NHS
Quality Improvement Scotland

Draft Standards ~ *July 2007*

Sexual Health Services

NHS QIS is committed to equality and diversity. This document, and the research on which it is based has considered the likely impact on the six equality groups defined by age, gender, race/ethnicity, religion/faith, disability and sexual orientation. An equality impact assessment will be carried out before the final standards are published and this will be available online or on request.

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www.nhshealthquality.org

Contents

1 Sexual health services in NHSScotland

Scotland has poor sexual health with a rising incidence of sexually transmitted infections (STIs), including HIV, and some of the highest teenage pregnancy rates in Europe. As for health generally, sexual health is worst where people are poorest. Though cost-effective by treating large numbers of patients with low cost interventions, sexual health services in Scotland have, in many cases, been poorly developed through under-investment, lack of strategic leadership and low prioritisation resulting in a wide variation in access and quality between different NHS board areas. In addition, the personal and sensitive nature of sexual health and the stigma associated with use of services have resulted in lack of public involvement and difficulty in ascertaining a patient voice.

Respect and Responsibility

To address these issues, the Scottish Executive appointed a multidisciplinary Expert Reference Group which reported in November 2003, leading, after wide public consultation and debate, to the publication of Scotland's first sexual health and relationships strategy, Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health. This national strategy was launched in January 2005, backed initially by £15 million of new funding over three years.

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

In addition, and as proposed in Respect and Responsibility, NHS Quality Improvement Scotland (NHS QIS) was tasked with taking forward the development of appropriate clinical standards in relation to sexual health services provided by or secured by NHSScotland. This document reflects the work undertaken to discharge this important task.

Role of sexual health services

As Respect and Responsibility emphasises, improving sexual health is not just about improving clinical services. But good services do have a vital contribution to make to the wider effort to promote good sexual health. Their role is not simply to deal with the consequences of sexual behaviour. Rather, high quality clinical services have an important part to play in the prevention of poor sexual health by educating those who attend and supporting behaviour change, by detecting asymptomatic infection to prevent onward transmission, by provision of effective contraception to prevent unintended conception, by offering immunisation, and by working with partner organisations. Clinical services are also vital to the delivery of public health improvement more generally and to support the wider drive to reduce health inequalities in Scotland.

2 Development of the draft standards for sexual health services

NHS QIS was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. To fulfil the task assigned to it in Respect and Responsibility, NHS QIS convened a preliminary project group to consider both the work of NHS QIS and that of other organisations to improve the quality of sexual health service provision. The project group made the following four recommendations in its preliminary report published in June 2006.

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

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

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

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

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

The development of NHS QIS service-level standards commenced in summer 2006. As a first step, a scoping exercise to review current evidence relating to sexual health services and define the topic areas of the standards was undertaken. These topic areas are linked to the six key themes mentioned above. The scoping exercise involved not only a literature review but discussion with executive directors and lead clinicians in each NHS board area to identify key areas for standards development. Details of a scoping report highlighting the results of this exercise are available on request. A meeting of non-statutory sector representatives took place in November 2006 to ensure user perspectives were taken into account. To take forward the development of the standards, NHS QIS appointed a project group, which first met in January 2007. Its membership is set out in Appendix 4.

NHS QIS also appointed an advocacy group, consisting of non-statutory sector representatives, to work in parallel with the project group to ensure user and potential user issues remained central to the development of the standards. The group's membership is in Appendix 5. As well as contributing to the content of the draft standards, the advocacy group helped prepare a short summary document for the public giving details of what individuals can expect from sexual health services as well as information to help empower individuals to safeguard their own sexual wellbeing. This document will be offered to NSHAC to consider how it can be put to best use. The document which was approved by the advocacy group is in Appendix 2.

Parameters

These standards are applicable to all NHS boards with responsibility for delivering sexual health services in Scotland, including NHS 24. Consideration has been given to the specific issues with which rural and remote areas may be faced. These are summarised in Appendix 9. The standards are linked to measurable outcomes and data that can be collected by self-assessment. The aim of the standards is not to tell NHS boards how to arrange services locally as each NHS board will develop solutions according to their local circumstances. The standards, therefore, focus on outcomes rather than process.

Format of NHS QIS standards and definition of terminology

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

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

Clinical governance and risk management standards

Every individual using healthcare services should expect these to be safe and effective. There are existing NHS QIS standards for clinical governance and risk management to ensure NHS boards can provide assurance that clinical governance and risk management arrangements are in place, and that they are supporting the delivery of safe, effective, patient-focused care and services. The clinical governance and risk management standards underpin all care and services delivered by NHSScotland and provide the context within which NHS QIS service and condition-specific standards apply. They should be read in conjunction with these sexual health standards. The clinical governance and risk management standards are available on request from NHS QIS or can be downloaded from the website (www.nhshealthquality.org).

Assessment of performance against the standards

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

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

3 Draft standards for sexual health services

Access to services

Standard 1 Access to specialist sexual health services

Standard 2 Comprehensive provision of specialist sexual health services

Standard 3 Information provision

Capacity of services

Standard 4 Termination of pregnancy

Co-ordination of approach

Standard 5 Partner notification

Standard 6 Sexual healthcare for people living with HIV

Equity of service provision

Standard 7 Male and female sterilisation

Standard 8 Chlamydia testing

Standard 9 Hepatitis B vaccination for men who have sex with men

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Choice of service provision

Standard 10 Intrauterine and implantable methods of contraception

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Quality of care delivery

Standard 11 Appropriately trained staff providing sexual health services

Standard 12 Service delivery consistent with national guidelines

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Standard 1: Access to specialist sexual health services

Standard Statement 1: Individuals with priority sexual health conditions are seen in specialist services within two working days of initial contact with the service to minimise individual morbidity and to safeguard public health.

Rationale

Prompt access to sexual and reproductive health services is required to reduce individual morbidity and to maintain public health. Evidence in relation to STIs suggests that timely assessment reduces:

- the level of patient distress,
- the risk of complications,
- the risk of onward transmission, and
- the total number of people infected.

However, not all conditions need to be investigated or managed urgently (eg routine sexual health screening, cervical cytology or longstanding symptoms). A universal access target may compromise rapid assessment of individuals with the greatest need. Priority conditions which require to be seen promptly on clinical grounds have previously been defined on a UK-wide basis (See Appendix 8). To meet this standard, it is expected that individuals in the following categories will be given the highest priority in NHSScotland.

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

This standard recognises that some individuals with priority conditions require to be seen within 24 hours rather than 2 working days. The efficacy of emergency contraception (EC) is dependent on time after unprotected intercourse. Oral EC requires to be administered within 72 hours. It is more effective if used within 24 hours of intercourse and diminishes in effectiveness thereafter. Postexposure prophylaxis (PEP) is recommended as soon as possible, ideally within 4 hours, following exposure to a source known to be HIV infected.

There is an existing NHSScotland objective to improve access to GP services (Target identifier A.01T) to ‘ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other healthcare professional within 48 hours from April 2004’. Therefore this standard is aimed primarily at specialist sexual health services. However community-based services (including emergency medicine departments) should ensure there are no barriers which would delay assessment of individuals with priority sexual health conditions.

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Essential Criteria	
1.1	75% of individuals with priority sexual health conditions are offered the opportunity to be seen within 2 working days of initial contact with a specialist sexual health service.
1.2	There is a mechanism in place to monitor trends of missed telephone calls (9am–5pm) to specialist sexual health services.
Desirable Criteria	
1.3	60% of individuals with priority sexual health conditions are offered the opportunity to be seen within one working day of initial contact with a specialist sexual health service by the end of 2010.
1.4	50% of all individuals are offered the opportunity to be seen within five working days of initial contact with a specialist sexual health service by the end of 2010.
1.5	Specialist sexual health services demonstrate measures to increase the number of new attendees.

Standard 2: Comprehensive provision of specialist sexual health services

Standard Statement 2: A comprehensive range of specialist sexual health services are provided to meet the identified needs of local populations.

Rationale

Considerable progress has been made developing integrated sexual health services in Scotland with an emphasis on wellbeing rather than ill health. Despite many examples of high quality practice, there remains inequity in the range of services provided to the residents of different and often adjacent NHS boards reflecting variations in the local prioritisation of sexual health. This is exacerbated by the lack of specialist practitioners with knowledge of latest and best evidence-based practice to champion and lead local services.

Each NHS board requires a full spectrum of sexual health services available to meet the identified needs of its local population, ensuring that no-one is excluded whatever their life circumstances (Standard 11 addresses the necessary staff competencies to achieve this). The focus of this standard is to describe the characteristics which define specialist service provision. Services need to be confidential and non-judgemental, however, this is difficult to measure. The criteria therefore describe quantifiable outcomes which are likely to support such delivery.

In order to meet local access for priority sexual health conditions as described in Standard 1, a minimum of 2 days service per week (on appropriate days) is essential. Previous workforce planning calculations and evidence from existing best practice in integrated specialist sexual health services in Scotland operating 'hub and spoke' models suggest 3 days per week of local comprehensive specialist sexual health service (ie providing a full range of contraception, STI management in both men and women and routine opt-out HIV testing) is desirable. It is important that local services are linked to consultant-led expertise for more complex care as described in Standard 11. In some geographical areas it is accepted that over 30 minutes travel may be required for more complex clinical need, particularly if services are linked as part of a formal network.

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Scottish Executive. Partnership for care. Scotland's health white paper [online]. 2003 [cited 2007 April 26]; Available from: http://www.sehd.scot.nhs.uk/publications/PartnershipforCareHWP.pdf

Essential Criteria	
2.1	Each NHS board has local specialist sexual health services, which as a minimum, deliver the full range of contraception options, facilities for the diagnosis and treatment of all STIs in men and women, and HIV testing and counselling.
2.2	There is a minimum of 2 days of local specialist sexual health service provision available within 30 minutes travel time from each settlement of over 10,000 people.
2.3	Specialist genitourinary medicine and reproductive health service providers work together to deliver integrated services with consideration of the social determinants of health.
2.4	There are targeted services for communities of interest with specific needs (eg young people, men who have sex with men, homeless people).
2.5	Each individual has a choice of sexual healthcare providers within their NHS board area of residence.
2.6	The standard of specialist sexual health service accommodation is of a high quality with clear signposting for the public and sound proofing to facilitate confidential discussion.
2.7	The emphasis of services must not just be on sexual ill health but also on promoting good health including the provision of services for the assessment of psychosexual health, gender dysphoria**,** and sexual dysfunction in both men and women.
2.8	Sexual health promotion activities are closely co-ordinated with the delivery of specialist sexual health services.

Standard 3: Information provision

Standard Statement 3: The public has access to factually accurate and consistent information about sexual health from services.

Rationale

Information on sexual and reproductive health is produced by a number of organisations within each NHS board area. These sources include specialist and generic sexual health services, health promotion departments and partner organisations such as the non-statutory sector and local authorities.

In addition, NHSScotland provides sexual health information relevant to individuals across several NHS boards. Most notable of these is NHS 24. NHS 24 was specifically tasked with ensuring accurate information in relation to clinical management algorithms in Respect and Responsibility. The NHSScotland e-library and NHS Education for Scotland (NES) are also important providers of information from within the health service.

In relation to sexual health specifically, the Sexual Health and Wellbeing Learning Network (which is part of NHS Health Scotland) serves to: share learning, develop evidence, disseminate good practice, particularly from the National Health Demonstration Project, Healthy Respect and support Respect and Responsibility.

It is also recognised that there are a number of external information sources over which the NHS has little or no direct influence, although these sometimes refer to NHS source material. These include websites, educational resources, published literature and the mass media.

Information can broadly be broken down into that referring to specific conditions (eg chlamydia infection) or interventions (eg contraceptive methods), and to that describing local service provision (eg locations, opening times etc).

The need for individuals to have access to accurate, unbiased information was specified in page 12 of Respect and Responsibility. Inconsistent or incorrect information can be at best confusing to the public and at worst can perpetuate ill health. There is therefore merit in ensuring that NHS information providers work with each other to ensure consistency of approach to make information trustworthy and accurate.

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Essential Criteria	
3.1	Process: each NHS board has clear and effective reviewing arrangements in place to ensure the factual accuracy of information describing sexual health conditions and local service provision arrangements, and in doing so links with partner organisations outside the NHS.
3.2	Internal provision: each NHS board has a system in place to identify the diverse sexual health information needs of their population and to respond to those needs appropriately using relevant information formats.
3.3	External provision: Regularly updated accurate information on local sexual health service provision is made available to other NHS boards, including NHS 24.
3.4	Information is available at specialist sexual health services on where to obtain emergency contraception locally on days when the service is closed.
Desirable Criterion	
3.5	Each NHS board develops a sexual health information resource which the public can access directly.

Standard 4: Termination of pregnancy

Standard Statement 4: Women receive safe termination of pregnancy with minimal delay, followed by a contraceptive review and counselling.

Rationale

The earlier in pregnancy a therapeutic abortion is performed, the lower the risk of complications. Services should, therefore, offer arrangements that minimise delay in accessing a safe termination of pregnancy, whilst also allowing sufficient time for reflection to consider other options. The percentage in this standard takes into account that some women may first present to services after 9 weeks gestation and that the legal limit relating to the grounds which apply to most terminations of pregnancy remains at 24 weeks. In pages 13 and 19 of Respect and Responsibility, it states that '…in accordance with the Royal College of Obstetrician and Gynaecologists guidelines, no woman should have to wait longer than 3 weeks from her initial referral to termination.'

In some NHS boards, delays occur when a woman seeks advice about termination of pregnancy, as a result of the time to initial consultation, and/or because of the care pathway for onward referral and assessment. While conscientious objection by clinical staff must be recognised, clinicians must practise within the guidance of the relevant bodies by making timely referral and providing appropriate information and advice.

Ideally this standard would have included a statement on the percentage of terminations taking place within 3 weeks of initial medical assessment (usually by a GP). However, measuring this has proven difficult in practice. Therefore the key indicator is the proportion of women undergoing termination of pregnancy before 10 weeks gestation. This cut-off makes allowance for reflection time and for later presentation to services. Eligible women should be offered a choice of medical or surgical termination of pregnancy.

Up to one in four terminations of pregnancy is carried out for women who have previously had a termination of pregnancy. Repeat unintended pregnancy can be prevented by correct and consistent use of the most effective methods for contraception. Contraceptive advice after termination of pregnancy is sometimes sub-optimal and women may leave the abortion facility without a contraceptive method or plan.

Psychological support is intrinsic for service delivery. From a psychological perspective, many women experience relief after an unwanted pregnancy has been terminated. However, a small number suffer from feelings of loss, grief and regret. These feelings are more likely to arise in women who lack social support, whose decision to have termination of pregnancy is in conflict with their family or religious beliefs, who feel they were pressurised into having the termination of pregnancy or who are young or have a very late abortion.

References:

Ingham R, Lee E, Clements S, Stone N. Second-trimester abortions in England and Wales. Southampton: University of Southampton; 2007

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Essential Criteria	
4.1	70% of women seeking termination of pregnancy undergo the procedure before 10 weeks gestation.
4.2	There is a mechanism to ensure that all women who have undergone termination as a result of unintended pregnancy are offered a range of contraceptive methods other than condoms, including hormonal implants or intrauterine methods where appropriate.
4.3	70% of women leave the termination of pregnancy facility with one of the more effective methods of contraception (hormonal methods, intrauterine devices or contraceptive implants).
4.4	A robust system is in place to ensure timely and efficient referral for male or female sterilisation after a termination of pregnancy for women and men who request it.
Desirable Criterion	
4.5	Post termination of pregnancy counselling is available within 4 weeks for women (and their partners) who request it.

Standard 5: Partner notification

Standard Statement 5: Individuals who are diagnosed with a sexually transmitted infection see an appropriately trained member of staff to organise partner notification (contact tracing).

Rationale

Partner notification (contact tracing) is defined as the process of informing the sexual partners of people with STIs of their potential exposure to infection, ensuring their evaluation and/or treatment, and providing advice about preventing future infection. Although voluntary, partner notification is an essential element in maintaining public health. Partner notification breaks the chain of transmission and reduces the incidence of STIs. Participation in partner notification is often welcomed by individuals who wish to ensure that their partner(s) have an opportunity to maintain sexual wellbeing.

Specialist sexual health advisers are practitioners specifically trained in partner notification and are usually based in genitourinary medicine clinics. In Scotland, there are existing models of best practice where sexual health advisers have supported the delivery of partner notification in community settings. There is high quality evidence that nurse-led partner notification, with support from specialist health advisers, is an effective strategy for ensuring treatment of the sexual partners of people diagnosed in primary care with uncomplicated chlamydia. This strategy can also be extended to nurses in family planning clinics, youth sexual health services and other settings.

There are published evidence-based national outcome standards for expected partner notification rates for uncomplicated chlamydia and gonorrhoea. Rates are lower in urban centres owing to a more mobile population, greater clinic workload and longer waiting times which may discourage re-attendance.

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Society for Sexual Health Advisers (SSHA). The manual for sexual health advisers. Section A: partner notification [online]. [cited 2007 April 25]; Available from: www.ssha.info/public/manual/index.asp

Trelle S, Shang A, Nartey L, Cassell JA. Low N. Improved effectiveness of partner notification for patients with sexually transmitted infections: systematic review. BMJ. 2007;334(7589):354-357.

Essential Criteria	
5.1	A sexual health adviser, or a professional trained and supported by a sexual health adviser (eg a practice nurse), is available to all individuals diagnosed with chlamydia or gonorrhoea.
5.2	Individuals are offered partner notification in all settings delivering sexual healthcare, including in general practice.
5.3	0.43 contacts per case of chlamydia will be verified as having attended within 4 weeks of the first partner notification interview.
Desirable Criteria	
5.4	0.64 contacts per case of chlamydia will be verified as having attended within 4 weeks of the first partner notification interview.
5.5	All individuals diagnosed with chlamydia have partner notification initiated by the end of 2010.
5.6	80% of individuals diagnosed with gonorrhoea are seen by a sexual health adviser, or a professional trained and supported by a sexual health adviser, for specialist partner notification within 7 days of the diagnosis being made.
5.7	Individuals are offered the choice of patient referral, conditional referral or provider referral for partner notification.

Standard 6: Sexual healthcare for people living with HIV

Standard Statement 6: Individuals attending for ongoing HIV care are offered high quality sexual and reproductive healthcare to improve personal wellbeing and to minimise the risk of transmitting infections to others.

Rationale

Many people living with HIV are well. Effective antiretroviral therapy has improved wellbeing and put sexual activity back on the agenda. This standard aims to support people with HIV to have good sexual and reproductive health for their own personal wellbeing. It also aims to help services to provide care for people with HIV and to reduce the risk of unplanned pregnancy, cervical neoplasia and onward transmission of HIV and sexual infections.

There are a wide range of interventions which can be used to improve the sexual and reproductive health of people living with HIV. A number of these such as routine testing of blood for syphilis at the same time as HIV laboratory markers have been demonstrated to be highly effective in reducing morbidity. There is a wide spectrum of possible interventions, which are described in the 2007 joint sexual and reproductive health guidelines. These include the detection and treatment of STIs (including reactivated conditions), cervical screening, contraception, postexposure prophylaxis, pre-conception counselling and care during and after pregnancy.

The aim of this standard is to ensure that sexual healthcare is not forgotten given the time pressure to deal with other issues such as antiretroviral therapy and HIV monitoring. A non-judgemental and culturally-sensitive approach is also essential given the diversity of individuals living with HIV.

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Farley TA, Cohen DA, Wu SY, Besch CL. The value of screening for sexually transmitted diseases in an HIV clinic. J Acquir Immune Defic Syndr. 2003;33(5):642-648.

Kravcik S, Victor G, Houston S, Sutherland D, Garber GE, Hawley-Foss N, et al. Effect of antiretroviral therapy and viral load on the perceived risk of HIV transmission and the need for safer sexual practices. J Acquir Immune Defic Syndr Hum Retrovirol. 1998;19(2):124-129.

Nandwani R, on behalf of the Clinical Effectiveness Group of the British Association for Sexual Health and HIV (BASHH). 2006 United Kingdom national guideline on the sexual health of people with HIV: sexually transmitted infections. Int J STD AIDS. 2006;17(9):594-606. STD Control Program and the HIV/AIDS Control Program, Public Health – Seattle & King County. Sexually transmitted disease and HIV screening guidelines for men who have sex with men. Sex Transm Dis. 2001;28(8):457-459.	
Essential Criteria	
6.1	90% of individuals receiving ongoing HIV care have the result of syphilis serology taken within the preceding 6 months recorded in their HIV records.
6.2	90% of women living with HIV have a cervical cytology result taken within previous year documented in their HIV records.
6.3	80% of HIV+ individuals presenting for the first time in Scotland have their sexual and reproductive history documented within 4 weeks of their initial HIV diagnosis. (This can be 4 weeks before or after.)
6.4	80% of individuals receiving ongoing HIV care have a documented offer of a sexual health screen within the previous 12 months even if this is declined.
6.5	There is a documented local care pathway for sexual and reproductive healthcare, including provision of contraceptive counselling and supplies for individuals with HIV and this is communicated directly to HIV+ individuals and to organisations who provide support for individuals with HIV.

Standard 7: Male and female sterilisation

Standard Statement 7: Men and women of reproductive age have timely access to sterilisation.

Rationale

Male and female sterilisation both provide highly effective non-reversible contraception for couples whose families are complete or who choose not to have children.

Rates of female sterilisation have declined sharply in Scotland since 1998. While the reasons for this may relate to changing user preference, there is a suggestion that access to both female sterilisation and vasectomy has been reduced in some parts of Scotland and waiting lists are often long. Men and women who wish a permanent method of contraception should be able to choose sterilisation.

References:

Dash Project, NHS National Services Scotland. Key clinical indicators for sexual health: action 12 subgroup report on baseline data for 2005 [online]. 2006 [cited 2007 April 26]; Available from: http://www.scotland.gov.uk/Resource/Doc/924/0044637.pdf

National Institute for Clinical Health and Excellence (NICE). Long-acting reversible contraception. Clinical guideline 30 [online]. 2005 [cited 2007 April 12]; Available from: http://guidance.nice.org.uk/CG30/niceguidance/pdf/English

Royal College of Obstetricians and Gynaecologists. Male and female sterilisation. Evidence based clinical guideline No 4 [online]. 2004 [cited 2007 April 12]; Available from: http://www.rcog.org.uk/resources/Public/pdf/Sterilisation_full.pdf

Essential Criteria

7.1	There are systems in place to ensure that information, counselling and referral are provided to all men and women requesting sterilisation methods.
7.2	No more than 10% of men wait more than 6 months for vasectomy.
7.3	No more than 10% of women wait more than 6 months for sterilisation.

Standard 8: Chlamydia testing

Standard Statement 8: Chlamydia testing is offered to sexually active 16–24 year olds.

Rationale

Genital chlamydia infection is highly prevalent, especially among young people. 17,926 individuals were diagnosed with chlamydia in Scotland in 2006, of whom 12,974 (72.3%) were aged under 25. The infection is usually carried without causing symptoms, but can progress to cause medical complications such as pelvic inflammatory disease and ectopic pregnancy in women, and infertility in both sexes. Increased testing results in improved detection of chlamydia in asymptomatic individuals, thereby reducing individual morbidity and onward transmission if treated appropriately.

The highest chlamydia rates are found in men aged 20 to 24 years, and women aged 15 to 19 years. The number of sexually active individuals in these age bands can be calculated for each NHS board area. It is therefore possible to collect data on the proportion tested during a defined period. Infection rates are significantly lower in those aged over 25 and so this age band is excluded from this standard.

It is for each NHS board to define its optimal strategy for offering young people tests for chlamydia. Non-invasive testing makes it possible to test easily in community settings. The challenge is to ensure that testing initiatives engage young men (regardless of sexual preference) as well as women.

In England, almost 100,000 people were tested between 1 April 2005 and 31 March 2006 as part of the national chlamydia screening programme. A high disease burden was detected with positivity rates of 10.4% in women and 10.7% in men.

Rates of chlamydia testing are highly influenced by the amount of available resource dedicated for this purpose. Different NHS boards will choose local strategies to deliver chlamydia testing (such as postal testing kits and enhanced community initiatives). The thresholds of this standard are based on existing chlamydia testing rates in Scotland as described in Key Clinical Indicator 1 (see Appendix 3). The figures take account of individuals having repeat tests in a given year. Higher chlamydia testing rates are achievable if resource is prioritised for this purpose. Increased awareness and chlamydia test uptake are positive interventions for preventing sexual ill health.

References:

Emmett L, Simms I, Randall S, Battison T, Clarke J, Macintosh M, The national chlamydia screening programme in England: the challenge of full implementation. London: Health Protection Agency; 2006.

Low N, McCarthy A, Macleod J, Salisbury C, Campbell R, Roberts TE, et al. for the Chlamydia Screening Studies Project Group. Epidemiological, social, diagnostic and economic evaluation of population screening for genital chlamydial infection [online]. 2007 [cited 2007 May 24]; Available from: http://www.hta.ac.uk/fullmono/mon1108.pdf

National Chlamydia Screening Steering Group. New frontiers: annual report of the national chlamydia screening programme in England 2005/06 [online]. 2006 [cited 2007 May 24]; Available from: http://www.hpa.org.uk/publications/2006/ncsp/

Scottish Intercollegiate Guidelines Network (SIGN). Management of genital chlamydia trachomatis infection. A national clinical guideline. No. 42 [online]. 2000 [cited 2007 May 25]; Available from: http://www.sign.ac.uk/pdf/sign42.pdf

Scottish Programme for Clinical Effectiveness in Reproductive Health. National audit of the management of chlamydia trachomatis infection: assessing the impact of SIGN guideline 42. Results and recommendations [online]. 2003 [cited 2007 May 25]; Available from: http://www.abdn.ac.uk/spcerh/publications/corrected%20chlamydia%20report%20for%20mackay%20&%20inglis.pdf

Essential Criteria	
8.1	The rate of chlamydia tests performed in the NHS board area is greater than 100 per 1,000 men aged 16–24 years.
8.2	The rate of chlamydia tests performed in the NHS board area is greater than 300 per 1,000 women aged 16–24 years.
Desirable Criteria	
8.3	60% of chlamydia tests are taken from men and women aged under 25 years.
8.4	The rate of chlamydia tests performed in the NHS board area is greater than 200 per 1,000 men aged 16–24 years by the end of 2010.

Standard 9: Hepatitis B vaccination for men who have sex with men

Standard Statement 9: Men who have sex with men who are at risk of sexually transmitted hepatitis B are offered vaccination.

Rationale

Hepatitis B is more prevalent in men who have sex with men (MSM) than in the general population and can be transmitted by sexual contact. Hepatitis B is 100 times more infectious than HIV. Hepatitis B virus (HBV) can lead to acute jaundice, but 5–10% of cases progress to develop chronic infection with an increased risk of liver cirrhosis and hepatocellular carcinoma.

A safe, cost-effective vaccine offering protection against HBV has been available for over 20 years. It is UK policy to offer routine immunisation to all men identified as having same gender partners. Uptake of vaccine in MSM is known to be sub-optimal. Improved delivery would reduce ill health. It is also recognised that it is cost-effective to immunise other individuals such as sex workers and those who inject drugs, but it is difficult to collect data on these populations for the purpose of measuring the standard in relation to sexual health services.

It is difficult to identify systematically MSM registered in general practice and other generic sexual health services unless specifically provided for lesbian, gay, bisexual, transgender (LGBT) populations. Therefore for data collection reasons, the essential criteria currently apply to specialist sexual health services only. Data on hepatitis B immunisation have been routinely collected in genitourinary medicine clinics using the STISS system since September 2006.

References:

Bhatti N, Gilson RJ, Beecham M, Williams P, Matthews MP, Tedder RS, et al. Failure to deliver hepatitis B vaccine: confessions from a genitourinary medicine clinic. BMJ. 1991;303(6794):97-101.

Clinical Effectiveness Group (British Association of Sexual Health and HIV). United Kingdom national guideline on the management of the viral Hepatitides A, B and C 2005 [online]. 2005 [cited 2007 April 13]; Available from: http://www.bashh.org/guidelines/2005/hepatitis_abc_final_0905.pdf

Salisbury D, Ramsay M, Noakes K, editors. Immunisation against infectious disease – “The Green Book” [online]. 2006 [cited 2007 April 12]; Available from: http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Greenbook/DH_4097254

Essential Criteria	
9.1	There is a protocol to promote hepatitis B vaccination of all individuals in community settings such as primary care who are at increased risk of hepatitis B.
9.2	80% of all MSM attending genitourinary medicine services and not known to be immune to hepatitis B receive at least one dose of hepatitis B vaccine.
9.3	MSM have a choice of where hepatitis B vaccination is available (eg not just in addiction services) and information on other health promoting activities such as risk reduction and STI testing must also be available in that setting.
Desirable Criterion	
9.4	40% of MSM who commence hepatitis B immunisation complete the full course of injections and return for an antibody titre level to ensure effective protection.

Standard 10: Intrauterine and implantable methods of contraception

Standard Statement 10: All individuals have access to intrauterine and implantable methods of contraception.

Rationale

Intrauterine and implantable contraceptives are more effective than oral contraceptives or barrier methods in preventing unintended pregnancy because they depend much less, if at all, on adherence to therapy for their effectiveness.

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

Once correct insertion has been verified, women using either contraceptive implants or intrauterine methods require no routine regular follow-up until the method is due to be changed.

Most women get contraception from their GP and provision of intrauterine and implantable methods in the primary care setting in Scotland is currently limited.

Reference:

National Institute for Clinical Health and Excellence (NICE). Long-acting reversible contraception. Clinical guideline 30 [online]. 2005 [cited 2007 April 12]; Available from: http://guidance.nice.org.uk/CG30/niceguidance/pdf/English

Essential Criteria	
10.1	Women requiring contraception are given information (including written information) about, and offered a choice of, all methods of contraception including intrauterine and implantable contraceptives.
10.2	100 females per 1,000 females of reproductive age are prescribed intrauterine and implantable contraceptives.
10.3	Contraceptive service providers who do not provide intrauterine and implantable contraceptives within their own practice or service should have an agreed mechanism in place for referring women for intrauterine and implantable contraceptives.
10.4	An appointment with a service providing intrauterine and implantable contraceptives is available within 5 days.
Desirable Criterion	
10.5	150 females per 1,000 females of reproductive age are prescribed intrauterine and implantable contraceptives by the end of 2010.

Standard 11: Appropriately trained staff providing sexual health services

Standard Statement 11: All staff who deliver sexual health services are adequately and appropriately trained.

Rationale

Generic sexual health interventions are delivered in a variety of settings including primary care, community settings and young people's services. While many are supported by committed staff, on occasions little or no training in sexual health has been undertaken. Delivering sexual healthcare requires generic competencies, delivered to a high level by all staff, especially in relation to confidentiality, a non-judgemental sensitive approach, and knowledge of child protection and chaperoning policies. Additional clinical skills required include sexual history taking and intimate examination.

All NHS boards require access to consultants holding the appropriate postgraduate qualifications in order to support service delivery both in primary care and generic services and also to directly deliver more complex care. Owing to a lack of specialists, some NHS boards remain unable to offer a full range of contraception options. Others lack the facilities to manage conditions such as menopause and complex contraception, or STIs such as syphilis, lymphogranuloma venereum and gonorrhoea, particularly in circumstances with a greater risk of complications such as in pregnancy, or when systemic complications have arisen. A lack of local specialist expertise may result in increased costs related to sub-optimal practice, eg inappropriate prescribing of antiviral drugs for long-term suppression of recurrent genital herpes rather than episodic therapy or lack of use of the most effective methods of contraception.

It is important to differentiate specialist knowledge from leadership in relation to sexual health services. While lead clinicians can be drawn from a range of disciplines, local knowledge and championship are enhanced by knowledge of national scientific and strategic developments in the appropriate specialty.

Lack of local specialist expertise has been a major impediment in improving the quality of services across Scotland. The difficulties of recruiting and retaining staff in more rural and remote parts of Scotland are recognised but it is essential that such populations do not receive second class services. The linkage of such posts to managed clinical networks (MCNs) may provide a solution to this difficulty. It is also noted that travel time and access may be equally difficult in urban areas where there is lack of local specialist sexual health service provision.

As part of Respect and Responsibility, NSHAC subgroup 14 was charged with reviewing sexual health training in conjunction with NES. The recommendations of this subgroup have been taken into account in preparing this standard. Work is ongoing to develop accredited training to deliver sexual and reproductive health competencies in Scotland, especially for professionals and volunteers not working in specialist settings.

References:

Department of Health. Competencies for providing more specialised sexually transmitted infection services within primary care – assessment toolkit [online]. 2006 [cited 2007 May 25]; Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139358

National Sexual Health Advisory Committee (NSHAC) Subgroup 14, Discussion Paper: Education and training in Sexual Health. Unpublished 2006.

NHS Education for Scotland. A route to enhanced competence in sexual and reproductive health nursing (post-registration pre-specialist level). Edinburgh: NHS Education for Scotland; 2004.

NHS Education for Scotland. A route to enhanced competence in sexual and reproductive health nursing (specialist level). Edinburgh: NHS Education for Scotland; 2005.

Royal College of Nursing. Sexual health competencies: an integrated career and competency framework for sexual and reproductive health nursing [online]. 2004 [cited 2007 May 25]; Available from: http://www.rcn.org.uk/publications/pdf/sexual_health_competencies.pdf

Scottish Executive. National standards relating to healthcare support workers in Scotland – consultation document [online]. 2006 [cited 2007 April 13]; Available from: http://www.scotland.gov.uk/Resource/Doc/924/0030505.pdf

Scottish Executive. NHS code of practice in protecting patient confidentiality [online]. 2003 [cited 2007 April 13]; Available from: http://www.confidentiality.scot.nhs.uk/publications/6074NHSCode.pdf

Essential Criteria

11.1	Each NHS board has clinical services led by a consultant holding a certificate of completion of training (CCT) in genitourinary medicine.
11.2	Each NHS board has clinical services led by a consultant holding a CCT in sexual and reproductive healthcare.
11.3	All nursing staff working in specialist sexual health services demonstrate knowledge gained from post registration courses in sexual and reproductive health.
11.4	A mechanism is in place to ensure staff competencies are signed off and recorded.
11.5	Practitioners providing more specialised STI services within primary care demonstrate core and additional competencies recommended by the Department of Health.
11.6	All health professionals providing sexual and reproductive interventions in both generic and specialist services demonstrate evidence of relevant continuing professional development.

Desirable Criteria	
11.7	All medical staff in specialist sexual health services hold or are in the process of obtaining the Sexually Transmitted Infection Foundation (STIF) certificate or the Diploma of the Faculty of Family Planning (DFFP) or ideally both qualifications.
11.8	All sexual health advisers working in specialist sexual health services hold a relevant professional qualification (eg nursing diploma or degree and have completed sexual health adviser competencies).
11.9	All counsellors working in specialist sexual health services hold an appropriate professional qualification accredited by a recognised organisation, for example a diploma in counselling which is accredited at this level by the British Association for Behavioural Psychotherapy (BABP) or by Counselling & Psychotherapy in Scotland (COCSA).
11.10	All healthcare assistants employed in specialist sexual health services require a minimum of a Scottish Vocational Qualification (SVQ) or equivalent in a health-related topic at level 2.
11.11	There is a local staff induction programme for all healthcare support workers and unregulated staff in generic and specialist sexual health services (including reception staff) which includes training in confidentiality, information handling, the use of chaperoning for intimate examinations and child protection in relation to sexual health.

Standard 12: Service delivery consistent with national guidelines

Standard Statement 12: Services are provided to individuals in line with current recommendations made in national guidelines.

Rationale

There are ongoing rolling programmes by the UK relevant specialist organisations to produce clinical effectiveness guidelines on a comprehensive range of sexual and reproductive health conditions. These are evidence-based and internationally accredited.

The three key sets of United Kingdom guidelines are produced by:

1 The British Association for Sexual Health & HIV (BASHH) Clinical Effectiveness Group (available at www.bashh.org/guidelines.asp)

2 The Faculty of Family Planning & Reproductive Healthcare Clinical Effectiveness Unit (available at www.ffprhc.org.uk/)

3 The Royal College of Obstetricians and Gynaecologists Guidelines (available at www.rcog.org.uk/index.asp?PageID=1740)

In addition, there may be guidelines relevant to sexual health service delivery in Scotland produced by the National Institute for Health and Clinical Excellence (www.nice.org.uk) and the British HIV Association (www.bhiva.org).

It is expected that NHS boards will ensure that these guidelines are taken into account when producing local service protocols to ensure high quality consistent delivery of care based on best practice. This requirement applies equally to all NHS boards. Local delivery of the guidelines also needs to take account of the Scottish Executive/NHSScotland equality and diversity approach.

References:

Department of Health. 10 high impact changes for genitourinary medicine 48-hour access. London: Department of Health; 2006.

National Institute for Health and Clinical Excellence (NICE). One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups: NICE public health intervention guidance 3 [online]. 2007 [cited 2007 May 30]; Available from: http://guidance.nice.org.uk/PHI3/guidance/pdf/English/download.dspx

Scottish Intercollegiate Guidelines Network (SIGN). Management of genital chlamydia trachomatis infection. A national clinical guideline. No. 42 [online]. 2000 [cited 2007 May 25]; Available from: http://www.sign.ac.uk/pdf/sign42.pdf
Scottish Executive. Protecting children and young people: framework for standards [online]. 2004 [cited 2007 April 12]; Available from: http://www.scotland.gov.uk/Publications/2004/03/19102/34603

Scottish Executive. Fair For All: Working together to provide culturally-competent services in NHSScotland. 2006. Available from: http://www.scotland.gov.uk/library3/society/ffas-00.asp	
Essential Criteria	
12.1	There is a system in place to ensure that national guidelines on clinical governance, clinical effectiveness and child protection are disseminated to specialist and generic sexual health service providers.
12.2	Local care protocols are adapted to include recommendations made in the national guidelines.
12.3	There is a system in place to demonstrate a rolling programme developing local services in line with national sexual health guidelines.

4 How to participate in the consultation process

We may use several different methods of consultation during the development of the draft standards:

- wide circulation of the draft standards document to relevant professional groups, health service staff, voluntary organisations and individuals
- open meetings
- public consultation exercises involving distribution of comments forms and/or questionnaires
- focus group discussions, and
- pilot review visits.

If you would like to know how you can participate in the consultation process, please contact:

Sarah Lindsay
Project Officer
NHS Quality Improvement Scotland
Glasgow Office
Delta House
50 West Nile Street
GLASGOW
G1 2NP

Phone: 0141 225 6882

Textphone: 0141 241 6316

Fax: 0141 248 9746

Email: sarah.lindsay@nhs.net

Submitting your comments

Responses to the draft standards for sexual health services should be submitted (by post, phone, fax or email) to the above contact details by **Friday 12 October 2007**.

Consultation feedback

At the end of the consultation period, all comments and responses will be collated and the project group will respond to all comments received on the draft standards. The response will explain how the comments were taken into account.

The response will be made available on the NHS QIS website (www.nhshealthquality.org) and from Sarah Lindsay, Project Officer.

5 Appendices

Appendix 1 About NHS Quality Improvement Scotland

Appendix 2 Rights and responsibilities

Appendix 3 National Sexual Health Advisory Committee Key Clinical Indicators

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Appendix 4 Membership of the draft standards for sexual health services project group

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Appendix 5 Membership of the draft standards for sexual health services advocacy group

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Appendix 6 Core evidence base

Appendix 7 Working definitions and glossary

Appendix 8 British Association for Sexual Health and HIV guidance on priority groups for access to genitourinary medicine services

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Appendix 9 Remote and rural considerations

Appendix 1: About NHS Quality Improvement Scotland

NHS QIS is an independent organisation and achieves its objectives through five key functions that link together:

1 Providing clear advice and guidance on effective clinical practice
2 Setting clinical and non-clinical standards of care
3 Reviewing and monitoring the performance of NHS services
4 Supporting NHS staff in improving services, and
5 Promoting patient safety and implementation of clinical governance.

The work of NHS QIS is:

- partnership-focused – working with patients and the public, NHSScotland and many organisations to improve the quality of care and avoid duplication
- evidence-based – conclusions and recommendations are based on the best evidence available
- quality-driven – with internal and external monitoring and evaluation.

Development of NHS Quality Improvement Scotland standards

Basic principles

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

In fulfilling its responsibility to develop and run a system of quality assurance, NHS QIS takes account of the principles set out in Fair for All and Partnership for Care, to ensure that 'our health services recognise and respond sensitively to the individual needs, background and circumstances of people's lives'. Therefore NHS QIS endeavours to ensure that consideration of equality and diversity issues feature prominently in the design, development and delivery of all its functions and policies.

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

Further information about NHS QIS is available at www.nhshealthquality.org or directly by using the contact information given on page 32 of these draft standards.

Appendix 2: Rights and responsibilities

Worried about your sexual health?

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

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

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

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

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

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

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

There are also specific things which can help maintain good sexual health:

- If you are aged 16 to 24 you will be offered a chlamydia test.
- You will be offered vaccination against hepatitis B if you are at increased risk of being infected through sex.
- The full range of contraceptive methods will be available to you wherever you live.
- Vasectomy and female sterilisation will be available within a reasonable time if you decide you do not want to have children.
- If you are a woman who needs a termination of pregnancy this will be carried out safely without a long delay, followed by a choice of contraception and counselling if you wish.
- If you are HIV-positive we won't forget that you have a sex life.

What we expect of you

In return, there are a few things that we ask of you to make sure you continue to enjoy positive sexual health.

Respect yourself and your partner.

Protect yourself and protect others.

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

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

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

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

If you have symptoms, seek care promptly and avoid having sex before you have treatment.

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

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

Be respectful towards our staff.

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

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

Appendix 3: National Sexual Health Advisory Committee Key Clinical Indicators

The key clinical indicators (KCIs) for sexual health have been developed by the Action 12 subgroup on behalf of NSHAC, supported by NHS QIS as detailed in the preliminary project group report in June 2006.

The KCIs are part of the wider quality framework for sexual health. The indicators have informed the development of the NHS QIS sexual health services standards and also the National Sexual Health System (NaSH) with its associated datasets, developed by the National Clinical Dataset Development Programme (NCDDP).

The first five indicators published were as follows:

1 **Chlamydia** The proportion of the population within each NHS board having a chlamydia test and the proportion of those tests which are positive. The data is analysed by gender and are age stratified.

2 **Access to male and female sterilisation** The number of female tubal ligation procedures and male vasectomies performed by each NHS board per women and men of reproductive age and the waiting times for these procedures.

3 **Termination of pregnancy** Percentage of termination of pregnancy procedures taking place at less than or equal to nine weeks gestation per NHS Board.

4 **HIV therapy** The proportion of HIV positive people in specialist care and eligible for antiretroviral therapy (ART) who have been treated and the proportion of those treated who have an undetectable viral load.

5 **Hepatitis B vaccination for MSM** The proportion of men who have sex with men (MSM) attending a genitourinary medicine clinic and eligible for hepatitis B vaccine who receive their first dose in this setting.

Baseline data for 2005 from the NSHAC Action 12 subgroup have been reported and are available with a commentary from NHS National Services Scotland: www.isdscotland.org/isd/info3.jsp?pContentID=4628&p_applic=CCC&p_service=Content.show&

Work is also being progressed to develop further key clinical indicators in relation to:

- **long acting reversible methods of contraception**
- **sexual healthcare for people living with HIV, and**
- **sexual health service access.**

Appendix 4: Membership of the draft standards for sexual health services project group

Name	Title	NHS board area/ organisation
Mr James T Brown CBE	Chair	
Dr Rak Nandwani	Clinical Adviser	NHS Quality Improvement Scotland
Dr Eric Baijal	Director of Public Health	Directors of Public Health Group
Dr Alison Bigrigg	Chair, NSHAC subgroup 12	National Sexual Health Advisory Committee
Dr Jim Chalmers	Consultant in Public Health Medicine	Information Services Division
Mr Phil Eaglesham	Health Improvement Officer	Inverclyde Council
Dr Gillian Flett	Consultant in Sexual and Reproductive Health	Royal College of Obstetricians and Gynaecologists
Professor Anna Glasier	Lead Clinician for Sexual Health	Faculty of Family Planning and Reproductive Healthcare
Professor David Goldberg	Consultant Epidemiologist	Health Protection Scotland
Mrs Hawys Kilday	Chief Executive	Caledonia Youth
Dr Gordon McKenna	Consultant in Genitourinary Medicine	British Association for Sexual Health and HIV
Mr Martin Murchie	Senior Sexual Health Adviser	Society of Sexual Health Advisers
Dr Anne Nicolson	General Practitioner representing rural interests	NHS Orkney
Dr Ewen Stewart	General Practitioner	Royal College of General Practitioners
Mrs Julia Trowell	Senior Lead Nurse	Royal College of Nursing
Dr Andrew Winter	Chair, Sexual Health Data Standards Clinical Working Group	National Clinical Dataset Development Programme

Appendix 5: Membership of the draft standards for sexual health services advocacy group

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

Support from NHS QIS is provided by the Standards Development Unit: Mrs Sarah Brown (Senior Project Officer), Ms Hilary Davison (Team Manager), Miss Louise Fitzpatrick (Project Administrator), Mrs Paula Leggat (Team Administrator), Miss Sarah Lindsay (Project Officer) and Mr Neill O'Shaughnessy (Senior Project Officer).

Appendix 6: Core evidence base

During the development of draft standards a wide range of evidence was considered. Evidence relating to particular standards can be found in the references section of each. An evidence stocktake was carried out, the results of which have not been included here in the interests of length.

These results are in a scoping report on sexual health service standards, details of which are available on request.

The following key documents formed the core evidence in the development of these draft standards:

1 Scottish Executive. Enhancing sexual wellbeing in Scotland: a sexual health and relationships strategy: proposal to the Scottish Executive. Edinburgh. 2003. Available from: http://www.scotland.gov.uk/Publications/2003/11/18502/28850

2 Scottish Executive. Respect and Responsibility: strategy and action plan for improving sexual health [online]. 2005 [cited 2007 May 24]; Available from: http://www.scotland.gov.uk/Publications/2005/01/20603/51174

3 Dash Project. (2006) Key Clinical Indicators for Sexual Health: Action 12 Subgroup Report on Baseline Data for 2005. NHS National Services Scotland. Available from: www.scotland.gov.uk/Resource/Doc/924/0044637.pdf

4 NHS National Services Scotland. Moving forward: sexually transmitted infections including HIV, in Scotland 2005 [online]. 2006 [cited 2007 may 24]; Available from: http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=STI-2005-report.pdf&pContentDispositionType=inline

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Appendix 7: Working definitions and glossary

Service definitions

For the purpose of this set of draft standards, **specialist sexual health services** are defined as clinical services whose primary function is delivery of sexual health. Prime examples are genitourinary medicine and sexual and reproductive health clinics. Because of the need for access within two working days as defined in Standard 1, this working definition excludes specialist services with remits limited only to psychosexual health, gender dysphoria and sexual dysfunction. The importance of such services which promote positive sexual wellbeing are noted in Standard 2.

Specialist sexual health services can also be provided to an extent **in general practice** providing staff are trained to the appropriate competencies as defined in Standard 11 and such services are supported by specialists in genitourinary medicine and sexual and reproductive health. It is appropriate for uncomplicated sexual and reproductive health presentations to be managed locally within 30 minutes travelling time, however, it may be necessary to refer complex or specialist conditions to regional centres of excellence. A formal care pathway as part of an MCN would be a mechanism to achieve this.

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

Sexual health interventions provided by the Scottish Prison Service, non-statutory sector services not secured by the NHS, in the private sector and in schools and higher learning establishments without direct NHS support are all outside the scope of NHS QIS. However, there is an expectation that standards should at least meet the minimum criteria.

HIV treatment and care provision was specifically excluded from the scope of the NHS QIS sexual health service standards project with the exception of sexual and reproductive health provison as described in Standard 6. There are numerous international guidelines already in existence for clinical management of opportunistic infection and for antiretroviral therapy. Following wide consultation, UK standards for HIV clinical care produced by the British HIV Association, Royal College of Physicians, British Association for Sexual Health and HIV and British Infection Society were launched in March 2007 (available at http://www.bhiva.org/cms1191535.asp).

Definitions of specific terms used in the standards

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

Short definitions are given here for each standard where terms are used which carry a specific meaning that can influence what is to be measured in the self-assessment framework.

Standard 1

Acute sexually transmitted infection	Recently acquired symptomatic STIs like gonorrhoea, urethritis, syphilis, herpes, etc. all have risk of being passed including mother to child transmission.

Standard 2

Opt-out HIV testing	Routine testing unless individual says not.
Full range of contraception options	Including injectable and implants
Facilities for the diagnosis and treatment of all STIs in men and women	Dark ground microscopy for syphilis, ability to plate gonorrhoea, detect lymphogranuloma venereum taking appropriate rectal samples, etc.

Standard 4

Post abortion counselling	Emotional support for women who are having difficulty coping with having had an abortion.

Standard 5

Patient referral	When index patients themselves inform their sexual contacts to seek treatment.
Conditional referral	Where the healthcare provider notifies sexual contacts if the patient has not done so after a given time.
Provider referral	When the healthcare provider informs a patient's contacts anonymously that they should seek treatment. This is obviously more time consuming for the healthcare provider.

Standard 10

Reproductive age	For data purposes, ISD define this as females aged 15–50 years.

General glossary

NHS QIS understands the importance of accurate and consistent information as illustrated in Standard 3. Below is a list of terms that may not be well understood by the public. A limited number of phrases have been defined here, such as psychosexual health, gender dysphoria, and sexual dysfunction.

Comprehensive definitions of medical terms can be found at the NHS Direct health encyclopedia: http://www.nhsdirect.nhs.uk/encyclopaedia/ or on the BBC website medical notes section: http://news.bbc.co.uk/1/hi/health/medical_notes/default.stm.

Alternatively, if you do not have access to the internet, please contact NHS QIS directly at:

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Standards Development Unit
NHS Quality Improvement Scotland
50 West Nile Street
GLASGOW
G1 2NP

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antibody titre level	An antibody is a protein produced in the blood, in response to the presence of harmful substances (called antigens) which it then destroys. Measuring the titre (amount) of antibody in the blood provides a gauge of immunity and therefore of whether a vaccine has been effective.
antiretroviral therapy	Drugs used to treat the HIV virus. HIV belongs to a family of viruses called retroviruses.
cervical cytology	Also known as the cervical smear test. Designed to detect pre-cancerous changes in the cervix (neck of the womb).
chlamydia	Infection caused by certain subtypes of Chlamydia trachomatis. Genital infection can cause inflammation of the sexual organs and infertility. However, it does not cause any symptoms in most people and so can be passed on without individuals knowing they have it. Chlamydia can also be passed from mother to baby.
cirrhosis	Inflammation of the liver leading to scarring, and reducing the function of the liver. Cirrhosis increases the risk of liver cancer.
ectopic pregnancy	When implantation of the fertilised egg occurs outside the womb.
gender dysphoria	A person with gender dysphoria experiences anxiety, uncertainty or persistently uncomfortable feelings about their birth gender. They feel that they have a gender identity that is different from their anatomical sex.
genital herpes	Infection of the genitals caused by the Herpes simplex virus, also known as the cold sore virus. Usually causes multiple painful ulcers. The virus lies dormant in the body and so can cause recurrences.
gonorrhoea	Sexually transmitted infection caused by Neisseria gonorrhoeae. Usually causes a pus discharge from the water passage in men, from the neck of the womb in women, or can infect the throat or rectum. Gonorrhoea can also be passed from mother to baby.
hepatitis B	Virus spread through the blood or bodily fluids from an infected person, including by sex, sharing needles or blood products. Can cause liver inflammation or failure. Rare cause of liver cancer.
hepatocellular carcinoma	Liver cancer.
implantable methods of contraception	An implant is a form of contraception that is placed under the skin. It releases a progestogen hormone similar to the natural progesterone that women produce in their ovaries.
integrated sexual health services	Bringing together sexual health services which are sometimes provided separately, for example provision of contraception and diagnosis of STIs.
intrauterine methods of contraception	An intrauterine device (IUD) is a small plastic and copper contraceptive which fits inside the womb and can stop sperm from reaching the egg. It may also make the egg move slower down the fallopian tube or stop a fertilised egg from settling in the womb. Sometimes a hormone is released and it is called an intrauterine system (IUS).

lymphogranuloma venereum	Infection caused by specific subtypes of the bacteria Chlamydia trachomatis. The bowel is infected, usually in MSM, causing diarrhoea and symptoms of bowel inflammation.
MSM	Men who have sex with men. MSM refers to any man who has sex with a man, whether he identifies as gay, bisexual, or heterosexual.
postexposure prophylaxis (PEP)	A treatment that may prevent HIV infection after the virus has entered the body.
psychosexual health	The mental and emotional aspects of sexuality. A general term used to classify many difficulties men or women experience with their capacity to undertake sexual activity.
sexual dysfunction	A general term used to classify many difficulties men or women experience with their capacity to undertake sexual activity.
STI	Sexually transmitted infection
syphillis	An STI caused by the spiral-shaped bacterium, Treponema pallidum. If the infection is left untreated it can spread throughout the body and cause complications affecting the heart and nervous system. Pregnant women are routinely tested to prevent mother-to-child transmission.

Appendix 8: British Association for Sexual Health and HIV guidance on priority groups for access to genitourinary medicine services

In response to a 48-hour access target for genitourinary medicine clinics in England, the British Association for Sexual Health and HIV (BASHH) Clinical Governance Group produced guidance on priority groups in February 2006. These were updated in March 2007 and can be found at: www.bashh.org/committees/cgc/index.asp

The aim of this guidance was to minimise the distortions of having a universal 48-hour access where individuals with no symptoms or longstanding conditions were being given the same priority as urgent presentations which required to be seen within 48 hours on the basis of medical priority.

This guidance has been adapted for the Scottish context to support the delivery of Standard 1. Modifications have been made to make allowance for the fact these were drafted specifically for English genitourinary medicine clinics, whereas integrated service delivery in Scotland encompasses reproductive health and family planning as well as some specialist service delivery based in general practice. However for ease of reference, the BASHH guidance is reproduced here in full.

BASHH priority male and female patients

- Untreated sexually transmitted infection (STI)
- Contacts of a known sexually transmissible infection, eg chlamydial infection, gonorrhoea, trichomoniasis, syphilis
- Postexposure/sexual exposure prophylaxis (PEP/PEPSE) required
- Genital or perianal ulceration
- Recent history of alleged sexual assault
- Under 16 years of age
- Sex industry workers
- Systemic symptoms, eg fever, joint pains, generalised rash
- At discretion of the healthcare worker, eg distressed or anxious patient

BASHH priority female patients

- Dysuria
- Abnormal or changed vaginal discharge
- Pelvic or low abdominal pain, which is of recent onset
- Painful sex
- Emergency contraception required
- Pregnant women

BASHH priority male patients

- Dysuria
- Urethral discomfort or discharge
- Rectal pain or discharge
- Testicular pain or swelling

Appendix 9: Remote and rural considerations

The standards development process highlighted from the outset that remote and rural areas face specific challenges in delivering generic and specialist sexual health services. During the phase prior to standards development, NHS QIS contacted key service stakeholders. Telephone consultation with lead clinicians and executive directors flagged this issue, as well discussions at local NHS board implementation and strategy groups which NHS QIS attended. These issues include:

- geographical distance
- travelling time
- public transport
- communities that consider themselves separate from a city even if they are geographically close
- perceptions around confidentiality and anonymity
- attitudes to sexual health
- training and development ie how do you achieve and maintain clinical competencies, and
- recruitment and retention issues.

The point was made that consistent universal standards were required which applied across all NHS boards in Scotland. It was requested that the standards be drafted to focus on outcome and not process to ensure they do not disadvantage particular NHS boards. The standards did not require to be prescriptive on how NHS boards should configure local services.

NHS QIS convened a 'remote and rural' meeting in May 2007 in advance of the final project group meeting. This was to ensure amendments taking on board remote and rural issues could be incorporated into the standards before the consultation stage. A meeting of executive directors, lead clinicians, health promotion and public health professionals from NHS boards with the highest percentages of population living in remote and rural areas took place. Wendy Peacock, Chair of the NSHAC remote and rural working group chaired this meeting to ensure appropriate links were maintained.

Remote and rural meeting participants:

- Wendy Peacock (Chair) NHS Tayside
- Rak Nandwani, NHS QIS Clinical Adviser
- Jim Brown, Chair of NHS QIS Sexual Health Service Standards Project Group
- Derek Cox, NHS Dumfries & Galloway
- Ann Eriksen, NHS Tayside
- Shirley Fraser, NHS Health Scotland
- Margaret Gurney, NHS Dumfries & Galloway
- Susan Jappy, NHS Grampian
- Anne Nicolson, NHS Orkney
- Andrew Riley, NHS Borders
- Isabelle Steele, NHS Western Isles
- Carol Stewart, NHS Dumfries & Galloway

Dan Clutterbuck, NHS Borders and Susan Laidlaw, NHS Shetland submitted comments to be considered in advance of the meeting.

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