Healthcare Improvement Scotland

Improving Sexual Health Services in Scotland

Integration and Innovation

National Overview

November 2011

Scrutiny

NHS SCOTLAND

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One of the more challenging features of this work was selecting the initial criteria we used to assess performance against the standards. We wish to thank the project steering group for identifying criteria which enabled us to take a risk based and proportionate approach.

We also acknowledge the commitment and enthusiasm of the team leaders, review team members and members of the public who carried out the programme of review visits.

Finally, our thanks are extended to NHS board liaison co-ordinators, lead clinicians and staff from sexual health services and other nominated staff for their involvement in preparing for visits and throughout the review programme.

Contents

Executive summary

The improvements made by NHS boards to sexual health services over the last few years reflect the World Health Organization's view of sexual health.

'Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'[1]

There are many positive aspects of sexuality but we need to acknowledge some of the undesirable consequences including sexually transmitted infections and unintended pregnancy. These can be lifelong for individuals, families and communities and we know that those most affected are often economically disadvantaged, ethnic minorities, persons with different sexual orientations, disabled people and young people.

Our challenge is to make sure that everyone of any age and background who is at risk should have access to information and services that promote and protect sexual health.

Scotland faces many challenges in relation to sexual health and the Scottish Government has provided long term and sustainable direction and funding to address these. In the recently published sexual health and blood borne virus framework, Michael Matheson, Minister for Public Health, states that 'We want to live in a society where attitudes towards sexual health and wellbeing...are supportive and non-stigmatising. Where people of all ages and from all backgrounds feel enabled to seek the support they require without fear of discrimination or recrimination...'[2]

This sets the context for the role of Healthcare Improvement Scotland in improving access for all to person-centred, safe and effective sexual health services.

This is a summary of the key messages.

Highlights and progress made

Sexual health services serve a broad spectrum of people and their emphasis is on reducing inequality of access to care. NHS boards have all developed a strategic, informed and pragmatic approach with a high degree of commitment and innovation from sexual health services.

- Sexual health services are multi-agency and depend on collaboration across a range of services. We found that all but one NHS board now have integrated services that have broken down barriers between medical specialties (such as sexual and reproductive health and genitourinary medicine). NHS boards have also reached out to local authority and third sector services including schools, social work and youth outreach.
- Communities and individuals with special needs are being provided with targeted sexual health services. NHS boards are commended for the work they have undertaken to achieve the quality of services being provided.
- The sexual health and wellbeing of young people has been, and continues to be, a key priority for all NHS boards. Much consideration has been given to the location and opening times of young people's clinics to maximise access for this group. Ways in which free condoms are made available to young people were also demonstrated.
- NHS boards also play a crucial role in supporting the delivery of sexual health and relationships education training to professional groups including teachers, youth workers and social workers.

Opportunities for further improvement

This review has identified a number of areas where improvement is required.

- Partner notification (contact tracing) arrangements are generally weak and NHS boards need to make sure these are robust in all settings delivering sexual health care, particularly in primary care. NHS boards with centralised systems for partner notification, covering both primary care and sexual health services, demonstrated more effective results than those with a variety of systems. NHS boards should have a system that records patient consent for partner notification purposes and follows this through effectively. This system needs to cover all settings where a person may present with a sexually transmitted infection.
- Data collection systems and processes need to be improved as they range in quality and scope. National data collection and information systems, such as the NHSScotland National Sexual Health System (NaSH), should also be used where possible.
- Providing a minimum of 2 full days each week of integrated, local, specialist sexual health care is challenging for some areas. Where this is not possible, NHS boards should demonstrate that they have acceptable and accessible alternatives.
- Further work is needed to make sure each NHS board has a system in place to identify and meet the specific sexual health information needs of the population it serves.
- Men who have sex with men should have a choice of where they are vaccinated for hepatitis B, and not be restricted to specialist sexual health services. This is not currently the case in all NHS boards.

Conclusion

There is no doubt that a strong strategic lead from Scottish Government and the supported development of a funded infrastructure is now showing clear improvement in access to high quality, person-centred sexual health care. In this field particularly we have seen so many good examples of innovative approaches to quite complex situations: these could easily be translated into other services and are not high cost. They do rely on good inter-agency working and in our experience, sexual health services are leading the way on this.

NHS board performance against the sexual health services standards is presented in a table in Chapter 3. Detailed information on the findings of our review is provided in Chapter 4.

1 Background

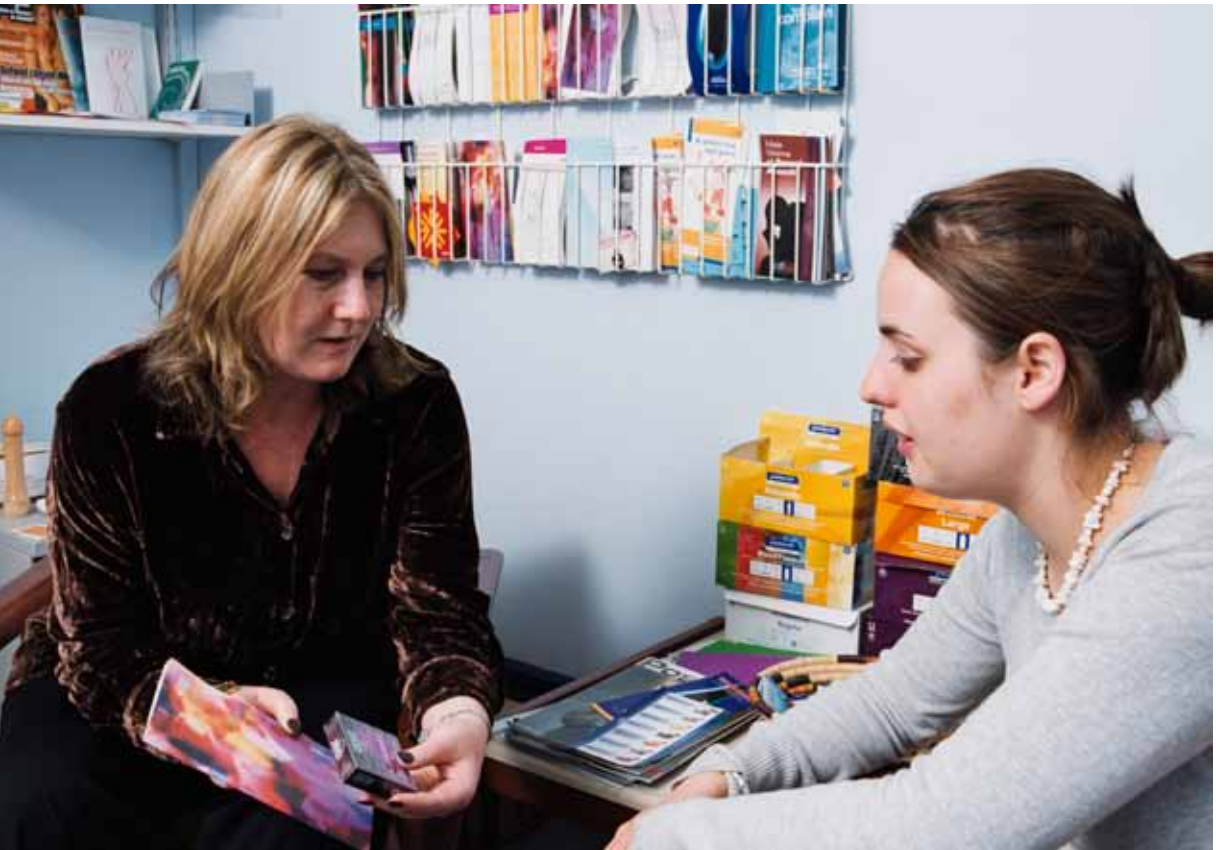
Scotland has had a history of poor sexual health with rising instances of sexually transmitted infections, HIV and teenage pregnancies.

- The number of chlamydia diagnoses in Scotland increased by 110% between 2000 and 2004, from 7,644 to 16,069. Two thirds of cases were in people aged under 25.[3]
- In 2004, there were 845 diagnoses of gonorrhoea, similar to numbers in the previous 4 years but 50% higher than in 1999. Three quarters of diagnoses were in men, a high proportion of those were in men who have sex with men.[3]
- There were 364 new cases of HIV identified in 2004, the highest annual total since recording began in 1986.[3]
- Teenage pregnancy rates are higher than in most other western European countries. In 2003–2004, the teenage pregnancy rate in Scotland was 42.4 per 1,000 females.[3]

To address this, the Scottish Government published the first national sexual health and relationships strategy, *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health*, in 2005.[4] Progress reports on the implementation of the strategy were published in 2006 and 2007. Collaboration and joint working with key agencies were integral to the success of the strategy.

The strategy emphasised that improving the sexual health of the population was not simply improving clinical services, but also improving services that make a contribution to promoting good sexual health and education. This was underpinned by £15 million of funding.

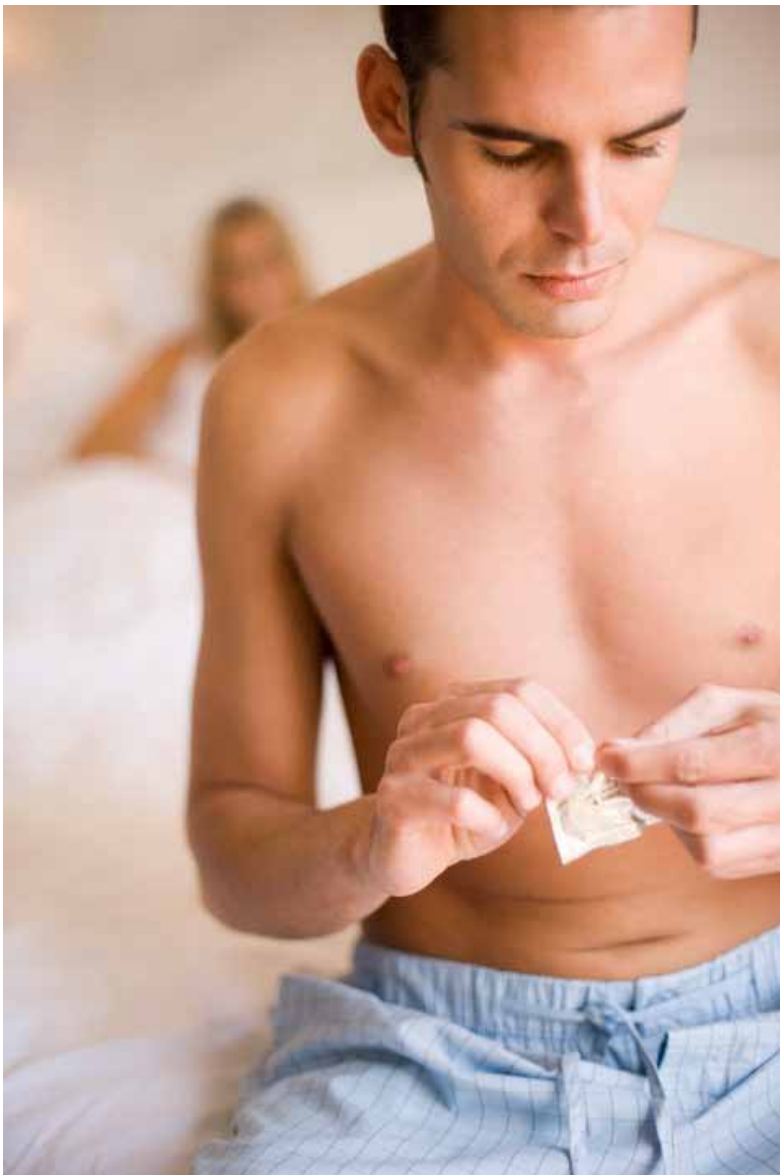
As part of Respect and Responsibility, Healthcare Improvement Scotland (then NHS Quality Improvement Scotland) was tasked with taking forward the development of sexual health services standards which were published in March 2008 following extensive consultation.[5] These standards formed the basis for a number of sexual health improvement programmes across NHS boards in Scotland before we began the review visit programme.



2 What we did

In spring 2010, we established a sexual health group to develop a focused and proportionate approach to assessment of the standards. This group comprised experts in the field of sexual health who were involved in developing the standards. The group identified key criteria from each of the standards for review (25 of the 47 criteria within the standards). These criteria focused on **ease and equality of access, quality of services** provided and **timeliness**.

During summer 2010, we established and trained review teams comprising sexual health professionals, voluntary organisation staff and members of the public. On-site visits to every territorial NHS board (14) took place between November 2010 and June 2011. Teams met with staff involved in delivering sexual health services to: discuss areas which required further clarification; highlight areas of good practice; and validate their self-assessment. After each visit, a report was published on the NHS board's performance. These reports are available on the Healthcare Improvement Scotland website (http://www.healthcareimprovementscotland.org/default.aspx?page=11837).



3 NHS board performance against the sexual health services standards

Criteria reviewed		AA	BO	DG	FI
1.1	The NHS board has integrated local specialist sexual health services, which as a minimum, deliver a full range of contraception options, facilities for the diagnosis and treatment of all sexually transmitted infections in both men and women, and HIV testing and counselling.	Met	Met	Met	Not met
1.2	There is a minimum of 2 full days per week of integrated local specialist sexual health service provision available within 30 minutes travel time from each settlement of over 10,000 people.	Met	Not met	Not met	Not met
1.3	80% of individuals with priority sexual health conditions are offered the opportunity to be seen within 2 working days of initial contact with a specialist sexual health service.	89	89	99	80
1.4	There are targeted services for communities or individuals with specific needs.	Met	Met	Met	Met
2.1	The NHS board has a system in place to identify the diverse sexual health information needs of its population and to respond to those needs appropriately using relevant information formats.	Met	Met	Met	Not met
2.2	There are clear and effective arrangements to ensure accurate information describing sexual health conditions and local service provision arrangements. The information details links with partner organisations outside the NHS, such as local authorities.	Met	Met	Met	Not met
3.4	There is evidence of active engagement of local key partners including health, education, social work, youth services and the voluntary sector, to improve sexual health for young people and reduce teenage pregnancy.	Met	Met	Met	Met
3.6	Targeted interventions are demonstrated for young people at greatest risk of teenage pregnancy and poor sexual health, including looked-after children.	Met	Met	Met	Met
3.7	The NHS board supports the delivery of sex and relationship education training for professionals in partner organisations such as youth workers and social workers, who work with the most vulnerable young people.	Met	Met	Met	Met
4.1	A sexual health adviser, or a professional trained and supported by a sexual health adviser (eg a practice nurse), is available to all individuals diagnosed with chlamydia or gonorrhoea.	Not met	Met	Met	Not met
4.2	Individuals are offered partner notification in all settings delivering sexual healthcare, including in primary care, youth services and community pharmacies.	Not met	Met	Not met	Not met

NHS boards:		
AA – Ayrshire & Arran	GR – Grampian	OR – Orkney
BO – Borders	GGC – Greater Glasgow and Clyde	SH – Shetland
DG – Dumfries & Galloway	HI – Highland	TA – Tayside
FI – Fife	LA – Lanarkshire	WI – Western Isles
FV – Forth Valley	LO – Lothian	

	FV	GR	GGC	HI	LA	LO	OR	SH	TA	WI
1.1	Met	Met	Met	Not met	Met	Met	Not met	Not met	Met	Not met
1.2	Met	Not met	Met	Not met	Met	Met	Not applicable	Not applicable	Not met	Not met
1.3	100	Data not available	83	Data not available	48	Data not available	88	Data not available	87	Data not available
1.4	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
2.1	Not met	Not met	Met	Met	Met	Not met	Met	Met	Met	Not met
2.2	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
3.4	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
3.6	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
3.7	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
4.1	Met	Met	Met	Met	Met	Not met	Not met	Not met	Met	Not met
4.2	Met	Not met	Met	Met	Not met	Not met	Not met	Not met	Not met	Not met

continued on next page

NB The data in this table should not be compared between NHS boards. Each NHS board used a different methodology to gather data. The only exceptions to this are 6.1 and 8.2. Data for these criteria are gathered centrally by the Information Services Division of NHS National Services Scotland.

3 NHS board performance against the sexual health services standards continued

Criteria reviewed		AA	BO	DG	FI
5.1	90% of adults receiving ongoing HIV care have the result of syphilis serology taken within the preceding 6 months recorded in their HIV records, or documentation why this is not required updated at 6 monthly intervals.	92	67	93	65 and 84*
5.2	80% of HIV+ adults presenting for the first time in Scotland have their sexual and reproductive history documented within 4 weeks of their initial HIV diagnosis, and are given advice to prevent onward HIV transmission, backed by the availability of condoms.	69	Data not available	80	100 and 71*
5.3	80% of adults receiving ongoing HIV care have an offer of a sexual health screen at least once every 12 months. If a sexual health screen is not required or if the offer is declined, this information is documented at 12 monthly intervals.	95	58	86	Data not available
6.1	70% of women seeking termination of pregnancy undergo the procedure at 9 weeks gestation or earlier.	57.8	75.8	59.7	62.6
6.2	There is a mechanism to ensure that all women are offered, at the time of termination of pregnancy, a range of contraceptives in addition to condoms, including implants or intrauterine methods where appropriate.	Met	Met	Met	Met
6.3	60% of women leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).	81	71	66	66
6.4	Post termination of pregnancy counselling to provide psychological support is available within 4 weeks for women (and their partners) who request it.	Met	Met	Not met	Met
7.2	Men who have sex with men have a choice of where hepatitis B vaccination is available, with a protocol to promote hepatitis B vaccination of all individuals at risk outside specialist sexual health services. Information on other health promoting activities such as risk reduction and sexually transmitted infection testing is also available in that setting.	Not met	Met	Met	Not met
7.3	70% of all men who have sex with men attending specialist sexual health services and not known to be immune to hepatitis B receive at least one dose of hepatitis B vaccine.	Data not available	74	76	74
8.2	60 or more females per 1,000 females of reproductive age per year are prescribed intrauterine and implantable contraceptives.	59.2	56.3	71.9	46.4
8.3	Contraceptive service providers who do not provide intrauterine and implantable contraceptives within their own practice or service have an agreed mechanism in place for referring women for intrauterine and implantable contraceptives.	Met	Met	Met	Met
8.4	A consultation appointment with a service providing intrauterine and implantable contraceptives is available within 5 working days.	Not met	Not met	Met	Not met
9.3	All health professionals providing sexual health interventions in both generic and specialist services demonstrate knowledge gained from post registration courses in sexual health and provide evidence of relevant continuing professional development.	Met	Met	Met	Met

NHS boards:		
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	FV	GR	GGC	HI	LA	LO	OR	SH	TA	WI
5.1	97	65	91	86	77	72 and 87*	Not applicable	Data not available	15	Data not available
5.2	52	71	82	93	22	96 and 71*	Not applicable	Data not available	75	Data not available
5.3	77	Data not available	67	86	72	98 and 94*	Not applicable	Data not available	Data not available	Data not available
6.1	60.1	68	62.4	53.4	67.8	61.4	74.1	71	54.8	34.8
6.2	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
6.3	26	78	77	74	81	70 and 52*	67	Data not available	79	Data not available
6.4	Met	Met	Met	Met	Not met	Met	Met	Not met	Met	Not met
7.2	Met	Met	Met	Met	Met	Met	Met	Not met	Not met	Not met
7.3	88	33	78	83	83	87	Not applicable	100	100	Data not available
8.2	49.5	56.6	69.2	64.8	39.3	49.6	73.5	60.8	58.4	59.8
8.3	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
8.4	Met	Not met	Met	Not met	Not met	Not met	Met	Not met	Met	Met
9.3	Met	Met	Met	Met	Not met	Met	Not met	Not met	Met	Not met

* Care provided by two separate services within the NHS board.

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4 What we found

In response to Respect and Responsibility, a tremendous amount of hard work and commitment has been shown by sexual health services. NHS boards faced many challenges in meeting the actions from Respect and Responsibility and implementing the sexual health services standards. These challenges have been taken up with enthusiasm, resulting in changes that go above and beyond these actions.

During the last 4 years, sexual health services across Scotland have made significant headway in:

- service development
- raising the profile of sexual health services
- improving the individual's experience, and
- providing more suitable accommodation for clinics.

Much of this has been achieved through a high degree of service innovation and dedication from staff. Specific developments, such as telephone results systems, walk-in contraceptive clinics and direct termination referral systems, are examples of the types of improvements made.

NHS boards need to continue to improve strategic engagement and improve monitoring of, and responding to, services. This is particularly important for those services being delivered within primary care and services accessed by people outwith their own NHS board areas. This will ensure that a high quality, equitable service is being provided and delivered to individuals.

Detailed findings are presented below using the key ambitions of *The Healthcare Quality Strategy for NHSScotland*[6]: that health care is person-centred, safe and effective.

Person-centred care

Highlights and progress made

Wherever you live and whoever you are, you should have a choice of free, confidential and non-judgemental sexual health services available to suit your needs. Prompt **access to sexual health services** is necessary to reduce individual illness and to maintain public health. Access is particularly important for young people, and the attitudes and approaches taken are key to tackling poor sexual health including sexually transmitted infections.

We found that all NHS boards had done well at **targeting services for communities or individuals with specific needs**. The majority of NHS boards are focusing on addressing the sexual health needs of young people and, in particular, vulnerable young people. Other groups include:

- lesbian, gay, bisexual and transgender communities
- people from ethnic minorities
- people with substance misuse issues
- people with learning disabilities
- people who are homeless
- people living with HIV
- prisoners, and
- sex workers.

Sexual health services are engaging well with colleagues across different departments and with voluntary sector organisations to better provide tailored services for high risk groups.

All NHS boards were able to demonstrate that they were delivering an integrated approach to sexual health improvement, particularly in relation to young people. Most sexual health services consider **young people's sexual health** of highest priority and there is strong partnership working with other agencies. All NHS boards are engaging and consulting with young people directly.

All NHS boards provide **sexual health and relationships education training** to various professional groups, including teachers, youth workers and social workers, in an attempt to ensure consistent sex education. School nurses also have a key role. Within some NHS boards they are helping to increase access to information and advice, signposting to services, undertaking basic testing for sexually transmitted infections and providing condoms.

NHS boards also provide specific services for vulnerable young people, especially looked after and accommodated young people. Links have also been formed with maternity services and young mum groups to help reduce repeat teenage pregnancies.

Opportunities for further improvement

Half of all NHS boards are finding it challenging to provide prompt **access to specialist sexual health** in line with the requirements of the standards. However, NHS boards are looking at where best to place services geographically and have been responsive to local need. Clinics are offered at various times of the day and evening to ensure access and there are also some weekend clinics operating. These innovative responses to service need may not always meet the standard criteria to the letter, but it was clear to us that NHS boards have assessed need and risk and based their arrangements on this.

Individuals require access to accurate, unbiased **information about sexual health** and available services. The provision of information which is inconsistent or incorrect can be confusing to the individual and could even prolong ill health.

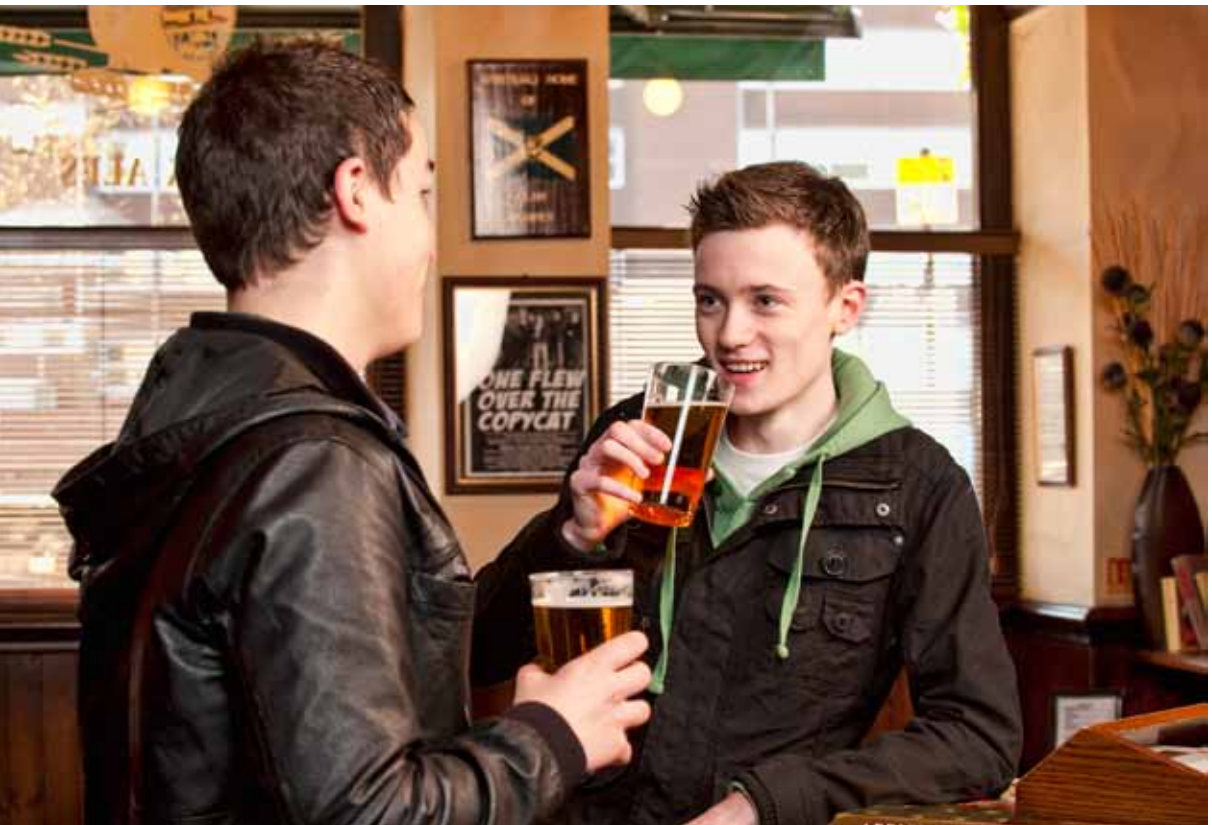
Most NHS boards would benefit from a more strategic approach to identifying the information needs of the population served. Although sexual health services are responsive to information requests, there is room for improvement. They should be more proactive in ensuring all information needs of the local population have been addressed. Specific resources have been developed for groups such as young people, people with learning disabilities and ethnic minority communities. Resources are provided in a range of formats including leaflets, posters, websites and DVDs. There is also an issue with access to NHS board sexual health websites which are not easily accessed from the main NHS board website or indeed from popular search engines.

Men who have sex with men are at increased risk of being infected with hepatitis B and so it is important that they are offered **vaccination against hepatitis B**. Five of the 14 NHS boards were unable to show that men who have sex with men are being offered a choice of where to receive the hepatitis B vaccination. Although the vaccine is available in all sexual health services, NHS boards were unclear about the arrangements within GP practices and could not confirm that the vaccine would always be available there. Some NHS boards have managed to make arrangements so that the vaccine is available in GP practices. However, more work needs to be done within primary care to promote hepatitis B vaccination for men who have sex with men.

4 What we found continued

Good practice examples

- NHS Dumfries & Galloway has undertaken work to protect vulnerable groups. It offers hepatitis B vaccinations to young people considered at high risk in residential care homes.
- NHS Forth Valley offers advice and support for gay men on the dating and social networking site Gaydar on a regular basis as well as having profiles on Bebo and Facebook.
- The Saturday Brook Highland clinic aims to increase access for young people, especially those who travel to Inverness from more rural and remote areas.
- NHS Greater Glasgow and Clyde has worked well at developing targeted services for its population. A large number of projects and initiatives have been set up and supported by the NHS board to support certain groups. These include the Steve Retson Project for gay men, Base 75 and the Open Road Project for women and men involved in prostitution and the Archway for those affected by rape and sexual assault.
- NHS Lothian has a network of 24 Healthy Respect drop-in clinics set up specifically for young people across the whole NHS board area.
- NHS Shetland has worked with young people to produce a DVD about the sexual health and wellbeing clinic specifically aimed at young people.
- NHS Tayside has a high level of partnership working with young people's voluntary organisations, such as The Corner which offers advice, support and treatment to young people in the Dundee area.



Safe and effective care

Highlights and progress made

About 1 in 4 women who have a **termination of pregnancy** go on to have another termination of pregnancy. Advice about effective contraception following termination of pregnancy is, therefore, essential to reduce these rates. Every NHS board has a mechanism in place to ensure women are offered a range of contraceptive options at the time of a termination of pregnancy. These include condoms, implants and intrauterine methods where appropriate.

Only three of the 14 NHS boards met the 70% target for women seeking termination of pregnancy to undergo the procedure at 9 weeks gestation or earlier. NHS boards have worked hard to increase this rate, which is dependent on when a woman first presents and has made a decision about the future of the pregnancy. They have done this by making the termination pathway as seamless as possible and trying new and innovative approaches to ensure women are seen as quickly as possible.

Intrauterine (eg the coil) and implantable **contraceptives** are more effective in preventing pregnancy than oral contraceptives and barrier methods (eg condoms) . Only five of the 14 NHS boards achieved the required 60 per 1,000 women being prescribed intrauterine and implantable contraceptives each year. However, all but one NHS board have made significant improvements in increasing the number of women choosing these methods of contraception. NHS boards have also invested in training for GPs, midwives and nurses to fit these types of contraception in different settings.

We found good **clinical leadership** within sexual health services. Staff are appropriately trained and continue to develop their knowledge and skills through various training and professional development courses. Nurse development was a particularly notable area. A number of NHS boards have conducted a training needs analysis to inform future training plans.

Opportunities for further improvement

If someone is diagnosed with a sexually transmitted infection they should be offered help to make sure that the people they have had sex with are also seen by a healthcare professional. This is called **partner notification** or contact tracing and is an essential element in maintaining public health. Partner notification breaks the chain of transmission and reduces the incidence of sexually transmitted infections.

We found that partner notification procedures varied greatly from NHS board to NHS board. Ten NHS boards could not guarantee partner notification would take place in all settings delivering sexual health care. Only four NHS boards had robust mechanisms in place to ensure that this takes place outwith specialist services.

Evidence from reviews confirmed that using sexual health advisers and managing partner notification centrally across primary care and sexual health services are effective ways of ensuring treatment of sexual partners of people diagnosed with a sexually transmitted infection. Only eight NHS boards were able to ensure a sexual health adviser, or a professional trained and supported by a sexual health adviser, was available to these individuals. Links with primary care need to be improved and robust arrangements put in place to ensure partner notification is managed effectively.

4 What we found continued

Data collection processes can also be challenging for sexual health services. In many cases where audits are being conducted, data are not always interpreted and analysed well. There is no consistency of data being collected which results in data not being comparable between NHS boards. An example of this is monitoring of services being delivered to people living with HIV in relation to their sexual and reproductive health care. Better use of methodical audit processes should be made. Using existing NHS board processes and tools, as well as the knowledge and skills of clinical effectiveness staff, would greatly improve the usefulness of data captured.

Additionally, NHS boards should be using NaSH where data can be input and reports generated for audit purposes. Better use of audit information would allow sexual health services to promote their performance and demonstrate to senior management and clinical governance committees where areas of improvement could be made. This would also help to raise the profile of sexual health services within NHS boards.

Good practice examples

- NHS Dumfries & Galloway has implemented a system of telephone consultations in preparation for intrauterine and implantable contraceptive fitting so women do not have to travel for multiple appointments.
- NHS Grampian has integrated partner notification into their primary care Order Communication system. When GPs request laboratory tests for sexually transmitted infections, they are prompted to ask for the patient's consent to pass positive results to the community sexual health nurse in the sexual health clinic. The system also documents whether partner notification will be undertaken by the GP or practice nurse. The community sexual health nurse then phones the patient to discuss the need to notify contacts. This system should increase the proportion of patients who get partner notification support.
- NHS Greater Glasgow and Clyde carried out a mapping exercise in each community health and care partnership. This was done to highlight any gaps in service provision and to enable local practitioners to identify and improve access to intrauterine and implantable methods of contraception.
- NHS Greater Glasgow and Clyde has developed a system where any woman can self-refer to the termination of pregnancy assessment and referral service to make the process as timely and efficient as possible.
- NHS Lanarkshire has robust partner notification procedures in place. It uses NaSH to electronically manage this process and ensure access to a health adviser for all people diagnosed with a sexually transmitted infection. People are referred to a sexual health adviser through this system after a positive result is received.
- NHS Orkney has developed a sexual health folder containing local information about sexual health services, referral pathways, contact details and advice for all GP practices and clinical areas. This is of particular benefit due to the high number of locum doctors.

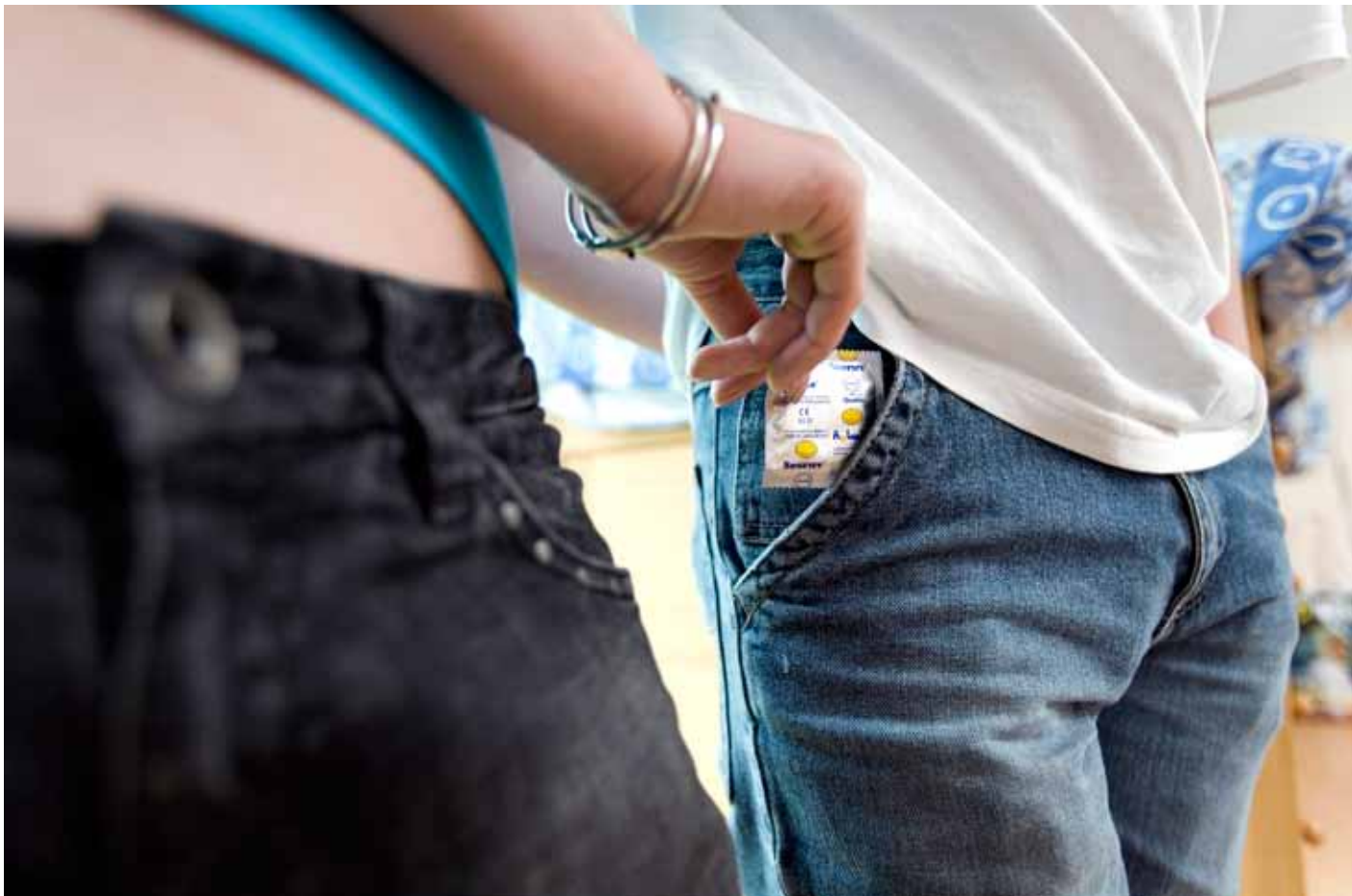
5 What next

NHS boards, sexual health service managers, clinicians and healthcare professionals should continue to ensure that the high standards of care demonstrated during these reviews are maintained. They are encouraged to build on the momentum and enthusiasm created through this programme to implement improvement plans and further enhance performance where necessary.

There are several national initiatives which will help to keep the services energised and focused on development opportunities. *The Sexual Health and Blood Borne Virus Framework* outlines actions for the support and delivery of the framework by the Scottish Government and a range of national organisations. Accountability for delivery and monitoring is also set out.

With this in mind, we published standards for HIV services in July 2011.[7] These standards form part of a wider implementation and improvement programme. It is envisaged that stakeholders involved in the delivery of HIV services will be brought together to identify those areas within the standards that will benefit from national support to implement them. This will ensure that excellence in sexual health services remains on the agenda for all NHS boards and their partner organisations.

We are now developing a new Healthcare Scrutiny Model for NHSScotland which will allow us to target our assurance and inspection activities in a more risk based and proportionate way.



Appendix 1 – References

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Appendix 2 – Glossary

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.
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.
intrauterine methods of contraception	An intrauterine device (IUD) is a small plastic and copper contraceptive which fits inside the womb and can stop sperm from reaching the egg. It may also make the egg move slower down the fallopian tube or stop a fertilised egg from settling in the womb. Some devices, called intrauterine systems (IUS), release a progestogen hormone.
NaSH	NHSScotland national sexual health system
partner notification	A process whereby the sexual partners of people with a diagnosis of sexually transmitted infection are informed of their exposure to infection.

Healthcare Improvement Scotland

www.**healthcareimprovementscotland**.org

Edinburgh Office: Elliott House | 8-10 Hillside Crescent | Edinburgh | EH7 5EA

Telephone 0131 623 4300 **Fax** 0131 623 4299

Glasgow Office: Delta House | 50 West Nile Street | Glasgow | G1 2NP

Telephone 0141 225 6999 **Fax** 0141 248 3778

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are key components of our organisation.

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