**Sexual Health Service**

**Performance Monitoring Framework**

This section details the required performance indicators that make up the full Integrated Sexual Health Service Performance Management Framework (PMF).

The Council has produced a suite of Key Performance Indicators (KPIs) based on nationally set (and evidence based) indicators as well as examples of best practice established by other local authorities.

**Contract Management and Quality Assurance Schedule**

**Performance and Quality Assurance Standards**

Providers will be monitored against a number of predetermined performance and quality standards which are highlighted in the Schedule.

The objectives of the Key Performance Indicators and Quality Assurance standards are to:

* ensure that the Services are of a consistently high quality and meet the requirements of the Council and outcomes of the Service User;
* provide a mechanism whereby the Council can attain meaningful recognition of inconvenience and/or loss resulting from the Provider’s failure to deliver the level of service for which it has contracted to deliver; and
* ensure the Provider complies with and expeditiously remedies any failure to comply with the Key Performance Indicators.

Performance measures are subject to annual review. The Council will take into account the relevant issues, including any changes in national and Council policies and the priorities of Service Users. Any resulting adjustment to the KPIs or targets will be agreed between the Council and the Service Provider. If the dispute cannot be resolved the Council shall (acting reasonably) ultimately determine the changes made to the PMF.

* 1. **Quality Specific Standards**

The Provider is expected to have in place a robust governance framework and supporting processes, which ensure that it is compliant with appropriate legal requirements and standards.

We would expect the governance framework to include but not be limited to the following:

**Local Quality Management**

* Communication between Service Users, and staff (including managers and clinicians);
* Communication between staff across wider services, including clinicians and managerial staff;
* Effective reporting and monitoring mechanisms for issues of concern whether relating to the Service Users, or people connected or employees;
* Service User recording; Service IT / data recording and storage systems;
* Incident reporting and health and safety matters;
* Child Protection & Adult Protection – Safeguarding;
* Reporting and monitoring of incidents and accidents to staff, volunteers and Service Users [including the management of violence and domestic violence];
* Health & Safety Inspection, and fire safety;
* Clinical Governance;
* Infection Control;
* Inspections by CQC, OFSTED, or LHW or Commissioners;
* Complaints and Compliments management for paid staff, volunteers and Service Users;
* Service User engagement and co-production;
* Records Management;
* Equality of opportunity in service provision, recruitment and employment;
* Occupational health;
* Information sharing and Information Security;
* Policies relating to confidentiality of information;
* Codes of conduct for staff and Service Users;

**Patient Safety**

* Incident Management
* Risk Management
* Alerting System
* Waste Management
* Medicines Optimisation
* Safe Environment
* Safeguarding

**Clinical Effectiveness**

* Cost effectiveness
* Clinical Guidelines
* NICE guidance
* Evidence-based practice
* Care pathways
* Clinical Audits
* Policy Development
* Claims Management
* Information Governance
* Staff Management
* Education and Training
* Equality and Diversity

**Patient/Public Experience**

* Complaints Management
* Consent
* Patient/Public Information
* Patient/Public Involvement
* Patient/Public Needs

All appropriate policies and protocols must be current and in place following contract award and prior to the service mobilisation phase being completed [including with sub contracted services]. The Commissioner would expect to receive information and assurance that these are current and in place. Clear and routine review arrangements to maintain effective governance would also be expected. Service Users must be made aware of the range of policies which may impact upon their support and be given access to them should they wish.

* 1. **Quality Assurance**

The Provider is required to complete quality assurance checks in relation to Service delivery to ensure that outcomes are being met and that contract compliance is achieved.

1. The Provider will have quality assurance processes which clearly include the standards and indicators to be achieved and monitored on a continuous basis by the Provider to ensure that the Service is delivered in accordance with the best interests of the Service User.
2. The quality assurance processes will include the standards required, the method of attaining the standards, the audit procedure, the population of action plans (where applicable), with timescales and outcomes
3. The quality assurance processes will analyse feedback and measure the success of the Service in meeting the requirements set out in this Service Specification and the Monitoring Schedule
4. A quality assurance report summary will be made available to Service Users and the Council upon request
5. When negative written feedback is received by the Provider, either formally or informally, a formal written response from the Provider will be supplied noting its receipt and the action that will follow. This feedback will be copied to the Council
6. The Provider will be committed to, and evidence their responsibility for, continuous Service development

**2. Performance Management**

**2.1 Performance Management Reporting**

The Provider must ensure that a dedicated ‘Performance Management Function’ is established as part of the contract to provide system wide reporting. The Provider will ensure the effectiveness of such reporting, demonstrating assurance processes for systems and procedures to Commissioners and other key stakeholders, and support the continued development of both output and outcome monitoring for the service.

The Provider is required to complete performance checks in relation to service delivery to ensure that outcomes and contract compliance are being met.

1. The Provider is responsible for having performance and quality assurance processes that are capable of providing evidence of achieving outcomes, quality of service and Key Performance Indicators
2. It is the Provider’s responsibility to submit performance and quality information and failure to complete and return the required information will be dealt with under Service failure and contractual action
3. The Council may choose to further verify submitted claims through feedback from Service Users, partners, stakeholders, Provider staff interviews and/or feedback as required
4. The Provider must have robust business continuity and contingency plans in place with regards to all levels of Service interruption or disruption. If Service interruption or disruption occurs, the Provider is to notify the Council immediately and ensure that alternative provision is sought.
5. The Provider will need to evidence ongoing business viability in order that risks or threats to Service delivery are minimised and any threat to the Service User, the overall organisation or the Council is highlighted well in advance to the Council of any potential or actual incident
6. The Provider will allow inspection of financial records relevant to the service upon being given reasonable notice in writing. This shall include details of rates of pay for staff and any other information deemed necessary by the Council to ascertain the stability of The Provider workforce or business
7. The Provider must ensure that their nominated managers attend multi-disciplinary meetings and submit monitoring information to the Council
8. The Council reserves the right to review or amend the contract management and quality assurance process during the contract term with three months’ notice and in consultation with the provider

Reporting requirements may change over the lifetime of this contract to embrace wider governance reporting structure requirements. The Commissioner will hold quarterly contract monitoring meetings with annual performance reviews. The Provider will operate as the leader in the sexual health economy across Cheshire East and provide Service User forum/s covering the geography of Cheshire East and liaise with other forums on key related issues. (See Sexual Health specification 3.15)

The Performance Reporting frequency for indicators is set out in this Schedule. Data should be submitted on the 25th of each month or quarter following the close of the previous reporting period (e.g. the report for April should be submitted on 25th May). Contract Review meetings to review dashboard data and KPIs will be held on a quarterly basis, the Council reserves the right to increase the frequency of contract review meetings. It is expected that Contract Review meetings would be more frequent during the initial contract period (first 6 months).

**2.2 Performance Indicators**

**2.2.1 Key performance Indicators (KPI’s)**

The Council has set Key Performance Indicators (KPI’s) and targets which will be used as part of the Service evaluation. Providers must submit their KPIs in their quarterly Monitoring Returns and the Council may conduct validation checks to determine the accuracy of the data submitted and the quality of the service delivered to Service Users. (see appendix 1 for detail of KPI requirements).

Providers that fail to reach the relevant KPI targets, or do not adhere to specified timescales for submitting KPI information, will be subject to performance improvement measures.

**2.2.2 Baselining**

1. The Council accepts that for some KPIs there is insufficient or inadequate data available to set the performance target at the Integrated Sexual Health Services Commencement Date. These KPIs are marked as ‘Baseline’ and will be referred to for reporting purposes as ‘the Baseline KPIs’
2. For the period of the first 12 months post contract start date the Service Provider shall carry out a Baselining process in relation to Baseline KPIs to capture sufficient data to allow the performance against the indicator to be properly measured.
3. During the Baselining process no performance rectification measures will be applied in respect of the Baseline KPIs
4. The Service Provider, working jointly with the Commissioner, shall propose a target to be applied as evidenced by the Baselining process. Once the parties have agreed the target this shall take effect for the following Quarterly Performance Report, If the target cannot be agreed the Council shall (acting reasonably) determine the target.
5. If as a result of the Baselining process, the Service Provider can reasonably demonstrate to the Council’s satisfaction that a Baseline KPI cannot be adequately measured, the Service Provider, shall propose an alternative indicator. If the Council accepts the alternative proposal this shall become the new Baseline KPI.

**2.2.2 Critical Performance Failure**

Any of the following circumstances could constitute a Critical Performance Failure:

* 1. Failure to achieve any Critical Performance Indicators highlighted in RED in appendix 1 below and in accordance with the Contract (schedule 4).
	2. Safeguarding - issues or incidents relating to breaches in Service delivery, which may also include safeguarding incidents
	3. A refusal to provide or non-delivery of the Services by the Provider in accordance to the Service Specification.
	4. In the opinion of the Authority the provider is persistently and intentionally falsifying data provided to both commissioner and/or national data sets
	5. Any other delay on the part of the Provider without good cause in delivering the Services that could reasonably be considered by the Council as being inconsistent with the Provider performing its obligations under the contract agreement and in accordance with the service specification

The consequences of a Critical Performance Failure are set out in point 2.7.

**2.3 Outcomes**

Outcomes can be defined as what a person wishes to achieve in order to lead their day-to-day life in a way that maintains or improves their health and wellbeing. These outcomes will vary from one person to another because each individual Service User will have different interests, preferences, relationships, demands and circumstances within their lives.

The Provider must deliver a Service to meet individual Service User Outcomes and the Service is to be delivered in line with the ethos and standards as detailed in the Service Specification.

The provider must also identify Social Value Outcomes (appendix 2 below sets out Cheshire East Social Value objectives).

**2.3.1 High Level Service Outcomes**

The Service will support service delivery against the three, main sexual health Public Health Outcome Framework measures:

* Under 18 yrs. conceptions
* Chlamydia detection (15-24 yrs.)
* People presenting with HIV at a late stage of infection

In addition, it will deliver the following outcomes to improve the sexual health in the local population as a whole, with all work based on local needs assessments to recognise risk changes in the population:

* Early diagnosis and treatment of sexually transmitted infections and prevention of onwards transmission, including providing opportunistic Chlamydia screening for asymptomatic 15 to 24 year olds and early identification of HIV;
* Reducing unintended/unplanned pregnancies;
* Reducing health inequalities.

**2.3.4 Service User Feedback**

This is one way of the Provider determining and evidencing that outcomes have been supported and achieved.

The Provider will collate all feedback centred around Service Users detailing information on Service improvements, the quality of provision and whether outcomes are being achieved, and report/make this available to The Council upon request as specified within the monitoring schedule.

It is expected that the Provider will collate Service User experience feedback as a routine activity within day to day service delivery which seeks timely feedback from Service Users on their experience of using the service. As a minimum it is expected that this will include feedback on waiting times, staff attitudes, confidentiality, quality of advice and treatment and overall quality of the service. The findings from routine Service User feedback shall be reported to the Commissioner on a quarterly basis as part of the Quarterly Contract Monitoring process.

In addition the Provider will conduct an annual Service User Satisfaction Survey. The purpose of the annual survey is to identify good practice, assess the overall quality of the service, measure the longer term outcomes of the service and ensure that Service Users and potential Service Users are able to access services and that services are provided at the right time and in the right location. The findings of the annual survey will be reported to the Council and published on the Provider’s and Council’s website.

The format and method for conducting each satisfaction survey will be at the discretion of the Provider; however the Council reserves the right to request the Provider to alter the format, method or content of the Satisfaction surveys in order to ensure that the relevant information is obtained.

As soon as possible following the completion of each satisfaction survey and in any event within one (1) month of completing each satisfaction survey, the Provider shall make available the survey, its results and details of action taken in response to the survey.

The Provider shall permit the Council to use the information which is generated by the satisfaction surveys to assist it in future commissioning and procurement activities.

The Council may at its discretion gather Service User insight information. The Council may ask the Provider to address any issues which are highlighted through this insight information. The Provider will take steps to address the issues raised by the Council within the timescales set out.

The Provider is required to maximise opportunities for Service User Engagement and Co-production in the design, development and delivery of services wherever possible. The opportunities for Service User Engagement and Co-production will be set out in a Service User Engagement Plan to be developed by the Provider and agreed with the Council during the contract mobilisation period. As a minimum this should include the development of a Service User Forum, which comprises past and potential future users of the Service. Progress against the Service User Engagement Plan will be monitored during quarterly contract review meetings.

Failure to comply with the requirement to conduct routine and annual satisfaction surveys and the development and implementation of a Service User Engagement Plan will result in Service failure and will be dealt with via contractual action.

**2.4 Monitoring Returns**

The Provider is required to collate and return the monitoring information to the Council using the templates provided by the Council. The Council retains the right to amend or update the templates if required, and Providers will be notified if any changes are made.

The Provider will strictly adhere to the timescales set out in this Schedule for returning monitoring information and failure to do so may result in service failure and / or contractual action being taken.

The Provider will comply with contract monitoring arrangements including sample checks of monitoring record (electronic or otherwise) and monitoring return validation. The Provider will be informed and consulted on changes to contract management arrangements as and when they occur.

**2.4.1 Quarterly Monitoring Return**

The Provider shall provide a quarterly return to the Council containing the information detailed in Appendix 1 and qualitative information which will include but not be limited to; organisation/contract information, outcome reporting, case studies, equality monitoring, Issues and challenges for commissioners attention, Service User feedback as per Service User engagement plan, overview of any compliments /complaints received, opportunities taken to promote or celebrate the service, stakeholder survey (to be developed with commissioners), staffing, finance, policies and qualitative quarterly overview commentary in relation to the reporting period. The Council will set clear dates for the monitoring return to be submitted by during the mobilisation period.

**2.4.2 Annual Monitoring Return**

The Provider shall make an annual return to the Council which shall provide evidence of each of the areas identified in appendix 1. This information is to be submitted annually by no later than 30 April.

**2.4.3 Submission of Returns**

The Council is committed to simplifying the collection and analysis of monitoring information and will implement a process which will require submission of information electronically either by email or a secure portal. The Provider is required to have the facility to undertake this.

In the event that the Provider fails to submit accurate monitoring information in accordance with this schedule, this shall constitute a Service Failure.

**2.4.4 Low Level Incident/Concerns**

Low Level Incidents/Concerns are defined as issues or concerns, which do not meet the threshold for safeguarding and are not being treated as a formal complaint.

Any comment or concern made by a Service User to the Council or provider on the quality and delivery of the service will be recorded as a ‘’low level incident / concern’’.

Providers will respond to and resolve any incidents that are reported directly to the council to the satisfaction of the Service User and the Council within the timescale stipulated by the Council.

Any concerns or comments being made in relation to the quality of the service can result in increased monitoring of the Provider.

All Low level Incidents/Concerns will be reported on as part of the quarterly monitoring submission.

**2.5 Data Submission KPI’s**

The KPI’s set out in appendix 1 are relevant to any information or data which the Provider is contractually obliged to submit to the Council, including finance data, monitoring returns and any other information as detailed within the Monitoring Schedule or Service Specification.

1. **Timeliness of data and information submissions**

Providers are to submit the required data and information to the Council as per the stated timescales e.g. weekly, monthly, and quarterly

**Target: 95%**

1. **Accuracy of data and information submissions**

Providers are to submit accurate data and information to the Council (and are to ensure that any checking processes put in place by the Council is adhered to prior to submitting the data or information)

**Target: 95%**

If data or information is not submitted to the Council as per the required timescales for three consecutive periods, then this will result in service failure and contractual or improvement action being taken.

The three periods are proportionate to the set timescales in place within this agreement, e.g. if a data submission is required on a weekly basis and the data has not been submitted for three weeks this will result in service failure.

The accuracy of data will be validated by the Council using various methods including; analysing anonymised datasets, cross reference against national reported data sets data and cross referencing invoices.

**2.6 Inspection Reports**

The Provider shall provide the Council with copies of any inspection reports (including regulatory feedback or reports such as CQC action plans) affecting the Service on request within 2 working days.

**2.7 Underperformance by Provider**

Should the Council identify that a Provider is underperforming against the terms of the Agreement:

1. the Council may without prejudice to its other rights and remedies including initiate one or more of the following: a Quality Assurance Form, Quality Assurance Visit or Contract Review Meeting
2. The Provider must produce a Service Improvement Action Plan which will be agreed with the Council and the Council may specify additional actions or requirements proportionate to any underperformance
3. exercise its right to clawback 5% of the annual contract value for failure of the Critical Performance Indicators in accordance with the Contract (Schedule 4)
4. exercise its rights under the terms of the Contract (Schedule 4) for failure of KPIs
5. exercise its rights under the terms of the Contract (Provider Default and Termination)
6. Where there has been a serious breach or multiples breaches which may affect Service User safety and wellbeing, the Council retains the right to move existing Provider business to alternative Providers. This may be via a staggered approach or moving the business as a whole and is at the Councils discretion

Where improvements are evidenced and the required standard reached, referrals will be resumed to The Provider, initially with a phased approach which will be decided by the Council

**2.7.1 Consequence of Critical Performance Failure**

If there is a Critical Performance Failure (point 2.2.2), the Provider shall immediately notify the Council in writing and the Council, in its absolute discretion and without prejudice to any other of its rights to Service under this Schedule howsoever arising, may:

1. require the Provider to immediately take all remedial action that is reasonable to mitigate the impact on the Contracting Body and to rectify or prevent a Performance Failure or a Critical Performance Failure from taking place or recurring; and
2. if the action taken above has not already prevented or remedied the Performance Failure or Critical Performance Failure, the Council shall be entitled to instruct the Provider to comply with the Improvement Plan Process; or
3. The Council may without prejudice to its other rights and remedies including initiate one or more of the following: a Quality Assurance Form, Quality Assurance Visit or Contract Review Meeting.

**2.7.2 Implementation of Improvement Action Plan**

Approval and implementation by the Council of any Improvement Action Plan shall not relieve the Provider of any continuing responsibility to achieve the Key Performance Indicators, or remedy any failure to do so, and no estoppels or waiver shall arise from any such Approval and/or implementation by the Council.

**3. Contract Management and Quality Assurance Governance and Validation**

**3.1 Contract Management and Quality Assurance Meetings**

The Provider will be required to attend regular contract management and quality assurance meetings chaired by representatives of the Council. These meetings will be set by the Council from the Commencement Date and will usually be in three monthly intervals.

The Council will arrange to meet with the Provider at least every quarter to review its performance against the provisions of the Specification and Performance Management Framework and to discuss its plans for Service improvement. The Council reserves the right to alter the frequency of these meetings. Wherever possible, the meetings will be arranged by the Council in such a way that they do not impede the Provider in the delivery of the Service.

From time to time, officers from the Council may visit the Provider to verify evidence of service activity and compliance with the requirements of the Agreement and the Specification.

The Council will decide which Council representatives are to be in attendance at the meetings which may include Council staff from teams other than commissioning/ Contract Management and Quality Assurance.

**3.2 Monitoring and Quality Assurance Visits / Audits**

Monitoring, quality assurance, inspection or audit visits can be announced or unannounced and will be carried out by Council representatives. Monitoring and quality assurance visits can be carried out as part of a routine monitoring schedule for Providers to ascertain contract compliance or in response to general or specific concerns. The visits have no set duration and will depend on what aspects of the service are being monitored and quality assured.

The Provider may be subject to monitoring, quality assurance or audit visits and service reviews by the Council at any time during the duration of the Agreement.

The visits or audits can include on-site visits to the Providers offices and Council representatives have the right to access all information in relation to the service that is not patient identifiable:

1. Full Staff records (including DBS checks, insurance details, references, application forms, supervisions / appraisal records, disciplinary records, training records)
2. Full complaints records (including details of complaints, investigation, responses to complainants, actions taken)
3. Full safeguarding Records (including details of safeguarding alerts and concerns, enquiries, responses to safeguarding allegations, actions taken
4. Full CQC documentation and certificates, including copies of notifications and pending applications
5. All levels of insurance certificates
6. Any other documentation deemed relevant by the Council to a Service Users’ needs, support delivery, wellbeing, health or Care Plan

The Council may also undertake spot checks to satisfy itself as to the ongoing quality of service delivery and to validate performance data. Should any issues be identified, the Provider will ensure that remedial action is taken as per the Councils feedback and within the timescale specified at the time of notification or discussion.

Additional or more in-depth inspections or monitoring will be triggered by any of the following:

1. Whereby an active informal Improvement Notice or formal Default Notice is in place
2. Whereby the Provider is under Large Scale Safeguarding Enquiry (LSE) procedures
3. An increase in Safeguarding incidents, or receipt of a serious safeguarding referral which may indicate risk to Service Users
4. Failure to meet required Critical Performance Indicators or Best Practice elements
5. Contract Monitoring non-compliance
6. Concerns arising from previous inspections and reviews
7. Concerns arising from Service User or representative feedback
8. CQC Statutory Notice or intelligence shared with the Council
9. Complaints (including verbal, written, formal and informal)
10. Whistle blowing
11. Changes in local branch / local management for this contract without adequate contingencies, handover or not informing the Council
12. Any other issues deemed to be a risk

**Appendix 1**

 **Quality and Performance Monitoring Frameworks**

| **Key Performance Indicators** |
| --- |
| **No.** | **Key Performance Indicator** | **Technical Guidance Reference** | **Indicator construction** | **Comments** | **2019/20 Target** | **Reporting frequency** |
| **Accessibility** |
| A1 | The proportion of Service Users offered an appointment within 2 working days following triage/ assessment | National Indicator BASHH Standard 1 | Numerator: Number of Service Users that require an appointment who are offered an appointment in 2 working daysDenominator: Number of Service Users requiring an appointment following triage/assessment | Critical Performance Indicator | >98% may be changed to reflect local needs | Quarterly |
| A2 | Proportion of all Service Users receiving clinic appointment | Local Quality Standard | Numerator: Number of Service Users receiving clinic appointment Denominator: Total number of all Service Users who receive a triage service of any kind (online, clinic and outreach |  | Baseline Year 1 | Quarterly |
| A3 | Proportion of under 18 year old women who have their LARC method (IUD, IUS [contraception] or implant) within two weeks of contraception assessment | FSRH Standard 8  | Numerator: The number under 18 year old with IUD, IUS (contraception) or implant within two weeks of contraceptive assessmentDenominator: Total number of IUD, IUS (contraception) or implant fitted for under 18 year old women | This was not reported for the previous Sexual Health contract so no baseline data is available – target set by national standards | >90% | Quarterly |
| A4 | Proportion of over 18 year old women who have their LARC method (IUD, IUS [contraception] or implant) within two weeks of contraception assessment | FRSH Standard 8 | Numerator: The number over 18 year old with IUD, IUS (contraception) or implant within two weeks of contraceptive assessmentDenominator: Total number of IUD, IUS (contraception) or implant fitted for over 18 year old women | Target and indicator included in national PMF with the description left as for local determination | >90%  | Quarterly |
| **Diagnosis** |
| D1 | The proportion of all STI test results notified to the Service User within 10 calendar days  | BASHH Standard 4 | Numerator: The number of STI results notified to Service User within 10 calendar days of the service receiving resultDenominator: Total number of STI results |  | 95% | Quarterly  |
| D2 | Proportion of all under 25 year olds screened for chlamydia | National Indicator (to support Public Health Outcomes Indicator 3.2) | Numerator: The number of new Service Users aged <25 screened for chlamydia within the contract year (tested via online, clinic or outreach)Denominator: The number of new Service Users aged <25 accessing service within the contract year |  | 75% (National PMF) | Quarterly |
| D3 | Achieve a diagnostic rate of 2,300 / 100,000 for chlamydia screening 15 to 24 year olds | Public Health Outcome Framework measure (3.2)National Guidance | Numerator: Number of Positive TestsDenominator: Number of 15-24 year old residents in Cheshire East  | Critical Perfromance Indicator | 2,300 / 100,000 15 to 25 year olds | Quarterly |
| D4 | Proportion of Service Users with needs relating to STIs who are offered an HIV test at first attendance(Excluding those already diagnosed HIV positive). | National Indicator (to support Public Health Outcomes Framework Indicator 3.4)GUMCAD | Numerator: Number of Service Users with needs relating to STIs who are offered an HIV test at first attendance at a clinicDenominator: Total number of services users seen in a clinic with needs relating to STIs | Critical Performance Indicator  | 97% | Quarterly |
| D5 | Proportion of Service Users with needs relating to STIs who have a record of having an HIV test at first attendance (excluding those for whom a test is not appropriate)  | National standard (to support Public Health Outcomes Framework Indicator 3.4)GUMCAD | Numerator: Number of Service Users with needs relating to STIs who have a record of having an HIV test at first attendance of a clinicDenominator: Total number of Service Users seen in a clinic with needs relating to STIs  | Those to be excluded are to be agreed with the providerBHIVA (2008) UK National Guidelines for HIV Testing 2008 | 80% | Quarterly |
| **Treatment** |
| T1 | Proportion of online Service Users who received treatment within 4 weeks of an STI diagnosis | Local Quality Standard(*not in National PMF*) | Numerator: Number of online Service Users receiving treatment within 4 weeks of an STI diagnosisDenominator: Number of online Service Users who received a positive STI diagnosis |  | Baseline year 1 | Quarterly |
| T2 | Proportion of Service Users seen in a clinic who received treatment within 4 weeks of an STI diagnosis | NCSP Standard 4 | Numerator: Number of Service Users seen in a clinic who started treatment within 4 weeks of positive STI diagnosisDenominator: The total number of Service Users who received a positive STI diagnosis  | Critical Performance Indicator  | >95% | Quarterly |
| T3 | Proportion of online Service Users who tested positive for chlamydia to be treated within six working days of the positive result | Local Quality Standard(not in national PMF) | Numerator: The number of online Service Users receiving treatment within six working days of the service receiving the positive result from the labDenominator: The total number of positive online test results  |  | Baseline year 1 | Quarterly |
| T4 | Proportion of Service Users seen in a clinic who tested positive for chlamydia to be treated within six working days of the positive result | National IndicatorNCSP Standard 4 | Numerator: The number of Service Users seen in a clinic receiving treatment within six working days of the service receiving the positive result from the labDenominator: The total number of positive results from tests carried out as a result of a clinic appointment |  | 95% | Quarterly |
| T5 | Proportion of under 18 year old women who receive a contraception assessment who choose LARC option to be fitted by the service (note. If medically appropriate\*) | Local Quality Standard\*Medically appropriate defined in NICE 2005 CG 30 | Numerator: The number of IUD, IUS and implants fitted by the service for contraceptive purposes for under 18 year old women (if medically appropriateDenominator: The total number of under 18 provided with methods of contraceptive by the service | national PMF states “for local determination” without age breakdown | Baseline | Quarterly |
| T6 | Proportion of over 18 year old women who receive a contraception assessment who choose LARC option to be fitted by the service (note. If medically appropriate\*) | Local Quality Standard\*Medically appropriate defined in NICE 2005 CG 30 | Numerator: The number of IUD, IUS and implants fitted by the service for contraceptive purposes for over 18 year old women (if medically appropriateDenominator: The total number of over 18 provided with methods of contraceptive by the service |  | Baseline | Quarterly |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| T7 | Sexual history taking:The percentage of people accessing services with needs relating to STIs, who have a relevant sexual history taken (as defined by BASHH national guidelines for differing symptoms) by the STI service provider.  | National indicatorBASHH standards | Numerator: Number of clinic attendances who have needs relating to STIs who have a sexual history (and HIV/STI risk assessment) undertakenDenominator: Total number of clinic attendances who have needs relating to STIs | Critical Performance Indicator  | 97% | Quarterly |
| T8 | Proportion of men who have sex with men who are offered HIV test at first attendance (MSM) | Local Quality Standard (*not in National PMF*) |  | Critical Performance Indicator  | 100% | Quarterly |
| T9 | Proportion of men who have sex with men who accepted HIV test at first attendance (MSM) | Local Quality Standard (*not in National PMF*) | Numerator: Number of 'Eligible new GUM attendees seen at a clinic' in whom (a maximum of) one HIV test was acceptedDenominator: The number of ‘eligible new GUM attendees seen at clinic’ | Possibility to audit whether MSM accept HIV test at subsequent attendance reflecting positive relationship of trust between the service and Service User | 85%  | Quarterly |
| T10 | Proportion of Service Users presenting with HIV at late stage of infection | Local Quality Standard (*not in National PMF*) | Numerator: The number of infections diagnosed as having <CD4 count of 350 mm3 of all Service Users (tested via online, clinic and outreach)Denominator: The number of newly diagnosed HIV infections |  | <25%  | Quarterly |
| T11 | Proportion of IUD, IUS or implants that are still fitted after 6 months  | Local Quality Standard(*not in National PMF)* | Numerator: The number of IUD, IUS or implants still fitted after six monthsDenominator: The number Service Users who had IUD, IUS and implants that were available to be contacted after six months |  | Baseline | Quarterly |
| T12 | Monitor percentage of LARCs prescribed as a proportion of all contraceptives by age | National PMF | Numerator: Number of patients prescribed LARC Denominator: Number of patients prescribed all contraceptives (x100)  |  | 50% | Quarterly?  |
| **Partner Notifications** |
| **PN1** | The percentage of index cases and subsequent cases for acute STIs documented as offered at least one discussion, which may be a telephone discussion, for the purpose of PN with a sexual health adviser with the appropriate documented competency. | BASHH Statement on PN for STIs | Numerator: The number of index cases and subsequent cases for acute STIs offered at least one discussion with a sexual health advisor for the purpose of PNDenominator: The total number of index cases having outcome documented | Critical Performance Indicator  | ˃97% | **Quarterly**  |
| **PN2** | The percentage of index cases and subsequent cases having the outcome of (an) agreed action(s), or the decision not to contact, documented for all contacts following a PN discussion | BASHH Statement on PN for STIs | Numerator: The number of index cases and subsequent cases having an outcome documentedDenominator: The total number of index cases and subsequent cases |  | ˃97% | **Quarterly** |
| **PN3** | The proportion of all contacts of index cases of gonorrhoea (and all other STIs, excluding chlamydia) who attend service within 4 weeks of the date of first PN discussion. | BASHH Standard 4 | Numerator: The number of identified partners documented as attending a service within 4 weeks of first PN discussion for gonorrhoea and all other STIsDenominator: The total number of index cases for gonorrhoea and all other STIs |  | 0.4 contacts per index | **Quarterly** |
| **PN4** | The proportion of all contacts of index cases of chlamydia who attend service within 4 weeks of the date of first PN discussion. | NCSP Standard 4 (Result notification and treatment) | Numerator: The number of identified partners documented as attending a service within 4 weeks of first PN discussion for chlamydiaDenominator: The total number of index cases for chlamydia |  | 0.6 contacts per index | **Quarterly** |
| **PN5** | The percentage of contacts who have documented partner notification outcomes or a progress update at 12 weeks after first PN discussion with the index case | BHIVA Standard 7 | Numerator: The number of identified partners (contacts) with documented outcomes or progress update at 12 weeks after first PN discussionDenominator:The total number of identified partners |  | ˃90% | **Quarterly** |
| **PN6** | The percentage of Service Users who receive a positive HIV diagnosis who have documented evidence within clinical records that partner notification has been discussed within 4 weeks of receiving a positive HIV diagnosis | BHIVA Standard 7 | Numerator: The number of Service Users diagnosed with HIV who have documented evidence within clinical records that partner notification has been discussed within 4 weeks of receiving a positive HIV diagnosisDenominator:The total number of Service Users receiving a positive HIV diagnosis |  | ˃90% | **Quarterly** |

| **Management Information – ALL indicators within this section to be BASELINED in Year 1 of contract and reporting arrangements reviewed** |
| --- |
| **No.** | **Activity measure** | **Technical Guidance Reference** | **Measure Construction** | **Frequency**  |
| **Digital Activity** |
| 1 | Proportion of Service Users self-triaging online  | Local Quality Standard (*not in National PMF*) | Numerator: Number of Service Users self-triaging on-lineDenominator: Total number of Service Users triaged | Quarterly |
| 2 | Proportion of online Service Users requesting test | Local Quality Standard (*not in National PMF*) | Numerator: Number of Service Users triaging online who requested a test as a resultDenominator: Total Number of Service Users who triaging on-line | Quarterly |
| 3 | Proportion of online Service Users returning test | Local Quality Standard | Numerator: Number of online Service Users who returned a testDenominator: Number of tests requested online that were sent out | Quarterly |
| 4 | Proportion of tests returned from online Service Users who live in a 20% most deprived LSOA | Local Quality Standard (*not in National PMF*) | Numerator: Number of tests returned from online Service Users who live in a 20% most deprived LSOADenominator: Number of tests requested from online Service Users that have been returned | Quarterly |
| 5 | Proportion of Service Users who returned tests requested online and blood sample was not viable for testing | Local Quality Standard *(not in National PMF)* | Numerator: Number of Service Users who returned tests and blood sample was viable for testingDenominator: Total number of tests sent out to Service Users who requested tests online | Quarterly |
| 6 | Proportion of online Service Users receiving test results within the following categories: Under 24 hrs, Under 48 hours, Under 72 hours, over 72 hours, of service receiving tests for analysis | Local Quality Standard | Numerator: Number of online Service Users receiving test results in each time category from service receiving test for analysisDenominator: Total number of returned tests that were requested online | Quarterly |
| **Clinic Activity**  |
| 7 | Proportion of Service Users receiving clinic appointment | Local Quality Standard (*not in National PMF*) | Numerator: Number of Service Users receiving clinic appointmentDenominator: Total Number of all Service Users who receive a triage service of any kind) (online, clinic and outreach) | Quarterly |
| 8 | Number of first appointments | Local Quality Standard | Same as indicator wording | Quarterly |
| 9 | Number of rebook appointments | Local Quality Standard | Same as indicator wording | Quarterly |
| 10 | Number of follow up appointments | Local Quality Standard | Same as indicator wording | Quarterly |
| 11 | Percentage of users experiencing waiting times of >30 minutes for a booked appointment  | Local Quality Standard | Numerator: Number or Service Users waiting longer than 30 minutes for a booked appointmentDenominator: Number of booked appointments | Quarterly |
| 12 | Proportion of users experiencing waiting times of more than 2 hours at a walk in clinic | Local Quality Standard | Numerator: Number of Service Users waiting longer than two hoursDenominator: Total number of Service Users seen at walk in clinic | Quarterly |
| 13 | Number of Service Users turned away from the clinic | Local Quality Standard |  | Quarterly |
| 14 | Proportion of Service Users who did not attend their booked appointment | Local Quality Standard | Same as indicator wording | Quarterly |
| 15 | Proportion of Service Users who walked out of the walk-in clinics | Local Quality Standard | Same as indicator wording | Quarterly |
| **Safeguarding** |
| 16 | Number of young people being reported, in line with local safeguarding procedures, as being exposed to child sexual exploitation | Local Quality Standard | Same as indicator wording | Quarterly |
| 17 | Number of Safeguarding referrals (both Children & Adults) | Local Quality Standard | Same as indicator wording | Quarterly |
| **Pharmacy/GP Activity** |
| 18 | Number of Pharmacies contracted to deliver; 1. Emergency Hormonal Contraception (EHC)
2. Quick Start Contraception
3. Chlamydia Screening Services for people under 25
 | Local Quality Standard | Same as indicator wording | Quarterly |
| 19 | Number of GP’s contracted to deliver; A) IUCD’sB) Hormonal Contraceptive Implants C) Chlamydia Screening Services for people under 25 |  | Same as indicator wording | Quarterly |
| 20 | Number of Services delivered within pharmacy for;1. EHC consultations
2. Number of levonorgestrel tablets supplied
3. Number of Ulipristal Acetate tablets supplied
4. Number of quick start consultations
5. Number of starter contraception pack given
6. Number of chlamydia postal testing kits supplied for under 25’s
7. Number of chlamydia treatment consultations for under 25’s
 |  | Same as indicator wording  | Quarterly |
| 21 | Number of service delivered within GP practices for;1. IUCD insertions / packages of care
2. Hormonal contraceptive implant inserted
3. Hormonal contraceptive implants removed
4. Number of chlamydia postal testing kits supplied for under 25’s
5. Number of chlamydia testing kits transported to laboratory for testing for under 25’s
6. Number of chlamydia treatment consultations for under 25’s
 |  | Same as indicator wording | Quarterly |
| **Outreach Activity** |
| 22 | Numbers of attendees at outreach sessions conducted in areas of high deprivation or aimed at vulnerable groups | National Indicator[NCSP Outreach Guidance](https://www.bashh.org/about-bashh/publications/sti-outreach-standards/) | An outreach session is defined as a face to face activity that promotes the sexual health service and/or raises awareness of the importance of STI and HIV testing  | Quarterly |
| 23 | Number of point of care test carried out | Local Quality Standard | Number of point of care test carried out | Biannually |
| 24 | The percentage of reports (or preliminary reports) issued by the laboratory within five working days of the specimen being received by the laboratory | BASHH Standard 1(Section 3.2.2a) | Numerator: Number of reports issued by the lab within five working days of receiving sampleDenominator: Number of reports issued by the lab | Quarterly  |
| 25 | Number of evening and weekend clinics | Local Quality Standard | Same as indicator wording | Quarterly |
| 26 | Number of C-card registration sites | Local Quality Standard | Same as indicator wording | Quarterly |
| 27 | Number of C-card distribution sites | Local Quality Standard | Same as indicator wording | Quarterly |
| 28 | Total number of cervical screens in the service  | Local Quality Standard | Same as indicator wording – This will be reported to NHSE | Quarterly |
| 29 | Number of appointments for Cervical screening only | Local Quality Standard  | Same as indicator wording – This will be reported to NHSE | Quarterly |
| **Contraception** |
| 30 | Number of contraceptive injections administered | Local Quality Standard | Same as indicator wording | Quarterly |
| 31 | Number of hormonal contraceptive implants fitted and number removed within a year of fitting | Local Quality Standard | Same as indicator wording | Quarterly |
| 32 | Quantity of contraceptive prescriptions by type (including emergency contraception) | Local Quality Standard | Same as indicator wording | Quarterly |
| 33 | Number of Service Users (female and male) receiving condoms | Local Quality Standard | Same as indicator wording | Quarterly |
| 34 | Proportion of women who are offered access to LARC method of choice within 6 weeks of contacting service | Local Quality Standard | Numerator: Number of female Service Users accessing LARC contraception within 6 weeks of first contactDenominator: Number of Service Users accessing LARC | Quarterly |
| **Out of Area Activity**  |
| 35 | Number of Service Users accessing the service from Out of Area by area of residence  | Local Quality Standard | Same as indicator wording | Annually |
| 36 | Proportion of Service Users accessing the service from Out of Area (broken down by activity) | Local Quality Standard | Numerator: Number of Service Users who are not residents of the Cheshire West and Chester accessing the service (excluding Welsh residents)Denominator: Number of Service Users accessing the service | Annually |
| 37 | Total amount received in payment for Out of Area Service Users  | Local Quality Standard | Same as indicator wording | Annually |
| **Referrals** |
| 38 | Number of referrals from external agencies | Local Quality Standard | Same as indicator wording | Annually |
| 39 | Number of referrals to abortion services | Local Quality Standard | Same as indicator wording | Annually |
| 40 | Number of referrals to drug & alcohol services | Local Quality Standard | Same as indicator wording | Annually |
| 41 | Number of referrals to weight management services | Local Quality Standard | Same as indicator wording | Annually |
| 42 | Number of referrals to domestic violence services | Local Quality Standard | Same as indicator wording | Annually |
| 43 | Number of referrals to other psychosexual health services | Local Quality Standard | Same as indicator wording | Annually |

| **Quality Report** |
| --- |
| **Quality Standard** | **Frequency** | **Related Docs** | **Technical Guidance Reference** | **Comments** |
| A Service User Engagement plan which affords Service User consultation and feedback. Including the progress towards the plan for each quarter, i.e. the actions detailed in the plan that have been carried out | Quarterly |  | National Indicator BASHH Standard 9 | This plan should include 360 degree feedback from Service Users as well as professional partners. The 70% target set for the return rate is based on the total number of those engaged with, and then how many of those returned were rating the service as good or excellent. |
| Evidence and results of Service User outcomes and experience collated by routine Service User surveys | Quarterly |  | National Indicator BASHH Standard 9 |  |
| Evidence of person-centred care and treating Service Users with dignity and respect in the form of case studies | Quarterly |  | National Indicator BASHH Standard 9 |  |
| Evidence demonstrating a positive impact on client outcomes to include at least 4 case studies annually | Quarterly |  | National Indicator |  |
| Notification of any formal complaints received (100% must be reported), response and subsequent corrective action taken. As well as notification of any compliments made | Quarterly |  | National IndicatorCQC 2014 Regulation 16: Receiving and acting on complaints.BASHH Standard 9(Patient and public engagement) |  |
| Governance 1. Number of Serious Untoward Incidents reported quarterly
2. Notification of any serious untoward incident will be reported to the commissioner within 24 hours
 | Quarterly |  | Local Quality Standard(*not in National PMF)* |  |
| Provide forward looking Communications plan and an update on actions taken in most recent quarter and impact on service delivery  | Quarterly |  | Local Quality Standard(*not in National PMF)* |  |
| External Training Plan * Which external partners have you identified need training?
* Detail the training provided in the most recent quarter to each of these partners, e.g. number of training sessions for each partner, subjects covered in the session, number of delegates (inc. their job role) any issues arising during those training sessions and how those issues were addressed
* Detail future training plans with each of these partners, including topics of training to be covered.
* Detail number of awareness raising sessions delivered to health and social care related staff and voluntary sector, and future plans for these
* Number of GP/Practice nurses trained to insert and remove LARCS in the last quarter
 | Quarterly |  | Local Quality Standard(*not in National PMF)* |  |
| Schedule of clinic times and locations | Quarterly |  | Local Quality Standard(*not in National PMF)* |  |
| Staff Training Plan A Staff Training Plan as an embedded document is requiredNeeds to include:- The mandatory training programme- Percentage of staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant updated CPD requirements commensurate with their work (BASHH Standard 2)- Clearly state actions and timescales required for members of staff whose training is not up to date/refreshed | Annually |  | Local Quality Standard(*not in National PMF)* |  |
| Documented evidence that best practice guidance is being implemented | Annually |  | Local Quality Standard(*not in National PMF)* |  |
| Documented evidence that the hours of operation for the service is meeting the needs of Service Users using comparative activity from previous periods. This needs to include intelligence of numbers and demographics of anyone not seen on the day they have attempted to attend | Annually |  | Local Quality Standard(*not in National PMF)* |  |
| Evidence of improved service based on comprehensive service review: needs, trends, reach, gaps, barriers, what worked well and added value (including social value)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 | Annually  |  | National IndicatorCQC 2014 regulation 17(2)(e)BASHH Standard 9(Patient and public engagement) |  |
| Evidence that 100% of clinics, including any new clinics opened during the contracts, have met the “You’re Welcome” Quality Standards | Annually |  | National Indicator |  |
| Evidence an Equality Impact Assessment (EIA) has been undertaken and outcomes utilised to inform forward year planning | Annually |  | National Indicator |  |
| Evidence of care pathways that are in place, in addition to this detail any changes to the pathways that have occurred in the last quarter, including why the changes are being made. A list of pathways required is below but is not an exhaustive list:* General contraception consultation
* Implant fitting
* Implant removal
* Irregular and prolonged bleeding with implant and contraceptive injection
* IUD/IUS fitting (contraception only)
* IUD/IUS check/removal
* Irregular, prolonged and /or heavy breathing with an IUD/IUS (for contraception only)
* HIV testing
* Look-back for late diagnosis of HIV
* Reporting test results, negative/positive/repeat test needed
 | Annually |  | National IndicatorBASHH Standard 8 (Links to other services) |  |
| Service cost breakdown for the full year | Annually |  | Locally required | To detail all operational costs including workforce, premises, prescribing and consumables.  |
| Service staffing structure | Annually |  | Locally required |  |

**Appendix 2**

**Social Value Outcomes**

The Provider will report on an annual basis their achievement against the relevant social value outcomes identified in their contract. Below are the key objectives

|  |  |
| --- | --- |
| Objective | Outcomes |
| 1. Promote Employment & Economic Sustainability
 | Outcome 1: More local people in work |
|  | Outcome 2: Thriving local businesses |
|  | Outcome 3: Responsible businesses that do their bit for the local community |
| 1. Raise the living standard of local residents
 | Outcome 4: A Local workforce which is fairly paid and positively supported by employers |
| 1. Promote Participation and Citizen Engagement
 | Outcome 5: Individuals and communities enabled and supported to help themselves |
| 1. Build capacity and sustainability of the Voluntary and Community Sector
 | Outcome 6: An effective and resilient third sector |
| 1. Promote Equity and Fairness
 | Outcome 7: A reduction in poverty, health and education inequalities.  |
|  | Outcome 8: Acute problems are avoided and costs are reduced by investing in prevention. |
| 1. Promote Environmental Sustainability
 | Outcome 9: We are protecting our physical environment and contributing to climate change reduction. |

Provider[s] will undertake Cost Benefit Analysis (CBA) for their identified social value targets, which will be monitored through the contract monitoring process by the end of their first quarter following contract award. Benchmarking for CBA will be undertaken by the Provider[s] once the contract has been awarded.