Office for Health Improvement & Disparities

Integrated sexual health service specification

Produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency

Published 20 March 2023

Contents

Key updates

This service specification recognises the Coronavirus (COVID-19) pandemic response and the potential for associated continuing changes. These included prioritising access to physical clinics for those in greatest need, increasing remote and online provision, and managing the redeployment of healthcare staff to support the pandemic response.

The commissioning of human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) became routine during 2020, and the National Chlamydia Screening Programme (NCSP) announced changes in 2021. The language and content of the specification now reflects these.

The outcome indicators and information provisions have been updated in line with national guidance and includes information on the routine commissioning of HIV PrEP. The main body of the document remains largely unchanged, but links or references to key national and clinical guidance have been updated.

It is intended that this update should be used to inform the development of local service provision. Service changes should be informed by local needs assessment and evaluation of the impact of changes made to sexual and reproductive health (SRH) provision during the pandemic.

Health and Care Act (2022)

In April 2022, the Health and Care Act (2022) was passed. The act will allow for the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs) across England. This will be done at the same time as abolishing clinical commissioning groups (CCGs). The ICBs will take on the NHS commissioning functions of CCGs as well as some of NHS England's (NHSE) commissioning functions. It will also be accountable for NHS spend and performance within the system.

The Health and Care Act (2022) will also enable the transition of commissioning responsibilities for primary care services to ICBs. Each area will also have an ICP, a joint committee which brings together the ICB and their partner local authorities, and other locally determined representatives (for example from health, social care, public health; and potentially others, such as housing providers).

The ICP will be tasked with developing a strategy to address the health, social care and public health needs of their system, and being a forum to support partnership working. The ICB and local authorities will have to have regard to ICP strategies when making decisions.

The ICB and ICP will work closely with local health and wellbeing boards (HWBs) utilising their experience as ‘place-based’ planners. The ICB will be required to have regard to the joint strategic needs assessments and joint local health and wellbeing strategies produced by HWBs

Cooperation is central to the work of integrated care systems. Under Section 82 of the NHS Act 2006, NHS bodies and local authorities have a statutory duty to cooperate when exercising their functions to secure and advance health and welfare.

Introduction

This service specification covers the specialist integrated sexual health services (ISHSs) that local authorities are responsible for commissioning including testing and treatment for sexually transmitted infections (STIs), the provision of HIV PrEP and provision of the full range of contraception. It is recognised that these services form part of a wider landscape of local provision. It is very common, if not universal, that the provider of services described in this specification will also be providing services that are commissioned by other bodies; often to the same service user and in the same consultation as the service set out here. This specification should not be seen in any way to limit the range of services a local provider delivers; but to articulate the specialist services a local authority is responsible for.

Likewise, it is recognised that the specialist ISHS is only part of a range of the provision that will need to be provided to meet the sexual health needs of the local population. Services delivered by primary care, third sector and community-based organisations form an essential part of any local sexual health system. This service specification only describes the ISHSs that a specialist service would be expected to deliver.

Local authority, NHSE and ICB commissioners are expected to work collaboratively to map service user pathways and plan services according to population need. The need for NHS organisations and local authorities to work more closely and to collaboratively commission SRH services was restated in the green paper Advancing Our Health: Prevention in the 2020s. In some areas, commissioners may choose to formally jointly commission services, however, it is recognised that local areas need to be able to decide what suits them best. Whatever contractual route is chosen, all local commissioners should work together to provide a seamless and efficient service for service users and the population, regardless of which body is responsible for commissioning. Each commissioner is expected to discuss plans at as early a stage as possible with other commissioners in the area to identify, plan for and mitigate risks to services that they may not commission, but which their commissioning decisions may impact upon. Some local authorities may also choose to commission with their neighbouring authorities to realise economies of scale. Further advice on whole system commissioning can be found in Making it Work and examples of collaboration can be found in the Local Government Association (LGA) document Sexual Health Commissioning in Local Government.

This service specification is not intended to be prescriptive and recognises the need for commissioners to undertake sexual health needs assessment to inform their own local communities. This will include those groups where the burden of sexual ill health is recognised to be greater, but also particularly vulnerable groups such as those with learning difficulties, people who are homeless and others. While a needs assessment will inform the development of

the specification, both providers and commissioners must recognise the need to respond to changes and emerging trends within their population. This may include new and/or re-emerging infections, new technologies, changing population profile and changing behaviours.

An ISHS model aims to improve sexual health by providing non-judgmental and confidential services through open access, where the majority of sexual health and contraceptive needs can be met at once, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends) and locations which are accessible by public transport. Services are increasingly being provided remotely and online as a result of changes made to service models during the pandemic. Service models and access should be regularly informed by local review and service user feedback.

Providers of ISHSs are expected to operate in line with the most recent guidance and established clinical practice. While this document includes guidance current at the time of publication, providers must ensure services reflect updates in guidance and recommendations as and when they are produced, and commissioners will support them to do so. In addition, this specification will be reviewed periodically and updated as appropriate.

Anyone, regardless of gender identity or natal sex, is expected to be able to access SRH services in order to maintain their health, and it is important to acknowledge that people with gender identities that do not align with their natal sex have unique and specific sexual and reproductive health needs. SRH care must therefore be inclusive, appropriate, and sensitive to the needs of all people, including those individuals whose gender identity does not align with their natal sex, non-binary people, and people of diverse gender identities.

Within this document, the broad terms 'females' and 'males,' and 'women' and 'men' are used. Where the term 'female' or 'male' is used, this refers to a person’s biological sex (including intersex), irrespective of their gender identity. The term 'women' or 'men' refers to the gender with which people identify.

Acknowledgements

OHID and UKHSA would like to thank the following organisations for their input:

Association of Directors of Public Heath, British Association for Sexual Health and HIV, English HIV and Sexual Health Commissioners’ Group, Faculty of Sexual and Reproductive Health, NHS England (Specialised Commissioning).

Service specifications

All subheadings for local determination and agreement

Service Specification No.	
Service	**Integrated Sexual Health Service(s)**
Authority Lead	
Provider Lead	
Period	
Date of Review	

1. Population needs

National and local context and evidence base

A specialist integrated sexual health service (ISHS) provides service users with open access to confidential, non-judgemental services including sexually transmitted infections (STIs) and blood borne viruses (BBV) testing (including HIV), treatment and management; HIV prevention including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP); the full range of contraceptive provision; health promotion and prevention including relevant vaccination.

Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. The government in 2013 set out its ambitions for improving sexual health in its publication, a framework for sexual health improvement in England. In December 2021, the government published an action plan towards ending HIV transmission, AIDS and HIV-related deaths in England 2022 to 2025.

Sexual health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, young people, and people from ethnic minority backgrounds. Similarly, HIV infection in the UK disproportionately affects gay, bisexual and other MSM, and black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services. Despite the increased provision of remote and online services improving access for some, it should be recognised that some will be excluded or may be disadvantaged by these approaches (2020 data on internet access revealed 5% of the adult population of Great Britain had not used the internet in the last 3 months and 16% of the population does not use a smartphone for private use). *O*ffering a *mixture of face-to-face* and *online services* is required to

meet the needs of different population groups. Services and modes of delivery should be designed to meet the needs of local populations and work to reduce inequalities in both access and health outcomes.

An ISHS model aims to improve sexual health by providing non-judgmental and confidential services through open access, where the majority of sexual health and contraceptive needs can be met at once, often by one health professional, in services with a mix of provision types (e.g. - booked clinic, walk-in, sit and wait, outreach) and extended opening hours (evenings after 6pm and weekends) and locations which are accessible by public transport. This should be supported by remote and online provision.

The provision of ISHSs is supported by current accredited training programmes and guidance from relevant professional bodies including; Faculty of Sexual and Reproductive Health (FSRH), British Association for Sexual Health and HIV (BASHH), British HIV Association (BHIVA), Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute for Health and Care Excellence (NICE), as well as relevant national policy and guidance issued by the Department of Health and Social Care (DHSC) and the UK Health Security Agency (UKHSA).

Providers must ensure commissioned services are in accordance with this evidence base and in line with current national guidance, standards of training and care and quality indicators.

The 2013 Framework for Sexual Health Improvement in England highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental ISHSs (including for STIs and BBVs, contraception, health promotion and prevention).

Local authorities are mandated to commission comprehensive open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons, advice on, and reasonable access to, a broad range of contraception, and advice on preventing unplanned pregnancy. As noted in the introduction to this specification, services may also provide a wider range of services including diagnosis and treatment for non-STI conditions and broader SRH services that are set out with the commissioning responsibility of local authorities: Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

.

2. Key service outcomes

Locally agreed aims, objectives and outcomes

The service will support delivery against the 5 main sexual health Public Health Outcomes Framework measures:

- under 18 conceptions
- chlamydia detection rate
- new STIs diagnosis (excluding chlamydia in the under 25s)
- prescribing of long-acting reversible contraception (LARC) excluding injections (females aged 15 to 44)
- people presenting with HIV at a late stage of infection

In addition, it will deliver the following outputs and outcomes to improve sexual health in the local population, while also being based on local needs assessments to recognise risk changes in the population.

SRH services:

- clear, accessible, and up-to-date information in a range of formats available about services providing contraception and sexual health services for the whole population, including preventative information targeted at those at highest risk of sexual ill health
- increased uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods (including LARC) for all age groups
- a reduction in unplanned pregnancies in all ages as evidenced by teenage conception and abortion rates

STI services:

- improved access to services among those at highest risk of sexual ill health
- reduced sexual health inequalities among young people
- increased timely diagnosis and effective management of STIs and BBVs
- repeat and frequent testing of those that remain at risk
- increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk
- improved access to HIV PrEP among those at highest risk of HIV infection
- monitor late diagnosis and uptake of partner notification
- increase availability of condoms and adoption of safer sex practices

Overarching:

- increased development of evidence-based practice and ensure service user consultation and involvement
- maintenance of research governance and other necessary arrangements to participate in trials
- ensure that participants receive continued support to be able to access trials through the commissioned service in the event of the service being re-tendered

Commissioners should work collaboratively with providers to determine the most effective mechanisms by which to measure these outcomes. Suggested outcome measures should be based on local needs assessments and identified areas within the joint strategic needs assessment.

The service will agree with the commissioner a yearly programme of audit, research and evaluation to ensure continuous improvements in service quality. For advice on using audit in commissioning sexual health, reproductive health and HIV services see this guidance for commissioners.

3. Scope

3.1 Aims and objectives of service

The ISHS will aim to improve sexual health outcomes by:

- promoting good sexual health through primary prevention activities including condom use, vaccination, the sexual health aspects of psychosexual counselling, HIV PrEP, behaviour change and those which aim to reduce the stigma associated with STIs, HIV and unplanned pregnancy
- providing rapid and easy access to open access STI and BBV testing, treatment and management services through a variety of mechanisms which should include remote and online services
- providing rapid and easy access to open access reproductive health services including the full range of contraceptive services; supported referral to NHS funded abortion services (based on up-to-date knowledge of local contractual arrangements for abortion services including late gestations and those with comorbidities); and support in planning for a healthy pregnancy; through a variety of mechanisms which should include remote and online services

- reducing late diagnosis of HIV and undiagnosed HIV and improving the sexual health of those living with HIV
- providing a quality service with appropriately trained staff, clinical governance and service user safety arrangements
- being responsive to local need by (a) providing rapid response to outbreak management; and (b) through continuous improvement and response to local population need
- operating as a leader in the local sexual health economy providing clinical leadership, involvement in local networks and development of clear referral pathways between providers
- Overarching service objectives include:
- ensure that services are acceptable and accessible to people disproportionately affected by unplanned pregnancy and sexual ill health based on up-to-date sexual health needs assessment which identifies the needs of vulnerable or at-risk groups.
- engage local prevention groups and non-governmental organisations to facilitate collaboration with service development, health promotion and outbreak management
- ensure service users' views inform service evaluation, development and continuous improvement to ensure services remain responsive to the needs of local populations
- proactively assess and respond to the public health needs of the local population and ensure robust links and pathways are in place to wider public health issues
- rapid and easy access to services for the prevention (including vaccination and HIV PrEP), detection and management (treatment and partner notification) of STIs and BBVs to reduce prevalence and transmission, including for people living with HIV
- ensure robust information governance systems are in place and the service is reporting to mandatory national datasets
- support and champion evidence-based practice in sexual health (this should include participation in audit and service evaluations and may include research)
- promote service and key sexual health messages to the local population, via the use of innovative and appropriate media and marketing techniques tailored to specific audiences
- understand the wider determinants around both sexual health and unplanned pregnancy

- prompt referral and signposting of service users to services such as HIV services, the sexual assault referral centre, drug and alcohol services and other services relevant to their individual needs

STI service objectives include:

- provide opportunities for people who choose to manage their own sexual health either independently or with support
- provision of chlamydia screening, treatment and partner notification as part of the NCSP
- provision of STI testing, treatment and partner notification
- all diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed and acted upon quickly
- increase the uptake of HIV testing
- provide HIV PrEP for populations at risk (in line with current BHIVA and BASHH guidelines on the use of HIV PrEP)
- monitor HIV late diagnosis and partner notification, undertaking root cause analysis for these cases where possible
- rapid referral to HIV treatment and care services following diagnosis, to ensure timely initiation of treatment
- management of complex STIs including gonorrhoea, syphilis, mycoplasma genitalium (Mgen), recurrent genital infection with an STI

SRH service objectives include:

- provide sexual health information, including information about safer sex practices, contraceptive methods and access to free condoms and advice to develop increased knowledge, especially in high need communities, working in collaboration with the wider system partners
- access for all age groups to a complete range and choice of contraception including LARC, emergency contraception, condoms and support to reduce the risk of unplanned pregnancy
- access to free pregnancy tests and appropriate onward referral to abortion services or maternity care
- promote access and reduce waiting times to abortion services and maternity care through the provision of information on client self-referral (where available)

Training objectives include:

- develop the sexual health workforce ensuring staff have access to the full range of nationally accredited postgraduate training including specialist training programmes
- deliver undergraduate training when linked to a university that trains health care professionals
- co-ordinate and support the delivery of sexual health care across a locality through expert clinical advice, clinical governance and clinical networks
- provide specialist expert advice to other service providers and organisations, and training of nursing and medical sexual health experts
- deliver multidisciplinary training, including to primary and secondary care; as well as undergraduate training and postgraduate training including placements
- deliver training for medical and nursing students in line with requirement of the relevant regulator (General Medical Council (GMC) or Nursing and Midwifery Council (NMC)) and training and education for speciality medical trainees in line with GMC requirements and relevant curricula
- ensure that healthcare professionals undertake accredited transferable qualifications which are kept up-to-date
- work with partners to support the local implementation of Relationships, Sex and Health Education, including providing up-to-date information and contact details for contraception and sexual health information for educational settings

3.2 Service description and pathway

The service will provide a confidential, open-access, cost-effective, high quality and comprehensive SRH service in line with the requirements set out in this specification and in accordance with evidence-based protocols, national guidance, adapted to the needs of the local populations. The service is characterised by:

- providing a confidential integrated SRH service where the majority of sexual health and contraceptive needs can be met on one site, remotely or online, and usually within a single consultation
- service provided on an open access basis and available to anyone requiring care, irrespective of their age, sex, gender, sexual orientation, accessibility requirements, place of residence or general practice (GP) registration, without referral

- having walk-in, and appointment clinics, including evenings and weekends and offering remote and online services alongside in-person attendance to improve service provision
- using various models of care that could include a hub and spoke model of care (working with primary care and linking into local outreach work)
- multidisciplinary working with key stakeholders
- delivery of post-exposure prophylaxis (PEP) or post-exposure prophylaxis following sexual exposure (PEPSE) on site (with medicine funded by NHSE)
- delivery of HIV PrEP (with medicine funded by NHSE)
- providing a full range of sexual health services as detailed below
- providing interpretation services for clients whose first language is not English and who require interpretation, including British Sign Language

3.2.1 Service levels

The service will provide a range of interventions to meet the needs of local populations. The ISHS will be delivered in broad accordance with the Level 1, 2 and 3 service models which are well established for sexual health service provision and are outlined in the NHS Data Dictionary. The integrated service will include the elements outlined below.

3.2.2 Self-managed care

Service users of all ages will be able to access the following without the need to see a healthcare practitioner, although support must be available if needed. Vulnerable adults must receive appropriate assessment procedures. Those under the age of 16 must be assessed following Fraser competency guidelines. Those under the age of 18 must be assessed for child sexual exploitation (CSE).[1] [2] [3]

Self-managed care delivered through the integrated service includes:

- health information
- generic information on pregnancy, STIs and HIV prevention and safer sex, Child Sexual Exploitation (CSE) and female genital mutilation (FGM) advice

[1] Department of Health (2004). Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health.

[2] Gillick v West Norfolk and Wisbech Area Health Authority [1985] UKHL 7 (17 October 1985).

[3] Sexual Offences Act 2003.

- information on the full range of contraceptive methods and where these are available
- primary prevention initiatives to improve overall sexual health to the community linking to national sexual health campaigns
- self-sampling and test kits accessed via online services
- pregnancy testing kits
- condoms
- treatment

Some self-managed services may be accessed online.

3.2.3 Level 1 and 2

Overarching:

- information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- full sexual and social history taking and risk assessment (all practitioners)
- cervical cytology: it is acknowledged that arrangements for cervical screening in ISHSs are variable across the country. Most cervical screening is carried out in GP settings; 0.5% of those eligible screen in sexual health clinics, but over 2% of abnormalities are detected there. Since 2013, some local authorities continued to include and fund opportunistic cervical screening in sexual health services. However, NHSE has the commissioning responsibility for cervical screening in ISHS, and have published a service specification for the provision of NHS cervical screening sample taking services in sexual health settings.
- assessment and referral for psychosexual issues
- assessment and referral to address chemsex concerns to the relevant organisation including drug and alcohol treatment (DAAT) services
- assessment and referral for brief interventions (BIs) / Making Every Contact Count (MECC) including alcohol, weight management, and stop smoking services
- referral for FGM specialist advice and care
- holistic sexual health care for young people including child protection and safeguarding
- assessment and referral of sexual assault cases (including STI testing at an appropriate time)

- outreach services for STI prevention and contraception
- urgent and routine referral pathways to and from related specialties (GP, urology, accident and emergency, gynaecology) should be clearly defined. These may include general medicine and infectious diseases for inpatient HIV care
- urgent and routine referral pathways to and from social care
- regular audit against national guidelines

STI services:

- STI testing and treatment of symptomatic but uncomplicated infections in people (except MSM), excluding:
  - males with dysuria and/or genital discharge
  - symptoms at extra-genital sites, for example rectal or pharyngeal
  - genital ulceration other than uncomplicated genital herpes
  - partner notification, including HIV and BBV
- case management of uncomplicated chlamydia
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- prompt referral and signposting to HIV services
- initiation of PEP with referral to Level 3 for ongoing management (non-NHS providers may need to have a service level agreement with an NHS trust for them to gain the reimbursement for PEP or PEPSE. The cost of the medicines will be based on current NHSE HIV drug framework arrangements and the costs will be paid using the NHSE tariff)
- promotion and delivery of hepatitis A and B and Human Papilloma Virus (HPV) vaccination, with a particular focus on key target groups. For hepatitis A this includes all MSM attending a sexual health clinic in line with the Green Book and BASHH guidance. MSM attending sexual health services aged to up and including 45 years olds should be offered HPV vaccination in line with the Green Book. HPV vaccination is commissioned by NHSE.
- hepatitis C testing and discussion (with referral pathways in place)
- management of first episode uncomplicated vaginal discharge (low risk)
- management of contacts of gonorrhoea and trichomonas vaginalis (TV) (excluding symptomatic men)

- assessment and treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis or lymphogranuloma venereum (LGV)

SRH services:

- pregnancy testing
- advice and referral for infertility and menorrhagia and preconception advice and support
- supply of male and female condoms and lubricant
- all methods of oral emergency contraception and the intrauterine device (IUD) for emergency contraception
- first prescription and continuing supply of hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist
- first prescription and continuing supply of injectable contraception
- uncomplicated insertion of IUD and intrauterine system (IUS) for contraceptive purposes, follow up and removal
- uncomplicated contraceptive implant insertion, follow up, and removal
- diaphragm fitting and follow up
- assessment and referral for difficult implant removal
- direct referral for antenatal care
- direct referral for abortion care and to support self-referral
- counselling and direct referral for male and female sterilisation dependant on commissioning arrangements
- provide comprehensive advice and support to people experiencing difficulties with choice of contraceptive methods
- management of problems with hormonal contraceptives

3.2.6 Level 3 service provision in addition to levels 1 and 2

Overarching:

- sexual health aspects of psychosexual counselling

- participation in research trials
- co-ordination of outreach clinical services for high-risk groups
- co-ordination of contraceptive and STI care across a network including clinical leadership of contraceptive and STI management
- Co-ordination of clinical governance:
- co-ordination and oversight of training in SRH and genitourinary medicine (GUM)
- co-ordination of pathways across clinical services
- co-ordination of partner notification for STIs and HIV

STI Services:

- management of complicated or recurrent STIs (including tropical STIs) with or without symptoms
- testing for Mgen where clinically indicated (while the BASHH Mgen management guideline is primarily aimed at level 3 sexual health services, it could also serve as a reference guide for sexual health services at other levels)
- management of STIs in pregnant people (except those with uncomplicated infections requesting abortions)
- management of HIV partner notification
- interface with specialised HIV services as commissioned by NHSE
- risk assessment and provision and follow up of PEPSE
- risk assessment, initiation and clinical follow up and monitoring of HIV PrEP
- support local arrangements for the National Chlamydia Screening Programme (NCSP) operating outside sexual health services (for example partner notification)

SRH services:

- management of complex contraceptive problems
- specialist contraception services, for example IUD or IUS problem clinics, difficult, non-palpable implant removal with appropriate diagnostic services (for example, ultrasound) to support this

3.3 Population covered

The local authority is mandated to commission open access confidential services. As an integrated SRH service, the provider must operate an open access policy for both contraception and STI services regardless of residence of the service user in line with regulations.

Services should demonstrate that user and public involvement has been fundamental to service development, provision, monitoring and evaluation of the service and improvement, including taking into account local safeguarding policies.

3.4 Any acceptance and exclusion criteria and thresholds

This specification excludes HIV treatment and care, which are subject to separate service agreements, unless jointly procured and commissioned under a separate arrangement. The specialised HIV service specifications for adults and children can be found here:

NHS standard contract for specialised human immunodeficiency virus services (adult)

NHS standard contract for specialised human immunodeficiency virus services (children)

Termination of pregnancy is commissioned by ICBs and is covered under a separate specification.

The provider has the right to refuse service provision to users:

- who are unsuitable for treatment under the conditions of this service specification;
- who have not validly consented to the treatment provided under the services; and
- for any unreasonable behaviour unacceptable to the provider, its staff, the consultant or the named professional clinically responsible for the management of the care of such service user.

3.5 Interdependencies and referrals to other services

The ISHS will maintain efficient working relationships with allied services, agencies and stakeholders to enhance the quality of care delivered and ensure the holistic nature of the service. Specifically, linkages will be maintained by making use of existing service pathways, with, GPs, HIV treatment and care services, sexual assault and abuse services, and wider local authority services, health promotion, other sexual health and secondary health service providers for use when relevant.

The service cannot work in isolation and is required to work with partners such as NHSE, ICB, local authority and community providers to address the needs of the local population and increase the opportunity for service users to achieve optimum sexual health outcomes, utilising

equality impact assessments (EIAs) where appropriate. Any potential or proposed changes to services must be discussed and planned for as at early a stage as possible, including assessment and mitigation of risks to other services regardless of whether they are commissioned by the local authority or other commissioners.

Stakeholders will include:

- abortion providers
- antenatal and postnatal services
- cervical screening programme
- child and adolescent mental health services
- clinical psychology services
- community pharmacy
- CSE and safeguarding teams
- defence medical services
- dermatology
- domestic abuse and domestic violence services
- drug and alcohol services
- emergency departments
- FGM services
- GPs including primary care networks
- gynaecology
- health protection teams outbreak management
- health visiting and intensive family support visiting
- hepatitis services
- HIV treatment and care services
- homeless, veteran and traveller organisations

- ICBs
- lesbian, gay, bisexual, trans and queer or questioning plus community (LGBTQ+), MSM, women who have sex with women (WSW), non-binary people and people with diverse gender identities
- maternity services
- mental health services
- nephrology
- NHSE
- online testing and treatment for STIs
- online provision of contraception
- other healthcare service areas including voluntary sector
- pathology and laboratory services
- prisons and youth offender institutions
- providers of relationship and sex education
- school and education services, including higher education
- services for sex workers
- services for those with disabilities, including learning disabilities
- sexual assault referral centre
- sexual dysfunction services
- social care
- urology
- voluntary sector working with communities at risk of poorer sexual health including black African, black Caribbean and other minority ethnic communities
- weight management, smoking cessation and physical activity services
- youth services

This list is not definitive, and meant to signal an inclusive and collaborative approach, bringing together a broad stakeholder partnership, which will be influenced by local arrangements and future service and system transformation.

The provider is expected to actively participate in local, regional and national clinical networks, relevant trials, training, and research and audit programmes where applicable.

3.6 Any Activity Planning Assumptions

(Insert details of activity planning assumptions if applicable)

Services should be planned and operated based on findings from local needs assessments and EIAs that include an understanding of the differing needs of different communities within the local population.

4. Applicable service standards

4.1 Applicable national standards

The ISHS is underpinned by, and the provider will ensure it adheres to the following minimum standards:

- BASHH standards for the management of STIs (2019)
- BASHH guideline for sexual history taking (2019)
- BASHH and Brook. Spotting the signs: a national proforma for identifying risk of CSE in sexual health services (2014)
- BHIVA, BASHH and BIA adult HIV testing guidelines (2020)
- BHIVA and BASHH guidelines on the use of HIV PrEP (2018)
- BHIVA Guidelines for the SRH of people living with HIV; Current out for consultation (2017)
- DHSC sexual health services: key principles for cross charging (2018)
- FSRH service standards for risk management in SRH care (2017)
- FSRH service standards for SRH care (2016)
- Information Commissioners Office: guide to the UK general data protection regulation (UK GDPR)
- NCSP standards 8th edition (2022)

- Society of sexual health advisors guidance on partner notification (2015)
- NHS entitlements: migrant health guide
- All relevant NICE and Green Book guidance (see service standards for further detail)

Relevant UK clinical guidance covering the specialities of SRH care and GUM can be found at www.fsrh.org and www.bashh.org. The provider must ensure services reflect updates in guidance and recommendations as and when produced. For psychosexual assessment and counselling, providers should follow relevant guidance from the College of Sexual and Relationship Therapist (COSRT) and the Institute of Psychosexual Medicine (IPM).

For further applicable standards, see Service Standards.

Providers must ensure services reflect updates in guidance and recommendations as and when produced.

The service should use the DHSC's You're Welcome quality criteria and local resources where available, as guiding principles when planning and implementing changes and improvements, in order for the service to be young people friendly where appropriate.

4.2 Applicable local standards

(Insert local standards if applicable)

4.3 Requirements

The service is required to generate a quarterly data extract of all service user attendances and associated diagnoses and services in accordance with the service specification of the GUMCAD STI Surveillance System. The submission of GUMCAD extracts is mandatory for all local authority commissioned Level 2 and 3 sexual health services, including those offered online. Where the service provides testing through an online service, this activity should also be included with their routine GUMCAD submissions. The service is also required to be responsive and flexible to any amendments to the datasets including frequency of submission and addition of new modules in line with nationally agreed information standards and lead-in times.

The service is also required to capture contraception and other SRH activities through collection of the Sexual and Reproductive Health Activity Dataset (SRHAD) which should be submitted annually to NHS Digital.

All service users newly diagnosed with HIV should be reported to UKHSA. This can be done either through a quarterly data extract to the HIV and AIDS Reporting System (HARS) or via a HIV new diagnosis proforma, available online or by request from UKHSA. Following a medical consultation related to HIV care, the service is required to generate and submit a quarterly data extract to the HARS.

The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for all publicly funded chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through measurement of population screening coverage, proportion of all tests that are positive and diagnosis rates. It is the responsibility of the sexual health service provider to ensure the core CTAD data requirements are provided to the laboratory for each chlamydia test, in particular, postcode of residence of the service user and testing service type.

The service is expected to discuss with commissioners' regular analysis of GUMCAD, CTAD, HARS and SRHAD data to enable informed commissioning decisions relating to ISHS attendances, activity and STI diagnosis and contraceptive usage trends. Services should make any necessary changes to IT systems as new information standards are published.

These requirements for submission of mandatory surveillance data are in addition to the NHSE data requirements such as those relating to drug usage for HIV PrEP that must be reported as outlined in the NHSE contract insert through the Minimum Data Set in accordance with requirements.

5. Location of provider premises

5.1 The provider's premises

Location of premises should be agreed in consultation with the commissioner, based on a local health needs assessment and understanding of public transport routes. Premises must be accessible by public transport and visible to the public. Service information must be available in a range of formats and languages to ensure all communities can access them. To ensure a broad range of people are able to access and use facilities within buildings, providers can review this letter which clarifies the relationship between the Equality Act 2010 and Part M (Access to and use of buildings) of the Building Regulations 2010.

Premises for the provision of the clinical ISHS must be fit for purpose and in accordance with DHSC Guidance and Care Quality Commission (CQC) requirements. Each premise will be fit for purpose for the services delivered in that location and be well maintained. The provider will carry out the risk assessment on all the premises used to deliver ISHS, including infection control, and ensure that all significant risks identified are addressed.

The service model will provide evidence and assurance that maintenance, and insurance cover if required, of the assets (including items such as examination couches, medical equipment, furniture, IT systems and phones) will be included within the financial envelope of the contract. The Public Health Services template contract (DHSC, 2015/16) outlines that the provider must provide and maintain, at its own cost (unless otherwise agreed in writing) all equipment necessary for the supply of the services in accordance with any required consents and must ensure that all equipment is fit for purpose.

Services must be compliant to the specific building regulation notices. All necessary equipment must be provided to undertake the prescribed requirements, tailored to meet the service user requirements.

The provider will offer a friendly and welcoming waiting area with the aim of reducing service user anxiety.

The ISHS must be provided in an environment that promotes access and ensures safe and effective care. This includes ensuring there is adequate privacy and confidentiality, cleanliness and maintenance, meeting the national specification for clean NHS premises. All premises must be compliant with the requirements set out in the Equality Act 2010.

Confidentiality policies must be clearly displayed, adhered to and discussed with service users which include anonymity where applicable.

Remote and online services must meet the appropriate standards for the services provided.

5.2 Service user confidentiality and sexually transmitted infections

Following the Health and Social Care Act 2012, in England the 'NHS trusts and primary care trusts (Sexually Transmitted Diseases) Directions' 2000 apply only to the few remaining NHS hospital trusts, and they do not apply to NHS foundation trusts or the wider range of services that now provide STI testing and treatment. These Directions are due to be revoked in 2023 and DHSC will be publishing guidance to accompany this change.

However, DHSC’s policy will remain unchanged in that people should continue to use SRH and HIV services with assurance that their information and data will not be included in shared care records (including, but not limited to, the Summary Care Record) without their consent. Clear information should be available to patients about how their information is stored and how it may be shared with organisations with a legal right to receive it for public health and surveillance purposes in order for them to make an informed decision.

Whilst still in place the Directions do not directly address how service user information and records are retained. Nor do they prohibit the sharing of service user data for public health purposes under the Health Service (Control of Patient Information) Regulations 2002, or local authorities from receiving non-identifiable service user information for the purposes of cross-charging. In practice, most NHS sexual health services maintain separate service user records which remain within the service. Information is not shared with other NHS services (including the person’s GP) and information about attendance, STI testing, or treatment is not recorded in a service user’s shared NHS records. This practice encourages people to use sexual health clinics and get tested and treated for STIs without fear that very personal information will be shared with their GP or other NHS services. Information obtained in ISHSs should be shared within the integrated team.

To ensure service users with diagnosed HIV are treated safely and appropriately across the NHS, information for people receiving HIV treatment and care services is, with their consent, shared with other healthcare professionals, including their GP. However, information about an HIV positive service user's use of NHS sexual health clinics for STI testing and treatment should not be disclosed without their consent.

6. Required insurances

If required, insert types of insurances and levels of cover required.

6.1 Conditions precedent

Provide the authority with a copy of the provider’s registration with the CQC where the provider must be so registered under the Law.

Please insert any locally agreed conditions that must be satisfied prior to commencing service deliver, for example, provide a copy of insurance certificate

7. Quality outcome indicators

The tables below list suggested indicators based on evidence of good practice and national standards and guidance. Their inclusion is for local determination. There are more indicators available for consideration in the technical references listed in the table below.

1. Access

No	Quality outcomes indicators	Threshold	Technical guidance references	Method of measurement
1.1	Percentage of people offered an appointment or walk-in option (where available) within 2 working days of contacting the service	98%	BASHH 2019 standards for the management of STIs see standard 1	routine monitoring of access data
1.2	Percentage of people contacting a service who are seen or assessed by healthcare professional within 2 working days of first contacting the service	80%	BASHH 2019 standards for the management of STIs see standard 1 FSRH 2020 service standards for workload in SRH Services see standard 1	routine monitoring of access data
1.3	A) Percentage of people contacting the service with a clinically urgent care need relating to STIs (such as PEPSE or symptomatic) who are offered to be seen or assessed on the same day (within 4 hours) B) Percentage of people contacting the service with an urgent care need relating to contraception (such as	80% for STIs (to be agreed locally for contraception)	BASHH 2019 standards for the management of STIs see standard 1 BASHH/BHIVA 2021 guideline for the use of HIV PEP FSRH 2020 service standards for workload in SRH services see standard 1	routine monitoring of access data

No	Quality outcomes indicators	Threshold	Technical guidance references	Method of measurement
	emergency contraception) who are seen or assessed on the same day			
1.4	Percentage of appointments for procedures for LARC that are offered within 4 weeks of initial contact (if clinically appropriate)	to be agreed locally	FSRH 2020 service standards for workload in SRH services see standard 1	routine monitoring of access data
1.5	Percentage of people with needs relating to STIs who attend as a walk-in with a waiting time of less than 2 hours	80%	BASHH 2019 standards for the management of STIs see standard 1	routine monitoring of access data
1.6	Percentage of specialist SRH referrals from GP seen with 18 weeks of referral	100%	NHS constitution referral to treatment	audit
1.7	Percentage of psychosexual clients seen within 18 weeks of referral	100%	NHS constitution referral to treatment	audit

2. Clinical assessment and management

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
2.1	Percentage of individuals accessing the service who have sexual health history and risk assessment undertaken. This does not include individuals accessing self-managed care	97%	BASHH 2019 standards for the management of STIs see standard 2 see also NICE quality standard 178 sexual health (2019) quality statement 1	clinical audit

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
			see also NICE guideline NG221 reducing STIs (2022)	
2.2	Percentage of people with needs relating to STIs who are offered screening for chlamydia, gonorrhoea, syphilis and HIV at first attendance	97%	BASHH 2019 standards for the management of STIs see standard 2 see also NICE guideline NG221 reducing STIs (2022)	clinical audit
2.3	The percentage of people with needs relating to STIs who have a documented HIV test at first attendance	85%	Expected to contribute to reducing the number of people diagnosed with HIV at a late stage of infection (PHOF 3.04) BASHH 2019 standards for the management of STIs standard 2 BHIVA, BASHH and BIA 2020 HIV testing guidelines	clinical audit
2.4	Percentage of people at risk of reinfection who are offered repeat screening for chlamydia, gonorrhoea, syphilis and HIV according to best practice guideline, for example young people or MSM	85%	BASHH 2019 standards for the management of STIs standard 2 see also NICE guideline NG221 reducing STIs (2022)	

3. Diagnostics

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
3.1	Percentage of people who have symptoms suggestive of gonorrhoea or are Nucleic Acid Amplification Test (NAAT) positive for neisseria gonorrhoeae who have a culture performed	97%	BASHH 2019 standards for the management of STIs see standard 3	clinical audit
3.2	Laboratory turnaround times: A) the percentage of reports (or preliminary reports) issued by the laboratory within 4 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 9 working days of the specimen being received by the laboratory	97% 97%	BASHH 2019 standards for the management of STIs see standard 3	clinical audit

4. Clinical Management

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
4.1	Service turnaround times: A) Percentage of people having STI tests who have their results (both positive or negative) within 8 working days of the date of the sample	95%	BASHH 2019 standards for the management of STIs see standard 4	clinical audit

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
	(excluding those requiring supplementary tests) B) Percentage of people diagnosed with an infection should be treated within 3 weeks of the date of test	 85%		
4.2	Effective partner notification: A) The ratio of all contacts of index cases of gonorrhoea who access a service commissioned to manage STIs within 4 weeks of the date of first partner notification discussion B) The ratio of all contacts of index cases of chlamydia who access a service commissioned to manage STIs within 4 weeks of the date of first partner notification discussion C) The ratio of all contacts of index cases of early syphilis who access a service commissioned to manage STIs within 4 weeks of the date of first partner notification discussion	 A) gonorrhoea at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within 4 weeks B) chlamydia at least 0.6 contacts per index case within 4 weeks C) syphilis at least 0.4 contacts per index case within 4 weeks	BASHH 2019 standards for the management of STIs see standard 4	clinical audit
4.3	Documented partner notification outcomes or a progress update at 12 weeks after the	90%	BASHH 2019 standards for the management of	clinical audit

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
	start of the process (HIV) A) number of contacts* tested per total number of index cases. (* status-known contacts + number of contactable status-unknown contacts) B) proportion (%) of contactable partners tested* (*status-known contacts + contactable status-unknown contacts tested / total number of status-known contacts and contactable status-unknown contacts [expressed as %]) C) proportion (%) of indexes for whom there is a documented partner notification plan in the case notes 4 weeks after index case diagnosis. This 4 week timeline may change if there is ongoing risk to a contact and disclosure has not occurred (this should be dealt with under local policy).	A) at 3 months 0.6 healthcare professional (HCP) verified 0.8 index reported or HCP verified (those captured via either) B) at 3 months 65% HCP verified 85% Index reported of HCP verified (those captured via either) C) at 4 weeks 97% of index cases with a documented partner notification plan within 4 weeks of diagnosis at time of HIV diagnosis (when made in service) 97% indexes with PEP assessment: documented evidence of partner notification discussion to determine if any at risk contact has occurred within previous 72 hours	STIs see standard 4 BHIVA and BASHH HIV partner notification for adults: definitions, outcomes and standards BHIVA (2018) standards of care for people living with HIV see standard 5 (Sexual health and reproductive health)	

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
		to identify and refer partners potentially eligible for PEP.		
4.4	Ratio of contactable contacts of index cases of HIV who have had an HIV test, as verified by a healthcare professional, within 3 months of the date of first partner notification discussion	at least 0.6 contacts per index case	BASHH 2019 standards for the management of STIs see standard 4	clinical audit

5. Chlamydia screening

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
5.1	Percentage of positive patients under 25 offered A) chlamydia retest at 3 months post treatment B) percentage of positive patients under 25, offered a retest between 3 and 6 months after treatment	for local determination	BASHH guideline for management of infection with chlamydia trachomatis (2015)	clinical audit (drawing on CTAD where appropriate)

6. Contraception and reproductive health

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
6.1	A) Percentage of people with access to and availability of the full range of contraceptive methods should be provided and include choice within products (for example, a range of different combined hormonal contraceptives and intrauterine contraception) to maximise patient acceptability B) Percentage of females aged under 25 accessing contraceptive appointments or interventions that are being offered and accept a chlamydia screen	100% 100% offered % accepted for local determination	FSRH 2016 service standards for SRH care see standard 2 NCSP standards 8th edition (2022)	
6.2	A) Percentage of women who have access to emergency contraceptive advice (including intrauterine contraceptive device) within xx hours of contacting the service B) Percentage of women who have access to emergency contraceptive services (including intrauterine contraceptive device) within xx hours of contacting the service	Percentage and xx: for local determination	FSRH 2016 service standards for SRH care see standard 2	for local determination
6.3	Provider can demonstrate that arrangements are in place for the management of complex contraceptive problems (or onward referral as necessary)	evidence of compliance	FSRH 2016 service standards for SRH care see standard 2	for local determination

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
6.4	Provider should offer advice and information on medical gynaecological issues such as the perimenopause and menopause, premenstrual syndrome, and menstrual dysfunction. Where this is not available patients should be offered timely onward referral.	evidence of compliance	FSRH 2016 service standards for SRH care see standard 2	for local determination
6.5	Provider can demonstrate that direct referral or signposting is provided for people requiring or requesting: • sterilisation • maternity care • abortion care	evidence of compliance	FSRH 2016 service standards for SRH care see standard 2	for local determination

7. Clinical governance

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
7.1	Provider can demonstrate that the integrated SRH service is safe, well-managed and accountable	evidence of compliance evidence of participation in relevant annual regional or national audits and actions taken as a result of the audit findings	BASHH 2019 standards for the management of STIs based on standard 6 FSRH 2016 service standards for SRH care see standard 1 CQC 2014 regulation see 12, 13, 16, 17 and 20 CQC 2009 registration see	for local determination

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
			12 and 18	
7.2	Provider can demonstrate adherence to BASHH and FSRH clinical guidelines and the relevant NICE quality standards	evidence of compliance	BASHH clinical guidelines FSRH guidelines and statements NICE quality standard 178 NICE quality standard 129	clinical audit
7.3	People should have their care managed by an appropriately skilled healthcare professional	evidence of compliance	BASHH 2019 standards for the management of STIs based on standard 6 FSRH 2016 service standards for SRH care see standard 1 CQC 2014 regulation see 12 and 18	for local determination
7.4	Provider can demonstrate that appropriate policies and procedures are in place and adhered to in relation to safeguarding children and vulnerable adults	evidence of compliance	BASHH 2019 standards for the management of STIs based on standard 6 FSRH 2016 service standards for SRH care see standard 7	for local determination

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
7.5	Care pathways with other organisations to include partner notification and linked services (for example alcohol and drugs, mental health, FGM, CSE, smoking, domestic violence, sexual violence) are clearly defined	evidence of established pathways attendance at multi-agency meetings	BASHH 2019 standards for the management of STIs see standard 8 BASHH 2021 guideline on the management of STIs and related conditions in children and young people FSRH 2016 service standards for SRH care see standard 2	for local determination

8. Inclusion and reducing inequalities

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
8.1	An EIA is undertaken on any material changes to services and outcomes utilised to inform forward year planning	completion of EIA	locally determined	for local determination
8.2	Provider to demonstrate that all functions and policies are equality impact assessed	agreed programme to achieve compliance	locally determined	for local determination
8.3	Adopt the You're Welcome criteria	100%	You're Welcome quality standards and You're Welcome self-assessment tool	for local determination

9. Patient and public engagement

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
9.1	Patient and public engagement A) A patient and public engagement (PPE) plan which affords public consultation and feedback B) The use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to collect information from patients C) Evidence of person-centred care and treating service users with dignity and respect D) Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation	evidence of compliance	BASHH 2019 standards for the management of STIs see standard 9 FSRH 2016 service standards for SRH care see standard 4 CQC 2014 regulation see 9 and 10	for local determination
9.2	Evidence of at least one user experience survey annually	evidence of compliance	For local determination (however suggested best practice is ongoing real time surveys)	for local determination

No	Quality Outcomes Indicators	Threshold	Technical Guidance References	Method of Measurement
			CQC 2014 regulation see 17	
9.3	Percentage of service user feedback on surveys that rates satisfaction as good or excellent	for local determination (suggested threshold is 70%. any lower may indicate poor service delivery)	For local determination	for local determination
9.4	Evidence of improvements made to service as a result of user feedback	examples of compliance	BASHH 2019 standards for the management of STIs see standard 9 FSRH 2016 service standards for SRH care see standard 4 CQC 2014 regulation see 17	for local determination

8. Information provision

The following tables list a provision of data in addition to national reporting mechanisms such as GUMCAD, SRHAD and CTAD. Providers must ensure they are fully compliant with GDPR regulations.

1. Reducing inequalities

Information to be provided	Frequency of information provision
In order to reduce inequalities, the provider will meet [insert frequency] with the commissioner to review the demographics of service attendees [demographic characteristics to be included will be agreed with commissioner] compared to the demographics of the local population. Development of an action plan if there is under-representation of a particular demographic that the service should be reaching. Demographic characteristics may include (by not be restricted to): age; gender; gender at birth; sexual orientation; ethnicity; lower layer super output area (LSOA) by deprivation	for local determination

2. Contraceptive methods

Information to be provided	Frequency of information provision
2.1 Number of service users receiving condoms	for local determination
2.2 A) Number of IUDs fitted, and number removed B) Percentage removed within a year of fitting (could be achieved via clinical audit)	for local determination
2.3 A) Number of IUSs fitted and number removed B) Percentage removed within a year of fitting (could be achieved via clinical audit)	for local determination
2.4 Number of contraceptive injections administered	for local determination
2.5 A) Number of hormonal contraceptive implants fitted and number removed B) Percentage removed within a year of fitting (could be	for local determination

Information to be provided	Frequency of information provision
achieved via a clinical audit)	
2.6 A) Number of contraceptive pills prescribed (combined oral contraception (COC) and progestogen-only pill (POP)) as a new method of contraception B) Number of contraceptive pills (POP and COC) prescribed as an existing method of contraception	for local determination
2.7 Number of diaphragms, patches and rings prescribed	for local determination
2.8 Numbers of service users provided with information and timely offer of emergency contraception (oral and device)	for local determination

•

3. STI service provision

Information to be provided	Frequency of information provision
3.1 A) Number of chlamydia screens offered and accepted to females aged under 25 years B) Percentage of chlamydia screens offered and accepted to females aged under 25 years	for local determination
3.2 Number of positive chlamydia diagnoses among females aged under 25 years	for local determination
3.3 Number of diagnoses of chlamydia (all ages, all genders)	for local determination
3.4 Number of diagnoses of gonorrhoea	for local determination
3.5 Number of HIV diagnoses	for local determination
3.6 Number of diagnoses of syphilis (primary, secondary and early latent)	for local determination

4. HIV PrEP

For more information please read the HIV PrEP Monitoring and Evaluation Framework.

Information to be provided	Frequency of information provision
4.1 Determining PrEP need - proportion of all HIV negative individuals accessing ISHSs with PrEP need Numerator: the number of HIV negative individuals accessing ISHSs with PrEP need Denominator: the number of HIV negative individuals accessing ISHSs	for local determination
4.2 PrEP need identified - proportion of all HIV negative individuals with estimated PrEP need (indicator 4.1) who had this need identified Numerator: the number of HIV negative individuals accessing ISHSs with PrEP need identified Denominator: the number of HIV negative individuals accessing ISHSs (numerator of indicator 4.1)	for local determination
4.3 Initiation or continuation of PrEP among those with PrEP need - proportion of all HIV negative individuals with estimated PrEP need (indicator 4.1) who started or continued PrEP Numerator: the number of HIV negative individuals accessing ISHSs who started or continued PrEP Denominator: the number of HIV negative individuals accessing ISHSs with PrEP need (numerator of indicator 4.1)	for local determination
4.4 Number of people receiving PrEP - absolute number of individuals accessing ISHSs who are receiving PrEP Numerator: the number of HIV negative individuals accessing ISHSs who are receiving PrEP in each quarter Denominator: not applicable	for local determination
4.5 Number of people stopping PrEP - absolute number of individuals accessing ISHSs stopping PrEP in each quarter Numerator: the number of PrEP users accessing ISHSs who stop PrEP in the current quarter Denominator: not applicable	for local determination
4.6 HIV seroconversions among people receiving PrEP - proportion of people who are newly diagnosed with HIV among individuals accessing ISHSs who have received PrEP in the last 12 months Numerator: the number of new HIV diagnoses among individuals accessing ISHSs who received PrEP at least once in the last 12 months	for local determination

Information to be provided	Frequency of information provision
Denominator: the number of individuals accessing ISHSs who received PrEP at least once in the last 12 months	
4.7 STI diagnosis among people receiving PrEP - proportion of people who are newly diagnosed with HIV among individuals accessing ISHSs who have received PrEP in the last 12 months Numerator: the number of new HIV diagnoses among individuals accessing ISHSs who received PrEP in the last 12 months Denominator: the number of individuals accessing ISHSs who received PrEP at least once in the last 12 months	for local determination

5. Access to service provision

Information to be provided	Frequency of information provision
5.1 Number of users by: Age Gender Gender at birth Sexual orientation Ethnicity Local authority and out of area residents	for local determination
5.2 Percentage of users waiting longer than (to be agreed locally) from booking to appointment	for local determination
5.3 Percentage of users experiencing waiting times of >2 hours in a walk-in clinic	for local determination
5.4 Percentage of users experiencing waiting times of >30 minutes for a booked appointment	for local determination
5.5 Percentage of appointments where consultation time for a new routine appointment is 30 minutes and for a routine follow up appointment is 15 minutes	for local determination
5.6 Number of service users making formal complaints about the service	for local determination
5.7 Number of service users making compliments about the service	for local determination

6. Training provision

Information to be provided	Frequency of information provision
6.1 Details of training provision including course information, number of delegates and delegate details (including job title and organisation)	for local determination (suggest annual)

9. Transfer of accommodation and assets

The list below includes some of the key aspects we are aware of and questions to think about. However, this should not be taken as an exhaustive list.

Premises

Where do you want the service to be located? Do you want to specify the general location or the specific building? Who owns the building the current service uses? Will it still be available going forward? If so, on what terms? How long a lease do you want the provider to take out, or is that at their risk? Does the financial envelope include premise costs? Do you need tenders to include provisional guarantees of premises? Do you need bidders to detail how they will secure premises?

A new service may inherit a mixture of freehold and leasehold premises which the current incumbent will have specific legal requirements for. Consideration must be given by the commissioner to the complexity of arrangements of inherited premises.

Assets

Who owns the assets and is responsible for maintenance and insurance cover, if required, (such as examination couches, medical equipment, photocopiers, furniture, IT systems and phones) that the current provider uses? Will the assets be available when the new contract is let? If so, on what terms? If the service model has changed, are the current IT systems fit for purpose?

The Public Health Services template contract may be helpful in this circumstance. It states that ‘The Provider must provide and maintain at its own cost (unless otherwise agreed in writing) all equipment necessary for the supply of the services in accordance with any required consents and must ensure that all Equipment is fit for the purpose of providing the applicable Services.’ Commissioners should check the terms of their existing contract.

Commissioners should own the intellectual property rights of websites and/or names, logos, straplines and telephone numbers to ensure, in the event of re-procurement changes, users have consistency of access (any imagery or branding should be non-discriminatory and consistent to avoid confusion).

10. Service user surveys

The provider will gather and reflect feedback from engagement with service users and key stakeholders.

To ensure continuous service improvement, a quality provision and a service responsive to the populations needs, we will expect the provider to use a number of methods to seek the views of service users. This should include working with those most at risk of poor sexual health and the most vulnerable groups, for example LGBTQ+, young people, black African, black Caribbean and other minority ethnic populations. The provider will produce an annual report of the findings of the participation work with service users and it should also incorporate the view of the key stakeholders. This will demonstrate how the service has been modified a “fit for purpose” service.

It is important that both local and national data is used to inform a collective understanding of the changing circumstances of population. Some of this will be generated from service utilisation data, epidemiological data, as well as feedback from service user engagement.

It is expected that a number of methods of engagement will be used, from face-to-face to survey based questionnaires. The use of innovative methods of engagement, such as greater use of technology, including social media, will be welcomed.

11. Safeguarding policies

[Please append safeguarding children and vulnerable adult policy of provider]

The provider shall ensure all staff are aware of, trained to a level appropriate to their role (levels 1, 2 and 3, and CSE) and abide by guidance and legislation on safeguarding (children and adults). The service provider should ensure that staff are aware of and abide by (insert local standards if applicable). This should include understanding safeguarding referral procedures and referral pathways to social care.

Practitioners also need to be aware of the specific responsibilities that they have for young people aged 13 to 15 and for those under the age of 13. In principle, all service users under the age of 16 should be seen in a clinical setting.

Local authorities to work within legislative and procedural frameworks, in particular: Working Together to Safeguard Children (2018), Mental Capacity Act (2005) the Care Act Guidance (2014) and other relevant legislation including the Children Act (1989), the Children Act (2004); and the Sexual Offences Act (2003). The guidance and legislation place a number of duties and responsibilities on relevant agencies and partner organisations to comply and work together to:

- cooperate with the local authority when requested to do so
- to promote the safety and wellbeing of children and promote the wellbeing of adults in need of safeguarding, due either to care and support needs or other vulnerabilities associated with sexual health such as FGM, CSE, victims of human trafficking, domestic abuse or other risk indicators
- ensure where required adults who may appear to be vulnerable, particularly adults with care and support needs are provided with access to advocacy
- to inform and share information with services users and communities as required under the Care Act 2014 within the constraints of the 2018 Data Protection Act, the GDPR and the Caldicott Principles
- identify children, young people and adults who are vulnerable due to care and support needs or other risk factors and who require safeguarding interventions
- to undertake or cause enquiries to be made where there is reason to believe that harm is occurring or likely to occur to children and vulnerable adults, who are vulnerable due to care and support needs or other risk factors that impact on their abilities to safeguard themselves
- provide supervision to practitioners
- work together and cooperate with partner agencies
- work to ensure early identification and risk assessment of vulnerable adults at risk
- keep and maintain records regarding safeguarding practice in accordance with information sharing and data protection recording protocols
- inform and communicate with the public about safeguarding practice
- ensure any local multi agency safeguarding pathways and referral processes are understood and adhered to

12. Transfer of and discharge from care protocols

[Insert any locally agreed protocols including contents for discharge correspondence and relevant timescales for delivering such correspondence]

Sexual health service users are not formally discharged from the service. However, it is recognised that service users may choose not to attend the service in future or may attend another service provider for their continuing care for example, ISHS for Level 3 services or referral to providers abortion support.

13. Digital services

Service users should have the option of accessing services without the need for seeing a practitioner and/or attending a clinic. Service users should be provided with information about sexual health, online triage, signposting to the most appropriate services for their needs and the option of ordering self-sampling STI or HIV kits.

Clinics should offer service users the opportunity to triage and self-sample on site and routine STI test results should be available electronically to service users within 72 hours. Service users who are diagnosed with an STI will be offered an appointment within 24 hours or fast-tracked, if available, to a walk-in service. Remote and/or online provision for treatment may also be available.

Examples of existing services that could be offered without the need to see a practitioner:

- condom and lube distribution
- remote chlamydia screening
- digital self-triage to appropriate services
- STI self-sampling kits for self-declaring asymptomatic residents
- HIV self-sampling (for example, via the national HIV self-sampling service) and/or self-testing
- online self-care information to support residents to understand and manage their sexual health without the need to attend a clinic (see Note 1)
- ability to book appointments online
- results by text message and/or online remote access

- digital partner notification that service users can complete remotely
- routine contraceptive provision
- opportunities to obtain advice and information via phone, instant messaging (web chat) and/or video consultations
- opportunities for self-managed treatment, including antibiotics and wart treatments, by post or via GPs and community pharmacies
- robust follow up of all positive or reactive results to ensure confirmation of diagnosis, access to treatment and completion, and/or partner notification

Digital services have been developed with 2 distinct purposes to date:

- to improve population coverage and increase detection of infection. These services have largely been targeted at particular population groups, for example, HIV self-sampling for MSM and black African communities
- to manage demand and improve access to clinic-based services. These digital services have been developed as an integral part of clinic-based services with appropriate triage processes to identify whether digital or face-to-face services are most appropriate and with clear pathways into clinic-based services where appropriate

Services must have safeguarding frameworks in place to manage under-18 digital requests for screening and advice.

Online service providers should record all service activity accurately and appropriately for quality assurance and surveillance purposes in line with mandatory requirements for GUMCAD, CTAD, HARS and SRHAD.

Providers and commissioners should use the FSRH and BASHH standards for Online and Remote Providers of SRH Services (January 2019).

Note 1. HIV self-sampling and HIV self-testing definitions:

- HIV self-sampling: individual takes the sample which is then sent to a laboratory for processing. The individual is then provided with the result by a healthcare worker
- HIV self-testing: individual takes the sample, undertakes the HIV test and interprets result autonomously without any interaction with a healthcare worker. As of 2014 this option has been legal in England

14. Education and training

It is expected that providers who are delivering sexual health services will work in partnership with those responsible for education and training to develop new and existing staff in the field within the local health economy. This will entail specifically working with Health Education England (HEE) / NHSE and integrated care systems (see below regarding HEE moving into NHSE).

Where a local authority commissions GPs to deliver specialist contraceptive service such as LARC, providers must ensure the staff delivering these services have the appropriate training and maintain their competence [to fit and remove devices].

In addition, the Royal College of Nursing (RCN) has developed a series of resources on education, training and career progression in sexual health.

Workforce and Leadership

All SRH services should have appropriately trained leadership with specialist knowledge of both GUM and CSRH to ensure quality of service provision and improvement, development, training and clinical governance.

Health Education England (within NHSE from April 2023)

HEE is responsible for the education and training of the healthcare workforce in England. It was established as a special health authority in 2012 and, from 1 April 2015, became a Non-Departmental Public Body (NDPB) of the DHSC under the provisions of the Care Act 2014. In November 2021 it was announced that the organisation would be incorporated into NHSE by April 2023.

Where applicable under section 1(F) (1) of the NHS Act 2006, providers must cooperate with and provide support to HEE (NHSE) to help them secure an effective system for the planning and delivery of education and training. This may include postgraduate medical education, undergraduate medical education and training of other professional groups as required.

All education and training activity is funded at standard tariffs with different tariffs for different professions.

Activity will include:

- working with acute providers to ensure that undergraduate medical training funding flows to any newly commissioned sexual health services providing student placements as appropriate

- providing training locations (in discussion with the Postgraduate Dean) for postgraduate medical trainees in community sexual and reproductive health (CSRH) and in GUM, foundation training, core medicine and GP trainees, but may also include those wishing to gain experience in the field

- funding the non-tariff salary component and any out of hours or on call payments recognising that trainees make a contribution to service while in training

- ensuring that those providing educational and clinical supervision meet required standards

- ensuring that trainers have time allocated to train within their job plans and have protected time recognised within their supporting professional activities (SPA) time

- where appropriate, working with HEE (NHSE) to ensure that the provider is recognised by the GMC for training

- where necessary for their training, allowing trainees to be released on secondment to undertake specialist experience outside the provider such as HIV inpatient experience, abortion services and so forth

- providing training locations for nurses and allied health professionals on standard placement tariff rates

- supporting postgraduate medical trainees to attend external mandatory training courses outside the provider unit and allowing them access to study leave to do so

- working with other providers of services and training (for example if GUM trainees work in another provider to gain HIV inpatient competencies) to resolve potential financial issues around the tariff for the trainee for that period and for out of hours work in an acute trust on call

- key principles on the impact of educational opportunities within the commissioning process can be found in the guidance document and the accompanying flow chart

The LGA has developed '[standards for employers of public health teams in England]' for all employers of people working in public health and commissioners of services. The standards outline employer responsibilities in following areas:

- partnerships and accountability

- effective workforce planning

- continuing professional development

- professional registration
- education and training

Some sexual health and reproductive health services can be commissioned under local public health contracts by local authorities or delivered under the GP contract.

There may be opportunities for the education and training needs of those working in GP to be met through training hubs. Training hubs have been established to:

- provide support for workforce planning and development in GP to respond to local needs and enable the redesign of services within primary care
- improve education capability and capacity in primary and community settings through the development of multi-professional educators and the creation of additional learner placements
- improve education quality and governance and act as a local co-ordinator of education and training for primary and community care to support GP

For any queries, please contact HEE (NHSE) local or regional teams.

15. Clinical governance

The provider shall have in place and be able to evidence appropriate and workable clinical governance arrangements which are in accordance with the Sexual Health Clinical Governance Principles, including:

- a named clinical lead for all clinical services delivered as part of this contract; services may need to look for clinical leadership or system pathways from regional colleagues
- governance policies which are clear and accessible to all staff and service users, setting out organisational accountabilities and reporting mechanisms
- the provider will link into local, regional and national networks, including clinical networks
- a published organisational complaints policy and process and 'whistle blowing' policy
- policies and operating procedures to ensure that all clinical interventions are delivered in line with clinical guidelines, NICE guidance and robust evidence bases

- a planned annual clinical audit programme which includes the review of clinical performance, the refining of clinical practice as a result and the measurement of performance against agreed standards. The provider shall use performance data, clinical developments and customer feedback to inform the programme

- a planned programme of service improvement informed by the audit cycle, customer feedback, performance and evidence for change

- clear operational policies and procedures for the reporting and management of serious incidents and never events and a process to evidence learning from such situations to ensure continued service quality improvement

- where the provider is registered with the CQC it shall have in place an operational policy setting out its response to the requirements for Duty of Candour

- the provider shall provide an annual written summary of clinical audit undertaken, outcomes and actions taken and any plans for further clinical audit

- clinical governance policies shall be accessible to all staff, including volunteers and reviewed by the provider annually and whenever required to comply with national and local policy change

- the development and review of suitable clinical governance structures shall be compliant with CQC requirements and national standards. This shall cover the 5 main elements:

    - Are they safe?

    - Are they effective?

    - Are they caring?

    - Are they responsive to people's needs?

    - Are they well led?

- service users' compliments, comments and complaints procedure is clearly displayed in all service locations and sites

- the provider shall keep abreast of technical developments as they become available and shall build innovative solutions into the service, ensuring compliance at all times to maintain delivery of a good quality and responsive service

16. Exceedance, outbreaks and clusters

Clinical services are well placed to identify changes in the patterns of infection (changes to the gender, sexual orientation or age of people affected; changes to clinical presentation of an infection; general increase in numbers). Changes seen at a local level may not be detected through routine surveillance but could still represent an important local focus of infection which requires public health action.

Services should be familiar with their clinic population, in terms of age and gender profiles and the frequency with which different infections are diagnosed. Any changes to this can be investigated with local public health teams; preliminary investigation may involve a simple review of case numbers and demographic information, exploring whether any change to diagnostic methods or whether any specific events or exposures have taken place. Under section 6 of the Health and Social Care Act (2012) Directors of Public Health have a duty to prepare for and lead the (upper tier and unitary) local authority public health response to public health incidents. Such incidents are discussed between UKHSA Health Protection Teams and local authorities to determine the most appropriate overall lead organisation.

The provider and sub-contracted providers (including laboratory services) should comply with all requests from relevant national bodies (including, but not limited to NHSE, Medicines and Healthcare Products Regulatory Agency (MHRA) and UKHSA) relating to the management of national and local incidents and outbreaks.

Depending on findings of initial analysis, further investigation and public health action may be indicated; this will usually be led by the local public health or health protection team.

Actions may include:

- case finding: taking actions to identify further cases of infection, through awareness raising in clinical and other settings, encouraging people to get tested and contract tracing

- enhanced surveillance of cases: gathering more detailed information about cases, to explore particular risk factors or exposures. The purpose of this further information gathering is to inform control measures. For example, are there particular venues, activities or other factors associated with the increase in infections?

- public health control measures: there are a wide range of activities that might be suggested including awareness raising, offering testing in non-traditional settings (for example outreach in saunas and sex-on-premises venues), vaccination sessions for at risk groups (may be delivered in outreach settings), pre- or post-exposure prophylaxis

The response to an increase or outbreak of infections is usually co-ordinated through an Incident Management or Incident Control Team, and staff from the sexual health service would be expected to participate in these arrangements.

For further information refer to Public Health England (2018) Managing Outbreaks of STIs: Operational Guidance.

17. Laboratory and diagnostics

High quality services for the diagnosis of STIs are vital for effective control of infections in the population. There is increasing concern about the development of antimicrobial resistance and it is important that services, and the laboratories that they use, keep up-to-date with this rapidly evolving issue.

Commissioners of laboratory services should ensure that all laboratories commissioned to perform STI diagnostic testing are appropriately accredited and deliver optimal standards of laboratory services including specimen turnaround times. They should be United Kingdom Accreditation Services (UKAS) accredited and have evidence of External Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality Assurance (IQA). Commissioners should ensure that commissioned laboratories are using the ‘gold standard’ test wherever possible and adhere to national standard operating procedures where these are available.

Providers should consider how to capture point of care testing (POCT) and the appropriate use of POCT, while being aware of the sensitivity and specificity of the POCT used.

Providers should work in collaboration with microbiology and virology services to ensure quality standards are met.

Contract monitoring should be undertaken for all commissioned laboratories including for the samples sent to reference laboratories. Continuity planning provision action plan needs to be developed should the contracted laboratory be unable to provide the service.

Detailed quality standards are available, however services and commissioners should be aware that this is a rapidly evolving field and they should keep up-to-date with developments through appropriate professional websites (BASHH, UKHSA and UKAS).

The provider and sub-contracted providers (including laboratory services) should comply with all requests from relevant national bodies (including, but not limited to NHSE, MHRA and UKHSA) relating to the management of national and local incidents and outbreaks.

18. Immunisation, including hepatitis

Immunisation against hepatitis A (HAV) and hepatitis B (HBV) is recommended for people who may be at increased risk of infection; in the context of sexual health the Green Book on Immunisation (Chapters 17 and 18) recommends that MSM with multiple sexual partners are offered vaccination against HAV and HBV.

Hepatitis A

In 2016 and 2017, there was a large and long-running outbreak of hepatitis A in MSM; cases in the UK were initially concentrated in London but occurred in all areas of the country as well as across Europe.

The extent to which the infection spread among the MSM population was thought to be, in part, due to falling rates of vaccination in sexual health clinics. Reports from clinics where routine preventative vaccination had continued for longer suggest that, even in areas with large MSM populations, the level of HAV infection was lower.

An important factor to consider is the wider impact of infection and risk of transmission through non-sexual contacts; in the recent outbreak of HAV, there was transmission of infection from MSM to wider, non-sexual contacts through family and household contacts, schools and food premises.

Hepatitis B

Sexual transmission (through vaginal and anal sex) is one of the main routes of transmission of hepatitis B. In addition, it may also be transmitted through injecting drug use and therefore there is a possible risk of transmission associated with chemsex episodes. Furthermore, outbreaks of hepatitis B have occurred usually in high risk groups and settings.

As such, sexual health providers should, in line with DHSC guidance, as set out in the Green Book:

- risk assess service users and consider the possibility of hepatitis B transmission
- offer testing of hepatitis B for high risk individuals
- arrange passive immunisation with hepatitis B immunoglobulin for persons who have had a recent high risk exposure where rapid protection is required
- notify acute cases of hepatitis B to UKHSA

- offer hepatitis B immunisations to persons at high risk attending their service. These include: injecting drug users, individuals who change partners frequently (especially MSM, and sex workers), sexual contacts and close family contacts of a case or an individual with chronic infection with hepatitis B. Please note occupational immunisation is excluded from this contract.

Furthermore, in rare instances of outbreaks of hepatitis B providers should be prepared to assist with prevention and control measures that may include high risk individuals attending their service.

Response to occupational exposure to hepatitis B is not commissioned by local authorities, it is commissioned through the relevant employer's occupational health provision.

Human Papilloma Virus (HPV) Vaccination

HPV vaccination is commissioned by NHSE (under agreement section 7A). Providers are required to support national efforts to vaccinate target groups in line with national guidance and policy set out in the Green Book. This includes:

- MSM up to and including the age of 45 years who attend ISHSs and HIV clinics. The aim of the programme is to extend protection against HPV infection, HPV associated cancers and genital warts

- females and males in cohorts who are eligible for the routine programme (for England, females born after 01/09/1991 and males born after 01/09/2006) that may not have been offered protection against HPV should be signposted for vaccination if they are aged under 25 years. Delivery and contractual arrangements for these programmes should be checked with relevant commissioners

19. Chemsex

Chemsex is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. Chemsex commonly involves crystal methamphetamine, gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL) and mephedrone, and sometimes injecting these drugs (also known as slamming).

Public Health England issued a briefing about chemsex for commissioners and providers of drug and alcohol services in 2015. The briefing includes background, data and prompts for delivering services. Although the primary focus was MSM who engage in chemsex, many of the principles apply to all groups and in particular other LGBTQ+.

Key points about people who engage in chemsex include:

- some may not present to certain healthcare services because they fear experiencing stigma or they may feel that service provision is not equipped to help them
- people accessing drug treatment services may benefit from talking about specific sexual practices (for example, sex with multiple partners or fisting) but many are concerned that this can cause staff to be unsympathetic to their needs
- some people may feel that sexual health services are more likely to be empathetic and knowledgeable compared to drug treatment services
- people who present to services and require support for chemsex may not consider that they have a drug problem or may not present the problem in typical substance misuse terms
- people engaged in chemsex can be at increased risk of infection from BBVs, STIs and other diseases such as shigella infection
- people engaged in chemsex are a diverse group, with people from ethnic minority backgrounds having different needs
- people who engage in chemsex are often in full time employment, use drugs intermittently and often generally function well in life
- individuals who use drugs occasionally may be unaware of safer injecting practices and the availability of services, equipment and advice that can reduce risks
- patterns of alcohol and drug use and chemsex are often related to broader wellbeing issues or problems
- commissioners of drug and alcohol services and sexual health commissioners should work together on developing joint strategic commissioning plans and commissioning integrated care pathways for people engaged in chemsex

20. Levels for STIs

The management of STIs outlined as Levels 1 – 3 as in the BASHH Standards for the management of STIs (2019)

Level 1

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 PEPSE
- sexual assault with referral as appropriate
- signposting to appropriate sexual health services
- opportunistic screening for chlamydia in sexually active asymptomatic females under the age of 25
- STI screening and treatment of asymptomatic infections (except treatment for gonorrhoea and syphilis) in people (except MSM) (see Note 1)
- 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 A, hepatitis B and hepatitis C and vaccination for hepatitis and B in line with the green book recommendations.
- 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 incorporates level 1 plus:

STI testing and treatment of symptomatic but uncomplicated infections in people (except MSM) 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 (see Note 2)
- symptoms at extra-genital sites, for example rectal or pharyngeal
- pregnant people
- genital ulceration other than uncomplicated genital herpes
- gonorrhoea if unable to perform gonorrhoea cultures with rapid transport to the laboratory

Level 3 incorporates level 1 and 2 plus:

- STI testing and treatment of MSM (see Note 1)
- STI testing and treatment of men with dysuria and genital discharge (see Note 2)
- testing and treatment of STIs at extra-genital sites
- STIs with complications
- STIs in pregnant people
- gonorrhoea cultures and treatment of gonorrhoea (see Note 3)
- recurrent conditions
- recurrent or recalcitrant STIs and related conditions
- management of syphilis and BBVs including the management of syphilis at all stages of infection
- tropical STIs
- specialist HIV treatment and care
- provision and follow up of HIV PrEP
- provision and follow up of HIV PEPSE (see Note 4)

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

Note 1. The testing and case management of 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.

Note 2. 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.

Note 3. Gonorrhoea culture is an essential test before treating gonorrhoea or giving empirical antibiotics to people with symptoms (see Standard 3).

Note 4. Note 4: PEP ‘starter packs’ are often available in other settings such as Accident and Emergency or Occupational Health, but referral to a specialist GUM (Level 3) service is required for ongoing management and provision of antiretroviral drugs. PEP/PEPSE antiretroviral drugs are funded by NHSE. Provision of PEP for non-sexual exposure is the commissioning responsibility of ICBs but provision of PEP and PEPSE should be included in specifications for specialist sexual health services. Local authorities and ICBs should agree local arrangements for any recharging of activity costs as required.

21. Levels for SRH

Level 1 (every GP)

- sexual history and risk assessment
- STI testing for women
- assessment and referral of men with STI symptoms

- HIV testing and counselling
- hepatitis B immunisation
- provision of oral hormonal contraception
- information about choice of full range of contraceptive and where available
- cervical cytology screening and referral
- pregnancy testing and referral

Level 2 (primary care teams with a specialist interest)

- testing and treating STIs
- partner notification
- IUD and implant insertion
- management of psychosexual problems
- vasectomy surgery

Specialist level 3 (specialist services)

- outreach for STI prevention and contraception
- specialised STI management and partner notification
- specialist HIV treatment and care
- highly specialised contraception
- termination of pregnancy services
- local co-ordination and back up for sexual assault
- psychosexual or sexual dysfunction services
- make sure local guidelines and framework for monitoring and improving practice are in place

- support clinical governance requirements at all levels
- provide professional training, designing and updating care pathways and developing new services

Table setting out the minimum provision of contraceptive measures by providers

Contraceptive Method	General Practice	Specialist level 3 services	Level 1 or 2
Emergency contraception – progestogen-only	yes	yes	yes
Emergency contraception – ulipristal acetate	yes	yes	yes
Emergency contraception – IUD	referral	yes	referral
Condoms – male	yes	yes	yes
Condoms – female	yes	yes	yes
Diaphragm	referral	yes	yes
Progestogen-only – oral	yes	yes	yes
Progestogen-only – injectable	yes	yes	yes
Progestogen only – subdermal	referral	yes	referral
Progestogen-only – intrauterine	referral	yes	referral
Combined hormonal – oral†	yes	yes	yes
Combined hormonal – transdermal	yes	yes	yes
Combined hormonal – vaginal ring	yes	yes	referral
Copper – intrauterine	referral	yes	referral
Natural family planning	referral	yes	referral
Sterilisation – male	referral	referral	referral
Sterilisation – male	referral	referral	referral

22. Service standards

- BASHH and Brook. Spotting the signs: a national proforma for identifying risk of CSE in sexual health services (2014)
- BASHH guideline for the management of infection with mycoplasma genitalium (2018)
- BASHH standards for the management of STIs in outreach services (2016)
- Link to all BASHH Guidelines
- BHIVA and BASHH UK guideline for the use of HIV PrEP (2021)
- BHIVA and BASHH guidelines on the use of HIV PrEP (2018)
- BHIVA standards of care for people living with HIV (2018)
- BHIVA UK national guidelines on safer sex advice (2012)
- BHIVA standards for psychological support (2011)
- Link to all BHIVA guidelines
- COSRT code of ethics (2022)
- FSRH service standards for SRH care (2016)
- FSRH standards for emergency contraception (2017 amended 2020)
- FSRH service standards for confidentiality in SRH services (2020)
- FSRH service standards for consultations (2020)
- FSRH quality standard for contraceptive services (2014)
- FSRH clinical standards medicine management in SRH services (2018)
- FSRH service standards for workload in SRH services (2020)
- FSRH service standards for record keeping in SRH care services (2019)
- Link to all FSRH standards and guidelines
- Female genital mutilation: safeguarding women and girls at risk of FGM (DHSC 2017)

- GMC projection children and young people (2012, amended April 2019)
- Hepatitis A, Green Book, chapter 17 (PHE 2013)
- Hepatitis B, Green Book, chapter 18. (PHE 2013 updated November 2019)
- Hepatitis B and C testing: people at risk of infection. NICE Public Health Guidance 43 (2012 updated 2013)
- Link to Institute of Psychosexual Medicine
- NICE NG68 STIs: condom distribution schemes (2017)
- NICE NG221 reducing STIs (2022)
- NICE QS129 quality standard contraception (2016)
- NICE QS129 quality statement on emergency contraception (2016)
- NICE QS 69 guidance for ectopic pregnancy and miscarriage (2016)
- NICE QS157 HIV testing, encouraging uptake (2017)
- NICE PH51 contraceptive services for under 25s (2014)
- NICE NG55 harmful sexual behaviour among children and young people (2016)
- NICE NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV (2016)
- NICE PH49 behaviour change; individual approaches (2014)
- NICE PH50 domestic violence and abuse: multi-agency working (2014)
- NICE CG30 LARC (2005 updated July 2019)
- NICE NG88 heavy menstrual bleeding: assessment and management (2018 updated May 2021)

Office for Health Improvement and Disparities