



Department  
of Health &  
Social Care



Public Health  
England

# Integrated Sexual Health Services

A suggested national service specification

August 2018

<p><b>Title:</b> Integrated Sexual Health Services: A suggested national service specification.</p>
<p><b>Author:</b> Public Health England and Department of Health and Social Care/Healthy Behaviours/10800</p>
<p><b>Document Purpose:</b> <b>Guidance</b></p>
<p><b>Publication date:</b> August 2018</p>
<p><b>Target audience:</b> Commissioners of sexual and reproductive health services Providers of sexual and reproductive health services</p>
<p><b>Contact details:</b> Sexual Health Policy Healthy Behaviours Team Department of Health and Social Care 39 Victoria Street London SW1H 0EU Email: <a href="mailto:healthybehaviours@dh.gsi.gov.uk">healthybehaviours@dh.gsi.gov.uk</a></p>

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit [www.nationalarchives.gov.uk/doc/open-government-licence/](http://www.nationalarchives.gov.uk/doc/open-government-licence/)

© Crown copyright

Published to gov.uk, in PDF format only.

[www.gov.uk/dh](http://www.gov.uk/dh)

# Contents

Contents .....	3
Introduction .....	4
Service Specifications .....	5
1. Population Needs .....	5
2. Key Service Outcomes .....	7
3. Scope .....	9
4. Applicable Service Standards .....	18
5. Location of Provider Premises.....	20
6. Required Insurances .....	22
Quality Outcomes Indicators.....	23
Information Provision .....	34
Transfer of Accommodation and Assets.....	37
Service User Surveys.....	38
Safeguarding Policies .....	39
Transfer of and Discharge from Care Protocols .....	40
Digital Services .....	41
Education and Training .....	43
Clinical Governance .....	45
Exceedance, Outbreaks and Clusters .....	47
Laboratory and Diagnostics .....	48
Immunisation, including Hepatitis .....	49
Chemsex .....	51
Levels for Sexually Transmitted Infections.....	52
Levels of Sexual and Reproductive Healthcare; FSRH; Quality Standards for Contraception 2014.....	55
Service Standards .....	57

# Introduction

This service specification covers the specialist integrated sexual health services that local authorities are responsible for commissioning including testing and treatment for sexually transmitted infections 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 patient 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, we recognise that the specialist integrated sexual health service 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 integrated sexual health services that a specialist service would be expected to deliver.

Local authorities are expected to work collaboratively with NHS England and Clinical Commissioning Group (CCG) commissioners to map patient pathways and plan services according to population need. In some areas, commissioners may choose to formally jointly commission services, however, even when this route is not taken, all local commissioners should work together to provide a seamless and efficient service for patients 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](#).

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. Whilst 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, changing behaviours.

An integrated sexual health service 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 one site, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends) and locations which are accessible by public transport.

Providers of integrated sexual health services are expected to operate in line with most recent guidance and established clinical practice. Whilst 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. This specification will be reviewed annually and updated as appropriate.

# Service Specifications

All subheadings for local determination and agreement

<b>Service Specification No.</b>	
<b>Service</b>	<b>Integrated Sexual Health Service(s)</b>
<b>Authority Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	
<b>Date of Review</b>	

## 1. Population Needs

### National/Local Context and Evidence Base

An integrated sexual health service provides patients with open access to confidential, non-judgemental services including STI and BBV testing, treatment and management; the full range of contraceptive provision; health promotion and prevention.

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 has set out its ambitions for improving sexual health in its publication, [A Framework for Sexual health Improvement in England](#).

Sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STIs), teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. Similarly HIV infection in the UK disproportionately affects 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.

An integrated sexual health service 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 one site, often by one health professional, in services with extended opening hours (evenings after 6pm and weekends) and locations which are accessible by public transport.

The provision of integrated sexual health services 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) and relevant national policy and guidance issued by the Department of Health and Social Care (DHSC) and Public Health England (PHE).

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 integrated sexual health services (including for STIs and BBVs, contraception, health promotion and prevention).

## Integrated Sexual Health Services

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 and advice on, and reasonable access to, a broad range of contraception; and advice on preventing unplanned pregnancy, DHSC has produced guidance to assist local authorities to commission these and other sexual health interventions. As noted in the introduction to this specification, it is an expectation that services may also provide a wider range of services including diagnosis and treatment for non-STI conditions and broader reproductive health 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 three main sexual health [Public Health Outcomes Frameworks](#) measures:

- Under 18 conceptions
- Chlamydia detection (15-24 year olds)
- People presenting with HIV at a late stage of infection

In addition it will deliver the following outcomes to improve the sexual health in the local population as a whole but based on local needs assessments to recognise risk changes in the population.

Sexual and Reproductive Health (SRH) services:

- Clear accessible and up to date information 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 Long Acting Reversible Contraceptive (LARC) for all age groups.
- A reduction in unplanned pregnancies in all ages as evidenced by teenage conception and abortion rates.

Sexually Transmitted Infection (STI) services:

- Improved access to services amongst those at highest risk of sexual ill health.
- Reduced sexual health inequalities amongst young people and young adults.
- Increased timely diagnosis and effective management of sexually transmitted infections and blood borne viruses.
- Repeat and frequent testing of these 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.
- Monitor uptake of late diagnosis and partner notification.
- Increase availability of condoms and safer sex practices.

Overarching:

- Increased development of evidence-based practice and ensure patient consultation, involvement and development.
- Maintenance of research governance and other necessary arrangements to participate in trials e.g. PrEP impact trial.
- 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.

## Integrated Sexual Health Services

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 (JSNA).

The Service will agree with the Commissioner a yearly programme of audit, research and evaluation to ensure continuous improvements in the quality of service delivery.

### 3. Scope

#### 3.1 Aims and Objectives of Service

The integrated sexual health service will aim to improve sexual health outcomes by:

- Promoting good sexual health through primary prevention activities including behaviour change and those which aims 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 may include digital 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 co-morbidities); and support in planning pregnancy; through a variety of mechanisms which may include digital 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 patient safety arrangements.
- Being responsive to local need (a) providing rapid response to outbreak management; and (b) through continuous improvement and response to local population need.
- Operating as leader in local sexual health economy providing clinical leadership, involvement in local networks and development of clear referral pathways between providers.

Service objectives include:

#### Overarching

- 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 need.
- Assessment which identifies the needs of vulnerable/at risk groups.
- Engage local prevention groups and non-governmental organisations to facilitate collaboration with service development, health promotion and outbreak management.
- 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) 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.

## Integrated Sexual Health Services

- Support 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.

## STI services

- Provide opportunities for people who chose to manage their own sexual health either independently or with support.
- Provision of chlamydia screening and treatment as part of the National Chlamydia Screening Programme (NCSP).
- 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.
- Monitor HIV late diagnosis and partner notification.
- Rapid referral to treatment and care services following diagnosis, to allow timely initiation of treatment.

## Sexual and Reproductive Health services

- 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 long acting methods, 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

- 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.

## Service Specifications

- Coordinate 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; training of nursing and medical sexual health experts.
- Deliver multidisciplinary postgraduate training, including to primary and secondary care; and may include delivering undergraduate training and postgraduate training including placements.
- Deliver training for medical and nursing students in line with requirement of the relevant regulator (GMC or 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.

### 3.2 Service Description/Pathway

The service will provide a confidential open access, cost-effective, high quality provision for contraception, diagnosis and management of sexually transmitted infections including HIV, according to evidence-based protocols and current national guidance, adapted to the needs of local populations.

The service is characterised by:

- Provide a confidential integrated sexual and reproductive health service where the majority of sexual health and contraceptive needs can be met on one site, usually within a single consultation.
- Service provided on an open access basis and available to anyone requiring care, irrespective of their age, gender, place of residence or GP registration, without referral.
- Having walk-in and appointment clinics, including evenings and weekends and offering digital services as an alternative to in-person attendance to improve services.
- Using a hub and spoke model of care (working with local general practices and linking into local outreach work).
- Multidisciplinary working.
- Delivery of Post Exposure Prophylaxis (PEP)/Post Exposure Prophylaxis following Sexual Exposure (PEPSE) on site (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.

#### 3.2.1 Service Levels

The service will provide a range of interventions to meet the needs of local populations. The integrated sexual health service will be delivered in broad accordance with the Level 1, 2 and 3 service models which is well established for sexual health service provision outlined in [The](#)

[National Strategy for Sexual Health and HIV](#). The integrated service will include the following elements.

### 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 CSE<sup>1,2,3</sup>

- Health information
  - Generic information on pregnancy, STIs and HIV prevention/safer sex, CSE and FGM advice
  - 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
- Home remote sampling and test kits accessed via online services
- Pregnancy testing kits
- Condoms
- Treatment

Some self-managed services may be accessed digitally.

### 3.2.3 Level 1 & 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 (there is current no agreement between NHSE and LA as to who is responsible for funding cervical cytology in SRH services. Local arrangements may be agreed between provider, NHSE and LA for cervical cytology screening in SRH services, especially in opportunistic screening, ie those considered high risk or due. Where those local

---

<sup>1</sup> 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* ([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4086960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960))

<sup>2</sup> Gillick v West Norfolk & Wisbech Area Health Authority [1985] UKHL 7 (17 October 1985) (<http://www.bailii.org/uk/cases/UKHL/1985/7.html>)

<sup>3</sup> Sexual Offences Act 2003 (<http://www.legislation.gov.uk/ukpga/2003/42/contents>)

## Service Specifications

agreements have been reached, all partners should support their continuation. A higher risk cohort of women attends SRH services. Only 0.5% of women are screening in sexual health clinics but over 2% of abnormalities are detected there).

- Domestic and sexual violence, and CSE screening and referral (all practitioners).
- Assessment and referral for psychosexual issues
- Assessment and referral to address CHEMSEX concerns to the relevant organisation including DAAT services
- Assessment and referral for Brief Alcohol Interventions (BAIs) including weight management, MECC and stop smoking services
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- Holistic sexual health care for young people including child protection / safeguarding
- Assessment and referral of sexual assault cases (including STI testing at appropriate time).
- Outreach services for STI prevention and contraception
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /infectious diseases for inpatient HIV care
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines

### 3.2.4 STI Services

- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women excluding:
  - Men with dysuria and/or genital discharge
  - Symptoms at extra-genital sites e.g. rectal or pharyngeal
  - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds, including on-line testing.
- 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).
- Initiation of PEP with referral to Level 3 for on-going management (non NHS providers may need to have an SLA with an NHS Trust for them to gain the reimbursement for PEP/PEPSE and to be aware that the costs will be paid using the NHSE tariff).
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups. For Hepatitis A this includes all MSM attending a sexual health clinic in line with BASHH guidance.
- Hepatitis C testing and discussion (with referral pathways in place).

## Integrated Sexual Health Services

- Management of first episode uncomplicated vaginal discharge (low risk).
- Management of contacts of gonorrhoea and Trichomonas Vaginalis (TV) (excluding symptomatic men).
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/LGV (Lymphogranuloma Venereum).

### 3.2.5 Sexual and Reproductive Health services

- Pregnancy testing
- Advice and referral for infertility and menorrhagia and pre-conceptual advice and support.
- Supply of male and female condoms and lubricant.
- All methods of oral emergency contraception and the intrauterine device for emergency contraception.
- First prescription and continuing supply of combined 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 IUS uncomplicated insertion 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, for example PrEP impact trial.
- Coordination of outreach clinical services for high risk groups.
- Coordination of contraceptive and STI care across a network including:

## Service Specifications

- Clinical leadership of contraceptive and STI management.
- Co-ordination of clinical governance:
  - Co-ordination and oversight of training in SRH and GUM;
  - Co-ordination of pathways across clinical services;
  - Co-ordination of partner notification for STIs and HIV.

### STI Services

- Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms.
- Management of STIs in pregnant women (except women with uncomplicated infections requesting abortions).
- Management of HIV partner notification.
- Interface with specialised HIV services as commissioned by NHS England.
- Risk assessment and provision and follow up of post-exposure prophylaxis after sexual exposure to HIV.

### Sexual and Reproductive Health Services

- Management of complex contraceptive problems.
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult, non-palpable implant removal with appropriate diagnostic services (e.g. ultrasound) to support this

## 3.3 Population Covered

The Local Authority is mandated to commission open access confidential services. As an integrated sexual and reproductive health service, the provider must operate an open access policy for both contraception and STI services regardless of residence of the patient 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 cross reference [B6a Specialised HIV Services for Adults](#) and [B6b Specialised HIV Services for Children](#) NHS England.

Termination of pregnancy is commissioned by CCGs 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 Patient.

### 3.5 Interdependencies and referrals to other Services

The Integrated Sexual Health Service 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 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 i.e. NHSE, CCG 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 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 post-natal services
- Cervical Screening Programme
- Child and adolescent mental health services
- Clinical psychology services
- Community pharmacy
- Child Sexual Exploitation and Safeguarding teams
- Services for those with disabilities, including learning disabilities
- Domestic abuse/ domestic violence services
- Drug and alcohol services
- Weight management, smoking cessation and physical activity services
- Emergency Departments
- FGM (female genital mutilation) services
- General Practice
- Gynaecology
- Health visiting and intensive family support visiting
- Health Protection teams outbreak management
- HIV treatment and care services
- Homeless, veteran and traveller organisations
- LGBTQ+ community, MSM, WSW, gay and bi-sexual men and women, trans and non-binary community

## Service Specifications

- Maternity services
- Mental health services
- Online testing and treatment for STI's
- Other healthcare service areas including voluntary sector
- Pathology and laboratory services
- Prisons and youth offenders institutions
- Providers of relationship and sex education
- School and education services, including higher education
- Services for sex workers
- Sexual Assault Referral Centre
- Sexual dysfunction services
- Social Care
- Weight management services
- Youth services

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 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 ISHSS is underpinned by, and the Provider will ensure it adheres to the following minimum standards:

- [BASHH: Standards for the management of Sexually Transmitted Infections 2014](#)
- [BASHH Standards for Sexual History Taking 2013](#)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (BASHH 2012)
- BASHH/Brook (April 2014) Spotting the Signs. A national proforma for identifying risk of child sexual exploitation in sexual health services
- [BHIVA Guidelines for HIV testing 2008](#)
- [BHIVA: Guidelines for the Sexual and Reproductive Health of people living with HIV; Current out for consultation 2017](#)
- [DH; Sexual Health Key Principles for Cross Charging 2013](#)
- [FSRH Service Standards for Risk Management 2017](#)
- [FSRH Service Standards for Sexual and Reproductive Health care 2016](#)
- [Information Commissioners Office; Guide to the General Data Protection Regulations](#)
- National Chlamydia Screening Programme Standards (7th Edition 2014) updated 2016
- All relevant NICE and Green Book guidance (see accompanying guidance for further detail)

Relevant UK clinical guidance covering the specialities of Sexual and Reproductive Healthcare and Genitourinary Medicine can be found at <http://www.fsrh.org> and [www.bashh.org](http://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 accompanying guidance.

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 patient attendances and associated diagnoses and services at GUM and non-GUM clinics in accordance with [Public Health England \(GUMCAD STI Surveillance System\)](#). The submission of GUMCAD extracts is mandatory for all LA commissioned Level 2 and 3 sexual health services, including those

## Service Specifications

offered on-line. Where the service provides testing through an on-line service, this activity should also be included with their routine GUMCAD submissions to PHE. 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, such as the introduction of behavioural and partner notification monitoring, in line with nationally agreed information standards and lead-in times.

The Service is also required to capture contraception and other sexual and reproductive health activities through collection of the [Sexual and Reproductive Health Activity Dataset](#) (SRHAD) which should be submitted annually to NHS Digital.

All patients newly diagnosed with HIV should be reported to PHE. 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 PHE. Following a medical consultation related to HIV care, the Service is required to generate and submit a quarterly data extract to the HIV and AIDS Reporting System (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 patient and testing service type.

SRHAD, HARS and GUMCAD form the basis for a standardised sexual health dataset collected from sexual health clinic settings (plus CTAD from laboratories). The Service is expected to discuss with commissioners quarterly analysis of GUMCAD, CTAD, HARS and SRHAD data from PHE 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 codes are updated/introduced (for example where codes are added for outbreaks).

## 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.

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 premises will be fit for purpose for the services delivered in that particular location, be well maintained and compliant with Disability Discrimination Act (DDA). The provider will carry out the risk assessment on all the premises used to deliver sexual health services, 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, 2013) 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 prescribed requirements, tailored to meet the patient requirements.

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

Online services must meet the appropriate standards for the services provided.

### 5.2 Patient 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. However, the DHSC's policy remains unchanged in that people should continue to use sexual health services with assurance that information on STI testing, diagnosis and treatment will be not be included in their shared patient records without their consent.

The Directions do not directly address how patient information and records are retained. Nor do they prohibit the sharing of patient data for public health purposes under the Health Service (Control of Patient Information) Regulations 2002, or local authorities from receiving non identifiable patient information for the purposes of cross-charging. In practice, most NHS sexual health services maintain separate patient records (or their electronic equivalent) 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 patient's shared

## Service Specifications

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 integrated sexual health services should be shared within the integrated team.

To ensure patients 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 patient'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.

# Quality Outcomes Indicators

This table lists suggested indicators based on evidence of good practice and national standards and guidance. Their inclusion is for local determination.

Indicators	Threshold	Technical Guidance Reference	Method of Measurement
1. Clinical Assessment and Management			
1.1 Sexual history taking The percentage of individuals accessing the service who have sexual health history and risk assessment undertaken. This does not include individuals accessing self-managed care (see 3.2.1).	97%	<a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>  <a href="#">BASHH Standard 2 (Clinical assessment)</a>	Clinical Audit
1.2 HIV testing The percentage of people who are eligible for (based on local epidemiological and prevalence information) and offered (and accepted) an HIV test at first attendance (excluding those already diagnosed HIV positive).	97%	<a href="#">BHIVA (2008) UK National Guidelines for HIV Testing 2008</a>  (To support Public Health Outcome Framework 3.4)	GUMCAD
1.3 Chlamydia testing: a) Percentage of positive	For local determination	a) <a href="#">NCSP Guidance</a>	Clinical audit (Drawing on

## Integrated Sexual Health Services

<p>patients under 25 offered a chlamydia re-test at 3 months post treatment</p> <p>b) percentage of positive patients under 25, offered a re-test between three and six months after treatment</p>		<p>b) <a href="#">Guideline for management of infection with chlamydia trachomatis</a></p>	CTAD where appropriate)
<p>1.4 Adherence to the latest BASHH and FSRH Clinical Effectiveness guidelines</p>	<p>Evidence of use of the specific audit measures in each of BASHH clinical effectiveness group or FSRH clinical effectiveness unit</p>	<p><a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a></p> <p><a href="#">FSRH clinical effectiveness unit (CEU) guidance</a></p>	Clinical audit
<p>2. Diagnostics and turnaround time</p>			
<p>2.1 Diagnostics</p> <p>The percentage of people who are symptomatic or Nucleic Acid Amplification Test (NAAT) positive for Neisseria gonorrhoeae who have a culture performed.</p>	<p>80%</p>	<p>See Standard 3 (Diagnostics) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>,</p>	Clinical Audit
<p>2.2 Laboratory turnaround times</p> <p>a) The percentage of reports (or preliminary reports) issued by the laboratory within five working days of the specimen being</p>	<p>a) 97%</p>	<p>See Standard 3 (Diagnostics) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a></p>	Clinical Audit

## Quality Outcomes Indicators

<p>received by the laboratory.</p> <p>b) The percentage of final reports on supplementary testing, or following referral to the reference laboratory, which are issued by the laboratory within 10 working days of the specimen being received by the laboratory.</p>	<p>b) 97%</p>		
<p>2.3 Service turnaround times</p> <p>a) The percentage of people having STI tests who can access their results (both positive and negative) within ten working days of the date of the sample (excluding those requiring supplementary tests).</p> <p>b) The percentage of people who tested positive for Chlamydia to be treated within six working days of the date of test</p>	<p>a) 95%</p> <p>b) 95%</p>	<p>See Standard 4 (clinical management) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a></p> <p>See Standard 4 (result notification and treatment) of <a href="#">National chlamydia screening programme</a></p>	<p>Clinical Audit</p>
<p>3. Partner notification</p>			
<p>3.1a) The percentage of all contacts of index cases of gonorrhoea who attend a service commissioned to</p>	<p>a) gonorrhoea at least 0.4 contacts per index case in large conurbations</p>	<p>See Standard 4 (clinical management) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a></p> <p>See Standard 4 (result notification and treatment) of <a href="#">National Chlamydia</a></p>	<p>Clinical Audit</p>

## Integrated Sexual Health Services

<p>manage STIs within four weeks of the date of first PN discussion.</p> <p>3.1b) The percentage of all contacts of index cases of chlamydia who attend a service commissioned to manage STIs within four weeks of the date of first PN discussion.</p>	<p>or 0.6 contacts elsewhere within four weeks</p> <p>b) chlamydia 0.6 contacts per index case</p>	<p><a href="#">Screening Programme</a></p>	
<p>3.2 Documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk</p>	<p>90%</p>	<p>See Standard 7 (Sexual health and identification of contacts at risk of infection) of <a href="#">British HIV Association (2013). Standards of Care for People Living with HIV</a></p>	<p>Clinical Audit</p>
<p>3.3 Documented PN outcomes or a progress update at 12 weeks after the start of the process (HIV)</p> <p>a) Number of contacts* tested per total number of index cases.</p> <p>(* Status-known contacts + number of contactable status-unknown contacts)</p> <p>b) Proportion (%) of contactable partners</p>	<p>90%</p> <p>a) At 3 months 0.6 HCP verified 0.8 index reported or HCP verified (i.e. those captured via either)</p> <p>b) At 3 months</p>	<p>BHIVA Standard 7(Sexual health and identification of contacts at risk of infection) of <a href="#">British HIV Association (2013). Standards of Care for People Living with HIV</a></p> <p><a href="#">BHIVA/BASHH</a> HIV Partner Notification Standard 2015</p>	<p>Clinical audit</p>

Quality Outcomes Indicators

<p>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 PN 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).</p>	<p>65% HCP verified            85% Index reported of HCP verified (i.e. those captured via either)            c) At 4 weeks            97% of index cases with a documented PN plan within 4 weeks of diagnosis            At time of HIV diagnosis (when made in service)            97% indexes with PEP assessment: documented evidence of PN discussion to determine if any at risk contact has occurred within previous 72 hours to identify and refer partners potentially eligible for PEP.</p>		
<p>4. Contraception</p>			
<p>4.1 Percentage of women having access to and</p>	<p>100%</p>	<p>See Standard 2 (Service provision) of <a href="#">Faculty of Sexual and Reproductive</a></p>	<p>Clinical Audit</p>

## Integrated Sexual Health Services

availability of the full range of contraceptive methods (including choice within products) to maximise patient acceptability.		<a href="#">Healthcare (2016) Service Standards.</a>	
4.2a) Percentage of women who have access to emergency contraceptive advice (including Intrauterine Contraceptive Device) within xx hours of contacting the service  4.2b) 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	<a href="#">Faculty of Sexual &amp; Reproductive Healthcare (2016). Service Standards for Sexual and Reproductive Healthcare</a>  <a href="#">NICE Quality Statement on Emergency Contraception</a>	For local determination
5. Improving Productivity			
5.1 People should have their care managed by an appropriately skilled healthcare professional.	Demonstrate compliance with CQC 2014 regulations 12 (Safe care and treatment) and 18 (Staffing)	See Standard 7 (appropriately trained staff) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a> <a href="#">CQC Regulations 2014</a> <a href="#">FSRH Quality Standard 6</a>	For local determination
6. Chlamydia Screening			

## Quality Outcomes Indicators

6.1 Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	For local determination	Contributes towards <a href="#">Public Health Outcome Framework measure (3.2)</a>	CTAD Data
6.2 Percentage of all under 25 year olds screened for chlamydia	For local determination	Contributes towards <a href="#">Public Health Outcome Framework measure (3.2)</a>  <a href="#">NCSP Standards 7th edition</a>	For local determination  (Drawing on CTAD where appropriate)
7. Service User Experience			
7.1 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	a) Evidence of a current Patient and Public Engagement plan which affords public consultation and feedback.  b) Evidence from providers of effectiveness of care from the patients' perspective and the patient experience of the humanity of their care via annually reporting validated PROMs and PREMs.  c) compliance with CQC 2014 regulations 9	See Standard 9 (patient and public engagement) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>  <a href="#">FSRH Quality Standard 4</a> (User and public involved)	For local determination

## Integrated Sexual Health Services

public involvement is fundamental to service development, provision, monitoring and evaluation	(Person-centred Care) and 10 (Dignity and Respect)		
7.2 Adopt the You're Welcome criteria	100%	<a href="#">National Expectation</a>	For local determination
7.3 Evidence of at least one user experience survey annually	Yes/No	For local determination (However suggested best practice is on-going real time surveys)	For local determination
7.4 Percentage of service user feedback on surveys that rates satisfaction as good or excellent	For local determination (However suggested threshold is 70%. Any lower may indicate poor service delivery)	For local determination	For local determination
7.5 Evidence of improvements made to service as a result of user feedback	Demonstrate compliance with CQC 2014 regulation 17	CQC 2014 regulation 17(2)(e): seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;  See Standard 9 (patient and public engagement) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>	For local determination
7.6 Number of service users making formal complaints(verbal or written) and incidents about the service	For local determination Provider to notify Commissioner of complaints and incidents in	CQC 2014 Regulation 16: Receiving and acting on complaints. CQC 2014 Regulation 18: Notification of other incidents  Reporting of incidents as per locally agreed procedures. Supporting documents:	For local determination

## Quality Outcomes Indicators

	accordance with the relevant incident reporting procedures	DHSC's 'Sexual health: clinical governance, key principles to assist service commissioners and providers to operate clinical governance systems in sexual health services'. <a href="#">NHS England Serious Incident Framework 2015</a> <a href="#">NCSP incident reporting policy</a>	
8. Reducing Inequalities			
8.1 An Equality Impact Assessment (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
9. Access			
9.1 The percentage of people contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service.	98%	See Standard 1 (access) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>	Routine monitoring of access data
9.2 The percentage of people contacting a service who are seen or assessed by	80%	See Standard 1 (access) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>	Routine monitoring of access data

## Integrated Sexual Health Services

a healthcare professional within 2 working days of first contacting the service.		<a href="#">FSRH Service Standard</a>	
9.3 Percentage of symptomatic, PEPSE, or emergency contraception clients accessing service to be seen within 48 hours of contacting the service	85%	Locally Determined	For local determination
9.4 Care pathways with other organisations to include partner notification and linked services (e.g. alcohol and drugs, mental health, FGM, CSE, smoking, domestic violence, sexual violence etc.) are clearly defined	Evidence of established pathways Attendance at multi-agency meetings	See Standard 8 (links to other services) of <a href="#">BASHH (British Association Sexual Health &amp; HIV) and MEDFASH (2014). Standards for the Management of Sexually Transmitted Infections</a>	For local determination
9.5 Percentage of specialist SRH referrals from General Practice seen with 18 weeks of referral	100%	NHS Constitution – referral to treatment	
9.6 Percentage of psychosexual clients seen within 18 weeks of referral	100%	NHS Constitution – referral to treatment	
10. Clinical Governance			
10.1 Services that manage integrated sexual health services must be safe, well-	Evidence that clinical governance arrangements are in	<a href="#">CQC 2014 Regulations in relation to clinical governance:</a> 12 (Safe care and treatment)	For local determination

Quality Outcomes Indicators

<p>managed and accountable</p>	<p>place and effective: demonstrate compliance with CQC 2014 Regulations 12, 17, 18, 19, 20</p> <p>Evidence of participation in relevant annual regional or national audits and actions taken as a result of the audit findings</p>	<p>17 (Good governance), 18 (Staffing), 19 (Fit and proper persons employed), 20 (Duty of candour)</p> <p><a href="#">BASHH Standard 6 (Clinical governance)</a> <a href="#">FSRH Service Standard 1 (Standard Statement on Leadership)</a></p>	
--------------------------------	---	---	--

# Information Provision

The table lists a provision of data in addition to national reporting mechanisms i.e. GUMCAD, SRHAD and CTAD. Providers must ensure they are fully compliant with GDPR regulations.

Information to be provided	Frequency of information provision (will usually be in line with contract monitoring meetings)
1. Reducing inequalities	
<p>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.</p> <p>Demographic characteristics may include (by not be restricted to): age; gender; ethnicity; LSOA by deprivation</p>	For local determination
2. Contraceptive methods	
2.1 Number of patients (female and male) receiving condoms	For local determination
2.2 Number of IUD's fitted and number removed within a year of fitting	For local determination
2.3 Number of IUS's fitted and number removed with a year of fitting	For local determination
2.4 Number of contraceptive injections administered	For local determination
2.5 Number of hormonal contraceptive implants fitted and number removed within a year of fitting	For local determination
<p>2.6 Number of contraceptive pills prescribed (COC, POP and combined):</p> <p>Number of repeat prescriptions at 3, 6 and 12 months</p>	For local determination

## Information Provision

2.7 Number of Diaphragm, Patches and Rings prescribed	For local determination
2.8 Numbers of clients provided with information and timely offer of emergency contraception (oral and device)	For local determination
3. STI provision	
3.1 Number of chlamydia screens offered and accepted to those aged under 25 years	For local determination
3.2 Number of positive chlamydia diagnoses amongst those aged under 25 years	For local determination
4. Access to service provision	
4.1 Number of clients by Age Gender Ethnicity LA and out of area residents	
4.2 Percentage of people offered an appointment within 48 hours of contacting a provider	For local determination
4.3 Percentage of people waiting longer than (to be agreed locally) from booking to appointment	For local determination
4.4 Percentage of users experiencing waiting times of >2 hours in a walk-in clinic	For local determination
4.5 Percentage of users experiencing waiting times of >30 minutes for a booked appointment	For local determination
4.6 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
4.7 Percentage of users referred to online screening due to full capacity within the clinic	For local determination
4.8 Number of service users making formal complaints about the service	For local determination

## Integrated Sexual Health Services

4.9 Number of service users making compliments about the service	For local determination
5. Training provision	
5.1 Details of training provision including course information, number of delegates and delegate details (including job title and organisation)	For local determination (suggest annual)

# 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?

## 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/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).

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.

## Service User Surveys

The Provider will gather and reflect feedback from engagement with patient/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 patients/service users. This should include working with those most at risk of poor sexual health and the most vulnerable groups e.g. LGBT, young people, BME populations. The Provider will produce an annual report of the findings of the participation work with patients/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 e.g. some of this will be generated from service utilisation data as well as feedback from patients/service user engagement and epidemiological data.

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.

# 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 13-15 and for those under the age of 13. In principle, all patients under the age of 16 should be seen in a clinical setting.

LAs to work within legislative and procedural frameworks; in particular these are Working Together to Safeguard Children (2015), 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 places 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 Data Protection Act and the Caldecott Guardian principles
- Identify children, young people and adults who are vulnerable due to care and support needs or other risk factors 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.

# 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 patients are not formally discharged from the Service. However, it is recognised that patients 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.

# Digital Services

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

Clinics should offer patients the opportunity to triage and self-sample on site and routine STI test results should be available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered an appointment within 24 hours or fast tracked, if available to a walk-in service.

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 (e.g. national HIV self-sampling service) and/or self-testing
- On-line 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 patients can complete remotely
- 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/reactive result to ensure confirmation of diagnosis, access to treatment and completion, and/or partner notification

Digital services have been developed with two 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, online chlamydia screening for 15-24 year olds or HIV home 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.

## Integrated Sexual Health Services

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

### Note 1: HIV Self-Sampling/HIV Self-Testing Definition

HIV Self-Sampling – individual takes the sample which is then sent to a laboratory for processing and is provided with the result by a healthcare worker

HIV Self-Testing – Individual takes the samples, 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

# 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, Clinical Commissioning Groups (CCGs) and NHS England.

NHS England and Clinical Commissioning Groups should facilitate access to training for general practitioners (both established and those in training) practice nurses, and other groups for specialist contraceptive services such as Long Acting Reversible Contraception (LARC).

## Workforce and Leadership

All sexual and reproductive health services should have appropriately trained leadership to ensure quality of service provision, development, training and clinical governance.

## Health Education England

Health Education England (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) under the provisions of the Care Act 2014.

Where applicable under section 1(F) (1) of the NHS Act 2006, providers must co-operate with and provide support to Health Education England 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. This is normally undertaken through a formal contract with HEE.

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 genito-urinary medicine (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 whilst 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 to ensure that the provider is recognised by the General Medical Council (GMC) for training.

## Integrated Sexual Health Services

- Where necessary for their training, allowing trainees to be released on secondment to undertake specialist experience outside the provider such as HIV in-patient 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 Local Government Association (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 as an "additional service" under the GP contract commissioned by NHS England.

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

- Provide support for workforce planning and development in general practice 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 coordinator of education and training for primary and community care to support general practice.

For any queries please contact HEE Local/Regional Teams.

# 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 [DH 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/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/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 Care Quality Commission 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 five 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/sites.

## Integrated Sexual Health Services

- 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.

# 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 / gender profile 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.

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 contact tracing
- Enhanced surveillance of cases: gathering more detailed information about cases, to explore particular risk factors / exposures. The purpose of this further information gathering is to inform control measures – i.e. 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 (outreach – e.g. saunas, 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 / outbreak of infections is usually coordinated through an Incident Management / Incident Control Team, and staff from the sexual health service would be expected to participate in these arrangements.

[PHE \(2017\) Sexually Transmitted Infections; managing outbreaks.](#)

## 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 POCT testing and the appropriate use of POCT testing v diagnostics, whilst being aware of the sensitivity and specificity of the POCT used.

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 develop 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, PHE and UKAS).

# 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 / 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 amongst 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 (personal communication – Brighton).

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 / 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 patients 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 Public Health England
- offer hepatitis B immunisations to persons at high risk attending their service. These include: injecting drug users, individuals who change partners frequently (especially men who have sex with men, 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.

## Human Papilloma Vaccination (HPV)

## Integrated Sexual Health Services

Providers are required to support national efforts to vaccinate target groups with HPV in line with national guidance and policy such as what is set out in the Green Book. This includes signposting eligible individuals to relevant services for HPV, or where required provide immunisations to individuals in the target group attending services who have not completed their primary immunisation course for HPV.

# 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, 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 men who have sex with men (MSM) who engage in chemsex, many of the principles apply to all groups and in particular other LGBT.

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 blood-borne viruses, STIs and other diseases such as Shigella infection.
- People engaged in chemsex are a diverse group, with people from black, asian and minority ethnic groups (BAME) 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.

# Levels for Sexually Transmitted Infections

The management of sexually transmitted infections outlined as Levels 1 – 3 as in the [Medfash Levels of Service 2014](#).

## 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 post-exposure prophylaxis following sexual exposure (PEPSE)
- Sexual assault with referral as appropriate
- Signposting to appropriate sexual health services
- Chlamydia screening
- Opportunistic screening for genital chlamydia in sexually active asymptomatic males and females under the age of 25
- STI screening and treatment of asymptomatic infections (except treatment for gonorrhoea and syphilis) in women and men (except MSM). 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 men (except MSM) and women including:

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

The following should be referred to Level 3:

## Levels for Sexually Transmitted Infections

- men with dysuria and / or genital discharge. See Note 2
- symptoms at extra-genital sites e.g. rectal or pharyngeal
- pregnant women
- genital ulceration other than uncomplicated genital herpes
- gonorrhoea if unable to perform gonorrhoea cultures with rapid transport to the 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 women
- Gonorrhoea cultures and treatment of gonorrhoea. See Note 3
- Recurrent conditions
- Recurrent or recalcitrant STIs and related conditions
- Management of syphilis and blood borne viruses

Including the management of syphilis at all stages of infection:

- Tropical STIs
- Specialist HIV treatment and care
- Provision and follow up of HIV post exposure prophylaxis (PEP). 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 management of men who have sex with men (MSM) has been defined as an element of specialist care at Level 3 because the majority of infections in this group are in the rectum and/or pharynx rather than the urethra and the management of these infections is more complex and requires specialist provision<sup>1, 2</sup> (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

## Integrated Sexual Health Services

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: 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.

# Levels of Sexual and Reproductive Healthcare; FSRH; Quality Standards for Contraception 2014

## **Level 1 (Every General Practice)**

- 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 STI's
- Partner Notification
- IUD and Implant insertion
- Management of psychosexual problems
- Vasectomy surgery

## **Specialist level 3 (specialist services)**

- Outreach for STI prevention / contraception
- Specialised STI management / partner notification
- Specialist HIV treatment and care
- Highly specialised contraception
- Termination of pregnancy services
- Local co-ordination and back up for sexual assault
- Psychosexual//sexual dysfunction services
- Make sure local guidelines and framework for monitoring and improving practice are in place
- Support clinical governance requirements at all levels

## Integrated Sexual Health Services

- Provide professional training, designing and updating care pathways and developing new services.

### A 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 – intrauterine device	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 – female	Referral	Referral	Referral

# Service Standards

- BASHH/Brook (April 2014) Spotting the Signs. A national proforma for identifying risk of child sexual exploitation in sexual health services
- British HIV Association Standards of Care for People Living with HIV (BHIVA 2013)
- [BASHH Standards for Outreach](#)
- [BASHH-BHIVA Position Statement on PrEP in UK \(May 2016\)](#)
- [Link to all BASHH Guidelines](#)
- [BHIVA: UK National Guidelines on Safer Sex Advice \(2012\)](#)
- [BHIVA: StandardsForPsychologicalSupport \(2011\)](#)
- [Link to all BHIVA Guidelines](#)
- COSRT Code of Ethics (COSRT 2013)
- [FSRH Service Standards for Sexual and Reproductive Healthcare - September 2016](#)
- [FSRH Standards for Emergency Contraception 2017](#)
- [FSRH Standards Service Standards on Confidentiality 2015](#)
- [FSRH Service Standards Consultations in SRH 2015](#)
- [FSRH Quality Standard for Contraceptive Services 2014](#)
- [FSRH Clinical Standards Medicine Management Feb 2014](#)
- [FSRH Service Standards for Workload in Sexual and Reproductive Health 2017](#)
- [FSRH Service Standards for Record Keeping in Contraception in Sexual and Reproductive Healthcare Services 2014](#)
- [Link to all FSRH standards and guidelines](#)
- Female genital mutilation: Safeguarding women and girls at risk of FGM (DH 2016)
- [GMC Projection Children and Young People \(2012\)](#)
- [Hepatitis A, Green Book, Chapter 17 \(PHE 2013\)](#)
- [Hepatitis B, Green Book, chapter 18. \(PHE 2013 revised 2017\)](#)
- Hepatitis B and C testing: people at risk of infection Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE 2012) updated 2013;
- [Institute of Psychosexual Medicine](#)
- [MEDFASH;Progress and Priorities, for high quality sexual health \(2008\)](#)
- [MEDFASH. Recommended Standards for Sexual Health Services \(2005\)](#)
- [National Chlamydia Screening Programme Guidelines for Outreach](#)
- NICE PH3 Sexually transmitted infections and under-18 conceptions (NICE 2007)

## Integrated Sexual Health Services

- NICE NG68 Sexually transmitted infections: condom distribution 2017
- 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 25's 2014](#)
- [NICE NG55; Harmful sexual behaviour among children and young people 2016](#)
- [NICE PH49; Behaviour Change, encouraging individual approaches 2014](#)
- NICE NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV (2016)
- NICE PH43 Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. (2013)
- [NICE PH49 Behaviour change; individual approaches \(2014\)](#)
- [NICE PH50 Domestic violence & abuse, how services can response effectively \(2014\)](#)
- [NICE PH51 Contraceptive services for under 25's \(2014\)](#)
- [NICE CG30 Long acting reversible contraception \(2005 updated 2014\)](#)
- [NICE CG44 Heavy Menstrual Bleeding \(2007 updated 2016\)](#)
- UK Guideline for the use of HIV Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) 2015