# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Sexual health

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 20 June 2018

## Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for Sexual health. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

## *1.2 Development source*

The key development sources referenced in this briefing paper are:

Sexually transmitted infections: condom distribution schemes (2017) NICE guideline NG68. This guideline was produced as a result of the review of NICE guideline PH3 in February 2014. Next review April 2021.

British Association of Sexual Health and HIV (2016) United Kingdom national guideline on the sexual health care of men who have sex with men. No review date available.

British Association for Sexual Health and HIV (2015) Guidance on tests for Sexually Transmitted Infections. No review date available

British Association for Sexual Health and HIV (2013) UK national guideline for consultations requiring sexual history taking. No review date available

Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3. Last reviewed February 2014. Decision to produce additional guideline on “the optimal methods of condom distribution and increasing condom use in those at increased risk of STIs”.

# 2 Overview

## *2.1 Focus of quality standard*

This quality standard will cover sexual health across the life course with a focus on reducing sexually transmitted infections (STIs). This quality standard will not cover harmful sexual behaviour or contraception for the prevention of conception.

## 2.2 Definition

The World Health Organisation defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality. Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity. However, there are needs common to everyone such as the provision of high quality information and education to enable people to make informed responsible decisions, and access to high quality services, treatment and interventions[1].

## 2.3 Incidence and prevalence

The national surveys of sexual attitudes and lifestyles shows that most people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and abortions.

In 2017 there were approximately 420,000 diagnoses of STIs made in England, around the same number reported in 2016. Of these, the most commonly diagnosed STIs were:

- chlamydia (203,116; 48%)
- first episode genital warts (59,119; 14%)
- gonorrhoea (44,676; 11%)

Recent trends show there were:

- 7,137 diagnoses of syphilis reported in 2017, a 20% increase relative to the year prior and around 150% increase relative to 2008
- 44,676 diagnoses of gonorrhoea reported in 2017, a 22% increase relative to the year prior and around a 200% increase relative to 2008;
- Emergence of drug resistant Neisseria gonorrhoeae

The impact of STIs remains greatest in young heterosexuals aged 15 to 24 years, black ethnic minorities, and gay, bisexual and other men who have sex with men (MSM)[2].

## 2.4 Management

In Sexual and reproductive health and HIV: applying All Our Health Public Health England have highlighted interventions for sexual health at population, community, and family and individual level.

[1] Public Health England (2018). Sexual and reproductive health and HIV: applying All Our Health.
[2] Public Health England (2018). Sexually Transmitted Infections and Chlamydia Screening in England: 2017

**Population level**

- Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex to reduce the stigma associated with sexual health and HIV
- Ensure children receive good quality sex and relationships education at school, at home and in the community; Statutory guidance and supplementary advice have been produced by the Department for Education
- Raise awareness that prescribed contraception and STI and HIV treatment are provided free from prescription charge to reduce the risk of unwanted pregnancy and onward transmission of infection
- Ensure that prevention is prioritised and people are motivated to practise safe sex, including using contraception and condoms
- Ensure testing for HIV and STIs is effectively promoted in at-risk populations

**Community level**

- Ensure local authorities commission services for the full range of contraception, the testing and treatment of STIs and provision of condoms for the benefit of everyone in the community
- Protect people from reinfection with partner notification - an essential component of STI management and control
- Offer chlamydia testing to young people as a routine part of every primary care and sexual health consultation; the goal of the national chlamydia screening programme (NCSP)
- Ensure easy access to sexual health advice, free condoms, and testing for HIV and other STIs for young people and other high risk groups in a range of accessible settings with condom distribution schemes

**Family and individual level**

- Provide information about the full range of contraceptive methods and promoting prompt access to the method that best suits their needs
- Ensure that women seeking an abortion have easy, quick and confidential access to services
- Ensure people understand the different STIs, associated potential consequences and how to reduce the risk of transmission
- Provide information about where to get prompt access to HIV testing
- Ensure people who are diagnosed with HIV receive prompt referral into care and high quality treatment services

# 3 Summary of suggestions

## *3.1 Responses*

In total 10 stakeholders responded to the 2-week engagement exercise 25/04/18 – 09/05/18.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 1 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 2 for information.

**Table 1 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **Identifying people at risk of sexually transmitted infections and providing advice**<br>• Identification<br>• Providing information and support | ADPH, BASHH, FSRHCEU, LGBTF and SCMs |
| **Referral to specialist sexual health services** | ADPH, BASHH, FSRHCEU, LGBTF, RCGP and SCMs |
| **Testing for sexually transmitted infections**<br>• Tests for sexually transmitted infections | FSRH, FSRHCEU, LGBTF, PHE and SCMs |
| **Helping people with sexually transmitted infection to get their partners tested**<br>• Partner notification | BASHH and SCMs |
| **Condom distribution schemes** | FSRH, RCN and SCMs |
| **Additional areas**<br>• Awareness<br>• Management of gonorrhoea<br>• Pre-exposure prophylaxis of HIV (PrEP)<br>• Online services<br>• Screening (chlamydia and cervical cancer)<br>• Sex and Relationship Education<br>• Termination of pregnancy services<br>• Training<br>• Vaccination | ADPH, BASHH, FSRH, FSRHCEU, LGBTF, PHE, RCPath and SCMs |

ADPH, The Association of Directors of Public Health
BASHH, British Association for Sexual Health and HIV
FSRH, The Faculty of Sexual and Reproductive Healthcare
FSRHCEU, The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit,
LGBTF, The LGBT Foundation
NUBS, Nottingham University Business School
PHE, Public Health England
RCGP, Royal College of GPs
RCN, Royal College of Nursing
RCPath, Royal College of Pathologists
SCM, Specialist Committee Member(s)

## *3.2 Identification of current practice evidence*

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 689 papers were identified for Sexual health. In addition, 9 papers were suggested by stakeholders at topic engagement and 2 papers internally at project scoping.

Of these papers, 10 have been included in this report and are included in the current practice sections where relevant. Appendix 1 outlines the search process.

# 4 Suggested improvement areas

## *4.1 Identifying people at risk of sexually transmitted infections and providing advice*

### 4.1.1 Summary of suggestions

**Identification**

Stakeholders highlighted that certain groups such as men who have sex with men, (MSM) young people between 15 and 24 and black ethnic minorities have the highest risk of poor sexual health outcomes. In addition vulnerable groups such as asylum seekers and refugees, sex workers and their clients, those who are homeless and young people in or leaving care, find it difficult to access sexual health services. As a result stakeholders felt that there should be specialist targeted services for these people to ensure they are identified and can access care appropriately.

**Providing information and support**

Stakeholders suggested that once high risk or vulnerable groups have been identified that they should receive tailored interventions to help reduce their risk of sexually transmitted infections. This includes structured one-to-one discussions about behavioural change and information about how to protect their sexual health. In addition stakeholders suggested information should be provided to people exhibiting high risk behaviours including the misuse of alcohol and/or substances.

### 4.1.2 Selected recommendations from development source

Table 2 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 2 to help inform the committee's discussion.

**Table 2 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Identification | NICE PH3 Recommendation 1 |
| | British Association for Sexual Health and HIV (BASHH) UK national guideline for consultations requiring sexual history taking Recommendation 3.3.1 |
| Providing information and support | NICE PH3 Recommendation 2 |
| | NICE NG68 Recommendation 1.2.8 to 1.2.11 |

**Identification**

NICE PH3 Recommendation 1

- Identify individuals at high risk of STIs using their sexual history. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, and when carrying out a cervical smear test, offering an STI test or providing travel immunisation. Risk assessment could also be carried out during routine care or when a new patient registers.
- Have one to one structured discussions with individuals at high risk of STIs (if trained in sexual health), or arrange for these discussions to take place with a trained practitioner.

BASHH UK national guideline for consultations requiring sexual history taking Recommendation 3.3.1

All individuals being assessed for risk of STIs should be asked about:

- The gender of partner(s)
- The type of sexual contact/sites of exposure (oral, vaginal, anal)
- Condom use/barrier use (and whether properly used).
- The relationship with the partner (live-in, regular, casual partner, etc.), duration of the relationship and whether the partner could be contacted.
- The time interval since the last sexual contact
- Any symptoms or any risk factors for blood-borne viruses in the partner including known or suspected STIs, injecting drug use, previous homosexual sex (for male partners) and any other risk of sexual infection.

**Providing information and support**

NICE PH3 Recommendation 2

- Have one to one structured discussions with individuals at high risk of STIs. The discussions should be structured on the basis of behaviour change theories. They should address factors that can help reduce risk-taking and improve self-efficacy and motivation. Ideally, each session should last at least 15–20 minutes. The number of sessions will depend on individual need.
- For details of a range of behaviour change theories see 'Predicting health behaviour' (Conner and Norman 2005).

NICE NG68 Recommendation 1.2.8

Tailor information and advice according to the young person's needs and circumstances, including their sexual identity and whether or not they are having sex or are in a relationship.

NICE NG68 Recommendation 1.2.9

Discuss the effect that alcohol and drugs can have on decision-making and their ability to consent.

NICE NG68 Recommendation 1.2.10

Teach young people to use condoms effectively and safely (using education, information and demonstrations) before providing them.

NICE NG68 Recommendation 1.2.11

Provide information about emergency contraception and post-exposure prophylaxis so that young people know what to do and where to go in the event of a condom failure.

### 4.1.3 Current UK practice

**Identification**

In 2010 the British Association of Sexual Health and HIV conducted a case note audit of GUM clinics to assess sexual history documentation[3]. It found:

- The proportion of new/rebooked patients asked about the gender of their last sexual partner – **96%**
- The proportion of new/rebooked patients offered a chaperone
    - Women – **57%**
    - Men – **51%**
- The proportion of new/rebooked patients asked about condom use at the last sexual intercourse
    - Heterosexual cases (vaginal sex) – **89%**
    - MSM (anal sex) – **74%**
- The proportion of new/rebooked patients who had a HIV risk assessment recorded:
    - Injecting drug use (men) – **90%**
    - Injecting drug use (women) – **85%**
    - Sex abroad (men) – **81%**
    - Sex abroad (women) – **67%**
    - Sex with another man – **81%**

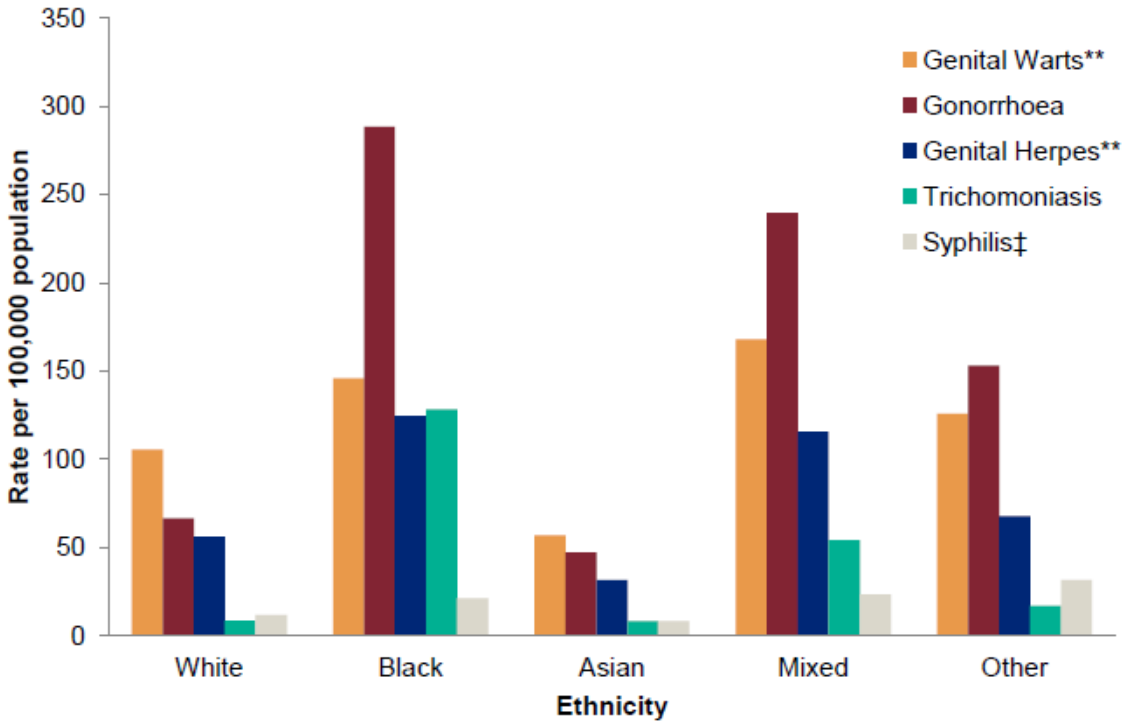
Public Health England's report Sexually Transmitted Infections and Chlamydia Screening in England: 2017 highlighted the rates of STIs in particular at risk groups.

[3] Sullivan et al (2012) UK national re-audit of sexual history-taking.

For MSM there were around 50,000 new diagnoses of STIs. The highest proportion of these were for gonorrhoea (43%, 21,346) and chlamydia (31%, 15,284). There has been a marked decrease in new HIV diagnoses.

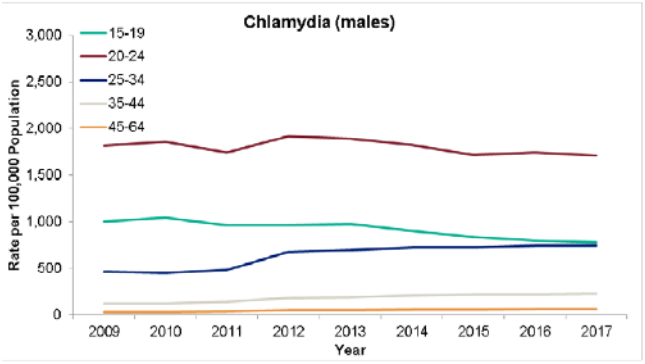
STI distribution by ethnicity was highest in people of black ethnicity. Of these people the highest rate was in black Caribbean and black non-Caribbean /non-African. Rates for selected STI diagnoses by ethnicity are presented in figure 1 below.

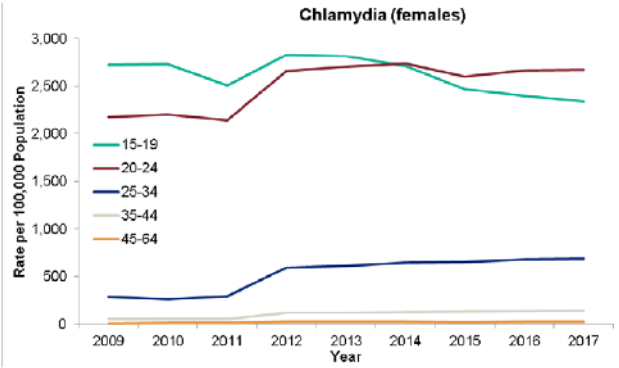
**Figure 1. Rates of selected sexually transmitted infection (STI) diagnoses by ethnicity and STI, 2017, England**

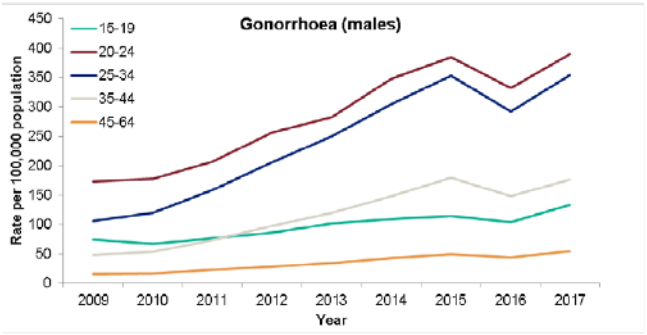


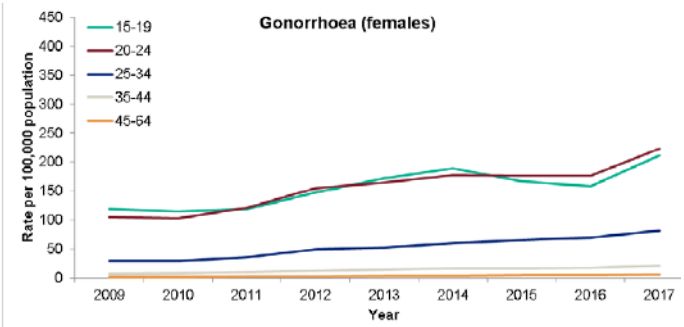

STI distribution by age was highest in younger people between 15 and 24. Figure 2 provides rates of chlamydia and gonorrhoea by age and sex.

**Figure 2. Rates of new sexually transmitted infection diagnoses among people attending sexual health services by age-group and gender, 2009-2017, England**




In their report [Sexual and Reproductive Health: Time to Act] the Royal College of GPs highlighted that some of the most at-risk patients are the least able to reach the support they need due to cultural, language, financial or geographical difficulties. They also suggested that in some services, there is evidence of restriction of access to contraception and STI testing based on residency or age[4].

In addition the Kings Fund have also highlighted that outreach services that target high-risk groups such as sex workers and MSM have been cut back as a result in overall reduced spending on GUM services[5].

**Providing information and support**

No studies were identified that focus on the provision of information and support for those at risk of vulnerable. However a cross-sectional, qualitative study by Howarth et al looked at patient's experience of attending a central London walk-in sexual health clinic. During interviews 14 out of 17 participants rated their overall care as excellent or very good. In regards to information about their condition or treatment most felt the information was adequate though 4 out of 17 felt there was not enough information[6].

[4] Royal College of General Practitioners (2017)Sexual and Reproductive Health: Time to Act
[5] The King's Fund (2017) What do cuts in sexual health services mean for patients?
[6] Howarth et al (2017). "They made me feel comfortable": a comparison of methods to measure patient experience in a sexual health clinic

### 4.1.4 Resource impact

PH3 recommendations 1 and 2 to offer risk assessments and one to one discussions for those at high risk were identified in the resource impact report as having a potentially significant impact (>£1m in England each year). Increasing the number and length of assessments for high risk people may result in additional costs. There may be offsetting savings from fewer re-infected cases and the avoidance of associated costs. Due to significant local variation the national impact could not be estimated.

Recommendation 3.3.1 from BASHH UK national guideline outlining how to take a sexual history is unlikely to have significant resource impact.

NG68 recommendations 1.2.8 to 1.2.11 were not included in the resource impact report for this guideline. It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

## *4.2 Referral to specialist sexual health services*

### 4.2.1 Summary of suggestions

**Referral to specialist sexual health services**

Stakeholders highlighted the need for people identified with a possible STI to be able access specialist sexual health services within 48 hours of referral. Ensuring prompt access reduces the likelihood of onward transmission of STIs and ensures that interventions can be provided to reduce health complications. Stakeholders also suggested that these services should be developed in partnership between the local health, public health and community services and provide specialist clinics for people at risk and those who are considered to be vulnerable.

### 4.2.2 Selected recommendations from development source

Table 3 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 3 to help inform the committee's discussion.

**Table 3 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| Referral to sexual health services | NICE PH3 Recommendation 4 |
| | NICE NG68 Recommendation 1.2.4 |

**Referral to sexual health services**

NICE PH3 – Recommendation 4

- Ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).
- Define the role and responsibility of each service in relation to partner notification (including referral pathways).
- Ensure staff are trained.
- Ensure there is an audit and monitoring framework in place.

NICE NH68 – Recommendation 1.2.4

Offer pathways into other services including: sexual and reproductive health, alcohol and drug, mental health and partner violence services, as needed.

### 4.2.3 Current UK practice

#### Referral to sexual health services

Foley et al studied whether access to genitourinary medicine (GUM) clinics in the UK met targets of 48 hours. These targets were set by the Department of Health and Social Care white paper 'Choosing health' in 2004. The target was that by 2008 all patients referred to a GUM clinic would have an appointment within 48 hours[7]. It is now part of the Integrated Sexual Health Services: National Service Specification produced by Department of Health.

Researchers posed as symptomatic and asymptomatic 'patients'. The study found that **95.5%** of clinics offered symptomatic 'patients' an appointment within 48 hours in 2014, which reduced to **90.8%** in 2015. For asymptomatic patients the proportion offered an appointment increased form **50.7%** in 2014 to **74.5%** in 2015. For both sets of patients, women were less likely to be offered an appointment within 48 hours[8].

### 4.2.4 Resource impact

NG68 recommendation 1.2.4 to offer pathways into other services from condom distribution schemes as needed, was identified in the resource impact report as having a potentially significant impact (>£1m in England each year). Increasing referrals of young people to sexual health services may result in additional costs. There may be offsetting benefits and savings from earlier access to services and fewer cases of sexually transmitted infections, pelvic inflammatory disease and HIV. Due to significant local variation the national impact could not be estimated.

This area is not included in the resource impact report for prevention of STIs and under 18 conceptions guideline (PH3). It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

[7] Department of Health (2004) Choosing Health: Making healthy choices easier
[8] Foley E, Furegato M, Hughes G et al. Inequalities in access to genitourinary medicine clinics in the UK: results from a mystery shopper survey. Sexually Transmitted Infections 2017.

## *4.3 Testing for sexually transmitted infections*

### 4.3.1 Summary of suggestions

**Tests for sexually transmitted infections**

Stakeholders highlighted that prompt accurate testing for STIs reduces delays in diagnosis and improves management. They highlighted there was a trade-off between speed of results and accuracy, such as the benefits and limitations of point of care testing. Therefore a minimum standard of which tests are provided is required to ensure positive results are not missed. In addition a stakeholder suggested that at risk groups should receive regular testing.

### 4.3.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

**Table 4 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Tests for sexually transmitted infections | NICE PH3 Recommendation 4 |
| | British Association for Sexual Health and HIV (BASHH) Guidance on tests for Sexually Transmitted Infections |
| | BASHH Recommendations for Testing for Sexually Transmitted infections in Men who have Sex with Men |
| | British Association for Sexual Health and HIV (BASHH) United Kingdom national guideline on the sexual health care of men who have sex with men: Sexually Transmitted Infections STI and HIV testing |
| | NICE QS157 Statements 4 and 5 |

**Tests for sexually transmitted infections**

NICE PH3 Recommendation 4

Ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).

BASHH Guidance on tests for Sexually Transmitted Infections

This guidance provides details about which patients should have serology for HIV and syphilis, Hepatitis A, Hepatitis B, Hepatitis C as well as which tests should be offered for gonorrhoea and chlamydia and genital ulcers.

BASHH Recommendations for Testing for Sexually Transmitted infections in Men who have Sex with Men

The following samples are recommended:

- clinician taken samples from the urethra, pharynx and rectum
    - first pass urine is a suitable alternative to a urethral sample
    - self taken samples from the urethra, pharynx and rectum are acceptable alternatives but the evidence base for their use is very limited
- venous blood
    - self taken blood spot or oral samples are suitable alternatives for HIV point of care testing

BASHH Recommendations for Testing for Sexually Transmitted infections in Men who have Sex with Men

Point of care tests for chlamydia and gonorrhoea are an area of active development but those currently available have limited sensitivity/specificity, are relatively expensive and/or are associated with a significant delay before the result is available. Their limited use is recommended e.g. when an alternative sample for testing is not available, following informed patient choice.

BASHH Guidance on the sexual health care of men who have sex with men: STI and HIV testing

Annual STI testing including HIV testing should be recommended to all sexually active MSM (other than those with one long-term mutually exclusive partner).

NICE QS157 Statement 4

Young people and adults in at-risk groups who test negative for HIV are advised that the test should be repeated at least annually.

BASHH Guidance on the sexual health care of men who have sex with men: STI and HIV testing

Three-monthly STI testing including HIV should be offered to all those with:

- unprotected anal intercourse (UAI) with partner(s) of unknown or serodiscordant HIV status over last 12 months (1B)
- >10 sexual partners, over last 12 months

- Drug use (methamphetamine, inhaled nitrites) during sex over last six months also, although the evidence base is less robust:
- Drug use (GBL, ketamine, other novel psychoactive substances during sex over last six months)
- Multiple or anonymous partners since last tested and possibly, consistent with existing BASHH guidance and US cost-effectiveness data:
- Any unprotected sexual contact (oral, genital or anal) with a new partner since last tested

NICE QS157 Statement 5

People who may have been exposed to HIV by a person newly diagnosed with HIV are offered an HIV test.

BASHH Guidance on the sexual health care of men who have sex with men: STI and HIV testing

Testing should form part of an integrated risk reduction strategy aimed at reducing behavioural risk.

BASHH Guidance on the sexual health care of men who have sex with men: STI and HIV testing

SMS text reminders should be used to increase re-attendance and STI detection rates in MSM.

### 4.3.3 Current UK practice

Public Health England highlighted that the total number of sexual health screens (tests for chlamydia, gonorrhoea, syphilis and HIV) increased between 2013 and 2017 (18%; from 1,513,288 in 2013 to 1,778,306 in 2017). While there were increases in testing nationally, there is some variability regionally with small (2-5%) declines in attendances at Sexual Health Services in the East Midlands, North East and South West PHE Centre areas between 2016 and 2017.

However, between 2016 and 2017 there was an 8% decline in the number of chlamydia tests carried out as part of the national chlamydia screening programme. Most of this decrease took place in sexual and reproductive health (SRH) services, where chlamydia testing has fallen by 61% since 2015[9].

The Public Health Outcome Framework indicators show that in England, 40.1% of HIV diagnoses are considered late, which may act as a proxy outcome measure for

[9] Public Health England (2018). Sexually Transmitted Infections and Chlamydia Screening in England: 2017

access to STI testing. In addition the Chlamydia detection rate for England is 1,882 per 100,000. The target detection rate is above 2,300 per 100,000[10].

Testing for HIV has been covered in the NICE quality standard HIV testing: encouraging uptake (QS157).

### 4.3.4 Resource impact

PH3 recommendation 4 was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

BASHH guidance recommendations on the frequency and access of tests for sexually transmitted infections may have a significant resource impact depending upon how services are configured at a local level and on activity level.

[10] Public Health England (2018) Sexual and Reproductive Health profiles

## *4.4 Helping people with sexually transmitted infection to get their partners tested*

### 4.4.1 Summary of suggestions

**Partner notification**

Stakeholders highlighted the importance of partner notification in assisting in the control of sexually transmitted infections as this can break the “chain” of transmission and reduce reinfections. It will also ensure that people are able to receive testing and treatment earlier to prevent long term complications.

### 4.4.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee’s discussion.

**Table 5 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Partner notification | NICE PH3 Recommendation 3 and 4 |

**Partner notification**

NICE PH3 Recommendation 3

- Help patients with an STI to get their partners tested and treated (partner notification), when necessary. This support should be tailored to meet the patient's individual needs.
- If necessary, refer patients to a specialist with responsibility for partner notification. (Partner notification may be undertaken by the health professional or by the patient.)
- Provide the patient and their partners with infection-specific information, including advice about possible re-infection. For chlamydia infection, also consider providing a home sampling kit.

NICE PH3 Recommendation 4

- Ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).
- Define the role and responsibility of each service in relation to partner notification (including referral pathways).

- Ensure staff are trained.
- Ensure there is an audit and monitoring framework in place.

### 4.4.3 Current UK practice

The BASHH national audit group and the British HIV Association audited HIV partner notification against the 2015 BASHH standards[11]. It found:

- Partner notification discussion at diagnosis:
    - MSM – **69.9%**
    - Heterosexual men – **72.1%**
    - Heterosexual female – **67.2%**
- Partner notification documented within 4 weeks:
    - MSM – **81.4%**
    - Heterosexual men – **79.9%**
    - Heterosexual female – **79.3%**
- Proportion of contactable contacts tested:
    - MSM – **59.0%**
    - Heterosexual men – **70.9%**
    - Heterosexual female – **71.1%**

Public Health England conducted an audit into partner notification in chlamydia screening[12]. It found:

- Proportion of index patients offered a partner notification discussion – **92%**
- Proportion of contacts reported to have attended a sexual health service within four weeks of the date of the first partner notification discussion – **53%**
- Proportion of contacts whose attendance at a sexual health service was verified by a healthcare worker within four weeks of the date of the first PN discussion – **29%**

### 4.4.4 Resource impact

PH3 recommendation 3 to offer partner testing and treatment was identified in the resource impact report as having a potentially significant impact (>£1m in England each year). Increasing referrals for partner testing may result in additional costs. There may be offsetting savings from fewer re-infected cases and the avoidance of associated costs. Due to significant local variation the national impact could not be estimated.

[11] British Association for Sexual Health and HIV (2018) HIV partner notification (re-audit)
[12] Public Health England (2016) Partner notification in chlamydia screening National audit report

PH3 recommendation 4 was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

## *4.5 Condom distribution schemes*

### 4.5.1 Summary of suggestions

**Condom distribution schemes**

Stakeholders highlighted the need for condom distribution schemes to ensure the availability of free condoms. Schemes would need to be both single and multicomponent to ensure that they meet the needs of local populations, such as those most at risk.

### 4.5.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| Condom distribution schemes | **Targeting services**<br>NICE NG68 Recommendation 1.1.1 to 1.1.4 |

**Targeting services**

NICE NG68 Recommendation 1.1.1

Provide a range of condom distribution schemes (also known as condom schemes) to meet the needs of different local populations, based on needs assessment, consultation and sexually transmitted infection (STI) rates. Target those most at risk. Include multicomponent schemes, single component schemes (free condoms) and cost-price sales schemes.

NICE NG68 Recommendation 1.1.2

Provide condom schemes as part of existing services that are likely to be used by those most at risk. This could include services provided by the voluntary sector (such as advice projects and youth projects), school health services and primary healthcare (including GP surgeries and community pharmacies).

NICE NG68 Recommendation 1.1.3

Ensure links exist between condom schemes and local sexual and reproductive health services. For example, consider:

- Providing condoms with information about local sexual health services.
- Displaying posters and providing leaflets advertising local sexual health services where condoms are available.

NICE NG68 Recommendation 1.1.4

Publicise condom schemes to people most at risk of getting an STI. For example:

- Put posters and leaflets in places used by those most at risk.
- Advertise on geospatial social networking apps (used to find local sexual partners) or websites (such as the NHS condom locator) and social media.

### 4.5.3 Current UK practice

Using a combination of public surveys in 2015/16, Public Health England found that **85%** (129/152) of upper tier local authorities (UTLA) reported operating either C-Card Schemes (one type of multicomponent condom distribution scheme which provides registered young people with a C-Card (which entitles them to free condoms)) or other condom distribution schemes. No schemes were found in **7%** (10/152) and **9%** (13/152) did not respond. Figure 2 provides a distribution of schemes.

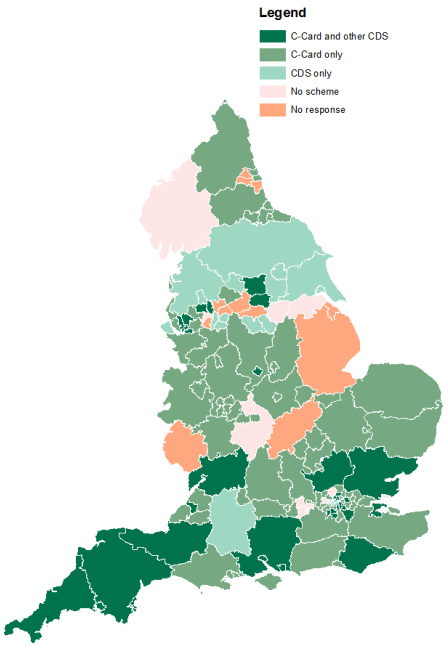



**Figure 2. Distribution of types of condom distribution schemes (CDS) in England in 2015/16, by upper tier local authorities (UTLA)**

The report also found that the most common outlet of a CDS depended on the type of CDS. For C-Card pharmacies were the most common outlet at 30%, for other CDS GPs were the most common at 33%.[13]

### 4.5.4 Resource impact

This area is not included in the resource impact report for sexually transmitted infections: condom distribution schemes guideline (NG68). It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year).

[13] Public Health England (2017). Condom Distribution Schemes in England 2015/16

## *4.6 Additional areas*

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 20 June 2018.

#### Awareness

A stakeholder highlighted that sexual health promotion campaigns can help to raise awareness of sexual health and improve knowledge among different target groups. This area is not covered by NICE or NICE accredited guidance and the promotion of public health campaigns are within the remit of Public Health England.

#### Management of antimicrobial resistant gonorrhoea

Stakeholders suggested that the emergence of antimicrobial resistant gonorrhoea poses a risk to its management and effective treatment. Pathways and protocols should be established to monitor this. This area is not covered by NICE or NICE accredited guidance.

#### Online services

Stakeholders highlighted that online services provide a convenient way for people to access sexual health information as well as providing diagnostics through the order of STI testing. However stakeholders noted that not all of these services work to a robust evidence base and can vary in the type and quality of care they provide. This area is not covered by NICE or NICE accredited guidance and the inspection of whether appropriate care is being provided is within the remit of the Care Quality Commission.

#### Pre-exposure prophylaxis of HIV (PrEP)

Stakeholders suggested that PrEP should be available to at risk populations in order to reduce the transmission of HIV. PrEP is currently subject to an NHS England

impact trial which aims to address the outstanding questions about eligibility, uptake and length of use. This trial will help to determine future implementation.

**Screening (chlamydia and cervical cancer)**

A stakeholder highlighted the importance of screening to prevent the transmission of infections such as a chlamydia and the identification of conditions such as cervical cancer.

Screening is within the remit of the UK National Screening Committee within Public Health England.

**Sex and Relationship Education**

A stakeholder highlighted that good quality sex and relationship education is needed to improve sexual health in the population. This area is not covered by NICE or NICE accredited guidance and the provision of education is within the remit of the Department for Education.

**Termination of pregnancy services**

A stakeholder suggested that termination of pregnancy services is not equal across the UK, such as the provision of misoprostol in Scotland and Wales. Termination of pregnancy services has been referred in the NICE quality standards topic library.

**Training**

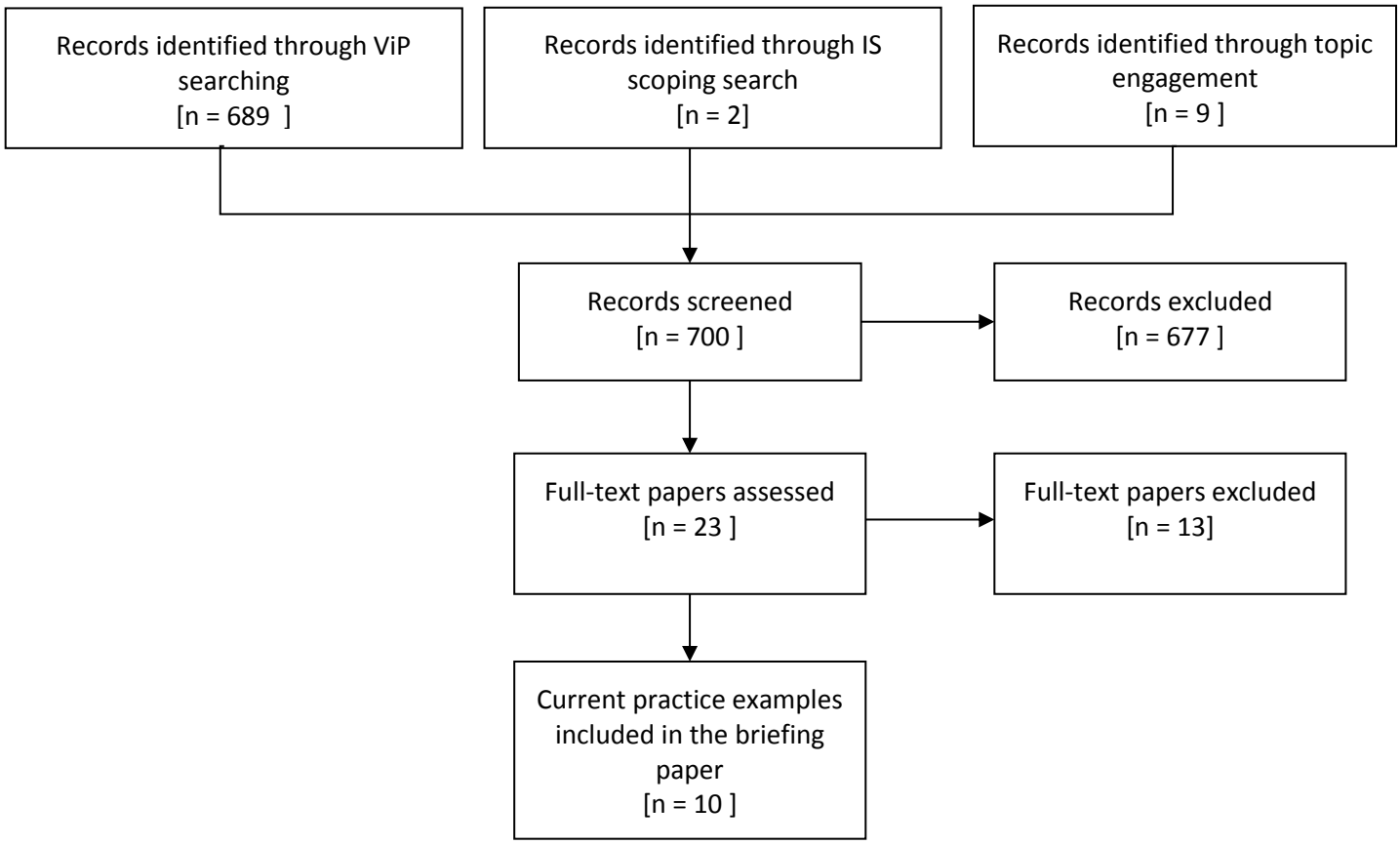
The training of staff was suggested as an area of quality improvement.

This suggestion has not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, training may be referred to in the audience descriptors.

**Vaccination**

Stakeholders highlighted that hepatitis B virus (HBV) and Human Papilloma Virus (HPV) are sexually acquired. Therefore vaccination should be delivered to reduce the incidence of disease associated with these viruses. Increasing vaccine uptake among children and young people is covered in the NICE quality standard on Vaccine uptake in under 19s. Vaccination for hepatitis B is covered in the NICE quality standard on Hepatitis B.

## Appendix 1: Review flowchart



## Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|
| **General comments** | | | | | |
| 001 | British Association for Sexual Health and HIV (BASHH) | General comment | The British Association for Sexual Health and HIV (BASHH) welcomes the opportunity to comment on this consultation which will inform the development of a new NICE Quality Standard for Sexual Health.<br><br>It is important that this new NICE Quality Standard compliments the existing BASHH/MEDFASH Standards for the management of sexually transmitted infections (STIs).1 These Standards set out nine key areas that support commissioners and healthcare providers to improve local sexual health outcomes and reduce variation in the quality of care delivered across the country. | The Standards were revised in 2014 and have been formally endorsed by a wide range of leading relevant stakeholders, including the Association of Directors of Public Health, the Faculty of Public Health, the Local Government Association, Public Health England, the Royal College of General Practitioners, the Royal College of Nursing and the Royal College of Physicians.<br><br>As these Standards have been in use for several years and are now familiar to those involved in the commissioning and delivery of sexual health services, we believe that it is essential that close consideration is given to how this new NICE Quality Standard can best align with them. With this in mind, it is important in the first instance that they are listed within the Key policy documents, reports and national audits segment of future versions of the Quality Standard and are also factored into the Quality Standard Advisory Committee's discussion that will inform the development of this document over the coming months. | 1 - BASHH / MEDFASH Standards for the management of sexually transmitted infections (STIs). January 2014. Available online at: https://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf |
| 002 | The Faculty of | Additional developmental | Please note that we feel that if, as | | |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | Sexual and Reproductive Healthcare Clinical Effectiveness Unit | areas of emergent practice | stated, this QS is to relate almost entirely to sexually transmitted infection, with other, separate QS documents for contraception, termination of pregnancy etc, the title “QS for Sexual Health” is misleading. Sexual health encompasses much more than just STI. “QS for Sexually transmitted infection” would be more appropriate | | |
| 003 | SCM1 | Additional evidence sources for consideration | The title “QS for Sexual Health” is misleading. Sexual health encompasses much more than just STI. “QS for Sexually transmitted infection” would be more appropriate if this relates almost entirely to sexually transmitted infection. | | |
| **4.1 Identifying people at risk of sexually transmitted infections and providing advice** | | | | | |
| 004 | British Association for Sexual Health and HIV (BASHH) | Key area for quality improvement 4: Supporting effective management of high-risk and/or vulnerable population groups | Some groups are at higher risk of poor sexual health outcomes or have heightened vulnerabilities and it is important that this Quality Standard highlights the need to have effective management strategies in place to support their needs.<br><br>Groups at the highest risk of poor | As demonstrated by the latest available data from Public Health England, high-risk population groups continue to experience poorer sexual health outcomes compared to other parts of the population and account for a disproportionate amount of new STI diagnoses.4 Taking steps to address this should be considered a key focus for quality improvement within this Quality Standard. | 1 – Department of Health. A Framework for Sexual Health Improvement in England. March 2013. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO- |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | sexual health outcomes include young people, MSM and transgender people and those from black, Asian and minority ethnic (BAME) communities.<br><br>Vulnerable groups also have sexual health needs and it is important that services are tailored to support their access to care. Vulnerable groups include those with learning, educational or broader mental health needs, those with physical or other disabilities, those who are less able to communicate in English or have limited reading and writing abilities, including the ability to access electronic forms of media, as well as those from the prison population.<br>The management of STIs in individuals from high-risk population groups has consistently been identified as a public health priority within national sexual health strategy documents1,2 and is also emphasised within the BASHH / MEDFASH Standards for the management of STIs.3 | As highlighted within the BASHH / MEDFASH Standards, to help identify at-risk groups, people with needs relating to STIs should have a medical and sexual history taken which includes sexual behaviour and other risk factors.<br><br>It's also important to ensure that people living with HIV (PLWH) receive STI care and support to help protect themselves and others from acquiring new STIs, through regular screening and prevention interventions.<br><br>Vulnerable population groups may find it difficult to negotiate routine models of service access and support should be provided to provide alternative models tailored to their needs. Online testing will not be suitable for those at risk of sexual exploitation for instance, and in these cases, support should be available within clinics to identify those at risk and help with often complex needs.<br><br>The Quality Standard should promote the importance of ensuring that staff involved in the delivery of care for high-risk population groups receive appropriate and ongoing training. | SexualHealthPolicyNW_ACCESSIBLE.pdf<br><br>2 – Public Health England. Health promotion for sexual and reproductive health and HIV, Strategic Action Plan, 2016 to 2019. December 2015. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf<br><br>3 - BASHH / MEDFASH Standards for the management of sexually transmitted infections (STIs). January 2014. Available online at: https://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf<br><br>4 - Public Health England. Sexually Transmitted |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | Infections and Chlamydia Screening in England, 2016. June 2017. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/617025/Health_Protection_Report_STIs_NCSP_2017.pdf |
| 005 | The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit | Key area for quality improvement 1<br>Interventions relating to STIs should take place at the time of consultations regarding other sexual health issues including contraceptive consultations, cervical screening consultations and pregnancy-related consultations - all across a wide range of settings. | Potential for increased STI screening and more efficient use of NHS resources. Amongst women presenting for eg. pregnancy care, abortion care or contraception there may be opportunities for intervention re STI in women who may otherwise be hard to reach. | Recommendation 1 in NICE PH3: “Sexually transmitted infections and under-18 conceptions: prevention”<br>NICE guideline 60: “HIV testing: increasing uptake among people who may have undiagnosed HIV”<br>NICE guideline 62: “Antenatal care for uncomplicated pregnancies”<br>FSRH (Faculty of Sexual and Reproductive Healthcare)guideline “Contraceptive Choices for Young People”<br>FSRH guideline “Contraception after Pregnancy”<br>FSRH guideline “Emergency Contraception”<br>FSRH guideline “Contraception for Women Aged Over 40”<br>FSRH guideline “Intrauterine Contraception”<br>FSRH guideline “Barrier Methods for Contraception and STI Prevention” | |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 006 | The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit | Key area for quality improvement 2<br>High-risk /vulnerable groups should be prioritised. Access to services in an environment that is accessible and acceptable to them should be ensured for and promoted to them. | People in high risk/ vulnerable groups may be at highest risk of STI but can face significant barriers to accessing information regarding, testing for and management of STI. | · NICE PH3: “Sexually transmitted infections and under-18 conceptions: prevention”<br>BASHH(British Association for Sexual Health and HIV): “UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011”<br>BASHH: “2016 United Kingdom national guideline on the sexual health care of men who have sex with men”<br>(British HIV Association, BASHH and FSRH guideline for the management of the sexual and reproductive health of people living with HIV infection 2008) –updated guidance is imminent | |
| 007 | LGBT Foundation | Meeting the sexual health needs of trans communities, including non-binary and gender-fluid people, particularly around gender identity monitoring, testing services and vaccinations. This would focus on risk of acquisition and prevalence of STIs and HIV, particularly amongst trans women. | | | |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 008 | LGBT Foundation | Meeting the sexual health and wellbeing needs of gay, bi and other MSM partaking in ChemSex. This may be a focus on multi-disciplinary approach focused on safer injecting packs, testing provision in drug and alcohol services (sexual health outreach POCT clinic?) | | | |
| 009 | Nottingham University Business School | Delivery of sexual health services to minors | There is evidence that the current application of the Fraser Guidelines in the delivery of sexual health services to minors (including those aimed at preventing or treating STIs) has helped to perpetuate child sexual exploitation.<br><br>Guidance should clarify that the delivery of sexual health services to minors aimed at preventing STIs must take account of risks surrounding child sexual exploitation in the provision of such services. The Guidance should further clarify that delivery of such services should involve parents in all but the most | The 2018 Newcastle Joint Serious Case Review identified that "approximately 85% of victims of sexual exploitation had received services from sexual health services." (p. 90). The Review also recommended that "The Government should urgently arrange for the principles applied to confidentiality and safeguarding in sexual health settings to be reviewed having regard to the body of knowledge about sexual exploitation." (Recommendation 2.11, p.95) www.nscb.org.uk/joint-serious-case-review-concerning-sexual-exploitation-newcastle<br><br>At least 10 other Serious Case Reviews in recent years, including from Rochdale, Oxfordshire, Torbay and Thurrock have identified similar links between sexual health services for minors and child sexual | |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | exceptional of circumstances. | exploitation. | |
| 010 | SCM4 | Key area for quality improvement 2<br><br>Provision of adequate time and training for structured one to one discussions for those at high risk of STIs. | NICE guidance on sexually transmitted infections and under 18 conceptions guidance recommends one to one structured discussions with individuals at high risk of STIs structured on the basis of behaviour change theories, addressing factors that can help reduce risk taking and improve self efficacy and motivation. | The NICE recommendation is that each session should last 15 – 20 minutes. There may be pressure to reduce the time for structured discussions or lack of training on behaviour change techniques. There may lack of time from a variety of sexual health professionals as well as cuts in health advisers who are trained to carried out these discussions. | A framework for sexual health improvement in England 2013 summarises the evidence for the evidence linking alcohol, vulnerability and risky sexual behaviour that need unpacking in structured discussions.<br>Evidence is lacking on the uptake of the recommendation for a 15 – 20 minute structured discussion with individuals at high risk of STIs.<br>A BASHH reaudit of sexual history taking found improvements but still variability in the quality e.g. only 50% of women had a discussion on anal sex. The report is available at https://www.bashh.org/bashh-groups/national-audit-group/<br>Improved sexual history taking in the 2012 BASHH asymptomatic screening |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | re-audit. https://www.ncbi.nlm.nih.gov/pubmed/24047881 The King's Fund report (see link below) on cites concerns "We were particularly concerned about cuts to health adviser posts in clinics. These are professionals trained in giving advice to patients newly diagnosed with infections, and in tracing and notifying current and past sexual partners so that they can be brought in for testing" https://www.kingsfund.org.uk/blog/2017/03/what-do-cuts-sexual-health-services-mean-patients |
| 011 | SCM4 | Key area for quality improvement 3<br><br>Access to services for the most vulnerable | Sexual health problems disproportionately affect those experiencing poverty and social exclusion. Individuals and groups who find it most difficult to access services include asylum seekers and refugees, sex workers and their clients, those who are homeless and young people in or | As pressure increase on funding there is the risk of services being cut, reducing accessibility. The most vulnerable groups that are being targeted need to be involved in ensuring that services are and continue to be accessible.<br><br>The RCGP document Time to Act sates that" | It is hard to find evidence on accessibility of services for the most vulnerable groups and their inclusion in services planning.<br><br>NIHB report: health care needs of the most vulnerable groups in |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | leaving care. The highest burden is borne by men who have sex with men, some black and minority ethnic groups and young people. NICE guidance on sexually transmitted infections and under 18 conceptions recommends that service provision is targeted at these groups and ensures accessibility. FSRH Service Standards for sexual and reproductive healthcare recommends choice in terms of times and types of clinics including an option of walk in appointments. | The Primary Care Women's Health Forum reports tha 37% of their GP members have experienced a recent increase in women seeking appointments for contraception as SRH clinic appointments become harder to obtain." | society not being met because of gaps in health information and data gaps. https://www.gov.uk/government/publications/effective-health-care-for-vulnerable-groups-prevented-by-data-gaps<br><br>Kings Fund report "cuts to outreach services that target high-risk groups such as sex workers and men who have sex with men; and to sexual health advice, promotion and prevention services." https://www.kingsfund.org.uk/blog/2017/03/what-do-cuts-sexual-health-services-mean-patients<br><br>Study showing access to GUM services has worsened for those with symptoms suggestive of an acute STI and is significantly poorer for asymptomatic women. http://sti.bmj.com/content/9 |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | 3/7/472 |
| 012 | SCM2 | Key area for quality improvement 2<br><br>Health Promotion | To influence the ability for adults and young people to make positive lifestyle changes and minimise risk as a result of health promotion interventions.<br><br>Improving sexual health and wellbeing requires a holistic approach that takes into account the physical, mental, social and economic factors that all influence sexual behaviour. We know the importance of ensuring people have the information, knowledge, skills and accessible services that allow them to make healthy choices about the sexual lives.<br><br>Alongside this, the wider determinants of sexual behaviour need to be addressed including, positive mental wellbeing, substance use (particularly alcohol), aspirations for the future and equality.<br><br>It is important for Sexual Health Services to be proactive in order that people to know how to protect their sexual health and | Having a range of service and educational provision is important to meet the needs of people's sexual health needs across their lifecourse and for their emotional health and wellbeing.<br><br>Throughout life individuals need access to good quality information, advice and services delivered in an appropriate manner to maintain their sexual health and wellbeing. This includes not only sexual health specific information on contraception and sexually transmitted infections but on wider issues such as perimenopause, menopause, psychosexual health, emotional wellbeing, communication skills and managing relationships.<br><br>The need for sexual health messages aimed specifically at older men and women was stated in the Department of Health Framework for Sexual Health Improvement in England (2013). The Framework notes that there is a small, but increasing, incidence of sexually transmitted infections (STIs) in people over 50. However, it is important to note the suggestion that better communication is needed to inform older people of sexual health risks. | Department of Health (2013) A Framework for Sexual Health Improvement in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf<br><br>Public Health England (2015) https://www.gov.uk/government/publications/sexual-and-reproductive-health-and-hiv-strategic-action-plan<br><br>Public Health England (2015) provides the case for prioritising prevention in order to achieve a culture in which our residents can enjoy good sexual health and wellbeing:<br>Poor sexual and reproductive health and |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | know how to access appropriate services and interventions when they need them. All individuals require age-appropriate education, information and support to help them make informed and responsible decisions. | The known sexual health problems in this age group may well be underestimated because of their reluctance to seek help, due to embarrassment or stigma. This underlines the need to raise awareness to support adults in this age group seeking help for problems related to sexual activity and function, which may have important impacts on quality of life. | ongoing transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing, and result in significant costs for health service and local authority budgets<br>Sexual relationships, although an intensely private matter, are a major component of the wellbeing of the whole adult population and of wider society<br>There is a strong association between poor sexual and reproductive health and other risk behaviours, and by seeking to improve sexual and reproductive health and HIV outcomes, these other determinants of health may also be identified and addressed<br>Sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities, and improving sexual and |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | reproductive health and HIV outcomes will address these major health inequalities. |
| 013 | Association of Directors of Public Health | 3. Impact on drugs, alchohol and PreP on STI risk | | | |
| 014 | Association of Directors of Public Health | 4. Building individual capacity to negotiate safe sex | | | |
| 015 | SCM1 | Key area for quality improvement 2 | High-risk /vulnerable groups should be prioritised. Access to services in an environment that is accessible and acceptable to them should be ensured for and promoted to them. | These may be at highest risk of STI but can face significant barriers to accessing information, testing and management of STI. These barriers have been further increased by budget cuts. | NICE PH3: “Sexually transmitted infections and under-18 conceptions: prevention”<br>BASHH Outreach standards: https://www.bashh.org/about-bashh/publications/sti-outreach-standards<br>BASHH(British Association for Sexual Health and HIV): “UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011”<br>BASHH: “2016 United Kingdom national guideline on the sexual health care of men who |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | have sex with men" British HIV Association, BASHH and FSRH guidelines for the management of the sexual and reproductive health of people living with HIV infection 2008". |
| **4.2 Referral to specialist sexual health services** | | | | | |
| 016 | British Association for Sexual Health and HIV (BASHH) | Key area for quality improvement 1: Ensuring timely access to STI testing, diagnosis and management within GUM services, appropriate to the needs of the patient | It is important that this Quality Standard supports timely access for those who need STI testing, diagnosis and ongoing management services within their local genitourinary medicine (GUM) clinic.<br><br>As set out within the BASHH/MEDFASH Standards for the Management of STIs, people with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment.1<br><br>Ensuring rapid access to these services reduces the likelihood of onward transmission of STIs and lessens the risk of additional | There has been a longstanding commitment to ensure that patients should be offered an appointment to be seen by a GUM clinic within 48 hours of contact. In England, the Government introduced a mandatory target that 98 per cent of patients should be offered an appointment within this timeframe.6<br><br>The results of a UK-wide two year 'mystery shopper' exercise however has demonstrated that this target is increasingly being missed.<br><br>In 2014, 95.5 per cent of patients with symptoms suggestive of an acute STI were offered an appointment within 48 hours. In 2015 however, this figure dropped to 90.8 per cent, well below the 98 per cent level that was previously recommended. Analysis revealed that the most marked declines in | 1 - BASHH / MEDFASH Standards for the management of sexually transmitted infections (STIs). January 2014. Available online at: https://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf<br><br>2 – Caroline White. Sexual health services on the brink. BMJ 2017: 359. November 2017. Available online at: https://www.bmj.com/content/359/bmj.j5395<br><br>3 – Public Health England. |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | health complications for individuals. As set out below however, developments in recent years have made it increasingly challenging to meet this ambition.<br><br>Demand for access to GUM clinics has grown significantly in recent years, increasing from 1.6 million people accessing services in 2011, to more than 2.1 million in 2015. This represents an increase in demand of more than 30 per cent in just four years.2<br><br>This increased demand for access to services has occurred alongside a considerable growth in the levels of new diagnoses for several STIs across England.<br><br>Syphilis rates are at their highest levels since the 1950s, with all regions in England, bar the North East, reporting large increases in new diagnoses in recent years. Despite a reduction in overall diagnoses according to the most recent year of available data, gonorrhoea levels have also risen markedly in England recently, | access were amongst clinics in England.7<br><br>A subsequent 'mystery shopper' evaluation was carried out between October-November 2016, in which all 262 GUM clinics across the United Kingdom were contacted via telephone to assess ease of accessing care. The results of the exercise showed that access has fallen further below the target of 98 per cent of patients being offered an appointment within 48 hours of contact, with only 83.4 per cent of callers being able to secure an appointment within this timeframe.8<br><br>These findings are in line with feedback from BASHH members which suggests that patients are increasingly being turned away from local services due to insufficient resources to meet the growing demand. As an example of this, a major provider in London has published data showing that it is having to turn away an estimated 600 patients per week.9<br><br>The introduction of a NICE Quality Statement within this document highlighting the importance of timely access to GUM services for those that need them, within 48 hours of contact, would highlight the importance of reversing the recent | Sexually Transmitted Infections and Chlamydia Screening in England, 2016. June 2017. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/617025/Health_Protection_Report_STIs_NCSP_2017.pdf<br><br>4 – The King's Fund. What do cuts in sexual health services mean for patients? April 2017. Available online at: https://www.kingsfund.org.uk/blog/2017/03/what-do-cuts-sexual-health-services-mean-patients<br><br>5 - The King's Fund. Big cuts planned to public health budgets. July 2017. Available online at: https://www.kingsfund.org.uk/press/press-releases/big-cuts-planned-public-health-budgets |

| ID | Stakeholder | Suggested key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | increasing by 142 per cent since 2008, from 14,985 to 36,244 newly diagnosed cases in 2016.3 Sexual health services have had to manage this increase in demand against a backdrop of challenging and persistent cuts that have been applied to the public health budget, from which they are funded.<br><br>Whilst some local authorities have reported increases in their overall spend on sexual health, this varies significantly, and a quarter of localities have cut their spend in the area by 20 per cent in the past two years.4<br><br>In 2017/18 local councils spent £30m less on sexual health compared to 2016/17, representing a 5 per cent reduction in the total amount of money available for services. Over the past four years, planned spending on sexual health services has fallen by £64 million (equivalent to 10 per cent).5<br><br>Taken together, these pressures | deterioration seen in this area. It would also help to provide a valuable measurable performance benchmark.<br><br>The Quality Statement should also emphasise the need to ensure that a range of access methods are available, appropriate to the needs of the patient and that appropriate and ongoing training is available for staff involved in the delivery of these services. | 6 – Department of Health. Genitourinary Medicine 48-hour Access: Getting to target and staying there.<br><br>7 - Foley E, Furegato M, Hughes G et al. Inequalities in access to genitourinary medicine clinics in the UK: results from a mystery shopper survey. Sexually Transmitted Infections 2017; 93. Available online at: http://sti.bmj.com/content/93/7/472<br><br>8 – Agathangelou G, Khatun A, Yekini S, Rose T, Foley E, Patel R. What is telephone access really like for GUM clinic patients in the U.K.? Sexually Transmitted Infections, June 2017, Volume 93, (Suppl 1) A68. Available online at: http://sti.bmj.com/content/93/Suppl_1/A68.2 |

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| | | | are making it increasingly difficult to ensure that timely access to services is available for those that need it. | | 9 – Guys and St Thomas. October 2017 board papers. Available online at: https://www.guysandstthomas.nhs.uk/resources/membership/papers-2017/october/20171025-bod-full-set.PDF |
| 017 | British Association for Sexual Health and HIV (BASHH) | Key area for quality improvement 2: Provision of effective primary prevention services | This Quality Standard should promote the importance of ensuring that effective sexual health primary prevention services are in place for local populations.<br><br>Primary prevention services are an effective means of promoting good sexual health within a population and help to reduce the level of onward STI transmission and HIV acquisition.<br><br>Promoting primary prevention services would also help to align this Quality Standard with Public Health England's Health Promotion for Sexual and Reproductive Health and HIV Strategic Action Plan 2016-2019. Alongside education, the Action | The quality of primary prevention services varies greatly across the country, and this is influenced by the relative priority placed upon the area by respective local commissioning groups.<br><br>Whilst it is important that the delivery of primary prevention services are tailored to suit local needs, they should incorporate key elements such as condom promotion and distribution initiatives, HIV testing and provision of accurate information on risk reduction for all STIs and HIV.<br><br>Prevention initiatives should also incorporate effective vaccination strategies, including human papillomavirus (HPV) vaccination for girls and men who have sex with men (MSM), in line with the national HPV vaccination programme for MSM that commenced from April 2018.2 | 1 – Public Health England. Health promotion for sexual and reproductive health and HIV, Strategic Action Plan, 2016 to 2019. December 2015. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf<br><br>2 – Public Health England. HPV vaccination programme for men who have sex with men (MSM). Clinical and operational guidance. April 2018. Available online at: https://assets.publishing.s |

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| | | | Plan identified early prevention as the area that would achieve the greatest improvements in sexual health and reductions in health inequalities.1<br><br>Pre-exposure prophylaxis (PrEP) for HIV has been rolled out in the PrEP Impact Study and recruitment has been rapid as STI services have been actively educating patients on primary prevention of HIV acquisition through negotiating safer sex practices. It is important that ongoing support for this intervention is assured, as the risk of HIV infection will increase if drug provision is stopped. | Other effective vaccination strategies include hepatitis A vaccination for MSM and hepatitis B vaccination for all individuals at risk of acquisition as a result of sexual behaviour.<br><br>The Quality Standard should promote the importance of ensuring that staff involved in the delivery of primary prevention services receive appropriate and ongoing training. | ervice.gov.uk/government/uploads/system/uploads/attachment_data/file/697362/HPV_MSM_clinical_and_operational_guidance.pdf |
| 018 | SCM4 | Key area for quality improvement 4<br><br>Integration between sexual and reproductive health services | MEDFASH standards for the management of sexually transmitted infections recommend that integration between reproductive and sexual health services is essential. Different groups of people have varying and complex health needs .e.g. women who believe they are at risk an STI may also be at risk of an unintended pregnancy or vice versa. If the provider is not an | Since the 2013 Health and Social Care act commissioning for integrated sexual and reproductive health has become fragmented. The All party Parliamentary Group on sexual and reproductive health reported evidence that changes in commissioning were leading to: Restrictions in access for patients. Fragmentation between providers which in the past delivered integrated care, making it more difficult and time consuming for service users to get all of the support they | The RCGP document Time to Act states that “the apportioning of SRH commissioning responsibilities between CCGs, local authorities and NHS England disrupts patient pathways in SRH because services are shaped by the source, availability and amount of funding rather than by |

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| | | | integrated SRH services it is vital that clear pathways to relevant services are in place to ensure timely access to advice and care that can meet individual needs | needed.<br>Patients having a poorer experience of their care as a result. | patient need."<br><br>Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England, All-Party Parliamentary Group on Sexual and Reproductive Health in the UK, 2015 reported that |
| 019 | SCM5 | 2 - accessible, confidential #STI testing services | | | |
| 020 | SCM2 | Key area for quality improvement 1<br><br>Partnership Working & Equity | Sexual health should not be seen as simply the testing and treatment of sexually transmitted infections and the prevention of unplanned pregnancy, but must be seen in its widest context, taking into account the persons environment, the geography within which they live and the life stage they are at.<br><br>Partnerships should be created and extended with community partners, local authorities, Clinical | The Public Health White Paper Healthy Lives, Healthy People: Our Strategy for Public Health in England highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services (including for sexually transmitted infections (STIs), contraception, health promotion and prevention).<br><br>Many of the challenges that need to be addressed rely on the combined efforts of public, private and voluntary partner | Public Health England (2014) 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV' https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services<br><br>Department of Health (2010) Healthy Lives, |

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| | | | Commissioning Groups and NHS England with their SRH commissioning responsibilities in line with the collaborative and whole-system approach to commissioning outlined in PHE's 'Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV' in order to develop more streamlined care around patient convenience. | organisations working together and the involvement of the public through consultation and community planning mechanisms.<br>In order to address the issue of equity, support need to be available to facilitate liaison with the commissioners of other strands of sexual health provision such as HIV treatment and care and abortion services. | Healthy People: Our Strategy for Public Health in England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf |
| 021 | SCM2 | Key area for quality improvement 4<br><br>Public, Service User, Carer and Staff Involvement | Any sexual health model of delivery should be informed by and developed with public, service user, carer and staff involvement, including those agencies who refer into sexual health services. | Service planning and improvement should always include consultation with service users and local populations. | We must acknowledge and consider the sexual problems older people face, whether it is because they are exploring relationships or starting a new one or due to the menopause (and perimenopause which starts for many women in their 40s) or the presence of psychosexual health problems as a result of ageing or long-term health conditions which can adversely affect sexual activity and satisfaction. |

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| 022 | SCM2 | Key area for quality improvement 5<br><br>Accessible Services | Sexual health services should be accessible by various means including via digital media, self referral and referral from other partner agencies (with clear pathways), supported by a culture of proactive engagement.<br><br>Sexual health services should provide equity of access for all groups, deliver a non-judgemental and inclusive service and should be committed to continuous improvement from childhood through to older age.<br><br>PHE Guidance 'Sexual and reproductive health and HIV: applying All Our Health' (2018) notes the importance of ensuring easy access to sexual health advice, free condoms, and testing for HIV and other STIs for young people and other high risk groups in a range of accessible settings with condom distribution schemes. | Early diagnosis, intervention and support are key to improving quality of life. As diagnosis is the first step, it is important to ensure there is information and advice to help people easily access services and support in a timely manner.<br><br>Sexual health services should demonstrate innovation in developing a range of delivery options that take into account geographical challenges and optimise accessibility, and ensures equal and fair access to services.<br><br>Services delivered must be of the same high quality regardless of the service user's residence or the location of the service premises.<br><br>Accommodation used by sexual health services must be of a high standard to ensure a comfortable, hospitable welcome that will create an atmosphere of value and respect. Facilities should provide a comfortable environment whilst using energy and resources in an efficient manner.<br><br>Provision of services should promote well-being through community centred services and signposting to local activities. It is vital that sexual health services have an | Some groups will need special consideration because they are at higher risk, are particularly vulnerable or have particular access requirements including: young people and those in or leaving care; older people, gay, bisexual and transgender people; people misusing drugs and alcohol; people living with HIV and other people affected by HIV; people with physical disability; people with learning difficulties; people with mental health problems; people living with chronic conditions; people with any specific cultural or language needs, including refugees and asylum seekers; and people living in rural areas where access is often restricted. |

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| | | | | understanding of modes of transport and transport routes and acceptable service delivery locations for children, young people, families, adults and communities in order to ensure flexible, innovative and accessible service delivery times/ locations. The location of services should support access on foot, by bicycle and by public transport to prevent access becoming a barrier to accessing services. | |
| 023 | Royal College of GPs | Key area for quality improvement 1 | We would like to highlight the RCGP Time to Act 2017 report on sexual health services (http://www.rcgp.org.uk/policy/rcgp-policy-areas/maternity-care.aspx)<br><br>which shines a light on sexual health services and makes key recommendations around commissioning of sexual health services :<br><br>Frequently, related services do not refer between or communicate with one another. In some areas, for example, family planning services do not link up with contraceptive advice services. | | England Commissioners from Clinical Commissioning Groups (CCGs), local authorities and NHS England should work through Sustainability and Transformation Partnerships (STPs) to agree joint plans for SRH, with the aim of maximising choice and creating the best outcomes for patients, according to assessed local need;<br>ii. Review the contracts and payment systems used to commission SRH and Genitourinary medicine (GUM) services so that they focus on |

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| | | | exemplars given bellows | | integration, incentivising prevention and early intervention;<br>iii. Introduce a public health indicator which measures the availability of LARC through GPs' surgeries;<br>iv. The Department of Health should give Public Health England responsibility for responding to the data collected around SRH, and mandate the organisation to make recommendations for action when outcomes decline;<br>v. Regulations should be amended to enable the introduction of statutory guidance on the number, type, and specifications of SRH services which local authorities must provide;<br>vi. Introduce public health indicators which cover the whole care pathway for SRH and include over 25s;<br>vii. The Department of Health should review the |

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| | | | | | Framework for Sexual Health Improvement in England and establish an indicator set to monitor progress against it. |
| 024 | Royal College of GPs | Key area for quality improvement 2 | | | Specialist SRH services should meet the requirements of the Service Standards for Sexual and Reproductive Healthcare, outlined by the Faculty for Sexual and Reproductive Healthcare and equivalent standards should be developed for GUM services, drawing on sources such as the British Association for Sexual Health and HIV (BASHH) clinical guidelines;<br>ix. Training for local GPs, medical students and nurses must be a mandatory part of specialist SRH services' contracts;<br>x. Health Education England, The Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland |

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| | | | | | and Wales Deanery must work with Local Education and Training Boards (LETBs) or deaneries to assess local need for training in SRH and the best way to meet it |
| 025 | Association of Directors of Public Health | 1. Impact of contraceptive choice on sexual behaviour and infection risk | | | |
| **4.3 Testing for sexually transmitted infections** | | | | | |
| 026 | The Faculty of Sexual and Reproductive Healthcare (FSRH) | Key area for quality improvement 2<br>Use of rapid tests for STI diagnosis | Speeds up diagnosis and management and reduces transmission.<br>Currently tests not reliable enough. | In testing for STIs, there remains a trade-off between speed of result and accuracy.<br><br>There is evidence that point-of-care tests for chlamydia and gonorrhoea are not fully effective. They have limited sensitivity/specificity, are relatively expensive and/or are associated with a significant delay before the result is available.<br><br>The gold standard for testing remains laboratory tests - I.e. samples being sent to laboratory for analysis which can delay diagnosis, management and partner notification.<br><br>BASHH“2016 United Kingdom national | https://www.hivpreventionengland.org.uk/wp-content/uploads/2016/04/HPE_briefing_HIV_testing_technologies.pdf<br><br>https://www.bashhguidelines.org/media/1083/bashh-recommendations-for-testing-for-stis-in-msm-final.pdf<br><br>http://www.who.int/reproductivehealth/topics/rtis/pocts/en/<br><br>Toskin I, Peeling RW, |

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| | | | | guideline on the sexual health care of men who have sex with men" | Mabey D, et al Point-of-care tests for STIs: the way forward Sex Transm Infect 2017;93:S1-S2 |
| 027 | The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit | Key area for quality improvement 4<br>STI screening for all groups (including asymptomatic individuals) should include testing for chlamydia, gonorrhoea, syphilis and HIV as a minimum standard. | Undiagnosed HIV/ syphilis infection amongst groups not considered to be at highest risk. | 2015 BASHH CEG guidance on tests for STI | |
| 028 | The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit | Key area for quality improvement 5<br>In MSM, testing of extragenital as well as genital sites for C trachomatis and Neisseria gonorrhoeae as standard. | A large number (?majority) of CT/GC infections may be missed if testing is done only from genital sites in MSM. | BASHH "2016 United Kingdom national guideline on the sexual health care of men who have sex with men" | |
| 029 | LGBT Foundation | Meeting the sexual health needs of lesbian and bisexual women, particularly around the lack of engagement with mainstream sexual health services, and therefore the need for | | | |

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| | | community organisations to offer services such as testing. | | | |
| 030 | LGBT Foundation | Increasing the uptake in STI tests in community settings amongst gay, bi and other MSM - making the case for STI point of care tests, in particular Syphilis and Hepatitis. If it could also address gonorrhoea through postal kits (administered in the community) that would be great too. | | | |
| 031 | LGBT Foundation | Testing, vaccinating and treating Hepatitis in community settings particularly amongst gay, bi and other men who have sex with men. This would address the increase in Hep A amongst this cohort. | | | |
| 032 | SCM3 | Key area for quality improvement 3<br>HIV testing (linked to HIV testing: encouraging uptake NICE quality statements) | Early diagnosis of HIV is associated with better health outcomes for the individual and has a public health benefit through linkage to treatment and achievement of an undetectable | Testing according to the NICE guidance is variable across the country. Achievement of the UNAIDS 90:90:90 targets are also variable across England. Increasing testing can help to reduce the undiagnosed fraction, help us to meet the 90:90:90 | In 2014-16, 40% of new HIV diagnosis among adults in England were made at a 'late' stage (see PHOF dashboard). |

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| | | | viral load (=uninfectious). NICE guidance and PHOF indicators exist. Having a quality standard linked to these could help to drive quality improvement in this area. | targets, reduce inequalities, improve individual and public health. | https://www.nice.org.uk/guidance/qs157 |
| 033 | SCM5 | 3 - accurate and timely diagnostics | | | |
| 034 | SCM5 | 4 - robust pathways for timely treatment by competent practitioners | | | |
| 035 | PHE | Ensuring frequent testing for STIs, including syphilis, in higher risk groups | There is good evidence, from analysis of surveillance data, that those groups at higher risk of STIs are not being tested frequently (as recommended by extant guidance from professional bodies). | This lack of systematic approaches to frequent testing results in a potential pool of undiagnosed infection which then contributes to the sustained transmission of infections in the community.<br>Evidence from the work to increase frequency of HIV testing in higher risk groups has demonstrated how concerted effort to improve testing frequency can have a significant impact on incidence of infections | BASHH guidelines recommend 3-monthly testing in higher risk groups https://www.bashhguidelines.org/media/1083/bashh-recommendations-for-testing-for-stis-in-msm-final.pdf<br><br>HIV in the United Kingdom: decline in new HIV diagnoses in gay and bisexual men in London, 2017 report https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/648913/hpr3517_HIV_AA.pdf |

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| **4.4 Helping people with sexually transmitted infection to get their partners tested** | | | | | |
| 036 | British Association for Sexual Health and HIV (BASHH) | Key area for quality improvement 3: Provision of effective secondary prevention services | This Quality Standard should promote the importance of providing effective sexual health secondary prevention services.<br><br>Sexual health services operate and deliver in a range of key overlap areas within the wider health and social ecology. Service staff engage with and have a competence and expertise in delivery of care to populations that other services may not necessarily be able to access.<br><br>Support should therefore be given towards enhancing and augmenting this capacity within sexual health services, towards the provision of a seamless public health delivery model. This could incorporate expanding the range of vaccination delivery models in support of other services, such as offering catch-up vaccination for adolescents who missed HPV vaccinations in schools for instance, or providing hepatitis vaccinations or other outbreak control/prevention activity | People presenting to sexual health services with STIs, or with high-risk behaviours or vulnerabilities, need access to effective evidence based secondary prevention interventions. Partner notification is also a key plank of STI management, not only to treat infected partners but to prevent further transmission.<br><br>This Quality Standard therefore provides an important opportunity to highlight how sexual health services are ideally placed to effectively address the key determinants of health in many marginalised populations. This could incorporate providing screening, signposting and if appropriate, support for smoking cessation, mental health disorders, obesity, drug and alcohol misuse issues, alongside support for those identified at risk of sexual ill-health or unwanted pregnancy.<br><br>Encouraging the delivery of effective secondary prevention services, including supporting increased HIV testing across the broader pathway, will also ensure GUM services are more ‘joined-up’ with other parts of the pathway, helping to address the increased fragmentation that has come about as a result of the diffused existing commissioning structure. | |

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| | | | including meningococcal vaccination.<br><br>It should also incorporate providing care for the prison and youth detention population, who often struggle to secure access to the STI care they need.<br><br>Alongside this, sexual health services are well-placed to augment other prevention-based initiatives, including providing support for existing cervical cytology screening programmes, offering STI care for HIV populations and delivering vaccination at clinics post-presentation.<br><br>Services also provide important leadership, training and referral support in other areas, including for Emergency Departments, Acute Admission Units and GP practices involved in the delivery of NICE Guideline 60 HIV testing: increasing uptake among people who may have undiagnosed HIV.1 | The Quality Standard should also promote the importance of ensuring that staff involved in the delivery of secondary prevention services receive appropriate and ongoing training. | |

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| 037 | SCM3 | Key area for quality improvement 1 Partner Notification for STIs and HIV | Improved PN outcomes can facilitate individual and public health outcomes relating to STIs by facilitating earlier diagnosis, linkage to care and reducing risk of ongoing or incident infection. | National audits of PN outcomes for HIV and specific STIs are led by the National Audit Group at the British Association for Sexual Health and HIV.<br><br>The National Chlamydia Screening Programme also audits chlamydia PN outcomes for those tested within the programme. The NCSP 2015 and 2017 audits showed that 92% (2015) and 94% (2017) of patients had a PN discussion documents (target 97%) that 0.53 (2015) and 0.42 (2017) contacts per index case attended within four weeks of the date of discussion (target 0.6) and that 0.29 (not included in 2017 audit) contacts per index with verified attendance within four weeks of discussion (target 0.4).<br><br>There are multiple challenges with recording PN outcomes and which measures to use. However, there is agreement that PN is essential and cost effectiveness data suggests that improving PN outcomes is more cost effective than increasing testing coverage.<br><br>Therefore, agreeing what PN standards should look like and for which STI may be challenging within the work that NICE is setting out to do but I think it should be | https://www.gov.uk/government/publications/national-chlamydia-screening-programme-audit-report<br><br>https://www.bashh.org/bashh-groups/national-audit-group/<br><br>https://www.bashhguidelines.org/media/1070/hiv_partner_notification_standards_2015.pdf<br><br>http://ssha.info/wp-content/uploads/ssha-guidance-on-partner-notification-aug-2015.pdf<br><br>http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=12007008073 |

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| | | | | considered. | |
| 038 | SCM4 | Key area for quality improvement 1<br><br>Partner notification | Partner notification is vital in assisting in the control of infection as it offers sexual contacts the opportunity for screening, assessment and treatment and can break the chain of transmission. It can prevent long term complications of infections, reduce reinfections and offer health education opportunities and encourage behaviour change. It is widely included in sexual health standards e.g. MEDFASH standard for the management of sexually transmitted infections and NICE guidance on sexually transmitted infections and under 18 conceptions. | High quality partner notification can be costly and time consuming. The intensity of PN activity may vary considerably between settings, ranging from brief advice only to a more complex labour intensive process involving in-depth interactive interviews, recording partner details, provider referrals, follow-up interviews to check progress and verifying partner attendance. Intensive approaches are more effective.<br><br>There is variability in PN along a range of factors, Partner notification completion appears to be substantially higher for regular sexual partners than ex-regular or known casual ones. | Partner notification for sexually transmitted infections in the modern world: a practitioner perspective on challenges and opportunities http://sti.bmj.com/content/87/Suppl_2/ii34<br><br>McClean H, Carne CA, Sullivan AK, Radcliffe KW, Ahmed-Jushuf I; National Audit Group of British Association for Sexual Health and HIV. Chlamydial partner notification in the British Association for Sexual Health and HIV (BASHH) 2011 UK national audit against the BASHH Medical Foundation for AIDS and Sexual Health Sexually Transmitted Infections Management Standards. Int J STD AIDS. 2012 Oct;23(10):748-52 Herzog SA, McClean H, Carne CA, Low |

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| | | | | | N. Variation in partner notification outcomes for chlamydia in UK genitourinary medicine clinics: multilevel study. Sex Transm Infect. 2011 Aug;87(5):420-5 |
| **4.5 Condom distribution schemes** | | | | | |
| 039 | The Faculty of Sexual and Reproductive Healthcare (FSRH) | Key area for quality improvement 4 Condom schemes/free condoms | Reduces STI but budget cuts have impacted on availability of free condoms | Public Health England. Sexual Health, Reproductive Health and HIV A Review of Commissioning 2017<br><br>NICE guideline: Sexually transmitted infections: condom distribution schemes | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640578/Sexual_health_reproductive_health_and_HIV_a_survey_of_commissioning.pdf<br><br>https://www.nice.org.uk/guidance/ng68 |
| 040 | Royal College of Nursing | Key area for quality improvement 1 Contraceptive services for Under 25s | · NICE guidelines supports the provision of information and advice on all types of contraception to help young men and women choose the method that best suits their individual needs and lifestyle. Thereby making it more likely that they will use contraception and use it effectively. | Healthcare professionals must be able to provide the most effective methods of contraception on demand, where clinically appropriate without needing further appointments.<br><br>The services that is provided should meet the needs of under 25s and to ensure that we reach them and meet their needs. We should provide/use communication systems and channels that these young people are | Contraceptive services for under 25s (2014) NICE guideline PH51.<br><br>Long-acting reversible contraception (2014) NICE guideline CG30 |

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| | | | There is currently variation in clinical practice in how sexual health provision is made available to young people. It is therefore important that provision is consistent and standardised across board. We suggest that:<br>Services provide LARC fitting and fitting of IUDs for emergency contraception at walk-in centres.<br>There is daily walk-in access including out of hours services for provision of contraception and emergency contraception<br>Ensure services are accessible at weekends.<br>Under 25s have facility to book appointments via text or online<br>Patient information leaflets are issued to the patients' phone. | used to for example sending information to them via text etc. | |
| 041 | SCM4 | Key area for quality improvement 5<br><br>Provision of both multicomponent and single component condom schemes | NICE guidance on condom distribution schemes recommends providing a range of condom schemes to meet the needs of different local populations. | There is variability across the country in commissioning condom distribution schemes and it appears that the minority of areas commission both single and multicomponent schemes. PHE carried out a recent survey of sexual health commissioners, it is not clear whether some areas of the county have multicomponent schemes and there are areas of the county with no spend on single component schemes. Single component schemes are | PHE report on condom distribution schemes in England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/666306/Condom_Distribution_Schemes_in_England_2015.pdf |

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| | | | | less likely to be provided, however they target different groups of people. | |
| 042 | SCM5 | 5 - access to prevention eg male/female #condoms +/- #PrEP | | | |
| 043 | Association of Directors of Public Health | 2. Barriers to condom use | | | |
| 044 | SCM1 | Key area for quality improvement 5 | Condom schemes/free condoms | Budget cuts have caused several schemes to close | NICE guideline: Sexually transmitted infections: condom distribution schemes |
| **4.6 Additional areas** | | | | | |
| 045 | British Association for Sexual Health and HIV (BASHH) | Key area for quality improvement 5: Robust and coherent provision of online service elements | Recent years have seen a significant increase in the availability and use of online sexual health service elements.<br><br>Whilst online sexual health platforms can represent an innovative means of providing sexual health care to a local population and should be seen as an increasingly important aspect of the 'blend' of available promotion and testing services, it is important to ensure that they are underpinned by robust, evidence-based guidance and do | The Quality Standard should emphasise the need to have in place a local strategy to support effective online sexual health service elements.<br><br>It is important that this recognises population groups who are less suitable for online testing and instead require 'in person' appointments.<br><br>It should also take into account people who do not fully engage with online services, such as those who request testing kits but do not return them, or those who test positive for a STI but do not then present within a clinic for treatment. | |

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| | | | not jeopardise timely access to care.<br><br>Individuals with limited digital literacy or those unable to easily access digital platforms may for instance fail to get access to their required testing needs and they could be inappropriately triaged when physical service elements move over to an online sphere.1 Online testing will also not be suitable for all asymptomatic patients, particularly those identified as being from high-risk populations.<br><br>In light of the recent closure of a number of physical 'in person' sexual health services, online sexual health care will likely become an increasingly relevant means of addressing the growing demand for access to testing. It is hugely important therefore to ensure that clear and well-defined mechanisms are in place within a local area to support online sexual health service elements and to address the risks outline above. | The management of these patients can require significantly more work for a service and it is important that well-defined processes are in place locally to ensure that the necessary functions are delivered for patients.<br><br>The Quality Standard should also recognise the importance of ensuring that staff receive appropriate and ongoing training to support the delivery of these services. | |

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| 046 | The Faculty of Sexual and Reproductive Healthcare (FSRH) | Key area for quality improvement 1: Online/Remote provision of STI diagnosis and management | People like to access health care online, speeds up the process more acceptable for some groups of people- but some providers not adhering to best practice. | There is variable quality of provision as shown through CQC inspections- best practice not being adhered to. | CQC report summary http://www.cqc.org.uk/sites/default/files/new_reports/AAAG4530.pdf<br><br>http://www.cqc.org.uk/location/1-2861459913<br><br>http://www.cqc.org.uk/sites/default/files/20180322_state-of-care-independent-online-primary-health-services.pdf |
| 047 | The Faculty of Sexual and Reproductive Healthcare (FSRH) | Key area for quality improvement 3 Provision of PrEP | Reduces transmission risk among high risk groups- currently inequitable provision across the UK. | See BASHH PrEP paper – The Current State of Play. December 2017. | https://www.bashh.org/news/blogging-4-bashh/prep-the-current-state-of-play/ |
| 048 | The Faculty of Sexual and Reproductive Healthcare (FSRH) | Key area for quality improvement 5 Home termination/MTOP | Current provision of TOP services is not equitable across the UK | Unevenness stemming from variations in legislation is the subject of much research and publication. See, for instance, Brook, Abortion Law in the UK.<br><br>This is further evidenced by the recent decision of the Scottish government to allow women to take the drug Misoprostol outside of a clinical setting and the decision of the Welsh Health Sectary to start work immediately on how the Welsh government can amend the legal framework to allow for | https://www.brook.org.uk/our-work/abortion-law<br><br>https://www.fsrh.org/news/abortion--improvement-to-existing-services-women-in-scotland/<br><br>https://gov.wales/newsroom/health-and-social-services/2018/sexual-health/?lang=en |

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| | | | | Misoprostol to be taken by women outside of a clinical setting. Other nations within the UK have not made such movements. | |
| 049 | The Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit | Key area for quality improvement 3 Pathways and protocols for management of gonorrhoea must incorporate systematic monitoring for gonococcal antimicrobial resistance | There is significant emerging resistance in the UK of N. gonorrhoeae to antimicrobials | Awaiting BASHH 2018 guideline on Gonorrhoea | |
| 050 | Royal College of Pathologists | Laboratory investigation of antimicrobial resistance of clinical isolates of Neisseria gonorrhoeae using minimum inhibitory concentration (MIC) testing | The emergence of multi-resistant strains of Neisseria gonorrhoeae has become a significant problem over the last five years (ref 1). Pan-resistant strains are now being reported. Resistance threatens the effective treatment of infections due to N gonorrhoeae. Increasing MICs to key antibiotics prefigure established resistance (ref 2). | A variety of disc diffusion methods have been published for susceptibility testing of N gonorrhoeae.(ref 3). These provide a dichotomous result (resistant/sensitive). However, this method does not detect small increases in MIC that are still classed as sensitive and so do not provide an early warning of an impending problem. EUCAST methodology is now the preferred method in Europe (ref 4). EUCAST does not publish a disc diffusion method but instead recommends MIC testing. However, this approach is not yet standard in the UK for N gonorrhoeae susceptibility testing. Laboratories undertaking GUM work should provide MIC sensitivity testing instead of disc diffusion testing | 1. Clifton S et al. Prevalence of and factors associated with MDR Neisseria gonorrhoeae in England and Wales between 2004 and 2015: analysis of annual cross-sectional surveillance surveys. Journal of Antimicrobial Chemotherapy, Volume 73, Issue 4, 1 April 2018, Pages 923–932 Town K et al. Drifting towards ceftriaxone treatment failure in gonorrhoea: risk factor analysis of data from the |

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| | | | | | Gonococcal Resistance to Antimicrobials Surveillance Programme in England and Wales.Sex Transm Infect 2017; 93: 39–45 http://bsac.org.uk/wp-content/uploads/2014/06/Neisseria-gonorrhoeae.pdf http://www.eucast.org/clinical_breakpoints/ |
| 051 | SCM3 | Key area for quality improvement 2<br>Vaccination for HBV and HPV | Hepatitis B virus (HBV) and Human Papilloma Virus (HPV) are sexually acquired and can cause significant mortality and morbidity. They are also causes of vaccine preventable cancers. Delivery of these vaccines to key populations can help to reduce disease associated with these viruses. | Variable coverage of HBV vaccination among key populations in GUM clinics. A quality standard could help to support better coverage (although recent issues with supply chains).<br><br>HPV vaccination already widespread in school aged girls but recently been delivered to MSM under the age of 46 in GUM clinics. I am not aware of the coverage figures within the pilot but feel a standard could support delivery. | http://sti.bmj.com/content/92/Suppl_1/A99.2 |
| 052 | SCM5 | 1 - good quality #SRE | | | |
| 053 | SCM2 | Key area for quality improvement 3<br><br>Training - Building Public Health Capacity and Workforce Development | Capacity building and workforce development are important instruments in tackling social health inequities by enhancing the capacity and skill mix of other health professionals in delivering sexual health services (for | Sexual Health services can contribute to capacity building and workforce development in order to develop competency amongst involved health professionals and to install institutional measures that are conducive to such efforts. | EuroHealthNet (2014) http://www.health-inequalities.eu/HEALTHEQUITY/EN/tools/capacity_building/ |

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| | | | example GPs, Pharmacists, School Health, Midwives, Health Visitors and other community and voluntary organisations on a range of services including EHC, chlamydia screening, condom distribution and brief intervention.<br><br>This encompasses not only providing skills and awareness, but also creating channels, by means of policy, partnerships and leadership, through which this learning can be transferred into sustainable action . | This will enable and contribute towards wider workforce development for the health, education and social care economy that facilitates earlier intervention and reducing risk taking behaviours. | |
| 054 | Association of Directors of Public Health | 5. Effectiveness of social media health promotion | | | |
| 055 | SCM1 | Key area for quality improvement 1 | Online/Remote provision of STI diagnosis and management | Currently, the standards are variable. There is a need for consistent standards as applicable to face to face consultations | CQC report summary http://www.cqc.org.uk/sites/default/files/new_reports/AAAG4530.pdf<br><br>http://www.cqc.org.uk/location/1-2861459913<br><br>http://www.cqc.org.uk/sites/default/files/20180322_state-of-care-independent-online-primary-health- |

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| | | | | | services.pdf |
| 056 | SCM1 | Key area for quality improvement 3 | Pathways and protocols for management of gonorrhoea must incorporate systematic monitoring for NG antimicrobial resistance. | There is significant emerging resistance in the UK of NG to antimicrobials | |
| 057 | SCM1 | Key area for quality improvement 4 | Provision of PrEP | Currently inequitable provision across the UK. Good evidence of reduced transmission risk among high risk groups | BASHH PrEP guideline 2016 |
| 058 | PHE | Chlamydia testing of 15-24 years olds | The National chlamydia screening programme is an England wide STI control programme which aims to prevent the harms of infection and to reduce transmission. Currently it identifies over 125k infections a year but delivery is varied across England. | Data collected by Public Health England shows that chlamydia screening delivery varies widely across the country. The variation is not based on local prevalence or difference in need. | NCSP annual data tables show wide variation in testing coverage and diagnoses.<br><br>https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp |
| 059 | PHE | Ensuring complete HPV and HBV vaccination of eligible MSM attending Sexual Health Clinic | Risk of long-term harms from both infections | Effective interventions (long-standing evidence for HBV vaccination and new evidence from pilot study about efficacy of HPV) are available – but concerns re systematic / consistent delivery. | https://www.gov.uk/government/collections/hpv-vaccination-for-men-who-have-sex-with-men-msm-programme<br>This includes the guidance for health professionals which also mentions (very briefly) Hep B vaccination in the section on concomitant vaccination (also links to the Green |

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| | | | | | Book)<br><br>The page for the pilot is here: https://www.gov.uk/government/publications/hpv-vaccination-pilot-for-men-who-have-sex-with-men-msm<br>and the results of the pilot here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/678987/HPV_msm_year1_evaluation_report.pdf<br><br>The Green Book (Immunisation against Infectious Disease) Chapter on Hepatitis B includes recommendations re MSM https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18 |
| 060 | PHE | Cervical cancer screening in secondary care services (i.e. Sexual | Sexual health clinics providing cervical screening ensures opportunities to screen those who | Fragmented commissioning responsibilities (post-2012 Health & Social Care Act) have led to the offer of screening in SH clinics | Details of commissioning arrangements for sexual health |

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| | | Health Clinics) | may not engage with 'traditional screening' arrangements and as such be more vulnerable | being variable across the country and decreasing uptake of screening in general | https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services<br><br>Health Matters on cervical screening<br><br>https://publichealthmatters.blog.gov.uk/2017/09/20/health-matters-your-questions-on-cervical-screening/ |
| 061 | PHE | Using sexual health promotion campaigns to raise awareness in non-traditional / not previously targeted groups (e.g. older heterosexuals, trans, undisclosed MSM) | Sexual Health Promotion campaigns serve to bridge communication among a diverse range of users, in various geographic and social contexts. They help provide anonymity and confidentiality in communication about prevention and treatment of HIV and other STIs<br><br>Changing epidemiology of some STIs (syphilis, gonorrhoea) and current trends on HIV transmission mean that there is a potential to expand SH prevention messages to new communities at-risk without | The evaluation of the HIV prevention programme for most at-risk communities (MSM and Black Africans) has shown that sexual health promotion campaigns have an impact on i) improving knowledge in target groups ii) reappraise accessibility and acceptability of HIV testing iii) self-efficacy and motivation to test iv) motivation to take other actions<br><br>Further information is needed to understand if this impact can be translated into non-traditional communities. | Evaluation of health promotion campaign for the national HIV prevention programme for most-at risk communities |

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| | | | disinvesting on current approaches | | |