

# Sexual health

Quality standard

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This standard is based on PH3, NG68 and PH51.

This standard should be read in conjunction with QS157, QS156, QS148, QS129 and QS65.

## Quality statements

Statement 1 People are asked about their sexual history at key points of contact.

Statement 2 People identified as being at risk of sexually transmitted infections have a discussion about prevention and testing.

Statement 3 Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.

Statement 4 People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.

Statement 5 Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

Statement 6 People diagnosed with a sexually transmitted infection are supported to notify their partners.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](#)), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing sexual health services include:

- [HIV testing: encouraging uptake](#) (2017) NICE quality standard 157
- [Physical health of people in prisons](#) (2017) NICE quality standard 156
- [Community engagement: improving health and wellbeing](#) (2017) NICE quality standard 148
- [Contraception](#) (2016) NICE quality standard 129
- [Hepatitis B](#) (2014) NICE quality standard 65

A full list of NICE quality standards is available from the [quality standards topic library](#).

## Quality statement 1: Asking people about their sexual history

### *Quality statement*

People are asked about their sexual history at key points of contact.

### *Rationale*

Asking people about their sexual history enables healthcare professionals to identify if they are at risk of sexually transmitted infections (STIs) and ensures that they can be given information and support to prevent infection. It can also help local services to understand the needs of their populations.

### *Quality measures*

#### **Structure**

a) Evidence of local agreement on the key points of contact when people will be asked about their sexual history.

**Data source:** Local data collection, such as service protocols.

b) Evidence of local processes to ensure that people are asked about their sexual history at key points of contact.

**Data source:** Local data collection, such as service protocols.

#### **Process**

Proportion of people who have a discussion about their sexual history at key points of contact.

Numerator – the number in the denominator who have a discussion about their sexual history.

Denominator – the number of people attending a key point of contact.

**Data source:** Local data collection. Documenting that a discussion has taken place could form part of an electronic health record.

## Outcome

Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Local data collection, for example, the proportion of young people screened for chlamydia and HIV testing coverage is collected as part of Public Health England's [Sexual and reproductive health profiles](#).

### *What the quality statement means for different audiences*

**Service providers** (such as primary care services, contraceptive services, genitourinary medicine clinics, abortion services, community sexual health services, and voluntary and community organisations) ensure processes are in place and staff are trained to ask people about their sexual history in a sensitive and supportive way at key points of contact. Service providers can help staff to ensure sexual history taking becomes routine by providing tools such as self-completion checklists.

**Healthcare professionals** (such as GPs, midwives, nurses, doctors, and drug and alcohol workers) ask people about their sexual history at key points of contact. Healthcare professionals ensure that they discuss sexual history in a sensitive and supportive way.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that identify people who are at risk of STIs by asking them about their sexual history at key points of contact. Commissioners agree key points of contact when people should be asked about their sexual history with service providers. Commissioners ensure that services that engage with people who are less likely to attend primary care or sexual health services are included.

**People using healthcare services** are asked about their sexual history, for example, the gender of their last partner and their use of condoms, when they attend relevant appointments. This will ensure that they are given the support they need if they are at risk of getting an STI.

### *Source guidance*

[Sexually transmitted infections and under-18 conceptions: prevention](#) (2007) NICE guideline PH3, recommendation 1

## *Definitions of terms used in this quality statement*

### Key points of contact

Key points of contact could be consultations:

- with newly registered patients
- about contraception, pregnancy (including planning a pregnancy), abortion, alcohol or substance misuse
- when carrying out a cervical smear test, offering an STI test, or providing travel immunisation.

[NICE's guideline on [sexually transmitted infections and under-18 conceptions: prevention, recommendation 1](#)]

### Asking about sexual history

Services may take a brief core sexual history to establish whether someone is at any risk of STIs and then take a more detailed history if the screen is positive. A more detailed sexual history should include:

- the gender of sexual partner(s)
- the type of sexual contact/sites of exposure (oral, vaginal, anal)
- condom use/barrier use (and whether properly used)
- relationship with the partner (for example, live-in, regular or casual partner), duration of the relationship and whether the partner could be contacted
- the time interval since the last sexual contact
- any symptoms or any risk factors for blood-borne viruses in the partner including known or suspected STIs, injecting drug use, previous homosexual sex (for male partners) and any other risk of sexual infection.

[Adapted from the British Association of Sexual Health and HIV's [UK national guideline for consultations requiring sexual history taking](#), recommendation 3.3.1]



## *Equality and diversity considerations*

When asking people about their sexual history, be aware that they may have additional needs such as physical, sensory or learning disabilities, and that they may not speak or read English, or may have reduced literacy skills. People should have access to an interpreter or advocate if needed.

Healthcare professionals should ensure that older people are asked about their sexual history in order to identify if they are at risk of STIs. Healthcare professionals should also be trained to identify and respond to the specific needs of lesbian, gay, bisexual, and transgender people when asking about their sexual history.

Safeguarding links should be in place with all services that may engage with young people and vulnerable adults about their sexual health. Services should be clear what action should be taken if concerns are raised about child sexual exploitation or abuse, female genital mutilation, human trafficking or modern slavery.

## Quality statement 2: Discussing prevention and testing with people who are at risk of sexually transmitted infections

### *Quality statement*

People identified as being at risk of sexually transmitted infections have a discussion about prevention and testing.

### *Rationale*

Discussing how to prevent and be tested for sexually transmitted infections (STIs) can increase opportunities for testing and harm reduction. A structured discussion can help identify and reduce behaviours that put a person at risk of STIs.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements to ensure that trained healthcare professionals are available to discuss behaviour change with people identified as being at risk of STIs.

*Data source:* Local data collection, such as training records and staff rotas.

b) Evidence of local processes to ensure that people identified as being at risk of STIs have a discussion about prevention and testing.

*Data source:* Local data collection, such as service protocols.

#### **Process**

Proportion of people identified as being at risk of STIs who have a discussion about prevention and testing.

Numerator – the number in the denominator who have a discussion about prevention and testing.

Denominator – the number of people identified as being at risk of STIs.

*Data source:* Local data collection. Documenting that a discussion has taken place could form part of

an electronic health record.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Local data collection, for example, the proportion of young people screened for chlamydia and HIV testing coverage are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, contraceptive services, genitourinary medicine clinics and community sexual health services) ensure that they have healthcare professionals trained in sexual health who discuss the prevention of and testing for STIs with people identified as being at risk. Service providers should ensure that healthcare professionals signpost people at risk to high-quality supporting information and services, including online sexual health services.

**Healthcare professionals** (such as GPs, midwives, practice nurses and doctors who work in sexual health services) have one-to-one structured discussions with people identified as being at risk of STIs about how they can reduce their risk and how to get tested. Healthcare professionals should signpost people at risk to high-quality supporting information and services, including online sexual health services.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) work together to ensure that they commission a range of services that provide information on the prevention of and testing for STIs to people identified as being at risk. Commissioners ensure that services that

engage with people who are less likely to attend primary care or sexual health services are included.

People who are at risk of getting an STI talk to their healthcare professional about how to prevent STIs. They should also be given information about how to get tested for STIs and where to get further advice.

### *Source guidance*

- British Association of Sexual Health and HIV (2013) [UK national guideline for consultations requiring sexual history taking](#), recommendation 3.8
- [Sexually transmitted infections and under-18 conceptions: prevention](#) (2007) NICE guideline PH3, recommendations 2 and 5

### *Definitions of terms used in this quality statement*

#### **Discussion about prevention and testing**

Discussions should be structured on the basis of behaviour change theories. They should address factors that can help reduce risk taking and improve self-efficacy and motivation. Ideally, each session should last at least 15 to 20 minutes. The number of sessions will depend on individual need.

[NICE's guideline on [sexually transmitted infections and under-18 conceptions: prevention](#), recommendation 2]

#### **People at risk of sexually transmitted infections**

This includes the following key groups and behaviours:

- men who have sex with men
- people who have come from or who have visited areas of high HIV prevalence
- people who misuse alcohol or substances, or both
- people who have early onset of sexual activity
- people who have condomless sex and frequently change or have multiple sexual partners.

[NICE's guideline on sexually transmitted infections and under-18 conceptions: prevention, recommendation 2]

### *Equality and diversity considerations*

A discussion about prevention and testing for STIs should be age appropriate and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English, or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

Healthcare professionals should be trained to identify and respond to the specific needs of lesbian, gay, bisexual, and transgender people when discussing prevention and testing for STIs.

## Quality statement 3: Condom distribution schemes

### *Quality statement*

Local authorities provide a range of condom distribution schemes tailored to the needs of their populations.

### *Rationale*

Providing a variety of condom distribution schemes ensures that different populations, including those most at risk of sexually transmitted infections (STIs), can access a scheme that will meet their needs. Condom schemes should be provided alongside existing services that are likely to be used by people most at risk of getting an STI. This can increase rates of condom use and reduce STI rates.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements to assess the needs of local populations for condom distribution schemes.

**Data source:** Local data collection, such as needs assessments based on consultation and STI rates.

b) Evidence of local arrangements to provide a range of condom distribution schemes tailored to the needs of the population.

**Data source:** Local data collection, such as service specifications for a mix of different types of condom distribution scheme.

c) Evidence of local arrangements to publicise condom distribution schemes to people most at risk of getting an STI.

**Data source:** Local data collection, such as posters, leaflets and social media campaigns.

#### **Outcome**

a) Proportion of people who are at risk of STIs who used a condom at last intercourse.

**Data source:** Local data collection, such as a survey of young people or other groups at risk of STIs.

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

### *What the quality statement means for different audiences*

**Service providers** (voluntary sector services, school health services and primary healthcare services) provide a range of condom distribution schemes tailored to the needs of different local populations. Service providers publicise condom schemes to people most at risk of getting an STI. Service providers also ensure that referral pathways are in place to other services to meet the needs of those using the service.

**Healthcare professionals** (such as GPs, practice nurses, pharmacists and sexual health consultants) are aware of condom distribution schemes and tell people who are at risk of getting an STI how to access them.

**Commissioners** (local authorities) ensure that they commission a mix of different types of condom distribution schemes tailored to the needs of the population, including multicomponent schemes, single-component schemes (free condoms) and cost-price sales schemes. Commissioners should commission tailored multicomponent condom schemes in preference to other types of condom scheme for young people aged under 16. Commissioners ensure there are links between condom schemes and local sexual and reproductive health services.

People at risk of getting an STI are made aware of where they can get condoms.

### *Source guidance*

[Sexually transmitted infections: condom distribution schemes](#) (2017) NICE guideline NG68, recommendation 1.1.1

## *Definitions of terms used in this quality statement*

### **Condom distribution schemes**

These are usually referred to as 'condom schemes'. The term refers to all schemes that provide free or cost-price condoms, female condoms and dental dams, with or without lubricant. Schemes also offer advice, information or support. They include:

- Cost-price sales schemes that provide cost-price condoms and, if appropriate, lubricant. They include community schemes that provide cost-price condoms to sex workers and online services.
- Multicomponent schemes (such as C-card) that distribute free condoms with or without lubricant, together with training, information or other support.
- Single-component schemes that provide or distribute free condoms and if appropriate, lubricant. This includes online services for specific groups or areas of the country, and distribution schemes in public places.

[NICE's guideline on [sexually transmitted infections: condom distribution schemes](#), terms used in this guideline]

### *Equality and diversity considerations*

Condom schemes should be accessible for young people including those who use public transport.

Safeguarding links should be in place with all services that may engage with young people and vulnerable adults about their sexual health. Services should be clear what action should be taken if concerns are raised about child sexual exploitation or abuse, female genital mutilation, human trafficking or modern slavery.



## Quality statement 4: Access to sexual health services

### *Quality statement*

People contacting a sexual health service about a sexually transmitted infection are offered an appointment that is within 2 working days.

### *Rationale*

Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Ensuring people are offered quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs), ensuring that tests and interventions can be provided to reduce health complications. If walk-in clinics are provided there should be reasonable waiting times to encourage people to use the service.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure that people contacting a sexual health service about an STI are offered an appointment that is within 2 working days.

**Data source:** Local data collection, such as service protocols. Included in the Department of Health and Social Care's [Integrated sexual health services: a suggested national service specification](#).

#### **Process**

a) Proportion of contacts with a sexual health service about an STI in which an appointment that is within 2 working days, was offered.

Numerator – the number in the denominator in which an appointment that is within 2 working days, was offered.

Denominator – the number of contacts with a sexual health service about an STI.

**Data source:** Local data collection, such as an audit of patient health records. Included in the Department of Health and Social Care's [Integrated sexual health services: national service specification](#).

b) Proportion of attendances at a sexual health service walk-in clinic in which the waiting time was less than 2 hours.

Numerator – the number in the denominator in which the waiting time was less than 2 hours.

Denominator – the number of attendances at a sexual health service walk-in clinic.

**Data source:** Local data collection, such as clinic wait time records. Included in the Department of Health and Social Care's [Integrated sexual health services: national service specification](#).

## Outcome

a) Satisfaction with access to services among people who contact sexual health services about an STI.

**Data source:** Local data collection, such as a patient survey.

b) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Local data collection, for example, the proportion of young people screened for chlamydia and HIV testing coverage are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

c) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

d) Chlamydia detection rate per 100,000 people aged 15 to 24.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

## *What the quality statement means for different audiences*

**Service providers** (sexual health services) ensure that they offer people who contact the service about an STI either an appointment or the option to attend a walk-in clinic, which is within 2

working days. Service providers ensure that walk-in clinics are sufficiently resourced so that waiting times are less than 2 hours. Providers should offer a mix of timed appointments and walk-in clinics to meet the needs of the local population.

**Healthcare professionals who work in sexual health services** offer people contacting the service about an STI either an appointment or the option to attend a walk-in clinic, which is within 2 working days.

**Commissioners (local authorities)** commission sexual health services with sufficient capacity to ensure that people contacting the service about an STI are offered either an appointment or the option to attend a walk-in clinic, which is within 2 working days, and monitor waiting times.

**People who contact a sexual health service about an STI** are offered either an appointment or attendance at a walk-in clinic within 2 working days. If they go to a walk-in clinic they wait no longer than 2 hours.

### *Source guidance*

- [Contraceptive services for under 25s \(2007\) NICE guideline PH51, recommendation 3](#)
- [Sexually transmitted infections and under-18 conceptions: prevention \(2007\) NICE guideline PH3, recommendation 4](#)
- The timeframe of 48 hours is from the Department of Health and Social Care's [Integrated Sexual Health Services: A Suggested National Service Specification](#)

### *Definitions of terms used in this quality statement*

#### **Sexual health services**

Sexual health services include arrangements for the notification, testing, treatment and follow-up of partners of people who have an STI (partner notification).

[NICE's guideline on [sexually transmitted infections and under-18 conceptions: prevention, recommendation 4](#)]

The service should be delivered in accordance with the level 1, 2 and 3 service model. It does not include self-managed care such as home remote sampling and test kits accessed via online services.

[Department of Health and Social Care's [Integrated sexual health services: a suggested national service specification](#)]

## **An appointment**

A scheduled time at a clinic or the option to attend a walk-in clinic.

[Expert opinion]

## ***Equality and diversity considerations***

Services should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced literacy skills, can contact sexual health services to make appointments. People should have access to an interpreter or advocate if needed.

Sexual health services should be accessible for young people including those who use public transport.

## Quality statement 5: Repeat testing for sexually transmitted infections

### *Quality statement*

Men who have sex with men have repeat testing every 3 months if they are at increased risk of sexually transmitted infections.

### *Rationale*

Regular repeat testing for sexually transmitted infections (STIs) for men who have sex with men and who are at increased risk of STIs will ensure that diagnosis is made as soon as possible and further transmission of STIs can be avoided.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements to provide STI repeat testing every 3 months for men who have sex with men and are at increased risk of STIs.

*Data source:* Local data collection, such as service protocols.

b) Evidence of local arrangements to encourage men who have sex with men to have repeat STI tests every 3 months if they are at increased risk of STIs.

*Data source:* Local data collection, such as health promotion leaflets and materials.

#### **Process**

a) Proportion of men who have sex with men and are at increased risk of STIs who were sent a reminder to have repeat testing for STIs within the past 3 months.

Numerator – the number in the denominator who were sent a reminder to have repeat testing for STIs within the past 3 months.

Denominator – the number of men who have sex with men and are at increased risk of STIs.

*Data source:* Local data collection, such as an audit of patient health records.

b) Proportion of men who have sex with men and are at increased risk of STIs who were tested for STIs within the past 3 months.

Numerator – the number in the denominator who were tested for STIs within the past 3 months.

Denominator – the number of men who have sex with men and are at increased risk of STIs.

**Data source:** Local data collection, such as an audit of patient health records.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Local data collection, for example, the proportion of young people screened for chlamydia and HIV testing coverage are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

b) New STI diagnoses (excluding chlamydia in people aged under 25) per 100,000 people aged 15 to 64.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

c) Chlamydia detection rate per 100,000 people aged 15 to 24.

**Data source:** These data are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, genitourinary medicine clinics, community sexual health services and online sexual health services) offer men who have sex with men repeat STI testing every 3 months if they are at increased risk of STIs. Service providers ensure men are signposted to an alternative service for repeat testing if necessary. They ensure that recall reminders are sent every 3 months to improve re-attendance rates.

**Healthcare professionals** (such as GPs, practice nurses and sexual health consultants) offer men who have sex with men repeat appointments for STI testing every 3 months if they are at increased

risk of STIs. If their service does not provide repeat testing, healthcare professionals should signpost the person to an alternative service.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that arrange repeat appointments for STI testing every 3 months for men who have sex with men and are at increased risk of STIs. This could include online sexual health services.

**Men who have sex with men and who have a high risk of getting an STI** are offered testing for STIs every 3 months.

### *Source guidance*

British Association of Sexual Health and HIV (2016) [United Kingdom national guideline on the sexual health care of men who have sex with men](#), recommendations on STI and HIV testing

### *Definitions of terms used in this quality statement*

#### **Men who have sex with men and are at increased risk of sexually transmitted infections**

Men who have sex with men, who have:

- condomless anal intercourse with partner(s) of unknown or serodiscordant HIV status over last 12 months
- over 10 sexual partners, over last 12 months
- drug use (such as methamphetamine, mephedrone, inhaled nitrites, gamma-butyrolactone (GBL), ketamine, and other novel psychoactive substances) during sex over last six months
- multiple or anonymous partners since last tested
- any condomless sexual contact (oral, genital or anal) with a new partner since last tested.

[Adapted from the British Association of Sexual Health and HIV guideline on [United Kingdom national guideline on the sexual health care of men who have sex with men](#), recommendations on STI and HIV testing]

## Quality statement 6: Partner notification

### *Quality statement*

People diagnosed with a sexually transmitted infection are supported to notify their partners.

### *Rationale*

Supporting people who have been diagnosed with a sexually transmitted infection (STI) to notify their partners can help to prevent reinfection and reduce the transmission of STIs. It can also ensure that their partners are tested, and if necessary treated, as soon as possible to prevent health complications.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements for partner notification to be discussed with people diagnosed with STIs.

**Data source:** Local data collection, such as service protocols. Included in the Department of Health and Social Care's [Integrated sexual health services: national service specification](#).

b) Evidence of local arrangements for partner notification support to be provided to people diagnosed with STIs.

**Data source:** Local data collection, such as service protocols and referral pathways. Included in the Department of Health and Social Care's [Integrated sexual health services: national service specification](#).

#### **Process**

Proportion of people diagnosed with an STI who have partner notification initiated.

Numerator – the number in the denominator who have partner notification initiated.

Denominator – the number of people diagnosed with an STI.

**Data source:** Local data collection. Public Health England's [GUMCAD STI surveillance system](#)



collects data on partner notification being initiated.

## Outcome

a) Coverage of testing for STIs: proportion of people attending the service who are tested for STIs.

**Data source:** Local data collection, for example, the proportion of young people screened for chlamydia and HIV testing coverage, are collected as part of Public Health England's [Sexual and reproductive health profiles](#).

b) Number of people presenting as a partner of an index case diagnosed with an STI.

**Data source:** Local data collection. Public Health England's [GUMCAD STI surveillance system](#) collects data on people presenting as a partner of a person identified as having an index case of chlamydia, gonorrhoea, HIV or non-specific genital infection.

## *What the quality statement means for different audiences*

**Service providers** (such as primary care services, genitourinary medicine clinics and community health services) ensure that processes are in place for discussions about partner notification to take place when people are diagnosed with an STI. Service providers ensure that they have clear partner notification procedures in place, including referral pathways to specialist providers, so that people can be supported to notify their partners.

**Healthcare professionals** (such as GPs, practice nurses and sexual health consultants) ensure they are aware of local partner notification procedures and provide support to people diagnosed with an STI to notify their partners. Partner notification may be undertaken by the healthcare professional or the person diagnosed with an STI and may require referral to a specialist service.

**Commissioners** (clinical commissioning groups, local authorities and NHS England) ensure that they commission services that support people who are diagnosed with an STI to notify their partners. Commissioners ensure that the roles and responsibilities of different services in relation to partner notification are clear and that referral pathways are in place. Commissioners regularly monitor and review the overall effectiveness of local partner notification procedures.

**People diagnosed with an STI** are given encouragement and support from a healthcare professional to tell their partners about the STI. This will help partners to get tested as soon as possible and to receive treatment if they are also infected.

## *Source guidance*

Sexually transmitted infections and under-18 conceptions: prevention (2007) NICE guideline PH3, recommendation 3

## *Definitions of terms used in this quality statement*

### **Support to notify their partners**

Partner notification procedures should be in place to provide support to contact, test and treat partners of people diagnosed with an STI. The support provided should be tailored to meet the individual's needs and if necessary people should be referred to a specialist with responsibility for partner notification. Partner notification may be undertaken by the healthcare professional or the person diagnosed with an STI.

[NICE's guideline on sexually transmitted infections and under-18 conceptions: prevention, recommendation 3].

## *Equality and diversity considerations*

Services to support people to notify their partners about an STI should be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English, or who have reduced literacy skills. People should have access to an interpreter or advocate if needed.

## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See [quality standard advisory committees](#) on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard's webpage](#).

This quality standard has been included in the NICE Pathways on [contraception services for under 25s](#), [HIV testing and prevention](#) and [preventing sexually transmitted infections and under-18 conceptions](#), which bring together everything we have said on a topic in interactive flowcharts.

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## *Improving outcomes*

This quality standard is expected to contribute to improvements in the following outcomes:

- incidence of sexually transmitted infections (STIs)
- earlier diagnoses of STIs
- use of condoms and lubricants
- people's experience of using sexual health services.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- [Adult social care outcomes framework](#)
- [NHS outcomes framework](#)
- [Public health outcomes framework for England](#).

## *Resource impact*

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

- [costing report and template](#) for the NICE guideline on contraceptive services for under 25s
- [implementation advice](#) for the NICE guideline on sexually transmitted infections and under-18 conceptions: prevention
- [resource impact report and template](#) for the NICE guideline on sexually transmitted infections: condom distribution schemes.

## *Diversity, equality and language*

During the development of this quality standard, equality issues were considered and [equality assessments](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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### *Endorsing organisation*

This quality standard has been endorsed by The Department of Health and Social Care, as required by the Health and Social Care Act (2012)

### *Supporting organisations*

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Faculty of Sexual and Reproductive Healthcare](#)
- [Family Planning Association](#)
- [Royal College of General Practitioners](#)
- [National AIDS Trust](#)
- [British HIV Association](#)
- [British Association for Sexual Health and HIV](#)
- [Brook](#)
- [Public Health England](#)