



# Sexual health

Quality standard

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This standard is based on NG68, PH51, NG221, NG60 and NG201.

This standard should be read in conjunction with QS157, QS156, QS148, QS129, QS65, QS196 and QS199.

## Quality statements

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

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

Statement 3 Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.

Statement 4 People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.

Statement 5 Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

Statement 6 People diagnosed with a sexually transmitted infection are supported to notify their partners.

# 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 if they are at risk of sexually transmitted infections (STIs) and ensures that they can be given information and support to prevent infection. It can also help local services to understand the needs of their populations.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

a) Evidence of local agreement on the key points of contact when people will be asked about their sexual history.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service protocols.

b) Evidence of local processes to ensure that people are asked about their sexual history at key points of contact.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service protocols.

## Process

Proportion of people who have a discussion about their sexual history at key points of contact.

Numerator – the number in the denominator who have a discussion about their sexual history.

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

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, documenting that a discussion has taken place could form part of an electronic health record.

## Outcome

Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The proportion of young people screened for chlamydia and HIV testing coverage are collected as part of the [Office for Health Improvement and Disparities' Sexual and reproductive health profiles](#).

## What the quality statement means for different audiences

**Service providers** (such as primary care services, contraceptive services, genitourinary medicine clinics, abortion services, community sexual health services, and voluntary and community organisations) ensure processes are in place and staff are trained to ask people about their sexual history in a sensitive and supportive way at key points of contact. Service providers can help staff to ensure sexual history taking becomes routine by providing tools such as self-completion checklists.

**Healthcare professionals** (such as GPs, midwives, nurses, doctors, and drug and alcohol workers) ask people about their sexual history at key points of contact. Healthcare

professionals ensure that they discuss sexual history in a sensitive and supportive way.

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

Commissioners agree key points of contact when people should be asked about their sexual history with service providers. Commissioners ensure that services that engage with people who are less likely to attend primary care or sexual health services are included.

**People using healthcare services** are asked about their sexual history, for example, the gender of their last partner and their use of condoms, when they attend relevant appointments. This will ensure that they are given the support they need if they are at risk of getting an STI.

## Source guidance

- [Reducing sexually transmitted infections. NICE guideline NG221 \(2022\)](#), recommendations 1.1.8, 1.1.11, 1.1.14, 1.2.7 and 1.2.8
- [Antenatal care. NICE guideline NG201 \(2021\)](#), recommendations 1.2.1 and 1.2.13
- [UK national guideline for consultations requiring sexual history taking. British Association for Sexual Health and HIV \(2019\)](#), introduction and methodology
- [HIV testing: increasing uptake among people who may have undiagnosed HIV. NICE guideline NG60 \(2016\)](#), recommendations 1.1.8 and 1.1.9
- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\)](#), recommendation 3

## Definitions of terms used in this quality statement

### Key points of contact

Key points of contact could be consultations:

- with newly registered patients

- about contraception, pregnancy, abortion, alcohol or substance misuse
- when offering an STI test.

[Expert opinion]

## Asking about sexual history

Services may take a brief core sexual history to establish whether someone is at any risk of STIs and then take a more detailed history if the screen is positive. A more detailed sexual history should include:

- time since last sexual contact
- time since previous sexual contact (if within the past 3 months)
- number of sexual partners in the past 3 months
- the gender of the partner(s)
- the partnership type and whether the partner can be contacted
- the type of sexual contact/sites of exposure
- condom use/barrier use
- any symptoms or any risk factors for blood-borne viruses in the partner.

[[British Association for Sexual Health and HIV's UK national guideline for consultations requiring sexual history taking](#), recommendation 3.3 and table 1]

## Equality and diversity considerations

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

Healthcare professionals should ensure that older people are asked about their sexual history in order to identify if they are at risk of STIs. Healthcare professionals should also be trained to identify and respond to the specific needs of lesbian, gay, bisexual, and



transgender people when asking about their sexual history.

Safeguarding links should be in place with all services that may engage with young people and vulnerable adults about their sexual health. Services should be clear what action should be taken if concerns are raised about child sexual exploitation or abuse, female genital mutilation, human trafficking or modern slavery.

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

## Quality statement

People identified as being 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

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

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, training records and staff rotas.

b) Evidence of local processes to ensure that people identified as being at risk of STIs have a discussion about prevention and testing.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service protocols.

## Process

Proportion of people identified as being 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 as being at risk of STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, documenting that a discussion has taken place could form part of an electronic health record.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The proportion of young people screened for chlamydia and HIV testing coverage are collected as part of the Office for Health Improvement and Disparities' 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 the Office for Health Improvement and Disparities' 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 the Office for Health Improvement and Disparities' Sexual and reproductive health profiles.

## What the quality statement means for different audiences

**Service providers** (such as primary care services, contraceptive services, genitourinary medicine clinics and community sexual health services) ensure that they have healthcare professionals trained in sexual health who discuss the prevention of and testing for STIs with people identified as being at risk. Service providers should ensure that healthcare professionals signpost people at risk to high-quality supporting information and services, including online sexual health services.

**Healthcare professionals** (such as GPs, midwives, practice nurses and doctors who work in sexual health services) have one-to-one structured discussions with people identified as being at risk of STIs about how they can reduce their risk and how to get tested. Healthcare professionals should signpost people at risk to high-quality supporting information and services, including online sexual health services.

**Commissioners** (integrated care systems, clinical commissioning groups, local authorities and NHS England) work together to ensure that they commission a range of services that provide information on the prevention of and testing for STIs to people identified as being at risk. Commissioners ensure that services that engage with people who are less likely to attend primary care or sexual health services are included.

**People who are at risk of getting an STI** talk to their healthcare professional about how to prevent STIs. They should also be given information about how to get tested for STIs and where to get further advice.

## Source guidance

- [Reducing sexually transmitted infections. NICE guideline NG221 \(2022\)](#), recommendations 1.1.8, 1.2.8, 1.4.2 and 1.5.14
- [UK national guideline for consultations requiring sexual history taking. British Association for Sexual Health and HIV \(2019\)](#), recommendation 3.7
- [HIV testing: increasing uptake among people who may have undiagnosed HIV. NICE guideline NG60 \(2016\)](#), recommendations 1.1.8 and 1.1.9
- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\)](#), recommendation 3

## Definitions of terms used in this quality statement

### Discussion about prevention and testing

Discussions should be structured on the basis of behaviour change theories and recognise people's individual needs. Discussions could include:

- information and education about:
  - STIs
  - the impact of alcohol and drugs on sexual decision making
- information about:
  - sexual health services available, including that they are free, confidential and open access
  - the rates of STIs to explain why some groups are at higher risk
  - the impact of stigma
- sex-positive approaches to providing advice on the consistent and correct use of barrier methods
- risk assessment and risk-reduction activities, for example developing personalised risk-reduction plans, identifying triggers and setting goals
- Information Motivation Behavioural skills (IMB) model approaches and motivational interviewing techniques to guide conversations about risk reduction or safer-sex practices and address informational, motivational and skills-based barriers to change
- activities to increase sexual self-efficacy (for example, talking about sexual consent, negotiating the use of barrier methods and negotiating sexual preferences) and broader self-efficacy (for example, self-esteem)
- activities exploring the links between emotion and sexual behaviour, and coping skills (for example, using cognitive behavioural approaches)
- a plan for follow-up (for example, repeated contact to review progress or make new plans).

[[NICE's guideline on reducing sexually transmitted infections](#), recommendations 1.1.8, 1.1.9 and 1.2.8]

## People at risk of sexually transmitted infections

People are most at risk of STIs if they are involved in higher rates of condomless sex with multiple partners or frequently change partners. There may be more people practising these behaviours in some groups than others, but this does not mean that everyone in the group is necessarily at higher risk. For example, gay, bisexual and other men who have sex with men are a higher risk group for STIs and HIV, but this does not mean that every person in that group is at higher risk. [[NICE's guideline on reducing sexually transmitted infections](#), terms used in this guideline]

## Equality and diversity considerations

A discussion about prevention and testing for STIs should be age appropriate and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English, or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

Healthcare professionals should be trained to identify and respond to the specific needs of lesbian, gay, bisexual, and transgender people when discussing prevention and testing for STIs.

# Quality statement 3: Condom distribution schemes

## Quality statement

Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.

## Rationale

Providing a variety of condom distribution schemes ensures that different populations, including those most at risk of sexually transmitted infections (STIs), can access a scheme that will meet their needs. Condom schemes should be provided alongside existing services that are likely to be used by people most at risk of getting an STI. This can increase rates of condom use and reduce STI rates.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

a) Evidence of local arrangements to assess the needs of local populations for condom distribution schemes.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, needs assessments based on consultation and STI rates.

b) Evidence of local arrangements to provide a range of condom distribution schemes tailored to the needs of the population.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service specifications for a mix of different types of condom distribution scheme.

c) Evidence of local arrangements to publicise condom distribution schemes to people most at risk of getting an STI.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, posters, leaflets and social media campaigns.

## Outcome

a) Proportion of people who are at risk of STIs who used a condom at last intercourse.

**Data source:** Data could be collected from a local survey of young people or other groups who may be at risk of STIs.

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 the [Office for Health Improvement and Disparities' 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 the [Office for Health Improvement and Disparities' Sexual and reproductive health profiles](#).

## What the quality statement means for different audiences

**Service providers** (voluntary sector services, school health services and primary healthcare services) provide a range of condom distribution schemes tailored to the needs of different local populations. Service providers publicise condom schemes to people most at risk of getting an STI. Service providers also ensure that referral pathways are in place to other services to meet the needs of those using the service.



**Healthcare professionals** (such as GPs, practice nurses, pharmacists and sexual health consultants) are aware of condom distribution schemes and tell people who are at risk of getting an STI how to access them.

**Commissioners** (integrated care systems and local authorities) ensure that they commission a mix of different types of condom distribution schemes tailored to the needs of the population, including multicomponent schemes, single-component schemes (free condoms) and cost-price sales schemes. Commissioners should commission tailored multicomponent condom schemes in preference to other types of condom scheme for young people aged under 16. Commissioners ensure there are links between condom schemes and local sexual and reproductive health services.

**People at risk of getting an STI** are made aware of where they can get condoms.

## Source guidance

[Sexually transmitted infections: condom distribution schemes. NICE guideline NG68 \(2017\), recommendation 1.1.1](#)

## Definitions of terms used in this quality statement

### Condom distribution schemes

These are usually referred to as 'condom schemes'. The term refers to all schemes that provide free or cost-price condoms, female condoms and dental dams, with or without lubricant. Schemes also offer advice, information or support. They include:

- Cost-price sales schemes that provide cost-price condoms and, if appropriate, lubricant. They include community schemes that provide cost-price condoms to sex workers and online services.
- Multicomponent schemes (such as C-card) that distribute free condoms with or without lubricant, together with training, information or other support.
- Single-component schemes that provide or distribute free condoms and if appropriate, lubricant. This includes online services for specific groups or areas of the country, and distribution schemes in public places.

[[NICE's guideline on sexually transmitted infections: condom distribution schemes](#), terms used in this guideline]

## Equality and diversity considerations

Condom schemes should be accessible for young people including those who use public transport.

Safeguarding links should be in place with all services that may engage with young people and vulnerable adults about their sexual health. Services should be clear what action should be taken if concerns are raised about child sexual exploitation or abuse, female genital mutilation, human trafficking or modern slavery.

# Quality statement 4: Access to sexual health services

## Quality statement

People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.

## Rationale

Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Ensuring people are offered quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs), ensuring that tests and interventions can be provided to reduce health complications. If walk-in clinics are provided there should be reasonable waiting times to encourage people to use the service.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

Evidence of local arrangements to ensure that people contacting a sexual health service about an STI are offered an appointment that is within 2 working days.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service protocols. Included in the [Department of Health and Social Care's Integrated sexual health services: a suggested national service specification](#).

## Process

a) Proportion of contacts with a sexual health service about an STI in which an appointment that is within 2 working days, was offered.

Numerator – the number in the denominator in which an appointment that is within 2 working days, was offered.

Denominator – the number of contacts with a sexual health service about an STI.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient health records. Included in the Department of Health and Social Care's Integrated sexual health services: a suggested national service specification.

b) Proportion of attendances at a sexual health service walk-in clinic in which the waiting time was less than 2 hours.

Numerator – the number in the denominator in which the waiting time was less than 2 hours.

Denominator – the number of attendances at a sexual health service walk-in clinic.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, clinic wait time records. Included in the Department of Health and Social Care's Integrated sexual health services: a suggested national service specification.

## Outcome

a) Satisfaction with access to services among people who contact sexual health services about an STI.

**Data source:** Data could be collected from a local patient survey.

b) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records. The proportion of young people screened for chlamydia and HIV testing coverage are collected as part of the Office for Health Improvement and Disparities' Sexual and reproductive health profiles.

c) 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 the Office for Health Improvement and Disparities' Sexual and reproductive health profiles.

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

**Data source:** These data are collected as part of the Office for Health Improvement and Disparities' Sexual and reproductive health profiles.

## What the quality statement means for different audiences

**Service providers** (sexual health services) ensure that they offer people who contact the service about an STI either an appointment or the option to attend a walk-in clinic, which is within 2 working days. Service providers ensure that walk-in clinics are sufficiently resourced so that waiting times are less than 2 hours. Providers should offer a mix of timed appointments and walk-in clinics to meet the needs of the local population.

**Healthcare professionals who work in sexual health services** offer people contacting the service about an STI either an appointment or the option to attend a walk-in clinic, which is within 2 working days.

**Commissioners** (integrated care systems and local authorities) commission sexual health services with sufficient capacity to ensure that people contacting the service about an STI are offered either an appointment or the option to attend a walk-in clinic, which is within 2 working days, and monitor waiting times.

**People who contact a sexual health service about an STI** are offered either an appointment or attendance at a walk-in clinic within 2 working days. If they go to a walk-in clinic, they wait no longer than 2 hours.

## Source guidance

- [Contraceptive services for under 25s. NICE guideline PH51 \(2014\)](#), recommendation 3
- [Reducing sexually transmitted infections. NICE guideline NG221 \(2022\)](#), recommendation 1.1.1
- The timeframe of 48 hours is from the [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).

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. [Adapted from the [Department of Health and Social Care's Integrated sexual health services: a suggested national service specification](#)]

### An appointment

A scheduled time at a clinic or the option to attend a walk-in clinic. [Expert opinion]

## 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 who do not speak or read English, or who have reduced literacy skills, can contact sexual health services to make appointments. People should have access to an interpreter or advocate if needed.

Sexual health services should be accessible for young people including those who use public transport.

# Quality statement 5: 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

Regular repeat testing for sexually transmitted infections (STIs) for men who have sex with men and who are at increased risk of STIs will ensure that diagnosis is made as soon as possible and further transmission of STIs can be avoided.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

a) Evidence of local arrangements to provide STI repeat testing every 3 months for men who have sex with men and are at increased risk of STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service protocols.

b) Evidence of local arrangements to encourage men who have sex with men to have repeat STI tests every 3 months if they are at increased risk of STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, health promotion leaflets and materials.

## Process

a) Proportion of men who have sex with men and are at increased risk of STIs who were sent a reminder to have repeat testing for STIs within the past 3 months.

Numerator – the number in the denominator who were sent a reminder to have repeat testing for STIs within the past 3 months.

Denominator – the number of men who have sex with men and are at increased risk of STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient health records.

b) Proportion of men who have sex with men and are at increased risk of STIs who were tested for STIs within the past 3 months.

Numerator – the number in the denominator who were tested for STIs within the past 3 months.

Denominator – the number of men who have sex with men and are at increased risk of STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient health records.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records. The proportion of young people screened for chlamydia and HIV testing coverage are collected as part of the Office for Health Improvement and Disparities' 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 the [Office for Health Improvement and Disparities' 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 the [Office for Health Improvement and Disparities' Sexual and reproductive health profiles](#).

## What the quality statement means for different audiences

**Service providers** (such as primary care services, genitourinary medicine clinics, community sexual health services and online sexual health services) offer men who have sex with men repeat STI testing every 3 months if they are at increased risk of STIs. Service providers ensure men are signposted to an alternative service for repeat testing if necessary. They ensure that recall reminders are sent every 3 months to improve re-attendance rates.

**Healthcare professionals** (such as GPs, practice nurses and sexual health consultants) offer men who have sex with men repeat appointments for STI testing every 3 months if they are at increased risk of STIs. If their service does not provide repeat testing, healthcare professionals should signpost the person to an alternative service.

**Commissioners** (integrated care systems, 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 who have sex with men and are at increased risk of STIs. This could include online sexual health services.

**Men who have sex with men and who have a high risk of getting an STI** are offered testing for STIs every 3 months.

## Source guidance

[UK national guideline on the sexual health care of men who have sex with men. British Association for Sexual Health and HIV \(2016\)](#), recommendations on STI and HIV testing

## Definitions of terms used in this quality statement

### Men who have sex with men and are at increased risk of sexually transmitted infections

Men who have sex with men, who have:

- had condomless anal intercourse with partner(s) of unknown or serodiscordant HIV status over the past 12 months
- had over 10 sexual partners over the past 12 months
- used drugs (such as methamphetamine, mephedrone, inhaled nitrites, gamma-butyrolactone, ketamine, and other novel psychoactive substances) during sex over the past 6 months
- had multiple or anonymous partners since last tested
- had 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's 2016 UK national guideline on the sexual health care of men who have sex with men](#), recommendations on STI and HIV testing]

# Quality statement 6: 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 prevent reinfection and 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

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

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service protocols. Included in the [Department of Health and Social Care's Integrated sexual health services: a suggested national service specification](#).

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

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, service protocols and referral

pathways. Included in the [Department of Health and Social Care's Integrated sexual health services: a suggested 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:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records. [UK Health Security Agency's GUMCAD STI surveillance system](#) collects data on partner notification being initiated in sexual health services.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records. The proportion of young people screened for chlamydia and HIV testing coverage are collected as part of the [Office for Health Improvement and Disparities' Sexual and reproductive health profiles](#).

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

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, patient records. [UK Health Security Agency'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 in sexual health services.

## What the quality statement means for different audiences

**Service providers** (such as primary care services, genitourinary medicine clinics and community health services) ensure that processes are in place for discussions about partner notification to take place when people are diagnosed with an STI. Service providers ensure that they have clear partner notification procedures in place, including referral pathways to specialist providers, so that people can be supported to notify their partners.

**Healthcare professionals** (such as GPs, practice nurses and sexual health consultants) ensure they are aware of local partner notification procedures and provide support to 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 and may require referral to a specialist service.

**Commissioners** (integrated care systems, clinical commissioning groups, local authorities and NHS England) ensure that they commission services that support people who are diagnosed with an STI to notify their partners. Commissioners ensure that the roles and responsibilities of different services in relation to partner notification are clear and that referral pathways are in place. Commissioners regularly monitor and review the overall effectiveness of local partner notification procedures.

**People diagnosed with an STI** are given encouragement and support from a healthcare professional to tell their partners about the STI. This will help partners to get tested as soon as possible and to receive treatment if they are also infected.

## Source guidance

Reducing sexually transmitted infections. NICE guideline NG221 (2022), recommendations 1.3.1 to 1.3.5

## Definitions of terms used in this quality statement

### Support to notify their partners

Advise people diagnosed with an STI about the importance and benefits of partner notification, the possibility of sex partners being infected even if asymptomatic, and the risk of reinfection. Encourage them to engage in partner notification, regardless of where they are tested and discuss the different methods of partner notification with them.

Help people decide how to notify their sex partners. Discuss ways of having these potentially difficult conversations and suggest ways to deliver this information. Discuss the best method of partner notification in light of the person's relationship status and other circumstances. Alternative methods of disclosure may need to be used in different contexts (for example, those who may be at risk of domestic violence, or if the person expresses a need for anonymity).

There should be a clear referral pathway to specialist sexual health services that can help with partner notification so that people can be referred seamlessly and without the need for self-referral. If a person feels unable to tell their sex partners about the STI or is showing signs of difficulty dealing with their diagnosis, refer them to specialist sexual health services that can offer them more support with partner notification.

Partner notification on behalf of a person with an STI should be carried out by professionals with expertise in contact tracing and counselling. [[NICE's guideline on reducing sexually transmitted infections](#), recommendations 1.3.1 to 1.3.5]

### 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 who do not speak or read English, or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

# Update information

## Minor changes since publication

**June 2022:** Changes have been made to align this quality standard with the updated [NICE guideline on reducing sexually transmitted infections](#). Links, measures, definitions and source guidance references have been updated throughout. Additional source guidance references have also been added to statements 1 and 2.

## 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 our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

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 guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to 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 summary report for the NICE guideline on reducing sexually transmitted infections](#) to help estimate local costs.

## Diversity, equality and language

During the development of this quality standard, equality issues were considered and [equality assessments for this quality standard](#) 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.

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## Endorsing organisation

This quality standard has been endorsed by The Department of Health and Social Care, as required by the Health and Social Care Act (2012)

## Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Faculty of Sexual and Reproductive Healthcare](#)
- [Family Planning Association](#)
- [Royal College of General Practitioners \(RCGP\)](#)
- [National AIDS Trust](#)
- [British HIV Association](#)
- [British Association for Sexual Health and HIV](#)

- Brook
- Public Health England