

Recommended standards for sexual health services

For all settings providing NHS-funded sexual health services including general practice, hospital and community-based clinics, pharmacies, voluntary and independent sector organisations.

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MEDICAL FOUNDATION FOR
AIDS & SEXUAL HEALTH*

Endorsed by
Department of Health

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- Colleagues at the Centre for Sexual Health and HIV Research, Royal Free and University College Medical School who reviewed evidence to support the standards (see below).

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Foreword

The Department of Health is pleased to welcome the publication of these recommended standards and fully endorses them as excellent markers of good practice which will help to improve the quality of sexual health services.

This publication could not be more timely, with the recent publication of the public health white paper, *Choosing health*, signalling a major boost to the priority given to sexual health along with significant new investment to improve services and raise public awareness.

Achieving good sexual health for the population has always brought its own unique challenges. Poor sexual health so often disproportionately affects those who are already vulnerable and suffering from inequalities, such as young people, gay men, black and minority ethnic groups and those in lower socio-economic groups. Sexually transmitted infections have been increasing since the mid 1990s and rates of unintended pregnancies are still high. Poor sexual health can have serious longer term implications, including infertility and chronic health conditions.

The public health White Paper, the Public Service Agreement target on under-18 conceptions and improving sexual health, the planning framework and the inclusion of sexual health in local delivery plans are all designed to address this issue. These recommended standards provide primary care trusts and strategic health authorities with invaluable information which will help them to meet these requirements and enhance the quality of services in all settings.

MedFASH worked in partnership with the British HIV Association; the National Association of Providers of AIDS Care and Treatment and the Department of Health to produce *Recommended standards for NHS HIV services*, which were published in 2003. Those have been welcomed by people working in the field, and I am sure these recommended standards for sexual health services will be equally well received.



Cathy Hamlyn

Head of Sexual Health and Substance Misuse, Department of Health (DH)

Preface

MedFASH is delighted to be publishing these *Recommended standards for sexual health services* at such a critical time for sexual health in England. The public health White Paper, *Choosing Health*, sets new challenges for all those commissioning and providing sexual health services. These recommended standards should prove a valuable tool for them in planning how to deliver on its commitments, as well as for those managing local performance in the NHS. Through their implementation at local level, we expect these recommended standards to play a significant role in improving the sexual health of individuals and the population.

The *Recommended standards for sexual health services* are the result of a major project managed by MedFASH and commissioned by the Department of Health. We could not have produced them without the advice, encouragement and active participation of a large number of individuals and organisations with expert knowledge and varied experience of sexual health, including users of sexual health services. They have a broad scope, addressing many different aspects of sexual healthcare provided by a wide range of services and professionals in a multiplicity of settings.

The *Recommended standards for sexual health services* are designed to be complementary to the *Recommended standards for NHS HIV services*, published by MedFASH in 2003. Some aspects of service provision, such as sexual health promotion and HIV testing, are addressed in both documents, but most are distinct to one or the other. However, the key common feature of both sets of recommended standards is delivery through service networks, which help clinicians and other providers to meet shared standards of care. MedFASH will be undertaking further work in 2005 to facilitate the development of service networks.

We are eager for feedback on how the recommended standards are implemented. Please let us know how you use them, and in what ways they have supported service improvement. Please also tell us, based on your experience, how you think they should be amended in the future. They draw their strength and relevance from the on-the-ground experience of those who helped us to write them. They will only remain relevant if such experience also informs their review and updating over time.

Ruth Lowbury
Executive Director
Medical Foundation for AIDS & Sexual Health (MedFASH)

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Executive summary

These *Recommended standards for sexual health services* will support healthcare organisations to implement *The national strategy for sexual health and HIV* and to deliver the Public Service Agreement (PSA) 2005/06-2007/08 target for sexual health, which includes specific commitments arising from the government's White Paper *Choosing health*. The recommended standards are not setting-specific and can be applied wherever sexual health services are provided or sexual health need may be identified.

The recommended standards have been developed with the aim of enabling people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare. They describe what people should be able to expect from a sexual health service and will serve as a tool for planning, developing and evaluating local services, as well as for local performance management.

This document builds upon previous work by MedFASH to develop *Recommended standards for NHS HIV services*.

Recommended standard 1: Sexual health service networks

This standard sets out how providers can deliver a comprehensive local service to meet the range of sexual health needs, involving primary care, specialist services and other relevant settings within and outside the NHS. Managed service networks should facilitate prompt and equitable access, coordination between services, development of integrated care pathways, increased user choice and consistent quality of care.

Recommended standard 2: Promoting sexual health

The promotion of sexual health should enhance sexual and emotional wellbeing and help people to reduce the risk of STIs and unwanted pregnancy. Health promotion interventions should provide the information, support, and opportunities to enhance personal and social skills, to enable people to exercise control over, and improve, their sexual health. A comprehensive, multi-component programme of sexual health promotion is needed, which can address local needs, reduce inequalities in sexual health and reach marginalised groups. It should be fully integrated within local services and settings, clinical and non-clinical, using both targeted and opportunistic intervention strategies.

Recommended standard 3: Empowering and involving people who use services

This standard sets out how people can be enabled to have greater input into their individual care as well as being involved in planning and monitoring services. At the individual level, people need information and support to assess their personal risk, and to access and use services effectively. Shared decision-making between professionals and service users can result in better health outcomes. At the collective level, the involvement of users and the public in the planning and organisation of sexual healthcare can help services become more responsive to individuals and communities. Services should take account of social exclusion, discrimination, power imbalances and stigma.

Recommended standard 4: Identifying sexual health needs

Sexual health needs may be associated with STIs, HIV, unintended pregnancy, or sexual dysfunction; related problems such as infertility; experiences such as sexual assault or coercion; and a range of

medical conditions. In the face of significant rates of unmet sexual health need, commissioners and services should ensure action to encourage service uptake, target high need communities and expand opportunities to identify needs in a range of health settings. This standard recommends a number of measures to improve detection of sexual health need, including chlamydia screening.

Recommended standard 5: Access to services

Improving access to services is a key NHS priority. People should have prompt access to a full range of sexual health services and to comprehensive information on local sexual health service provision. Adequate capacity is needed to ensure services can respond to local need and demand. This standard specifies time limits for access to each type of service, in line with the sexual health PSA target and other national guidelines. Other measures to facilitate access include maintaining open access and self-referral for GUM and community contraceptive services, agreeing integrated care pathways within a sexual health network, and ensuring adequate STI and contraceptive services are provided on each working day within a network area.

Recommended standard 6: Detecting and managing sexually transmitted infections (STIs)

In the face of rapidly rising diagnoses of most STIs (including HIV), this standard is relevant for the range of services where STIs may be diagnosed and treated, including GUM, primary care and other community settings. Access is needed without delay, within two working days of first contact, to effective diagnostic services using the most reliable testing technology, facilitating prompt and appropriate treatment and care of people with STIs. This will reduce the risk of complications and limit further transmission. Partner notification is key to STI control and can be supported and coordinated across settings within a local service network.

Recommended standard 7: Contraceptive advice and provision

This standard is relevant for general practice, specialist contraceptive services and any other settings where contraceptive advice and provision take place. People should have prompt access to accurate information about, and free provision of, all contraceptive methods, either from their chosen provider or via an integrated care pathway. Appointments should be available within two working days and local services should be well-advertised, especially those for emergency contraception. Services should offer ongoing support in the use of chosen methods and take opportunities to ensure wider sexual health needs are addressed, including STI screening or prophylaxis when appropriate.

Recommended standard 8: Pregnancy testing and support

Women need to be able to find out without delay whether they are pregnant so that they can make and act upon informed choices. They should have rapid access to free and confidential pregnancy testing services, with same-day (preferably on-the-spot) results, and to a health provider who can give accurate information and non-directive support with pregnancy decisions. An integrated care pathway should be agreed and implemented by all providers, enabling prompt referral to a range of specialist services as necessary. Processes should be in place to help identify and care for women needing additional support. Discussion of test results may increase the uptake and effective use of regular contraception and also facilitate discussion of STIs and safer sex.

Recommended standard 9: Abortion service provision

Women seeking an abortion and who meet current legal requirements should be able to access an NHS-funded abortion ideally within two weeks (but within a maximum of three) of their first contact

with a service or referring practitioner. Services should be organised to provide abortion as early as possible in pregnancy, with a choice of appropriate methods, while ensuring provision up to the legal limit for those who need it. Screening and prophylactic treatment for genital chlamydial infection, information about the full range of contraceptive methods, and their initial supply, should be available, with integrated pathways in place for those who need to access specialist counselling or have other sexual health needs addressed.

Recommended standard 10: Protection and use of sexual health information

Information about individuals' sexual health is needed to optimise their care. Data derived from such information supports local service planning and audit processes, and is also used for surveillance to inform action to promote sexual health. Identifiable information should be retained securely, shared between services only with specific consent and when necessary for care, and anonymised when reported for statistical analysis and application. Explicit confidentiality procedures are essential to encourage service uptake. This standard sets out a number of measures to ensure confidentiality within a framework of developments in information technology and to facilitate consistent sexual health data collection.

The development of the standards has drawn heavily on the knowledge and expertise of a wide range of professionals, as well as the views and experience of service users. Supporting evidence is referenced in each standard. As the pattern of service need changes along with our knowledge of how best to meet it, the recommended standards should be regularly reviewed and updated.

Setting the scene

Introduction

- 1 These recommended standards, endorsed by the Department of Health (DH), support the implementation of the DH's policy for sexual health.
- *The national strategy for sexual health and HIV*,¹ (drawn up in line with the principles of The NHS plan) and its *Implementation action plan*, include the development of standards as a key action point.
 - The toolkit for primary care trusts (PCTs) and local authorities, *Effective commissioning of sexual health and HIV services*² states that recommended standards should underpin the planning and delivery of services to communities disproportionately affected by sexual ill health.
 - The Department of Health's *national standards, local action: health and social care standards and planning framework* clearly reflects the importance of sexual health. This document includes the national target, set out in the Department of Health's Public Service Agreement (PSA) 'to reduce the under-18 conception rate by 50 per cent by 2010 as part of a broader strategy to improve sexual health'. It also signposts the public health White Paper, *Choosing health*, which sets out comprehensive measures for improving sexual health, and introduces sexual health into local delivery plans (LDPs) for the first time.^{3,4} In their LDPs, PCTs and strategic health authorities (SHAs) are required to detail proposed action to ensure delivery of this target and demonstrate an integrated approach to their broader strategy for improving sexual health. The specific activity indicators to be included in LDPs are, in summary:
 - the percentage of patients attending genitourinary medicine (GUM) clinics who are offered an appointment to be seen within 48 hours of contacting a service, aiming to reach 100 per cent by 2008,
 - the number of new diagnosis of gonorrhoea per 100,000 population,
 - the percentage of the sexually active population aged 15-24 accepting screening for chlamydia,
 - the under-18 conception rate defined as the number of conceptions to under-18 year olds in a calendar year per thousand females aged 15 to 17.

These recommended standards will support such planning requirements and help commissioners and service providers to achieve, and monitor their progress in achieving, the target.

- 2 The recommended standards address operational aspects of sexual health services and are intended to signpost and complement clinical and service-specific guidelines. They are not setting specific and can be applied to all areas where sexual health services are provided or where sexual health need may be identified. As the document focuses on health service

provision, it does not make recommendations for other services which are linked to, but not part of, sexual health service provision, such as local authority education services. Implicit within it, however, is a recognition that effective sexual health service provision requires collaboration across a broad network of different organisations and sectors.

- 3 Sexual health services are provided in a range of settings, in primary care and acute trusts, in other statutory sector settings such as prisons, as well as in the community, voluntary and independent sectors. This document promotes consistent standards of care and a coordinated approach to service delivery, while recognising that clinical activity in different settings will vary in scope. Sexual health service networks are recommended to support development of a cohesive and comprehensive local service.
- 4 The standards cover sexually transmitted infections (STIs), contraception, abortion, access to sexual dysfunction services and sexual health promotion. Core elements of care covered by the standards are those provided by general practice, hospital and community-based clinics such as genitourinary medicine (GUM) and contraceptive services, independent or voluntary sector organisations, pharmacies and health promotion teams. Aspects of the recommended standards will also apply to various related or general health services, such as hospital gynaecology, maternity, paediatric, accident and emergency (A&E), urology, pathology and mental health services.
- 5 The recommended standards for sexual health services are presented as a means for service improvement to support more people to enjoy healthy and happy sex lives, receive effective and rapid treatment for sexually transmitted infections, and more people to have appropriate access to contraception and abortion when needed. Given the devolution of power within the NHS to local services as set out in *Shifting the balance of power*,⁵ these recommended standards are not intended to be prescriptive, rather to help guide and inform the delivery and development of services.
- 6 The development of the recommended standards was undertaken by the Medical Foundation for AIDS and Sexual Health (MedFASH), with the support of an expert advisory group chaired by Dr Sheila Adam, Director of Public Health for the North East London Strategic Health Authority, (see Appendix C for advisory group membership). National consultation with key stakeholder organisations during autumn 2004 also informed their development.

Why recommended standards?

- 7 England is facing increasing levels of poor sexual health. Since the 1990s, rates of STIs and HIV, and levels of high risk sexual behaviour have been rising, alongside continuing high rates of unintended pregnancy and abortion. These are placing huge pressures on services which are struggling to meet demand, highlighting inequalities in the accessibility of services and in the range of provision across England. In a report published by the House of Commons Health Select Committee in 2003, the state of sexual health services in England was described as being in 'crisis'.⁶

- 8 These recommended standards have been developed to help tackle this situation and improve sexual health service provision by promoting enhanced service access and consistent, equitable and high quality care. They describe the care which service users can expect to receive, and should serve as a tool for commissioners, providers and service users to support the planning, development and evaluation of services. They are also intended to help support greater prioritisation of sexual health services at national, SHA and PCT levels, as set out in *Choosing health*,⁷ and to support the development of a sexual health performance management framework for NHS-funded services.

Background

- 9 The government's *National strategy for sexual health and HIV*⁸ proposes a comprehensive model of sexual health service provision in the context of a broader framework of sexual health promotion, with an explicit focus on a small number of goals. The aims of the strategy include:
- reducing the transmission of HIV and STIs
 - reducing the prevalence of undiagnosed HIV and STIs
 - reducing the rates of unintended pregnancy
 - reducing the stigma associated with HIV and STIs.
- 10 To support the development of modern, efficient and user-centred sexual health services, the strategy's proposals include providing these new recommended standards to address unjustified variations in service access, quality and provision. Managed service networks are proposed as the model for implementing standards and for strengthening and improving service delivery. Commissioners and local providers in primary care, acute and community-based services will work together to plan and deliver a comprehensive sexual health service which incorporates, and expands, the different levels of service in different settings.
- 11 The strategy and its implementation action plan have been supported by a number of other publications including a commissioning toolkit, *Effective commissioning of sexual health and HIV services*,⁹ and a health promotion toolkit, *Effective sexual health promotion: a toolkit for primary care trusts and others working in the field of promoting good sexual health and HIV prevention*.¹⁰ Both of these provide best practice guidance on how the sexual health strategy might be implemented locally. It complements the national teenage pregnancy strategy, set out in the Social Exclusion Unit's report on teenage pregnancy, which set targets to reduce teenage conception rates and increase the participation of teenage parents in education, training or work.¹¹
- 12 Implementation of both strategies is devolved to local responsibility, but their importance is highlighted by national priorities for sexual health referenced in the 2004 government public service agreement (PSA),¹² in NHS planning guidance for the period 2005/08 *National standards, local action*¹³ and in the public health white paper, *Choosing health: making healthy choices easier*.¹⁴ Commitments include the reduction of teenage pregnancy rates, improvements in public health, expanded service access, and improved patient experience, all of which are relevant to sexual health services. Specific commitments in *Choosing health*

include investment to support service modernisation, accelerated implementation of the national chlamydia screening programme (NCSP) and enabling access to GUM services within 48 hours.

Sexual health service networks

- 13 The *National strategy for sexual health and HIV* recommends the development of local managed service networks for sexual health. These networks will involve commissioners, providers and people who use services to develop and evaluate integrated care pathways and service models to improve sexual health in response to local needs and priorities. Collaboration between network partners can ensure the provision of a comprehensive local service centred on the service user. Care needs to be integrated at PCT level as well as coordinated across wider geographical areas, such as those of SHAs.
- 14 The coordination of services within a service network should provide particular benefits for those using sexual health services where, traditionally, different elements of care have been provided by two or more organisations. Networks can help to ensure equitable care across a locality, through the application of national standards and guidelines, including these recommended standards, underpinned by systematic audit processes. Regardless of the initial point of access or location of care, the service user should be able to expect to receive care of a consistent standard. Transition between services, when necessary, should be facilitated with minimum inconvenience.

Sexual health inequalities

- 15 Sexual health matters for everyone, but we also know that sexual health needs vary from one person to another and from one community to another, as well as evolving throughout life. Sexual ill health also disproportionately affects groups already experiencing high levels of social exclusion and health inequality. Specific action should recognise and meet the needs of particular groups of people, such as:
 - young people who are, or are contemplating becoming, sexually active: teenage conception and abortion rates are consistently high, and numbers of new STIs among those in their teens and early twenties continue to rise.
 - men who have sex with men: after early achievements in limiting the spread of HIV, more recent data indicate increases in new infections, and that a significant number of those with HIV are unaware they are infected. High rates of STIs are also diagnosed, especially gonorrhoea and syphilis, compared with other population groups.
 - black and minority ethnic communities: surveillance data demonstrate a disproportionate burden of STIs, including HIV, in some black and minority ethnic communities in England.

- other individuals and groups within local populations who may have higher levels of sexual health need or who may be less likely, or unable, to access mainstream services: these might include refugees and asylum seekers, homeless people, sex workers, people in custodial settings, looked after young people and those leaving care.

Guiding principles

16 The following overarching principles should guide the implementation of the recommended standards:

- Confidentiality - Although a duty of confidentiality applies to all aspects of health service delivery it is particularly vital within sexual health services, which deal with a range of sensitive and stigmatising needs. The stigma can impact on others beyond the individual service user. Services should not only ensure confidentiality, but should make it very clear that they do so. This applies to the conduct of all members of the clinical team and support staff, whether in specialist or primary care. Legislative provision also backs up professional obligations to provide confidential sexual health services. Young people under 16 have the same right to confidentiality as people over the age of 16: recent DH guidance sets out best practice for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health.¹⁵
- Respect - There can be no place for any form of discrimination or judgmental attitude. Service providers should respect the choices and lifestyles of service users, some of which may predispose them to sexual health problems such as STIs or unwanted pregnancy. It is vital to encourage those with sexual health needs to attend services. Any demonstration of attitudes which are critical could deter uptake. While mainstream services should recognise and address this, in some areas it will be appropriate to establish dedicated services to meet the needs of specific groups eg young people, men who have sex with men, some black and minority ethnic groups, and women who wish to be cared for by female healthcare practitioners. Services must be fully accessible for people with disabilities.
- Choice - Choice is key to service improvement. Diversity of provision has traditionally been associated with the field of sexual health, which includes services provided in the independent and voluntary sectors as well as the statutory sector. People have been able to choose to self-refer to open access GUM services and to community contraceptive services, or to access their primary care provider. However, real choice for service users requires clear and appropriate information about sexual health and about what is available within local services; prompt access; and services with a reputation for confidentiality and respect.
- Community involvement - DH policy on patient and public involvement aims to ensure that healthcare services are designed around the needs of people using them. Section 11 of the

Health and Social Care Act (2011) places statutory duties on NHS organisations to ensure patients and the public are consulted in the planning and organisation of services. The involvement of individuals and the wider community, in contributing to the development of sexual health services, is therefore essential. This is particularly important if services are to meet the needs of diverse communities, and of those, such as young people, who are anxious about approaching service providers. Service delivery should model user empowerment, with practitioners enabling individuals to be involved in their care, including the prevention of further sexual health problems.

- Equity and diversity - It is important that service providers understand and tackle the range of health inequalities. Commissioners can help to address the geographical variations in service access, by contracting services which seek to address the systematic inequalities in sexual health experience amongst different communities.
- A whole person approach - It is important for all those involved in the planning and delivery of sexual health services to understand the manner in which biological, psychological and social factors interact to determine people's sexual health. The impact of treating infections, prescribing contraception and managing abortion will be inherently limited unless the social and psychological factors determining health behaviour are also addressed.

Aims and content

17 These recommended standards aim to:

- define a level of care that is achievable in all parts of England
- facilitate equity of access to services for all
- provide a framework for consistent and high quality care
- promote involvement of service users in the planning and delivery of care
- support an outcomes-oriented approach to care
- ensure comprehensive sexual health service provision through integrated care pathways
- facilitate the development of managed service networks to ensure multidisciplinary collaboration across clinical teams and organisations.

18 For each recommended standard:

- an **aim** identifies the desired health outcome
- the **recommended standard** summarises what needs to be achieved
- the **rationale** provides background on why the recommended standard is needed
- **key interventions** provide evidence for what is known to work
- **implications for service planning** indicate the action needed from commissioners and service providers in order to achieve the recommended standard
- **guidance on practice** signposts other relevant recommended texts
- the **suggested audit indicators** are provided for measuring performance against the recommended standard.

Supporting evidence

- 19 The standards have been informed by the expertise and opinions of a wide range of professionals, as well as drawing on the views and experience of service users. A full systematic review of the evidence for sexual health services was not undertaken as the size and scope of such a task made it unfeasible within available resources. However, a pragmatic and iterative approach was agreed by the project advisory group which focused the search for supporting evidence on standards and interventions as they were drafted. The evidence for key interventions has been identified and reviewed by the Centre for Sexual Health and HIV Research at Royal Free and University College Medical School, London and has been graded according to the following system, used by Bandolier.¹⁶
- **Type I evidence** - at least one good systematic review, including at least one randomised controlled trial
 - **Type II evidence** - at least one good randomised controlled trial
 - **Type III evidence** - at least one well designed intervention study without randomisation
 - **Type IV evidence** - at least one well designed observational study, or published qualitative study or audit*
 - **Type V evidence** - expert opinion, including the opinion of service users and carers.
- * Peer reviewed published qualitative studies or audits have been added to Type IV evidence for use in this document.
- 20 Regular review will be important to identify key new findings and consider their implications, both to update these recommended standards and to prioritise new research.

Workforce development

- 21 There is scope across sexual health services to look imaginatively at role development within workforce planning. Traditionally, many roles have been undertaken by doctors - as evidenced by the literature. However, agreed competencies and governance arrangements are supporting expanded roles for nurses, sexual health advisers, pharmacists and others within the multidisciplinary team. A competency-based approach has enabled a sharper focus on the training and experience necessary to secure and maintain the skills required for each element of service provision. Examples of such competencies for sexual health have been published by the Royal College of Nursing.¹⁷
- 22 Inevitably, the development of these recommended standards has highlighted the need for pre- and post-qualification training opportunities to be maintained or developed. Although this is referred to within relevant standards in the sections on implications for service planning, it is beyond the scope of this document to provide detailed recommendations about training. The DH has commissioned separate work on the training requirements to support the implementation of the strategy.

- 23 Staff who work in sexual health, and in particular those working in settings where sexual health is not the main focus of work, such as general practice or pharmacy, need access to relevant multidisciplinary training opportunities to develop knowledge, skills and awareness. Dedicated training courses, such as the Diploma of the Faculty of Family Planning (DFFP) theory course, or the STI Foundation Course (STIF), should be complemented by opportunities for supervised practice, and where available, competency based assessment (such as the practical component of the DFFP). Ongoing access to specialist support will enable practitioners to develop and maintain relevant knowledge and skills, to ensure a consistent standard of service across settings.
- 24 All staff involved in providing care, not only clinicians, should develop skills in communicating about sex, and maintain awareness of some of the social, psychological and cultural issues impacting upon sexual health and service use. They also need to be able to understand, apply and convey relevant confidentiality guidance. Services should be provided within a framework of equality and non-discriminatory practice, requiring staff to have skills and attitudes which communicate acceptance, and which recognise differences in sexual relationships, sexualities and sexual lifestyles. In addition, it is crucial that those who may provide care for young people undertake child protection training and are aware of guidance and established local systems and support available.

How the NHS and its partners can deliver the recommended standards

- 25 Each part of the NHS can play a part in the achievement of these recommended standards.
 - PCTs are directly responsible for improving the health of their population, for reducing health inequalities, and for ensuring that services are in place to meet local health need. They do this by both providing and commissioning healthcare services, and by working in partnership with relevant organisations. PCTs have the principal responsibility for ensuring that *The national strategy for sexual health and HIV* is implemented at a local level, for coordinating local sexual health planning and commissioning, and for ensuring the appropriate capacity and resources are available to deliver these standards. By April 2006, PCTs' commissioning responsibilities will include prison health.
 - SHAs are the headquarters of the local NHS and hold both PCTs and NHS trusts (except foundation trusts) directly to account for their performance, and are in turn held to account by the DH. They have responsibility for overall strategy and performance management, and take the lead in shaping local programmes of service improvement and modernisation. They monitor local progress and support PCTs in implementing sexual health policy. In their LDPs, SHAs are required to submit detailed and specific plans to the DH that reflect their local PCT plans for meeting the 2005-08 PSA target for reducing teenage conceptions and improving sexual health.
 - Primary care services, in particular general practice, community reproductive health services and pharmacy services, play an important role in the delivery of, and in some cases referral to, sexual health services. Contract provisions and PCT funding policy for

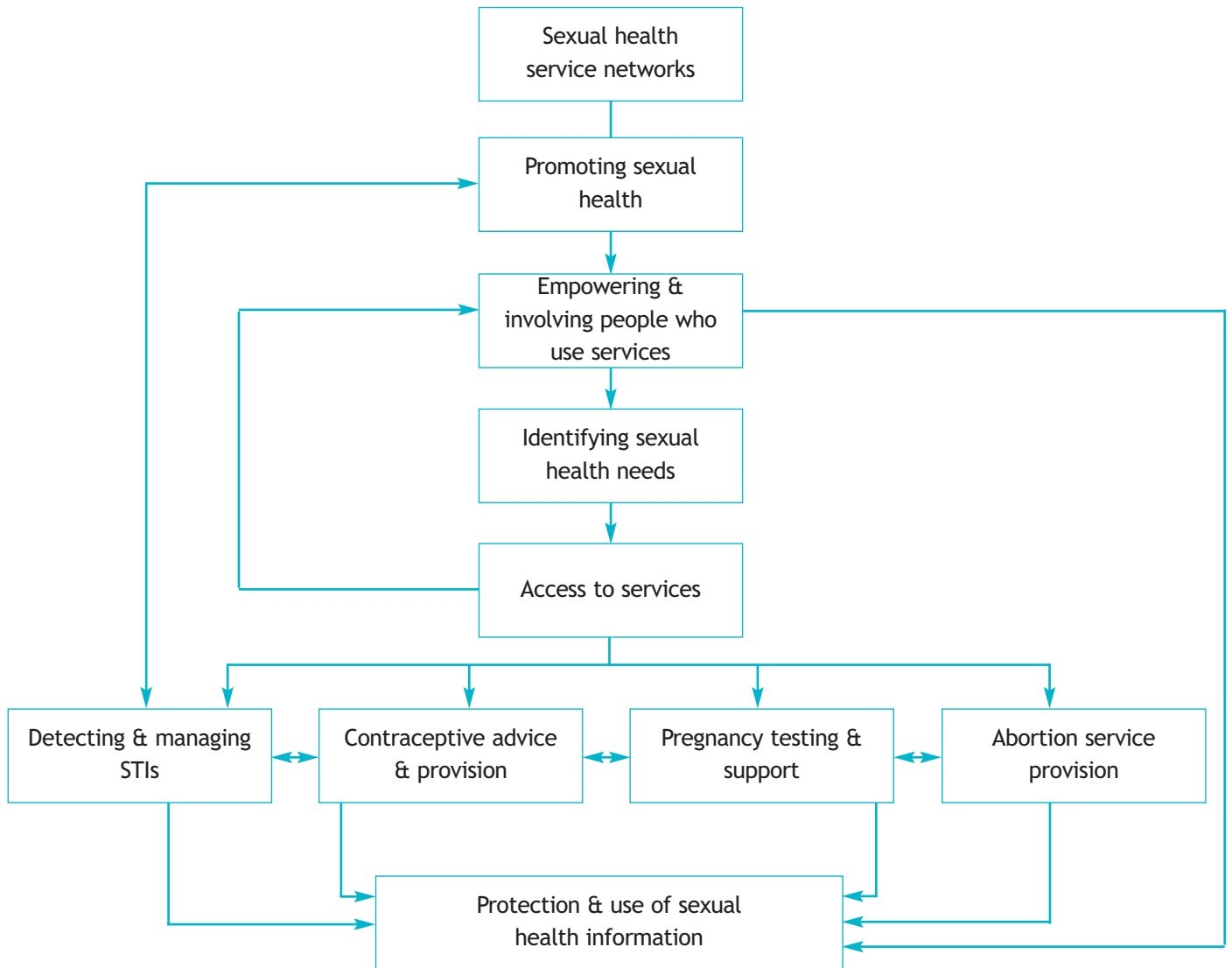
sexual health in primary care should take into account these recommended standards.

- NHS trusts and foundation trusts have a key role in the delivery of many sexual health services, under contract from PCTs. They have a responsibility for ensuring that services are delivered in line with established standards and by the most effective and efficient means possible. They also have an important role in supporting other front line sexual health services.
- Voluntary and community organisations (VCOs) play an important role in the delivery of some sexual health services. Funded by PCTs, they should also apply the recommended standards to provision of these services.
- These recommended standards will also apply to organisations in the independent sector providing sexual health services under contract to the NHS.

Links to *Standards for better health*

- 26 These recommended standards have been written to complement the DH's *Standards for better health*.¹⁸ They support the delivery, within sexual health services, of the national core standards and are designed to inform the achievement, within sexual health services, of the developmental standards. They are also designed to be of practical assistance in supporting and further developing local clinical governance arrangements. The implementation of these recommended standards will, therefore, be an important contributor to local success in achieving the *Standards for better health*, as they relate to sexual health services, to be assessed nationally by the Healthcare Commission.

The recommended standards



Sexual health service networks

Aim

To improve the sexual health and wellbeing of a defined population through the provision of coordinated and integrated sexual healthcare within managed service networks.

Recommended standard 1

People should be able to:

- access the full range of sexual health services within or via a choice of settings
- receive coordinated and integrated care, with clear information and direction or referral to other services when needed
- choose services which are geographically convenient for them and which best meet both clinical and cultural needs.

Commissioners and service providers should ensure:

- sexual health services are organised within a service network to reflect patterns of service use and need
- consistent standards of care are agreed and implemented across the service network to optimise clinical outcomes and service user experience
- care pathways within and across organisations are explicitly defined
- shared and cooperative governance, accountability and performance management arrangements are agreed and implemented.

Rationale

- 1 *The NHS plan* highlighted the need for improved access to, and links between, services. Proposed actions in *The national strategy for sexual health and HIV* include the development of shared service standards to support the move towards more integrated provision of sexual health services and the establishment of managed service networks.
- 2 Traditionally, sexual health services have been provided by separate clinical teams, in various different provider organisations. Contraception has been delivered mainly in primary care, in general practice and in community contraceptive services, STIs have been managed in hospitals and in some community-based settings, and NHS-funded abortions have been provided by both hospital and independent sector organisations. People with sexual dysfunction may present to a variety of services in both primary and secondary care, and may also access services in private or voluntary sectors, but provision for their care has been fragmented and inconsistent.
- 3 People often have multiple sexual health needs, for example those at risk of pregnancy may also be at risk of STIs, and the converse is often also true. Interventions to prevent adverse outcomes and to promote positive sexual health are integral to meeting such needs. Consequently, people are better served by linked and networked services than by a discrete, limited service unable to meet all their needs.
- 4 Strategy recommendations include expanded roles for practitioners and services to maximise access and provision. Three service levels are also proposed in the strategy, which reflect the differences in the scope of clinical activity in different settings. Level 1 describes some of the basic elements of sexual health service already provided in many general practices. Level 2 specifies a wider range of care which may be undertaken by clinicians in primary care with a special interest in sexual health or by those providing additional elements of care not traditionally provided in their service. Level 3 refers to specialist services. A range of provision at different levels allows people to benefit from opportunities to make choices about their sexual healthcare based on convenience and accessibility, availability of expertise or comprehensiveness of service.
- 5 Managed service networks are proposed to strengthen and improve service provision, with local providers collaborating to plan and deliver a comprehensive sexual health service. The service network model will support coordination within and between providers, levels and sectors as necessary. Commissioners and providers in primary care, acute and community settings need to work together to set up a network that engages all relevant service providers and partner organisations involved in delivery of the various services and levels in meeting the needs of their local population.
- 6 Currently in England there is no consensus on the meaning of 'integration' as it relates to sexual health services, although the term is widely used. Some work to define this is being undertaken by University College London and Bristol University as part of the evaluation of the one-stop-shop pilots. For the purposes of this document, the term integration is used to

describe separate services working together to meet the sexual health needs of individuals, either 'under one roof' or, as this standard implies, 'under one umbrella' via clearly defined care pathways within a local service network.

- 7 Varying degrees of procedural or structural integration between services have been established since the early 1990s. These have included co-location of services and the development of more comprehensive sexual health services for specific populations, such as those for young people. Professionals from GUM, reproductive and public health specialties have recommended moving towards greater convergence of the various sexual health services in order to maximise individual and public health gain. Since the publication of *The national strategy for sexual health and HIV*, work to integrate elements of sexual healthcare has gathered momentum, to implement strategic recommendations. Examples of more formal service collaboration across a number of PCTs are emerging, including the South West London HIV and GUM network and the first comprehensive sexual health service network in England, established for Greater Manchester SHA.^{19 20 21}
- 8 The collaboration needed for local implementation of the NCSP has fostered the development of a service network approach. Managed service networks can facilitate the joint working necessary to provide a coordinated service in response to particular individual or population needs, such as those of people who have been raped or sexually assaulted, or to contain a disease outbreak.
- 9 Some service integration can be, and has been, achieved by broadening the range of services provided by existing clinical teams or expanding practitioner roles such as those undertaken by nurses or sexual health advisers. More complex service integration is required between primary and secondary care, within PCTs or across a group of PCTs, to ensure provision of comprehensive services to meet local needs and priorities, and also at SHA level to enable implementation of key health agendas and effective performance management.
- 10 A managed service network approach may enable stakeholders to provide an integrated local service. This should bring together complementary expertise from general practice, community and hospital based specialist services, other relevant acute and community settings and the independent and voluntary sectors. The involvement of people who use services is essential. Relevant partner organisations such as local authorities' education, youth and social services also have an important contribution.
- 11 Professionals and service users working together may provide credible arguments to influence commissioning priorities. All those involved should be able to complement, learn from, and support each other, across organisational boundaries, in order to provide flexible delivery of sexual healthcare, including self-care.
- 12 Stated simply, networks should enable services to do better together what cannot be done alone. There are well established examples of specialist services operating through managed network arrangements in other areas of healthcare, such as those for cancer, coronary heart disease, renal and children's services, and, more recently, for HIV. These have been established with the aim of ensuring that appropriate knowledge and expertise is made available to individuals at every stage in their care pathway and that the care they

experience is seamless. Many of these networks are supported by published national standards, such as those supporting the national Cancer Plan and the *Recommended standards for NHS HIV services*.

- 13 Experience from other areas of healthcare demonstrates that the size, scope and degree of formality of networks can vary. A variety of factors may help to identify potential network partners or define geographical coverage, such as the shared commissioning arrangements which already exist between PCTs for sexual health services spanning more than one PCT, or current strong but informal links between services.
- 14 The potential for service networks to improve user experience, service access, and the clinical and cost effectiveness of services, as well as contributing to better sexual health, and therefore public health, are all strong incentives for PCTs and SHAs to support and facilitate their development.
- 15 Managed clinical or service networks can foster agreement to work to consistent clinical and service standards and provide evidence of this through systematic audit and other clinical governance processes.
- 16 Managed service networks can:
 - be used as a framework for planning services and for improving access
 - enable people to have increased choice in where to access their sexual healthcare
 - promote equity in service access and quality of care
 - provide a structure for service modernisation
 - enhance coordination and communication between services
 - create opportunities to establish integrated care pathways.

Key interventions

- Managed service network arrangements across defined geographical areas may ensure services are commissioned, planned and configured to meet local demand.
- Managed networks can ensure provision of the full range of sexual health services, shaped to meet the needs of individuals and populations using those services.
- Agreement, implementation and evaluation of shared service standards within a sexual health service network can facilitate equitable care and consistent information, and contribute to the achievement of better health outcomes.

Implications for service planning

- 17 To meet the needs and preferences of service users, PCTs should aim to commission a full range of services which provide different levels of sexual healthcare in a variety of settings. A full range of services includes promotion of sexual health, diagnosis and treatment of STIs, contraceptive advice and provision of all methods, pregnancy testing and support, abortion, and access to care for sexual dysfunction. A choice of provision in both specialist sexual health settings and within primary care and, for some services, in the voluntary, community and independent sectors will enable optimum access and choice for users. Robust integrated care pathways, including arrangements for directing or referring people to the services they need, should be established.
- 18 PCTs may wish to prioritise the development of service networks as part of their broader strategy for improving sexual health and related service delivery. Service network arrangements will benefit from SHA support as well as that of individual PCTs.
- 19 Commissioners may be best placed to drive the development of a sexual health service network and to engage the commitment of key stakeholders. Local service networks should build upon informal network arrangements and collaborative working already in place. Responsibility for the network will be determined locally, and will include decisions regarding:
 - clinical leadership
 - clear arrangements for accountability
 - the degree to which governance may be shared
 - a planned process for engaging public and service user involvement
 - operational and administrative support needed
 - financial arrangements for the development and functioning of the network
 - transparent decisions about the network's input to funding allocation processes.
- 20 At the PCT level, it is important to draw together representatives of all those who commission, plan, provide, support, use and evaluate sexual health services, to ensure a systematic approach to service development. The involvement of service users in contributing to planning and improving sexual health services is essential. Links with local public health services are crucial, as providers will contribute to, and need to benefit from, local public health activity and surveillance in order to achieve commitments in the public health White Paper, *Choosing health*. Sexual health services should be planned in response to local needs assessment. Comprehensive mapping of service configuration, skill mix, workload, demand and capacity is also required to inform service planning.
- 21 Decisions regarding the scope, shape, size and geographical boundaries of a sexual health service network should be determined at local level, and involve local stakeholders. A range of influencing factors will determine such decisions, such as the needs of service users, demographic and epidemiological profiles, or commissioning arrangements. Other factors such as gaps in provision, connections with services beyond potential network boundaries, or transport links, will be useful to consider when identifying potential network partners.

- 22 The partners within any service network should clarify and establish clear links between the network and the local commissioning structure. Where services span more than one PCT, as many will, joint commissioning or consortium arrangements need to be in place. Cross-PCT commissioning may be required for GUM or contraceptive services, abortion provision and also for some other specialised aspects of sexual healthcare, such as those for sexual dysfunction. Specialised commissioning arrangements should already be in place across PCTs for HIV treatment and care.
- 23 Networks should have a mechanism for contributing to decisions about local sexual health priorities and informing the required sexual health content of LDPs.
- 24 At the local level these recommended standards can be implemented as part of a range of measures to improve sexual health services. The suggested audit indicators can be used to monitor access and quality of service delivery. Use of 'improvement' and modernisation methodologies to map clinical processes and user pathways should help to identify the barriers, duplication and bottlenecks within and across services, informing plans to improve access and to make services more efficient, cost effective, and responsive to service pressures such as increasing demand. Structured evaluation tools such as health impact assessments and health equity audits can facilitate knowledge about health outcomes related to service delivery, and assess whether there are inequalities in service access and uptake.
- 25 A service network perspective can help identify local workforce development requirements. Network partners can also support action to develop or sustain training and continuous professional development opportunities. A local training strategy should illustrate the information and skills development needed for clinical and administrative staff to support sexual health service provision. This should include ensuring all those involved in providing elements of sexual healthcare in generic or non-traditional settings have the necessary training, competence and supervision mechanisms.

Guidance on practice

- 26 O'Brien O & Lowbury R. (2002) *Networking for quality in HIV treatment and care*. London: Medical Foundation for AIDS & Sexual Health. (Available at: www.medfash.org.uk)
- 27 French K, Flaherty B. *HIV network practice guide*. London: Medical Foundation for AIDS & Sexual Health. Unpublished
- 28 Greater Manchester Sexual Health Network
Network information pack and newsletters available from www.sexualhealthnetwork.co.uk
or from the Network's administrator martin.jones@manchester.nhs.uk
- 29 South West London GUM and HIV network (SWAGNET) www.swagnet.org
- 30 Integrated care network website www.integratedcarenetwork.gov.uk

For further reading on networks, see page 88.

Suggested audit indicators

- A local strategy for improving sexual health is in place. This should reflect both national and local priorities and include plans for ensuring implementation of *The national strategy for sexual health and HIV*, ensuring progress against these recommended standards and also the developmental standards in *Standards for better health*.
- The PCT LDP demonstrates the action required locally, and how local services are working together, to deliver on the PSA target and commitments in the government's White Paper *Choosing health*.
- A local sexual health service network operating within an agreed framework, or in development with clear timeframes for set-up.
- Each organisation or setting involved in the delivery of sexual health services represented on a network development steering group.
- Evidence of service user and public involvement in the development and evaluation of the sexual health service network.
- Regular mapping of both offer and uptake of elements of service within each provider setting.
- Explicit integrated care pathways defined, agreed and established for different elements of sexual healthcare.

Promoting sexual health

Aim

To maximise sexual health and wellbeing and reduce inequalities in sexual health.

Recommended standard 2

People should have access to:

- consistent, accurate and culturally appropriate information on sexual health (and services)
- effective interventions to minimise risks of STIs and HIV or unintended pregnancies
- opportunities to develop the personal and social skills to support their decisions and choices about sexual health.

Commissioners and services should ensure delivery and evaluation of a comprehensive programme of sexual health promotion, which:

- is planned and coordinated by a local multi-agency group, including public involvement
- is fully integrated across a range of local services and in multiple settings
- takes action to address local needs, reduce inequalities in sexual health and reach marginalised groups
- is evidence-based, using activities known to work (or those undergoing evaluation).

Rationale

- 1 The World Health Organisation defines sexual health as follows:
‘Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled’.²²
- 2 Sexual health promotion can be defined as activities which proactively and positively support the sexual and emotional health and wellbeing of individuals, groups, communities and the wider public (definition adapted from DH sexual health promotion and commissioning toolkits).^{23 24}
- 3 The five areas of action specified in the Ottawa Charter provide a framework to support the development of best practice in promoting health at various levels:²⁵
 - build healthy public policy
 - create supportive environments
 - strengthen community action
 - develop personal skills
 - reorient health services.

A local sexual health promotion strategy which incorporates action across the range of levels is recommended and may include:

 - developing or contributing to health and social policy which promotes sexual health and addresses inequalities
 - creating environments which are supportive of sexual health, and which recognise the diversity of sexualities and sexual lifestyles
 - empowering and involving communities to take action to achieve better sexual health
 - supporting individuals to develop and sustain personal and social skills to enable them to make and act on choices conducive to sexual health
 - working together to achieve a health system which includes sexual health as integral to health and wellbeing, and prioritises action in response to need.
- 4 To meet the sexual health promotion needs of local communities it is important to involve public health, health promotion, sexual health services across the range of settings, and partner agencies in education, social services and the voluntary, community and independent sectors. The sexual health service network can convene a multi-agency planning group, which includes public and service user involvement, to develop a local strategy and formulate an action plan. Data on local profiles, trends and needs related to sexual health will help to inform prevention responses and influence proactive work to promote sexual health. Mechanisms to enable the planning group to access relevant information are needed. A comprehensive local programme of sexual health promotion should be widely integrated with related initiatives, such as sex and relationships education, and directly linked with local sexual health service provision.²⁶

- 5 *The national service framework for children, young people and maternity services* requires PCTs and local authorities to ensure interventions to improve young people's sexual health and reduce teenage pregnancy are included in local health promotion strategies. *Choosing health* also outlines plans for every school to provide comprehensive personal, social and health education (PSHE), including education on sex and relationships. A variety of actions are also proposed to ensure young people can access confidential information and services for sexual health. A national campaign, targeted particularly at young people, will aim to ensure people understand the risks of unprotected sex and promote condom use to prevent STIs and unintended pregnancies.
- 6 *The national strategy for sexual health and HIV* states that 'sexual ill health is not equally distributed among the population' and statistics demonstrate how STIs and unwanted pregnancy disproportionately affect communities already experiencing inequalities related to ethnic origin, sexual orientation, age and gender. There is also a strong link between social deprivation and STIs. The gonorrhoea rates among some inner city black and minority ethnic groups have been shown to be significantly higher than in white population counterparts. Particular attention should be paid to identifying and meeting the needs of individuals and communities who are vulnerable or marginalised and those experiencing inequalities in sexual health and service access. Health equity audits can be used to identify how services or resources are distributed in relation to the sexual health needs of different groups. Such evidence should help services to address inequalities in service access and in health outcomes.^{27 28 29 30 31 32 33 34}
- 7 *The national strategy for sexual health and HIV* states that 'the crucial role of sexual health services in prevention needs to be recognised and strengthened, supported and linked closely to health promotion work taking place outside sexual health services'. Sexual health promotion should be integral to service delivery and a core component of sexual health consultations.³⁵
- 8 Key elements of sexual health promotion are relevant for all sexual health consultations, regardless of setting. All individuals attending a service with a sexual health-related issue should have a sexual health risk assessment offered to identify needs. Clear, unambiguous information should be available to support healthcare interventions, alongside exploration of risk management strategies for achieving and maintaining positive sexual health.^{36 37 38}
- 9 Sexual health promotion interventions are essential in supporting the achievement of strategy goals, as well as the delivery of specific commitments in the public health White Paper *Choosing health* and the sexual health PSA target. These focus on reducing rates of unintended pregnancy and reducing newly acquired or undiagnosed STIs, including HIV. Health promotion activities aiming to normalise and promote STI and HIV testing, in order to improve uptake and detection, can contribute to achieving these aims. Effective sexual health promotion is essential if PCTs are to deliver on commitments to reduce the under-18 conception rate and, as part of a broader strategy to improve sexual health, to reduce rates of new diagnoses of gonorrhoea.³⁹
- 10 Research suggests that around 50 per cent of pregnancies in Great Britain are unintended. However, unintended does not necessarily mean 'unwanted'. People should have access to

interventions to support them both to plan for, and to prevent, pregnancy, with the aim of reducing the rates of unwanted pregnancy and abortion. When unintended conception does occur, people need access to impartial support and information on pregnancy options, including abortion, and relevant service provision.^{40 41 42}

- 11 Promotion of sexual health is most effective if it is ongoing and sustained. An evaluation of safer sex campaigns in the Netherlands showed attitudes and intentions towards safer sex were affected positively but that the effect was lost when the intervention ended.⁴³
- 12 Research has demonstrated that consistent condom use is associated with strong intentions to use them, high levels of 'self regulation', high 'self efficacy', relationships which are 'less close' and positive peer norms supportive of condom use.⁴⁴
- 13 Simply telling people not to engage in risky behaviours tends to be ineffective. The more successful sexual health promotion interventions are multi-component, ie they address a range of personal and structural determinants of risk. Interventions are more likely to be effective if they are developed using theoretical models; provide information that is basic, accurate, and unambiguous; use behavioural, communication and social skills training; and are tailored and targeted to particular communities, making use of needs assessment or formative research.⁴⁵
- 14 STI prevention interventions can be cost effective, and even cost saving and particularly if targeted at groups at higher risk. NHS contraceptive provision to prevent unplanned pregnancy is also cost saving.^{46 47}
- 15 Both general and specialist healthcare present many situations where sexual health promotion interventions would be of benefit. For example, some illnesses and some treatments may affect libido, or men with diabetes may experience erectile problems. People with sexual dysfunction may wait months or years before seeking professional help. It is important to create supportive environments that will enable early self-referral.
- 16 Service user experience has demonstrated that sexual health needs, including contraception, for people with serious medical conditions are often ignored. The promotion of sexual health should be addressed as part of their specialist care.
- 17 In addition, various healthcare situations may allow for opportunistic sexual health promotion, where sexual health information and support is offered to those who may not receive it through other channels. Such opportunities may include sexual health advice for people attending their general practice for a new patient check or travel vaccinations. Advice and information about contraception and preventing or treating STIs should be available for all people who are offered screening for chlamydial infection as part of the NCSP.

Key interventions

- Programmes and interventions which are multi-component are most effective in reducing sexual ill health. Interventions are more likely to be effective if they include use of theoretical models, are targeted for particular communities making use of needs assessment or formative research, and provide information and behavioural skills training.^{48 49 50 51 52} (level I)
- Programmes that focus on strengthening perceived norms that promote safer sex can lead to reduced sexual risk-taking (for example, through use of peers or popular opinion leaders).^{53 54 55 56} (level II, V)
- Sustained sexual health promotion campaigns, as part of multi-component programmes, can positively affect individual attitudes and intentions regarding safer sex.⁵⁷ (level IV)
- High quality sexual history-taking and risk assessment can provide opportunities for targeted sexual health promotion to become a routine part of good patient care and enable people to receive appropriately targeted advice and information on prevention of STIs, HIV, and unintended pregnancy within clinical settings.⁵⁸ (level IV)

Implications for service planning

- 18 A multi-agency planning group, with public involvement, can ensure a comprehensive approach to promoting sexual health. As part of a broader strategy to improve sexual health, it is recommended that a local strategy for sexual health promotion be put in place, which:
- is systematically planned and evaluated
 - includes initiatives to prevent STIs, HIV and unintended pregnancies
 - links with other key strategies and the LDP
 - is informed by an up-to-date assessment of local sexual health needs
 - supports and encourages early self-referral for sexual health problems
 - ensures there are links between the activities of health, education and other relevant settings
 - is delivered in a choice of clinical and non-clinical settings
 - is transparently commissioned in line with the DH's *Effective commissioning of sexual health and HIV services*
 - is adequately resourced in a way which reflects priorities identified through needs assessment and in line with current best practice and policy guidance.
- 19 A comprehensive programme of multi-site, multi-level and multi-component interventions should be planned, taking account of local social, cultural and demographic factors and information on the sexual health profile of the local population. Sexual health promotion activities should be evidence-based and evaluated using appropriate research or evaluation tools.

- 20 PCTs should maintain and develop partnership working with local authorities to reduce unwanted teenage pregnancies, within a wider strategy to improve the sexual health of young people. They should ensure action against the joint DH and DfES PSA target to reduce the under-18 conception rate by 50 per cent by 2010 (from the 1998 baseline). PCTs should continue to ensure local implementation of the DH-supported programme of PSHE certification for teachers and community nurses.
- 21 In order to tackle health inequalities within the local population, PCTs and partner organisations should ensure sexual health promotion interventions are implemented, which target population groups disproportionately affected by sexual ill health, such as men who have sex with men, black and minority ethnic groups and young people, including vulnerable or disadvantaged young people, such as those in public care.
- 22 To enable clinical practitioners to incorporate prevention initiatives and interventions to promote sexual health within their services, PCTs should ensure that training is available on sexual health promotion and on evaluating interventions. Local sexual health promotion specialist teams and partner agencies, in addition to providing direct health promotion interventions, should contribute to training and development programmes and support local services to coordinate a consistent and effective approach to promoting sexual health. Training should provide relevant theory and evidence for sexual health promotion, develop skills in communicating about sex and support clinical and practical skill development, such as how to capitalise on time-limited opportunities to promote sexual health within consultations. Training should also promote attitudes and values which are positive about sex and sexual health.

Guidance on practice

- 23 Department of Health (2003) *Effective sexual health promotion: a toolkit for primary care trusts and others working in the field of promoting good sexual health and HIV prevention*. London: Department of Health. (Available at: www.dh.gov.uk)
- 24 Department of Health, African HIV Policy Network and National AIDS Trust (2004) *HIV and AIDS in African communities. A framework for better prevention and care*. London: Department of Health (Available at: www.dh.gov.uk)
- 25 Hickson F, Nutland W & Weatherburn P et al (2003) *Making it count. A collaborative planning framework to reduce the incidence of HIV infection during sex between men*. (Available at: www.sigmaresearch.org.uk)

Suggested audit indicators

- Local strategy in place for sexual health promotion.
- Sexual health promotion included within local sexual health strategy.
- Sexual health promotion included in LDP.
- Evidence of integrated, multi-component health promotion interventions.
- Locally agreed proforma or structured case note template for sexual health assessments (see also recommended standard 4).
- Targeted and appropriate sexual health information for populations served.
- Sexual health information available in a range of settings, in different languages and media.

Empowering and involving people who use services

Aim

To empower people to have confidence, personal control and choice in managing their sexual healthcare and service use, and to improve sexual health services by involving people in their planning and development.

Recommended standard 3

People should receive a sexual health service which:

- is service-user centred
- enables self-referral to services
- encourages partnership in decision-making
- enables them to make informed and autonomous choices
- supports them in taking responsibility for their sexual health and care.

Commissioners and services should:

- promote active user participation and involvement in the planning and organisation of services
- develop their awareness and understanding of the various communities they serve
- recognise and respond to social exclusion, discrimination and power imbalances (such as those between genders or individuals) in a way that enhances access, and promotes effective use of services
- ensure all staff involved in sexual health services are committed to non-discriminatory working practices and delivery of care.

Rationale

- 1 Current health policy emphasises the need to put people using services at the centre of NHS activity and to enable them to have greater input into their individual care as well as into helping to plan and monitor services.^{59 60 61 62 63}
- 2 Action to ensure that services and professionals work to enable people to have individual control over decisions affecting their care is different from the action needed to promote and implement collective involvement in service planning and delivery. This recommended standard addresses both.
- 3 Services should promote active user involvement in healthcare. Section 11 of the Health and Social Care Act 2001 places a duty on NHS trusts, PCTs and SHAs to make arrangements to involve and consult patients and the public in the planning and organisation of services. Patient fora enable NHS trusts and PCTs to bring a service user perspective to management and decision making.⁶⁴
- 4 The overall aim of involving people who use services is to provide more user-focused services with a view to improving the quality of care. Public and service user involvement enables services to gain understanding of peoples' needs and preferences, to achieve shared input to decisions and to make services more responsive to the individuals and communities who use them. Accessible and more responsive services should lead to improved health outcomes.^{65 66 67}
- 5 People should be able to make their own choices in maintaining their sexual wellbeing. This means being informed about sexual health, about the services available, including self-care, and feeling able to access these. The DH consultation on *Choice, responsiveness and equity in the NHS and social care* states that '...people who are more involved in their treatment, who understand the options available to them and who have taken responsibility and control of their own healthcare have better long term health outcomes'.^{68 69}
- 6 The degree to which people want to share in decisions about their healthcare will vary, although most people will have some preferences which may influence their care. Both people who use services and health professionals will need support to make decisions in partnership. Each brings important, relevant information and expertise to the consultation process.^{70 71}
- 7 People's decision-making processes can impact upon their health-seeking behaviour. Information and support are needed to help people assess risk, consider the benefits of seeking help, access and use services effectively, and understand the implications of professional advice. For example, people may need information about the range of contraceptive methods, how they are used and where or how to access them. When considering whether to have tests for STIs or HIV, people may need information about which tests are available, what they involve, the different infections, how they are treated and the outcomes of treatment. Information on the long-term health consequences of undiagnosed infection is also important. People are then able to balance the advantages of knowing their diagnosis against hindering factors such as their fears about disease, or embarrassment about disclosing sexual behaviour.^{72 73}

- 8 Fears about seeking help and hopes that problems will go away mean some people fail to attend services when this would provide benefit. People may ignore symptoms and only seek medical advice when they become intolerable. STIs are often asymptomatic, or have symptoms which may clear quickly and lead people to think they do not need to take action. As well as how to recognise and act upon symptoms, they need to know that neither the lack nor the apparent resolution of symptoms necessarily mean the absence of infection.
- 9 Intimate examinations, such as those of the genitals which may be necessary in sexual health services, can be experienced by service users as stressful and embarrassing. People should receive services which maintain their dignity, safety and privacy. Professional guidance such as that provided by the General Medical Council (GMC) recommends that people should receive information on why an intimate examination is necessary and what it involves, and be offered a chaperone. Following publication of the Ayling inquiry, it is recommended that chaperoning should only be undertaken by trained staff, and not by untrained administrative staff or patients' friends or family.^{74 75 76}
- 10 People need information that allows them to have safe and happy sexual lives and to make effective use of services. Access to information and services may be more difficult for those who are already disadvantaged and it is important to ensure services are designed to respond to their needs and are culturally competent. Community-based services in locations which people are more likely to attend, or opening times which reflect their preferences, may support service uptake. Additionally, targeted outreach services may empower socially excluded or transient populations to access care.^{77 78}
- 11 The stigma associated with some aspects of sexual health ill health has impacted on perceptions and use of services as well as on how the services are delivered. STIs, abortion and sexual problems have been experienced as particularly stigmatising and it has therefore been perceived to be more difficult to access the views, opinions and experiences of service users. People are less likely to provide feedback about or complain about sexual health services than about other aspects of healthcare, as doing so will acknowledge their use of such services, which they may prefer remained confidential. The House of Commons Health Committee report on sexual health concluded that the absence of a patient voice has contributed to the crisis in the sexual health of the nation.^{79 80 81 82}
- 12 There has been wide involvement of people with HIV in service development. However, there may be greater scope for involving other people who use, or might use, sexual health services than has been recognised. Existing HIV service user groups may also contribute to GUM and sexual health involvement processes. Mechanisms for involving people can include user satisfaction surveys, focus groups, user fora and representation on management and steering committees. Mystery shopper exercises, where trained individual service users are tasked with attending services to assess them against predetermined criteria, can provide actionable feedback. Service developments informed by coordinated user involvement programmes can contribute to quality improvement, and increase both uptake and user satisfaction. Various guidance is available on involving people who use services. Use of validated tools and robust survey and research methodologies are needed to evaluate the quality of services.^{83 84 85 86 87}

Key interventions

- Public and service user involvement mechanisms for facilitating feedback about services, in particular those which are user-centred and/or user-led, can contribute positively to improving quality of services.^{88 89 90 91 92*} (level IV)
- Shared decision-making between professionals and individual service users can result in better health outcomes.^{93 94} (level IV)
- Wider community-based access to some elements of sexual healthcare, such as pharmacy provision of emergency hormonal contraception (EHC), or STI screening and prevention interventions in community venues, alongside clear signposts and care pathways for access to mainstream services, can facilitate choice and control, and enhance service access. (level IV)
- Clear, easily accessible information about services - what is provided and where, including how they meet particular needs - can support individuals to select the service they need.⁹⁵ (level IV)

* Evidence from conference abstract only

Implications for service planning

- 13 It is important for sexual health services to create and maintain inclusive and user-friendly environments and a climate that promotes a positive attitude to sex, sexuality and sexual health. Sexual health services should be provided in settings which are fit for purpose. Every effort should be made to ensure the physical environment is comfortable and the layout is conducive to protecting confidentiality and dignity. Accredited training in chaperoning and adequate resource for its provision should be available. As a result of the Ayling enquiry, it is recommended that NHS trusts make their chaperoning policies explicit to patients.
- 14 PCTs and services need to develop and maintain awareness and understanding of the needs of the various communities which they serve. They should find ways to engage those less likely to use mainstream services, and provide positive encouragement to access services. It is recommended that sexual health services are commissioned from a range of different providers and based on assessment of local needs, to promote choice and accommodate different user needs and preferences.
- 15 Mechanisms should be in place which can enable healthcare organisations to improve the service user experience, based on feedback from the public and from people using local sexual health services. These might include leadership arrangements and structures for public and service user involvement, links with patient fora and user advocacy organisations, clear

complaints procedures, and the commitment of services to the process of involvement and user-centred care. Links should be developed with professional membership organisations which either have a consumer forum or regularly survey the views of service users. It is important that the views of users of the range of sexual health services are sought, via a range of media, some of which should enable anonymity to be preserved. Locally agreed and standardised criteria for seeking feedback on the views and experiences of service users should help enhance the consistency of data received.

- 16 The views of service users (and potential users) should be sought and taken into account in the design, planning, delivery and improvement of sexual health services. PCTs should consider making provision in their budgets for the costs of user involvement in relation to sexual health.
- 17 Practitioners should respect the autonomy of people using services and work in partnership with them in managing their care. Services should be commissioned which can address the sexual health needs of resident communities, reflecting local epidemiological and demographic profiles. Sexual health services should address the needs of both women and men, at all stages in their sexual lives. A range of services are needed which are able to meet, for example, the requirements of young people under 16 as well as those of post-menopausal women. Responses to individual, community and public health needs should be appropriate in terms of culture, gender, age, sexuality and sexual lifestyle.
- 18 Services should ensure staff receive appropriate training in equality and diversity issues and understand the impact of social inequalities, and of stigma, on people's access to, and use of, services.

Guidance on practice

- 19 Royal College of Obstetricians and Gynaecologists (2002) *Patient involvement in enhancing service provision*. Clinical Governance Advice No 4. RCOG. (Available at: www.rcog.org.uk)
- 20 Department of Health (2001) *The expert patient: a new approach to chronic disease management for the 21st century*. London: Department of Health. (Available at: www.dh.gov.uk)
- 21 Department of Health (2003) *Strengthening accountability: involving patients and the public. Policy Guidance. Section 11 of the Health and Social Care Act 2001*. London: Department of Health.
- 22 Department of Health (2003) *Choice, responsiveness and equity in the NHS and social care: a national consultation*. London: Department of Health.
- 23 Department of Health (2004) Public Health White Paper, *Choosing health: making healthy choices easier*. London: Department of Health.

Suggested audit indicators

- Service users feel adequately involved in their care, as measured by audit sample questionnaire responses.
- Evidence from case notes of informed involvement of individual users in decisions about their care, including discussion of consent, testing or treatment options and offer and uptake of chaperone.
- Evidence of services working with user groups.
- Service specifications include user involvement.
- Involvement of all communities and population groups served, including high need communities, in planning and evaluating services.
- Services able to demonstrate action they have taken in response to feedback.

Identifying sexual health needs

Aim

To ensure the range of sexual health needs of individuals are identified so that they can access services to achieve positive sexual health and wellbeing.

Recommended standard 4

People need access to services which are able to:

- utilise opportunities to identify a range of sexual health needs
- make a comprehensive and appropriate assessment of their sexual health needs, including:
 - STI and HIV risks and need for screening (including cervical cytology)
 - contraceptive need or use
 - problems relating to, or impacting upon, sexual function and wellbeing
- direct or refer to other sexual health and related services as needed.

Commissioners and providers of services should:

- develop and implement strategies to encourage and support uptake of sexual health services
- ensure service capacity to identify, and to address, the sexual health needs of individuals and populations served
- have an efficient system of integrated care pathways to facilitate the movement of people between services.

Rationale

- 1 Sexual health may be compromised by problems associated with STIs and HIV, unintended pregnancy or sexual dysfunction; by related outcomes such as infertility or other conditions resulting from STIs; and by psychological concerns related to, for example, sexual assault or coercion, violence or abuse, or unwanted pregnancies. A range of medical conditions, mental health problems and acute or chronic illness can also have an impact on sexual health.
- 2 Significant rates of unmet sexual health need and subsequent adverse outcomes have been associated with inadequate provision, delayed access to services and lack of public awareness. Official figures for STI diagnoses understate the overall burden of infections. People may be unaware of their risks and many infections are asymptomatic. Continuing high rates of unintended pregnancy and abortion demonstrate a need for increased uptake and effective use of contraceptive methods. Wider identification of the full range of sexual health needs, alongside the capacity to meet these needs, can help to reduce the prevalence of STIs, including undiagnosed infections, and rates of unintended pregnancy.
- 3 The lack of priority accorded to sexual problems, along with variable access and insufficient provision of specialist services for sexual dysfunction, have meant that high rates of sexual dysfunction remain undetected or are not being managed. People may also be reticent to disclose problems with sexual satisfaction or function. Professionals may be reluctant to encourage such disclosure due to lack of expertise or limited local care options.
- 4 Every time a person uses a specialist sexual health service, or requests sexual health advice or services from their general practice, an opportunity is presented to identify related needs. Other opportunities to identify a range of sexual health needs may arise, or may even be created, in various other health and community settings. Increasing the priority given to sexual health may encourage both service users and local services and professionals to capitalise on such opportunities.
- 5 People using health services may have additional sexual health needs, whether or not these are related to their attendance. For example, those attending for contraceptive advice may be at risk from STIs. A person attending a family planning clinic for contraception should be able to gain access to STI services whether on site or in another setting via an integrated care pathway. A holistic approach to those presenting for sexual healthcare can enable a range of needs and risks to be identified and addressed.
- 6 Proactive discussion of sexual health may be beneficial in a number of scenarios. In general practice, routine discussion of sexual health needs can be incorporated within new patient health checks or travel immunisation clinics. People with medical conditions, or receiving treatments, which effect sexual health or libido should have the opportunity to explore and address the impact of these on their sexual life.
- 7 Opportunities to identify infection have been missed. It is estimated that more than a quarter of people with HIV in England are undiagnosed. Studies of those diagnosed during later stages

of infection have shown that many had attended health services with problems suggestive of underlying immune suppression and indicative of their HIV status, but the possibility of HIV had not been investigated. Unlinked anonymous screening studies of GUM attenders have also demonstrated that a significant number of people with acute STIs have concurrent undiagnosed HIV infection. (See *Recommended standards for NHS HIV services* for recommendations on detecting HIV infection in a range of settings.)^{96 97}

- 8 Rates of undetected infection for other STIs are unclear. Asymptomatic STIs may remain undetected if people are unaware of their risk, and these may lead to significant long term health problems. Effective means of STI case-finding are needed, such as partner notification and community-based testing. National screening programmes, such as those for cervical abnormalities in women or for genital chlamydial infection, can detect evidence of disease or infection, although it is important to note that these two programmes target different age groups. Screening for chlamydia trachomatis can reduce prevalence of infection and incidence of pelvic inflammatory disease.
- 9 Data from the *National health service cervical screening programme* (NHSCSP) show that the majority of eligible women in England (more than 80%) have been screened at least once in the previous five years. An opportunity to discuss sexual health may be provided when women attend services for cervical smears, although care should be taken that this does not compromise the cervical screening experience or intention. Conversely, sexual health consultations may create an opportunity to identify women between 25 and 64 who have not had a recent smear test.⁹⁸
- 10 Studies of prevalence of genital chlamydial infection, including those from early implementation sites for the NCSP, have demonstrated high rates of infection in young people under 25 years old who attended healthcare settings. Chlamydia screening undertaken as part of the *National survey of sexual attitudes and lifestyles* (NATSAL) in 2000, confirmed prevalence of infection in the general population. As a high proportion of those infected often have no symptoms, without access to screening, many people may not have their infection diagnosed or treated. Undetected infection can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Studies demonstrate high rates of infection in men, and although it has proved more difficult to engage them in opportunistic screening, the need to ensure men are also included in population screening is crucial. There is growing evidence regarding the effectiveness of screening programmes and the case to support the NCSP is well established. The White Paper *Choosing health* has indicated the DH commitment to achieving full national coverage for the NCSP by the end of March 2007. All PCTs are expected to take action to increase screening volumes and action to support the management of those with infection and their partners.^{99 100 101 102 103 104 105 106}
- 11 Good history-taking and sexual health assessment by trained staff can help services to identify people's sexual health needs. An agreed framework for these processes, across all settings and levels of sexual health provision, may enable people to have their core needs identified in the setting they choose to attend, with further assessment facilitated by being directed to the most appropriate service. Such a system may take the form of structured case note sheets, pro formas and computer templates.^{107 108 109 110 111}

- 12 Structured assessment and history-taking sheets can support consistent practice, provide appropriate documentation and facilitate audit. Templates can be designed to be compatible with data surveillance requirements and can be used as a basis for developing integrated care pathways.
- 13 Service environments supportive of sexual health will promote uptake of services, providing opportunities to identify sexual health needs (see recommended standard 5).
- 14 Research has suggested that prevalence of sexual problems in the general population is high, with most studies suggesting that about a third of adult men and up to half of adult women have experienced sexual dysfunction. Although smaller proportions have sought or received professional help, many would like to. Sexual difficulties are common in people attending sexual health services, including general practice, and many are prepared to talk about these. Among men using general practice, a high consulting rate has been shown to be a predictor of sexual problems. Men have also been more likely to present with sexual problems since the licensing of sildenafil to treat erectile dysfunction, although access to NHS treatment is restricted.^{112 113 114}
- 15 Some people using services may find it difficult to ask for help with sexual difficulties, and it is important to create an environment which enables people to choose to disclose. Routinely asking a question related to sexual function during sexual history-taking - eg satisfaction or difficulties with sex life - may help to identify those with sexual problems. The acknowledgement of sexual problems associated with some medical conditions or the availability of the service information may also support disclosure. However, it is important that such needs assessment is undertaken within a local service network that has adequate service provision for those with sexual dysfunction.
- 16 A sensitive question about any unwanted sexual experiences they want to discuss may help people who have been sexually assaulted, and those in previous or current abusive sexual relationships, to seek the help they need.

Key interventions

- Normalising sexual health as integral to general health and wellbeing can be achieved through discussion of sexual health during relevant opportunities within consultations (examples: new health checks, cervical cytology, travel clinics).^{115 116 117 118} (level IV)
- Training and structured sexual history-taking templates or case notes will facilitate a consistent approach to identifying sexual health needs across settings.^{119*} (level IV)
- Following national clinical effectiveness guidelines for STI screening (by the British Association for Sexual Health and HIV (BASHH)) will help identify asymptomatic infection in those who approach sexual health services and who, therefore, may have some degree of awareness of their risks.^{120 121} (level IV)
- The NCSP, and other opportunistic screening which targets high need population groups, can detect infection in those who might otherwise not access sexual health services or be aware of their risks. The inclusion of community-based venues as screening sites can further identify infection or STI risk.^{122 123 124 125 126} (level IV)

* Evidence from conference abstract only

Implications for service planning

- 17 All practitioners delivering elements of sexual healthcare should be competent to undertake basic assessments to identify a range of sexual health needs. PCTs and local service networks can support competency development by ensuring relevant training opportunities are available.
- 18 Training for practitioners should include communication skills for sexual health, sexual health assessment, the process of taking a sexual history and the recognition and basic assessment of sexual problems. Practitioners' sexual history-taking and assessment skills will improve as their knowledge, experience and awareness of sexual health increase.
- 19 Sexual health service networks (see recommended standard 1) should help facilitate a consistent approach to sexual history-taking and sexual health assessments. As far as possible, basic assessments should be common to each level and type of service, and should include requests for information which reflect requirements of the (forthcoming) sexual health services common dataset. Local surveillance information regarding the latest sexual health trends may inform content of history-taking.
- 20 PCTs and service networks should seek to ensure that practitioners identifying the sexual health needs of their service users are then able to respond to those needs, or direct people

to relevant practitioners or services that can provide the treatment or service they require, including more detailed assessments as necessary. A functioning network of integrated care pathways, and referral systems will enable movement between different levels and types of service.

- 21 PCT strategies to encourage sexual health service uptake should include specific actions to reach population groups who are less well served by, or find it more difficult to access, existing provision. The selection and targeting of these populations should be informed by local demographic and surveillance profiles, patterns of service delivery and use, user feedback and community involvement mechanisms. This may include work to support service uptake among young people, men, black and minority ethnic communities, refugees and asylum seekers, lesbian, gay, bisexual and transgendered people, those with physical or learning disabilities and those whose first language is not English.
- 22 Information about local sexual health service provision should be readily available for both staff and members of the public, to enable people to access the services they need. All practitioners should maintain knowledge of relevant user and/or care pathways into, and from, their service and be familiar with related local service provision and configuration, or be able to access such information.
- 23 Services can both contribute to, and benefit from, local surveillance information on sexual health (see recommended standard 10). Identifying needs at the service level contributes to local population needs assessment. PCTs should consider a range of indicators of need to inform service and capacity planning, including service use. They should ensure mechanisms are in place for accessing local public health data and service user feedback regarding offer and uptake of services. Rates of preventable adverse sexual health outcomes can be used to help predict levels of unmet need.
- 24 PCTs should be aware of government action to achieve complete national coverage of the NCSP by March 2007. Until such time as their locality is fully integrated into the programme, PCTs should plan for, and work towards, increasing the percentage of women and men under 25 years old and others at risk accepting chlamydia screening.
- 25 Awareness of the prevalence of sex and relationship difficulties and the range of reported sexual dysfunction can enable practitioners to become more alert to such needs in people accessing sexual healthcare. They should also be aware that such difficulties often remain undisclosed.
- 26 Services contracted to offer STI screening opportunities in non-traditional or non-clinical settings, such as those in pharmacies and community venues, should have clearly defined pathways to enable those diagnosed with infection to receive prompt treatment and partner management.

Guidance on practice

- 27 Society for Sexual Health Advisers (2004) *The manual for sexual health advisers*. London: SSHA. (Available at: www.ssha.info).
- 28 British Association for Sexual Health and HIV (2005) *Sexually Transmitted Infection Screening and Testing Guidelines for UK Genitourinary Medicine Clinics*. (In development, managed by the Bacterial Special Interest Group and commissioned by the Clinical Effectiveness Group of BASHH).
- 29 Ross J, Ison C and Robinson A et al (2005 in development) *Testing for sexually transmitted infections in primary care settings - Recommendations from the Bacterial Special Interest Group of BASHH*.
- 30 *Colposcopy and programme management. Guidelines for the NHS Cervical Screening Programme* NHSCSP Publication No 20. (Available at: www.cancerscreening.nhs.uk)

Suggested audit indicators

- Proportion of practitioners who use a locally agreed structured case note format to guide sexual history-taking.
- Percentage of the sexually active population under 25 years old, and others defined as 'at risk', accepting chlamydia screening. (This will be collected as part of NCSP. This indicator will also be used to monitor progress against the delivery of the PSA target for sexual health 2005-08, as part of its broader strategy to improve sexual health. PCTs are expected to demonstrate increases in this percentage each year, as progress towards achieving coverage of 50 per cent of the sexually active population each year.)
- HIV testing in those screened for STIs - rates of offer, uptake and diagnosis.
- Percentage of STI consultations in which contraceptive needs are raised appropriately, as documented in case notes.
- Percentage of consultations for contraception where STI risk and STI screening or testing are discussed.
- Local integrated care pathways defined for service users with sexual dysfunction and percentage of practitioners demonstrating knowledge of these.
- Percentage of service users with identified sexual dysfunction referred according to agreed local protocols.
- Percentage of people using services who feel their sexual health needs are adequately addressed.
- Percentage of consultations in general practice for travel immunisation in which sexual health is discussed.
- Sexual health included in topics to be covered in new patient checks in general practice. Percentage of such consultations where discussion of sexual health is documented.

Access to services

Aim

To maximise the sexual health of individuals and their sexual partners, by facilitating convenient and timely access to sexual health services.

Recommended standard 5

People with sexual health needs should:

- have access to a full range of sexual health services
- be able to access, either by booked appointment or, where available, via walk-in, within the following specified time limits:
 - STI services within two working days
 - contraceptive services within two working days and prompt access to their chosen method
 - abortion assessment ideally within five working days from the initial contact with an abortion provider or referring service
 - an abortion ideally within two weeks, but within a maximum of three weeks (if clinically appropriate), from the initial contact with a healthcare provider
- also be able to have:
 - urgent, same day access for emergency contraception
 - urgent access to relevant prophylactic treatment for those with known or high risk exposure to HIV or for those who have been sexually assaulted
 - prompt access to comprehensive services needed following sexual assault
 - access to services for sexual dysfunction
- have access to comprehensive information on local sexual health service provision to enable them to choose where to attend.

Commissioners and services should ensure:

- service capacity is adequate to address identified needs and to meet the stated time limits for access
- integrated care pathways are agreed which prioritise ease of access
- open access to GUM and community contraceptive services is maintained (ie people can choose to attend services outside their area of residence)
- adequate STI and contraceptive services are provided on each working day within a network area
- information on services is widely available, including services for those who may need urgent access to care.

Rationale

- 1 Improved access to services is a key NHS priority. In a climate of rising rates of STIs and continuing high rates of unintended pregnancy, the demand for, and workload of, sexual health services continues to increase, and consequently access to services has become more difficult.^{127 128 129 130}
- 2 This recommended standard focuses on action to improve access to the range of sexual health services. Those which follow, recommended standards 6-9, address in more detail access to and provision of services to meet specific sexual health needs.
- 3 Services need to be adequately resourced to enable sufficient time in consultations to support holistic care. Enhanced access can be achieved with attention to process improvements and modernisation, which can lead to greater efficiency. However, the time available for consultations has become progressively shorter to meet rising demand, with a resulting focus on minimising input to manage increased workload. If expectations to provide comprehensive, user-focused services are to be fully realised, this trend needs to be reversed. Service modernisation should seek to address these conflicting requirements.
- 4 Expansion of practitioner and service roles in delivering sexual health services, for example, increased provision of nurse-led services, should help to improve access. Pharmacy supply of emergency hormonal contraception under patient group directions may ease pressure on services and support self-care. It is important the range of services are coordinated. Despite trends towards integrated provision of some elements of care, local links and interdependence between sexual health services are often ill-defined or incomplete, and where they exist, are based on informal networking processes. In *The national strategy for sexual health and HIV's* recommendations for coordinating services across healthcare sectors and settings, the formation of sexual health service networks is promoted as the framework for a comprehensive service. Such networks can work to prioritise access to services in response to locally identified need. (See also recommended standard 1.)
- 5 The House of Commons' Health Committee report on sexual health in 2003, established that considerable investment in service provision is needed to fund expansion to meet demand. In the public health White Paper, *Choosing health*, the government has committed additional capital and revenue funding to improve the nation's sexual health. Commitments include those to improve prevention and treatment services and enable faster access to these, to support the modernisation of the range of sexual health services, to tackle high rates of STIs and to meet gaps in contraceptive service provision. Specific actions and goals include access to an appointment within 48 hours for everyone contacting, or referred to, a GUM clinic by 2008 and provision of efficient and convenient screening services, with accelerated national coverage of the NCSP by March 2007.^{131 132 133}
- 6 Sexual health needs and problems are common but varied and a range of generalist and specialist provision exists to serve these, with access points in hospital, primary care and community settings. The choices available to individuals with regard to where they access

sexual healthcare are limited by the capacity of local providers to meet local need and demand for services.

- 7 Continued 'open access' policies for GUM and young people's sexual health services can facilitate access and choice for those using services. In some localities, contraceptive service provision has been restricted to those resident within particular PCTs, and is no longer commissioned as open access. However, preserving open access, which does not require a referral from another practitioner and enables people to self-refer to the sexual health service they choose regardless of location, is crucial in maintaining user choice and enabling access. Some open access services are also provided on a 'walk-in' basis, so that people may access services without an appointment during opening hours. Although these can be subject to long waiting times, they can facilitate same day access to contraceptive or STI care. It is particularly important that services are able to provide rapid access for those with emergency needs. This may be achieved with triage arrangements, combined with either a walk-in service or with a proportion of appointments which can be booked only on the same day.^{134 135}
- 8 Increased awareness is a key factor in improving service access. Both public and professionals need greater awareness of sexual health and of the range of available services, to facilitate improved access to, and uptake of, services. Opportunities for health professionals to improve their communication and assessment skills and to enhance their knowledge of sexual health and fertility regulation should enable them to be proactive in identifying and addressing sexual health concerns of service users. Effective sexual health assessment needs to be underpinned by knowledge of local epidemiological and demographic information relating to sexual health.^{136 137 138 139 140} (See also recommended standard 4.)
- 9 Clear information about sexual health services available locally is needed for people using these services, and for potential users, to help them find the most appropriate care or support for their needs. Service providers also need good up-to-date information about local services to assist in making referrals or directing people to the most appropriate care.
- 10 People select and make contact with sexual health services in a variety of ways, for example, some local audits have shown that a significant proportion of GUM attenders had already consulted their GP and been referred, at least informally, from primary care. Services which are linked and coordinated can enable access for all people with minimum delay for every aspect of sexual healthcare and fertility control, irrespective of the setting of the first point of contact. Individuals should be able to access services which are responsive, timely and effective.
- 11 Within the context of the new general medical services (GMS) contract for general practice, diagnostic testing should be arranged for people with symptoms of STIs as part of essential service provision. The availability of on-site testing for common and uncomplicated STIs within this setting would be preferable, with arrangements for prompt access to GUM where this is not possible. Provision for more specialised sexual health services, contracted to national enhanced service specification, should enable increased choice of provider for people requiring STI services. Increased access to STI testing in general practice and other primary care settings may enable more people to access an appointment and diagnostic testing for common STIs within two working days.¹⁴¹

- 12 Where referral to GUM is needed for treatment of STIs diagnosed in other settings, clear care pathways should help to facilitate timely access to treatment, partner notification and follow-up services as necessary. Some studies have shown a higher rate of treatment access and uptake when treatment is provided at the testing site. While access to treatment should not be delayed, contact between services is essential to support surveillance, contact tracing and follow-up as relevant.^{142 143} (See also recommended standard 6.)
- 13 Post exposure prophylaxis (PEP) for HIV - the provision of antiretroviral drugs with the aim of preventing HIV infection in people who may have been exposed - is increasingly being offered following sexual exposure. Although data supporting the efficacy of PEP following sexual exposure (PEPSE) are limited, studies to reduce the risk of occupational and mother-to-child transmission suggest that PEP may be protective. National guidelines developed by BASHH recommend that a decision to initiate PEPSE is made on an individual basis following assessment of risks. This would include, for example, consideration of the potential risk of transmission associated with an exposure, the risk that the source is HIV infected, the wishes of the individual and their ability to tolerate and adhere to the course of treatment.^{144 145}
- 14 Most contraception is provided in general practice settings, although audit suggests that people receiving contraceptive services from general practice do not always have access to the full range of methods. Integrated care pathways should ensure and enable access to all methods of contraception.^{146 147 148} (See also recommended standard 7.)
- 15 An opportunity to understand and address local delays or variation in access to abortion will be provided by auditing access to abortions. The achievement of the PCT performance indicator for the proportion of women meeting the legal requirements who have access to an abortion within a maximum of three weeks from their first appointment with a referring service, or from first contact with an abortion service, should be monitored. Guidelines from the RCOG set a similar three-week maximum, but recommend that access should ideally be within two weeks. The proportion of abortions which are NHS-funded, and the percentage of abortions performed at gestations under 10 weeks, should also be measured.
- 16 Service provision for people with sexual dysfunction is varied and involves practitioners from different specialties, disciplines and sectors. Some provision exists within sexual health services, for example in GUM or in contraceptive services, where services may be doctor, psychologist or nurse-led, and may either reflect the interests, training and skills of individual practitioners, or be the result of collaboration with mental health teams to provide a dedicated service. The long waiting times for sexual dysfunction services suggest that demand outweighs capacity. Lack of resources and training opportunities have been identified as barriers to wider provision.^{149 150}
- 17 Coordinated provision within sexual health service networks is key to improving access. There are increasing examples of co-located and integrated services, including the one-stop-shop sites piloted with DH funding, and many services are expanding their range of sexual health provision. Further such developments should be encouraged. However, while most individual services do not provide a fully comprehensive range of care, clear pathways will be needed to enable coordinated access to elements of care provided in different services and settings. Obvious examples include meeting the contraceptive needs of those attending GUM, or access

to full STI screens for women accessing abortion services.

- 18 Service collaboration is of particular importance where people have a number of needs requiring the involvement of a variety of agencies, both within and outside the health sector. These include services for people who have been raped or sexually assaulted whose multiple care needs may be managed in parallel with criminal justice procedures. Their immediate needs may include safety, emergency medical care for physical injuries, emergency contraception, psychological support and prophylactic treatment for STIs and, if deemed to be at risk, for HIV. Dedicated sexual assault referral centres (SARCs) provide supportive environments in which women and men can receive optimal care, including forensic examination, whether or not they choose to report an assault to the police. The option to contribute to intelligence and evidence anonymously can also be provided alongside support with decisions about police involvement. Constructive working arrangements between health services and the police, with agreed local protocols, can facilitate optimal management.^{151 152 153 154}
- 19 Other situations benefiting from clearly defined, multi-agency processes include services for children when sexual abuse is suspected.

Key interventions

- Production and dissemination of regularly updated local service information, including location, opening times and services provided, using a range of formats and media, can influence perceptions about sexual health services and improve uptake of services.^{155 156} (level IV)
- Clearly advertised, welcoming and accessible services for those who may need them can facilitate improved access.^{157 158} (level IV)
- Explicit and demonstrable confidentiality can be a key determinant in access and uptake of services.^{159 160 161* 162} (level IV)

* Evidence from conference abstract only

Implications for service planning

- 20 PCTs should ensure that service capacity is adequate to address need and demand. Mechanisms should be in place for monitoring access to services within time limits specified within this recommended standard. These waiting times reflect, where possible, those recommended within national strategic or guidance documents.
- 21 Service networks can help ensure adequate STI and contraceptive service provision is

available on each working day and coordinate provider opening hours to support this aim. Arrangements should be in place for facilitating out-of-hours provision and urgent access to care.

- 22 PCTs should support continued open access and self-referral to GUM and community contraceptive services. For providers serving more than one PCT, shared commissioning arrangements should be in place, as recommended in the DH's *Effective commissioning of sexual health and HIV services: A sexual health and HIV commissioning toolkit for primary care trusts and local authorities*. Where access to a specific sexual health service is restricted to particular population groups or by PCT of residence, this should be made clear in service information, with alternative provision identified for people who may not be eligible.
- 23 PCTs and service networks should facilitate the collection and regular update of local sexual health service information and enable this to be made widely available and accessible to both public and professionals. Local health information resources, such as NHS Direct, should also be kept updated. Information should be available in a variety of formats and media, such as on the web and in languages appropriate for the local population. Services should take responsibility for providing and updating information about what they offer, including the elements of service provided, opening times, location, how appointments are made and access for people with disabilities.
- 24 Collaboration between service providers and relevant partners within a service network should be encouraged and fostered by PCTs, to enable integrated care pathways which support service access to be agreed and defined.
- 25 PCTs and networks can and should support local action to develop sexual health services in primary care, as these can help to increase access. This includes ensuring professionals in general practice and community clinics are able to take up training opportunities in reproductive health and managing STIs.
- 26 PCTs should ensure collaboration between relevant agencies and sectors to meet the sexual healthcare needs of people who have been raped or sexually assaulted, both for their acute care needs and for related longer-term sequelae. Sexual health services should also be involved in multi-agency collaboration to plan for and meet the needs of those who have been, or are being, sexually abused.
- 27 BASHH recommendations for PEPSE include 24 hour access. Collaboration between A&E professionals and specialists in HIV, GUM, infectious diseases or virology/microbiology to support the establishment of local care pathways and policies can help enable timely and appropriate management for people who have been exposed to HIV.
- 28 PCTs should ensure collaboration between relevant agencies and sectors to meet the sexual healthcare needs of people who have been raped or sexually assaulted, both for their acute care needs and for related longer-term sequelae. Sexual health services should also be involved in multi-agency collaboration to plan for and meet the needs of those who have been, or are being, sexually abused.

- 29 PCTs should ensure that people with identified sexual dysfunction have access to services which can address their needs. Increased local coordination of available resources and clear information on referral criteria will support this, as well as ongoing needs assessment to establish local demand.

Guidance on practice

- 30 Department of Health (2004) *Guidance to support planning requirements for meeting the PSA targets 2005-2008* (technical note).
- 31 Department of Health (2004) Public health white paper, *Choosing health: making healthy choices easier*. London: Department of Health. (Available at: www.dh.gov.uk)
- 32 Royal College of Obstetricians & Gynaecologists (2004) *The care of women requesting induced abortion. Evidence-based clinical guideline number 7*. (Available at: www.rcog.org.uk)

Suggested audit indicators

- D Proportion of people attending GUM who are seen within 48 hours of first contact with a service (government commitment contained in public health White Paper *Choosing health*, and supporting the national PSA target, to be achieved by 2008).
 - Access to STI services within two working days in, or via, non-GUM settings.
 - Proportions of STI tests generated, and STIs diagnosed, in settings other than GUM, such as primary care or community-based sites (audited through laboratory reporting of number of tests generated, where initiated and percentage of positive results for STIs and HIV).
 - Proportion of contraceptive service attenders seen within two working days.
 - Range of contraceptive methods provided in each service.
 - Proportion of abortions which are NHS-funded.
 - Proportion of women having abortions within two weeks, and within three weeks, of first contact with a service (to measure performance against both the ideal and the maximum).
 - Proportion of points of access for sexual health services where up-to-date service information is available and displayed.
 - Information is widely advertised and includes elements of service provided, links with alternative providers, location, opening times and how to access the service.

Detecting and managing sexually transmitted infections (STIs)

Aim

To enable people and their sexual partner(s) to access prompt diagnosis and treatment for STIs, minimising risks of onward transmission, re-infection or longer-term negative health outcomes, and so reducing total numbers of people infected.

Recommended standard 6

People who may have been at risk from STIs, including HIV, should:

- have prompt access to services to detect or treat infection within two working days of first contact with a service
- be tested using the most reliable diagnostic tests
- receive information on the infections they are being tested for, and know how and when they can receive their results
- receive treatment, care and follow-up of infection according to national clinical effectiveness guidelines
- receive a consistent quality of care, whether at point of access or via defined integrated care pathways
- be offered education and support to minimise the risk of transmission or further acquisition of infection, or of negative psychosocial outcomes associated with STIs
- be encouraged and supported to ensure their sexual partners access advice, treatment and testing.

Commissioners and services should ensure:

- local GUM and STI services have adequate capacity to respond to need and demand
- basic STI services are provided in primary care and community settings to complement specialist GUM services
- integrated pathways are defined to facilitate prompt access to diagnostic and treatment services
- STI services are consistent across settings, with equivalent tests used for common and uncomplicated STIs
- systems are in place to enable coordinated partner notification across all providers of STI services
- adequate STI control measures are in place to respond to changing demand or crises such as outbreaks.

Rationale

- 1 While the majority of STI diagnosis and treatment continues to be provided by GUM clinics, a range of other service settings, such as general practice and community contraceptive services, are increasingly involved in testing and treating common and uncomplicated STIs. Wider access to STI testing can be achieved by offering tests in community-based venues or pharmacies, or through providing screening opportunities for targeted populations, for example, the local delivery of the NCSP. This recommended standard addresses the range of different services provided for detecting and managing STIs, including the offer of testing to detect HIV infection. More detailed recommendations for the prevention, diagnosis, treatment and care of HIV infection are contained in *Recommended standards for NHS HIV services*.¹⁶³
- 2 *The national strategy for sexual health and HIV* recommends that general practice and community reproductive health services contribute to managing STIs by assessing risk and offering tests as appropriate. The strategy proposes different levels of sexual health service to be provided within a range of settings and identifies that all general practice settings should be able to provide STI testing for women as necessary and non-invasive testing for men (recommended level 1 service). In addition, the GMS contract includes as essential the assessment and diagnosis of people with symptoms of infectious disease. Other STI related screening and treatment in general practice would be likely to require additional funding as a GMS enhanced service to an agreed specification, or be provided under specific PMS contracts, and reflect strategy recommendations for level 2 services. These services should be provided by those practitioners who are trained and experienced, for example GPs or nurses with a special interest (GPwSI, NwSI). Even where direct testing and treatment is not available, all practitioners in general practice need to remain alert to risks of STIs, including HIV, when providing for wider health or sexual health needs.^{164 165}
- 3 Annual numbers of all STIs diagnosed in GUM clinics in England rose by 43 per cent between 1996 and 2002, with an overall GUM clinic workload increase of 79 per cent in the same period.^{166 167}
- 4 To facilitate prompt treatment and care of people with STIs, access to diagnostic services without delay is needed for those with symptoms, those who have had sexual contact with someone with an STI, and those who think they may have been at risk. Rapid response has long been a principle of GUM, to optimise STI control. Prompt management can reduce the risk of complications and limit further transmission. Access should be possible within two working days. The White Paper *Choosing health: making healthy choices easier*, sets out government commitments to invest in services to tackle rising rates of STIs. Proposals include a goal that by 2008, people needing GUM services will be able to have an appointment within 48 hours. According to DH guidance issued in November 2004, all PCT LDPs must describe their intended action to ensure this is achieved. (See also recommended standard 5.)
- 5 Screening for a range of infections in those who have identified themselves, or been assessed, as being at risk of having an STI should enable any infections to be diagnosed. Selection of

tests should be based on sexual history, gender and sexual activity as recommended in national STI clinical effectiveness guidelines for screening and testing produced by BASHH, and may be influenced by, but are not necessarily dependent on, whether a person has symptoms or signs. Service users may also express preferences which influence the choice of test, such as speed of access to results, convenience or testing method.¹⁶⁸

- 6 Developments in testing technology are producing more sophisticated and sensitive tests for STIs. Equity of access to the best available tests should be assured within all services offering STI testing across a local sexual health network. Nucleic acid amplification tests (NAATs) should be used for detecting chlamydial infection, and the DH has supported action to encourage universal use of these. Use of sub-optimal tests risks people being falsely reassured of the absence of infection (or falsely diagnosed as infected). Failure to detect infection can result in potentially serious health consequences for those undiagnosed, removes the opportunity to notify partners who may also be infected, and increases the risk of onward transmission of infection.^{169 170 171 172 173}
- 7 New opportunities for testing are increasingly being introduced, including home testing kits, self-collected urine or self-taken swabs and 'near patient' testing technologies which can enable testing in a wider range of settings, including community-based venues. Where these are used (and particularly if outside health settings) clearly defined care pathways need to be in place for provision of treatment, follow-up and partner management.^{174 175 176 177}
- 8 *The national strategy for sexual health and HIV* aims to reduce rates of undiagnosed HIV infection in order to minimise late-stage disease and death, much of which is currently associated with late or missed diagnosis. The strategy therefore recommends that all people attending GUM services are routinely offered HIV testing on first screening for STIs, and subsequently according to risk. Anonymous unlinked screening has demonstrated relatively high rates of apparently undiagnosed HIV in people attending GUM services with other STIs. In antenatal services, significant increases in the proportion of pregnant women accepting HIV tests were achieved following publication of guidance that promoted strengthening the universal offer of testing to a 'universal recommendation'. Uptake targets were also introduced. An 'opt out' approach to antenatal HIV screening is now becoming the norm. Many GUM services have also introduced 'opt out' HIV testing as part of a full STI screen. Not all those at risk of HIV will attend GUM. There is evidence that other healthcare services, including general practice, are failing to diagnose HIV in people seeking help for conditions which may be associated with undiagnosed HIV infection. If the wider range of services and settings providing sexual healthcare also adopt 'opt out' HIV testing for those screened for STIs, rates of undiagnosed HIV infection and late diagnosis may be reduced.^{178 179}
- 9 *The national strategy* recommends that hepatitis B screening be offered to all gay and bisexual men, commercial sex workers, current (and ex) injecting drug users and their sexual partners, and people from areas where hepatitis B is endemic. For those with ongoing risk, easy access to vaccination should be available. To improve uptake, the strategy sets a goal that all men who have sex with men attending GUM clinics be offered hepatitis B vaccination at first visit. A process in place for recall should help to ensure completion of the course of vaccine. Safer sex information and risk reduction strategies should be offered to all those attending for hepatitis B screening, vaccination or treatment.¹⁸⁰

- 10 To optimise STI control, all those with a diagnosed STI should receive treatment and information regarding the infection(s) and treatment(s), advice about how to avoid onward transmission and reinfection, and discussion of future strategies for risk reduction, including safer sex.
- 11 Partner notification is key to STI control and therefore an essential public health strategy for STI services. The aims are to ensure current and former partners of those with diagnosed infections are informed that they may have been exposed and to encourage them to seek testing and treatment, and so limit further transmission, re-infection or complications. Systems for partner notification are an established core element of GUM services, usually coordinated by sexual health advisers. Community-based practitioners can also undertake this important aspect of care and STI control. NCSP sites have demonstrated that partner follow-up can be achieved in non-GUM settings.^{181 182 183 184}
- 12 All those with diagnosed STIs should be supported and encouraged to inform partners of their need for testing and treatment, either verbally or with the aid of contact (or 'contact tracing') slips which can be given to the partner(s). The slip ensures that the partner receives appropriate treatment and testing whichever sexual health service they attend. That service then returns the slip to the initiating service to indicate the partner has been treated. Generally such contact slips have contained coded reference to a diagnosis, although there is evidence that reference to a named infection is both acceptable to service users and leads to increased partner treatment rates. Subject to consent, and the names and contact details being provided, GUM sexual health advisers undertake provider referral, contacting partners on behalf of people who are reluctant or unable to do so themselves. The identity of the person with the diagnosis is not revealed and their confidentiality should be respected throughout this process.¹⁸⁵
- 13 Appropriate recall procedures need to be in place to ensure anyone with an STI receives treatment, care and follow-up when required. Guidance on follow-up is included in BASHH clinical effectiveness guidelines for managing STIs and in national outcome standards for STIs.^{186 187 188 189 190}
- 14 Delayed access to services may result in apparent resolution of initial symptoms, which may lead to loss of resolve to seek testing, complications associated with longer term infection and onward transmission. Surveys have demonstrated unacceptably long waiting times for GUM services, with some turning many people away each week. There is some evidence that people whose appointments are delayed continue to be sexually active during the waiting period. Knowledge of what happens to those turned away is limited. Audit of workload and demand can inform planning processes to ensure service capacity to manage STIs is adequate to meet local need. Wider opportunities for STI detection and management outside GUM may help facilitate both timely and convenient access.^{191 192 193 194 195 196}

Key interventions

- Adherence to evidence based guidelines leads to optimal management and/or resolution for people with STIs.¹⁹⁷ (level I)
- Rapid and early diagnosis and management of STIs minimises associated complications and can break the chain of transmission, limiting further spread.^{198 199} (level IV)
- Increased awareness among professionals and the public about STIs and associated health problems leads to increased uptake of STI testing and use of services.²⁰⁰ (level IV)
- Increased uptake of HIV testing can be achieved by introducing 'universal recommendation' or 'opt-out' approaches and by providing people with information either verbally or in the form of a leaflet to outline the process and benefits of HIV testing.^{201 202 203}(level II, IV)
- Integrated care pathways to diagnose and treat STIs and facilitate onward referrals for more specialist care, can improve the co-ordination of care.^{204 205} (level IV)
- Treatment at the site issuing STI test results may increase service user satisfaction and treatment uptake.^{206 207} (level IV)

Implications for service planning

- 15 As part of the development of local sexual health service networks, PCTs should ensure STI services are planned and delivered across the network to meet local needs (see recommended standard 1).
- 16 PCTs should ensure all local services providing STI testing have access through local pathology services to the high quality tests. DH work programmes are in place to ensure national availability of NAATs for detecting chlamydial infection. It is recommended these are available regardless of setting. Where possible and appropriate, the choice of testing kits and media should be consistent across settings. Services also need timely access to results for tests they have generated. It is important that pathology services are part of the sexual health service network and involved in service planning which impacts them.
- 17 SHAs, Workforce Development Confederations, PCTs and NHS trusts should support arrangements for postgraduate training and continuing professional development relating to detecting and managing STIs. It is recommended that these include:
 - communicating about sex and sexual risk-taking in a way that is sensitive to the needs of different populations and is culturally competent
 - sexual history-taking and risk assessment

- presentation, symptoms and signs of common infections and their sequelae
 - selection of tests and sites to be sampled, transport and cold chain requirements for specimen
 - the sensitivity and specificity of tests
 - understanding and communicating results, including those which may be equivocal
 - processes for contact tracing and partner notification.
- 18 The NHS and partner agencies should ensure clear care pathways are defined and established between providers of different levels of STI services within a network, as recommended in *The national strategy for sexual health and HIV*, to:
- facilitate access to information for the public and professionals about STIs
 - enable individuals, following risk assessment, to have prompt access to STI screening either directly on site, by appointment or by being directed to the necessary service
 - ensure those with diagnosed infection receive prompt treatment and care
 - support partner notification processes and facilitate partner access to services
 - support ease of movement within and between the levels of service, including those specified in core and enhanced GMS, or PMS, contracts with general practice
 - enable wider sexual health needs, such as contraception, to be identified and addressed.
- 19 The sexual health service network should develop shared and 'user-friendly' protocols for the management of uncomplicated STIs, including clear referral pathways where needed. (These should be based on BASHH national clinical effectiveness guidelines.)
- 20 The PCT and the local service network should ensure a coordinated system is in place to support a consistent approach to partner management in all settings providing STI care. GUM sexual health advisers, or newly established community health adviser posts, with a specific remit for assisting partner notification across sexual health settings, can support and advise on this process. Methods for contacting and treating partners need to be in place for all settings offering STI testing and this important process should be introduced, supported, coordinated and audited within a local service network. Contact slips should be revised or developed as appropriate for use in primary care, reproductive health and other settings as well as GUM.
- 21 PCTs should support action to enable those diagnosed outside GUM clinics to access treatment for STIs via pathways to GUM, through direct supply at the testing site or by arrangement with community pharmacy services.
- 22 PCTs should support a framework that will enable shared governance arrangements for detecting and managing STIs. Within a local service network specialist STI professionals should provide clinical advice and support for local STI services outside GUM clinics, and support the development of pathways for access to specialist care. Collaborative working between professionals will support service development in primary care for managing and/or referring those with suspected or diagnosed STIs.
- 23 PCTs should be aware of progress with national and local plans to implement the National Programme for Information Technology (NPfIT) and, in relation to this, the particular needs of

sexual health services for confidentiality and security of identifying data. PCTs should support implementation of coordinated, cross-sector collection of sexual health data, including that on STIs. All providers of services which detect STIs will be expected to meet the forthcoming sexual health services common data set reporting requirements for disease monitoring and surveillance. (See recommended standard 10.)

Guidance on practice

- 24 Clinical Effectiveness Guidelines of the British Association for Sexual Health & HIV (BASHH) (Available at: www.bashh.org.uk).
- 25 British Association for Sexual Health and HIV (2005) *Sexually Transmitted Infection Screening and Testing Guidelines for UK Genitourinary Medicine Clinics*. (In development, managed by the Bacterial Special Interest Group and commissioned by the Clinical Effectiveness Group of BASHH).
- 26 Ross J, Ison C and Robinson A et al (2005 in development) *Testing for sexually transmitted infections in primary care settings - Recommendations from the Bacterial Special Interest Group of BASHH*.
- 27 PRODIGY is a source of clinical knowledge, based on the best available evidence, about the common conditions and symptoms managed in primary care. www.prodigy.nhs.uk
- 28 Patient Group Directions www.groupprotocols.org.uk
- 29 Department of Health (2001) *The national strategy for sexual health and HIV*. London: Department of Health. (Available at: www.dh.gov.uk)
- 30 Department of Health (2003) *Effective commissioning of sexual health and HIV services. A sexual health and HIV commissioning toolkit for primary care trusts and local authorities*. London: Department of Health.
- 31 Royal College of Obstetricians and Gynaecologists (2003) *Management of acute pelvic inflammatory disease*. Guideline No. 32. (Available at www.rcog.org.uk).
- 32 Department of Health (2003) *Screening for infectious diseases in pregnancy: standards to support the UK antenatal screening programme*. London: Department of Health.
- 33 Medical Foundation for AIDS & Sexual Health (2003) *Recommended standards for NHS HIV services*. London: Medical Foundation for AIDS & Sexual Health. (Available at: www.medfash.org.uk)
- 34 Madge S, Matthews P, Singh S & Theobald N (2004) *HIV in primary care*. London: Medical Foundation for AIDS & Sexual Health. (Available at: www.medfash.org.uk)

Suggested audit indicators

- D Proportion of people attending GUM who are seen within 48 hours of first contact with a service (government commitment contained in public health White Paper *Choosing health* and supporting national PSA target, to be achieved by 2008).
- Percentage of people attending non-GUM services who are seen within two working days in, or via, non-GUM settings.
- Percentage of people with STIs treated according to national clinical effectiveness guidelines for the management of STIs (BASHH) and forthcoming national screening guidelines, including those developed for primary care (also BASHH).
- Percentage of people attending GUM services who have HIV testing offered (or recommended) on first screening for STIs, and percentages for uptake and detection.
- Percentage of those attending other services for sexual healthcare who have HIV testing offered (or recommended), and percentages for uptake and detection.
- D Percentage of the sexually active population under 25 years old, and others defined as 'at risk', accepting chlamydia screening. (This will be collected as part of NCSP. This indicator will also be used to monitor progress against the delivery of the PSA target for sexual health 2005-08, as part of its broader strategy to improve sexual health. PCTs are expected to demonstrate increases in this percentage each year, as progress towards achieving coverage of 50 per cent of the sexually active population each year.)
- Genital chlamydia trachomatis infection rate in women and men under 25 screened within a PCT or network.
- D Rates of new diagnoses of gonorrhoea. (This indicator will be used to monitor progress against the delivery of the PSA target for sexual health 2005-08, as part of its broader strategy to improve sexual health. This rate is expected to decrease annually.)
- Partner notification rates - percentage of contact slips returned to initiating service indicating partners have been treated.

Contraceptive advice and provision

Aim

To enable women and men to choose acceptable and effective contraception to plan for pregnancy and to prevent unintended pregnancy.

Recommended standard 7

People should be able to:

- receive accurate information about the full range of emergency, reversible and permanent contraceptive methods, to enable informed choice
- have access to free provision of all methods, including condoms
- get appointments with a contraceptive provider within two working days and prompt access to their chosen method
- have fast and convenient access to emergency hormonal contraception (EHC) and intrauterine (IUD) emergency contraception
- access ongoing support in the use of their chosen method(s).

Commissioners and services should ensure:

- contraceptive service provision meets the needs of the local population
- staff training and continuing professional development is in place to enable service providers to meet local needs
- integrated care pathways exist within and between services
- contraceptive providers use opportunities to ensure wider sexual health needs are identified and addressed.

Rationale

- 1 Access to appropriate contraception enables women to avoid the potential negative health consequences of an unwanted pregnancy. Although not all unintended pregnancies will be unwanted, it has been estimated that almost half of all pregnancies in England are unintended.^{208 209 210}
- 2 Clearly defined care pathways are important in ensuring equal access to the complete range of contraceptives because these are provided in a variety of settings, with the full range of methods not necessarily supplied by each provider. The majority of contraception is provided in general practice (about 80%), community family planning clinics and specialist young people's sexual health services. Some elements of contraception are provided by other services, including, but not limited to, maternity, genitourinary medicine, abortion, gynaecology, pharmacy, and accident and emergency services, and NHS Walk-in Centres. In addition, some methods can be obtained without attending a sexual health service, such as condoms which are available at a number of outlets, or EHC which can be purchased from pharmacies and may be available free in designated pharmacies.^{211 212 213 214}
- 3 People need to have access to the most effective contraceptive methods for their individual needs and circumstances. Their preferences, as well as information about their health, will need to be considered in selecting the most appropriate method. To help ensure consistent and effective provision, national clinical guidelines and practice recommendations for clinicians, as developed by the Faculty of Family Planning and Reproductive Health Care (FFPRHC), should be followed by prescribers. Patient group directions (PGDs) for supply by nurses, pharmacists and other health professionals can also support consistent clinical practice.^{215 216 217} (See Guidance on practice)
- 4 Both undergraduate and postgraduate training opportunities for specialists and generalists are essential, to support practitioners to develop and maintain local contraceptive services which enable individuals to access their chosen method and are sufficient to meet demand. Specialist training can also ensure adequate numbers of practitioners are trained and skilled in fitting and removing implants and intrauterine devices and systems (IUD, IUS). *The national strategy for sexual health and HIV* recommends that level 3 (specialist) providers have a role in supporting services provided at levels 1 and 2. Practical advice and support from specialist practitioners for other contraceptive providers, such as those in general practice or GUM, can help extend the capacity to meet the range of local contraceptive needs.^{218 219}
- 5 In addition to the obvious public health benefits of preventing unplanned pregnancy, economic evaluation has demonstrated that contraceptive services are highly cost-effective. Adequate funding and provision of all methods of contraception, including long-acting methods, is a cost-saving measure for local health economies.^{220 221 222}
- 6 The FFPRHC service standard for access to a contraceptive service provider states that for non-urgent appointments a person should be able to be seen within two working days, and expects walk-in services to have a maximum waiting time of two hours. Where onward

referral to specialist contraceptive services is needed, for access to some methods, or for advice when there is difficulty in identifying a suitable method, a consultation with specialist contraceptive services within two working days from the appointment with the first provider should also be assured.²²³

- 7 People should be able to make informed choices about their contraception. To enable them to choose a method best suited to their needs, they need access to information and advice about each method. To maximise uptake and effective use, contraceptive information should be consistent across all services. Such information and advice should include discussion of evidence for the relative effectiveness of available methods, how they work, how to use them, risks and benefits, any common side-effects, and return to fertility after discontinuing use. Contraceptive choices should be made within the context of people's lives, aiming to achieve confident, consistent and correct use of the method selected.²²⁴
- 8 Clear, accurate and up-to-date information leaflets for each method of contraception, to supplement verbal advice, may also help to inform decisions and facilitate proper use. A range of leaflet formats, such as written, pictorial and audio, and versions which are culturally appropriate and in relevant languages for the local population, should help to reduce inequalities in access to such information and promote more informed choices by those potentially most excluded.²²⁵
- 9 Specialist contraceptive support should be available for people with more complex contraceptive needs, for example those with medical conditions, to ensure safe and effective contraception.
- 10 Some women referred to be sterilised have changed their minds after receiving comprehensive information and advice about the full range of reversible, as well as permanent, options. Adequate consultation time is needed to support informed decision-making for people seeking permanent methods of contraception.²²⁶
- 11 People accessing contraceptive services may have additional needs related to their sexual health. Where contraception is the primary sexual health need, it is important also to consider a person's wider sexual health needs. Whether these can be met directly by the service accessed, or require referral or direction to another service, ease of access is important in ensuring uptake. Integrated care pathways can clarify arrangements for access to specialist contraceptive support where necessary and to services for detecting and managing STIs (including treatment and partner notification), psychosexual care and sexual function, pregnancy testing, pre-conceptual advice, antenatal care and abortion. Established care pathways and the availability of local service information can facilitate access to relevant services.^{227 228 229}
- 12 All providers of contraceptive services should either provide, or signpost where people can access, free condoms. Schemes where condoms are available free, funded by the NHS and provided within both NHS and non-NHS settings (such as voluntary sector organisations, shops, bars and clubs) can be used to promote condom use, provide information about sexual health and advertise services.²³⁰ 'Dual protection' - use of condoms alongside another form of contraception - should be promoted where people using other contraceptive methods may be

at risk of STIs, including HIV.²³¹ (See also recommended standard 2.)

- 13 Assessment of STI risk should be undertaken for all those seeking contraception. Women who are having an IUD/IUS inserted should be offered screening if deemed to be at risk from STIs (such as those aged less than 25, those with a new partner, or those with two or more partners in the previous 12 months who have had unprotected sex). If results are not available prior to the procedure, prophylactic antibiotic treatment should be considered, based on local epidemiology and likelihood of infection. Advice on abstinence from sex during treatment, on safer sex after treatment, and the need for partner(s) to be screened and treated may reduce the risks of a woman diagnosed with an STI becoming re-infected. Management of results, and partner notification, should be based on BASHH current evidence-based STI treatment guidelines (see recommended standard 6). Prior to instrumentation for IUD insertion as emergency contraception, prophylaxis and screening should be considered for all women assessed to be at risk from STIs.
- 14 Community-based, voluntary or outreach services can improve access to contraceptive advice and provision for those who cannot or do not access mainstream services (eg vulnerable groups, those with mobility problems).

Key interventions

- Ensuring accessible provision of the full range and choice of methods will maximise effective contraceptive use and so help prevent unintended pregnancy, benefiting individual and public health. (level V)
- Providing contraceptive services and supply of the full range of contraceptive methods is cost effective.^{232 233 234} (level IV)
- Sufficient time during consultations and the provision of accurate, up-to-date information, including leaflets, can enable individuals to choose a method of contraception best suited to their needs and to use contraceptives correctly and consistently.^{235 236 237} (level II)
- Well advertised and accessible provision of both emergency contraceptive (EC) methods (including the option of free pharmacy provision of EHC), will enable women to access EC within the relevant time limits and may help to reduce unwanted pregnancies. (level V)

Implications for service planning

- 15 To support continuing and improved access to, and use of, contraception, the NHS should:

- support and fund services which enable access to the full range of contraceptive methods for all those seeking contraception
 - ensure adequate provision and distribution of free condoms
 - enable sufficient numbers of health professionals to receive training in the administration and supply of the range of contraceptive methods, including specialist training provision for long-acting, permanent or new methods
 - maintain and develop postgraduate training for local primary care practitioners (such as GPs, practice nurses and other health professionals) and continuing professional development opportunities in contraceptive provision to ensure adequate service capacity
 - deliver training to enable non-health service personnel, for example peer educators, to provide contraceptive information and advice
 - facilitate the provision by specialist, community-based contraceptive services of local training and support for best practice, including opportunities to gain practical experience through clinical placements and supervised practice.
- 16 PCTs and service networks should facilitate access to specialist practitioner advice, such as telephone support, for general practice and other providers of contraceptive services. Arrangements for shared clinical governance for elements of sexual healthcare delivered in a range of settings should be established, alongside existing clinical governance structures in place for contraceptive services.
- 17 PCTs and service networks can ensure clear care pathways are defined and established between providers of different levels (and types) of contraceptive services, to:
- facilitate access for service users to information about the full range of methods
 - following assessment and advice, enable individuals to have equitable access (fast track as necessary) to their chosen method of contraception, either directly on site, by appointment or with direction to the most convenient, relevant service
 - support ease of movement within and between the levels of service recommended in *The national strategy for sexual health and HIV*, as well as those specified in additional and enhanced GMS, or PMS contracts for general practice
 - enable the regular contraceptive and STI-related needs of those initially attending services for EC to be met.
- 18 Providers that offer only a limited range of contraceptive methods should be able to provide information about the full range of methods, promote consistent contraceptive use and positive sexual health, and direct people to other services within the local sexual health network to meet their contraceptive and sexual health needs. They should ensure staff are aware of these responsibilities and have relevant and up-to-date information to enable prompt and appropriate referral.
- 19 Where a general practice has opted not to provide contraceptive services, this should be made explicit in practice information and to people registered with, or accessing care from, such a practice. PCTs should ensure suitable alternative provision is contracted and available, either from another practice, a community contraceptive service or other provider.
- 20 To facilitate informed choices about contraceptive methods and service use, the NHS and

partner agencies should make information widely available in a range of formats and styles, appropriate to local needs. These should use clear, unambiguous language that can be easily understood, including pictorial or audio formats for people with reading difficulties and in languages other than English, according to local population needs.

- 21 The NHS should develop or maintain outreach contraceptive services to reach those who cannot, or do not, access mainstream services.

Guidance on practice

- 22 Faculty of Family Planning & Reproductive Health Care *Clinical Effectiveness Guidelines*, (Available at: www.ffprhc.org.uk)
- 23 Faculty of Family Planning & Reproductive Health Care (2003) *Service standards for sexual health services*, (Available at: www.ffprhc.org.uk)
- 24 World Health Organisation (2004) *Improving access to quality care in family planning: medical eligibility criteria for contraceptive advice (3e)*. (Available at: www.who.int/en)
- 25 World Health Organisation (2004) *Selected practice recommendations for contraceptive use (2e)*. (Available at: www.who.int/en)
- 26 Faculty of Family Planning & Reproductive Health Care (2002) *UK selected practice recommendations for contraceptive use. Developed through a Faculty of Family Planning and Reproductive Health Care expert consensus meeting*. Adapted from WHO *Selected Practice Recommendations for Contraceptive Use (2002)*. (Available at: www.ffprhc.org.uk)
- 27 Royal College of Obstetricians & Gynaecologists (2004) *Male and female sterilisation. Evidence based clinical guideline number 4*. RCOG press. (Available at: www.rcog.org.uk)
- 28 National Institute for Clinical Excellence (NICE) *Guideline on long acting reversible contraceptives (in development - due 2006)*
- 29 Royal Pharmaceutical Society of Great Britain, *Practice Guidance on the supply of emergency contraception as a Pharmacy medicine*. (Available at: www.rpsgb.org.uk)

Suggested audit indicators

- Number and percentage of contraceptive users provided with each method of contraception by general practice, community contraceptive services and other providers respectively.
- Availability of information on all contraceptive methods within all settings providing sexual and reproductive health services.
- Percentage of service users offered an appointment for contraceptive provision within two working days.
- Waiting times from initial contact with a provider to procedure for all long-term methods of contraception - insertion (and removal) of implants, IUD and IUS; male and female sterilisation.
- Explicit links and care pathways defined between the range of contraceptive providers, specialist contraceptive services and other relevant local providers. Percentage of staff in those services aware of these.
- All general practitioners and practices opting out of contraceptive provision known to PCTs and alternative arrangements in place and made known to all (including new) patients.
- Percentage of women assessed as being at high risk* who are tested for chlamydial infection (and percentage positive) prior to instrumentation for routine or emergency intrauterine contraception (**those aged < 25, or women with new partners, or 2 or more partners in previous 12 months*).
- Documented time from initial contact with provider to receiving emergency hormonal contraception.
- Arrangements in place for insertion of emergency IUD within five days of unprotected sexual intercourse and percentage of staff in relevant services who are aware of where to refer for this.
- Percentage of sexual health service providers in a PCT, network or other geographical area who supply EHC.
- Percentage of people receiving EHC who received it on the same day as they requested it.

Pregnancy testing and support

Aim

To enable women to find out without delay whether they are pregnant so that they can make and act upon informed choices related to pregnancy which arise from their test result.

Recommended standard 8

Women who think they may be pregnant should be able to have:

- rapid access to free and confidential pregnancy testing at clearly advertised locations
- on-the-spot or same day results
- the opportunity to consult a health provider who can give accurate and unbiased information about pregnancy options and non-directive support to make informed choices
- prompt referral to specialist services as needed.

Commissioners and services should ensure:

- an integrated care pathway for pregnancy testing and options is developed and implemented
- processes are in place to help identify and provide care for women who need additional support
- all relevant legislation and guidance is followed by all service providers.

Rationale

- 1 Free testing should be available to women who need it regardless of whether they are planning for or hoping to avoid pregnancy. Opportunities for impartial discussion of feelings or concerns related to the result are particularly important for those who do not receive the result they desire, ie those with negative results who had hoped to be pregnant and those with unintended pregnancies. Information and support should be available to help women with all pregnancy choices, whether planned and wanted, unplanned and wanted, unplanned and unwanted, or planned and subsequently unwanted.
- 2 Accurate, home pregnancy testing kits are available and widely used. However, for some women, costs, and other factors such as literacy or understanding, may be a barrier to their use. A comprehensive sexual health service should include access to free pregnancy testing at clearly advertised locations, with results available on-the-spot, or at least on the same day. Opportunities to discuss and consider the consequences of a positive or negative result should also be available. Integrated care pathways should facilitate access to further services as necessary.
- 3 Either a positive or a negative pregnancy test result can be distressing if it is not the result that was wanted, and the need to make a major, and possibly unexpected, decision can be stressful. Services providing information and support with pregnancy options can enable women, and their partners where appropriate, to explore their reaction to their result and its consequences for them, and help with decision making. It is essential such services are non-directive and impartial.
- 4 Discussion of pregnancy test results, whether positive or negative, and pregnancy choices may facilitate uptake of other sexual health services, and enables women to receive information and advice regarding their sexual health and relevant local service provision. It is important for women to be able to choose when and whether to take advantage of discussion opportunities and not to make these a condition of access to free testing. Uptake of discussion opportunities will depend on women's perceptions and experiences about whether such services are confidential, impartial and non-directive, and if they can use them without fear of being judged.
- 5 Regardless of the setting in which pregnancy testing is provided, and whatever the result, an opportunity is presented for promoting sexual health and discussion of STI risk.
- 6 For women testing negative and for whom pregnancy would have been unwelcome, an opportunity is provided to address regular contraceptive needs.
- 7 Women happy to have a pregnancy confirmed will require referral for antenatal care and information about staying well in early pregnancy.²³⁸
- 8 Women hoping to become pregnant and who receive a negative result may experience varying degrees of disappointment or distress depending how long they have been trying and their

individual circumstances. Access to pre-conceptual and pregnancy planning advice may help enable women to conceive. Where fertility problems are suspected, national guidance regarding initial investigations and referral for specialist support should be followed.²³⁹

- 9 Women who receive a positive result, despite not having intended to conceive, may wish to discuss options open to them. Not all unintended pregnancies will be unwanted. For women who are ambivalent or unhappy about a positive result, impartial and non-directive discussion is essential to enable them to decide for themselves whether or not they wish to continue the pregnancy, and if so, whether to bring up that child or to place her/him for adoption. Women choosing to continue with their pregnancy may need information and support, and direction or referral to antenatal services. Links with social services can enable women to explore further support services available, whether or not they intend to bring up the child.
- 10 Those women not wanting to continue with their pregnancy will require information about abortion methods appropriate and available for their gestation and prompt access to local abortion services.
- 11 Earlier access and uptake of pregnancy testing will contribute to enabling those women who will seek to terminate their pregnancy to do so at earlier gestations, so allowing a range of abortion options to be considered and both clinical outcomes and experience to be improved. (See recommended standard 9.)
- 12 Discussion of results should help to identify women needing professional support with coping and adjusting to their situation, or likely to need psychological support interventions further along the pathway. Review evidence shows an increase in the rate of adverse psychological outcomes in those who have terminated pregnancies compared to women who carry to term or who are not pregnant, although no causal relationship is identified or implied.²⁴⁰
- 13 Assessment of the factors associated with regret following abortion may enable those women requiring additional support to be identified. Studies have shown that such factors include:
 - abortions undertaken on medical grounds
 - abortions performed later in pregnancy
 - history of mental health problems
 - limited social support
 - feelings of ambivalence towards the abortion
 - pressure from partners, family or parents to have, or not to have, an abortion
 - belonging to a religious, social or cultural group which is antagonistic towards abortion.^{241 242 243 244}

Key interventions

- A defined care pathway for pregnancy testing and support, agreed and implemented by all providers, can ensure women, and their partners where relevant, receive consistent management and access to relevant services, including access to further support with their decisions.²⁴⁵ (level IV, V)
- Availability of pregnancy testing which is free and/or provided in a variety of settings may support timely access to antenatal services, and for women seeking abortion, enable them to access services at early gestations.²⁴⁶ (level IV, V)
- Opportunities for impartial discussion of pregnancy options can enable women with unintended pregnancies to make an autonomous and informed choice about continuing, or not, with a pregnancy. (level IV, V)
- Risk assessments may help to identify women who need additional support or specialist counselling during or after decision-making related to unintended pregnancy (and so help to reduce psychological distress). (level IV, V)
- Discussion of test results may increase the uptake and effective use of regular contraception and can also facilitate discussion of safer sex, risks of STIs and how to access STI screening.²⁴⁷ (level IV)

Implications for service planning

- 14 Practitioners and others contracted or funded to provide NHS services for supporting women with pregnancy choices should have an understanding of the needs of women, and their partners as necessary, in response to pregnancy test results. They should also have knowledge of, and links with, services to meet these needs, understand their respective responsibilities with regard to provision of accurate, unbiased information, and be familiar with the relevant local service network, including access and pathways to services for the different pregnancy options. (The same applies to any relevant services not directly involved in providing these elements of care.)
- 15 All staff involved in provision of NHS-funded services for supporting women with pregnancy choices, and related counselling services, must be prepared to support women who may wish to terminate their pregnancy, or to refer them to those who will.
- 16 PCTs should ensure that health practitioners who are ethically opposed to abortion are aware of, and follow, relevant professional guidance for those with conscientious objection. Arrangements should be in place to enable women with unplanned pregnancies to be seen immediately by another practitioner known not to have objections, to enable impartial discussion of options.

- 17 Competencies and training needs for practitioners providing services to support pregnancy decision-making should be defined and met. The training needs of reception and other support staff with patient contact should also be assessed and met.
- 18 Some women may need additional support, including psychological or other sexual health interventions, during and following the decision-making process for unintended pregnancy. These may include women who have become pregnant as a result of sexual assault. PCTs and service networks should ensure that services are available for those who need them.
- 19 A service network can define an integrated care pathway to enable access to appropriate services. The pathway should be supported by a written policy for all those providing this service which includes specific guidance on working with young people.

Guidance on practice

- 20 Royal Pharmaceutical Society (2001) Practice guidance - *Pregnancy testing in the pharmacy*. (Available at: www.rpsgb.org.uk)
- 21 Forthcoming framework for pregnancy counselling, information and support for women with unplanned pregnancy, from the DH.
- 22 Department of Health (2004) *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. London: Department of Health.
- 23 Department of Health (1999) *Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children*. London: Department of Health.
- 24 Royal College of Obstetricians & Gynaecologists (2004) *The care of women requesting induced abortion. Evidence based clinical guideline number 7*. (Available at: www.rcog.org.uk)
- 25 BMA/GMC guidance for doctors with conscientious objection to abortion and NMC guidance on this for nurses (*also mentioned in GMS contract regulations for provision of contraceptive services and in RPSGB practice guidance on EHC provision*).

Suggested audit indicators

- An integrated care pathway agreed and implemented to guide consistent practice across the service network.
- Services that are funded by the NHS to provide free pregnancy tests also provide impartial support with pregnancy choices.
- Services providing NHS-funded pregnancy testing and non-directive support with pregnancy choices are advertised widely - in all sexual health services, all general practices, and other relevant settings such as pharmacy.
- Women's experience of the service:
 - satisfaction,
 - clarity of information received,
 - whether written information provided (leaflets or other media).
- Transparent local arrangements in place for the care of women registered with practices declaring objection to being involved in abortion referral or care.

Abortion service provision

Aim

To enable women to have prompt access to abortion services and to reduce their risk of physical complications or negative psychological outcomes arising from abortion.

Recommended standard 9

Women considering or seeking abortion should:

- have direct access to, or be referred for, an abortion assessment within five working days of initial contact with an abortion provider or other healthcare provider
- receive comprehensive, accurate and unbiased information
- be able to access an abortion ideally within two weeks, but within a maximum of three weeks, of initial contact with healthcare providers
- be offered a choice of abortion methods clinically appropriate for their gestation and individual circumstances
- be offered screening for chlamydial infection, and treatment as necessary, with prophylactic treatment provided when results are not available prior to the procedure
- be able to access screening for other STIs, including HIV
- have individualised support and access to specialist counselling if needed at any time during or after the abortion process.

Commissioners and services should ensure:

- local NHS-funded abortion is provided to meet the needs of women resident in a PCT or network locality
- arrangements are in place to facilitate self-referral to abortion services
- intervals between first contact and procedure should be achieved within time limits specified in the RCOG guidelines and *The national strategy for sexual health and HIV*
- local services are organised to enable abortions to be provided at as early a gestation as possible
- when late abortions are needed, provision is available up to the maximum legal time limit
- abortion services are able to provide immediate advice about, and initial supply of, the full range of reversible contraceptive methods, including condoms, and access to permanent methods
- screening and prophylactic treatment for chlamydial infection are available for women having an abortion
- integrated care pathways are established to enable those requesting abortion also to have their other sexual health needs addressed, including those for ongoing contraception and for diagnosis and treatment of STIs
- arrangements are in place for those who need or request medical or psychological follow-up.

Rationale

- 1 Despite the estimate that almost one in three women will have an abortion in their lifetime, there is widespread lack of knowledge among the public about the procedures that can be used to terminate pregnancies. Sexual health services should promote awareness and provide information regarding abortion procedures and services.²⁴⁸
- 2 Delays and barriers to access, including those caused by lack of information regarding procedures or services, may impact upon uptake of abortion, limit the choice of abortion method available to women and result in some women having abortions at later gestations than necessary, increasing the rate of associated complications. There are wide variations in access to NHS-funded abortion services and the methods available. Rates of abortion (including the proportion which are NHS-funded) are lower in geographical areas without a local dedicated abortion service, or where access is difficult. The proportion of conceptions resulting in abortion is also lower in areas of high economic and social deprivation.^{249 250 251 252 253}
- 3 Service capacity needs to be responsive to local need and enable equitable access for all women seeking abortion, including women with special needs or pre-existing medical conditions and who require specialist hospital care.
- 4 Once a woman has made an informed decision to seek an abortion, and meets current legal requirements, she should have access to an abortion without delay. *The national strategy for sexual health and HIV implementation action plan* (DH 2002) recommends that women who meet the legal requirements should have access to an abortion procedure within three weeks of the first appointment with a referring doctor (except where a woman's circumstance or health problems necessitate a delay). There is support for further reducing the time between assessment and procedure to the absolute minimum.^{254 255}
- 5 Self-referral via a locally organised central booking system may help to facilitate early access and so reduce unnecessary delay. Some abortion providers have contracts enabling women to self-refer, but this is not universally available. Such arrangements may, however, be associated with high rates of non-attendance, if those self-referring have not had an opportunity to explore pregnancy choices or receive support with decision-making. Action will be needed to minimise the impact on services of non-attendance for direct appointments, such as signposting opportunities for discussing pregnancy options at the time of central booking.
- 6 The earlier in pregnancy an abortion is performed the lower the risk of complications and death. There are also cost advantages to enabling earlier access where possible, as abortions after 12 weeks are likely to incur higher costs. There has been wide variation between PCTs in the percentage of abortions undertaken at less than 10 weeks gestation.^{256 257 258 259}
- 7 Early medical abortion is currently under-utilised among those having abortions even though availability and use of this method can facilitate earlier access. Information and improved access may lead to greater use of this option. The Abortion Act (1967) enables NHS hospitals and approved independent sector settings to provide abortions. The amendments to the Act,

as contained in the Human Fertilisation and Embryology Act (1990) enables places to be approved specifically for medical abortion. If provision of early medical abortion could be arranged and approved in community contraceptive and sexual health service settings, increased access to this method could be facilitated. The DH has established pilots to determine the types of setting which can be approved and to develop protocols to support the provision of medical abortions in non-traditional settings.^{260 261}

- 8 High rates of sexually transmitted infections amongst populations having abortions, and the risk of ascending upper genital tract infection associated with abortion, support the recommendation that women should be screened for chlamydia trachomatis and be offered prophylactic treatment prior to the procedure when results are not available. Routine prophylaxis in the absence of screening results in sub-optimal management of infected women and may lead to them being re-infected by untreated partners, with the consequent increased risk of tubal damage, infertility and ectopic pregnancy. Appropriate management of those diagnosed with chlamydial infection should therefore include pathways to enable partners to access treatment and testing.
- 9 There is some evidence that rates of HIV among populations of women having an abortion are higher than in women attending antenatal services, where HIV testing is universally recommended. Many of these women may be unaware of their infection. As there are personal and public health advantages of earlier diagnosis, and also because women may have subsequent planned and wanted pregnancies, it may be worth considering whether local circumstances merit the routine recommendation (or opt-out, see recommended standard 6) of HIV testing prior to abortion.²⁶²
- 10 The maintenance of access to late abortion, up to the legal limit, is important. Research shows that women who seek late abortions (at gestations of more than twelve weeks) do so for reasons that are not trivial and are often those for whom an unwanted pregnancy would be most damaging, such as the very young. Delays in seeking advice for abortion may arise because a pregnancy has not been recognised until late in gestation, or be due to stigma, denial or fear, a change in relationship or circumstance, or be related to difficulties in addressing the decision to terminate a pregnancy. In addition, late abortions are performed for women with medical conditions and following the diagnosis of fetal abnormalities. Delays can also be caused by inadequate service provision, or by inefficient referral systems.^{263 264}

Key interventions

- The earlier in pregnancy an abortion is performed, the lower the risk of complications. A central booking and referral service, including arrangements for self-referral, for abortion services can enable women to have abortions at early gestations^{265 266* 267*} (level IV)
- Referral for abortion early in pregnancy can facilitate access to a choice between medical and surgical abortion procedures. Choosing an early medical abortion may also facilitate faster access to an abortion.²⁶⁸ (level IV,V)
- High rates of genital chlamydial infection in populations of women having abortions necessitate screening and treatment, or prophylactic treatment at the time of the abortion procedure, to reduce the risk of ascending genital tract infection. Screening has the advantage of enabling women with diagnosed infection, and their sexual partner(s), to access the optimum treatment, reducing their risks of complications associated with undetected infection or of re-infection.^{269 270 271 272 273 274 275} (level I, II, IV)
- Accurate, printed information on the abortion procedure and aftercare, and on possible complications and negative outcomes of abortion, can support verbal advice.^{276 277 278} (level IV, V)
- Clear and up-to-date information and advice for women on the range of available contraceptive methods, initial supply and access to a contraceptive provider for ongoing care may help to increase uptake of regular contraception and so reduce the risk of a further unintended pregnancy.^{279* 280*} (level IV)

* Evidence from conference abstract

Implications for service planning

- 11 PCTs should enable women seeking abortion to have their pregnancies terminated at the earliest possible gestation by providing access to both medical and surgical methods of abortion through a well-advertised local referral system.
- 12 PCTs should monitor access, and local arrangements for access, to abortion services, and to ensure that of the total number of abortions, the percentage performed under 10 weeks of gestation meets annual national performance target thresholds equal to, or above, average. In 2004, performance was banded as 'good' if 70 per cent or more abortions took place at less than 10 weeks gestation, with 'average' being 45 - 60 per cent.

- 13 Systems should be developed, where needed, for facilitating ease of access, such as the establishment of a central information and booking service which enables women to self-refer, as well as enabling provider referral, for the earliest possible appointment for an NHS-funded abortion. Where central booking is not available, arrangements should be in place to facilitate prompt referral.
- 14 PCTs should aim to enable early access to abortion. However, they also need to ensure that there is adequate local abortion provision available up to the legal limit for women who need it.
- 15 Commissioners should ensure that clear care pathways are in place to enable women who have medical conditions, or other needs which require specialist management, to have their abortions performed in hospital obstetrics and gynaecology departments. Protected and staffed inpatient beds should be sufficient to meet the needs of women who are unsuitable for day case care.
- 16 All PCTs should take action to ensure the time between first contact with a service, or an initial appointment with a referring practitioner, and the abortion procedure is as short as possible, ideally within two weeks, but within a maximum of three weeks.
- 17 Ideally, as recommended in RCOG guidelines, abortion providers need to be able to arrange appointments for pre-abortion assessments within five working days.
- 18 Commissioners should be aware of local demand for abortion services and ensure adequate service arrangements are in place to meet such demand, to support prompt and early access. Local action which aims to reduce rates of unintended pregnancy, and thus reduce demand for abortion, should also be in place.
- 19 PCTs, through service networks, should agree and implement a policy on the provision of genital chlamydia screening for women seeking abortion, and commission services accordingly.
- 20 All services commissioned to provide sexual healthcare should be able to provide information about, and access to, local abortion services. Information about local abortion services should also be made widely available in other health and community settings.
- 21 Practitioners who are ethically opposed to abortion should follow relevant professional guidance (see Guidance on practice) for those with conscientious objection. Where such practitioners receive an abortion request, they should follow professional and contractual obligations to refer without delay to another practitioner who has no such objection or directly to an abortion service.

Guidance on practice

- 22 Royal College of Obstetricians & Gynaecologists (2004) *The care of women requesting induced abortion. Evidence based clinical guideline number 7. (Available at: www.rcog.org.uk)*
- 23 BMA/GMC guidance for doctors with conscientious objection to abortion and NMC guidance on this for nurses (*also mentioned in GMS contract regulations for provision of contraceptive services and in RPSGB guidance on EHC provision*).

Suggested audit indicators

- Percentage of abortions provided within individual PCTs which are NHS funded.
- Waiting times:
 - Percentage of women seen for assessment within five days of first contact with health provider
 - Percentage having abortion procedure within two weeks of first contact
 - Percentage having abortion procedure within the maximum three weeks.
- Gestation at abortion and percentage of abortions performed under 10 weeks (*early gestation at abortion may represent an indicator of the accessibility and responsiveness of services*).
- Percentage of women at nine weeks gestation or less who are offered both medical and surgical options.
- Percentage of women having an abortion who are offered screening for chlamydial infection.
 - Percentage uptake.
 - Percentage diagnosed and treated.
 - Percentage receiving prophylactic treatment for chlamydial infection.
 - Percentage whose partners have accessed treatment (where this can be confirmed).
- Percentage offered screening for other STIs, HIV, other lower genital tract infection.
- Numbers or percentage receiving advice and supply of regular contraception from abortion provider.
- Numbers or percentage referred to or directed to alternative services for contraception.
- Percentage of service level agreements with clear care pathway for those with medical conditions or other special needs.

Protection and use of sexual health information

Aim

To improve sexual healthcare and service planning, through the recording, secure management and application of information derived from individuals and from services.

Recommended standard 10

People can expect information relevant to their sexual health will be:

- requested from them as necessary to ensure safe and effective care
- treated by staff as confidential
- retained securely
- shared within the clinical team providing the service, as necessary for their care
- shared between services only with their specific consent, as necessary for their care
- used for surveillance, service planning, commissioning and clinical audit, only in an anonymised form that does not disclose their identity.

Commissioners and services should ensure:

- all staff adhere to legislation and professional guidance to protect confidentiality
- current information reporting requirements, including the (forthcoming) sexual health services common dataset, are followed
- optimal use is made of information technology to collect, retain, transfer or report sexual health data securely and efficiently, within current confidentiality guidelines
- data reported for statistical analysis or applied to planning processes are anonymised and unlinked from information which could identify individuals.

Rationale

- 1 Information about their sexual health and their use of sexual health services is needed to enable each individual to receive optimum care. Data are collected from services for surveillance, to ensure that necessary action can be taken to promote and protect public health. Information collation and analysis are also used to support planning decisions and to improve the performance of services.
- 2 An open and clear outline of how information is collected, stored and used is of particular importance in the field of sexual healthcare, to promote uptake of services. If people have no confidence in what will happen to information related to their sexual health, it may act as a barrier to their seeking care. The public health outcomes associated with delayed access to services include high rates of undiagnosed STIs with resulting ill-health and further transmission of infection, and unwanted pregnancies ending in late abortion. It is essential that people can attend services knowing that their confidentiality is assured. Explicit confidentiality procedures are essential, especially when handling information that can identify individuals.
- 3 Integrated care pathways for sexual healthcare necessitate coordinated information pathways within and between local services. Regardless of initial point of access, arrangements for secure transfer of information are essential for good care. Government plans to introduce an individual electronic record for every person using NHS services - the NHS Care Records Service - will connect general practice, acute and community services in a single, secure national information system. It is intended that records will be available instantly to health professionals who have authorised access. The availability of electronic data and information can enable people to receive efficient and integrated care and to experience less delays in waiting for appointments or test results.
- 4 All members of the multidisciplinary team must have a contractual obligation not to reveal information about people using services without their consent. In addition, for health practitioners, professional responsibilities apply. These duties apply whatever the age of the person receiving care. Only in exceptional circumstances may confidentiality be breached, when failure to do so would result in serious harm to an individual, e.g. suspected abuse, or when ordered by the courts. If information about a patient will be disclosed to someone else, the healthcare worker should first discuss this with the patient. A breach of confidentiality should be considered a serious disciplinary offence, and health workers may have to justify disclosures to their employer and/or their professional body.
- 5 Local and national surveillance allows the incidence and prevalence of STIs to be measured and for other outcomes and trends related to sexual behaviour to be measured. These data can be used for needs assessment, to inform service planning which is responsive to local needs, and to enable appropriate targeting of interventions. This improves the quality of service provided, supports action to manage adverse events or changes, monitors the implementation of *The national strategy for sexual health and HIV* and also enables an assessment of the performance of services.

- 6 For surveillance to be most effective, common sexual health data need to be collected from all relevant settings. At the time of developing these standards, action to establish the sexual health services common dataset as an NHS Information Standard is being undertaken by the Health Protection Agency and DH in collaboration with the NHS Information Authority (NHSIA). It is intended that collection of the dataset will be implemented through the NPfIT.
- 7 An improved information systems infrastructure is needed to support the implementation of the sexual health services common dataset. Systems are needed which are compatible across settings and sectors and nationally, while secure enough to protect the identity of individuals. Use of electronic patient records and software which allows direct and immediate data entry on to structured case note templates should reduce reporting delays, enable 'real time' surveillance and mean that patterns and trends can be identified and acted upon quickly.
- 8 Having access to local surveillance data which can be attributed to relevant PCTs will help commissioners to negotiate and prioritise services and funding to meet the needs of their resident population and can also highlight areas where there are gaps in service provision. PCT-based data also support the public health function and enable targeting of interventions as and where they are most needed. Where services hold contracts with more than one PCT, anonymised data need to be available which are relevant for each PCT as well as at a service wide level.

Key interventions

- A service or practice policy on confidentiality, applicable to all staff and displayed prominently, will help encourage uptake of services. This is particularly the case for young people.^{281 282 283 284 285} (level IV)
- The local implementation of the sexual health services common dataset will allow more comprehensive data to be collected in both primary care and specialist sexual health service settings.²⁸⁶ (level V)
- Use of structured case notes for sexual history-taking will enable a consistent approach across services and facilitate the collection of sexual health services common dataset requirements. (level V)
- Use of electronic patient records (subject to appropriate confidentiality provisions) will allow for improved capture of relevant data, improve national and local surveillance and support local multi-agency working.^{287 288 289} (level V)
- Development and use of referral protocols can help ensure secure transfer of relevant sexual health information between providers. (level V)
- Comprehensive surveillance and epidemiological data relating to sexual health should be available for all PCTs and SHAs to assist local service planning and monitoring. (level V)
- Comprehensive national data relating to sexual health are essential to monitor the implementation and effectiveness of *The national strategy for sexual health and HIV*, and to inform policy development and resource allocation at national and local level. (level V)

Implications for service planning

- 9 Service staff should be able to explain to service users how information requested about their sexual health is necessary to provide their care, and how their confidentiality is assured. Providers should also be able to explain how electronic patient records and information pathways, once these are fully established, protect confidentiality.
- 10 Care pathways should contain detail of the need to inform individuals about who has access to information held. Where necessary for care, consent to share personal details should be sought and documented.
- 11 Protocols should be in place to guide the secure storage, transfer and relevant sharing of information within service teams and between relevant services.

- 12 Staff also need to understand and be able to explain, as necessary, how anonymised sexual health information may be used to inform research or local clinical audit of their care, to plan and organise local sexual healthcare services, and for national surveillance. It should be made clear how such use of information eventually benefits all, by ensuring services can provide the best and most responsive care. This has training implications for professionals across the range of services.
- 13 PCTs should ensure that plans for local implementation of the NPfIT enable the secure retention of identifiable information about people using sexual health services, with access to such information limited to those in the relevant sexual health teams who have authorisation.
- 14 PCTs should also ensure that services comply with the latest local and national data reporting requirements for sexual health, including those for the forthcoming sexual health services common dataset. Where a service holds contracts with more than one PCT, anonymised data should be available which are relevant for each PCT as well as at a service-wide level.
- 15 Services should ensure that staff maintain awareness of, and adhere to, legislation and professional guidance to protect confidentiality.
- 16 All services and professionals who engage in the management of STIs should be aware of how NHS STD Regulations 2000 (or latest version) apply to their service.

Guidance on practice

- 17 Department of Health (2000) *NHS trusts and primary care trusts (sexually transmitted diseases) directions 2000*. London: Department of Health. (Currently under review, 2004.)
- 18 General Medical Council (2004) *Confidentiality: protecting and providing information*. GMC. (Available at: www.gmc-uk.org)
- 19 Department of Health (2003) *Confidentiality: NHS code of practice*. London: Department of Health.
- 20 Department of Health (2004) *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. London: Department of Health.
- 21 Brook *Under 16s: the law and public policy on sex, contraception and abortion in the UK*.
- 22 The Health Service (Control of Patient Information) Regulations 2002, made under section 60 of the Health and Social Care Act 2001, allows confidential patient information to be lawfully used in specified circumstances, such as for surveillance.

- 23 Association of British insurers & British medical Association (2002) *Medical information & insurance - Joint guidelines*. These advise GPs on how to deal with requests from insurance companies for medical reports with regard to information about STIs and HIV. (Available at: www.bma.org.uk)

Suggested audit indicators

- Services/practices have a written confidentiality policy with regard to sexual health, which is advertised and displayed prominently and made available to service users.
- Percentage of users aware of confidentiality policy.
- Percentage of staff demonstrating an understanding of confidentiality policy and process, and communicating this to people using services.
- Secure arrangements can be demonstrated for the collection, storage and transfer of relevant information between services, including that in electronic format.
- Proportion of services and practices meeting the sexual health services common dataset reporting requirements, once these are in place (*implementation expected 2006*).
- Audit of data recording - completeness, quality, accuracy.
- Whether and how data are being used to improve services.

Appendix A

References

- ¹ Department of Health (2001) *The national strategy for sexual health and HIV*. London: Department of Health. (Available at: www.dh.gov.uk)
- ² Department of Health (2003) *Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for primary care trusts and local authorities*. London: Department of Health.
- ³ HM Treasury (2004) *Public Service Agreements 2004*. (Available at: www.hm-treasury.gov.uk)
- ⁴ Department of Health (2004) *Choosing health: making healthier choices easier*. London: Department of Health.
- ⁵ Department of Health (2001) *Shifting the balance of power within the NHS. Securing delivery*. London: Department of Health.
- ⁶ House of Commons Health Committee (2003) *Sexual health. Third report of Session 2002-2003*. HC 69. London: The Stationery Office. (Available at: www.parliament.uk)
- ⁷ Department of Health (2004) *Choosing health: making healthier choices easier*. London: Department of Health.
- ⁸ Department of Health (2001) *The national strategy for sexual health and HIV*. London: Department of Health.
- ⁹ Department of Health (2003) *Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for primary care trusts and local authorities*. London: Department of Health.
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Appendix B

Glossary of abbreviations

BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
DfES	Department for Education and Skills
DFFP	Diploma of the Faculty of Family Planning
DH	Department of Health
EC	Emergency contraception
EHC	Emergency hormonal contraception
FFPRHC	Faculty of Family Planning and Reproductive Health Care
fpa	Family Planning Association
GMC	General Medical Council
GMS	General Medical Services (<i>contracts in general practice</i>)
GP	General practitioner
GPwSI	GP with a Special Interest (<i>in sexual health where referred to in this document</i>)
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
IUD	Intrauterine device
IUS	Intrauterine system
LDP	Local delivery plan
MedFASH	Medical Foundation for AIDS and Sexual Health
NAAT	Nucleic acid amplification test
NATSAL 2000	National Survey of Sexual Attitudes and Lifestyles (2000)
NCSP	National Chlamydia Screening Programme
NHSCSP	National Health Service Cervical Screening Programme
NHS	National Health Service
NHSIA	National Health Service Information Authority
NPfIT	National Programme for Information Technology
NwSI	Nurse (usually a practice nurse) with a Special Interest (<i>in sexual health</i>)
PCT	Primary care trust
PGDs	Patient group directions
PHLS	Public Health Laboratory Service (<i>now the Health Protection Agency</i>)
PMS	Personal Medical Services (<i>contracts in general practice</i>)
PSA	Public Service Agreement
PSHE	Personal, social and health education
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
RPSGB	Royal Pharmaceutical Society of Great Britain
SHA	Strategic health authority
SSHA	Society of Sexual Health Advisors
STI	Sexually Transmitted Infection
STIF	Sexually Transmitted Infections Foundation (<i>course</i>)
VCOs	Voluntary and community organisations

Glossary of terms

Care pathway/ service user pathway	Route used to access various linked elements of care needed by an individual. Care pathways may be organised by local healthcare organisations' custom and practice. Service user pathways may differ in that they reflect the routes selected by individuals.
Contact tracing	Literally - tracing sexual contacts of people with diagnosed STIs. The term is often used interchangeably with 'partner notification' (see below).
Near patient testing	Testing technologies which enable people to receive an immediate result.
Open access service	A health service which can be attended by any person regardless of their area of residence.
Partner notification	The process of ensuring sexual partners of people with a diagnosed STI are advised that they have been exposed to infection and enabled to access treatment and testing (also see contact tracing).
Primary care	Healthcare settings which are usually the first point of contact between individuals and health professionals such as general practice, community clinics or NHS Walk-in Centres. In sexual health, primary care usually includes community contraceptive services.
Referral	A formal procedure followed by a healthcare worker (eg letter, pro-forma, on-line referral) to enable a person to access another service appropriate to their needs, eg from general to specialist services, or between different specialist services.
Secondary care	Healthcare which is conventionally provided by hospitals such as medical, surgical and specialist inpatient care and outpatient services.
Self-referral	Direct access to a service without the need for a referral from another service.

Service networks/ managed service networks/ sexual health service networks	Linked groups of service providers, service users and commissioners - from NHS primary, secondary, and tertiary care, voluntary, community and independent sectors, and social care - which work together, within and across existing professional and organisational boundaries, to ensure the equitable provision of high quality and effective services throughout the network area. <i>Adapted from the Scottish Executive definition: Managed clinical networks within the NHS in Scotland (1999)</i>
Signposting	Telling a person about the availability of, and where to find, information or services.
Specialist services	Services provided by health professionals with specific training, expertise and facilities in a particular type of healthcare. Although such services are not routinely available in every general practice, they may be provided within either primary or secondary care settings.
Walk-in service	A service which can be attended during opening hours without the need for an appointment.

Appendix C

Membership of advisory group

Sheila Adam (Chair)

Director of Public Health, North East London Strategic Health Authority. Honorary chair in public health at Queen Mary College, University of London. Former Deputy Chief Medical Officer and co-chair of the group which developed *The national strategy for sexual health and HIV*. Now represents SHAs on the national Independent Advisory Group on Sexual Health and HIV.

Jan Barlow

Chief Executive, Brook. Member of the Independent Advisory Group on Teenage Pregnancy and also of the Independent Advisory Group on Sexual Health and HIV.

Teresa Battison

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Toni Belfield

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Consultant Clinical Psychologist. Head of Sexual Health Psychology Services, Camden PCT. Chair of British Psychological Society (DCP) HIV and Sexual Health Faculty. Honorary Senior Lecturer, Royal Free and University College Medical School.

Chris Ford

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Kathy French

Royal College of Nursing's Adviser in Sexual Health. Member of the Independent Advisory Group on Sexual Health and HIV. Clinical Nurse Specialist in sexual health at Lewisham PCT London.

Mitzy Gafos (to May 2004)

Former Primary Care Lead, Sexual Health Team, Department of Health.

Vanessa Griffiths

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Kate Henderson-Nichol (from May 2004)

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Appendix D

Consultation on development of the recommended standards

Consultation process

The recommended standards were developed by MedFASH with the expert advice of the project advisory group (see Appendix C for membership).

Consultation took place in August / September 2004 through:

- a one-day national consultation event attended by representatives of national stakeholder organisations (see below)
- three regional consultation events, attended by colleagues involved in the planning and delivery of sexual health services (see below)
- individual meetings with representatives of professional groups and a service user group
- availability of draft standards on MedFASH website with invitation to comment
- written feedback from individuals and organisations consulted.

Following consultation, comments were considered in detail by the advisory group and the standards were revised by MedFASH.

Expert readers were then asked to comment on a penultimate draft in November 2004 and final amendments were made by MedFASH in December 2004.

Consultation with national stakeholders

The following mostly national organisations were invited to participate in the consultation process:

African HIV Policy Network (AHPN)

All Party Parliamentary Group on AIDS

All Party Parliamentary Pro-choice and Sexual Health Group

All Party Parliamentary Group on Population, Development and Reproductive Health

Association of the British Pharmaceutical Industry (ABPI)

Association of Medical Microbiologists

Black Health Agency

British Association for Sexual and Relationship Therapy (BASRT)

British Association for Sexual Health and HIV (BASHH)

British Federation against Sexually Transmitted Diseases (BFSTD)

British HIV Association (BHIVA)

British Medical Association (BMA)

British Pregnancy Advisory Service (BPAS)

British Society for Sexual Medicine (BSSM)

Brook

Commission for Patient and Public Involvement in Health (CPPIH)

Commission for Racial Equality (CRE)

Community Practitioners and Health Visitors Association (CPHVA)

Consumers' Association

Counsellors and Psychotherapists in Primary Care
 English HIV and Sexual Health Commissioners Group
 Equal Opportunities Commission
 Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists (FFPRHC)
 Faculty of HIV and Sexual Health of the British Psychological Society
 Faculty of Public Health Medicine of the Royal College of Physicians
 fpa (Family Planning Association)
 Gay Men Fighting AIDS (GMFA)
 Genito Urinary Nurses Association (GUNA)
 Healthcare Commission
 Health Development Agency (HDA)
 Health Protection Agency (HPA)
 Herpes Viruses Association
 Independent Advisory Group on Sexual health and HIV (IAG)
 Institute of Psychosexual Medicine
 London School of Hygiene and Tropical Medicine (LSHTM), Centre for Reproductive and Sexual Health Research
 London Standing Conference for Nurses, Midwives and Health Visitors' Sexual Health Working Group
 Marie Stopes International (MSI)
 Medical Research Council (MRC), Sexual Health and HIV Research Strategy Committee
 Men's Health Forum (MHF)
 National AIDS Manual (NAM)
 National AIDS Trust (NAT)
 National Association of NHS Providers of AIDS Care and Treatment (PACT)
 National Association of Nurses for Contraception and Sexual Health (NANCSH)
 National Pharmaceutical Association (NPA)
 Naz Project London
 NHS Confederation
 Nursing and Midwifery Council (NMC)
 Patients Association
 Pro Choice Alliance
 Refugee Council
 Royal College of General Practitioners (RCGP)
 Royal College of General Practitioners (RCGP), Adolescent Task Group
 Royal College of General Practitioners (RCGP), Sex, Drugs and HIV Task Group
 Royal College of Midwives (RCM)
 Royal College of Nursing (RCN)
 Royal College of Nursing (RCN), Practice Nurse Association
 Royal College of Nursing (RCN), Sexual Health Forum
 Royal College of Obstetricians and Gynaecologists (RCOG)
 Royal College of Obstetricians and Gynaecologists (RCOG), Consumers' Forum
 Royal College of Pathologists (RCPATH)
 Royal College of Physicians (RCP)
 Royal College of Paediatrics and Child Health (RCPCH)
 Royal Institute of Public Health (RIPH)

Royal Pharmaceutical Society of Great Britain (RPSGB)
Royal Society of Medicine (RSM), Sexual Health and Reproductive Medicine Section
Sex Education Forum
Sexual Dysfunction Association
Society for Health Education and Health Promotion Specialists(SHEPS)
Society for Sexual Health Advisers (SSHA)
Society of Consultants in Reproductive Health
Teenage Pregnancy Unit (TPU) of the Department for Education and Skills (DfES)
Terrence Higgins Trust (THT)
UK Clinical Pharmacy Association
UK Coalition of People Living with HIV and AIDS (UKC)
Women's Health.

Consultation with regional colleagues

Three regional consultation events were organised, for colleagues involved in commissioning and providing sexual health services:

- Northumberland, Tyne and Wear, Cumbria and North Lancashire
- South East London
- West Midlands.

Service user consultation

A service user consultation event was held with members of the service user involvement group of the Modernisation Initiative - Sexual Health Programme in Lambeth and Southwark, South East London, funded by the Guy's and St Thomas' Charity.

Expert Overview

The following provided expert advice on the penultimate draft:

- Patrick French, Consultant in Genitourinary Medicine, Camden Primary Care Trust and UCL
- Sarah Randall, Consultant in Reproductive Health, Portsmouth & DH Adviser for National Chlamydia Screening Programme
- Peter Greenhouse, Consultant in Sexual Health and Associate Clinical Director, Milne Centre for Sexual Health, Bristol

Many other individuals and organisations responded to queries and requests for advice during the development of these recommended standards, including Professor Jonathon Ross, Sally Openshaw, Dr Phil Kell, Dr Jan Welch, Emily Whitehead.

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