**Vers 2021 STIF Intermediate**

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***Revalidation***

**PART A: to be completed by the Revalidation Applicant.**

|  |  |
| --- | --- |
| Title (Dr, Mr, Mrs, Ms etc.) |  |
| First name |  |
| Surname |  |
| Job Title |  |
| Place of Work |  |
| Correspondence address  *To which your new certificate will be mailed including postcode* |  |
| Mobile telephone number |  |
| Email address |  |
| The date shown on your original Certificate of STIF *Intermediate* Competency |  |
| Name of Original STIF *Intermediate* Competency Trainer  (as shown on your Certificate of Competency) |  |
| IF there is not a Registered STIF Competency Trainer in your location to approve your Revalidation application you can Self Certify. Are you Self Certifying? [ ] YES [ ] NO | |
| *IF NO* : Please state the Name of the Registered STIF Competency Trainer approving your revalidation application |  |

Are you a current paid-up member of BASHH?

|  |  |
| --- | --- |
| **[ ]** | **Yes** |
|  | Revalidation is free. Please give your BASHH username below. |
|  | BASHH username: |

|  |  |
| --- | --- |
| **[ ]** | **No**  Please pay the full registration fee of £60  **Please email** [**STIF@bashh.org**](mailto:STIF@bashh.org) **to arrange payment by BACS or by credit card** |

**1. Clinical experience**

In order to maintain skills, Revalidation Applicants should be seeing a minimum of 15 patients/ year with sexual health related problems during the course of their clinical practice. *You do not have to submit your evidence with this form, but BASHH reserves the right to request this evidence at any time.*

In the case of long term sickness or maternity leave, trainees will need to submit their revalidation application *after their return to clinical practice* and only when they have met the revalidation criteria in full.

***I have evidence that demonstrates that I have been seeing a minimum of 15 patients with sexual health related problems in the last 12 months during the course of my clinical practice.***

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| --- | --- |
| **NAME OF REVALIDATION APPLICANT**  **Please type here:** | **SIGNATURE**  **Sign here:** |
| Date |  |

**2. Continued Professional Development**

In order to maintain and update their knowledge, Revalidation Applicants should undertake a minimum of 10 hours of CPD in the last 12 months, in areas pertaining to Sexual Health. For medical staff this is equivalent to 10 CPD points.

**Please ensure evidence of 10 hours of CPD undertaken in the 12 months preceding revalidation is submitted.**

CPD Credit may be derived from:

1. Educational events e.g. BASHH OGM/Annual BASHH conference/Masterclass or local/regional events
2. Educational tutorials/courses (both in-house and external)
3. Self-directed e-learning modules e.g. e-learning for healthcare sessions from eHIV-STI, doctors.net sexual health modules
4. Reading Journal articles pertaining to sexual health

Not all CPD can comprise self-directed learning. At least 5% must be acquired through departmental, regional or national educational events/tutorials or courses.

………..continued/….

***Please list the CPD you have undertaken in the 12 months preceding revalidation and accompany each entry with (approx.) 100 word learning reflection.***

*For example:*

|  |  |  |
| --- | --- | --- |
| Date, Title and reflection | Type of CPD | No. of Hours |
| 01/01/2014 “Herpes serology: To do or not to do – that is the question”  Short reflection on the presentation that you attended e.g. what you learnt from it and how it might change your practice. | Departmental presentation | 1 |
| 02/02/2014 BASHH Afternoon OGM: Title  Short reflection on the meeting that you attended e.g. what you learnt from it and how it might change your practice. | National educational meeting | 3 |
| 03/03/2014 *Int J STD AIDS* 2013 24: 593 Title  Short reflection on the article that you read e.g. what you learnt from it and how it might change your practice. | Journal article | 0.5 |

|  |  |  |
| --- | --- | --- |
| **Date, Title and reflection** | **Type of CPD** | **No. of Hours** |
|  |  |  |
|  |  |  |
| **Date, Title and reflection** | **Type of CPD** | **No. of Hours** |
|  |  |  |
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***IF you need additional space to list your CPD, please copy and insert extra pages as needed***

**3. Audit**

**Please give a brief description of a clinical audit relating to sexual health care that you have personally completed *within the last five years.***

* **The audit you present should demonstrate that as an investigator you can manage data collection, interpretation and where appropriate should indicate how it will influence clinical practice or clinic management.**
* **The Registered STIF Competency Trainer approving your application *needs to sign below to confirm* that your audit meets the criteria.**
* **If self-certifying, please sign to indicate that your audit meets the criteria.**

A summary of the audit should be included in your paperwork. This should be structured as follows:

* + Background
  + Objectives
  + Standards
  + Sample
  + Data source(s)
  + Key findings
  + Results
  + Conclusions
  + Recommendations (including recommendations for re-audit)

**Registered STIF Competency Trainer SIGNATURE : DATE:**

**Self certifying: *I confirm that my audit meets the specified criteria***

Signed: DATE:

**PART B: To be completed by (any) Registered STIF *Intermediate* Competency Trainer:**

The Revalidation Applicant’s logbook may not cover all the competencies seen below, in which case **you may want to discuss the topic with them or undertake a formal observed assessment or CBD so that you are confident that the trainee remains competent in this area.**

***I have seen evidence that demonstrates that the above-named individual has been seeing a minimum of 15 patients per year with sexual health related problems during the course of his/her clinical practice. The audit meets the required criteria.***

***I confirm that the applicant remains competent in the following STIF Intermediate Competencies:***

***(Please tick)***

Sexual history taking and management of men and women, including young people and men who have sex with men

Genital examination of men and women (excluding bimanual pelvic examination)

Consultations with patients with limited English proficiency \*

Consulting by Phone/Video \*

Risk reduction and Sexual Health Promotion

Partner notification

Managing women who present with Unwanted/Unplanned Pregnancy \*

Diagnosis and management of genital tract infections (chlamydia, gonorrhoea, trichomonas, mycoplasma)

Management of vaginal discharge

Management of male urethral discharge

Management of genital warts and molluscum contagiosum

Management of urinary tract infection

Management of genital infestations

Management of genital ulcer disease due to Herpes Simplex Virus

Screening and prevention of hepatitis A, B, C

Assessment and management of need for PEPSE

ARV as prevention (PrEP and TASP) \*

HIV pre- and post-test discussion

Assessment of the patient who reports a sexual assault

Domestic Violence and abuse

Safeguarding Children

Female Genital Mutilation

Psychosexual problems \*

Trans and non-binary awareness \*

\* = *topics which have been added to STIF Intermediate in the past 2-3 years so which may not have been covered in your original STIF Intermediate Competency assessments. If you would like to formally record assessments for these, please contact the STIF secretariat* [*stif@bashh.org*](mailto:stif@bashh.org)

*Extract: GMC Guidance “Good Medical Practice”*

***Maintaining Trust: Communicating information***

*71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.*[*16*](http://www.gmc-uk.org/guidance/good_medical_practice/references.asp#16) *You must make sure that any documents you write or sign are not false or misleading.*

*Extract: NMC Code 2015 for Registered Nurses*

***In relation to assessments,*** *registered nurses must*‘*complete all records at the time or as soon as possible after the event*’ (10.1: p9) ensuring that they ‘*complete all records accurately and without any falsification, taking immediate and appropriate action if (they) become aware that someone has not kept to these requirements*’ (10.3: p9).

|  |
| --- |
| **Registered STIF *Intermediate* Competency Trainer NAME - Please print**  **SIGNATURE : DATE:** |

**PART C: Self-certification route : To be completed in absence of local Registered STIF Competency Trainer :**

**Candidates who need to self-certificate should use the reflection form(below) to provide written evidence.** The cases should be examples of management of the below topics during their clinical practice. *Candidates need only to see one patient that demonstrates their knowledge and skills related to each of the core competencies listed; it is also recognised that a single consultation may cover one or more of the competencies.*

***I confirm that I remain competent in the following STIF Intermediate Competencies:***

***(Please tick)***

Sexual history taking and management of men and women, including young people and men who have sex with men

Genital examination of men and women (excluding bimanual pelvic examination)

Consultations with patients with limited English proficiency \*

Consulting by Phone/Video \*

Risk reduction and Sexual Health Promotion

Partner notification

Managing women who present with Unwanted/Unplanned Pregnancy \*

Diagnosis and management of genital tract infections (chlamydia, gonorrhoea, trichomonas, mycoplasma)

Management of vaginal discharge

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Management of genital warts and molluscum contagiosum

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Management of genital ulcer disease due to Herpes Simplex Virus

Screening and prevention of hepatitis A, B, C

Assessment and management of need for PEPSE

ARV as prevention (PrEP and TASP) \*

HIV pre- and post-test discussion

Assessment of the patient who reports a sexual assault

Domestic Violence and abuse

Safeguarding Children

Female Genital Mutilation

Psychosexual problems \*

Trans and non-binary awareness \*

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**SELF CERTIFICATION REVALIDATION APPLICANT SIGNATURE**

**DATE**

**Self-certification PLEASE USE THE FORM BELOW to provide evidence of management for *all STIF Intermediate* competencies – copy and reprint as needed**

|  |  |
| --- | --- |
| **STIF COMPETENCY**  **demonstrated** | *Type in STIF competency/competencies being demonstrated in consultation* |

|  |
| --- |
| What happened?  What was I thinking? Feeling?  What was good, what was bad about the experience?  What sense can I make of the situation?  What other options are there that I could have done?  What will I do next time if this arises?  Action planning based on this  Signed……….……………………………………………………….............. Date…………………………………………. |

**PLEASE SEND THE COMPLETED FORM to**

**BASHH STIF SECRETARIAT**

**STIF@bashh.org**

**retaining a copy for your records**

*Additional pages for CPD listing*

|  |  |  |
| --- | --- | --- |
| Date, Title and reflection | Type of CPD | No. of Hours |
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| --- | --- | --- |
| Date, Title and reflection | Type of CPD | No. of Hours |
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| Date, Title and reflection | Type of CPD | No. of Hours |
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**PLEASE SEND THE COMPLETED FORM**

**retaining a copy for your records**

**BASHH STIF SECRETARIAT**

[**STIF@bashh.org**](mailto:STIF@bashh.org)

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