Dated **2022**

NORTH YORKSHIRE COUNTY COUNCIL

and

YORK AND SCARBOROUGH TEACHING HOPSITALS NHS FOUNDATION TRUST

SECTION 75 PARTNERSHIP AGREEMENT

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BETWEEN

(1) **North Yorkshire County Council** of County Hall, Northallerton DL7 8AD (the "**Council**"); and

(2) **York and Scarborough Teaching Hospitals NHS Foundation Trust** of Trust Headquarters, York Hospital, Wigginton Road, York YO31 8HE (the "**Trust**")

WHEREAS

(A) The Council is a Local Authority established under the Local Government Act 1972 (as amended) and by virtue of Part 1 of the Care Act 2014 the Council is responsible for ensuring access to, commissioning and/or providing sexual health services on behalf of the population of North Yorkshire.

(B) The Trust is an NHS Foundation Trust established under Section 30 of the National Health Service Act 2006 ("**2006 Act**").

(C) Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 ("**Regulations**") enable NHS bodies to exercise prescribed local authority health-related functions and for local authorities to exercise various prescribed NHS functions. The power to enter into section 75 agreements is conditional on the following:

- The arrangements are likely to lead to an improvement in the way in which those functions are exercised.
- The partners have jointly consulted people likely to be affected by such arrangements.

(D) The health-related functions that could be exercised by an NHS body on behalf of the Council under a Section 75 agreement include sexual health services.

(E) The Partners enter into this Agreement in exercise of the powers in Section 75 of the 2006 Act and the Regulations in order to establish a framework for the exercise of health related functions, and the integrated provision of sexual health services to people within the Council's administrative area in accordance with the terms of this Agreement. The delivery of the service is managed through joint governance mechanisms in which both the Trust and Council participate through a process of co-operation and joint working.

(F) The objective of this Agreement is to improve the delivery of sexual health services for the local health population through the provision of an integrated service. The service will be known as the specialist sexual health service ("**the Service**"). This will be achieved through close working between the NHS and the Council and which is pursuant to the obligations for the Partners to co-operate with each other in providing such services in accordance with Section 82 of the 2006 Act.

(G) The Agreement promotes and implements the joint delivery and support of the Service by bringing together public health and NHS services to ensure that the Services is an integrated part of comprehensive services for the local health population. The Partnership Arrangements will allow for more coordinated approaches to the delivery of the Service, leading through shared outcomes, coordinated support and joined up oversight. This will enable improved efficiency within the system and better experience and outcomes for people accessing services. The aims and objectives of the Partners are set out in Clause 3.

(H) The Partners intend to develop their partnership over time and move towards further integration in respect of service provision. Key work streams including looking at further integration of working practices and pathways, co-location of services, integrated data and information systems and, potentially, service management. The ongoing aim is to ensure that needs and issues are identified early, and the right interventions and support by the right practitioner at the right time and place are implemented. During the Agreement the Partners will continually pursue opportunities for wider partnership working.

(I) This Agreement follows consultation jointly by the Partners with such persons as appear to the Partners to be affected by these arrangements and these arrangements contribute to the fulfilment of the objectives set out in the Health Improvement Plan as required under the Regulations.

(J) The Partners are satisfied that the arrangements contemplated by this Agreement are likely to lead to an improvement in the way that their funds and services for sexual health services are managed and delivered.

(K) The Council and the Trust have approved the terms and conditions of this Agreement.

(L) The Partners are entering into this Agreement in exercise of powers referred to in Section 75 of the 2006 Act.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, except where the context otherwise requires, the following expressions shall have the meanings respectively ascribed to them:-

"2000 Act" means the Freedom of Information Act, 2000;

"2006 Act" means the National Health Service Act, 2006;

"Additional Services" means any services that are not included in the Services on the Commencement Date but are subsequently included within the scope of this Agreement by agreement between the Partners in accordance with Clause 34;

"Agreement" means this Agreement, Schedules and Annexes and any variation of it from time to time agreed by the Partners;

"Aims and objectives" means as described in Clause 3 of this Agreement;

"Annual Review" means a review undertaken by the Partners to demonstrate the extent to which the Aims and Objectives have been delivered for each year of the Agreement;

"Authorised Signature" means the person authorised to sign the agreement on behalf of the respective organisations;

"Authorised Officers" means the person notified by each of the Partners to the other from time to time as authorised to act on behalf of that Partner (which person shall until further notice be for the Council Health Improvement Manager in Public Health and for the Associate Chief Operating Officer, Care Group 5);

"**Change in Law**" means a change in Law that impacts on the Partnership Arrangements, which comes into force after the Commencement Date;

"Commencement Date" means 1 April 2022;

"Council" means North Yorkshire County Council (and any successor to its statutory function);

"Council Health Related Functions" means those of the health related functions of the Council specified in Regulation 6 of the Regulations from time to time as are relevant to the Service, including but not limited to the Council's public health functions under Sections 2B or 6C(1) of, or Schedule 1 to, the 2006 Act;

"Data Controller" has the meaning set out in the Data Protection Legislation;

"Data Protection Legislation" means, for the periods in which they are in force in the United Kingdom, the GDPR, the Data Protection Act 2018, the Electronic Communications Data Protection

Directive 2002/58/EC, the Privacy and Electronic Communications (EC Directive) Regulations 2003 and all applicable laws and regulations relating to Processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner, in each case as amended or substituted from time to time;

"Exit Strategy" means the exit strategy agreed between the Partners within six (6) months of the Commencement Date of this Agreement;

"Expiry Date" means 31 March 2026;

"Financial Contributions" means the financial contributions of the Partners as set out in Schedule 3;

"Financial Year" means the financial year from 1st April in any year to 31st March in the following calendar year;

"GDPR" means (a) the General Data Protection Regulation (Regulation (EU) 2016/679); and (b) any equivalent legislation amending or replacing the General Data Protection Regulation;

"Health Improvement Plan" means the local NHS health improvement and modernisation plan which applies to the Trust and any other plan known to incorporate the Aims and Outcomes;

"Information Commissioner" means the UK's supervisory authority in relation to information rights, based at Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF;

"Integrated Sexual Health Board" means the Integrated Sexual Health Board which shall be the joint officer group responsible for the review of performance and oversight of this Agreement as set out in the governance arrangements in Schedule 4;

"Integrated Sexual Health Operational Group" means the Integrated Sexual Health Operational Group which shall be the joint group responsible for overseeing the sexual health service**;**

"Law" means any applicable law (including but not limited to decisions of the European Court of Justice) provision of the EC Treaty, legislation of the European Union, statute, bye-law, regulation, order, regulatory policy, guidance or code of practice (to the extent that such policy, guidance or code is legally binding) rule of court or directions or requirements of any Regulatory Body, delegated or subordinate legislation or notice of any Regulatory Body;

"NHS Functions" means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the Trust as are relevant to the provision of the Services, including in particular those set out in Schedule 2;

"Partners" means the parties to this Agreement and the term "Partner" shall mean either one of them; the term "Partnership" shall be construed accordingly;

"**Partnership Arrangements**" means the arrangements made between the Partners under this Agreement;

"Personal Data" shall have the meaning set out in the Data Protection Legislation;

"Pooled Fund" means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations;

"**Quarter**" means one of the following periods in each Financial Year:

(a) 1 April to 30 June (quarter one);

(b) 1 July to 30 September (quarter two);

(c) 1 October to 31 December (quarter three); and

(d) 1 January to 31 March (quarter four);

"Regulations" means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 as amended by the Care Act 2014 (Consequential Amendments) (Secondary Legislation) Order, 2015 and other amendments as may be made from time to time;

"Regulatory Body" means a government department and regulatory, statutory and other entities committees and bodies which whether under statute, rules and regulations, codes of practice or otherwise are entitled to regulate or investigate the matters dealt with in this Agreement or any other affairs of either of the Partners;

"Service" means the sexual health services as set out in in **Schedule 1** (Service Specification);

"Service Transformation and Development Plan" has the meaning set out in Clause 8;

"Service User" means any eligible person receiving or entitled to receive the benefit of the Service;

"Trust" means York and Scarborough Teaching Hospitals NHS Foundation Trust (and any successor to its statutory functions);

"TUPE" means the Transfer of Undertakings (Protection of Employment Regulations) 2006;

"**VAT Guidance**" means the guidance published by the Department of Health entitled "VAT arrangements for Joint NHS and Local Authority Initiatives including Disability Equipment Stores and Welfare- Section 31 Health Act 1999" as amended or replaced from time to time;

"**Working Day**" means any day other than Saturday, Sunday, a public or bank holiday in England.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 COMMENCEMENT AND DURATION

2.1 This Agreement will come into force on the Commencement Date.

2.2 Unless terminated earlier in accordance with Clause 30 or other prior lawful termination and subject to Clauses 2.3, 2.4 and 2.5, the Agreement will terminate on the Expiry Date.

2.3 The Partners may extend this Agreement for a period of four (4) years by agreement in writing, subject to approval of the Partners **("the First Extension").** The First Extension will commence on the day after the Expiry Date.

2.4 The Partners may extend this Agreement for a further period of two (2) years beyond the First Extension, **("the Second Extension")** by agreement in writing, subject to approval of the Partners, which shall commence on the day after the expiry of the First Extension.

2.5 The Partners will enter into discussions about whether to extend this Agreement 18 months prior to the Expiry Date. Such discussions shall include negotiations of the Financial Contributions for the relevant extension period. The Partners will enter into discussions about whether to further extend this Agreement 18 months prior to the expiry of each subsequent period of extension i.e. 18 months prior to the expiry of the Fist Extension and 18 months prior to the Second Extension. Any agreement to extend this Agreement will be formally confirmed in writing by the partners 12 months prior to the Expiry Date or, as applicable, 12 months prior to the expiry of the First Extension or 12 months prior to the expiry of the Second Extension, unless otherwise agreed by the Partners.

3 AIMS AND OBJECTIVES

3.1 The Partners have agreed to enter into partnership arrangements as described in this Agreement for the purpose of developing and providing the Service as set out in **Schedule 1**.

3.2 The overall strategic aim of the Service will be to ensure the delivery of high quality services for the local health population through joint working across the health and social care system.

3.3 The strategic objectives of the Partnership are:

Partnership Working

- The partnership 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 our 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 agreement.

- 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.
- The partnership will take a strengths based approach, utilising the skill sets available from each organisation e.g. business intelligence or communications.
- The partnership will explore opportunities to work as part of a wider system collaborative.

Resources

- The partnership must ensure statutory requirements continue to be met and any future service adaptions 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 provided is dealt with in one location as far as is practicably possible.

4 PRINCIPLES

4.1 The Partners agree to adopt the following principles when carrying out this Section 75 agreement:

4.1.1 To be openly accountable for performance of the Partners' respective roles and responsibilities set out in this Section 75;

4.1.2 To communicate openly and transparently about major concerns, issues or opportunities relating to the delivery of this Section 75;

4.1.3 To commit to learn, develop and seek to achieve full potential from the Service;

4.1.4 To share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.5 To adopt a positive outlook and behave in a positive, proactive manner;

4.1.6 To act in the best interests of Service Users and to ensure that they are always at the forefront of decision making;

4.1.7 To adhere to statutory requirements and evidence based best practice, complying with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation;

4.1.8 To act in a timely manner, recognising the time-critical nature of the project and to respond accordingly to requests for support;

4.1.9 To act in good faith to support achievement of the key objectives and compliance with these principles; and

4.1.10 To provide coherent, timely and efficient decision-making. The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of the Services in accordance with the terms of this Agreement.

5.2 The Council agrees that the Trust will exercise the Council's Health Related Functions to the extent necessary for the purposes of performing its obligations under this Agreement in conjunction with the NHS Functions.

5.3 The Council Health Related Functions that are being exercised under the Agreement by the Trust are further set out in Schedule 2 of this Agreement. The NHS Functions which the Trust will exercise in conjunction with the Council Health Related Functions are described in Schedule 2 of this Agreement.

6 SERVICES

6.1 The Trust agrees to provide the Service in accordance with the Service specification in Schedule 1 and subject to the governance arrangements set out in Schedule 4. The Trust will be responsible for the management and the delivery of the Services under this Agreement.

6.2 The Trust shall ensure that all relevant legislation and statutory guidance in relation to delivery of the Service are complied with and shall manage its staff and the Service in accordance with all such legislation and statutory guidance.

7 STAFFING

7.1 The Trust shall ensure that adequate staff are allocated to the provision of the Service, and that those staff members are competent and able to carry out their duties, including but not limited to, having the appropriate and up-to-date qualifications where applicable to that role. The Trust shall ensure compliance with section 2.4.5 of the Specification with regards to their workforce in the delivery of the Service.

7.2 Staff remain subject to their respective employer's terms and conditions and employment policies.

7.3 Each Partner will bear responsibility for all costs associated with their directly employed staff, including basic costs of employment and associated non- pay costs including professional indemnity, and costs associated with development and training.

7.4 The Partners may wish to develop/create integrated service functions in the future.

8 SERVICE TRANSFORMATION AND DEVELOPMENT PLAN

8.1 The Partners shall prepare a Service Transformation and Development Plan for the Service which shall operate for the entirety of this Agreement. The Service Transformation and Development Plan shall:

8.1.1 set out the agreed Aims and Outcomes for each specific Service and any Additional Services;

8.1.2 describe any changes or development required for the specific Service; and

8.1.3 provide information on how changes in funding or resources may impact the specific Service.

8.2 The Service Transformation and Development Plan shall be developed by the Partners within the first six (6) months from the Commencement Date and shall continually be developed throughout the Agreement.

8.3 The development of the Service Transformation and Development Plan will be led by the Trust and will involve a collaborative approach with both Partners working together to agree the contents. The Service Transformation and Development Plan will be developed with the Sexual Health Operational Group and approved by the Sexual Health Board.

8.4 In the event that any agreed changes to the Service Transformation and Development Plan results in any increases or reductions in the level of services in the scope of the Agreement, the partners shall vary the Agreement in accordance with Clause 34. It is acknowledged that the Partners may be required to agree corresponding adjustments to the financial arrangements as set out in Schedule 3 of this Agreement.

8.5 If the Partners cannot agree the contents of the Service Transformation and Development Plan or any subsequent changes to the Service Transformation and Development Plan, the matter shall be dealt with in accordance with Clauses 29.1 and 29.2. Pending the outcome of the dispute resolution process (without for the avoidance of doubt does not include the mediation process set out in Clauses 29.3 to 29.27 or termination of the Agreement under Clause 30), the Partners shall continue to provide the Service on the same basis as the Services were provided as at the Commencement Date or in accordance with the latest agreed version of the Service Transformation and Development Plan, as applicable.

9 PERFORMANCE MANAGEMENT

9.1 The Partners shall adhere to the performance management framework set out in Schedule 5.

10 FINANCIAL ARRANGEMENTS

10.1 The financial arrangements in respect of the delivery of this Agreement shall be as described in Schedule 3, which may be amended from time to time in accordance with Clause 34.

10.2 Each Partner shall pay its own costs and expenses incurred from time to time in the negotiation and management of this Agreement, save as expressly otherwise provided in this Agreement.

10.3 For the avoidance of doubt, it is not the intention of the Partners through this Agreement to establish a Pooled Fund, although there is nothing in this Agreement that precludes the Partners from doing so if subsequently agreed in accordance with Clause 34. If the Partners do agree to establish a Pooled Fund, the Parties recognise that this Agreement will require amendments to ensure compliance with the Regulations.

11 RISK SHARE, OVERSPENDS AND UNDERSPENDS

Risk Share

11.1 The risk share arrangements are as set out in Schedule 3.

Overspends and overspends

11.2 Liability for overspends and underspends shall sit with the Trust. The Trust shall make the Council aware of any potential overspends or underspends as soon as it becomes aware of this possibility. The Trust will confirm reasons for the overspend or underspend, both current and projected.

12 CAPITAL EXPENDITURE

12.1 The Financial Contributions shall be directed exclusively to revenue expenditure. Any arrangements for the sharing of capital expenditure shall be made separately and in accordance with section 256 (or section 76) of the NHS Act 2006 and Directions made thereunder.

13 SET UP COSTS

13.1 Each Partner shall bear its own costs of the establishment of the Partnership Arrangements under this Agreement.

14 PREMISES/NON-FINANCIAL CONTRIBUTIONS

The Council and the Trust may agree to share premises in the delivery of the Service. Any such use of premises shall be governed under a separate licence agreement.

15 GOVERNANCE

15.1 The governance arrangements in respect of this Agreement are set out in Schedule 4.

15.2 The Trust shall nominate its Authorised Officer, who shall be the main point of contact for the Council and shall be responsible for representing the Trust and liaising with the Council's Authorised Officer in connection with the Partnership Arrangements.

15.3 The Council shall nominate the Council's Authorised Officer, who shall be the main point of contact for the Trust and shall be responsible for representing the Council and liaising with the Trust's Authorised Officer in connection with the Partnership Arrangements.

15.4 The Authorised Officers shall be responsible for taking decisions concerning the Partnership Arrangements on behalf of their respective organisations, unless they indicate that the decision is one that must be referred to their respective boards or committees. All decisions in respect of this Agreement shall be made by each Partner in line with its own Standing Orders and Scheme of Delegation.

15.5 The Partners shall each nominate officers to the Integrated Sexual Health Board in accordance with Schedule 4 terms of reference for the Integrated Sexual Health Board. The terms of reference for the Integrated Sexual Health Board, as at the Commencement Date, are set out in Schedule 4. The terms of reference for the Integrated Sexual Health Board may be amended from time to time by agreement between the Partners in writing).

15.6 The Partners shall each nominate officers to the Integrated Sexual Health Operational Group in accordance with the terms of reference for the Integrated Sexual Health Operational Group. The terms of reference for the Integrated Sexual Health Operational Group, as at the Commencement Date, are set out in Schedule 4. The terms of reference for the Integrated Sexual Health Operational Group may be amended from time to time by agreement between the Partners in writing.

16 QUARTERLY REVIEW AND GENERAL REPORTING

16.1 The Partners shall carry out a joint quarterly review of the Partnership Arrangements within 6 weeks of the end of each reporting Quarter. The aim of the review is to identify and consider new issues as have arisen during the Quarter and to address/confirm progress in respect of previously agreed actions.

16.2 The Trust shall submit a quarterly report to the Integrated Sexual Health Board setting out:

i. Progress against the Service Transformation and Development Plan;

ii. Financial management information including programme budget, programme costs and narrative describing the financial position and performance against the Service Transformation and Development Plan;

iii. A summary of new issues/actions arising during the Quarter and a summary of progress against previously agreed actions;

iv. the Service delivery against the agreed outcomes and performance as set out in Schedule 5; and

v. an update on the workforce position including key risk and mitigations to the partnership such as staffing capacity, sickness absence and recruitment.

17 ANNUAL REVIEW

17.1 The Partners agree to carry out a review of the Partnership Arrangements within three months of the end of each Financial Year ("**Annual Review**)" in line with the process set out in Clauses 17.3 and 17.4 of this Agreement.

17.2 The scope of the Annual Review will be agreed by the Integrated Sexual Health Board in advance and will include as a minimum:

17.2.1 the performance of the Partnership Arrangements against the Aims and Objectives set out in Clause 3 of this Agreement;

17.2.2 the performance of the individual Service against the service levels and other targets contained in this Agreement;

17.2.3 plans to address any underperformance in the Services;

17.2.4 actual expenditure compared with agreed budgets, and reasons for and plans to address any actual or potential underspends or overspends;

17.2.5 review of plans and performance levels for the following year; and

17.2.6 plans to respond to any changes in policy or legislation applicable to the Services or the Partnership Arrangements.

17.3 The Integrated Sexual Health Operational Group will, as part of the Annual Review, review the Service and the Partnership Arrangements, having regard to the scope of the Annual Review agreed by the Integrated Sexual Health Board in accordance with Clause 17.2, and prepare a report for consideration by the Integrated Sexual Health Board. The Integrated Sexual Health Board will review the report and consider and agree any recommendations for the Service that are to be made to the Trust's Board and the Council.

17.4 The Integrated Sexual Health Board will agree a final version of the report for submission to both the Trust's board and to the Council for approval.

18. STANDARDS

18.1 The Partners shall collaborate to ensure that the Partnership Arrangements are discharged in accordance with:

18.1.1 the service standards set out in Schedule 1 and Schedule 5;

18.1.2 the prevailing standards of clinical governance; and

18.1.3 the requirements specified by the Care Quality Commission and any other relevant external regulator.

18.2 The Trust shall ensure its operational guidance and procedures reflect compliance with this Clause 18.

18.3 The Trust shall ensure that each employee is appropriately managed and supervised in accordance with all relevant prevailing standards of professional accountability.

19 HEALTH AND SAFETY

19.1 The Trust shall (and shall use reasonable endeavours to ensure its Representatives) comply with the requirements of the Health and Safety at Work etc Act 1974 and any other legislation, orders, regulations and codes of practice relating to health and safety, which may apply to the Service and persons working on the Service.

19.2 The Trust shall ensure that its health and safety policy statement (as required by the Health and Safety at Work etc Act 1974), together with related policies and procedures, are made available to the Council on request.

19.3 The Trust shall notify the Council if any incident occurs in the performance of the Service, where that incident causes any personal injury or damage to property that could give rise to personal injury.

20 EQUALITY DUTIES

20.1 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance equality of opportunity and foster good relations between different groups.

20.2 The Trust agrees to adopt and apply policies in its carrying out of the Council's Health-Related Functions, to ensure compliance with their equality duties.

20.3 The Trust shall take all reasonable steps to secure the observance of this Clause 20 by all servants, employees or agents of the Trust employed in delivering the Service described in this Agreement.

21 DATA PROTECTION

21.1 The Partners acknowledge that for the purpose of this Agreement, they are each Data Controllers and agree to comply with their obligations under the Data Protection Legislation and abide by Schedule 6 (Information Sharing Agreement).

22 FREEDOM OF INFORMATION ACT AND ENVIRONMENTAL PROTECTION REGULATIONS

22.1 The Partners acknowledge that each of them is subject to obligations under the 2000 Act ("**FOIA**") and the 2004 Regulations.

22.2 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request in relation to this Agreement under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include (but not be limited to) finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any reasonable requests by the Partner receiving a request for comments or other assistance.

22.3 Any and all agreements between the Partners as to confidentiality shall be subject to duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 23 if it makes disclosures in accordance with the 2000 Act and/or the 2004 Regulations.

23 CONFIDENTIALITY

23.1 The Partners shall ensure that confidentiality is maintained at all times in all matters relating to the services provided under this Agreement.

23.2 In this Agreement "**Confidential Information**" shall mean any information or data (of whatever nature and however recorded or preserved) of a confidential nature relating to either Partner or its activities or the activities and affairs of its employees, agents, Service Users or relatives, under this Agreement. Save that Confidential Information shall not include information or data that is or becomes:-

23.2.1 generally available to the public otherwise than by reason of breach of the provisions of this Clause;

23.2.2 known to the other Partner and is at its free disposal (having been generated independently by the other Partner or a third party) and not derived directly or indirectly from the Partner's Confidential Information prior to its receipt from the Partner;

23.2.3 subsequently disclosed to the other Partner without obligations of confidence by a third party owing no such obligations to the Partner in respect of that Confidential Information;

23.2.4 required by law to be disclosed;

23.2.5 required by the Local Government Commissioner for England.

23.3 The Partners agree at all times during the continuance of this Agreement to keep confidential all the other Partner's Confidential Information, and only to share such information to the extent permitted by Law. For avoidance of doubt, this Clause shall not affect the rights of any workers under Section 43 A-L of the Employment Rights Act 1996.

23.4 The Partners hereby warrant that in respect of the Confidential Information of the other Partner (including any person employed or engaged by them in connection with this Agreement) they shall:

23.4.1 only use the other Partner's Confidential Information for the performance of their obligations under this Agreement;

23.4.2 not disclose any of the other Partner's Confidential Information to any third party without the prior written consent of the other Partner;

23.4.3 take all necessary precautions to ensure that all the other Partner's Confidential Information is treated as confidential and not disclosed (save as aforesaid) or used other than for the performance of their obligations under this Agreement by their employees, servants, agents or sub-contractors.

23.5 Nothing in this Clause 23 shall be deemed or construed to prevent either Partner from disclosing any Confidential Information obtained from the other to any employee, consultant, contractor or other person engaged by them in connection herewith, provided that they shall have obtained from the employee, consultant, contractor or other person a signed confidentiality undertaking on substantially the same terms as are contained in this Clause.

23.6 Upon termination or expiry of this Agreement, howsoever occurring, the Partners shall return or destroy at the direction and request of the other Partner all Confidential Information and all notes and memoranda prepared in relation to the Confidential Information, of the other Partner.

23.7 The Partners must ensure that all matters relating to the individual Service User's circumstances are treated as confidential. When information is to be shared with other agencies a Service User consent form will be signed, the form of which shall be agreed between the Partners.

23.8 The provisions of this Clause 23 shall continue to apply notwithstanding termination of this Agreement.

24 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

24.1 The Partners shall co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) or any other Regulatory Body in connection with this Agreement.

25 AUDIT

25.1 The Trust shall provide to the Council any reports reasonably required concerning the Health-Related Functions for the purposes of their audit on reasonable notice. The Partners shall agree an annual audit schedule pertaining to elements of the Health Related Functions to determine compliance and quality.

25.2 The Partners shall co-operate in the provision of Information, and access to premises and staff, to ensure compliance with any statutory inspection requirements, or other monitoring or scrutiny functions. The Partners shall implement recommendations arising from these inspections, where appropriate.

26 INDEMNITY AND INSURANCE

26.1 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by National Health Service Resolution) in respect of all potential liabilities arising from this Agreement. Both Partners will seek to recover any losses incurred as a result of the arrangements set out in this Agreement through the insurance arrangements set out in this Clause 26.1. Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

26.2 Each Partner shall provide to the other upon request such evidence as may reasonably be required to confirm that the insurance arrangements are satisfactory and are in force at all times.

26.3 The Trust (the "**Indemnifying Partner**") shall indemnify the Council, its officers, employees and agents against any damage, cost, liability, loss, claim or proceedings whatsoever arising in respect of:

26.3.1 any damage to property real or personal, including any infringement of third party patents, copyrights and registered designs;

26.3.2 any personal injury including injury resulting in death;

26.3.3 any award or recommendation of compensation payable to a Service User following complaint or investigation by the Health Service Commissioner or Local Government Commissioner for England or any similar entity;

arising following the commencement date of this Agreement out of or in connection with the Service, to the extent such damage, cost, liability, loss, claim or proceedings shall be due directly to any negligent act or omission, fraud or a breach of contract in relation to this Agreement, by the Indemnifying Partner, its officers or employees, any fraudulent or dishonest act of any of its officers, employees or contractors or any breach of statutory or common law duty.

26.4 Under this Agreement neither Party shall be liable to the other for any indirect loss of profit, loss of use, loss of production, loss of business, loss of business opportunity, loss of business revenue, loss of goodwill or any claim for consequential loss or for indirect loss of any nature.

26.5 The indemnity shall not apply to any such claim or proceeding:

26.5.1 unless as soon as reasonably practicable following receipt of notice of such claim or proceeding, the Council shall have notified the Trust in writing of it and shall, upon the Trust's request and at the Trust's cost, have permitted the Trust to have full care and control of the claim or proceeding, using legal representation approved by the Council, such approval not to be unreasonably withheld or delayed; or

26.5.2 if the Council, its employees or agents shall have made any admission in respect of such claim or proceeding or taken any action related to such claim or proceeding prejudicial to the

defence of it without the written consent of the Trust (such consent not to be unreasonably withheld or delayed), provided that this condition shall not be treated as breached by any statement properly made by the Council, its employees or agents in connection with the operation of its internal complaints procedures, accident reporting procedures or disciplinary procedures or where such statement is required by Law.

26.6 Each Partner shall keep the other Partner and its legal advisers fully informed of the progress of any such claim or proceeding, will consult fully with the other Partner on the nature of any defence to be advanced and will not settle any such claim or proceeding without the prior written approval of the other Partner (such approval not to be unreasonably withheld).

26.7 The Partners shall use their reasonable endeavours to inform each other promptly of any circumstances reasonably thought likely to give rise to any such claim or proceedings of which they are directly aware and shall keep each other reasonably informed of developments in relation to any such claim or proceeding even where they decide not to make a claim under this Clause 26.

26.8 The Partners shall each give to the other such help as may reasonably be required for the efficient conduct and prompt handling of any claim or proceeding.

26.9 No Council staff will be transferring to the Trust under the terms of this Agreement. The Council therefore warrants that there are no individuals presently employed by the Council (including, for the avoidance of doubt, the Council's Staff) whose contracts of employment will, by virtue of TUPE, would or could be deemed as employees of the Trust after the Commencement Date.

26.10 No Trust staff will be transferring to the Council under the terms of this Agreement. The Trust therefore warrants that there are no individuals presently employed by the Trust (including, for the avoidance of doubt, the Trust's staff) whose contract of employment will, by virtue to TUPE, would or could be deemed as employees of the Council after the Commencement Date.

26.11 Nothing in this Agreement shall absolve the Council or the Trust of their statutory duties to Service Users or others.

27 LIABILITIES

27.1 Each Partner shall, at all times, take all reasonable steps to minimise and mitigate any loss or damage for which the relevant Partner is entitled to bring a claim against the other Partner under this Agreement.

28 COMPLAINTS

28.1 Complaints, incidents and serious incidents related to the Service will be managed by the organisation from which they originate. If there is a complaint in relation to the provision of the Services, the Trust will investigate and respond to the complaint, and where a complaint relates to a serious incident the Trust must notify the Council's Authorised Officer within 48 hours. If there is a perceived benefit in shared accountability the Partners will together take a decision on which Partner is best placed to lead the appropriate process to investigate and respond.

28.2 Where a complaint cannot be handled in the way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Authorised Officers, or their nominated deputies will set up a complaints subgroup to examine the complaint and recommend remedies.

28.3 Any dispute or uncertainty about which procedure to follow should be resolved jointly by the Council and Trust's Authorised Officers.

28.4 Where the complaint is being brought against both the Trust and the Council, it will be managed within the shortest timeframe of whichever Partner.

28.5 Both parties shall co-operate in the investigation of all complaints and will participate in the complaints resolution process as required.

28.6 Both parties shall co-operate in the investigation of enquiries from elected members of the Council.

28.7 The Trust shall ensure that all Services provided and arrangements for complaints are in accordance with its policy and that of the Equality and Human Rights Commission and all or any policies and procedures approved by the Trust as available through its web site under the 2000 Act.

28.8 During the term of the Agreement, the Partners shall work together to develop closer integration on a range of issues including complaints management.

28.9 Each Partner shall use their reasonable endeavours to inform the other Partner of any circumstance reasonably thought likely to give rise to a complaint or in which a complaint has been made.

29 DISPUTE RESOLUTION

29.1 The Partners will use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement.

29.2 In the event of a dispute over the application or interpretation of this Agreement, the dispute may be referred by the Partners in writing as follows:

29.2.1 in the first instance to the Authorised Officers or their nominated deputy to resolve through ordinary negotiations within ten (10) Working Days;

29.2.2 in the second instance (if resolution by the Authorised Officers cannot be reached in line with Clause 29.2.1) to, the Integrated Sexual Health Board. The members of the Integrated Sexual Health Board shall use their best endeavours to resolve such disputes through ordinary negotiations within sixty (60) days;

29.2.3 in the third instance (if resolution by the Integrated Sexual Health Board cannot be reached in line with Clause 29.2.2) to, the Chief Executives or relevant Director within each organisation who shall co-operate in good faith to resolve the dispute as amicably as possible within thirty (30) days of service of the notice.

29.3 If the Dispute is not resolved within thirty (30) days following a referral under clause 29.2.3, the Partners shall attempt in good faith to resolve the dispute through the model mediation procedure of the Centre for Effective Dispute Resolution ("**CEDR**").

29.4 If the Partners are unable to agree on the joint appointment of a mediator within five (5) days, they shall make a joint application to CEDR to nominate the mediator.

29.5 The mediator, after consultation with the Partners where appropriate, will:

29.5.1 attend any meetings with either or both of the Partners preceding the mediation, if requested or if the mediator decides this is appropriate and the Partners agree;

29.5.2 read before the mediation each case summary and all the documents sent to him;

29.5.3 chair, and determine the procedure for the mediation;

29.5.4 assist the Partners in drawing up any written settlement agreement; and

29.5.5 abide by the terms of CEDR's model mediation procedure and CEDR's code of conduct for mediators.

29.6 The mediator (and any member of the mediator's firm or company) will not act for either of the Partners individually in connection with the dispute in any capacity during the Term. The Partners accept that in relation to the dispute neither the mediator nor CEDR is an agent of, or acting in any capacity for, either of the Partners. Furthermore, the Partners and the mediator accept that the mediator (unless

an employee of CEDR) is acting as an independent contractor and not as an agent or employee of CEDR.

29.7 CEDR, in conjunction with the mediator, will make the necessary arrangements for the mediation including, as necessary:

29.7.1 nominating, and obtaining the agreement of the Partners to, the mediator;

29.7.2 organising a suitable venue and dates;

29.7.3 organising exchange of the case summaries and documents;

29.7.4 meeting with either or both of the Partners (and the mediator if appointed), either together or separately, to discuss any matters or concerns relating to the mediation; and

29.7.5 general administration in relation to the mediation.

29.8 If there is any issue about the conduct of the mediation upon which the Partners cannot agree within a reasonable time, CEDR will, at the request of either Partner, decide the issue for the Partners, having consulted with them.

29.9 The Partners agree to notify the mediator of any of the relevant timescales which they wish to observe.

29.10 Each Partner will state the names of:

29.10.1 the person(s) who will be the lead negotiator(s) for that Partner, who must have full authority to settle the dispute; and

29.10.2 any other person(s) (such as professional advisers, colleagues or sub-contractors) who will also be present at, and/or participating in, the mediation on that Partner's behalf.

29.11 Each Partner will send to CEDR at least 2 (two) weeks before the mediation, or such other date as may be agreed between the Partners and CEDR, sufficient copies of:

29.11.1 its case summary; and

29.11.2 all the documents to which the case summary refers and any others to which it may want to refer in the mediation.

29.12 In addition, each Partner may send to the mediator (through CEDR) and/or bring to the mediation further documentation which it wishes to disclose in confidence to the mediator but not to the other Partner, clearly stating in writing that such documentation is confidential to the mediator and CEDR.

29.13 The mediator will be responsible for sending a copy of each Partner's case summary and supporting documents (pursuant to clause 29.10) to the other simultaneously.

29.14 The Partners should try to agree:

29.14.1 the maximum number of pages of each case summary; and

29.14.2 a joint set of supporting documents or the maximum length of each set of supporting documents.

29.15 The mediation will take place at the time and place arranged by CEDR.

29.16 The mediator will chair, and determine the procedure at, the mediation.

29.17 No recording or transcript of the mediation will be made.

29.18 If the Partners are unable to reach a settlement in the negotiations at the mediation, and only if both the Partners so request and the mediator agrees, the mediator will produce for the Partners a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the mediator suggest are appropriate settlement terms in all of the circumstances.

29.19 Any settlement reached in the mediation will not be legally binding until it has been reduced to writing and signed by, or on behalf of, the Partners. The mediator will assist the Partners in recording the outcome of the mediation.

29.20 The mediation will terminate when:

29.20.1 a Partner withdraws from the mediation;

29.20.2 a written settlement agreement is concluded;

29.20.3 the mediator decides that continuing the mediation is unlikely to result in a settlement; or

29.20.4 the mediator decides he should retire for any of the reasons in CEDR's code of conduct.

29.21 Every person involved in the mediation will keep confidential and not use for any collateral or ulterior purpose:

29.21.1 information that the mediation is to take place or has taken place, other than to inform a court dealing with any litigation relating to the dispute of that information; and

29.21.2 all information (whether given orally, in writing or otherwise) arising out of, or in connection with, the mediation including the fact of any settlement and its terms.

29.22 All information (whether oral or documentary and on any media) arising out of, or in connection with, the mediation will be without prejudice, privileged and not admissible as evidence or disclosed in any current or subsequent litigation or other proceedings whatsoever. This does not apply to any information, which would in any event have been admissible or disclosed in any such proceedings.

29.23 Clauses 29.21 and 29.22 shall not apply insofar as any such information is necessary to implement and enforce any settlement agreement arising out of the mediation.

29.24 None of the Partners will call the mediator or CEDR (or any employee, consultant, officer or representative of CEDR) as a witness, consultant, arbitrator or expert in any litigation or other proceedings whatsoever. The mediator and CEDR will not voluntarily act in any such capacity without the written agreement of both the Partners.

29.25 CEDR's fees (which include the mediator's fees) and the other expenses of the mediation will be borne equally by the Partners. Payment of these fees and expenses will be made to CEDR in accordance with its fee schedule and terms and conditions of business.

29.26 Each Partner will bear its own costs and expenses of its participation in the mediation.

29.27 Neither the mediator nor CEDR shall be liable to the Partners for any act or omission in connection with the services provided by them in, or in relation to, the mediation, unless the act or omission is shown to have been in bad faith.

30 TERMINATION

30.1 Without prejudice to other rights and remedies at law, and unless terminated under clause 30.3, either Partner may terminate this Agreement at any time by giving 12 months' written notice to the other Partner.

30.2 The Partners may, without prejudice to any other provision of this Agreement, agree in writing to terminate the Agreement, and if the Partners so agree, they must agree the date upon which termination takes effect.

30.3 Either Partner (for the purposes of this clause 30.3, the **First Partner**) may terminate this Agreement in whole or part with immediate effect by the service of written notice on the other Partner (for the purposes of this clause 30.3, the **Second Partner**) in the following circumstances:

30.3.1 if the Second Partner is in breach of any material obligation under this Agreement, provided that, if the breach is capable of remedy, the First Partner may only terminate this Agreement under clause 30.3, if the Second Partner has failed to remedy the breach within twenty-eight (28) days of receipt of notice from the First Partner (**Remediation Notice**) to do so.

30.4 Either Partner may terminate this Agreement in whole or part upon a minimum of twelve (12) months' written notice following a failure to resolve a dispute under Clause 29.

30.5 If there is a Change in Law that:

30.5.1 prevents either Partner from complying with its obligations under this Agreement; or

30.5.2 makes provision of the Service significantly more or less onerous for the Trust,

the Partners will discuss the impact on the Services (including any financial impact) and agree a way forward, including whether termination under Clause 30.2 is required.

30.6 The provisions of clause 31 shall apply on termination of this Agreement.

31 CONSEQUENCES OF TERMINATION

31.1 On the termination or expiry of this Agreement, howsoever occurring:

31.1.1 the Partners shall co-operate in good faith in order to terminate this Agreement with as little adverse impact on Services Users and staff as reasonably possible;

31.1.2 the Partners will comply with the Exit Strategy;

31.1.3 The Trust shall, at the request of the Council, assign any contracts or parts thereof, which relate to services it performs on behalf of the Council under this Agreement; and

31.1.4 the Trust shall transfer to the Council all records in its possession relating to the Health-Related Functions in accordance with the Data Sharing Agreement at Schedule 6.

31.2 Overspends on termination of the Agreement shall be dealt with in accordance with Clause 11.

31.3 Subject to clause 31.4, underspends on termination of the Agreement shall be dealt with in accordance with Clause 11.

31.4 The Trust shall be entitled to direct any underspends to the following purposes:

31.4.1 to meet obligations under existing contracts in connection with this Service;

31.4.2 to defray the costs of making any alternative arrangements for Service Users; and

31.4.3 to meet the costs of any redundancies arising from the termination of the Partnership Arrangements.

31.4.4 The provisions of the following clauses shall survive termination or expiry of this Agreement:

31.4.5 Clause 21;

31.4.6 Clause 22

31.4.7 Clause 23;

31.4.8 Clause 26;

31.4.9 Clause 27;

31.4.10 Clause 28;

31.4.11 Clause 34; and

31.4.12 Clause 40.

31.5 In addition to the Clauses listed in Clause 31.5 above, any other provision of this Agreement that expressly or by implication is intended to continue in force on or after termination of this Agreement, howsoever caused, shall remain in full force and effect.

32 PUBLICITY

32.1 No Partner shall issue any press release or any statement containing information relating to or connected with or arising out of this Agreement or the matters contained in it, including information relating to the business or affairs of any other Partner, without obtaining the previous approval of the other Partner such approval to be in relation to its contents and the manner of its presentation and publication or disclosure (such approval not to be unreasonably withheld or delayed).

33 EXCLUSION OF PARTNERSHIP, JOINT VENTURE OR AGENCY

33.1 Nothing in this Agreement shall create a legal partnership as defined under the Partnership Act 1890 or joint venture between the partners or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

33.2 Neither Partner nor any of its employees or agents will in any circumstances hold itself out to be the servant or agent of the other Partner, except where expressly permitted by this Agreement.

33.3 Save as expressly provided otherwise in the Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner shall in any way whatsoever have authority to, or hold itself out as having authority to:

33.3.1 act as an agent of the other;

33.3.2 make any representations or give any warranties to third parties on behalf of or in respect of the other;

33.3.3 bind the other in any way; or

33.3.4 vary, amend revoke or create any byelaw.

34 VARIATION

34.1 The Partners anticipate that over the lifetime of this Agreement the provisions may need to change in order to support the delivery of the Aims and Objectives and the Service Specification in Schedule 1, which may themselves change from time to time (as agreed between the Partners) to reflect national and local priorities. This Agreement shall not be varied or amended unless such variation or amendment has been agreed in writing and signed by the Partners.

35 ASSIGNMENT AND SUB-CONTRACTING

35.1 Subject to Clause 35.2 and other than as required by Law, neither Partner shall:

35.1.1 assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partner, which shall not be unreasonably withheld or delayed.

35.1.2 create any interest, charge or security over or deal in any other manner with this Agreement or part of it without the prior written consent of the other and for the avoidance of doubt, a partner shall be absolutely entitled to withhold such consent;

35.1.3 only sub-contract the performance of this Agreement or any part thereof with the prior written consent of the other partner, which consent the other partner shall be absolutely entitled to withhold;

35.1.4 cease to sub-contract if the other Partner in writing withdraws such consent, save that in such event the partner who has so sub-contracted shall be allowed a reasonable period in which to rearrange its affairs of not less than three months; and

35.1.5 consent to sub-contract (if given) shall not relieve the sub-contracting partner from any liability or obligation under this Agreement.

35.2 The Council may assign, novate, or otherwise dispose of its rights and obligations under this Agreement without the consent of the Trust, provided that such assignment, novation or disposal shall not increase the burden of the Trust's obligations under this Agreement and such assignment, novation or disposal is limited to any legal entity with which the Council merges or which is a successor body of the Council by reason of statutory reorganisation.

36 INTELLECTUAL PROPERTY

36.1 In this Clause 36 "**Intellectual Property**" shall mean all copyright, patents trademarks, service marks, database rights, design rights (whether registered or unregistered) and all other similar proprietary rights as may exist anywhere in the world.

36.2 The Partners hereby grant each other a royalty free licence with the right to sub-license to use any of existing Intellectual Property of either Partner required for the performance of the other's obligations under this Agreement in accordance with the provisions of this Agreement. Such license and any sub-licence to expire when this Agreement is terminated or expires howsoever occurring. Upon termination of the licence each Partner shall return or destroy and procure the return or destruction by any sub-licensee at the direction and request of the other Partner all the other Partner's Intellectual Property.

36.3 Any Intellectual Property that arises solely as a result of this Agreement shall be assigned as follows:

36.3.1 If the Intellectual Property relates to the NHS Functions the rights shall be vested in the Trust;

36.3.2 If the Intellectual Property relates to the Council's Health Related Functions the rights shall be vested in the Partner which created the Intellectual Property;

36.3.3 Where any Intellectual Property cannot be so determined as belonging to the Trust or Council ("**Joint Intellectual Property**") then the Joint Intellectual Property shall vest in the Partner in the best position to exploit the Intellectual Property as determined by the Sexual Health Board. The other Partner shall be entitled to be paid royalties at a reasonable rate to be determined by the Sexual Health Board on any commercial exploitation of the Joint Intellectual Property.

36.4 Each Partner hereby grants to the other Partner an irrevocable royalty free license of all Intellectual Property arising in the course of this Agreement, with the right to sub license, to use such Intellectual Property for any purposes the other Partner sees fit, save that where a Partner is receiving royalties from the exploitation of Joint Intellectual Property from the other Partner it shall be entitled to sub-

license such Joint Intellectual Property on a commercial basis with the prior consent of the other Partner, such consent not to be unreasonably withheld or delayed.

37 EVIDENCE IN LEGAL PROCEEDINGS

37.1 Each Partner shall if required to do so by the other provide any relevant information in connection with any legal proceedings, internal disciplinary hearing or other hearing arising in connection with this Agreement, save in connection with any proceedings or potential proceedings between the Partners.

37.2 Each Partner shall immediately on becoming aware of any accident, damage or breach of any statutory provision relating to or connected in any way with the Partnership arrangements under this Agreement, notify the other of the said accident, damage or breach.

37.3 Any information or assistance provided by either Partner to the other in accordance with this Clause 37 shall be provided free of charge unless the subject of the proceedings or hearing arose prior to the Commencement Date of this Agreement.

38 ENTIRE AGREEMENT

38.1 The terms herein contained together with the contents of the Schedules and Annexes constitute the complete agreement and understanding between the Partners and supersede all previous communications representations understandings and agreements with respect to the subject matter hereof, and any representation promise or condition not incorporated herein shall not be binding on either Partner.

38.2 Each of the Partners acknowledges and agrees that in entering into this Agreement, and the documents referred to in it, it does not rely on, and shall have no remedy in respect of, any statement, representation, warranty or understanding (whether negligently or innocently made) of any person (whether party to this Agreement or not) other than as expressly set out in this Agreement, excluding fraudulent misrepresentation.

39 FORCE MAJEURE

39.1 In this Agreement, "**Force Majeure**" shall mean any cause preventing either Partner from performing any or all of its obligations which arises from or are attributable to either acts, events, omissions or accidents beyond the reasonable control of the Partner so prevented including act of God, war, riot, civil commotion, fire, flood or storm or war, civil war, armed conflict or terrorist attack, nuclear, chemical or biological contamination or sonic boom.

39.2 If either Partner is prevented or delayed in the performance of any of its obligations under this Agreement by Force Majeure, that Partner shall forthwith serve notice in writing on the other Partner specifying the nature and extent of the circumstances giving rise to Force Majeure, and shall, subject to service of such notice and having taken all reasonable steps to avoid such prevention or delay (including exploring the possibility of sub-contracting the Service, subject to the Council's consent), have no liability in respect of the performance of such of its obligations as are prevented by the Force Majeure events during the continuation of such events, and for such time after they cease as is necessary for that Partner, using all reasonable endeavours, to recommence its affected operations in order for it to perform its obligations.

39.3 If either Partner is prevented from performance of its obligations, by reason of Force Majeure, for a continuous period in excess of one (1) month, the other Partner may terminate this Agreement forthwith on service of written notice upon the Partner so prevented, in which case neither Partner shall have any liability to the other except that rights and liabilities which accrued prior to such termination shall continue to subsist.

40 OBSERVANCE OF STATUTORY REQUIREMENTS

40.1 The Partners shall comply and ensure that their employees, agents and sub-contractors shall comply with all the relevant legal provisions, whether in the form of orders, regulations, statutes, statutory

instruments, codes of practice, bye laws, directions or governmental guidance or the like, to be performed in connection with this Partnership arrangements under this Agreement.

41 THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT, 1999

41.1 The Contracts (Rights of Third Parties) Act, 1999 shall not apply to this Agreement.

42 WAIVERS

42.1 The failure or delay of either Partner to exercise a right or remedy provided by this Agreement or by law shall not be construed to be a waiver of the right or remedy. A waiver of a breach of any provision of this Agreement or of a default under this Agreement shall not be construed to be a waiver of any other breach or default and shall not affect the terms of this Agreement.

42.2 A waiver of a breach of any terms of this Agreement or a default under this Agreement will not prevent a Partner from subsequently requiring compliance with the waived obligation. The rights and remedies provided by this Agreement are cumulative and (subject as otherwise provided in this Agreement) are not exclusive of any rights or remedies provided by law.

43 NOTICES

43.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 43.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

43.1.1 personally delivered, at the time of delivery;

43.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

43.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

43.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

43.3 The address for service of notices as referred to in Clause 43.1 shall be as follows unless otherwise notified to the other Partner in writing:

43.3.1 if to the Council, addressed to [x]; and

43.3.2 if to the Trust, addressed to [x].

44 SEVERANCE

44.1 If any provision of this Agreement shall be found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this Agreement, which shall remain in full force and effect.

44.2 If any provision of this Agreement is so found to be invalid or unenforceable but would be valid or enforceable if some part of the provision were deleted, the provision in question shall apply with such modifications as may be necessary to make it valid or enforceable.

45 GOVERNING LAW

45.1 This Agreement shall be governed by and construed in all respects in accordance with the laws of England and the Partners submit to the exclusive jurisdiction of the Courts of England.

46 COUNTERPARTS

46.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Parties shall constitute a full original Agreement for all purposes.

IN WITNESS whereof the Partners Authorised Signatories have signed and executed as a Deed and delivered this Agreement on the day and year first before written.

EXECUTION OF AGREEMENT BY THE TRUST

THE COMMON SEAL of York and Scarborough Teaching Hospitals NHS Foundation Trust
Was hereunto affixed in the presence of:

Authorised Signature……..

Name (print)…….

Position…….

Date…….

Authorised Signature……..

Name (print)…….

Position…….

Date…….

EXECUTION OF AGREEMENT BY THE COUNCIL

THE COMMON SEAL of North Yorkshire County Council
Was hereunto affixed in the presence of:

Authorised Signature……..

Name (print)…….

Position…….

Date…….

SCHEDULE 1 – SERVICE SPECIFICATION

1 OVERVIEW

1.1 Introduction

1.2 Evidence Base

1.3 Service Delivery Model

1.4 Services Out of Scope

1.5 Principles of the Integrated Sexual Health Service

2 Service Specification for the Integrated Sexual Health Service

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1 Overview

1.1 Introduction

North Yorkshire County Council wishes to enter into a Section 75 Partnership Agreement with York and Scarborough Teaching Hospitals NHS Foundation Trust 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 Trust shall ensure the Integrated Sexual Health Service is flexible in its delivery to address the range of factors that affect accessibility of our residents to services. It will also be responsive to the different and changing needs of our residents and in particular utilising advances in technology to achieve this.

The Trust shall ensure the 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 strong focus on prevention, and targeted support will be provided for at risk groups and communities from experiencing sexual health inequalities.

1.2 Evidence Base

Local service provision is informed by need as identified in both local and national data; including the North Yorkshire Sexual Health Needs Assessment and the Sexual and Reproductive Health profiles.

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,

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

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.

The Trust shall deliver an Integrated Sexual Health Service that aims to address these inequalities by providing easily accessible services across all groups including targeted access for those who may experience barriers to accessing 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, UKHSA/OHID 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 (excluding HIV) have been recorded both nationally and internationally since the early 1990s; despite the recent fall in 2020, STIs remain a concern.
- 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").
- The impact of STIs remains greatest in young heterosexuals aged 15 to 24 years; black ethnic minorities; and gay, bisexual and other men who have sex with men (MSM). 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.
- There has been a decline in new HIV diagnoses in recent years, largely driven by a steep fall among gay and bisexual men (GBM). In 2019, the UK met the UNAIDS 90-90-90 target nationally for the third consecutive year, with 94% of people living with HIV being diagnosed, 98% of those diagnosed being on treatment, and 97% of those on treatment having an undetectable viral load[3].
- 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 about treatment and following successful treatment can significantly decrease their ability for onward infection to others.

[2] BASHH Standards for the management of sexually transmitted infections (STI's) 2019 Standards for the Management of STIs | British Association for Sexual Health and HIV (bashh.org)

[3] Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019

- Chlamydia is the most commonly diagnosed STI in England and North Yorkshire. Chlamydia often has no symptoms but, if left untreated, can have serious health complications in women[4].

- Good access to chlamydia screening is essential for 15 to 24 year olds through a range of settings, including online services, screening should include partner notification and retesting those who are diagnosed to ensure reductions in onward transmission and subsequent harm.

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[5].

- Under 18s conceptions rate in North Yorkshire is 12.8 cases per 100,000, better than the England rate 16.7. Under 16 conceptions rate per 1000 is 2.2 similar to the England average 2.5. However, there are district variations with U18 conceptions, with Scarborough having the highest rate of 22.7, which is statistically similar to the national average for England.

- 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[6].

- The highest abortion rate is amongst women aged 22 (31.6 per 1,000). The under 18-abortion rate for 2019 is 6.9 per 1,000 women. Abortion rates for those aged under 18 have declined over the last ten years. There has been an increase in the rates for all ages 25 and above. The largest increases in abortion rates by age are amongst women aged 30-34 which have increased from 15.7 per 1000 in 2009 to 20.9 per 1000 in 2019. This reinforces the need to remain focused on 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[7].

- Guidance from NICE[8] 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

[4] NCSP guidance: programme overview updated June 2021
[5] 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
[6] Abortion Statistics, England and Wales:2019, Department for Health and Social Care, 2020
[7] Health Behaviour in School-Aged Children, World Health Organization, 2012
[8] National Institute for Health and Care Excellence. *Long-acting reversible contraception*. Clinical Guideline 30. London: NICE, 2005, updated 2019

than condoms. However, a condom should also always be used to protect against STIs.

HIV

- Great progress has been made in the UK in the control and prevention of HIV. In 2019, the UK met the UNAIDS 90-90-90 target nationally with over 90% of people living with HIV being diagnosed, over 90% of those diagnosed being on treatment and over 90% of those on treatment having an undetectable viral load.

- After a peak of new HIV diagnoses in the United Kingdom in 2014, a rapid decline has been observed from 6,278 in 2014 to 4,139 in 2019. This decline was particularly marked among gay and bisexual men (GBM) from a peak of 3,214 in 2014 and 2,079 in 2018 to 1,700 diagnosed in 2019 (a 47% and 18% drop respectively). The steepest fall was observed among GBM who are white, born in the UK, aged 25 to 49 and residing in London[9].

- Of the 4,139 new HIV diagnoses in the UK in 2019, about three quarters (76%, 3,165) were first diagnosed in the UK with the remaining (24%, 974) previously diagnosed abroad. Of the 1,700 new HIV diagnoses among GBM in 2019, 1,258 (74%) were first diagnosed in the UK. In 2019, of the 736 new HIV diagnoses among heterosexual men and 823 diagnoses among heterosexual women, 566 (77%) of men and 595 (72%) women were first diagnosed in the UK. The number of persons previously diagnosed abroad across all exposure groups have remained steady over the past 5 years. In contrast, the number of GBM first diagnosed in the UK has halved whilst those among heterosexual men and women have fallen slightly.

- 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, partner notification, the scale up of pre-exposure prophylaxis (PrEP) and anti-retroviral therapy (ART).

- The overall number of persons diagnosed late decreased from 1,861 in 2015 to 1,279 in 2019; equivalent to 39% and 42% of all new diagnoses respectively. There was substantial variation in subpopulations experiencing late HIV diagnosis rates. The highest rates were among black African men (65%), white men who acquired HIV heterosexually (59%), people aged over 50 years (59%) and people who inject drugs (58%).

- 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 treatment choices and following successful treatment can significantly impact on the ability for onward infection to others.

[9] Trends in HIV testing, new diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2019

- Although only small numbers of new diagnoses are made each year, in North Yorkshire during 2017-19, 51% (25) were classified as 'late diagnoses' (as measured by the CD4 count of less than 350mm). North Yorkshire is worse than the England rate for late diagnosis of HIV (43.1%)[10].

- 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.

- HIV elimination can only be achieved by combination prevention; by bringing together prevention interventions such as high levels and frequency of HIV testing, pre-exposure prophylaxis (PrEP), rapid linkage to care and treatment, and support so people with diagnosed HIV attain viral suppression.

[10] Sexual and Reproductive Health Profiles, Fingertips, Public Health England

COVID-19

National surveillance data from multiple settings show a decline since March 2020 in consultations at sexual health services (SHSs); tests and diagnoses for STIs, HIV and viral hepatitis; vaccinations of MSM; and HCV treatment initiations. These changes follow the implementation of nationwide social and physical distancing measures, including the emphasis on staying at home, and a reduction in capacity and throughput at services. Test positivity at SHSs was also highest in April 2020, likely due to the prioritisation of services for those at higher risk, who are clinically vulnerable, or who have STI-related symptoms.

New data from Public Health England (PHE) reveal that diagnoses of sexually transmitted infections (STIs) decreased in 2020 by 32% compared to 2019. The decline reflects a combination of reduced STI testing because of disruption to sexual health services leading to fewer diagnoses, and changes in behaviour during the coronavirus (COVID-19) pandemic that may have reduced STI transmission. Despite the fall in diagnoses, PHE's data highlights that STI diagnoses overall remain high.

In 2020, sexual health services continued to diagnose hundreds of thousands of STIs after scaling up testing accessed using telephone and internet consultations as well as continuing face-to-face appointments for urgent or complex cases. However, compared to 2019, consultations at sexual health services in 2020 decreased by 10%. The biggest drop occurred in face-to-face consultations, which fell by 35% since 2019, but internet consultations doubled over the same period.

Although people could still access STI testing, there was a 25% fall in sexual health screens (tests for chlamydia, gonorrhoea, syphilis or HIV) and the change in service delivery affected the diagnoses of STIs in different ways. For example, STIs that require a clinical in-person assessment, such as genital warts and herpes saw a greater drop in diagnoses (46% and 40% falls, respectively), compared to STIs that could be diagnosed using self-sampling kits following an internet consultation, such as chlamydia and gonorrhoea (29% fall and 20% fall, respectively).

As in previous years, in 2020 the highest rates of STI diagnoses were still seen in young people 15 to 24 years; people of Black ethnicity; and gay, bisexual and other men who have sex with men.

Innovations in service delivery have happened at pace and, from April 2020; there was a marked shift towards remote service provision to maintain access during the COVID-19 pandemic.

The full impact of the COVID-19 measures on infection transmission and longer-term health outcomes will take time to emerge.

1.3 Service Delivery Model

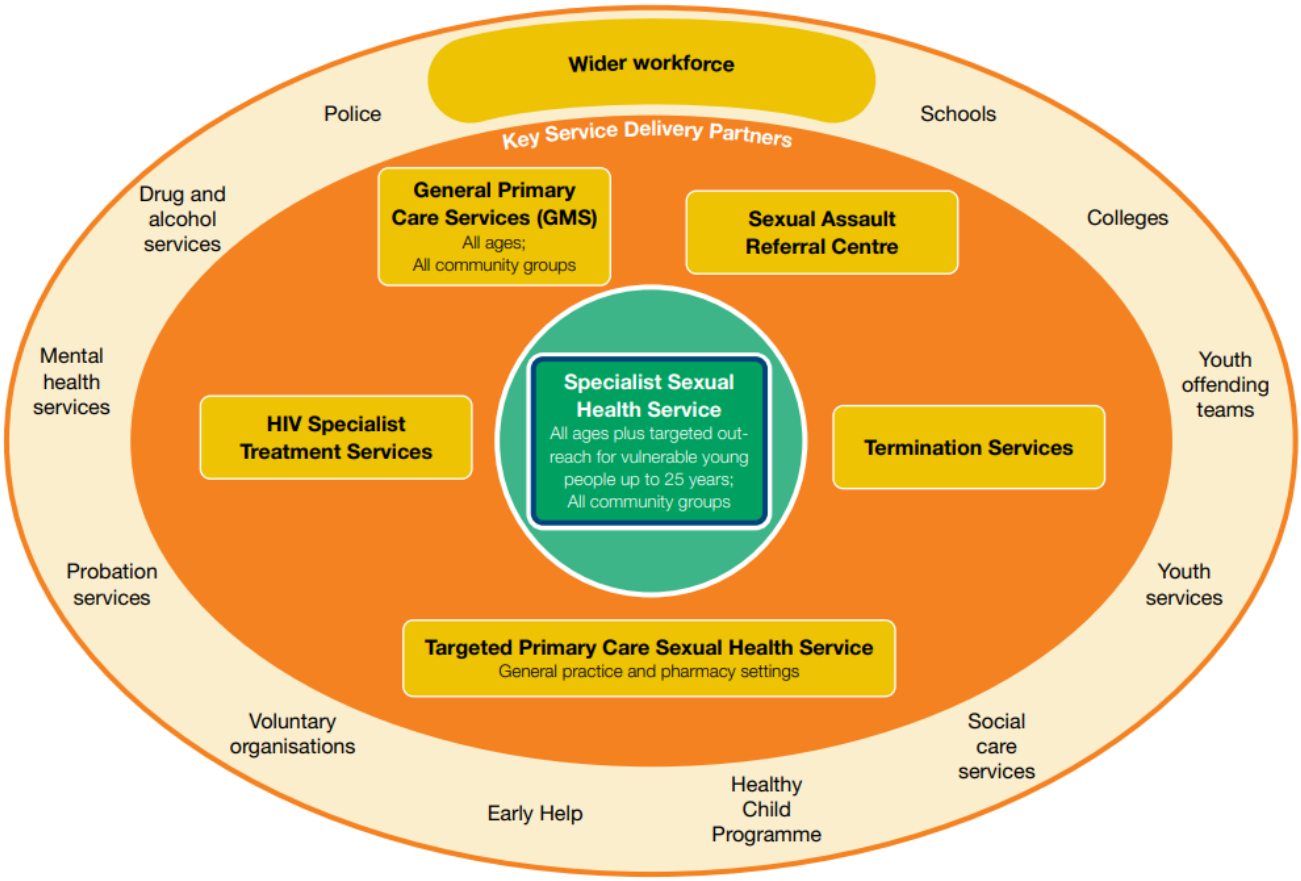
The S75 Partnership Agreement will commence on 1 April 2022.

The Service will run between 1 April 2022 and 31 March 2026 for an initial term of 4-years. The agreement has two options to extend, with a total possible term of 10 years the decision to extend will be at the discretion of the Partners and subject to satisfactory performance.

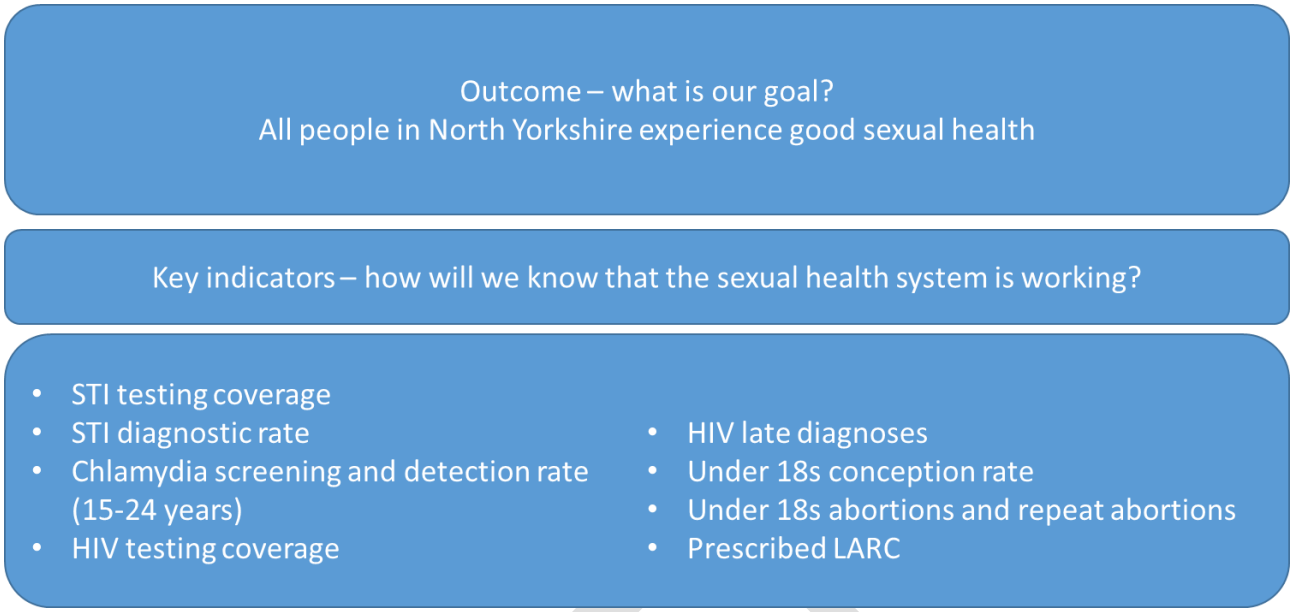
It is recognised that there are many other organisations and services that are responsible for commissioning and providing services that impact on the sexual health outcomes of the population. the Council only has responsibility for parts of the local sexual health system. However, it is an expectation that the Integrated Sexual Health Service will not work in isolation from the wide range of other services and workforces that are delivering sexual health services. Both partners (the Council and the Trust) 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.

Integrated Sexual Health Service Model



The Integrated Sexual Health Service will *contribute* to a number of nationally reported sexual health indicators as set out below:



This outcome will be achieved by strengthening a coordinated system-wide approach to reducing the adverse consequences of poor sexual and reproductive health, including sexually transmitted infections and unplanned pregnancies, and to reduce stigma and discrimination.

The local system will support individuals and communities, irrespective of background and circumstance, to make informed choices and to develop safe, healthy, enjoyable and consensual sexual relationships.

For the purpose of the Section 75 Partnership Agreement the following definition will be used:

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

1.4 Services Out of Scope of this Contract

For this Section 75 Partnership Agreement is it important to be clear what is out of scope of this Specification.

The following services are not the Council'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.

e. Cervical Screening – commissioned by NHS England.

The following services are the responsibility of the Council 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.

While these services are out of scope, The Trust shall have clear, established pathways into these services where appropriate.

1.5 Principles of the Integrated Sexual Health Service Model

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

- 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, across all groups including targeted access for those who may experience barriers to accessing services and delivering services in appropriate settings.
- All contraceptives, STI diagnosis and treatment shall be provided and dealt with in one location as far as is practicably possible.

2 Service Specification for the Integrated Sexual Health Service

2.1 Outline of the Integrated Sexual Health Service

The Trust 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 Trust shall ensure there is a particular focus on meeting the sexual health needs of young people and the most at-risk groups.

There will be an offer of face-to-face clinics across a range of locations five days a week for those who need it. As a minimum the four main hubs across North Yorkshire will provide the full offer of provision, these are Harrogate, Northallerton, Scarborough and Selby. As a minimum, community clinics will remain in Skipton and Catterick Garrison, additional community clinics will continue to evolve and flex over the life of the partnership, utilising the latest available data and demand data in decision making to ensure service offer reflects the needs of the local population.

To ensure rapid and easy access The Trust shall provide open access 'hubs' in each locality area where the majority of contraceptive and STI needs shall be dealt with by appropriately trained health professionals at each site (exception scanning for deep implant removal), 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 Trust 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 at risk groups are lesbian, gay, bisexual, transgender and questioning (LGBTQ+) adults and young people; people with learning disabilities, people with mental health conditions young people in the care system (looked after) or children at risk of child sexual exploitation.

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 Trust will deliver a Targeted Clinical and Community Outreach Service. This will be community orientated and delivered in a targeted way across localities, and will facilitate rapid access to clinical and community services as required. The team will be a mix of skilled clinical nurses and community development workers 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 Trust shall play a key role in supporting residents of North Yorkshire living with HIV and their carers 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 Trust 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 Trust shall take into account any responsibilities under The Care Act 2014.

The Staff employed within the ISHS will be viewed as the leaders of the Local Sexual Health System. The Trust shall ensure the ISHS Staff provide community and clinical leadership across the Local Sexual Health System supporting, advising and providing expertise to other organisations and 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 Trust shall ensure that the ISHS Staff are known to local professionals and can be easily contacted when required.

2.2 Service Objectives

The Trust 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 at risk groups e.g. people with learning disabilities, mental health conditions or young people in the care system) 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 people to address the wider risk factors which may impact their sexual health (e.g. alcohol and drug use, chemsex).
- To increase access, for all age groups 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 self-referral to termination services or maternity care.
- To provide rapid and easy access to services for the prevention (including vaccination), detection and management (including treatment and partner notification) of sexually transmitted infections (complex and non-complex) 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 HIV Testing (POCT) to the 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 BHIVA testing guidelines 2020[11]), and ensure rapid referral to HIV care services following diagnosis, in order to reduce late diagnosis and onward transmission.
- Provide support to improve physical and mental health, and social and economic wellbeing, for people living with HIV and their carers.
- To promote the 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.

[11] BHIVA/BASHH/BIA Adult HIV Testing guidelines 2020

- 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, facilitate and support local 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 organisations.

2.3 Service Description

This section sets out the detail of the ISHS which The Trust 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 Trust shall ensure the ISHS plays a key role in identifying and offering information, advice, support and interventions to these individuals or communities. The Trust 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 Specialist Clinical and Community Outreach Service

2.3.6 Sexual Health Counselling

2.3.7 HIV Wellbeing Support Service

2.3.8 Training

2.3.9 Campaigns

2.3.10 Clinical leadership within the Service and wider sexual health system

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 Trust 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) child criminal exploitation (CCE) and Female Genital Mutilation (FGM) advice. Any health promotion interventions should be appropriate to meet individual needs. The Trust shall ensure that national NICE, FSRH and BASHH 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. The service will utilise behavioural insights when developing sexual health information, will use a range of platforms to present information such as websites, social media channels, webinars, and printed materials.

2.3.2 Clinical assessment

The Trust shall ensure that a full medical and sexual health history and risk assessment is undertaken when Service Users access the ISHS whether virtual or face-to-face in line with UK National Guideline for consultations requiring sexual history taking, 2019[12]. 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 Trust 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 Trust should work closely with the North Yorkshire drug and alcohol services to ensure needs of service users are met.

The Trust can choose to provide a cervical screening offer in line with the NHSCSP requirements for people who choose not to access this service via their GP or are not registered with a GP– funding arrangements for this will need to be agreed with NHS England.

The Trust 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 Trust 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 Trust'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[13].

[12] UK National Guideline for consultations requiring sexual history taking, 2019 Clinical Effectiveness Group British Association for Sexual Health and HIV CEG National Guidelines – consultations requiring sexual history-taking (bashhguidelines.org)

[13] Faculty of Sexual and Reproductive Healthcare (2017) *FSRH Guideline Emergency Contraception* March 2017 (Updated December 2020) https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/

- First prescription of oral hormonal contraception (combined and progesterone only) and follow up prescriptions for under 19 year olds, over 19s who are requesting a routine and non-complex repeat prescription will be signposted to General Practice.

- First prescription of 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 Trust shall be aware of alternative local clinical pathways for IUD/IUS insertion.

- IUD/IUS follow up three to six weeks after insertion if required (to check threads, exclude perforation, and exclude expulsion or presence of any pelvic tenderness). The Trust should ensure Service Users are aware of return 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.

- Advice about natural family planning.

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

- 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 removal of the implant at the same visit, and location of intrauterine devices with threads not visible on vaginal examination.

- External support may be required when clinically necessary e.g. implants placed within the muscle and COILS requiring gynaecology input.

Condom Distribution Scheme

The Trust shall establish and co-ordinate the delivery of a free condom distribution scheme to ensure condoms are widely available in a range of clinical and non-clinical settings. Condoms will also be available to order online for people over 16 years old. Consistent and correct use of male latex condoms can reduce the risk of STI transmission and prevent pregnancies. NICE Quality Standard, 2019[14] and NICE guideline NG68, 2017[15] recommend that free condoms (including female condoms) are readily accessible, to young people and those most at-risk from a variety of settings.

[14] Sexual Health Quality Standard, NICE February 2019 Sexual health (nice.org.uk)
[15] Sexually transmitted infections: condom distribution schemes, NICE April 2017

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 Trust 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 their policies around safeguarding, particularly for under16s.

2.3.4 STI Services

The Trust shall provide STI services following an assessment of need and risk (see section 2.3.2). The assessment process will clearly identify those Service Users at risk and would benefit from tests and examinations. Based upon the clinical history and identified risks tests for Chlamydia, Gonorrhoea, Syphilis and HIV, Hepatitis A, Hepatitis B and Hepatitis C will be undertaken. Hepatitis A and B immunisations, management of complex and non-complex STIs, partner notification and post exposure prophylaxis (PEP, PEPSE) and Pre-exposure prophylaxis (PrEP) provision is available. The The Trust shall ensure that Service Users displaying symptoms are offered a full genital examination (and offered a chaperone for this examination). All diagnostics processed and results conveyed and acted upon appropriately. All tests will be available to individuals once every 3 months, unless there is no change in risk. The The Trust shall ensure that all assessments and examinations follow BASHH national guidelines.

Immunisations

Hepatitis A and B

The Trust 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 Trust 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 UKHSA
- offer hepatitis B immunisations to persons at high risk attending the service. These include: injecting drug users, individuals who change partners frequently (especially men who have sex with men, and sex workers), sexual contacts or an individual with chronic infection with Hepatitis B. Please note occupational immunisation is excluded from this specification.
- In rare instances of outbreaks of hepatitis B, The Trust should be prepared to assist with prevention and control measures that may include high-risk individuals attending their service.

Human Papilloma Vaccination (HPV)

The Trust is required to support national efforts to vaccinate target groups against HPV in line with national guidance and policy such as what is set out in the Green Book. This includes signposting eligible school age individuals to relevant services for HPV vaccinations. MSM and some transgender people up to and including the age of 45 are eligible for free HPV vaccination on the NHS when they visit sexual health or HIV clinics.

Diagnostics

The Trust 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 Trust 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 Trust 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 Trust 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 Trust should be aware that this is a rapidly evolving field and they should keep up to date with developments through appropriate professional websites (BASHH, UKHSA and UKAS).

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

The Trust shall ensure that there is on-site microscopy available at all level 3 premises. The Trust 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 Trust shall ensure that Service Users are informed and invited to re-test.

Clinical Management

The Trust shall ensure that people using the ISHS for STI testing receive the results, both positive and negative, within 10 working days via digital communication where appropriate. The Trust 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 Trust shall ensure that Service Users are advised to re-test when they have new partners with annual screening strongly advised.

Following positive results, The Trust shall have the ability to provide additional tests needed and shall ensure that the Service User receives the best available treatment according to BASHH Clinical Effectiveness Group guidelines.

The Trust 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 (STI's and contraception) although The Trust shall ensure that Service Users are made aware that if they receive treatment from other settings, such as primary care, charges may apply. Service Users will be advised to visit local pharmacy or GP practice where appropriate for self-care.

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

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

The Trust 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 Trust 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 Trust will initiate PEPSE and then will transfer the Service User on to the local HIV specialist treatment service for the continuation of treatment. The Trust should note that costs of the PEPSE treatment are not covered within this Agreement but should be directed to NHS England.

PrEP

HIV PrEP forms part of combination HIV prevention alongside health promotion, condom use, regular testing and swift initiation of HIV treatment where indicated. Active risk reduction provides a major opportunity to control HIV transmission. In addition, the regular sexually transmitted infection (STI) testing which forms part of the PrEP package of care provides opportunities to test and treat STIs, thereby supporting the control of STIs.

As described in the BHIVA/ BASHH guidelines 'Initiation of PrEP should occur within the context [of] a comprehensive package of prevention services including level 3 sexual health services and access to substance misuse and counselling services. Provision of PrEP should be accompanied by addressing risk factors (e.g. inconsistent condom use, recreational drug use), screening and referral for treatment for other STIs and viral hepatitis, vaccination against hepatitis A and B (if indicated), education on limitations of PrEP (including adherence and lead-in times), management of possible side effects, education on long-term safety of medications, drug resistance and symptoms of primary HIV infection (PHI).'

The current national guidelines (BHIVA/BASHH guidelines on use of pre-exposure prophylaxis (PrEP) 2018) apply to this element of service. In the event of changes to the national guidelines the LA, NHSE and The Trust reserve the right to review their specifications/Agreement documents for the service, including eligibility criteria. LA, NHSE and the Trust must agree revised eligibility criteria prior to implementation.

Service description

HIV PrEP should be delivered in line with BHIVA/BASHH guidelines on the use of HIV pre-exposure prophylaxis (PrEP) 2018. These guidelines provide detailed information for clinicians, The Trust and others and the detail is not repeated here. The service will include the following key elements:

- Baseline risk assessment (see Section 5 of the guidelines including 5.2.7 – Risk assessment)

- Initiation of PrEP (including education, behavioural support and adherence; settings and context to administer PrEP; baseline assessment and testing; other considerations; supplying PrEP) (see Section 6 of guidelines)

- Clinical follow-up and monitoring (including continued supplying ; assessing adherence and adverse effects; management of short-term side effects; monitoring on PrEP: HIV testing and management of HIV seroconversion, STI screening, viral hepatitis, renal monitoring[1], pregnancy testing; coding and data collection, indicators for stopping PrEP) (see Section 7 of guidelines).

Population covered and eligibility

As set out in The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, each local authority is mandated to provide, or make arrangements to secure the provision of, open access sexual health services in its area including services for 'preventing the spread of sexually transmitted infections' including HIV. PrEP is now recognised in UK guidelines as an effective prevention measure for protecting persons at higher risk of acquiring HIV.

All those attending level 3 sexual health services should be assessed for eligibility for PrEP in line with BHIVA/BASHH guidelines on use of HIV pre-exposure prophylaxis (PrEP) 2018 (Table 5.1.1 – Summary table of recommendations for PrEP from guideline document is copied below. This must be considered in context of the full guideline document in particular section 6.4 Baseline Assessment and Testing).

Table 5.1.1. Summary table of recommendations for PrEP

<table>
<tr><th colspan="2">Recommend PrEP</th></tr>
<tr><td colspan="2">(i) HIV-negative MSM and trans women who report condomless anal sex in the previous 6 months and on-going condomless anal sex. (1A)
(ii) HIV-negative individuals having condomless sex with partners who are HIV positive, unless the partner has been on ART for at least 6 months and their plasma viral load is <200 copies/mL. (1A)</td></tr>
<tr><th colspan="2">Consider PrEP on a case-by-case basis</th></tr>
<tr><td colspan="2">PrEP may be offered on a case-by-case basis to HIV-negative individuals considered at increased risk of HIV acquisition through a combination of factors that may include the following:</td></tr>
<tr><td>Population-level indicators
Heterosexual black African men and women
Recent migrants to the UK
Transgender women
People who inject drugs
People who report sex work or transactional sex</td><td>Clinical indicators
Rectal bacterial STI in the previous year
Bacterial STI or HCV in the previous year
Post-exposure prophylaxis following sexual exposure (PEPSE) in the previous year; particularly where repeated courses have been used</td></tr>
<tr><td rowspan="2">Sexual behaviour/sexual-network indicators
High-risk sexual behaviour: reporting condomless sex with partners of unknown HIV status, and particularly where this is condomless anal sex or with multiple partners
Condomless sex with partners from a population group or country with high HIV prevalence (see UNAID definitions [1])
Condomless sex with sexual partners who may fit the criteria of 'high risk of HIV' detailed above
Engages in chemsex or group sex
Reports anticipated future high-risk sexual behaviour
Condomless vaginal sex should only considered high risk where other contextual factors or vulnerabilities are present</td><td>Drug use
Sharing injecting equipment
Injecting in an unsafe setting
No access to needle and syringe programmes or opioid substitution therapy</td></tr>
<tr><td>Sexual health autonomy
Other factors that may affect sexual health autonomy
Inability to negotiate and/or use condoms (or employ other HIV prevention methods) with sexual partners
Coercive and/or violent power dynamics in relationships (e.g. intimate partner/domestic violence)
Precarious housing or homelessness, and/or other factors that may affect material circumstances
Risk of sexual exploitation and trafficking</td></tr>
</table>

Whilst trial data for transgender men and those of other gender identities is not available individuals should be assessed on a case-by-case basis with regard to risk of HIV acquisition and PrEP made available in line with other indicators described.

Interdependencies and referrals to other services

In addition to interdependencies already referred to in Integrated Sexual Health Services – A suggested national service specification key stakeholders will also include:

- Other medical and surgical specialities as required, such as dermatology, urology, nephrology.

Applicable service standards

In addition to national standards referred to in this specification The Trust will ensure they adhere to the following minimum standards:

- BASHH/BHIVA guidelines on the use of HIV pre-exposure prophylaxis (PrEP) 2018

Surveillance requirements

As set out in the suggested national service specification 'The Service 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 UKHSA (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 service provides testing through an on-line service, this activity should also be included with their routine GUMCAD submissions to UKHSA. The service 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.'

This guidance now also applies to those assessed for and/or accessing routinely commissioned PrEP as well as those enrolled in a PrEP-related trial or who have purchased PrEP drugs over the internet. Up to date guidance on surveillance requirements can be found at: https://www.gov.uk/government/publications/gumcad-data-specification-and-technical-guidance

These requirements for submission of mandatory surveillance data are in addition to NHS England's data requirements relating to drug usage that must be reported through the Minimum Data Set in accordance with requirements.

Monitoring of medicine supplied (generic Tenofovir Disoproxil (TD) /Emtricitabine (FTC))

In addition to this service specification, NHS England will also set out the contract requirements for the monitoring of medicine supplied (Tenofovir Disoproxil (TD)/ Emtricitabine (FTC), which is bio-equivalent to the branded product Truvada).

These requirements are included in an existing contract The Trust has with NHS England.

2.3.5 Specialist Clinical and Community Outreach Team

The Trust will deliver a Specialist Clinical and Community Outreach Team to provide services to the most socially complex, at risk young people and adults. This will include, but is not limited to, people with learning disabilities, people with mental health problems, men who have sex with men (MSM), black African communities, people misusing drugs, sex workers and military populations. Other higher risk groups are lesbian, gay, bisexual, transgender and questioning (LGBTQ+) adults and young people. Practitioners from different disciplines (nurses and community development workers) will work closely together and use innovative practice to improve reach for those in high-risk groups. The Trust shall take a holistic approach when supporting and providing interventions to Service Users and shall 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.

In each locality there will be provision of clinical care in settings acceptable to the service user with a priority to a clinic first model of care. It will be essential for staff to develop close partnership working with partner agencies in order to engage with the most at risk service users; and safeguarding will be a key aspect of this work – see section 2.4.7.

The service will facilitate community/face to face and virtual sexual health care that will meet the needs of people with greater sexual health risks and needs. The service offer will be reviewed using a combination of service user/professional feedback and monitoring. The clinical and community approach acknowledges the specific access needs and preferences of those groups and will offer the flexibility and responsiveness required to facilitate access and participation in both prevention and care.

The service shall be experienced at using community development approaches to provide sexual health promotion and prevention interventions to 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 Trust 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 Trust shall ensure wide and easy access of these communities to free condoms, dental dams and lubricants.

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

The Trust 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 Trust 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 young women and The Trust shall tailor the ISHS accordingly. The Trust 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 Trust shall ensure that all sexually active young people are offered Chlamydia screening as a routine part of every sexual health consultation.

The Trust shall ensure that Chlamydia screening is widely available to all under 25s in accordance with the *NCSP Standards 7th Edition (updated November 2018-changes to the programme were announced in June 2021 but are yet to be updated within the guidelines*, and so there will be no standalone local Chlamydia screening service or office. The Trust shall ensure Chlamydia screening is embedded across the Local Sexual Health System. The Trust shall develop creative solutions for ensuring that Chlamydia tests are taken up by the most at risk under 25s. The Trust 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.

Community HIV Point of Care Testing (POCT)

The Trust shall deliver a standardised point of care testing service as part of the clinical and community outreach team offer (as a minimum to include HIV testing). The Trust shall ensure the most up-to-date tests available are used. Where this results in a positive result, The Trust 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 Trust shall have in place clear governance arrangements for the delivery of this POCT service.

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

- provide information on tests (smart kits) 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 onsite tests and deliver 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 Trust 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 The Trust 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 Trust shall ensure that PrEP/PEPSE/Vaccinations and testing are discussed and high risk individuals are sign posted into clinical services as required.

The Trust 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 Trust shall provide those 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 Trust 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.

2.3.6 Sexual Health Counselling Service

The Trust 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. Referrals can be made by YSH staff or via self-referral online or via telephone.

Counsellors will be experienced, trained professionals, both in counselling and sexual health and members of recognised professional associations. The Trust has a clear criteria for accepting referrals.

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

Out of scope of this service includes: erectile dysfunction, gender dysphoria, emotional effects of surgical interventions, chronic conditions or terminal care, survivors of historical or childhood sexual abuse, and the effects of aging, disability or illness on sexuality.

2.3.7 HIV Wellbeing and Support Service

The Trust 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 Trust 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 Trust shall conduct an assessment of the Service User including Carers where appropriate and including assessment of level of self-management needs. The Trust 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 Trust 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 Trust 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 Trust 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 Trust shall also, where required, enable people to access support with financial, housing, education, training and employment needs.

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

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

The Trust shall ensure the Positive Support Service has strong collaborative working arrangements with local HIV treatment and care centres for those with a North Yorkshire postcode.

2.3.8 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, targeting safer sex messages, and tackling stigma and discrimination.

Some staff groups that either work directly with at risk or complex 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 partners (often referred to as level 2). The Trust 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 Trust 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 Trust shall deliver training in creative and efficient ways, to ensure that staff groups are able to access the training easily and effectively this will include webinars, videos and face to face where appropriate. The Trust shall be responsive to emerging issues and trends and the evidence base. The Trust shall keep a database of all staff trained and conduct regular training needs assessments. The Trust 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 Trust 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 Trust 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 Trust should also provide Faculty of Sexual and Reproductive Health accredited training including practical training to achieve Letters of Competence; and explore delivering 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 Trust 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 Clinical and system leadership

The Trust 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 The Trust e.g. regional sexual health partnership 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 Trust 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 Trust shall provide across the whole Local Sexual Health System as illustrated in Diagram 1 in paragraph 1.3. The Trust 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 Trust shall ensure that Staff signpost and refer Service Users to other sources of help and advice. The Trust 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 Trust shall establish good relationships with the following key partners:

- local GPs;
- Pharmacists;
- Healthy Child Programme team;
- termination service The Trusts;
- Sexual Assault Referral Centres (SARC); and
- HIV specialist treatment centre within the Trust
- Looked After Children (LAC)

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

Interdependencies and Referral Routes

The Trust cannot work in isolation and is required to work with partners i.e. NHSE, ICSs 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 Trust shall have in place links to receive and also refer on, from and to a range of sources. The Trust 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
- The Council's Children and Young People Service (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 Trust 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 Trust shall take action to try to address this and inform the Partnership as appropriate.

Contribution to Local Strategies

The Trust 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 Trust 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

In most aspects of sexual and reproductive health, variations in outcomes are evident between and within local areas and populations or communities. Some of these differences have a clear relationship with social and health inequalities; and may be impacted by differences in behaviour, social networks and risk exposures. Others may indicate geographic variation in local populations' demographics or in access to, and use of sexual and reproductive health services, or in the availability and provision of interventions.

The Trust shall address the range of factors that impact on accessibility of the Integrated Sexual Health Service including geographic variation in local populations, demographics or in access to, and use of 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 Trust shall be able to demonstrate reach of the Integrated Sexual Health Service into every locality area in North Yorkshire. It is also expected The Trust shall ensure awareness of sexual health services outside the Council boundary and shall ensure Service Users have a seamless patient journey if accessing services across boundaries.

The Trust 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 Trust shall ensure that the delivery of the Integrated Sexual Health Service reflects the principles of anti-discriminatory practice and reduces stigma. The Trust will ensure access to interpretation services for clients whose first language is not English and who require interpretation.

The Trust 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 Trust shall ensure the Integrated Sexual Health Service is available throughout the year, at times that increase its accessibility to Service Users. Access will be available via a website and online self-care 24 hours a day. The Trust 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 Trust shall have clear plans in place for how it supports Service Users to access PEPSE out of hours.

2.4.2 Digital services

- The Trust will operate an online booking system where individuals will be able to book their appointments, create their own confidential individual record where they can track test results and next steps if treatment is required.

- A telephone triage system will operate 5 days a week via highly skilled clinical staff, which will ensure that people reach the right place at the right time. A mobile number for young people will operate for access into the service in a discrete and confidential manner.

- Service Users will have the option of accessing services online 24 hours a day, without the need for seeing a practitioner and/or attending a clinic. Patients will be provided with information about sexual health, on line triage, signposting to the most appropriate services for their needs, based upon risk criteria with the option of ordering condoms and self-sampling kits for chlamydia, gonorrhoea, syphilis and HIV. Routine STI test results will 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. Free postal treatment service should be provided where it is clinically safe to do so (e.g. chlamydia), including follow up as required.

- In addition to the above The Trust will enhance the 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 Trust must have safeguarding frameworks in place to manage 16-17year olds requests for digital services.

2.4.3 Premises and environment

In order to maximise communications, partnership working and clinical governance support The Trust 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 Trust shall co-locate the workforce of the Integrated Sexual Health Service with other relevant professional groups rather than working as isolated teams.

Premises for the provision of the clinical ISHS must be fit for purpose and in accordance with DHSC Guidance and Care Quality Commission (CQC) requirements. Each premises will be fit for purpose for the services delivered in that particular location, be well maintained and compliant with Disability Discrimination Act (DDA). The Trust will carry out the risk assessment on all the premises used to deliver sexual health services, including infection control, and ensure that all significant risks identified are addressed.

Services must be compliant to the specific building regulation notices. All necessary equipment must be provided to undertake prescribed requirements, tailored to meet the patient requirements. The Trust will offer a friendly and welcoming waiting area with the aim of reducing patient anxiety. The ISHS must be provided in an environment that promotes access and ensures safe and effective care. This includes ensuring there is adequate privacy and confidentiality, cleanliness and maintenance, meeting the national specification for clean NHS premises. All premises must be compliant with the requirements set out in the Equality Act 2010. Confidentiality policies must be clearly displayed, adhered to, and discussed with service users which include anonymity where applicable. Online services must meet the appropriate standards for the services provided.

2.4.4 Campaigns, marketing and publicity

The Trust 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 Trust 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 Trust should ensure they target these settings via local systems and partners. The Trust shall use a range of technology platforms such as websites, social media (e.g. Facebook, blogs, Twitter, TikTok, Snap Chat), Skype (or equivalent), Apps, mobile phones etc. to support the Integrated Sexual Health Service. The Trust shall ensure that Staff have the necessary training and technical and systems support to ensure they can use these technology platforms effectively.

The Trust shall maintain the established name ('YorSexualHealth') and branding of the Integrated Sexual Health Service, any changes should be discussed and agreed via the Section 75 Partnership.

The Trust 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 Trust shall ensure that nationally produced materials are utilised. The Trust shall make sexual health information available in a range of formats and mediums e.g. easy read, to meet language and literacy needs of Service Users.

In order to reduce stigma and promote good sexual health and enable and empower self-care and self-management The Trust shall support national, regional and local sexual health campaigns such as HIV testing week, sexual health awareness week and UKHSA/OHID sexual health campaigns. The Trust will lead a local co-ordinated approach to these campaigns using behavioural insights and the most appropriate channels 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 Trust 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.

2.4.5 The Employment and Management of a Skilled and Competent Workforce

The Trust 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 and resources can be deployed more efficiently, and it will enable joint planning and help minimise duplication of provision.

The Trust 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 Trust shall ensure that the skill mix of the workforce reflects both the business requirements and also the needs of the Service Users. The Trust 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 Trust 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 January 2019*[16].

In particular, The Trust 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 Trust 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 Trust will employ a Consultant to lead the Service, for reasons of training, supervision, and clinical governance. As The Trust will be delivering contraception, STI screening and treatment services in one place The Trust shall also ensure there are sufficient Staff within the ISHS that are dual trained.

The Trust shall ensure that Staff are appropriately trained with defined clinical governance arrangements to deliver a POCT service. The Trust 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 Trust shall ensure that training is updated annually and that Staff have access to clinical advice and supervision.

The Trust 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 Trust to deliver the Integrated Sexual Health Service to a high standard will be reliant on the performance of its workforce. The Trust shall ensure that Staff are able to use technology, input into 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 Trust shall ensure that these are sufficiently robust to assure Partnership of the ability of The Trust 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 Trust shall ensure that processes are in place to deal with these situations to ensure the Partnership Agreement requirements are met.

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

[16] RCPCH *Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate 4th ed. January 2019*

2.4.6 Clinical Governance

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

The Trust shall be responsible for ensuring compliance with all legislative requirements applicable to the delivery of the Integrated Sexual Health Service.

The Trust 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 Trust shall be clear how these regulatory requirements would apply to these areas of Integrated Sexual Health Service delivery.

The Trust 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 Trust even if they choose to sub-contract any of the Service Areas.

The Trust 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 Resolution

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

SUI's are defined as 'an incident is an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public[17].

The Trust 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 report from this meeting to the Partnership via the quarterly performance review.

2.4.7 Safeguarding

The safety and wellbeing of children, young people and adults that may access the Integrated Sexual Health Service is paramount. The Trust shall ensure that all Staff (including administrative and voluntary staff) are compliant with Children and Adult Safeguarding Policies. The Trust 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 4th ed. 2019*[18] 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 Trust shall comply with their specific responsibilities and safeguarding protocols relating to young people aged 13-17 years and for those under the age of 13 years.

The Council 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 Safeguarding Partnership Board 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
- Ensure where required adults who may appear to be at risk, particularly adults with care and support needs are provided with access to advocacy

[17] National Framework for Reporting and Learning from Serious Incidents requiring investigation; National Patient Safety Agency, 2010
[18] RCPCH *Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate – 4th ed. January 2019*

- 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 at risk 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 adults, who are at risk due to care and support needs or other risk factors that impact on their abilities to safeguard themselves

- Provide child safeguarding supervision to ISHS practitioners

- Work together and cooperate with partner agencies

- Work to ensure early identification and risk assessment of 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 Trust shall have a named lead for safeguarding covering both children and adults.

The Trust shall comply with the North Yorkshire Safeguarding Adults and Safeguarding Children Board's policies and procedures including best practice guidance. The The Trust 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

The Trust shall have robust child protection and adult safeguarding policies and procedures. When working in outreach settings The Trust 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 Trust 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)*[19].

The Trust has a duty to cooperate with and comply with Section 11 of the Children Act 2004, this places duties on organisations and individuals to ensure their functions, and any services, are discharged having regard to the need to safeguard and promote the welfare of children.

[19] 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 Trust will have Safer Recruitment practices in place and all staff employed by The Trust 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 The Trust 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 MACE (Multi-agency Child Exploitation) and Contextual Safeguarding Procedures.

The vulnerabilities that MACE focuses on are listed below. Although it is important to note that this is not an exhaustive list:

- Child Sexual Exploitation (CSE)
- Child Criminal Exploitation (CCE) including County Lines
- Missing from Home (MFH)
- Modern Slavery and Human Trafficking
- Harmful Sexual Behaviour (HSB)
- Online Child Exploitation
- Wider Contextual Safeguarding

2.4.8 Service user feedback and engagement

The views of those Service Users accessing the Integrated Sexual Health Service, including any sub-contracted elements 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, BAME populations.

The Trust 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 important that both local and national data is used to inform a collective understanding of the changing circumstances of population e.g. some of this will be generated from service utilisation data as well as feedback from patients/service user engagement and epidemiological data. 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. Summary information will be provided in the annual report.

The Trust 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 Trust 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 Trust 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 Trust shall ensure that professional records (both manual and electronic) are managed and accessed in accordance with GDPR, data protection and security protocols.

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

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

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

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

Submission and use of data

The Trust 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 UKHSA (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 Trust provides testing through an on-line service, this activity should also be included with their routine GUMCAD submissions to UKHSA. The Trust 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 Trust 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 UKHSA. 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 Trust 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 Trust is expected to discuss with the Partnership quarterly analysis of GUMCAD, CTAD, HARS and SRHAD data from UKHSA to enable informed 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 Trust shall be proactive in using its local intelligence and data to identify public health issues and in generating responses to unmet need. The Trust shall respond efficiently to requests from the Partnership for data on local populations to help inform needs assessments and other reports.

2.4.10 Performance and Section 75 management

Quarterly Service Review Meetings will be held between the Council and the Trust. The Trust shall provide a quarterly report of performance data. This will include the GUMCADv3 and SRHAD submissions and performance against the agreed Key Performance Indicators in the Performance and Monitoring Framework in a specified format.

Review Meetings will be held on either Partners premises or remotely unless the parties agree otherwise. The Partnership will not pay for any expenses for attendance at any of the Review Meetings.

The Trust 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 Section 75 Review Meeting will be held to assess performance over the previous year where The Trust 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, these will be included as part of the service development and transformation plan and will be reviewed by the Board.

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, any amendments will be developed by the Operational Group and approved by the Board. The impact of The Trust'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 Trust in year one.

Auditing Impact and Outcomes

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

Staffing performance

As part of the quarterly/annual reporting process The Trust shall provide updates on Staff performance; this will include vacancies, sickness, recruitment/retention, appraisals. These will be reported by exception to the Partnership 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 include these in the development and transformation plan.

Organisational Performance

The Section 75 Partnership will work together to demonstrate the value of this Agreement 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 Section 75 Partnership shall provide information for needs assessment and any other monitoring reports required from the Council, York and Scarborough NHS Hospitals Foundation Trust, 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 Trust 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 delivering 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.

2.4.12 Exclusion Criteria

This Service Specification excludes:

- HIV treatment and care; including the drug cost of post-exposure prophylaxis (PEPSE) and PrEP.
- Termination of pregnancy.
- Level 3 education and training provision.
- LARC IUS insertion for non- contraceptive reasons

The Trust 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 Trust, its Staff, the consultant, or the named professional clinically responsible for the management of the care of the Service User.

The Trust 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 Trust shall provide a free, open access, ISHS to anyone that attends without referral, irrespective of their place of residence or GP registration. The Trust 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 Trust will adhere to the Yorkshire and Humber cross-charging agreement that the Council 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 a service near to their place of work. However, over the period of the previous contract, The Trust has put a range of service options in place that have reduced out of area attendances. The Partnership Agreement would like to continue to lower out of area attendances.

2.4.14 Responding to Sexual Health Outbreaks/Incidents

The Trust 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 Trust 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 (UKHSA and the Council); 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; this will usually be led by the local public health or health protection team.

Actions may include:

- Case finding: taking actions to identify further cases of infection, through awareness raising in clinical and other settings, encouraging people to get tested and contract tracing

- Enhanced surveillance of cases: gathering more detailed information about cases, to explore particular risk factors / exposures. The purpose of this further information gathering is to inform control measures – i.e. are there particular venues, activities or other factors associated with the increase in infections?

- Public health control measures: there are a wide range of activities that might be suggested including awareness raising, offering testing in non-traditional settings (outreach – e.g. saunas, sex-on-premises venues), vaccination sessions for at risk groups (may be delivered in outreach settings), pre- or post-exposure prophylaxis.

The response to an increase / outbreak of infections is usually coordinated through an Incident Management / Incident Control Team, and staff from the sexual health service would be expected to participate in these arrangements.

2.4.15 Service Delivery and Quality Standards

The ISHS is underpinned by, and The Trust 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 (2019)
- 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 (4th edition, 2019)
- 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 Trust 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.

SCHEDULE 2 - FUNCTIONS

1 INTRODUCTION

1.1 This Schedule details the Council Health Related Functions that will be exercised by the Trust under this Partnership Agreement. This Schedule may be subject to amendment from time to time.

2 COUNCIL HEALTH RELATED CARE FUNCTIONS

2.1 The Council Health Related Functions include sexual health services.

3 TRUST NHS FUNCTIONS

3.1 The NHS Functions which the Trust will exercise in conjunction with the Council Health Related Functions include those functions that the Trust exercises to deliver the following NHS services:

- Concurrent delivery by the sexual health team of HIV specialist treatment service and HTLV services.
- Psychology and counselling
- Gynaecology
- Infectious diseases (including joint roles in ID and psychology)
- Laboratory services
- Dermatology
- Liver and renal services
- Urology
- Maternity services
- Cancer services
- Primary care pathways

SCHEDULE 3 – FINANCIAL CONTRIBUTIONS

1.1 This Agreement is proposed to continue in force for an initial period of four years with two potential extensions of four and two years respectively, totalling a maximum of ten years.

1.2 Subject to paragraph 1.4 below, the Council agrees to pay the Financial Contributions set out in the table below to the Trust until the Expiry Date in respect of the delivery of the Council's Health Related Functions:

Initial Contract Period				
Year 1 2022-23 £	Year 2 2022-24 £	Year 3 2022-25 £	Year 4 2022-26 £	1-4 years 2022-26 £
2,792,450	**2,792,450**	**2,792,450**	**2,792,450**	**11,169,800**

1.3 The Council's Financial Contribution for each Financial Year will be paid quarterly in advance in four equal instalments. The Trust is not required to issue an invoice.

1.4 The Parties agree that the Financial Contribution shall be fixed until the Expiry Date, and the Trust shall not receive any uplifts whether inflationary or otherwise for the Service.

1.5 The Financial Contribution for subsequent extension periods (First Extension and/or Second Extension) shall be agreed between the parties. In accordance with clause 2, 18 months prior to the Expiry Date (and/or 18 months prior to the expiry of the First Extension) the Parties shall enter into discussions regarding extending this Agreement, including the financial contributions. The Parties shall use best endeavours to negotiate the financial contributions. If after four (4) months no agreement has been reached regarding finances, the matter shall be referred to the Integrated Sexual Health Board.

1.6 If the Parties cannot reach agreement at the Integrated Sexual Health Board and the Agreement is extended in accordance with clause 2, the previous Financial Contributions for the Initial Term, as detailed in the table above shall be deemed to apply for the duration of any future extension periods.

1.7 It is acknowledged that the Trust is currently the provider of sexual health services for the area of York City Council (CYC). If a resident of North Yorkshire accesses sexual health services in the area of York City Council whilst the Trust is the provider of the sexual health service for CYC, the Council shall pay the Trust for the out of area service through the cross charging arrangement detailed at Schedule 7 to this Agreement. This service is outside the scope of this Agreement.

2. VAT

2.1 As at the Commencement Date, the Services are exempt from VAT and VAT is therefore not payable in additional to the Financial Contributions.

SCHEDULE 4 – GOVERNANCE STRUCTURE

Integrated Sexual Health Service Board (ISHS Board)
TERMS OF REFERENCE

PLEASE NOTE: These Terms of Reference will continue to evolve

1. Purpose/Role

- Ensure the provision of the Service;
- Ensure the Service delivers its public health mandate and meets the financial; performance; quality; and safeguarding requirements as set out in the Section 75 Agreement;
- Review and approve an annual report (formulated in accordance with Clause 17 of this Agreement) to cover all service, financial, performance, quality and safeguarding issues for further review and approval by the Trust's Board and the Council so that the ISHS Board can be assured that this Agreement is being delivered effectively and the public health mandate met;
- Ensure the delivery of the operational or service development and transformation programme;
- Oversee the work of the Sexual Health Operational Group responsible for delivering the Integrated Sexual Health service model as set out in the Service Specification;
- Receive regular reports from the Sexual Health Operational Group on performance and service development and transformation;
- Resolve issues escalated to the ISHS Board by the Sexual Health Operational Group;
- Put in place periodic Service audits and deep dives, as agreed between the partners;
- Reviewing opportunities for integrated approaches between the Council and the Trust;
- Monitor, review and develop the Partnership in line with the S75 Agreement;
- To actively explore opportunities to strengthen the collaborative approach and further develop effective and efficient services

2. Composition; Membership

2.1 The ISHS Board ("the Board") comprises representatives of the following organisations: -

- York and Scarborough Teaching Hospitals NHS Foundation Trust
- North Yorkshire County Council

2.2 The initial membership of the Board will be:

<u>York and Scarborough Teaching Hospitals NHS Foundation Trust</u>
Chief Operating Officer
Head of ContractingAssociate Chief Operating Officer, Care Group 5 (Family Health)
General Manager Care Group 5 (Family Health)

<u>North Yorkshire County Council</u>
Director of Public Health
Public Health Consultant
Health Improvement Manager

Head of Projects Integrated Finance

2.3 Other relevant officers may attend any meeting of the ISHS Board by invitation, as and when required, and as agreed by both Partners. Any invited attendee who is not a member or appointed deputy may contribute to the discussion but does not have a say in decision making i.e. their agreement is not required for the ISHS Board to make a decision.

2.4 Subject to paragraph 2.3, decisions of the ISHS Board can only be taken where all the members (or their deputies) in attendance at the meeting agree.

2.5 Where a decision to be taken by the ISHS Board is a decision that for the Trust is a decision that is delegated to the Deputy Chief Executive only (being any decision which would otherwise be a Board decision save for such delegation), the ISHS Board may only take a decision where that decision is agreed by the Deputy Chief Executive on behalf of the Trust and the Council members.

2.6 Where members of the ISHS Board do not have the requisite authority to make decisions, they must escalate such decisions to the relevant authority holder in line with their respective organisation's constitution and governance arrangements.

3. Substitutes

3.1 Consistency of attendance for this Board will be important. Where a member of the ISHS Board is unable to attend a meeting, the relevant Partner will appoint a deputy to attend on their behalf. Where a deputy is appointed, the relevant Partner will ensure that the deputy has appropriate authority to take decisions as required and that the appointment is recorded in writing and sent to the chair and vice chair ahead of the scheduled meeting.

4. Quorum

4.1 For a meeting to proceed there must be at least one representative from the partner organisations referred to above in addition to the chair or vice-chair.

5. Chairing arrangements

5.1 The Board will be chaired by the Council's Director of Public Health.

5.2 The Trust's Associate Chief Operating Officer will be vice-chair.

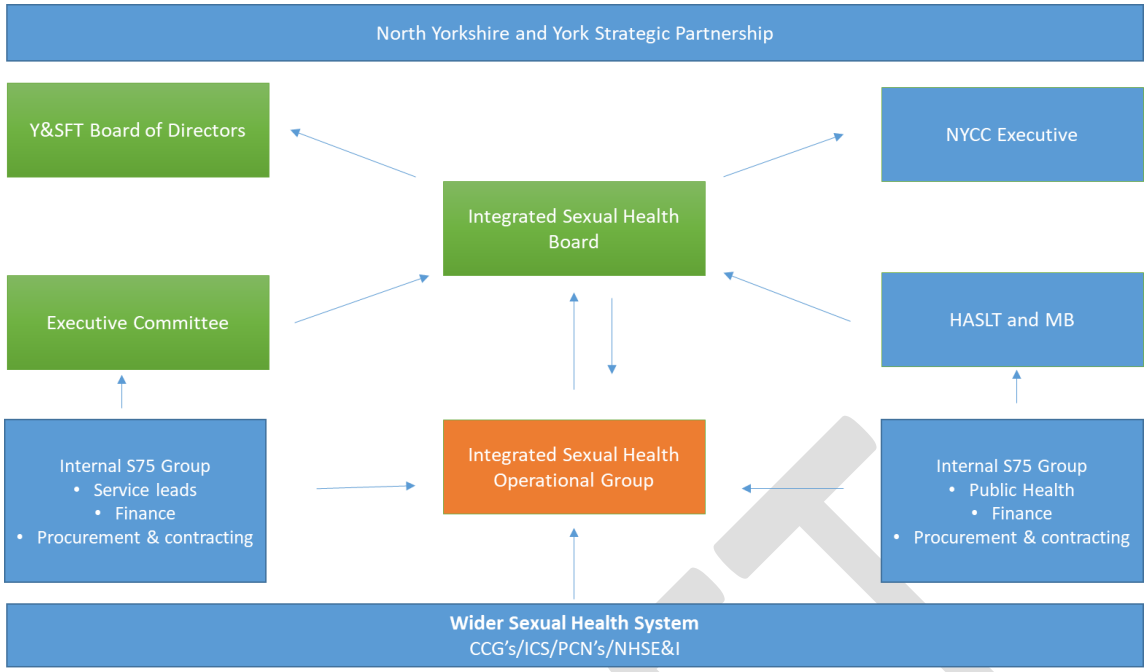
5.3 In the absence of the chair or vice chair, a deputy chair will be appointed by members in attendance at the relevant meeting.

6. Record of discussions

6.1 Minutes will be produced and the Board will be asked to approve these as a correct record at the following meeting.

7. Reporting/Linkages

7.1 Each partner will report back to its own organisation via its normal reporting processes and governance arrangements.



8. Frequency of Meetings

8.1 The ISHS Board will meet as frequently as required to undertake its business, but shall hold a minimum of 4 meetings per annum. In the first year of this Agreement the ISHS Board will meet on a bi-monthly (8 weekly) basis.

9. Secretariat

9.1 In terms of circulating the agenda and producing Minutes, this support will be provided by the Council.

9.2 Any board member can request an item be discussed and all requests should be forwarded to the nominated individual from the Council to add to the agenda.

9.3 Meetings will for the foreseeable future be conducted over Microsoft Teams due to the Covid 19 Pandemic, however the partners may by mutual agreement meet in person.

9.4 Where meetings are virtual, board members will be expected to present their information to the group using virtual means.

10. Circulation of papers

10.1 These will be emailed to Members of the group, three days prior to the meeting. To provide Members with sufficient time to acquaint themselves with the issues, the aim will be to avoid papers that are "tabled" but it is recognised that there may be occasions when this is unavoidable.

11. Review

11.1 It is anticipated that these Terms of Reference will evolve. A review will take place after 3 months.

Terms of Reference Sexual Health Operational Section 75 Group

S75 Operational Group – Sexual Health Service	
Purpose:	To oversee the ongoing development and delivery of the service ensuring that the Service is delivered in accordance with the S75 Partnership Arrangement
Membership:	**The Council:** • Health Improvement Consultant • Health Improvement Manager • Health Improvement Officer **The Trust:** • General Manager Care Group 5 (Sexual health, HIV and Family Health) Lead Nurse Sexual Health • Consultant Sexual Reproductive Health • Operational Service Manager Care Group 5
Roles & Responsibilities:	• Report on overall progress to the Integrated Sexual Health Board including any risks; • Undertake regular reviews to assess progress including monitoring of performance measures to confirm that the service remains on course to deliver as required; • Oversee the development and delivery of the service – through a service development and transformation plan; • Seek to resolve issues escalated to the Sexual Health Operational Group by either Partner or where this is not possible, escalating issues to the Integrated Sexual Health Service Board; • Operate as system leaders for sexual health, working with other partners such as Primary Care and the HCV ICS to improve the effectiveness and efficiency of the service; • Prepare an annual report (formulated in accordance with Clause 17 of the Agreement) on all service elements, financial, performance, quality and safeguarding issues for review by the Integrated Sexual Health Service Board.

Must Jointly:	• Create a collaborative environment to enable the service to develop and deliver the best possible sexual health outcomes for North Yorkshire residents; • Ensure that the appropriate resources required by the service are made available in accordance with agreement; • Take decisions as necessary throughout the life of the service; • Provides the forum to negotiate solutions to any problems or conflicts and agree action against potential threats/risks; • Ensure that quality and integrity of those aspects of the service for which they are accountable for is being maintained.

The group may invite additional attendees in relation to their specialist subject matter if required.

Frequency of meetings

The Sexual Health Operational Group meetings will initially be fortnightly, frequency may be increased / decreased if deemed necessary. If there are no items to discuss the meeting may be cancelled. If required, ad-hoc exceptional Sexual Health Operational Group meetings can be requested. The Sexual Health Operational Group may meet virtually or physically.

Standing Agenda Items

Standing agenda items will include, but not limited to:

- Actions from previous operational meeting
- Review progress against Service Development and Transformation Plan
- Decisions on operational delivery and development
- Focussed session (service development)
- Communication

Preparation for Board and agenda setting preparation for and feedback

  - Risks / Issues
  - Decision/escalation

- AOB

Decision Making

1. The Council will provide the secretariat to the Sexual Health Operational Group and will collate and distribute the agenda for each meeting, with papers being sent out in advance of each meeting.
2. In order for any meeting of the Sexual Health Operational Group to be quorate, there must be at least one Council member and two Trust members in attendance.
3. The Sexual Health Operational Group can make decisions by consensus through its membership but only if the members in attendance have the relevant authority to make such decisions. If members in attendance cannot reach consensus the decision will be escalated to the Integrated Sexual Health Board.

4. Key decisions outside of the scope of the Sexual Health Operational Group will be escalated to the Integrated Sexual Health Board these could include, timescales, finance or scope.

Information Management

All documentation will be stored using the MS Teams site. Hyperlinks to documents on the MS Teams site will be used via email as opposed to attachments where possible; this assists with document version control and allows real-time updates to specific documents when required.

Confidentiality

If this project is confidential, the folders and/or documents can be password protected or access restricted to specific individuals.

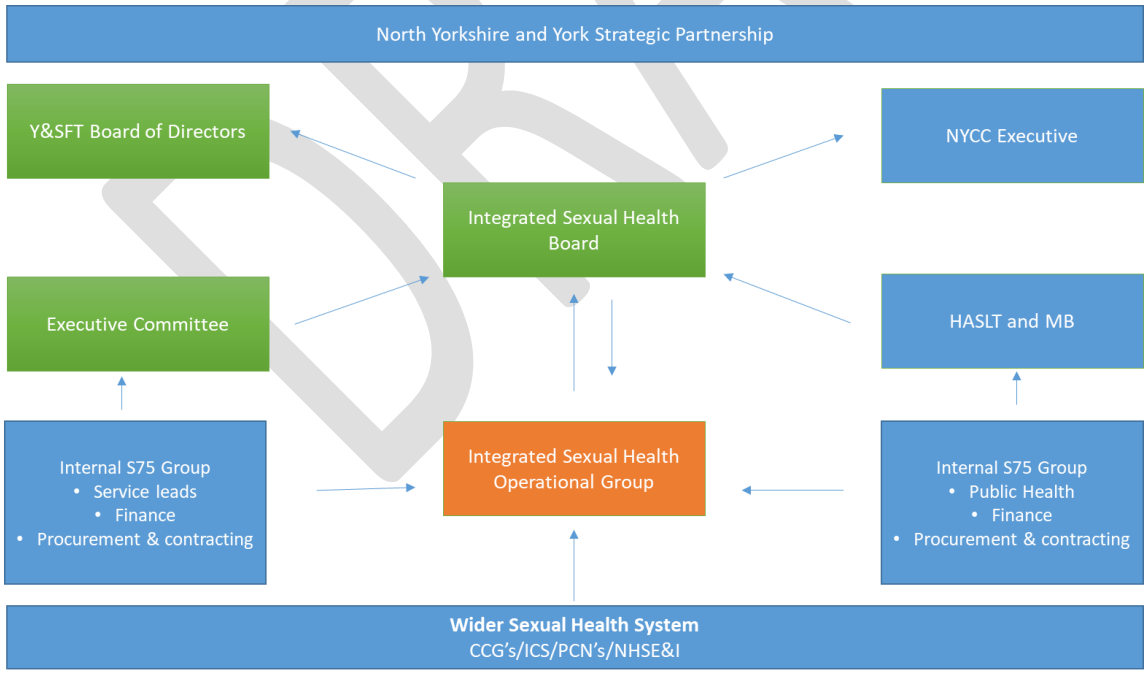
Reporting

- Quarterly reporting of performance data reviewed at the Operational Group and presented to the Integrated Sexual Health Board;
- Annual reporting via a written report presented to the Integrated Sexual Health Board.

Reviews

The Sexual Health Operational Group will review the Terms of Reference on a quarterly basis to ensure relevancy.

Governance structure



SCHEDULE 5 – PERFORMANCE MANAGEMENT FRAMEWORK

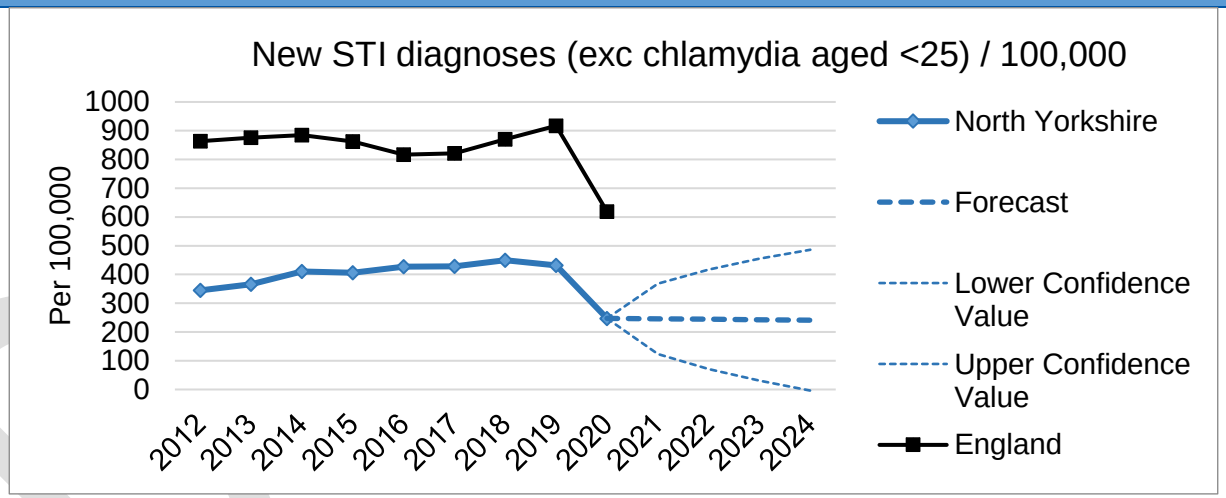
The overarching outcome for the service:

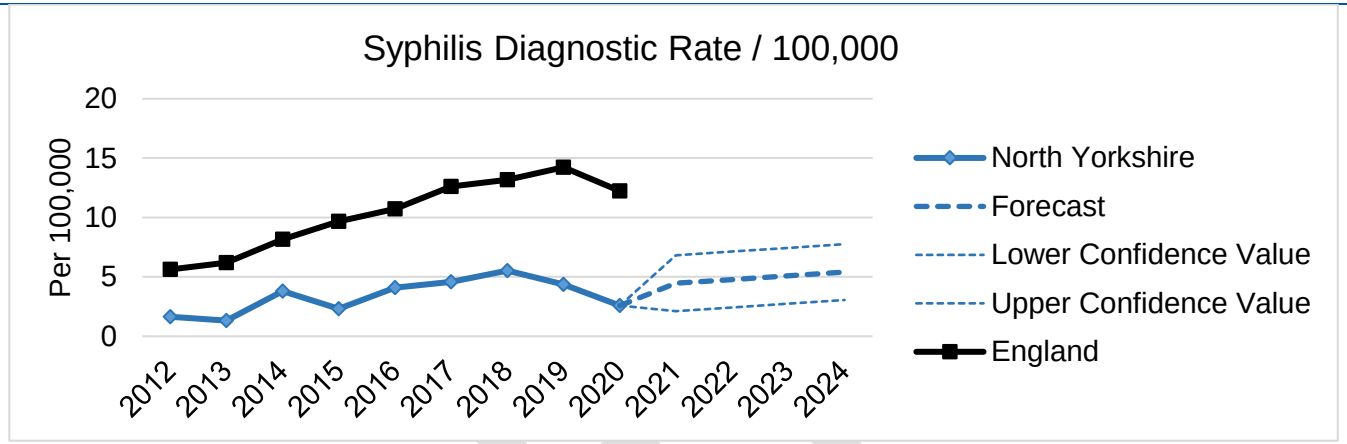
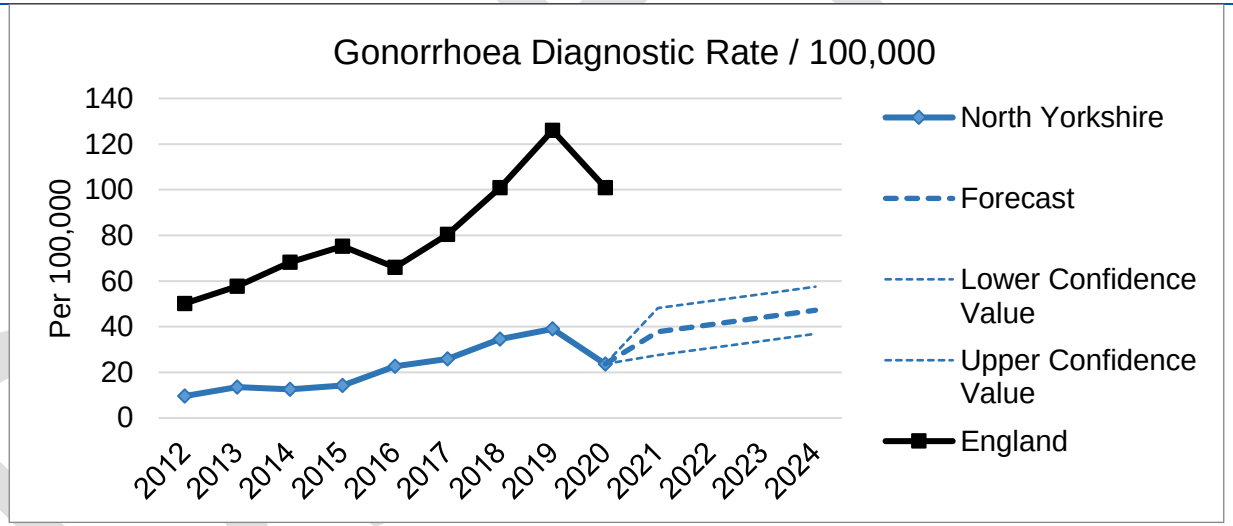
All people in North Yorkshire experience good sexual health

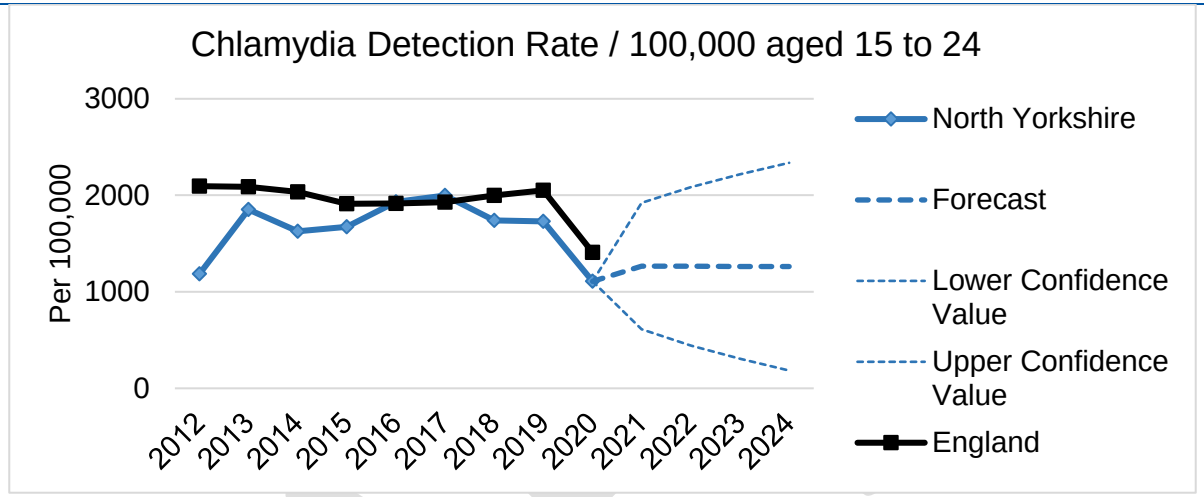
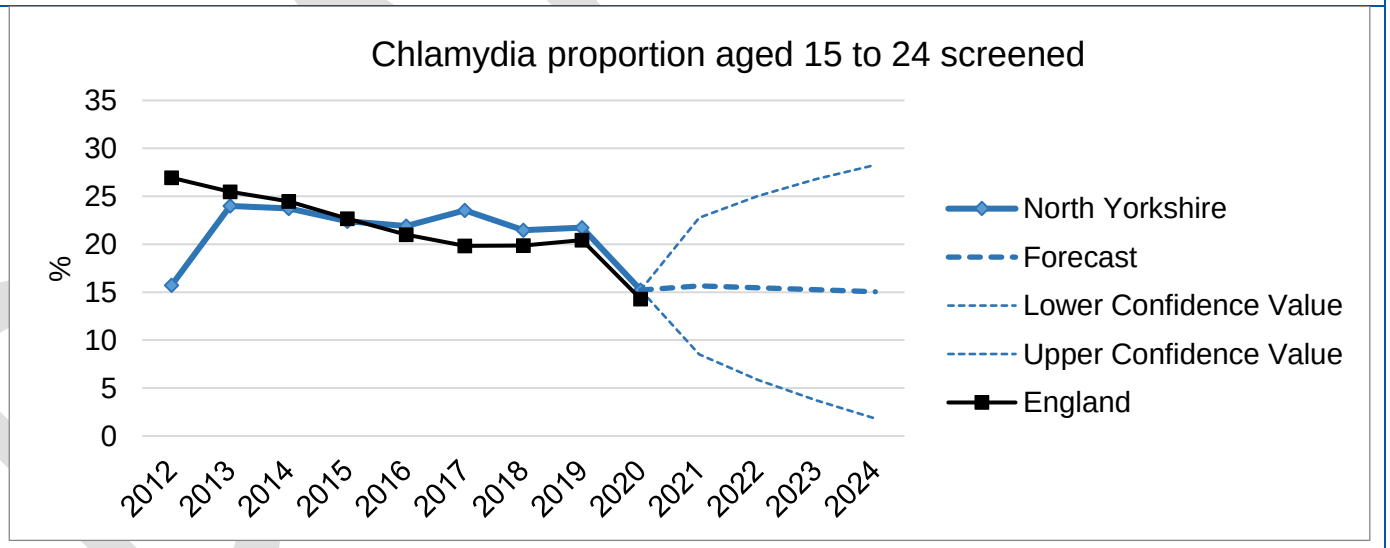
Sexual and Reproductive Health Profiles developed by Public Health England support Local Authorities monitor the sexual and reproductive health of their population and the contribution of local public health related systems. The data below highlights North Yorkshire's historical, current and projected rates against the key performance indicators for sexual and reproductive health.

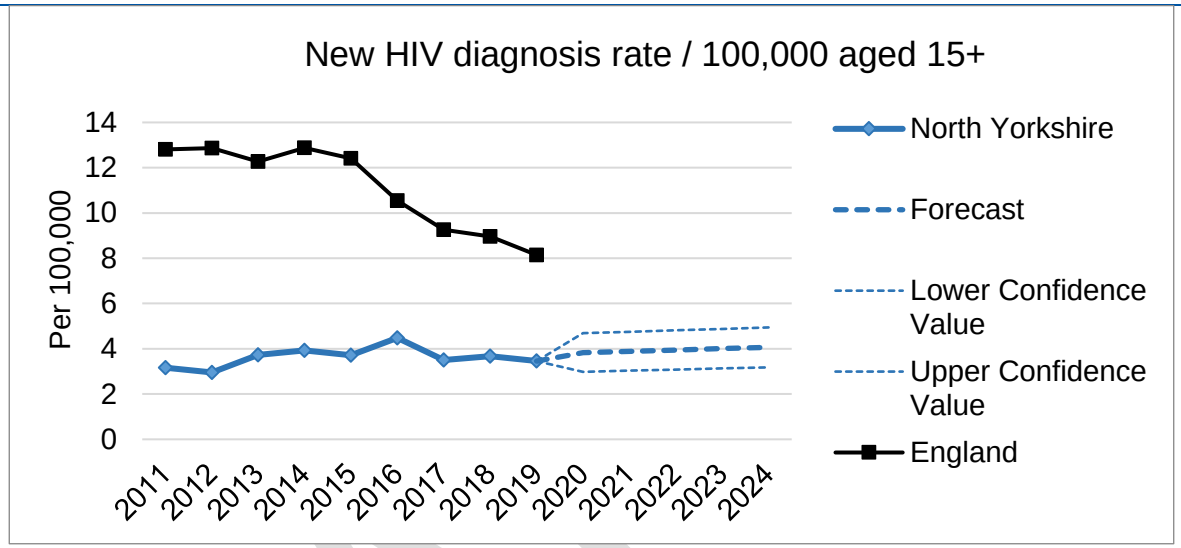
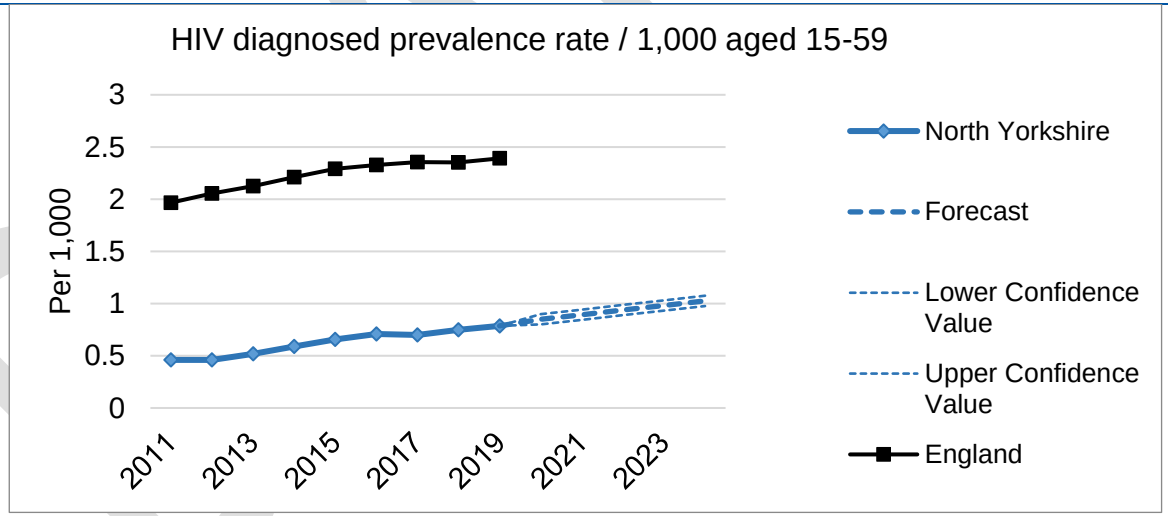
All service performance measures will ***contribute*** to one or more of the following *Key Performance Indicators* (KPIs):

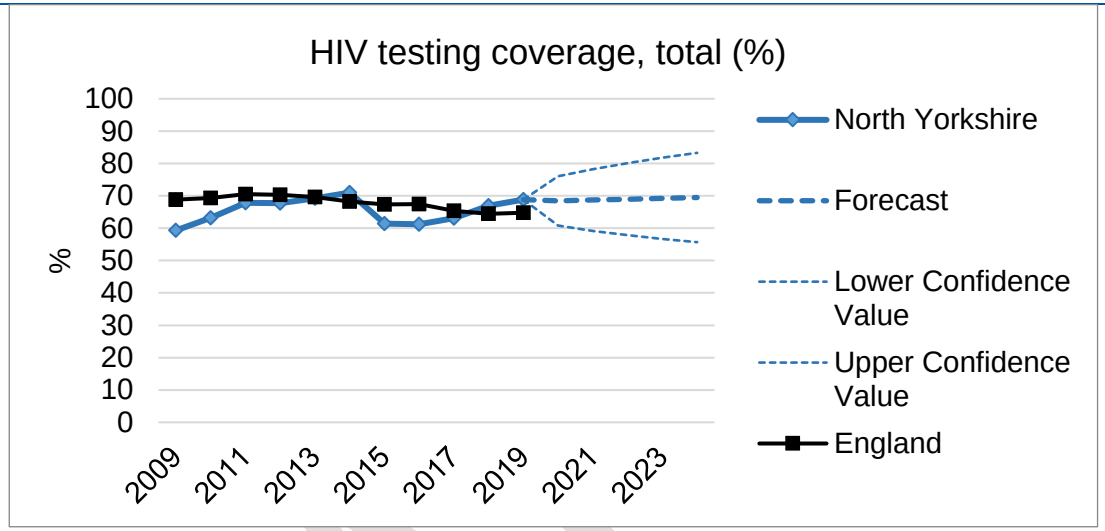
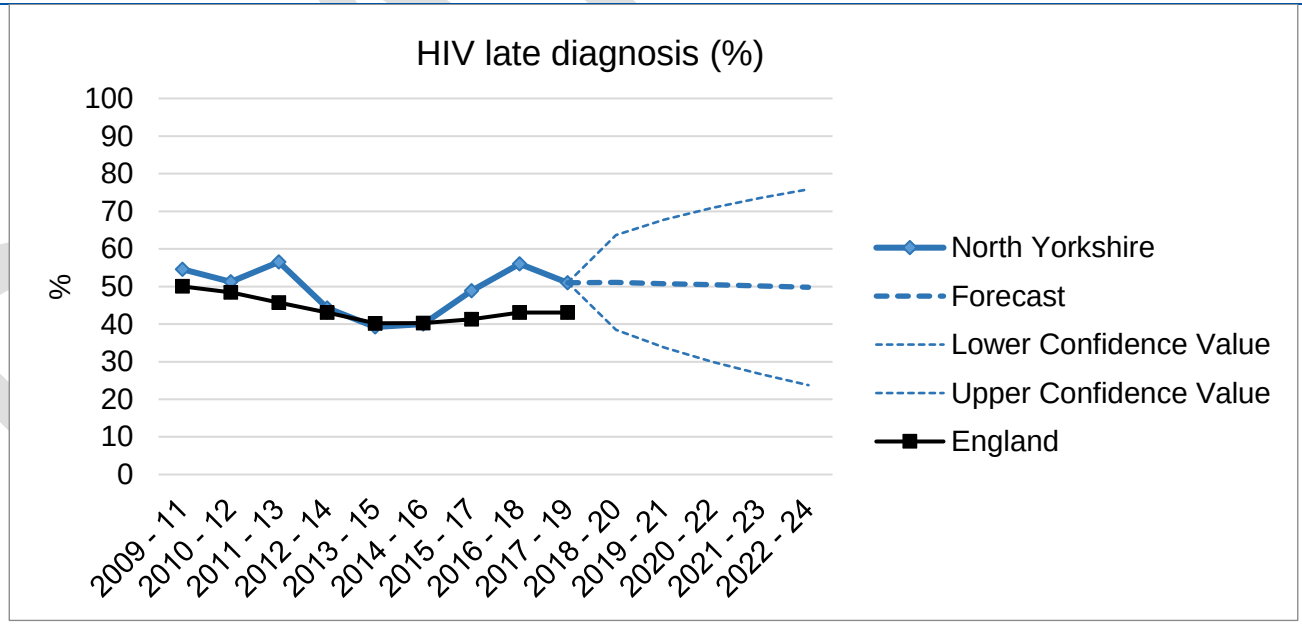
Key Performance Indicators – Sexual and Reproductive Health Profiles

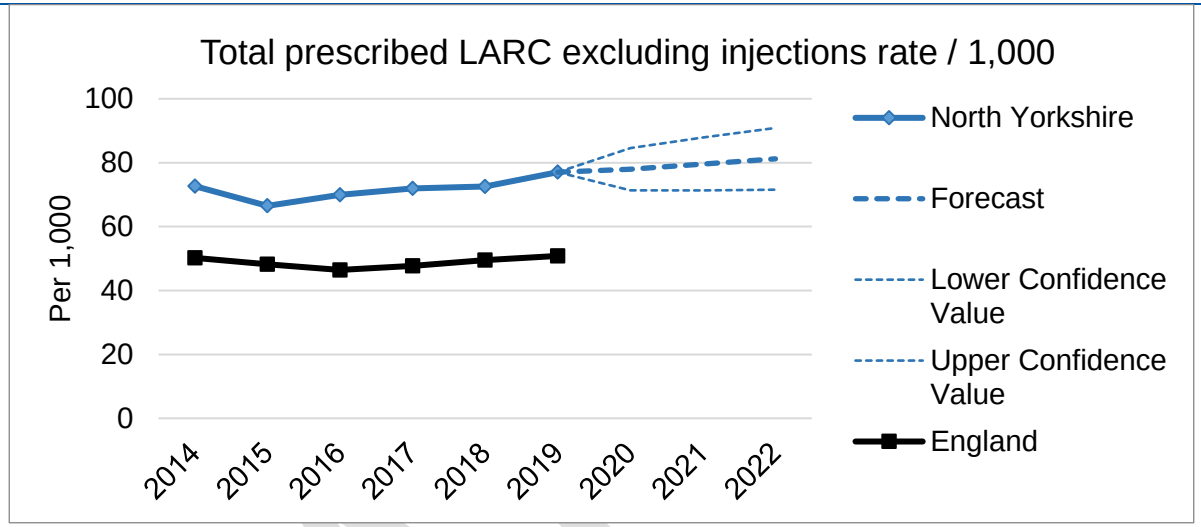
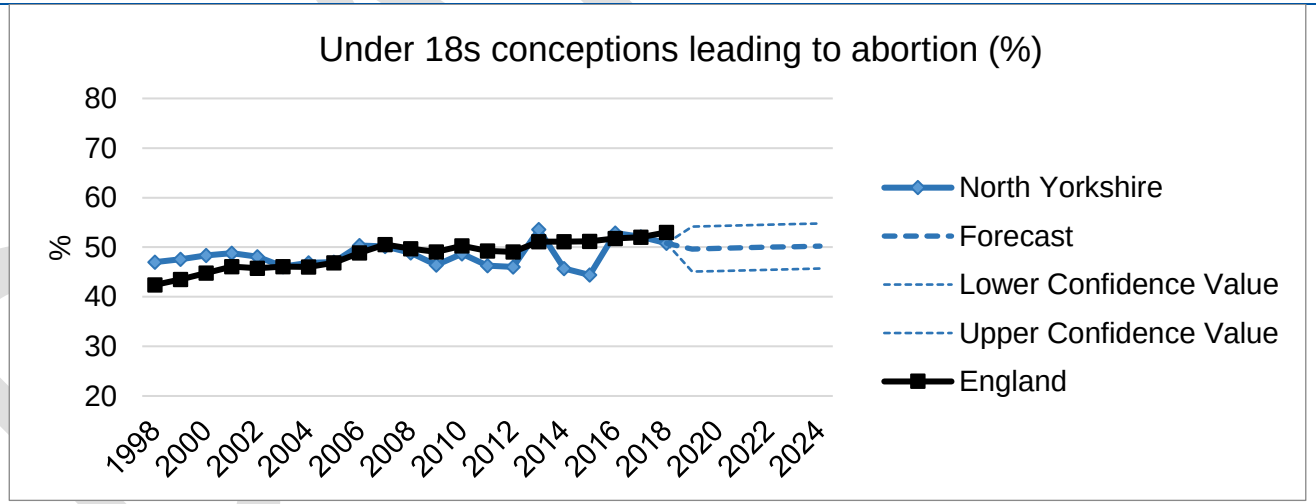
KPI	Target	Historical trend, current and projected rates
New STI diagnoses (excluding chlamydia aged <25)	Maintenance of good levels of detection for all STI's in North Yorkshire (excluding chlamydia aged <25) from 2019 baseline	

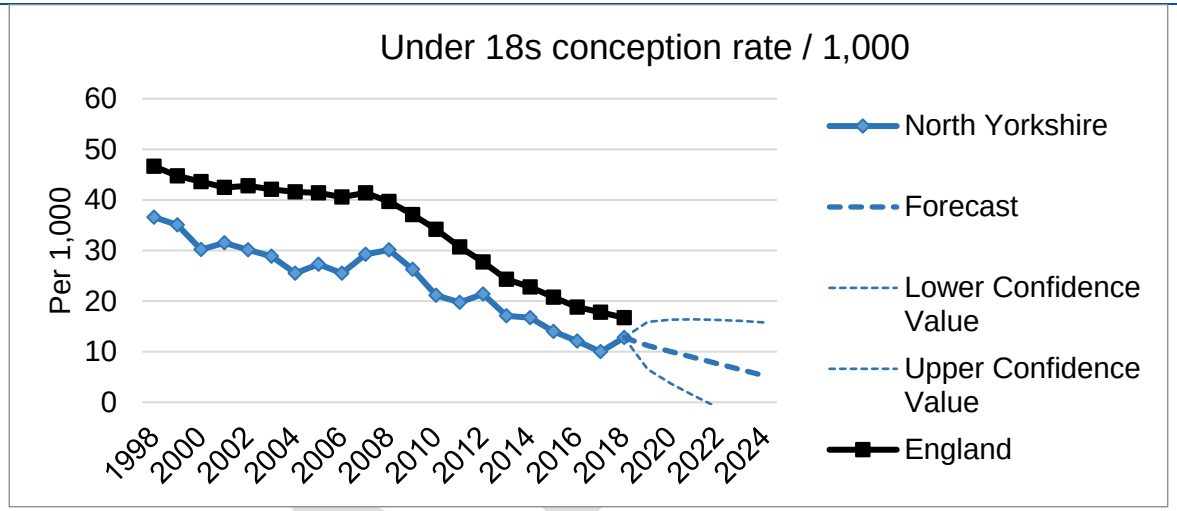
Syphilis diagnostic rate/ 100,000	Maintenance of low rates of syphilis in North Yorkshire from 2019 baseline	
Gonorrhoea diagnostic rate/ 100,000	Maintenance of low rates of gonorrhoea in North Yorkshire from 2019 baseline	

Chlamydia detection rate aged 15-24	Working towards a Chlamydia diagnostic rate of 2,300 people aged 15-24 years old, per 100,000 population from 2019 baseline	
Chlamydia proportion screened aged 15-24	Maintenance of good proportion of chlamydia screening from 2019 baseline	

New HIV diagnosis rate / 100,000 aged 15+	Maintenance of good levels of HIV detection in those aged 15+ in North Yorkshire from 2019 baseline	
HIV diagnosis prevalence rate/1,000 aged 15-59	Maintenance of low levels of HIV prevalence in North Yorkshire from 2019 baseline	

HIV testing coverage, total %	Maintenance of good levels of HIV testing coverage in North Yorkshire from 2019 baseline	
HIV late diagnoses %	Improve the higher than England rate of late diagnosis of HIV against the 2017-19 North Yorkshire baseline of 51% in HIV diagnoses made late (where CD4 count is <350 cells/mm³ within three months of diagnosis)	

Total prescribed LARC excluding injections rate/ 1,000	Maintenance of good levels of LARC provision in North Yorkshire from 2019 baseline	
Under 18 conceptions leading to abortion %	Reduction in the rate of under 18 abortions from 2018 baseline (50.8%)	

Under 18 conception rate/1,000	Reduction in the rate of under 18 conceptions per 1000 females (15-17) from 2018 baseline (12.8%) continuing the decreasing trend	

*The 2020 data, where available needs to be viewed with a level of caution due to the COVID-19 pandemic and therefore the subsequent effect on data projections.

Note: there are additional national indicators available however; these are the key indicators for sexual and reproductive health.

Data requirements

NB: This performance and outcomes framework includes both well-established and new measures. The new measures will take time to embed and develop and the Partnership will work together to progress towards reporting across all measures outlined.

All service activity to allow reporting by:

- age bands (Under 16's, under 18's, 15-24, 25-34, 35-44, 45-54, over 55's)
- gender
- ethnicity
- area of residence (by postcode)
- sexual orientation

- locality of service delivery (at main hub, community clinic and virtual level)

Additional data requirements

To support equity audits, needs assessments and service planning the Partnership 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 – Integrated sexual health service

Using Outcomes based accountability approach, working backwards from a set of outcomes, measured by a set of indicators and performance measures.

1. **How much activity/intervention has been delivered – what, where, to whom - quantity**
2. **How good was the activity /intervention delivered – how well did the service deliver it – quality**
3. **What was the overall overcome for the individual/s receiving the service/intervention – is anyone better off? – outcome**

Local baselines calculated using 2017/18 – 2019-20 data from YSFT

General activity		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism for reporting**
• Number of new (first ever) service users	F2F and virtual 5,073	Quarterly report
• Number of first attendances (including re-registrations) for new episodes of care	5,711	Quarterly report
• Number of follow up appointments (subsequent to first attendance)	5,052	Quarterly report
• Number of service users age <16 female/male, 16-18, 19-24, • Number of service users age 25-34, 35-44, 45-54, over 55s		Quarterly report 6 monthly report
Quality Measures		
• The percentage of people contacting a service who are offered to be seen or assessed with an appointment or as a 'improved access' within two working days of first contacting the service.	98% See Standard 1 (access) of BASHH (British Association Sexual Health & HIV) and MEDFASH (2014). Standards for the Management of	Routine monitoring of access STI/HIV data

	Sexually Transmitted Infections	
• % of appointments who DNA (exception reporting in specific service areas)	7% or less	Quarterly report
• Proportion (%) of North Yorkshire resident attendances in North Yorkshire clinics (excludes York) • Proportion (%) of North Yorkshire resident attendances in clinics outside of North Yorkshire	75% 25%	GUMCAD data report
Clinical assessment, management and productivity		
Quality measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
• The percentage of individuals accessing the service who have sexual health history and risk assessment undertaken. This does not include individuals accessing self-managed care.	97% BASHH 100% ISHS	Clinical audit - annual
• Adherence to the latest BASHH and FSRH Clinical Effectiveness guidelines	Evidence of use of the specific audit measures in each of BASHH clinical effectiveness group or FSRH clinical effectiveness unit	Clinical audit – annual
• Care is managed by appropriately skilled healthcare professionals in line with FSRH, BASHH and CQC standards	Evidence of use of the specific audit measures in each of BASHH clinical effectiveness group or FSRH clinical effectiveness unit Demonstrate compliance with CQC 2014 regs 12 (Safe care and treatment)	Clinical audit - annual • Report rating and any areas requiring improvement • Audit presentations via CLP • CQC standards improvement plan
• Services that manage integrated sexual health services are safe, well-managed and accountable	Evidence that clinical governance arrangements are in place and effective: demonstrate compliance	Clinical audit – annual • Safe and well led – annual review programme

	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	• CQC regulations 14 inspection framework • BASHH Standard 6-standards for the management of STIs 2019 • FSRH service standards for sexual and reproductive healthcare 2016 Standard 1
• All serious untoward incidents reported to the Board within 5 days of their occurrence	100%	As issues arise In accordance to Trust SI Policy
• Undertake and evidence of response to results of 360 professional partners survey undertaken, including with clinical network members to identify any areas of improvement	To be developed	Professional survey – annual
• Explore self-assessment and peer review for the ISHS as part of the wider sexual health system	To be developed	Local HIV, Reproductive health and sexual health self-assessment tool
• Evidence of clinical pathways across the system to ensure seamless care e.g. Primary Care, NHSE, ICS's, PCN's	Case studies	Annual report – case studies
• Evidence of engagement with wider sexual health forums and networks (local and national) e.g. child sexual exploitation, COI Y&H, FSRH, BASHH, BHIVA, and safeguarding that result in service developments.	Case studies	Annual report – case studies
Workforce		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism**

• Number and type of employed posts	TBC	Annual report
• Workforce issues that impact on service delivery e.g. sickness, vacancies, difficulties in recruitment - dual trained staff, and COVID-19	As issues arise	As and when required
Quality measures		
• % 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 (mandatory and enhanced training)	Annual report statement	Annual report
• Results of staff surveys	To be established	Annual report
Sexually Transmitted Infections		
Quantity measures (in clinic and online)	**Local annual baseline or national threshold**	**Frequency and mechanism**
• Number of STI tests conducted by coding - In clinic - Online	 7,960 1927	Quarterly report
• Number of new STI diagnoses - In clinic - Online	 1822 94	Quarterly report
• Number of asymptomatic STI presentations in clinic	40% TBC	Quarterly report
• Number of symptomatic STI presentations in clinic	60% TBC	Quarterly report
• Number of new STI diagnoses (exe Chlamydia) - In clinic - Online	 1169 To be developed	Quarterly report
• Number of new syphilis diagnoses - In clinic - Online	 29 To be developed	Quarterly report
• Number of new gonorrhoea diagnoses - In clinic - Online	 153 To be developed	Quarterly report
• Number of index cases with a case of lab confirmed gonorrhoea	To be established	Quarterly report
• Number of index cases with gonorrhoea where PN discussion has taken place	To be established	Quarterly report

• Number of index cases of gonorrhoea for whom a culture test was documented as offered	To be established	Clinical audit – case note analysis
• Number of index cases of gonorrhoea for whom a culture test was done	To be established	Quarterly report
• Number of new genital wart diagnoses in clinic	764	Quarterly report
• Number of new genital herpes diagnoses in clinic	217	Quarterly report
• Number of 15-24 year olds tested for chlamydia within clinics • Number of 15-24 year olds tested for chlamydia within Preventx (online)	4645 TBC	Quarterly report
• Number of chlamydia index cases where PN discussions have taken place	To be established	Quarterly report
Quality measures		
• The % of reports (or preliminary reports) issued by lab within 5 working days of the specimen being received by the lab.	97% BASHH Standard	Exception reporting – threat to 5 day turnaround
• % of final reports on supplementary testing, or following referral to the reference lab, which are issued by the lab within 10 working days of the specimen being received by the lab	97% NCSP and BASHH Standards	Exception reporting – threat to 10 day turnaround
• % of service users who have received results of STI tests within 10 working days of the date of the sample (excluding those requiring supplementary tests)	95%	Exception reporting – threat to 10 day turnaround
• Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	**BASHH/NCSP** **Local target TBC**	Annual report
• Percentage of those tested receiving positive chlamydia result (age 15-24) within clinics • Percentage of those tested receiving positive chlamydia tests (age 15-24) online	8% TBC	Quarterly report
• The % of all contacts per gonorrhoea index case, who have accessed a sexual health service within 4 weeks of the date of first PN discussion (patient reported or healthcare professional verified)	0.6 contacts within 4 weeks	Quarterly report
• The % of people who are symptomatic or Nucleic Acid Amplification Test (NAAT) positive for Neisseria gonorrhoeae who have a culture performed	80% BASHH and MEDFASH	GRASP Survey Clinical audit - annual
• The % of people who tested positive for chlamydia to be treated within 6 working days of date of test	At least 95% NCSP	Quarterly report

• The % of all contacts of chlamydia index case, who have accessed a sexual health service within 4 weeks of the date of first PN discussion (patient reported or healthcare professional verified)	0.6 contacts per index case	Clinical audit - annual
• % of positive patients (age 15-24) offered a chlamydia re-test at 3 months post treatment	NCSP 100%	Exception only (e.g. system failure) 100% automated text system
• % of people within a quarter that have completed a final Hep B vaccination in a series	BASHH Standards	Quarterly
HIV		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
• Number of first time service users eligible for HIV test	97% BHIVA guidelines	Quarterly report
• Number of first time service users eligible offered HIV test	97% BHIVA	Quarterly report
• Number of first time eligible accepted HIV test	85% uptake	Quarterly report
• Number of first time service users who went on to have a HIV test	85% uptake	Quarterly report
• Number of index cases of newly diagnosed HIV		Quarterly report
Quality measures		
• The percentage of people who are eligible for (based on local epidemiological and prevalence information) and offered (and accepted) an HIV test at first attendance (excluding those already diagnosed HIV positive).	97% BHIVA	Quarterly report
• 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	90% BIHVA	Clinical audit – annual
• Documented PN outcomes or a progress update at 12 weeks after the start of the process (HIV)	90% BHIVA	Clinical audit - annual
• Number of contacts* tested per total number of index cases. (* Status- known contacts + number of contactable status-unknown contacts) a) Proportion (%) of contactable partners tested*	At 3 months 0.6 HCP verified	

b)*Status-known contacts + contactable status-unknown contacts tested / total number of status-known contacts and contactable status-unknown contacts [expressed as %])	0.8 index reported or HCP verified (i.e. those captured via either) At 3 months 65% HCP verified	
• Proportion (%) of indexes for whom there is a documented PN plan in the case notes 4 weeks after index case diagnosis. This 4- week timeline may change if there is ongoing risk to a contact and disclosure has not occurred.	85% index cases with a documented PN plan within 4 weeks of diagnosis At time of HIV diagnosis (when made in service) 97% indexes with PEP assessment: documented evidence of PN discussion to determine if any at risk contact has occurred within previous 72 hours to identify and refer partners potentially eligible for PEP.	Clinical audit - annual
• % of people accessing for PEPSE seen within 48 hours of contact	85% BHIVA	Quarterly report
PrEP		
Quality measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
Assessment of eligibility • The percentage of all attendees at level 3 service whose risk of HIV and eligibility for PrEP is assessed by age, gender, ethnicity, sexual orientation, gender identity.	100% - mandated field	Quarterly report GUMCAD
Numbers categorised as eligible for PrEP for each indication. • Of those supplied PrEP, the percentage who are categorised as eligible for PrEP for each indication by age, gender, ethnicity, sexual orientation, and gender identity.	To be developed	Quarterly report GUMCAD
PrEP period prevalence • Number of all attendees 'on PrEP' by age, gender, ethnicity, sexual orientation, gender identity; and as a proportion of total attendees.	To be developed	Quarterly report GUMCAD

Dosing regimen • Number of all attendees 'on PrEP' who are on event-based or daily dosing; and as a proportion of total attendees	To be developed	Quarterly report GUMCAD
PrEP stops • Number of attendees still on PrEP at 6 and 12 months; as proportion of total number on PrEP (3 month supply issued)	To be developed	Quarterly report GUMCAD
HIV diagnoses • Number and proportion of those diagnosed with HIV who report previous PrEP use	To be developed	Quarterly report GUMCAD
Contraception		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
• Number attending for contraception		Quarterly report
• Number who had access to all methods	100% as standard	Exception report
• Number who required contraception		Quarterly report
• Total number of LARC fittings IUD/IUS	TBC	Quarterly report
• Total number of LARC removals IUD/IUS	TBC	Quarterly report
• Number of injections administered	647/161	Quarterly report
• Number of implants fitted	TBC	Quarterly report
• Number of implants removed	TBC	Quarterly report
• Number of contraceptive pills (COC & POP)	1916/479	Quarterly report
• Number of over 19 repeat contraceptives (complex, change, emergency)	To be established	Quarterly report
• Number of under 19 repeat contraceptives (excluding LARC)	To be established	Quarterly report
• Number of referrals to Primary Care for repeat prescriptions Over 19's from ISHS initiation (non-complex, basic contraception)	To be established	Quarterly report
• Number of service users who required urgent contraception within 48 hours • Number accepted appointment within 48 hours • Number of EHC issued	287	Quarterly report

• Number of individuals signed up to CDS	TBC	Annual report
• Number of organisations signed to CDS	TBC	Annual report
• Number of condoms and related products distributed across the system broken down by setting and service areas	318 boxes	Quarterly report
Quality measures		
• Percentage of service users having access to and availability of the full range of contraceptive methods (including choice within products) to maximise patient acceptability	100% FSRH Standard	Exception report (travel, staff sickness, location)
• % of service users who have access to emergency contraceptive advice (including IUD) within 48 hours of contacting the service (clinic and remote)	100%	Quarterly report
• % of service users who have access to emergency contraceptive services (including IUD) within 48 hours of contacting the ISHS service (excludes weekends)	100%	Quarterly report
• % of LARCS prescribed as a proportion of all contraceptive methods provided (measured as “Initiation” and “Changes”)	40%	Quarterly report
• % of failed insertions of LARC		Quarterly report
• Annual quality assurance audit of the CDS including patient and professional feedback, complaints, product supply and wastage		Clinical audit – annual
HIV Support service		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
• Number of new referrals with HIV diagnosis (self and direct)	8	Quarterly report
• Number of new referrals partners/carers/family members	2	Quarterly report
• Total number of service users on caseload (people with a HIV diagnosis and partners/carers/family members)	22	Quarterly report
• Number of service users receiving each type of support (nutrition, physical activity, financial etc.) (people with a HIV diagnosis and partners/carers/family members)	Case studies	Quarterly report
• Number of condoms and related products distributed	TBC	Quarterly report

• Number of onward referrals or signposts made	TBC	Quarterly report
Sexual health counselling		
• Number of sessions delivered (FA)	43	Quarterly report
• Number of FU sessions delivered	191	Quarterly report
• Total number of referrals	87	Quarterly report
• Total number on caseload	To be established	Quarterly report
• Average number of sessions delivered per person	10 sessions	Quarterly report
• Number of discharge summaries returned to referring clinician within 2 weeks of discharge when agreed with patient (where a referral came from a clinician)	53	Quarterly report
Quality measures		
HIV		
• Percentage of appointments DNA	7%	Quarterly report
• Improvements in self-reported health and well-being measures from baseline assessment to 6 month review	TBC	Quarterly report
• Percentage of service users referred or self-referred who are offered an appointment within 48 hours	100%	Quarterly report
Sexual health counselling		
• Percentage of referrals responded to within 10 working days	100%	Quarterly report
• Percentage of people seen within 8 weeks of referral	100%	Quarterly report
• Percentage of appointments DNA	7%	Quarterly report
• Improvements in self-reported health and wellbeing measures from baseline assessment	TBC	Quarterly report
Community and clinical outreach		
Quantity measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
• Number of new Service Users (in receipt of clinical intervention)	88	Quarterly report
• Number of new service users (in receipt of non-clinical interventions, peer support, MI, workshops, 121 support)	TBC	Quarterly report Case studies

• Total number of outreach referrals	TBC	Quarterly report
• Number of service users identifying as at greater risk (sex workers, homeless, D&A users, BAME, young people, MSM, LGBTQ+)		Quarterly report
• Number issued Emergency contraception	15	Quarterly report
• Number of new started on a hormonal contraceptive (excluding LARC)	15	Quarterly report
• Number of new started on a LARC method of contraception	20	Quarterly report
• Number of STI tests undertaken	TBC	Quarterly report
• Number of STI self-tests issued	TBC	Quarterly report
• Number of STI diagnoses	TBC	Quarterly report
• Number and type of POCT delivered	TBC	Quarterly report
• Number of condoms and related products distributed	TBC	Quarterly report
• Number of onward referrals and sign-post (to where e.g. counselling)	TBC	Quarterly report
Quality measures		
• HIV POCT positivity rate	TBC	Quarterly report
Service User Experience		
Quality measures	**Local annual baseline or national threshold**	**Frequency and mechanism**
Patient and public engagement a) A Patient and Public Engagement (PPE) plan which affords public consultation and feedback. b) The use of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) to collect information from patients. c) Evidence of person centred care and treating service users with dignity and respect. d) Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation	a) Evidence of a current Patient and Public Engagement plan, which affords public consultation and feedback. b) Evidence from providers of effectiveness of care from the patients' perspective and the patient experience of the humanity of their care via annually reporting	Annual plan

	validated PROMs and PREMs. c) compliance with CQC 2014 regulations 9 (Person-centred Care) and 10 (Dignity and Respect)	
• Adopt the You're Welcome criteria	100%	National standards – annual review
• User experience survey	Yes/No	Annual survey – included in annual report Friends and Family (F&F) – quarterly report
• Percentage of service user feedback on surveys that rates satisfaction as good or excellent	At least 70%	Quarterly – F&F
• Evidence of improvements made to service as a result of user feedback	Demonstrate compliance with CQC 2014 reg 17 BASHH and MEDFASH	Quarterly – F&F
• Number of service users making formal complaints (verbal or written) and incidents about the service	DHSC Sexual health clinical governance NHSE SI framework NCSP incident reporting policy	As arise – include in quarterly report
• Referral 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.)	BASHH Standard 8 Evidence of established pathways Reporting into multi-agency meetings	360 feedback Numbers report referrals in/out annually

Reducing inequalities		
Quality measures	**Local annual baseline or national threshold**	
• An Equality Impact Assessment (EIA) is undertaken on any material changes to services and outcomes utilised to inform forward year planning	Completion of EIA	Annual report
• To demonstrate that all functions and policies are equality impact assessed	Annual statement	Annual report
• In order to reduce inequalities the provider will meet [insert frequency] with NYCC to review the demographics of service attendees [demographic characteristics to be included will be agreed jointly] compared to the demographics of the local population. Development of an action plan if there is under-representation of a particular demographic that the service should be reaching. Demographic characteristics may include (by not be restricted to): age; gender; ethnicity; LSOA by deprivation	To be developed	Annual service development and transformational plan
Communications		
Quantity measures	**Local annual baseline or national threshold**	
• Production of an annual communications calendar, featuring local, regional and national campaigns • Number of website hits	Annual plan TBC	Annual plan and report
Quality measures		
• Evaluation reach of local, regional and national communications • Twitter, Facebook and other platforms reach • YSH website reach		Annual report
Training		

Quantity measures	Local baseline or national threshold	
• Number of training sessions delivered, broken down by topic, course length, level (to include levels 1-3), locality and by professional groups, method (virtual or F2F) • Number of people attending training broken down by course • Number and type of placements provided • Number and type of external training requests		All quarterly reporting
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) • % of external training requests met		Quarterly Annual report Annual report
Managing Outbreaks of STIs		
• Establish a locally agreed outbreak plan and process for STIs including HIV and refresh annually (NYCC, YSFT & UKHSA)	Outbreak STI plan – annual – to be developed	Service development and transformational plan
• Establish a monitoring system to look for exceedances	To be developed	Monthly monitoring- reporting exceedances

Appendix G – Partner Agency Information Sharing Arrangement

This Information Sharing Arrangement (the "Arrangement") has been drawn up under the umbrella of the Multi Agency Information Sharing Protocol (the "Protocol"), which sets out the core information sharing principles which have been agreed by its signatory organisations.

The core Protocol documents and list of signatories can be found here.

This Arrangement should be read in conjunction with the Protocol which sets out the core information sharing principles which have been agreed by the Partner Agencies. Any defined terms in this Arrangement are set out in the Glossary of Terms of the Protocol. Partners entering into a Partner Agency Information Sharing Arrangement accept the terms of the Protocol and this Arrangement sets out the practical details of the data sharing.

By signing this Arrangement, all signatories accept responsibility for its execution and agree to ensure that the information processing referred to in this agreement is done in accordance with all relevant legislation, particularly the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA), the Protocol and this agreement.

Once complete, circulate to the Information Sharing Contacts within each organisation who will publish and circulate accordingly, and add to the register of Partner Agency Information Sharing Arrangements, held by each organisation.

Please complete all of the following sections. Do not leave boxes blank, and seek guidance from your Data Protection Officer if you are unsure of the level of detail/requirements. Please delete any explanatory comments (Red) before the Arrangement is signed.

REFERENCE:	[Subject]	**TITLE:**	[Title]
EFFECTIVE DATE:	**1st April 2022**	**REVIEW DATE:**	2 years from effective date

Part One : Partners				
Partner	**Address**	**Project information sharing contact** (name, job title & contact)	**Data Protection Officer** (name, job title & contact)	**Authorisation** (name, job title & date)
1. North Yorkshire	County Hall Racecourse Lane	Emma Davis Health Improvement Manager	David Kempen Senior Data Governance Officer	David Kempen

County Council	Northallerton DL7 8AD	emma.davis@northyorks.gov.uk	Datagovernance@northyorks.gov.uk	Senior Data Governance Officer 20/01/2022
2. York and Scarborough Teaching Hospitals NHS Foundation Trust	Monkgate Health Centre, 31-35 Monkgate,YO31 7PB	Vicki Finlay,Interim Clinical Services Manager Care Group 5 vicki.finlay@york.nhs.uk	Rebecca Bradley, Head of Information Governance Information.Governance@york.nhs.uk	Andy Thompson IG Officer 29/11/2021
3.				

Part Two : Purpose (Principle Two)

It is The Council's intention to enter into a Section 75 Partnership Agreement with York and Scarborough Teaching Hospitals NHS Foundation Trust to deliver an Integrated Sexual Health Service (ISHS) for North Yorkshire.

From April 2013, North Yorkshire County Council became responsible under Local Authorities Regulations 2013 to arrange for the provision of open access sexual health services for everyone present in their area covering:

- free sexually transmitted infection (STI) testing and treatment, and notification of sexual partners of infected persons;
- free contraception and reasonable access to all methods of contraception.

Sexual health is an important area of public health. Most of the adult population are sexually active and access to high quality sexual health services improves the health and wellbeing of both individuals and populations. Sexual health is not equally distributed within the population. Strong links exist between deprivation and sexually transmitted infections (STI's), teenage conceptions and abortions, with the highest burden being borne by women, men who have sex with men (MSM), trans community, teenagers, young adults and black and minority ethnic groups. HIV infection in the UK disproportionately affects 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.

An integrated sexual health service model aims to improve sexual health by providing non-judgemental and confidential services through open access, where the majority of sexual health and contraceptive needs can be met at one site, often by one health professional, in services with extended opening hours and in locations, which are accessible, by public transport.

The current sexual health service commenced on 1 July 2015 and was due to end on 31 March 2020. Due to the impact of COVID-19 the contract was extended to 31st March 2022. The incumbent provider is York and Scarborough Teaching Hospitals NHS Foundation Trust (YSFT) who deliver the service under the YorSexualHealth brand name.

The intension is to enter into a section 75 agreement with the current provider to continue to deliver the service on our behalf.

Discussions between the Public Health and Data Governance Teams in relation to the implications of GDPR legislation for existing service provision concluded that it would be beneficial to review all information sharing that occurs within the existing and proposed YorSexualHealth Service as part of the Section 75 process.

The Section 75 is to be progressed and overseen by The Integrated Sexual Health Service Board with both Trust and Council representatives.

Categories of Data to be Disclosed	**Purpose of disclosure**
Data Flow:	
a. Performance data – e.g., numbers of: new service users, first attendance, follow up appointments, waiting times and other quality measures (anonymised and aggregated to prevent identification of any individual)	Required for performance and service development purposes.
b. Sexual health data – including diagnoses of various specified STI and provision of contraception (anonymised and aggregated to prevent identification of any individual)	Required to meet The UK Health Security Agency objectives regarding national service provision/performance metrics

Part Three : Lawful Basis for Sharing (Principle One)

Every disclosure of personal data, and processes used to transmit it, are to be compliant with Human Rights legislation and with Data Protection legislation.

Purpose *(As per Part Two)*	**Article 6 Processing Condition**	**Article 9 Processing Condition**	**Article 13 and14 Privacy Notice**	**Other Evidence**

1. To provide open access sexual health services for everyone present in North Yorkshire	Article 6 (1)(e) Public Task	Article 9 (2)(i) Processing is necessary for reasons of public interest in Public Health	SexualHealth - Privacy Policy	
2.				
3.				

Part Four : Information Flow, Limitation, Minimisation, and Accuracy (Principles Two, Three, and Four)

Discussions between Public Health and Data Governance on this ISA have confirmed that for the purposes of the Data Protection Legislation, the two organisations involved in the S75 agreement (THE COUNCIL and THE TRUST) are **Joint Independent Data Controllers.**

The Public health team intend to delegate the delivery of the integrated sexual health service to York and Scarborough Teaching Hospitals NHS Foundation Trust in line with the North Yorkshire Integrated Sexual Health Service Specification. The Council will be asking The Trust to collect and report data from the North Yorkshire population at an individual level on sexual health outcomes based on a performance and outcomes framework developed by both The Council and The Trust. Public Health will receive quarterly performance data from The Trust at an aggregated population level for performance and service development purposes. The Public Health team does not have access to individual personal identifiable data.

A range of information sharing is necessary and/ or required, as follows:

1. **To meet needs of service users - operational:**

Service users who access the integrated sexual health service for support often have complex health, wellbeing and social needs. YorSexualhealth is commissioned to identify and respond to needs at the earliest opportunity; promote safety of service users and others including dependents; prescribe medicines and be compliant with relevant regulations; and support and facilitate service users' to achieve optimum sexual health outcomes.

YorSexualhealth may need to communicate, and share personal data, with a wide range of organisations to effectively deliver the service and respond to service users' needs, including (not exhaustive but outlines key relationships):

- GP's
- Pharmacies
- Sexual Assault Referral Centre (SARC)

- Termination Service Providers
- HIV Specialist Treatment and Care Centres
- Adult and Young People's Safeguarding Teams
- Health and Adult Services
- Children and Families Services – e.g. The Healthy Child Team
- Health Protection Teams

The Public Health Team does not receive this personal data, unless otherwise stated. Any data sharing is conducted between organisations including other Council service areas.

1. HIV/STI Data Exchange: https://hivstidataexchange.phe.gov.uk/hivsti (managed by the UKHSA)

The Trust 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 UKHSA (HIV/STI Data Exchange). The submission of GUMCAD extracts is mandatory for all LA commissioned Level 2 and 3 sexual health services, including those offered online. The Trust 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.

GUMCAD data are subject to strict data sharing principles which are given in the UKHSA HIV and STI data sharing policy.

2. SRHAD – Sexual and Reproductive Health Activity Dataset (managed by NHS Digital)

The Sexual and Reproductive Health Activity Data set (SRHAD) came into effect on 1 April 2010. It consists of anonymised patient-level data submitted on an annual basis.

The Trust is required to capture contraception and other sexual and reproductive health activities through collection of the SRHAD Dataset which is submitted annually to NHS Digital.

The SRHAD data is used to populate an annual National Statistics report called Sexual and Reproductive Health Services. The report contains national, local authority and provider level tables. Those users requiring access to the attendance level data can apply through the Data Access Request Service

2. HARS – HIV and AIDS Reporting System (managed by UKHSA)

The HIV and AIDS Reporting System (HARS) is a data set that underpins national HIV surveillance. It is used to:
- inform the public health response and policy formulation for HIV in England
- identify the groups at risk of HIV infection in England
- monitor the short and long term clinical outcomes of people living with HIV infection
- monitor the effectiveness of national policies and guidance
- adapt and refine interventions, as appropriate.

The Trust is required to report all patients newly diagnosed with HIV, this can be done via a quarterly data extract to the HARS or via a HIV new diagnoses proforma, available online or on request from UKHSA.

3. CTAD – Chlamydia Testing Activity Dataset (managed by UKHSA)

CTAD Chlamydia Surveillance System data are used to provide detailed reports at national and local levels on screening coverage, the proportion of chlamydia tests that are positive and the chlamydia detection rate in England.
The UKHSA uses chlamydia data combined from the CTAD Chlamydia Surveillance System and the HIV/STI data exchange to report chlamydia testing activity.

The completion of the 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 Trust to ensure the core CTAD data requirements are provided to the laboratory for each Chlamydia test, in particular, postcode of residence of patient and testing service type.

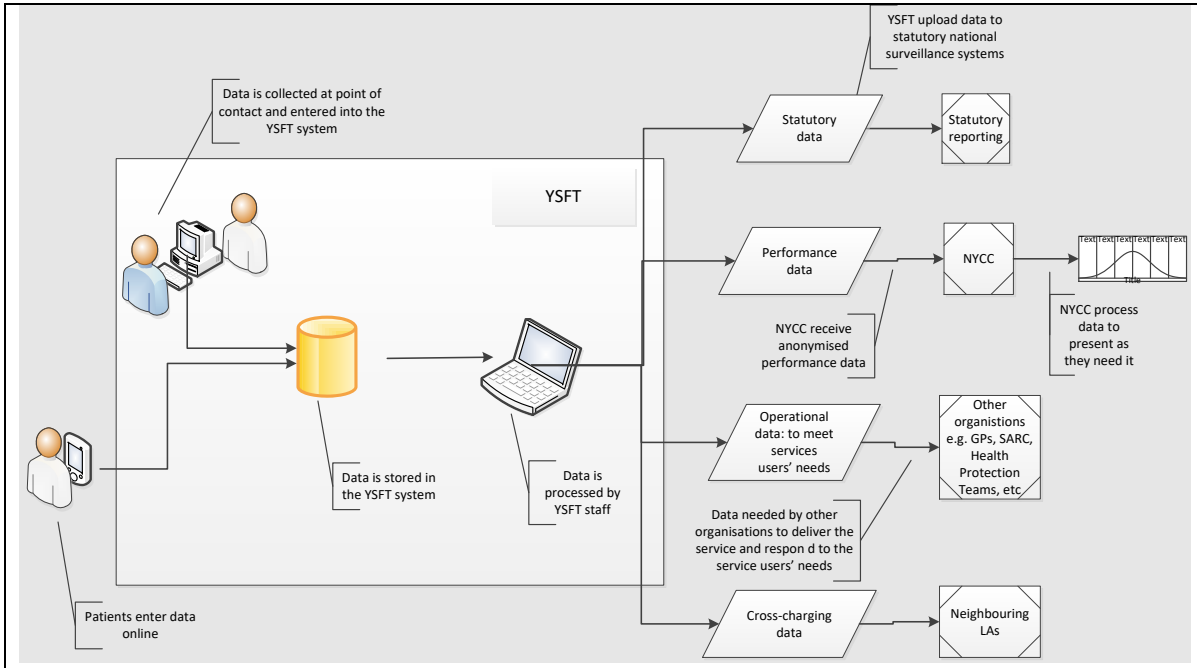
SRHAD, HARS and HIV/STI data exchange form the basis for a standardised sexual health dataset collected from sexual health clinic settings (plus CTAD from laboratories). The Trust is expected to discuss with The Council quarterly analysis of HIV/STI, CTAD, HARS and SRHAD data from UKHSA/NHS Digital to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

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

Cross Charging – Out of Area Attendances
The Trust shall have in place a cross charging mechanism for charging other Local Authorities for out of area attendances. Patient postcode, excluding the last 2 digits, which allows the patient to maintain confidentiality, is required to facilitate this. Out of area Providers delivering sexual health services for other Local Authorities will invoice The Council for North Yorkshire residents seen within their services, the same backing data will be required by The Council finance to authorise payments using Yorkshire and Humber tariffs.

Performance Metrics
This document details the performance metrics for the Partnership Agreement.

S75
POFvFINALv.docx



The data shared between organisations is the minimum amount of data required in order to measure the effectiveness of the services delivered.
The quality of the data is the responsibility of all involved partners – every effort should be made to ensure that data shared is accurate and up-to date.
Partners will act as joint independent data controllers under this agreement.

Part Five : Retention and Deletion (Principle Five)

The Partnership retention period is included in the Section 75 Agreement.

Clinical services will hold data for a maximum 10 years

All data used by The Council will be anonymised.

Part Six: Means of Transmission and Security (Principle Six)

The Protocol provides details of the overall security standards required of partners to manage the information they receive from other parties under this Arrangement. These must be respected by all signatories.

All anonymised performance reports will be stored on The Council N Drive – which is a secure drive only accessible to specified members of Council staff.

All Council staff have undertaken mandatory GDPR and information security training.

Information will be transferred between partners using corporately approved encrypted mechanisms i.e. nhs.net and gov.uk email addresses.

Data protection clause and schedule will be included in S75 terms – clarifies responsibilities and partnership expectations.

Part Seven: Other Considerations

If an information security incident/breach occurs the party who first becomes aware of the incident should notify the other partners as soon as possible. The relevant DPO should then be contacted to provide input. Any issues should be rectified as quickly as possible. Any learning points from the incident may be communicated amongst partners (where appropriate) to reduce the chance of further issues.

In regard to FOI requests – the service area which receives the request shall review it and determine whether it is appropriate for them to answer it directly – or whether it needs to be passed to another team. Partners shall also share information appropriately with each other in order to fulfil the needs of the request.

Part Eight: Termination of Arrangement

This arrangement can be suspended, by any Partner for any reason, with immediate effect and then terminated by any Partner. The terminating Partner will do so in writing and will cite the reason for termination. Refer to S75 agreement for details.

Part Nine: Signatures

By signing this Arrangement, all signatories accept responsibility for its execution and agree to ensure that the information processing referred to in this agreement is done in accordance with all relevant legislation, particularly the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA), the Protocol and this agreement.

Partner	Project Officer *or* Information Asset Owner	PO / IAO Signature and Date	Data Protection Officer	DPO Signature and Date
1. North Yorkshire County Council	Emma Davis	E J Davis 04.02.2022	Senior Data Governance Officer	David Kempen 20/1/2022
2. York and Scarborough Teaching Hospitals NHS Foundation Trust	Vicki Finlay	V Finlay 04.02.2022	Rebecca Bradley, Head of Information Governance	Andy Thompson 29/11/2021

SCHEDULE 7 – CROSS CHARGING OF OUT OF AREA SERVICES

Cross Charging agreement S75 NYC(

Schedule 1- YORKSHIRE & HUMBER PUBLIC HEALTH REGIONAL SEXUAL HEALTH COMMISSIONERS

REGIONAL CROSS CHARGING UPDATE

Date: 21 January 2022

To: Commissioners / Providers of Sexual Health Services

Dear Colleague

I am writing on behalf of the Yorkshire & Humber Public Health Regional Sexual Health Commissioners Community of Improvement, to update you regarding annual amendments to our cross-charging payment schedules. This letter is provided to confirm payment terms for GUM and PrEP that apply between the 1 April 2022 and 31 March 2023.

Please note in particular:

- Payment schedules
- List of Yorkshire & Humber Authorities and out of area invoicing arrangements in relation to cross-charging for GUM and PrEP (Appendix A)
- Invoice requirements (Appendix B)

The regional approach to cross charging was formally implemented in October 2015 and has recently been reviewed again by the Yorkshire and Humber Regional Network of the Association of Directors of Public Health.

All local authorities in the region will continue with the following principles:

1. Authorities will only pay for invoices for GUM and PrEP activity within the agreed regional tariff cost envelope (tariff rates are detailed in the table below)
2. Authorities will not reimburse invoices for contraception activity
3. Authorities will not reimburse for market forces factor (MFF)
4. Before making payment, invoices and supporting data will clearly provide all the required information (the regional information requirement is detailed in Appendix B)
5. Providers should seek information from students as to where they are currently residing. In term time, this will be the local authority in which they are living, and payment should be made by that Authority. When the student returns to their “home” area outside of term time, it is that home LA that should be invoiced.

With local authorities required to manage within a reducing public health allocation, there have had to be some difficult decisions in previous years in order to find the required savings and efficiencies across contracted public health activity. The Yorkshire and Humber Regional Network of the Association of Directors of Public Health determined that non-contracted activity should not be exempt from contributing to the required savings.

However, as agreed by the Directors of Public Health, and in order to support sexual health services, the tariffs will be maintained at 2021/22 rates for 2022/23.
Local authorities within the Yorkshire and Humber region will reimburse invoices for Genito-Urinary Medicine treatments, which are within the following rates:

Year	First - Single Professional	First - Multi Professional	Follow up
2017/18	£134	£140	£105
2018/19	£131	£137	£103
2019/20	£128	£134	£101
2020/21	£125	£131	£99
2021/22	£123	£128	£97
2022/23	**£123**	**£128**	**£97**

Please be aware that some local authorities do not have systems in place to process part-payment against invoices, so if you are not able to invoice at these rates or provide credit notes, there is a risk of the whole of the invoice amount remaining unpaid in cases of dispute.

PrEP - routine sexual health commissioning

The Yorkshire and Humber Community of Improvement for Sexual Health (COI) have worked closely together following the release of the Local Authority PrEP allocations, modelled estimates and national service specification and subsequent release of the national costed pathway to agree Yorkshire and Humber regional tariffs for out of area PrEP. In addition, the COI asked all Yorkshire and Humber Providers to cost the additional service elements for PrEP. Using the information available, modelled scenarios were developed and informed the decision. The Yorkshire and Humber Directors of Public have agreed tariff rates for PrEP, outlined below from 1 October 2020. **It has been determined that the PrEP tariff agreed in October 2020 will continue to apply in 2022/23.**

Local Authorities or Local Authority Sexual Health Providers within the Yorkshire and Humber Region will only pay for invoices for PrEP activity up to the level of the agreed regional tariff cost envelope.

Agreed PrEP tariff rates for 2022-2023:

Year	First Appointment	Follow up
2021/22	£175	£139
2022/23	**£175**	**£139**

The PrEP tariff covers the full cost of attendance; providers should therefore apply either the PrEP or GUM tariff and not both.

Please be aware that some areas may use an 'episode of care' model for PrEP and may therefore ask for additional information if multiple PrEP claims are made for the same patient within the same quarter.

Non-Face-to-Face activity

The Yorkshire and Humber Community of Improvement for Sexual Health are developing a position for non-face-to-face activity cross-charging following a detailed review with both Providers and Commissioners. Please note that currently invoices received for non-face-to-face activity will not be paid.

A copy of this letter will be posted on the National Commissioners Forum with a request to circulate to commissioned sexual health services. Copies of this letter will be sent to providers who invoice Yorkshire & Humber Local Authorities.

If this approach has any impact on your service or your local authority then please detail your concerns via email to emma.davis@northyorks.gov.uk who will collate responses on behalf of the Yorkshire & Humber Commissioners. Any feedback received will inform the Regional Directors of Public Health Network in their annual review of sexual health provision.

Yours faithfully
Emma Davis

On behalf of the Yorkshire & Humber Public Health Regional Sexual Health Commissioners Community of Improvement

Health Improvement Manager
North Yorkshire County Council

Email: emma.davis@northyorks.gov.uk

Appendix A – List of Yorkshire & Humber Authorities and out of area invoicing arrangements

Please note below the correct Yorkshire and Humber Local Authority invoicing arrangement for GUM and PrEP out of area cross charging.

NB. Please send claims invoices to the email addresses detailed in the table below, which may have changed in some cases.

The following Local Authorities are signed up to this approach within the Yorkshire and Humber region:

Local Authority Area	GUM invoices to be sent to:	PrEP invoices to be sent to:
Barnsley Metropolitan Borough Council	publichealth@barnsley.gov.uk	publichealth@barnsley.gov.uk
Bradford Metropolitan District Council	Shabnum.Novis@bradford.gov.uk	Shabnum.Novis@bradford.gov.uk
Calderdale Metropolitan Borough Council	Debra.Rodgers@calderdale.gov.uk	Debra.Rodgers@calderdale.gov.uk
Doncaster Council	PHEnquiries@doncaster.gov.uk	PHEnquiries@doncaster.gov.uk
East Riding of Yorkshire Council	publichealthpayments@eastriding.gov.uk	publichealthpayments@eastriding.gov.uk
Kingston upon Hull City Council	PublicHealthAdmin@hullcc.gov.uk	PublicHealthAdmin@hullcc.gov.uk
Kirklees Council	publichealthcommissioning@kirklees.gov.uk	publichealthcommissioning@kirklees.gov.uk
Leeds City Council	phinvoicing@leeds.gov.uk	phinvoicing@leeds.gov.uk
North Lincolnshire Council	Kelly.crow@northlincs.gov.uk	Kelly.crow@northlincs.gov.uk
North East Lincolnshire Council	PublicHealth@nelincs.gov.uk	PublicHealth@nelincs.gov.uk
North Yorkshire County Council	Publichealth.claims@northyorks.gov.uk	Publichealth.claims@northyorks.gov.uk
Rotherham Metropolitan Borough Council	hannah.maccio@nhs.net alison.humphries4@nhs.net	hannah.maccio@nhs.net alison.humphries4@nhs.net
Sheffield City Council	From South Yorkshire services (Barnsley, Rotherham, Doncaster) Sth.sexualhealthadmin@nhs.net From other services guminvoicesSheffield@sheffield.gov.uk	From South Yorkshire services (Barnsley, Rotherham, Doncaster) Sth.sexualhealthadmin@nhs.net From other services guminvoicesSheffield@sheffield.gov.uk
Wakefield Metropolitan District Council	phcommissioning@wakefield.gov.uk	phcommissioning@wakefield.gov.uk
City of York Council	publichealth.claims@york.gov.gov.uk	tina.ramsey@york.nhs.uk

Appendix B – Minimum Information Requirements for Invoicing

Invoice must include:

- Name of Provider
- Date
- Bank Details
- Invoice Period
- Invoice total

Invoices should be submitted as soon as possible following the date of provision, and within a period of three (3) months where possible.

***For 2022/23 Local Authorities are able to accept both GUMCAD 2 and GUMCAD 3 data.**

Supporting Data for each activity claimed GUMCAD2:

- LA Code
- LA Name
- GUM Number / Identifier
- Attendance Type – New / Follow Up / Single / Multi Professional/specifying if PrEP initiation or follow-up attendance
- *Activity / Treatment Code (SHHAPT Code)
- LSOA Code (partial postcode does not always relate to a specific Local Authority area so is not acceptable evidence of residence)
- Appointment Date
- Tariff

Supporting Data for each activity claimed GUMCAD3:

- Patient ID
- LSOA
- Consultation Date
- Consultation medium (face to face/ phone/ online)
- Consultation type (New/ Follow-up)
- Consultation speciality (Integrated/ STI/ SRH/ HIV/ Other)
- Episode activity – services provided (SNOMED/ SHHAPT/ other code*)
- PrEP Uptake (Accepted/ Declined - patient choice/ Declined – obtained at another source)

*Codes used should be as set out in: Guidance overview: GUMCAD: data specification and technical guidance - GOV.UK (www.gov.uk)

Schedule 2 – ACTIVITY TEMPLATE

		Month	Values						
		1		2		3		Total Activity	Total Price
POD	SUB POD	Activity	Price	Activity	Price	Activity	Price		
ISHS	BLOCK								
	CROSS CHARGE BLOCK								
ISHS-FA	CROSS CHARGE								
	(blank)								
ISHS-FUP	CROSS CHARGE								
	(blank)								
PrEP	PREP SERVICE CHARGES - BLOCK								
PrEP-FA	PrEP								
	PrEP - CROSS CHARGE								
PrEP-FUP	PrEP								
	PrEP - CROSS CHARGE								
Grand Total									

Copy of Cross charge Excel templat