Healthcare Improvement Scotland is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the nine equality protected characteristics as stated in the Equality Act 2010 and defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. For this impact assessment, please see our website (www.healthcareimprovementscotland.org). The full report in electronic or paper form is available upon request from the Healthcare Improvement Scotland Equality and Diversity Officer.

On 1 April 2011, Healthcare Improvement Scotland took over the responsibilities of NHS Quality Improvement Scotland.

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www.healthcareimprovementscotland.org
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1 Setting the scene

Healthcare Improvement Scotland was launched on 1 April 2011. This health body was created by the Public Services Reform (Scotland) Act 2010 and marks a change in the way the quality of healthcare across Scotland will be supported nationally.

Our key purpose is to support healthcare providers in Scotland to deliver high quality, evidence-based, safe, effective and person-centred care; and to scrutinise services to provide public assurance about the quality and safety of that care.

We are building on work previously done by NHS Quality Improvement Scotland and the Care Commission.

For further information on Healthcare Improvement Scotland, please visit our website (www.healthcareimprovementscotland.org).

Background

Scotland's first national sexual health and relationships strategy Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health was launched in January 2005. A range of actions were set out in Respect and Responsibility to enhance sexual health promotion, education, and service provision. As part of Respect and Responsibility, NHS Quality Improvement Scotland took forward the development of appropriate standards for sexual health services provided by or secured by NHS boards. The Standards for Sexual Health Services were published in March 2008.

We are taking a risk based and proportionate approach to the review of the sexual health services standards and have identified the following criteria for assessment through the peer review process:

- **Standard 1** ~ criteria 1.1, 1.2, 1.3, 1.4, 1.6
- **Standard 2** ~ criteria 2.1, 2.2
- **Standard 3** ~ criteria 3.4, 3.6, 3.7
- **Standard 4** ~ criteria 4.1, 4.2
- **Standard 5** ~ criteria 5.1, 5.2, 5.3
- **Standard 6** ~ criteria 6.1, 6.2, 6.3, 6.4
- **Standard 7** ~ criteria 7.2, 7.3
- **Standard 8** ~ criteria 8.2, 8.3, 8.4
- **Standard 9** ~ criterion 9.3

About this report

This report presents the findings from the sexual health services peer review visit to **NHS Borders**. The review visit took place on 5 April 2011 and details of the visit, including membership of the review team, can be found in Appendix 1.

The review process has three key phases: preparation prior to the performance assessment review, the review visit, and report production and publication following the visit.
Review teams are multidisciplinary and include both healthcare professionals and members of the public. All reviewers are trained. Each peer review team is led by an experienced reviewer, who guides the team in its work and ensures that team members are in agreement about the assessment reached. The composition of each team varies, and members are not employed by the NHS board they are reviewing.
2 Summary of findings

A summary of the findings from the review, including strengths and recommendations, is shown in this section.

During the visit, the most appropriate assessment category is agreed by the review team to describe the NHS board’s current position against each standard criterion – indicated by the shaded areas, percentages or value in the table below.

For some criteria, ‘met’ or ‘not met’ applies.

- ‘Met’ applies where the evidence demonstrates the criterion is being achieved.
- ‘Not met’ applies where the evidence demonstrates the criterion is not being achieved.

For all other criteria, either a % (criteria 1.3, 5.1–5.3, 6.1, 6.3 and 7.3) or a value per 1000 (criterion 8.2) applies.

- ‘% or value per 1000 achieved (required)’ indicates the % or value demonstrated in the NHS board’s evidence against the % or value required.

Criterion 1.6 will not be assessed using the above categories. The NHS board’s performance against this criterion is described in Section 3.

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**Strengths**

The NHS board has:

- well-established links with wider services, particularly links with the education department of the local authority which has led to impressive service provision in schools
- done significant work for young people including involvement with young people in service development, and
- good partner notification rates.

**Recommendations**

The NHS board to:

- improve the rates of offer of long acting and reversible methods of contraception in primary care, particularly implantable methods
- reduce consultation appointment times for women who request intrauterine and implantable contraceptives, and
- better plan for capacity and resource issues, in particular relating to HIV care.
### 3 Detailed findings against the standards

#### Standard 1: Comprehensive provision of specialist sexual health services

**Standard statement 1**

A comprehensive range of specialist sexual health services is provided locally and individuals with the greatest need are treated as a priority.

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.

**STATUS: Met**

NHS Borders has a fully integrated specialist sexual health service. The service operates under one brand, with a single point of contact, and uses common protocols and referral pathways. Borders sexual health service was established in 2002. It operates from a purpose-built site in Galashiels and has also set up a network of local clinics throughout the NHS board area. Other clinics take place in Hawick, Peebles, Duns and Eyemouth.

Borders sexual health service sits within primary and community services alongside dental, GP services and community hospitals. Primary and community services operate within the single community health and care partnership. Although a small service, supported by part-time staff, it is well integrated with good communication links both internally and with other health departments and services. There is a Borders sexual health strategy group in operation which is multi-agency. It includes representation from a number of voluntary organisations, the education department of the local authority and a GP representative.

Borders sexual health service offers a full range of contraception options. All clinics, both nurse and doctor led, offer combined oral contraceptive pills, progestogen only pills, injectables and emergency contraception. Pregnancy testing, male and female condoms, lube and dams, diaphragm and spermicide supplies are also available. Most clinics offer implant fittings as most nurses are trained in this. Only doctor-led clinics offer the combined hormonal patch and ring, and insert intrauterine devices and systems. There are no non-medical prescribers. This is something the NHS board may wish to consider for future service development.

Gynaecology clinics, held at Borders General Hospital, Melrose, also provide intrauterine and implant insertion. A range of contraception options is also offered through primary care. Male and female sterilisation is referred on to the appropriate colleagues in general surgery and gynaecology departments respectively.

A weekly clinic is run by the clinical lead for sexual and reproductive health where GPs are able to refer women on for more specialist advice and treatment. This clinic includes contraception advice for women with chronic conditions, such as epilepsy, hypertension and diabetes as well as the menopause and menstrual disorders.

Diagnosis of all sexually transmitted infections and treatment for uncomplicated sexually transmitted infections is offered at all clinics, including drop-ins. Treatment and management of more complex sexually transmitted infections, including HIV care, takes.
place at consultant-led clinics in Galashiels. Testing and treatment for some sexually transmitted infections also takes place in primary care and is facilitated by the GP sexually transmitted infection testing kit.

Borders sexual health service offers HIV testing on an opt-out basis. In recent years, the majority of the small number of positive tests have been identified by the sexual health service. Pre-test discussion and post test counselling is also offered by the service.

### 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.

**STATUS: Not met**

Within the Scottish Borders there are two towns with estimated populations over 10,000 – Hawick and Galashiels. At the Galashiels clinic there is at least 2 full days of integrated specialist sexual health service provision. Clinics are available each week day and of the six clinics available, two are consultant led. However, the minimum level of service provision is not available in Hawick with only two 3–4 hour clinics running each week.

The NHS board has chosen to balance service location across its rural area. It serves the outlying, more rural populations by offering clinics in Peebles, Duns and Eyemouth. It, therefore, had to decide to concentrate resources at either the Hawick or Galashiels site. An informed decision was made to base Borders sexual health service in Galashiels because there are better transport links to and from the town. Also, the flow of young people to Galashiels for recreational purposes is far greater than young people travelling to Hawick. It is worth noting that it is only marginally over 30 minutes travel time between Galashiels and Hawick.

Borders sexual health service has expanded considerably over the last 4 years and has had to absorb much of the extra workload within existing resources. There are issues with regards to capacity, especially in relation to HIV care. There are also challenges for staff particularly in relation to cover for clinics during periods of sickness or annual leave.

### 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.

**STATUS: 89%**

A local audit for appointment availability was carried out in November–December 2010. Of the 95 calls received, 19 were categorised as a priority condition. Seventeen of the 19 (89%) individuals with priority sexual health conditions were offered an appointment within 48 hours of initial contact with the specialist sexual health service.

Priority is given to individuals with the greatest need and reception staff are trained to identify which patients are to be seen urgently. An appointments protocol was implemented in October 2010 to formalise these procedures. Priority is given to those with symptoms suggestive of a sexually transmitted infection, young people and women requesting emergency contraception among other things. A telephone clinic runs every day and can be accessed by staff from any of the smaller, more remote clinic locations.
Due to the part-time nature of the service and multiple clinic locations, it is difficult to staff the central phone line continuously during working hours. There is now a telephone answering system in place which allows callers to leave messages when the phone line is busy. Previously, this had not been possible. An automated telephone results line was also set up in September 2010 and this has reduced the number of calls needed to give results.

1.4 There are targeted services for communities or individuals with specific needs.

**STATUS: Met**

The NHS board stated that the process for identifying and targeting communities with specific needs is set out in its sexual health strategy 2005–2010. This document is currently under review and the new sexual health strategy 2011–2015 will be circulated for consultation in May 2011. Evidence and data from local and national sources are used to inform policy, and gaps in service provision have been identified. However, a population needs assessment has not been carried out.

Given the geographical nature of NHS Borders, one of the main challenges has been accessibility to sexual health services for people who live outwith the central Borders area. Perceived confidentiality issues can also be problematic. Clinics have, therefore, been set up in a number of strategic locations across the Borders to facilitate access. From 2006, drop-in services were commenced.

Borders sexual health service states that evidence shows holistic interventions at an early age are likely to have the most effective long-term impact. It has, therefore, focused the majority of its targeting efforts on young people and those groups in that population most at risk. These include:

- young people living in deprived areas
- young people who do not attend school
- young people who are looked after by, or who are leaving, local authority care services
- young people who are homeless
- young people who are children of teenage parents, and
- the lesbian, gay, bisexual and transgender (LGBT) community, especially young gay men.

Scottish Borders Council education department has recently identified specific areas of deprivation that relate to three local school catchment areas. It is likely that targeted health improvement work will focus on these schools and local areas in the near future. Further information relating to targeted services and interventions for young people is described more fully in Standard 3.

Other groups and communities that also have had specific targeted action include: homeless people; drug users; and people with learning disabilities. For example, the learning disability health improvement strategy group has implemented the ‘making choices keeping safe’ policy and guidelines. These guidelines advise health professionals how best to support individuals with learning disabilities to have positive relationships and good sexual health. ‘Making choices keeping safe’ training continues to be rolled out among staff.

After identifying poor levels of sexual health among some local migrant workers, in the Duns area, a local drop-in clinic was established. Community nurse specialists also visited local food packing and processing factories where a number of southern and eastern
European migrants work to promote the service. They were able to leave translated literature as well as chlamydia testing kits in the premises.

The Big River Project, set up by Turning Point Scotland, offers support to individuals in the Borders region who are experiencing difficulties due to their substance misuse. This includes sexual health advice, signposting to services and condoms through the needle exchange service.

Borders sexual health service has worked with various voluntary sector organisations such as Waverley Care, Relationships Scotland, LGBT Youth, Rape Crisis Scotland, and Open Secret, among others. Currently there is one modest funding contract with Relationships Scotland and a small number of individuals can be referred to this service for counselling. No scoping work has been carried out to evaluate where and how many individuals are directed to Borders sexual health service from the voluntary sector.

The standard of specialist sexual health service accommodation conforms with recommendations made by Department of Health, Health Services Building Notes and the Monks report.

The main specialist sexual health service accommodation is based at Galashiels Health Centre. Borders sexual health service was able to relocate to this purpose-built centre in 2007. Funding from Respect and Responsibility helped enable this move, as well as support from the NHS Borders Board. This has greatly improved accommodation for staff and patients.

Borders sexual health service has used the accommodation checklist produced by the West of Scotland sexual health managed clinical network to assess its four main clinic locations in Galashiels, Hawick, Duns and Peebles. The checklist allows NHS Borders to focus on any issues that may need to be addressed and review accommodation on an annual basis. On the whole, Borders sexual health team is happy with the standard of accommodation available.
Standard 2: Sexual health information provision

**Standard statement 2**

The public has access to accurate and consistent information about sexual health relevant to its needs.

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.

**STATUS: Met**

Information about sexual health conditions and local service provision is available in a variety of mediums such as leaflets, posters and on the NHS Borders sexual health website (www.borderssexualhealth.org.uk). The comprehensive website includes links to a number of condition-specific leaflets which are also available in other languages. Information is also available, on request, in other formats including easy read leaflets. Borders sexual health service has been advertised through the local bus service and on radio.

Sexual health information needs have been identified in the sexual health strategy 2005–2011. The health improvement team has done much work in this area, with a focus on delivering training to various agencies and services that offer advice and information to young people. Individual pieces of work to identify the information needs of certain groups within NHS Borders have been carried out. For example, the NHS board has commissioned a piece of research which is currently being carried out to establish the health information and service needs of men who have sex with men (MSM) in the Borders region. Much of the work in this area has been as a result of requests from certain groups or individuals. The NHS board is encouraged to further develop its approach to identifying the diverse sexual health information needs of the population it serves.

Every year Scottish Borders Council surveys a proportion of young people from all secondary schools in the region. NHS Borders health improvement team has been involved with the design and included some key questions around sexual health information. In 2010, all first and third year pupils were asked to complete the survey. Almost 83% responded that it was easy or very easy to find information about relationships or sexual health. NHS Borders was successful in submitting a business case to Scottish Borders Council to ensure school firewall systems would allow access to the Borders sexual health website, particularly as there is a separate young people’s section on it.

HIV Wake Up campaign materials have been used to target MSM. It has, however, proved challenging to disseminate these in a rural location with no ‘gay scene’ as such. Traditionally, this has always been a difficult group to engage with. Anecdotal evidence suggests that MSM prefer to go elsewhere to access sexual health services such as Edinburgh, Glasgow and Newcastle. LGBT Youth are assisting the commissioned MSM research by allowing access to focus groups with young gay men to gather their views. This, in turn, will inform future awareness raising campaigns and information needs of this particular group.
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.

 STATUS: Met

The health improvement team is responsible for ensuring information describing sexual health conditions and local service provision is accurate. Information resources are managed and distributed by the health improvement team secretary. All information leaflets provided by NHS Borders are produced by NHS Health Scotland, the Family Planning Association and other reputable and well-used sources. Therefore, consistency and quality assurance processes have already been met.

Partner organisations, such as schools, school nurses, youth services, GPs and voluntary sector organisations, receive updated service leaflets, contact tracing cards and service business cards when required. There is also a website (www.youngpeoplehealthtoolbox.info) that details the resources that are available from the health improvement team. It is used by professionals working with young people in partner organisations to request appropriate information resources from NHS Borders.
Standard 3: Services for young people

Standard statement 3
NHS boards ensure the development and delivery of integrated approaches to sexual health improvement, particularly in relation to young people.

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.

STATUS: Met

NHS Borders has identified young people as a key target group in its sexual health strategy. Evidence exists of engagement with local key partners in work to improve sexual health for young people and reduce teenage pregnancy. The sexual health strategy group includes representation from a number of organisations including Scottish Borders Council education department, LGBT Youth and a community paediatrician.

Strong links have been established between the NHS board and Scottish Borders Council education department. Joint working is evident in the development of school drop-in clinics, the roll-out of sexual health and relationships education (SHARE) in schools and collaboration on the young people’s survey (details in Standard 2). Links with the social work department are less developed but efforts have been made to include social work representation on the strategy group.

Weekly school drop-in clinics run during lunch breaks in nine of the 10 secondary schools. School nurses offer advice about sexually transmitted infections; information about contraception; provide condoms and chlamydia postal testing kits, as well as offering pregnancy testing. At present, there is an informal condom distribution scheme in place, however, this is soon to be formalised. NHS Borders is in the final planning stages for the implementation of a condom card (c-card) scheme to be delivered through the school nursing service and youth projects. Community nurse specialists also attend schools to give presentations and raise awareness of the service when invited to do so.

Apart from the education department survey, the NHS board also undertook consultation with young people through contact with groups such as the Youth Health Forum. The sexual health strategy group also carried out a survey among school pupils in 2008. There were 437 responses. Such consultation has led to service changes and the development of the young people’s section on Borders sexual health website.

‘Involved’ is the local LGBT Youth group for young people aged 12–25 living in central Borders area. It supports and advises young LGBT people in a number of ways including helping them access sexual health services.

GATE is a local youth project for young people aged 12–25 in the Galashiels area. Youth workers, trained by NHS Borders health improvement team, run sexual health information sessions on a regular basis. Condoms are also available.
3.6 Targeted interventions are demonstrated for young people at greatest risk of teenage pregnancy and poor sexual health, including looked-after children.

**STATUS: Met**

Borders sexual health service works closely with colleagues in looked after and accommodated children services. There is also a looked after and accommodated children’s nurse in post. All staff have received SHARE training. Surestart midwives support young mums and offer advice on contraception following the birth of their baby. They work in partnership with family centres and youth services. In comparison with other NHS boards in Scotland, NHS Borders has a relatively low teenage pregnancy rate. However, unintended teenage pregnancy remains a significant problem and its reduction is a key objective for NHS Borders.

Much collaborative working occurs with other agencies and key individuals sit across a number of groups. For example, the health improvement specialist is a member of the strategic youth work services group. Currently she is involved with a subgroup working on the action plan which includes recommendations made in teenage pregnancy self-assessment guidelines. She has a key role in disseminating information to Borders sexual health service from the various groups she is part of.

A recent education department report identified the three most deprived areas in the Scottish Borders region. They relate to three local school catchment areas for Eyemouth High School, Hawick High School and Galashiels Academy. It was reported that future health improvement interventions will target these areas.

NHS Borders links with a number of agencies and voluntary organisations such as Children 1st, Open Secret and In Care Survivors Service Scotland which work with young people at greatest risk of teenage pregnancy and poor sexual health. Another organisation, LetSBsafe2, offers young people aged under 18 in the Borders the opportunity to work through their experience of living with domestic abuse.

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.

**STATUS: Met**

SHARE training is carried out by the health improvement team. The health improvement team has been building capacity with partner organisations through the delivery of this training. Targeted training has been delivered to staff working with looked after and accommodated children and those working with people with learning disabilities. Other partners include school nurses, youth workers, community learning and development workers and teachers, particularly guidance staff. However, it was reported that engagement with social work has been difficult to date. A SHARE training session was organised specifically for social work but was not attended.

The SHARE programme has been rolled out across all 10 secondary schools in NHS Borders. Nine of the 10 schools reported that they use the programme as their main sexual health education material. The implementation of this has been a priority for both the NHS board and Borders Council education department. A review of the sexual health and relationships education programme in schools was carried out in 2009. It concluded that SHARE has been well received, gives clear messages and teachers are confident delivering
it. Overall, feedback about the programme has been positive. One of the recommendations was that SHARE training be delivered on a regular basis at least twice a year.

Within primary schools, the ‘Respect’ work and resources to encourage healthy relationships is progressing. However, to date, little training has been carried out. The NHS board reported that it is waiting for the right time to fully initiate this piece of work. Currently, it would be competing with a number of other priorities within schools. It will then target individual schools to begin a training programme. The DVD resource ‘Living and growing’ is used in primary schools.
Standard 4: Partner notification

Standard statement 4

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

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.

STATUS: Met

Borders sexual health service has developed a partner notification policy. All nurses within the service have had in-house partner notification training and are able to carry out basic partner notification. More complex partner notification can be referred to the lead nurse/health adviser.

Borders sexual health service has also offered partner notification training within primary care. A number of GPs and practice nurses have attended these information sessions. A chlamydia protocol was developed in 2009 which is primarily aimed at GPs and practice nurses. It explains four methods of partner notification and states the preferred options: referral to Borders sexual health service or shared responsibility.

Testing and treatment of sexually transmitted infections in general practice is facilitated by the GP sexually transmitted infection testing kit. The kit includes instructions and information on tests for chlamydia, syphilis, HIV and nucleic acid amplification test (NAAT) for gonorrhoea. The kit was piloted in three practices and then introduced to all practices from September 2010. Positive results are copied to the GP and Borders sexual health service. If consent is given, the community nurse specialist will contact the patient and initiate partner notification. If consent is not given, the GP will facilitate partner notification. Borders sexual health service is commended on the development and roll-out of the testing kit. However, uptake within primary care has been slow and the NHS board should encourage GP practices to take advantage of this useful service.

4.2 Individuals are offered partner notification in all settings delivering sexual healthcare, including in primary care, youth services and community pharmacies.

STATUS: Met

Much work has been done to facilitate partner notification in all settings where testing is happening. Links between the gynaecological wards, the termination clinic and community midwives are well established. Borders sexual health service is informed of all positive results. A link nurse has been identified to deal with contacting the patient for treatment and to begin partner notification. Work was also done with community pharmacists when launching a chlamydia postal testing kit in 2009. However, the number of positive tests returned was low and, therefore, this initiative ended. Procedures in primary care are explained above.

Following publication of Scottish Intercollegiate Guidelines Network (SIGN) Guideline 109, Borders sexual health service piloted a retesting protocol for chlamydia. Following results of the audit, the service now routinely contacts people 6 months later after their first
positive test for retesting. The lead nurse has responsibility for this. Partner notification is the only element of Borders sexual health service that remains paper-based and it is working towards implementing this section on the NHSScotland national sexual health system (NaSH).
Standard 5: Sexual healthcare for people living with HIV

Standard statement 5

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

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.

STATUS: 67%

Recent audit data show that 16 of 24 patients (67%) receiving ongoing HIV care have the result of syphilis serology recorded in their HIV records, or documentation why this is not required, within the preceding 6 months.

The audit includes all patients attending Borders sexual health service for HIV care as of 1 October 2010. It also shows that 22 of the 24 patients (92%) had information about syphilis serology updated within the preceding 12 months. The NHS board states that joint working on the development of an integrated care pathway for HIV care with NHS Lothian will help to formalise the offer of syphilis testing. Work is also ongoing to adopt the HIV database developed by NHS Lothian which includes prompts for sexual health screening at each visit.

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.

STATUS: Data not available

Eleven of 12 patients attending on 1 October 2010 had their sexual and reproductive history recorded within 4 weeks of diagnosis. However, within the total cohort of 24, an additional 12 patients had their HIV care transferred in to NHS Borders. It is not known how many were transferred in from outwith Scotland.

It was reported that HIV clinics are run in parallel and often combined with general sexual health and contraceptive clinics. A full range of condoms, contraceptive options, sexually transmitted infection testing and cervical smear testing is, therefore, available during routine HIV appointments. Clinic proformas include reminders to ask about sexually transmitted infection testing and specific questions on partner testing, condom use and sexually transmitted infection screening are addressed at each patient’s annual review.

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.

STATUS: 58%

Recent audit data show that 14 of 24 patients (58%) receiving ongoing HIV care have had an offer of a sexual health screen at least once every 12 months.
Twenty-two of the 24 patients had their sexual health history taken and documented within the last 12 months. However, only 14 were offered a chlamydia test.
Standard 6: Termination of pregnancy

Standard statement 6
Women receive safe termination of pregnancy with minimal delay, followed by contraceptive advice and psychological support.

6.1 70% of women seeking termination of pregnancy undergo the procedure at 9 weeks gestation or earlier.

STATUS: 75.8%

Audit data published by the Information Services Division in 2009 show that 75.8% of women seeking a termination within NHS Borders had the procedure at 9 weeks gestation or earlier. The review team commended NHS Borders for being the highest performing NHS board in Scotland in 2009 for this criterion. The NHS board also undertook a local audit of women who had a termination between 1 February–31 August 2009. Data from this audit show 83% of procedures being carried out within the specified timescale.

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.

STATUS: Met

NHS Borders has mechanisms to ensure that women are offered a range of contraception options at the time of termination of pregnancy. An integrated care pathway for termination of pregnancy is in place. Contraceptive advice is given at the initial clinic visit and plans for future contraception are documented in the integrated care pathway.

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).

STATUS: 71%

Audit data show that following a termination of pregnancy, 71% of women leave the facility with one of the more effective methods of contraception. The integrated care pathway requires documentation of whether contraception has been given on discharge. It also asks for a reason to be recorded if contraception has not been given.

Previous audit results had demonstrated that the NHS board was not meeting this criterion. At the time of the first audit, only 14% of women left the facility with one of the more effective methods of contraception. NHS Borders, therefore, took steps to address this and improve results. Nursing staff on the ward have been educated to raise awareness of the importance of women being discharged with contraception. Ward protocols have also been altered to support the prescription of hormonal contraception prior to discharge. Two members of nursing staff have been trained to insert contraceptive implants. The recent audit data show that this has increased the number of women leaving the facility with a contraceptive implant. In addition, the gynaecology registrar can insert an intrauterine device or system before discharge.
6.4 Post termination of pregnancy counselling to provide psychological support is available within 4 weeks for women (and their partners) who request it.

STATUS: Met

Trained members of nursing staff offer pre and post termination counselling to all women attending the service for termination of pregnancy. The offer of counselling after termination of pregnancy is documented. This is considered to be an example of good practice. Audit results show that 92% of women had a documented offer of counselling. Counselling sessions are held on a weekly basis and an appointment is routinely offered 1–2 weeks after termination.
Standard 7: Hepatitis B vaccination for men who have sex with men

Standard statement 7
Men who have sex with men who are at risk of sexually transmitted hepatitis B are offered vaccination.

7.2 Men who have sex with men (MSM) 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.

STATUS: Met
Hepatitis B vaccination is available at all clinic sites run by Borders sexual health service. All MSM are offered routine testing for hepatitis B as well as vaccination.

Borders sexual health service has developed and disseminated the NHS Borders sexually transmitted infection management protocol to all GPs in the NHS board region. It is circulated in electronic and hard copy format. Within the document, there is guidance on offering hepatitis B vaccination to at risk groups, which includes MSM. However, it was reported that it is unlikely that all GPs offer the hepatitis B vaccination to MSM. It is more common that they would refer on to the specialist sexual health service.

NHS Borders uses various media to make MSM aware of the availability of hepatitis B vaccination. For example:

- leaflets about clinics and drop-ins and what is offered there, and
- through the Borders sexual health website which also links information on the ROAM and Gay Men’s Health websites.

Various other information leaflets on hepatitis B are also available in clinics, such as the British Liver Trust Foundation leaflet.

7.3 70% of all MSM attending specialist sexual health services and not known to be immune to hepatitis B receive at least one dose of hepatitis B vaccine.

STATUS: 74%
During the period 2009–2010, local audit data show that 11 of 15 (73.5%) of all eligible MSM attending Borders sexual health service received at least one dose of hepatitis B vaccination. Of those not eligible for vaccination, it was noted that a high proportion had already completed a vaccination course. Figures also show 47% of eligible men went on to receive the full course of three vaccinations.
Standard 8: Intrauterine and implantable methods of contraception

Standard statement 8
All individuals have access to intrauterine and implantable methods of contraception.

8.2 60 or more females per 1,000 females of reproductive age per year are prescribed intrauterine and implantable contraceptives.

STATUS: 56.3 per 1,000

Key clinical indicator audit data show that 56.3 per 1,000 females of reproductive age were prescribed intrauterine and implantable contraceptives in 2009–2010. This has increased from 48 per 1000 women from the previous year.

Over recent years, Borders sexual health service has worked hard to increase the provision of long acting and reversible methods of contraception (LARC) both within the service and in the community. For example, over the last 2 years, provision of the contraceptive implant by Borders sexual health service has increased by 120% from 134 to 295 insertions. Implant provision has been increased through the training of all community nurse specialists and offering it at all drop-in clinics. Additionally, two further evening implant clinics have been opened to meet demand. Staff have also trained colleagues in the gynaecology ward to be able to offer implants to women who are undergoing a termination of pregnancy.

NHS Borders recognises that it still must increase its provision of intrauterine and implantable contraceptives. Within primary care, intrauterine methods of contraception are offered widely, however, this contrasts with low provision of implants. Although, the specialist sexual health service has seen huge increases in implant provision, figures within primary care have changed little. A recent survey of the availability of LARC in the community confirmed that GPs are willing to provide intrauterine methods of contraception as this is reimbursed. However, most did not offer implants as these are not paid for by the NHS board.

As Borders sexual health service does not have the capacity on its own to meet this standard, attempts have been made to address this issue. For example, Borders sexual health service has provided training to GPs for the Letter of Competence in Subdermal Implants from the Faculty of Sexual and Reproductive Healthcare. Members of Borders sexual health team are also available to GPs at the end of various clinics to help support training. GP colleagues can also phone or email at any time when requiring further support.

The NHS board has also been investigating the development of a local enhanced service for very long acting and reversible contraception with GP colleagues. However, the review team was informed this is currently on hold. Another possibility for increasing implant provision has been to assess whether community nurses, treatment room nurses, midwives and health visitors might be trained to offer counselling and implant provision. At present, this is under discussion, with a number of issues having to be resolved. Provision of implants in the primary care setting remains a challenge for NHS Borders.
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.

**STATUS: Met**

A recent survey of the availability of LARC in the community showed that most GPs refer women requesting implants on to Borders sexual health service. However, a small number of practices do offer implants. Most GPs provide intrauterine device and system fittings. Those that do not, either refer on to a neighbouring GP practice or to Borders sexual health service. A referral pathway for intrauterine contraception within NHS Borders has been created.

8.4 A consultation appointment with a service providing intrauterine and implantable contraceptives is available within 5 working days.

**STATUS: Not met**

Borders sexual health service carried out a telephone audit to find out if a consultation appointment for intrauterine and implantable contraceptives was offered within 5 working days. The audit was conducted over 16 days and of the 95 calls received, 24 (25%) were requests for intrauterine and implantable contraception. The average time for a consultation appointment was 17 days. The NHS board pointed out that as implants are available at drop-in clinics, it is likely that women would be able to have an implant fitted sooner than the 17 days.
Standard 9: Appropriately trained staff providing sexual health services

Standard statement 9
All staff who deliver sexual health services are adequately and appropriately trained.

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.

STATUS: Met

In-house training update sessions are run twice a year by Borders sexual health service. Nurses within the service must attend at least one each year but normally attend both. One of the training sessions is specifically aimed at GPs but open to all. Attendance has been good at these sessions with a mix of disciplines, including community, school and practice nurses. There is a close working relationship with NHS Lothian; some staff work across both NHS boards. A number of staff attend training days hosted by NHS Lothian.

All seven nurses employed by Borders sexual health service have family planning and cervical screening qualifications. Five of the nurses have a qualification in genitourinary medicine. Medical staff also have specialist qualifications in sexual health. Two of the doctors are registered trainers for the Diploma of Sexual and Reproductive Healthcare and also provide practical training for insertion of implants and intrauterine contraceptive methods. The lead consultant has provided training for medical staff in genitourinary medicine through a course of shared sessions and continues to share two sessions a year for supervisory purposes.

Training for healthcare support workers and administrative staff is provided in-house. Within the small service, staff have been dual trained and share some roles. This has added to the flexibility and efficiency of this part-time service. Nursing and administrative staff are up to date with completion of their NHS Knowledge and Skills Framework. All have a personal development plan to support them in their professional development. All those working in Borders sexual health service have completed alcohol brief intervention training.

There is no formal clinical supervision in place, however, communication channels among staff are very good. There is a staff meeting once a month where case reviews and various issues can be discussed.
Appendix 1 – Details of review visit

The review visit to NHS Borders was conducted on 5 April 2011.

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## Appendix 2 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>LARC</td>
<td>long acting and reversible methods of contraception</td>
</tr>
<tr>
<td>LGBT</td>
<td>lesbian, gay, bisexual and transgender</td>
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<tr>
<td>MSM</td>
<td>men who have sex with men</td>
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<tr>
<td>NAAT</td>
<td>nucleic acid amplification test</td>
</tr>
<tr>
<td>NaSH</td>
<td>NHSScotland national sexual health system</td>
</tr>
<tr>
<td>SHARE</td>
<td>sexual health and relationships education</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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</tbody>
</table>
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- by email
- in large print
- on audio tape or CD
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- in community languages.

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