

BASHH



British Association for Sexual Health and HIV



Standards for the management of sexually transmitted infections (STIs) in outreach services

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BASHH based the outreach standards on the *Standards for the management of sexually transmitted infections (STIs)* produced by BASHH/ MEDFASH originally in 2010 and then updated in 2014. We acknowledge and thank MEDFASH for their role in the development of the format of the original standards and also for their constructive comments.

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British HIV Association

Faculty of Sexual & Reproductive Healthcare

Genito-Urinary Nurses Association

National AIDS Trust

Royal College of Physicians

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Foreword

Over the past decade, diagnoses of many sexually transmitted infections (STIs) have increased considerably. The number of people living with HIV in the UK continues to increase and the number living with undiagnosed HIV remains high.

The impact of STIs is greatest in young heterosexuals under the age of 25 and in men who have sex with men (MSM). In 2014, large increases in STI diagnoses were seen in MSM, including a 46% increase in syphilis and a 32% increase in gonorrhoea.

Timely diagnosis and treatment of STIs are crucial to reduce onward transmission and the risk of developing health issues related to an untreated infection. Health promotion and education remain the cornerstones of STI prevention, through improving risk awareness and encouraging safer sexual behaviour.

Prevention efforts should include ensuring open access to sexual health services and STI screening, and should focus on groups at highest risk. Some of these groups, such as MSM, some black and minority ethnic groups, sex workers and some young people, face stigma and discrimination, which can influence their ability to access services.

Outreach services have an important role to play in the detection and management of STIs, including HIV. Continued high rates of sexual ill health and disparities in the most affected populations have contributed to an increase in the range and scope of outreach services, and the variety of organisations delivering them.

The provision of services operates across a diverse landscape, including healthcare and non-healthcare settings, so it is important to ensure that users receive the same level of care wherever they access services and regardless of who is providing them.

From access and assessment to diagnosis and data-sharing, the new Standards for the management of sexually transmitted infections (STIs) in outreach services provide a comprehensive overview of best practice, derived from the best-available evidence. Increasing access to services is a crucial step in improving sexual health outcomes and reducing inequalities. These new standards provide the first national benchmark to support commissioners and services to make this ambition a reality.



Professor Kevin Fenton
National Director, Health and Wellbeing
Public Health England

Executive summary

The UK continues to face challenges in relation to sexual ill health. Outreach sexual health services usually target populations disproportionately at risk of poor sexual health and not accessing mainstream services. These include men who have sex with men (MSM), some black and minority ethnic groups (BME), sex workers (SW) and some young people (YP).

This document sets out standards for the management of sexually transmitted infections (STIs) in outreach services. It complements the 2014 publication of the *Standards for the management of sexually transmitted infections (STIs)* and is designed to be read, either as a standalone document, if an organisation is only delivering outreach services, or in conjunction with it.

The outreach standards have been developed with the aim of supporting commissioners and providers in achieving high quality outreach services for the populations they serve. Importantly they also specify what the public can expect of the outreach services they access.

The standards represent current best practice and are intended for use in all outreach services commissioned by local authorities, or the NHS, including those provided by the independent and third sector. They are also strongly recommended for use in independent services not commissioned by the public sector. While they are written to be applicable to the commissioning system in England, their clinical recommendations on STI management also apply to Wales and Northern Ireland. NHS Quality Improvement Scotland published Sexual Health Service Standards for Scotland in 2008 but these outreach standards should be considered of relevance.

The nine standards bring together and contextualise existing guidance. They cover all aspects of the management of STIs in outreach settings including access, the diagnosis and treatment of individuals, links to specialist Level 3 GUM providers and the contribution that outreach services can make to broader public health outcomes.

In order to align with the *Standards for the management of sexually transmitted infections (STIs)*¹ each one contains a quality statement, quality measures, quality standards, implications for commissioners, service providers, healthcare professionals and people with needs relating to STIs, supporting information and references.

Standard statements

Standard 1 Access in outreach services

People with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment. Outreach services should be determined by local sexual health needs assessment and consultation with the communities being targeted.

Standard 2 Clinical assessment in outreach services

People with needs relating to STIs should have a medical and sexual history taken which includes questions about sexual behaviour and other risk factors. Those with symptoms should be offered a genital examination. If examination is clinically indicated but not possible in outreach settings, or if tests that are clinically indicated are not available, seamless referral pathways should be in place for swift transfer into appropriate services. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV and should include samples from extra-genital sites

Standard 3 Diagnostics in outreach services

People being tested for STIs should have the most accurate diagnostic test in its class (according to national guidelines) for each infection for which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately. Robust pathways should be in place when STI testing is undertaken in outreach services to ensure timely transit of samples to the laboratory to eliminate any risk of delay in conveying and acting on results.

Standard 4 Clinical management in outreach services

People using an outreach service for STI testing should receive their results, both positive and negative, within 10 working days. Those diagnosed with an infection should receive prompt treatment, and be managed according to BASHH national guidelines, including the delivery of partner notification (PN). If treatment and / or PN are not provided in an outreach service robust pathways should be in place to ensure seamless and timely transfer into an appropriate service for ongoing management.

Standard 5 Information governance in outreach services

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

Standard 6 Clinical governance in outreach services

People should receive their care from high quality services managing STIs that are safe, well managed and accountable regardless of where that service is delivered.

Standard 7 Appropriately trained staff in outreach services

People with needs relating to STIs should have their care, in an outreach service, managed by an appropriately skilled individual.

Standard 8 Links to other services

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

Standard 9 Patient and public engagement

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

Introduction

- i) This document sets out standards for the management of sexually transmitted infections (STIs) in outreach services. It complements the 2014 publication of the *Standards for the management of sexually transmitted infections (STIs)*¹ and is designed to be read either as a standalone document, if an organisation is only delivering outreach services, or in conjunction with it.
- ii) Outreach services are often delivered in partnership between NHS and non NHS organisations utilising the expertise of specialist third sector organisations and Level 3 Genitourinary Medicine (GUM) services. The standards are intended for use in all outreach settings where STIs are managed regardless of provider (NHS and non-NHS) and regardless of whether the outreach service is staffed by healthcare professionals or non-registered healthcare workers. It is however recognised that some of the quality measures may only be auditable in services specifically commissioned to manage STIs, or in partnership with a specialist Level 3 GUM service, or across a sexual health network.

Standards for the management of sexually transmitted infections (STIs) in outreach settings

Background

- iii) These are the first national standards specifically for the management of STIs in outreach services. Since publication of the *Standards for the management of sexually transmitted infections (STIs)*¹ challenges have been recognised, by commissioners and organisations delivering outreach, that have identified the need for specific standards for the delivery of outreach services. These standards are the result which reflect current best practice in STI management and support Department of Health (DH) commissioning guidance.² The outreach standards will aid:
 - local authorities in commissioning and monitoring outreach services to ensure consistently high standards of care regardless of provider.
 - service providers in the delivery of high quality care.
- iv) Outreach services can be defined as community orientated services undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health channels. Hard to reach groups can include men who have sex with men (MSM), some black and minority ethnic groups (BME), sex workers (SW) and some young people (YP). Outreach services can provide vital STI testing and management services; health promotion and prevention messages; and a range of other services to individuals who otherwise may not receive them. Commissioning, providing and working in these services can pose complex challenges and require specialist skills.

- v) In an increasingly cost conscious health system, providing evidence of the effectiveness of services is commonplace. Outreach services are often costly to deliver and accessed by small numbers of people. Their success may therefore need to be measured by other means e.g. STI and HIV diagnoses that may otherwise not have been made. Service monitoring arrangements need to be specific to the services commissioned and take account of the populations targeted.
- vi) 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 providers of outreach services and identified the need for the development of standards to ensure consistent and high quality care. BASHH set standards for STI care while the Faculty of Sexual and Reproductive Health (FSRH) set standards for reproductive healthcare. The FSRH worked with BASHH in development of these standards.

Standards development

- vii) The BASHH Clinical Standards Unit (CSU) established a project group to develop the outreach standards. The group comprised members of the CSU, along with additional individuals co-opted for the purposes of the project.

Consultation

- viii) Following development of the draft outreach standards, and the approval of the CSU, the standards underwent a period of consultation. They were made available on the BASHH website and relevant professional organisations, local authority commissioners, third sector and other organisations, established service user groups and BASHH members were invited to submit comments. The consultation process lasted for three weeks in January 2016. All feedback from the consultation was considered by the project group and informed final revision.

Future updating of the outreach standards

- ix) To ensure that content remains applicable and up-to-date it is intended that this document will be reviewed and updated five years after publication, or sooner if indicated.

The management of STIs in outreach services

Context

- x) Continued high rates of sexual ill health in the UK, and disparities in the populations most affected by STIs, have contributed to an increase in recent years in the range and scope of outreach services commissioned to manage STIs. Alongside this, changes in commissioning policy have increased the range of organisations, both NHS and non-NHS, delivering services.

- xi) These outreach standards should support local authorities in identifying gaps in their current commissioning and facilitate the commissioning of safe, high quality services. They also present a framework that providers or potential providers can use to ensure their services meet the standards required to deliver safe high quality care in outreach settings.

Public health outcomes

- xii) Services commissioned to manage STIs in outreach settings have an important public health role to increase the uptake of STI testing, including HIV testing, in high risk populations.³

The Public Health Outcomes Framework⁴ contains two indicators to measure progress in the effective management of STIs:

- a) Chlamydia detection rate (15-24 year olds)
- b) People presenting with HIV at a late stage of infection.

Elements of STI management

- xiii) The '*Standards for the management of sexually transmitted infections (STIs)*¹ describes three levels of care for the management of STIs – Levels 1 (asymptomatic), 2 (symptomatic) and 3 (complex/specialist). See Appendix B. **All** elements of care in all three levels should be commissioned and available in all local authority areas.
- xiv) The commissioning of outreach services should be based on findings from a local sexual health needs assessment. Outreach services should complement existing sexual health services, which may be integrated, and provide specific elements of care targeted towards hard to reach populations.
- xv) The outreach STI standards are **not** prescriptive regarding who can deliver which elements of care as this will be dependent on:
- the local needs assessment
 - the competence of healthcare professionals and non-registered healthcare workers delivering the service
 - the service being provided
 - the specific contract arrangements

Specialist services (Level 3)

- xvi) When commissioning outreach STI services local authorities should ensure that explicit pathways and links are made with local specialist Level 3 GUM services. These should form part of all contract and monitoring arrangements, as having outreach services that function in isolation from local specialist providers is not in the interests of:
- the organisation providing the service.
 - people accessing the service.
 - public health outcomes.

The outreach standards

- xvii) The format and structure of the outreach standards mirrors that of the *Standards for the management of sexually transmitted infections (STIs)*¹ and is reproduced with the kind agreement of the Medical Foundation for HIV and Sexual Health (MEDFASH).
- xviii) The outreach standards cover all the key principles of STI service provision. They bring together and contextualise existing guidance and are therefore derived from the best available evidence.
- xix) Unless only commissioning or providing outreach services, the outreach standards are designed to be read in conjunction with the *Standards for the management of sexually transmitted infections (STIs)*¹. Content in the *Standards for the management of sexually transmitted infections (STIs)*¹ continues to constitute national best practice guidance and for the large part is not replicated in the outreach standards. Instead the outreach standards focus on issues specific to delivering services managing STIs in outreach settings.
- xx) Representing current best practice, the outreach standards are intended for use in all publicly funded outreach services managing STIs regardless of whether the service is delivered by an NHS or non-NHS or organisation. It is recognised that some of the quality measures may only be auditable in services specifically commissioned to manage STIs or in partnership with a specialist Level 3 GUM service, or across a sexual health network. The outreach standards are also strongly recommended for use in the private healthcare sector.
- xxi) Home STI and HIV sampling and testing services are a recent development in the delivery of outreach. These standards alongside the *Standards for the management of sexually transmitted infections (STIs)*¹ should be utilised in all such publicly funded services.
- xxii) The outreach standards are designed for use in all community settings including: NHS and non NHS premises e.g. clinics, prisons, halls, clubs, buses, public sex venues and anywhere else STI screening is commissioned to take place.

Scope of the outreach standards

- xxiii) The outreach standards cover all aspects of the management of STIs within outreach services including the diagnosis and, where appropriate, treatment of individuals and the broader public health function of infection control. Where services are jointly commissioned e.g. ChemSex services the STI component will be covered by these standards however interventions for drug use fall outside the remit. For some outreach services STI screening will form only a small component of wider services offered. The Standards cover issues for commissioners, service providers, healthcare professionals, non-registered healthcare workers and the public including service users.
- xxiv) The following are outside the scope of the outreach standards:
- a. Other aspects of sexual health care which are equally important but outside the remit of this project, such as contraception and reproductive health. The Faculty of Sexual and Reproductive Health (FSRH) published its own service standards in 2013⁵.
 - b. HIV treatment and care, which is covered by the British HIV Association (BHIVA) *Standards of care for people living with HIV 2013*⁶.
 - c. Mental health and drug and alcohol care.
 - d. Domestic violence and abuse, relevant guidance is available from NICE⁷.
 - e. Female Genital Mutilation (FGM) which is illegal in the UK, relevant guidance is available from the Royal College of Obstetricians (RCOG)⁸.
 - f. Social care.

Structure of each standard

- xxv) In order to achieve greater alignment with the National Institute for Health and Care Excellence (NICE) quality standards⁹ each standard contains:
- A quality statement
 - Quality measures
 - Quality standards
 - Implications for different audiences
 - Supporting information
 - References
- xxvi) The *quality statements* are consistent with those in the *Standards for the management of sexually transmitted infections (STIs)*¹.

- xxvii) The *quality measures* and *quality standards* aim to improve care outcomes and where possible are based on existing national standards (most are the same as those included in the *Standards for the management of sexually transmitted infections (STIs)*¹). They will assist commissioners and providers of outreach services to measure performance against key indicators and thereby benchmark standards of care. Many of these measures can be collected via existing mandatory reporting datasets, proof of compliance with the *Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental Standards*¹⁰ (England only, but framework for assessment of compliance could be useful elsewhere) or established audit templates (see www.bashh.org).
- xxviii) *What the quality statement means for each audience* describes the responsibilities of commissioners, service providers, healthcare professionals, non-registered healthcare workers and the implications for people with needs relating to STIs.
- xxix) The *supporting information* contains important facts, evidence and currently accepted best practice in relation to the quality statement and the implications for different audiences.
- xxx) Supporting *references* for each standard are listed at the end of each standard.

Language

- xxxi) The language used through the document reflects suggestions made by consumer forums responding to consultation for the *Standards for the management of sexually transmitted infections (STIs)*¹.
- xxxii) 'Healthcare professional' is defined as an individual with a registered healthcare qualification e.g. doctor, nurse or pharmacist.
- xxxiii) 'Non-registered healthcare worker' is defined as an individual without a registered healthcare qualification involved in the delivery of healthcare.
- xxxiv) 'People with needs relating to STIs' are defined as those who have needs or concerns about STIs either expressed spontaneously, during the history taking or on a self-completed history-proforma.
- xxxv) When referring to people using STI services the term 'service user' is generally adopted. 'Patient' is used instead where it is embedded in phrases and terminology in everyday use.
- xxxvi) The term 'NHS or non-NHS organisations' refers to providers of services who might be NHS, independent or third sector organisations.

How the outreach standards can be used

xxxvii) As with the NICE quality standards, these outreach standards can be used for a wide range of purposes both locally and nationally. For example:

- a. **commissioners** can use the standards to ensure that safe, high quality, evidence-based outreach services are commissioned through the contracting and / or tendering process.
- b. **service providers** can quickly and easily examine the performance of their service and, where appropriate, highlight areas for improvement. The outreach standards can also be used to enhance partnership working between NHS and non-NHS organisations to ensure consistently high standards of STI care and assist in partnership bids.
- c. **healthcare professionals and non-registered healthcare workers** will be assisted in making decisions about care based on the latest evidence and practice.
- d. **people** accessing outreach services and the **public** can use the standards to find information about the type of services and care they should receive.

xxxviii) The outreach standards should contribute to the outcomes outlined in the following frameworks:

- the public Health Outcomes Framework 2013-2016³
- the NHS Outcomes Framework¹¹
- the Framework for Sexual Health Improvement in England¹²
- the *Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental Standards*⁹

References

1. MEDFASH, BASHH (2014) *Standards for the management of sexually transmitted infections (STIs)*. Available at: <http://www.bashh.org/documents/StandardsforthemangementofSTIs2014FINALWEB.pdf>
2. Department of Health (2013) *Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities*. London: department of Health. available at: <https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities>
3. National Aids Trust (2014) *Commissioning HIV Testing Services in England*. Available at: http://www.nat.org.uk/media/Files/Publications/Nov_2013_Toolkit.pdf

4. Department of Health (2013) Public Health Outcomes Framework 2013-2016. London: Department of Health. Available at: <https://www.gov.uk/government/collections/public-health-outcomes-framework>
5. Faculty of Sexual & Reproductive Healthcare (2013) *Service Standards for sexual and Reproductive Healthcare*. London: Clinical Standards Committee, FSRH, RCOG. Available at: www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf
6. British HIV Association (2013) *Standards of care for people living with HIV 2013*. London: British HIV Association. Available at: <http://www.bhiva.org/documents/Standards-of-care/BHIVASStandardsA4.pdf>
7. National Institute for Health and Clinical Excellence (NICE) (2016) *Domestic violence and abuse*. **Publication expected February 2016**
8. Royal College of Obstetricians (2015) *Female Genital Mutilation and its Management*. Available at: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/>
9. National Institute for Health and Clinical Excellence (NICE) *Quality Standards*. Available at: <https://www.nice.org.uk/standards-and-indicators>
10. Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
11. Department of Health (2014) *NHS Outcomes Framework 2015/6* London: Department of Health. Available at: <https://www.gov.uk/government/collections/public-health-outcomes-framework>
12. Department of Health (2013) *A Framework for Sexual Health Improvement in England*. London: Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

STANDARD 1

ACCESS IN OUTREACH SERVICES

1.1. Quality statement

1.1.1. People with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment. Outreach services should be determined by local sexual health needs assessment and consultation with the communities being targeted.

1.2. Quality measures

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

1.2.2. **two working days may not be possible in a weekly/monthly outreach service but access at core sites should be able to meet two working days.*

1.2.3. The percentage of people with needs relating to STIs contacting a service who are seen or assessed by a healthcare professional, or non-registered healthcare worker, in the core or the outreach service within two working days of first contacting the service.

1.2.4. The outreach service is explicitly linked to a specialist Level 3 GUM service for further management if required. If the Level 3 service is not local, then a referral pathway with the nearest Level 3 GUM service should be agreed and in place.

1.3 Quality standards

1.3.1 Offered an appointment or walk-in in either the core or outreach service: Standard 98%

1.3.2 Seen or assessed by a healthcare professional or non-registered healthcare worker: Standard 80%

1.3.3 Evidence of a referral pathway with a local specialist Level 3 GUM service.

1.4 What the quality statement means for each audience

Responsibilities of commissioners

- 1.4.1 Commissioners should ensure that when commissioning outreach services they are aligned with the local sexual health needs assessment. Service specifications and contracts should be explicit in their expectations in relation to access and the range of services provided including self-managed care. Realistic expectations of start-up timelines should be discussed with providers.
- 1.4.2 Commissioners should ensure that all outreach services are linked with a local specialist Level 3 GUM service for appropriate further management when required.
- 1.4.3 Commissioners should regularly review access data, with outreach service providers, including the utilisation of referral pathways to local specialist Level 3 GUM services.
- 1.4.4 Commissioners should regularly evaluate all outreach initiatives to ensure they remain relevant and able to meet changes in local health intelligence that affect access.

Responsibilities of service providers

- 1.4.5 Where partnership working has been commissioned, service providers should work together to establish realistic timelines for service delivery.
- 1.4.6 Service providers should clearly advertise the opening times and locations of outreach services, along with the range of services that can be accessed in each outreach setting, in places relevant to potential service users.
- 1.4.7 Service providers should ensure that patients are clearly signposted to the nearest STI service at which they could choose to be seen within two working days.
- 1.4.8 Service providers should establish clear referral pathways to other relevant services including local specialist Level 3 GUM services.
- 1.4.9 Service providers should regularly review demand for services in each outreach setting and be prepared to respond to changing health needs. This should include reviewing intelligence on patients turned away, non-targeted / less appropriate attendees and any seasonal or other variation affecting activity.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

- 1.4.10 All healthcare professionals and non-registered healthcare workers in outreach settings should:

- a. clearly inform service users of the range of services that can be accessed in each setting and signpost them to the most appropriate service to meet their needs.
- b. understand and utilise referral pathways when emerging needs are identified and cannot be met within the existing service.

People with needs relating to STIs

1.4.11 Should be made aware of the scope of outreach services.

1.5 Supporting Information

Sexual health needs assessment

- 1.5.1 In order to better manage the public health implications of STIs every local authority should consider commissioning STI outreach services, to improve access, based on information in the local sexual health needs assessment. Services may be commissioned for a number of reasons including providing access in rural or deprived areas and targeting specific populations not accessing mainstream services e.g. MSM, BME, SW and YP.
- 1.5.2 Commissioners may require services to provide opportunities for people to manage their own sexual health either independently or with support from outreach and core services^{1,2}. Publicly funded STI outreach services may therefore be commissioned not only to improve access to information and STI screening for targeted groups, but to also support access to free condoms and lubricant and home STI sampling and testing for HIV. Extending responsibility for self-management to patients is in line with the NHS Constitution (section 3b)³.

Local sexual health economy

- 1.5.3 All outreach STI services, regardless of provider, should form part of a local cohesive sexual health network led by a specialist Level 3 GUM provider. Seamless referral pathways across the local health economy will support outreach services in effectively referring appropriate patients as necessary.

Service monitoring

- 1.5.4 Data sets for monitoring of outreach services should form part of all contractual arrangements in order to ensure that commissioned services are improving access for the group being targeted and demonstrate value for the investment^{1,2}.

1.6 References

1. Department of Health (2013) *Integrated Sexual Health Services: National service specification*. London: Department of Health. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf
2. Department of Health (2013) *Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities*. London: Department of Health. Available at: <https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities>
3. Department of Health (2015) *NHS Constitution*. London: Department of Health.

STANDARD 2

CLINICAL ASSESSMENT IN OUTREACH SERVICES

2.1 Quality statement

People with needs relating to STIs should have a medical and sexual history taken which includes questions about sexual behaviour and other risk factors. Those with symptoms should be offered a genital examination. If examination is clinically indicated but not possible in outreach settings, or if tests that are clinically indicated are not available, seamless referral pathways should be in place for swift transfer into appropriate services. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV and should include samples from extra-genital sites in all MSM and in women if indicated by the sexual history.

2.2 Quality measures

2.2.1 Sexual history taking: The percentage of people accessing services with needs relating to STIs who have a relevant sexual history taken (as defined by BASHH national guidelines for differing symptoms) by the STI service provider or by completing relevant service documentation.

2.2.2 HIV testing:

- a. The percentage of people with needs relating to STIs who are offered an HIV test at first attendance (excluding those already diagnosed HIV positive).
- b. The percentage of people with needs relating to STIs who have a record of having an HIV test at first attendance (excluding those already diagnosed HIV positive).
- c. If the outreach service is targeting high risk MSM, a recommendation for three monthly HIV testing should be made^{2,6}.

2.2.3 Self-assessment against the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 15: Premises and equipment

2.3 Quality standards

2.3.1 Sexual history taking:

- a. Standard: 97%*

2.3.2 HIV testing:

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

2.3.3 Meets the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulations 9, 10, 11, 12, 13 and 15.

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

2.4 What the quality statement means for each audience

Responsibilities of commissioners

- 2.4.1 Commissioners should have a clear rationale, based on sexual health needs assessment and / or local public health data if they wish to commission stand alone testing services e.g. those only offering HIV testing in MSM.
- 2.4.2 Commissioners should ensure that all providers of outreach services commissioned to manage STIs:
 - a. have premises that are fit for purpose. As a minimum there should be privacy for consultations, hand-washing facilities and a suitable space for STI sample collection.
 - b. are able to provide evidence of confidentiality, safeguarding and vulnerable adults policies and the training of staff to support these.

- c. have clear links to local specialist Level 3 GUM services with pathways in place for onward referral for examination, treatment and HIV post-exposure prophylaxis following sexual exposure (PEPSE).

Responsibilities of service providers

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

- a. recording of a medical and sexual history whether self-completed or taken by a healthcare professional or non-registered healthcare worker.
- b. providing interpreting services where requested or required.
- c. identifying people at risk of infection. Incubation periods for STIs should always be considered and indications for re-testing communicated to people.
- d. discussing the window period and limitations of HIV testing (including point of care testing (POCT)), if it is offered.
- e. performing a genital examination if facilities allow, with the offer of a chaperone, or referral for this.
- f. collecting specimens for STI testing including for HIV or offering self-collected pharyngeal, urine, vaginal or rectal sampling with adequate instructions.
- g. safe storage and timely transport of specimens to and from the outreach location.
- h. safe disposal of clinical waste and sharps. An agreement should be in place with the location where the service will be held for who is responsible for the disposal of sharps and waste.
- i. implementing confidentiality, safeguarding and vulnerable adults policies and the training of staff to support these.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

2.4.4 All healthcare professionals and non-registered healthcare workers in outreach settings should be fully competent in:

- a. ideally obtaining a minimum of two methods of contact, with each service user, to allow result giving and recall for repeat testing and / or treatment as indicated. If only one point of contact e.g. a mobile number is obtainable then agreement needs to be reached with the individual about how they will access their results in the event of the service not being able to contact them. Additionally, consent should be sought for GP communication if all other forms of contact are unsuccessful.
- b. managing issues related to confidentiality, safeguarding and vulnerable adults, acting on concerns as appropriate.
- c. explaining to people which STI tests have been taken and how and when the results will be available.
- d. assessing the need for further STI testing and vaccination if appropriate.

People with needs relating to STIs

- 2.4.5** Should be made aware of the elements of care available at the outreach service and understand that they may need to be seen in mainstream services if the outreach service is unable to meet their health needs e.g. if only HIV testing is offered.
- 2.4.6** Should be offered appropriate STI testing and vaccination (if indicated). This may involve having an examination or self-taken swabs or urine test.
- 2.4.7** Should be informed which infections they have been tested for, and how and when they will get their results.
- 2.4.8** Should be advised what will happen if they get a positive result including what will be needed if they have a reactive result in HIV POCT.

2.5 Supporting information

Clinical premises

- 2.5.1** In order to reach the risk groups being targeted for STI testing, outreach providers may deliver services in a variety of different locations. The premises used should not compromise either service user or provider safety. Premises need to offer space and facilities which allow for taking of a safe and appropriate clinical history and STI samples, and meet the needs of the service user. If results are being given in person (on site) care should be taken to maintain privacy and avoid inadvertent disclosure.

Sexual history

- 2.5.2** A sexual history may be taken by a healthcare professional / non-registered healthcare worker or may be a self-completed assessment. The history may be abbreviated if only HIV POCT is offered. Otherwise outreach providers should adhere to BASHH sexual history taking standards². If an outreach service is only providing HIV testing, the minimum required information should include: risk assessment; details of last sexual exposure; timing (to assess for PEPSE); gender of partners; condom use; HIV status of partner (if known); and any other risk exposure in past 3 months.
- 2.5.3** There maybe particular issues around confidentiality for people attending outreach STI testing venues and these might be why the person has chosen not to use mainstream services. It is therefore important that all involved in the process of STI testing understand the importance of confidentiality and their responsibilities in relation to it.
- 2.5.4** All staff working in outreach services should be able to discuss, and assess understanding of, issues including consent and sexual and lifestyle behaviours including drug and alcohol use. In addition staff should be competent in assessing safeguarding, including Fraser Competence, and vulnerability.

Examination

- 2.5.5** If examination is necessary and cannot be carried out at the outreach facility pathways should be in place to seamlessly transfer people into mainstream services. People attending outreach services should be made aware of the limitations of the outreach service and that referral to another service is a possibility dependent on their health needs

Testing

- 2.5.6** The STI tests offered to individuals should be explained clearly, including what they are for, how samples are taken, the limits of each test i.e. window periods and when and how results will be made available. It is the responsibility of the person taking the history / tests to ensure appropriate contact methods are obtained. Ideally two methods of contact should be obtained but in the event that this is not possible an agreed plan should be in place for how the service user will access results in the event they are not contactable (e.g. if mobile phone is lost). If possible consent for GP communication should be obtained for use if all other methods are unsuccessful.
- 2.5.7** If the outreach service is targeting high risk MSM, HIV testing should be offered every three months^{2,4,5,6}. Recording the date of the last HIV test and offer of repeat testing helps to monitor this target.

- 2.5.8** If home sampling or testing kits are distributed, it is the providers' responsibility to ensure that there are clear and comprehensive written instructions on how to use the kit and how to access follow up and support if necessary.
- 2.5.9** If the outreach is targeting MSM, extra genital testing at pharynx, urethra and rectum should always be offered, regardless of sexual history².
- 2.5.10** It is important that outreach providers have mechanisms in place for safe disposal of clinical waste and transportation of samples to the laboratory. Where outreach services are collaboratively delivered (by a range of organisations) roles and responsibilities should be explicit.

2.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
- 2 [BASHH \(2014\) Recommendations for testing sexually transmitted infections in men who sex with men](http://www.bashh.org/documents/BASHHRecommendationsfortestingforSTIsinMSM-FINAL.pdf). Available at: <http://www.bashh.org/documents/BASHHRecommendationsfortestingforSTIsinMSM-FINAL.pdf>
- 3 BASHH (2013) *UK national guidelines for consultations requiring sexual history taking*. Available at: <http://www.bashh.org/documents/SexualHistoryGuidelines2013final.pdf>
- 4 NICE (2011) *Increasing uptake of HIV testing in men who have sex with men*. Available at: <https://www.nice.org.uk/guidance/ph34>
- 5 BHIVA (2008) *UK National Guidelines for HIV testing*. Available at: <http://www.bhiva.org/HIV-testing-guidelines.aspx>
- 6 Public Health England (2014) *HIV in the United Kingdom: 2014 Report*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/401662/2014_PHE_HIV_annual_report_draft_Final_07-01-2015.pdf

STANDARD 3

DIAGNOSTICS IN OUTREACH SERVICES

3.1 Quality statement

People being tested for STIs should have the most accurate diagnostic test in its class (according to national guidelines) for each infection for which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately. Robust pathways should be in place when STI testing is undertaken in outreach services to ensure timely transit of samples to the laboratory to eliminate any risk of delay in conveying and acting on results.

3.2 Quality measures

3.2.1 Diagnostic tests:

The percentage of people who have a reactive HIV POCT and have a confirmatory sample sent to the laboratory.

3.2.2 Laboratory turnaround times:

- a. The percentage of reports (or preliminary reports) issued by the laboratory within five working days of the specimen being received by the laboratory.
- b. The percentage of final reports on supplementary testing, or following referral to the reference laboratory, which are issued by the laboratory within 10 working days of the specimen being received by the laboratory.

3.3 Quality standards

3.3.1 Diagnostic tests: Standard: 100%

3.3.2 Laboratory turnaround time:

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

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

3.4 What the quality statement means for each audience

Responsibilities of commissioners

- 3.4.1 Commissioners should ensure that commissioned laboratories are using the 'gold standard' test wherever possible.
- 3.4.2 HIV POCT should be commissioned for screening purposes only with laboratory confirmation of any reactive POCT result. The HIV POCT used should be 'gold standard' and fit for purpose. Pathways for referral of people with reactive results in outreach settings, to local specialist Level 3 GUM services, should be in place.
- 3.4.3 Commissioning the use of dried blood spot testing (DBST) in outreach services may be especially useful in screening "hard to reach" groups
- 3.4.4 Commissioners should ensure that all providers of outreach services commissioned to manage STIs:
 - a. have systems in place to store and transport diagnostic specimens in a safe and timely manner.
 - b. are enrolled in a suitable External Quality Assurance (EQA) scheme if HIV POCT are undertaken. Performance in such schemes should be monitored.

Responsibilities of service providers

- 3.4.5 All providers of outreach services commissioned to manage STIs should use the 'gold standard' test for the infection they are screening for.
- 3.4.6 All providers of outreach services managing STIs should ensure they have appropriate mechanisms in place for:
 - a. safe collection, storage and transport of diagnostic specimens.
 - b. safe disposal of clinical waste including HIV POCT cartridges.
 - c. monitoring of laboratory turnaround times, including monitoring the time taken for the specimen to be received by the laboratory.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

- 3.4.7 All healthcare professionals and non-registered healthcare workers in outreach settings should be fully competent in:
 - a. the limitations of diagnostic tests used.

- b. the safe handling of diagnostic equipment and diagnostic samples including the disposal of sharps.
- c. correct completion of laboratory documentation.

People with needs relating to STIs

- 3.4.8 Should be made aware of the limitations of any diagnostic test.
- 3.4.9 Should be made aware that HIV POCT may not always be appropriate for them. If this is the case they should be advised of alternative options with recommendations on when and where to test.

3.5 Supporting information

Diagnostic tests

- 3.5.1 Some diagnostic tests are not suitable for outreach settings. *Neisseria gonorrhoea* culture should only be performed where there is rapid transport to the laboratory available and a positive culture should be used in every batch of tests transported to ensure organism viability. This is unlikely to be practicable in outreach services.

HIV point of care testing (POCT)

- 3.5.2 HIV POCT can facilitate early diagnosis leading to effective treatment of an individual and limiting progression of disease. It can also facilitate a reduction in ongoing transmission.
- 3.5.3 Where possible HIV POCT should be a 4th generation test (detecting both HIV 1 and 2 antibody and P24 antigen), however in certain outreach settings a 3rd generation (HIV 1 and 2 antibody only) test may be used either on its own or for example in combination with a syphilis test. Commissioners, service providers, healthcare professionals, non-registered healthcare workers and service users should be aware of the caveats of HIV POCT (that early infections in the “window period” may not be picked up) and may not always be appropriate for every service user¹.
- 3.5.4 Services that use HIV POCT should:
 - involve the local laboratory who can advise on training, interpretation of results, trouble shooting, quality control and health and safety. There should be an identified lead for HIV POCT.
 - be aware of health and safety-handling and disposal of body fluids, sharps and reagents outside a laboratory setting².

- provide training and ensure that all staff receive training and their competence is established (and recorded). Standard Operating Procedures (SOPs) must contain the manufacturer's instructions for use.
- in the case of a reactive result ensure a confirmatory serology sample is taken in the form of a venous sample, if venesection is possible, or finger prick serology sample e.g. DBST or TINIES.
- analyse quality control material to assure the system is working correctly.
- review POCT results, an appropriately qualified healthcare professional should do this with reference to the service user's history.
- keep results, recording the reagent lot numbers and member of staff performing the test.
- audit and report any untoward instances e.g. false positive or false negative result. See Standard 6. False negatives will only be picked up if both reactive and non reactive HIV POCT are backed up with serology testing.

Laboratory standards

3.5.5 Laboratories should be credited with Clinical Pathology Accreditation (CPA) / United Kingdom Accreditation Services (UKAS). Laboratories should also provide evidence of participation in EQA, Internal Quality Assurance (IQA) and Internal Quality Control (IQC)³.

Turnaround times

3.5.6 The turnaround time in this standard is for the time taken in the laboratory. This does not take into account the time taken for a specimen to reach the laboratory. There is no evidence base for laboratory turnaround times; those recommended in this standard are based on expert opinion. Turnaround times will be expedited by the use of electronic laboratory reporting.

3.6 References

- 1 Medicines and Healthcare Products Regulatory Agency (2013) *Management and use of IVD point of care test devices*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/371800/In_vitro_diagnostic_point-of-care_test_devices.pdf
- 2 Health and Safety Executive (2015) *Information about health and safety*. Available at: <https://www.hse.gov.uk>

- 3 Public Health England (2014) *UK Standards for Microbiology Investigations*. Investigation of genital tract and associated specimens. SMIB 28. Available at: <https://www.gov.uk/government/collections/standards-for-microbiology-investigations-smi>

STANDARD 4

CLINICAL MANAGEMENT IN OUTREACH SERVICES

4.1 Quality statement

People using an outreach service for STI testing should receive their results, both positive and negative, within 10 working days. Those diagnosed with an infection should receive prompt treatment, and be managed according to BASHH national guidelines, including the delivery of partner notification (PN). If treatment and / or PN are not provided in an outreach service robust pathways should be in place to ensure seamless and timely transfer into an appropriate service for ongoing management.

4.2 Quality measures

4.2.1 Timely provision of test results:

- a. The percentage of people having STI tests who can access their results (both positive and negative) within ten working days of the date of the sample (excluding those requiring supplementary tests).
- b. The review of people, with a reactive HIV POCT in an outreach service, at an HIV treatment centre of the patient's choice preferably within 48 hours but definitely within 14 days¹.

4.2.2 Clinical management:

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

4.2.3 Partner notification (PN):

- a. The percentage of all contacts of index cases of gonorrhoea who attend a service commissioned to manage STIs within four weeks of the date of first PN discussion.
- b. The percentage of all contacts of index cases of chlamydia who attend a service commissioned to manage STIs within four weeks of the date of first PN discussion.
- c. The percentage of contactable contacts of index cases of HIV who have had an HIV test, as verified by a healthcare professional, within 3 months of first PN discussion².
- d. The percentage with documented evidence of PN discussion at time of HIV diagnosis, including with HIV POCT, to determine if any at risk contact has occurred within the previous 72 hours to identify and refer partners potentially eligible for PEPSE².

4.3 Quality standards

4.3.1 Timely provision of test results:

- a. Percentage of people having STI tests that can access results. Standard: 95%
- b. HIV retention into care: Standard 95%

4.3.2 Clinical management:

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

4.3.3 Partner notification:

- a. Gonorrhoea at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks.
- b. Chlamydia 0.6 contacts per index case.
- c. HIV: 0.6 contacts per index case within 3 months.
- d. HIV: 97% index cases with documented PEPSE assessment at diagnosis to identify any contacts within the last 72 hours potentially eligible to receive PEPSE².

4.4 What the quality statement means for each audience

Responsibilities of commissioners

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

- a. provide treatment according to BASHH CEG Guidelines. Treatment should be at an appropriate level to the outreach service and only available if outreach staff are qualified/registered to issue medication either by independent prescribing or via Patient Group Direction (PGD). Where staff are not qualified / registered robust pathways into an appropriate local service should be agreed and in place.
- b. have staff trained to assess risk and support access to PEPSE in a timely manner. Referral pathways should be in place to support this. Where possible, provision of a PEPSE starter pack given under PGD at outreach would enhance timely uptake with follow up for the full course and subsequent testing at a local specialist Level 3 GUM service.
- c. have pathways in place for prompt review of those given HIV diagnoses within outreach, at the HIV treatment centre of their choice.

- 4.4.2 Commissioners should ensure that if the outreach service does not have the infrastructure or expertise to instigate or support PN then robust pathways into an appropriate service are agreed and in place prior to commencement of the outreach service.
- 4.4.3 Services should not be commissioned to provide syndromic treatment for STIs e.g. for urethral discharge. However, limited syndromic management for symptoms suggestive of vaginal candidiasis may be appropriate in an outreach setting. Patients with symptoms that cannot be investigated at an outreach service should be seen at a local specialist Level 3 GUM service.

Responsibilities of service providers

- 4.4.4 Results should be reviewed and actioned in a timely manner by a healthcare professional competent in their interpretation. If results review is undertaken by a non-registered healthcare worker adequate training and assessment should be in place beforehand to ensure competence and, as with any healthcare professional, be subject to annual review. See Standard 7.
- 4.4.5 All providers of outreach services commissioned to manage STIs should ensure they have appropriate mechanisms in place to give results, both positive and negative, in a timely manner and no more than 10 working days from the initial consultation.
- 4.4.6 All providers of outreach services should ensure that conditions identified within outreach requiring further specialist testing or assessment (e.g. those with gonorrhoea requiring culture samples to establish antibiotic sensitivities or with syphilis requiring medical examination) should be seen within the appropriate local specialist Level 3 GUM service for assessment and treatment.
- 4.4.7 It is the responsibility of the outreach service taking the specimens to ensure that any abnormal results are acted on. Ideally consent for contact via at least two different means should be sought as well as consent to contact the GP in the event of not being able to contact the patient. If only one point of contact e.g. a mobile number is obtainable then agreement needs to be reached with the individual about how they will access their results in the event of the service not being able to contact them.

In addition people accessing outreach services should be made aware of the sharing of positive results with the local specialist Level 3 GUM service.

- 4.4.8 All providers of outreach services managing STIs should ensure they have appropriate mechanisms in place:
 - a. to provide treatment to people with an STI or refer them to the appropriate treatment service. Pathways should be agreed and in place before an outreach service is initiated. Treatment of infections requiring specialist testing, e.g. gonorrhoea, should not be undertaken within outreach.

- b. provide vaccination for Hepatitis B to people in high risk groups³ or refer them to an appropriate treatment service. This may also include vaccination for Hepatitis A dependent on risk.
- c. to instigate PN for relevant infections. If the provider is unable to undertake PN or offer a choice of type of PN (patient or provider referral) then agreed referral pathways to another service should be utilised to ensure this takes place in a timely fashion.
- d. to report notifiable infections, if identified, in accordance with PHE guidance.

4.4.9 If treatment is undertaken at the outreach site, guidance for appropriate storage of any medications used needs to be in place, followed and its use audited, in line with local policies and pharmacy guidelines.

4.4.10 It is the responsibility of the outreach service to either epidemiologically treat sexual partners or refer them to an appropriate service for epidemiological treatment i.e. prior to the confirmation of infection, provided appropriate tests have been offered to identify infection and, according to BASHH CEG guidelines.

4.4.11 PN outcomes should be monitored for HIV, gonorrhoea and chlamydia against national standards. If the outreach service is unable to do this then arrangements should be in place for the local specialist Level 3 GUM service to undertake monitoring to ensure this occurs.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

4.4.12 Healthcare professionals and non-registered healthcare workers in outreach services commissioned to manage STIs should ensure that:

- a. they are fully competent to manage STIs in accordance with current BASHH CEG treatment guidelines. Empirical and epidemiological treatment while awaiting results are acceptable practices; syndromic management, with few exceptions (see supporting information) is not.
- b. if not competent or able to provide appropriate management for particular conditions, they have clear agreed referral pathways to local specialist Level 3 GUM services in place, with systems to confirm effective transfer of care.
- c. they are competent in reporting of notifiable diseases in accordance with PHE guidance. If not competent, referral pathways to a local specialist Level 3 GUM service should be utilised to ensure this takes place.

People with needs relating to STIs

4.4.13 Should be referred to an appropriate service of their choice if the outreach service cannot meet their clinical needs.

4.5 Supporting information

Interpretation of results

4.5.1 If results review, in outreach services, is carried out by non-registered healthcare workers agreed mechanisms should be in place to facilitate healthcare professional review of both results and appropriate patients if needed.

4.5.2 Where an HIV diagnosis is made by HIV POCT in an outreach service, people should be seamlessly transferred into specialist Level 3 GUM services for confirmatory testing. UK national guidelines indicate that this should ideally occur within 48 hours of a reactive result but no later than 14 days¹.

Provision of results

4.5.3 Provision of results whether positive or negative, is important for effective clinical management of infection and user satisfaction. The exact turnaround time will vary in different settings but a period of 10 working days from consultation to provision of results represents a maximum, agreed by consensus in the development of the *Standards for the management of sexually transmitted infections (STIs)*⁴. It is therefore likely that results will need to be managed and conveyed from a central clinical hub / service, rather than the individual outreach clinic where diagnostic samples were taken, if these standards are to be met.

Treatment

4.5.4 For both public health and individual health reasons, treatment regimens should follow current BASHH CEG treatment guidelines⁵. Resistance profiles will be monitored and, in the case of resistance to first-line treatment, laboratories will advise on appropriate regimens.

4.5.5 In England and Wales, the national Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) has identified drifts towards decreased susceptibility to the third generation cephalosporins, particularly cefixime, the oral agent. In 2011 the national guidelines were changed to recommend ceftriaxone, an injectable, at the increased dose of 500mgs in combination with Azithromycin 1mg, given orally⁶. Effective therapy and PN is essential for public health control of gonorrhoea and infected individuals diagnosed in primary care or outreach settings should be referred to a specialist Level 3 GUM service for culture and treatment management.

Syndromic management

4.5.6 Syndromic management of STIs i.e. the prescribing of antimicrobial regimens chosen to cover the major pathogens responsible for a syndrome, e.g. urethral discharge without taking appropriate swabs for laboratory investigation, was developed for resource-poor settings where diagnostic laboratory tests are not available⁷. In the UK it is considered sub-optimal care and such management should only be used in outreach services in exceptional circumstances by a senior healthcare professional.

Vaccination

4.5.7 In some outreach populations e.g. sex workers, the level of vaccination has been shown to be significantly higher within outreach programmes when compared to standard services. In a study comparing vaccination of sex workers in Belgium within outreach as compared to standard services, rates of Hepatitis B vaccination were as high as 67.9% for an accelerated Hepatitis B vaccination course or 47.9% for a standard course within outreach versus 7% within standard services⁸.

Partner notification

4.5.8 All services testing for STIs should be expected to identify the need for PN as part of the management of STIs including HIV^{2,9,10}. If the outreach service is unable to instigate or manage PN or monitor PN outcomes then appropriate arrangements should be in place with another service to ensure this takes place.

4.6 References

- 1 BHIVA (2008) *UK National Guidelines for HIV testing*. Available at: <http://www.bhiva.org/HIV-testing-guidelines.aspx>
- 2 BASHH (2015) *HIV Partner Notification for adults: definitions, outcomes and standards*. Available at: http://www.bashh.org/documents/HIV_Partner_Notification_Standards_2015.pdf
- 3 BASHH (2011) *United Kingdom National Guideline on the Management of the Viral Hepatitides A, B & C 2008*. Available at: <http://www.bashh.org/documents/1927.pdf>
- 4 MEDFASH, BASHH (2014) *Standards for the management of sexually transmitted infections (STIs)*. Available at: <http://www.bashh.org/documents/StandardsforthemangementofSTIs2014FINALWEB.pdf>
- 5 BASHH Clinical Effectiveness Group national guidelines. Available at: <http://bashh.org>
- 6 Bignell C, Fitzgerald M; (Guideline Development Group). (2011) UK national guideline for the management of gonorrhoea in adults. *Int J STD AIDS*, 2011; 22: 541-7

- 7 World Health Organization (2004) *Guidelines for the management of sexually transmitted infections*. Geneva: World Health Organization. Available at: <http://www.who.int/hiv/pub/sti/pub6/en/>
- 8 Mak R, Traen A, Claeysesen M et al (2003) Hepatitis B vaccination for sex workers: do outreach programmes perform better? *Sex Transmitted Infections*, 2003; 79: 157-9
- 9 SSHA (2015) *Partner Notification Guidance*. Available at: <http://www.ssha.info/>
- 10 BASHH (2012) *BASHH statement on partner notification for sexually transmitted infections*. Available at: <http://www.bashh.org/documents/4445.pdf>

STANDARD 5

INFORMATION GOVERNANCE IN OUTREACH SERVICES

5.1 Quality statement

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

5.2 Quality measures

5.2.1 Record keeping:

Self-assessment against the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for:

- Regulation 17: Good governance.

5.2.2 Information governance:

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

5.2.3 Data reporting:

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

5.3 Quality standards

5.3.1 Record keeping: Meets the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulation 17.

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

5.3.3 Data reporting: Standard: 100%

5.4 What the quality statement means for each audience

Responsibilities of commissioners

- 5.4.1 Commissioners should have a clear understanding of how to commission confidential outreach services in line with DH guidance on confidentiality in sexual health services³.
- 5.4.2 Commissioners should define minimum locally agreed service monitoring datasets for outreach services (these may differ from those of other mainstream sexual health services).
- 5.4.3 Commissioners should ensure that all providers of outreach services commissioned to manage STIs can:
 - a. provide robust assurance that they can deliver agreed confidentiality levels and provide minimum datasets.
 - b. transmit datasets to commissioners by secure means

Responsibilities of service providers

- 5.4.4 All providers of outreach services should ensure risk assessments and policies for robust and secure data collection are in place, to protect data collected in outreach settings and the secure storage and transport of data by physical or electronic means.
- 5.4.5 All providers of outreach services should have robust policies and guidelines in place for:
 - a. the recording and identification of clinical records.
 - b. the recording of diagnostic samples taken.
- 5.4.6 All providers of outreach services should provide clear information to service users regarding:
 - a. the quantity and type of data collected and how the data will be processed and stored including the contact details of the organisation holding the data.
 - b. the provision of test results, in case of positive result or subsequent patient query.
- 5.4.7 When outreach services are undertaken in commercial / non-NHS properties safeguards should be in place to prevent inappropriate disclosure of client information to third parties (such as other venue users and venue workers). Outreach workers should have facilities available to discuss positive test results without the risk of inadvertent disclosure.

- 5.4.8** Where safety equipment is in place that utilises remote monitoring and geo-location technology outreach workers are fully trained in its use, and are aware of how data obtained through these technologies may be used.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

- 5.4.9** Healthcare professionals and non-registered healthcare workers in outreach services commissioned to manage STIs should ensure that:
- a. they understand the need to maintain the confidentiality of service users in line with national and provider organisation guidelines.
 - b. they are aware of guidelines relating to, and have had appropriate training in, the collection, transport and storage of confidential medical information obtained when working in outreach services.
 - c. they should ensure that any breaches in confidentiality are promptly reported via local incident reporting procedures. The service user should be made aware of the data breach in a timely and appropriate manner.

People with needs relating to STIs

- 5.4.10** Should receive clear information on the level of confidentiality the service is able to offer them and in which situations confidentiality may be broken e.g. in the case of safeguarding concerns, or contacting the GP if other methods of communication are unsuccessful.
- 5.4.11** Should have access to clear information about how the outreach service collects and holds their personal data, and how that data will be stored and used.
- 5.4.12** Should receive clear information on how to request access to the results and health records relating to their outreach attendance.

5.5 Supporting information

- 5.5.1** Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The type and amount of information collected will vary with the type of outreach service provided.

Confidentiality

- 5.5.2** The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000⁴ imposed on organisations an obligation not to disclose any information about STIs obtained, and capable of identifying an individual, except to a medical practitioner (or someone employed under their direction) for the purposes of treatment or prevention. These directions lapsed for all organisations (except NHS Trusts without foundation status) with the introduction of the Health and Social Care Act⁵.
- 5.5.3** In 2015 the DH released a statement confirming that their policy on confidentiality remains unchanged and that people should continue to use sexual health services with assurance that information on STI testing, diagnosis and treatment will not be included in their shared patient record without their consent³. DH guidance on clinical governance for commissioners and providers of sexual health services includes statement of confidentiality⁶.

Collecting and recording information

- 5.5.4** For those services providing anonymous HIV POCT, collection of patient identifiable Information will be standard. Minimum datasets should be agreed with commissioners to allow appropriate service and contract monitoring, these should always include the number and location of tests.
- 5.5.5** For people needing onward referral to services after a reactive HIV POCT result the minimum appropriate information should be collected to allow an effective transition into a local specialist Level 3 GUM service. Pre-test discussion for HIV POCT should include discussion that in the event of a reactive result personal information and contact details will be confirmed to ensure safe referral and follow up. That information should be secured and stored in line with the stated standards^{2,3,4,6,7}.
- 5.5.6** Outreach services providing STI testing and treatment should record data in line with national standards including contact information for results notification. This data should be recorded and stored in accordance with national standards and requirements^{2,3,4,6,7}.

Geo-Location Security Devices

- 5.5.7** As part of lone worker policies many organisations use electronic Geo-Location security devices and alarms. On receiving activation from a workers device an alarm will be triggered in a remote monitoring centre. The device will present the user's location allowing the user to be tracked if their location changes. A voice channel may also be opened up to verify the alarm and provide support. When verified, the operator can notify the Police or other emergency contacts. Audio, location and alarm signals can be also recorded for evidential purposes.

5.5.8 Geo-Location devices enhance the personal security of lone and outreach workers however they also make it technically possible to track and remotely monitor workers. Full discussion of device capabilities and consent for their use should be obtained from outreach staff prior to their implementation^{8,9}

5.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
- 2 Department of Health / Health and Social Care Information Centre (2013) *Information Governance Toolkit. Version 13*. Available at: <https://www.igt.hscic.gov.uk/>
- 3 Department of Health (2015) *Patient confidentiality in sexual health services*. Available at: <http://www.bashh.org/documents/UpdatefordisemminationSTIconfidentialityFinal0100915.pdf>
- 4 Department of Health (2000) *NHS Trusts and Primary Care Trusts(Sexually Transmitted Diseases) Directions 2000*. Available at: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4083027
- 5 *Health and Social Care Act 2012*. London: The Stationary Office (TSO). Available at: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>
- 6 Department of Health (2013) *Sexual Health: Clinical Governance*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252975/Sexual_Health_Clinical_Governance_final.pdf
- 7 BASHH (2014) *Standards for the management of sexually transmitted infections (STIs)*. Available at: <http://www.bashh.org/documents/StandardsforthemangementofSTIs2014FINALWEB.pdf>
- 8 Information Commissioners Office (2013) *Privacy in mobile apps*. Available at: <https://ico.org.uk/media/1596/privacy-in-mobile-apps-dp-guidance.pdf>
- 9 *European Commission Data Protection Working Party Opinion 02/2013 on apps on smart devices.2013*. Available at: http://ec.europa.eu/justice/data-protection/article-29/documentation/opinion-recommendation/files/2013/wp202_en.pdf

STANDARD 6

CLINICAL GOVERNANCE IN OUTREACH SERVICES

6.1 Quality statement

People should receive their care from high quality services managing STIs that are safe, well managed and accountable regardless of where that service is delivered.

6.2 Quality measures

6.2.1 Clinical Governance Arrangements:

Self-assessment against the Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental Standards¹ for:

- Regulation 4: Requirements where the service provider is an individual or partnership
- Regulation 6: Requirements where the service provider is a body other than a partnership
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 15: Premises and equipment
- Regulation 16: Receiving and acting on complaints
- Regulation 17: Good governance
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed
- Regulation 20: Duty of candour

6.2.2 Audit:

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

6.2.3 Local network:

Close links to local relevant specialist services (eg sexual health, reproductive health, HIV, drug and alcohol) with effective referral pathways and necessary clinical governance arrangements.

6.3 Quality standards

6.3.1 Clinical Governance Arrangements:

Meets the CQC Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulation 4, 6, 12, 13, 15, 16, 17, 18, 19 and 20.

6.3.2 Audit:

- a. Evidence of participation in relevant annual local, regional or national audits.
- b. Evidence of actions based on audit findings.

6.3.3 Local network:

Evidence that effective referral pathways and necessary clinical governance arrangements are in place with local relevant specialist services (e.g. sexual health, reproductive health, HIV, drug and alcohol). Evidence might include minutes of clinical governance meetings and appropriate referrals to other specialist services.

6.4 What the quality statement means for each audience

Responsibilities of commissioners

- 6.4.1 Commissioners should ensure that requirements for governance and accountability are explicit in all contracts with providers of outreach services^{2,3,4} and seek evidence of effective clinical governance arrangements from providers regardless of whether the service is directly commissioned by commissioners, or sub-contracted through commissioned providers.
- 6.4.2 Commissioning of outreach services should enable the development of an effective integrated governance system that complies with agreed performance levels in service specifications.
- 6.4.3 The role of specialist Level 3 GUM providers in providing clinical leadership, and governance of outreach services, if required, should be explicitly commissioned and form part of service specifications.
- 6.4.4 Commissioners should seek assurance that all staff, including those involved in providing outreach services, have enhanced clearance through the Disclosure and Barring Service (DBS). This should be explicit in all contracts.

- 6.4.5** Commissioners should ensure that audit requirements relating to STI management are specific in all contracts and that audit activity is monitored via an annual audit plan.

Responsibilities of service providers

- 6.4.6** All providers of outreach services should ensure that their services operate to the same standards of quality and safety as those delivered in mainstream healthcare settings regardless of whether or not the service is provided by healthcare professionals or non-registered healthcare workers.
- 6.4.7** All providers should ensure that premises, from which outreach STI services are delivered, meet the required health and safety and infection control requirements.
- 6.4.8** All providers of outreach services should be able to demonstrate that effective clinical governance arrangements are in place. This includes, but is not limited to, the following areas:
- a. having a nominated clinical governance lead with responsibility for overseeing the clinical quality of the outreach service delivered and establishing robust links between local services, including the local specialist Level 3 GUM service. Independent / third sector organisations should consider either nominating a suitably qualified medical and/or nursing advisor to provide clinical leadership or establish contractual arrangements with healthcare professionals from specialist settings.
 - b. using information technology (IT) securely to support clinical governance within and across organisations, taking into account the required information governance standards (see Standard 5), and using IT and IT equipment securely when transferring data collected at outreach venues to other computer systems.
 - c. having a clear framework to support education and training that includes mentorship, clinical supervision, case note review (where appropriate) and assessment of ongoing competence (see Standard 7).
 - d. having an annual audit plan and, as a minimum, annually auditing elements of clinical practice to ensure adherence to current local and national guidelines and evidence-based procedures.
 - e. demonstrating action taken based on audit findings.
 - f. fostering and encouraging clinical research and development.
 - g. having procedures in place to minimise risk to service users, ensuring that all staff are checked through the Disclosure and Barring Service (DBS).

- h. regularly undertaking risk assessments to minimise risk to staff. Policies for lone working should be in place if staff provide outreach services without colleagues present.
- i. having clear mechanisms in place to report, review and respond formally to all clinical incidents and complaints.

6.4.9 All providers of outreach services should avoid using inappropriate or disproportionate incentives to encourage people to come forward for testing.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

6.4.10 Healthcare professionals and non-registered healthcare workers in outreach services commissioned to manage STIs should ensure that they understand and comply with all clinical governance requirements and demonstrate a commitment to patient safety, quality improvement and clinical efficiency. This includes, but is not limited to, the following areas:

- a. compliance with all mandatory training requirements including information governance, infection control, and safeguarding children and vulnerable adults.
- b. wearing visible identification depicting name and employing organisation.
- c. ensuring safe transport of clinical samples (adhering to HSE standards)⁵.
- d. ensuring IT systems and IT equipment are used safely in outreach settings. Handling all data in accordance with information governance requirements.
- e. regular attendance at clinical governance meetings (e.g. as part of clinical network meetings or “in-house” governance meetings).
- f. compliance with local, regional and national audits as appropriate e.g. hand hygiene standards; prescribing policies.

People with needs relating to STIs

6.4.11 Should find the outreach services they attend to be safe and of a high quality.

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

6.4.13 Should receive services from providers that continually improve as a result of learning from:

- a. adverse events.

- b. incidents, errors and near misses.
- c. comments and complaints.
- d. review/s of practice and / or the advice of expert bodies.

6.5 Supporting information

6.5.1 Services delivered as outreach should operate to the same standards of quality and safety as those delivered in mainstream healthcare settings.^{2,4,6,7,8}

Clinical leadership

6.5.2 Clinical governance, for outreach services, can either be provided by the organisation commissioned to deliver the service or via contractual arrangements with another organisation e.g. a local specialist Level 3 GUM service. However all providers of outreach services should have a nominated lead for clinical governance and, if the service is not a Level 3 GUM provider, robust links with the local specialist Level 3 GUM service should be established.

6.5.3 Sexual health networks can provide clinical leadership and support a framework for clinical governance across a range of organisations⁹.

Information technology

6.5.4 Patients have a right to confidentiality regardless of where testing and treatment take place (CQC Outcomes 1A, 6E and 21A)¹. Confidential data (i.e. clinic or NHS number, date of birth, and postcode) should not be disclosed to anyone other than the provider of the data, provider responsible for results management and communication, and staff handling the data. Issues to consider are:

1. Encrypting any personal information held electronically that could cause damage or distress if it were lost or stolen¹⁰.
2. Applying DH *You're Welcome: Quality criteria for young people friendly health services*¹¹ for confidentiality and consent, to assist in assuring confidentiality.

Teaching and training

Outreach services should be developed with input from user groups and third sector organisations to ensure that the service is culturally appropriate. Healthcare professionals and non-registered healthcare workers providing services should demonstrate the knowledge, attitudes and behaviours necessary to provide care to the outreach groups targeted.

6.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
- 2 Department of Health (2013) *A Framework for Sexual Health Improvement in England*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf
- 3 Department of Health (2013) *Commissioning sexual health interventions: Best practice guidance for local authorities*. Available at: <https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities>
- 4 Local Government Association and Public Health England (2013) *Sexual health commissioning – FAQs*. Available at: http://www.local.gov.uk/c/document_library/get_file?uuid=de86daf2-19e3-42f4-95c8-29bb6cc80a65&groupId=10180
- 5 Health and Safety Executive (2015) *Information about health and safety*. Available at: <https://www.hse.gov.uk>
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- 7 Department of Health (2005) *Recommended Quality Standards for sexual health training*. Available at: <http://www.sexualhealthnetwork.co.uk/media/documents/dohQualitystandardsforsexualhealthtraining-6ea9e5160019c237fae19f12b1ee5ae6.pdf>
- 8 Public Health England (2014) *Doing. Supporting and using public health research*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/453993/Research_translation_and_innovation_strategy_final
- 9 Department of Health (2013) *Sexual Health: Clinical Governance*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252975/Sexual_Health_Clinical_Governance_final.pdf
- 10 Information Commissioner's Office (2015) *IT security top tips*. Available at: <https://ico.org.uk/for-organisations/it-security-top-tips/>

- 11 Department of Health (2011) *You're welcome: Quality criteria for young people friendly health services*. Available at: <https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services>

STANDARD 7

APPROPRIATELY TRAINED STAFF IN OUTREACH SERVICES

7.1 Quality statement

People with needs relating to STIs should have their care, in an outreach service, managed by an appropriately skilled individual.

7.2 Quality measures

7.2.1 Competence to deliver services:

Self-assessment against the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for:

- Regulation 4: Requirements where the service provider is an individual or partnership
- Regulation 6: Requirement where the service provider is a body other than a partnership
- Regulation 18: Staffing
- Regulation 19: Fit and proper persons employed

7.3 Quality standards

7.3.1 Competence to deliver services:

Meets the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulations 4, 6, 18 and 19.

7.4 What the quality statement means for each audience

Responsibilities of commissioners

7.4.1 All services commissioned to provide outreach STI services should have an appropriate contract that explicitly states requirements in relation to clinical governance (see Standard 6) including education and training, assessment of competencies, ongoing maintenance of skills and clinical governance arrangements.

7.4.2 If a third sector organisation is commissioned to deliver STI services (e.g. HIV POCT, chlamydia screening) then commissioners should ensure that a local specialist Level 3 GUM provider supports training of staff, assessment of competence, clinical governance issues, supervision and follow up.

Responsibilities of service providers

- 7.4.3** All providers of outreach services should ensure that staff working in outreach settings have sufficient experience / seniority to work away from a clinic / main service site. Access to clinical advice from either a senior member of staff in the service or a local specialist Level 3 GUM service should always be available.
- 7.4.4** All services should be able to provide assurance that healthcare professionals and non-registered healthcare workers delivering outreach STI care can demonstrate that they are competent and remain competent to do so. This should include competence in undertaking a sexual history and in ascertaining risk and the need for referral to another sexual health service e.g. for symptomatic patients or PEPSE.
- 7.4.5** All providers of outreach services should be able to provide access for their staff to specific competency based training according to need in areas such as: HIV POCT, cultural issues, drugs, alcohol, domestic violence and young people. Training should be provided by the most appropriate means, including utilising the expertise of partner agencies within the outreach service.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

- 7.4.6** All staff, regardless of professional background or discipline, should be experienced in working with the group of people that the outreach service is aimed at.
- 7.4.7** All staff should identify themselves and their role and level of knowledge / expertise so that people accessing the outreach service are aware of each individuals employing organisation and professional background / expertise.
- 7.4.8** All staff should be aware of limitations in their own knowledge and when to access senior support.
- 7.4.9** All staff should be familiar with their organisations lone working policy and ensure that they work within it to maintain the safety of themselves and outreach service users.

People with needs relating to STIs

- 7.4.10** People with STI concerns should have their care managed by an appropriately skilled individual.

7.5 Supporting information

Competence

- 7.5.1** Competence may be defined as²: the knowledge, skills, abilities and behaviours that a practitioner needs to perform their work to a professional standard. Competencies should be relevant to the service commissioned and, as many outreach services do

not solely cover STI screening, other competencies such as motivational interviewing techniques and providing information on sexual health, risk reduction and contraception are likely to be required. The standards needed to achieve competence should be the same regardless of professional background or employing organisation.

Maintaining competence

- 7.5.2** All individuals have a responsibility to maintain their own competence demonstrating this through routine annual appraisal and revalidation processes (healthcare professionals). Commissioners and providers of services need to work together to ensure that maintenance of competencies forms part of a robust local governance framework^{1,3}.

Training

- 7.5.3** Specialist Level 3 GUM services are responsible for providing different types of training relating to STI management across local sexual health economies. Commissioners should ensure that where non NHS providers are delivering outreach services specialist Level 3 GUM services are engaged in providing relevant training and assessment of STI competencies e.g. for HIV POCT.

BASHH qualifications of clinical competence

- 7.5.4** The BASHH portfolio of clinical competency learning assessment qualifications⁴ provides a standardised training and assessment pathway. All staff working in outreach services whether from a health or other background, employed by an NHS or non NHS provider, should ideally as a minimum have completed STIF 'Fundamental' Competency (risk assessment and testing for asymptomatic STIs and offering health promotion and signposting to other services).

7.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
- 2 Storey L, Howard J, Gillies A (2002) *Competency in Healthcare: a practical guide to competency frameworks*. Oxford: Radcliffe
- 3 Department of Health (2013) *A Framework for Sexual Health Improvement in England*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf
- 4 BASHH Sexually Transmitted Infections Portfolio. Available at: <http://www.stif.org.uk/>

STANDARD 8

LINKS TO OTHER SERVICES

8.1 Quality statement

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

8.2 Quality measures

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

8.2.3 Self assessment against the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for:

- Regulation 12: Safe care and treatment

8.3 Quality standards

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

8.3.2 Meets the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulation 12.

8.4 What the quality statement means for each audience

Responsibilities of commissioners

8.4.1 Commissioners should ensure that in order to address specific needs, commissioning of outreach services forms part of an integrated commissioning plan for sexual health services in a local authority area. This plan should form part of the local authorities wider health and well being strategy.

8.4.2 When outreach services are commissioned referral pathways between outreach services and local specialist Level 3 GUM services should be established. Referral pathways should be explicit in service specifications and form part of performance monitoring arrangements.

8.4.3 Commissioners should ensure that all referral pathways, across a local authority area, for both sexual health and other services, are explicit and negotiated with the knowledge and support of all the services involved. A local sexual health network can provide a framework to support this.

Responsibilities of service providers

8.4.4 All providers of outreach services commissioned to manage STIs should ensure that effective links to other clinical services are in place. This includes but is not limited to, the following areas:

- a. ensuring that referral pathways are in place and are two-way linking outreach and mainstream services in a quick, easy and non discriminatory way e.g. SRH, abortion services, HIV services, safeguarding, mental health and other relevant organisations.
- b. ensuring staff are trained and supported in the use of referral pathways.
- c. monitoring performance of referral pathways ensuring that they meet the needs of people using them.
- d. reporting and sharing all incidents and complaints that occur as a consequence of referral to other services, in order that pathways are subject to continuous review and improvement.
- e. working closely with other services to develop and share local policies and guidelines.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

8.4.5 Healthcare professionals and non-registered healthcare workers in outreach services commissioned to manage STIs should ensure that:

- a. they have an understanding of all referral pathways, including those for safeguarding, and receive appropriate training in their use.
- b. referrals to other services are appropriate and timely and that reasons for referral are clearly documented. All information should be shared safely. See Standard 5.
- c. if relevant, people using services understand the referral process including time frames.
- d. they understand how to escalate an issue when a referral pathway does not work effectively.

People with needs relating to STIs and other sexual health needs

8.4.6 Should have a clear understanding to where they are being referred and why.

8.4.7 Should have an understanding of what to expect from the service they are referred to.

8.5 Supporting information

8.5.1 There is a strong public health case for STI screening to be offered outside mainstream sexual health services to assist with the early diagnosis of new cases, and onward referral for, and uptake of, treatment e.g. for HIV.

Clinical links

8.5.2 All providers of outreach STI services have a responsibility to establish robust links with local specialist Level 3 GUM services in order to provide high quality, safe and effective services which meet the needs of the local population^{2,3}.

Care Pathways

8.5.3 The DH's Framework for Sexual Health Improvement in England⁴ identifies collaboration and integration between services as essential. This is of particular importance to services delivered in outreach settings which may be targeting high risk individuals with complex health needs e.g. MSM or SW.

8.5.4 Care pathways describe a seamless patient journey across a range of health and social care services, using evidence-based guidelines and multidisciplinary working. Care pathway development for referral pathways from outreach to specialist Level 3 GUM services is likely to cover referral criteria, triage criteria, out of hours advice, diagnostics advice, two-way communication, clinical guidelines, management options and training and education of staff. All providers of outreach STI services should be aware of, and adhere to, agreed care pathways which should be monitored for effectiveness.

Sexual health networks

8.5.6 The role of outreach providers, both NHS and non NHS, in sexual health networks is important. They can valuably contribute to the work of the network including; sharing of intelligence e.g. local sexual health behaviours of high risk groups; providing access to hard to reach groups; facilitating STI testing and diagnosis and facilitating transfer into services. For this reason membership of sexual health networks should be broad and holistic in focus.

8.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
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STANDARD 9

PATIENT AND PUBLIC ENGAGEMENT

9.1 Quality statement

People should be consulted about the development and delivery of outreach STI services in their community. Users of outreach services should be encouraged to give feedback about them.

9.2 Quality measures

9.2.1 The involvement of target group users in outreach service development.

9.2.2 A Patient and Public Engagement (PPE) plan which affords public consultation and feedback from users of specific outreach services.

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

9.2.4 Self-assessment against the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3) Fundamental standards¹ for:

- Regulation 17: Good governance.

9.2.5 The use of the NHS Friends and Family Test to collate standardised service performance data².

9.3 Quality standards

9.3.1 Evidence of target group user involvement in outreach service development.

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

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

9.3.4 Meets the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 (Part 3), Fundamental standards¹ for Regulation 17.

9.3.5 Annual NHS Friends and Family test undertaken.

9.4 What the quality statement means for each audience

Responsibilities of commissioners

- 9.4.1** Commissioners should develop an STI Patient and Public Engagement (PPE) strategy for their local area and this should be used to identify the need for outreach services, whether for specific user groups or specific populations.
- 9.4.2** Commissioners should work with local service providers to develop local quality measures which should include regular monitoring of patient satisfaction.

Responsibilities of service providers

- 9.4.3** All service providers should have robust PPE arrangements in place, proactively engaging with their target populations in a meaningful way.
- 9.4.4** All service providers should provide evidence of changes initiated as a result of patient feedback to their users, and report and provide evidence of quality improvement to commissioners.

Responsibilities of healthcare professionals and non-registered healthcare workers in outreach services

- 9.4.5** All healthcare professionals and non-registered healthcare workers working in outreach settings should encourage feedback from patients whether it is positive or negative.

People with needs relating to STIs

- 9.4.6** Should be encouraged to provide feedback on their personal experience of care.
- 9.4.7** Should be encouraged to be involved in decision making about outreach services managing STIs.
- 9.4.8** Should always receive responses to their feedback and views.
- 9.4.9** A sample should be asked to undertake the Friends and Family Test at least annually.

9.5 Supporting information

Public and patient engagement

- 9.5.1** The NHS Constitution³ includes a right for people to expect the NHS to assess the health requirements of their community and to commission and put in place the services (whether delivered in healthcare or non healthcare settings) to meet those needs as considered necessary.
- 9.5.2** Outreach services often target high risk hard to reach populations which is why, despite challenges, engagement with the populations being targeted is particularly important when developing and monitoring outreach services. This may require engagement with commercial organisations, community groups and third sector organisations. Bespoke methods are likely to be required to ensure feedback is meaningful⁴.

NHS Friends and Family Test

- 9.5.3** The Friends and Family Test is a simple patient feedback tool which asks patients about their satisfaction with services dependent upon whether or not they would recommend the service to their family and friends. It is relevant for use in all healthcare settings including outreach.

9.6 References

- 1 Care Quality Commission (2015) *Guidance for providers on meeting the regulations. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Part 3)(as amended).Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)*. London: Care Quality Commission. Available at: http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
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APPENDIX A

Project group members and representatives

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Hilary Lord	Senior Nurse	Central Manchester University Hospitals NHS Foundation Trust
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The following are thanked for their support and advice

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Dr John Saunders	Clinical Champion NCSP	Public Health England
Dr Nick Theobald	STIF Foundation Executive and Academic Lead	
Dr Debbie Thomas	Service Manager	Central Manchester University Hospitals NHS Foundation Trust

APPENDIX B

Project definitions for elements of STI management

This table is reproduced from the *Standards for the management of sexually transmitted infections (STIs)*.

The following lists comprise elements of STI management that are appropriate at various levels of service provision. They are drawn from the three Levels (1, 2 and 3) originally defined in the *National strategy for sexual health and HIV (2001)* and have been updated by this project to take account of the descriptor of specialist services in *A Framework for Sexual Health Improvement in England (DH, 2013)*. They look specifically at STIs and related conditions and do not include elements of contraceptive and reproductive healthcare that may also be provided at these levels. The FSRH has developed descriptors of specialist contraceptive and reproductive healthcare.

The elements of care listed below are the maximum specifications for each service level, not the minimum requirements. Care pathways should be in place for onward referral if the clinical condition is beyond the scope or competence of the original service. To ensure optimum care for service users, it is recommended that there should be formal links between services providing STI management at Levels 1 or 2 and those at Level 3 as set out in Standard 8. Clinical guidance on STI management relevant to the elements of care listed below can be found at www.bashh.org.uk

It should be noted that the elements of care do not suggest where these can be delivered as this will be a commissioning decision based on the services commissioned and individual competence of the healthcare professionals / non-registered healthcare workers.

Level 1 - Asymptomatic

Sexual history taking and risk assessment

Including identifying:

- safeguarding issues in under 18s and vulnerable adults with referral as appropriate
- the need for emergency contraception
- the need for HIV post-exposure prophylaxis following sexual exposure (PEPSE)
- sexual assault with referral as appropriate

Signposting to appropriate sexual health services

Chlamydia screening

- Opportunistic screening for genital chlamydia in sexually active asymptomatic males and females under the age of 25
- STI screening and treatment of asymptomatic infections (except treatment for gonorrhoea and syphilis) in women and men (except MSM)*
- Partner notification of STIs or onward referral for partner notification

HIV testing

- Including pre test discussion and giving results

Point of care HIV testing

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

Screening for hepatitis B and hepatitis C and vaccination for hepatitis B

- Appropriate screening and vaccination in at-risk groups

Sexual health promotion

- Provision of verbal and written sexual health promotion information

Condom distribution

- Provision of condoms for safer sex

Assessment and referral for psychosexual problems

Level 2 - Symptomatic

Incorporates Level 1 plus:

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

- gonorrhoea if able to perform gonorrhoea cultures with rapid transport to the laboratory

The following should be referred to Level 3:

- men with dysuria and / or genital discharge**
- symptoms at extra-genital sites e.g. rectal or pharyngeal
- pregnant women
- genital ulceration other than uncomplicated genital herpes
- gonorrhoea if unable to perform gonorrhoea cultures with rapid transport to the

Level 3 - Complex / Specialist

Incorporates Level 1 and 2 plus:

- STI testing and treatment of MSM*
- STI testing and treatment of men with dysuria and genital discharge**
- Testing and treatment of STIs at extra-genital sites
- STIs with complications
- STIs in pregnant women
- Gonorrhoea cultures and treatment of gonorrhoea***
- Recurrent conditions
 - Recurrent or recalcitrant STIs and related conditions

- Management of syphilis and blood borne viruses
 - Including the management of syphilis at all stages of infection
- Tropical STIs
- Specialist HIV treatment and care
- Provision and follow up of HIV post exposure prophylaxis (PEPSE)****

STI service co-ordination across a network including:

- Clinical leadership of STI management
- Co-ordination of clinical governance
- Co-ordination of STI training
- Co-ordination of partner notification

- * The testing and management of men who have sex with men (MSM) has been defined as an element of specialist care at Level 3 because the majority of infections in this group are in the rectum and/or pharynx rather than the urethra and the management of these infections is more complex and requires specialist provision^{1,2} (see Standard 3). However, for asymptomatic MSM there may be some Level 2 services which have the full range of investigations available, and the necessary clinical and prevention skills, to effectively manage care.
- ** The appropriate management of men with dysuria and/or urethral discharge requires immediate microscopy (see Standard 3). This is usually only available at specialist GUM (Level 3) services so the testing and treatment of such men has been defined as an element of care at Level 3. However some other services, at Level 2, may be able to provide immediate microscopy (with the appropriate training and quality assurance) and management of such men would then be appropriate at these services.
- *** Gonorrhoea culture is an essential test before treating gonorrhoea or giving empirical antibiotics to people with symptoms (see Standard 3).
- **** PEPSE 'starter packs' are often available in other settings such as Accident and Emergency or Occupational Health, but referral to a specialist GUM (Level 3) service is required for ongoing management and provision of antiretroviral drugs.

References

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

APPENDIX C

Education and training matrix

This table collates current training courses for STI management . It is reproduced from the *Standards for the management of sexually transmitted infections (STIs)* and has been updated by Dr Nick Theobald.

Although many outreach STI services only deliver elements of care at Level 1 the education and training matrix remains relevant as some specialist providers are commissioned to deliver

LEVEL 0/1										
Existing courses	Training provided		Assessment method		Professional group					Evidence of training
	Knowledge	Skills	Knowledge	Skills	Doctor	Nurse	Sexual Health Adviser	Pharmacist	Non Registered healthcare Worker	
Health Education England / BASHH / RCP / e-Learning for Healthcare: eHIV-STI	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes [#]	Online learning management system records. Certificate on completion
RCGP Introductory Certificate in Sexual Health (online and face- to-face training)	Yes	Yes*	Yes	No	Yes	Yes	Yes	Yes	Yes*	Certificate on completion
Centre for Postgraduate Pharmacy Education (CPPE) (online) 1. Chlamydia screening and treatment: community pharmacy enhanced service 2. Sexual Health in Pharmacies	Yes	No	Yes	No	No	No	No	Yes	No	Certificate on completion

elements of care at Level 2 or 3 (see Appendix B).

LEVEL 1										
Existing courses	Training provided		Assessment method		Professional group					Evidence of training
	Knowledge	Skills	Knowledge	Skills	Doctor	Nurse	Sexual health adviser	Pharmacist	Non registered healthcare worker	
BASHH STIF Core: 1 day course*	Yes	Yes**	No	No	Yes	Yes	Yes	Yes	Yes	Certificate on completion
BASHH STIF-Plus: 1 day course	Yes	Yes**	No	No	Yes	Yes	Yes	Yes	Yes	Certificate on completion
Health Education England / BASHH / RCP / e- Learning for Healthcare: eHIV- STI	Yes	No	Some elements in respect of Level 1 and 2	No	Yes	Yes	Yes	Yes	Yes	Online learning management system records progress Certificate on completion
BASHH STIF 'Fundamental' Competency	No (part of STIF Core is designed to deliver this)	No (Local clinic-based training advised)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Certificate on completion and registration on BASHH database
Faculty of Sexual & Reproductive Healthcare (FSRH) Diploma Course (DFSRH)	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Diploma awarded after full competency assessment for contraceptive provision and Level 1 STI management.***
BASHH Web-based STI knowledge assessment	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Certificate awarded if successful

LEVEL 2									
Existing courses	Training provided		Assessment method		Professional group				Evidence of Training
	Knowledge	Skills	Knowledge	Skills	Doctor	Nurse	Sexual health adviser	Pharmacist	
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	No	No	Yes	Yes	Yes	Yes	Online learning management system records progress.
BASHH STIF Intermediate Competency (Entry Level)****	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
BASHH STIF 'Advanced' Competency	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Certificate on completion and registration on BASHH database
Certificate of Completion of Training (CCT) in SRH	Yes	Yes	Yes	Yes	Yes	No	No	No	CCT

LEVEL 3									
Existing courses	Training provided		Assessment method		Professional group				Evidence of training
	Knowledge	Skills	Knowledge	Skills	Doctor	Nurse	Sexual health adviser	Pharmacist	
BASHH STI Course	Yes	Yes	No	No	Yes	Yes	No	No	Certificate on completion
Society of Apothecaries Diploma in GU Medicine (DipGUM) *****	No	No	Yes	Yes	Yes	No	No	No	DipGUM
Certificate of Completion of Training (CCT) in GUM	Yes	Yes	Yes	Yes	Yes	No	No	No	CCT
Health Education England / BASHH / RCP / e-learning for Healthcare: eHIV-STI	Yes	No	No	No	Yes	Yes	Yes	Yes	Online learning management system records progress.

- * Includes learning by interactive case-based discussion
- ** Developed through role play
- *** BASHH STIF-Core Study Day is highly recommended to complement STI training in DFSRH.
- **** The University of Greenwich will award 15 credits at Level 6 (Bachelor degree) or Level 7 (Masters Degree) for successful completion of 'STIF Intermediate Competency' training and assessment with an academic component. This can be undertaken anywhere in the UK under the supervision of a sexual health specialist who is a BASHH registered trainer. The credits can be counted towards a related degree at any University using the CATS (Credit Accumulation and Transfer Scheme) system.
- ***** BASHH STI Course and Society of Apothecaries Diploma in GU Medicine: the Course has no assessment and the Diploma has no course. However the BASHH STI Course is the best way to prepare for the Diploma.
- # Charge may apply for Non-NHS employees

GLOSSARY OF ABBREVIATIONS

BASHH	British Association for Sexual Health & HIV
BASHH CEG	BASHH Clinical Effectiveness Group
BASHH CSU	BASHH Clinical Standards Unit
BHIVA	British HIV Association
BME	Black and minority ethnic groups
CCG	Clinical Commissioning Group
CPA	Clinical Pathology Accreditation
CPD	Continuing professional development
CQC	Care Quality Commission
DBS	Disclosure and Barring Service
DBST	Dried blood spot testing
DH	Department of Health
EQA	External Quality Assessment
FSRH	Faculty of Sexual and Reproductive Healthcare of the RCOG
GC	Gonorrhoea / Gonococcal
GRASP	Gonococcal Resistance to Antimicrobials Surveillance Programme
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HBV	Hepatitis B virus
HSE	Health and Safety executive
ICO	Information Commissioners Office
IQA	Internal Quality Assurance
IQC	Internal Quality Control
IT	Information technology
MSM	Men who have sex with men
NAAT	Nucleic acid amplification test

NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PEPSE	Post-exposure prophylaxis following sexual exposure
PGD	Patient Group Direction
PHE	Public Health England
PN	Partner notification
POCT	Point of care test
PREM	Patient-reported experience measure
PPE	Patient and public engagement
PROM	Patient-reported outcome measure
RCOG	Royal College of Obstetricians and Gynaecologists
SSHA	Society of Sexual Health Advisers
SRH	Sexual and Reproductive Healthcare
STI	Sexually Transmitted Infection
STIF	Sexually Transmitted Infections Foundation
SW	Sex worker
UKAS	United Kingdom Accreditation Services
YP	Young people