

Schedule 2 Part 1: Integrated Sexual Health Services Draft Service Specification

[Mandatory headings, but detail for local determination and agreement]

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| Service | West Sussex Integrated Sexual Health Service |
| Commissioner Lead | Paul Woodcock |
| Provider Lead | |
| Period | July 2012- June 2015 (subject to 2 year extension option) |

1. Purpose

1.1 Aims

The aim of the service is to deliver a range of accessible, high-quality, responsive, cost-effective, confidential, Integrated Sexual Health Services to the population of West Sussex and to support the delivery of sexual health services in primary care and other community settings through the provision of professional training.

The service will aim to achieve the following for the population of West Sussex in support of national and local strategies for Sexual Health & HIV:

- **To maximise the sexual health of individuals and their sexual partners** by promoting local sexual health services effectively and facilitating convenient and timely access to integrated sexual health care for all residents
- **To reduce inequalities in sexual health** by targeting vulnerable groups and communities with greater sexual health needs and tackling the stigma and discrimination associated with HIV and poor sexual health in partnership with other agencies
- **To improve access to integrated sexual health services** – by delivering a ‘one stop shop’ approach to sexual health service provision, ensuring that patients have access to a range of Sexually Transmitted Infections (STI) and contraception & reproductive health services within a greater range of locations and reducing the number of appointments that patients require to improve their sexual health
- **To reduce rates of STIs and HIV** through the provision of integrated services for STI screening, diagnosis and treatment with services for contraception and reproductive health and the provision of targeted sexual health promotion and partner notification
- **To reduce teenage conceptions** - by improving access to contraception services (including LARC) for young people across a broad range of settings and by ensuring that contraception is available as part of all STI and Termination of Pregnancy care pathways
- **To reduce unintended conceptions and repeat terminations of pregnancy** - by improving access to long acting reversible contraception (LARC) and ensuring that access to contraception is included in all termination of pregnancy pathways
- **To contribute to the effective delivery of the national Chlamydia screening programme** – through targeted outreach and improving the uptake of Chlamydia screening for 15-24 year olds in all sexual health and community settings
- **To reduce the prevalence of undiagnosed HIV infection and late diagnosis of people with HIV** through the effective uptake of HIV testing across a broader range of settings
- **To develop increasingly user-focused sexual health services** by involving service

- users, stakeholders and related services in service design, development and evaluation
- **To create more co-ordinated and sustainable sexual health services** - by maximizing existing workforce skills and expertise and ensuring that all service providers are supported to deliver high quality care through the development of agreed care pathways and the provision of training and development through the **co-ordination of local sexual health network**.
 - **To ensure maximum effectiveness and the best use of finite resources** by reducing service duplication, ensuring an effective skill mix of staff and sharing good practice, where appropriate, developing services in line with local need with referral and partner agencies
 - **To reduce out of area activity for Contraception, STI and other sexual health services** by improving access to high quality services within area while at the same time maintaining patient choice.
 - **To improve the sexual health of the local population, especially those at risk of poor sexual health** – by providing evidence based behaviour change interventions tailored to meet specific needs of target groups/individuals

1.2 Evidence Base

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 STI by services being delivered through accessible contraceptive and sexual health provision.

Sexual ill health is not equally distributed among the population; there is a strong link between deprivation and STIs, teenage conceptions and abortions with the highest burden being borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic (BME) groups. It is not possible to tackle sexual ill health without addressing the wider determinants of health through education, welfare and employment.

The national picture for sexual health and HIV is as follows;

- Latest data (Health Protection Agency Report 2011) indicates the number of new cases of STIs in the UK rose in 2009
- The total number of new cases of STIs diagnosed in GU medicine and community based settings for chlamydia rose by 3% last year whilst other STIs rose by 2%
- The rise in STI diagnoses between 2009-2010 was primarily associated with increased diagnoses of chlamydia, genital herpes, and gonorrhoea.
- During the same period, new diagnoses of genital warts were relatively unchanged while those of syphilis and non specific genital infection fell slightly
- Young people under 25 experience the highest rates of STIs
- In those attending GU medicine in 2010 – 65% of chlamydia, 50% of gonorrhoea, 55% of genital warts and 43% of genital herpes diagnoses were in those aged 25 and under
- Young people are more likely to become more re-infected with STIs. In England at least 11% of 16 to 19 year old women and 12% of 16-19 year old men presenting with an acute STI at a GU medicine will become re-infected with an STI within a year.
- Young people may be at risk of re infection because they lack skills and confidence to negotiate safer sex

Policy

The National Sexual Health and HIV Strategy (DH, 2002) and the public health white paper

“Choosing Health: Making

Healthier Choices Easier” (DH, 2005) identify sexual health as key public health priorities. Delays in access to diagnosis and treatment lead to more people becoming infected with sexually transmitted infections (STIs).

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In 2005 the Department of Health published “Recommended Standards for Sexual Health Services”. These concluded that communities should be able to:

1. Access the full range of sexual health services within or via a range of settings
2. Receive co-ordinated and integrated care, with clear information and direction or referral to other services when needed
3. Choose services which are geographically convenient for them and which best meet both clinical and cultural needs

Providers of services should demonstrate that:-

- Consistent standards of care are agreed and implemented across the service network to optimise clinical outcomes and service user experience
- Care pathways within and across organisations are explicitly defined
- Shared and co-operative governance, accountability and performance management arrangements are agreed and implemented

In 2008 the Independent Advisory Group on Sexual Health and HIV (IAG) commissioned a report from the Medical Foundation for AIDS and Sexual Health (MedFASH) to review progress towards implementing the national sexual health strategy. Recommendations for making local progress included:

- Prioritising sexual health and providing strong local leadership
- Building strategic partnerships
- Commissioning for improved sexual health
- Investing in prevention
- Delivering modern sexual health services

In July 2009 the government published its response to the recommendations, 'Moving forward: Progress and priorities working together for a high-quality sexual health

The publication of the white paper 'Healthy Lives, Healthy People: update and way forward' in July 2011 reiterated that, with the move of Public Health into Local Authorities, that Local Authorities would take on responsibilities for local activity on the provision of comprehensive sexual health services, including testing and treatment for sexually transmitted infections, contraception outside of the GP contract, termination of pregnancy, and sexual health promotion and prevention.

1.3 General Overview

The integrated, 3- tiered, hub and spoke model is detailed in the national strategy for sexual health and HIV (2001 and 2008). The 3 levels of sexual health services to be commissioned were adapted from the National Strategy for Sexual Health & HIV.

Within the hub and spoke model, the integrated sexual health service will contain the following components below ;

1. Community services, including outreach services
2. Genito-Urinary Medicine (GUM)
3. Health promotion
4. Local Chlamydia Screening Programme – “Target Chlamydia”?
5. Psychosexual Counselling

Level 1

- Sexual history taking, risk assessment and sign posting
- Asymptomatic STI testing and treatment (men and women)
- 'Simple' partner notification
- HIV testing (including pre-test discussions and giving results)
- Point of care HIV testing
- Pregnancy testing and counselling
- Referral for termination of pregnancy
- Provision of hormonal emergency contraception
- Contraception information and services including Long-Acting Reversible Contraception (LARC)
- Condom distribution
- Screening and vaccination for Hepatitis B

Level 2

- Level 1 plus:
- IUD/ IUS insertion and removal (including emergency IUD)
- Contraception implant insertion and removal
- Symptomatic STI testing and treatment (men and women)
- Counselling and referral for vasectomy

Level 3

- Level 1 and 2 plus:
- Specialist level: responsible for supporting provider quality, teaching and training and clinical governance (e.g. support for GPs and pharmacists and via networks)
- STI outreach
- Contraception outreach
- Specialist services for 'at risk groups' e.g. young people, gay men, BME, LAC etc
- Specialist infection management
- Genital dermatoses
- Co-ordination of partner notification
- Highly specialised contraception
- Difficult IUD insertion and removal
- Difficult implant removal
- Psychosexual/erectile dysfunction services
- Provision and follow-up of post-exposure prophylaxis for HIV (Reference Peter Nieuwets)
- Provision of termination of pregnancy services (These services may be delivered in partnership with other organisations or agencies or subcontracted to other providers in consultation and agreement with commissioners.)

Level 0

Are offered by a range of partner organisations (Connexions, the youth service, drug and homeless agencies)

- Brief Interventions for a range of lifestyle risk management services (i.e. sexual health, alcohol, drug misuse, mental health, smoking etc.)
- Signposting
- C-card and condom distribution schemes
- Chlamydia screening

1.4 Objectives

The broad objective of the integrated sexual health service is to enable the residents of West Sussex to have positive sexual health and wellbeing. The service should provide a holistic approach to sexual health, enabling services users to address issues of contraception and testing for STIs delivered in one holistic sexual health appointment, delivered, ideally, by one practitioner. Hence eliminating the need for separate CASH and GUM appointments.

The service is the local specialist sexual health referral service for General Practice, seeing patients with more complex sexual health needs or who require sexual health services which their GP may not provide (for example complex contraception, complex STI screening and treatment). The service will have clear referral mechanisms to allow patients to be treated closer to home, unless specialist treatment from the central hub is clinically appropriate. The integrated sexual health service is expected to be flexible to the needs of West Sussex residents and achieve all of the expected outcomes as detailed in section 1.5.

The specialist Integrated Health Service ("ISH") will act as the local sexual health service leader. Therefore it will provide support and effective clinical governance systems for integrated sexual health across the county. The service will have an integral role to work with the commissioner to develop sexual health services across West Sussex. These includes developing appropriate care and referral pathways between providers, development of services (including development of Pharmacy Group Directives for other Professionals) and deliver a range of training sessions across the county to build capacity.

1.5 Expected Outcomes

The integrated sexual health service is expected to deliver the following outcomes;

- To improve the sexual health and wellbeing of West Sussex residents
- To deliver flexible services that meets the sexual health needs of local residents, by ensuring that service access and location are reflective to need and public and patient engagement.
- Increased awareness of a positive sexual health through a range of health promotion activities.
- Reduction in STI rates across the county (including Chlamydia, gonorrhoea, syphilis, HIV).
- Increase in contraception uptake and effect use across the West Sussex.
- Reduce the stigma and discrimination associated with HIV and STI's
- To contribute to key sexual health indicators;
 - To continue to reduce the under 18 conception rate.
 - To screen minimum of 35% of 15-24year olds for Chlamydia (a new outcome measure is under development nationally)
 - To offer 100% of patients a GUM appointment within 48hours
 - To see 93% of GUM patients within 48hours.
- Implement a fit for purpose, high quality, fully integrated sexual health service within the hub and spoke model
 - To deliver level 2 contraceptive and GUM services in an integrated manner.
 - One contact number and website for the service including an appropriate telephone advice and triage service.
 - To maintain specialist services for complex cases.
 - To ensure that each patient is seen by the most appropriate clinician.
 - Fully utilising nurse-led clinics - Ensuring efficient use of current staffing resource, using a multidisciplinary team approach
 - Increased access and uptake of contraception, in particular Long Acting Reversible Contraception (LARC).
 - To ensure that young people have access to a range of services (that reflect teenage pregnancy hotspots), specific to their needs.
 - Increase access to condoms to under 25's by implementing the C-Card (distribution and registration site.)
 - Normalise and increase uptake of opportunistic STI testing (in level 2 spokes).
 - Patients seen in one stop shop model, unless clinically inappropriate
 - Increase access to vaccination for at risk groups.

- To have effective, efficient partner notification mechanisms to contact and treat positive partners.
- To provide leadership and specialist sexual health support and knowledge to the county
 - Provide effective, high quality clinical governance systems for the Integrated Sexual Health service and advise on clinical governance to other parts of the local sexual health system (i.e. levels 0-3).
 - To support primary care to develop effective sexual health services.
 - To provide support and training to increase access to sexual health services
- Deliver an effective Chlamydia screening programme, delivered through the integrated sexual health service and other relevant services that work with the target age group, including school nursing, Family Nurse Partnership, Health Visiting with a minimum of 60% of screens offered through core services.

Integrated Termination of Pregnancy Services:

- To provide a self-referral, accessible, legal and clinically effective abortion service in accordance with the Law, RCOG guidance, MEDFASH standards for sexual health services and current best evidence
- Impartial support and advice should be provided to all women with unintended pregnancies who request a termination of pregnancy, regardless of age, ethnicity, language, disability, religious or personal circumstances. (RCOG recommendation 2)
- Information on the availability and range on all methods of termination should be provided to all patients contacting the service
- Women should be provided with a choice of abortion methods clinically appropriate for a woman's gestation and clinical circumstances.
- Terminations should be provided at the earliest gestation practicable, endeavouring to meet the <10 week national target for termination of pregnancy.
- When a late abortion is needed, provision should be made available up to the maximum legal time limit. (RCOG recommendation 6)
- It is the intention that all women requesting an abortion should be offered an assessment appointment within 5 days of referral and as a minimum standard within two weeks of referral. The intention is that the abortion should be able to take place within 7 days of the decision to proceed being agreed, with a minimum standard of the abortion taking place within 2 weeks. (RCOG recommendation 7)
- Consultation and Early Medical Abortion services should be available in the majority of Level 3 sites with access to surgical terminations within each locality/service network area. Late abortions may be referred to services outside of the local area.
- Services should provide facilities to confirm pregnancy
- Treatment should be provided which ensures that risks of infection and complications are minimised.
- To reduce repeat terminations all patients should receive information and advice on the full range of available methods of contraception and should ideally be provided with a method of contraception before discharge (RCOG recommendation 5)
- Follow up arrangements should be made for women who do not receive contraception at the time of the termination
- Patients under 19 who do not receive a method of contraception at the time of termination should be referred to the local level 3 service or outreach service for follow-up
- Women should be offered screening for Chlamydia and treatment as necessary, with prophylactic treatment provided when results are not available prior to the abortion
- Patients at risk of other STIs including HIV should be offered a full sexual health screen as part of an integrated sexual health service.
- Where a woman wishes her partner to be involved, this should be respected and supported and partners should be included in the pathway and provided with information and advice.
- The service should recognise the specific needs of under 16 year olds (young women under 16 can self-refer to the service without the need for parental/carer consent)
- Provision for CRB checks to be carried out /updated

- To work in liaison with HIV treatment and care services to ensure a seamless care pathway after diagnosis of HIV infection.
- To ensure that people at greatest risk of HIV, especially men who have sex with men, and Black African Community members are encouraged to access the Integrated Sexual Health Service and screen for HIV.
- The service is equitable to all residents of West Sussex regardless of their race, religion, age, gender, economic status, physical or mental ability or sexuality.
- Services are delivered in a range of outreach locations to move care closer to home.
- To develop strong public and patient engagement protocols to ensure that services are shaped by the local population.
- Has strong partnership working with other agencies working on the sexual health agenda.
- Develop and support a highly trained sexual health workforce across the county
- The service should meet You're Welcome Quality Standards to ensure services are Young Person friendly.
- Effective data monitoring mechanisms and systems to demonstrate the outcomes identified above including nationally mandatory data systems and agreed local datasets

2. Service Scope

2.1 Service Description

The integrated community sexual health service hub and spoke model will involve a multidisciplinary team approach, delivering a full range of sexual health services. The integrated hub will deliver comprehensive sexual health services (e.g. combining, where possible, contraception and STI testing in one appointment).

It is envisaged that the integrated community sexual health service will support triage of patients to assist them in accessing the correct level of care as appropriate.

The service will provide a free, confidential and easily accessible service that allows choices for the individual around control of their fertility, sexual and reproductive health. The service will offer sensitive, considerate, confidential and non-judgmental care to all. A significant proportion of the service will be nurse delivered, referring, where appropriate, to a consultant led specialist provision.

Clients will be directed to a professional whose primary discipline relates to the presenting conditions where possible, however that professional will also be able to deliver any required service under the other discipline. For example, a patient presenting with symptomatic GU conditions will be directed to a GU based professional who will also be qualified to provide contraception services as part of the same appointment. This represents the essence of an integrated service.

For the above model there remains a need for a separate delivery of specialist services for both disciplines.

N.B. A significant range of contraceptive services are also available as routine from primary care; the integrated community sexual health service will work in partnership with them to provide a service to the population as a whole. The service increases patient choice by providing a different style of service from that received as routine from primary care: patients are seen predominantly on a "drop in" basis, advice is easily obtained over the telephone, clinics are during the day and in the evening, the staff are predominantly female, advice is available from specialist trained nurses as well as doctors, people are seen outside the context of their family, and the emphasis is health promotion rather than being illness-related.

The service will be made up of the following components:

1. Integrated Community Sexual Health Service Hub

The integrated community sexual health service hub will provide a full range of sexual health services. The service is provided on a predominantly drop-in basis, with more complex, specialist procedures using some booked appointments or referral into the specialist consultant-led sessions. (Appointments may be used when clinically appropriate, e.g. IUD, cytology, etc. needing to be at certain points of the menstrual cycle or due to resourcing specialist equipment or if the patient chooses to have a booked appointment.) The hub is expected as a minimum to deliver:

- Issue of all methods of contraception, including LARC, pills, patches and condoms.
 - Provision of safer sex materials, including condoms, dental dams, lubricant and female condoms as appropriate.
 - Sexual health counselling and education.
 - Outreach Services for young people aged from 11 to 19 to ensure seamless referral to and from the Integrated Community Sexual Health Service where appropriate. The service should enable young people to discuss any health issues or concerns relating to their sexual health and referral to other agencies as appropriate.
 - Access to and provision of Emergency Contraception to all ages deemed Fraser competent.
 - Pregnancy testing within protocols.
 - Provide advice for unintended pregnancy and referral for termination of pregnancy.
 - Pre- and post-termination advice to include contraception planning and implementation post-termination.
 - Follow-up of women who have been referred for a termination to ensure that post-termination contraceptive plans have been discussed and are being implemented.
 - Opportunistic Chlamydia screening (as part of the NHS National Screening Programme) offered to all under 25s. It is expected that 100% of under 25s will be offered a Chlamydia screen, with an 80% uptake rate (as quoted in the National Chlamydia Screening Programme (2008) Quick wins and sustainable services: Hitting the target without missing the point, page 12).
 - Provide levels 1 & 2 STI and HIV screening and testing and contraception, with appropriate counselling and referral as required. To provide a specialist GUM service which is complementary to, but different from, those services provided by primary healthcare teams.
 - Deliver basic treatment of STIs and contraception under nurse prescribers and PDGs, as appropriate in the community, or refer onto the specialist consultant for more complex cases.
 - Direct referrals for vasectomy and Psychosexual Therapy, any other conditions should be referred back to the GP
- Sexual Health training

The integrated community sexual health service hub should provide and assist in practical sexual health training for health care professionals across the city. This training will include:

- a. Physician training for the Diploma of the Faculty of Sexual and Reproductive Health and letters of competence in intrauterine techniques (LoCIUT) and Subdermal implants (LoCSdl).
 - b. General contraception and sexual health updating for all interested health care professionals.
 - c. Providing training to other professionals involved in the care of people with sexual health needs, including condom distribution and Chlamydia screening as part of the National Chlamydia Screening Programme and C-card Scheme.
 - d. Specialist support to GPs and other professional colleagues including partner notification
 - e. Providing specialist training to nurses and doctors in contraception, STI and general sexual health.
 - f. Training needs identified from workforce planning must be met within reasonable timescales as agreed with the individual.
- General duties expected in a Sexual Health Service include:
 - a. GUM and contraception specialists should work in partnership and interchangeably (work within each other's specialty), training permitting.

- b. To be a member of and proactive participant in the Sexual Health Network and development of sexual health services in West Sussex.
- c. To contribute to appropriate surveys, questionnaires and PPE forums, and to help service development locally, regionally and nationally.
- d. Supporting the development of a clear, consistent data set (modelled on the Sexual Health Common Data set) for monthly performance monitoring.
- e. Further development and integration of the clinical and non-clinical provision within the all sexual health services, ensuring that there are seamless pathways between providers.
- f. Providing high quality care regardless of race, religion, age, gender, economic status, physical or mental ability or sexuality.
- g. Challenging the stigma associated with sexual health issues and services to increase the accessibility and uptake of the integrated community sexual health service.

Integrated Community Sexual Health Service core services.

| Service | Detailed description | Monitoring/performance indicators |
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| Advice and where appropriate onward referral re unintended pregnancy | <p>Confirmation of pregnancy by near patient test.</p> <p>Discussion of options aiming to ensure that patient makes right decision for her. This MAY require time to think and a later appointment, but this is not mandatory.</p> <p>Referral to pregnancy counselling</p> <p>STI risk assessment and testing as indicated.</p> <p>Discussion of post-TOP contraception and arrangements made to start, e.g. oral contraception provided, appointment for LARC booked or requested at time of procedure.</p> <p>Post TOP contraceptive follow-up.</p> | <p>Number referred, gestation, number using regular method contraception after procedure</p> |
| Contraceptive implant insertion and removal | <p>All LARCs offered to all women who require contraception.</p> <p>Pre-implant consultation to ensure informed consent, no contraindications and awareness of side effects; procedure explained.</p> <p>STI risk assessment/STI testing.</p> <p>Insertion/removal by trained doctor/nurse.</p> <p>Offered appointment to be seen if any problems.</p> | <p>Number implants inserted and removed.</p> <p>Age profile.</p> <p>Percentage having STI risk assessment and tests.</p> |
| IUD/IUS insertion and removal | <p>ALL LARCS offered to all women requiring contraception and IUS to women with menorrhagia after appropriate investigation. Where IUS is required for reasons other than contraception, these patients should be referred to a medical gynaecology clinic.</p> <p>Pre IUD/S consultation to ensure</p> | <p>Number IUDs/IUSs inserted.</p> <p>Age profile.</p> <p>Percentage having STI risk assessment and tests.</p> |

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| | <p>informed consent.</p> <p>STI risk assessment/STI testing.</p> <p>Insertion by trained doctor/ nurse with assistant.</p> <p>Follow-up at 6 weeks and anytime thereafter if problems.</p> | |
| Emergency IUD | <p>Offered to ALL women requesting emergency contraception. Ability to offer appointment within timeframe for individual.</p> <p>STI risk assessment/STI testing.</p> <p>Provision of Levonelle if IUD not being fitted that day.</p> | <p>Number of emergency IUDs.</p> <p>Percentage having STI risk assessment and tests.</p> |
| Diaphragm fitting and follow-up | <p>Discussion of method, including failure rate (always discuss other methods).</p> <p>STI risk assessment/STI testing.</p> <p>Appointment to teach use and practice insertion.</p> <p>Follow-up appointment to ensure correct insertion.</p> <p>May require further appointments.</p> | <p>Number of women using.</p> <p>Percentage having STI risk assessment and tests.</p> |
| Investigation and treatment of problems with oral contraceptives. | <p>Awareness of common problems.</p> <p>STI risk assessment and appropriate testing, especially if bleeding problems.</p> <p>Discussion of alternative pills or methods.</p> | <p>Number of women experiencing problems with oral contraceptives.</p> <p>Number changing contraception as a result of discussions</p> |
| Problems with choice of contraceptive methods. | <p>Spend time discussing the methods following assessment of woman's medical history.</p> <p>Explore her concerns/ideas.</p> <p>Appropriate leaflets available.</p> | <p>Number of women experiencing problems with contraceptive method</p> |
| Appropriate management of adults who have been sexually assaulted. | <p>Address emotional and psychological issues as well as medical, e.g. risk of pregnancy and/or STIs.</p> <p>Assess re hepatitis and HIV risk – refer to GUM for PEPSE/HepB immunisation.</p> <p>Provide emergency contraception (oral or IUD) if required.</p> <p>STI testing as appropriate.</p> <p>Provide ongoing support/refer counselling service.</p> <p>Awareness that management can be affected by ongoing police investigation.</p> <p>Referral to/discussion with The Saturn Centre (Sussex Sexual Assault Referral Centre) should take place for all experiencing sexual assault.</p> | <p>Number of people referred to SARC</p> <p>Number of people reporting sexual assault</p> |
| Management of designated complicated genital tract | <p>Diagnosis of complicated infections (e.g. PID / testicular pain) should be managed</p> | <p>Number of patients with complicated genital tract</p> |

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| | – in line with BASHH guidelines. | receiving tests of cure |
| Contact tracing/ partner notification | <p>Discuss partner notification with all patients with positive diagnoses.</p> <p>Advise patient referral, i.e. patient contacts partner/s, and tells them diagnosis and/or that he/she needs testing and treatment as a result.</p> <p>Advise that partner can attend your service.</p> <p>Follow up (usually telephone) to ensure partner treated.</p> <p>Referral to GUM Health Advisor, if difficult.</p> | <p>Number partners to notify.</p> <p>Number notified by service and number received appropriate management.</p> |
| Management of genital ulcer disease | <p>Awareness of differential diagnosis and likely causes if painful and painless.</p> <p>Referral on to GUM.</p> | Number diagnosed |
| Management of viral hepatitis | <p>Carry out tests for hepatitis if positive risk factors (e.g. contact with positive, IVDU, sells sex).</p> <p>Repeat tests as requested by lab if positive.</p> <p>Give preliminary result to patient on basis of pattern of positivity (see BASHH guidelines).</p> <p>Refer to GP for ongoing management if active / chronic disease.</p> <p>Arrange testing and immunisation of partner</p> | <p>Number of tests taken, number positive. Numbers immunised</p> |
| Management of vulvovaginitis and balanitis | <p>Assess symptoms.</p> <p>Carry out tests if appropriate.</p> <p>Treat if history/tests suggest positive diagnosis, e.g. Candida.</p> <p>Advice re personal hygiene.</p> <p>Refer to GUM if not responsive to simple management.</p> | Numbers diagnosed |
| <p>Management of sexual dysfunction</p> <p>Organic</p> <p>Psychosexual</p> | Referral to appropriate specialist clinic | Number of patients referred |

STI data recording and sharing

All services must provide annual data detailing attendances, positive STI diagnoses and contraception provision, including LARCs and TOP referrals (and gestation at TOP). To ensure adequate/appropriate data collection, the provider must ensure services/practices liaise closely with their commissioners so that they are clear what information is required and how frequently reports will need to be produced. This may also require review of how data is recorded, e.g. on practice computer system, to ensure that all necessary

information can be captured.

Audit

Audit is required as part of clinical governance. The lead clinician for each service should ensure that this takes place and plan an audit programme for his/her service. Successful review of a service must include evidence of regular audit at least annually.

Quality Standards

The integrated community sexual health service should support the implementation of the latest national and local guidance for sexual health and HIV services. The service should:

- Ensure clinical practice is evidence-based and incorporate findings/guidelines from institutions such as BASHH, FSRH and NICE. The appropriate emphasis should be placed upon the provision and implementation of the NICE LARC guidance.
- Use clinical practice that is informed by evidence-based information and by the findings of NICE, including the implementation of LARC.
- Work towards meeting national and locally agreed targets.
- Be appropriate to individual needs.
- Respect the privacy, dignity, religion and culture of the individual.
- Focus on the positive promotion of overall good health and positive sexual health, including safer sex, control of fertility and informed choice
- Ensure the rights of the patient and standards of care are met as outlined in the Healthcare Commissions Standards for Better Health.
- Give the highest standard of healthcare possible within the scope of professional practice and resource constraints.
- Integrated governance process to be in place to monitor service and developments
- Develop strong public and patient involvement strategies to ensure the service responds to the views of service users.
- The service will ensure the it supports and implements:
 - Best Practice Guidance for Doctors and Other Health Professionals on the Provision and Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health
 - NICE Clinical Guidelines on Long Acting Reversible Contraception 2005
 - Clinical Effectiveness Guidelines (Faculty of Family Planning and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists
 - Choosing Health (DH, 2004)
 - Our NHS Our Future (2008)
 - The national strategy for sexual health and HIV and the Public Service Agreement and vital signs target for sexual health (as mentioned in 1.2.2)
 - MedFASH Standards for Sexual Health Services.

Clinical Effectiveness

The service will:

- Audit screening processes against national standards annually
- Evaluate the experience of users/carers 6-monthly in a continuing cycle of audit
- Evaluate the outcome of the education/training programmes to staff and the impact of this on service users
- Follow local and national policies and guidance including Public Health / Clinical Commissioning Group guidance and recommendations.
- Provide evidence of public awareness and involvement through the continuing audit cycle.

Data Requirements

Static rates of teenage conception and changes in sexual behaviour make it essential to monitor the epidemiological profile for sexual health and inform service planning. Knowledge of uptake of contraceptive provision by geographical area is essential to ensure that services and health promotion initiatives are targeted at appropriate population groups. In order to inform the epidemiological profile of sexual health in West Sussex and regionally, the service will provide anonymised, aggregate data on all clients on a quarterly basis, in accordance with agreed purchaser requirements. The provider is also expected to fulfil and aspire to exceed all local and national data requirements (as mentioned in 1.5 expected outcomes) associated with running the service. These include:

- Annual report on the overall performance of the service that demonstrates evidence to all expected outcomes as mentioned in 1.5 of the Service Specification.
- Data requested by regional and local surveillance systems/teams
- Clinic-based disaggregated data to the HPA Regional surveillance team
- Data should be used to determine the extent of service users' awareness of local sexual health services. Therefore, all service users should be asked how they learned about the service and if they were aware of recent media campaigns.
- SHRAD, routine Family Planning activity to PCT on a quarterly basis
- GUMCAD, routine STI activity to PCT on a quarterly basis:
 - % complex cases, defined by as those taking >3 antiretrovirals
 - % of new drug prescribing
 - ratio of backbone prescribing, e.g. combivir : Kivexa : Tenofovir based combination
 - average drug treatment cost per patient per month
 - Number and % of new diagnoses assessed by THT (target 100%)
 - All data split by age, gender, sexuality, where HIV likely to be acquired, ethnicity, postcode
- Minimum data set for the national Chlamydia screening programme in accordance with the DH requirements, additional information as requested. Additional monthly local data set must be developed (including cleaning and analysis of out-of-programme data) and reported to the sexual health commissioner by the 22nd of the following month.
- All statutory returns, including notifications of infectious diseases, will be completed accurately and on time.
- Sexual health service users will have their details, including full postcode and ethnic origin, recorded in the local dedicated system to allow cross-charging with other PCTs. Commissioners will only pay for those individuals who have demonstrated that they are a resident of West Sussex or registered with a West Sussex GP.
- The service will ensure that it works towards the implementation of a local Data Set for Sexual Health (CDSSH). The Common Data Set is intended to provide a single, standard structure for collecting data on sexual health within the National Health Service. It will apply to all settings, providing sexual health services such as GUM clinics, contraceptive services, integrated sexual health services and primary care.
- The service will ensure that all developments in the area of data collection are in accordance with the requirements of the PCT / Council as the host commissioner.
- The provider of the Service will agree to any reasonable request for further information and will not refuse any reasonable request to allow the Purchaser to inspect any records or patient data relating to the service covered by this Agreement. Any information acquired by the Purchaser as a result of any such inspection shall be confidential and its access will be regulated under the Data Protection Act

2.2 Accessibility/acceptability

- The service will work in partnership with service users in an integrated way across a range of sexual health and other providers including the chlamydia screening programme, GP, pharmacy, youth services, third sector providers such as the Terrence Higgins Trust.
- The service will be flexible and responsive to the needs of service users, teenage pregnancy and chlamydia hotspots as determined through national and local needs assessments, data and results from public and patient engagement consultations.
- The service will be fully accessible to all the diverse communities of West Sussex and demonstrated by regular equality and diversity impact assessments and consequent action plans.

- Work at community and systems level should only be initiated in response to identified needs. This would be via Health Needs assessment or via identification following discussion with a range of agencies working within the locality.
- Providers will be required to evidence effective working arrangements with a range of local services to deliver evidence based progressive and specialist elements.
- Providers will be expected to use evidence based programmes and to deliver financial benefits whenever possible.
- The service will implement You're Welcome quality criteria.

2.3 Whole System Relationships

The integrated sexual health service will actively engage in interagency partnerships with other statutory and voluntary agencies

2.4 Interdependencies

Public Health
 Commissioners
 Clinical Commissioning Groups
 Primary care practitioners
 Local Authority- Health and Social Care providers
 Third sector agencies
 Other services, for example Community Health Services (e.g. Health Visiting, School Nursing, Looked-After Children's Services, Community Drug Teams, etc.)

2.5 Relevant networks and screening programmes

- National Chlamydia Screening Programme
- West Sussex sexual health network
- West Sussex primary care, sexual health liaison group
- GUM website
- NHS Direct website
- NHS Choices website

3. Service Delivery

3.1 Service model

The service should be delivered in an integrated, tiered manner using the three levels of sexual health services where appropriate as described above. The service should be located using the hub and spoke model. Clear and concise referral pathways must be developed between the hub and spokes and with Primary care services

3.2 Care Pathways

Clear referral pathways must be developed between the tiered services. With care provided as close to home as possible and the centralised services used for complex cases. The service shall provide a partner/contact tracing facility to enable the reduction of secondary transmission of STIs

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

Integrated Sexual Health Services are open access and therefore available to all. It is expected that all non West Sussex residents or those not registered with a West Sussex GP will have service costs charged to responsible authority in their own area of residence by the ISH Service.

4.2 Location(s) of Service Delivery

The service should be delivered in easily accessible locations, using the hub and spoke model as described in 1.3. The specialist hubs should be located in areas with good access to travel links. Spokes should be allocated in a range of clinically appropriate settings. Services specific for young people should also include schools, FE colleges, youth centres and universities. These should be placed in areas with the greatest sexual health need, using evidenced based decision making such as teenage pregnancy and chlamydia hotspots areas. The spokes must be flexible to move with demand and need of West Sussex residents.

4.3 Days/Hours of operation

Opening times, where possible, should reflect the needs of clients and should include weekend and evening appointments and/or drop-in services whilst recognising the limitations of the service to do so. Individual clinics should be clearly indicated

4.4 Referral criteria & sources

The service should be accessible through referral or open access, to all registered and non-registered service users of all genders and ages with no exemptions.

4.5 Referral route

Self-referral, Primary Care and other organisations may refer.

4.6 Exclusion criteria

It is intended that HIV treatment will be commissioned by the NHS Commissioning Board outside the remit of this sexual health tender.

Contraception for non-contraceptive purposes, treatment of menopause.

4.7 Response time & detail and prioritisation

Drop-in and appointment available at all services.

GUM only:

- 100% patients offered appointment within 48 hours
- 70% patients seen within 48 hours. (Current regional target). This may be amended in light of national guidance.
- GUM will give priority to patients with a history of symptoms and/ or known infection.

5. Transfer of and Discharge from Care Obligations

| | |
|--|--|
| Integrated community sexual health service | The client decides where and when to continue accessing the service. |
|--|--|

6. Self-Care and Patient and Carer Information

The service will provide accurate and up-to-date information suitable to the user to encourage self-care wherever possible, including safer sex and contact tracing.

7. Quality Requirements

| Quality Performance Indicator | Threshold | Method of measurement | Report Due |
|--|--|--|---|
| Infection Control | Awareness of and response to infectious diseases, outbreaks and other threats to health | | Annually via annual report (unless infection outbreak) |
| Service User Experience | Service user surveys, focus groups, feedback forms | Number of surveys completed, additional PPE work and how this has been implemented into service development | Quarterly as part of local data report. Local report must be sent to the sexual health commissioner within 4 weeks of the end of the quarter. |
| Improving Service Users & Carers Experience | Actively engaging service users in the development of health interventions | Number of complaints / compliments received and actions from these. | Quarterly as above |
| Unplanned care | Reduction in unplanned conceptions Reduction in unplanned attendees to A&E for HIV related cases. | Reduction on EHC prescribed, TOP and antenatal referrals. Increased numbers of residents on systematic, longer term contraceptive regimes. | Annually as part of the annual report to be sent to the sexual health commissioner by within 3 weeks of the end of the financial year. |

| | | | |
|--------------------------------------|--|---|--|
| <p>Reducing Inequalities</p> | <p>Reduction in teenage conception rates and numbers.</p> <p>Increased opportunistic Chlamydia screening levels in under-25s.</p> <p>Reduced prevalence of all STIs in West Sussex (including Chlamydia, gonorrhoea, syphilis, HIV, herpes)</p> <p>Reduced number of late diagnosed HIV cases.</p> | <p>Sees outcomes 1.5 section</p> | <p>Monthly Chlamydia screening local data, quarterly GUMCAD, SHRAD, HIV local data set, quarterly report, annual report to be sent within 3 weeks of end of term</p> |
| <p>Reducing Inequalities</p> | <p>Reduction in teenage conception rates and numbers.</p> <p>Increased opportunistic Chlamydia screening levels in under-25s.</p> <p>Reduced prevalence of all STIs in West Sussex (including Chlamydia, gonorrhoea, syphilis, HIV, herpes)</p> <p>Reduced number of late diagnosed HIV cases.</p> | <p>Sees outcomes 1.5 section</p> | <p>Monthly Chlamydia screening local data, quarterly GUMCAD, SHRAD, HIV local data set, quarterly report, annual report to be sent within 3 weeks of end of term</p> |
| <p>Reducing Barriers</p> | <p>Assuring delivery of service from a range of community settings</p> | <p>Increased service delivery from non-secondary care premises</p> | <p>Annually, as above</p> |
| <p>Improving Productivity</p> | <p>Ensure flexible resources are targeted using a needs-based approach</p> <p>GUM follow-up ratio should not exceed the SHA average of 0.75</p> <p>Increased number of patients seen through nurse-led clinics. All nurses should be trained in asymptomatic and non-complex symptomatic STI testing and treatment.</p> <p>Nurses to be dual trained to deliver contraceptive and sexual health (GUM) services</p> <p>Support workers (HCAs) trained to deliver the Fast</p> | <p>Repeat audit of caseloads / workloads to demonstrate equity</p> <p>GUM monthly follow up ratio</p> <p>Number of patients seen through nurse delivered clinics, split by symptomatic and asymptomatic</p> <p>% of nurses trained to deliver comprehensive sexual health</p> | <p>Quarterly as above. These will be monitored in conjunction to the agreed action plan to integrate the service.</p> |

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|-----------------------|---|--|---------------------|
| | Track clinic | services (e.g. CASH & GUM services) % of support workers trained to deliver the Fast track clinic | |
| Access | Improved access to the service Hours of service reflects the needs of the locality Other professionals' ability to access service | Participation in outreach and increase presence in a range of community settings | Annually, as above. |
| Care Management | Ref to CCHS policy document | | Annually, as above |
| Outcomes | See outcomes section 1.5 for outcomes and how measured | | Quarterly, as above |
| Staff turnover rates | Numbers and % of staff leaving | | Annually, as above |
| Sickness levels | | | Annually, as above |
| Agency and bank spend | | | Annually, as above |

Consequences of breach of Quality Requirements will be developed at contract establishment

9.1 Price

| Basis of Contract | Unit of Measurement | Price | Thresholds | Expected Annual Contract Value |
|---|---------------------|-------|------------|--------------------------------|
| National Tariff plus Market Forces Factor | | | | |
| Non-Tariff Price (cost per case/cost and volume/block/other)* | | | | |
| | | | | |
| Total | | £ | | £ |

**delete as appropriate*

9.2 Cost of Service by commissioner

| Total Cost of Service | Co-ordinating PCT Total | Associate PCT Total | Associate PCT Total | Associate PCT Total | Total Annual Expected Cost |
|-----------------------|-------------------------|---------------------|---------------------|---------------------|----------------------------|
| £ | £ | £ | £ | £ | £ |