SSHA
Society of Sexual Health Advisers

Guidance on Partner Notification

August 2015

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Appendices

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Introduction

Partner notification (PN) may be defined as the process of providing access to specific forms of healthcare for sexual contacts who may be at risk of infection from an individual (index case) diagnosed with a sexually transmitted infection (STI). The PN process includes providing access to advice, testing and if appropriate treatment for known sexual contacts[1]. Apart from breaking the chain of infection effective PN can reduce re-infection rates, prevent long term complications of infection, offer health education opportunities and encourage behaviour change.

PN has been used to help contain the spread of STIs since the early 1900s. Aside from individual clinical benefits PN has important public health benefits including; controlling the spread of STIs, reducing STI related morbidity and mortality and reaching people with asymptomatic STI infections[2].

Background

As the professional organisation representing Sexual Health Advisers (SHA) in the UK the Society of Sexual Health Advisers (SSHA) commissioned the updating of it's guidance on partner notification in order to:

- support SHAs, clinicians and service providers in the delivery of high quality PN.
- support the consistent commissioning and monitoring of services to ensure high standards of PN regardless of provider.

Context

Local authorities in England are legally required to commission sexual health services for everyone 'present' in their local area. These services must include free STI testing and treatment, as well as, notification of sexual partners of infected persons[3,4.]

Many local authorities commission services from a range of STI providers across primary and secondary care based on their local needs. Despite this the UK continues to have high rates of sexual ill health reinforcing the need for all services that manage STIs to deliver a strong public health function. It is the responsibility of all providers to ensure that clear pathways are in place to support partner notification processes and facilitate partner access to services. As a minimum all services should be expected to instigate PN[5].

Public health outcomes

The Public Health Outcomes Framework[6] contains two indicators to measure progress in the management of STIs:

- Chlamydia diagnoses (15-24 year olds)
- People presenting with HIV at a late stage of infection

SSHA partner notification guidance

This document covers the PN process and includes explanations about the different types of PN and when they might be appropriate, conducting a PN interview, issues specific to PN and HIV, and the monitoring of PN outcomes. It brings together current best practice guidance and is intended for use by all SHAs and other health professionals involved in the PN process.

This guidance should be read in conjunction with the following documents:

1. BASHH (2014) Standards for the management of sexually transmitted infections[5]
2. BASHH (2012) Statement on Partner Notification for sexually transmitted infections[1]
3. BHIVA (2012) Standards of Care for People Living with HIV[8]
4. BASHH (2015) HIV Partner Notification for adults: definitions, outcomes and standards

Competence

All individuals undertaking PN have a responsibility to ensure that they have the requisite skills and knowledge. SSHA have developed a competency that supports PN and strongly recommend that this framework is used to assess competence[7.]

References

*1 BASHH (2012) Statement on Partner Notification for Sexually Transmissible Infections. Available at:*http://www.bashh.org/documents/4445.pdf

2 European Centre for Disease Prevention and Control (2013) Public health benefits of partner notification for sexually transmitted infections and HIV. Available at: http://ecdc.europa.eu/en/publications/Publications/Partner-notification-for-HIV-STI-June-2013.pdf

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4 The Local authorities (Public Health functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2015. London: The Stationary Office (TSO). Available at:http://www.legislation.gov.uk/ukdsi/2015/9780111128053/contents

5 BASHH (2014) Standards for the management of sexually transmitted infections (STIs). Available at: http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

6 Department of Health (2016) Public Health Outcomes Framework 2013-2016. london: Department of Health. Available at: https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

7 Society of Sexual Health Advisers (2013) National Sexual Health Adviser Competency Framework. Available at: http://www.ssha.info/wp-content/uploads/SSHA_National_Competency_Framework_Final_Jan13.pdf

8 *BHIVA (2012) Standards of Care for People Living with HIV. Available at: http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf*

9 *BASHH (2015) HIV partner notification for adults: definitions, outcomes and standards. Available at: http://www.bashh.org*

Types of partner notification

There are three main types of partner notification[1]:

1. Patient referral
2. Provider referral
3. Contract referral

The type of partner notification instigated will depend on the choice and circumstances of the index patient.

Patient referral

With patient referral the index patient takes responsibility for informing their sexual partner(s) of their possible exposure to an STI and for referring them to services. In many cases the index patient will be given paper contact slips from the service where they are diagnosed, to give to their sexual partners. This is the most common form of PN in the UK.

Provider referral

With provider referral the provider (service) takes responsibility for informing sexual partner(s) of the index patient of their possible exposure to an STI. This requires SHAs / health professionals to obtain from the index patient the names of sexual partners along with other identifying information.

Contract referral

With contract referral the provider (service) agrees with the index patient i.e. ‘makes a contract’ that the index patient will contact their sexual partners within a certain time period. Provider referral is carried out if the index patient fails to do this.

References

1 *European Centre for Disease Prevention and Control (2013) Public health benefits of partner notification for sexually transmitted infections and HIV. Available at: http://ecdc.europa.eu/en/publications/Publications/Partner-notification-for-HIV-STI-June-2013.pdf*

Conducting a partner notification interview

The objectives of any PN interview are to:

1. ensure that the person diagnosed with an infection understands their diagnosis, is able to comply with treatment and understands the importance of any follow up arrangements.

2. ensure whenever possible that sexual contacts are informed, that they are contacts of an STI, either by the index patient or by a SHA / health professional.

3. explore ways of helping individuals to reduce the risk of acquiring or transmitting STIs.

4. identify an individuals need for additional support or onward referral.

5. identify any specific public health issues, eg networks hosting transmission, in order to guide complementary control strategies or if necessary public health interventions.

Securing a partner notification interview

In order to support PN being undertaken in a timely fashion and by an appropriate health professional the SHA or individual with lead responsibility for sexual health advising should ensure that al staff:

1. understand the rationale, process and importance of PN.

2. understand their role in undertaking or facilitating the PN Interview identifying appropriate patients and working with the SHA / lead to avoid people slipping through the net eg leaving the service with the correct treatment but without instigation of PN. Many SHAs and non medical health professionals are now able to issue treatment via Patient Group Direction or Independent Prescibing allowing them to manage this element of the patient's care alongside PN.

3. understand which patient's need to be seen by a SHA/ health professional for PN and, if this is not available in their service, how to facilitate timely onward referral.

PN interviews normally occur at the time of diagnosis and treatment allowing the SHA / health professional to clarify the index patient's understanding of their diagnosis and plan of care. However, some index patients are informed of their diagnosis over the telephone and advised when and where to attend for treatment. The need to inform sexual partners should be raised at this time in order to minimise delay in the testing and treatment of partners. Arranging for the index patient and any regular partner(s) to attend for treatment on the same day can reduce the risk of re-infection.

In many services referrals to a SHA are dependent upon the complexity of the infection diagnosed and/or the index patient's sexual lifestyle and behaviours with PN for common infections often managed by other health professionals. This can work well provided that individuals undertaking PN are competent to fulfil the role[1] and adhere to national

standards[2].

Preparing for a partner notification interview

Before greeting the patient, it is important to be familiar with:

- their reason for attendance.
- their symptoms.
- their medical and sexual history which should have been taken in line with current BASHH national guidelines and include information about sexual partners. The sexual history should also include a risk assessment for STIs, HIV and other blood-borne viruses including whether people are from the population groups most at risk of these infections[3].
- their results and any treatment given.
- any concerns or issues raised at the time of presentation.

The success of a PN interview may be influenced by the quality of the environment therefore only a suitable room offering privacy should be used.

Interview structure

It is useful to utilise a structure to conduct a PN interview. The table below provides a useful guide which can be adapted to suit individual style and circumstances.

Beginning the interview	A PN interview is more likely to be successful if the patient feels relaxed, safe, supported and in control. To generate the necessary confidence, encourage participation and minimise resistance the SHA / health professional should: • greet the patient in the waiting area with an open and friendly manner. • exclude third parties unless the index patient requests their presence as they may inhibit discussion. • introduce him/herself and explain the purpose of the interview. • Enquire about, identify and address any presenting concerns particularly if the patient looks upset, angry, worried or in a hurry. Prioritising the patient's needs at an early stage provides an opportunity to build trust, goodwill and rapport. • Establish whether the patient has any specific needs eg relating to language • Clarify confidentiality

Check understanding of diagnosis and compliance with treatment	An STI diagnosis can provoke a range of strong emotions including shame, guilt, fear and anger which can make it difficult for an individual to absorb and process information. Clarifying a patient's understanding and addressing any emotional feelings provoked by the diagnosis is beneficial in both reducing any associated anxiety and ensuring their compliance with treatment.
Identify partners at risk	It is important to revisit the sexual history to identify all partners including any that may have been overlooked. Always take time to explore the patient's perceptions of who may be involved. The SHA / health professional should refer to BASHH guidance regarding look back periods as this differs with the infection diagnosed [2]. Clarify the routes of transmission and use of condoms.
Negotiating a PN plan for each partners	Consider the options and explore potential difficulties or patient concerns. If patient referral is taking place support the patient in developing an approach to doing this and provide them with the necessary information on their infection(s) and a contact slip for each sexual contact. If provider referral is being utilised discuss and agree the way/s in which this is going to be done.
Data recording	Re iterate confidentiality arrangements for both the index patient and their sexual contacts. Record partner details with full name and DOB, if known, so that attendance can be verified. If provider referral is being undertaken record the address and phone number of all contacts If the index patient is reluctant to share contact details, it can be useful to remind them of the benefits including; risk of re-exposure to infection; long term sequelae of infection; the benefit of cross referencing of results to ensure there are no additional infections requiring treatment.
Risk reduction	Use a motivational interviewing approach to help the patient reduce the risk of future STIs.
Follow up	Agree a time and method for further discussion / action if required.

Style of questioning

Person centred communication skills utilising open-ended questions, affirmations, reflections and summarising (OARS) are basic tools used in motivational interviewing to express empathy, build rapport, explore the patient's thoughts and feelings, build self-

efficacy and develop plans. OARS and can be used successfully in all PN interviews and comprises the use of:

1 Open-ended questions

Open-ended questions do not allow a one worded answer (yes/no) and provide an opportunity for a patient to explain in their own words. They can however feel intrusive so should be used in conjunction with reflection[4].

2 Affirmations

Positive feedback can strengthen confidence and commitment and build rapport with the patient. However affirmations need to be sincere, specific and proportionate to avoid the risk of them appearing insincere or patronising.

3 Reflections

Use of statements that feedback the SHA / health professionals understanding of what the patient has said are useful to convey empathy, check their accuracy of understanding, clarify thoughts and encourage further disclosure.

4 Summarising

Allows the SHA / health professional to pull together and clarify key points of discussion, reinforce commitment and clarify plans.

Appendix 1 provides a dialogue example of OARs. Appendix 2 explores techniques for resolving ambivalence and eliciting a commitment to PN.

Motivational interviewing and partner notification

Motivational interviewing (MI) is a collaborative, person centred form of guiding to explore and resolve ambivalence and strengthen motivation for change[5]. MI can be a useful tool to overcome barriers and resistance to the PN process. A Dutch study investigating the impact of MI on PN found that patients receiving an MI intervention reported significantly higher self-efficacy for PN and informed a higher number of partners than patient's receiving a standard educational approach[6].

MI lends itself to being utilised for PN because the stigma associated with STIs and some sexual behaviours require a non judgemental, empathetic approach to gain a patient's trust. Furthermore as PN depends entirely on the willingness and ability of the index patient to identify partners, to either inform them of their exposure or provide their details so that the service can contact them, establishing a relationship which puts the patient in control is much more likely to yield desirable outcomes.

There is NICE guidance[7] pertaining to motivational interviewing and one-to-one behavioural change in the reduction of contraction of further STIs. For some high risk individuals referral to psychology services may be appropriate[8].

Principles of motivational interviewing

MI is underpinned by the following three principles:

1. **Autonomy**: respecting the patient's right to make their own decisions, act on their wishes and take responsibility for their own actions.

2. **Collaboration**: working with the patient as an equal

3. **Evocation**: drawing the necessary motivation, confidence and commitment from the patient to successfully undertake PN.

Appendix 3 identifies PN behaviours consistent with the principles of MI.

Managing resistance to partner notification

Some degree of resistance to PN is not uncommon, and is understandable, given the intrusive nature of the discussion and concerns index patients may have about informing partners. Overcoming resistance to gain a patient's co-operation with PN is a core skill for all SHA / health professionals.

Resistance is either a reflection of discord in the SHA / health professional's relationship with the index patient or, an indication that the pros of the index patient informing a partner might be outweighed by the cons.

Signs of resistance

Signs of resistance to PN may be overt including a refusal to:

- discuss PN.
- inform partners.
- give details of partners.

However more typically resistance to PN exhibits as passive avoidance:

- being 'unable' to discuss PN due to lack of time, lack of privacy, partners or children present or a bad phone line.
- refusing to engage in a PN interview by not sitting down, avoiding eye contact, giving one word answers or using a phone while with a SHA / health professional.
- agreeing without engaging by humouring a SHA / health professional to bring a PN interview to a close.

A confrontational response to resistance is likely to create or entrench behaviour. Instead Naar-King and Suarez[9] recommend that the SHA / health professional adopt a strategy of:

1. **STOP**: to pause and consider what might be provoking the resistance.

2. **DROP**: to change your approach if it has caused discord.

3. **ROLL**: focus on reflecting your understanding and empathy for the patient.

Appendix 4 identifies techniques for responding to resistance.

Documenting the partner notification interview

Information gathered during the course of a PN interview is normally recorded either directly in the patient's notes or health record or onto a partner notification pro-forma which forms part of their notes or health record. Some of the information recorded will relate to third party individuals not the client being interviewed. Records may be paper based or electronic.

For each contact the following data should be recorded:

Method of PN agreed	eg - patient to inform - SHA / health professional to inform - untraceable -patient to seek more details -patient refuses to give details
Actions taken	eg - contact slip issued - contact telephoned - contact informed by … - clinic appointment booked for date / time
Outcome by 4 weeks	eg - attended (documenting whether verified by health professional or whether a patient reported attendance) - untraceable - failed to attend - exceptions to achieving PN outcomes at 4 weeks, eg managing HIV PN, should have a clearly documented time frame for resolution.
If attended own service or another service (verified attendance)	- service attended - clinic number - date of tests and treatment - diagnosis
If reports unverified attendance	- record when and where eg GP or treatment in another country

Conclusion

A range of techniques including motivational interviewing can be employed to encourage index patients to inform sexual partners of their infection(s) or to provide the necessary information for a SHA / health professional to inform them. The personal and public health benefits of negotiating a successful contact attendance, not only ensures that contacts

unaware of the infection access appropriate testing and treatment, but also protect the index patient from potential re -exposure and the community from onward transmission.

References

1 Society of Sexual Health Advisers (2013) National Sexual Health Adviser Competency Framework. Available at: http://www.ssha.info/wp-content/uploads/SSHA_National_Competency_Framework_Final_Jan13.pdf

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6 Kuyper L et al (2009) Influencing risk behaviour of sexually transmitted infection clinic visitors: efficacy of a new methodology of motivational preventive counselling. AIDS Patient Care STDs, Vol 23 (6). Doi:10.1089/apc.2008.0144

7 National Institute for Health and Clinical excellence (2007) Prevention of sexually transmitted infections and Under 18 conceptions. London:NICE. Available at: http://www.nice.org.uk/guidance/ph3

8 BASHH (2014) Standards for the management of sexually transmitted infections (STIs). Available at: http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

9 Naar-King & Suarez (2011) Motivational Iterviewing with Adolescents and Young Adults. London. Guildford Press.

Partner notification and social networking sites

Despite many NHS services not currently being social media friendly there is an increasing use of social media as a forum for promoting services and enhancing or enabling PN. Facebook is by the far the most popular site with over 900 million users worldwide. Some services have developed Facebook web pages which are used to advertise services and provide information. Establishment of web pages on any social media sites requires organisational and Information Governance (IG) approval. Pages are usually set up as 'fan' rather than 'friend' pages.

Sometimes index patients know the social network profile of their sexual contacts rather than other contact details. Using Facebook / social networking sites for work purposes requires organisational permission, if this is in place and SHAs / health professionals have access to social media sites then accessing the website profile of sexual contacts can be very helpful in identifying details including their full name, date of birth and phone number. Patient referral can sometimes be done via the private messaging service of social networking sites potentially linking contacts to the clinic Facebook page.

Interacting with a sexual contact's profile is fraught with moral and ethical considerations and caution should be exercised by any SHA / health professional attempting to contact a person directly as this carries with it risks including; breaching the rules of the website; and potentially accessing a considerable amount of unnecessary personal information about an individual.

The following are considered good practice for social network use:

- always reply to social network site private messages using the service / clinic profile never use personal profiles.
- when replying to private messages the same standards of confidentiality apply as in any other professional interaction[1].
- always either sign private messages with your first name only or from the SHA team including a contact telephone number.
- avoid liking service / clinic pages as this will expose your personal profile.
- ensuring the Information governance (IG) department have access to regular updates about the service / clinic Facebook page but never see screen shots or pages with any person identifiable data. These pages should be available to service / clinic staff only.
- screen names, user IDs and online identities should be as protected as real names are.

References

1 BASHH (2014) Standards for the management of sexually transmitted infections (STIs). Available at: http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

Provider partner notification

Provider referral can be defined as the process of a health professional tracing a sexual contact. As with all forms of PN the confidentiality of the index patient should be protected although potential loss of confidentiality should be discussed with the index patient before any provider referral is commenced. The identity of the index patient should never be disclosed without their consent.

In order to carry out provider referral it is often necessary for a SHA / health professional to request the assistance of colleagues in other clinics throughout the UK. If a contact does not reside in the area of the sexual health service treating the index patient it is often best to ask the clinic closest to where the contact resides to carry out the provider referral. This often increases the likelihood of a contact accessing testing and treatment and best serve public health outcomes.

The main modes of provider referral are:

1. Telephone
2. Text messaging
3. E mail
4. Letter
5. Dating sites
6. Visit in person

The method for use in provider referral should have been agreed with the index patient during the PN interview. The available information on the contact may well influence the choice e.g. if only a first name and mobile number are known.

It is important to note that most provider referral methods will require the approval and co-operation of the services / clinics employers IG department. All IG implications should be fully explored and advice taken, before provider referral systems are put in place.

Telephone PN

Telephones are by far the most popular method for provider partner notification. Most index patients requesting provider PN have a mobile number for their sexual contact or can get hold of one.

If the index patient doesn't have a telephone number for their contact but are able to give other details including full name, date of birth and address a telephone number can sometimes be obtained from clinic records, the hospital PAS system or GP records. The use of social media sites to obtain details has been covered previously. For contacts who are not clinic patients permission may be needed from the IG department before details can be obtained.

The major advantage of telephone PN is the opportunity to have a conversation with the contact, provide them with information and re assurance and organise their attendance at a clinic. Most SHA / health professionals make calls from an NHS landline which will appear on a mobile as a private or blocked number. If the contact does not appear to be accepting calls from a withheld number it is worth trying to contact them using a work

mobile phone.

With the rise in unsolicited calls from marketing organisations it is really important that once telephone contact is made the SHA / health professional quickly identifies that they are speaking to the right person and introduces themselves and the reason for their call so as not to risk disconnection.
It is not uncommon to experience resistance when making telephone calls for provider PN. The discussion therefore needs to be flexible and clearly identify the important health message which prompted the call.

If the person doesn't pick up and a voicemail message is left it is important that a name and contact number form part of the message.

Text messaging

Text messaging has proved a successful and popular method for contacting people and is widely used in many services for the conveying of results. Texts are usually sent from a work mobile phone or web based SMS messaging service. Most messaging services deliver messages with an official logo or address which can be re assuring for some people.

The aim of a text message is to facilitate a telephone conversation and therefore it can be used to establish communication with sexual contacts not responding to telephone calls. Messages should be simple and direct and always include a name and contact number for the recipient to call back. An example might be:

'I've been trying to contact you. Please phone the health adviser's at xxx hospital about an important matter concerning your health.'

E mail

The use of e mail for provider referral will depend on the employing organisations e mail policies. Most organisations allow for the exchange of patient information via organisation e mail addresses but this must always be checked before using e mail as a mode of contact communication. Any e mail PN must comply with organisational e mail policies and have IG department approval.

Like text messaging the aim of an e mail is to facilitate a telephone conversation and therefore may be used to establish communication with someone not responding to telephone calls or text messages; or where the index patient does not have a phone number for the sexual contact.

The subject of the e mail should not identify the reason for the e mail. E mails should always be sent from secure NHS accounts otherwise they risk looking like spam. Messages should be simple and direct and always include a name and contact number for the recipient to call. An example might be:

'Please phone the health adviser's at xxx hospital about an important matter concerning your health.'

If the sexual contact lives abroad and PN needs to proceed via e mail the name of the infection will need to be disclosed in order that correct treatment can be accessed. In these circumstances it is good practice to provide information about the infection itself, this can be done using web links to online information.

Letter

With the widespread use of more immediate means of communication the use of letters to notify sexual contacts has been less common in recent years. However there is still a place for their use particularly if a person is not responding to other attempts at communication or if a mobile phone number is not known.

If a letter is to be sent it is good practice to use a standard letter template which clearly states a contact name and a phone number for the service. The envelope containing the letter should have a first class stamp rather than a hospital frank as this can cause anxiety and raise suspicion. The envelope should be marked as private or confidential.

Online

Creating a SHA / health professional profile on social networking / dating sites for provider PN has been done successfully in the UK. However creating such a profile should only be done by specialist services and requires IG and Ethics Committee approval. Profiles should only be used when an index patient only knows the user name of their sexual contact on that site and doesn't want to contact them themselves.

The use of anonymous websites set up especially for provider PN may be a more robust way of contacting partners who are only known by online dating profiles. In the USA websites such as inSPot are well established. In the UK GMFA have set up “Let Them Know” an online partner notification facility[1] to help index patients and services / clinics to notify sexual contacts; by text message; dating site message or e mail. The service is only intended for use where other means of contact are not available and where the index patient or service would otherwise not be in a position to do anything.

The GMFA service is easy to use and importantly can be used anonymously. GMFA have produced a booklet 'Let Them Know' which SHA / health professionals are encouraged to give to all MSM diagnosed with an STI. On the back of this leaflet is an access code to use the online PN service. For a service / clinic to use the GMFA site for provider referral they need to be set up on the GMFA system and be provided with a log in code.

Other types of electronic partner notification systems have been trialled by services in the UK including the ePN programme at Chelsea and Westminster Hospital[2]. This system was found to be an acceptable way of delivering PN.

Whilst finding sexual partners online remains popular, mobile phone applications are increasingly being used. These applications use GPS to locate registered users nearby for a person to contact and meet. Some online PN systems (including the GMFA “Let Them Know”) interface with some mobile applications. It is therefore always worth ascertaining which applications an index patient has used to check whether sexual contacts are contactable using online PN services.

Visit

A home, workplace or social visit by an experienced SHA / health professional for PN purposes should be seen as a last resort and only considered if the benefits to the sexual contact outweigh the risks associated with a visit. Thus the advantages and disadvantages of a visit should be weighed up on a case by case basis. The safety of staff carrying out a visit is paramount and a process must be agreed with the service including a risk assessment before any visit is undertaken. With the advent of technology and the modernisation of services visits are now rarely undertaken but remain an option where otherwise sexual contacts would be lost to follow up.

References

1 GMFA Online PN. Available at: http://www.gmfa.org.uk/pn

2 Sullivan A et al. Available at: http://bhiva.org/documents/Conferences/2014Liverpool/Presentations/140403/AnnSullivan.pdf

Partner notification and HIV

Although treatments have become more effective in reducing the morbidity and mortality associated with HIV, rates of HIV continue to rise. In the UK latest Public Health England data[1] identifies that there are around 100,000 people living with HIV: with in excess of 77,000 of them accessing treatment and care and 21,000 undiagnosed.

HIV PN is a vital clinical intervention in detecting undiagnosed HIV and avoiding the chain of onward infection. It also benefits the individuals' health with early diagnosis and links to HIV treatment and care[2]. In 2012 NAT published a report which cited evidence that in some audits up to 37% of partners traced and tested via PN were found to be HIV positive[3] proving that where conducted thoroughly HIV PN is highly effective in diagnosing people with HIV.

The potential for psychological trauma, that an HIV diagnosis can induce[4], means that it can be challenging for a SHA / health professional to engage with patients around PN. It is therefore appropriate that HIV PN be undertaken in specialist services which are also likely to offer HIV treatment and care[5]. Where a patient has tested HIV positive in another health care setting robust referral pathways should be in place for timely onward referral to specialist centres.

Issues specific to HIV PN

The British HIV Association (BHIVA) standards comprehensively address standards for the care of people living with HIV[4]. In relation to PN among other things BHIVA recommend that:

- people living with HIV should be offered support and guidance with PN at the time of diagnosis and whenever they have new partners whose HIV status is not known.
- the HIV status of children born to people with HIV should be assessed for risks of vertical transmission.
- people living with HIV should have access to one or more one-to-one-risk-reduction discussions based on the theory of behaviour change such as motivational interviewing and / or a risk reduction support group.
- people living with HIV should be made aware of their legal position on HIV transmission and protecting themselves from prosecution.

Methods of HIV PN

Methods of PN for people with HIV are the same as with any other STI and have been outlined above. SHAs / health professionals should refer to BASHH guidance regarding look back periods for HIV PN[6].

It should be noted that recommended follow up arrangements differ from other STI diagnoses with HIV PN documented as being addressed on a minimum of two occasions immediately following diagnosis and ideally in person. Effective HIV PN will not only explore PN at the time of diagnosis but re-visit HIV PN in future consultations where there

are risks identified eg with a change of sexual partner or a new STI diagnosis.

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Monitoring partner notification outcomes

Monitoring the outcomes of partner notification is the responsibility of all services managing STIs and HIV. In order to do this, mechanisms need to be in place to monitor and audit performance against both local and national standards[1].

National standards

BASHH Standards for the management of STIs[2] identify two quality measures in relation to PN. These are:

1. The percentage of all contacts of index cases of gonorrhoea who attend a service commissioned to manage STIs within four weeks of the date of first PN discussion.

2. The percentage of all contacts of index cases of chlamydia who attend a service commissioned to manage STIs within four weeks of the date of first PN discussion.

With the following quality standards:

1. gonorrhoea at least 0.4 contacts per index case in large conurbations or 0.6 contacts elsewhere within four weeks.

2. chlamydia 0.6 contacts per index case.

In the case of HIV, BASHH *HIV partner notification for adults: definitions, outcomes and standards*[3] sets out clear primary outcomes and standards for HIV PN.

BHIVA Standards of Care for people living with HIV[4] identify the following measurable and auditable outcomes in relation to PN:

1. Documented evidence in the clinical record that partner notification has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis, and within 1 week of identifying subsequent partners at risk (target: 90% of patients).

2. Documented evidence that testing of children has been considered within 4 weeks of diagnosis for mothers with children where the mother's HIV status is positive or unknown (target: 90% of patients).

3. Documented PN outcomes or a progress update at 12 weeks after the start of the process (target: 90% of patients).

BASHH

Appendix 5 provides a sample template for auditing PN outcomes against national standards.

Local outcome standards

A range of local outcome standards for PN practice can be audited to ensure that PN

practice is both consistent and of a high quality. Aspects of care audited might include the following:

- Documented PN discussion when result / treatment are given
- Documentation of partner details
- Speed of action on provider referrals. SSHA recommend this takes place within 2 working days.
- Evidence of collaboration on provider referral if the contact lives outside of the area.
- Evidence of follow up for index patients electing to notify their own contacts.
- Evidence of contacting the index patient's service if partner attends, either by telephone or by return of contact slip.
- Auditing PN outcomes against national standards.

References

1 BASHH (2012) Statement on Partner Notification for Sexually Transmissible Infections. Available at: http://www.bashh.org/documents/4445.pdf

2 BASHH (2014) Standards for the management of sexually transmitted infections (STIs). Available at: http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

3 BASHH (2015) HIV partner notification for adults: definitions, outcomes and standards. Available at: http://www.bashh.org

4 BHIVA (2012) Standards of Care for People Living with HIV. Available at: http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf

APPENDIX 1 Dialogue example of an partner notification interview utilising OARs

Person speaking	Dialogue	Technique
SHA / health professional	How do you feel about speaking to your partner?	Open-ended question
Patient	Well I've got no choice, but he might not take it very well. He'll probable blame me and it will cause a row.	
SHA / health professional	You're clear about needing to tell him, but a bit worried it may cause trouble between you.	Reflection
Patient	Yes, he'll say it must be me because there's nothing wrong with him, so I must have been with somebody else!	
SHA / health professional	He may jump to conclusions thinking if he has no symptoms he can't be infected, so you must have been unfaithful. Would it help if I explained a bit more about chlamydia?	Reflection
Patient	Yes please.	
SHA / health professional	Many people are infected but have no symptoms, so its hard to say how long it has been there. Does that make sense?	
Patient	So he could have had it first! I'll tell him it must have come from him because I haven't been with anyone else!	
SHA / health professional	There's no way of knowing who had it first. How might you stop this turning into a row?	Open-ended question
Patient	Maybe if I just stick to the facts. I've got it. He must have it. We won't know who had it first. Let's just get it treated.	
SHA / health professional	Yes, that's a really good approach. Staying calm and focusing on what to do helps avoid blame.	Affirmation
Patient	I'll talk to him tonight and try and get him to come to clinic tomorrow	
SHA / health professional	So you have a good plan. You're going bring it up tonight, keeping calm, no-one's to blame, just need to get treated. You will try to get him in tomorrow. Would it be OK if I made a note of his name so I can look out for him and make sure he gets the right treatment? I won't contact him directly unless you ask me to.	Summarising

APPENDIX 2 Techniques for resolving ambivalence and eliciting commitment to partner notification

Open – ended questions Invite the patient to discuss their feelings about PN and provide an opportunity for the SHA / health professional to acknowledge difficulty.	*"How do you feel about speaking to your ex?"*
Reflections Can be used to encourage the person to elaborate further, and to reinforce commitment by feeding back all the person's own arguments for PN**.**	*"You want to do the right thing. You feel she has a right to know, and it wouldn't be fair not to tell her."*
Double- sided reflections Are used to reflect back mixed feelings	*"So you are a bit concerned your ex might take it badly, but you don't want her to come to any harm."*
Pros and cons. It is helpful to begin by exploring concerns about PN, to identify barriers which may then be addressed. Finish by eliciting arguments in favour of PN.	*"Why might it be important for you to inform your ex? ……Why else? …….Are there any other reasons? "*
Affirmations Can be used to reward and therefore strengthen a patients commitment to PN	"Its great you have the decency to take care of this. I'm sure she will appreciate it." "That would be really helpful, if you could ring me with her phone number."
Looking forward Focusing on the longer term consequences can help a person see beyond the immediate fear of breaking bad news.	*"If you tell her now, how will things be 3 months from now? …., How will they be if you don't tell her?'"*
Looking back Focusing on the patients previous experience of being notified may elicit a favourable attitude towards PN.	*"How did you feel when you were told you might have been in contact with an infection? Did you appreciate someone letting you know?"*
Develop discrepancy Between what the persons values and the potential consequences of not informing a partner.	*"You are worried that telling her would cause trouble. What if you didn't tell her, how would you feel about that?'"*

APPENDIX 3 Approaches to partner notification with the principles of motivational interviewing

Principle	Do's (consistent with MI)	Do nots (inconsistent with MI)
Autonomy:	Respect the patient's right to make their own decisions. Offer adequate information for patients to make informed decisions about PN eg transmission routes, look – back period, confidentiality policy etc. Empower patients to act as safely and effectively as possible, by exploring what to say, building confidence and offering useful tips to avoid or manage difficult reactions.	Remove choice or tell people what to do (unless required by law). Withhold relevant information eg ensure patient's are aware of the option of provider referral. Leave the patient unprepared or unsupported.
Collaboration:	Treat the patient as an equal. Respect the patient's greater knowledge of the partner and their situation. They may be the best judge of their how to approach PN in this instance. Support the patient's chosen approach.	Adopt an authoritative manner. Assume you know best. Pressurise the patient into a course of action.
Evocation	Enquire how the patient feels about informing partners. Express empathic understanding and acceptance. Explore reasons for resistance by exploring pros and cons. Elicit views on how best to approach PN with each individual partner, considering potential difficulties / solutions.	Express judgment, disapproval or distaste. Block discussion. If you do conflicts will remain unresolved Argue in favour of PN, this is likely to provoke counter arguments. Patients are more likely to act on what they say themselves, so it's important not to 'steal the best lines' and throw them into defending no PN. Give impersonal guidance.

APPENDIX 4 Techniques for responding to resistance to partner notification

Adapted from Naar-King and Suarez (2011)

Simple reflection Repeating or paraphrasing what as been said. This gives the patient an opportunity to 'hear themselves' and re-evaluate their position.	*"You are not comfortable about informing your ex."*
Omission reflection The SHA / health professional raises what the patient may be avoiding	*"So far you haven't mentioned your ex. I wonder what your thoughts are about letting them know?"*
Amplified reflection The SHA / health professional exaggerates an objection to PN, with the aim of provoking the person to express ambivalence	*"You are not willing to even consider informing your ex …"*
Minimising reflection The SHA / health professional understates the importance of PN to encourage the patient to redress the balance by giving arguments in favour of PN.	*"You see no reason to let your ex know."*
Coming alongside The SHA / health professional gives an empathic reflection which may provoke a shift in perspective.	*"Its hard for you to consider informing your ex while you are feeling so hurt and angry."*
Agreement with a twist The SHA / health professional makes an empathic reflection followed by a re-framng.	*Patient: "If I tell her she will go mad!"* *SHA / HP: "You're worried about her reaction, even though by telling her you would be doing her a big favour."*
Shifting focus Steering around the stumbling blocks	*Patient: "There is no way I could talk to him!"* *SHA / HP: "That would be very difficult for you. Would it be easier for us to let him know, without your name being mentioned?"*
Reframing Looking at the situation another way, putting PN in a more positive light.	*Patient: "She will think I am just causing trouble!"* *SHA / HP: "She may be glad you have made the effort to let her know."*

Emphasizing personal choice and control. Resistance may be rooted in the patient's fear of losing autonomy. Reassure the person that they are in control and will not be pressurised to act against their wishes.	*"What you decide to do is entirely up to you."*

APPENDIX 5 **Example of a partner notification outcome audit tool**

Infection.....

Index ID Number/Name		Date of 1st PN consultation	Contact name	PN Action Plan	PN Outcome	Contact ID Number	Place seen	Attendance date	Contact Diagnosis	Comments

PN Action Plan Codes

PTI Patient referral (Patient to Inform)

PR Provider referral (SHA / health professional to inform)

AA Contact already attended

Outcome Codes

V Verified by health professional

PRA Patient reported attendance

I Informed, not known if tested