



Sexual Health Services Project

Preliminary Report

June 2006

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Summary

Scotland's population suffers from poor sexual health with high rates of unwanted pregnancy and sexually transmitted infections (STIs), including HIV. These affect individuals of all age groups, including large numbers of young people and those from socially excluded communities. Sexual health services in Scotland have previously been relatively neglected owing to stigma, under-investment and lack of strategic leadership, resulting in wide variation in access and quality of services in different NHS board areas. In addition, the personal and sensitive nature of sexual health has resulted in lack of public involvement and difficulty in ascertaining a patient voice.

To address these issues, the Scottish Executive appointed a multidisciplinary expert group which reported in November 2003, leading to the publication of Scotland's first sexual health and relationships strategy, *Respect and Responsibility*. This national strategy was released in January 2005 backed initially by £15 million of new funding over three years. In this strategy, NHS Quality Improvement Scotland (NHS QIS) was specifically charged with taking forward the development of appropriate clinical standards.

To take this work forward, a sexual health services project group was set up to consider both the work of NHS QIS and that of other organisations to improve the quality of sexual health service provision. Shortly afterwards, the National Sexual Health Advisory Committee (NSHAC), chaired by the Minister for Health and Community Care, established a subgroup to develop appropriate indicators and targets. In order to ensure strategic unity, and minimise duplication of work, it was agreed that one group would be established to undertake the work required by both NHS QIS and NSHAC.

The group convened for five meetings held between September 2005 and March 2006. The group identified and discussed the following key themes around sexual health services:

- 1 access
- 2 capacity
- 3 choice
- 4 equity of service provision
- 5 co-ordination of approach
- 6 quality of care

The group subsequently developed a series of key clinical indicators (KCI) on behalf of NSHAC to monitor progress of the national strategy, and a report, on behalf of NHS QIS, making recommendations for future quality improvement work.

The five initial indicators representing the major specialisms were identified for implementation in 2006, to be followed by a further four to be taken forward for 2007. The five immediate KCIs topics are:

- abortion procedures performed at gestation of 9 or less weeks
- access to male and female sterilisation
- genital chlamydia testing by age and sex within each NHS board area
- provision of HIV therapy, and
- hepatitis vaccine uptake of men who have sex with men.

To best support improvement in the quality of care for those affected by sexual health conditions in Scotland, the group has made four recommendations for consideration by NHS QIS:

- development of service-level standards for sexual health services
- support for the development of managed clinical networks (MCNs)
- support for the development of KCIs, and
- a cohesive approach to all quality work within sexual health services.

In addition to the principal recommendations above, the group acknowledged the wider sexual health agenda being addressed by other subgroups linked to NSHAC which would support quality improvement in NHSScotland:

- quality improvement in education and training
- the establishment of managed knowledge networks (MKNs), and
- a 'scoping study' to map sexual health services in Scotland.

Acknowledgements

Many thanks to all who have given their time, expertise and knowledge to inform the recommendations made in this preliminary report. In particular, there has been considerable support for the reflective approach taken, and many useful documents, initiatives and ideas have been shared.

NHS QIS would like to thank the following in particular for their input and support:

- members of the project group (see Appendix 1)
- Ruth Lowbury, Executive Director, Medical Foundation for AIDS & Sexual Health (MedFASH)

1 Introduction

NHS QIS was set up as a special health board by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. The responsibilities of NHS QIS cover all aspects of the services provided by the NHS and provide an independent check on how these services are performing. NHS QIS also supports NHS staff by issuing clear, authoritative advice on effective clinical practice and service improvements.

NHS QIS aims to support the delivery of:

- higher standards of care
- improved outcomes for patients
- better experiences for patients and carers, and
- better value for money.

Objectives are achieved through four key functions that link together:

- providing advice and guidance on effective practice
- setting standards
- reviewing and monitoring performance, and
- supporting staff to improve services.

The purpose of this sexual health services project preliminary exercise was to gain an overview of how to most meaningfully approach quality improvement of sexual health services in NHSScotland and to identify areas which may require further investigation. This NHS QIS report is the summary of the preliminary exercise, and contains recommendations to the NHS QIS Board on how NHS QIS can best support services in improving the quality of care in this area.

In the case of this sexual health project, much of the areas for improvement, as well as current and planned work, is captured in *Respect and Responsibility*, the national strategy for improving sexual health and relationships.

2 Background to sexual health services in Scotland

Sexual health in Scotland is poor. Rates of STIs are widespread and increasing rapidly year on year, while teenage conceptions are among the highest in Western Europe. Fifty per cent of teenagers in Scotland have become sexually active by the age of 16¹ and a substantial proportion regrets this early sexual activity².

There has been a dramatic rise in diagnosed genital chlamydia infection, especially in young people. The number of diagnoses in Scotland more than doubled between 2000 and 2004 from 7,644 to 16,069 per year³, although some of the increase is related to improved sensitivity of testing, as well as an increase in the amount of testing being done. There have been marked increases in diagnoses of gonorrhoea, syphilis, herpes and genital warts since 2000³. STIs account for individual morbidity affecting physical and psychological wellbeing and can also be transmitted to others, particularly if there are delays in providing care because of poor access to services.

In 2005, 406 new cases of HIV infection were identified⁴, which is the highest ever recorded and contrasts sharply with the steady level of 150–180 new cases per year in the 1990s. Sex between men cumulatively accounts for the largest proportion of the HIV cases diagnosed to date. Recently, there has been a large rise in the number of heterosexuals infected abroad being treated in Scotland. Owing to the rapid implementation of needle exchanges and methadone projects, the number of new Scottish HIV cases acquired by needle sharing is now in single figures each year.

Scotland's rate of births in the 15–19 year old age group in 1998 was 30.6 per 1,000. This compares with rates of 6.2 in the Netherlands, 8.1 in Denmark and 9.3 in France⁵. Scotland-wide indicators published by NHS QIS⁶ showed that teenagers in the most deprived areas are three times more likely to become pregnant than their counterparts in the most affluent parts of the country.

Since 1967, when abortion was legalised in the UK, abortion rates in Scotland have risen year on year. In 2004, 12,448 pregnancies were terminated in Scotland, a rate of 11.8 per 1,000 women of reproductive age⁷. While much publicity is given to abortion among teenagers, the rate is highest among women aged between 20 and 24 (a rate of 23.0 per 1,000), arguably a group for whom access to contraception should not be difficult. Amongst all ages, abortion is related to deprivation and the rate rises from 8.5 among the least deprived quintile to a rate of 14.6 per 1,000 among the most deprived⁷.

Teenage pregnancy rates in Scotland (which include abortions and childbirth) have fallen since the early 1990s and remain static at 42.4 per 1,000 teenagers aged 13–19 in 2003/04⁷. Teenage pregnancy is closely linked to deprivation, and teenage motherhood is associated with single motherhood, lost educational opportunities, poverty and social isolation⁵. The daughters of teenage mothers are more likely to become teenage mothers themselves⁵.

Not all unintended pregnancies end in abortion. It has been estimated that up to 30% of pregnancies which end in childbirth are unplanned⁸. Unintended pregnancy can be prevented by contraceptive use, but throughout the UK few women use the most effective methods of contraception⁹. At least one third of women undergoing abortion used no contraception at the time they conceived and most of the rest were

using a method inconsistently or incorrectly¹⁰. Data specific to Scotland are hard to come by, however, in 2003/04, 3% of couples in the UK who wished to avoid pregnancy were using the withdrawal method of contraception⁹. Most women who claim to have been using contraception at the time when an unintended pregnancy was conceived were using condoms or oral contraceptives¹⁰. Both rely on perfect use for their effectiveness. The failure rate of the pill is at least 8% when used typically¹¹. Perfect use of a method which has to be used every day or with every act of intercourse is not easy, and inconsistent use is common. Only 8% of women in the UK are using long-acting reversible methods of contraception which depend much less, or not at all, on compliance for their effectiveness⁹.

Other sexual health issues (in addition to unintended pregnancy or sexually transmitted infections) can affect people throughout and beyond the reproductive years. Over 1,200 women each year are diagnosed with cancer of the cervix, uterus or ovary in Scotland⁷. Menstrual dysfunction is one of the commonest reasons for attending a GP, and sexual dysfunction among both women and men is common and often poorly managed even when people do seek advice.

In January 2005, the Scottish Executive Health Department (SEHD) published the Scottish sexual health and relationships strategy, *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health*¹², and the Minister for Health and Community Care approved funding totalling £15 million over 3 years to support improvement of sexual health services in NHSScotland. An aim of *Respect and Responsibility* was to improve the quality of sexual health services, and the ministerially-led NSHAC was established to advise on policy, monitoring, and supporting implementation of this strategy. *Respect and Responsibility* stated that the NSHAC should offer advice on developing targets appropriate to the strategy; and NHS QIS will “take forward the development of appropriate clinical standards for dealing with sexually transmitted infections in its 2005/06 work programme, in consultation with the Scottish Infection Standards and Strategy Group”.

NHS QIS invited Dr Rak Nandwani to chair a project group on the topic of sexual health services. Shortly afterwards, NSHAC established a subgroup under the chairmanship of Dr Alison Bigrigg to take forward the work on developing targets appropriate to the national strategy. In September 2005, these two groups merged under the joint chairmanship of Drs Bigrigg and Nandwani to advise both NSHAC and NHS QIS. This merger was intended to minimise duplication of work, and it was hoped that the compatibility of the group’s remits (both from NSHAC and from NHS QIS) would maintain unity of strategic direction. Group membership is given in Appendix 1.

The launch in April 2005 of *Respect and Responsibility* has resulted in an intensive period of investment and change for sexual health services. In order that NHS boards can ensure investment and change is directed according to national priorities and standards, as well as local needs, the project group feels that it is vital for NHS QIS to commence further work in the area of sexual health services as a matter of priority.

This report outlines the preliminary findings of the NHS QIS project group.

3 Methods

The remit of the NHS QIS sexual health services project group is to:

- provide expert advice and support to NHS QIS
- inform the drafting of the work programme for sexual health services, including options and recommendations
- scope NHS QIS quality assurance activity for sexual health services within NHSScotland, and
- identify NHS QIS products to support this work.

In total, five meetings of the project group were held to progress this work.

Liaison with and input from other bodies and groups was essential in gaining a full picture of current and planned work in sexual health services in NHSScotland, including current quality improvement activities. Key influences on the NHS QIS project work were:

- *Respect and Responsibility*, NSHAC, and relevant work of NSHAC subgroups
- the Medical Foundation for AIDS & Sexual Health (MedFASH), and
- the intention of the Scottish Intercollegiate Guidelines Network (SIGN) to undertake a review of *SIGN 42: Management of Genital Chlamydia Trachomatis Infection*.

Group members also sought input from key specialist and non-statutory stakeholders, including NHS QIS public partnership staff, to ensure adherence to the principles stated in *Fair for All*¹³.

4 Discussion and related work

Discussion

The NHS QIS project group noted that *Respect and Responsibility* previously made a range of recommendations, including specifically that:

- **the Scottish Executive Health Department** will monitor progress against the current target of reducing the pregnancy rate by 20% (per 1,000 population) in 13–15 year olds from 8.5 in 1995 to 6.8 in 2010 together with the further target of reducing teenage pregnancies among 13–15 year olds in the most deprived communities by 33%, from a rate of 12.6 in 2000/02 to 8.4 in 2007/09¹².
- **lead clinicians** will develop a framework to ensure that HIV testing is offered to all genitourinary medicine (GUM) clinic attendees who present with a new STI and are not known to be HIV infected. This offer should be made in the context of the HIV test being presented as a routine recommended test. Reasons for non-uptake should be recorded¹².

Because these recommendations were clearly set out in the strategy, no work was done in developing them further; however, it was noted that NHS QIS may have a role in supporting implementation mechanisms.

The group identified and discussed the following key sexual health services themes.

1 Access

There are wide variations in waiting times for sexual health services in Scotland. Where waiting times are longest, those with possible sexually transmitted infections might wait weeks for testing and treatment, and suffer physical and emotional distress as well as possibly transmit infections to others in that time. For particular sexual health issues, such as management of sexual dysfunction, specialist services are both limited and overstretched. The new General Medical Services (GMS) contract has made sexual health an enhanced service which NHS boards can choose to commission and GPs can choose to opt out of. In Scotland, most practices are providing only contraceptive advice, cervical cytology, and management of acute presentations which often involves referral to GUM clinics. Overall, access to sexual health services in primary care is currently minimal, and, whilst at present there are no signs of short-term growth in provision, it could be considered that a large resource remains untapped.

2 Capacity

The capacity of NHSScotland to provide the best possible sexual health services is inherent to improving quality, and lack of capacity can result in patients being denied access to services. For instance, the screening rate per 100,000 population in GUM clinic settings varies according to provision by different NHS boards. There is a three-fold variation from 500 to 1,500 per 100,000, resulting in waiting times of up to 6–8 weeks in some parts of Scotland³. Referral for abortion can involve unacceptable delays in some parts of Scotland. The risks of induced abortion rise with increasing gestation and waiting for weeks once a decision has been made is distressing.

3 Choice

Choice of at least two health service providers is important to users of these services, for reasons such as to preserve anonymity or confidentiality, or for convenience of locality. For instance, young people and those from rural areas may prefer not to see GPs or other health workers drawn from the same community who might also provide care for other members of their families. At present, however, general practice cannot be seen as an alternative provider other than for the most basic sexual health services. Choice is also required to ensure that the needs of individuals can be respected, especially for those with particular needs, or from socially excluded populations. Specific expertise is desirable for individuals from different ethnic and geographical backgrounds, those who have same-sex partners, and others.

4 Equity of service provision

There is marked variation in the range and quality of sexual health services in Scotland, depending on NHS board area. Some NHS boards have given sexual health a very low priority and some have no relevant specialist expertise or support services. There are also relevant local issues, such as in rural parts of Scotland.

5 Co-ordination of approach

There is already a significant move to integrating or converging generic sexual health services in Scotland, while maintaining specialist expertise. This has occurred to a greater extent than in other parts of the UK. However, more needs to be done to ensure that different partners (including non-NHS and NHS stakeholders) work in a seamless way for the convenience of patients¹⁴. Data (such as will be collected for the KCIs developed by the NSHAC subgroup) covering the last 12 months in sexually active people per NHS board area would provide hard outcomes whilst allowing for each NHS board to retain flexibility on how to improve services locally.

6 Quality of care

There are existing clinical guidelines (eg those from the British Association for Sexual Health & HIV, the Faculty of Family Planning and Reproductive Healthcare Clinical Effectiveness Unit, the Royal College of Obstetricians and Gynaecologists, the Scottish Intercollegiate Guidelines Network, the National Institute for Clinical Excellence and the British HIV Association) for the management of specific conditions. There are a variety of existing and potential products that could be used to improve quality of care over a range of healthcare settings.

The NHS QIS project group considered these important themes and focused especially on the areas where NHS QIS can most meaningfully support quality improvement in NHSScotland.

Related work

At the second meeting, the group began to develop a series of KCIs on behalf of NSHAC. The KCIs cover clinical aspects of sexual health services, and can be implemented so that NHS boards can monitor their progress with the national

strategy and action plan for improving sexual health. The indicators were particularly chosen to be practicable, deliverable, and evidence-based, and to reflect the themes from the discussion.

It was agreed that five KCIs can be implemented in 2006. These five KCIs span a range of sexual healthcare stages, including prevention, diagnosis and treatment, and include the major specialties represented in sexual health.

KCIs for implementation in 2006:

- abortion procedures performed at gestation of 9 or less weeks
- access to male and female sterilisation
- genital chlamydia testing by age and sex within each NHS board area
- provision of HIV therapy, and
- hepatitis vaccine uptake of men who have sex with men.

The group would also like to develop the remaining KCIs in future.

KCIs for development in 2007 and beyond:

- long-acting reversible methods of contraception (LARC)
- staffing of sexual health services
- sexual healthcare for people living with HIV, and
- service access for individuals with symptoms of acute STIs.

Further priorities for quality improvement were also identified.

Further priorities:

- partner notification
- laboratory diagnostic methods, and
- promotion of positive sexual health.

5 Recommendations

The wider work being done within NHSScotland in the area of sexual health, both within and outwith services, was also discussed, and the group agreed this was an essential consideration in planning any future work in this area. It was acknowledged that work done by sexual health services needs to be set in the context of the wider agenda which includes lifelong learning, influence of the media, faith perspectives and others. Furthermore, *Respect and Responsibility* and its associated ministerially-led committee and subcommittees have a substantial bearing on this. Not only does *Respect and Responsibility* outline a Scotland-wide strategy for improving sexual health, but it also includes an action plan which details the steps to be taken by various agencies to uphold the strategy. Further information on the Minister's recommendations for ongoing work can be found on pages 15–22 of *Respect and Responsibility*.

Looking ahead

There are a number of options for NHS QIS to consider for inclusion on forthcoming work programmes, as well as to consider for forthcoming work to be requested or commissioned to be carried out external to NHS QIS.

Recommendations

1 Development of service-level standards for sexual health services

The group perceived that national standards would also be a useful tool to ensure improved equity and improved quality of care.

2 Managed clinical networks (MCNs)

The group felt strongly that sexual health services within each NHS board area must be managed in a way which is sensitive to local populations, resources and priorities. In addition, the development of three regional MCNs could be a way to support the ministerially-cited "responsibility [by NHS boards] to deliver a co-ordinated approach to sexual health"¹².

3 Development of Key Clinical Indicators (KCI)s

Those involved with the development of the initial five KCIs will work closely with NSHAC to take these forward and to define a process for developing and implementing the remaining KCIs as detailed in the previous section of this report. While the indicators will continue to be owned by NSHAC, the group felt that this would be best undertaken by a single group to ensure strategic unity and minimise duplication of work.

4 Cohesive approach to quality work

The group recognised the limited resource within sexual health services. Consequently, NHS QIS and NSHAC will ensure that work programmes will work cohesively to avoid duplication of effort and optimise the use of specialist group members' time and expertise.

Future work programme

The wider sexual health agenda is concurrently being addressed by the range of subgroups linked to NSHAC (see Appendix 2). Other work which would support quality improvement in NHSScotland is:

Quality improvement in education and training

The group felt strongly that there should be programmes for quality improvement and monitoring of performance in the areas of sexual relationship education, and the training and education of providers of sexual health services. While this will not fall within a single group's remit, it could naturally fit with similar ongoing work that *Respect and Responsibility* has tasked to relevant organisations (eg NHS Education for Scotland).

Managed knowledge networks (MKNs)

A main need of NHSScotland that the group identified was the requirement for a clear evidence base for planners of sexual health services that could enable them to maximise resources while tailoring solutions to local situations.

A scoping study to map sexual health services in Scotland

The group considered the possibility of commissioning such a study, potentially including sexual health services provided by sectors other than NHSScotland. This work, however, could be complex and lengthy; it would be critical for those commissioning the work to have a clear idea of how this information would be valuable before committing the time and resources to undertake a multi-sector, nationwide mapping exercise.

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Appendix 1: Project group members – sexual health services in NHSScotland

Dr Alison Bigrigg (Chair)	Director, The Sandyford Initiative, NHS Greater Glasgow
Dr Rak Nandwani (Chair)	Consultant in HIV & Genitourinary Medicine, NHS Greater Glasgow
Dr Indranil Banerjee	Consultant in Genitourinary Medicine, NHS Fife
Dr James Chalmers	Consultant in Public Health Medicine, Information Services Division, NHS National Services Scotland
Ms Shirley Fraser	Health Improvement Programme Manager (Sexual Health and Wellbeing), NHS Health Scotland
Professor Anna Glasier	Lead Clinician in Sexual Health, NHS Lothian
Professor David Goldberg	Consultant Epidemiologist, Health Protection Scotland
Mr Tosh Lynch	Sexual Health Adviser, Russell Institute
Mrs Margaret McArthur	Nurse Manager, NHS Grampian
Mr Martin Murchie	Sexual Health Adviser, NHS Greater Glasgow
Dr Ewen Stewart	General Practitioner, NHS Lothian
Ms Christine Wallis	Programme Leader: Healthy Respect, NHS Lothian
Dr Hugh Young	Consultant Clinical Scientist, NHS Lothian

Support from NHS QIS was provided by:

Ms Hilary Davison	Team Manager, Standards Development Unit
Ms Clare Echlin	Senior Project Officer, Standards Development Unit
Ms Brin Jardine	Project Officer, Standards Development Unit
Mr Wladyslaw Mejka	Public Partnership Co-ordinator, Patient Focus and Public Involvement Unit (until February 2006)

Appendix 2: Background – National Sexual Health Advisory Committee actions

The National Sexual Health Advisory Committee (NSHAC) is divided into various subgroups which correspond to the recommendations identified for action in *Respect and Responsibility*. Below is a list of the actions as allocated to various subgroups.

Workstream A: Promoting Respect and Responsibility
<ul style="list-style-type: none"> • seek to ensure that no-one is excluded from appropriate sexual health services, whatever their life circumstances, by means of a comprehensive equality and diversity impact assessment (EDIA) process
<ul style="list-style-type: none"> • review the needs of rural communities
<ul style="list-style-type: none"> • in conjunction with the Sexual Health and Wellbeing Learning Network address the needs of those groups facing the greatest barriers to sexual wellbeing
<ul style="list-style-type: none"> • together with NHS Health Scotland and the Scottish Executive, develop a communications strategy for improving sexual health. This should include media campaigns, media advocacy and media literacy and link activities at national and local levels
<ul style="list-style-type: none"> • recommend on further research on targeted learning interventions aimed at behaviour change in adults
<ul style="list-style-type: none"> • offer advice on a sexual health research programme for Scotland in partnership with key policy, research and practice stakeholders in Scotland and elsewhere
Workstream B: Preventing Sexually Transmitted Infections and Unintended Pregnancies
<ul style="list-style-type: none"> • consider how best to build on current good practice in school-based sex and relationships education (SRE) in Scotland consistent with the principles of the McCabe report (NOTE: to dovetail with review of SRE programmes being led by NHS Health Scotland)
<ul style="list-style-type: none"> • keep the HIV health promotion strategy under review to ensure its continuing relevance
Workstream C: Providing Better Services
<ul style="list-style-type: none"> • offer advice on developing targets appropriate to this strategy (NOTE: this is being taken forward jointly with the NHS QIS project group)
<ul style="list-style-type: none"> • consider the proposals developed by Health Protection Scotland for potential adoption as a national data collection framework
<ul style="list-style-type: none"> • in conjunction with NSHAC work with professional bodies, regulatory institutions and statutory and voluntary training providers of non-healthcare professionals, to ensure under-graduate, post-graduate and ongoing continuing professional development (CPD) programmes provide staff with the range of skills and knowledge to respond to the sexual health and wellbeing agenda

Appendix 3: Websites

- **Strategy documents**

Respect and Responsibility:

<http://www.scotland.gov.uk/Publications/2005/01/20603/51174>

Enhancing Sexual Wellbeing in Scotland: A Sexual Health and Relationships Strategy – Proposal to the Scottish Executive (known as the Draft Scottish Sexual Health Strategy):

www.scotland.gov.uk/sexualhealthstrategy

Draft Scottish Sexual Health Strategy – see also:

<http://www.scotland.gov.uk/News/Releases/2005/01/27151420>

- **Organisations**

British Association for Sexual Health & HIV (BASSH):

<http://www.bashh.org/>

British HIV Association (BHIVA):

<http://www.bhiva.org/>

Faculty of Family Planning and Reproductive Healthcare Clinical Effectiveness

Unit: <http://www.ffprhc.org.uk/>

The Royal College of Obstetricians and Gynaecologists (RCOG):

<http://www.rcog.org.uk/>

National Institute for Clinical Excellence (NICE):

<http://www.nice.org.uk/>

Scottish Intercollegiate Guidelines Network (SIGN):

<http://www.sign.ac.uk/index.html>

NHS Health Scotland:

<http://www.healthscotland.com/>

Public Health Institute for Scotland (PHIS), a predecessor organisation to NHS Health Scotland:

<http://www.phis.org.uk>

- **Other relevant resources**

Scottish sexual health statistics:

www.show.scot.nhs.uk/scieh and www.isdscotland.org/isd/

Scottish online GUM clinic data collection:

www.show.scot.nhs.uk/sticoding/

Healthy Respect, a national health demonstration project on young people's sexual health:

www.healthyrespect.co.uk

Sexual Health & Wellbeing Learning Network: merging policy, practice and research:

www.health.scot.nhs.uk/SHW

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