NHS Quality Improvement Scotland

Standards ~ *March 2008*

# Sexual Health Services

NHS Quality Improvement Scotland is committed to equality and diversity. We have assessed this area of work for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. An equality and diversity impact assessment report has been published along with these standards and is available online or in hardcopy on request.

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# 1 Introduction

### Sexual health services in NHSScotland

Scotland has a history of poor sexual health with rising incidence of sexually transmitted infections, including HIV, and has one of the highest teenage pregnancy rates in Europe. Many sexual health indicators are worse where people are poorest. Although sexual health services in Scotland treat large numbers of individuals with low cost interventions, in many cases, services have been poorly developed through under-investment, lack of strategic leadership and low prioritisation. As a result of this, wide variations in access and quality exist among different NHS board areas. In addition, the personal and sensitive nature of sexual health and the stigma associated with use of services have resulted in lack of public involvement and difficulty in ascertaining a patient voice.

### Respect and Responsibility

Scotland's first national sexual health and relationships strategy, Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health[1], was launched in January 2005 with £15 million of funding over 3 years. This funding was extended by the Scottish Government within Better Health, Better Care: Action Plan (2007)[2].

A range of actions were set out in Respect and Responsibility[1] to enhance sexual health promotion, education, and service provision. The National Sexual Health Advisory Committee (NSHAC) was established to provide strong national leadership, bringing together key stakeholders who could influence the wider aspects of sexual health. Recognising the many dimensions of sexual health, the NSHAC set up a number of subgroups to look at particular issues such as national data collection, rural issues and staff training, as well as engaging with key stakeholders from both within and outside the NHS to address the wider societal issues related to sexual health.

### Role of sexual health services in learning and prevention

As Respect and Responsibility[1] emphasised, improving sexual health is not just about improving clinical services. Services also make a contribution to the wider effort to promote good sexual health rather than simply dealing with the consequences of sexual behaviour.

The variable quality and amount of sexual health and relationships education provided to individuals demands that clinical services make efforts to prevent poor sexual health by educating those who attend and by supporting behaviour change. Provision of safer sex advice and condom distribution are integral to this. Prevention is also achieved by detecting asymptomatic infection to prevent onward transmission, by provision of effective contraception to prevent unintended conception, by offering vaccination, and by working with partner organisations.

Clinical services are also vital to the delivery of public health improvement more generally and to support the wider drive to reduce health inequalities in Scotland.

## 2 Development of the standards for sexual health services

### Context

To fulfil the role assigned to it in Respect and Responsibility[1], NHS Quality Improvement Scotland (NHS QIS) was tasked with taking forward the development of appropriate clinical standards in relation to sexual health services provided by or secured by NHSScotland. NHS QIS convened a preliminary project group to consider both the work of NHS QIS and that of other organisations to improve the quality of sexual health service provision. The project group made the following four recommendations in its preliminary report published in June 2006.

- The need to develop service-level standards for sexual health focusing on the following six key themes:

  - access to services
  - co-ordination of approach
  - capacity of services
  - equity of service provision
  - choice of service provision, and
  - quality of care delivery.

- Support for the development of sexual health managed clinical networks (MCNs).

- Support for the development of key clinical indicators for sexual health.

- A cohesive approach to all quality work within sexual health services.

### Scoping process

The development of NHS QIS service-level standards commenced in summer 2006. As a first step, a scoping exercise to review current evidence relating to sexual health services and define the topic areas of the standards was undertaken, details of which are available on request. A meeting of non-statutory sector representatives took place in November 2006 to ensure user perspectives were taken into account.

### Standards development

To take forward the development of the standards, NHS QIS appointed a project group, which met between January and May 2007. The project group membership is set out in Appendix 3.

NHS QIS also appointed an advocacy group, consisting of non-statutory sector representatives, to work in parallel with the project group to ensure user and potential user issues remained central to the development of the standards. The group's membership is in Appendix 4. As well as contributing to the content of the draft standards, the advocacy group helped prepare a short summary document for the public giving details of what individuals can expect from sexual health services as well as information to help empower individuals to safeguard their own sexual wellbeing. This document, approved by the advocacy group, has been offered to NSHAC to consider how it can be put to best use (see Appendix 5).

The standards development process highlighted from the outset that remote and rural areas face specific challenges in delivering generic and specialist sexual health services. These issues include geographical distance, travelling time, communities that consider themselves separate from a city even if they are geographically close, and perceptions around confidentiality and anonymity. NHS QIS convened a remote and rural meeting of executive directors, lead clinicians, health promotion and public health professionals from

NHS boards with the highest percentages of population living in remote and rural areas to discuss these issues prior to the publication of the draft standards.

**Consultation**

Following publication of the draft standards in July 2007, the standards were widely circulated to relevant professional groups, health services staff, voluntary organisations and individuals, providing them with the opportunity to influence the development of the final standards. NHS QIS used several consultation methods including open meetings, pilot peer review visits and formal public consultation to test the measurability of the standards. All feedback from the consultation phase was considered by the project group in order to develop the final standards. The response of the project group to each comment is available on the NHS QIS website (www.nhshealthquality.org).

**To whom do these standards apply?**

These standards are applicable to all sexual health services provided by and secured by NHS boards (including NHS 24). The standards are linked to measurable outcomes and data that can be collected by self-assessment. The aim of the standards is not to tell NHS boards how to arrange services locally as each NHS board will develop solutions according to its local circumstances. The standards, therefore, focus on outcomes rather than process.

**Service definitions**

For the purpose of this set of standards, **specialist sexual health services** are defined as clinical services whose primary function is delivery of sexual health. Examples are the specialty of genitourinary medicine and the specialty of sexual and reproductive health (formerly known as family planning). Because of the need for access to specialist sexual health services within 2 working days as defined in Standard 1, this working definition excludes specialist services with remits limited only to psychosexual health, gender dysphoria and sexual dysfunction. Provision of safer sex advice, condom distribution schemes and infection prevention are an integral function of specialist sexual health services.

**Specialist sexual health services** can also be provided to an extent in **general practice**, providing staff are trained to the appropriate competencies as defined in Standard 9 and such services are supported by consultants in genitourinary medicine and by consultants in sexual and reproductive health. It is appropriate for uncomplicated sexually transmitted infections and reproductive health presentations to be managed locally within 30 minutes travelling time; however, it may be necessary to refer complex or specialist conditions to regional centres. A formal care pathway as part of an MCN would be a mechanism to achieve this.

**Generic sexual health services** are defined as NHS services that provide sexual health services as one of a broad range of more general services, such as in primary care, gynaecology outpatients, community pharmacists and youth services. It is also recognised that acute sexual health interventions are delivered by emergency medicine departments.

Sexual health interventions provided by non-statutory sector services not secured by the NHS, the private sector, schools and higher learning establishments without direct NHS support are all outside the scope of NHS QIS. However, there is an expectation that within these organisations, standards at least meet the minimum criteria. A key role of NHS specialist sexual health services is to support work done by stakeholders and partners such as local authorities.

**Following discussion in the advocacy and project groups, the preferred term to describe those using the services was agreed to be 'individuals' in preference to 'patients' or 'clients'. Unless otherwise specified, this is an inclusive term with no assumption made in relation to age, gender, gender identity, sexual orientation, ethnic origin, disability, housing status or engagement in paid-for sex.**

HIV treatment and care provision was specifically excluded from the scope of the NHS QIS sexual health service standards project with the exception of sexual health provision as described in Standard 5. There are numerous international guidelines already in existence for clinical management of opportunistic infection and for antiretroviral therapy. Following wide consultation, UK standards for HIV clinical care produced by the British HIV Association, Royal College of Physicians, British Association for Sexual Health and HIV and British Infection Society were launched in March 2007 (available at http://www.bhiva.org/cms1191535.asp). NHS QIS is currently considering how best to support implementation of HIV standards in Scotland.

## 3 Standards for sexual health services

### Access to services

**Standard 1** **Comprehensive provision of specialist sexual health services**

**Standard 2** **Sexual health information provision**

**Standard 3** **Services for young people**

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### Co-ordination of approach

**Standard 4** **Partner notification**

**Standard 5** **Sexual healthcare for people living with HIV**

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### Capacity of services

**Standard 6** **Termination of pregnancy**

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### Equity of service provision

**Standard 7** **Hepatitis B vaccination for men who have sex with men**

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### Choice of service provision

**Standard 8** **Intrauterine and implantable methods of contraception**

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### Quality of care delivery

**Standard 9** **Appropriately trained staff providing sexual health services**

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## Standard 1: Comprehensive provision of specialist sexual health services

**Standard Statement 1**
A comprehensive range of specialist sexual health services is provided locally and individuals with the greatest need are treated as a priority.

**Rationale**

Each NHS board is expected to provide the full spectrum of sexual health services to meet the identified needs of its local population and to prevent inequity among NHS board areas. NHS boards are responsible for ensuring that sexual health services provide high quality delivery of care consistent with current evidence-based practice.

Prompt access to sexual health services is necessary to reduce individual morbidity and to maintain public health. Services are required to offer access to individuals with priority sexual health conditions within 2 working days.

Individuals in the following categories will be given the highest priority in NHSScotland.

- Individuals with symptoms suggestive of an acute sexually transmitted infection (eg genital pain or ulceration, genital discharge or systemic symptoms suggestive of a sexually transmitted infection or HIV seroconversion).
- Individuals who have been diagnosed with an acute sexually transmitted infection.
- Individuals who have had sexual contact with a person known to have been diagnosed with an acute sexually transmitted infection.
- Requests for emergency contraception or termination of pregnancy.
- Women who have run out of hormonal contraceptive supplies or who are late for a contraceptive injection.
- Recent sexual assault.
- Individuals aged less than 16 years.
- Recent HIV or hepatitis B exposure.

It is anticipated that this list is widely circulated to all frontline staff to ensure those individuals with the greatest clinical need are accorded due priority.

References: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26

**Essential Criteria**

1.1 The NHS board has integrated local specialist sexual health services, which as a minimum, deliver a full range of contraception options, facilities for the diagnosis and treatment of all sexually transmitted infections in both men and women, and HIV testing and counselling.

1.2 There is a minimum of 2 full days per week of integrated local specialist sexual health service provision available within 30 minutes travel time from each settlement of over 10,000 people.

1.3 80% of individuals with priority sexual health conditions are offered the opportunity to be seen within 2 working days of initial contact with a specialist sexual health service.

1.4 There are targeted services for communities or individuals with specific needs.

1.5 There is a mechanism in place to monitor missed telephone calls (9am–5pm) to specialist sexual health services.

1.6 The standard of specialist sexual health service accommodation conforms with recommendations made by Department of Health[19], Health Services Building Notes[20] and the Monks report[21].

1.7 The emphasis of services is not just on sexual ill health but also on promoting good health including the provision of services for the delivery of condoms and safe sex advice, assessment of psychosexual health, gender dysphoria, and sexual dysfunction.

1.8 There is a system in place to ensure that national guidelines on clinical governance, clinical effectiveness and child protection are disseminated to specialist and generic sexual health service providers.

1.9 Evidence is available to demonstrate local care protocols are adapted to include recommendations made in national guidelines produced by the British Association for Sexual Health and HIV (BASHH), the Faculty of Reproductive and Sexual Health (FRSH) and the Royal College of Obstetricians and Gynaecologists (RCOG) in relation to sexual health.

**Desirable Criterion**

1.10 50% of all individuals requesting a booked appointment are offered one within 5 working days of initial contact with a specialist sexual health service by the end of 2011.

## Standard 2: Sexual health information provision

**Standard Statement 2**
The public has access to accurate and consistent information about sexual health relevant to its needs.

**Rationale**

Individuals need access to accurate, unbiased information about sexual health and available services. Inconsistent or incorrect information can be at best confusing to the public and at worst can perpetuate ill health. There is, therefore, merit in ensuring that NHS information providers work with each other to ensure consistency of approach.

There is also an expectation that information is in a format which can be offered to partner organisations outside the NHS for further dissemination to the public.

References: 1, 27, 28, 29, 30

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**Essential Criteria**

2.1 The NHS board has a system in place to identify the diverse sexual health information needs of its population and to respond to those needs appropriately using relevant information formats.

2.2 There are clear and effective arrangements to ensure accurate information describing sexual health conditions and local service provision arrangements. The information details links with partner organisations outside the NHS, such as local authorities.

2.3 Updated accurate information on local sexual health service provision is made available to other NHS boards, including NHS 24, and to partner organisations outside the NHS.

2.4 Information about time-dependent sexual health emergencies (eg emergency contraception, postexposure prophylaxis) is available locally.

## Standard 3: Services for young people

**Standard Statement 3**
NHS boards ensure the development and delivery of integrated approaches to sexual health improvement, particularly in relation to young people.

**Rationale**

Accessibility of sexual health services to young people, and the attitudes and approach taken, is key to tackling poor sexual health including sexually transmitted infections and unintended pregnancy.

The role of parents and carers is increasingly being understood as critical to the likelihood of positive choices being made by young people. Evidence indicates that the most successful approaches to tackling teenage pregnancy and poor sexual health outcomes among young people incorporate an integrated multi-agency approach.

The highest prevalence of genital chlamydia infection is in those aged under 25 with about 1 in 10 of those currently tested found to be infected. Therefore the level of opportunistic testing is an important marker of sexual health engagement with young people. Recent review of the evidence suggests that long term complication rates of chlamydia might be lower than originally thought but it remains necessary to treat individuals to prevent short term morbidity and to break chains of transmission. It is emphasised that this standard does not advocate a national chlamydia screening programme but supports opportunistic testing for young people at levels representing existing best practice in Scotland. Testing levels in Criteria 3.2, 3.3 and 3.8 are informed by key clinical indicator data. A revised SIGN 42 guideline on chlamydia is currently in development.

References: 4, 5, 9, 10, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40

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**Essential Criteria**

3.1 60% of chlamydia tests per year are taken from males and from females aged under 25 years.

3.2 The annual rate of chlamydia tests performed in the NHS board area is greater than 100 per 1,000 males aged 15–24 years.

3.3 The annual rate of chlamydia tests performed in the NHS board area is greater than 300 per 1,000 females aged 15–24 years.

3.4 There is evidence of active engagement of local key partners including health, education, social work, youth services and the voluntary sector, to improve sexual health for young people and reduce teenage pregnancy.

3.5 Emergency contraception is well publicised and available for young people.

3.6 Targeted interventions are demonstrated for young people at greatest risk of teenage pregnancy and poor sexual health, including looked-after children.

3.7 The NHS board supports the delivery of sex and relationship education training for professionals in partner organisations such as youth workers and social workers who work with the most vulnerable young people.

**Desirable Criterion**

3.8 The annual rate of chlamydia tests performed in the NHS board area is greater than 300 per 1,000 males aged 15–24 years.

## Standard 4: Partner notification

**Standard Statement 4**
Individuals who are diagnosed with a sexually transmitted infection see an appropriately trained member of staff to organise partner notification (contact tracing).

**Rationale**

Partner notification (contact tracing) is an essential element in maintaining public health as it breaks the chain of transmission and reduces the incidence of sexually transmitted infections.

Sexual health advisers are practitioners specifically trained in partner notification and are usually based in genitourinary medicine clinics. Nurse-led partner notification, with support from sexual health advisers, is an effective strategy for ensuring treatment of the sexual partners of people diagnosed in primary care with uncomplicated chlamydia. This strategy can also be extended to nurses in sexual health clinics, community pharmacies, youth sexual health services and other settings.

References: 9, 10, 41, 42, 43, 44, 45, 46

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**Essential Criteria**

4.1 A sexual health adviser, or a professional trained and supported by a sexual health adviser (eg a practice nurse), is available to all individuals diagnosed with chlamydia or gonorrhoea.

4.2 Individuals are offered partner notification in all settings delivering sexual healthcare, including in primary care, youth services and community pharmacies.

4.3 For every 100 individuals diagnosed with chlamydia in specialist sexual health settings, 64 contacts are verified as having attended within 90 days of the first partner notification interview.

**Desirable Criterion**

4.4 80% of individuals diagnosed with gonorrhoea, syphilis or HIV infection are seen for partner notification within 5 working days of the diagnosis being made by a sexual health adviser, or a professional trained and supported by a sexual health adviser.

## Standard 5: Sexual healthcare for people living with HIV

**Standard Statement 5**
Individuals attending for ongoing HIV care are offered high quality sexual and reproductive healthcare to improve personal wellbeing and to minimise the risk of transmitting infections to others.

**Rationale**

Quality of life for people living with HIV has improved since the availability of effective antiretroviral therapy. High quality sexual and reproductive healthcare is important for the wellbeing of individuals and to prevent onward transmission of infections and unplanned pregnancy.

A non-judgemental and culturally-sensitive approach is essential.

References: 4, 5, 10, 47, 48, 49, 50, 51, 52

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**Essential Criteria**

5.1 90% of adults receiving ongoing HIV care have the result of syphilis serology taken within the preceding 6 months recorded in their HIV records, or documentation why this is not required updated at 6 monthly intervals.

5.2 80% of HIV+ adults presenting for the first time in Scotland have their sexual and reproductive history documented within 4 weeks of their initial HIV diagnosis, and are given advice to prevent onward HIV transmission, backed by the availability of condoms.

5.3 80% of adults receiving ongoing HIV care have an offer of a sexual health screen at least once every 12 months. If a sexual health screen is not required or if the offer is declined, this information is documented at 12 monthly intervals.

5.4 There is a documented local care pathway for sexual and reproductive healthcare, including provision of contraceptive counselling and condoms for individuals with HIV, and this is communicated directly to HIV+ individuals and to organisations who provide support for individuals with HIV.

## Standard 6: Termination of pregnancy

**Standard Statement 6**
Women receive safe termination of pregnancy with minimal delay, followed by contraceptive advice and psychological support.

**Rationale**

The earlier a termination of pregnancy is performed, the lower the risk of complications. Services must, therefore, offer arrangements that minimise delay in providing a safe termination of pregnancy, whilst also allowing sufficient time for reflection to consider other options.

In accordance with the Royal College of Obstetrician and Gynaecologists guidelines, 'no woman should have to wait longer than 3 weeks from her initial referral to termination'. Eligible women ought to be offered a choice of medical or surgical termination of pregnancy.

Approximately 1 in 4 women who have a termination of pregnancy subsequently have another termination of pregnancy. Advice about effective contraception following termination of pregnancy is essential to reduce termination of pregnancy rates.

References: 1, 4, 5, 9, 10, 53, 54, 55, 56

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**Essential Criteria**

6.1 70% of women seeking termination of pregnancy undergo the procedure at 9 weeks gestation or earlier.

6.2 There is a mechanism to ensure that all women are offered, at the time of termination of pregnancy, a range of contraceptives in addition to condoms, including implants or intrauterine methods where appropriate.

6.3 60% of women leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).

6.4 Post termination of pregnancy counselling to provide psychological support is available within 4 weeks for women (and their partners) who request it.

6.5 The NHS board has an agreed referral mechanism in place (where services are not available locally) for women who require a termination of pregnancy up to the legal time limit for such procedures.

## Standard 7: Hepatitis B vaccination for men who have sex with men

**Standard Statement 7**
Men who have sex with men who are at risk of sexually transmitted hepatitis B are offered vaccination.

**Rationale**

Hepatitis B is more prevalent in men who have sex with men (MSM) than in the general population and can be transmitted by sexual contact. A safe, cost-effective vaccine offering protection has been available for over 20 years. Hepatitis B immunisation also offers an opportunity to engage with MSM to support safer sex interventions and to address inequalities.

References: 4, 5, 10, 57, 58, 59

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**Essential Criteria**

7.1 There is a protocol to promote hepatitis B vaccination of all individuals in community settings such as primary care who are at increased risk of hepatitis B.

7.2 MSM have a choice of where hepatitis B vaccination is available, with a protocol to promote hepatitis B vaccination of all individuals at risk outside specialist sexual health services. Information on other health promoting activities such as risk reduction and sexually transmitted infection testing is also available in that setting.

7.3 70% of all MSM attending specialist sexual health services and not known to be immune to hepatitis B receive at least one dose of hepatitis B vaccine.

## Standard 8: Intrauterine and implantable methods of contraception

**Standard Statement 8**
All individuals have access to intrauterine and implantable methods of contraception.

**Rationale**

Intrauterine and implantable contraceptives are more effective than oral contraceptives or barrier methods in preventing unintended pregnancy because they are independent of adherence to therapy for their effectiveness.

Intrauterine systems and implants are more cost effective than the combined oral contraceptive pill even if continued for only 1 year. This outweighs the higher initial costs and time involved in insertion. Increasing the use of these methods will result in a reduction in unintended pregnancy rates.

Once correct insertion has been verified, women using either contraceptive implants or intrauterine methods require no routine regular follow-up until the method is due to be changed. It is anticipated that wider availability of intrauterine and implantable contraception will reduce the number of women requiring sterilisation procedures. The rates of prescribed contraception in Criteria 8.2 and 8.5 are informed by existing best practice.

Reference: 60

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**Essential Criteria**

8.1 Women requiring contraception are given information (including written information) about, and offered a choice of, all methods of contraception including intrauterine and implantable contraceptives.

8.2 60 or more females per 1,000 females of reproductive age per year are prescribed intrauterine and implantable contraceptives.

8.3 Contraceptive service providers who do not provide intrauterine and implantable contraceptives within their own practice or service have an agreed mechanism in place for referring women for intrauterine and implantable contraceptives.

8.4 A consultation appointment with a service providing intrauterine and implantable contraceptives is available within 5 working days.

**Desirable Criterion**

8.5 100 or more females per 1,000 females of reproductive age per year are prescribed intrauterine and implantable contraceptives by the end of 2011.

## Standard 9: Appropriately trained staff providing sexual health services

**Standard Statement 9**
All staff who deliver sexual health services are adequately and appropriately trained.

**Rationale**

Delivering sexual healthcare requires generic competencies, delivered to a high level by all staff, especially in relation to confidentiality, a non-judgemental sensitive approach, and knowledge of child protection and chaperoning policies. Additional clinical skills required include sexual history taking and intimate examination.

All NHS boards require access to fully trained consultants holding the appropriate postgraduate qualifications in order to support service delivery, act as local champions and to deliver more complex care. Although generic integrated sexual health services can be delivered by a range of staff, complex care necessitates specialist local expertise drawn from both the specialty of genitourinary medicine and the specialty of sexual and reproductive health (formerly known as family planning).

Work is ongoing to develop accredited training to deliver sexual and reproductive health competencies in Scotland, especially for professionals and volunteers not working in specialist settings.

References: 61, 62, 63, 64, 65, 66, 67

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**Essential Criteria**

9.1 The NHS board has a contracted arrangement for clinical services to be led locally by a consultant holding a certificate of completion of training in genitourinary medicine.

9.2 The NHS board has a contracted arrangement for clinical services to be led locally by a consultant holding a certificate of completion of training in obstetrics and gynaecology and with sub-specialty (or equivalent) training in sexual and reproductive health.

9.3 All health professionals providing sexual health interventions in both generic and specialist services demonstrate knowledge gained from post registration courses in sexual health and provide evidence of relevant continuing professional development.

9.4 There is a local induction programme for all staff in generic and specialist sexual health services which includes training in confidentiality, information handling, the use of chaperoning for intimate examinations and child protection in relation to sexual health.

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## 5 Appendices

**Appendix 1 About NHS Quality Improvement Scotland**

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**Appendix 4 Membership of the standards for sexual health services advocacy group**

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**Appendix 5 Rights and responsibilities**

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## Appendix 1: About NHS Quality Improvement Scotland

NHS Quality Improvement Scotland was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

We achieve our objectives through five key functions that link together:

- providing clear advice and guidance on effective clinical practice
- setting clinical and non-clinical standards of care
- reviewing and monitoring the performance of NHS services
- supporting NHS staff in improving services, and
- promoting patient safety and implementation of clinical governance.

We deliver our commitments to the public and to NHSScotland by following an approach that is:

- **independent** – we reach our own conclusions and report on what we find
- **open and transparent** – we explain what we do, how and why we do it, and what we find, using language and formats that are easy to understand and to access
- **sensitive and professional** – we recognise needs, beliefs and opinions and respect and encourage diversity.

Our work is:

- **partnership-focused** – we work with patients and the public, NHSScotland and many organisations to improve the quality of care and avoid duplication
- **evidence-based** – we base our conclusions and recommendations on the best evidence available
- **quality-driven** – we make sure our own work is monitored and evaluated, internally and externally.

# Appendix 2: Development of NHS Quality Improvement Scotland standards

## Basic principles

A major part of the remit of NHS QIS is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, NHS QIS sets standards for clinical services, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service.

In fulfilling its responsibility to develop and run a system of quality assurance, NHS QIS takes account of the principles set out in Fair for All and Partnership for Care, to ensure that 'our health services recognise and respond sensitively to the individual needs, background and circumstances of people's lives'.

NHS QIS standards are developed in accordance with the commitments of the National Health Service Reform (Scotland) Act (2004) which state that 'individual patients receive the service they need in the way most appropriate to their personal circumstances and all policy and service developments are shown not to disadvantage any of the people they serve'.

Therefore NHS QIS endeavours to ensure that consideration of equality and diversity issues feature prominently in the design, development and delivery of all its functions and policies.

## Format of NHS QIS standards and definition of terminology

NHS QIS standards are designed to be clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. All NHS QIS standards follow the same format.

- Each standard has a **title**, which summarises the area on which that standard focuses.
- This is followed by the **standard statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the standard is considered to be important.
- The standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached. Some criteria are **essential**, in that it is expected that they will be met wherever a service is provided. Other criteria are **desirable** in that they are being met in some parts of the service, and demonstrate levels of quality, which other providers of a similar service should strive to achieve. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering of the criteria is not a reflection of priority.

## Clinical governance and risk management standards

Every individual using healthcare services should expect these to be safe and effective. There are existing NHS QIS standards for clinical governance and risk management to ensure NHS boards can provide assurance that clinical governance and risk management arrangements are in place, and that they are supporting the delivery of safe, effective, patient-focused care and services.

The clinical governance and risk management standards underpin all care and services delivered by NHSScotland and provide the context within which NHS QIS service and condition-specific standards apply. They should be read in conjunction with these sexual health standards.

The clinical governance and risk management standards are available on request from NHS QIS or can be downloaded from the website (www.nhshealthquality.org).

**Assessment of performance against the standards**

After publication of the final standards document, each relevant NHS board is asked to undertake a self-assessment of its service against the standards. A review team visits the NHS board on behalf of NHS QIS to follow up this self-assessment exercise with an external peer review of performance in relation to the standards. To minimise duplication of work for NHS boards and to ensure a consistent quality assurance framework and reporting mechanism, areas covered by NHS QIS standards complement the key clinical indicators that NSHAC is developing.

Action 13 subgroup of NSHAC was tasked with developing sexual health information. In parallel, the National Clinical Dataset Development Project has been working on developing national clinical data definition standards in the area of sexual health – the first phase of this work has been approved and the second phase is now in development. As a result of these two pieces of work, and also the work on key clinical indicators, there has recently been considerable emphasis on sexual health data analysis performed centrally by Information Services Division (ISD) and Health Protection Scotland (HPS). This means that some of the data required by NHS boards to produce their self-assessments are already available from ISD and are in the public domain. Some of these comparative data have already been used by NHS boards for benchmarking exercises. Such data include those relating to termination of pregnancy, chlamydia testing and HIV. Information about this can be found on the key clinical indicators website (www.isdscotland.org/kci)

**Revision of the standards**

NHS QIS standards are considered for revision and updating every 3 years. If a revision of a set of standards is undertaken the original standards will be withdrawn and the revised standards would be considered for further updating every 3 years thereafter.

# Appendix 3: Membership of the standards for sexual health services project group

| Name | Title | NHS board area/ Organisation represented |
|---|---|---|
| Mr James T Brown CBE | Chair | Lothian |
| Dr Steve Baguley (from September 2007) | Consultant in Genitourinary Medicine | British Association for Sexual Health and HIV |
| Dr Eric Baijal | Director of Public Health | Directors of Public Health Group |
| Dr Alison Bigrigg | Chair, NSHAC subgroup 12 | National Sexual Health Advisory Committee |
| Dr Jim Chalmers | Consultant in Public Health Medicine | Information Services Division, NHS National Services Scotland |
| Dr Gillian Flett | Consultant in Sexual and Reproductive Health | Royal College of Obstetricians and Gynaecologists |
| Professor Anna Glasier | Lead Clinician for Sexual Health | Faculty of Family Planning and Reproductive Healthcare |
| Professor David Goldberg | Consultant Epidemiologist | Health Protection Scotland, NHS National Services Scotland |
| Mrs Hawys Kilday | Chief Executive | Caledonia Youth |
| Dr Gordon McKenna (until September 2007) | Consultant in Genitourinary Medicine | British Association for Sexual Health and HIV |
| Mr Martin Murchie | Senior Sexual Health Adviser | Society of Sexual Health Advisers |
| Dr Rak Nandwani | Clinical Adviser | NHS Quality Improvement Scotland |
| Dr Anne Nicolson (until May 2007) | General Practitioner representing rural interests | NHS Orkney |
| Mrs Ailsa Spindler (from January 2008) | Highland Services Manager | Terrence Higgins Trust |
| Dr Ewen Stewart | General Practitioner | Royal College of General Practitioners |
| Mrs Julia Trowell | Senior Lead Nurse | Royal College of Nursing |
| Mr John Watson | Chair, Advocacy Group | Ayrshire & Arran |
| Dr Andrew Winter | Chair, Sexual Health Data Standards Clinical Working Group | National Clinical Dataset Development Programme |

## Appendix 4: Membership of the standards for sexual health services advocacy group

| Name | Title | NHS board area/ Organisation represented |
|---|---|---|
| Mr John Watson | Chair | Ayrshire & Arran |
| Mr Steve Aitken | Health Inclusion Project | Stonewall Scotland |
| Ms Jackie Anderson | Information Officer | Family Planning Association |
| Mr Paul Barton | Project Manager | Fair for all – LGBT |
| Ms Nine Davidson | Project Worker | Scottish Prostitutes Education Project |
| Miss Kez Dugdale | Public Affairs Officer | National Union of Students |
| Ms Heather Gourlay | Infection Control Adviser | Scottish Prisons Service |
| Ms Marion Harkin | Counselling Supervisor | Childline Scotland |
| Mr Michael McGrath | Director | Scottish Catholic Education Service |
| Ms Fiona Mitchell | Health Co-ordinator | Barnardo’s |
| Dr Rak Nandwani | Clinical Adviser | NHS Quality Improvement Scotland |
| Mr Tarsisio Nyatsanza | African Health Project Outreach Worker | Waverley Care |
| Ms Liz Rowlett | Parliamentary and Policy Information Officer | Scottish Disability Equality Forum |
| Ms Cara Spence | Lothian Team Leader | LGBT Youth Scotland |
| Mrs Ailsa Spindler | Highland Services Manager | Terrence Higgins Trust |
| Ms Sarah Watson | Women's Officer | National Union of Students |
| Dr Ann Wilson | Convenor | Inclusion Scotland |
| Mrs Dianna Wolfson | Convenor | Scottish Interfaith Council |

Support of the project and advocacy groups from NHS QIS is provided by the Standards Development Unit: Ms Hilary Davison (Head of Standards Development Unit), Miss Louise Fitzpatrick (Project Officer), Miss Margaret McAlees (Project Administrator) and Mr Neill O’Shaughnessy (Senior Project Officer).

## Appendix 5: Rights and responsibilities

# Worried about your sexual health?

### What you can expect from sexual health services provided by the NHS in Scotland

Wherever you live, whoever you are - a choice of free, confidential, non-judgemental sexual health services will be available to suit your needs.

If you have a condition which needs to be treated urgently you will be seen by a specialist within two working days.

The staff you see will be properly trained in dealing sympathetically with sexual health matters and will treat you with respect.

You can be assured that the sexual health service you go to is keeping up to date with best recognised national standards.

Information you are given about sexual health will be consistent, accurate and up to date.

If you are diagnosed with a sexually transmitted infection you will be offered help to make sure the people you've had sex with are also seen, if you are happy for this to happen.

Your sexual health is important and we are positive about supporting you to enjoy it safely.

- If you are under 25 and sexually active you may consider having a test for chlamydia.
- You will be offered vaccination against hepatitis B if you are at increased risk of being infected through sex.
- The full range of contraceptive methods will be available to you wherever you live.
- If you are a woman who needs a termination of pregnancy this will be carried out safely without a long delay, followed by a choice of contraception and psychological help if you wish.
- If you are HIV+ you will be offered services to support your sexual health and wellbeing.

## What we expect of you

In return, there are a few things that you can do to make sure you continue to enjoy positive sexual health.

Respect yourself and your partner.

Protect yourself and protect others.

Consider the consequences before having sex and take precautions to avoid pregnancy.

Remember that if you're drunk or under the influence of drugs you might not be as good at weighing up risks if you have sex, especially with people you have not met before.

Bear in mind that having two or more sexual partners in a short space of time increases the risk of transmitting infections.

Don't force anyone to have sex against their will or if they cannot give proper consent.

If you have symptoms, it's a good idea to seek care promptly and avoid having sex before you have treatment.

When you make your appointment, tell us (truthfully!) if you feel you need to be seen urgently.

Attend your appointment or let us know as soon as possible if you can't make it so that we can arrange to see someone else.

Be respectful towards our staff.

Use any medicines we give you in the right way and finish your full course of treatment.

We value comments, good or bad, to help us improve sexual health services. If you are not happy about anything, please let us know. If you can, first talk to a member of staff involved in your care. Or if you prefer you can discuss matters with a senior member of staff.

## Appendix 6: Glossary

| | |
|---|---|
| **30 minutes travelling time** | Travel no more than 30 minutes (by any method of transport) to access specialist sexual health services. |
| **adult** | An individual aged 16 years or over. |
| **antiretroviral therapy** | Drugs used to treat the HIV virus. HIV belongs to a family of viruses called retroviruses. |
| **chlamydia** | Infection caused by certain subtypes of *Chlamydia trachomatis*. Genital infection can cause inflammation of the sexual organs and infertility. However, it does not cause any symptoms in most people and so can be passed on without individuals knowing they have it. Chlamydia can also be passed from mother to baby. |
| **full range of contraception options** | Including injectable, intrauterine devices and systems, and implants. |
| **gender dysphoria** | A person with gender dysphoria experiences anxiety, uncertainty or persistently uncomfortable feelings about their birth gender. They feel that they have a gender identity that is different from their anatomical sex. |
| **genitourinary medicine** | Medical specialty relating to the diagnosis and management of sexually transmitted infections (including HIV) and other genital conditions in both men and women. |
| **gonorrhoea** | Sexually transmitted infection caused by *Neisseria gonorrhoeae*. Usually causes a purulent discharge from the urethra in men, or the cervix in women, or can infect the throat or rectum. Gonorrhoea can also be passed from mother to baby. |
| **hepatitis B** | Virus spread through the blood or bodily fluids from an infected person, including by sex, sharing needles or blood products. Can cause liver inflammation or failure. Rare cause of liver cancer. |
| **HIV postexposure prophylaxis (PEP)** | A course of antiretroviral therapy given to someone exposed to HIV in an attempt to prevent infection. Sometimes called 'PEPSE' when relating to sexual exposure. |
| **HIV seroconversion** | The development of antibodies in the blood to the human immunodeficiency virus. This can be associated with a flu-like illness and rash and usually occurs 6–8 weeks after a person is infected with HIV. |
| **implantable methods of contraception** | An implant is a form of contraception that is placed under the skin. It releases a progestogen hormone similar to the natural progesterone that women produce in their ovaries. |
| **integrated sexual health services** | Bringing together sexual health services which are sometimes provided separately, for example, provision of contraception and diagnosis of sexually transmitted infections. |
| **intrauterine methods of contraception** | An intrauterine device (IUD) is a small plastic and copper contraceptive which fits inside the womb and can stop sperm from reaching the egg. It may also make the egg move slower down the fallopian tube or stop a fertilised egg from settling in the womb. Some devices, called intrauterine systems (IUS), release a progestogen hormone. |
| **MSM** | Men who have sex with men. MSM refers to any man who has sex with a man, whether he identifies as gay, bisexual, or heterosexual. |
| **opportunistic testing** | Testing an individual for an infection outwith a recognised national screening programme, for example, when they attend for another reason such as cervical smear testing or travel advice. |

| | |
|---|---|
| **partner notification (contact tracing)** | A process whereby the sexual partners of people with a diagnosis of sexually transmitted infection are informed of their exposure to infection. For example, for every 100 individuals diagnosed with chlamydia, 64 sexual partners are tested for chlamydia. |
| **psychosexual health** | The mental and emotional aspects of sexuality. A general term used to classify many difficulties men or women experience with their capacity to undertake sexual activity. |
| **reproductive age** | For data purposes, this is defined as females aged 15–50 years. |
| **screening** | The organisation of a system of testing to ensure complete population coverage, such as register-based call-recall cervical smears testing. |
| **sexual and reproductive health** | A medical sub-specialty of obstetrics and gynaecology relating to contraception and female sexual health (formerly known as family planning until 2007). |
| **sexual dysfunction** | A general term used to classify many difficulties men or women experience with their capacity to undertake sexual activity. |

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