NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Sexual health

Date of quality standards advisory committee post-consultation meeting:
17 October 2018

2 Introduction

The draft quality standard for sexual health was made available on the NICE website for a 4-week public consultation period between 22 August and 20 September 2018. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 20 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

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.

4. Do you have an example from practice of implementing the NICE guidelines that underpin this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- There was general support for the quality standard and the areas identified for quality improvement.
- There was some concern, however, that the broad title could cause confusion - it was suggested that the title should be changed to focus on sexually transmitted infections.
- There was concern that some of the quality statements may be unrealistic for primary care.
- How will the quality standard reflect any changes to the mandate which is currently under review and any outcomes from the House of Commons Health and Social Care Committee: Inquiry on sexual health consultation?
- More emphasis on LGBTQ equality considerations is needed including training for front line staff.
- It would be preferable to reference the original source guidelines (BASHH/FSRH) rather than the Department of Health and Social Care national service specification for integrated sexual health services.
- Add ‘and lubricants’ to the overall outcome for ‘use of condoms’.

Consultation comments on data collection

- The quality standard should reflect the significant differences in reporting and data collection between sexual and reproductive health services and primary care. Primary care may require investment in IT to standardise data collection.
- Data collection can be challenging if it is necessary to track people across providers as there are no common identifiers.
- More detail on measuring the uptake of tests for STI’s is needed e.g. should it be among people at high rather than low risk?
- There was a concern that referencing the GUMCAD STI surveillance system and Public Health England’s Sexual and Reproductive Health profile datasets will

mean the quality standard becomes outdated as the datasets are due to be refreshed.

Consultation comments on resource impact

- There were concerns about the resource impact of 4 out of the 5 statements given the impact of significant cuts to sexual health budgets and increasing demand in recent years.
- It was suggested that online sexual health services can help to manage demand within the resources available.
- There were concerns about current fragmented commissioning arrangements for sexual health which may impact on implementation of the quality standard.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Rationale
  - The terminology ‘at high risk of STIs’ may need to be reviewed.
- Measures
  - It should be feasible to collect the data although not all services will have existing systems in place.
  - The discussion about sexual history will need to be recorded.
  - It is not clear what the expected impact is on new STI diagnoses and chlamydia detection rate – it could go up, down or stay the same and it may not be obvious what the cause is.
  - It would also be useful to measure the chlamydia detection rate per number of tests.
- Audience descriptors
  - Should suggest that implementation aids (such as online or paper self-completion checklists) and training could help to normalise the introduction of sexual history and testing into routine consultations.
  - More emphasis is needed on ensuring discussions about sexual history are handled in a sensitive and supportive manner to ensure people are encouraged to access sexual health care.
  - It would be helpful to emphasise the relevance to primary care, for example, by referencing the Sexual Health in Practice (SHIP) programme’s Rapid Sexual Health Risk Assessment training.
  - Should ‘community services’ be reworded to ‘community sexual health services’?

- Definitions
  - The definition of key points of contact:
    - Should be clearer, particularly for GPs.
    - Could also include new GP registrations, all primary care chronic disease health checks, urology, viral hepatitis clinics, addiction and young people's services.
    - Why are travel clinics included?
  - The definition of sexual history assessment:
    - The elements included are overly detailed for some settings including primary care where time is more limited.
    - Should 'sex partner' be reworded to 'sexual partner'?
    - Additional questions were suggested as follows: sexual difficulties; psychological impact of an STI diagnosis; if sex was consensual; non-injecting drug use.
- Equality and diversity considerations
  - The section on vulnerable/underage young people should ensure safeguarding links are in place.
  - Additional considerations were suggested as follows: human trafficking and modern slavery and what to do if concerns are raised; transgender; how to manage sexual history taking when the person is accompanied.

5.2 Draft statement 2

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement
  - It is not clear if services should have the discussion about prevention and testing when risk is identified or if a referral to a sexual health service is needed.
  - Should emphasise the need for a ‘structured’ discussion.
  - There were concerns about the resource implications of a 15-20 minute discussion and training needs.
- Measures
  - Identifying ‘at risk’ groups is not systematic currently and could be challenging, particularly in primary care. In primary care, people may only be identified as at risk after the advice is given.
  - The discussion about prevention and testing will need to be recorded.
- Audience descriptors
  - Should include online sexual health services and abortion providers.
  - Should signpost to resources to help healthcare professionals deliver these discussions.
  - More information is needed about when a referral to a sexual health service (including online) is appropriate.
  - More emphasis on the importance of joined up commissioning.
- Definitions
  - It was suggested that the definition of people at risk of sexually transmitted infections should be extended to include: young people aged 15-24; people from specific black or minority ethnic groups, gender and sexual minorities (GSM); sex workers; people who have been sexually assaulted.

  - It needs to be clearer that you cannot get an STI just by visiting an area of high prevalence if you do not have any sexual partners.
  - It should be clear that there is also a risk if a person has sex with a partner who is from or has visited an area of high prevalence.
  - Condoms and condom distribution schemes should be included in the discussion about prevention and testing.
- Equality and diversity considerations
  - Should emphasise the need for discussions to be delivered in an age-appropriate manner, respecting the cultural, linguistic, physical and mental health needs of the individual.
  - Should ensure services are accessible at convenient times and locations for young people and others who rely on public transport.

5.3 Draft statement 3

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Statement
  - Although there was some support for the statement, stakeholders suggested it is not appropriate or achievable to focus on all sexual health consultations as some people may not want or need to be seen within 48 hours.
  - It may be more appropriate to focus the statement on STI consultations but even then testing within 48 hours is not always appropriate.
  - It was suggested that, because services have changed significantly since the guidance was published, the statement should focus on ensuring that people who contact a sexual health service are triaged at the point of contact so that people can be seen within 48 hours if they need to be (because they are symptomatic, vulnerable, at high-risk of passing infection on, need post exposure prophylaxis after sexual exposure to HIV (PEPSE) or emergency contraception).
  - Should it be within 48 hours or two working days?
  - The statement is not appropriate for primary care.
  - There were concerns about the achievability and resource impact of this statement.
- Measures
  - The denominator for the process measure could be subject to manipulation if calls are not answered or aborted. It would be more appropriate to focus on attempted contacts.
  - It needs to be clear if access to a walk-in clinic counts as an appointment. If so, should there be a maximum waiting time? Should the measure capture if people are turned away (as per BASHH data collections)? Walk-in may not be convenient for people.

  - How should access to e-services be measured?
  - Consider including a mystery shopper service access indicator.
- Audience descriptors
  - Should include when it may be appropriate to refer people to online triage and testing services (for example, people who are asymptomatic in low risk groups).
- Definitions
  - Sexual health services should include online services and home sampling to reflect current provision.

5.4 Draft statement 4

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement
  - The population should be extended to include all groups at increased risk of STIs, including gender and sexual minorities (GSM).
  - The wording should be 'offer' rather than 'have'.
  - There were concerns about the resource impact of this statement as it will lead to increased demand for sexual health services.
- Measures
  - It may be useful to include a measure on text reminders sent by providers.
- Audience descriptors
  - Repeat testing may not be appropriate for primary care unless it is commissioned by the local authority.
  - Primary care could have a role in sending out reminders.
  - Should ensure online sexual health services are available so that increased demand can be managed effectively.
  - Commissioners should ensure that health promotion messages for higher risk groups identify the need for repeat testing.
- Definitions
  - A definition of repeat testing is needed – it was suggested this could be based on BASHH guidance and should include extragenital as well as genital sites for chlamydia (CT) and gonorrhoea (NG).
  - The definition of men who have sex with men at increased risk of STIs
    - ◊ Should include those who have previously been diagnosed with an STI.
    - ◊ It is not clear why there are 2 separate bullets points on drug use.
    - ◊ Why is the most widely used drug, mephedrone, not included?

5.5 Draft statement 5

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- General
  - More emphasis on the complex nature of partner notification and the need for staff training and resources.
- Measures
  - A measure of the success of partner notification (the number traced and tested) should also be included.
  - The BASHH standards for partner notification may help with additional measures.
  - How should services outside of sexual health services evidence partner notification?
- Audience descriptors
  - Although GPs can support people with self-testing, because of patient confidentiality, they cannot contact partners - the statement is therefore not achievable in primary care.
  - More emphasis on the need for providers and commissioners to review and improve their approach to partner notification.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Online sexual health services – stakeholders indicated that a statement on the availability and accessibility of effective, coherent and robust online sexual health services should be included. It was suggested that this could be based on the joint BASHH/FSRH standards for online and remote providers of sexual and reproductive healthcare services which are expected to publish in December 2018.
- Sexual health needs of older people – stakeholders suggested additional statements are needed to highlight the importance of recognising the sexual health needs of older people and in particular the needs of older people in care homes.
- Access to psychological support for treatment of psychosexual problems and impact of a positive STI diagnosis.
- Minimum standard for STI screening for all groups to include testing for chlamydia (CT), gonorrhoea (NG), syphilis and HIV.
- Management of antimicrobial resistant gonorrhoea (GC).

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Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement Number	Comments[1]
1	British Association for Sexual Health and HIV	General	The British Association for Sexual Health and HIV (BASHH) welcome this consultation on the draft NICE Quality Standard for Sexual Health and is grateful for the opportunity to provide feedback on its contents. Whilst BASHH are broadly supportive of the five proposed individual Quality Statement areas set out within this draft Quality Standard, we have concerns over the proposed focus, structure and supporting information currently underpinning several of these Quality Statements and have set these out below in further detail. We also strongly believe that this Quality Standard needs to include a Quality Statement promoting the availability of effective, coherent and robust online sexual health services in all areas of the country. Recent years have seen a rapid expansion in the number of providers of online sexual health services and whilst provision is currently variable, they represent an increasingly important and accessible element in the blend of available sexual health testing options. Further details on how we recommend this area is incorporated into the final Quality Standard is included within 'comment number 7'.
2	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	General	Title is still inappropriate; the focus of this document is entirely on STI rather than on sexual health more broadly. STI services QS would be a more appropriate title.
3	FPA (Family Planning Association)	General	Sexual Health covers a range of issues. As well as sexually transmitted infections, this includes contraception, conception, pregnancy and sexuality. We recommend this Quality Standard is renamed Quality Standard on Sexually Transmitted Infections, to avoid confusion and more accurately reflect the content.
4	Homerton Sexual Health Services	General	Homerton Sexual Health Services welcomes this consultation into quality standards for sexual health. They relect many key areas for quality improvement.

[1] PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement Number	Comments[1]
			There are a few areas where we wonder whether the proposed data collection meets the objectives in the guidelines
5	MSD UK Ltd	General	MSD thanks NICE for the invitation to comment and believes this quality standard will support progress towards the reduction of sexually transmitted infections. MSD would like to get further clarification as to how this quality standard will incorporate /reflect any changes to the mandate which is currently under review and any outcomes from the House of Commons Health and Social Care Committee: Inquiry on sexual health consultation.
6	Public Health England	General	The document frequently references the Department of Health and Social Care Integrated sexual health services contract specification as the source for the standards. However, this specification refers to the original source of the standards, for example from British Association for Sexual Health & HIV (BASHH) or Faculty of Sexual and Reproductive Healthcare. It would be more appropriate to refer to the original sources from the professional bodies, not the service specification.
7	Royal College of General Practitioners	General	This quality statements nominally recognises primary care services as a key (and major) provider of sexual health services. However the statements themselves seem unrealistic in the context of current primary care These quality standards would improve the identification, management and prevention of STIs. There is a significant difference in the reporting arrangements and data collection within SRH services and within primary care which will make this very difficult for primary care to complete and measure without investment in IT as there are no standardised templates for use between the different EPR systems used. There are no targets for sexual health provision for primary care and the funding and commissioning for level 3 work (MSM and contact tracing) require training of primary care clinicians with funding from PH/LA.
8	Royal College of General Practitioners	General	Improving outcomes section Add to 'use of condoms'… and lubricant (for anal sex)
9	The National LGB&T Partnership	General	For each statement there is an Equality and Diversity Considerations section. These do not mention considerations around LGBTQ equality which is worrying in a document that seeks to engage with MSM on sexual health. There additionally needs to be explicit reference to the additional training that front line staff will need in sensitively addressing LGBTQ issues.
10	University Hospitals Birmingham NHS Foundation Trust	General	Statement 1, 2,4 We do agree with the rationale for these statements. However, it may be difficult to measure the numerator and denominator in local settings (GPs, practice nurses, midwives) currently. This would need to be incorporated into the electronic patient record. As a result, it would also be difficult to measure the uptake of tests for STI's. We support the statements, but think that stronger recommendation regarding the importance of local settings measuring this data is necessary. In addition, more detail regarding the actual outcome measure would be useful.

ID	Stakeholder	Statement Number	Comments[1]
			Consideration could be given to advising that all GP new patient registrations are asked about sexual health issues, STI risk and gender of partners and advised how to test locally. On this note and in line with the NICE HIV testing guidance, an HIV test and STI discussion could be included for all chronic disease health-checks in primary care. It would also help to have implementation aids to support local settings to normalise the introduction of sexual health discussion and testing into routine consultation. Our organisation is delivering training our primary care partners to encourage them to integrate this into practice, but engagement of local contacts is required to implement these standards.
11	Department of Health and Social Care	General	I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation.
12	Royal College of Physicians	General	The RCP endorses the responses submitted by BASHH and BHIVA.
13	Royal College of Paediatrics and Child Health	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft quality standard for Sexual Health. We have not received any responses for this consultation.
14	British Association for Sexual Health and HIV	Question 1	BASHH strongly recommends that a Quality Statement on promoting the availability of effective, coherent and robust online sexual health services in all areas of the country is included within this Quality Standard. Recent years have seen a rapid expansion in the number of providers of online sexual health services and whilst provision is currently variable, they represent an increasingly important and accessible element in the blend of available sexual health testing options. In recognition of the increasing relevance and opportunities presented through online sexual health services, new joint BASHH and FSRH standards promoting and supporting the commissioning and delivery of high-quality online services are due to be published shortly (draft standards are currently released for consultation). BASHH/FSRH-Draft Standards for Online and Remote Providers of Sexual and Reproductive Health Services. A Joint BASHH/FSRH Standard. September 2018. Available online at: https://www.bashhguidelines.org/media/1184/sorp-srhs-final-version-for-public-consultation-20180827_fully-watermarked_030918.pdf Including such a Statement would have a hugely positive impact in terms of encouraging increased access to sexual health testing and would also support services to effectively manage growing demand. It could also be underpinned by the new BASHH and FSRH standards currently out for consultation.

ID	Stakeholder	Statement Number	Comments[1]
			We strongly recommend that the Committee considers how best this area can be incorporated within the final Quality Standard - failure to do so will be a considerable missed opportunity to support earlier diagnoses of STIs and improvements in people's overall experience of using sexual health services across the life course, which are key stated priorities for the Quality Standard. It would also help manage record demand for services and increase the ability to 'futureproof' this area of NICE guidance, in a rapidly changing environment for sexual health service delivery.
15	Edge Hill University	Question 1	Recent research has found that not enough is being done to ensure older people have access to good sexual health care and support. No standards specifically relating to older people have been included in the draft document, the standard therefore does not address sexual health across the life course. 4 standards relating to older people are suggested below. • Care staff to recognize and address the rights of diverse older individuals resident in care homes accommodating older people to express themselves as sexual and/or intimate beings. • Healthcare providers need to recognise that adults over the age of 50 can remain sexually active and have under-recognised sexual healthcare needs. • Older people should have their diverse sexual health and wellbeing needs recognised in the delivery of health service in primary and secondary care and in specialist sexual health services. • Care staff across all care sectors need evidence-based education about the sexual health needs and difficulties that older adults may encounter. The programs of education should take account of the physical, psychological, social, cultural and relationship issues that impact on sexual activities and intimacy. A multidisciplinary 'Age, Sex and Intimacy Forum' has been formed to inform research and practice to improve the sexual health and wellbeing needs of older people. The suggested standards have been designed to ensure age-equality and inclusion in sexual health care. Further information is available as we are happy to work with NICE to further develop standards for older people.
16	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Question 1	We still consider that • STI screening for all groups should include testing for CT, NG, syphilis and HIV as a minimum standard (reflecting the prevalence of undiagnosed HIV amongst e.g. heterosexual men) and • Pathways and protocols for management of GC must incorporate systematic monitoring for gonococcal microbial resistance are extremely important areas of concern.
17	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Question 1	For STI, yes. For Sexual Health as a whole, no. The title really needs to be specific to STI. STI services QS would be a more appropriate title.

ID	Stakeholder	Statement Number	Comments[1]
18	FPA (Family Planning Association)	Question 1	We agree that the draft quality standard reflects key areas for improvement.
19	FPA (Family Planning Association)	Question 1	Online testing represents a clear opportunity to increase uptake of testing for STIs amongst asymptotic individuals from low risk groups. It has clear potential to alleviate pressure on an already overburdened system. Having said this, we are concerned about variable quality and there is a requirement for clear, evidence based guidance and training to ensure standards are maintained. Whilst we note the response to calls for inclusion of online testing in the QS within the briefing paper, given the rapid expansion of online service, we recommend NICE consider future guidance into the quality and availability of tests.
20	Manchester Health and Care Commissioning	Question 1	Recent research has found that not enough is being done to ensure older people have access to good sexual health care and support. No standards specifically relating to older people have been included in the draft document, the standard therefore does not address sexual health across the life course. 4 standards relating to older people are suggested below. • Care staff to recognize and address the rights of diverse older individuals resident in care homes accommodating older people to express themselves as sexual and/or intimate beings. • Healthcare providers need to recognise that adults over the age of 50 can remain sexually active and have under-recognised sexual healthcare needs. • Older people should have their diverse sexual health and wellbeing needs recognised in the delivery of health service in primary and secondary care and in specialist sexual health services. • Care staff across all care sectors need evidence-based education about the sexual health needs and difficulties that older adults may encounter. The programs of education should take account of the physical, psychological, social, cultural and relationship issues that impact on sexual activities and intimacy. A multidisciplinary 'Age, Sex and Intimacy Forum' has been formed to inform research and practice to improve the sexual health and wellbeing needs of older people. The suggested standards have been designed to ensure age-equality and inclusion in sexual health care. Further information is available as we are happy to work with NICE to further develop standards for older people.
21	Manchester Metropolitan University	Question 1	Recent research has found that not enough is being done to ensure older people have access to good sexual health care and support. No standards specifically relating to older people have been included in the draft document, the standard therefore does not address sexual health across the life course. Four standards relating to older people are suggested below.

ID	Stakeholder	Statement Number	Comments[1]
			• Healthcare providers need to recognise that adults over the age of 50 can remain sexually active and have under-recognised sexual healthcare needs. • Older people should have their diverse sexual health and wellbeing needs recognised in the delivery of health service in primary and secondary care and in specialist sexual health services. • Care staff across all care sectors need evidence-based education about the sexual health needs and difficulties that older adults may encounter. The programs of education should take account of the physical, psychological, social, cultural and relationship issues that impact on sexual activities and intimacy. • Care staff to recognize and address the rights of diverse older individuals resident in care homes accommodating older people to express themselves as sexual and/or intimate beings. A multidisciplinary 'Age, Sex and Intimacy Forum' has been formed to inform research and practice to improve the sexual health and wellbeing needs of older people. The suggested standards have been designed to ensure age-equality and inclusion in sexual health care. Further information is available as we are happy to work with NICE to further develop standards for older people.
22	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Question 2	Locally, within specialist services, yes. In primary care, uncertain.
23	Public Health England	Question 2	• The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) measures should be straight forward for people to collect / review. • Measures of 'at risk' groups are more challenging as this is not done in a systematic way. Some clinics flag records, others could pull off lists of higher risk groups but don't routinely flag records and in some cases they would only be able to estimate. This level of information would be even less reliable / complete in primary care. • Data collection of the 'softer' measures such as discussion of sexual history and sexual health risks / prevention are more difficult – protocols would state what 'should be done' but this would need to be validated so services would need to have some way of recording this; this might be relatively straight forward in sexual health clinics but less so in other settings and in these settings (primary care/other medical specialities) it is important to get healthcare professionals to start to think about sexual risks / testing.
24	Faculty of Sexual and Reproductive	Question 3	Statement 3 is not achievable (or appropriate) if it relates to all Sexual Health consultations. It may be more appropriate if it relates to STI consultations, but even then, testing within 48 hours is not always appropriate.

ID	Stakeholder	Statement Number	Comments[1]
	Healthcare Clinical Effectiveness Unit		
25	Public Health England	Question 3	Some statements, such as better use of GUMCAD and adding simple measures to clinical systems to record discussion about sexual history, should be reasonably manageable within current resources but others are more challenging: • The 48 hour access to services may be difficult to achieve (see recent BASHH and Local Government Association coverage in media) There is also an issue about the staff time as a resource to undertake this – and anecdotal reports about loss of health advisor time/capacity, which will be crucial in the risk reduction interventions
26	British Association for Sexual Health and HIV	Statement 1	**Content of Quality Statement** BASHH support the principle of including a Quality Statement that encourages people to be asked about their sexual history at key points of contact. We believe that this Quality Statement can help to normalise conversations about an individual's sexual health, as well as support the identification of those at greater risk of acquiring sexually transmitted infections (STIs) and encourage signposting to appropriate sexual health services where needed. It is important however that the need for these conversations to be handled in a sensitive and supportive manner is emphasised within the wording of this Quality Statement or its supporting '*rationale'* / *'What the quality statement means* for *different audiences'* segments. Failure to approach these discussions in a sensitive manner can inadvertently make individuals less likely to access appropriate sexual health care, particularly those at high-risk of infection or from vulnerable groups. **Local systems and structures and resource implications** It is also unlikely that all the relevant services identified within this Quality Statement currently have local systems in place to collect the data outlined in the proposed quality measure. However, with clear and robust guidance on how to record these conversations, it should be feasible to collect this data and we do not believe that it would be unduly resource-intensive to do so.
27	British HIV Association (BHIVA)	Statement 1	While entirely supportive of the normalisation of sexual health & risk assessment, and broadening the clinical services where this will take place, is there evidence that this will increase uptake? It will be down to primary care, travel vaccination clinics, etc., to advise you of any implications for their services (e.g. recording on electronic records the discussion about sexual health). Considering that in many cases, assuming a sexual health discussion triggers a check-up, that check-up may well take place elsewhere, most likely a sexual health service where it will not be possible to link a primary care-led discussion with a STI clinic-led intervention thus making it difficult to assess the impact.

ID	Stakeholder	Statement Number	Comments[1]
			In terms of measures: 1) uptake of tests for STIs – we would ideally want this to go up but not if all the new tests are in people with minimal risk for on STI 2) new STI diagnoses – what effect would you expect? Could go up if a large number of undiagnosed people are picked up, but would then expect it to go down again as the public health benefits of treatment and partner notification are realised. However, if the additional STI tests are all inappropriately performed in people with no risk for STIs, then number of new diagnoses would not change. Furthermore, if offering more tests further stretches already struggling sexual health services, and people at high risk of STIs experience delay in diagnosis and treatment it is even possible that eventually STI rates will increase 3) Chlamydia detection rate: similar comments to (2). Recent figures show the number of tests have declined so if the denominator used is the whole population of people aged 15–24 then the apparent chlamydia rate will decline – it is therefore important to also look at chlamydia rates using the number of screens performed as the denominator. Additionally we would be interested in the rationale for discussing sexual health at travel clinics? Is there evidence that this is a population at higher risk of STIs? Finally the recommended sexual health assessment is detailed - while this is entirely appropriate where STI screening/counselling can take place, but it may be over detailed in a busy primary care service. Perhaps a self-completion checklist with appropriate signposting may be more efficient.
28	Homerton Sexual Health Services	Statement 1	It is unclear which key points of contact other than sexual health clinics are included. Examples could be:- antenatal , termination of pregnancy, urology, viral hepatitis clinics, travel clinics, addiction services, young people's services. More generic services such as primary care and accident and emergency should have guidelines on when to consider a sexual history. Examples could be:- new patient registration (primary care), when presenting with symptoms potentially suggestive of a sexually transmitted infection, when providing contraception services Many sexual health services use a self-triage system (either paper based or on-line) which asks about the sexual history. Consideration should be given to considering this an adequate sexual history taking if there are processes in place to alert individuals to their sexual health needs and to signpost them or have referral pathways in place to access support. This should be considered as a sexual history

ID	Stakeholder	Statement Number	Comments[1]
			It is unclear how services outside of sexual health will provide a meaningful denominator, as it will be difficult to assess whether a sexual history is indicated without taking a sexual history. The proposed data sources of the proportion of young people screened for chlamydia, uptake of HIV testing, chlamydia detection rate and new STI diagnoses will include those people who have an STI screen, but not those who have a sexual history. Consideration should be given to collecting data outside of sexual health, and not related to STIs alone. This could include contraception prescriptions NHS Prescription Services' Prescribing Database.
29	Institute of psychosexual medicine	Statement 1	Definition - asking about a sexual history A missing key area for quality improvement - there is no reference to asking about sexual difficulties or psychological impact of an STI diagnosis within the section on sexual history.
30	National AIDS Trust	Statement 1	There should be further clarity on primary care being a key point of contact in certain circumstances – GPs are mentioned in the accompanying text for this Statement a couple of times but with less clarity as to when questions on sexual history would be useful in this setting. Such uncertainty will mean it is either never done or done inappropriately. We recommend further discussion with BASHH and RCGP representatives here – of course presentation with possible STI symptoms including HIV indicator conditions will be one but not the only one.
31	NHS England	Statement 1	It may be helpful to include some information about adult slavery/SG and signposting clinicians where to raise concerns.
32	Public Health England	Statement 1	About the list of questions • If the list of questions applies to sexual health setting only, it's fine, but if it applies to all settings, the list of questions needs to be modifiable as not all questions are equally applicable (i.e. in non-sexual health settings, it may be sufficient to know about sexual orientation, number of partners and recent testing / risks) • More questions need to be included about consent and if the sex was consensual. • Some of the terminology may need reviewing, for example 'at high risk of STIs'. • Under 'Equality and diversity considerations': o Add consideration to be given to issues around human trafficking and modern slavery (as sexual health services are a key service for attendance). o No mention of transgender issues o Need to strengthen the need to ensure safeguarding links are in place for any vulnerable/underage young people.
33	Royal College of General Practitioners	Statement 1	Definition - Asking about sexual history (page 6) The Sexual health in Practice SHIP programme has been teaching Rapid Sexual Health Risk Assessment in primary care for over 20 years. They have expertise in understanding the primary care setting with relation to

ID	Stakeholder	Statement Number	Comments[1]
			sexual health care. They have published evidence of effectiveness of this educational intervention (sustained increase in HIV testing rates after attending the training and positivity rates of 1.4%, paper link: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199891 They are currently working on analyses – for the same training dataset – on chlamydia and viral hepatitis. BASHH guidance is not always appropriate for the primary care setting and it is important to distinguish where the differences lie. Otherwise the guideline may not be appropriate for general practice, and therefore will lead to clinicians ignoring the advice within. Regarding the specific advice given about asking people about their sexual history (page 6) it is appreciated that this is based on the BASHH guidance, however some of these statements are not appropriate for the primary care setting. Not all patients who are asked a sexual history and have a rapid sexual health risk assessment in primary care should be asked: - types of sexual contact/site of sexual exposure - relationship with the partner (live-in, regular, casual partner etc.) - whether the partner could be contacted The primary care setting is different to the specialist setting. Often patients are not expecting questions about their sexual history as this may be brought up opportunistically by the clinician. Also time is more limited and it is important not to put clinicians off asking a sexual history if they feel the questions are over-inclusive. Gender of partner, condom use, duration of relationship with current partner are all appropriate questions for primary care. GPs would not always ask about type of sexual contact. E.g. 34 year old asymptomatic woman in 6 year mutual monogamous relationship – in the primary care setting it would not be appropriate to ask about this. However there are other scenarios where this would be a question to ask. Please see Fig 1 Barriers to HIV testing in primary care here: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199891 Unfortunately the definition is so wide, that it suggests that, for instance, a married couple attending to discuss a newly confirmed pregnancy should be asked to answer the list of questions on p6. This would undoubtedly be seen as intrusive, offensive and inappropriate. The same applies equally to many consultations about routine contraception, cervical cytology, and certainly travel immunisation. If one establishes the duration of relationship and whether the person has had any other sexual partners in that time (and whether their partner has had any other partners) then whether they live with the partner, consider the

ID	Stakeholder	Statement Number	Comments[1]
			relationship 'regular' (very subjective term) is not information that is necessary to find out to undertake a rapid risk assessment, GPs usually would not ask about whether the partner could be contacted until an STI test was positive. In the primary care setting it is not going to affect the initial management to know this information in the vast majority of cases. These questions may be relevant in certain situations. The concept that more patients should be asked about their sexual history to improve the uptake of screening is important. However this would be extremely difficult to measure for primary care as there are not agreed codes, templates or reporting structures. This would require development of templates and training to use them as well as upskilling of many primary care clinicians, including the nursing workforce who do the majority of cervical screening and contraception appointments, in the skills of sexual history taking.
34	Royal College of General Practitioners	Statement 1	Equality and diversity considerations Mention should be made of what to do about the 'accompanied patient 'as this is a common occurrence in general practice and in fact is often of value bearing in mind the wide range of reasons for consulting a family doctor. Sometimes a partner or family member acting as an informal interpreter and if it becomes clear that a sexual history is appropriate to the consultation then GPs should be able to manage the situation - even if the patient initially says it is ok to be accompanied- they will not always be aware of what questions may follow and may find the presence of another person inhibits their capacity to give accurate answers. The accompanying person should be respectfully asked to leave the room before sexual history is asked. If interpreting is required then efforts should be made for alternative arrangements e.g. telephone interpreting, google translate or bringing patient back another time if feasible.
35	Royal College of General Practitioners	Statement 1	Audience descriptors "Key points of contact" could apply to GPs, practice nurses, or Out of Hours contact so may be difficult to measure.
36	Royal College of Nursing	Statement 1	Definition Page 6: Asking about "sex partners", should this be sexual partner?
37	Royal College of Nursing	Statement 1	Page 6 upwards: "*What the quality standard means to different audiences*". Where *"community services"* are listed, should this read Community sexual health services?
38	The National LGB&T Partnership	Statement 1	This statement includes asking about injecting drug use in sexual history taking. This should also include non-injecting drug use. GUMCAD v3 includes data about drug use for GUM clinics. In addition, there is no mention of the training needed for practitioners around LGBTQ specific issues and approaching the subject of LGBTQ people's sexual health in an appropriate way.
39	British Association for Sexual Health and HIV	Statement 2	**Content of Quality Statement**

ID	Stakeholder	Statement Number	Comments[1]
			BASHH support the principle of including a Quality Statement that encourages people identified at risk of STIs to have a discussion about prevention and testing. A structured approach can help identify and reduce behaviours that put a person at risk of acquiring STIs and directly supports the ambitions set out within Making Every Contact Count.[i] However, in order to achieve the desired '*outcome', 'uptake of tests for STIs',* it is important that this Quality Statement includes a greater emphasis on the need to encourage referral to easily accessible sexual health services where need is identified. The Statement should also note that 'discussions' may vary depending on whether the person attends face to face or online services. It is important that the need to provide these discussions in a structured way is emphasised, alongside the need to utilise available technology and algorithms, across blended sexual health services. Discussions should also be delivered in an age-appropriate manner, respecting the cultural, linguistic, physical and mental health needs of the individual, alongside any other needs or factors that may present obstacles to someone accessing sexual health services. At present, the importance attached to signposting to appropriate sexual health services is inconsistently referenced throughout this Statement and therefore risks the principle of referral being overlooked – signposting is mentioned for instance within '*Quality Measures Structure a'* but does not appear in the '*rationale'* segment or *'what the quality statement means'* for '*service providers'* or '*healthcare professionals'.* It is important that the list of key groups and behaviours outlined within the '*people at risk of sexually transmitted infections'* segment should be expanded to include 'gender and sexual minorities (GSM)' and 'commercial sex workers'. This should also not be seen as an exhaustive list. **Local systems and structures and resource implications** BASHH has concerns over the availability of appropriately trained healthcare professionals who would be able to deliver effective prevention and testing-based conversations in the settings outlined. It is important that the supporting source guidance referenced within this Quality Statement is clearly signposted to the healthcare professionals identified as relevant, and additional support is available to help them deliver these discussions where needed.
40	British HIV Association (BHIVA)	Statement 2	Similar to statement 1, the accuracy of the data will depend very much in clinic's ability to collect the denominator figures accurately. Will EPR across services be able to collect accurately the number identified as being at risk of STIs and again, the challenges if linking this to STI test uptake when the test may be performed under another service, with a different patient identifier, must be considered.

ID	Stakeholder	Statement Number	Comments[1]
41	British HIV Association (BHIVA)	Statement 2	This discusses the role of CCGs and NHSE in commissioning 'a range of services that provide information on the prevention of, and signpost testing for, STIs' yes this is now almost entirely in the remit of local authorities. We fear that the current, fragmented commissioning process will continue to act as a barrier to the joined up commissioning that would be required to meet this standard.
42	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Statement 2	The list of those at risk of STIs does not specifically include young people (other than those who have early onset of sexual activity), sex workers, those who have been sexually assaulted.
43	FPA (Family Planning Association)	Statement 2	It is clear that MSM are at disproportionate risk of certain STIs and in 2017, 47% of gonorrhoea diagnoses in England were amongst MSM.[ii] As such we welcome the focus on MSM throughout the Quality Statement. Having said this, we are concerned that other high risk groups, including young people, people from black or minority ethnic groups, or socially excluded groups have been overlooked. PHE statistics show that in 2017 over 25% of gonorrhoea and 36% of herpes diagnoses in England were amongst heterosexual people aged 15 -24. Over 60% of chlamydia diagnoses in England were amongst people ages 15-24.[ii] Whilst STI rates vary significantly amongst BME groups, black Caribbean and black non-Caribbean/non-African have the highest rates of numerous STIs than any other ethnic group.[iii] Given this, we recommend "people at risk of sexually transmitted infections" under definitions of QS2 is expanded to include young people between 15 and 24 and certain BME groups. The needs of these groups should be also be considered when thinking about equality and diversity. For example, to ensure open access for young people it is necessary to ensure that clinics are open outside of school or college hours. It is also important to consider location. Recent trends have seen many clinics closing and others moving to less convenient locations, this disproportionately affects people who rely on public transport, for example, young people.
44	FPA (Family Planning Association)	Statement 2	Although QS2 refers to prevention and testing, specific references to condoms and condom distribution scheme are notably absent.

ID	Stakeholder	Statement Number	Comments[1]
			Condom schemes are an important behaviour change intervention, and we recommend they are specifically referenced within QS2.
45	Homerton Sexual Health Services	Statement 2	It is unclear whether the proposed outcome (Uptake of tests for STIs) meets the aims of identifying the proportion of people identified at risk of STIs who have a discussion about prevention and testing. Many STI tests are deliverable without a referral to a sexual health clinic and so the proposed outcome measure of referral to sexual health clinic may erroneously imply that service outside of sexual health clinics do not need to have discussions about prevention and testing. It may be more meaningful to ask for evidence of staff training on one-to-one structured discussions with people at risk of STIs about how they can reduce their risk and how to be tested.
46	Public Health England	Statement 2	The discussion about prevention and treatment to last 15 – 20 minutes: this may have resource implications
47	Royal College of General Practitioners	Statement 2	Definition - People at risk of sexually transmitted infections There is no difficulty about this statement in theory. However in reality the process of labelling will work the other way around. In practice it's not that certain patients are considered to be at risk, and then some of them receive appropriate advice; more often patients are advised and are then labelled retrospectively as being at risk. Statement that 'people who have come from or who have visited areas of high HIV prevalence' at higher risk of STIs. This could be more clearly worded. Some people who originate from areas of high prevalence may have acquired their 'STI' vertically (particularly hepatitis B for example). Also of course if you have visited an area of high prevalence but not had any sexual partners there you will not be at risk (it is important not want to imply that you can acquire these infections by simply visiting a high prevalence area). A sentence could be added to acknowledge that some organisms that are sexually transmitted are also transmitted vertically and via needles, sharing drug taking equipment, iatrogenic transmission. Then the statement following would make more sense. Also consider adding – people who have had sex with a partner from an area of high HIV prevalence (it doesn't matter whether you have visited the area, but who you have sex intercourse with). Otherwise there may lead to confusion between risk groups with risk behaviours.
48	Royal College of General Practitioners	Statement 2	There is a difference between the training needs and standards of clinicians working in SRH services and primary care. To fulfil this standard would require significant training and resources for primary care clinicians although referring or signposting to a SRH service or to on line testing would be achievable – but not measurable.

ID	Stakeholder	Statement Number	Comments[1]
			Recommendation that consultations should last 15-20 minutes. What is the evidence is on which this recommendation is based? It is unrealistic in the context of primary care in the UK. This could imply GPs spend more time (and therefore resources) on such patients than on others with existing serious illnesses.
49	Royal College of Nursing	Statement 2	Audiences Page 6, 7: Different audiences. Could abortion providers be included?
50	Royal College of Nursing	Statement 2	Definition Page 9: *"Discussion about prevention and testing".* With current cuts to services, it will be impossible to offer clients 15-20 minutes as there are not enough staff available to deliver that service.
51	British Association for Sexual Health and HIV	Statement 3	**Content of Quality Statement** BASHH believes that the focus of this Quality Statement should be on ensuring that people who contact a sexual health service for an appointment are triaged at the point of contact and that where appropriate, they are seen within 48 hours (e.g. those who are identified as symptomatic, vulnerable or at higher-risk of passing on infection to be seen within 48 hours). Joint BASHH/MEDFASH Standards for the Management of STIs (updated in 2014) highlight the importance of providing people with an appointment (including availability within a 'walk-in' service) within 2 working days of first contacting a sexual health service.[iv] Whilst it is still essential to ensure that rapid access to sexual health services is available to those who need it, it is important to note that the sexual health landscape has changed considerably since these Standards were last updated in 2014. Not only do the Standards pre-date the emergence of effective online sexual health services, they were also published before significant and repeated funding restrictions were applied in recent years to sexual health service budgets, which has consequently led to reduced service provision and an increasing importance to manage growing demand through effective triage. Instead, the Statement should set out the importance of all individuals being triaged at the point of contact to assess the most appropriate way and time for them to be seen, and those who are most at need should be seen within 48 hours. It is also important to highlight the opportunity to provide online triage and direction to online services where available and when appropriate (drawing on the new BASHH/Faculty of Sexual and Reproductive Health (FSRH) Standards in this area).[v] **Local systems and structures and resource implications** Reshaping the focus of this Quality Statement so that it facilitates effective triage of those who contact a sexual health service within 48 hours would be broadly achievable based on local systems and is resource-efficient. This would be especially cost-effective if the Statement emphasised the increasing availability of online testing services

ID	Stakeholder	Statement Number	Comments[1]
			for those who are asymptomatic and who do not therefore necessarily need to be seen in a face to face sexual health service setting within 48 hours.
52	British HIV Association (BHIVA)	Statement 3	48-hour access was one of the elements that truly impacted sexual health service access but since its removal as a mandatory requirement in 2010 the proportion of people offered an appointment within that time frame has declined (https://www.bashh.org/news/news/new-study-shows-worrying-deterioration-in-access-to-sexual-health-services-for-patients/) – unless this requirement is mandatory we fear the leverage to ensure adequate investment to support that target will be inadequate. Ensuring accuracy and transparency with regards to access figures is fundamental. If a clinic were to close its appointment line as soon as all appointments were filled then the figures may show that all users contacting the service were offered an appointment within 48 hours but not those who were unable to get through. Many clinics collect data on unanswered/aborted calls but not necessarily the percentage of those calls that did get answered eventually. Anecdotally, some Trusts are very cautious about producing figures and the tendering/competition process has created a culture of uneasiness with regards to sharing data and information – frankly, some clinics appear to be more concerned about appeasing commissioners than shouting about the impact of commissioning on service provision, quality and morale. In London we have yet to see an assessment of the value of e-services. Ultimately, we call for reintroduction of a mandatory 48-hour offer of appointment target and for this to be based not just on those who get through to a service but the number who *attempt* to do so.
53	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Statement 3	Number of patients offered an appointment within 48hrs of initial contact with a service - I think from our experience this is nearly always 100% as we can offer walk-in services. However these are not always at a time they can attend or in a clinic they can access. It may be too soon for testing and clinically waiting 4-5 days may be indicated. This should be measured by a more qualitative outcome. *A "Service Access Indicator" tool could be a more realistic way to assess many of these standards. The "Service Access Indicator- Mystery Shopper Service access Indicator" looked at ways of contacting the service i.e. telephone and the experience, whether they were offered appointment within 48 hrs which was appropriate and accessible, scenarios of Chalmydia, Genital Ulcers (male and female) and urethral discharge"* *http://www.isdscotland.org/Health-Topics/Sexual-Health/Key-Clinical-Indicators/Mystery%20Shopper%202009%20Report.pdf*
54	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Statement 3	If a woman contacts a service needing an IUD change in 3 months is concerned about an STI after UPSI the previous evening, she does not need to be seen within 48 hours (it is inappropriate to do so). This comes back partly to the choice of language and not being specific that this document is talking exclusively about STI. Perhaps should be 'where appropriate an appointment to be seen within 48 hours'
55	Faculty of Sexual and Reproductive	Statement 3	Re 48 hr access to services from the point of contact.

ID	Stakeholder	Statement Number	Comments[1]
	Healthcare Clinical Effectiveness Unit		I think it would probably be more realistic to say access should be within 48 working hours e.g. if a patient phones on a Friday pm, they won't necessarily be seen until Monday. This would particularly be unrealistic in areas which don't have a full time service.
56	FPA (Family Planning Association)	Statement 3	We are pleased that QS3 recommends those who contact a sexual health clinic for an appointment are seen within 48 hours. BASHH research suggests that, at present, the number of people who are being seen within 48 hours is declining. Research carried out in 2014 found that, when contacted by telephone, 95.5% of clinics offered patients, who presented with symptoms suggestive of an acute STI an appointment within 48 hours whilst in 2015 90.8% of clinics offered symptomatic 'patients' an appointment within 48 hours in 2015. [vi] Given this we are pleased that that standard highlights the importance of timely access. Having said this, in the context of increased pressed and reduced budgets, we are concerned about feasibility. There have been significant increases in the number of diagnoses cases of some STIs, including syphilis and gonorrhoea[ii] as well as sharp increases of attendances at sexual health clinics. PHE figures show that the total number of new attendances at sexual health services grew by 18.5% between 2013 and 2017, from 2.21 million to 2.62 million.[vii] This is only compounded by well documented cuts to Public Health budgets,[viii] and as a result cuts to sexual health services. In 2017, 72 of 151 local authorities stated that they plan to cut sexual health funding in 2018-2019 compared with 2017-2018, and some clinics are reporting high turn away rates.[ix] Online testing represents an opportunity to increase uptake of testing for STIs amongst asymptotic individuals from low risk groups and subsequently reduce the pressure on services and increase the likelihood of symptomatic patients, those from high risk groups and for those for whom online testing is unsuitable, being seen within 48 hours.
57	Homerton Sexual Health Services	Statement 3	Many services offer a walk in structure, rather than appointments. It may be helpful to rephrase the quality statement to 'Proportion of people who are offered an appointment within 2 working days of first contacting the service. Many interventions (eg LARC provision) need to be scheduled for times which may be beyond the 2 day limit and these need to be excluded from the denominator.

ID	Stakeholder	Statement Number	Comments[1]
58	Institute of psychosexual medicine	Statement 3	A missing quality measure – that sexual health services provide access to services providing support and treatment of psychosexual problems and psychological impact of positive STI diagnosis. This would ensure service users have access to these services. This would ensure health care professionals have clear pathways for referral or services within their department. This would ensure these level 3 services are commissioned and service providers deliver these services.
59	National AIDS Trust	Statement 3	Many clinics have no or very few appointment services – and rely mainly on walk-in clinics. A quality statement is needed in relation to maximum waiting time in walk-in clinics if the aim of this Standard is to improve access to sexual health services. This also reduces the risk of clinics 'gaming' the system.
60	National AIDS Trust	Statement 3	The 'Definition of terms' section excludes self-managed care including online services and home sampling. This is not appropriate. This exclusion derives from guidance drafted in 2014 and the world has moved on significantly since then. There has for example been a major move to online services within London sexual health clinics. Access quality standards need to include turnaround for online service access and results. It would for example make sense to have a similar timeline expectation of two working days for receipt of an online testing kit once ordered. There should also be timing expectations for the receipt of any results once a kit is received by the clinic/lab, and for being seen once a positive result is confirmed via an online test.
61	National AIDS Trust	Statement 3	The quality standard of being seen within 48 hours is one of three in the integrated sexual health service specification relating to access timing. In our view the two more relevant indicators in the service specification are being offered an appointment within two working days and being seen if you are symptomatic, need PEPSE or need emergency contraception within 48 hours. Some people seeking an appointment do not want to be seen within the next 48 hours – the other two more appropriately reflect capacity and need for an appointment, and ideally should both be the ones cited in this Statement.
62	National AIDS Trust	Statement 3	We note an oscillation between the service spec and the quality statement on whether we refer to 48 hours or two working days – the corresponding indicator in the service spec to that currently in the quality standard refers to two working days not 48 hours.
63	Public Health England	Statement 3	• It is currently not really capturing the demand or capacity in the measure of 'able to access and be given an appointment': many may be able to access a walk-in within 48 hours, but there is a need to capture how many are turned away. There are other data collections going on (via BASHH) about turn-aways/unmet need, that may be useful here. • Need to clarify how to measure access to e-services – or how that would be counted.
64	Royal College of General Practitioners	Statement 3	Offering an appointment within 48 hours. This statement is not geared around primary care. Patients often don't wish to disclose the reason for requesting the appointment, so may well not be offered an appointment within 48 hours.
65	The National LGB&T Partnership	Statement 3	The 48hr standard for appointment is very welcome. However, at present many clinics are reporting unprecedented strains on capacity; 56 Dean Street for example has recently had to reduce their bookable

ID	Stakeholder	Statement Number	Comments[1]
			appointments from 350 to just 75 due to funding cuts, and has warned that it can no longer guarantee appointments within 48 hours. This is at a time of rising incidents of some STIs among men who have sex with men. This should not change the standard, but what course of action is there if the standard cannot be met?
66	University Hospitals Birmingham NHS Foundation Trust	Statement 3	We would support a return to a target for access, but think that 48 hours is difficult to achieve. It is important to consider that not all patients would choose to be seen in 48 hours as it may not be convenient for them. We would consider that all patients with urgent symptoms are seen on the same day, but many patients who attend the clinics do not require urgent assessment. Our service offers a combination of booked and walk-in slots currently to try and accommodate patient choice. In our previous experience, there has been "clinical gaming" for all services to therefore switch to a fully walk-in service in order to appear to meet the 48 hour target access, which may not be in the interests of patient care. From previous experience within our organisation, the DNA rate has also increased when the target has been reduced to 48 hours. What is the evidence for a 48 hour target? Perhaps consideration could be given to lengthening the recommended accessibility target.
67	British Association for Sexual Health and HIV	Statement 4	**Content of Quality Statement** BASHH supports the inclusion of a Quality Statement that would necessitate men who have sex with men (MSM) to be tested for STIs every 3 months if they are perceived to be at increased risk of acquiring infection. We also believe that the scope of this Statement should be widened to encompass gender and sexual minorities (GSM) and all other populations identified as at increased risk of STIs. Widening the scope of this Statement as set out above would support more equitable access to services and improved outcomes across the life course for those at-risk of poorer sexual health - a key aim of this Quality Standard. **Local systems and structures and resource implications** Whilst regular access to testing should be encouraged for those at risk to support improved sexual health outcomes across the life course, it is important to note that delivering this Statement without promoting the importance of providing universal coverage and access to online services is likely have a significant impact on available resources. Mapping analysis undertaken in 2013 suggested that if all high-risk MSM were to take up the offer of being tested every 3 months, services could experience an up to five-fold increase in workload.[x] It is important therefore that commissioners and services receive appropriate support to help manage likely increases in demand for services were this Statement to be implemented, particularly when viewed against the wider backdrop of the year-on-year increases in service demand that are already being seen.

ID	Stakeholder	Statement Number	Comments[1]
			As highlighted above, an effective way of managing increases in demand will be through encouraging universal provision of online sexual health services across the country, which can deliver improved returns on investment, can streamline care and also help to depressurize limited face to face appointment availability.[xi]
68	British HIV Association (BHIVA)	Statement 4	We support this completely and it is in line with BASHH MSM guidelines. If this was implemented successfully it would undoubtedly place further strain on sexual health services – the concerns of local authorities about the ability to manage the increased demand for services has been a key part of the discussion related to the roll-out of HIV pre-exposure prophylaxis (PrEP) – how much this has contributed to the fact that England still does not offer routine PrEP would be hard to quantify.
69	Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit	Statement 4	What constitutes "testing"? Needs to be clarified, and to be in line with BASHH guidance, should include extragenital as well as genital sites for CT and NG.
70	Homerton Sexual Health Services	Statement 4	Given the plurality of service providers, it is difficult to collect this information on a service specific level. Consideration needs to be given to a cross service identifier if this information is to be collected across multiple service providers.
71	National AIDS Trust	Statement 4	There is a particular importance of repeat testing for those MSM who have been diagnosed with an STI, which is a powerful predictor of future incidence. Reference to this would be useful.
72	Public Health England	Statement 4	• There should also be something in here about commissioners making sure that health promotion/prevention messages for higher risk groups include messaging about frequent testing
73	Royal College of General Practitioners	Statement 4	<u>Quality measures – data source</u> Could collecting data on text reminders sent be used to assess this?
74	Royal College of General Practitioners	Statement 4	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. - while this is desirable sexual health screening is not currently commissioned in most practices so is unlikely to occur. MSM have been encouraged to attend SRH services as the testing required is complex for primary care. Text reminders to attend for retesting would be possible with agreement but difficult to measure this. This has been deemed to be level 3 sexual health work and therefore commissioned under LA and therefore funding for work and training would need to be provided by the LA commissioned services. In Australia there is a follow-up system for repeat testing every 3 months. This would take considerable organisation and expense in this country unless the person themselves took responsibility. (?organised by Public Health or a separate screening programme as for cervical smears?). This group of people include those who move

ID	Stakeholder	Statement Number	Comments[1]
			frequently, may be discharged from prison or moved. (Communication with Primary Care is very poor from prisons and the Sexual Health services)
75	Royal College of General Practitioners	Statement 4	Very small error. There is an unrealistic implication of coercion here. Can this be altered to mean 'Men who have sex with men should be *offered* repeat testing …'
76	The National LGB&T Partnership	Statement 4	This statement lists different drugs used in sexual contexts, but does so over two different bullet points. What is the rationale for this? Some substances are specifically named, but others are not e.g. mephedrone, which the Gay Men's Sex Survey 2014 indicated was the most widely used of the three drugs characterised as the 'chemsex drugs' (the others being GHB/GBL and methamphetamine).
77	British Association for Sexual Health and HIV	Statement 5	**Content of Quality Statement** BASHH support the inclusion of this Quality Statement and welcome the ambition to encourage increased delivery of partner notification by an appropriately trained professional. Providing effective partner notification is an essential element of STI management and control[xii] and should be a crucial component of every type of sexual health service accessed by an individual. It is also a complex, specialist activity and therefore needs to be delivered by the appropriate expertise and underpinned by sufficient resource. The complex nature of delivering partner notification needs to be better reflected in the Quality Statement, to ensure that those providing it are appropriately trained and to help support the best possible sexual health outcomes across the life course. Whilst BASHH are supportive of the majority of this Statement as it is currently positioned, we have concerns over the suggested datasets that have been included within the supporting *quality measures* segment. Signposting to *GUMCAD STI surveillance system* and *Public Health England Sexual and Reproductive Health profile datasets* present the risk that this Statement becomes outdated, as the datasets themselves need to be refreshed. **Local systems and structures and resource implications** BASHH believes that local systems and structures are in place to deliver this Quality Statement and that the commissioning of services to support partner notification should be encouraged. It is important to highlight the importance of ensuring partner notification is delivered by those with appropriate training and expertise, and that resources are in place to support this.
78	British HIV Association (BHIVA)	Statement 5	Again, we support this. Partner notification (PN) is an essential part of managing STIs but, again, accuracy of data is the key challenge. Despite attempts to implement systems that enable cross-service documentation (i.e. to accurately collect where a partner notification initiated at one service has been completed at another) this process is fragmented and time-consuming. The cuts to sexual health funding have, in some cases, significantly impacted the number of staff available to perform PN. Simply collecting the data on initiation of PN is one thing but

ID	Stakeholder	Statement Number	Comments[1]
			translating this into subsequent uptake of STI screening/identification is another. Again, it is likely that only mandatory targets in terms if ON offer AND uptake will truly impact provision.
79	Homerton Sexual Health Services	Statement 5	Consideration needs to be given to how services outside of sexual health clinics evidence partner notification
80	Public Health England	Statement 5	• As well as measuring the proportion of people who have a discussion/ parent notification initiated, there should be some measure of success of partner notification – how many people are traced and tested • This links to the issue about resources for undertaking high quality partner notification • The statement (what it means for different audiences) should encourage providers and commissioners to review their approaches to partner notification, ensure adequate attention/resource/training is being given to it and plans for how to improve it
81	Royal College of General Practitioners	Statement 5	Although GPs can support patients with self-testing because of confidentiality primary care clinicians should not contact partners – especially those who are not registered at the GP practice – with patient information. So this is not achievable for primary care.
82	University Hospitals Birmingham NHS Foundation Trust	Statement 5	Within our Sexual health organisation, partner notification is an important part of the work we do. However, we do not think this is routine practice for local settings in the community. More work is required for the measurement of the partner notification to be meaningful. For example, please see the national BASHH standards for partner notification for the management of sexually transmitted infections, which states some targets for patient-reported partner notification. https://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf

Registered stakeholders who submitted comments at consultation

- British Association for Sexual Health and HIV
- British HIV Association (BHIVA)
- Department of Health and Social Care
- Edge Hill University
- Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit

- FPA (Family Planning Association)
- Homerton Sexual Health Services
- Institute of Psychosexual Medicine
- Manchester Health and Care Commissioning
- Manchester Metropolitan University
- MSD UK Ltd
- National AIDS Trust
- NHS England
- Public Health England
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- The National LGB&T Partnership
- University Hospitals Birmingham NHS Foundation Trust

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