessing these, but it is likely they will encompass large geographical areas incorporating a number of organisations and health economies.

Network development, both local and regional, should be informed by sexual health needs assessment and take account of strengths and gaps in services, existing collaborations, patient referral pathways and service need.

Membership of the network should be reflective of the sexual health economy and inclusive, involving all providers of sexual healthcare – not just providers of STI management – as well as service users, local Health Protection Units (HPUs), NHS public health teams and commissioners. All providers delivering STI services whether statutory or non-statutory, specialist or non-specialist, should be members.

The role and purpose of networks should be defined and include promoting and facilitating equitable service access and provision, sharing quality standards and guidelines, defining care

pathways between organisations, supporting training and clinical governance arrangements across providers and improving local public health. Networks should always be person-centred to meet the needs of service users wherever they access services.

7.2 Rationale

7.2.1 Clinical links

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 care. The role of the specialist GUM provider (Level 3) in supporting other services and providing leadership in STI management is crucial and should provide value at both a local and national level.

7.2.2 Care pathways

It is best practice to have locally agreed clinical care pathways to support the range of STI providers to achieve optimum care outcomes. Care pathways help facilitate seamless care for people accessing STI services for testing or treatment as well as wider sexual health services. People who believe they are at risk of an STI may also be at risk of an unintended pregnancy and vice versa. It is vital that there are clear pathways between relevant services to ensure access to advice and care in a timely way that supports best use of local resources.

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, clinical guidelines and management options. All providers should be aware of, and adhere to, agreed care pathways which should be monitored for effectiveness.

7.2.3 Sexual health networks

Sexual health networks were advocated in the *National Strategy for Sexual Health and HIV*[1], their purpose being to allow providers and commissioners to collaborate in order to provide more comprehensive and equitable local services. Most people's sexual health needs are likely to be wider than the management of STIs and for this reason networks should be as clinically broad and holistic in focus as practicable.

There are a number of different sexual health and HIV networks established around the country, both local and regional, which provide a framework for collaborative working and more integrated delivery of sexual healthcare. The role of commissioners is vital in all of them, though varying in the extent to which networks are commissioner-led.

7.3 Implications for commissioning

7.3.1 Commissioners should consider how to incentivise service providers to ensure close and effective collaborative working and optimise clinical outcomes.

7.3.2 Engagement by commissioners with clinicians is critical in ensuring that contracts and service specifications reflect high standards of clinical governance and services that are safe, effective and personalised. In undertaking this, commissioners must remain aware of potential conflicts of interest.

7.3.3 Commissioners should ensure that care pathways are transparent and integrated across the local sexual health economy.

7.3.4 Commissioners can assist development, management and clinical leadership of networks by identifying specific resources to support them and being explicit about the clinical leadership role for STI management of the specialist Level 3 GUM provider.

7.3.5 Commissioners should manage knowledge of local need and services to inform partner organisations and contribute to robust and ongoing joint strategic needs assessment. These will enhance local intelligence and datasets and inform local area agreements.

7.4 Key performance indicator

7.4.1 Care pathways: evidence of care pathways linking all providers of services which manage STIs with the local Level 3 specialist GUM service.

7.5 References

1. Department of Health (2001) *Better prevention, better services, better sexual health. The national strategy for sexual health HIV.* London: Department of Health. (Available at: www.dh.gov.uk)

2. Department of Health (2006) *10 High Impact Changes For Genitourinary Medicine 48-hour Access.* London: Department of Health. (Available at www.dh.gov.uk)

3. Mercer CH, Sutcliffe L, Johnson AM et al (2007) How much do delayed healthcare seeking, delayed care provision, and diversion from primary care contribute to the transmission of STIs? *Sex Transm Infect* **83**:400-5.

4. Medical Foundation for AIDS & Sexual Health (2005) *Recommended standards for sexual health services.* London: MedFASH. (Available at: www.medfash.org.uk)

7.6 Further supporting documents and guidance

Medical Foundation for AIDS & Sexual Health, for the Independent Advisory Group on Sexual Health and HIV (2008) *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV.* London: MedFASH. Available at: www.medfash.org.uk

Flaherty B, French K, Battison T et al (2006) *Developing sexual health and HIV networks. A practical guide.* MedFASH, unpublished draft.

Department of Health (2007) *Sexual Health Needs Assessments (SHNA). A 'How to Guide'.* (Available at www.dh.gov.uk)

STANDARD 8

Clinical governance

8.1 Recommendations

8.1.1 Clinical leadership

Level 3 specialist GUM services (those led by consultants on the specialist register of the GMC for GUM) should provide clinical leadership, including training, clinical expertise and clinical governance in the management of STIs, within local health economies[1,2,3]. (Similarly, specialist services led by consultants in Community Sexual and Reproductive Health (SRH) should provide such clinical leadership within local health economies for the management of contraceptive care.)

However all providers of services managing STIs should have a nominated clinical governance lead. This post will have responsibility for overseeing the clinical quality of the service delivered and should establish robust links with the local specialist GUM service (Level 3).

Sexual health networks should provide clinical leadership and support a framework for clinical governance across a range of organisations both statutory and non-statutory[4]. (See Standard 7.)

8.1.2 Information technology

Information technology (IT) should be used to support clinical governance within and across organisations. IT infrastructure within local sexual health economies should support both clinical and data reporting requirements. Standard 6 covers information governance.

8.1.3 Teaching and training

Specialist GUM providers (Level 3) should support the delivery of clinical training for the management of STIs. Every provider of STI services should have a clear framework to support education and training that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of ongoing competence. Standard 2 makes a number of recommendations relating to appropriately trained staff.

8.1.4 Audit

Every provider of STI services should, as a minimum, annually audit elements of clinical practice to ensure adherence to current local and national guidelines and evidence-based procedures. Within a clinical network, audit outcomes should be used to evaluate care pathways and monitor the quality of clinical activity[5,6].

8.1.5 Risk management

All providers of STI services should have procedures in place to minimise risk to both service users and staff. All services should be compliant with local and national requirements. Clear mechanisms should be in place to report, review and respond formally to all clinical incidents and complaints[7].

8.1.6 Research

Clinical research and development should be fostered and encouraged in all health economies[8].

8.1.7 Public engagement

See Standard 9.

8.1.8 Quality markers

The development of quality markers for the management of STIs, in the context of broader sexual health quality markers, should be undertaken in all health economies[9].

8.2 Rationale

8.2.1 Clinical leadership

High Quality Care for All[9] states that patient safety should be top of the healthcare agenda for the 21st century. Public trust in the NHS is conditional on the NHS's ability to keep patients safe.

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

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.

8.2.2 Information technology

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 (see Standard 6) would support this. Currently, STI providers in most areas are working on different IT systems or, at times, no IT system at all, making data collection and sharing very difficult.

8.2.3 Teaching and training

All people accessing services should have their care managed by an appropriately trained healthcare professional. A variety of allied professionals and other staff, eg youth workers or receptionists, may be involved in elements of sexual healthcare such as health promotion. They too should be trained and competent for their roles.

Teaching and training are central to any governance structure. The role of specialist GUM services (Level 3) in supporting teaching and training is vital, although they do not necessarily have to provide it themselves. See Standard 2.

8.2.4 Audit and research

Audit is an important component of clinical governance. It is a quality improvement process that seeks to improve clinical care and outcomes through systematic review and the implementation of change.

The DH is committed to the pursuit of high quality clinical research through its Research and Development strategy *Best Research for Best*[8]. Research in STI management should therefore be promoted to further knowledge and improve outcomes for people accessing STI services.

8.2.5 Risk management

Managing risk is a growing challenge in an increasingly litigation-conscious healthcare climate. If high quality care is the aspiration shared by all providers of STI services, then robust organisational arrangements for managing risk including critical incidents and complaints should be a priority. Much could be gained from transparency and sharing of incidents and learning within local sexual health networks.

8.2.6 Quality markers

The development of quality markers, including user experience, for STI management is consistent with national guidance on the development of quality measurement frameworks. Such frameworks for healthcare provide an opportunity to set and raise standards, measure, recognise and reward quality, and safeguard patients. The NHS Next Stage Review[9] concluded that, for the NHS, measuring quality should include the following aspects: patient safety, patient experience and effectiveness of care. Quality markers support quality assurance and provide a mechanism to support performance monitoring.

8.3 Implications for commissioning

8.3.1 Commissioners should ensure that requirements for governance and accountability are explicit in all contracts with providers of STI services.

8.3.2 Commissioners should enable an effective integrated governance system that complies with agreed performance levels identified within service specifications. It should also comply with the 24 core standards within the seven domains of the *Standards for Better Health* published by the DH in 2004, which are monitored by the Care Quality Commission.

8.3.3 The role of specialist GUM providers (Level 3) in providing clinical leadership, and governance if required, across the local sexual health economy needs to be explicitly commissioned and form part of the service specification.

8.3.4 Commissioners should ensure that audit requirements relating to STI management are specific in all contracts and that audit activity is monitored. They should require an annual audit report from providers.

8.4 Key performance indicator

8.4.1 Audit: evidence from providers of services managing STIs of their annual participation in a regional or national audit and completion of an annual audit plan. (Standard: all providers of services managing STIs)

8.5 References

1. Department of Health (2001) *Better prevention, better services, better sexual health. The national strategy for sexual health HIV.* London: Department of Health. (Available at www.dh.gov.uk)

2. Statutory Instrument 1995 No. 3208 *The European Medical Specialists Qualifications Order 1995.* London: The Stationery Office. (Available at www.opsi.gov.uk)

3. BMA Central Consultants and Specialists Committee (2008) *The Role of the Consultant, July 2008.* London: British Medical Association. (Available at www.bma.org.uk)

4. Medical Foundation for AIDS & Sexual Health, for the Independent Advisory Group on Sexual Health and HIV (2008) *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV.* London: MedFASH. (Available at www.medfash.org.uk)

5. General Medical Council (2006) *Good Medical Practice.* (Available at www.gmc-uk.org)

6. Department of Health (2005) *Recommended Quality Standards for sexual health training.* London: Department of Health. (Available at www.dh.gov.uk)

7. Department of Health information, legislation and guidance relating to the NHS complaints procedure. (Available at www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/nhscomplaintsprocedure/index.htm)

8. Department of Health (2006) *Best Research for Best Health: A new national health research strategy.* London: Department of Health. (Available at www.dh.gov.uk)

9. Department of Health (2008) *High quality care for all: NHS Next Stage Review final report.* London: The Stationery Office. (Available at www.dh.gov.uk)

8.6 Further supporting documents and guidance

Department of Health information on clinical governance.
(Available at www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114)

Health and Safety Executive information about health and safety. (Available at www.hse.gov.uk)

BASHH Clinical Effectiveness Group Guidelines. (Available at www.bashh.org/guidelines)

RCGP Sex, Drugs and HIV Task Group and BASHH (2006) *Sexually Transmitted Infections in Primary Care.* London: Royal College of General Practitioners. (Available at www.rcgp.org.uk)

FFPRHC & BASHH Guidance (2006) The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. *Journal of Faculty of Family Planning and Reproductive Health Care* **32(1)**:33-42. (Available at www.ffprhc.org.uk)

Department of Health (2004) *Standards for Better Health.* (Available at www.dh.gov.uk)

STANDARD 9

Patient and public engagement

9.1 Recommendations

9.1.1 Patient engagement

People should be consulted about the STI services they wish to attend as well as the one(s) they do attend. Their views and comments should be used to inform service delivery and development as well as access to, and opening times of, services[1]. Frameworks to engage with patients should be developed across the local sexual health economy.

9.1.2 Public engagement

The public, including non-users of STI services, should always be consulted when any major redesign or development is planned. Existing mechanisms in the wider health economy including Local Involvement Networks (LINks) and third sector organisations should be used, as well as any other organisations with close links to the community[1,2].

9.1.3 Patient-reported outcomes

The collection and reporting of patient-reported outcome measures should be developed[3]. The data these capture should include clinical outcomes and patient experience. Metrics could include: access, communication, interaction with professionals, co-ordination, care and respect, privacy and dignity, health information, involvement in health decisions and overall experience.

9.2 Rationale

9.2.1 Patient engagement

There still remains stigma about STIs and achieving engagement with many populations who use services is challenging. Yet consultation with service users provides opportunities to design and develop user-centred services that are responsive to their needs. There has been an increase in the use of mystery shoppers to sample STI services, comments boxes in clinical settings and invitations to service users to participate in strategic focus groups and complete satisfaction questionnaires.

9.2.2 Public engagement

Guidance on undertaking a sexual health needs assessment published by the DH in 2007 highlights the important perspective non-service users and hard to reach populations can provide in the planning and

design of future services. Therefore consultation with non-service users should always be undertaken when any redesign or major service development is planned or to assess why services are not being used by some groups in the population.

9.2.3 Patient-reported outcomes

The development of standard frameworks to engage with service users across the sexual health economy would support consistent data capture in a non-threatening and anonymous way. Patient-reported outcome measures (PROMs) are measures of a patient's health. They 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. From April 2009 the new Standard NHS Contract for Acute Services requires providers to report on PROMs for certain elective healthcare interventions. BASHH is developing tools for reporting PROMs as well as other quality indicator data which will be applicable for use across the whole sexual health economy.

9.3 Implications for commissioning

9.3.1 Commissioners should expect providers to contribute to an STI Patient and Public Engagement strategy for the local sexual health economy. The strategy should include clear feedback mechanisms.

9.3.2 Commissioners and providers should engage with the local population, both users and non-users of services, in the development of their local vision for sexual health, and in the monitoring and evaluation of services managing STIs.

9.3.3 Commissioners should work with the local health economy to develop local quality measurement frameworks for providers of STI services and engage in the development of PROMs, which would provide a consistent approach to measuring and improving the quality of all STI services.

9.4 Key performance indicator

9.4.1 Patient and Public Engagement: evidence from providers of services managing STIs that they have developed and implemented an annual Patient and Public Engagement Plan which includes evidence of service user feedback and the provider's response to this. (Standard: all providers of services managing STIs)

9.5 References

1. Department of Health (2009) *Understanding what matters: A guide to using patient feedback to transform services*. Gateway ref 11707. (Available at www.dh.gov.uk)

2. More information on patient and public engagement.
(Available at www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_293)

3. Department of Health (2008) *Guidance on the routine collection of Patient Reported Outcome Measures (PROMS) for the NHS in England 2009/10.* London: Department of Health. (Available at www.dh.gov.uk)

9.6 Further supporting documents and guidance

Department of Health (2001) *Better prevention, better services, better sexual health. The national strategy for sexual health HIV.* London: Department of Health. (Available at: www.dh.gov.uk)

Department of Health (2006) *Our health, our care, our say: a new direction for community services.* London: Department of Health. (Available at www.dh.gov.uk)

Department of Health (2007) *Sexual Health Needs Assessments (SHNA). A 'How to Guide'.*
(Available at www.dh.gov.uk)

Department of Health (2008) *High quality care for all: NHS Next Stage Review final report.* London: The Stationery Office.
(Available at www.dh.gov.uk)

Department of Health (2008) *Standard NHS Contract for Acute Services.* London: Department of Health.
(Available at www.dh.gov.uk)

APPENDIX A

Membership of the project groups

Project Working Group

NAME	DESIGNATION	ORGANISATION
Dr Immy Ahmed-Jushuf	President, and Project Clinical Lead	BASHH
Ruth Lowbury	Chief Executive	MedFASH
Claire Tyler	Project Consultant	MedFASH
Dr Raj Patel	GUM Physician	RCP Joint Specialty Committee
Dr Angela Robinson	GUM Physician	BASHH
Dr Janet Wilson	GUM Physician	BASHH
Dr Claudia Estcourt	Reader in Sexual Health & HIV	BASHH
Jane Bickford	GUM Nurse	BASHH
Ceri Evans	Sexual Health Adviser	BASHH
Dr Gwenda Hughes	Head of STI Section	HPA
Dr James McVicker	Faculty Council Member	FSRH
Dr Neil Lazaro	GUM Physician	RCGP SDHIV Group
Dr Kate Shardlow	GP	RCGP
Beth Taylor	Representative	RPSGB
Lynn Wilson	Sexual Health Commissioner	Durham PCT, seconded to the DH

Project Advisory Group

ORGANISATION	DESIGNATION	NAME
	Chair of Project Advisory Group	Prof Michael Adler CBE
British Association for Sexual Health and HIV (BASHH)	President, and Project Clinical Lead	Dr Immy Ahmed-Jushuf
Medical Foundation for AIDS & Sexual Health (MedFASH)	Chief Executive	Ruth Lowbury
MedFASH	Project Consultant	Claire Tyler
BASHH	Vice President	Dr Keith Radcliffe
BASHH	Representative, Clinical Governance Committee	Dr Elizabeth Carlin
BASHH	Branch Chair, Wales	Dr Olwen Williams
BASHH	Branch Chair, Northern Ireland	Dr Carol Emerson
Royal College of Physicians	Representative	Dr Raj Patel
Royal College of General Practitioners	Representative	Dr Ewen Stewart
Faculty of Sexual and Reproductive Healthcare	President	Dr Christine Robinson
Department of Health (DH)	Programme Manager, Sexual Health & HIV, Health Improvement Directorate	Andrea Duncan
DH	Deputy Head, Sexual Health and Response to Sexual Violence National Support Team	Steve Penfold
Terrence Higgins Trust	Deputy Chief Executive	Paul Ward
London Sexual Health Programme	Director	Hong Tan
English HIV and Sexual Health Commissioners Group	Chair	Rosie Gagnon
National Chlamydia Screening Programme	Director	Dr Mary Macintosh
Genito-Urinary Nurses Association	Education Officer	Margaret Bannerman
Society of Sexual Health Advisers	President	Jamie Hardie
National Association of Nurses for Contraception and Sexual Health	Chairwoman	Linda Hayes
Royal College of Nursing	Chair, Sexual Health Forum	Jacky Rogers
National Union of Students	Vice President (Welfare)	Ama Uzowuru, replaced by Ben Whittaker
Royal Pharmaceutical Society of Great Britain	President	Steve Churton
Health Protection Agency (HPA)	Head of STI Section	Dr Gwenda Hughes
HPA	Director, Sexually Transmitted Bacteria Reference Laboratory	Professor Cathy Ison
BASHH	Branch Chair, Scotland (remote member)	Dr Gordon McKenna

APPENDIX B

Project definitions for elements of STI management at Levels 1, 2 and 3

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) defined in the *National strategy for sexual health and HIV,* published by the DH in 2001, and have been updated by this project to take account of modern service provision in 2009. 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 elements of care listed below are not to be considered as minimum requirements, but rather as maximum specifications, for each service level. 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 7. Clinical guidance on STI management relevant to the elements of care listed below can be found at www.bashh.org.uk. See also Appendix D.

Level 1

Sexual history-taking and risk assessment
including assessment of need for emergency contraception and HIV post-exposure prophylaxis following sexual exposure (PEPSE)

Signposting to appropriate sexual health services

Chlamydia screening
Opportunistic screening for genital chlamydia in asymptomatic males and females under the age of 25

Asymptomatic STI screening and treatment of asymptomatic infections (except treatment for syphilis) in men (excluding MSM)* and women

Partner notification of STIs or onward referral for partner notification

HIV testing
including appropriate pre-test discussion and giving results

Point of care HIV testing
Rapid result HIV testing using a validated test (with confirmation of positive results or referral for confirmation)

Screening and vaccination for hepatitis B
Appropriate screening and vaccination for hepatitis B in at-risk groups

Sexual health promotion
Provision of verbal and written sexual health promotion information

Condom distribution
Provision of condoms for safer sex

Psychosexual problems
Assessment and referral for psychosexual problems

Level 2

Incorporates Level 1 plus:

STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)* and women excluding:

- 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

Level 3

Incorporates Levels 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, with or without symptoms

STIs in pregnant women

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)***
both sexual and occupational

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 care at Level 3 as the majority of infections in this group are in the rectum and/or pharynx rather than the urethra (with prevalence in a GUM clinic sample found to be 20% vs 7% respectively for gonorrhoea, and 10% vs 5% for chlamydia)[1]. Therefore, adequate testing requires access to NAATs, and gonorrhoea cultures, from extra-genital sites. No NAATs are approved for use on extra-genital samples, so these should only be used in liaison with the local microbiologists and culture is often not feasible in Level 2 services because it requires immediate transport of samples to the laboratory. However, for the management of asymptomatic MSM there may be exceptions in Level 2 services which have the full range of investigations available and the necessary clinical and prevention skills.

** The appropriate management of men with dysuria and/or urethral discharge requires immediate microscopy (see 4.2.1 for rationale). 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.

*** 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.

Reference

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

APPENDIX C

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, that 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	
RCGP *Introductory Certificate in Sexual Health* (online and face-to-face training)	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Certificate on completion
DH/BASHH/RCP *e-Learning for Healthcare: eHIV-STI* (online, anticipated 2009/10)	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Online learning management system records progress
Centre for Postgraduate Pharmacy Education (CPPE) (online)	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 1 Course* (1 day)	Yes	Yes*	No	No	Yes	Yes	Yes	Yes	Certificate on completion
BASHH *STIF 1 Additional Course* (1 day with a menu of modules, eg genital dermatology, partner notification, erectile dysfunction)	Yes	Yes*	No	No	Yes	Yes	Yes	Yes	Certificate on completion
BASHH *STIF 1 Course (alternative providers)* (1 day specifically developed for alternative providers, ie non-healthcare professionals) (in development)	Yes	Yes*	No	No	No	No	No	No	Certificate on completion
BASHH/CPPE *Pharmacy STIF 1 Course* (in development)	Yes	Yes	Planned	Planned	No	No	No	Yes	Certificate on completion
BASHH *STIF 1 Local Enhanced Service Competencies*	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
DH/BASHH/RCP *e-Learning for Healthcare: eHIV-STI* (online, anticipated 2009/10)	Yes	No	Some elements in respect of Levels 1 and 2	No	Yes	Yes	Yes	Yes	Online learning management system records progress
Faculty of Sexual and Reproductive Healthcare (FSRH) *Diploma Course (DipFSRH)*	Yes	Yes	Yes	Yes	Yes	No	No	No	Diploma awarded after full competency assessment for contraceptive provision and Level 1 STI management.**

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	
BASHH *STIF 2 Competencies for delivery of Level 2 STI services* (in development)	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
DH/BASHH/RCP *e-Learning for Healthcare: eHIV-STI* (online, anticipated 2009/10)	Yes	No	Some elements	No	Yes	Yes	Yes	Yes	Online learning management system records progress

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
DH/BASHH/RCP *e-Learning for Healthcare: eHIV-STI* (online, anticipated 2009/10)	Yes	No	Some elements	No	Yes	Yes	Yes	Yes	Online learning management system records progress

* Developed through role play.

** BASHH STIF 1 is highly recommended to complement STI training in DipFSRH.

*** 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 D

Recommended tests for STIs at different levels of service and for different service users

For details of exact specimens and diagnostic methods see:
BASHH Clinical Effectiveness Group (2006) *Sexually Transmitted Infections: UK National Screening and Testing Guidelines*. (Available at www.bashh.org/guidelines)

Level 1 (Asymptomatic screening excluding MSM)

Asymptomatic women and heterosexual men
- Gonorrhoea and chlamydia tests
- Serology for HIV and syphilis

Level 2 (Symptomatic but uncomplicated infections in men and women excluding MSM, men with genital discharge, pregnant women and anyone with genital ulceration other than presumed herpes simplex virus (HSV))

Genital discharge in women*
- Bacterial vaginosis (BV), *Trichomonas vaginalis* (TV) and candida tests
- Gonorrhoea and chlamydia tests
- Rectal samples for gonorrhoea culture ± NAAT and chlamydia test if indicated by sexual history**
- Pharyngeal sample for gonorrhoea culture ± NAAT if indicated by sexual history**
- Serology for HIV and syphilis

Symptoms other than genital discharge in heterosexual men
- Gonorrhoea and chlamydia tests
- Serology for HIV and syphilis

Additional tests for people presenting with genital ulceration presumed to be HSV
- HSV test from ulcer

Level 3 (All MSM and any people with any symptoms)

Genital discharge in women*
- Urethral and endocervical microscopy
- Vaginal smear and wet preparation microscopy
- TV and candida tests
- Gonorrhoea and chlamydia tests
- Rectal samples for gonorrhoea culture ± NAAT and chlamydia test if indicated by sexual history
- Pharyngeal sample for gonorrhoea culture ± NAAT if indicated by sexual history
- Serology for HIV and syphilis

Genital discharge in heterosexual men

- Urethral microscopy
- Gonorrhoea and chlamydia tests
- Serology for HIV and syphilis

Asymptomatic MSM**

- Urine or urethral sample for gonorrhoea and chlamydia tests
- Rectal samples for gonorrhoea culture ± NAAT and chlamydia test if indicated by sexual history**
- Pharyngeal sample for gonorrhoea culture ± NAAT if indicated by sexual history**
- Serology for HIV, syphilis, hepatitis B HBsAg, anti-HBcAb and anti-HBsAb

Genital discharge in MSM

- Urethral microscopy
- Urine or urethral sample for gonorrhoea and chlamydia tests
- Rectal samples for gonorrhoea culture ± NAAT and chlamydia test if indicated by sexual history
- Pharyngeal sample for gonorrhoea culture ± NAAT if indicated by sexual history
- Serology for HIV, syphilis, hepatitis B HBsAg, anti-HBcAb and anti-HBsAb

Symptoms other than genital discharge in MSM

- Urine or urethral sample for gonorrhoea and chlamydia tests
- Rectal samples for gonorrhoea culture ± NAAT and chlamydia test if indicated by sexual history
- Pharyngeal sample for gonorrhoea culture ± NAAT if indicated by sexual history
- Serology for HIV, syphilis, hepatitis B HBsAg, anti-HBcAb and anti-HBsAb

Additional tests for people presenting with genital ulceration

- Ulcer specimen dark ground microscopy
- HSV test from ulcer
- Other specimens for chancroid, donovanosis and Lymphogranuloma venereum (LGV) if indicated by sexual history and/or local symptoms and signs
- Syphilis serology including EIA IgM

* Immediate microscopy of smears from women with symptoms of abnormal discharge can potentially identify gonorrhoea, Trichomonas vaginalis, candidiasis, and bacterial vaginosis (BV). Indeed this is the preferred method of diagnosis for BV. Ideally all women presenting with abnormal vaginal discharge should have this performed, as immediate diagnosis allows administration of the correct treatment at the initial visit, resulting in quicker resolution of symptoms and reducing the need for further follow-up. However, this is usually only available at specialist GUM (Level 3) providers. As the most frequent causes of abnormal vaginal discharge are candidiasis or BV, which are not sexually transmitted infections, treatment for these conditions whilst awaiting the results of microbiology tests sent to the laboratory is appropriate in the absence of immediate microscopy.

** The majority of infections in MSM are in the rectum and/or pharynx rather than the urethra (see Appendix B, first footnote). Therefore adequate testing requires access to NAATs, and gonorrhoea cultures, from extra-genital sites. However, no NAATs are approved for use on extra-genital samples so these should only be used in liaison with the local microbiologists, and culture is often not feasible in Level 2 services because it requires immediate transport of samples to the laboratory. Asymptomatic MSM should therefore normally be tested in specialist GUM (Level 3) services, although there may be exceptions in Level 2 services which have the full range of investigations available and the necessary clinical and prevention skills. This would also apply to any rectal and pharyngeal samples taken from women.

APPENDIX E

Key performance indicators (KPIs)

Each of the nine standards in this document contains one or two key performance indicators (KPIs). These are listed here for ease of reference.

In monitoring performance, commissioners are urged as a minimum to use these KPIs plus:

- relevant national targets
- audit outcomes identified in all BASHH Clinical Effectiveness Group national guidelines
- all measurable quality benchmarks identified within this document.

In addition, identification of further performance and quality indicators could be supported by local sexual health networks.

STANDARD 1 – Principles of STI care

1.4.1 Access to STI services: percentage of people offered an appointment, or walk-in, within 48 hours of contacting an STI provider. (Standard: 98%)

STANDARD 2 – Appropriately trained staff

2.4.1 Competence to deliver services: Percentage of of staff delivering STI services who have successfully completed competency-based training, according to their scope of practice, and fulfilled relevant update requirements. (Standard: 100%)

STANDARD 3 – The clinical assessment

3.4.1 Sexual history: percentage of individuals accessing services with STI concerns who have a sexual history and STI/HIV risk assessment made by the STI service provider. (Standard: 100%) See BASHH guidelines for sexual history-taking[2].

3.4.2 STI testing: percentage offer and uptake of HIV testing for people having a first STI check (screen). (Standard: offer 100%, uptake by those offered 60%)

STANDARD 4 – Diagnostics

4.4.1 Percentage of reports (or preliminary reports – see 4.4.2) which are received by clinicians within seven working days of a specimen being taken. (Standard: 100%)

4.4.2 Where supplementary testing or referral to the reference laboratory is necessary, percentage of preliminary reports issued within seven days and final reports received by clinicians within 14 working days of a specimen being taken. (Standard: 100%)

STANDARD 5 – Clinical management

5.4.1 Partner notification: rate of partner notification for chlamydia and gonorrhoea by each STI provider. (Standard: at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks)

5.4.2 Timely provision of test results: period of time from consultation to receipt of results by service user. (Standard: time period regularly monitored by service providers and findings used to set local standard)

STANDARD 6 – Information governance

6.4.1 Data reporting: provision of data by all service providers complies with national and local data reporting requirements.

STANDARD 7 – Links to other services

7.4.1 Care pathways: evidence of care pathways linking all providers of services which manage STIs with the local Level 3 specialist GUM service.

STANDARD 8 – Clinical governance

8.4.1 Audit: evidence from providers of services managing STIs of their annual participation in a regional or national audit and completion of an annual audit plan. (Standard: all providers of services managing STIs)

STANDARD 9 – Patient and public engagement

9.4.1 Patient and Public Engagement: evidence from providers of services managing STIs that they have developed and implemented an annual Patient and Public Engagement Plan which includes evidence of service user feedback and the provider's response to this. (Standard: all providers of services managing STIs)

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GLOSSARY OF ABBREVIATIONS

BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
BIS	British Infection Society
BV	Bacterial vaginosis
CCT	Certificate of Completion of Training
CPA	Clinical Pathology Accreditation
CPD	Continuing professional development
CPPE	Centre for Pharmacy Postgraduate Education
DH	Department of Health
DSCN	Data Set Change Notice
EQA	External Quality Assessment
EQAS	External Quality Assessment Scheme
FSRH	Faculty of Sexual and Reproductive Healthcare of the RCOG
GMC	General Medical Council
GRASP	Gonococcal Resistance to Antimicrobials Surveillance Programme
GUM	Genitourinary Medicine
GUMAMM	GUM Clinic Access Monthly Monitoring
GUMCAD	GUM Clinic Activity Dataset
GUNA	Genito-Urinary Nurses Association
HIV	Human Immunodeficiency Virus
HPA	Health Protection Agency
HPU	Health Protection Unit
HSV	Herpes simplex virus
ICO	Information Commissioner's Office
IQA	Internal Quality Assurance
IQC	Internal Quality Control
ISB	Information Standards Board
ISB HaSC	Information Standards Board for Health and Social Care
IT	Information Technology
KPI	Key performance indicator
LINks	Local Involvement Networks
LGV	Lymphogranuloma venereum
MedFASH	Medical Foundation for AIDS & Sexual Health
MSM	Men who have sex with men
NAAT	Nucleic acid amplification test
NANCSH	National Association of Nurses for Contraception and Sexual Health
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NPT	Near patient test
NUS	National Union of Students
NVQ	National Vocational Qualification
ONS	Office for National Statistics
PAG	Project Advisory Group
PCR	Polymerase chain reaction
PCT	Primary Care Trust
PEP	Post-exposure prophylaxis

PEPSE	Post-exposure prophylaxis following sexual exposure
PGD	Patient Group Direction
PN	Partner notification
POCT	Point of care test
PPV	Positive predictive value
PROMs	Patient-reported outcome measures
PWG	Project Working Group
RCGP	Royal College of General Practitioners
RCGP SDHIVG	Royal College of General Practitioners Sex, Drugs and HIV Group
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RPSGB	Royal Pharmaceutical Society of Great Britain
SARC	Sexual Assault Referral Centre
SHA	Strategic Health Authority
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*
UKAS	United Kingdom Accreditation Service

The effective management of STIs, as specified in the standards, will improve health outcomes for individuals. But critically, by preventing new infections, it will also play a key role in protecting the broader public health and containing costs to the NHS.

BASHH

MEDICAL FOUNDATION FOR AIDS & SEXUAL HEALTH
a charity supported by the British Medical Association

Standards for the management of sexually transmitted infections (STIs)

People seeking help for sexually transmitted infections (STIs) now have a wider choice of services than ever to meet their needs, in specialist genitourinary medicine (GUM) clinics and a range of community settings. Whichever they choose, they are entitled to the same standards of safe and high quality care.

To support commissioners and providers of such care, these *Standards for the management of sexually transmitted infections (STIs)* bring together for the first time the key elements of best practice in STI management, providing a framework for monitoring performance applicable to all settings. The effective management of STIs, as specified in the standards, will improve health outcomes for individuals. But critically, by preventing new infections, it will also play a key role in protecting the broader public health and containing costs to the NHS.

The standards were developed by MedFASH with and for BASHH, supported by a multi-organisation and multi-professional advisory group. The project was funded by BASHH.

About MedFASH and BASHH

MedFASH is a charity dedicated to the pursuit of excellence in the healthcare of people affected by HIV, sexually transmitted infections and related conditions. 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 healthcare 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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