# National Clinical Audit of STIs and HIV: Feasibility Study Report

# Contents

This document contains annexes referred to in the National Clinical Audit of STIs and HIV Feasibility Study Report www.hqip.org.uk/resources/report-hiv-sti-feasibility-study

# Annex 1 - Contract and Project Management

## *I. Feasibility study team members*

MEDFASH (Medical Foundation for HIV & Sexual Health) was appointed by HQIP to manage the feasibility study following a competitive tender exercise. The MEDFASH bid had been submitted in partnership with Public Health England (PHE), the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA).

Overall contract and project management was provided by MEDFASH, working closely with the feasibility study Steering Group. The Study Manager was employed by PHE and seconded to MEDFASH. The Clinical Lead was seconded to MEDFASH from Chelsea and Westminster Hospital NHS Foundation Trust.

The following organisations collaborated on the feasibility study:

- British Association for Sexual Health and HIV (BASHH) is the UK's leading professional organisation dealing with all aspects of sexual health care. It champions good sexual health, provides education and training and develops standards and clinical guidelines.
- British HIV Association (BHIVA) is the leading UK association representing professionals in HIV care. It is a national advisory body on all aspects of HIV care and provides clinical guidelines and standards as well as educational events
- MEDFASH is an independent charity dedicated to improving the quality of HIV and sexual healthcare. It promotes understanding and good practice across sexual and reproductive health and HIV treatment and care, promoting evidence-based policy, service development and service delivery. Its outputs include standards and guidance, educational resources and policy reviews.
- Public Health England (PHE) is an executive agency, sponsored by the Department of Health. It exists to protect and improve the public's health and wellbeing and reduce health inequalities through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services.
- Public Health Wales (PHW) exists to protect and improve health and wellbeing and reduce health inequalities. It is part of the NHS and reports to the Minister for Health and Social Services in the Welsh Government.

The ***Steering Group*** met on alternate months, in rotation with the Project Team, to discuss higher-level project details and guide the development of the study.

*Members*:

| | |
|---|---|
| Prof. Jackie Cassell | Chair in Primary Care Epidemiology, Brighton and Sussex Medical School |
| Mr David Crundwell | BASHH Public Panel Representative |
| Dr Valerie Delpech | Head of HIV Surveillance, Public Health England |
| Miss Esther Dixon-Williams | UK Community Advisory Board (UK-CAB) Representative |
| Dr Claudia Estcourt | Chair of Steering Group |
| Dr Andrew Freedman | Chair, BHIVA Audit and Standards Subcommittee |
| Dr Gwenda Hughes | Head of STI Surveillance, Public Health England |
| Ms Ruth Lowbury | Chief Executive, MEDFASH |
| Dr Hugo McClean | Vice Chair, BASHH National Audit Group |
| Dr Katy Sinka | Consultant Scientist, HIV and STIs, Public Health England |
| Dr Ann Sullivan | Clinical Lead |
| Dr Melvina Woode Owusu | Study Manager, MEDFASH/ Public Health England |

The ***Project Team*** met *o*n alternate months, in rotation with the Steering Group, to discuss, plan and action lower level project activities and tasks, and to oversee the drafting of the study report by the Study Manager.

*Members*:

| | |
|---|---|
| Dr Valerie Delpech | Head of HIV Surveillance, Public Health England |
| Dr Gwenda Hughes | Head of STI Surveillance, Public Health England |
| Ms Ruth Lowbury | Chief Executive, MEDFASH |
| Dr Katy Sinka | Consultant Scientist, HIV and STIs, Public Health England |
| Dr Ann Sullivan | Clinical Lead |
| Dr Melvina Woode Owusu | Study Manager, MEDFASH/ Public Health England |

Additional Steering Group members were co-opted based on the objectives for each Steering Group meeting and to share their expertise; these were Daniel Thomas (Surveillance Lead at PHW), Hamish Mohammed (Principal STI Surveillance Scientist at PHE), Mick Peake (Clinical Lead for the National Cancer Intelligence Network (NCIN) and the National Lung Cancer Audit Programme (NLCA) and a member of the National Advisory Group on Clinical Audit and Enquiries (NAGCAE)), Mary Tully (Academic Lead for Engagement and Involvement in at the University of Manchester and Public Engagement Theme Lead at the Farr Institute's Health eResearch Centre (HeRC)) and Andrew Skingsley (Principal HIV Surveillance Scientist at PHE).

Other study consultees included Caroline Sabin (Professor of Medical Statistics and Epidemiology at UCL), Jane Hatfield (Chief Executive of FSRH), and Hilary Curtis (BASHH Audit Coordinator and Co-ordinator of the BHIVA Audit and Standards Subcommittee) and the members of the Patient and Public Involvement group who took part in the consultation meeting on HIV patient data.

### *II. Feasibility Study - Reference Group*

| Organisation | Organisation Acronym | Representative | Designation |
|---|---|---|---|
| **Brook** | Brook | Anatole Menon-Johansson | Clinical Director |
| **English HIV and Sexual Health Commissioners Group** | EHSHCG | Jackie Routledge | Co-Chair |
| **Faculty of Sexual and Reproductive Healthcare** | FSRH | Eleanor Draeger | Member |
| **HIV Pharmacy Association** | HIVPA | Nadia Naous | HIVPA Co- Chair |
| **INVOLVE** | INVOLVE | Maryrose Tarpey | Assistant Director |
| **Local Government Association** | LGA | Louise Smith | Deputy Director of Public Health Commissioning and Health Improvement at Hertfordshire CC |
| **National AIDS Trust** | NAT | Yusef Azad | Director of Policy and Campaigns |
| **National Chlamydia Screening Programme** | NCSP | Kevin Dunbar | Director |
| **National HIV Nurses Association** | NHIVNA | Michelle Croston<br><br>Matthew Grundy Bowers | Chair<br><br>Member |
| **Public Health England - Sexually Transmitted Bacteria Reference Unit** | PHE STBRU | Helen Fifer | Microbiologist |
| **Public Health Wales** | PHW | Daniel Thomas | Lead Surveillance Scientist |
| **Royal College of Nursing** | RCN | Jason Warriner | Public Health Forum Chair |
| **Royal College of Pathologists** | RCPath | Samuel Moses | Consultant Medical Virologist |
| **Royal Pharmaceutical Society** | RPS | Lucy Hedley | Member |
| **Society for Sexual Health Advisors** | SSHA | Martin Murchie | President |
| **Terrence Higgins Trust** | THT | Mandy Tyson | Executive Director for Clinical Leadership & Clinical Governance |

### *III. Feasibility study deliverables*

| | *Elapsed time in months* | *Dates* |
|---|---|---|
| **1. Recurring Deliverables** | | |
| 1.1 HQIP Contract review meetings | 6 | September 2015 |
| 1.2 HQIP financial review | 6 | September 2015 |
| 1.3 Keep HQIP informed about changes to staff or project personnel | ongoing | |
| **2. Project set up** | | |
| 2.1 Appointment of study manager and clinical lead | 1 | April 2015 |
| 2.2 Establish the steering group and project reference group | 2 | May 2015 |
| 2.3 Appoint an expert patient / public involvement (PPI) adviser | 3 | June 2015 |
| 2.4 Establish a project web page which has the following information (as and when available):<br>• Dates of contract<br>• Funding bodies and collaborating partners<br>• Geographical cover of the feasibility study<br>• Aims and objectives and methodology<br>• Project timelines including when the final report will be ready | 3 | June 2015 |
| 2.5 Draft criteria for determining future rollout of the audit to share with HQIP for sign off | 3 | June 2015 |
| **2 Feasibility Study** | | |
| 3.1 Consult with stakeholders to define the scope and priority areas for a national audit of sexual health services for patients with HIV/Chlamydia/Gonorrhoea and Syphilis | 6 | September 2015 |
| 3.2 Assess the resulting data requirements and explore the feasibility of collection and linkage using existing sources of data (including GUMCAD and linkages to HES) | 9 | December 2015 |
| 3.3 Identify any new sources of data which would be required for national roll out | 9 | December 2015 |
| 3.4 Complete a scan of relevant national quality improvement initiatives and how these might overlap with or complement a national audit | 9 | December 2015 |
| 3.5 Consult with patients over the consent model and identify approvals which would be needed for a national audit | 9 | December 2015 |
| 3.6 Investigate the feasibility of including all levels of sexual health services in the audit or whether the audit should be restricted to Level 2 and 3 services | 11 | February 2016 |
| 3.7 Review Welsh datasets, identify common measures and potential for development of new measures in Wales. | 12 | March 2016 |
| 3.8 Liaise with Public Health Wales and produce joint recommendations for cross-border audit measures | 12 | March 2016 |

| | *Elapsed time in months* | *Dates* |
|---|---|---|
| 3.9 Categorise target audiences and detail how to report to each focussing on who can lever quality improvement and how | 11 | February 2016 |
| **3 Reporting** | | |
| 4.1 Report submitted to HQIP; the report to summarise the activities and findings of the project and including the recommendations as to whether a national clinical audit is likely to be effective in this care area; the report must address the specific points set out in the tender specification | 12 | March 2016 |
| 4.2 Complete contract closing process and review with HQIP | 12 | March 2016 |

| IV. *Study workstreams and activities* | | | Timeline | | | |
|---|---|---|---|---|---|---|
| **Workstream** | **Activity** | **Deliverable** | Q 1 | Q 2 | Q 3 | Q 4 |
| **Workstream 1. Scoping and prioritising issues for audit** | | | | | | |
| | Review published and grey literature on service provision and care pathways, standards and guidance | 3 | | | | |
| | Undertake epidemiological scoping of vulnerable populations | 3 | | | | |
| | Review relevant previous audit findings | 3 | | | | |
| | Collate list of issues regarding quality of care and outcomes to consider for audit | 3 | | | | |
| | Determine criteria for ranking; rank issues and outcomes for audit in order of priority | 2.5 | | | | |
| | Consult: feasibility study reference group and their constituencies and patient & public representatives and steering group | 3.1 | | | | |
| | Revise priority ranking of issues and outcomes | 3 | | | | |
| **Workstream 2: Assessing data requirements and exploring feasibility of collection and linkage** | | | | | | |
| | Assess data requirements for measuring prioritised issues and outcomes using Public Health England (PHE) and other datasets, including data linkage | 3.2 | | | | |
| | Identify the priority issues/outcomes for which data are already available and how to access and analyse the data | 3.2; 3.3 | | | | |
| | Identify those issues for which new data collection or new data linkage would be necessary and how this could be done | 3.3 | | | | |

| IV. *Study workstreams and activities* | | Timeline | | | | |
|---|---|---|---|---|---|---|
| **Workstream** | **Activity** | **Deliverable** | Q 1 | Q 2 | Q 3 | Q 4 |
| | Define feasibility and cost of developing new data items and/or linkage between datasets and identify technical, information governance and patient consent issues | 3.5 | | | | |
| | Explore technical solutions for data linkage | 3.2 | | | | |
| | Explore patient and public views on data linkage through focus groups or attendance at meetings | 3.5 | | | | |
| | Divide list of issues into 3 categories:<br>i) data already collected<br>ii) data not currently collected /linked but this is feasible<br>iii) data collection /linkage is not feasible, with reasons for this noted | 3.2; 3.3 | | | | |
| | Rank items in i) and ii) according to priority for inclusion in audit, taking account of workstream 2 findings | 3.2;3.3 | | | | |
| **Workstream 3: Scanning quality assessment initiatives** | | | | | | |
| | Scan current quality assessment initiatives and identify potential duplication with future STI/HIV audit | 3.4 | | | | |
| | Identify potential linkages between these initiatives and future STI/HIV audit | 3.4 | | | | |
| | Discuss and agree with bodies that report on these initiatives how to share data and collaborate on reporting to support quality improvement | 3.4 | | | | |
| **Workstream 4: Investigating feasibility of expanding audit beyond Level 2 and 3 services** | | | | | | |
| | Consult stakeholders through reference group on priorities for audit in Level 1 services | 3.1 | | | | |

| IV. *Study workstreams and activities* | | | Timeline | | | |
|---|---|---|---|---|---|---|
| **Workstream** | **Activity** | **Deliverable** | Q 1 | Q 2 | Q 3 | Q 4 |
| | Explore datasets which provide relevant data or to which new data items could be added, or which provide a model for a potential STI/HIV audit beyond Level 2 and 3 services | 3.6 | | | | |
| | Explore potential for data linkage, eg to identify missed opportunities for early HIV diagnosis in Level 1 | 3.6 | | | | |
| | Identify Level 1 services and aspects of care amenable to cost effective STI/HIV audit (if any) | 3.6 | | | | |
| | Agree priority ranking for early inclusion in audit | 3 | | | | |
| **Workstream 5: Exploring patient and service consent issues for data processing** | | | | | | |
| | Review relevant literature on information governance and patient consent, with reference to audit and data linkage | 3.5 | | | | |
| | Seek advice on consent requirements for data linkage proposed | 3.5 | | | | |
| | Consult patient groups and public | 3.5 | | | | |
| | Propose solutions, undertake impact assessment and revise | 3.5 | | | | |
| **Workstream 6: Planning audit feedback and reports** | | | | | | |
| | Describe options for dissemination of audit findings and how to stimulate quality improvement | 3.9 | | | | |
| | Categorise target audiences and detail how to report to each, focusing on who can lever quality improvement and how | 3.9 | | | | |

| IV. *Study workstreams and activities* | | | Timeline | | | |
|---|---|---|---|---|---|---|
| **Workstream** | **Activity** | **Deliverable** | Q 1 | Q 2 | Q 3 | Q 4 |
| **Workstream 7: Wales** | | | | | | |
| | Review Welsh datasets, identify common measures and potential for development of new measures in Wales | 3.7 | | | | |
| | Liaise with Public Health Wales and produce joint recommendations for cross-border audit measures | 3.8 | | | | |
| **Workstream 8. Contract management** | | | | | | |
| | Study Manager and Clinical Lead in post | 2.1 | | | | |
| | Recruit reference group | 2.2 | | | | |
| | Steering group start-up meeting | | | | | |
| | Establish study webpage | 2.4 | | | | |
| | Ongoing project management and reporting to HQIP | 1 | | | | |
| | Produce final report and circulate to stakeholders via reference group for comment | 4.1 | | | | |
| | Revise and submit to HQIP | 4.2 | | | | |

## Annex 2- STIs, HIV, and sexual health in context

### *I. England STI slideset, 2014*

PHE STI slideset

### *II. Explanatory notes regarding PHE's STI surveillance data*

Extract from PHE's England STI slideset, 2014:

- GUM services data are sourced from KC60 returns (2004-2008) & GUMCADv2 returns (2009-2014).
- Chlamydia test & diagnosis data from community (non-GUM) services are sourced from NCSP & NNNG services (2004-2011) & only include those aged 15-24. Chlamydia test & diagnosis data from 2012 onwards are sourced from CTAD & include all ages. Therefore chlamydia data from community services from 2012 onwards are not comparable to data from previous years. For further data from community services on chlamydia testing coverage, positivity & diagnostic rates (for those aged 15-24) please follow this link: https://www.gov.uk/government/statistics/national-chlamydia-screening-programme-ncsp-data-tables
- Chlamydia diagnoses from GUM services that were reported as 'previously diagnosed at another service' (SHHAPT codes C4X, C4OX, C4RX) are excluded from data from 2012 onwards. These diagnoses have been reported via CTAD & are already included in the community services data. Therefore, GUM services chlamydia data from 2012 onwards are not comparable to data from previous years.
- Rates are calculated using ONS population estimates based upon the 2011 census. Rates for 2014 have been calculated using 2013 population estimates. Ethnicity-specific population data are derived from mid-2011 ONS experimental data.
- Service data represent data from patients accessing services located in England, i.e. data may include people who are resident in England, Wales, Scotland, Northern Ireland or abroad.
- Residence data represent data from patients accessing services located in England who are also residents in England.
- Data reported with an unknown gender &/or sexual risk may be included in the data total.
- MSM includes men who reported being homosexual or bisexual. WSW includes women who reported being homosexual only.
- With the exception of HIV testing data, MSM & WSW reflect the sexual risk reported at the date of the patient attendance. For HIV testing, MSM & WSW reflect the sexual risk reported over a patient's entire clinic attendance history.
- With the exception of HIV test coverage, data represent the number of diagnoses & services reported & not the number of people diagnosed or provided services. HIV test coverage data represent the number of persons tested for HIV & not the number of tests reported.
- Data follow calendar years (Jan-Dec), not financial years (Apr-Mar).

## *III. Public Health England Reports, guidance and recommendations*

Sexually transmitted infections (STIs): annual data tables
Guidance for the detection of gonorrhoea in England
HIV in the UK: situation report, 2015: Incidence, prevalence and prevention
HIV new diagnoses, treatment and care in the UK: 2015 report

## *IV. Summary of responsibilities for commissioning sexual health services*

Extract from Public Health England:

Sexual health services are commissioned at a local level to meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

Local authorities commission comprehensive open access sexual health services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by clinical commissioning groups (CCGs), and at the national level by NHS England.

Local authorities commission:

- comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

CCGs commission:

- most abortion services
- sterilisation
- vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes

NHS England commissions:

- contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for PEPSE)
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
- sexual health elements of prison health services
- sexual assault referral centres
- cervical screening
- specialist fetal medicine services

Across England there is considerable regional variation in how sexual health services are provided and commissioned. They vary from distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genito-urinary medicine (GUM) services, to fully integrated sexual health services in the community. The variations occur because of differences in commissioning and contractual models used in local areas.

Further information about commissioning arrangements can be found in:

- Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV is PHE's national framework for HIV, sexual and reproductive health service commissioning in England, working with the Department of Health, Local Government Association, NHS England and Association of Directors of Public Health.
- A Framework for Sexual Health Improvement in England sets out the government's ambitions for improving sexual health, starting with the evidence base for sexual health and HIV improvement. It provides information and support tools to enable collaborative working locally resulting in accessible services and intervention.
- Commissioning Sexual Health Services and Interventions: Best Practice Guidance for Local Authorities: This guidance is designed to help local authorities to commission high quality sexual health services for their local area.
- The Integrated Sexual Health Services: National Service Specification is to help local authorities commission integrated sexual health care and can be used alongside the non-mandatory public health services contract.
- The Public Health Services Contract 2013 to 2014 is adaptable for use for a broad range of public health services and delivery models. It provides a framework to hold providers to account for the delivery of these services to achieve improved health outcomes.

## *V. Other useful data sources*

- PHE's Sexual and Reproductive Health Profiles enable local authorities, public health leads and other interested parties to monitor the sexual and reproductive health of their population, and the use of local public health systems.
- The HIV & STI Department of Public Health England regularly releases tables, official statistics, slide sets and reports based on data collected using its various surveillance systems. The tentative publication dates are provided in the HIV and STI data publication timetable (PDF, 75.2KB, 3 pages) .
- Sexually transmitted infections (STIs): surveillance, data, screening and management
- HIV: surveillance, data and management
- Chlamydia: surveillance, data, screening and management
- National Chlamydia Screening Programme (NCSP)
- HIV and STI Web Portal (restricted access: contact your local PHE team)
- Sexual and reproductive health in England: a guide to local and national data
- Public Health Outcomes Framework

## *VI. List of and links to standards of care relating to STIs and HIV*

Standards of Care for People Living with HIV (BHIVA)

Standards for the management of STIs (BASHH and MEDFASH)

BASHH Statement on Partner Notification

HIV Partner Notification for adults: definition, outcomes and standards – (NAT, BASHH, SSHA, BHIVA)

HIV testing: increasing uptake in black Africans (NICE)

HIV testing: increasing uptake in men who have sex with men (NICE)

## *VII. Overview of STI service levels*

The following list comprises elements of STI management that are appropriate at various levels of service provision. They are drawn from the three Levels (1, 2 and 3) originally defined in the *National strategy for sexual health and HIV* (DH, 2001) and were updated in the *Standards for the management of STIs* (BASHH and MEDFASH, 2014) to take account of the descriptor of specialist services in *A Framework for Sexual Health Improvement in England* (DH, 2013). They look specifically at STIs and related conditions and do not include elements of contraceptive and reproductive healthcare that may also be provided at these levels. The elements of care listed below are the maximum specifications for each service level, not the minimum requirements. It should be noted that the elements of care do not suggest where these can be delivered as this will be a commissioning decision based on the services commissioned and individual competence of the clinicians.

| **Sexual Health Services Provided** (summary*) | **Level of Service** | | |
|---|---|---|---|
| | **1** *Asymptomatic* | **2** *Symptomatic* | **3** *Complex/ specialist* |
| Sexual history taking and risk assessment | ✓ | ✓ | ✓ |
| Signposting to appropriate sexual health services | ✓ | ✓ | ✓ |
| Chlamydia screening (opportunistic screening in sexually active asymptomatic males and females under the age of 25) | ✓ | ✓ | ✓ |
| STI testing and treatment of *asymptomatic* infections (except treatment for gonorrhoea and syphilis) in women and men (except MSM) | ✓ | ✓ | ✓ |
| Partner notification of STIs or onward referral for partner notification | ✓ | ✓ | ✓ |
| HIV testing (including pre-test discussion and giving results) | ✓ | ✓ | ✓ |
| Sexual health promotion (provision of verbal and written sexual health promotion information) | ✓ | ✓ | ✓ |
| Condom distribution | ✓ | ✓ | ✓ |
| Assessment and referral for psychosexual problems | ✓ | ✓ | ✓ |
| STI testing and treatment of *symptomatic* but uncomplicated infections (including gonorrhoea if able to perform gonorrhoea cultures with rapid transport to the laboratory) in women and men (except MSM) | × | ✓ | ✓ |
| STI testing and treatment of MSM | × | × | ✓ |
| STI testing and treatment of men with dysuria and genital discharge | × | × | ✓ |
| STI testing and treatment of STIs at extra-genital sites | × | × | ✓ |
| STIs with complications | × | × | ✓ |
| STIs in pregnant women | × | × | ✓ |
| Gonorrhoea cultures and treatment of gonorrhoea | × | × | ✓ |

| **Sexual Health Services Provided** (summary*) | **Level of Service** | | |
|---|---|---|---|
| | **1** *Asymptomatic* | **2** *Symptomatic* | **3** *Complex/ specialist* |
| Recurrent conditions | × | × | ✓ |
| Recurrent or recalcitrant STIs and related conditions | × | × | ✓ |
| Management of syphilis and blood borne viruses | × | × | ✓ |
| Tropical STIs | × | × | ✓ |
| Specialist HIV treatment and care | × | × | ✓ |
| Provision and follow up of HIV post exposure prophylaxis (PEP) | × | × | ✓ |
| STI service co-ordination across a sexual health network | × | × | ✓ |

Please review full details in the *Standards for the management of STIs* (BASHH and MEDFASH, 2014) from which this list is adapted: http://www.medfash.org.uk/publications

## Annex 3 - Identifying and prioritising suitable topics and measures for audit

### *I. Topic selection criteria*

| Criteria | Key Indicators | Remarks |
|---|---|---|
| **1. The topics recommended for inclusion in the national clinical audit are a priority** | 1.1. The topics suggested have been reviewed against agreed topic selection criteria, which include assessment for<br>I. High risk a) at individual level and/or b) for Public Health<br>II. High volume (and/or burden) – may be influenced by criteria 1<br>III. High economic cost or labour intensive<br>IV. Inequities between sub-populations<br>I. Risk<br>II. Access to care<br>III. Provision of care<br>IV. Outcomes<br>V. Unacceptable variation in care quality and outcome | This would address, for example, the issue of non-measurement of sexual orientation (which can marginalize young MSM by only offering them a chlamydia test), assessment of chemsex risk and appropriate referral. |
| | 1.2. Key stakeholders, both clinical and non-clinical, agree that the clinical audit topic is a priority | Stakeholders will include providers, commissioners, nonclinical managers, trust boards (or equivalents), clinicians, staff, patients/service users and national organisations representing both clinicians and patients/users |
| **2. The topics recommended for inclusion in the national clinical audit are aligned with national priorities** | 2.1. The topics recommended are aligned with one or more of the following national priority setting documents:<br>Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV (full document) PHE (2014)<br>Public Health Outcomes Framework (PHOF)<br>NHS Outcomes Framework (NHS OF)<br>Framework for Sexual Health Improvement in England. DH (2013) | National priorities should be directly linked to an outcome |

| Criteria | Key Indicators | Remarks |
|---|---|---|
| **3. The recommended clinical audit measures against nationally accepted and measurable standards and/or outcome measures** | 3.1. The measures recommended for inclusion in the audit are included in and referenced back to one or more of the following :<br>I. BHIVA Standards of care for people living with HIV (2013)<br>II. BASHH/MEDFASH Standards for the management of STIs (2014)<br>III. Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007)<br>IV. Increasing the uptake of HIV testing among black Africans in England. NICE public health guidance 33 (2011)<br>V. Increasing the uptake of HIV testing among men who have sex with men. NICE public health guidance 34 (2011)<br>VI. NICE clinical management scenarios<br>VII. Other areas e.g. CQC standards that have not been referred to in any of the above documents | In addition to the listed standards and guidelines, the following may also be included:<br>• Established standards or quality measures, also to consider<br>• Quality outcome measures rather than process measures<br>• Strong evidence-based underlying process indicators or measures as a proxy for defined outcome measure<br>• New or revised national standards, measures or guidelines are produced. For example, NICE are in the process of updating their HIV testing guidelines (standards set out in the new guidelines would then also be used for future audit purposes)<br>• Standards or outcome measures developed specifically for the purpose of the audit. These will be developed through an appropriate process such as a properly designed consensus exercise.<br>All standards, regardless of derivation will be expressed in a format, which enables measurement. |

| Criteria | Key Indicators | Remarks |
|---|---|---|
| **4. The recommended clinical audit measures are amenable to change through national clinical audit** | 4.1. The proposed audit is likely to provide a driver(s) or lever(s) for infrastructural change, change in healthcare or healthcare systems or otherwise identify and/or result in improvement in the delivery of clinical care through:<br>I. Government policy and priorities<br>II. Commissioning of sexual health services, including the setting of contract performance measures and outcomes/quality indicators<br>III. the integrated Sexual Health agenda/strategies, or joined up working and clinical networks<br>IV. Nationally agreed clinical practice guidelines | Integrated Sexual Health agenda/strategies, or joined up working and clinical networks might include central partner notification provision to meet the needs of ID, GUMed, Contraception, Chlamydia Screening, TOP services, and/or Primary Care. |
| **5. The services relating to the proposed audit topics are publicly funded** | 5.1. Services to be included in the audit may be commissioned from an NHS provider, a non-governmental organisation and/or a private organisation. | All providers will be included in the audit provided the service is commissioned through public funds. |
| **6. The data required to answer the proposed audit questions is likely to be available within the proposed timescale of the audit** | 6.1. Availability of data will be determined by appraising the following:<br>I. costs incurred in accessing required data<br>II. permissions required to obtain high quality and well completed data<br>III. burden incurred to obtain high quality and well completed data from providers<br>IV. time required to obtain high quality and well completed data | Consider that YS suggested a good audit will get over 90% of providers supplying data (in acute) because there is a clear vision and everyone recognises the problem. |
| **7. The proposed audit is acceptable to clinicians and non-clinical stakeholders** | 7.1. Acceptability to clinicians and non-clinical stakeholders will be determined through consultation with relevant clinical leads, Reference and Steering Groups, including likelihood of maintaining the interest of those to be involved in the national clinical audit. | |
| | 7.2. A mechanism is identified or proposed through which senior leadership and commitment to the audit can be established. | |

| Criteria | Key Indicators | Remarks |
|---|---|---|
| **8. The proposed audit is acceptable to patients and the public** | 8.1. Acceptability to patients and the public, will be identified through consultation with relevant patient representative(s) and/or groups. | The patient group to whom the clinical audit standards apply is clearly defined. |
| | 8.2. Patients and the public are acknowledged as a key stakeholder in the audit process and a mechanism is identified or proposed through which patients can be involved in the audit process. | |
| **9. The proposed audit is complementary to previous, current or planned audits or quality improvement initiatives with the same or overlapping scope** | This will include for example: clinical reference groups, new dashboards as well as documented local clinical audits. | Memberships of specialty associations will be contacted to ask about good local clinical audits that have changed hearts and minds. |

## *II. Prioritisation of audit topics*

| Shortlisted audit topics | Outcome of prioritisation exercise[1] | Recommended audit topics |
|---|---|---|
| **Access to services within two working days of enquiry** | Retain | Access to services within two working days of enquiry |
| **Annual testing for all STIs (including HIV) for MSM** | Defer | Testing for chlamydia, gonorrhoea, syphilis and HIV, where indicated (all individuals) |
| **Three monthly testing for all STIs (including HIV) for higher risk individuals** | Defer | |
| **Chlamydia re-testing rates among young people** | Defer | |
| **HIV testing in different settings/missed opportunities for HIV testing outside specialist services** | Defer | |
| **Chlamydia partner notification** | Defer | Gonorrhoea partner notification |
| **HIV partner notification** | Retain | HIV partner notification |
| **Information & advice about prevention and transmission[2]** | Defer | Sexual History Taking (all individuals) |
| **Feedback of STI test results to patients (within 10 days of having the tests taken)** | Revise | Time between testing & treatment (all individuals) |
| **Completion of treatment for patients diagnosed with early syphilis** | Defer | First line treatment for gonorrhoea (all individuals diagnosed with gonorrhoea) |
| **Gonorrhoea pathway for test of cure (including cure)** | Defer | Offer and uptake of test of cure for patients treated for gonorrhoea (all individuals diagnosed with gonorrhoea) |
| **Referral of patients with identified mental health needs to appropriate services** | Revise | Existence of key referral pathways & policies (all individuals) |

[1] Where an audit measure is deferred, an alternate audit measure is recommended to address the highlighted sexual health concern.
[2] This measure may be more accurately explored using PREMs rather than clinician reports.

## *III. Topic selection survey questions*

The study's Reference Group were invited to complete the following online survey:

Thank you for agreeing to take part in this National Clinical Audit of STIs and HIV Feasibility Study survey on topic selection and prioritisation.

The aim of this survey is to gather a collective position from your organisation regarding aspects of STI and HIV care which influence transmission of STIs. This survey contains 12 questions and explores different aspects of care which have been identified by the Project Team and Steering Group as key to reducing STI and HIV transmission.

You have been asked to take part in this study because your organisation has been identified as being influenced by or influential on the delivery of clinical care for patients at risk of or diagnosed with STIs and/or HIV.

We are very grateful that you have agreed to take part and provide feedback by Monday 27th July 2015.

**Survey Instructions**

Before you complete this survey, please review the guidance notes which outline the purpose of the study, explain the differences between audit, research and service evaluation and present the aspects of STI and HIV care shortlisted for exploration in this study.

You may find it helpful to share these guidance notes with your colleagues to aid discussion of priority aspects of STI and HIV care, before completing the survey online.

As you complete the survey, your responses will be saved automatically. You may start and stop the survey at any point, provided that you:
1) use the original survey link provided above
2) access the survey through a new window
3) use the same computer/laptop/tablet at each session.

If you choose to complete the survey in more than one session, the survey will return to the last completed page, so you should not need to re-enter your previous answers. At the end of the survey, you will be able to print your responses.

If you have any questions or difficulties accessing or completing the online survey, please contact Study Manager, Melvina Woode Owusu on mwoodeowusu@medfash.bma.org.uk.

1. You can access the guidance notes here:

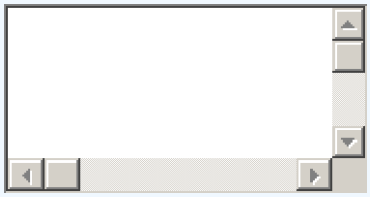
   Guidance Notes (opens in a new window)

   *

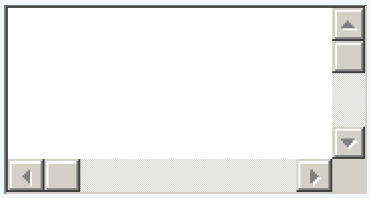
   Start Survey

**You and your organisation**

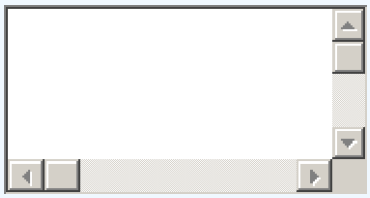
2. Please tell us your first name*



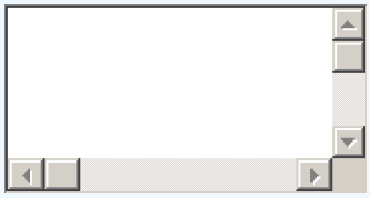
3. Please tell us your surname*



4. Which organisation are you representing in the National Clinical Audit of STIs and HIV Feasibility Study?*



5. What is your current role in your organisation?*



6. Have you consulted any other members of your organisation before completing this survey?*

○ Yes ○ No

## Quality Improvement Initiatives

These questions are about quality improvement initiatives relevant to specific aspects of STI and HIV care and services.

7. Are you aware of any previous, current or planned quality improvement initiatives relating to these aspects of STI and HIV care?*

| | Yes | No |
|---|---|---|
| Access to services within 2 working days of enquiry | ○ | ○ |
| Annual testing for all STIs (including HIV) for MSM | ○ | ○ |
| Three monthly testing for all STIs (including HIV) for | ○ | ○ |

| | | |
|---|---|---|
| higher risk individuals | | |
| Provision of information about prevention and transmission | ○ | ○ |
| Feedback of STI test results to patients within 10 days of having the tests taken | ○ | ○ |
| Referral of patients with identified mental health needs to appropriate services | ○ | ○ |
| Gonorrhoea pathway for test of cure (including cure) | ○ | ○ |
| Chlamydia re-testing rates among young people | ○ | ○ |
| Completion of treatment for patients diagnosed with early syphilis | ○ | ○ |
| HIV partner notification | ○ | ○ |

8.

**Select file to upload:**
(click "Browse" button below to locate file)

File size restricted to: 4194304 KB
File type restricted to: No file type restrictions.

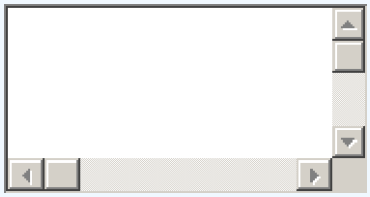
Upload

File Name: (limit 255 characters)

File Description: (limit 255 characters)

Files Uploaded:

9. Please add details or website links here:



## Priority aspects of care for people diagnosed with STIs and HIV

The next set of questions are about the aspects of care for people diagnosed with STIs and HIV, which the Project Team and Steering Group have short-listed.

10. To what extent do you feel each of the following aspects of care are important for reducing the transmission of STIs and/or HIV:*

| | Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Access to services within 2 working days of enquiry | ○ | ○ | ○ | ○ | ○ |
| Annual testing for all STIs (including HIV) for MSM | ○ | ○ | ○ | ○ | ○ |
| Three monthly testing for all STIs (including HIV) for higher risk individuals | ○ | ○ | ○ | ○ | ○ |
| Provision of information about prevention and transmission | ○ | ○ | ○ | ○ | ○ |
| Feedback of STI test results to patients within 10 days of having the tests taken | ○ | ○ | ○ | ○ | ○ |
| Referral of patients with identified mental health needs to appropriate services | ○ | ○ | ○ | ○ | ○ |
| Gonorrhoea pathway for test of cure (including cure) | ○ | ○ | ○ | ○ | ○ |
| Chlamydia re-testing rates | ○ | ○ | ○ | ○ | ○ |

| | | | | | |
|---|---|---|---|---|---|
| among young people | | | | | |
| Completion of treatment for patients diagnosed with early syphilis | ○ | ○ | ○ | ○ | ○ |
| HIV partner notification | ○ | ○ | ○ | ○ | ○ |

11. Please select three aspects of care which are most likely to be improved through national clinical audit: *
Please only select 3 aspects of care.

- ☐ Access to services within 2 working days of enquiry
- ☐ Annual testing for all STIs (including HIV) for MSM
- ☐ Three monthly testing for all STIs (including HIV) for higher risk individuals
- ☐ Provision of information about prevention and transmission
- ☐ Feedback of STI test results to patients within 10 days of having the tests taken
- ☐ Referral of patients with identified mental health needs to appropriate services
- ☐ Gonorrhoea pathway for test of cure (including cure)
- ☐ Chlamydia re-testing rates among young people
- ☐ Completion of treatment for patients diagnosed with early syphilis
- ☐ HIV partner notification

12. Please explain why you believe that these aspects of care are most likely to be improved through national clinical audit: *
Please provide a reason for each aspect of care selected. This will help to inform how the Project Team and Steering Group rank and prioritise topics for exploration in this study and for inclusion in a future national clinical audit.

13. Would you or colleagues at your organisation, like to highlight any other key aspects of care should be considered in this feasibility study and/or for a national clinical audit of STIs and HIV?*

- ○ No
- ○ Yes, please give details in the box below

**Thank you**

Thank you for completing this survey.

You can review your responses by selecting 'back'.

When you are happy with the responses provided, please select 'done'.

## *IV. Clinician survey questions*

Members of BASHH were invited to respond to the following survey

**Thank you for agreeing to take part in this Consultation Survey as part of the National Clinical Audit of STIs and HIV Feasibility Study**

1. The aim of this survey is to gather feedback from those providing clinical care for HIV, chlamydia, gonorrhoea and syphilis. Feedback received in this survey will be used to inform the National Clinical Audit of STIs and HIV feasibility study in which BASHH, BHIVA, MEDFASH (Medical Foundation for HIV & Sexual Health) and PHE are exploring the feasibility of a future national clinical audit in England and Wales.

   In this survey, you will be presented with a selection of aspects of care, which have been shortlisted for inclusion in a future national clinical audit.

   We would like your opinion on:

   1) your experience of auditing this aspect of care in your setting
   2) what might support you and your direct team in improving quality of care
   3) what might hinder you and your direct team in improving quality of care

   For more information about this study and for details of how the shortlisted aspects of care have been chosen, please see the Guidance Notes (opens in a new window).

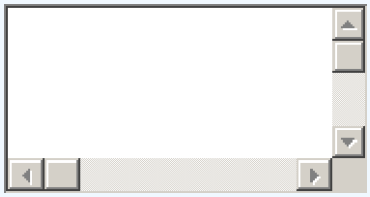
   This short survey should take between **5 and 10 minutes** to complete and will be accessible until **5pm GMT on Friday 30th October 2015**.

   If you have any questions or difficulties accessing or completing the online survey, please contact Study Manager, Melvina Woode Owusu on mwoodeowusu@medfash.bma.org.uk.
   *

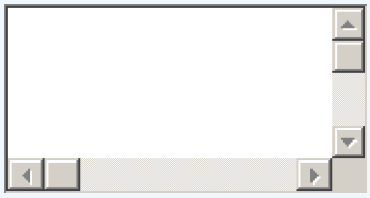
   Start Survey

**You and your organisation**

2. Please tell us your first and surname*



3. Which organisation(s) do you work for? *



4. What is your current role in your organisation?*

If you work for more than one organisation, please state your role in your main or primary organisation.

5. Do you have a defined role in clinical audit?*

- ○ No
- ○ Yes (please give details in the box below)

6. Do you work in any of the following clinical settings?*

- ☐ Level 1 services
- ☐ Level 2 services
- ☐ Level 3 services
- ☐ Other, please specify

## Audit in your clinic

7. In the past 3 years, has your clinic undertaken a local audit in any of the following aspects of care?*

| | Yes | No | I don't know | Not applicable |
|---|---|---|---|---|
| Access | ☐ | ☐ | ☐ | ☐ |
| STI testing | ☐ | ☐ | ☐ | ☐ |
| HIV testing | ☐ | ☐ | ☐ | ☐ |
| Time between test, results and/or treatment | ☐ | ☐ | ☐ | ☐ |
| Sexual history taking | ☐ | ☐ | ☐ | ☐ |
| Provision of information to patients | ☐ | ☐ | ☐ | ☐ |
| Referrals for additional health | ☐ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| needs | | | | |
| STI partner notification | ☐ | ☐ | ☐ | ☐ |
| HIV partner notification | ☐ | ☐ | ☐ | ☐ |
| Provision of recommended first line treatment | ☐ | ☐ | ☐ | ☐ |

8. In the past 3 years, has your clinic audited any other aspects of care?*
Apart from the aspects of care listed above.

- ○ No
- ○ I don't know
- ○ Yes (please give details in the box below)

**Proposed topics for inclusion in a national clinical audit**

Six themes for audit have been proposed by the Project Team, Steering Group and Reference Group.

These include:

1. Access
2. Testing
3. Turnaround Times (time between test, patient receiving result and treatment)
4. Information and Referrals
5. Partner Notification
6. Treatment

The proposed audit questions currently under evaluation relate to these topics.

The next section of the survey asks about the likelihood of quality improvement in your clinic for each proposed audit topic.

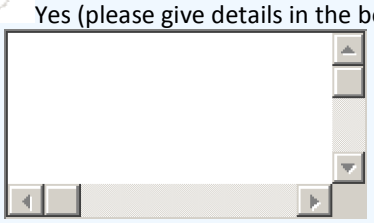
9. Which three aspects of care are **most** likely to be improved through national clinical audit,**in your clinic**: *
Please only select 3 aspects of care.

- ☐ Access
- ☐ STI testing
- ☐ HIV testing
- ☐ Time between test, results and/or treatment
- ☐ Sexual history taking
- ☐ Provision of information to patients

- [ ] Referrals for additional health needs
- [ ] STI partner notification
- [ ] HIV partner notification
- [ ] Provision of recommended first line treatment

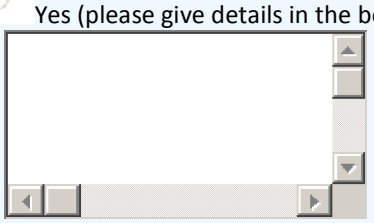
10. Is there anything specific that would help drive quality improvement in your clinic? *
For example, sharing of best practice among clinics; comparative clinic-level/benchmarking data.

- ○ No
- ○ Yes (please give details in the box below)

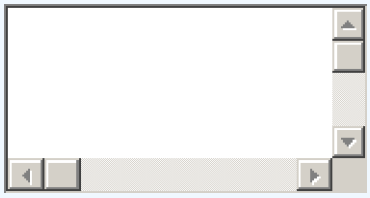


11. Is there anything specific that would hinder quality improvement in your clinic? *
For example, lack of support from trust level to fund quality improvement initiatives; lack of protected time to engage in the audit.

- ○ No
- ○ Yes (please give details in the box below)



12. Please use the space below to make any further comments regarding this feasibility study or national clinical audit.



**Thank you**

Thank you for completing this survey.

You can review and amend your responses by selecting 'back'.

When you are happy with your responses, please select 'done' to submit your feedback.

Survey of FSRH members

Members of the FSRH were invited to respond to the following survey

**Thank you for agreeing to take part in this Consultation Survey as part of the National Clinical Audit of STIs and HIV Feasibility Study**

1. The aim of this survey is to gather feedback from those providing clinical care for HIV, chlamydia, gonorrhoea and syphilis. Feedback received in this survey will be used to inform the National Clinical Audit of STIs and HIV feasibility study, which is commissioned by the Healthcare Quality Improvement Partnership (HQIP). MEDFASH (Medical Foundation for HIV & Sexual Health) is managing this study with PHE, BASHH, and BHIVA and together are exploring the feasibility of a future national clinical audit in England and Wales.

   As there is a connection between reproductive and sexual health, we are keen to explore the impact that auditing sexual health services might have on reproductive health services and outcomes.

   In this survey, you will be presented with a selection of aspects of care, which have been shortlisted for inclusion in a future national clinical audit of STIs and HIV care.

   We would like your opinion on:

   1) your experience of auditing this aspect of care in your setting
   2) what might support you and your direct team in improving quality of care
   3) what might hinder you and your direct team in improving quality of care

   For more information about this study and for details of how the shortlisted aspects of care have been chosen, please see the Guidance Notes (opens in a new window).

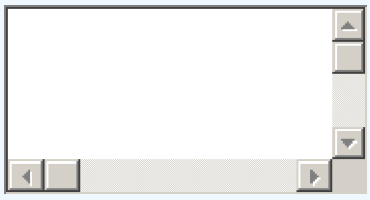
   This short survey should take between **5 and 10 minutes** to complete and will be accessible until **5pm GMT on Friday 11th December 2015**.

   If you have any questions or difficulties accessing or completing the online survey, please contact Study Manager, Melvina Woode Owusu on mwoodeowusu@medfash.bma.org.uk.*

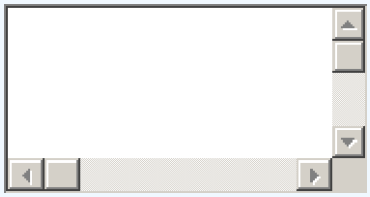
   Start Survey

**You and your organisation**

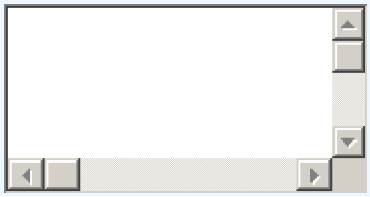
2. Please tell us your first and surname*



3. Which organisation(s) do you work for? *

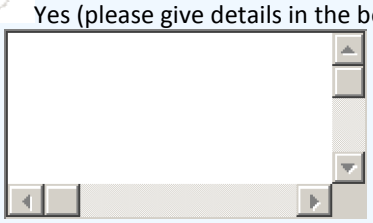


4. What is your current role in your organisation?*
   If you work for more than one organisation, please state your role in your main or primary organisation.



5. Do you have a defined role in clinical audit?*

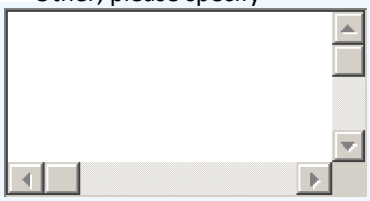
- ○ No
- ○ Yes (please give details in the box below)



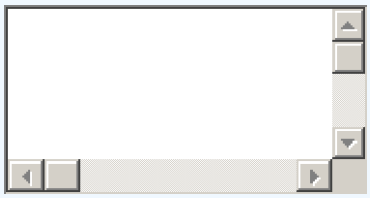
6. Do you work in any of the following clinical settings?

   For a definition of level 3, 2 and 1 sexual health services, click here
   *

- ☐ Level 1 services
- ☐ Level 2 services
- ☐ Level 3 services
- ☐ Other, please specify



7. Are there any areas of reproductive healthcare that, if audited, could help drive quality improvement in sexual health services?



## Audit in your clinic

8. In the past 3 years, has your clinic undertaken a local audit in any of the following aspects of care?*

| | Yes | No | I don't know | Not applicable |
|---|---|---|---|---|
| Access | ☐ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| STI testing | ☐ | ☐ | ☐ | ☐ |
| HIV testing | ☐ | ☐ | ☐ | ☐ |
| Time between test, results and/or treatment | ☐ | ☐ | ☐ | ☐ |
| Sexual history taking | ☐ | ☐ | ☐ | ☐ |
| Provision of information to patients | ☐ | ☐ | ☐ | ☐ |
| Referrals for additional health needs | ☐ | ☐ | ☐ | ☐ |
| STI partner notification | ☐ | ☐ | ☐ | ☐ |
| HIV partner notification | ☐ | ☐ | ☐ | ☐ |
| Provision of recommended first line treatment | ☐ | ☐ | ☐ | ☐ |

9. In the past 3 years, has your clinic audited any other aspects of care?*
Apart from the aspects of care listed above.

- ○ No
- ○ I don't know
- ○ Yes (please give details in the box below)

**Proposed topics for inclusion in a national clinical audit**

Six themes for audit have been proposed by the Project Team, Steering Group and Reference Group.

These include:

1. Access
2. Testing
3. Turnaround Times (time between test, patient receiving result and treatment)
4. Information and Referrals
5. Partner Notification
6. Treatment

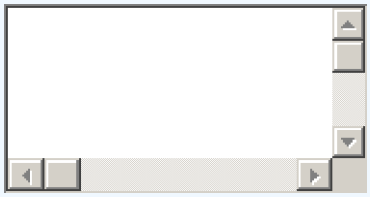
The proposed audit questions currently under evaluation relate to these topics.

The next section of the survey asks about the likelihood of quality improvement in your clinic for each proposed audit topic.

10. Which three aspects of care are **most** likely to be improved through national clinical audit,**in your clinic**: *
Please only select 3 aspects of care.

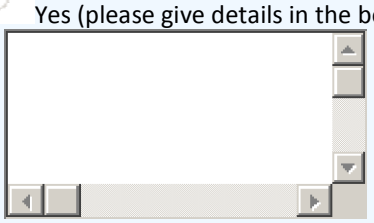
- [ ] Access
- [ ] STI testing
- [ ] HIV testing
- [ ] Time between test, results and/or treatment
- [ ] Sexual history taking
- [ ] Provision of information to patients
- [ ] Referrals for additional health needs
- [ ] STI partner notification
- [ ] HIV partner notification
- [ ] Provision of recommended first line treatment

11. If improvements are made to aspects of sexual health (HIV, chlamydia, gonorrhoea and syphilis) how might this impact on access to and provision of reproductive healthcare?
For example, do you believe it will have a positive or negative impact and why?



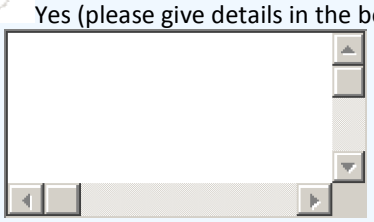
12. Is there anything specific that would help drive quality improvement in your clinic? *
For example, sharing of best practice among clinics; comparative clinic-level/benchmarking data.

- ○ No
- ○ Yes (please give details in the box below)

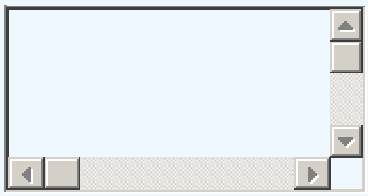


13. Is there anything specific that would hinder quality improvement in your clinic? *
For example, lack of support from trust level to fund quality improvement initiatives; lack of protected time to engage in the audit.

- ○ No
- ○ Yes (please give details in the box below)



14. Please use the space below to make any further comments regarding this feasibility study or national clinical audit.



**Thank you**

Thank you for completing this survey.

You can review and amend your responses by selecting 'back'.

When you are happy with your responses, please select 'done' to submit your feedback.

## Annex 4 - Assessing technical feasibility of data collection

### *I. GUMCADv2 dataset*

[1] Refers to the horizontal position of the field within CSV format
[2] AN = Alpha-numeric, N = Numeric, A = Character. Number in brackets denotes the string length. Code entries which are shorter than the string length should not include leading/trailing zeroes or spaces
[3] Example of field content, also used to illustrate extract format expected

| Position[1] | Field Name | Description | NHS Data Dictionary Data Element | Variable Length (Maximum)[2] | Example[3] |
|---|---|---|---|---|---|
| 1 | ClinicID | Clinic (service) ID code | SITE CODE (OF TREATMENT) | AN(9) | RCC25 |
| 2 | PatientID | Local patient identifier number | LOCAL PATIENT IDENTIFIER | AN(20) | PAT123 |
| 3 | Episode_Activity | SHHAPT code<br>**OR** | SEXUAL HEALTH AND HIV ACTIVITY PROPERTY TYPE | AN(6) | C10A |
| | *(previously 'KC60' or 'READ')* | READ code | DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODE) | AN(7) | 9Oq0.00 |
| 4 | Gender | Gender | PERSON STATED GENDER CODE | N(1) | 1 |
| 5 | Age | Age at attendance date in years | AGE AT ATTENDANCE DATE | N(3) | 16 |
| 6 | Sex_Ori | Sexual orientation | SEXUAL ORIENTATION (CURRENT) | N(1) | 1 |
| 7 | Ethnicity | Patient's ethnic category | ETHNIC CATEGORY | AN(2) | A |

| | | | | | |
|---|---|---|---|---|---|
| 8 | Country_Birth | Patient's country of birth | COUNTRY CODE (BIRTH) | A(3) | GBR |
| 9 | LA<br><br>*(previously 'PCT')* | Local Authority District (LA) code of patient residence | ONS LOCAL GOVERNMENT GEOGRAPHY CODE (LOCAL AUTHORITY DISTRICT) | AN(3) or AN(9) | 95A<br>or<br>E06000001 |
| 10 | LSOA | Lower Layer Super Output Area of residence code | LOWER LAYER SUPER OUTPUT AREA (RESIDENCE) | AN(8) or AN(9) | 95AA01S1 or<br>E01000001 |
| 11 | First_Attendance | Attendance type | FIRST ATTENDANCE | N(1) | 1 |
| 12 | AttendanceDate | Date of attendance | ATTENDANCE DATE | N(10) CCYY-MM-DD | 2007-10-31 |

## *I. GUMCADv2 SHHAPT codes and notes*

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| **Diagnosis Codes** | | |
| 40 | Sexual Assault (Acute Presentation) | The time between sexual assault and medical examination is within 7 days.<br><br>• this code is shared with the SRHAD report. Please speak to your software provider to determine if coding is required for GUMCAD and SRHAD ie this may need to be coded twice in order to appear in both reports<br><br>http://www.hscic.gov.uk/datacollections/srhad. |
| 41 | Sexual Assault (Non-acute Presentation) | The time between sexual assault and medical examination is more than 7 days.<br><br>• this code is shared with the SRHAD report. Please speak to your software provider to determine if coding is required for GUMCAD and SRHAD ie this may need to be coded twice in order to appear in both reports<br><br>http://www.hscic.gov.uk/datacollections/srhad. |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| A1 | Primary syphilis | This refers to primary infectious syphilis. Laboratory confirmation is required.<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A1X)*<br><br>*see tables D and E for further details on using suffixes.* |
| A2 | Secondary syphilis | This refers to secondary infectious syphilis. Laboratory confirmation is required.<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A2X)*<br><br>*see tables D and E for further details on using suffixes.* |
| A3 | Early latent syphilis | This refers to patients who acquired syphilis in the preceding 2 years who have no signs of primary or secondary syphilis. Proof of negative serology within the preceding 2 years is required.<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A3X)*<br><br>*see tables D and E for further details on using suffixes.* |
| A4 | Cardiovascular syphilis | This refers to cardiovascular syphilis<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A4X)*<br><br>*see tables D and E for further details on using suffixes.* |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| A5 | Neurosyphilis | This refers to syphilis of the nervous system.<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A5X)*<br><br>*see tables D and E for further details on using suffixes.* |
| A6 | All other late and latent syphilis | This refers to latent syphilis after the first two years of infection and all other latent syphilis.<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A6X)*<br><br>*see tables D and E for further details on using suffixes.* |
| A7A | Congenital syphilis | Serological evidence of syphilis in an infant or child and clinical signs consistent with congenital syphilis, for example:<br><br>• early (<2 years): snuffles, skin and mucous membrane lesions, lymphadenopathy, hepatosplenomegaly<br>• late (>2 years): gummatous ulcers, interstitial keratitis, optic atrophy, sensorineural deafness, Hutchinson's incisors<br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (A7AX)*<br>*see tables D and E for further details on using suffixes.* |
| B | Gonorrhoea | This includes all cases of complicated and uncomplicated genital gonorrhoea (pre- and post-pubertal).<br><br>• NAAT-positive or culture confirmed.<br>• Genital gonorrhoea would include urethral and cervical urethral infections.<br>• The O and R suffixes can be added to report pharyngeal (BO) and rectal infections (BR).*<br>• The X suffix can be added where the current episode is known to have been diagnosed at another sexual health |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| | | service. (BX)*<br>• Patients thought to be newly infected after a previous episode should be regarded as a new episode and investigated, treated and diagnosed/coded accordingly.<br>• Treatment failures should not be given a new diagnosis. Treatment failures include those in whom first line antibiotics have failed (for example, symptoms not resolved or antibiotics not taken correctly) and those who have had sexual intercourse with an untreated partner (not a new partner) within 6 weeks.<br><br>**see tables D & E for further details on using suffixes..* |
| C1 | Chancroid | Laboratory confirmation is required for this condition. |
| C2 | Lymphogranuloma venereum (LGV) | Laboratory confirmation is required for this condition.<br><br>• the O and R suffixes can be added to report pharyngeal (C2O) and rectal infections (C2R)*<br><br>**see tables D and E for further details on using suffixes.* |
| C3 | Donovanosis | Laboratory confirmation is required for this condition. |
| C4 | Chlamydia | This includes all cases of complicated and uncomplicated genital c*hlamydia trachomatis* infections (diagnosed by culture or antigen detection).<br><br>• genital chlamydia would include urethral and cervical urethral infections<br>• the O and R suffixes can be added to report pharyngeal (C4O) and rectal infections (C4R)*<br>• the X suffix can be added where the current episode is known to have been diagnosed at another sexual health service. (C4X)*<br>• patients thought to be newly infected after a previous episode should be regarded as a new episode and investigated, treated and diagnosed/coded accordingly<br>• treatment failures should not be given a new diagnosis. Treatment failures include those in whom first line |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| | | antibiotics have failed (for example, symptoms not resolved or antibiotics not taken correctly) and those who have had sexual intercourse with an untreated partner (not a new partner) within 6 weeks<br>**see tables D and E for further details on using suffixes.* |
| C4N | Non-specific genital infection (NSGI) | This includes all cases of complicated and uncomplicated NSGI.<br><br>• the R suffix can be added to report Proctitis (C4NR)*<br>• in males, NSGI is diagnosed in the absence of gonorrhoea and laboratory confirmed chlamydia and the presence of polymorphonuclear leucocytes at >5 per high power field<br>• females being treated for non-specific mucopurulent cervicitis should be coded C4N<br>• patients thought to be newly infected after a previous episode should be regarded as a new episode and investigated, treated and diagnosed/coded accordingly<br>• treatment failures should not be given a new diagnosis. Treatment failures include those in whom first line antibiotics have failed (for example, symptoms not resolved or antibiotics not taken correctly) and those who have had sexual intercourse with an untreated partner (not a new partner) within 6 weeks<br>**see tables D and E for further details on using suffixes.* |
| C5A | Pelvic inflammatory disease (PID) and epididymitis | This includes all cases of pelvic inflammatory disease and all cases of epididymitis<br>• C5A should be reported *with* B for gonococcal infections and *with* C4 for chlamydial infections<br>• all other complications should be coded D2B |
| C5B | Ophthalmia neonatorum | This includes all cases of ophthalmia neonatorum.<br>• C5B should be reported *with* B for gonococcal infections and *with* C4 for chlamydial infections. |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| C6A | Trichomoniasis | Diagnosis of trichomoniasis associated with bacterial vaginosis (BV) should *only* be coded C6A (for trichomoniasis) ie do *not* also code C6B (for BV).<br><br>• the X suffix can be added where the current episode is known to have been previously diagnosed at another sexual health service (C6AX)*<br><br>**see tables D and E for further details on using suffixes.* |
| C6B | Anaerobic/ bacterial vaginosis (BV) and anaerobic balanitis | Diagnosis of bacterial vaginosis (BV) is generally based on microscopy, pH vaginal fluid and the amine test.<br><br>• this diagnosis is very rarely appropriate in males and used only if the patient has confirmed anaerobic balanitis<br>• all other / non-confirmed anaerobic balanitis should be coded C6C |
| C6C | Other vaginosis/vaginitis/ balanitis | This includes 'other' and non-confirmed anaerobic balanitis. |
| C7 | Anogenital candidosis | This is diagnosed only when there is microscopic or culture evidence of candida infection.<br><br>• if there is no microbiological evidence then infection should be coded C6C<br>• asymptomatic patients who do not require treatment should be coded D3 |
| C8 | Scabies | This includes cases treated on either a clinical or epidemiological basis.<br><br>• treatment failures should not be given a new diagnosis. Patients who are thought to be re-infected should be regarded as new cases, and investigated, treated and diagnosed/coded accordingly |
| C9 | Pediculosis pubis | This includes cases treated on either a clinical or epidemiological basis.<br><br>• treatment failures should not be given a new diagnosis. Patients who are thought to be re-infected should be |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| | | regarded as new cases, and investigated, treated and diagnosed/coded accordingly. |
| C10A | Anogenital Herpes simplex: 1st episode | A first episode of anogenital herpes should only be recorded if the patient has *never* previously had a confirmed diagnosis (at any sexual health service). Laboratory confirmation is required for this condition. |
| C10B | Anogenital Herpes simplex: recurrence | This includes all subsequent episodes of anogenital herpes. If there has been previous laboratory confirmation, then clinical judgement is enough for this diagnosis. |
| C11A | Anogenital warts infection: 1st episode | A first episode of anogenital warts should only be recorded if the patient has *never* previously received treatment for the condition (at any sexual health service).<br><br>• diagnosis refers to macroscopic warts. It does not refer to acetowhite patches, abnormalities revealed by acetowhite staining nor the cytological finding of a wart virus change ie these should *not* be coded C11A |
| C11D | Anogenital warts infection: recurrence | This includes all subsequent episodes of anogenital warts.<br><br>• diagnosis refers to macroscopic warts. It does not refer to acetowhite patches, abnormalities revealed by acetowhite staining nor the cytological finding of a wart virus change ie these should not be coded C11D |
| C12 | Molluscum contagiosum | Diagnosis refers to presence of characteristic lesions, or characteristic histopathological features if biopsy has been performed. |
| C13 | Viral hepatitis B (HbsAg positive): first diagnosis | This includes 1st diagnoses of antigen positive hepatitis B only.<br><br>• subsequent attendances for hepatitis B management and/or other STI services should *not* be coded C13 (hepatitis B management should be coded D2B) |
| C14 | Viral hepatitis C: 1st diagnosis | First diagnoses of hepatitis C, defined as anti-HCV positive or HCV RNA positive. |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| C15 | Viral hepatitis A: acute infection | Diagnoses of acute hepatitis A, defined as detection of hepatitis A virus specific IgM antibodies. |
| C16 | Mycoplasma genitalium | Laboratory confirmation is required for this condition. |
| D2A | Urinary tract infection | This includes patients where any of the following conditions are met (otherwise patients should be coded D2B):<br><br>i. Culture positive UTI.<br>ii. Moderately to highly likely UTI based on clinical and dipstick* criteria.<br>iii. Treated for UTI based on moderate/severe symptoms of UTI without culture or dipstick*<br><br>* LE or Nitrite positive. |
| D2B | Other conditions requiring services/treatment at Sexual Health services | This includes any new episode where an STI service and/or treatment was required for a condition that is not covered by any other SHHAPT code. |
| H | HIV positive | For known HIV positive patients who are attending for STI care only (and can be coded as often as required within an episode).<br><br>• patient attending for HIV care should be coded H2 (not H)<br>• *cannot* be reported on the same date as H1, H1A, H1B or H2 |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| H1 | New HIV diagnosis | This includes all new HIV diagnoses (that are not defined as 'acute' or AIDS related).<br><br>• the X suffix can be added where the patient is known to have been previously diagnosed with HIV (at any other clinical setting) and has not previously accessed HIV care (H1X)*<br>• known HIV positive patients transferring their existing HIV care to a new service should be coded H2<br>• H can be coded at each associated attendance within a single episode.<br>• *cannot* be reported on the *same date* as H or H2.<br>• *cannot* be reported in the *same patient history* as H1A or H1B<br><br>**see tables D and E for further details on using suffixes.* |
| H1A | New HIV diagnosis: Acute | This includes all new HIV diagnoses which have evidence of one or more of the following in the last 6 months:<br><br>a) a documented negative HIV test.<br>b) laboratory evidence (eg RITA assay, RNA, neutralisable p24 antigen and antibody negative).<br>c) evidence of seroconversion illness.<br><br>• the X suffix can be added where the patient is known to have been previously diagnosed with HIV (at any other clinical setting) and has not previously accessed HIV care (H1X)*<br>• known HIV positive patients transferring their existing HIV care to a new service should be coded H2<br>• *cannot* be reported on the *same date* as H or H2<br>• *cannot* be reported in the *same patient history* as H1 or H1B |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| | | **see tables D and E for further details on using suffixes.* |
| H1B | New HIV diagnosis: Late (AIDS defined) | This includes all new HIV diagnoses which have a clinical AIDS diagnosis within 3 months of initial HIV diagnosis.<br>• the X suffix can be added where the patient is known to have been previously diagnosed with HIV (at any other clinical setting) and has not previously accessed HIV care (H1BX).*<br>• known HIV positive patients transferring their existing HIV care to a new service should be coded H2<br>• *cannot* be reported on the *same date* as H or H2<br>• *cannot* be reported in the *same patient history* as H1 or H1A<br>**see tables D and E for further details on using suffixes.* |
| H2 | Attendance for HIV-related care | This includes all attendances relating to HIV care.<br>• H2 can be coded at each associated attendance within a single episode<br>• *cannot b*e reported on the *same date* as H, H1, H1A or H1B |
| P4A | Cervical cytology: minor abnormality | Includes smears showing lower grades (ie “borderline” or “mild”) of dyskaryosis on cytological examination. |
| P4B | Cervical cytology: major abnormality | Includes smears showing moderate or worse (ie “moderate” or “severe”) dyskaryosis on cytological examination. |
| PR1 | Pregnant 1-12 weeks | For those known to be in the 1st trimester of pregnancy (only required once per pregnancy).<br>• *cannot* be reported on the *same date* as PR2 or PR3 |
| PR2 | Pregnant 13-28 weeks | For those known to be in the 2nd trimester of pregnancy (only required once per pregnancy).<br>• *cannot* be reported on the *same date* as PR1 or PR3 |

| SHHAPT code | Description | Definition and guidance |
|---|---|---|
| PR3 | Pregnant 29 weeks – full term | For those known to be in the 3rd trimester of pregnancy (only required once per pregnancy).<br><br>• *cannot* be reported on the *same date* as PR1or PR2 |
| SG1 | Shigella flexneri | Laboratory confirmation is required for this condition. |
| SG2 | Shigella sonnei | Laboratory confirmation is required for this condition. |
| SG3 | Shigella other / unspecified | Laboratory confirmation is required for this condition. |

| **Service Codes** | | |
|---|---|---|
| D3 | Other episodes not requiring treatment | This includes any new episode where no STI services and/or treatment were required ie no other SHHAPT code is appropriate.<br><br>• D3 can be used to code negative HIV/STI tests (P1A and T1-T7) although this is not strictly necessary ie negative HIV/STI tests can be reported without D3<br>• D3 can be used in conjunction with 'prisoner' (Z) and 'sex worker' (SW) codes<br>• D3 can be used to code patients who have been triaged or have seen a health advisor but have 'walked-out' before seeing a clinician<br>• patients who do not attend should not be coded D3<br>• D3 can be used only once per episode |
| P1A | HIV antibody test | For those receiving an HIV antibody test which is not part of a full sexual health screen (as described by code T4).<br><br>• Cannot be reported on the same date as P1B, P1C, T3, T4 or T7.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| P1B | HIV antibody test offered and refused | For those offered an HIV antibody test who decline the test.<br><br>• Including where a clinician believes there is a HIV risk that could be tested on that day, where a pre-test discussion/counselling has taken place or where the patient intends to test in the future.<br>• Cannot be reported on the same date as P1A, P1C, T4 or T7.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| P1C | HIV test not appropriate | For those accessing STI services who were not offered an HIV test because the clinician deemed it was not appropriate eg the patient has recently tested or is still inside the HIV 'window' period.<br><br>• Patients already known to be HIV positive do not need to be coded P1C – they should be coded H or H2 (as appropriate). |

| Service Codes | | |
|---|---|---|
| | | • It may be more appropriate to code some patients SRH instead of P1C e.g. patients attending for continued contraceptive care where HIV testing is not relevant to the consultation.<br>• Cannot be reported on the same date as P1A, P1B, T4 or T7.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| P2A | Hepatitis B vaccination: 1st dose | The 1st dose of any new hepatitis B vaccination course (including patients who may have been previously vaccinated but are now receiving the 1st dose of a new vaccination course).<br><br>• cannot be reported on the same date as P2B, P2C, P2D or P2E |
| P2B | Hepatitis B vaccination: 2nd dose | The 2nd dose of a hepatitis B vaccination course (including those who are known to have received a 1st dose at another service).<br><br>• cannot be reported on the same date as P2A, P2C, P2D or P2E |
| P2C | Hepatitis B vaccination: 3rd dose | The 3rd dose of a hepatitis B vaccination course (including those who are known to have received a prior dose at another service).<br><br>• cannot be reported on the same date as P2A, P2B, P2D or P2E |
| P2D | Hepatitis B vaccination: 4th dose | The 4th dose of a hepatitis B vaccination course (including those who are known to have received a prior dose at another service).<br><br>• cannot be reported on the same date as P2A, P2B, P2C or P2E |
| P2E | Hepatitis B vaccination: Booster | For hepatitis B vaccination boosters (including those who are known to have been vaccinated at another service).<br><br>• cannot be reported on the same date as P2A, P2B, P2C or P2D |
| P2I | Hepatitis B immune | Includes patients who have natural immunity and vaccinated immunity. |

| **Service Codes** | | |
|---|---|---|
| P3 | Contraception (excluding condom provision) | *For females only:* to be used to record the provision of contraception and family planning advice. The provision of condoms is not included.<br><br>• this code is related to multiple activities in the SRHAD report. Please speak to your software provider to determine if separate coding is required for GUMCADV2 and SRHAD *ie this may need to be coded twice in order to appear in both reports*<br>• integrated services should use code SRH where the patient only accessed SRH services without accessing STI services<br>See http://www.hscic.gov.uk/datacollections/srhad. |
| P4 | Cervical cytology done | Includes all patients having a cervical cytology, regardless of outcome. |
| PEPS | Post exposure prophylaxis: Sexual exposure | For patients given HIV prophylaxis following sexual exposure (PEPSE). |
| PN | Partner notification initiated | Partner notification has been initiated for this patient by this service.<br><br>• for use in non-GUM Level 2 and Level 1 services only |
| PNC | Partner notification: chlamydia contact | This includes those presenting as a partner of an index case diagnosed with chlamydia (at this or any other service).<br><br>• If the partner is found to be infected with chlamydia they should also be coded C4. |
| PNG | Partner notification: gonorrhoea contact | This includes those presenting as a partner of an index case diagnosed with gonorrhoea (at this or any other service).<br><br>• If the partner is found to be infected with gonorrhoea they should also be coded B. |
| PNH | Partner notification: HIV contact | This includes those presenting as a partner of an index case diagnosed with HIV (at this or any other service). |

| **Service Codes** | | |
|---|---|---|
| | | • If the partner is found to be infected with HIV they should also be coded H1, H1A or H1B. |
| PNN | Partner notification: non-specific genital infection (NSGI) contact | This includes those presenting as a partner of an index case diagnosed with NSGI (at this or any other service).<br>• If the partner is found to be infected with NSGI they should also be coded C4N. |
| PNP | Partner notification: PID / epididymitis contact | This includes those presenting as a partner of an index case diagnosed with PID / epididymitis (at this or any other service).<br>• If the partner is found to be infected with PID /epididymitis they should also be coded C5A.<br>• Can be reported on the same date as PNC or PNG. |
| PNS | Partner notification: syphilis contact | This includes those presenting as a partner of an index case diagnosed with syphilis – of any stage (at this or any other service).<br>• if the partner is found to be infected with syphilis they should also be coded A1, A2 A3, A4, A5, A6 or A7A |
| PNT | Partner notification: trichomoniasis contact | This includes those presenting as a partner of an index case diagnosed with trichomoniasis (at this or any other service).<br>• if the partner is found to be infected with trichomoniasis they should also be coded C6A |
| REF1 | Referred from chlamydia screening programme | To identify those referred from the chlamydia screening programme - self referral is sufficient.<br>• REF1 should be reported with supplementary STI test and/or diagnosis codes |
| REF2 | Referred to GUM (Level 3) Sexual Health Services | For Level 2 & Level 1 sexual health services to identify those being referred to Level 3 GUM services.<br>• <u>For use in non-GUM Level 2 & Level 1 services only</u><br>• REF2 should be reported with supplementary STI test and/or diagnosis codes. |
| REF3 | Referred from home testing / sampling | To identify those referred from home testing / home sampling services with a reactive test result - self referral is sufficient. |

| **Service Codes** | | |
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| | service | • home testing/home sampling services would include services accessed outside of a normal clinic setting eg outreach, over the counter or internet testing<br>• REF2 should be reported with supplementary STI test and/or diagnosis codes |

| | | |
|---|---|---|
| SRH | Sexual reproductive health patient (only) | To identify those attending for SRH services where a full sexual health screen / HIV testing was not relevant to the consultation ie those **not** coded P1A, P1B, P1C, T4 or T7.<br><br>*Please review BHIVA guidelines on HIV testing to determine whether HIV testing is relevant to the SRH consultation (see section 4 of the guidelines).*<br>*http://www.bhiva.org/documents/guidelines/testing/glineshivtest08.pdf*<br><br>• patients coded SRH do not need to be coded P1C (HIV testing not appropriate) or T9 (STI testing not required/appropriate)<br>• this code will identify patients that should be excluded from calculations to measure HIV test coverage/uptake<br>• SRH can be coded at each associated attendance within a single episode<br>• this code is related to multiple activities in the SRHAD report. Please speak to your software provider to determine if separate coding is required for GUMCADV2 *and* SRHAD, *ie this may need to be coded twice in order to appear in both reports* |
| SW | Sex worker | For the provision of services to a patient known to be a current sex worker.<br><br>SW can be coded at each associated attendance within a single episode. |
| T1 | Chlamydia test | For those tested for chlamydia (but are not tested for gonorrhoea or syphilis).<br><br>• Cannot be reported on the same date as T2, T3 or T4.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T2 | Chlamydia and gonorrhoea tests | For those given a sexual health screen which only includes chlamydia and gonorrhoea testing (and excludes syphilis testing).<br><br>• Cannot be reported on the same date as T1, T3, T4 or T7.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T3 | Chlamydia, gonorrhoea and syphilis tests | For those given a sexual health screen which only includes chlamydia, gonorrhoea and syphilis testing (and excludes HIV testing). |

| | | |
|---|---|---|
| | | • Cannot be reported on the same date as P1A, T1, T2, T4, T7 or T9.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T4 | Full sexual health screen (chlamydia, gonorrhoea, syphilis and HIV tests) | For those given a full sexual health screen including chlamydia, gonorrhoea, syphilis and HIV testing.<br><br>• Cannot be reported on the same date as P1A, P1B, P1C, T1, T2, T3, T7 or T9.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T5 | Herpes simplex virus (HSV) test | For those tested for the herpes simplex virus (HSV).*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T6 | Hepatitis A/B/C test | For those tested for hepatitis A, B or C.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T7 | Syphilis and HIV antibody test | For those tested for syphilis and HIV (and excludes chlamydia and gonorrhoea testing).<br><br>• Cannot be reported on the same date as P1A, P1B, P1C, T2, T3 or T4.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T8 | Self sampling (chlamydia, gonorrhoea or HIV) *without* HCW consultation | Self sampling of STIs without 'face to face' health care worker (HCW) consultation.<br><br>• Can be reported on its own or in conjunction with other test codes – P1A, T1, T2, T3, T4, T5, T6 or T7.*<br>• This code will identify patients that do not have a consultation / sexual health history taken.<br>• Self sampling includes urine specimens (commonly known as 'pee & go'), swabs (vaginal, anal or pharyngeal) or blood specimens.<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T9 | STI testing not required / appropriate | For those accessing STI services where testing for chlamydia, gonorrhoea or syphilis is not required, appropriate or is declined. |

| | | |
|---|---|---|
| | (chlamydia, gonorrhoea or syphilis) | • P1B or P1C should be coded when HIV testing is refused/not appropriate.<br>• Patients only attending for SRH care (and not STI care) should be coded SRH instead of T9.<br>• Cannot be reported on the same date as T3 or T4.*<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| T10 | Rapid testing – same-day results (chlamydia, gonorrhoea or HIV) | For those receiving at least 1 rapid test (same-day results) for chlamydia, gonorrhoea or HIV.*<br><br>• Should be reported in conjunction with other test codes - P1A, T1, T2, T3, T4 or T7.<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| TS | Microscopy (gonorrhoea or syphilis) | For use with any test where microscopy is undertaken.*<br><br>• Can be reported on its own or in conjunction with other test codes - T2, T3, T4 or T7.<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| TT | 3 site testing (chlamydia or gonorrhoea) | For those receiving 3 site testing (genital, pharyngeal and rectal) for chlamydia or gonorrhoea.*<br><br>• Should be reported in conjunction with other test codes - T1, T2, T3 or T4.<br><br>***see section 'F' for further details on HIV/STI test code combinations.*** |
| W1 | HPV vaccination: 1st dose | The 1st dose of any new human papillomavirus vaccination course (including patients who may have been previously vaccinated but are now receiving the 1st dose of a new vaccination course).<br><br>• the Q suffix can be added if the quadrivalent vaccine is used (W1Q)*<br>• cannot be reported on the same date as W2 or W3<br><br>*see tables D and E for further details on using suffixes. |
| W2 | HPV vaccination: 2nd dose | The 2nd dose of a human papillomavirus vaccination course (including those who are known to have received the 1st dose at another service). |

| | | |
|---|---|---|
| | | • the Q suffix can be added if the quadrivalent vaccine is used (W2Q)*<br>• cannot be reported on the same date as W1 or W3<br><br>*see tables D and E for further details on using suffixes. |
| W3 | HPV vaccination: 3rd dose | The 3rd dose of a human papillomavirus vaccination course (including those who are known to have received a prior dose at another service).<br><br>• the Q suffix can be added if the quadrivalent vaccine is used (W3Q)*<br>• cannot be reported on the same date as W1 or W2<br><br>*see tables D and E for further details on using suffixes. |
| Z | Prisoner | For the provision of services to a patient known to be a current prisoner.<br><br>• Z can be coded at each associated attendance within a single episode |
| **Unspecified Codes** | | |
| O11-O99 | Unspecified Codes | All codes from O11 to O99 are reserved by PHE for use with future national reporting requirements in response to newly identified sexual health issues.<br><br>• PHE will notify services as and when codes are officially released for use in GUMCAD reporting ie codes O11-O99 should not be used unless notified by PHE |

A range of unspecified ('dummy') codes has been devised to allow a more timely response to future infection outbreaks. The codes will be released by PHE as and when an appropriate need for new surveillance is identified (at which time detailed guidance will be given).

The unspecified ('dummy') codes range from O11 to O99 inclusive (O11, O12, O13 etc.) – this range of codes should be reserved in software systems and should not be used for any other surveillance (national or local) until notified otherwise by PHE.

Link to GUMCADv2 resources

## *II. GUMCADv3 dataset*

| Data Item[1] | Field Name | Field Description | Data Item Dependancies[2] | GUMCADv2 Data Item |
|---|---|---|---|---|
| 1 | ClinicID | Clinic ID code | - | Yes |
| 2 | PatientID | Patient ID code | - | Yes |
| 3 | Episode_Activity | SHHAPT or READ code | - | Yes |
| 4 | Gender | Patient gender | - | Yes |
| 5 | Age | Patient age at attendance | - | Yes |
| 6 | Sex_Ori | Patient's sexual orientation | - | Yes |
| 7 | Ethnicity | Patient's ethnicity | - | Yes |
| 8 | Country_Birth | Patient's country of birth | - | Yes |
| 9 | LA | Patient's LA of residence | - | Yes |
| 10 | LSOA | Patient's LSOA of residence | - | Yes |
| 11 | First_Attendance | Attendance type | - | Yes |
| 12 | AttendanceDate | Date of attendance | - | Yes |
| **Opposite sex partnerships** | | | | |
| 13 | het | How many sex partners did you have in the last 3 months? | - | No |
| 14 | het_new | Were any of these new sex partners (i.e. you haven't had sex with them before)? | 13 | No |

| | | | | |
|---|---|---|---|---|
| 15 | het_condom | Did you/your partner use a condom the last time you had penetrative (vaginal or anal) sex? | - | No |
| **Same sex partnerships - men** | | | | |
| 16 | msm | How many sex partners did you have in the last 3 months? | 4 | No |
| 17 | msm_hiv_pos | Have you had anal (receptive or insertive) sex with a known HIV positive partner in the last 3 months? | 16 | No |
| 18 | msm_uai | Have you had any condomless anal intercourse in the last 3 months? | 16 | No |
| 19 | msm_rec_uai | Have you had any receptive condomless anal intercourse in the last 3 months? | 18 | No |
| **Same sex partnerships - women** | | | | |
| 20 | wsw | How many sex partners did you have in the last 3 months? | 4 | No |
| 21 | wsw_new | Were any of these new sex partners (i.e. you haven't had sex with them before)? | 20 | No |
| **Alcohol and drug use behaviour** | | | | |
| 22 | alcohol_1 | Was alcohol use assessed? | - | No |
| 23 | alcohol_2 | Was alcohol use documented as problematic? | 22 | No |
| 24 | drugs_3_months | Have you used recreational drugs in the last 3 months? | - | No |
| 25 | drugs_1 | Did you take Amphetamine / Speed | 24 | No |
| 26 | drugs_2 | Did you take Benzodiazepines (non-prescribed) | 24 | No |
| 27 | drugs_3 | Did you take Cannabis | 24 | No |
| 28 | drugs_4 | Did you take Cocaine | 24 | No |
| 29 | drugs_5 | Did you take Crack | 24 | No |

| | | | | |
|---|---|---|---|---|
| 30 | drugs_6 | Did you take Crystal Meth / Methamphetamine | 24 | No |
| 31 | drugs_7 | Did you take Ecstasy (E) / MDMA | 24 | No |
| 32 | drugs_8 | Did you take GHB / GBL | 24 | No |
| 33 | drugs_9 | Did you take Heroin | 24 | No |
| 34 | drugs_10 | Did you take Ketamine | 24 | No |
| 35 | drugs_11 | Did you take Legal Highs | 24 | No |
| 36 | drugs_12 | Did you take Mephedrone (M-Cat) | 24 | No |
| 37 | drugs_13 | Did you take Methadone | 24 | No |
| 38 | drugs_14 | Did you take Poppers | 24 | No |
| 39 | drug_15 | Did you take Solvents / Glue | 24 | No |
| 40 | drugs_16 | Did you take any other recreational drug (not listed) | 24 | No |
| 41 | drugs_inject | Did you inject any recreational drug in the last 3 months? | 24 | No |
| 42 | share_eqp | Did you share equipment with anyone when injecting drugs? | 41 | No |
| 43 | drugs_sex | Were you under the influence of recreational drugs (before or during sex) the last time you had sexual intercourse? | - | No |
| **Previous STIs** | | | | |
| 44 | prev_shs | Have you ever attended another sexual health service? | - | No |
| | | **New registrations only (Questions 36-45)** | | |

| | | | | |
|---|---|---|---|---|
| 45 | prev_sti | Have you been diagnosed with an STI in the last year? | - | No |
| 46 | prev_chl | Did you have Chlamydia | 45 | No |
| 47 | prev_gon | Did you have Gonorrhoea | 45 | No |
| 48 | prev_her | Did you have Herpes (genital) | 45 | No |
| 49 | prev_lgv | Did you have LGV | 45 | No |
| 50 | prev_nsgi | Did you have a Non-Specific Genital Infection | 45 | No |
| 51 | prev_syp | Did you have Syphilis | 45 | No |
| 52 | prev_war | Did you have Warts (genital) | 45 | No |
| 53 | prev_oth | Did you have any other STI (not listed)? | 45 | No |
| 54 | prev_hiv_test | When did you last have an HIV test? | - | No |
| **Partner Notification -** *to be completed by a Health Care Worker (HCW)* | | | | |
| 55 | pn_date | Date of initial PN discussion | - | No |
| 56 | pn_partners | How many partners were reported during the relevant 'look-back interval'* for the STI(s) diagnosed? | - | No |
| 57 | pn_contact | How many of these partners were contactable**? | 56 | No |
| 58 | pn_contact_pat | How many of these partners were reported by the index patient, or by a HCW, as having attended a sexual health service (level 1, 2 or 3) within 4 weeks of the initial PN discussion? | 57 | No |
| 59 | pn_contact_hcw | How many of these partners were verified*** by a HCW as attending a sexual health service (level 1, 2 or 3) within 4 weeks of the initial PN discussion? | 58 | No |

| | | | | |
|---|---|---|---|---|
| 60 | pn_contact_abr | How many of these partners were encounters abroad (i.e. you did not have sex in the UK)? | 56 | No |
| | | **Only patients diagnosed with HIV and/or gonorrhoea** | | |
| 61 | pn_contact_abr_aua | Were any of these encounters abroad with someone born in Australasia? | 60 | No |
| 62 | pn_contact_abr_car | Were any of these encounters abroad with someone born in the Caribbean? | 60 | No |
| 63 | pn_contact_abr_e_eur | Were any of these encounters abroad with someone born in Eastern Europe? | 60 | No |
| 64 | pn_contact_abr_na | Were any of these encounters abroad with someone born in North America? | 60 | No |
| 65 | pn_contact_abr_sa | Were any of these encounters abroad with someone born in South America? | 60 | No |
| 66 | pn_contact_abr_sea | Were any of these encounters abroad with someone born in South East Asia? | 60 | No |
| 67 | pn_contact_abr_ssa | Were any of these encounters abroad with someone born in Sub-Saharan Africa? | 60 | No |
| 68 | pn_contact_abr_uk | Were any of these encounters abroad with someone born in the UK? | 60 | No |
| 69 | pn_contact_abr_w_eur | Were any of these encounters abroad with someone born in Western Europe? | 60 | No |
| 70 | pn_contact_abr_oth | Were any of these encounters abroad with someone born in any other/unknown World Region? | 60 | No |
| **PrEP** | | **Only for patients on or ending a course of PrEP** | | |
| 71 | prep_dos | If taken PrEP since last visit (PREP2, PREP4, or PREP5), overall, how often was PrEP taken in the last 3 months? | 3 | No |

| | | | | |
|---|---|---|---|---|
| 72 | prep_tab | If PrEP started or continued (PREP3 or PREP4), how many tablets were provided? | 3 | No |
| 73 | prep_stop | If PrEP has been stopped since the last attendance or at the current attendance (PREP5), what was the reason? | 3 | No |

Link to GUMCADv3 resources

### *III. Public Health Wales – SWS – dataset*

SWS reports
STI/BBV surveillance data
CDSC webpage

## Annex 5 - Defining and refining a scope for audit

### *I. Patient and Public Involvement consultation meeting on HIV patient data, trust, and confidentiality*

A consultation meeting was organised by MEDFASH to explore the use of HIV patient data to drive improvements in the quality of HIV-related care, as part of a feasibility study for a national clinical audit of STIs and HIV services in England and Wales. A national clinical audit would aim to stimulate improvements in the quality of clinical care provided to patients at highest risk of and/or diagnosed with HIV, chlamydia, gonorrhoea, and syphilis.

Concerning HIV, the main area in which patient outcomes require improvement is in prevention and diagnosis; according to the most recent data at the time of the meeting, 42% of people diagnosed in 2013 were diagnosed at a late stage in their infection, and 1 in 4 people living with HIV remained undiagnosed. Both late and missed diagnoses have implications for the efficacy of antiretroviral treatment. This contrasts with the high quality of care following diagnosis (linkage to care, treatment, and suppression of viral load).

On 10th October 2015, a group of patient representatives was convened to discuss how people living with HIV might feel about data from general practice and hospital sources being used to inform a national clinical audit aimed at reducing missed and late HIV diagnoses.

The consultation meeting focussed on the question:

***How can healthcare and public health professionals demonstrate that they are trustworthy with HIV patient data?***

The group's discussion covered the following themes:

- *Trust and confidentiality*
- *Concerns and benefits of sharing data for audit*
- *Implied consent for audit*
- *Information for patients*
- *Collaboration with third sector organisations*

The group's key recommendations in relation to the proposed use of GP and hospital data to the feasibility study team are:

- patient data from GP and hospital settings should be explored to help inform an audit of missing and late diagnoses of HIV, in an attempt to improve quality of care outcomes for patients

- an implied consent model would be the preferred model for gaining consent. This is on the condition that people living with HIV have been informed about how the data protection regulations have changed, how data are collected, and how they will be used.

- a minimum level of culturally appropriate information should be made available to people living with HIV. This information should be based on a simple and framework such as 'test – treat – inform – develop' which can be adapted to ensure this culturally appropriate and allows access to more detailed information as needed by the individual

- in normalising HIV by applying the same consent models as used for other areas of data use, care needs to be taken to balance this with the sensitive nature of HIV and the impact that this has on stigma, particularly in some communities

- a future audit committee should gain support from the third sector, which can endorse the audit and inspire trust among people living with HIV who are likely to appreciate being approached.