Public Health Specification
Integrated Sexual Health Service

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1. INTRODUCTION AND CONTEXT

1.1 Introduction

1.1.1 The Council wishes to commission an integrated sexual health promotion and provision that is equitable and accessible to everyone in Thurrock.

1.1.2 The service will enable open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections. This must be according to evidence-based protocols and adapted to the needs of local populations.

1.1.3 The Provider will be required to innovate, design and propose a service delivery model as part of the competitive tender process. The model should explore new ways of working whilst considering the scope of service aspirations and ensuring the required outcomes are met.

1.1.4 The Council is seeking a collaborative approach from the provision with the Service primarily delivered by a Single (Lead Provider) with some elements sub-contracted (e.g. within Primary Care). The Provider will additionally manage out of area payments for GUM within the block contract price.

1.2 National Context

1.2.1 Sexual health is an important area of public health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations. The Government has set out its ambitions for improving sexual health in its publication, A Framework for Sexual Health Improvement in England.\(^1\)

1.2.2 Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic groups. Similarly HIV infection in the UK disproportionately affects MSM and Black Africans in the UK. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

1.2.3 An integrated sexual health service model aims to improve sexual health by providing easy access to services through open access, where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and accessible locations.

1.2.4 The provision of integrated sexual health services is supported by current accredited training programmes and guidance from relevant professional bodies including FSRH, BASHH, BHIVA, MEDFASH, RCOG and NICE and relevant national policy and guidance issued by the Department of Health and Public Health England. Providers must ensure commissioned services are in accordance with this evidence base and guidelines.

1.2.5 The Public Health White Paper Healthy Lives, Healthy People: Our Strategy for Public Health in England\(^2\) highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental

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sexual health services (including for sexually transmitted infections (STIs), contraception, abortion, health promotion and prevention).

1.2.6 From the 1st April 2013, Local Authorities have been mandated to commission comprehensive open access sexual health services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of a full range of contraception, through GPs exemptions of payment for prescriptions apply) and the Department of Health has produced guidance to assist Local Authorities to commission these and other sexual health interventions.

1.3 Local Context

1.3.1 In 2015 Thurrock had the 132nd highest rate (out of 326 local authorities in England) of new STIs excluding chlamydia diagnoses in 15-24 year olds; with a rate of 654.2 per 100,000 residents which was significantly below the rate of 815 per 100,000 in England).

1.3.2 In 2015 43% of diagnoses of new STIs in Thurrock were in young people aged 15-24 years, which is similar to England (45%). This includes those tested in specialist Sexual Health Clinics (SHCs) only.

1.3.3 When considering diagnostic rates of specific STIs, Thurrock has some STIs where they have significantly lower rates than the England average [Gonorrhoea and Genital warts], and others where they have statistically similar diagnosis rates to England [Syphilis and Genital herpes]. (see below – colour denotes significance compared to England).

<table>
<thead>
<tr>
<th>STI</th>
<th>Diagnostic rate per 100,000 [Confidence Intervals in brackets]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thurrock [Confidence Intervals in brackets]</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>47.2 [37.3-58.9]</td>
</tr>
<tr>
<td>Syphilis</td>
<td>6.1 [2.9-11.1]</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>49.6 [39.5-61.6]</td>
</tr>
<tr>
<td>Genital warts</td>
<td>87.2 [73.5-102.6]</td>
</tr>
</tbody>
</table>

Appendix 9 shows trends over the last five years for each of the above conditions with their confidence intervals.

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3 It is an expectation that services must also provide diagnosis and treatment for non-STI conditions such as the management of Candida, bacterial vaginosis, urinary tract infections, molluscum contagiosum, balanitis, vulval conditions etc.

4 The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2012 (http://www.legislation.gov.uk/ukdsi/2012/978011531679)

5 Department of Health (2013), Commissioning Sexual Health Services and Interventions (http://www.dh.gov.uk/health/2013/03/sexual-health-services/)
1.3.4 STIs are not equally distributed across the Thurrock with particular hotspots found in certain areas of the borough (see below).

National Chlamydia Screening Programme

1.3.5 The Public Health Outcomes Framework (PHOF) indicator 3.2 suggests a minimum chlamydia detection rate of 2,300 per 100,000 amongst young people aged 15-24 would encourage high volume screening and diagnoses, and be likely to result in a reduction in chlamydia prevalence. In 2016 the Thurrock detection rate was 1,495 per 100,000 which was significantly lower than the England average of 1,882 per 100,000. 17.8% of 15-24 year olds were screened for Chlamydia in Thurrock, which is also below the England rate of 20.7%.

HIV

1.3.6 In 2015 there were 10 new HIV diagnoses in Thurrock. This equates to a new diagnostic rate of 7.7 per 100,000 population aged 15+, which is statistically similar to the England rate of 12.1 per 100,000. Thurrock has an HIV diagnosed prevalence rate of 2.03 per 1,000 aged 15-59 which is also statistically similar to the England rate of 2.26 per 1000. The small numbers of diagnoses involved mean that caution should be applied when drawing any conclusions from these figures. A priority in Thurrock is to reduce the late diagnosis of HIV through early identification and increased screening (PHOF 3.04). 18 cases of HIV were diagnosed late in Thurrock in 2013-15, which equates to 62.1% - which is significantly higher than the England average of 40.1% (see Appendix 9).

Risky behaviours

1.3.7 An estimated 5.8% of women and 7.8% of men presenting with a new STI at a specialist SHC in Thurrock during the 5 year period from 2010 to 2015 were re-infected with a new STI within 12 months which is an indicator of risky behaviour.

Conceptions and Abortions

1.3.8 In 2016 Thurrock had a total abortion rate of 18.4 per 1,000, which is significantly higher than the East of England and England rates of 15.0 and 16.7 per 1,000 respectively.

1.3.9 In 2015 Thurrock had an under-18 conceptions rate of 24.5 per 1,000 females aged 15-17, which is statistically similar to the England average of 20.8 per 1,000 (Public
Health Outcomes Framework indicator 2.04). 60.3% of these under-18 conceptions led to terminations. Thurrock is experiencing decreasing rates of under-18 conceptions (see below). It is Thurrock Council’s ambition to reduce the rate to 20 per 1,000 by 2020.

Under 18s conception rate / 1,000 (PHOF indicator 2.04) – Thurrock

Contraception

1.3.10 Good contraception services have been shown to lower rates of unwanted pregnancies and teenage conceptions.

1.3.11 Currently, data on contraception provision are only centrally collected from specialist SHCs, level 2 SRH services and some young person’s clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care.

1.3.12 In 2015 there were 6,496 attendances by Thurrock residents at SRH services in 2015 of which 5,969 (91.73%) attendances were made within Thurrock. A proportion of these represent repeat attendances by an individual. Further information regarding contraception usage in Thurrock residents can be found in Appendix 10.

Long Acting Reversible Contraception (LARC)

1.3.13 Thurrock has significantly lower rate of GP prescribed LARC (excluding injections) of 15.2 per 1,000 compared with the East of England and England at 33.4 and 29.8 respectively.

1.3.14 Further information can be found in Appendix 10 and Thurrock’s Sexual Health and Reproductive Health Profiles can be found at: http://fingertips.phe.org.uk/profile/sexualhealth/data
2. SERVICE ASPIRATIONS

2.1 Aims

2.1.1 Overall, this Contract shall deliver excellent universal and targeted sexual health services that aim to:

- Improve the sexual and reproductive health of the Thurrock population
- Prevent sexual ill-health in Thurrock
- Contribute to overall health improvement, health promotion and the reduction of health inequalities
- Reduce the stigma associated with STIs, HIV and unwanted pregnancy

2.1.2 The ethos of the Service will be a Public Health prevention service that intervenes as soon as possible to prevent unplanned pregnancies and STI transmission, reducing risk and addressing underlying issues to improve general wellbeing.

2.1.3 Achievement of the aims will generally be measured by the Provider’s performance as set out in the Key Performance Indicators in Appendix 1 to this specification.

2.2 Priorities, Objectives and Outcomes

Outcome Focus

2.2.1 The Integrated Sexual Health Service shall be outcome-focused in order to achieve a set of locally and nationally agreed priorities to meet the needs of the Thurrock population.

2.2.2 The Service will aim to fulfil the aspirations of the Thurrock Health and Wellbeing Strategy Outcomes Framework in the table below. The Service will focus on those key elements highlighted in green.

Thurrock Health and Wellbeing Strategy Framework

<table>
<thead>
<tr>
<th>Goals</th>
<th>A. Opportunity For All</th>
<th>B. Healthier Environments</th>
<th>C. Better Emotional Health And Wellbeing</th>
<th>D. Quality Care Centred Around The Person</th>
<th>E. Healthier For Longer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>A1. All children in Thurrock making good educational progress</td>
<td>B1. Create outdoor places that make it easy to exercise and to be active</td>
<td>C1. Give parents the support they need</td>
<td>D1. Create four integrated Medical Centres</td>
<td>E1. Reduce obesity</td>
</tr>
<tr>
<td></td>
<td>A2. More Thurrock residents in employment, education or training.</td>
<td>B2. Develop homes that keep people well and independent</td>
<td>C2. Improve children's emotional health and wellbeing</td>
<td>D2. When services are required, they are organised around the individual</td>
<td>E2. Reduce the proportion of people who smoke.</td>
</tr>
</tbody>
</table>
**Integrated Sexual Health Outcomes**

2.2.3 The Integrated Sexual Health Service will play a key role in the continuous improvement against the three main sexual health Public Health Outcome Framework Measures:

1. Under 18 conceptions (PHOF 2.4)
2. Chlamydia diagnoses of 15-24 year olds (PHOF 3.2)
3. People presenting with HIV at a late stage of infection (PHOF 3.4)

2.2.4 Additionally, the Service will contribute towards the achievement of the ambitions for sexual health improvement in England (DH 2013) as follows:

1. Build knowledge and resilience among young people
2. Improve sexual health outcomes for young adults
3. All adults have access to high quality services and information
4. People remain healthy as they age
5. Prioritise prevention
6. Reduce rates of STIs among people of all ages
7. Reduce onward transmission of and avoidable deaths from HIV
8. Reduce unwanted pregnancies among women of fertile age
9. Continue to reduce the rate of U16 and U18 conceptions

And also through partnership working:

10. Counselling for all women requesting an abortion

**Additional Priorities**

2.2.5 Over and above the specific priorities set out in this specification for the Integrated Sexual Health Service, the Provider shall be aware of the following general priorities, and shall work in partnership with the Council showing awareness and willingness to engage with developments with these where appropriate. The key priorities include:

- Violence against Women and Girls (VAWG) Strategy
- Child Sexual Exploitation (CSE) Strategy
- PREVENT (anti-terrorism strategy)
- Safeguarding Children and Vulnerable Adults

Full details of these priorities are set out in Appendix 4: Applicable Strategies.

2.2.6 Making Every Contact Count is also a key objective for Public Health Services to ensure that every point of contact with the public is used as an opportunity to promote healthy lifestyles. The Provider shall ensure all staff across the Service receive appropriate training and that clear referral pathways are in place. Details are contained within Section 3.8 – General Staffing.

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6 Counselling for women requesting an abortion is the responsibility of, and commissioned by, the CCG and not part of this Service. However the Provider will need to ensure the appropriate pathway is in place.
3. PROVIDER RESPONSIBILITIES - OVERVIEW

3.1 Contract Management

3.1.1 The Provider shall appoint a Contract Manager who will be the primary liaison between the Council and the Provider.

3.2 Service Scope

3.2.1 The Service is open access but targeted primarily at Thurrock residents who require support to address their sexual health.

3.2.2 The Integrated Service shall promote flexibility in the range of methods used to improve sexual health and contraception needs. Clinics should act as a ‘one stop shop’ where clients can access a variety of services under one roof.

3.2.3 The scope of the Integrated Sexual Health Service brings together a number of “Service Elements” as set out below:

<table>
<thead>
<tr>
<th>Service Definition</th>
<th>Detailed Section</th>
<th>Individual Service Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hub &amp; Spoke Contraceptive, Sexual health, Reproductive and Genito-Urinary (GUM) services</td>
<td>4</td>
<td>• Contraceptive services&lt;br&gt;• Sexual health and GUM services&lt;br&gt;• Prevention services&lt;br&gt;• Partner notification&lt;br&gt;• Data reporting to the relevant authorities&lt;br&gt;• GUM Cross Charging</td>
</tr>
<tr>
<td>Relationships &amp; Sex Education</td>
<td>5</td>
<td>• Delivery of Relationships &amp; Sex Education (RSE) in schools and/or train up the workforce who will be delivering the sessions</td>
</tr>
<tr>
<td>Outreach</td>
<td>6</td>
<td>• Campaigns&lt;br&gt;• Local outreach awareness events and drop in clinics</td>
</tr>
<tr>
<td>C-Card Condom Distribution Scheme</td>
<td>7</td>
<td>• Management of the Thurrock C-Card scheme&lt;br&gt;• Promotion of the scheme&lt;br&gt;• Training assessors and distributors</td>
</tr>
<tr>
<td>National Chlamydia Screening Programme (NCSP)</td>
<td>8</td>
<td>• Management of the National Chlamydia Screening Programme&lt;br&gt;• Data reporting</td>
</tr>
<tr>
<td>Primary Care and Pharmacy Service Level Agreements</td>
<td>9</td>
<td>• Long Acting Reversible Contraception (LARC)&lt;br&gt;• Emergency Hormonal Contraception (EHC)&lt;br&gt;• National Chlamydia Screening Programme (NCSP)</td>
</tr>
<tr>
<td>Sexual Health Training</td>
<td>10</td>
<td>• Sexual Health training courses&lt;br&gt;• Development of a training brochure&lt;br&gt;• Development of a Sexual Health Newsletter</td>
</tr>
<tr>
<td>Online STI Testing</td>
<td>11</td>
<td>• Home-based STI testing and notification of results</td>
</tr>
</tbody>
</table>

7 Refers to the relevant section within this specification.
3.3 **Out of Scope**

3.3.1 This Service does not include Termination of Pregnancy (TOP) services or HIV Treatment, although the Provider will work closely with the TOP and HIV treatment providers to set up formal agreements to ensure these pathways provide seamless provision for Patients.

3.4 **Service Development**

3.4.1 To ensure continuous improvement, and as this contract develops, the Provider will be required to submit proposed action plans for approval that improve service for users, embed prevention, promote innovation and increase value for money.

3.5 **Principles of Delivery**

3.5.1 The Service will be characterised by the following principles:

- Using a hub and spoke model of service delivery. This means that there will be a central “hub” providing a full range of services from Level 1 to Level 3, and a number of additional “spoke” clinics that provide a minimum of Level 1 and Level 2 services, spread across the borough.
- Seamless “one-stop-shop” provision that enables individuals to receive all the services they need, whether contraception, or sexual health, or a mixture of the two in one appointment.
- Appointments are through both walk-in and booked appointment clinics, including evenings and Saturdays.
- Working with local General Practices and Pharmacies, and linking into local outreach work.
- Providing care on an open access basis and available to men and women requiring care, irrespective of their age, place of residence or GP registration, without referral, and including provision of interpretation and support in other languages where English is not clearly understood.
- Multidisciplinary staff teams providing seamless care.
- Compliance with the spirit and letter of the Equality Act 2010, Data Protection Act 1998 and ensuring patient records are securely and confidentially maintained.
- Providing evidence-based care centred on recognised national best practice guidance where this exists.
- Prioritising Prevention and providing opportunities for people to manage their own sexual health either independently or with support.
- Delivering a seamless and auditable referral process with clearly defined care pathways in conjunction with other providers.
- Maintaining a strong focus on safeguarding young and vulnerable people by early identification of all forms of abuse (especially sexual abuse), child sexual exploitation and other activities likely to lead to harm.
- Delivering a behaviour change based model to encourage regular testing, reduce stigma and achieve point of care testing for STIs and HIV.

3.6 **Safeguarding**

3.6.1 It is imperative that all children and young people using the service understand consent, sexual consent and issues surrounding abuse and abusive relationships.

The Provider must ensure that:

- Gillick competence and Fraser guidelines are applied to all clients under 16.
• Risk assessments are conducted for sexual abuse and a CSE assessment taken with young people under 18
• Safeguarding and CSE pathways are clearly stated and anonymised evidence is available to demonstrate effectiveness

3.6.2 Overall, the Provider shall ensure safeguarding across the range of services is delivered. In practice, this means as a minimum:

- Safeguarding policies are in place for both children and adults that are acceptable to the Council and the CCG.
- All staff in contact with Patients (including individuals deemed ineligible at the point of assessment) are trained and supervised to recognise and act appropriately upon the signs of potential abuse, neglect or harm
- The Provider shall refer and report all relevant issues/concerns to the MASH (Multi-agency Safeguarding Hub (Children)) or Safeguarding Adults Board.
- The Provider will maintain efficient and effective multi-agency working relationships with allied services, agencies and stakeholders to enhance the quality of care delivered, ensure the ‘think family’ holistic nature of the Service and ensure practice meets the Thurrock LSCB and Southend, Essex and Thurrock (SET) procedures to safeguard vulnerable children and adults, including where necessary, home visits.

3.6.3 The Provider will have a safeguarding procedure which adheres to best practice and relevant national and local requirements and guidance, and must implement this in all elements of service delivery.

3.6.4 Details of Thurrock Safeguarding Procedures and protocols are as set out below:

<table>
<thead>
<tr>
<th>Title</th>
<th>Content</th>
<th>Web Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southend Essex And Thurrock Safeguarding and Child Protection Procedures</td>
<td>Contains the Southend, Essex and Thurrock Child Protection Procedures to set out what should happen in any local area when a child or young person is believed to be in need of support.</td>
<td><a href="http://www.thurrocklscb.org.uk/procedures/set-procedures/">http://www.thurrocklscb.org.uk/procedures/set-procedures/</a></td>
</tr>
<tr>
<td>Thurrock Local Safeguarding Children’s Board</td>
<td>Website of the LSCB. Contact details for the MASH team, Emergency Duty and others, Ofsted reports and results of Serious Case Reviews</td>
<td><a href="http://www.thurrocklscb.org.uk/">http://www.thurrocklscb.org.uk/</a></td>
</tr>
</tbody>
</table>

3.6.5 The Provider will work within inter-agency and single agency protocols, policies and procedures and in accordance with Working Together to Safeguard Children (HM Government, 2015), and use the national Safeguarding pathway for health professionals to provide clarity on roles and responsibilities for this programme.

3.6.6 The Provider will develop and implement a robust mechanism in place for the reporting of any form of abuse or child protection concerns (in accordance with the Children’s Act 1989 and 2004). This includes ensuring the workforce understands and recognises all forms of child abuse and neglect, and can determine the early signs relating to domestic abuse, child sexual exploitation, gangs, trafficking, modern slavery, female genital mutilation and Prevent.
3.6.7 Where any safeguarding recommendations are made that require action, these must be followed and reported to the relevant Thurrock Local Safeguarding Adult or Children's Board as required. This may include auditing of all face to face liaisons between General Practice staff, pharmacy staff, school nurses and Integrated Sexual Health Service professionals where there are child protection / safeguarding concerns, including those children subject to Child Protection Plans.

3.7 **Partnership and Service Interdependencies**

*Collaborative Working*

3.7.1 The Service cannot work in isolation and is required to work with partners to address the needs of Patients and increase the opportunity for Patients to achieve optimum sexual health outcomes. Partners will include:

- Abortion Providers
- Antenatal and post-natal services
- Cervical Screening Programme
- Child and adolescent mental health services
- Community pharmacy
- CVS Thurrock
- Drug, alcohol, obesity, smoking intervention services (Well-Being Services)
- General practices
- Gynaecology
- Healthwatch Thurrock
- HIV treatment and care services
- Male and female sterilisation services
- Maternity services
- Mental health services
- Other healthcare service areas including voluntary sector
- Pathology and laboratory services
- Prisons and youth offenders institutions
- School and education services
- Sexual Assault Referral Centre (SARC)
- Social Care professionals
- Youth services
- Local Safeguarding Board
- Health and Well Being Board
- Brighter Futures Providers

3.7.2 The Provider will ensure the Service is represented at the Thurrock Sexual Health Stakeholder meetings which occur on a quarterly basis.

*Care Pathways*

3.7.3 The Service must have clear and timely referral pathways between providers that enable effective planning through clinical leadership and clinical networks. Pathways will:

- Ensure provision is available to address the contraception needs of women who have left abortion services without their contraceptive needs being met
- Support women and couples to plan pregnancy
- Support men and women who express a desire for gender reassignment to access the appropriate services
- Work to reduce late diagnosis of HIV, Hepatitis B and C and facilitating entry to treatment
- Provide a seamless transfer of care into HIV treatment services with timely initiation of treatment when clinically indicated\(^8\)
- Provide a structured condom distribution service in a wide range of settings
- Provide local care pathways for individuals disclosing sexual assault and domestic violence
- Deliver onward referrals for psychosexual services if appropriate

**Wider Partnership Working**

3.7.4 The Provider will follow national information sharing guidance thus ensuring effective information sharing and proactive management of relationships with organisations within sexual health. This would include other services supporting services users including Thurrock MASH, adults and children’s social care, GPs, wider Local Authority services, Public Health services, secondary health service providers and other such agencies and organisations as deemed appropriate to safeguard the adult or child. This includes and is not limited to:

a) Working with an early prevention approach; allowing for a co-ordinated and flexible response in service according to the needs of Patients
b) Providing clear referral pathway(s) for those requiring additional support.

3.7.5 The Provider will link effectively with specialist providers where domestic abuse or any form of sexual violence is identified; ensuring correct referral pathways are followed.

3.7.6 The Provider shall actively participate in local, regional and national networks, training, research and audit programmes where applicable.

**3.8 Clinical Governance**

3.8.1 The Provider must be Care Quality Commission (CQC) Registered and meet the CQC Compliance Assessment Tool in full.

**Clinical Governance Framework**

3.8.2 The Provider is responsible for ensuring that the appropriate clinical governance is in place for the Service.

3.8.3 The Provider must have robust clinical, professional and consultant-level leadership and accountability across the entire service to advise on clinical governance, standards and the development of integrated care pathways and be appropriately resourced to do so by the provider organisation.

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\(^8\) HIV Standards suggest that people who have a new diagnosis of HIV should be informed of their CD4 count and have the opportunity to discuss management, antiretroviral therapy and opportunistic infection prophylaxis within 2 weeks of this initial assessment (i.e. within 1 month of initial diagnosis) *British HIV Association Standards of Care for People Living with HIV* (2013) [http://www.bhiva.org/standards-of-care-2012.aspx](http://www.bhiva.org/standards-of-care-2012.aspx)
3.8.4 The Service’s clinical governance arrangements must be integrated in organisational clinical and corporate structures and include the following as a minimum:

- Evidence that effective health programmes are in place (ensuring that programmes are informed by a robust evidence base and performance reviewed regularly)
- Explicit professional standards are set out for staff
- A risk management programme is in place
- Emergency and business continuity
- There is a Serious/Critical Incident reporting procedure in place
- Established Complaints Procedure
- Performance Appraisal System in place including medical revalidation where appropriate
- CPD programme for all staff
- Staff supervision
- Regular departmental meetings to: Review procedures, audit department’s work – this may involve audit of internal processes consideration should also be given to audits of commissioned work
- Develop annual work programmes/business plans and ensure adequate resources and infrastructure
- Regularly audit the Service against national guidelines
- Mechanisms in place to deal with poor performance
- External appraisal (including peer review)
- Induction of new staff
- Health and safety policy

Reporting of clinical governance shall be embedded within the Provider’s performance management arrangements.

3.8.5 The Provider shall develop Patient Group Directives (PGDs) for their own service and any sub-contracted services e.g. Chlamydia treatment and Emergency Hormonal Contraception. The PGD’s and medications chosen must be approved by the Authority prior to implementation and available on request.

**Serious Incidents**

3.8.6 NHS Thurrock CCG (TCCG) will support the Public Health Team in the Local Authority to review incidents which could meet the NHS framework as Serious Incidents (SIs). The authority will continue to manage the service provider including the incident reporting process, however the authority will share reports with the CCG Quality team who will review and provide guidance on the quality of the information in the report and findings, offering suggestions on how the learning can be embedded.

3.8.7 The Council will share the SI framework and our local SI policy with the Provider and this should be used to structure the Provider’s incident reporting and escalation process/s.

3.8.8 The Provider shall email the Thurrock CCG SI email with the details of the SI which would need to be declared through Strategic Executive Information System (StEIS). The information should be sent from the providers secure email address to Thurrock CCG secure SI email address (tccg.si@nhs.net) using the template which is provided by the Council.

3.8.9 The Provider shall comply with national reporting timescales.

3.9 **Infection Control**
3.9.1 The Provider shall have systems and processes in place which meet the requirements of the Health and Social Care Act 2008: Code of Practice for the prevention and control of infections and associated guidance (DH, 2010) and demonstrate proportionate compliance. This includes, but is not limited to:

- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible Patients are and any risks that their environment and other users may pose to them.
- Providing and maintaining a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Providing suitable accurate information on infections to patients and their visitors.
- Providing immediately suitable accurate information on infections to any person concerned with providing further support or nursing/medical care.
- Ensuring that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
- Ensuring that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
- Providing access to adequate isolation facilities.
- Securing adequate access to laboratory support as appropriate.
- Policies that will help to prevent and control infections.
- Ensuring, so far as is reasonably practicable, staff education and protection.

3.10 Staffing and Staff Competence

3.10.1 The Provider shall develop the sexual health workforce through delivery of the full range of FSRH and BASHH accredited postgraduate training including specialist training programmes.

3.10.2 In order to support full integration and seamless patient pathways for both sexual health and contraceptive services, the Provider shall put in place an appropriate staffing structure to ensure that service users have all their sexual health and contraceptive needs met in one visit.

3.10.3 The Provider will therefore structure the Service around a skills mix that ensures there is both sufficient leadership and distribution of skills to develop and supply the key interventions. Within the funding envelope, the Service shall be provided by sufficient collective competencies to deliver safe, effective and best value outcomes.

3.10.4 The Council considers that the recommended ratios (Royal College of Physicians and Faculty of Sexual and Reproductive Health) of 2 FTE GUM consultants per 250,000 population and 1 FTE Contraceptive and Sexual Health consultant to 25,000 population are the minimum number that should apply to this Contract.

3.10.5 In addition to service specific training for all frontline staff, the Provider shall ensure that they are trained to promote and achieve Making Every Contact Count (MECC) and Brief Opportunistic Advice (BOA) to encourage increased referrals into other Public Health services where appropriate, including but not limited to healthy lifestyle services including stop smoking, exercise, weight management, drug and alcohol. These are particularly important for women who are beginning to plan a pregnancy.

3.10.6 The Provider shall develop and provide a robust system to record all training (including MECC and BOA), specific qualifications and insurance in order to demonstrate compliance to the Council.
3.10.7 The Provider shall ensure they keep up to date with any developments in MECC training as it is released and to promote this to contractors and incorporate into face to face refresher training as appropriate. This includes, in line with the national action plan, the requirement on that all health visitors and school nurses should be trained to expected standards.9

3.10.8 Specifically with regard to safeguarding, the Provider shall:

- Ensure the workforce understands and recognises issues that are culturally specific such as female genital mutilation (FGM) and forced marriage.
- Ensure cultural, ethnic, linguistic, sexual orientation and religious needs are taken into account by all agencies when delivering services.
- All staff working with children and young people shall receive and maintain achievement of Level 2 Safeguarding Training in accordance with Thurrock Local Safeguarding Children’s Board/ Intercollegiate Document 2014 commensurate with their role, and the organisations in-house safeguarding training. Provision and receipt of training must be recorded.
- Have a designated safeguarding officer trained to Level 3 in safeguarding/Named Nurse trained to Level 4 in safeguarding.
- Be able to demonstrate that they have taken on board learning outcomes of serious case reviews undertaken by Thurrock LSCB where relevant to the Service and are implementing safe practice in line with both national and Thurrock thematic leads for changes or robust practice measures.
- Have a robust mechanism in place for the reporting of child protection concerns (in accordance with the Children's Act 1989 and 2004).
- Ensure safer recruitment procedures include adherence to the Disclosure and Barring Service (DBS) requirements for all staff who directly deliver services to patients, including sub-contracted staff.
- Recognise that Integrated working requires the timely and effective sharing of health information to support the development of a seamless and responsive service to maximise the level of support an individual needs at a time most appropriate to the need.

3.10.9 The Provider shall ensure staff are up-to-date with relevant evidence and national guidance relating to all service elements, and shall update the services and programmes as appropriate during the contract term

3.11 Advertising and Marketing

3.11.1 The Provider is responsible for all outreach and marketing work regarding the delivery of the Integrated Sexual Health Services available in Thurrock including C-Card, Emergency Hormonal Contraception, STI testing.

3.11.2 The majority of services will be delivered on a universal entitlement basis, or as a result of direct referral, however the Provider shall (as part of the single point of contact objective) ensure there is a communications plan in place to ensure individuals are aware of services, how they access these and what to do if they need help.

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9 Health Education England (HEE) and PHE have launched a suite of resources aimed at supporting the health care and wider workforce to “Make Every Contact Count”. These resources include training on influencing behaviour change and initiating difficult conversations about health and wellbeing, as well as targeted training for Health Visitors and School Nurses given their unique positioning which enables them to identify weight issues in children early on.
3.11.3 The Provider shall ensure messages are delivered in an innovative and age-appropriate manner, using approaches and marketing techniques tailored to specific audiences.

3.11.4 The Provider must ensure the Service has a user friendly website for people to access information on Sexual Health and Contraception and the services available in Thurrock. It must be quick and easy for people to find their nearest clinics via a postcode search function. The website must be updated regularly with full clinic information and contact details and fully operational within three months of contract start date.

3.11.5 The Service will have an active presence with regular posts on social media including Twitter and Facebook.

3.11.6 The Provider’s communication plans including proposals to meet all of the requirements in this section will be agreed by the Council prior to implementation. Individual updates (e.g. Twitter feeds) do not need to be approved but the Council reserves the right to require the Provider to remove or replace any item that does not align to the Council’s vision for this Service.

3.11.17 The Provider will promote the service and update partners and sub-contractors on a regular basis through, for example, a newsletter on a biannual basis. The aims of the newsletter are to:
- Raise awareness of the Service
- Promote the clinics
- Provide clinical and non-clinical updates e.g. new guidance
- Sharing best practice
- Promote upcoming training courses

3.12 Complaints

3.12.1 The Provider shall put in place a complaints system that is compatible with the Council’s Complaints Procedure, details of which are available on www.thurrock.gov.uk. Details of complaints and the remedial action where appropriate shall be shared with the Council's Commissioner at the performance meetings.

4. HUB & SPOKE CONTRACEPTIVE, SEXUAL HEALTH, REPRODUCTIVE AND GENITO-URINARY (GUM) SERVICES

4.1 Hub and Spoke Services - Overview

4.1.1 The Service will be provided using a Hub and Spoke model which spans:

- Pre-level - 1 Self-managed care e.g. health promotion, condom distribution, asymptomatic opportunistic Chlamydia screening
- Level 1 Basic – Primary care e.g. contraception provision by GPs and Pharmacies
- Level 2 Intermediate – delivery in Spoke Clinics e.g. asymptomatic and symptomatic STI provision including HIV testing and uncomplicated contraception provision
- Level 3 Complex – delivery in the hub e.g. complicated and recurrent STI provision and complicated contraception.

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4.1.2 The Provider will operate a core hub clinic (“the Hub”) at a central location and spoke clinics in local communities across the borough as determined by need and demand (See Section 15.2).

4.1.3 The Service must have a Central Booking System and triage patients appropriately (See Section 9).

4.1.4 The Hub will provide all levels of sexual and reproductive health care and self-managed care (microscopy will be available at this site). Spoke provision can be more limited and is likely to deliver elements from across all levels without attempting to deliver a full Level 3 service.

4.1.5 As far as is possible, the different levels of service that may be provided through the hub and spoke model should not create artificial barriers to service delivery. The aim of the “Integrated” Service shall always be to ensure ease of access for patients to appropriate services, preferably in a single visit.

4.1.6 The Provider will ensure that the service users can receive both contraception and STI screening and treatment services in the same appointment. This ensures a service that is fully integrated, not merely co-located.

4.2 Self-Managed Care

4.2.1 Some self-managed services may be accessed online. Patients of all ages will be able to access the following without the need to see a healthcare practitioner, although support must be available if needed. With the exception of the provision of sexual health information, those under the age of 16 must be seen by a worker trained to assess competence to receive sexual health advice and interventions in the absence of a parent or guardian and to ensure that safeguarding issues are identified and appropriately referred on.

4.2.2 Self-managed care is available to Thurrock residents only and will include:

- Health information including general information on pregnancy, STI’s including HIV and prevention/ safer sex advice and information on the full range of contraceptive methods and where these are available
- Primary prevention initiatives to improve overall sexual health of the community
- Male and female condoms and lubricant
- Chlamydia home sampling kits for under 25 year olds
- STI and HIV home sampling kits
- Pregnancy testing kits
- C-Card for under 25 year olds

4.3 Basic and Intermediate Care (Levels 1 and 2):

4.3.1 The Provider shall deliver basic and intermediate care (Levels 1 and 2) through the Hub and Spoke Model.

4.3.2 The Service will provide patients with appropriate information on services provided by local voluntary sector sexual health providers including referrals and/or signposting.

4.3.3 All practitioners will ensure they take full sexual health histories and carry out risk assessments where relevant. Where patients are under 16 years old, a child protection/safeguarding assessment will be completed and a referral made where appropriate.
4.3.4 With regard to the specialist elements of service to be provided, the following list is useful, though not exhaustive. Although grouped into sections, the Provider shall note that as stated throughout this specification, where more than one service is required by a patient, the different services shall be delivered as far as possible in the same appointment.

Contraception

4.3.5 Level 1 and 2 contraception services include the following:

- Pregnancy testing and appropriate onward referral to abortion services or maternity care
- Supply of male and female condoms and lubricant
- All methods or oral emergency contraception and the intrauterine device (IUD) for emergency contraception
- First prescription and continuing supply of combined hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist
- First prescription and continuing supply of injectable contraception
- IUD and IUD uncomplicated insertion, follow up and removal
- Diaphragm fitting and follow up
- Uncomplicated contraceptive implant insertion, follow up and removal
- Assessment and referral for difficult implant removal
- Natural family planning advice
- Management of problems with hormonal contraceptives
- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC)\textsuperscript{11}
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this

STI Screening and Treatment

4.3.6 The Provider shall deliver screening and treatment services for sexually transmitted infections that will include the following. The Provider shall note the exclusion criteria set out at 4.1.15:

- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- HIV and syphilis testing and pre and post- test discussions (with referral pathways in place)
- Initiation of Post Exposure Prophylaxis (PEP) with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on groups at risk
- Hepatitis C testing and discussion (with referral pathways in place)
- Contact tracing/partner notification including for HIV\textsuperscript{12}
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (Trichomonas vaginalis)(excluding symptomatic men)

\textsuperscript{11} UK Medical Eligibility Criteria and Contraceptive Use, FSRH 2009 (updated 2010) \url{http://www.fsrh.org/pdfs/UKMEC2009.pdf}

• Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/ LGV (Lymphogranuloma Venereum)
• Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
• Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV

4.3.7 The following patients are excluded from Level 1 and 2 Treatment:
- Men with dysuria and/ or genital discharge
- Those with symptoms at extra-genital sites e.g. rectal or pharyngeal
- Pregnant women (except women with uncomplicated infections requesting abortion)
- Those with genital ulceration other than uncomplicated genital herpes

Referral Services
4.3.7 The Provider will refer patients on to other services outside of the Integrated Sexual Health Service where appropriate. This will include:

• Direct referrals for antenatal care
• Direct referrals for abortion care and to support self-referral
• Counselling and direct referrals for male and female sterilisation
• Domestic abuse screening and referrals
• Assessment and referral for psychosexual issues
• Assessment and referral for Brief Alcohol Interventions (BIA’s)
• Safeguarding assessment and referral to the MASH
• Referral for Female Genital Mutilation (FGM) specialist advice and care
• Urgent and routine referral pathways to and from related specialities (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine/ infectious diseases for inpatient HIV care
• Urgent and routine referral pathways to and from social care
• Coordination of outreach clinical services for high risk groups
• Interface with specialised HIV services as commissioned by NHS England
• Assessment and referral of sexual assault cases

4.4 Specialist Care (Level 3)
4.4.1 The Integrated Sexual Health Service will also include more specialist (Level 3) services where required for patients. This will include:

• Management of complex contraceptive problems including application of the UK Medical Eligibility Criteria (UKMEC)\(^\text{13}\)
• Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this
• Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
• Management of STIs in pregnant women (except women with uncomplicated infections requesting abortion)
• Coordination of outreach clinical services for high risk groups
• Interface with specialised HIV services as commissioned by NHS England
• Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV

4.4.2 Other elements may be added or amended in response to guidance from BASHH, FSRH, NICE or other clinical groups and the list should not be seen as exhaustive.

4.5 Long Acting Reversible Contraception (LARC)

4.5.1 Improving uptake and access to LARC is a key priority for the Council and the Provider shall therefore promote LARC as a more reliable contraceptive method. Women shall be offered access to the intrauterine device (IUD), intrauterine system (IUS) and sub-dermal implant (SDI).

4.5.2 Use of LARC aims to:

- Provide value for money contraception
- Reduce unplanned conceptions
- Reduce teenage conceptions
- Reduce abortions

4.5.3 LARC will be supplied (both fitted and removed) directly by the Provider, and additionally through agreements with Primary Care, as set out in section 4.6 of this specification.

4.5.4 Within the Hub and Spoke Service, the Provider will:

- Ensure sufficient appointments are available in the hub and spoke clinics for LARC in order that waiting times are minimised
- Promote the LARC offer, thereby increasing awareness especially among young people
- Establish and monitor a common high standard across all providers
- Maximise the use of LARC beyond 12 months where possible
- Ensure LARC is readily available in areas of high unmet need e.g. where there are high rates of abortions and teenage conceptions

4.5.5 Reducing waiting times for LARC is a key priority for this Service. The Provider shall therefore ensure that waiting times do not exceed 30 calendar days in Year 1, during which period women shall be offered a choice of alternative contraception. Any issues with waiting times shall be reported to the Council immediately (not waiting for the next performance reporting cycle). Waiting time targets in Years 2 and 3 shall be reduced to 20 and 10 days respectively.

4.5.6 As part of this contract LARC may only be provided for contraceptive purposes.

4.7 Emergency Hormonal Contraception (EHC)

4.7.1 All women shall be offered access to EHC across the borough in order to:

- Reduce unplanned pregnancy among women aged under 30
- Reduce abortions - and especially - repeat abortions
- Reduce teenage conceptions

4.7.2 This will be achieved by:

- Increasing the knowledge, especially among young people, of the availability of emergency contraception
- Providing easy access to EHC
• Ensuring access to emergency contraception within 24 hours and within a 30 minute journey time wherever possible in Thurrock including ‘out of hours’.
• Increasing the use of EHC by women who have had unprotected sex to contribute to a reduction in the number of unplanned pregnancies
• Extending the EHC Service to Pharmacies as set out in Section 4.6.
• Ensure EHC is readily available in areas of high unmet need e.g. where there are high rates of abortions and teenage conception rates.

4.8 Out of Area (GUM) Cross Charging

Non-Thurrock Residents Using the Service
4.8.1 The Service must operate an open access policy regardless of the patient’s place of residence (including overseas visitors, migrants, asylum seekers and refugees as outlined in the NHS Migrants Health Guide).

4.8.2 The Provider will be directly responsible for reclaiming costs from other Local Authorities whose residents access Thurrock GUM services. Recharging for out of area activity shall follow most recent national guidance in terms of procedures and tariff costs and where income exceeds cost of direct service delivery this shall be reinvested into the Service.

Thurrock Residents Accessing Services in other Areas
4.8.4 The Provider will also manage within the block contract price the full recharging process (invoice and payments) from other Providers where Thurrock residents access GUM Services out of area (OOA) including invoices received after contract termination but for services that were delivered during the contract period.

Cross Charging Performance Reporting
4.8.5 The Provider shall produce a quarterly statement for the Council that demonstrates:

• Income received from other local authorities for any non-Thurrock resident accessing the Service
• Access by Thurrock Residents of Out of Area Services
• Evidence income/expenditure and reinvestment of the surplus

4.8.6 Note that historic data on cross-charging is provided at Appendix 8.

5. RELATIONSHIPS AND SEX EDUCATION

5.1 From September 2019 Relationships and Sex Education (RSE) will be mandatory in all secondary schools in the United Kingdom. The Provider shall support the provision of RSE in schools which may involve partnership working as part of a combined offer for schools alongside other Public Health providers and services (e.g. mental health). The offer of RSE delivery or support and training must be made available to all schools, however is dependent upon uptake.

5.2 The Provider will work with Public Health, the Council’s School Improvement team, School Nurses and other Brighter Futures providers to ensure there is excellent provision of RSE in all of Thurrock’s secondary schools either through direct supply or the provision of training for those delivering the sessions, should schools wish to provide sessions in-house. The Council will facilitate building relationships with schools and the Provider shall work with the schools to select dates of RSE delivery that are mutually convenient to both parties.
5.3 The sessions will be developed by the Provider in line with the new RSE curriculum (when published). Sessions will have a key focus on reducing risky behaviours and promoting the support and services available in Thurrock and must be agreed with the commissioner prior to commencing delivery. Recent engagement with young people in Thurrock has identified the preferences for innovative methods of delivery for education (e.g. workshops and interactive sessions) and more information on services available in Thurrock, particularly the C-Card. Teenage boys have requested information to also be tailored to them, particularly with regards to teenage pregnancy which often places a greater emphasis on the girl.

5.4 A minimum of one day will be allocated per school. Details of secondary schools in Thurrock can be found at: https://www.thurrock.gov.uk/secondary-schools. Please note Thurrock also has two special schools which are secondary schools and will require specific tailored RSE provision. Details can be found at https://www.thurrock.gov.uk/special-schools.

5.5 Providers will also support school assemblies and health promotion events in secondary schools and colleges across Thurrock.

6. OUTREACH

6.1 The aim of the outreach element is to:
- Provide appropriate support to prevent sexual ill health for those not accessing universal services
- Identify and remove barriers to accessing universal or targeted services
- Promote universal services and encourage their use
- Provide services in areas that lack sexual health provision
- Support individuals to make informed and responsible decisions regarding their sexual and reproductive health.

6.2 The Provider shall provide 1:1 contraception and sexual health outreach services to those who are not currently accessing services and those who are vulnerable and at greatest risk of sexual ill health. This will include, but is not limited to, the following groups:
- LGBT (Lesbian, Gay, Bisexual and Transsexual)
- Young people
- MSM (Men who have Sex with Men)
- BME (Black Minority Ethnic)
- Teenage parents or those at high risk of becoming teenage parents
- Those with learning disabilities or other disabilities
- Looked after children
- Those classified as Not In Employment, Education or Training (NEET)
- Sex workers

6.3 Information provided must be delivered in a form that is age appropriate and relevant to the target audience – and will include:
- Promotion of service information and key sexual health messages to the local population and stakeholders including that which aims to reduce the stigma associated with STI’s, HIV and unwanted pregnancy
- Supporting the local dissemination of key Public Health England and national campaigns
- Promotions at relevant events and the development and delivery of national campaigns at a local level
• Throughout the year, in addition to planned outreach events the Service may be expected to attend other events as required or requested by the Council. This will not exceed a total of 6 events per year.

6.4 Outreach Services will include some elements of direct delivery where this can be done safely and, where appropriate, privately – to include:

• Promoting LARC (and fitting where possible)
• Prescribing oral contraception
• Issuing emergency contraception
• Chlamydia screening and treatment
• HIV Point of Care Testing
• C-Card sign ups
• Issuing STI self-sampling kits

7. C-CARD CONDOM DISTRIBUTION SCHEME

7.1 The Provider will manage all aspects of the C-Card Condom Distribution Scheme for 13-24 year olds in Thurrock. The scheme must be delivered in line with the latest guidance and shall be paperless through the use of electronic C-Cards.

7.2 The Provider shall advertise and promote the scheme, ensuring the C-Card brand is recognised by young people in Thurrock. The scheme must target high-risk groups including those engaging or likely to engage in risky behaviours. Access to the C-Card must also feature in all aspects of the Integrated Sexual Health Service i.e. clinics, outreach activities and education based services.

7.3 The Scheme will be offered in a variety of venues such as GP practices, Pharmacies, youth centres, clubs, schools, colleges and other settings accessed by young people. As well as traditional face to face services the Provider shall have or develop an online offer for young people to order condoms online and have them posted to their home.

7.4 As per the NICE guidance the Scheme must ensure the following components are included:

• The competence of young people under 16 is assessed and for others whom there is a duty of care prior to providing condoms,
• Young people must be taught to use condoms effectively and safely (using education, information and demonstration) before providing condoms
• Lubricant is provided as well as condoms if young people need or want this
• A range of condoms should be provided (e.g. latex free, various sizes, female condoms and dental dams)
• Consultation with young people using the scheme in order to review its effectiveness.
• The Provider must take in to account young people’s circumstances. Once a young person has made a specified number of visits to get condoms, time must be allocated to talk to them again about their relationship and condom use
• Identification of any signs of child sexual exploitation or abuse
• Offer of other pathways into other services (e.g. chlamydia screening or pregnancy testing).

7.5 In addition to direct delivery, the Provider shall train a variety of health professionals and non-health professionals to be C-Card assessors and distributors including
Pharmacies which young people in Thurrock have identified as their preferred place to access the Scheme.

7.6 Through an easy ordering system, the Provider will supply and coordinate a free condom service that distributes condoms (including various sizes, thicker condoms and lube depending on individual choice). The service must be clear on the importance of the kite mark and CE mark for condoms in its promotion to the target audience.

8. NATIONAL CHLAMYDIA SCREENING PROGRAMME

8.1 The Provider will be responsible for all aspects of the National Chlamydia Screening Programme (NCSP) for those aged 15-24. In accordance with the Public Health Outcome Framework measure 3.2 the Provider will work towards achieving a diagnostic rate of 2,300/100,000 for chlamydia screening and follow the NCSP and other relevant guidance.

8.2 The aim of the NCSP is to:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection
- Reduce onward transmission to sexual partners
- Prevent the consequences of untreated infection
- Raise awareness and skills of health professionals to screen for chlamydia and provide the information young adults need to reduce the risk of infection and transmission.

8.3 The Provider will deliver the NCSP in Thurrock through:

- Providing the information young people need to reduce the risk of infection and onward transmission in innovative and culturally relevant ways
- Increasing awareness of the risks of unprotected sex amongst the target local population by general promotion of the service in innovative and culturally appropriate ways
- Ensuring easy no-cost access to testing and treatment for Chlamydia through clinic delivery
- Provision, where Pharmacies have received training to carry out the NCSP, of appropriate PGDs for Azithromycin and Doxycycline
- Promoting and supporting Chlamydia testing in a variety of young people focussed settings
- Providing access to online and postal sampling kits for Patients aged 16-24
- Ensuring that patients aged under 16 being seen by a trained health care professional
- Delivering a confidential, trusted and respected high quality service
- Ensuring rapid and accurate reporting of results to all screened patients by their preferred method of communication
- Offering retests for all positives 3 months after treatment
- Offering retest to all scheme users after 12 months or upon change of sexual partner

8.4 The Provider will directly deliver the NCSP and also widen provision through sub-contracting primary care and other providers, and through the supply of online, text and postal request facilities.
8.5 Chlamydia screening will be delivered on an opportunistic basis i.e. as part of routine consultations in primary care and contraception and sexual health services, rather than as a stand-alone programme of testing with no links into broader sexual and other healthcare services.

8.6 This Service Element will be compliant with the most recent NCSP standards and the Provider will put in place procedures to ensure staff and sub-contracted partners are kept up-to-date with standards and best practice guidance at all times.

The Provider is responsible for reporting all data relevant to the NCSP and will liaise with their contracted laboratories in order to ensure the labs report to the Chlamydia Testing Activity Database (CTAD) in an accurate and timely manner.

8.7 The Provider will ensure that:

- Patients under 16 years must have a face to face consultation in order to assess Fraser competency
- Patient Group Directive (PGD) for Azithromycin and appropriate governance processes are in place.
- Safeguarding and Child Sexual Exploitation are considered at all stages of the scheme
- Case management and partner notification are completed by suitably trained staff.

8.8 This Service includes the provision of Chlamydia testing kits to Primary Care Providers, whether or not the optional management of these providers as set out within Section 13 is included within the final contract. The

9. SEXUAL HEALTH TRAINING

9.1 The Provider shall co-ordinate and support the delivery of sexual health care across the locality through expert clinical training, advice, clinical governance and clinical networks. The Provider will deliver a programme of sexual health training and development sessions to a range of organisations to prevent sexual ill-health and promote sexual wellbeing to the population of Thurrock.

9.2 Training will ensure that accurate, consistent and culturally appropriate information on sexual health is available from a range of providers and agencies including and not limited to; health, education, adults’ and children’s services and the voluntary sector. Training should be promoted to all third sector organisations working with high risk groups including young people’s services (i.e. drugs and alcohol services), school health teams, those supporting looked after young people, services for sex workers and any other organisations providing sexual health services to the Thurrock population.

9.3 The Provider will include training to Primary Care providers, whether or not the optional management of services through primary care (as set out in Section 13 of this specification) is included within the final contract. This will include training for Chlamydia testing and treatment, provision of EHC and delivery of LARC, as appropriate.

9.4 The Provider will develop the content and materials required for the training. Training shall be delivered to level 2/3 of the Making Every Contact Count framework or similar for STI awareness (behaviour change intervention) and non-clinical issues such as values, attitudes and ethnics including developing a high level of knowledge and skills around diversity issues.
Training will include:

- An introduction to Sexual Health – to include sexual history/ risk assessment, sex, drugs and alcohol, health promotion and prevention work, C-Card and NCSP, STI and HIV prevention and awareness.
- Risky behaviours training
- PGD Training for relevant sub-contracted partners
- C-Card Assessor and Distributor training

9.5 Once the training programme is agreed, the Provider shall develop a brochure and calendar promoting the training available. Dates and locations shall be flexible to maximise attendance.

9.6 Where appropriate the Provider shall deliver multidisciplinary postgraduate training, including to primary and secondary care; and may include delivering undergraduate training and postgraduate training including placements for medical and nursing students and training and education for specialty medical trainees which should be in line with the latest GMC curriculum.

10. **ON-LINE STI TESTING**

10.1 With the aim of increasing take-up and reducing pressure on the Hub and Spoke provision, the Provider shall supply on-line STI testing service for asymptomatic people who wish to test themselves at home.

10.2 The Provider shall develop a model for the delivery of on-line testing for a range of STIs, including Chlamydia and in particular HIV for high-risk groups e.g. MSM and BME, and propose this through the tender process.

10.3 The Provider may also wish to offer online testing for chlamydia, gonorrhoea and syphilis. Chlamydia tests as part of the NCSP are included in Element 5 and should not be included within this element.

10.4 Preventx is currently providing online testing in Thurrock for the NCSP and HIV home-sampling. This agreement with the Authority terminates on 31st March 2018 and the Provider will need to put their own arrangement into place.

11. **MICROBIOLOGY AND LABORATORY SERVICES**

11.1 All laboratory service costs shall be contained within the block contract price. The Provider shall contract adequate laboratory support to comply with best practice and facilitate an efficient and effective test and treat service as appropriate to each level. This includes laboratory service costs for all chlamydia kits that are distributed through Primary Care.

11.2 The Provider shall ensure that the laboratory service is able to demonstrate satisfactory external quality control data for the tests undertaken and should have full accreditation status; being Clinical Pathology Association (CPAS) / United Kingdom Accreditation Service (UKAS) accredited and have evidence of External Quality Assessment (EQA), Internal Quality Control (ICQ) and Internal Quality Assurance (IQA).

11.3 Laboratories should use the ‘gold standard’ test wherever possible and adhere to national standard operating procedures where possible and adhere to national standard operating procedures where available. Guidance is available from PHE and BASHH for testing procedures. The Provider will ensure that the laboratory is aware
of all CTAD requirements to ensure the laboratory supplies the Provider with the relevant data for submission.

11.4 The Provider shall establish systems to ensure Patients receive their results for any test carried out. To accommodate user preference, the notification system shall have a choice of methods for informing Patients of their results (these should include email, text or telephone).

11.5 The Provider is responsible for the performance of all commissioned laboratories including the management of samples sent to reference laboratories and shall ensure that there is continuity planning provision in place should the contracted laboratory be unable to provide the service.

12. MEDICINES MANAGEMENT

12.1 Prescribing

12.1.1 The Provider shall meet the costs of all medicines and medical devices within the block contract price.

12.1.2 The Provider shall adhere to Department of Health guidance in relation to prescribing and best practice guidance of national bodies including, for instance:

- British Association for Sexual Health and HIV (BASHH)
- British HIV Association (BHIVA)
- Faculty of Sexual and Reproductive Healthcare (FSRH)
- National Institute of Clinical Excellence (NICE)
- Public Health England (PHE)

12.1.3 The Provider shall develop and adopt medicines management policies and procedures to inform the procurement, storage, administration and destruction of medicines and medical devices. NHS guidelines should be followed.

12.1.4 The Provider will develop and authorise Patient Group Directions (PGDs) to allow the interventions described in this specification to be provided.

*Please note NHS England is responsible for funding the drug costs associated with the provision of PEP. NHS England is working to agree a position on whether PrEP should be approved. The Commissioners understand that NHS England will be responsible for the drug costs associated with the provision of PrEP but this position has not been confirmed.)*

12.2 Vaccinations

12.2.1 The Provider is required to ensure that for Patients attending for sexual health screening or treatment, immunisation status is checked and that the Patient is up-to-date in line with the advice set out in the Green Book.

12.2.2 The Provider is required to adhere to national guidelines relating to the provision of screening for Hepatitis. Hepatitis A and Hepatitis B vaccinations should be offered to women and men in high risk groups including, for instance, men who have sex with men and people who inject drugs. The Provider should also offer, if appropriate, immunisation for immuno-suppressed Patients – e.g. flu vaccines.

12.2.3 The Provider will ensure a process is in place to recall Patients requiring additional doses.

12.2.4 The Provider is required to ensure that safer sex information and risk reduction strategies are offered to all those attending for screening, vaccination or treatment.
13. OPTIONAL SERVICE ELEMENT - PRIMARY CARE SERVICES

13.1 Introduction

13.1.1 Thurrock Council is committed to increase public health service availability and accessibility through delivery by Primary Care providers (GPs and Pharmacies) including sexual health services. The Council is, at the time of tendering this service, considering whether to manage this provision in-house, or to include the management within third party contracts. The Provider shall therefore prepare to deliver the primary service sub-contracting arrangements as an option, in accordance with the requirements set out in this Section 13. The Council’s decision will be advised to the successful bidder at the point of Contract Award.

13.2 Overview

13.2.1 Should this option be included within the Integrated Sexual Health Contract, the Provider shall deliver some provision through primary care providers. It is envisaged that the following delivery arrangements are including:

<table>
<thead>
<tr>
<th>Service Element</th>
<th>May Be Delivered by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GPs</td>
</tr>
<tr>
<td>Chlamydia Screening and treatment</td>
<td>Yes</td>
</tr>
<tr>
<td>LARC – Intrauterine System (IUS) &amp; Intrauterine Device (IUD)</td>
<td>Yes</td>
</tr>
<tr>
<td>LARC – Sub-dermal Implants</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Hormonal Contraception</td>
<td>No</td>
</tr>
<tr>
<td>Condoms via C-Card (free to YP)</td>
<td>No</td>
</tr>
</tbody>
</table>

13.2.2 The Provider will be fully responsible for all aspects of these schemes, including:

- Advertising
- Clinical management and governance
- Costs
- Literature
- Patient Group Directions (as necessary)
- Reporting data to the Authority in an accurate and timely manner
- Training

13.2.3 Specifically with regard to these services, the Provider shall deliver accredited FSRH training to the primary care workforce to fit and remove IUD/IUS and SDI LARC.

13.2.4 The Provider will ensure there is sufficient provision of primary care services in areas of identified sexual ill-health or teenage conceptions.

13.3 Supporting GPs and Pharmacies

13.3.1 In order to ensure effective delivery, it will be critical for the Provider to proactively support Primary Care to deliver these services in Thurrock.

13.3.2 The Provider will need to build supportive relationships across the wide variety of Primary Care services and manage these in a way that delivers the outcomes required for these specific services. Some Primary Care providers will need more support than others.
13.3.3 Sub-contracts with Primary Care should be proportionate and reasonable for the type and value of services to be delivered.

13.3.4 The Provider shall develop and provide a robust system across itself and all sub-contracted partners to record all training and continuing professional development (including MECC and BOA), specific qualifications and insurance in order to demonstrate compliance to the Council. This includes evidence of enhanced Disclosure and Barring Service checks for all “Relevant Staff”.

Relevant Staff are defined as those individuals who are directly delivering the Services on a one to one basis within a private (eg. consultation room) environment and who are not professionally regulated and therefore subject to similar checks. For avoidance of doubt, enhanced DBS checks will not apply to GPs, Nurses or Pharmacists.

13.3.5 All costs for Primary Care DBS checks where required shall be included within the Block Contract price.

13.4 Charging and Payments

13.4.1 The Council will pay the Provider a fixed fee of £60,000 per annum to provide and manage the Primary Care Service “the Primary Care Service Cost” as set out in this Section 13. This sum will cover all activity delivered by Primary Care with no maximum cap.

13.4.2 Payment to the Provider will be made in one single amount when the Provider achieves the minimum delivery (payment) target numbers set out in the table below. Should the Provider not achieve the minimum target figures by the end of each contract year\(^\text{14}\), the Council will pay the Provider 50% of the annual figure.

<table>
<thead>
<tr>
<th>Item</th>
<th>Minimum Delivery (Payment) Target</th>
<th>Target for Year 1 (set out in KPIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LARC (IUD insertion)</td>
<td>60</td>
<td>67</td>
</tr>
<tr>
<td>LARC (IUS insertion)</td>
<td>150</td>
<td>173</td>
</tr>
<tr>
<td>LARC (Implant insertion)</td>
<td>170</td>
<td>191</td>
</tr>
<tr>
<td>Number of pharmacies trained, signed up and delivering the NCSP testing and treatment and EHC</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

13.4.3 Primary Care Service Providers will be reimbursed for services by the Provider, in accordance with the payment structure to be agreed between those parties. For reference the current tariff and historic activity for SLAs and can be found in Appendix 11.

\(^{14}\) For avoidance of doubt, the contract years referred to in 13.4.2 will be 1.4.18 to 31.3.19, 1.4.19 to 31.3.20, 1.4.20 to 31.3.21 for the first three years and then this will continue if the two year extension is agreed. All targets will be reviewed annually.
14. INFORMATION TECHNOLOGY AND DATA SHARING

14.1 The Provider’s IT systems will require a single IT solution for both Sexual Health and Contraception. The Provider will put in place a method for sharing information (both from and to) Primary Care, where appropriate, either through access to Systm1 and/or EMIS or other method to be approved by the Council. The system must be capable of recording all information required for both national and local data reporting (see section 16.4).

14.2 The Provider must have effective governance in place in accordance with national / local guidance for maintaining data security and confidentiality.

14.3 The Provider must:

• Meet all NHS IG Tool Kit and CCG reporting requirements;
• Meet all Thurrock Council IG procedures;
• Allow collection and analysis of accurate and complete activity data to support service effectiveness and to produce all data returns for presentation to the Commissioner in accordance with the requirements at Appendix 1 and 2 of this specification;
• Enable accessible (controlled) patient information across different elements of the Model;
• Include reporting functions to support production of all data required for:
  o The Health and Wellbeing Strategy Outcome Framework
  o The Integrated Sexual Health Service KPIs (set out in Appendix 1)
  o All mandated service metrics and data returns
  o Any other activity information required by the Commissioner or to monitor service delivery and inform service redesign and innovation

14.4 The Provider will ensure that all relevant information sharing agreements are in place with GPs, Pharmacies, laboratories and other relevant Health Providers (such as Basildon and Thurrock Hospitals and it’s neighbouring hospitals, North East London Foundation Trust, South Essex Foundation Trust, and its neighbouring trusts) in order that they have access to relevant information about Patients.

14.5 The Provider shall ensure that referral and outcome information including appropriate personal client data is shared with GPs, Health Professionals and all Providers across the Integrated Sexual Health Service at all relevant stages in the pathway. This includes authorised third parties working with the Council, as advised.

14.6 Specific policy and legislative requirements are set out within Appendix 6: Data Protection and Consent.

15. ACCESSIBILITY AND PREMISES

15.1 Premises Introduction

15.1.1 The Provider shall operate Level 1-3 services as determined by need and demand, meeting the requirements laid out below. The Provider will ensure that residents have ease of access to the service and is required to take reasonable steps to ensure the service accessible and delivered in an appropriate manner.

15.1.2 The Provider will propose options for locations and access times for services for agreement by the Council. Any subsequent changes will also be agreed by the Council in advance of implementation.
15.2 **Premises Locations**

15.2.1 The Provider shall identify and secure the use of venues that are suitable for the delivery of the Integrated Sexual Health Service in a range of locations across Thurrock. There will be one main Hub that will serve as a GUM Clinic, providing mainly Level 3 services plus a minimum of three (3) Level 1 and 2 services in spoke clinics throughout Thurrock.

15.2.2 Provision of LARC must be made within a clinical setting, with LARC and STI clinics/spoke services targeted in areas of high teenage pregnancy and poor sexual health outcomes within Thurrock.

15.2.3 A choice of locations should be offered in order to best meet the needs of Thurrock residents and ensure maximum engagement. Locations must be easily accessible for all those who live in the local vicinity (including access by public transport and at times appropriate to the user, suitable for multi-disciplinary delivery of services and be conducive to flexible availability (e.g. early mornings, lunchtimes, after school/ FE College, evenings and weekends).

15.2.4 Premises should be good quality and visible. The Provider shall ensure venues are fit for purpose, have adequate insurance and liability cover. Clinics will be well maintained, easily accessible and compliant with the Equality Act 2010.

15.2.5 The GUM Clinic is currently held at Orsett Hospital and spoke clinics are held at Grays Health Centre, Tilbury Health Centre and Corringham Health Centre. The Provider shall note that there are plans to close Orsett Hospital during the term of this contract and therefore alternative premises must be sourced.

**Service Development – Integrated Medical Centres**

15.2.6 Thurrock Council and the CCG are currently developing four Integrated Medical Centres in the borough from where a range of health and support services will be available. There is a clear benefit for the Integrated Sexual Health Service to be co-located with other provision and the Provider will need to adapt their service delivery to support this development. Exact timescales are not yet clear however further details about the Integrated Medical Centres’ vision is provided for Providers’ information at Appendix 3.

15.2.7 Once the Integrated Medical Centres are operational, the Provider will need to relocate some services to these premises. Costs and practical arrangements are yet to be determined and will be subject to agreement between the Council and Provider.

15.3 **Appointments**

15.3.1 The Provider shall offer a combination of walk-in slots and booked appointments in order to best manage demand. Patients must be given the opportunity to book appointments in advance, preferably with choice of method (phone, email, on-line etc.).

15.3.2 An appointment reminder system should be put in place to remind people of their appointments e.g. text messaging or phone calls. The Provider is required to monitor and report on the number of people who Do Not Attend (DNA) booked appointments.

15.4 **Opening hours**

15.4.1 The Hub will be open access Monday to Saturday and offer clinics during the daytime with a minimum of 2 weekday clinics open until 20:00.
15.4.2 Young people in Thurrock have expressed their requirements for a dedicated clinic specifically for young people (aged under 25). The Provider will establish this clinic on a weekly basis, with appropriate opening times.

15.5 **Waiting areas**

15.5.1 The Provider will offer a friendly and welcoming waiting area with the aim of reducing Patient anxiety. A unisex waiting area will be provided, however when requested, an individual should be given the option to wait separately.

15.5.2 Facilities shall be made available for Patients to self-check-in.

15.5.3 Confidentiality policies must be clearly displayed, adhered to and discussed with Patients.

15.6 **Telephone Lines and Centralised Booking System (CBS)**

15.6.1 The Provider will operate a telephone lines for patient access which will be free to landlines and mobiles and have voicemail facilities. There will be sufficient telephone lines in operation at any one time in order to ensure quick access. The lines will be answered during opening hours as a minimum, with answerphone out-of-hours. The answerphone shall provide information on what to do “out-of-hours” and take voicemail requests for information or appointments.

15.6.2 The telephone line will act as a single point of access in to the Service where Patients will be triaged in to the most appropriate services for their needs by using a risk assessment and sexual history assessment through a centralised booking system (CBS).

15.7 **You’re Welcome**

15.7.1 The Provider shall review their accommodation and access provision in line with the You’re Welcome standards, ensuring they achieve self-accreditation within 12 months with annual renewals.

16. **PERFORMANCE MANAGEMENT AND REPORTING**

16.1 **Record and Data Management**

16.1.1 Provision of accurate up-to-date records is a key element of contract performance and the Commissioner’s ability to ensure that the service is operating as expected to deliver the required outcomes. At all times the Provider shall comply with the requirements and best practice in accordance with the Data Protection Act 1998.

16.2 **Performance Management**

16.2.1 The Council’s Commissioner will be responsible for Performance Management of the Contract. Management will take place through analysis of data, consideration of performance against the KPIs and regular meetings with the Provider.

16.2.2 Contract Management meetings shall take place at regular intervals between the Commissioner and the Provider, according to need, but in any case at a minimum of monthly during the implementation phase (first three months) or any replacement programme, and quarterly thereafter. The Contract Manager and Service Lead(s) must attend all performance meetings.
16.2.3 Should there be any failure to deliver the Service or standards required by the Commissioner, the Provider shall take appropriate action to review and improve these services, and shall advise the Commissioner of the steps they are taking, including any relevant timescales.

Annual Report

16.2.4 The Provider shall develop surveys to measure the views of those who receive the services – either on a universal basis or as part of specific programmes, and of staff delivering these, using validated measures in accordance with NICE requirements. Exact format and timescales will be agreed by both parties at the start of the contract, together with relevant KPIs. The Provider will compile the results in an Annual Report for submission to the Commissioner to a timescale to be agreed by both parties.

Annual Service Review

16.2.5 In addition to performance management, the Council will undertake all reasonable steps to quality assure service delivery, by a number of methods including but not limited to planned site visits, audits and validation of client records. The Provider must cooperate fully in this process. An Annual Review will occur during every year of the contract.

Patient and Public Engagement (PPE)

16.2.5 The Provider will actively engage with the public and ensure all Patients have an opportunity to give feedback and help develop the services. Such engagement will also ensure that the service is accessible and acceptable to current and future users. Feedback must be generated through a variety of methods including surveys and questionnaires, comments and compliments and mystery shopping. The Provider shall work with Thurrock Health Watch where appropriate.

16.2.6 The Provider will develop an Action Plan for PPE and the results and plans will be discussed with the Council at the quarterly meetings. Lessons learned will be shared and applied as appropriate to ensure the services are being continually improved.

16.2.6 In addition, the Provider shall conduct an annual patient survey and an annual staff survey.

Independent Evaluation of the Integrated Sexual Health Service

16.2.7 The Council may carry out an independent evaluation of the Integrated Sexual Health Service. This evaluation will look at both the implementation/process and outcomes of all elements. Details will be provided on award of contract.

16.3 Key Performance Indicators

16.3.1 The Provider shall provide data to evidence their performance against the Key Performance Indicators set out in Appendix 1. These KPIs are set for the first year of the contract. Detail shall be submitted to the Council’s Commissioner to the schedule as set out in the “Reporting Frequency” column.

16.3.2 The list of KPIs is not exhaustive but is intended to give a good indicator to the Provider as to what will be measured going forwards. Some targets will be confirmed prior to contract commencement and some are new; therefore needing a baseline figure before targets can be set. At any time during the contract term the Commissioner and the Provider may work together to incorporate suggest additional or amended KPIs and targets to better demonstrate performance against the Health and Wellbeing Strategy framework, as necessary.
16.3.3 As standard, the Commissioner will review both the performance against and the relevance of, the Key Performance Indicators on an annual basis and agree with the Provider any revisions of these in advance of the next contract year.

16.4 **Data Reporting and Monitoring**

16.4.1 For data sets mandated by the Information Standards Board, the Provider shall maintain an up-to-date understanding of the data sets required and implements data set changes as required by the Information Standards Board through data dictionary control notices. The Provider shall ensure they remain informed of data set changes by subscribing to the NHS Data Model and Dictionary Mailing List. The Provider shall submit all relevant Sexual Health and Contraception data to the relevant bodies in an accurate manner and within the timeline specified.

16.4.2 The Service will generate a quarterly data extract of all patient attendances and diagnosis within GUM and non-GUM clinics in accordance with the PHE Genitourinary Medicine Clinic Activity Dataset (GUMCADv2). Further information and a specification can be found at [https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2](https://www.gov.uk/guidance/genitourinary-medicine-clinic-activity-dataset-gumcadv2).

16.4.3 The Service shall utilise the current version of the Sexual and Reproductive Health Activity Dataset (SHRAD) to capture contraception and other sexual and reproductive health activities. Further information and a specification can be found at [http://content.digital.nhs.uk/datacollections/srhad](http://content.digital.nhs.uk/datacollections/srhad).

16.4.4 Completion of the Chlamydia Testing Activity Database (CTAD) is mandatory for all NHS and Non-NHS commissioned chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified, comprehensive reporting of all chlamydia data in order to effectively monitor the impact of the National Chlamydia Screening Programme. The Provider shall ensure that all testing data is also reported to the CTAD as per national guidelines which can be found at: [https://www.gov.uk/government/publications/chlamydia-guidance-on-reporting-in-ctad-and-gumcadv2](https://www.gov.uk/government/publications/chlamydia-guidance-on-reporting-in-ctad-and-gumcadv2). All core CTAD data requirements are provided to the laboratory for each chlamydia test, e.g. postcode of residence and testing service type.

16.4.5 The Provider shall provide data on new HIV diagnoses to PHE. This data set collects information on new HIV diagnoses, first AIDS diagnoses and deaths in the HIV infected individual (aged 15+). The Provider shall also provide data on all individuals diagnosed with HIV (aged 15+) who attend for HIV related care within the service within a calendar year. Further information and a specification for the HIV and AIDS Reporting System (HARS) can be found at: [https://www.gov.uk/government/publications/hiv-surveillance-systems](https://www.gov.uk/government/publications/hiv-surveillance-systems).

16.4.6 GUMCADv2, SHRAD and HARS will form the basis for a standardised sexual health dataset collected from the Hub and Spoke clinics (plus CTAD from laboratories). The Service shall discuss quarterly GUMCADv2 and SHRAD analysis with the Council in order to enable informed commissioning decisions relating to Gum attendances, activity and STI trends.

16.4.7 All the data requirements above shall apply to 100% of the Patients attending clinics. 95% compliance as a minimum will be expected.

16.4.8 The Provider shall comply with provision of any other ad-hoc data required by the Commissioners, PHE or Department of Health as and when required.

16.4.9 Additionally, the Provider shall supply data as requested by the Council’s Commissioner which will evidence further performance of service delivery. This data may not initially have a target figure, but may form part of the discussions and
amendments to the list of Key Performance Indicators. Data required from the contract outset is listed at Appendix 2 – Data Collection.

16.4.10 Amendments to regular data collection shall be agreed by both parties; however on occasions, information may be required to evidence specific performance as a “one off”. In this case, the Provider shall make every effort to supply the information within two weeks of the date of request, at no additional cost to the Council. This may include a range of geographies, as appropriate to allow for analysis and service planning, i.e., electoral division, Lower and Medium Super Output Areas, Local Authority Districts and CCGs.

16.5 Provider’s Quality Assurance

16.5.1 The Provider shall put in place a robust quality management system that they will use for internal monitoring to ensure that the level of service delivered is as required by the Commissioner. Details of the proposed quality Assurance System shall be provided within the tender submission.

16.5.2 As part of this the Provider will use a range of sources to benchmark the service and develop performance expectations; these sources include the previous performance of the service and regional and national performance.

17. OTHER REQUIREMENTS

17.1 Social Value

17.1.1 The Council is fully committed to implementing the aims of the Social Value Act 2012 and through this procurement, how the economic, social and environmental wellbeing of Thurrock could be improved both during the process and on an ongoing basis.

17.1.2 To this end, the Provider will implement a range of initiatives to achieve the relevant improvements to include, but not limited to:

- Local employment, training and apprenticeships
- Environmental sustainability – use of products and working practices

17.1.3 Bidders will make proposals around these as part of their tender submission and once agreed by the Commissioner, will become a contractual obligation for the successful Provider. The Council’s Social Value framework is available through the following link: https://www.thurrock.gov.uk/council-procedures-and-thresholds/social-values

11.2 Pricing and Payments

11.2.1 From 1st April 2015 it has been mandatory for all suppliers to Thurrock Council to sign up to Oracle iSupplier as part of our wider Digital Strategy. All payments will be processed through this system. Details are available on request and will be provided to the successful bidder.
**Appendix 1 – Key Performance Indicators**

The following table sets out the framework for performance reporting. All KPIs will be numbered and the Provider will be supplied with a template for completion of data returns to the reporting frequency. KPI targets are set below for year one, after which they may be revised to ensure there is continuous improvement within the Service.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>People offered an appointment, or walk-in, within 48 hours of contacting the service</td>
<td>98%</td>
<td>BASHH Standard 1</td>
</tr>
<tr>
<td>1.2</td>
<td>People accessing service to be seen within 48 hours of contacting the service</td>
<td>85%</td>
<td>BASHH Standard 1</td>
</tr>
<tr>
<td>1.3</td>
<td>Patients experiencing waiting times in clinics of &gt;2 hours</td>
<td>&lt;10%</td>
<td>National Service Specification Local Determination</td>
</tr>
<tr>
<td>1.4</td>
<td>New Patients who have sexual history and contraceptive / STI / HIV risk assessment</td>
<td>100%</td>
<td>BASHH Standard 1</td>
</tr>
<tr>
<td>1.5</td>
<td>Percentage of existing Patients who have sexual history and contraceptive / STI / HIV risk assessment</td>
<td>75%</td>
<td>BASHH Standard 1</td>
</tr>
<tr>
<td>1.6</td>
<td>Number of Chlamydia screens generated (not including screens generated by other providers, including freetestme and RUClear)</td>
<td>1,000</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.7</td>
<td>All under-25 year olds attending for the first time screened for chlamydia</td>
<td>75%</td>
<td>Contributes towards PHOF 3.2</td>
</tr>
<tr>
<td>1.8</td>
<td>Percentage positivity of chlamydia screen results</td>
<td>7%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.9</td>
<td>Chlamydia positive index cases receiving treatment within six weeks of test date</td>
<td>95%</td>
<td>NCSP Standard 4</td>
</tr>
<tr>
<td>1.10</td>
<td>Ratio of contacts of chlamydia index cases whose attendance at a Level 1-3 service was documented as reported by the index case, or by a healthcare worker, within 4 weeks of the date of the first Partner Notification discussion</td>
<td>0.6</td>
<td>BASSH Statement on Partner Notification for STIs NCSP Standard 4</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>KPI Target</td>
<td>Technical Reference Guide</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.11</td>
<td>Ratio of all contacts of chlamydia index case whose attendance at a Level 1-3 sexual health service was documented as verified by a healthcare worker, within four weeks of the first Partner Notification discussion</td>
<td>0.4</td>
<td>BASSH Statement on Partner Notification for STIs NCSP Standard 4</td>
</tr>
<tr>
<td>1.12</td>
<td>Percentage positive patients treated within 6 weeks of sample/test being taken</td>
<td>95%</td>
<td>NCSP Standard 4</td>
</tr>
<tr>
<td>1.13</td>
<td>Percentage of positive patients offered a followed up 2 weeks post treatment referral to ensure compliance with referral and treatment regime</td>
<td>100%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.14</td>
<td>Percentage of under-16 year olds risk assessed for Safeguarding</td>
<td>100%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.15</td>
<td>Percentage of under-16 year olds screened using Gillick competencies and Fraser Guidelines</td>
<td>100%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.16</td>
<td>Under 25 year olds diagnosed with an STI seen by Health Advisor for sexual health advice and contact tracing</td>
<td>95%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.17</td>
<td>Patients at high risk of HIV (e.g. MSM, BME, sex workers) offered HIV testing (excluding P1C)</td>
<td>97%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.18</td>
<td>Patients offered HIV testing who accept</td>
<td>80%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.19</td>
<td>Patients referred to specialist HIV treatment centre within 24 hours after receiving a positive result</td>
<td>100%</td>
<td>BASHH Standard 4</td>
</tr>
<tr>
<td>1.20</td>
<td>Documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk</td>
<td>90%</td>
<td>BHIVA Standard 7</td>
</tr>
<tr>
<td>1.21</td>
<td>Documented PN outcomes or a progress update at 12 weeks after the start of the process with a person newly diagnosed with positive HIV diagnosis</td>
<td>90%</td>
<td>BHIVA Standard 7</td>
</tr>
<tr>
<td>1.22</td>
<td>Routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within 7 working days of a specimen being taken</td>
<td>100%</td>
<td>BASHH Standard 4 NCSP Standard 4</td>
</tr>
<tr>
<td>1.23</td>
<td>Patient to be provided with results within 3 working days following clinician receiving results</td>
<td>100%</td>
<td>NCSP Standard 4</td>
</tr>
<tr>
<td>1.24</td>
<td>Ratio of contacts per gonorrhoea index case within four weeks of the date of the first PN discussion</td>
<td>0.6 contacts</td>
<td>BASSH Statement on Partner Notification for STIs</td>
</tr>
<tr>
<td>1.25</td>
<td>Females having access to and availability of the full range of contraceptive methods (including choice within products)</td>
<td>100%</td>
<td>FSRH Standard 2</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>KPI Target</td>
<td>Technical Reference Guide</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1.26</td>
<td>Females who have access to urgent contraceptive advice and services (including emergency contraception) within 4 hours of contacting the service.</td>
<td>80%</td>
<td>National Service Specification Local Determination</td>
</tr>
<tr>
<td>1.27</td>
<td>Females who have received LARC fitting through method of choice within 30 calendar days of contacting service Year 1 (20 calendar days Year 2, 10 calendar days Year 3)</td>
<td>80%</td>
<td>NCSP Standard 4 and Local Determination</td>
</tr>
<tr>
<td>1.28</td>
<td>Percentage of sexually active under-25 year olds that have had a discussion on LARC as a contraception option</td>
<td>&gt;60%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.29</td>
<td>Percentage of sexually active (or considering having sex) under-25 year olds that undertake an assessment for a C-Card</td>
<td>&gt;50%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.3</td>
<td>Sexually active under 25 year olds offered a full sexual health screen at hubs and spokes</td>
<td>100%</td>
<td>Local Determination</td>
</tr>
<tr>
<td>1.31</td>
<td>Sexually active under 25 year olds accepting a full sexual health screen at hubs and spokes</td>
<td>75%</td>
<td>NCSP Standard 4 and Local Determination</td>
</tr>
<tr>
<td>1.32</td>
<td>Hepatitis A &amp; B immunisations offered to at risk population groups split by (MSM, BME, Black African, etc.) and reasons refused documented in the Patients notes</td>
<td>100%</td>
<td>National Service Specification</td>
</tr>
<tr>
<td>1.33</td>
<td>Staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant update requirements</td>
<td>100%</td>
<td>BASHH Standard 2</td>
</tr>
<tr>
<td>1.34</td>
<td>Patient feedback from surveys rating the service as good or excellent</td>
<td>90%</td>
<td>NCSP Standard 4 and Local Determination</td>
</tr>
</tbody>
</table>

**Outreach**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Number of Sexual Health Campaigns to be held in the community</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>2.2</td>
<td>Number of school assemblies conducted</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>2.3</td>
<td>Number of events/drops in in colleges</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>2.4</td>
<td>Number of Chlamydia Tests conducted in outreach settings</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>2.5</td>
<td>No. of C-Card sign ups by the Outreach team</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
</tbody>
</table>

**Relationships & Sexual Health Education**
<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Relationships &amp; Sexual Health Education to be offered to Thurrock's secondary schools</td>
<td>100%</td>
<td>Local determination</td>
</tr>
<tr>
<td>3.2</td>
<td>RSE delivered in Thurrock's secondary schools</td>
<td>&gt;75%</td>
<td>Local determination</td>
</tr>
<tr>
<td>3.3</td>
<td>Percentage of young people rating SRE as either good or excellent</td>
<td>&gt;80%</td>
<td>Local determination</td>
</tr>
</tbody>
</table>

**Primary Care and Pharmacy Services**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Number of Pharmacies signed up to deliver the National Chlamydia Screening Programme and Treatment, and Emergency Hormonal Contraception</td>
<td>&gt;12</td>
<td>Local determination</td>
</tr>
<tr>
<td>6.2</td>
<td>Number of Chlamydia screens conducted through Pharmacies</td>
<td>Baseline set after year 1</td>
<td>Local determination</td>
</tr>
<tr>
<td>6.3</td>
<td>Number of Chlamydia treatments provided through Pharmacies</td>
<td>Baseline set after year 1</td>
<td>Local determination</td>
</tr>
<tr>
<td>6.4</td>
<td>Number of LARC IUD fitted in GP Surgeries</td>
<td>67</td>
<td>Local determination</td>
</tr>
<tr>
<td>6.5</td>
<td>Number of LARC IUS fitted in GP Surgeries</td>
<td>173</td>
<td>Local determination</td>
</tr>
<tr>
<td>6.6</td>
<td>Number of Sub-dermal implants fitted in GP surgeries</td>
<td>170</td>
<td>Local determination</td>
</tr>
</tbody>
</table>

**Sexual Health Training**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Number of new attendees at the Sexual Health Foundation Training Courses</td>
<td>40</td>
<td>Local determination</td>
</tr>
<tr>
<td>7.2</td>
<td>PGD Training Events - Chlamydia testing and treatment training</td>
<td>2</td>
<td>Local determination</td>
</tr>
<tr>
<td>7.3</td>
<td>Number of new attendees at the Risky Behaviours Training Course</td>
<td>40</td>
<td>Local determination</td>
</tr>
<tr>
<td>7.4</td>
<td>Newsletters to be developed and circulated</td>
<td>2</td>
<td>Local determination</td>
</tr>
</tbody>
</table>

**Online STI Testing**

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>KPI Target</th>
<th>Technical Reference Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Number of kits sent out</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>8.2</td>
<td>Return rate</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
<tr>
<td>8.3</td>
<td>Positivity rate</td>
<td>TBC</td>
<td>Local determination</td>
</tr>
</tbody>
</table>

**Social Value**

To be confirmed according to tender response.
Appendix 2 - Data Collection

The data and format required will be agreed between the Commissioner and the Provider prior to the start of the contract. The following are examples only and a full list will be supplied to the Provider at the contract implementation point:

<table>
<thead>
<tr>
<th>Hub &amp; Spoke Contraceptive, Sexual health, Reproductive and Genito-Urinary (GUM) services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attendances (broken down by service level/type)</strong></td>
</tr>
<tr>
<td>Total number of face to face contacts by type e.g. new/follow up</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>Age band e.g. &lt;16yrs, 16-24, 25-34, 35-44, 45-54, 55-64, &gt;64yrs</td>
</tr>
<tr>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Part postcode/ LSOA</td>
</tr>
<tr>
<td>Number of Thurrock residents</td>
</tr>
<tr>
<td>Number of non-Thurrock residents (broken down per authority)</td>
</tr>
<tr>
<td>Number of new referrals</td>
</tr>
<tr>
<td>Number of patients who return for a follow-up following a positive diagnosis</td>
</tr>
<tr>
<td>Number of patients who Did Not Attend (DNA) after booking an appointment</td>
</tr>
<tr>
<td><strong>All STI Tests broken down by coding/type and age band</strong></td>
</tr>
<tr>
<td>Number positive</td>
</tr>
<tr>
<td>Number negative</td>
</tr>
<tr>
<td>% positivity</td>
</tr>
<tr>
<td><strong>HIV Tests broken down by age band</strong></td>
</tr>
<tr>
<td>Number positive</td>
</tr>
<tr>
<td>Number negative</td>
</tr>
<tr>
<td>% positivity</td>
</tr>
<tr>
<td>% late diagnoses</td>
</tr>
<tr>
<td><strong>Contraception broken down by age band and gender where appropriate</strong></td>
</tr>
<tr>
<td>Volume of non-LARC contraception give out: by type</td>
</tr>
<tr>
<td>Volume of LARC fitted and removed: by type</td>
</tr>
<tr>
<td>Number of LARC removed early: by provider (ISHS, Thurrock GP, other provider)</td>
</tr>
<tr>
<td>Waiting list for LARC (number of people and average waiting time)</td>
</tr>
<tr>
<td>% Females given LARC</td>
</tr>
<tr>
<td>Number of pregnancy tests and outcomes</td>
</tr>
<tr>
<td><strong>Referrals to other services</strong></td>
</tr>
<tr>
<td>Number of referrals made to other services: broken down by service (e.g. HIV treatment)</td>
</tr>
<tr>
<td><strong>Vaccinations</strong></td>
</tr>
<tr>
<td>Number of vaccinations by type</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationships &amp; Sex Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
</tr>
<tr>
<td>Number of schools offered RSE</td>
</tr>
<tr>
<td>Number of schools that received RSE (by school)</td>
</tr>
<tr>
<td>Number of pupils who received RSE (by school)</td>
</tr>
<tr>
<td>Evaluation pre and post RSE feedback from pupils and teachers (by school)</td>
</tr>
<tr>
<td>Number of schools offered an assembly</td>
</tr>
<tr>
<td>Number of schools that received an assembly</td>
</tr>
<tr>
<td>Brief evaluation by Provider of assembly feedback</td>
</tr>
</tbody>
</table>
### Outreach

<table>
<thead>
<tr>
<th>Activity (broken down by location)</th>
<th>Number of outreach activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approximate number of people engaged with per event</td>
</tr>
<tr>
<td></td>
<td>Volume of activity e.g. C-Card sign-ups, brief interventions, sign-posting, no. of chlamydia kits given out</td>
</tr>
<tr>
<td></td>
<td>Partial postcodes of those having chlamydia tests in outreach settings</td>
</tr>
<tr>
<td></td>
<td>Narrative summary by Provider of the quarter's outreach activities</td>
</tr>
</tbody>
</table>

### C-Card Condom Distribution Scheme

<table>
<thead>
<tr>
<th>Activity</th>
<th>No. of C-Cards issued (breakdown by gender and age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of C-Card outlets in Thurrock (by type)</td>
</tr>
<tr>
<td></td>
<td>Volume of condoms distributed (by location)</td>
</tr>
<tr>
<td></td>
<td>No people trained to be C-Card assessors and job title</td>
</tr>
<tr>
<td></td>
<td>Narrative summary by Provider including C-Card feedback from Patients</td>
</tr>
<tr>
<td></td>
<td>Cost of condoms distributed as part of the scheme</td>
</tr>
</tbody>
</table>

### National Chlamydia Screening Programme

<table>
<thead>
<tr>
<th>Activity (broken down by setting e.g. ISHS, outreach, online, GP, pharmacy)</th>
<th>No of screens conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Results of the screens</td>
</tr>
<tr>
<td></td>
<td>% positivity</td>
</tr>
<tr>
<td></td>
<td>Partner notification rate</td>
</tr>
<tr>
<td></td>
<td>Return rate of kits</td>
</tr>
</tbody>
</table>

### Primary Care Service Level Agreements

<table>
<thead>
<tr>
<th>Activity (broken down to GP and Pharmacy)</th>
<th>No of providers signed up deliver LARC - broken down by IUS, IUD and SDI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No of providers signed up deliver chlamydia testing and treatment</td>
</tr>
<tr>
<td></td>
<td>No of providers signed up to deliver EHC</td>
</tr>
<tr>
<td></td>
<td>Volume of EHC given out</td>
</tr>
<tr>
<td></td>
<td>No of chlamydia treatments (pharmacy only)</td>
</tr>
<tr>
<td></td>
<td>No of LARC fittings and removals</td>
</tr>
<tr>
<td></td>
<td>Average LARC waiting times in GPs</td>
</tr>
<tr>
<td></td>
<td>Maximum waiting time in reporting period for LARC</td>
</tr>
</tbody>
</table>

### Training

<table>
<thead>
<tr>
<th>Activity (to be broken down by training course)</th>
<th>No of attendees broken down by job title and organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summary of pre and post course evaluations</td>
</tr>
</tbody>
</table>
Appendix 3 – Integrated Medical Centres

The following statement from Thurrock CCG set out the general proposals for Integrated Medical Centres for Bidders’ information

_________________________________________________________________________

NHS Thurrock Clinical Commissioning Group (CCG) along with our partners at Thurrock Council and Healthwatch Thurrock are embarking on an ambitious vision to radically change the way health and social care services are commissioned and provided for within Thurrock. One of our primary aims is to enhance care within the community and ensure that clients’ are at the centre of a network of care focused on and fully engaged with them.

Our local vision *For Thurrock in Thurrock* proposes a new model of health care that will place greater emphasis on neighbourhood based care in communities. Health and social care teams will work closely together to deliver care closer to home, moving away from the current more complex system.

We want to see less fragmentation between services and less reliance on services from outside of Thurrock. By focusing on local care with greater integration between providers, we plan to make the best use of Thurrock funds and resources to pay for healthcare in Thurrock and for Thurrock people.

Initiatives like the new ‘Integrated Medical Centres’ at Purfleet, Tilbury, Corringham and Grays will bring together elements of acute and primary care, linked to community services in new purpose built and leading edge buildings that offer staff and clients a new era of environment, care and wellbeing.

Developing a blueprint for new services with Thurrock residents including addressing root cause of bad health, improving social and mental wellbeing, managing long term health issues and bringing the hospital into the community is part of our wider communications and engagement planning.

August 2017
Appendix 4 – Applicable Strategies, Guidelines and Standards

1. Violence against Women and Girls (VAWG) Strategy:

Violence Against Women and Girls (VAWG) undermines confidence, opportunity and ambition for victim-survivors, especially where it takes place during childhood or adolescence. It is not only implicated in ongoing gender inequality, meaning women and girls do not reach their potential, but also results in mistrust and isolation that undermines communities.

Providers shall both understand and ensure their Service acts appropriately against any act of VAWG, defined as follows:

**Home Office Definition:**
any act of gender based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private.

**UN Definition**
Violence that is directed against a woman because she is a woman or that affects women disproportionately... The term “women” is used to cover females of all ages, including girls under the age of 18... manifested in a continuum of multiple, interrelated and sometimes recurring forms... physical, sexual and psychological/emotional violence and economic abuse and exploitation, experienced in a range of settings, from private to public, and in today’s globalised world, transcending national boundaries.

Female Genital Mutilation (FGM) should be reported to the appropriate services and staff trained in looking at the signs of FGM and reporting procedures in place. The reporting of FGM is now mandatory for health and social care professionals as detailed within the following guidance.


Provider staff shall be trained to understand and act on the signs of potential sexual abuse or domestic violence, both towards women and towards men. The following link has useful information:

http://www.nhs.uk/Livewell/abuse/Pages/signs-domestic-violence.aspx

2. Child Sexual Exploitation (CSE) Core Principles

Providers will be conversant with CSE, its complexities, the warning signs and children’s vulnerabilities toward CSE. It is critical to both victim and public confidence that the response of partners is reflected accurately through operational activity, communications material and channels, and the media.

CSE is a form of abuse which involves children (male and female, of different ethnic origins and of different ages) receiving something in exchange for sexual activity. Perpetrators of CSE are found in all parts of the country, rural and urban areas and are not restricted to particular ethnic groups.

This definition is supported by a set of national key messages:

- CSE (aged 18 and under) involves situations, contexts and relationships where the young person receives ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts and/or money) as a result of them performing, and/or others performing on them, sexual activities.

- CSE can occur through the use of technology without the child’s immediate recognition; for example, being persuaded to post images on the internet / mobile phones without immediate payment or gain.

Further information and advice on CSE can be obtained from the Local Safeguarding Children Board (LSCB) http://www.thurrocklscb.org.uk/.
The NSPCC website gives a basic awareness around child sexual abuse and exploitation. All staff should be versed in order to have a reasonable level of understanding if not already obtained. [http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/what-is-csa/#tab-3a4631c0-8b39f8d0](http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/what-is-csa/#tab-3a4631c0-8b39f8d0)

All staff should be versed on teenage relationship abuse at a basic level in order to gain a reasonable level of understanding. [http://thisisabuse.direct.gov.uk/](http://thisisabuse.direct.gov.uk/)

All Providers, when working with young people, parents and schools will as part of their service delivery, raise awareness on the hidden harms and exploitation within all forms of social media, social networking, mobiles, sexual bullying and the dangers of sharing both images and personal information.

### 3. PREVENT

Providers are expected to have an appropriate level of training regarding the Prevent agenda which is part of the government’s counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism. [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf)

Concerns should be reported where appropriate and engagement with the LSCB and organisation and local authority leads for PREVENT as necessary.
Appendix 5 – References

British Association of Sexual Health and HIV (BASHH) Guidelines https://www.bashh.org/guidelines


Brief Opportunistic Advice (BOA) http://www.walkgrove.co.uk/case-studies/nhs-brief-opportunistic-advice/

C-Card Guidance https://www.nice.org.uk/guidance/NG68


Disclosure and Barring Service (DBS) https://www.gov.uk/government/organisations/disclosure-and-barring-service/about


Fingertips Data http://fingertips.phe.org.uk/


Safeguarding Children and Vulnerable Adults


Violence against Women and Girls (VAWG) Strategy 2016-2020


You are Welcome criteria
Appendix 6 - Data Protection and Consent

Data Protection and Processing

The Provider will comply with all aspects of the Data Protection Act 1998 (DPA) and the following Council policies (attached):

- Data Protection Policy
- Information Security Policy
- Records Management Policy

The UK Government had previously agreed to sign up to the new General Data Protection Regulations (GDPR) from 2018. The result of the June 2016 referendum on membership of the EU has placed this agreement into question. The UK Government still intends to sign up to this agreement to ensure that organisations with international operations are compliant, however the final decision on this intended move is now subject to agreement by the UK Government. Should the UK Government sign up to the GDPR the Provider will fully comply with all of its regulations from the date of its inception and to any subsequent variations. A copy of the Information Commissioners Office (ICO) report on the GDPR is attached below for reference. In all instances within this document where data protection is mentioned this shall be taken as the GDPR once it is in force.

The Provider will act as a ‘Data Processor’ on behalf of the Council. Whilst providers currently have certain responsibilities under the Data Protection Act, the new GDPR will bring increased responsibility and accountability for data processors, with the Information Commissioners Office (ICO) being given new powers to issue financial penalties against data processors that do not adhere to the guidelines.

The Provider will ensure that it only sends confidential personally identifiable information to the Council and GPs/Primary Care via four specific methods of communication:

1. Via secure IT System where both parties have access (eg. Systm1).
2. By hand to the receiver of the information if this is paper based – documents should not be posted
3. By utilising the ‘Leapfile’ programme that the council uses (or any future applications the council may utilise in its place)
4. By using a recognised secure government email (where this is held by the provider). The provider will seek permission of the intended secure government email prior to utilising this. Any communication that is sent via this method will be transmitted from an agreed secure email address to a recipient secure government email address – communication has to be two-way i.e. a secure email address cannot be used to send to a standard non-government unsecure email and vice versa.

Only relevant data shall be collected and held under the ethos of ‘appropriate collection’
Consent and Confidentiality

The Provider will ensure:

- Information shared with other agencies is on a need to know basis or when required to do so under the law or for the purposes of the protection of the child/young person or of the public, but that this is balanced with the need to share with consent to ensure integrated working.
- Information is only shared when it is in the best interests of the individual.
- Provider staff follow information sharing guidance in accordance with the principles of the Data Protection Act 1998 and/or subsequent legislation which may come into force.
- Children and young people, or their families, consent to referrals and information sharing, and understand the need for this
- Patient information is kept confidential and shared with consent, except where there is a perceived or actual risk of harm which precludes this and/or it is required by law
- Records are kept up to date and secure and there is a records management policy in place

The Provider will prepare a consent form for Patients to sign at the first meeting following referral. This will be used to ensure that there is consent to share information with a range of non-statutory services. In cases where there is a ‘health’ or ‘social care’ issue and there is a ‘legitimate interest’ consent will not be required, however through the use of a consent statement the provider will ensure that the Patient is fully aware of who information might be shared with. This statement will be prepared on the Provider’s headed notepaper and will be broadly in line with the statement set out overleaf; any variations to this statement will be agreed in writing by the Commissioner prior to use.
TEMPLATE CONSENT FORM

In order for us to help you we need to record details of your case. These details may contain your personal and sensitive data. Personal data is data which can be used to identify you. This may include your name, date of birth, address, telephone number etc.

To comply with the Data Protection Act (1998) we must tell you how we use this data and ask for your permission. By signing this form you are providing your permission for us to process your data for the purposes below.

The storing of your data

In order to comply with our duties as a provider of family support services we are required to store the data that is provided to us about you. The data will contain details such as your personal and sensitive data. The record of your case will be stored in a shared electronic case management system accessed by members of the [service name] staff.

Paper copies of your data may also be stored securely by [service name].

For the purposes of the Data Protection Act the members of the [service name] service are Data Processors on behalf of Thurrock Council.

☐ I/We understand that the [service name] service will be recording personal and sensitive information about me/us

Name(s) : 
Signature: Date

Permission to share your data with other providers

Information will be shared with Thurrock council for the purpose of supporting you and your family including your children. Permission to share this information is not usually required if it relates to a 'social care' or 'health' issue and where there is a 'legitimate interest' in sharing information or if the sharing is required by law.

Where this ‘legitimate interest’ exists information may also be shared with the following agencies (non-exhaustive list):

- Law enforcement agencies including the police
- Health providers

However we may also suggest that you go to another organisation for support because they will be more able to help you, and for this purpose we require your consent. We are able to refer you to them and help get you an appointment. Ideally we would also give them the information you have given us.

If you give consent below, you are agreeing that the [service name] may:

- refer you to other providers;
- make appointments with other providers;
- share your personal information with other providers so that they have initial information about you.

☐ Yes - I/We give my/our consent to the [service name] sharing my personal information with other providers to help me and my family.

☐ No - I/We do not give my/our consent to the [service name] sharing my personal information with other providers to help me and my family.

Name(s) : 
Signature: Date
Appendix 7 – Population and Demographics

Demography

Thurrock’s population is 167,025\(^1\), with 50.7% male and 49.3% female. It has a young population by national standards; the median age is 37 years and there are 45,650 children aged 0-19 years (27.3% of population). There are 22,997 13-24 year olds and 17,220 16-24 year olds.

The population of Thurrock is set to increase to at least 207,660 by 2039\(^2\) although the ambitious local growth agenda could result in a greater increase than this. The population is increasingly diverse. According to the 2011 census, the BME population was 15.7% – a significant increase from the 2001 census of 4.7%. Thurrock’s proximity to London could be an influencing factor in this, as a sizeable proportion of the internal migration seen comes from London boroughs, who often have more ethnically diverse populations.

Overall levels of deprivation in Thurrock are lower than the national average; however Thurrock experiences significant pockets of deprivation and inequality, with several areas falling within the 20% most deprived areas in England. More than one in five children under 16 years in Thurrock is growing up in poverty (21.2%), which is higher than the national rate (20.1%)\(^3\). The gap between the highest and lowest areas of deprivation in respect of child poverty is wide. For example, parts of wards such as Grays Thurrock and Little Thurrock Rectory have 6% of children living in poverty, whereas in parts of Tilbury, 56.4% of children are living in poverty\(^4\). There is also a large amount of variation in life expectancy within the borough - life expectancy is lower (9.4 years for men and 6.5 years for women) for people living in the 10% most deprived areas compared to those living in the 10% least deprived areas of Thurrock\(^5\).
Appendix 8 - GUM Attendances

Non-Thurrock residents accessing Thurrock GUM services by attendance type

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17*</th>
</tr>
</thead>
<tbody>
<tr>
<td>New attendances</td>
<td>5124</td>
<td>5198</td>
<td>5097</td>
</tr>
<tr>
<td>Follow-up attendances</td>
<td>1441</td>
<td>1842</td>
<td>1564</td>
</tr>
<tr>
<td>Total attendances</td>
<td>6565</td>
<td>7040</td>
<td>6661</td>
</tr>
</tbody>
</table>

Thurrock Residents accessing GUM services within and outside Thurrock

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17*</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Thurrock</td>
<td>5572</td>
<td>5738</td>
<td>5404</td>
</tr>
<tr>
<td>Outside Thurrock</td>
<td>1329</td>
<td>1362</td>
<td>1399</td>
</tr>
<tr>
<td>Total</td>
<td>6901</td>
<td>7100</td>
<td>6803</td>
</tr>
</tbody>
</table>
Appendix 9 - Thurrock STI and HIV Data

Diagnostic rates of STIs in Thurrock over the last 5 years (2017 Fingertips data)
HIV rates (2017 Fingertips data)
Appendix 10 - Thurrock Contraception Data

Proportion* of SRH services attendees by age group, in residents of Thurrock, East of England PHE Centre and England: 2015

Warning - proportions may be distorted as numbers used to calculate the proportions are rounded – see footnotes.

Source: SRHAD. Data from Sexual and Reproductive Health Services.
This represents a breakdown of the number of individuals who have attended SRH services in the year, whether once or more than once. On average, there were 1.6 attendances per individual attendee in 2015 among England residents.
* Please note, to prevent deductive disclosure the underlying number of attendees by age group have been rounded to the nearest 5. Percentages may be distorted by rounding especially where small numbers are involved.
Number and proportion of contraceptive and other SRH services provided among residents of Thurrock, East of England PHE Centre and England by service provided: 2015

<table>
<thead>
<tr>
<th>SRH service provided</th>
<th>LA (n)±</th>
<th>LA (%)</th>
<th>PHE Centre (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular contraceptive care</td>
<td>4,480</td>
<td>35.7</td>
<td>48.1</td>
<td>43.7</td>
</tr>
<tr>
<td>Emergency contraceptive care</td>
<td>205</td>
<td>1.6</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Pre-contraception consultation</td>
<td>1,010</td>
<td>8.0</td>
<td>5.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Implant removal*</td>
<td>425</td>
<td>3.4</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>IUS Removal*</td>
<td>230</td>
<td>1.8</td>
<td>1.2</td>
<td>1.0</td>
</tr>
<tr>
<td>IUD Removal*</td>
<td>180</td>
<td>1.4</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>Sexual health advice</td>
<td>4,650</td>
<td>37.0</td>
<td>29.7</td>
<td>29.8</td>
</tr>
<tr>
<td>Pregnancy related care</td>
<td>680</td>
<td>5.4</td>
<td>5.6</td>
<td>6.6</td>
</tr>
<tr>
<td>Abortion related care</td>
<td>135</td>
<td>1.1</td>
<td>0.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Cervical screening</td>
<td>200</td>
<td>1.6</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Psychosexual related care</td>
<td>10</td>
<td>0.1</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Sterilisation/vasectomy related care</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>IUS insertion (non-contraception)</td>
<td>5</td>
<td>0.0</td>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>IUS check (non-contraception)</td>
<td>25</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Menopause management &amp; treatment</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Colposcopy related care</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Ultra sound scan</td>
<td>115</td>
<td>0.9</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Sub fertility treatment and care</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other Gynecology treatment and care</td>
<td>110</td>
<td>0.9</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Alcohol brief intervention</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
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<tr>
<td>Safe guarding children referral</td>
<td>0</td>
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<td>0.0</td>
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<tr>
<td>CAF# Referral</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other Referrals</td>
<td>75</td>
<td>0.6</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>12,550</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SRHAD. Data from Sexual and Reproductive Health Services.
Multiple services can be provided on the same attendance.
Regular contraceptive care’ includes all contraceptive consultations including new, change and maintenance of method and insertion and removal of devices for contraceptive purposes.
± Please note to prevent deductive disclosure the number of SRH services provided in the LA have been rounded to the nearest 5. Therefore the totals may not equal the sum of their parts. Percentages will be distorted by rounding especially where small numbers are involved.
* Clinics can remove implants, intrauterine systems (IUS) and intrauterine devices (IUD) that they have not provided themselves, therefore it is possible that a clinic may remove more devices than they provide.
# CAF: Common assessment framework.
Proportion of attendances at SRH services by 'contraception method status' among residents of Thurrock, East of England PHE Centre and England: 2015

Source: SRHAD. Data from Sexual and Reproductive Health services.
* 'No contraceptive method' includes: emergency contraceptive only; other SRH service only; emergency contraception and other SRH services and where no contraceptive method was recorded.
Proportion* of SRH Service attendees by chosen main method of contraception and by age group (years), among residents of Thurrock: 2015

<table>
<thead>
<tr>
<th>Choice</th>
<th>Method</th>
<th>&lt;16</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45+</th>
<th>Total**</th>
</tr>
</thead>
<tbody>
<tr>
<td>LARCs (excluding</td>
<td>IUD</td>
<td>0.0</td>
<td>0.0</td>
<td>1.0</td>
<td>4.0</td>
<td>7.9</td>
<td>11.8</td>
<td>9.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Implant</td>
<td>IUS</td>
<td>0.0</td>
<td>1.7</td>
<td>2.9</td>
<td>2.8</td>
<td>6.3</td>
<td>17.3</td>
<td>23.4</td>
<td>8.3</td>
</tr>
<tr>
<td>TOTAL LARCs</td>
<td>(excluding injections)</td>
<td>12.5</td>
<td>10.0</td>
<td>14.6</td>
<td>11.2</td>
<td>11.1</td>
<td>9.5</td>
<td>5.2</td>
<td>10.7</td>
</tr>
<tr>
<td>Injectable</td>
<td>Injectable Contraceptive</td>
<td>0.0</td>
<td>6.7</td>
<td>14.6</td>
<td>17.1</td>
<td>12.4</td>
<td>15.9</td>
<td>16.9</td>
<td>14.2</td>
</tr>
<tr>
<td>UDM</td>
<td>Oral Contraceptive#</td>
<td>37.5</td>
<td>45.0</td>
<td>36.9</td>
<td>42.2</td>
<td>35.2</td>
<td>23.2</td>
<td>24.7</td>
<td>34.5</td>
</tr>
<tr>
<td>Male Condom</td>
<td>50.0</td>
<td>36.7</td>
<td>29.1</td>
<td>21.5</td>
<td>25.1</td>
<td>21.8</td>
<td>19.5</td>
<td>24.4</td>
<td>21.8</td>
</tr>
<tr>
<td>Female Condom</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.3</td>
<td>0.0</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Contraceptive Patch</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.5</td>
<td>0.0</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Natural Family Planning</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
<td>0.0</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Other±</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.8</td>
<td>0.5</td>
<td>1.3</td>
<td>0.5</td>
</tr>
<tr>
<td>TOTAL UDM±</td>
<td>87.5</td>
<td>81.7</td>
<td>67.0</td>
<td>64.9</td>
<td>62.2</td>
<td>45.5</td>
<td>45.5</td>
<td>60.1</td>
<td></td>
</tr>
</tbody>
</table>

Source: SRHAD. Data from Sexual and Reproductive Health Services.
This is the percentage of attendees choosing each main method within each age group. Each column will add to 100%. This reflects the record of the last attendance in the year where a main method of contraception is recorded. This is an additional table compared to the 2014 LASER report.
IUD intrauterine device; IUS intrauterine system; UDM user dependent methods
* Proportion of attendees where a main contraception method is recorded. The underlying number has been rounded to the nearest 5 to prevent deductive disclosure. Percentages will be distorted by rounding especially where small numbers are involved.
** Includes those with unknown age.
# Includes combined pill and progesterone only pill.
± Includes vaginal ring, cap/diaphragm and spermicides.
## Appendix 11 - Primary Care Current Tariff and Activity

### Tariff

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia Tests</td>
<td>£2.00</td>
</tr>
<tr>
<td>Chlamydia Treatment</td>
<td>£15.00</td>
</tr>
<tr>
<td>EHIC</td>
<td>£15.00</td>
</tr>
<tr>
<td>C1 – coil fitted &amp; checked @ 6 weeks (price including removal)</td>
<td>£81.31</td>
</tr>
<tr>
<td>C2 – Mirena coil fitted &amp; checked at 6 weeks (price including removal)</td>
<td>£81.31</td>
</tr>
<tr>
<td>SI1 – Sub-dermal implant insertion</td>
<td>£42.62</td>
</tr>
<tr>
<td>SI2 – Sub-dermal implant removal</td>
<td>£50.00</td>
</tr>
</tbody>
</table>

### General Practice Activity

<table>
<thead>
<tr>
<th>Year/ Item</th>
<th>Coil IUD</th>
<th>IUS</th>
<th>Implant Insertion</th>
<th>Implant Removal</th>
<th>Chlamydia Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>56</td>
<td>130</td>
<td>169</td>
<td>129</td>
<td>0</td>
</tr>
<tr>
<td>2016/17</td>
<td>55</td>
<td>158</td>
<td>149</td>
<td>162</td>
<td>16</td>
</tr>
<tr>
<td>2017/18 (Q1)*</td>
<td>10</td>
<td>30</td>
<td>27</td>
<td>29</td>
<td>0</td>
</tr>
</tbody>
</table>

### Pharmacy Activity

<table>
<thead>
<tr>
<th>Year/ Item</th>
<th>National Chlamydia Screening Programme</th>
<th>EHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Testing</td>
<td>Treatment</td>
</tr>
<tr>
<td>2015/16</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>2016/17</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>2017/18 (Q1)*</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>
## Appendix 12 – Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASHH</td>
<td>The British Association for Sexual Health and HIV</td>
</tr>
<tr>
<td>BHIVA</td>
<td>British HIV Association</td>
</tr>
<tr>
<td>BME</td>
<td>Black, Minority and Ethnic</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
</tr>
<tr>
<td>CTAD</td>
<td>Chlamydia Testing Activity Database</td>
</tr>
<tr>
<td>DNA</td>
<td>Do Not Attend/s</td>
</tr>
<tr>
<td>EHC</td>
<td>Emergency Hormonal Contraception</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FSRH</td>
<td>Faculty of Sexual and Reproductive Health</td>
</tr>
<tr>
<td>GUM</td>
<td>Genito-urinary Medicine</td>
</tr>
<tr>
<td>GUMCADv2</td>
<td>Genito-urinary Medicine Clinic Activity Dataset</td>
</tr>
<tr>
<td>ISHS</td>
<td>Integrated Sexual Health Service</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
</tr>
<tr>
<td>LASB</td>
<td>Local Adult’s Safeguarding Board</td>
</tr>
<tr>
<td>LCSB</td>
<td>Local Children’s Safeguarding Board</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>MASH</td>
<td>Multi Agency Safeguarding Hub</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NEET</td>
<td>Not in Education, Employment or Training</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Direction</td>
</tr>
<tr>
<td>PREVENT</td>
<td>Anti-Terrorism Strategy (see Appendix 4)</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
</tr>
<tr>
<td>Service Elements</td>
<td>Individual areas of service as part of the overall requirement – e.g. C-Card Condom Scheme</td>
</tr>
<tr>
<td>SHC</td>
<td>Sexual Health Clinic</td>
</tr>
<tr>
<td>SHRAD</td>
<td>Sexual and Reproductive Health Activity Data Set</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>The Council</td>
<td>Thurrock Council</td>
</tr>
<tr>
<td>The Model</td>
<td>The Brighter Futures Model</td>
</tr>
<tr>
<td>The Service</td>
<td>The Integrated Sexual Health Service</td>
</tr>
<tr>
<td>UDM</td>
<td>User Dependent Methods</td>
</tr>
<tr>
<td>VAWG</td>
<td>Violence against Women and Girls Strategy (See Appendix 4)</td>
</tr>
</tbody>
</table>