# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# Sexual health

# NICE quality standard

## Draft for consultation

22 August 2018

**This quality standard covers** sexual health across the life course with a focus on reducing sexually transmitted infections (STIs). It describes high-quality care in priority areas for improvement. It does not cover harmful sexual behaviour or contraception for the prevention of conception.

**It is for** commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 22 August to 20 September 2018). The final quality standard is expected to publish in February 2019.

## Quality statements

Statement 1 People are asked about their sexual history at key points of contact.

Statement 2 People identified at risk of sexually transmitted infections have a discussion about prevention and testing.

Statement 3 People who contact a sexual health service for an appointment are seen within 48 hours.

Statement 4 Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

Statement 5 People diagnosed with a sexually transmitted infection are supported to notify their partners.

Quality standards that should be considered when commissioning or providing sexual health services include:

- HIV testing: encouraging uptake (2017) NICE quality standard 157
- Physical health of people in prisons (2017) NICE quality standard 156
- Community engagement: improving health and wellbeing (2017) NICE quality standard 148
- Contraception (2016) NICE quality standard 129
- Hepatitis B (2014) NICE quality standard 65

A full list of NICE quality standards is available from the quality standards topic library.

# Questions for consultation

## *Questions about the quality standard*

**Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?

**Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

**Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

## *Local practice case studies*

**Question 4** Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

# Quality statement 1: Asking people about their sexual history

## *Quality statement*

People are asked about their sexual history at key points of contact.

## *Rationale*

Asking people about their sexual history enables healthcare professionals to identify the sexual health needs of individuals. Identifying people's needs and whether they are at high risk of sexually transmitted infections (STIs) ensures that they are provided with information on sexual health services and can help reduce risk-taking. It can also help local services understand the needs of their populations.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that people are asked about their sexual history to identify their sexual health needs.

***Data source:*** Local data collection such as service protocols.

### Process

Proportion of people who are asked about their sexual history at key points of contact

Numerator – the number in the denominator who are asked about their sexual history.

Denominator – the number of people attending a key point of contact.

***Data source:*** Local data collection. Recording that a discussion has taken place could form part of an electronic health record.

### Outcome

a) Uptake of tests for STIs.

***Data source:*** Local data collection. The proportion of young people screened for chlamydia and uptake of HIV testing is collected as part of Public Health England's Sexual and reproductive health profiles.

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, contraceptive services, genito-urinary medicine clinics and community health services) ensure that support is in place for people to be asked about their sexual history at key points of contact.

**Healthcare professionals** (such as GPs, midwives, practice nurses and doctors who work in sexual health services) ask people about their sexual history to identify their risk of STIs.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that identify people at risk of STIs by asking people about their sexual history at key points of contact.

**People who visit a healthcare service for contraception, pregnancy advice, abortion, a cervical smear test or travel immunisation** are asked about their sexual history, for example the gender of their last partner and their use of condoms.

## *Source guidance*

Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3, recommendation 1.

## *Definitions of terms used in this quality statement*

### Key points of contact

Key points of contact can be consultations on contraception, pregnancy (including planning a pregnancy) or abortion, when carrying out a cervical smear test, offering an STI test, or when providing travel immunisation [NICE's guideline on Sexually transmitted infections and under-18 conceptions: prevention, recommendation 1].

### Asking about sexual history

All people should be asked about:

- the gender of sex 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.

[Adapted from the British Association of Sexual Health and HIV guideline on UK national guideline for consultations requiring sexual history taking, recommendation 3.3.1]

## *Equality and diversity considerations*

When asking people about their sexually history be aware that people may have additional needs such as physical, sensory or learning disabilities, and that they (including families and carers) may not speak or read English or have reduced literacy skills. People should have access to an interpreter or advocate if needed.

Vulnerable young people and individuals who engage in some sexual behaviours may be less likely to attend primary care or community health services on a regular basis. Less traditional settings need to be considered for the provision of sexual health services for these people. Education, training, employment and youth services play an important role in pointing young people to sexual health services.

# Quality statement 2: Discussing prevention and testing with people at risk of sexually transmitted infections

## *Quality statement*

People identified at risk of sexually transmitted infections have a discussion about prevention and testing.

## *Rationale*

Discussing how to prevent and be tested for sexually transmitted infections (STIs) can increase opportunities for testing and harm reduction. A structured discussion can help identify and reduce behaviours that put a person at risk of STIs.

## *Quality measures*

### Structure

a) Evidence of local arrangements of signposting to sexual health services for people at risk of STIs.

***Data source:*** Local data collection, such as service protocols.

b) Evidence of local arrangements to ensure that trained healthcare professionals are available to discuss behaviour change with people at risk of STIs.

***Data source:*** Local data collection, such as service protocols.

### Process

Proportion of people identified at risk of STIs who have a discussion about prevention and testing.

Numerator – the number in the denominator who have a discussion about prevention and testing.

Denominator – the number of people identified at risk of STIs.

***Data source:*** Local data collection. Recording that a discussion has taken place could form part of an electronic health record.

**Outcome**

a) Uptake of tests for STIs.

***Data source:*** Local data collection. Data on the proportion of young people screened for chlamydia and uptake of HIV testing are collected as part of Public Health England's Sexual and reproductive health profiles.

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, contraceptive services, genito-urinary medicine clinics and community health services) ensure that they have healthcare professionals trained in sexual health who discuss prevention of and testing for STIs with people who are at risk.

**Healthcare professionals** (such as GPs, midwives, practice nurses and doctors who work in sexual health services) have one-to-one structured discussions with people at risk of STIs about how they can reduce their risk and how to be tested.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission a range of services that provide information on the prevention of, and signpost testing for, STIs.

**People who are at risk of getting an STI (sexually transmitted infection)** have a discussion with their healthcare professional about how to prevent STIs. They should also be given information about how to get tested for STIs.

## *Source guidance*

Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3, recommendations 2 and 5.

## *Definitions of terms used in this quality statement*

### Discussion about prevention and testing

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 to 20 minutes. The number of sessions will depend on individual need. [NICE's guideline on sexually transmitted infections and under-18 conceptions: prevention, recommendation 2].

### People at risk of sexually transmitted infections

This includes the following key groups and behaviours:

- men who have sex with men
- people who have come from or who have visited areas of high HIV prevalence
- people who misuse alcohol and/or substances
- people who have early onset of sexual activity
- people who have condomless sex and frequently change and/or have multiple sexual partners.

[NICE's guideline on Sexually transmitted infections and under-18 conceptions: prevention, recommendation 2]

## *Equality and diversity considerations*

A discussion about prevention and testing for sexually transmitted infections should be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people (including families and carers) who do not speak or read English or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

Vulnerable young people and individuals who engage in some sexual behaviours may be less likely to attend primary care or community health services on a regular

basis. Less traditional settings need to be considered for the provision of sexual health services for these people. Education, training, employment and youth services play an important role in pointing young people to sexual health services.

# Quality statement 3: Access to sexual health services

## *Quality statement*

People who contact a sexual health service for an appointment are seen within 48 hours.

## *Rationale*

Prompt access to sexual health services reduces the likelihood of onward transmission of sexually transmitted infections (STIs) and ensures that tests and interventions can be provided to reduce health complications.

## *Quality measures*

### Structure

Evidence of local arrangements to ensure that people can access a sexual health service within 48 hours of contact.

***Data source:*** Contained in the Department of Health and Social Care's Integrated Sexual Health Services: A Suggested National Service Specification.

### Process

Proportion of contacts for an appointment with a sexual health service that take place within 48 hours.

Numerator – the number in the denominator that take place within 48 hours.

Denominator – the number of contacts for an appointment with a sexual health service.

***Data source:*** Contained in the Department of Health and Social Care's Integrated sexual health services: national service specification

### Outcome

a) Uptake of tests for STIs.

***Data source:*** Local data collection. Data on the proportion of young people screened for chlamydia and uptake of HIV testing are collected as part of Public Health England's Sexual and reproductive health profiles.

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

## *What the quality statement means for different audiences*

**Service providers** (sexual health services) ensure that they provide appointments for people who have contacted them within 48 hours of the initial contact being made.

**Healthcare professionals who work in sexual health services** offer appointments within 48 hours of people contacting them.

**Commissioners** (local authorities) commission sexual health services that can provide appointments within 48 hours of first contact.

**People who contact a sexual health service** are offered an appointment to take place within 48 hours.

## *Source guidance*

- Contraceptive services for under 25s (2007) NICE guideline PH51, recommendation 3
- Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3, recommendation 4
- Access to sexual health services within 48 hours is highlighted within Department of Health and Social Care's Integrated Sexual Health Services: A Suggested National Service Specification.

## *Definitions of terms used in this quality statement*

**Sexual health services**

Sexual health services include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).

[NICE's guideline on Sexually transmitted infections and under-18 conceptions: prevention, recommendation 4].

The service should be delivered in accordance with the level 1, 2 and 3 service model. It does not include self-managed care such as home remote sampling and test kits accessed via online services.

[Department of Health and Social Care's Integrated Sexual Health Services: A Suggested National Service Specification].

## *Equality and diversity considerations*

Services should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people (including families and carers) who do not speak or read English or who have reduced literacy skills can contact services to make appointments. People should have access to an interpreter or advocate if needed.

# Quality statement 4: Repeat testing for sexually transmitted infections

## *Quality statement*

Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

## *Rationale*

Men who have sex with men, whose behaviours increase the risk of sexual transmitted infections (STIs), are more likely to test positive for an STI within 1 year. Repeating tests for STIs every 3 months will ensure that diagnosis is made as soon as possible and further transmission of STIs can be avoided.

## *Quality measures*

### Structure

a) Evidence of local arrangements for STI repeat testing every 3 months.

***Data source:*** Local data collection, such as service protocols.

b) Evidence of local arrangements to encourage men who have sex with men whose behaviour increases their risk to repeat STI tests.

***Data source:*** Local data collection, such as service protocols.

### Process

Proportion of men who have sex with men who have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

Numerator – the number in the denominator who have repeat testing every 3 months.

Denominator – the number of men who have sex at increased risk of sexually transmitted infections.

***Data source:*** Local data collection. Data on the proportion of young people screened for chlamydia and uptake of HIV testing are collected as part of Public Health England's Sexual and reproductive health profiles.

**Outcome**

a) Uptake of tests for STIs.

***Data source:*** Local data collection. Data on the proportion of young people screened for chlamydia and uptake of HIV testing are collected as part of Public Health England's Sexual and reproductive health profiles.

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

***Data source:*** These data are collected as part of Public Health England's Sexual and reproductive health profiles.

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, genito-urinary medicine clinics and community health services) offer repeat STI testing for men at highest risk of STIs every 3 months. They also ensure that recall reminders are sent to improve re-attendance rates.

**Healthcare professionals** (such as GPs and practice nurses and sexual health consultants) offer men at highest risk of STIs repeat appointments for STI testing every 3 months.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that arrange repeat appointments for STI testing every 3 months for men at highest risk of STIs.

**Men who have sex with men who have a high risk of getting an STI (sexually transmitted infection)** have STI testing every 3 months.

## *Source guidance*

- British Association of Sexual Health and HIV (2016) United Kingdom national guideline on the sexual health care of men who have sex with men recommendations on STI and HIV testing.

## *Definitions of terms used in this quality statement*

**Men who have sex with men at increased risk of sexually transmitted infections**

Three-monthly STI testing should be available for men who have sex with men, who have:

- condomless anal intercourse with partner(s) of unknown or serodiscordant HIV status over last 12 months.
- over 10 sexual partners, over last 12 months.
- drug use (methamphetamine, inhaled nitrites) during sex over last six months.
- drug use (gamma-butyrolactone (GBL), ketamine, other novel psychoactive substances during sex over last six months)
- multiple or anonymous partners since last tested.
- any condomless sexual contact (oral, genital or anal) with a new partner since last tested.

[Adapted from the British Association of Sexual Health and HIV guideline on United Kingdom national guideline on the sexual health care of men who have sex with men recommendations on STI and HIV testing.]

# Quality statement 5: Partner notification

## *Quality statement*

People diagnosed with a sexually transmitted infection are supported to notify their partners.

## *Rationale*

Supporting people who have been diagnosed with a sexually transmitted infection (STI) to notify their partners can help to reduce the transmission of STIs. It can also ensure that their partners are tested, and if necessary treated, as soon as possible to prevent health complications.

## *Quality measures*

### Structure

a) Evidence of local arrangements for partner notification to be discussed with people diagnosed with STIs.

***Data source:*** Contained in the Department of Health and Social Care's Integrated sexual health services: national service specification.

b) Evidence of local arrangements for partner notification support to be provided for people diagnosed with STIs.

***Data source:*** Contained in the Department of Health and Social Care's Integrated sexual health services: national service specification.

### Process

Proportion of people diagnosed with an STI who have partner notification initiated.

Numerator – the number in the denominator who have partner notification initiated.

Denominator – the number of people diagnosed with an STI.

***Data source:*** Local data collection. Public Health England's GUMCAD STI surveillance system collects data on partner notification being initiated.

**Outcome**

a) Uptake of tests for STIs.

***Data source:*** Local data collection. Data on the proportion of young people screened for chlamydia and uptake of HIV testing are collected as part of Public Health England's Sexual and reproductive health profiles.

b) Number of people presenting as a partner of an index case diagnosed with a STI.

***Data source:*** Local data collection. Public Health England's GUMCAD STI surveillance system collects data on people presenting as a partner of a person identified as having an index case of chlamydia, gonorrhoea, HIV or non-specific genital infection.

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, genito-urinary medicine clinics and community health services) ensure that systems are in place for discussions about partner notification to take place when people are diagnosed with an STI. Systems are also in place to support people to notify their partners.

**Healthcare professionals** (such as GPs, practice nurses and sexual health consultants) support people diagnosed with an STI to notify their partners. Partner notification may be undertaken by the healthcare professional or the person diagnosed with an STI.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that have partner notification within their services for people who are diagnosed with an STI.

**People diagnosed with an STI (sexually transmitted infection)** are given encouragement and support from a healthcare professional to tell their partners about the STI.

## *Source guidance*

Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3, recommendation 3.

## *Definitions of terms used in this quality statement*

**Support to notify their partners**

Support to contact, test and treat partners of people diagnosed with an STI. This support should be tailored to meet the individual's needs and if necessary people should be referred to a specialist with responsibility for partner notification. Partner notification may be undertaken by the healthcare professional or the person diagnosed with an STI.

[NICE's guideline on Sexually transmitted infections and under-18 conceptions: prevention recommendation 3].

## *Equality and diversity considerations*

Services to support people to notify their partners about an STI should be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people (including families and carers) who do not speak or read English or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See quality standard advisory committees on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage .

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## *Improving outcomes*

This quality standard is expected to contribute to improvements in the following outcomes:

- incidence of sexually transmitted infections
- earlier diagnoses of sexually transmitted infections
- use of condoms
- peoples experience of using sexual health services

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for England.

## *Resource impact*

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

- costing report and template for the NICE guideline on Contraceptive services for under 25s.
- implementation advice for the NICE guideline on Sexually transmitted infections and under-18 conceptions: prevention
- resource impact report and template for the NICE guideline on Sexually transmitted infections: condom distribution schemes.

## *Diversity, equality and language*

During the development of this quality standard, equality issues were considered and equality assessments are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: