

Sexual health

Consultation on draft quality standard – deadline for comments 5pm on 20/09/18 **email:** QSconsultations@nice.org.uk

	<p>Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.</p> <p>We would like to hear your views on these questions:</p> <ol style="list-style-type: none">1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.
Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	British HIV Association (BHIVA)
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Nil
Name of commentator person completing form:	Dr Laura Waters on behalf of the BHIVA Executive Committee and Professor Chloe Orkin, BHIVA Chair
Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.	Yes
Type	[office use only]

Please return to: QSconsultations@nice.org.uk

Consultation on draft quality standard – deadline for comments 5pm on 20/09/18 email: QSconsultations@nice.org.uk

Comment number	Section	Statement number	<p style="text-align: center;">Comments</p> <p style="text-align: center;">Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.</p>
1	Quality statements	1	<p>While entirely supportive of the normalisation of sexual health & risk assessment, and broadening the clinical services where this will take place, is there evidence that this will increase uptake? It will be down to primary care, travel vaccination clinics, etc., to advise you of any implications for their services (e.g. recording on electronic records the discussion about sexual health). Considering that in many cases, assuming a sexual health discussion triggers a check-up, that check-up may well take place elsewhere, most likely a sexual health service where it will not be possible to link a primary care-led discussion with a STI clinic-led intervention thus making it difficult to assess the impact.</p> <p>In terms of measures:</p> <ol style="list-style-type: none"> 1) uptake of tests for STIs – we would ideally want this to go up but not if all the new tests are in people with minimal risk for on STI 2) new STI diagnoses – what effect would you expect? Could go up if a large number of undiagnosed people are picked up, but would then expect it to go down again as the public health benefits of treatment and partner notification are realised. However, if the additional STI tests are all inappropriately performed in people with no risk for STIs, then number of new diagnoses would not change. Furthermore, if offering more tests further stretches already struggling sexual health services, and people at high risk of STIs experience delay in diagnosis and treatment it is even possible that eventually STI rates will increase 3) Chlamydia detection rate: similar comments to (2). Recent figures show the number of tests have declined so if the denominator used is the whole population of people aged 15–24 then the apparent chlamydia rate will decline – it is therefore important to also look at chlamydia rates using the number of screens performed as the denominator. <p>Additionally we would be interested in the rationale for discussing sexual health at travel clinics? Is there evidence that this is a population at higher risk of STIs?</p> <p>Finally the recommended sexual health assessment is detailed - while this is entirely appropriate where STI screening/counselling can take place, but it may be over detailed in a busy primary care service. Perhaps a self-completion checklist with appropriate signposting may be more efficient.</p>
2	Quality statements	2	<p>Similar to statement 1, the accuracy of the data will depend very much in clinic's ability to collect the denominator figures accurately. Will EPR across services be able to collect accurately the number identified as being at risk of STIs and again, the challenges if linking this to STI test uptake when the test may be performed under another service, with a different patient identifier, must be considered.</p>

Consultation on draft quality standard – deadline for comments 5pm on 20/09/18 email: QSconsultations@nice.org.uk

3	Quality statements	2	This discusses the role of CCGs and NHSE in commissioning 'a range of services that provide information on the prevention of, and signpost testing for, STIs' yes this is now almost entirely in the remit of local authorities. We fear that the current, fragmented commissioning process will continue to act as a barrier to the joined up commissioning that would be required to meet this standard.
4	Quality statements	3	<p>48-hour access was one of the elements that truly impacted sexual health service access but since it's removal as a mandatory requirement in 2010 the proportion of people offered an appointment within that time frame has declined (https://www.bashh.org/news/news/new-study-shows-worrying-deterioration-in-access-to-sexual-health-services-for-patients/) – unless this requirement is mandatory we fear the leverage to ensure adequate investment to support that target will be inadequate. Ensuring accuracy and transparency with regards to access figures is fundamental. If a clinic were to close its appointment line as soon as all appointments were filled then the figures may show that all users contacting the service were offered an appointment within 48 hours but not those who were unable to get through. Many clinics collect data on unanswered/aborted calls but not necessarily the percentage of those calls that did get answered eventually. Anecdotally, some Trusts are very cautious about producing figures and the tendering/competition process has created a culture of uneasiness with regards to sharing data and information – frankly, some clinics appear to be more concerned about appeasing commissioners than shouting about the impact of commissioning on service provision, quality and morale. In London we have yet to see an assessment of the value of e-services.</p> <p>Ultimately, we call for reintroduction of a mandatory 48-hour offer of appointment target and for this to be based not just on those who get through to a service but the number who <i>attempt</i> to do so.</p>
5	Quality statements	4	We support this completely and it is in line with BASHH MSM guidelines. If this was implemented successfully it would undoubtedly place further strain on sexual health services – the concerns of local authorities about the ability to manage the increased demand for services has been a key part of the discussion related to the roll-out of HIV pre-exposure prophylaxis (PrEP) – how much this has contributed to the fact that England still does not offer routine PrEP would be hard to quantify.
6	Quality statements	5	Again, we support this. Partner notification (PN) is an essential part of managing STIs but, again, accuracy of data is the key challenge. Despite attempts to implement systems that enable cross-service documentation (i.e. to accurately collect where a partner notification initiated at one service has been completed at another) this process is fragmented and time-consuming. The cuts to sexual health funding have, in some cases, significantly impacted the number of staff available to perform PN. Simply collecting the data on initiation of PN is one thing but translating this into subsequent uptake of STI screening/identification is another. Again, it is likely that only mandatory targets in terms of ON offer AND uptake will truly impact provision.

Insert extra rows as needed

Please return to: QSconsultations@nice.org.uk

Consultation on draft quality standard – deadline for comments 5pm on 20/09/18 email: QSconsultations@nice.org.uk

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about e.g. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking [NICE Pathways](#).

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received from registered stakeholders and respondents during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.