North Yorkshire County Council

Executive

26 November 2019

North Yorkshire Integrated Sexual Health Services

Report of the Director of Public Health – Health and Adult Services

1.0 Purpose of report

1.1 This report:

- Highlights the results of the joint NYCC and York Teaching Hospital NHS Foundation Trust (YFT) Public Consultation on the S75 agreement;
- Shares the proposed service specification, performance and outcomes framework and the draft S75 principles;
- Confirms the available budget and future savings requirements;
- Requests a delegation of the final decision to the Corporate Directors of Strategic Resources and Health and Adult Services, the Assistant Chief Executive (Legal and Democratic Services) and the Director of Public Health, in consultation with the Executive Members for those respective portfolios, once YFT has confirmed its acceptance of the offer.

2.0 Issues and background

2.1 Sexual and reproductive health is not just about preventing disease or infection. It also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights. Good sexual health is a vital aspect of overall health and wellbeing. However, poor sexual health outcomes fall disproportionately on certain groups.

2.2 Since 1 April 2013, Local Authorities have been mandated to ensure that comprehensive, open access, confidential sexual health services are available to all people who are present in their area (whether resident in that area or not). The requirement for Genito-Urinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services to be provided on an open access basis is stipulated in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

2.3 During 2013/14 the Public Health team invested considerable time on the redesign and procurement of an integrated sexual health service, resulting in the

contract being awarded to one provider for a service which was historically delivered through nine different contracts.

2.4 York Teaching Hospital NHS Foundation Trust is the provider of the integrated sexual health service in North Yorkshire (YorSexualHealth). The contract commenced on 1 March 2015 with a Service commencement date of 1 July 2015 and an expiry date of 31 March 2018. Within the existing contract there was the option to extend the contract period for a further two years; this has been taken and the contract is now in place until 31 March 2020.

2.5 North Yorkshire County Council (NYCC) wishes York Teaching Hospital NHS Foundation Trust to continue to deliver an integrated sexual health service which provides effective, high quality, value for money services to its residents under a Section 75 Agreement.

2.6 On September 3 2019 NYCC Executive approved proposals for the initiation of a Section 75 agreement covering up to ten years for delivery of integrated sexual health services between NYCC and YFT subject to a 30 day consultation. The consultation has concluded and this paper provides a summary of the consultation responses received.

2.7 It is important to note that this Section 75 will devolve funding from the Public Health Grant for the provision of a specified service, in this case the integrated sexual health service, to current NHS provider York Teaching Hospital NHS Foundation Trust.

3.0 Performance Implications

3.1 The existing provider is very experienced and has established a high quality, well regarded integrated sexual health service across North Yorkshire which is continually reviewed to explore ways of improving service delivery. The existing provider is performing to expectations and often above, delivering the Key Performance Indicators (KPIs) within the contract, and works closely with the Council to address any areas of concern that may arise. The current service is being delivered within the agreed budget.

3.2 A Service Specification and Performance and Outcomes Framework will remain in place as part of the Section 75 agreement and are attached at appendix 1. These documents will form the basis of the Section 75 agreement.

4.0 Policy Implications

4.1 The integrated sexual health service supports the local population outcome which is that "all people in North Yorkshire experience good sexual health" as set out in the local strategic framework for sexual health.

5.0 Financial implications

5.1 There is a requirement for savings from the Public Health Grant that will contribute to North Yorkshire County Council's medium term financial plan (MTFP). This is anticipated to equate to around a 12% reduction in the total public health grant over the next two years

5.2 The annual contract value of the current integrated sexual health service is £2.7 million per year. As there is the need to make savings, NYCC requires a minimum 2% year on year reduction on the current contract value, which over the first five years of the contract would amount to a cumulative saving of 10%. In addition to this NYCC would require YFT to absorb any pay and inflationary cost increases over the agreement period.

5.3 As part of this agreement financial risk incurred by either party will remain with that party. Therefore there will be no sharing of financial risk within this agreement.

5.4 This arrangement is subject to YFT Board confirming their agreement (awaiting written confirmation).

5.5 Entering into a Section 75 Agreement with York Teaching Hospital NHS Foundation Trust will allow us to continue to work collaboratively to deliver a high quality integrated sexual health service. This approach will enable the delivery of the required savings which ensures that the service delivers value for money and remains sustainable.

6.0 Legal implications

6.1 The Local Authority is mandated as part of its public health statutory duties as stated in the Health and Social Care Act 2006 to ensure that comprehensive, open access, confidential sexual health services are available to all people in North Yorkshire (whether they live here or not).

6.2 Powers provided to local authorities and NHS bodies under Section 75 of the NHS Act 2006 and associated Regulations set out that a local authority and an NHS body can each delegate certain functions to the other, provided that the resultant arrangements are likely to lead to an improvement in the way those functions are exercised.

6.3 Arrangements under Section 75 may include (i) arrangements for the exercise by NHS bodies of certain local authority health-related functions in conjunction with the exercise by such bodies of their NHS functions and/or (ii) arrangements for the exercise by local authorities of certain NHS functions in conjunction with the exercise by such authorities of their health-related functions.

6.4 The particular functions that can be included within Section 75 agreements are prescribed by the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The recommended partnership agreement between the parties would accordingly be within the remit of the legislation.

6.4 Whilst there is a requirement to consult prior to entering into a Section 75 agreement (and also consult jointly with person affected by such arrangements (as per regulation 4(2) of the 2000/617 regulations), there is no requirement to do a full procurement exercise.

6.5 The NYCC Legal Team are working on a draft the Section 75 Agreement. The Section 75 will follow the standard format for such delegated agreements between Local Authorities and Health Bodies. The agreement will be guided by a set of principles, which will help shape the partnership agreement.

6.7 These principles are in draft format, and will be mutually developed and agreed between both parties as part of the legal development of the Section 75. The principles underpin the vision that ***"all people in North Yorkshire experience good sexual health***".

The *draft* principles are listed within 3 categories:

Partnership working

- The partnership (between NYCC and YFT) will build on its existing solid foundations and will seek to strengthen coordinated action across the sexual health system, providing system leadership, allowing for opportunities to exchange views, support innovation and provide additional momentum to achieve the best possible outcomes.
- The partnership will ensure available resources are focussed on delivering the best possible sexual health outcomes for all people in North Yorkshire.
- The partnership will agree and ensure clear governance arrangements are in place to oversee delivery of the contract.
- The partnership will ensure they work together openly and transparently.
- The partnership will promote consensual decision making based on evidence, insight, data and challenge to get to a point of consensus and one voice.
- The partnership will ensure that service delivery adapts to the changing needs of the population and is flexible in its approach.

- The partnership will ensure that the service offered is safe, evidence based and of high quality.

Resources

- The first 12 months will allow the partnership to agree an operational plan which clearly identifies how future efficiencies (to meet the yearly contractual reductions) will be met. The plan must ensure statutory requirements continue to be met and any future models will continue to deliver a safe and effective service.
- The partnership will ensure quality and value for money at all times.

Service model

- The partnership will ensure the service delivery model prioritises prevention and early intervention with a focus on young people and most at risk populations.
- The partnership will ensure the service is delivered by a skilled and competent integrated sexual health workforce (providing person centred care).
- The partnership will ensure strong clinical leadership is provided by the service that is embedded and visible across the local sexual health system.
- The partnership will ensure the service complies with evidence based practice, but also applies innovative practice which is monitored and evaluated.
- The partnership will ensure there is rapid and easy access to the Service including in rural areas, delivering services in appropriate settings.
- The partnership will ensure all contraceptive, STI diagnosis and treatment is provided and dealt with in one location as far as is practicably possible.

7.0 Consultation Undertaken and Responses

7.1 A 30 day joint consultation between both NYCC and YFT began on 7 October and ended 6 November 2019. The NHS and Local Authorities Partnership Arrangements Regulations 2000 stipulate that “the partners may not enter into any partnership agreements [under Section 75 of the NHS Act 2006] unless they have consulted jointly such persons as appear to them to be affected by such arrangements”. The consultation set out the proposal to put in place a formal Partnership Agreement for the delivery of the Integrated Sexual Health Service and invited comments from both the public and interested parties.

7.2 A total of 39 responses have been received from the online SNAP survey and hard copies. The majority (23 of the 39) responses were from members of the public, 9 were responding on behalf of an organisation or in a professional role

and 7 responded as a current provider of sexual health services. Of those responses received there is overwhelming support for the Section 75 Partnership Agreement to be developed to deliver integrated sexual health services between YFT and NYCC (38 agree and 1 disagree).

7.3 The reasons given by the general public to explain their response are extremely supportive of the current provider and the services they deliver across North Yorkshire.

"I think the services are currently being run well by York Trust and should continue".

"The current service is well organised and effective".

"Brilliant service offered, appropriate and accessible appointments given, approachable and knowledgeable staff".

"Local service for local people – excellent".

The reasons given by the 1 member of the public who disagreed felt that the Council should leave the responsibility to the NHS. They were not aware that the Council already have this responsibility for sexual health services.

8.0 Impact on Other Services/Organisations

8.1 The Council will work with the Provider to ensure that there is no significant negative impact on the health and wellbeing of the North Yorkshire population.

9.0 Equalities implications

9.1 An Equalities Impact Assessment on the integrated sexual health service has been completed and was shared with Executive on 3 September 2019.

10.0 Reasons for recommendations

10.1 Entering into a Section 75 Partnership Agreement with York Teaching Hospital NHS Foundation Trust will allow us to continue to work collaboratively to deliver a high quality and well regarded integrated sexual health service as shown by the consultation results. This approach will facilitate the delivery of the required savings and ensure that the service delivers value for money and remains sustainable over the next 10 years.

10.2 The partnership arrangements will also strengthen the existing relationships with York Teaching Hospital NHS Foundation Trust and allow greater scope and flexibility to explore further collaboration opportunities in the future.

11.0 Recommendation (s)

11.1 The Executive note the results of the joint NYCC and YFT Public Consultation on the S75 agreement.

11.2 The Executive support the proposed service specification, performance and outcomes framework and the draft S75 principles.

11.3 The Executive note and support the proposed budget.

11.4 The Executive delegate the final decision, once YFT have confirmed their acceptance of the offer to the Corporate Directors of Strategic Resources and Health and Adult Services, the Assistant Chief Executive (Legal and Democratic Services) and the Director of Public Health, in consultation with the Executive Members for those respective portfolios, once YFT has confirmed its acceptance of the offer.

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COUNTY HALL
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Date: 26 November 2019

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Appendix 1 – Service Specification and Performance Outcomes Framework

North Yorkshire County Council

Specification for an Integrated Sexual Health Service for North Yorkshire Residents

1 Overview

1.1 Introduction

North Yorkshire County Council ("NYCC") wishes to commission a provider ("the Provider") to deliver an integrated sexual health service ("the Integrated Sexual Health Service") which provides effective, high quality, value for money services to its residents.

The Provider shall ensure the Integrated Sexual Health Service is flexible in its delivery to address the range of factors that impact on accessibility of our residents to services. It will also be responsive to the different and changing needs of our residents and in particular utilising the advances in technology to achieve this.

The Provider shall ensure the commissioned Integrated Sexual Health Service supports our local population outcome which is that **"all people in North Yorkshire experience good sexual health".** Residents of North Yorkshire will be supported in making informed, confident choices around their sexual health with a particular focus on prevention, and supporting young people and other at risk and vulnerable groups and communities from experiencing sexual ill-health.

1.2 Evidence Base

Local service provision should be informed by need as identified in both local and national data; including the North Yorkshire Sexual Health Needs Assessment – available from http://hub.datanorthyorkshire.org/dataset/north-yorkshire-sexual-health-needs-assessment-2019

Sexual ill health has broad social and economic costs for society. The long term-health implications of sexual ill health, such as infertility, ectopic pregnancy, miscarriage, unemployment, social exclusion and discrimination and stigma, have far greater cost implications than the prevention of an unintended pregnancy or sexually transmitted infections ("STIs") by delivering accessible services from contraception to full sexual health provision.

Sexual health is an important and wide-ranging area of public health. Most of the adult population of England are sexually active and having the correct sexual health interventions and services can have a positive effect on individuals, families and population health and wellbeing. However, sexual ill health is not equally distributed among the population with the Government setting out its ambitions for improving sexual health in its publication, *A Framework for Sexual Health Improvement in England*[1]

Strong links exist between deprivation and STIs, teenage conceptions and abortions with the highest burden borne by women, men who have sex with men ("MSM"), trans communities, teenagers, young adults and black and minority ethnic groups. HIV infection also has an unequal impact on MSM and Black African populations. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

[1] Department of Health (2013). *A Framework for Sexual Health Improvement in England.* (http://www.dh.gov.uk/health/2013/03/sex-health-framework/)

The Provider shall deliver an Integrated Sexual Health Service which aims to address these inequalities by providing easily accessible services.

The evidence base for the advice, care and treatment provided by an Integrated Sexual Health Service consists of best practice and expertise as prescribed by current clinical training[2], guidance from appropriate professional bodies (such as BASHH, BHIVA, MEDFASH, NICE and FSRH etc.) and relevant national policy and guidance issued by the Department of Health, Public Health England and researched evidence.

Sexually Transmitted Infections ("STIs")

STIs, including HIV, are one of the major infectious disease problems in the UK today.

Rising rates of STIs including HIV infection have been recorded both nationally and internationally since the early 1990s and statistics in the UK reflect these trends.

STIs impact enormously on morbidity ranging from the acute and chronic disease manifestations of HIV to complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility from untreated Chlamydial and Gonococcal infection, and cervical cancer from human papilloma virus ("HPV").

Young people, black minority communities and men who have sex with men ("MSM") are disproportionately affected by STIs. There is a significant variation in the trends in STIs and HIV in these different sub-populations. Public health interventions need to be targeted appropriately focusing on these key prevention groups.

The late stage of diagnosis in new cases of HIV is concerning. Improved uptake of testing for HIV is vital for early detection and treatment to reduce morbidity and mortality. It also allows diagnosed people to make informed choices and following successful treatment can significantly impact on the ability for onward infection to others.

Young adults are advised to test for Chlamydia annually or on change of sexual partner, as part of the National Chlamydia Screening Programme ("NCSP") to control the infection and its complications.

The Chlamydia diagnoses indicator recommends a level of achievement for local areas to work towards – at least 2,300 Chlamydia diagnoses per 100,000 15-24 year olds per annum with an aspiration to diagnose 3,000 per 100,000.

Achieving this indicator (and managing infections appropriately with antibiotic treatment and partner notification) should lead to a fall in Chlamydia prevalence in England (National Chlamydia Screening Programme, 2012).

Contraception and Pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion. Research evidence shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children[3].

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[2] BASHH & MEDFASH (2014) *Education and Training Matrix: Standards for the Management of Sexually Transmitted Infections* (http://www.bashh.org/documents/Standards%20for%20the%20management%20of%20STIs%202014%20FINAL%20WEB.pdf)

[3] The Prevalence of Unplanned Pregnancy and Associated Factors in Britain: finding from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3), Wellings K et al, Lancet 2013; 382(9907): 1807-1816

U18 conceptions rate per 1000 in North Yorkshire is 10.0, better than the England rate 17.8. U16 conceptions rate per 1000 is 1.9 similar to the England average 2.7. However there are district variations with U18 conceptions, Scarborough having the highest rate of 23.7.

The percentage of women having an abortion in 2018 who had one or more previous abortions varies by ethnic group. In 2018, 35% of Asian women, 39% of White women and 47% of Black women who had an abortion had previously had an abortion[4].

The highest abortion rate is amongst women aged 21 (30.7 per 1,000). The under 18 abortion rate for 2018 is 8.2 per 1,000 women. This is less than half the 2007 rate of 19.8 per 1,000. The abortion rate for 30-34 year olds is increasing, 19.9 per 1,000 women in 2018. This has increased from a rate of 15.6 per 1,000 women in 2008[4].This indicates that more work needs to be done in promoting effective contraception to prevent unwanted pregnancy.

In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region and North America for condom use among sexually active young people; previously, England was in the top ten[5].

Guidance from NICE has found that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intra-uterine system or the intrauterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms[7]. However, a condom should also always be used to protect against STIs.

HIV

Data published in September 2019, by Public Health England (PHE) show that new HIV diagnoses in the UK have fallen to their lowest level since 2000. New diagnoses fell by almost a third (28%) from 6,271 in 2015 to 4,484 in 2018.

New HIV diagnoses have been declining in both gay and bisexual and heterosexual populations. The steepest falls have been seen among gay and bisexual men, where new diagnoses declined by 39% between 2015 and 2018. The biggest falls have been among gay and bisexual men who are:

- white (46% decrease from 2,353 in 2015 to 1,276 in 2018)
- born in the UK (46% decrease from 1,627 in 2015 to 873 in 2018)
- aged 15 to 24 (47% decrease from 505 in 2015 to 269 in 2018)
- living in London (50% decrease from 1,459 in 2015 to 736 in 2018)

During the same period, new diagnoses have also fallen by a quarter (24%) among people who acquired HIV through heterosexual contact.

The continued decline of HIV diagnoses is largely due to the success of combination HIV prevention over the past decade, which includes HIV testing, condom provision, the scale up of pre-exposure prophylaxis (PrEP) and anti-retroviral therapy (ART).

[4] *Abortion Statistics, England and Wales:2018*, Department of Health, 2019
[5] Health Behaviour in School-Aged Children, World Health Organization, 2012

Despite falling rates of new diagnoses there remain challenges in ensuring that more people are diagnosed early. Almost half (43%) of those newly diagnosed with HIV in 2018 were at late stage of infection.

There is substantial variation between sub-populations in rates of late diagnosis; the late diagnosis proportion was 60% among heterosexual men, 52% among black African adults and 59% in those aged 50 and older.

Late diagnosis is the most important predictor of morbidity and short-term mortality among those with HIV infection. Improved uptake of testing for HIV is vital for early detection and treatment. It also allows diagnosed people to make informed choices and following successful treatment can significantly impact on the ability for onward infection to others.

Although only small numbers of new diagnoses are made each year, in North Yorkshire during 2017, 41% were classified as 'late diagnoses' (as measured by the CD4 count of less than 350mm^3). North Yorkshire is worse than the England rate for late diagnosis of HIV.

The actual numbers of HIV infections are small; therefore communication of promotion activities must be comprehensive across key target groups. The use of local tacit information will help to identify risk taking groups. For example, key local knowledge on public sex environments ("PSEs") and dating websites.

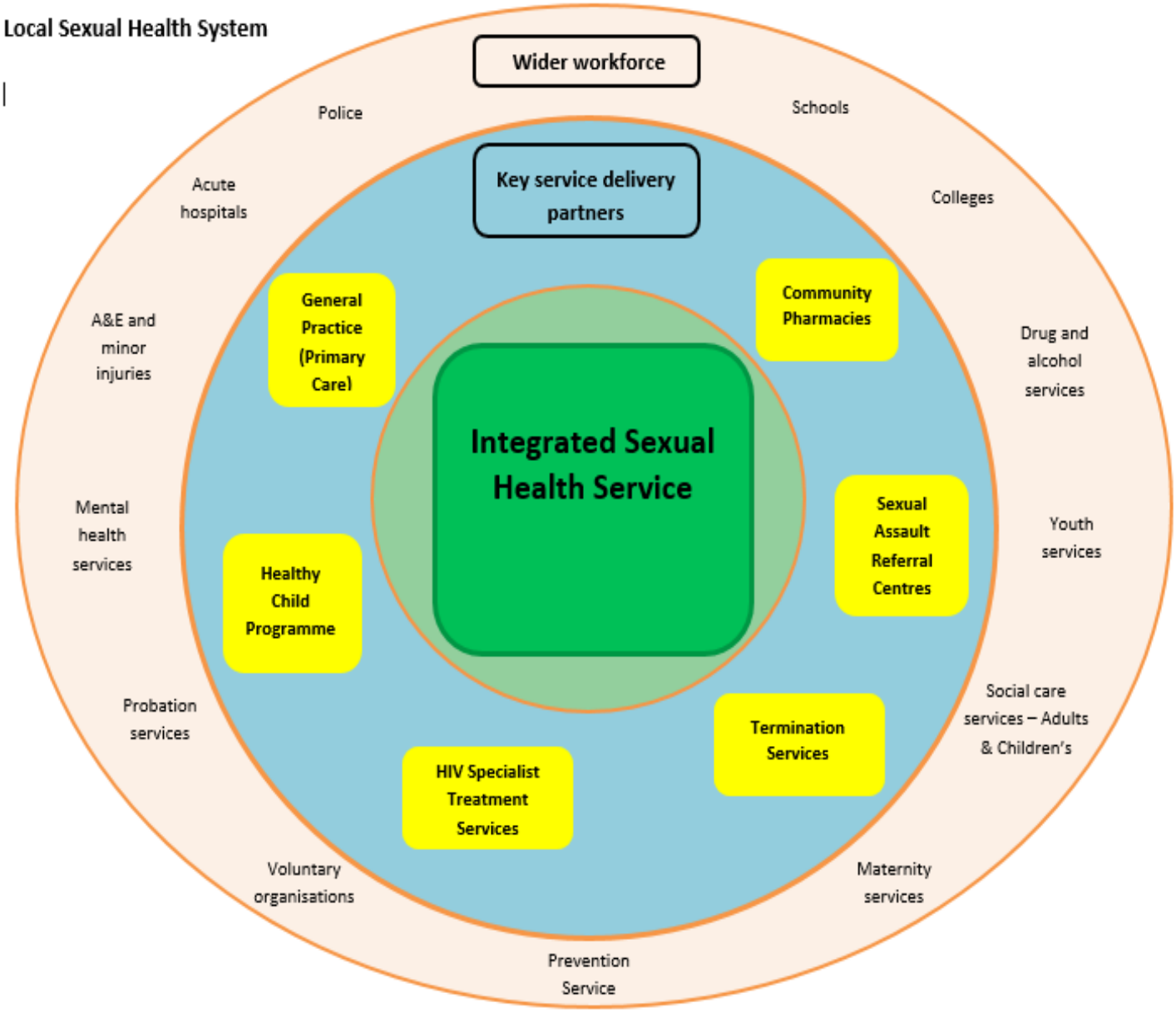
1.3 Service Delivery Model

The S75 partnership agreement will commence on 1 April 2020.

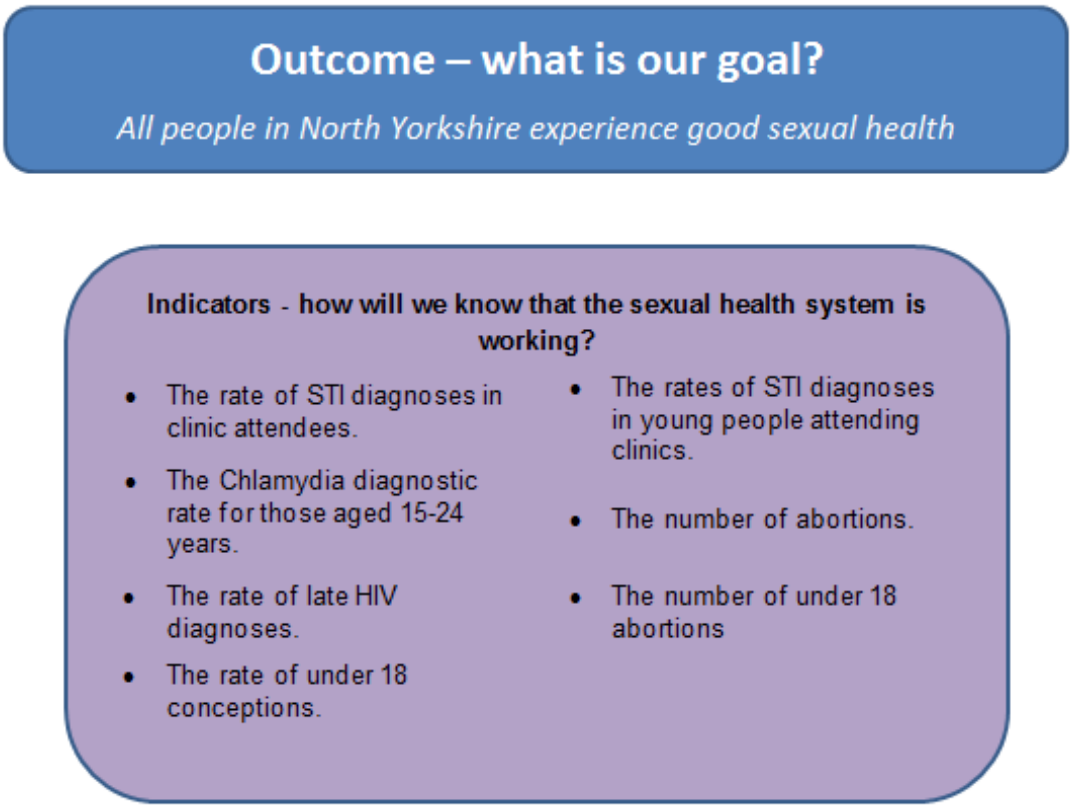
The Service will run between 1 April 2020 and 31 March 2030. The agreement has a total possible term of 10 years with the service intended to be in place for an initial period of five years. There will be an option to extend for a further period of three years and then a final further option of two years (5+3+2). The decision to extend will be at the discretion of the council and subject to satisfactory performance.

It is recognised that there are many other organisations and services that are responsible for commissioning and providing services that impact on the sexual health outcomes of the population. NYCC only has responsibility for commissioning parts of the local sexual health system. However, it is an expectation that the Integrated Sexual Health Service will not work in isolation from the wider range of other services and workforces that are delivering sexual health services and the Provider will be expected to evidence strong partnerships and pathways as appropriate.

Diagram 1 illustrates the Local Sexual Health System and where organisations sit within it.



The Integrated Sexual Health Service will contribute to the attainment of a number of sexual health indicators as set out below:



For the purpose of the Contract the following definition will be used:

The *"**Integrated Sexual Health Service**"* (ISHS) will relate to elements in scope of this specification.

The *"**Provider**"* will relate to the organisation that will be delivering this agreement under the service specification.

1.4 Services Out of Scope of this Contract

For this partnership agreement process is it important to be clear what is out of scope of this Specification.

The following services are not NYCC's responsibility and **out of scope** of this Specification:

a. Termination services – commissioned by Clinical Commissioning Groups.

b. Sexual assault referral centres – commissioned by NHS England.

c. HIV specialist treatment and care centres – commissioned by NHS England.

d. GP contraceptive services delivered as part of core General Medical Services (GMS) or Personal Medical Services (PMS) contracts – commissioned by NHS England.

The following services are the responsibility of NYCC but also **out of scope** of this specification. Delivery of these services is secured through different procurement routes:

Targeted Pharmacy sexual health services

Targeted General Practice sexual health services.

Healthy Child Programme (HCP) for 0-19 year olds.

While these services are out of scope, the Provider shall have clear, established referral pathways into these services.

1.5 Principles of the Integrated Sexual Health Service

The Provider shall ensure the following key principles are adhered to in the delivery of the Integrated Sexual Health Service (and all its constituent Service Areas):

Priority shall be given to prevention and early intervention with a focus on young people and most at risk populations.

The Integrated Sexual Health Service shall be delivered by a professional integrated skilled sexual health workforce (providing person centred care).

Strong clinical leadership shall be embedded across the local sexual health system.

Evidence based practice, innovation and use of technology shall be used.

There shall be rapid and easy access to the Integrated Sexual Health Service including in rural areas, delivering services in appropriate settings.

All contraceptive, STI diagnosis and treatment shall be provided and dealt with in one location as far as is practicably possible.

Ensure quality and value for money at all times.

The Council is keen to prioritise its Public Health spend in future years and move investment into areas of greatest identified need. Value for Money from existing contracts goes hand in hand with this aspiration and this partnership agreement process endeavors to achieve high performance within the capped maximum price over the life of the contract.

2 Service Specification for the Integrated Sexual Health Service

2.1 Outline of the Integrated Sexual Health Service

The Provider shall provide confidential, open access, cost-effective, high quality provision for contraception, diagnosis and management of sexually transmitted infections including HIV, according to evidence based protocols and current national guidance. The Provider shall ensure there is a particular focus on meeting the sexual health needs of young people and vulnerable and at-risk groups.

To ensure rapid and easy access the Provider shall provide open access 'one stop shops' in each district council area where the majority of contraceptive and STI needs shall be dealt with by appropriately trained health professionals at each site, without the need for onward referral to another member of Staff within the ISHS or on to another clinic site.

There are some groups of individuals or communities that are at higher risk of poor sexual health outcomes due to their risk taking behaviours or lifestyles. The Provider shall ensure that sexual health interventions are targeted at groups at high risk of exposure to HIV and other STIs in North Yorkshire. The most at risk groups include men who have sex with men (MSM), black African communities, people misusing drugs and sex workers. Other vulnerable groups are lesbian, gay, bisexual, transgender and questioning (LGBTQ+) adults and young people; people with learning disabilities and people with mental health conditions.

In order to address the needs of these groups, who are often not effectively contacted or reached by existing services or through traditional health channels, the Provider will deliver a Community Outreach Service. This will be community orientated and delivered across all localities, and will facilitate rapid access to clinical services as required. Staff will be skilled in community development and have specialist knowledge and understanding of the needs of the most at risk populations.

HIV is now considered a long term health condition in the UK, characterised by periods of good health punctuated with bouts of illness. Despite increased longevity and improved physical health, HIV continues to be a difficult and stressful condition for many people.

The Provider shall play a key role in supporting residents of North Yorkshire living with HIV to address their concerns about their quality of daily life as well as their other related medical, personal, and social issues - which may include experiencing discrimination and social isolation. The Provider shall ensure that Service Users and Carers accessing the Service receive an appropriate level of support dependent on their needs for as long as this is required and they continue to wish to access it. The Provider shall take into account any responsibilities under The Care Act 2014.

The Staff employed within the ISHS will be viewed as the clinical leaders of the Local Sexual Health System. The Provider shall ensure the ISHS Staff provide clinical leadership across the Local Sexual Health System supporting, advising and providing expertise to other organisations and providers delivering sexual health services in the locality, e.g. GPs and Pharmacists. This shall include providing clinical leadership and advice, support on governance, disseminating best practice, establishing and facilitating communication networks between organisations to support service delivery and sharing and understanding of local issues as well as delivering training. The Provider shall ensure that the ISHS Staff are known to local professionals and can be easily contacted when required.

2.2 Service Objectives

The Provider shall ensure the ISHS delivers the following specific objectives:

To provide sexual health information and advice in order to increase knowledge and understanding of sexual health issues (especially among high risk groups and other vulnerable groups e.g. people with learning disabilities or mental health conditions) to enable people to make informed choices about their sexual health and reduce sexual health inequalities.

To raise awareness of the benefits of sexual precautions and encourage safer sex practice.

To identify and provide brief interventions and onward referral where appropriate to support Service Users to address the wider risk factors which may impact upon their sexual health (e.g. alcohol and drug use, chemsex).

To increase access, for all age groups and vulnerable and at-risk groups, to a complete range and choice of contraception including long acting methods, emergency contraception, condoms and support to reduce the risk of unwanted pregnancy and STIs.

To enable individuals to make an informed and timely decision about their pregnancy, through pregnancy testing and counselling about pregnancy choices, including appropriate onward referral to termination services or maternity care.

To provide rapid and easy access to services for the prevention (including vaccination), detection and management (treatment and partner notification) of sexually transmitted infections (complex and uncomplex) and blood borne viruses, for all ages and vulnerable and at-risk groups, in order to reduce prevalence and transmission.

To provide proactive health promotion, including repeat and frequent testing; and Point of Care Testing (POCT) to most at risk populations.

To increase the uptake of HIV testing, in particular to promote and offer annual HIV testing of gay or bisexual men (in line with NICE guideline NG60, 2016), and ensure rapid referral to HIV care services following diagnosis, in order to reduce late diagnosis and onward transmission.

For people living with HIV and their carers provide support to improve physical and mental health, and social and economic well-being.

To promote service and key sexual health messages to the local population, via the use of innovative and appropriate media and marketing techniques tailored to specific audiences which aim to reduce stigma.

To deliver sexual health training to key workforce groups within North Yorkshire to ensure an effective Local Sexual Health System.

To be responsive to local need (a) providing rapid response to outbreak management; and (b) through continuous improvement and response to local population need.

To provide clinical leadership and facilitate networks across the Local Sexual Health System within North Yorkshire to support communication and joined up working including the development of clear referral pathways between providers.

2.3 Service Description

This section sets out the detail of the ISHS which the Provider shall provide.

There are some groups of individuals or communities that are at higher risk of poor sexual health outcomes, including unintended pregnancies due to their situation or lifestyle. The Provider shall ensure the ISHS plays a key role in identifying and offering information, advice, support and interventions to these individuals or communities. The Provider shall deliver the following range of services within the ISHS:

2.3.1 Sexual health promotion and information

2.3.2 Clinical assessment

2.3.3 Contraceptive services

2.3.4 STI Services

2.3.5 Outreach service targeting young people aged under 25 and vulnerable groups

2.3.6 Sexual health counselling

2.3.7 Community outreach service targeting most of risk populations

2.3.8 Positive Support Service for People Living with HIV and their Carers

2.3.9 Training

2.3.10 Campaigns

2.3.11 Clinical leadership

Service Users will access the services most appropriate to their needs following an assessment.

2.3.1 Sexual Health Promotion and Information

Health promotion is important in supporting lifestyle change and risk minimisation. The Provider shall ensure that Service Users accessing the ISHS receive evidence based sexual health information. This should include but not be limited to information on: pregnancy and abortion, the full range of contraception and where it is available, STIs and safer sex messages, sexual assault, Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) advice. Any health promotion interventions should be appropriate to meet individual needs. The Provider shall ensure that NICE guidance is utilised and that there is appropriate referral/ sign-posting to other local services, where this could be beneficial and where Service Users can access one-to-one behaviour change support.

2.3.2 Clinical assessment

The Provider shall ensure that a full medical and sexual health history and risk assessment is undertaken when Service Users access the ISHS. The risk assessment shall cover sexual assault, domestic violence, drugs, alcohol (using Audit-C), Chemsex, female genital mutilation, psychosexual issues, mental health issues, sexual exploitation and safeguarding; and onward referral where appropriate. Where applicable the Provider shall ensure risk reduction strategies are discussed and brief interventions on problematic drug and alcohol use and Chemsex are discussed and recorded, with onward referrals to other services as appropriate. The Provider should work closely with the North Yorkshire substance misuse services to ensure needs of service users are met.

The Provider can choose to offer opportunistic cervical screening – funding arrangements for this will need to be agreed with NHS England.

The Provider shall ensure that all Service Users requesting a sexual health check are offered and encouraged to accept HIV testing in order to reduce the proportion of individuals with undiagnosed HIV infection.

2.3.3 Contraceptive Services

The Provider shall provide contraceptive services following an assessment of need. The level of contraception offered will depend on the setting and whether it is considered safe to prescribe this method of contraception. It is the Provider's responsibility to ensure that the setting they work in is suitably safe from a clinical perspective. The contraceptive services provided shall include, but not be limited to:

Pregnancy testing and counselling about pregnancy choices e.g. termination counselling and onward referral to termination services or maternity care.

Supply of male and female condoms and lubricant.

Provision of information to Service Users to enable them to make an informed choice about and provide access to emergency oral contraception (three and five day methods) and emergency intrauterine device (IUD) insertion as clinically indicated by current guidance[6].

First prescription and continuing supply of hormonal contraception (combined and progesterone only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist.

First prescription and continuing supply of injectable contraception.

Copper and medicated IUD/IUS insertion and removal excluding for gynaecological reasons. The Provider shall be aware of alternative local clinical pathways.

IUD/IUS follow up three to six weeks after insertion (to check threads, exclude perforation, and exclude expulsion or presence of any pelvic tenderness). The Providers should ensure Service Users return in time for removal, otherwise there is no need for further follow-up, unless the woman experiences problems.

Diaphragm fitting and follow up.

Contraceptive implant insertion and removal.

All follow-up appointments shall be carried out by the Provider and the Service User shall not be referred back to primary care for follow-up unless it is Service User choice.

Advice about natural family planning.

Comprehensive advice and support to people experiencing difficulties with choice of contraceptive methods.

[6] Faculty of Sexual and Reproductive Healthcare (2017) *FSRH Guideline Emergency Contraception* March 2017 (Updated December 2017) https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/

Management of complex contraceptive problems.

Provision of free Chlamydia home sampling kits for 16-24 year olds.

Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. This will include ultrasound scanning for location of deeply placed impalpable implants prior to surgical removal of the implant at the same visit, and location of intrauterine devices with threads not visible on pelvic examination.

Condom Distribution Scheme

The Provider shall also establish and co-ordinate the delivery of a free condom distribution scheme ("Condom Distribution Scheme") to ensure condoms are widely available in a range of clinical and non-clinical settings. Consistent and correct use of male latex condoms can reduce the risk of STI transmission and prevent pregnancies. NICE guidance (NG68 published in 2017) recommends that free condoms (including female condoms) are readily accessible, to young people and those most at risk, from a variety of settings.

The objectives of a condom distribution scheme are to:

promote condom use to high risk groups

contribute to the reduction of unintended pregnancy and parenthood

contribute to the reduction of the risk of transmission of sexually transmitted infections (STIs), including HIV

promote the 'Double Dutch' method which is using a barrier method alongside another form of contraception to protect against pregnancy and STIs.

The scheme should be targeted at the following at risk groups:

young people aged 24 and under, with the emphasis on promoting condom use to boys and young men

gay and bisexual men

known injecting drug users

sexual health clinic attendees

sex workers

homeless people

any other group based on local needs assessment.

The Provider shall therefore set up a local system to recruit organisations to sign up to the Condom Distribution Scheme and have clear policies, procedures and training in place to ensure that staff distributing condoms as part of this scheme comply with policies around safeguarding, particularly for under 16s.

2.3.4 STI Services

The Provider shall provide STI services following an assessment of need. The assessment process will clearly identify those Service Users who are at risk and would benefit from tests and examinations. Where this has been identified the Provider shall offer tests for Chlamydia, Gonorrhoea, Syphilis and HIV as a minimum, even for those Service Users that are asymptomatic. The Provider shall ensure that Service Users displaying symptoms are offered a full genital examination (and offered a chaperone for this examination). The Provider shall ensure that all assessments and examinations follow BASHH national guidelines.

Immunisations

Hepatitis A and B

The Provider shall promote and deliver Hepatitis A and B vaccination, with a particular focus on key target groups, including operating a recall system for those who do not complete the course of vaccinations. Immunisation against Hepatitis A (HAV) and Hepatitis B (HBV) is recommended for people who may be at increased risk of infection; in the context of sexual health the Green Book on Immunisation (Chapters 17 and 18) recommends that MSM with multiple sexual partners are offered vaccination against HAV and HBV.

For Hepatitis B, the provider should:

- risk assess patients and consider the possibility of hepatitis B transmission
- offer testing of Hepatitis B for high risk individuals
- arrange passive immunisation with Hepatitis B immunoglobulin for persons who have had a recent high risk exposure where rapid protection is required
- notify acute cases of hepatitis B to Public Health England
- offer hepatitis B immunisations to persons at high risk attending their service. These include: injecting drug users, individuals who change partners frequently (especially men who have sex with men, and sex workers), sexual contacts and close family contacts of a case or an individual with chronic infection with Hepatitis B. Please note occupational immunisation is excluded from this contract.
- In rare instances of outbreaks of hepatitis B, Providers should be prepared to assist with prevention and control measures that may include high risk individuals attending their service.

Human Papilloma Vaccination (HPV)

The Provider is required to support national efforts to vaccinate target groups with HPV in line with national guidance and policy such as what is set out in the Green Book. This includes signposting eligible individuals to relevant services for HPV, or where required provide immunisations to individuals in the target group attending services who have not completed their primary immunisation course for HPV.

Diagnostics

The Provider shall ensure that Service Users being tested for STIs are given the most accurate diagnostic test in its class (according to national guidelines) for each infection for which they are being tested; and the correct transport medium, storage and transport of specimens is in place and comply with turnaround times.

The Provider shall ensure that all diagnostic samples are processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately. The Provider shall ensure that the laboratory they use (this may be sub-contracted) is appropriately accredited and deliver optimal standards including specimen turnaround times. They should be United Kingdom Accreditation Services (UKAS)

accredited and have evidence of External Quality Assessment (EQA), Internal Quality Control (IQC) and Internal Quality Assurance (IQA). The Provider should ensure the laboratory are using the 'gold standard' test wherever possible and adhere to national standard operating procedures where these are available. Detailed quality standards are available; however the Provider should be aware that this is a rapidly evolving field and they should keep up to date with developments through appropriate professional websites (BASHH, PHE and UKAS).

The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for laboratories. The Provider shall ensure that CTAD is submitted by their laboratories in line with national guidance.

The Provider shall ensure that there is on-site microscopy available. The Provider shall ensure that Staff performing microscopy are appropriately trained and undergo regular assessment for quality assurance.

In the event of an unsatisfactory screening, e.g. inhibitory or invalid result, the Provider shall ensure that Service Users are informed and invited to re-test.

Clinical Management

The Provider shall ensure that people using the ISHS for STI testing receive the results, both positive and negative, within 10 working days. Technology can support this. The Provider shall ensure that those diagnosed with an infection receive prompt treatment and are managed according to BASHH national guidelines, including the delivery of partner notification. The Provider shall ensure that Service Users are advised to re-test when they have new partners with annual screening strongly advised.

Following positive results the Provider shall have the ability to provide additional tests that are needed and shall ensure that the Service User receives the best available treatment according to BASHH CEG guidelines.

The Provider will manage both uncomplicated and complicated/recurrent STIs; and will provide management of STIs in pregnant women.

Treatment provided through the ISHS is free from prescription charges although the Provider shall ensure that Service Users are made aware that if they receive treatment from other settings, such as primary care, charges may apply.

The Provider shall ensure that all people under 25 that are diagnosed with Chlamydia are re-tested for Chlamydia three months after treatment.

The Provider shall have policies in place for the management of abnormal or positive results when there is difficulty in contacting the Service User tested.

The Provider shall have the ability to instigate partner notification as part of the management of all STIs including HIV. Partner notification is vital in assisting in the control of infection as it offers sexual health contacts the opportunity for screening, assessment and treatment and thus can break the chain of transmission. It can also prevent long term implications of infections, reduce re-infection, offer health education opportunities and provide behaviour change. The Provider shall follow BASHH guidance to ensure optimal management.

Post exposure prophylaxis (PEP) and post exposure prophylaxis after sexual exposure (PEPSE) are key preventive interventions for people who may have been exposed to HIV to reduce the risk of them acquiring HIV. The provider will initiate PEPSE and then will refer the Service User on to the local HIV specialist

treatment service for the completion of treatment. The Provider should note that costs of the PEPSE treatment are not covered within this contract but should be directed to NHS England. Non-NHS providers may need to have an SLA with an NHS Trust for them to gain the reimbursement for PEPSE and to be aware that the costs will be paid using the NHS England tariff.

The Provider will participate in research trials, including in the current UK PrEP impact trial; and will agree a future position regarding the support requirements for PrEP pending the outcome of the trial as part of the partnership agreement.

2.3.5 Targeted Services for Young People aged up to 25 and vulnerable groups

Most people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including higher rates of STIs, and abortions than older people. There is evidence that reducing the number of sexual partners and avoiding overlapping relationships can reduce the risk of STI acquisition[7].

The Provider shall find innovative methods for delivering the ISHS specifically to meet the sexual health and contraceptive needs of young people. This should include a range of digital solutions – see section 2.4.2. The Provider shall ensure confidential and easy access to the ISHS especially given the rurality of the County. The needs of boys and young men are different to that of girls and the Provider shall tailor the ISHS accordingly. The Provider will ensure the voice of young people is central to service developments.

Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people being most at risk. As Chlamydia often has no symptoms and can have serious and costly health consequences it is vital it is picked up early and treated. The Provider shall ensure that all sexually active young people are offered Chlamydia screening as a routine part of every sexual health consultation.

The Provider shall ensure that Chlamydia screening is widely available to all under 25s in accordance with the *NCSP Standards 7th Edition (updated November 2018)*, and so there will be no standalone local Chlamydia screening service or office. The Provider shall ensure Chlamydia screening is embedded across the Local Sexual Health System. The Provider shall develop creative solutions for ensuring that Chlamydia tests are taken up by the most at risk under 25s. The Provider shall treat, follow up, re-test and carry out partner notification in line with national guidance.

Ensuring that free condoms are widely available to young people and young adults is a key to reducing the risk of STI transmission and preventing teenage pregnancies. The Provider shall lead the management and co-ordination of an overarching scheme to improve access to condoms to a range of target groups, and shall ensure specifically the access of young people under 25 to free condoms from a range of both clinical and non-clinical settings. The Provider shall have robust systems, policies and procedures in place to manage and monitor the scheme and shall ensure that professionals distributing condoms within this scheme comply with the Provider's policies around safeguarding and issuing contraception, particularly for under 16s.

The Provider will deliver a Specialist Clinical Outreach Team (SCOT) to provide services to the most socially complex, vulnerable young people and adults. This will include, but is not limited to, people with learning disabilities, mental health problems and military populations including in Catterick and Harrogate. There will be a named nurse for each locality who will provide clinical care in settings acceptable to the service user. It will be essential for staff to develop close partnership working with partner agencies in order to engage with

[7] Sexually transmitted infections and Chlamydia screening in England 2017. PHE, HPR 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713962/hpr2018_AA-STIs_v5.pdf

the most at risk and vulnerable service users; and safeguarding will be a key aspect of this work – see section 2.4.7.

The Provider should develop close working relationships with the Healthy Child Programme (HCP) Team at a locality level. The HCP team work with children and young people up to the age of 19, and may include up to 25 for SEND. In terms of sexual health, the HCP team offer includes EHC, chlamydia screening and condom distribution. The Provider shall provide the HCP team with clinical advice, support and bespoke training and ensure that there are clear referral routes between each other.

2.3.6 Sexual Health Counselling Service

The Provider shall provide a free counselling service for people living in North Yorkshire who wish to seek support around different aspects of sex or sexual health.

Counsellors will be experienced professionals, both in counselling and sexual health and members of recognised professional associations. The Provider shall develop and maintain clear criteria for accepting referrals.

The Provider shall deliver brief counselling sessions which are focused and only provided for a maximum of six, one hour sessions. Upon completion of treatment the Provider shall ensure that a brief discharge summary is sent to the referring clinician within two weeks of discharge.

2.3.7 Community Outreach Service for Most at Risk Populations

The Provider shall be experienced at using community development approaches to provide sexual health promotion and prevention interventions to vulnerable and high risk groups to enable them to make informed and responsible choices in relation to their sexual health, wider health and wellbeing and improve their access to HIV/STI diagnostic and treatment interventions.

The most at risk groups include men who have sex with men (MSM), black African communities, people misusing drugs and sex workers. Other vulnerable groups are lesbian, gay, bisexual, transgender and questioning (LGBTQ+) adults and young people. The Provider shall take a holistic approach when supporting and providing interventions to Service Users and shall also offer brief advice on wider lifestyle issues such as smoking, mental health, drugs, alcohol, weight management issues and signpost Service Users to other services for additional support where appropriate.

The Provider shall ensure that interventions raise awareness and support skills development to enable Service Users to take control of their sexual health and any impacts on their general health, and also to raise awareness of the benefits of sexual precautions and encourage safer sex. The Provider shall ensure wide and easy access of these communities to free condoms, dental dams and lubricants.

The Provider shall work with Service Users around taking responsibility for their own sexual health. This could include establishing (or linking into existing) peer mentoring programmes, for example, to look at how sexual health behaviours might be affected by self-esteem, drug and alcohol use, and mental health issues, with the aim of empowering Service Users and engendering ownership of their sexual health and wellbeing. The Provider shall ensure that, where peer-workers are utilised, there is a structured recruitment and training process in place with access to appropriate supervision and professional development.

The Provider shall develop and implement innovative social marketing and publicity initiatives to raise awareness of specific sexual health issues with the target group and encourage access to local services. The

Provider will utilise a wide range of technology including websites, chat rooms, apps, Facebook, blogs etc. to effectively engage with target groups.

Community Point of Care Testing (POCT) Service

The Provider shall deliver a standardised point of care testing service (as a minimum to include HIV testing). The Provider shall ensure the most up-to-date tests available are used. Where this results in a positive result, the Provider shall ensure Service Users are supported to rapidly access the clinical service for a confirmatory diagnosis, and for management, treatment and partner notification as appropriate. The Provider shall have in place clear governance arrangements for the delivery of this POCT service.

The Provider shall ensure their Staff are trained to routinely offer and recommend POCTs. They shall:

provide information on tests and discuss why it is recommended (including to those who indicate that they may wish to decline the test), including information about the relatively poor specificity and sensitivity of POCT.

conduct post-test discussions, this includes giving positive test results and delivering post-test and general health promotion interventions including onward referral.

assess level of knowledge about HIV and provide health promotion interventions, if necessary.

The Provider shall recommend that all Service Users who have tested negative but who may have been exposed to HIV have another test once they are past the window period. The Provider shall recommend annual testing to all men who have sex with men, and more frequent testing for those who have a high risk of exposure to the virus, for example, through multiple sexual partners or unsafe sexual practices.

The Provider shall offer tests via outreach in areas where there is high-risk sexual behaviour or in venues sited in areas where there is high local prevalence of HIV. This could include community or voluntary sector premises, public sex environments (such as saunas or cruising areas) or other local venues identified. Tests shall be undertaken in a secluded or private area, in line with British HIV Association and NICE guidelines.

The Provider shall provide men who refuse, or who may not be able to consent to a test, with information about other local testing services. Inability to consent may be due to alcohol or drugs for example. A refusal might be because of the setting or concerns about privacy.

The Provider shall ensure that testing services are staffed by people who are aware of and sensitive to, the cultural issues facing black Africans and other ethnic minority groups. For example, black Africans may be less used to preventive health services and advice or may fear isolation and social exclusion should they test positive for HIV. Staff shall also be able to challenge the stigma of, and dispel any myths surrounding, HIV and HIV testing and be sensitive to the individual needs of people.

2.3.8 Positive Support service

The Provider shall support people living with HIV to develop an understanding of how their condition affects their lives and how to cope with the issues and symptoms it presents. The Provider shall support individuals to develop effective self-management techniques which will allow people to make the many daily decisions that improve their health-related behaviours and outcomes. This will also support people in preventing onward transmission and increase the quality of life and independence for those diagnosed with HIV, their partners and families.

The Provider shall conduct an assessment of the Service User including Carers where appropriate and including assessment of level of self-management needs. The Provider shall also screen for psychological distress and provide support to manage mild or transient psychological problems such as adaptation and acute distress following a HIV diagnosis or risky sexual health behaviour.

The Provider shall provide a range of self-management interventions and detail how these will meet the outcome of the assessment and where referral or signposting arrangements will be put in place. Some of the provision shall include workshops and peer support groups. The Provider shall ensure that where peer-workers are utilised there is a structured, recruitment and training process in place with access to appropriate supervision and professional development.

The Provider shall ensure the Positive Support Service is proactive in providing practical and empowering support and information about HIV, treatment, encouraging healthy living with HIV, diet and lifestyle, and optimisation of general health. The Provider shall also, where required, enable people to access support with financial, housing, education, training and employment needs.

The Provider shall support Service Users to overcome any barriers or issues relating to communicating with health care teams, family members and others.

The Provider shall ensure that Service Users and Carers have their support needs reviewed on a regular basis.

The Provider shall ensure the Positive Support Service has strong collaborative working arrangements with local HIV treatment and care centres.

2.3.9 Training Service

The Integrated Sexual Health Service cannot operate in isolation. It is imperative that it is supported by a knowledgeable Local Sexual Health System, in order that issues around sexual health can be raised or identified early and effective signposting and referral take place. Therefore it is essential that other universal professional groups who play a role within the Local Sexual Health System (e.g. maternity services, practitioners that work with young people) have at least a basic understanding and awareness of current and local sexual health issues and are aware of local services (often referred to as level 1 training). This may also include issues such as sexual exploitation, homophobic bullying, targeting safer sex messages, and tackling stigma and discrimination.

Some staff groups that either work directly with at risk or vulnerable groups or deliver sexual health interventions such as GPs, Pharmacists and the HCP team will require more tailored and targeted training packages to enable them to deliver the requirements of their contracted services, to ensure effective pathways are in place and there is good communication between these providers (often referred to as level 2). The Provider will deliver bespoke training, including to primary and secondary care, based on locally identified needs. This should include annual training to community pharmacy staff to support the supply and administration of emergency hormonal contraception and chlamydia screening in pharmacy settings. This may also include delivering undergraduate training and postgraduate training, including placements.

The Provider shall, therefore, co-ordinate and deliver an annual sexual health training programme across North Yorkshire which is specifically tailored to meet the needs of a range of staff and, where appropriate, ensures they maintain their competency to deliver their Local Authority contracted services. The Provider shall deliver training in creative and efficient ways, to ensure that staff groups are able to access the training easily and effectively. The Provider shall be responsive to emerging issues and trends and the evidence

base. The Provider shall keep a database of all staff trained and conduct regular training needs assessments. The Provider shall ensure that training is evaluated and any changes or improvements are made as a result of feedback. The training delivered as part of the agreed annual training programme will be free to attendees, although the Provider may charge a levy to participants that fail to attend without giving due notice. The training programme will be agreed annually in advance with the Council.

In order to sustain and build a trained local pool of qualified sexual health clinicians, the Provider shall be committed to education and training and shall have arrangements in place working with Health Education England - Yorkshire and Humber Education and Training Board (LETB), to support the training requirements of the both the current and future sexual health medical and nursing workforce, including placements. This will ensure there is a local offer of under-graduate and post-graduate specialist training for medical and nursing staff. The Provider should also explore providing Faculty of Sexual and Reproductive Health accredited training including practical training to achieve Letters of Competence; and British Association of Sexual Health and HIV accredited STIF training. This element of training and education is not paid for within this contract. However, the Provider shall have a mechanism in place for charging individuals or organisations for these specific training services where required (often referred to as level 3) and shall provide the Commissioner with information about its annual commitments to provision at level 3.

2.3.10 Campaigns

In order to reduce stigma and promote good sexual health and enable and empower self-care and self-management the Provider shall support national sexual health campaigns such as HIV testing week, sexual health awareness week and Public Health England sexual health campaigns. The Provider will lead a local co-ordinated approach to these campaigns using the most appropriate technique e.g. social and digital media and technology. Where appropriate, local community based events may be organised where they support a call to specific action e.g. Point of Care Testing ("POCT") clinics during HIV testing week. Where the Provider is leading or involved in events there shall be clear objectives around what they are setting out to achieve and an evaluation of the impact of their involvement.

2.3.11 Clinical and system leadership

The Provider's Staff in the ISHS will be viewed as the clinical leaders of the Local Sexual Health System by local partners e.g. GPs, Pharmacists, HCP team. They shall provide support and expert clinical advice, which may include guidance around clinical governance, good practice, evidence based working. In particular they will be responsible for establishing and facilitating excellent communication between providers delivering different aspects of sexual health interventions and services in the Local Sexual Health System, for example through clinical networks and the development of clinical pathways. The Provider shall ensure that Staff have a high profile and local professionals can easily contact them when required for information or support.

The clinical leadership role is an important remit of the Integrated Sexual Health Service which the Provider shall provide across the whole Local Sexual Health System as illustrated in Diagram 1 on page 7. The Provider shall provide support and expert advice, disseminate good practice and develop and facilitate excellent communication systems with other professional groups delivering sexual health services such as GPs and Pharmacists.

Partnership Working

The Provider shall ensure that Staff signpost and refer Service Users to other sources of help and advice. The Provider shall ensure that Staff have a sound understanding of what other services are available and, where appropriate, develop direct working relationships with local partners.

The Provider shall establish good relationships with the following key partners:

- local GPs;
- Pharmacists;
- Healthy Child Programme team;
- termination service providers;
- Sexual Assault Referral Centres (SARC); and
- HIV specialist treatment centres.

Communication and information across health providers is complex and therefore the Provider shall have in place effective systems to enable this. These key partners need to be aware of the roles and responsibilities of the Provider in delivering the ISHS in order to be able to make referrals to the ISHS.

Interdependencies and Referral Routes

The Provider cannot work in isolation and is required to work with partners i.e. NHSE, CCGs and community providers to address the needs of the local population and increase the opportunity for service users to achieve optimum sexual health outcomes, utilising equality impact assessments where appropriate. Any potential or proposed changes to services must be discussed and planned for as at early a stage as possible, including assessment and mitigation of risks to other services regardless of whether they are commissioned by the Local Authority or other commissioners.

As well as self-referrals, referrals may come from a variety of sources and the Provider shall have in place links to receive and also refer on, from and to a range of sources. The Provider shall ensure support provided is delivered as part of a pathway of care. The range of sources may include but are not limited to the following:

Termination services

Maternity services

Sexual Assault Referral Centres (SARCs)

HIV specialist services

Gynaecology

Cervical cytology

Urology

A&E

GPs

Local vasectomy services

Pharmacists

Healthy Child Programme team

NYCC CYPS Early Help Services

Substance misuse services

Mental health services

Services for those with disabilities, including learning disabilities

Other services within the sexual health system

Military institutions

Housing and homeless services

Domestic abuse/ violence services

Services for sex workers

Employment, education and training services

School and education services, including higher education

Weight management, smoking cessation and physical activity services

Youth services

Youth justice

Social care services

Safeguarding teams

Other health care services including voluntary sectors

The Provider shall provide evidence that these pathways are in place and that they are regularly reviewed to ensure they are operating smoothly. If there is evidence that pathways are not operating effectively, the Provider shall take action to try to address this and inform the Commissioner as appropriate.

Contribution to Local Strategies

The Provider shall contribute to relevant local strategies such as current on-going work led by the local safeguarding board addressing children at risk of sexual exploitation.

2.4 Service Delivery

The Provider shall deliver the ISHS as set out in this specification; and shall respond to changing needs as appropriate. The ISHS shall be delivered taking into account the following elements:

2.4.1 Accessibility

2.4.2 Digital services

2.4.3 Premises and environment

2.4.4 Marketing and publicity

2.4.5 Employment and management of skilled and competent workforce

2.4.6 Clinical governance

2.4.7 Safeguarding

2.4.8 Service user feedback and engagement

2.4.9 Information management

2.4.10 Performance and contract management

2.4.11 Eligibility criteria

2.4.12 Exclusion criteria

2.4.13 Cross charging

2.4.14 Responding to sexual health outbreaks/incidents

2.4.15 Service delivery and quality standards

These are detailed below:

2.4.1 Accessibility

The Provider shall address the range of factors that impact on accessibility of the Integrated Sexual Health Service. These include being able to deliver the Integrated Sexual Health Service to a diverse population living in the largest county in England. The geography of North Yorkshire presents practical difficulties in locating services and staff in the best possible locations to enable them to engage with the local community and to respond to service demands. Whilst the scale of local provision should be determined by local need and the requirement to provide value for money, the Provider shall be able to demonstrate reach of the Integrated Sexual Health Service into every District Council area in North Yorkshire. It is also expected the Provider shall ensure awareness of sexual health services outside the NYCC boundary and shall ensure Service Users have a seamless patient journey if accessing services across boundaries.

The Provider shall ensure the Integrated Sexual Health Service maximises accessibility for people disproportionately affected by unwanted pregnancy and sexual ill health who might not be pro-active in seeking early help and support for their sexual health needs. This will include those who experience stigma, discrimination and prejudice often associated with sexual health as well as those who experience physical, learning, language and/or cultural barriers in engaging with services. The Provider shall ensure that the delivery of the Integrated Sexual Health Service reflects the principles of anti-discriminatory practice and reduces stigma. The Provider will ensure access to interpretation services for clients whose first language is not English and who require interpretation.

The Provider shall ensure the delivery model of the Integrated Sexual Health Service reflects the different priorities and living patterns of Service Users. This will require a flexible and creative workforce that understands the population profile it is working with.

The Provider shall ensure the Integrated Sexual Health Service is available throughout the year, at times that increase its accessibility to Service Users, for example early morning, evenings, weekends, bank holidays. The Provider shall consult with Service Users regarding opening times. Opening times shall be regular and consistent so that Service Users become familiar with when the Service is available. The Provider shall have clear plans in place for how it supports Service Users to access PEPSE out of hours.

2.4.2 Digital services

The provider will operate a good patient access centralised booking system with online booking and triage; telephone access should also be available. This booking system will operate seven days a week and must operate in a way that enables Service Users to simply and easily access the Integrated Sexual Health Service in a timely way and minimise non-attendance (“DNAs”).

Patients should have the option of accessing services without the need for seeing a practitioner and/or attending a clinic. Patients should be provided with information about sexual health, on line triage, signposting to the most appropriate services for their needs and the option of ordering condoms and self-sampling kits for chlamydia, gonorrhoea, syphilis and HIV. Routine STI test results should be available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered an appointment within 24 hours or fast tracked, if available to a walk-in service. Free online treatment service should be provided where

it is clinically safe to do so (e.g. chlamydia), including a follow up procedure and tracking to check the treatment programme has been completed.

The provider should develop new ways to communicate with service users, for example, via social media, provision of an online help, text messaging for potential service users.

In addition to the above the Provider should explore options for enhancing their digital offer, this may include digital partner notification that patients can complete remotely, pregnancy testing kits, contraception provision, on-line consultations, provision of training via an e-learning platform.
The provider must have safeguarding frameworks in place to manage under-18 requests for digital services.

2.4.3 Premises and environment

In order to maximise communications, partnership working and clinical governance support the Provider shall deliver the Integrated Sexual Health Service from sites co-located with other relevant services based in the community, such as primary care settings, youth settings or voluntary agencies where appropriate.

Where appropriate the Provider shall co-locate the workforce of the Integrated Sexual Health Service with other relevant professional groups rather than working as isolated teams.

Where the delivery of the Integrated Sexual Health Service involves the provision of clinical services the Provider shall ensure that the premises from which those clinical services are being provided adhere to Good Clinical Practice. For example:

DH guidance - Out-patient care. Health Building Note 12-01: *Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics.* London: The Stationary Office. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142892/HBN_12-01_SuppA_DSSA.pdf

Essential *standards of quality and safety*; CQC 2010 http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards

2.4.4 Marketing and publicity

The Provider shall ensure the Integrated Sexual Health Service establishes an effective and visible profile both to Service Users and professionals to support increased awareness and uptake of local sexual health services. The Provider shall promote all of the Service Areas effectively using the most appropriate means of communication. This will differ depending on the target audience and the setting but the intention should be to raise the profile of the Integrated Sexual Health Service and ensure that Service Users access appropriate services in a timely way. One of the key settings is schools and other education establishments, the Provider should ensure they target these settings via local systems and partners. The Provider shall use a range of technology platforms such as websites, social media (e.g. Facebook, blogs, Twitter), Skype (or equivalent), Apps, mobile phones etc. to support the Integrated Sexual Health Service. The Provider shall ensure that Staff have the necessary training and technical and systems support to ensure they can use these technology platforms effectively.

Whilst there is no specific preference regarding the name of the Integrated Sexual Health Service and its Service Areas, any name chosen should reflect the nature of provision and not exclude or discriminate against Service Users. The Provider shall ensure that branding of the Integrated Sexual Health Service is agreed with the Council prior to the commencement of the service.

The Provider shall ensure that where sexual health information materials are provided these are evidence based. Localised materials shall only be produced if this is based on a needs analysis and a social marketing approach to their development should be evident. Where possible the Provider shall ensure that nationally produced materials are utilised. The Provider shall make sexual health information available in a range of formats and mediums to meet language and literacy needs of Service Users.

2.4.5 The Employment and Management of a Skilled and Competent Workforce

The Provider shall ensure that Staff understand they are working as part of a multi-disciplinary Integrated Sexual Health Service team. This will ensure that the skills and competence of Staff can be more effectively utilised, resources can be deployed more efficiently, it will enable joint planning and help minimise duplication of provision.

The Provider shall employ a workforce with the knowledge, skills, experience and qualifications to deliver the Integrated Sexual Health Service in accordance with the requirements of this Service Specification safely and competently. The Provider shall ensure that the skill mix of the workforce reflects both the business requirements and also the needs of the Service Users. The Provider shall ensure that all staff are safe to practice, including compliance with any professional standards, registration with appropriate national bodies, and completion of necessary employment checks for working with children, young people and vulnerable adults. The Provider shall ensure that all Staff are trained in accordance with the recommendations as contained within Safeguarding Children and Young people: roles and competences for health care staff *Intercollegiate Document March 2014*[8].

In particular the Provider shall have an excellent understanding of the factors that affect poor sexual health outcomes, and shall understand and know how to best address the needs of groups that are particularly at risk of poor sexual health.

The Provider shall ensure that staff within its organisation are appropriately qualified and trained to provide clinical leadership for the Integrated Sexual Health Service. Clinical leadership should be regarded as distinct to service leadership although the role may be provided by the same individual/s. The Provider will employ a Consultant to lead the Service, for reasons of training, supervision, and clinical governance. As the Provider will be delivering contraception, STI screening and treatment services in one place the Provider shall also ensure there are sufficient Staff within the ISHS that are dual trained.

The Provider shall ensure that Staff are appropriately trained with defined clinical governance arrangements to deliver a POCT service. The Provider shall ensure non-clinical practitioners delivering POCT are trained to collect blood spots and mouth swabs, handle test material and administer the test. Training shall be supervised and signed off by an appropriate clinician. The Provider shall ensure that training is updated annually and that Staff have access to clinical advice and supervision.

The Provider shall have effective performance management measures in place for Staff performance, to include those related to Staff competency and capability, professional development and appraisal procedures. Where required this shall also include evidence of professional registration and regular clinical supervision.

The ability of the Provider to deliver the Integrated Sexual Health Service to a high standard will be reliant on the performance of its workforce. The Provider shall ensure that Staff are able to use technology, input into

[8] RCPCH (2014) *Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document March 2014* http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

information management systems and record interventions effectively to ensure that data submission and monitoring requirements are accurate. This will be affected by the culture, performance management systems and management practices in the organisation. The Provider shall ensure that these are sufficiently robust to assure NYCC of the ability of the Provider to deliver a high quality, cost effective Integrated Sexual Health Service.

It is inevitable that in any workforce there will be vacancies and instances of absenteeism through sickness, maternity leave etc. The Provider shall ensure that processes are in place to deal with these situations to ensure the Contract requirements are met.

The Provider shall ensure its Staff actively participate in clinical and non-clinical networks, training, research trials and audit programmes where applicable.

2.4.6 Clinical Governance

The Provider shall ensure that robust Clinical Governance systems are in place for all aspects of the Integrated Sexual Health Service including any which are sub-contracted and include:

Patient safety (incident management (including serious incidents and never events), risk management, alerting system, waste management, medicines optimisations, safe environment, safeguarding)

Clinical effectiveness considerations (cost effectiveness, evidence-based practice, compliance with NICE guidance, participation in clinical audit, policy development)

Staff management (education and training, equality and diversity)

Patient/public experience (complaints management, consent, patient/public information, patient/public involvement)

Information governance

A planned programme of service improvement informed by the audit cycle, service user feedback, performance and evidence for change

The provider shall have a named clinical lead(s) for all clinical services delivered as part of this specification.

The Provider shall be responsible for ensuring compliance with all legislative requirements applicable to the delivery of the Integrated Sexual Health Service, for example Care Quality Commission Registration, the Human Medicines Regulations 2012*, Waste (England and Wales) Regulations 2011* etc.

* As amended from time to time.

The Provider shall provide some elements of the Integrated Sexual Health Service in non-clinical settings, such as services accessed via the internet or by text message and other e-services or ‘virtual clinics’. The Provider shall be clear how these regulatory requirements would apply to these areas of Integrated Sexual Health Service delivery.

The Provider shall have clear policies and procedures for clinical governance across all Service Areas. This includes clear policies aimed at managing risk and procedures to remedy poor professional performance, for example, failed insertions of LARCs or low rates of partner notification. They will provide clinical leadership and accountability, as well as a service culture, systems and working practices that ensure probity, quality

assurance, quality improvement and Service User safety at all times. This responsibility shall remain with the Provider even if they choose to sub-contract any of the Service Areas.

The Provider shall refer to the following organisations for guidance and other information about clinical governance to support their clinical leadership role:

Care Quality Commission.

Faculty of Sexual Health and Reproductive Healthcare.

British Association for Sexual Health and HIV.

Royal College of Nursing.

National Health Service Litigation Authority.

The Provider shall have in place a process for dealing with and responding to Incidents and Serious Incidents.

The Provider shall hold a quarterly internal meeting to discuss at least one Serious Incident (where at least one Serious Incident has occurred in the period) and provide a quarterly report from this meeting to the Commissioner.

2.4.7 Safeguarding

The safety and wellbeing of children, young people and vulnerable adults that may access the Integrated Sexual Health Service is paramount. The Provider shall ensure that all Staff (including administrative and voluntary staff) are compliant with Children and Adult Safeguarding Policies. The Provider shall ensure all Staff are aware of and trained to a level appropriate to their role in accordance with the *Safeguarding Children and Young People: roles and competences for health care staff Intercollegiate Document, March 2014*[9] and abide by national and local guidance and legislation on safeguarding (children and adults). Staff will be competent in joint working with safeguarding teams and Designated Health Professionals i.e. Designated Nurse and Designated Doctor for Child Protection/Safeguarding Children. The Provider shall comply with their specific responsibilities and safeguarding protocols relating to young people aged 13-15 years and for those under the age of 13 years.

NYCC works within legislative and procedural frameworks; in particular these are Working Together to Safeguard Children (2018), Mental Capacity Act (2005) the Care Act Guidance (2014) and other relevant legislation including the Children Act (1989), the Children Act (2004); and the Sexual Offences Act (2003). The guidance and legislation places a number of duties and responsibilities on relevant agencies and partner organisations to comply and work together to:

- Cooperate with the local authority when requested to do so

- To promote the safety and wellbeing of children and promote the wellbeing of adults in need of safeguarding, due either to care and support needs or other vulnerabilities associated with sexual health such as Female Genital Mutilation, Child Sexual and/or Criminal Exploitation, Victims of Human Trafficking, Domestic Abuse or other risk indicators

[9] RCPCH (2014) *Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document March 2014* http://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

- Ensure where required adults who may appear to be vulnerable, particularly adults with care and support needs are provided with access to advocacy

- To inform and share information with services users and communities as required under the Care Act 2014 within the constraints of the Data Protection Act and the Caldecott Guardian principles

- Identify children, young people and adults who are vulnerable due to care and support needs or other risk factors who require Safeguarding interventions

- To undertake or cause enquiries to be made where there is reason to believe that harm is occurring or likely to occur to children and vulnerable adults, who are vulnerable due to care and support needs or other risk factors that impact on their abilities to safeguard themselves

- Provide supervision to practitioners

- Work together and cooperate with partner agencies

- Work to ensure early identification and risk assessment of vulnerable adults at risk

- Keep and maintain records regarding safeguarding practice in accordance with information sharing and data protection recording protocols

- Inform and communicate with the public about safeguarding practice

- Ensure any local multi agency safeguarding pathways and referral processes are understood and adhered to

The Provider shall have a named lead for safeguarding covering both children and adults.

The Provider shall comply with the North Yorkshire Safeguarding Adults and Safeguarding Children Board's policies and procedures including best practice guidance. The Provider will ensure staff understand safeguarding referral procedures and pathways to social care. These can be found at the following webpage links: North Yorkshire Safeguarding Children Board (www.**safeguardingchildren**.co.uk) and https://www.northyorks.gov.uk/safeguarding (Policies and Procedures are available on the Partnerships website at this link) http://www.nypartnerships.org.uk/sabpolicies.

The Provider shall have robust child protection and adult safeguarding policies and procedures. When working in outreach settings the Provider shall ensure that Staff are familiar with and have due regard to the settings' child protection policy and safeguarding procedures. When working with Service Users under the age of 16, the Provider shall adhere to the Department of Health's guidance document *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health (DH 2004)*[10].

The Provider has a duty to cooperate with and implement the Section 11 audit process.

[10] Department of Health (2004). *Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health*
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationspolicyandguidance/DH_4086960

The Provider will have Safer Recruitment practices in place and all staff employed by the Provider to undertake direct or unsupervised work with children or vulnerable adults will be subject to Disclosure and Barring Services requirements (DBS).

The Office of the Children's Commissioner (OCC) recognises that sexual health services are often used by young people who are suffering or are at risk from child sexual exploitation (CSE). The Provider will ensure staff are trained and competent to identify and support young people at risk of CSE. They will also ensure all staff are aware of, and contribute to as appropriate, North Yorkshire multi-agency procedures in relation to CSE and other risks and vulnerabilities. Currently in North Yorkshire this is VEMT (Vulnerable, Exploited, Missing and Trafficked) Procedure and Practitioner Groups. This includes, but is not limited to vulnerable as a result of or at risk of:

- Child Sexual Exploitation (CSE)
- Missing From Home (MFH)
- Modern Slavery and Human Trafficking
- Radicalisation and Extremism
- Impacted by Domestic Abuse
- Forced Marriage, Female Genital Mutilation (FGM) and Honour Based Violence (HBV)
- Other forms of Exploitation (coercion and control – for example criminal exploitation and County Lines)

2.4.8 Service user feedback and engagement

The views of those Service Users accessing the Integrated Sexual Health Service are very important as they will help to identify those aspects of the Integrated Sexual Health Service which are working well, and those which require improvement. Key service users include those most at risk of poor sexual health and the most vulnerable groups e.g. LGBTQ+, young people, people with learning disabilities, BME populations.

The Provider shall have processes in place for routinely seeking and recording Service User feedback and shall be able to demonstrate how this informs practice and service development. It is expected that a number of methods of engagement will be used, from face to face to survey based questionnaires. The use of innovative methods of engagement, such as greater use of technology, including social media, will be welcomed. Summary information will be provided in the annual report.

The Provider shall have in place a well-publicised feedback and complaints procedure which includes quality standards related to how complaints are dealt with and responded to.

2.4.9 Information management

The Provider shall keep accurate records about any interventions carried out with Service Users and to comply with national sexual health dataset requirements.

Data protection and confidentiality

The Provider will maintain a separate patient record (or electronic equivalent) which remains within the service. Information will not be shared with any other NHS service through a shared patient record. The Provider shall ensure that professional records (both manual and electronic) are managed and accessed in accordance with GDPR, data protection and security protocols.

The Provider shall have in place a clear consent protocol and recording systems. The Provider shall ensure that confidentiality and consent protocols are made explicit to Service Users (especially young people and vulnerable groups) when accessing the Integrated Sexual Health Service.

The Provider shall ensure that consent is reviewed and updated as required within the consent protocol.

The Provider shall ensure there are appropriate consent procedures in place for medical interventions in line with national guidance.

The Provider shall ensure that compliance with GDPR, data protection and confidentiality protocols is not used as a barrier to appropriate information sharing. Timely and proper information sharing will contribute to the safeguarding of children, young people and adults.

Access to technology and technical support

The Provider shall provide Staff with the necessary equipment to enable them to fulfil the requirements of the contract with regards to data recording, collection and analysis. The Provider shall ensure that Staff have the necessary training, and technical and systems support to ensure that they can use equipment and software effectively. The Provider is responsible for the installation of, and updates to, management information systems and staff training

Submission and use of data

The Provider is required to generate a quarterly data extract of all patient attendances and associated diagnoses and services at GUM and non-GUM clinics in accordance with Public Health England (GUMCAD STI Surveillance System). The submission of GUMCAD extracts is mandatory for all LA commissioned Level 2 and 3 sexual health services, including those offered on-line. Where the Provider provides testing through an on-line service, this activity should also be included with their routine GUMCAD submissions to PHE. The Provider is also required to be responsive and flexible to any amendments to the datasets including frequency of submission and addition of new modules, such as the introduction of behavioural and partner notification monitoring, in line with nationally agreed information standards and lead-in times.

The Provider is also required to capture contraception and other sexual and reproductive health activities through collection of the Sexual and Reproductive Health Activity Dataset (SRHAD) which should be submitted annually to NHS Digital.

All patients newly diagnosed with HIV should be reported to PHE. This can be done either through a quarterly data extract to the HIV and AIDS Reporting System (HARS) or via a HIV new diagnosis proforma, available online or by request from PHE. Following a medical consultation related to HIV care, the Service is required to generate and submit a quarterly data extract to the HIV and AIDS Reporting System (HARS).

The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for all publicly funded chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified,

comprehensive reporting of all Chlamydia data, to effectively monitor the impact of the NCSP through measurement of population screening coverage, proportion of all tests that are positive and diagnosis rates. It is the responsibility of the Provider to ensure the core CTAD data requirements are provided to the laboratory for each Chlamydia test, in particular, postcode of residence of the patient and testing service type.

SRHAD, HARS and GUMCAD form the basis for a standardised sexual health dataset collected from sexual health clinic settings (plus CTAD from laboratories). The Provider is expected to discuss with commissioners quarterly analysis of GUMCAD, CTAD, HARS and SRHAD data from PHE to enable informed commissioning decisions relating to ISHS attendances, activity and STI diagnosis and contraceptive usage trends. Services should make any necessary changes to IT systems as new codes are updated/introduced (for example where codes are added for outbreaks).

The Provider shall be proactive in using its local intelligence and data to identify public health issues and in generating responses to unmet need. The Provider shall respond efficiently to requests from NYCC for data on local populations to help inform needs assessments and other reports.

2.4.10 Performance and contract management

Quarterly Service Review Meetings will be held between the Provider and the Commissioner Representative and other relevant colleagues, e.g. Contracting. The Provider shall provide a quarterly report of activity data, GUMCADv2 and SRHAD submissions, and performance against the Key Performance Indicators in the Performance and Monitoring Framework in a specified format.

Review Meetings will be held on NYCC's premises unless the parties agree otherwise. NYCC will not pay for any expenses for attendance at any of these Review Meetings.

The Provider may be requested to provide exception reports where there are queries or anomalies in their performance reports and/or data. Exception reports may also be requested where there have been good outcomes to demonstrate what has been effective.

An annual Contract Review Meeting will be held to assess performance over the previous year where the Provider shall produce an annual report. The annual Review Meeting will include a review of budget and performance against targets as well as agreeing any developments for the Integrated Sexual Health Service for the forthcoming year.

If at the quarterly and/or annual Review Meeting there are any concerns identified regarding the Integrated Sexual Health Service delivery meeting the requirements of this Service Specification, then a remedial action plan ("Remedial Action Plan") shall be agreed between the Provider and the Commissioner. At the following Review Meeting there will be a review of performance against the Remedial Action Plan. If the agreed improvement has not been achieved, or performance has deteriorated further, Clauses 31 and 34 and Schedule 3 of the Contract Conditions may be implemented.

The required outcome of the Integrated Sexual Health Service and its contribution to sexual health priority indicators are set out in section 1.3. The KPI's will be reviewed annually and may be amended to specifically address emerging needs or trends. The impact of the Provider's delivery of the Integrated Sexual Health Service will be monitored against these indicators through the Performance and Monitoring Framework. There are a number of measures within the Performance and Monitoring Framework where an estimated Baseline will be established by mutual agreement with the provider in year one.

Auditing Impact and Outcomes

To provide assurance that frontline practice is safe and delivering its stated objectives the Provider shall carry out relevant audit exercises and use the findings to inform and improve practice. These will be reported to NYCC through quarterly reports.

Staffing performance

The Provider shall provide regular updates on Staff performance; this will include vacancies, sickness, recruitment/retention, appraisals. These will be reported to NYCC through quarterly reports. Where there are issues that may have an adverse impact on the delivery of the Integrated Sexual Health Service, the service will implement an action plan.

Organisational Performance

Where appropriate the Provider and NYCC will work together to demonstrate the value of this contract in delivering outcomes for children, young people and adults, for example when either organisation is subject to an inspection by a government or professional body.

The Provider shall provide information for needs assessment and any other monitoring reports required from NYCC, the Children's Trust, the Health and Wellbeing Board or other relevant Committee or Board.

2.4.11 Eligibility Criteria

The Local Authority is mandated to commission open access confidential services. The provider must operate an open access policy for both contraception and STI services regardless of residence of the patient. The legislation defines services as:

(i) for preventing the spread of sexually transmitted infections;
(ii) for treating and caring for persons with such infections;
(iii) for notifying sexual partners of persons with such infections
(iv) advice on, and reasonable access to, a broad range of contraceptive substances and appliances;
(v) advice on preventing unintended pregnancy

However this service specification is commissioning a range of service elements over and above a core offer. Therefore not all service elements have to be delivered regardless of residence of the patient, it is acceptable for some elements to only be available for North Yorkshire residents' e.g. digital testing services.

2.4.12 Exclusion Criteria

This Service Specification excludes:

HIV treatment and care; including the cost of post-exposure prophylaxis (PEPSE).

Termination of pregnancy.

Level 3 education and training provision.

The Provider has the right to refuse to deliver the ISHS to Service Users:

Who are unsuitable for treatment under the conditions of this Service Specification.

Who have not validly consented to the treatment provided.

Who display unreasonable behaviour unacceptable to the Provider, its Staff, the consultant, or the named professional clinically responsible for the management of the care of the Service User.

The Provider shall maintain clear exclusion protocols which ensure Service Users who are excluded are referred into other services as appropriate to address their needs.

2.4.13 Cross Charging

The funding received for the ISHS pays for residents of North Yorkshire only. However, the Provider shall provide a free, open access, ISHS to anyone that attends without referral, irrespective of their place of residence or GP registration. The Provider shall have in place cross charging mechanisms for charging other Local Authorities for out of area attendances. Patient postcode, excluding the last two digits which allows the patient to maintain their confidentiality, is required to facilitate this. The Provider will adhere to the Yorkshire and Humber cross-charging agreement that NYCC is part of.

Cross Border Arrangements

There are challenges presented by the geography of North Yorkshire to cross boundary working. Currently a number of North Yorkshire residents' access sexual health services outside of the North Yorkshire boundary. Some of this relates to young people being away from home, such as being at University or accessing service near to their place of work. However, over the period of the previous contract, the incumbent Provider has put a range of service options in place that have reduced out of area attendances. NYCC want to continue to lower our out of area attendances, and have included a clear performance measure with an incentive payment attached to the achievement of the KPI.

2.4.14 Responding to Sexual Health Outbreaks/Incidents

The Provider will be able to identify changes in the patterns of infection (changes to the gender, sexual orientation or age of people affected; changes to clinical presentation of an infection; general increase in numbers). Changes seen at a local level may not be detected through routine surveillance, but could still represent an important local focus of infection which requires public health action.

The Provider should be familiar with their clinic population, in terms of age / gender profile and the frequency with which different infections are diagnosed. Any changes to this can be investigated with the local public health team; preliminary investigation may involve a simple review of case numbers and demographic information, exploring whether any change to diagnostic methods or whether any specific events or exposures have taken place. Depending on findings of initial analysis, further investigation and public health action may be indicated.

In the event of there being a sexual health outbreak/incident that threatens the public's health the Provider shall provide assistance with this. The Provider shall ensure there is an appropriate degree of surge capacity (ability to flex resources, including staffing) within the ISHS so that it can respond to local incidents in a timely fashion. This may include providing appropriate staff and specialist advice when called for to support the response to an incident.

The response will be activated by NYCC in consultation with Public Health England/ NHS England; with the threshold for activation based on a joint risk assessment. Any such incidents would be the exception rather than the norm, and may require the Provider to work flexibly.

2.4.15 Service Delivery and Quality Standards

The ISHS is underpinned by, and the Provider will ensure it adheres to the following minimum standards:

- BASHH Standards for the management of Sexually Transmitted Infections (2014)
- BASHH UK National guideline for Consultations Requiring Sexual History Taking (2013)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (2012)
- BASHH/Brook (April 2014) Spotting the Signs. A national proforma for identifying risk of child sexual exploitation in sexual health services
- BASHH Standards for Outreach (2016)
- BASHH UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (2015)
- BASHH-BHIVA Position Statement on PrEP in UK (May 2016)
- BHIVA Guidelines for HIV testing (2008, currently under revision)
- BHIVA: Guidelines for the Sexual and Reproductive Health of people living with HIV (Under consultation 2017)
- BHIVA: UK National Guidelines on Safer Sex Advice (2012)
- BHIVA: Standards For Psychological Support (2011)
- British HIV Association Standards of Care for People Living with HIV (BHIVA 2018)
- Chlamydia Testing Activity Dataset (CTAD): Commissioning Guidance (2015)
- COSRT Code of Ethics (COSRT 2013)
- Department of Health & Social Care; Sexual Health Services: Key Principles for Cross Charging (2018)
- Department of Health's You're Welcome quality criteria: making health services young people friendly (2007)
- Department of Health; Female genital mutilation Risk and Safeguarding (2016)
- FSRH Service Standards for Risk Management in SRH (2017)
- FSRH Service Standards for Sexual and Reproductive Healthcare (2016)
- FSRH Standards for Emergency Contraception (2017)
- FSRH CEU Clinical Guidance: Emergency Contraception (2017)
- FSRH Clinical Guidance: Male and Female Sterilisation (2014)
- FSRH Standards Service Standards on Confidentiality (2015)
- FSRH Service Standards Consultations in SRH (2015)
- FSRH Quality Standard for Contraceptive Services (2014)
- FSRH Service Standards for Medicines Management in Sexual and Reproductive Health Services (2018)
- FSRH Service Standards for Workload in Sexual and Reproductive Health (2017)
- FSRH Clinical Standards for Record Keeping (2014)
- GMC Protecting Children and Young People (2012)
- Hepatitis A, Green Book, Chapter 17 (PHE 2013)
- Hepatitis B, Green Book, Chapter 18 (PHE 2013 revised 2017)
- Hepatitis B and C testing: people at risk of infection Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE 2012, updated 2013)
- Information Commissioners Office; Guide to the General Data Protection Regulations
- Institute of Psychosexual Medicine
- MEDFASH Recommended standards for Sexual Health services (2005)
- National Chlamydia Screening Programme Standards (7th Edition 2014; updated 2016)
- National Chlamydia Screening Programme Guidelines for Outreach

- NICE Sexual Health quality standard (under consultation 2018)
- NICE PH3 Sexually transmitted infections and under-18 conceptions: prevention (2007)
- NICE NG68 Sexually transmitted infections: condom distribution (2017)
- NICE QS129 Contraception (2016)
- NICE QS69 Guidance for Ectopic Pregnancy and Miscarriage (2014)
- NICE QS157 HIV Testing, encouraging uptake (2017)
- NICE PH51 Contraceptive Services for under 25's (2014)
- NICE NG55 Harmful sexual behaviour among children and young people (2016)
- NICE PH49 Behaviour Change: individual approaches (2014)
- NICE NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV (2016)
- NICE PH43 Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. (2012 updated 2013)
- NICE PH49 Behaviour change: individual approaches (2014)
- NICE PH50 Domestic violence & abuse: multi-agency working (2014)
- NICE PH51 Contraceptive services for under 25's (2014)
- NICE CG30 Long acting reversible contraception (2005 updated 2014)
- NICE NG88 Heavy Menstrual Bleeding: assessment and management (2018)
- NICE NG44 Community engagement: improving health and wellbeing and reducing health inequalities (2016)
- PHE (2017) Sexually Transmitted Infections; managing outbreaks
- Royal College of Obstetricians and Gynaecologists, The Care of women Requesting Induced Abortion (2011)
- Royal College of Paediatrics and Child Health: Safeguarding Children and Young People, roles and competences for health care staff – intercollegiate document (3rd edition, 2014)
- UK Guideline for the use of HIV Post-Exposure Prophylaxis following Sexual Exposure (PEPSE) 2015
- UK Standards for Microbiology Investigations Chlamydia Trachomatis Infection: Testing by Nucleic Acid Amplification Tests (NAATs) (Public Health England, 2017)
- UK Policy Framework for Health and Social Care Research – NHS Health Research Authority (2018)

Relevant UK clinical guidance covering the specialities of Sexual and Reproductive Healthcare and Genitourinary Medicine can be found at www.fsrh.org and www.bashh.org. The Provider shall ensure the ISHS reflect updates in guidance and recommendations as and when produced.

The Service should use the DHSC's You're Welcome quality criteria, as guiding principles when planning and implementing changes and improvements, in order for the service to be young-people friendly where appropriate.

North Yorkshire County Council

Integrated Sexual Health Service

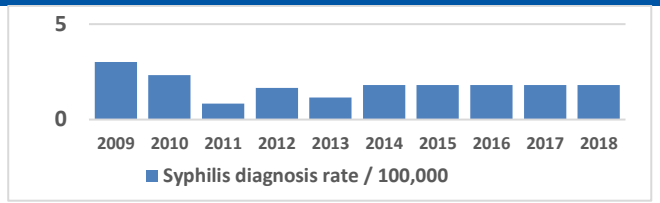
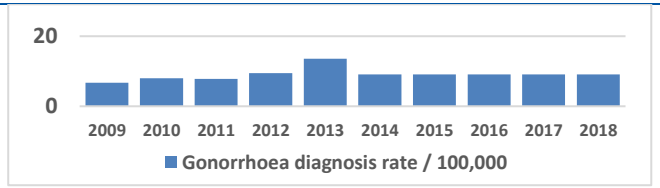
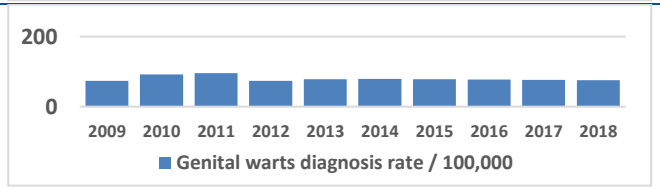
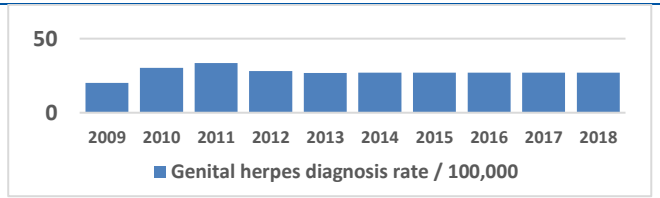
Performance and Monitoring Framework

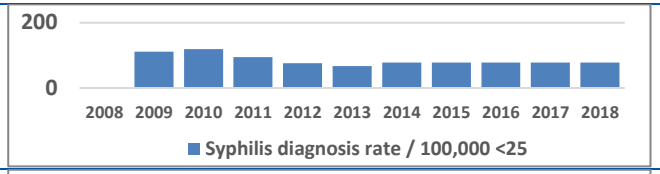
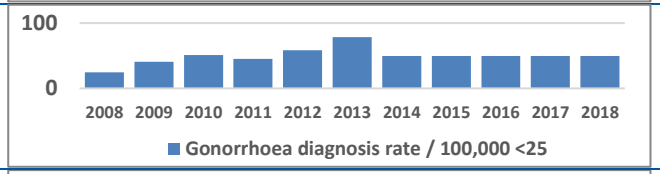
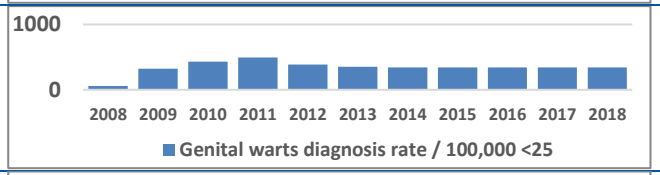
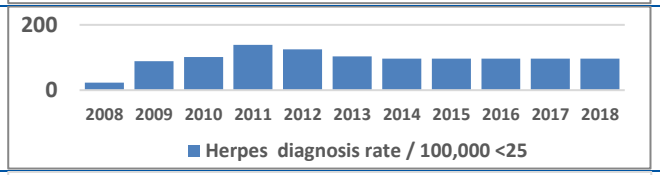
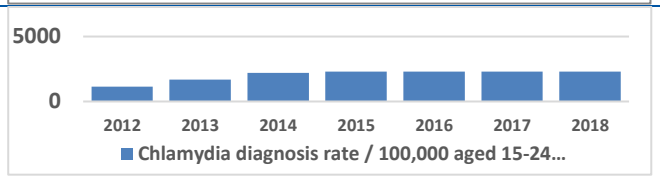
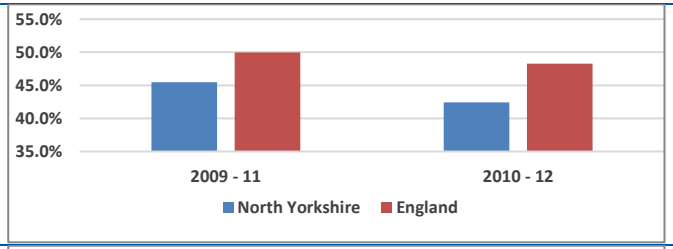
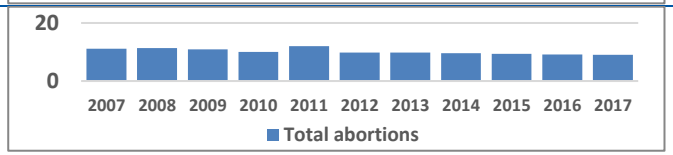
The overarching outcome for the service is for:

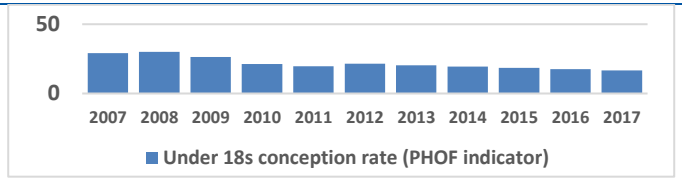
All people in North Yorkshire experience good sexual health

All performance measures will contribute to one or more of the following *Key Performance Indicators* (KPIs) or locally agreed *Principles*:

Key Performance Indicators

KPI	Target	Historical trend, and projected target rate
The rates of STI diagnoses in clinic attendees	Maintenance of low rates of syphilis against baseline (average rate 2009-2013) per 100,000 population	
	Maintenance of low rates of gonorrhoea against baseline (average rate 2009-2013) per 100,000 population	
	Maintenance of low rates of genital warts per 100,000 population, continuing the decreasing trend in 2009-2013	
	Maintenance of low rates of genital herpes against baseline (average rate 2009-2013) per 100,000 population	

The rates of STI diagnoses in young people in clinic attendees	Reduction in the rate in those aged under 25 of syphilis against baseline 78.5 (average rate 2009-2013) per 100,000 population	
	Reduction in the rate in those aged under 25 of gonorrhoea against baseline 49.8 (average rate 2009-2013) per 100,000 population	
	Reduction in the rate in those aged under 25 of genital warts against baseline 341.0 (average rate 2009-2013) per 100,000 population	
	Reduction in the rate in those aged under 25 of genital herpes against baseline 96.7 (average rate 2009-2013) per 100,000 population	
The Chlamydia diagnostic rate for those aged 15-24 years	Achieving a Chlamydia diagnostic rate of 2,300 people aged 15-24 years old, per 100,000 population.	
The rate of late HIV diagnoses	Maintain the lower than England rate of late diagnosis of HIV against the 2010-12 baseline of 42.4% in HIV diagnoses made late (where CD4 count is <350 cells/mm³ within three months of diagnosis)	
The number of abortions	Reduction in the rate of abortions from baseline of 9.8 Abortions per 1000 women aged 15-44 continuing the decreasing trend	

The number of under 18 abortions	Reduction in the rate of under 18 abortions from baseline continuing the decreasing trend	
The rate of under 18 conceptions	Reduction in the rate of under 18 conceptions per 1000 females (15-17) from baseline continuing the decreasing trend	

Principles

Priority to be given to prevention and early intervention with a focus on young people and most at risk populations.

Services to be delivered by a professional integrated skilled sexual health workforce.

Strong clinical leadership to be embedded across the local sexual health system.

Use of evidence based practice, innovation and use of technology.

Rapid and easy access to services including in rural areas delivering services in appropriate settings.

All contraceptive, STI diagnosis and treatment to be provided and dealt with in one place as far as practicably possible.

Ensure quality and value for money at all times

Data requirements

All service activity should be recorded in such a way to allow reporting by:

- age bands (Under 16's, 15-24, 25-34, 35-44, over 55's)
- gender
- ethnicity
- area of residence
- sexual orientation
- locality of service delivery

Additional data requirements

To support equity audit, needs assessment and service planning the local authority public health team may request additional data from the service. The pieces will be ad hoc and in a specifically described format that will require a small amount of processing by the service to apply various geographical lookups.

Performance measures - Specialist Sexual Health Service

General activity

Performance measure	Expected performance/ threshold	Frequency and method of measure

Quantity Measures
▪ Number of clinic hours available per locality and target group (young people): Capture "clinical hours" or slots available vs planned per area
  ○ Weekdays, before 6pm
  ○ Weekdays, after 6pm
  ○ Weekends
▪ Number of new Service Users
▪ Number of new attendances - booked appointments face to face (per clinic)
▪ Number of new attendances – booked appointments virtual (per clinic)
▪ Number of new attendances - walk-in appointments (per locality)
 	
Note: a new attendance is a new SU or an existing SU requiring a new episode of care
 	
▪ Number of follow up attendances
  ○ by face to face appointment
  ○ by telephone appointment
  ○ via walk in
▪ Number of Service Users seen with a North Yorkshire (NY) postcode
▪ Number of Service Users seen from out of area
▪ Breakdown of prescribing information and drug costs
	▪ An estimated Baseline will be established by mutual agreement with the provider in year one (number of new attendances should not be below current 2013/14 levels). From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one.
	
	No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.
		Quarterly report

Quality Measures		

▪ Increase in proportion of NY resident attendances in NY clinics (year on year decrease in out of area attendances) ▪ Decrease attendances by NY residents at Stockton, Darlington and Middlesbrough services by 50% (from 2012/13 levels based on GUMCAD data) ▪ Increase in number of young people (under 25) accessing the Service ▪ % of appointments Did Not Attend (DNA) ▪ % of Service Users offered services within 2 working days ▪ % of walk-in attendances carried out within 2 hours of registration ▪ % of all women choosing intrauterine (IUD/IUS), implant or depo LARC methods are offered an appointment to have this fitted within 2 weeks if medically appropriate.	▪ Baseline for year one to be established from GUMCAD 2013/14. Performance/thresholds for year two onwards will be established from GUMCAD 2014/15 onwards. ▪ Not exceeding 325 new attendances and 94 follow-up attendances (incentive payment of 2% of SSHS budget) ▪ Baseline to be established in year one. ▪ Baseline to be established in year one. ▪ 100% ▪ 100% ▪ 100% Where data is available it is expected that baselines will not be set below current activity.	

Clinical Management: STIs

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of Service Users presenting with an asymptomatic STI concern ▪ Number of Service Users presenting with a symptomatic STI concern ▪ Number of Service Users who are offered full STI tests (T4) where clinically appropriate ▪ Number of Service Users who are offered a HIV test ▪ Number of STI tests conducted by coding	▪ Estimated Baselines will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed.	Quarterly report

▪ Number of positive and negative STI tests by coding ▪ Number of results delivered to Service Users within 10 working days of consultation ▪ Number of patients who have had STI testing in previous 3/6/12 months who re-attend for further testing in the period	Where data is available it is expected that baselines will not be set below current activity.	
▪ **Quality Measures** % of Service Users who have sexual health history and risk assessment undertaken ▪ % of Service Users who are eligible for and offered a HIV test at first attendance ▪ % of Service Users who are offered full STI tests (T4) where clinically appropriate ▪ % of Service Users who are offered full STI tests (T4) where clinically appropriate that accept a test ▪ % of Service Users who have had STI testing in previous 3/6/12 months who re-attend for further testing in the period. ▪ % of Service Users completing a Hep B vaccination course – in line with BASHH ▪ % of Service Users offered a HIV test where clinically appropriate ▪ % of Service Users offered a HIV test who accept a test ▪ % of routine STI test conducted that lead to a positive diagnosis (baseline) ▪ % of people newly diagnosed with HIV who have a CD4 count recorded in their clinical record within one month of diagnosis (late diagnosis from HARS). ▪ % of results (positive and negative) delivered to Service Users within 10 working days of the date of the sample ▪ % of routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within seven working days of a specimen being taken ▪ % of all contacts where Partner Notification (PN) discussion has been initiated either by the index case or the Health Care Worker (HCW) within 4 weeks of first PN discussion.	▪ >97% ▪ >97% (excluding those already diagnosed HIV positive, to support Public Health Outcome Framework 3.4) ▪ 100% ▪ An estimated Baseline will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. ▪ >95% ▪ 95% ▪ 100% ▪ 0.6 contacts per index case within four weeks	

▪ % of Service Users who are symptomatic or Nucleic Acid Amplification Test (NAAT) positive for Neisseria gonorrhoeae who have a culture performed ▪ % of all contacts of index cases of gonorrhoea who attend for management of STIs within four weeks of the date of the first PN discussion ▪ % of reports (or preliminary reports) issued by the laboratory within five working days of the specimen being received by the laboratory ▪ % of final reports on supplementary testing, or following referral to the reference laboratory, which are issued by the laboratory within 10 working days of the specimen being received by the laboratory ▪ % of people having STI tests who can access their results (both positive and negative) within ten working days of the date of the sample (excluding those requiring supplementary tests) ▪ % of people who tested positive for Chlamydia to be treated within six working days of the date of test ▪ % of patients with documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk ▪ % of patents with documented PN outcomes or a progress update at 12 weeks after the start of the process (HIV) ▪ % of symptomatic, PEPSE, or emergency contraception clients accessing service to be seen within 48 hours of contacting the service	▪ 80% ▪ 0.6 contacts per index case within four weeks ▪ 97% ▪ 97% ▪ 95% ▪ 95% ▪ 90% ▪ 90% ▪ 85% No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	

Clinical Management: Chlamydia screening

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number and % of 15-24 year old population tested for Chlamydia ▪ Number and % of 15-24 year olds attending a YorSexual Health service offered a Chlamydia test; and number and % of those that accept ▪ Number of positive patients under-25 offered a chlamydia re-test at 3 months post treatment, and number offered a re-test between three and six months after treatment ▪ Work towards achieving a diagnostic rate of 2,300/100,000 for chlamydia screening	▪ An estimated Baseline will be established by mutual consent with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. ▪ 100% offered; acceptance rates to be established No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Quarterly report
Quality Measures ▪ % of tests delivered in core locations (i.e. primary care, GU, CASH) ▪ % of all results notified to the young person within 10 working days (from test data) ▪ % of those tested receiving a positive result	▪ At least 70% ▪ At least 95% ▪ An estimated Baseline will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one.	

▪ % of positive Service Users who received treatment within six weeks of test dates ▪ % of index cases documented as offered PN discussionNumber of all contacts whose attendance at the Service was documented **as reported** by the index case, or by a HCW, within four weeks of the date of the first PN discussion.	▪ At least 95% ▪ At least 97% of index cases At least 0.6 contacts per index case No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	

Clinical Management: Contraceptive services

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of male patients receiving condoms ▪ Number of female patients receiving condoms ▪ Number of IUD's fitted ▪ Number of IUD's removed ▪ Number of IUS's fitted ▪ Number of IUS's removed ▪ Number of failed IUD insertions ▪ Number of contraceptive injections administered ▪ Number of hormonal contraceptive implants fitted ▪ Number of hormonal contraceptive implants removed ▪ Number of contraceptive pills (COC & POP) 1st start ▪ Number of contraceptive pills (COC & POP) attendances ▪ Number of referrals to abortion services ▪ Numbers of Service Users provided with emergency contraception o Oral (EHC) o Device	▪ An estimated Baseline will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one.	Quarterly report

○ Both ▪ Number of young people under 19 and under 16 accessing emergency contraception ○ Oral (EHC) ○ Device ○ Both	No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	
Quality Measures ▪ % of women having access to and availability of a range of contraceptive methods (including choice within products) ▪ % of LARCS prescribed as a proportion of all contraceptive methods provided (measured as "Start" and "Changes" ▪ % of women who have their LARC fitting removed or changed within 12 months of fitting ▪ % of failed insertions of LARC % of women who have access to emergency contraceptive advice (including Intrauterine Contraceptive Device) within xx hours of contacting the service	▪ 100% ▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	

Service: Counselling service

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures		

▪ Number of psychosexual counselling sessions delivered – first appointments ▪ Number of psychosexual counselling sessions delivered – follow up appointments ▪ Number of Service Users seen ▪ Number of Service Users referred (need to capture waiting list quantity) ▪ % of all appointments DNA'd ▪ Number of Service Users on caseload ▪ Average number of sessions delivered per Service User ▪ Number of inappropriate referrals received ▪ Number of discharge summaries returned to referring clinician within 2 weeks of discharge	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Quarterly report
Quality Measures ▪ % of referrals responded to within 10 working days ▪ % of service users seen within 18 weeks of referral	▪ 100% ▪ 100%	

Service: Condom distribution service

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of individuals signed up to condom distribution scheme ▪ Number of organisations signed up to deliver the scheme ▪ Number of condoms and related products distributed across the system broken down by settings and service areas	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to	Quarterly report

	support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	
Quality Measures ▪ Annual quality assurance audit of the condom distribution service including service user and professional feedback, complaints, product supply and wastage	▪ One audit per year	Annual report

Service: Marketing and publicity

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of social marketing initiatives, campaigns and events the service has led or participated in	▪ Thresholds will be negotiated with the provider in year one.	Annual report
Quality Measures ▪ Positive evaluation of social marketing initiatives, campaigns and events	▪ One evaluation report per year	Annual report

Service: Clinical leadership

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Stakeholder 360 degree survey to be conducted on clinical leadership role to include communication, partnership working, strategic and clinical leadership style and effectiveness, clinical pathway development, etc.	▪ Thresholds will be negotiated with the provider in year one.	Bi-annually within annual report

▪ Number of clinical network sessions provided ▪ Services that manage integrated sexual health services must be safe, well managed and accountable	▪ Evidence that clinical governance arrangements are in place and effective: demonstrate compliance with CQC 2014 Regulations 12, 17, 18, 19, 20 ▪ Evidence of participation in relevant annual regional or national audits and actions taken as a result of the audit findings	Annual report
Quality Measures ▪ Evidence of response to results of 360 survey undertaken, including with clinical network members ▪ Evidence of clinical pathways and how these are disseminated throughout the system ▪ Evidence of engagement with wider sexual health forums and networks (local and national) e.g. child sexual exploitations	▪ One report every two years ▪ Every year ▪ Every year	Bi-annually Annual Report

Service: Training programme

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of training sessions (to be agreed) delivered, broken down by topic, course length, level (to include levels 1-3), locality and by professional groups ▪ Number and type of placements provided ▪ External Training requests met	▪ Thresholds will be negotiated with the provider in year one. ▪ 75%	Quarterly report
Quality Measures ▪ % of training sessions evaluated positively ▪ Evidence that the training is based on a training needs analysis (levels 1-3 across the whole system) ▪ Evidence that the service has engaged with the Local Education Training Board (LETB)	▪ One training report per year	Annual report

Performance measures - HIV Support Service

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Numbers of assessments including Carers Assessments ▪ Number of new referrals with HIV diagnosis (self and direct) ▪ Number of new referrals partners/carers/family member ▪ Total number of service users on caseload (people with HIV diagnosis and partners/carers/family members) ▪ Number of Service Users receiving each type of intervention (people with a HIV diagnosis and partners/carers/family members) ▪ Number of condoms and related products distributed (per quarter) ▪ Number of onward referrals and sign-posts	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Quarterly report
Quality Measures ▪ Improvements in self-reported health and well-being measures (to be agreed) from baseline assessment to 6 month review ▪ % of appointments DNA'd	▪ Threshold will be negotiated with the provider in year one. ▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one.	Quarterly report

▪ % of service users referred from the clinical nurse specialist who are offered an appointment within 48 hours	▪ Thresholds will be negotiated with the provider in year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	

Performance measures - Community Outreach Service

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number of new Service Users ▪ Number of community outreach contacts ▪ Number of service users receiving each type of intervention ▪ Number of service users identifying as sex workers ▪ Average number of counselling sessions received by service users ▪ Number and type of POCT delivered ▪ Number of condoms and related products distributed ▪ Number of onward referrals and sign-post	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Quarterly report
Quality Measures		

▪ Improvements in self-reported health and well-being measures (to be agreed) from baseline assessment to 6 month review ▪ % of counselling appointments DNA'd ▪ POCT positivity rate	▪ Threshold will be negotiated with the provider in year one. ▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. ▪ Estimated Baseline positivity rates will be established in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Quarterly report

Performance measures - Common requirements

Workforce

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Number and type of employed posts ▪ Number and type of unpaid posts including students	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. Baseline to be established in year one. No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Annual report
Quality Measures ▪ Workforce issues that impact on service delivery e.g. sickness, vacancies, difficulties in recruitment, are reported to the commissioner as soon as possible ▪ % of staff, broken down into service area, who have successfully completed competency based training, according to their scope of practice, and fulfilled relevant update requirements ▪ % of dual trained staff to deliver contraceptive (including LARC methods) and GUM services	▪ 100% ▪ 100% ▪ Thresholds will be negotiated with the provider in year one.	As issues arise Annual report Annual report

Service User Experience

Performance measure	Expected performance/ threshold	Frequency and method of measure
Quantity Measures ▪ Report on Service User experience including compliments/comments and how they were resolved ▪ Evidence of regular Service User engagement including within service developments ▪ A Patient and Public Engagement (PPE) plan which affords public consultation and feedback ▪ The use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to collect information from patients ▪ Evidence of person-centred care and treating service users with dignity and respect ▪ Care pathways with other organisations to include partner notification and linked services (e.g. alcohol and drugs, mental health, FGM, CSE, smoking, domestic violence, sexual violence etc.) are clearly defined	▪ An estimated Baseline to will be established by mutual agreement with the provider in year one. From year two onwards, performance/thresholds will be agreed with the provider based on the activity from year one. Baseline to be established in year one. ▪ Evidence of a current Patient and Public Engagement plan which affords public consultation and feedback. ▪ Evidence from providers of effectiveness of care from the patients' perspective and the patient experience of the humanity of their care via annually reporting validated PROMs and PREMs ▪ Evidence of established pathways ▪ Attendance at multi-agency meetings No additional payment to the contract value will be made available to the Provider to support the achievement of performance thresholds agreed. Where data is available it is expected that baselines will not be set below current activity.	Annual report
Quality Measures ▪ Evidence of improvements made to service as a result of user feedback ▪ You're Welcome accreditation (or equivalent) for clinics. ▪ Submission of a clinical governance and audit report to include patient safety, clinical effectiveness, and patient and public experience	▪ One service user experience report per year ▪ Clear plans in place for achievement across all clinics within 2 years ▪ One report per year	Annual report

▪ All 'near misses' to be recorded and reported at quarterly meetings. ▪ All serious untoward incidents reported to the commissioners within 5 days of their occurrence. ▪ An Equality Impact Assessment (EIA) is undertaken and outcomes utilised to inform forward year planning. ▪ % of service user feedback on surveys that rates satisfaction as good or excellent ▪ % of people contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service ▪ % of people contacting service who are seen or assessed by a healthcare professional within 2 working days of first contacting the service	▪ 100% ▪ 100% ▪ One report per year ▪ >70% ▪ 98% ▪ 80%	As issues arise Annual report

The provider will be required to report on progress against all performance measures. The Provider will meet quarterly with the Commissioner to review performance

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