

UK-Shrewsbury: Health services.

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Section I: Contracting Authority

I.1) Name, Addresses and Contact Point(s):

Shropshire Council

Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND, United Kingdom

Tel. +44 1743252992, Fax. +44 1743253910, Email: procurement@shropshire.gov.uk, URL:

www.shropshire.gov.uk

Contact: Procurement, Attn: Procurement

Further information can be obtained at: As Above

Specifications and additional documents: As Above

Tenders or requests to participate must be sent to: As Above

I.2) Type of the contracting authority:

Regional or local authority

I.3) Main activity:

General Public Services

I.4) Contract award on behalf of other contracting authorities:

The contracting authority is purchasing on behalf of other contracting authorities: Yes

Section II: Object Of The Contract: SERVICES

II.1) Description

II.1.1) Title attributed to the contract by the contracting authority: AMC 006 - Integrated Sexual Health Services

II.1.2) Type of contract and location of works, place of delivery or of performance: SERVICES

Service Category: 25

Region Codes: UKG22 - Shropshire CC

II.1.3) Information about a public contract, a framework or a dynamic purchasing system: The notice involves a public contract

II.1.5) Short description of the contract or purchase:

Health services. This is a notice for social and specific services in accordance with Directive 2014/24/EU, Article 74 Health and Social Related Services.

Shropshire Council is seeking a service provider to provide a community based integrated sexual health service providing a range of interventions according to the needs of the community.

The service will be delivered in broad accordance with the level 1, 2 and 3 service model which is well established for sexual health provision and will provide a system that ensures sexual health and HIV prevention, health promotion, diagnosis and treatment of sexually transmitted infections and provide referral to HIV treatment and care services. The service will deliver high quality, effective, and value for money interventions that conform to recognised national standards and are delivered consistently. A key requirement for the service will be seamless patient transition right through the sexual health pathway.

It is considered that the Employee 'Transfer of Undertakings (Protection of Employment) Regulations '2006 ('TUPE') will apply to this contract. Applicants are advised to seek their own legal advice about the practicality of these regulations.

As a public authority, in line with the Public Services (Social Value) Act 2012 the Council has due regard to economic, social and environmental well-being in Shropshire. Accordingly the council is looking, in relation to the delivery of this contract, for proposals from contractors that could help provide social value benefits within Shropshire where practicable and to maximise the social and economic impact of the proposed contract.

This is a notice for Social and specific services in accordance with Directive 2014/24/EU Article 74 being Public Health Services. Accordingly the Council will follow a process based on the principles of transparency. The Council will treat all economic operators equally and in a non-discriminatory way.

The contract duration will be for an initial 3 years from the commencement date of 1st April 2016 with the option to extend for a further two 12 month periods, with an estimated available budget of £4.43 million over 5 years.

II.1.6) Common Procurement Vocabulary:

85100000 - Health services.

II.1.7) Information about Government Procurement Agreement (GPA):

The contract is covered by the Government Procurement Agreement (GPA): No

II.1.8) Lots:

This contract is divided into lots: No

II.1.9) Information about variants:

Variants will be accepted: Yes

II.2) Quantity Or Scope Of The Contract

II.2.1) Total quantity or scope:

Not Provided

Estimated value excluding VAT: 4,430,000

Currency: GBP

II.2.2) Options: Not Provided

II.2.3) Information about renewals:

This contract is subject to renewal: Not Provided

II.3) Duration Of The Contract Or Time-Limit For Completion

Starting: 01/04/2016

Completion: 31/03/2021

Information About Lots

Section III: Legal, Economic, Financial And Technical Information

III.1) Conditions relating to the contract

III.1.1) Deposits and guarantees required:

see tender documentation

III.1.2) Main financing conditions and payment arrangements and/or reference to the relevant provisions governing them:

see tender documentation

III.1.3) Legal form to be taken by the group of economic operators to whom the contract is to be awarded:
Joint and severable liability

III.1.4) Other particular conditions:

The performance of the contract is subject to particular conditions: Yes

If Yes, description of particular conditions:

see tender documentation

III.2) Conditions For Participation

III.2.1) Personal situation of economic operators, including requirements relating to enrolment on professional or trade registers:

see PQQ documentation

III.2.2) Economic and financial capacity

Economic and financial capacity - means of proof required:

Information and formalities necessary for evaluating if requirements are met:

see PQQ documentation

Minimum Level(s) of standards possibly required:

see PQQ documentation

III.2.3) Technical capacity

Technical capacity - means of proof required

Information and formalities necessary for evaluating if requirements are met:

see PQQ documentation

III.2.4) Information about reserved contracts: Not Provided

III.3) Conditions Specific To Service Contracts

III.3.1) Information about a particular profession:

Execution of the service is reserved to a particular profession: Yes

If yes, reference to relevant law, regulation or administrative provision:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 or EU equivalent

III.3.2) Staff responsible for the execution of the service:

Legal persons should indicate the names and professional qualifications of the staff responsible for the execution of the service: Yes

Section IV: Procedure

IV.1) Type Of Procedure

IV.1.1) Type of procedure: Restricted

IV.1.2) Limitations on the number of operators who will be invited to tender or to participate:

Envisaged minimum number: 5 and maximum number: 6

Objective Criteria for choosing the limited number of candidates:

Please see PQQ documentation. It is the Council's intention to select up to 6 bidders to be issued with the

invitation to submit a tender, provided there are eight suitably qualified bidders at the pre-qualification stage.

IV.2)Award Criteria

IV.2.1)Award criteria:

The most economically advantageous tender in terms of

The criteria stated in the specifications, in the invitation to tender or to negotiate or in the descriptive document

IV.2.2)Information about electronic auction:

An electronic auction will be used: Not Provided

IV.3)Administrative Information

IV.3.1)File reference number attributed by the contracting authority: AMC 006

IV.3.2)Previous publication(s) concerning the same contract: Not Provided

IV.3.3)Conditions for obtaining specifications and additional documents or descriptive document:

Date: 04/09/2015

IV.3.4)Time-limit for receipt of tenders or requests to participate

Date: 07/09/2015

Time: 12:00

IV.3.5)Date of dispatch of invitations to tender or to participate to selected candidates: 17/09/2015

IV.3.6)Language(s) in which tenders or requests to participate may be drawn up: English

Section VI: Complementary Information

VI.1)This Is A Recurrent Procurement: Yes

Estimated timing for further notices to be published: 2021

VI.2)Information about European Union funds:

The contract is related to a project and/or programme financed by European Union funds: No

VI.3)Additional Information: The contracting authority considers that this contract may be suitable for economic operators that are small or medium enterprises (SMEs). However, any selection of tenderers will be based solely on the criteria set out for the procurement, and the contract will be awarded on the basis of the most economically advantageous tender.

For more information about this opportunity, please visit the Delta eSourcing portal at:

<https://www.delta-esourcing.com/tenders/UK-UK-Shrewsbury:-Health-services./DSG427NF9X>

To respond to this opportunity, please click here:

<https://www.delta-esourcing.com/respond/DSG427NF9XGO-201587-PRO-6903338 TKR-201587-PRO-6903337>

VI.4)Procedures For Appeal

VI.4.1)Body responsible for appeal procedures:

Shropshire Council

Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND, United Kingdom

Tel. +44 1743252992, Email: procurement@shropshire.gov.uk

VI.4.2)Lodging of appeals: The contracting authority will incorporate a minimum 10 day calendar day standstill period at the point of information on the award of the contract is communicated to tenderers. This period allows unsuccessful tenderers to seek further debriefing from the contracting authority before the contract is entered into. Additional information should be requested from the contact in Section 1.1. If an appeal regarding the award of contract has not been successfully resolved the Public Contracts Regulations 2006 (S1 2006 No 5) provide for aggrieved parties who have been harmed or are at risk

VI.4.3)Service from which information about the lodging of appeals may be obtained:

Shropshire Council
Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND, United Kingdom
Tel. +44 1743252992

VI.5) Date Of Dispatch Of This Notice: 07/08/2015

ANNEX A

IV) Address of the other contracting authority on behalf of which the contracting authority is purchasing
Purchased on behalf of other contracting authority details:

1: Contracting Authority

Shropshire Council is purchasing on behalf of itself and any wholly owned local authority company or other entity that is deemed to be a contracting authority by virtue of the Council's involvement. Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND, United Kingdom

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Procurement & Contracts

Shirehall, Abbey Foregate
Shrewsbury, SY2 6ND



Date 18 September 2015

Tel: (01743) 252993

Fax: (01743) 255901

Please ask for: [REDACTED]

Email: procurement@shropshire.gov.uk

Dear Sirs

**AMC 006 – INTEGRATED SEXUAL HEALTH SERVICES
SHROPSHIRE COUNCIL**

You have been invited to tender for the above requirement. With this letter please find copies of the following documents:

1. Tender Response Document (for completion and return)
2. Pricing Schedule spreadsheet (will be released on signing of undertaking)
3. Instructions for Tendering (for completion and return)
4. TUPE & Pricing Schedule Confidentiality Undertaking (for completion and return as soon as possible to obtain relevant information and pricing schedule)
5. Service Specification and the following appendices:
 - Appendix 1 – Shropshire CDS Spec
 - Appendix 2 – Shropshire HIV prevention Spec
 - Appendix 3 – SxH Needs Assessment Epidemiology
 - Appendix 4 – SxH Needs Assessment Consultation
 - Appendix 5 – Current Service provision premises
 - Appendix 6 – NHS CSP Service Specification 2015
6. Draft Form of Contract

Tenders should be made on the enclosed Tender Response Document and Pricing Schedule spreadsheet. Your Tender must be completed, signed and returned along with a signed copy of the instructions for tendering through our Delta Tenderbox. You are recommended to keep a copy of all tender documents and supporting documents for your own records.

Please pay particular attention to the points below concerning the returning of tenders.

Returning of Tenders

- The deadline for returning tenders is **noon on 30 October 2015** any tenders received after this time will not be accepted
- Tenders are to be submitted through Delta, our electronic tender portal
 - Please ensure that you allow yourself at least two hours when responding prior to the closing date and time, especially if you have been asked to upload documents. If you

are uploading multiple documents you will have to individually load one document at a time or you can opt to zip all documents in an application like WinZip. Failure to submit by the time and date or by the method requested will not be accepted.

- Once you upload documentation ensure you follow through to stage three and click the 'response submit' button. Failure to do so, will mean the documents won't be viewable by the Council.

Tenders **cannot** be accepted if:

- Tenders are received by post, facsimile or email
- Tenders are received after **12 noon on the given deadline**

European Requirements

In accordance with the EU Procurement Directive, Shropshire Council will accept equivalent EC member or international standards in relation to safety, suitability and fitness for purpose. Where a particular service has been referred to in the tender document, alternatives or equivalents which achieve the same result will be equally acceptable. In these cases Shropshire Council will take into account any evidence the tenderer wishes to propose in support of the claim that the service is equivalent to the named types.

All tender documents and any accompanying information must be submitted in English. A Contract Notice in respect of this requirement was dispatched on 7 August 2015 to appear in the Supplement to the Official Journal of the European Union.

Freedom of Information

Under the provisions of the Freedom of Information Act 2000 from 1 January 2005, the public (included in this are private companies, journalists, etc.) have a general right of access to information held by public authorities. Information about your organisation, which Shropshire Council may receive from you may be subject to disclosure, in response to a request, unless one of the various statutory exemptions applies.

Therefore if you provide any information to Shropshire Council in the expectation that it will be held in confidence, you must make it clear in your documentation as to the information to which you consider a duty of confidentiality applies. The use of blanket protective markings such as "commercial in confidence" will no longer be appropriate and a clear indication as to what material is to be considered confidential and why should be given.

Other Details

Please note that if supplementary questions are raised by any tenderer prior to the closing of tenders and Shropshire Council decides that the answers help to explain or clarify the information given in the Tender Documents, then both the questions and the answers will be circulated to all enterprises invited to submit a tender. Please raise all clarification questions before the deadline of 23 October 2015.

As part of its sustainability policy, Shropshire Council encourages tenderers to minimise packaging, particularly presentational or retail packaging.

Shropshire Council is purchasing on behalf of itself and any wholly owned local authority company or other entity that is deemed to be a contracting authority by virtue of the Council's involvement

personal info

TUPE information is available to all bidders along with the required Pricing Schedule. To obtain the same please complete the TUPE/Pricing Schedule Confidentiality Undertaking enclosed and email a signed copy to procurement@shropshire.gov.uk **as soon as possible..**

Please also note a date of the **3 December 2015** has been provisionally set aside for the interviewing of shortlisted tenderers. Please therefore keep this date free.

Please also note that Shropshire Council is committed to achieving Social Value outcomes through maximising the social, economic and/or environmental impact of all its procurement activity. Specific requirements for this contract are set out within the Tender Response Document and in addition for your further information the council's Social Value Framework guidance can be found at www.shropshire.gov.uk/doing-business-with-shropshire-council.

If you have any queries relating to this invitation to tender, please contact me through email: procurement@shropshire.gov.uk.

Yours faithfully



Procurement Manager
Procurement & Contracts
Enc



INSTRUCTIONS FOR TENDERING

**AMC006 - INTEGRATED SEXUAL HEALTH
SERVICES**

Shropshire Council Instructions for tendering

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1.0 Invitation to Tender

- 1.1 You are invited to tender for the provision of Integrated Sexual Health Services as detailed in the service specification, tender response document and other invitation to tender documentation provided. The contract will be for an initial period of three years with an option to extend for further 12 month periods up to a maximum of a further 2 years.
- 1.2 Tenders are to be submitted through the Delta e-tendering portal and in accordance with the Specification, Tender Response Document, the Terms and Conditions and the instructions outlined within this document and the tender letter.
- 1.3 Tenders must be submitted in accordance with the following instructions. Tenders not complying in any particular way may be rejected by Shropshire Council (the Council) whose decision in the matter shall be final. Persons proposing to submit a Tender are advised to read the Invitation to Tender documentation carefully to ensure that they are fully familiar with the nature and extent of the obligations to be accepted by them if their Tender is accepted.
- 1.4 The Invitation to Tender documents must be treated as private and confidential. Tenderers should not disclose the fact that they have been invited to tender or release details of the Invitation to tender document other than on an “in confidence” basis to those who have a legitimate need to know or who they need to consult for the purpose of preparing the tender as further detailed in these Instructions for Tendering.
- 1.5 Tenderers shall not at any time release information concerning the invitation to tender and/or the tender documents for publication in the press or on radio, television, screen or any other medium without the prior consent of the Council.
- 1.6 The fact that a Tenderer has been invited to submit a tender does not necessarily mean that it has satisfied the Council regarding any matters raised in the pre-tender questionnaire submitted. The Council makes no representations regarding the Tenderer’s financial stability, technical competence or ability in any way to carry out the required services. The right to return to any matter raised in any pre-tender questionnaire submitted as part of the formal tender evaluation is hereby reserved by the Council.
- 1.7 The Invitation to Tender is issued on the basis that nothing contained in it shall constitute an inducement or incentive nor shall have in any other way persuaded a tenderer to submit a tender or enter into a Contract or any other contractual agreement.
- 1.8 Shropshire Council is purchasing on behalf of itself and any wholly owned local authority company or other entity that is deemed to be a contracting authority by virtue of the Council’s involvement.

2.2 Terms and Conditions

2.1 Every Tender received by the Council shall be deemed to have been made subject to the specification of requirements, the Terms and Conditions and these Instructions for Tendering unless the Council shall previously have expressly agreed in writing to the contrary.

2.2 The Tenderer is advised that in the event of their Tender being accepted by the Council, they will be required to undertake the required services.

3.0 Preparation of Tenders

3.1 Completing the Tender Response Document

3.1.1 Tenders should be submitted using the 'Tender Response Document' following the instructions given at the front of the document. The Tenderer's attention is specifically drawn to the date and time for receipt of Tenders and that no submission received after the closing time will be considered.

3.1.2 All documents requiring a signature must be signed;

- a) Where the Tenderer is an individual, by that individual;
- b) Where the Tenderer is a partnership, by two duly authorised partners;
- c) Where the Tenderer is a company, by two directors or by a director and the secretary of the company, such persons being duly authorised for the purpose.

3.1.3 The Invitation to Tender Documents are and shall remain the property and copyright of the Council

3.2 Tender Preparation and Costs

3.2.1 It shall be the responsibility of Tenderers to obtain for themselves at their own expense all information necessary for the preparation of their Tender. No claim arising out of want of knowledge will be accepted. Any information supplied by the Council (whether in the Tender Documentation or otherwise) is supplied only for general guidance in the preparation of tenders.

3.2.2 Any Tenderer considering making the decision to enter into a contractual relationship with the Council must make an independent assessment of the Tender opportunity after making such investigation and taking such professional advice as it deems necessary.

3.2.3 Tenderers will be deemed for all purposes connected with their Tender submission where appropriate to have visited and inspected the Council, its assets, all the locations in respect of the delivery of the services/supplies/works and to have satisfied themselves sufficiently as to the nature, extent and character of the services supplies/works sought, and the human resources, materials, software, equipment, machinery, and other liabilities and other matters which will be required to perform the contract.

3.2.4 The Council will not be liable for any costs incurred by Tenderers in the preparation or presentation of their tenders.

- 3.2.5** Tenderers are required to complete all pricing schedules in the Invitation to tender documents. The terms “Nil” and “included” are not to be used but a zero or figures must be inserted against each item. Unit rates and prices must be quoted in pounds sterling and whole new pence.
- 3.2.6** It shall be the Tenderer’s responsibility to ensure that all calculations and prices in the Tender documentation are correct at the time of submission.
- 3.2.7** The Tenderer is deemed to have made him/herself acquainted with the Council’s requirements and tender accordingly. Should the Tenderer be in any doubt regarding the true meaning and intent of any element of the specification he is invited to have these fully resolved before submitting his Tender. No extras will be allowed for any loss or expense involved through any misunderstanding arising from his/her failure to comply with this requirement.
- 3.2.8** Any Tender error or discrepancy identified by the Council shall be drawn to the attention of the Tenderer who will be given the opportunity to correct, confirm or withdraw the Tender.
- 3.2.9** The Tender Documents must be treated as private and confidential. Tenderers should not disclose the fact that they have been invited to tender or release details of the Tender document other than on an In Confidence basis to those who have a legitimate need to know or whom they need to consult for the purpose of preparing the Tender.

3.3 Parent Company Guarantee

It is a condition of contract that if the tendering company is a subsidiary then its Ultimate Group/Holding Company must guarantee the performance of this contract and provide a letter to that effect signed by a duly authorised signatory of the Ultimate Group/Holding Company if requested to do so by the Council. Where the direct parent company cannot provide an adequate guarantee in the opinion of the Council, the Council will look to another group or associate company, with adequate assets, to be the guarantor. In cases where the contract is with a Joint Venture Company (JVC) or a Special Purpose Vehicle (SPV) company, which may have two or more parent companies and which may not be adequately capitalised or have sufficient financial strength on its own to support the risk and obligations it has under the contract, ‘joint and several’ guarantees / indemnities from the parent companies of the JVC or SPV may be sought.

3.4 Warranty

The Tenderer warrants that all the information given in their Tender and if applicable their Request to Participate Questionnaire is true and accurate. The information provided will be deemed to form part of any contract formed under this contract.

The Tenderer warrants that none of their current Directors have been involved in liquidation or receivership or have any criminal convictions

4.0 Tender Submission

- 4.1** Tenders must be submitted strictly in accordance with the letter of instruction

accompanying this Invitation to Tender through the Delta e-tendering portal. Tenders must be submitted by the deadline of **noon 30 October 2015**.

- 4.2 No unauthorised alteration or addition should be made to the Tender Response Document, or to any other component of the Tender document. If any such alteration is made, or if these instructions are not fully complied with, the Tender may be rejected.
- 4.3 Qualified tenders may be submitted, but the Council reserves the right not to accept any such tender. The Council's decision on whether or not a Tender is acceptable will be final.
- 4.4 Tenderers should note that their Tender must remain open and valid and capable of acceptance for a period of at least 90 days.
- 4.5 Tenderers should note that Tenders and supporting documents must be written in English and that any subsequent contract, which may or may not be entered into, its formation, interpretation and performance, shall be subject to and in accordance with the laws of England and subject to the jurisdiction of the Courts of England and Wales.
- 4.6 Where Tender submissions are incomplete the Council reserves the right not to accept them.

5.0 **Variant Bids**

- 5.1 The Council is interested in alternative solutions which would provide and develop opportunities for savings in service costs, service improvement or other financial benefits. In particular, the Council wishes to encourage solutions which also deliver benefits and added value to the local economy, residents and the business community.
- 5.2 Tenderers may submit, at their discretion, a Tender offering a different approach to the project as a "Variant Bid". However, to permit comparability, at least one bid must be submitted strictly in accordance with the Invitation to Tender Documents (the "Compliant Tender"). Any Tender variant proposed must clearly state how it varies from the requirements of the Compliant Tender Documents, and be explicit in demonstrating the benefits that will accrue to the Council from adopting this approach. Tenderers will be required to identify which submission, in their view, demonstrates best value to the Council.
- 5.3 Variant Bids must contain sufficient financial and operational detail to allow any Variant Bid to be compared with the standard Tender, permitting its considerations in written form.

6.0 **The Transfer of Undertakings (Protection of Employment) regulations**

- 6.1 Tenderers should note that the current Employee 'Transfer of Undertakings (Protection of Employment) Regulations ('TUPE') are likely to apply to this contract. Tenderers are advised to seek their own legal advice about the practicality of these regulations and should reflect the financial implications of such a transfer in their tender submissions.

6.2 Details of employees of companies who are currently carrying out the work that is included in the Contract can be requested by emailing procurement@shropshire.gov.uk Tenderers should note, however, that where the Council provides information to them for the purposes of TUPE, such information may originate from a third party. As the Council has no control over the compilation of such third party information, the Council gives no guarantee or assurance as to the accuracy or completeness of such information and cannot be held responsible for any errors or omissions in it.

7.0 Tender Evaluation

7.1 The Tenderers may be called for interview to seek clarification of their tender or additional or supplemental information in relation to their tender. The presentations will not carry any weighting to the final score achieved by Tenderers, but will be used to clarify and moderate issues raised in the Tenderer's submissions. Any areas of discrepancy between submissions and information gained from the presentations will be reviewed and scores previously awarded will be amended if necessary.

7.2 If the Council suspects that there has been an error in the pricing of a Tender, the Council reserves the right to seek such clarification, as it considers necessary from the Tenderer in question.

8.0 Clarifications

8.1 Tenderers are responsible for clarifying any aspects of the tendering process and/or the Invitation to Tender documents in the manner described below.

8.2 If you are unsure of any section and require further clarification, please contact via our Delta Tenderbox.

8.3 Where appropriate, the Authorised Officer named above may direct the Tenderer to other officers to deal with the matter.

8.4 All queries should be raised as soon as possible (in writing through the Delta portal), in any event not later than **23 October 2015**.

8.5 All information or responses that clarify or enhance the tendering process will be supplied to all Tenderers on a uniform basis (unless expressly stated otherwise). These responses shall have the full force of this Instruction and where appropriate the Conditions of Contract. If a Tenderer wishes the Council to treat a question as confidential this must be expressly stated. The Council will consider such requests and will seek to act fairly between the Tenderers, whilst meeting its public law and procurement duties in making its decision.

8.6 Except as directed in writing by the Authorised Officer, and confirmed in writing to a Tenderer, no agent or officer or elected Member (Councillor) of the Council has any express or implied authority to make any representation or give any explanation to Tenderers as to the meaning of any of the Tender Documents, or as to anything to be done or not to be done by a Tenderer or to give any warranties additional to those (if any) contained in the ITT or as to any other matter or thing so as to bind the Council in any way howsoever.

9.0 Continuation of the Procurement Process

9.1 The Council shall not be committed to any course of action as a result of:

- i) issuing this Invitation to Tender;
- ii) communicating with a Tenderer, a Tenderer's representative or agent in respect of this procurement exercise;
- iii) any other communication between the Council (whether directly or through its agents or representatives) and any other party.

9.2 The Council reserves the right at its absolute discretion to amend, add to or withdraw all, or any part of this Invitation to Tender at any time during the tendering stage of this procurement exercise.

9.3 At any time before the deadline for receipt of tender returns the Council may modify the Invitation to Tender by amendment. Any such amendment shall be numbered and dated and issued by the Council to all participating tenderers. In order to give prospective Tenderers reasonable time in which to take the amendment into account in preparing its Tender return, the Council may in its sole discretion, extend the deadline for submission of the tender returns. The Council reserves the right to amend, withdraw, terminate or suspend all or any part of this procurement process at any time at its sole discretion.

10.0 Confidentiality

10.1 All information supplied by the Council in connection with or in these Tender Documents shall be regarded as confidential to the Council unless the information is already within the public domain or subject to the provisions of the Freedom of Information Act 2000.

10.2 The Contract documents and publications are and shall remain the property of the Council and must be returned upon demand.

10.3 Tenderers shall ensure that each and every sub-contractor, consortium member and/or professional advisor to whom it discloses these papers complies with the terms and conditions of this ITT.

10.4 The contents of this Invitation to Tender are being made available by the Council on condition that:

10.4.1 Tenderers shall at all times treat the contents of the Invitation to tender and any related documents as confidential, save in so far as they are already in the public domain and Tenderers shall not, subject to the provisions relating to professional advisors, sub-contractors or other persons detailed below, disclose, copy, reproduce, distribute or pass any of the contents of the Invitation to tender to any other person at any time or allow any of these things to happen;

10.4.2 Tenderers shall not use any of the information contained in this Invitation to tender for any purpose other than for the purposes of submitting (or deciding whether to submit) the tender; and

- 10.4.3** Tenderers shall not undertake any publicity activity within any section of the media.
- 10.5** Tenderers may disclose, distribute or pass this Invitation to tender to their professional advisors, sub-contractors or to another person provided that:
- 10.5.1** this is done for the sole purpose of enabling an Invitation to tender to be submitted and the person receiving the Information undertakes in writing to keep the Invitation to Tender confidential on the same terms as if that person were the Tenderer; or
- 10.5.2** the Tenderer obtains the prior written consent of the Council in relation to such disclosure, distribution or passing of the Invitation to Tender; or
- 10.5.3** the disclosure is made for the sole purpose of obtaining legal advice from external lawyers in relation to the procurement or to any Contract(s) which may arise from it; or
- 10.5.4** the Tenderer is legally required to make such a disclosure.
- 10.6** The Council may disclose detailed information relating to the Invitation to Tender to its officers, employees, agents, professional advisors or Governmental organisations and the Council may make any of the Contracts and procurement documents available for private inspection by its officers, employees, agents, professional advisors, contracting authorities or Governmental organisations.

10.7 Transparency of Expenditure

Further to its obligations regarding transparency of expenditure, the Council may be required to publish information regarding tenders, contracts and expenditure to the general public, which could include the text of any such documentation, except for any information which is exempt from disclosure in accordance with the provisions of the Freedom of Information Act to be determined at the absolute discretion of the Council.

11.0 Freedom of Information

- 11.1** Please note that from 1 January 2005 under the provisions of the Freedom of Information Act 2000, the public (included in this are private companies, journalists, etc.) have a general right of access to information held by public authorities. One of the consequences of those new statutory responsibilities is that information about your organisation, which Shropshire Council may receive from you during this tendering process may be subject to disclosure, in response to a request, unless one of the various statutory exemptions applies.
- 11.2** In certain circumstances, and in accordance with the Code of Practice issued under section 45 of the Act, Shropshire Council may consider it appropriate to ask you for your views as to the release of any information before we make a decision as to how to respond to a request. In dealing with requests for information under the Act, Shropshire Council has to comply with a strict timetable and it would therefore expect a timely response to any such consultation within five working days.
- 11.3** If, at any stage of this tendering process, you provide any information to Shropshire

Council in the expectation that it will be held in confidence, then you must make it clear in your documentation as to the information to which you consider a duty of confidentiality applies. The use of blanket protective markings such as “commercial in confidence” will no longer be appropriate and a clear indication as to what material is to be considered confidential and why should be given.

- 11.4 Shropshire Council will not be able to accept that trivial information or information which by its very nature cannot be regarded as confidential should be subject to any obligation of confidence.
- 11.5 In certain circumstances where information has not been provided in confidence, Shropshire Council may still wish to consult with you as to the application of any other exemption such as that relating to disclosure that will prejudice the commercial interests of any party. However the decision as to what information will be disclosed will be reserved to Shropshire Council.

For guidance on this issue see: <http://www.ico.gov.uk>

12.0 **Disqualification**

- 12.1 The Council reserves the right to reject or disqualify a Tenderer’s Tender submission where:
 - 12.1.1 The tenderer fails to comply fully with the requirements of this Invitation to tender or is in breach of the Terms and Conditions relating to Bribery and Corruption or is guilty of a serious or intentional or reckless misrepresentation in supplying any information required; or
 - 12.1.2 The tenderer is guilty of serious or intentional or reckless misrepresentation in relation to its tender return and/or the procurement process.
 - 12.1.3 The tenderer directly or indirectly canvasses any member, official or agent of the Council concerning the award of the contract or who directly or indirectly obtains or attempts to obtain information from any such person concerning any other Tender or proposed Tender for the services. The Canvassing Certificate must be completed and returned as instructed.
 - 12.1.4 The Tenderer :
 - a) Fixes or adjusts the amount of his Tender by or in accordance with any agreement or arrangements with any other person; or
 - b) Communicates to any person other than the Council the amount or approximate amount of his proposed Tender (except where such disclosure is made in confidence in order to obtain quotations necessary for preparation of the Tender for insurance purposes); or
 - c) Enters into an agreement or arrangement with any other person that he shall refrain from tendering or as to the amount of any Tender to be submitted; or
 - d) Offers or agrees to pay or give or does pay or gives any sum of money, inducement or valuable consideration directly or indirectly to any person for

doing or having done or causing or having caused to be done in relation to any Tender or proposed Tender for the services any act or omission.

12.2 Any disqualification will be without prejudice to any other civil remedies available to the Council and without prejudice to any criminal liability which such conduct by a Tenderer may attract. The Non-Collusive Tendering Certificate must be completed and returned as instructed.

12.3 The Council reserves the right to disqualify an Applicant from further participating in this procurement process where there is a change in the control or financial stability of the Tenderer at any point in the process up to award of a contract and such change of control or financial stability has a materially adverse effect on the Tenderer's financial viability or ability to otherwise meet the requirements of the procurement process.

13.0 E-Procurement

As part of its procurement strategy Shropshire Council is committed to the use of technology that can improve the efficiency of procurement. Successful Tenderers may be required to send or receive documents electronically. This may include purchase orders, acknowledgements, invoices, payment advices, or other procurement documentation. These will normally be in the Council's standard formats, but may be varied under some circumstances so as not to disadvantage small and medium suppliers.

14.0 Award of Contract

14.1 Award Criteria

The Award Criteria has been set out within the Tender Response Document accompanying this invitation to tender. The Council is not bound to accept the lowest or any Tender.

14.2 Award Notice

The Council will publish the name and addresses of the successful Tenderers in the Official Journal of the European Union (OJEU) and Contract Finder where appropriate. The Contracting Authority reserves the right to pass all information regarding the outcome of the Tendering process to the Office of Fair Trading to assist in the discharge of its duties. Additionally, the Council will adhere to the requirements of the Freedom of Information Act 2000 and Tenderers should note this statutory obligation.

14.3 Transparency of Expenditure

Further to its obligations regarding transparency of expenditure, the Council may also be required to publish information regarding tenders, contracts and expenditure to the general public, which could include the text of any such documentation, except for any information which is exempt from disclosure in accordance with the provisions of the Freedom of Information Act to be determined at the absolute discretion of the Council.

15.0 Value of Contract

Shropshire Council cannot give any guarantee in relation to the value of this contract

16.0 Acceptance

16.1 Tenders must be submitted strictly in accordance with the terms of the Council's Invitation to Tender documentation and acceptance of the tender shall be conditional on compliance with this Tender Condition.

16.2 The Tender documentation including, the Terms and Conditions of Contract, the Tender Response document, these Instructions to Tender, the returned tender together with the formal written acceptance by the Council will form a binding agreement between the Contractor and the Council.

16.3 The Tenderer shall be prepared to commence the provision of the supply and services on the start date of the contract/framework arrangement being **1 April 2016**

17.0 Payment Terms

Tenderers should particularly note that the principles governing public procurement require that, as far as is reasonably possible, payments for Goods, Works or Services are made after the provision. Therefore any indication of a pricing strategy within a Tender which provides for substantial payments at the outset of the Contract will be examined carefully to decide whether or not a Tender in such form can be accepted. If in the opinion of the Council such substantial payments appear excessive in relation to the requirements of the Contract the Council reserves, without prejudice to any other right to reject any Tender it may have, the right to require the Tenderer to spread such proportion of the costs as are considered excessive over the duration of the Contract.

18.0 Liability of Council

18.1 The Council does not bind himself to accept the lowest or any tender.

18.2 The Council does not accept any responsibility for any pre-tender representations made by or on its behalf or for any other assumptions that Tenderers may have drawn or will draw from any pre-tender discussions.

18.3 The Council shall not be liable to pay for any preparatory work or other work undertaken by the Tenderer for the purposes of, in connection with or incidental to this Invitation to Tender, or submission of its Tender response or any other communication between the Council and any other party as a consequence of the issue of this Invitation to Tender.

18.4 The Council shall not be liable for any costs or expenses incurred by any Tenderer in connection with the preparation of a Tender return for this procurement exercise, its participation in this procurement whether this procurement is completed, abandoned or suspended.

18.5 Whilst the Tender Documents have been prepared in good faith, they do not purport to be comprehensive nor to have been formally verified. Neither the Council nor any of its staff, agents, elected Members, or advisers accepts any liability or responsibility for the adequacy, accuracy or completeness of any information given, nor do they make any representation or given any warranty, express or implied, with respect to the Tender Documents or any matter on which either of these is based (including, without limitation, any financial details contained within the Specification and Contract Documentation). Any liability is hereby expressly disclaimed save in the event of fraud, or in the event of specific warranties provided within the Contract Documentation.

19.0 Declaration

We, as acknowledged by the signature of our authorised representative, accept these Instructions to Tender as creating a contract between ourselves and the Council. We hereby acknowledge that any departure from the Instructions to Tender may cause financial loss to the Council.

Signed (1) Status.....

Signed (2) Status.....

(For and on behalf of)

Date

AMC 006 - INTEGRATED SEXUAL HEALTH SERVICES SHROPSHIRE COUNCIL

Confidentiality Undertaking Regarding TUPE and Pricing Schedule

[Date] 2015

[NAME]

Your ref: *

Our ref: AMC 006

Dear Procurement Team,

We have taken legal advice in this matter and anticipate preparing a Bid on the basis that the current Transfer of Undertakings Regulations (Protection of Employment) Regulations and the EC Acquired Rights Directive may apply to this Contract. We also understand that there is confidential information relating to employees which will be provided on receipt of this letter along with the pricing schedule which also contains TUPE information.

We now formally request from you full details of the current provider staff and conditions of employment.

We hereby acknowledge that this information is confidential. We undertake: -

1. To treat the information in the strictest confidence
2. That the information will be used solely for the purpose of preparing this Bid
3. That it will not be disclosed to any other party for any purpose whatsoever, except for the purpose of preparing this Bid and we will not make copies thereof

We acknowledge that all documents and other information received from the Council as detailed above shall remain the current provider's property and that we will hold them as bailee for the current provider, exercising reasonable care to keep them safe from access by unauthorised persons. We shall also return them to the Council forthwith on written request.

We acknowledge that we shall fully indemnify the current provider against all losses claims damages fines costs and other liabilities as a consequence of or arising from our failure to comply with our obligations to keep such information confidential.

DATED THIS DAY OF

Signature

Duly authorised to sign for and on behalf of the Bidder (print full name and address of Bidder)

Please return to: procurement@shropshire.gov.uk.

PRICING SCHEDULE
SHROPSHIRE COUNCIL
SHROPSHIRE INTEGRATED SEXUAL HEALTH TENDER

BIDDER NAME:

DATE

SCHEDULE

PRICING SCHEDULE

PRICING SCHEDULE
SHROPSHIRE COUNCIL
SHROPSHIRE INTEGRATED SEXUAL HEALTH TENDER

BIDDER NAME:

DATE

SCHEDULE

PRICING SCHEDULE

SERVICE SPECIFICATIONS

Service Specification No.	AMC006
Service	Integrated Sexual Health Service
Authority Lead	
Provider Lead	
Period	1st April 2016 to 31st March 2019 (+1+1)
Date of Review	15th September 2016

1. Population Needs

Introduction:

Shropshire Council (SC) is transforming how it commissions services with a greater focus on delivering outcomes that positively impact on people's health and well-being. The provision of an integrated sexual health service will support local ambitions to reduce health inequalities, support people to make positive choices to improve health and wellbeing. This specification has been developed to set out Shropshire Council's ambition to develop a service that is reflective and responsive to the needs of service users.

Outcome based commissioning puts the service user at the forefront of the commissioning process and over the course of the contract it is expected the role of service users will develop in the co-production of service design and delivery. By commissioning for outcomes it is anticipated this will allow providers to be innovative in their approach, to respond to local needs to improve outcomes and maximise value for money. We will underpin this with key quality standards, values and principles which we expect to be adopted into the new system to support the development of the ethos of partnership working with key stakeholders of the local health economy and co-production with service users.

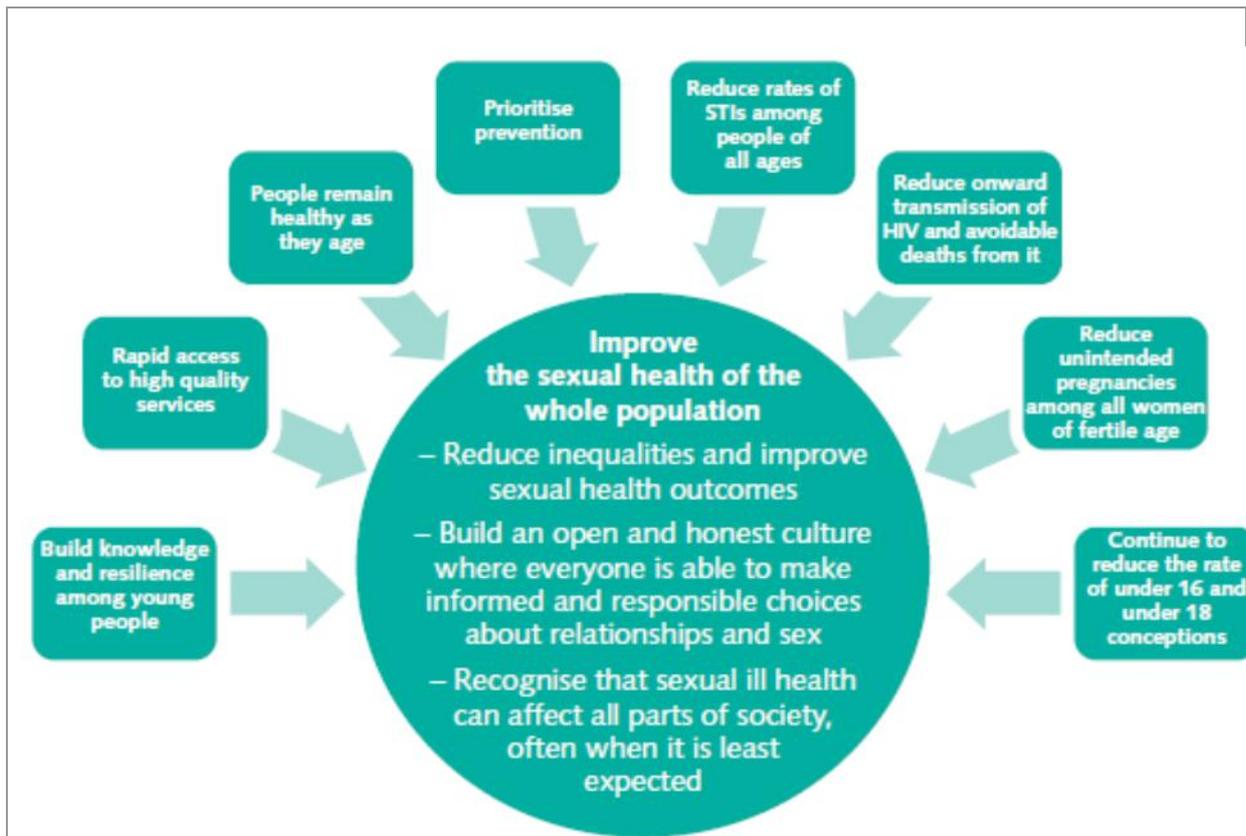
This specification has been written in accordance with the principles and expectations outlined within national and local policies (Please see section 4). All system elements and services will be developed in line with these expectations and will also need to be delivered in line with the forthcoming local or national frameworks.

Where there is ambiguity regarding the content or meaning of any part of this specification interpretation will favour service delivery in line with these guidelines.

National Context

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



Poor sexual 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.

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 contraception) and the Department of Health has produced guidance to assist Local Authorities to commission these and other sexual health interventions. The Public Health outcomes framework measures for sexual health include:

- Reducing under 18 conceptions
- Increasing the effectiveness and diagnosis of Chlamydia (15-24 year olds) as part of the National Chlamydia Screening Programme (NCSP)
- Reducing the number of people presenting with HIV at a late stage of infection

It is recognised that with these latest NHS reforms, providers of integrated sexual health services will need to work collaboratively across a number of organisations, responsible for commissioning different elements of care – Local Authority, NHS England and Clinical Commissioning Groups.

An integrated sexual health service model aims to improve sexual health by providing easy

access to services through open access 'one stop shops', 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. To do this effectively and affordably, it will require:

- An appropriately qualified workforce that can provide integrated sexual health services
- Health promotion through all care pathways to support service users in tackling underlying causes of risk taking behaviours leading to poor sexual health
- Services primarily delivered in accessible community settings.
- Services to be provided on a "drop in" and appointment system
- Service provision to be confidential (conforming to local Safeguarding policies) and welcoming
- Services to be available "out of hours" to include evenings and weekends as required

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, SSHA 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.

However, this model largely relies upon the individual realising that they may have a sexual health problem or that they need some help or resources in order to maintain their sexual health. People have to realise that something is wrong or that they need help before they might consider accessing sexual health services. For many conditions such as HIV infection or certain sexually transmitted infections (STIs) such as Chlamydia, people may be completely unaware of their infection as they can be asymptomatic. This may lead to an individual not accessing service as they believe there is nothing wrong with them until symptoms start to appear some time later. With both HIV and certain STIs, failure to have treatment early can lead to severe health problems and premature death.

We must therefore look to ways in which the service can reach out to the most vulnerable groups to enable them to make informed choices about their sexual health. A coordinated outreach service working in partnership with local 3rd sector organisations and other health and wellbeing services can take services to vulnerable priority groups that might be otherwise unable or unlikely to access sexual health services.

The system will contribute locally to the delivery of the Public Health Outcome Framework outcomes to increased healthy life expectancy and reduced differences in life and healthy life expectancy between communities, through the six indicators directly pertinent to sexual health and others where improving sexual health can contribute to other positive outcomes.

Local Context

Shropshire Council is committed to achieving social value outcomes through maximising the social, economic and or environmental impact of all its procurement activity in line with the Public Service (Social Value) Act 2012. Accordingly it is expected delivery of this specification will contribute to providing social value benefits to individuals, families and the

wider community.

<http://www.shropshire.gov.uk/doing-business-with-shropshire-council/social-value>

The new system will also support delivery of the local Health and Wellbeing Board's strategic outcomes:

Outcome 1: Health Inequalities are reduced

Outcome 2: People are empowered to make better lifestyle and health choices for their own, and their family's health and well being

Outcome 3: Better emotional and mental health and well-being for all

Outcome 4: People with long-term conditions and older people will remain independent for longer

Outcome 5: Health, social-care and well-being services are accessible, good quality and seamless

<http://www.shropshiretogether.org.uk/health-wellbeing-board/>

Local Need

Shropshire is situated in the West Midlands, with a population of approximately 309,000, of which 34,800 are aged 15-24 years. Shropshire remains a low transmission area for sexually transmitted infections (STIs), with total diagnosis rates 45 percent of the national rate.

The demographic factors most important to sexual health are that Shropshire has an older population than England, especially over 45s, therefore sexual health services need to ensure services are appropriate for all age groups. The major factor affecting the provision of any service in Shropshire, is the rurality/ sparseness of the population and services need to meet the needs of a large proportion of the population who live away from towns or any other great populous, with poor/ no public transport.

The Public Health England Sexual Health Profile for Shropshire (2013) highlights key areas of sexual health and compares local performance in Shropshire against the national average for England and also compares against the performance of other neighbouring local authorities in the West Midlands. For further information, please see the Public Health England Sexual & Reproductive Health Profile for Shropshire

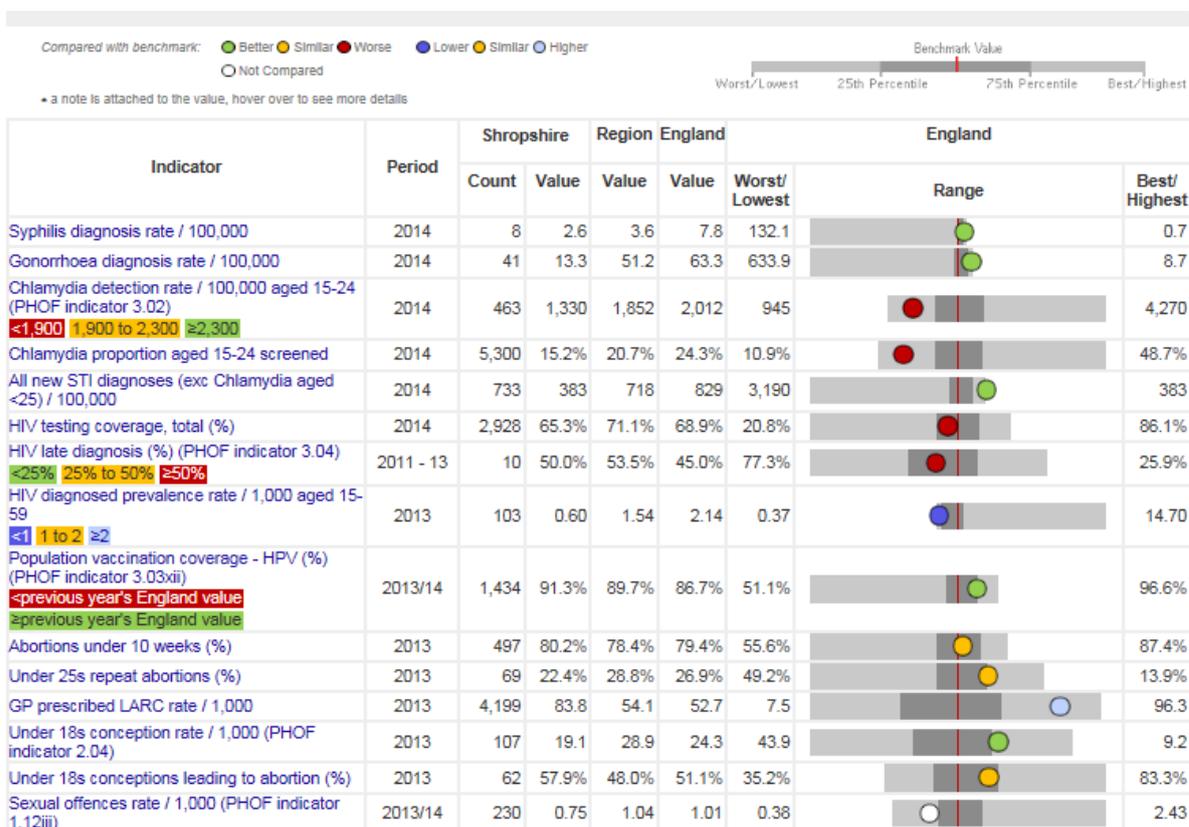
<http://fingerprints.phe.org.uk/profile/sexualhealth/data#qid/8000057/pal/6/at/102/page/1/pal/E12000005/arw/E0600005>. A snapshot of the indicators for Shropshire is presented below:

In summary, the key issues for Shropshire include:

- Chlamydia screening in Shropshire is not reaching large numbers of young people and only 14.9% of young people were tested which is lower than the West Midlands and England average in terms of diagnostics/ screening young people for Chlamydia.
- Teenage conceptions are reducing, at a lower rate than in England and the West Midlands, but are at a much lower rate. In 2014 19.1 per 1,000 compared to 28.9 in West Midlands and 24.3 in the England
- GP prescribing of LARC methods is much higher than the National and West Midlands average
- Numbers of women having abortions is 626 in 2013, and the numbers having repeat

abortions is 23 percent

- There are low numbers of diagnosed sexually transmitted infections, chlamydia being the commonest STI diagnosed in young people in Shropshire.
- 50% of HIV infection is diagnosed late in the disease, compared with 40% in England



The New Sexual Health System for Shropshire

The future system will be outcome based. Shropshire Council requires a new sexual health model/system; one that is coordinated and will be responsible for ensuring that sexual health prevention, promotion and treatment services, provided through a range of qualified providers from the statutory and 3rd sectors, are delivering high quality, effective and value for money services that conform to recognised national standards and are delivered consistently across Shropshire.

The provision of sexual health services are mandated to be “open access”; this means they are free at the point of delivery for anyone who seeks to use them, irrespective of any characteristic such of age, gender or sexual orientation. Simply, anyone within an area can use services in that area, therefore care has to be available to patients/ service users who are not residents of Shropshire or who are not registered with a general Practice in Shropshire. This extends to individuals living in devolved nations within the UK but outside of England, and indeed any other overseas visitor. NHS regulations state that family planning services (provision of contraceptive products and devices to prevent pregnancy) and STI treatment should be free to all, regardless of place of residency.

The Provider will be responsible for all aspects of delivery within the system including by:

- Establishing a single clinical governance system across all providers.
- Standardising protocols and procedures.
- Identifying and delivering the training needs within each organisation.
- Performance management of all provision against key performance indicators.
- Ensuring consistency in the promotion of good sexual health and enabling of patients/ service users to tackle the underlying causes of sexual health risk taking and coercion.
- Establishing quicker and easier access to comprehensive sexual health services for the most vulnerable groups through targeted outreach and rapid referral pathways to specialist services as required.
- Creating active partnerships with key local organisations such as drug and alcohol services, to ensure vulnerable/ at risk individuals receive the treatment, care and support to enable them to achieve good health and wellbeing.
- Ensuring that services are delivered in easily accessible locations with good public transport links, and that services are open 6 days per week, at times that are convenient to service users and at regular and predictable times.

2. Key Service Outcomes

The service will support the outcomes as outlined by “A framework for Sexual Health In England” and three main sexual health Public Health Outcome Framework measures

A framework for Sexual Health In England

- Reducing inequalities and improve sexual health outcomes
- Building an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognising that sexual ill health can affect all parts of society, often when it is least expected

Public Health Outcome Framework measures

Sexual health directly features in six of the indicators in the current public health outcomes framework (see below); whilst it has indirect impacts on many others:

- 1.12iii – Crude rate of sexual offences per 1,000 population
- 2.04 – Rate of conceptions per 1,000 females aged 15-17
- 2.21i – HIV pregnant women (new in February 2015)
- 3.02 – Crude rate of chlamydia screening detection per 100,000 young adults aged 15-24
- 3.03xii – Percentage of girls aged 12-13 who have received all 3 doses of the HPV vaccine
- 3.04 – Percentage of adults (aged 15+) newly diagnosed with HIV with a CD4 count <350 cells per mm

Local Service Outcomes

The recent sexual health needs assessment is summarised in Appendices 3 and 4. Appendix 3 presents the current epidemiological information on sexual health in Shropshire.

The needs assessment highlighted a number of priority areas that we have developed into local service outcomes:

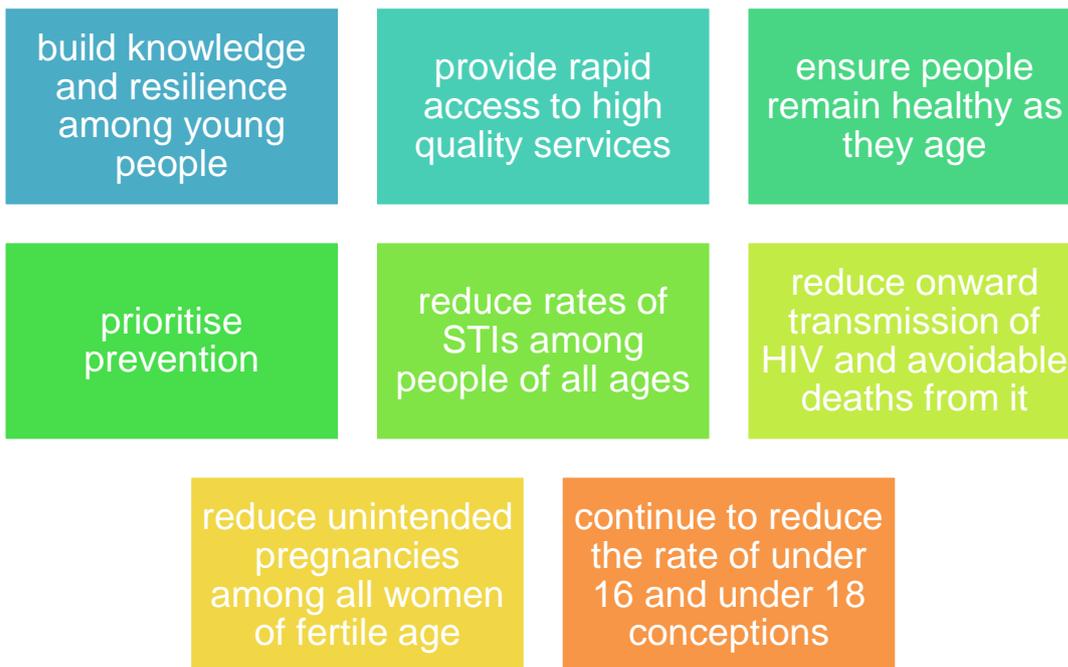
- The proportion of the population aged 15 to 24 years old covered by chlamydia testing

- The diagnosis rates for of chlamydia in those tested in the population aged 15 to 24 years
- The rate of late diagnosis of HIV
- Proportion of terminations that are a repeat termination
- The rates of prescribing long-acting reversible contraceptives in local sexual health services

3. Scope

3.1 Aims and Objectives of Service

The aim of the procurement is to commission an integrated sexual health system across Shropshire; ***which provides a care model for the delivery of good quality, easily accessible, value for money and effective sexual health services to meet the following ambitions for sexual health*** in Shropshire (those set out in ‘A Framework for Sexual Health Improvement in England’):



Scope:

This service specification describes the services to be made available to all people (depending on need) who attend sexual health services in Shropshire. The services are open access which means that people that do not reside in Shropshire are still able to use them; services provided will be subject to charging to the Local Authority of residence for each individual. The specification further covers the provision of the condom distribution scheme in Shropshire (appendix 1); and the HIV prevention and support services (appendix 2)

Services are to be provided for people of all ages that require them. Practitioners must be aware of their specific responsibilities for all vulnerable groups including children under 13 and those

between 13 to 15 years of age. Integrated sexual health care are to be offered and provided in all relevant and appropriate settings by appropriately qualified workforce. The provider will deliver the following elements, set out in detail below:

- A core service offer comprising of Prevention (including HIV Prevention) and Self-management, which will underpin delivery of services and activities;
- An equitable Basic and Intermediate (level 1 and 2) community-based contraception and sexual health service across Shropshire;
- An equitable integrated community-based sexual health service, in Shrewsbury, that will bring together all sexual health and contraception provision, including Prevention and Self-management, levels 1/2/3, HIV testing, counselling, outpatients (including collaboration of HIV treatment and care with NHSE)
- Health promotion/prevention planned outreach campaigns
- A local condom distribution scheme (CDS), see Appendix 1: *Condom Distribution Scheme*
- An HIV prevention and support programme, see Appendix 2
- Sexual health clinical outreach to vulnerable young people and adults
- Sexual health outreach facilitation in schools, colleges, educational and training institutes
- Additional Training for health professionals
- A Sexual Health Clinical network
- Laboratory services

Service values & aims

The new sexual health service in Shropshire will have to meet and adhere to some overarching values aims:

- Continuously improve service through development and innovation and consultation with service users and the local population
- Offer open access, confidential, integrated sexual health system across Shropshire that is welcoming to all that need to use it, regardless of gender, ethnicity, sexuality and physical or learning disabilities.
- Improve access to services – understanding the broadest meaning and connotations of the word access, including addressing physical, temporal barriers to services, and psychological barriers, such as perceived confidentiality.
- Create a sexual health economy that provides a comprehensive service with clear referral pathways between providers; enables effective planning through clinical leadership and clinical networks; train and educate staff, trainees and students
- Provide treatment free of charge
- Provide a 'one stop shop', where the majority of sexual health and contraceptive needs can be met at one site, usually within a single consultation
- Improving the sexual health of people living with HIV
- Reduce late HIV diagnoses in Shropshire
- Develop a sexual health system of care across Shropshire, working in partnership with general practice, local community groups/ 3rd Sector Organisations and linking into local

outreach to facilitate collaboration and service development

- Ensure that Sexual health promotion as a key, embedded component of all care pathways
- Provide a service tailored to the needs of service users and potential service users, especially those most vulnerable to poor sexual health
- Reduce unwanted pregnancies
- Multidisciplinary working, in partnership with local service providers (statutory and non-statutory) and other services supporting and working with vulnerable and at risk groups such as drugs and alcohol services.

Objectives:

This will be achieved through the following objectives:

- Proactively promote, publicise and raise awareness of the services offered to the local population.
- Ensure that interventions have a robust evidence base for their effectiveness
- Lead and participate in the local sexual health clinical network
- Provide evidence based care centred on recognised national best practice guidance where this exists (this should include participation in audit and service evaluations and may include research).
- Delivering training to wider workforce involved in Provide sexual health services; and develop the sexual health workforce
- Engage key services to participate in the screening and treatment of young people for Chlamydia (15-24) in Shropshire.
- Increase diagnosis and effective management of STIs, with rapid and easy access to services for prevention, detection and management (treatment and partner notification), to reduce prevalence and transmission.
- Increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk
- Provide a comprehensive range and choice of contraception including long acting methods (LARC) – increasing the uptake of this method; emergency contraception; condoms and support to reduce the risk of unwanted pregnancy; giving the methods most appropriate for the age.
- Offer and provide (as required) on-going support and guidance to women choosing LARC methods to avoid premature or unnecessary removal of contraceptive implants or intra uterine devices.
- Increase the uptake of effective methods of contraception, including LARC (Long Acting Reversible Contraceptive) for all appropriate age groups in line with national guidelines
- Facilitate and manage the local condom distribution scheme
- Reducing the number of abortions and repeat abortions
- Provide free pregnancy tests and appropriate rapid onward referral to abortion services or maternity care with an individualised future contraception plan agreed wherever possible in advance.

- Provide sexual health information and advice in order to develop increased knowledge and skills, especially in high-need individuals and communities.
- Work towards making the fullest use of existing sexual health encounters to promote effective contraception and sexual health, especially in the most vulnerable groups.
- Ensure that services are acceptable and accessible to people disproportionately affected by unwanted pregnancy and sexual ill health based on up to date sexual health needs assessment and equity impact assessment.
- Ensure there is confidentiality at all times that an attendee is within a service, including at reception, registration and all other times outside of the consultation room, as well as in.
- Promote access to service, through timings, locations and other facets – including the correct balance of walk-in and appointment clinics, and evenings and weekends
- Ensure that services are situated in easily accessible locations with good public transport links and that all premises comply with the DH guidance
- Implement “You’re Welcome” quality standard accreditation to ensure provision is welcoming to young people and encourages them to access services.
- Strengthen the provision of outreach sexual health services specific to young people. These should be for all young people, and with some outreach focused at vulnerable groups such as looked-after-children,
- Provide opportunities for people to manage their own sexual health either independently or with support, including increased availability and provision of self-testing kits, condoms and sexual health promotion information and referral on to other services as appropriate.
- Ensure those services currently engaged and delivering the local condom distribution scheme receive annual updates as a minimum. Providers currently engaged with the scheme consist of School Nurses, Pharmacists, Sexual Health Services, Supported Housing, GP Practice nurses, Further Education, Health Visitors, Family Nurse Partnership, Teenage Identified Midwives, Walk-in Centre, Minor Injury Units and the Youth Offending Service.

3.2 Service Description/Pathway

The Service will provide a range of interventions via clinics and outreach provision to meet the needs of the community based on Shropshire’s sexual health needs assessment. As part of this agreement, providers will ensure and demonstrate that pathways of care within the sexual health economy are formally agreed.

Whilst the intention is not to be too prescriptive to allow for innovation within the system, it is anticipated it will need to provide, as a minimum, the following service elements:

NB A service description and further detail of the condom distribution scheme in Shropshire is provided in appendix 1; and the HIV prevention and support services in appendix 2

- **Accessibility:**

The service will be on an open access basis. Provision of the service must be accessible. There

is a limited rural transport network in Shropshire; therefore the service should be accessible within the main market towns of **Shrewsbury (Town centre), Oswestry, Whitchurch, Ludlow, Market Drayton and Bridgnorth** as a minimum. Ensuring that services are situated in easily accessible locations with good public transport links and that all premises comply with the DH guidance²

The service will offer greater flexibility in access, with evenings and weekend availability to meet people’s needs.

The service will implement “You’re Welcome” quality standard accreditation to ensure provision is welcoming to young people and encourages them to access services

The service will provide interpretation services for clients whose first language is not English and who require interpretation and to people who have a sensory impairment and/ or learning disability etc.

- **Single Main Point of Contact**

There will be a single main point of contact for the entire system. This will be available to anyone who wants to make contact or access the service, However, service users should be able to contact other available services and other contacts within the service where appropriate.

- **Prevention**

Prevention interventions should follow best practice and NICE guidance. As part of the wider local agenda to reduce health inequalities the provider is also expected to deliver to Making Every Contact Count (MECC) principles and ensure personnel possess appropriate skills and knowledge to MECC activity to give appropriate brief opportunistic advice to service users and support them to adopt healthier lifestyles actively sign-posting patients into relevant local lifestyle-risk management services e.g. smoking cessation support services.

- **Self-Managed Care**

Service users 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. 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 onwards.

	Method of access		
	Internet	By phone	In person
Health information <ul style="list-style-type: none"> • Generic information on pregnancy, STIs including and HIV prevention/safer sex 	X	X	X

² Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.

advice <ul style="list-style-type: none"> Information on the full range of contraceptive methods and their availability 			
Primary prevention initiatives to improve overall sexual health to the community	X	X	X
Condoms and lubricants		X	X
Chlamydia and gonorrhoea testing kits		X	X
Pregnancy testing kits		X	X
HIV home testing kits		X†	X†

† **NB** HIV home testing kits will need to be accessed after speaking to a trained healthcare practitioner, although not for a clinical consultation

- **Service elements:**

Sexual health promotion and prevention

Sexual health promotion and prevention will be embedded in all aspects of the sexual health services – with the service elements of this spread through the other six elements below.

Basic and Intermediate Care (Level 1 and 2)

- Prevention and Self-management
- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)
- Pregnancy testing and expedient referral to antenatal or termination services as appropriate;
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device 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 IUS 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/IUD/IUS removal
- Natural family planning
- Young people's (13 to 25 years old) brief and focused counselling service, for issues such as pre- and post- termination support; and onward referral to a secondary service as appropriate
- Direct referral for antenatal care

- Direct referral for abortion care and to support self-referral
- Counselling and direct referral for male and female sterilisation
- Non prescribing brief and focused psychosexual counselling/interventions for service users aged 16 and over for the management of lack/loss of libido, non-consummation, orgasm problems, vaginismus, dyspareunia, erectile dysfunction, ejaculatory problems and other penile problems such as pain and anxiety.
- Screening service users (all practitioners) and referral for signs of domestic abuse, sexual coercion/ exploitation and violence etc., identifying clients at risk and complying with local Safeguarding policies and procedures.
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- Opportunistic cervical screening and onward referral to GP for routine follow-up thereafter.
- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women excluding:
 - Men with dysuria and/or genital discharge
 - Symptoms at extra-genital sites e.g. rectal or pharyngeal
 - Pregnant women (except women with uncomplicated infections requesting abortion)
 - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- Management of results notification and partner notification for young people (under 16) testing positive for chlamydia as part of the National Chlamydia Screening Programme, in line with local safeguarding policies and procedures
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- Screening for asymptomatic women and men (including Men who have sex with Men) for STIs
- Initiation of Post Exposure Prophylaxis following sexual exposure with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Ensuring opportunistic health promoting interventions across all service delivery to include, in particular: smoking, obesity, alcohol and mental health.
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of HIV/syphilis/LGV (Lymphogranuloma Venereum)
- Treatment of uncomplicated genital warts (plus referral to Level 3 service for recalcitrant/keratinised warts, and warts in pregnancy)
- Management of women with contraceptive related abnormal bleeding and abdominal pain

- Assessment and referral of sexual assault cases to sexual assault referral centres (SARCs)
- Holistic sexual health care for all ages including risk assessments for protection/safeguarding/exploitation and coercion.
- Clinical outreach services offering prevention, STI testing and treatment, and offer all methods of contraception but not limited to e.g. higher and further education settings.
- Nurse-delivered outreach service to under-19s in further education and college; and other young person settings on a regular basis
- Provide structured one-to-one sessions (in accordance with NICE guidance) to individuals at high risk of STIs, structured on the basis of behavioural changes theories, in order to reduce sexual risk taking, and improve self-efficacy and motivation.
- Management of heterosexual men with urethral/ urinary symptoms
- Management of problems with choice of contraceptive methods, including missing threads, menorrhagia, abdominal pain
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /respiratory/infectious diseases for inpatient HIV care
- Opportunistic cervical smear tests (responsible commissioner NHSE) and onward referral to GP (see NHSE specification appendix 6)
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines
- HIV prevention and support services following diagnosis
- Interpretation services for clients whose first language is not English and who require interpretation and to people who have a sensory impairment and/ or learning disability etc.
- All samples taken from clients who are victims and/or complainants in suspected sexual assault/ abuse/coercion cases must be handled with high quality forensic integrity and a robust chain of evidence for all samples taken should be in place.

Complex (Level 3) Service Provision in addition to Levels 1 and 2 in the “hub” of the model/system

- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC),
- 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)
- Management of complicated STIs in high risk groups, including MSM, people living with HIV and commercial sex workers
- Providing rapid referral to HIV treatment and care services, (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to national service specifications. This will include a preferred access to NHS list prices in the Commercial Medicines Unit (CMU) tender)

- Management of HIV partner notification
- Same day HIV test to be available for any service user requesting HIV test
- Increasing the uptake of HIV testing by offering
 - HIV testing to be routine (opt out) in clinical services with particular emphasis on first time service users and repeat testing of those that remain at risk
 - Point of care (POC) tests and clinical outreach to vulnerable groups
- Providing HIV PEPSE (Post Exposure Prophylaxis following Sexual Exposure) as clinically appropriate in line with national guidance.
- Management of sexual health aspects of psychosexual dysfunction
- Coordination of outreach clinical services including point of care testing for high risk groups
 - Interface with specialised HIV services as commissioned by NHS England (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East)
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this, under direction of a consultant /clinical lead qualified to provide such care
- Referral to imaging, ultrasound or x-ray service when appropriate
- Coordination of clinical contraceptive and STI care across a network including:
 - Clinical leadership of contraceptive and STI management
 - Co-ordination of clinical governance
 - Co-ordination and oversight of training in SRH and GUM
 - Co-ordination of pathways across clinical services
 - Co-ordination of partner notification for STIs and HIV
 - Development of clinical guidelines
 - Development and implementation of Patient Groups Directions (PGDs) including sign off
 - Provision of quarterly clinical network meetings

Laboratory Services

This specification is inclusive of the management and delivery of all sexual health laboratory testing activities. It is mandatory that the laboratory providing such local services is accredited and compliant to the Clinical Pathology Accreditation 'Standards for the Medical Laboratory' and in line with its transfer to the new UKAS accredited CPA standards.³

The laboratory must be enrolled in a nationally recognised quality assurance scheme (e.g. Quality Control molecular Diagnostics (QMD) and National External Quality Assessment Service in laboratory medicine (NEQAS)). Where the laboratory is to provide results directly to the patients e.g. Internet-based Chlamydia screening programme, the laboratory shall adhere to the appropriate national standards i.e. BAASH, NCSP etc. and sections within this specification for result notification time, information governance and clear pathways for the transfer of data into

³ UKAS is currently managing the transition of all CPA accredited laboratories to UKAS accreditation to the internationally recognised standard ISO 15189:2012, *Medical Laboratories – particular requirements for quality, competence and the transition of CPA accredited External Quality Assurance Providers (EQA) to ISO/IEC 17043:2010, Conformity Assessment – General requirements for proficiency testing* http://www.ukas.com/services/CPA/Clinical_Pathology_Accreditation_CPA.asp

sexual health services for treatment and partner notification.

The laboratory must have the capacity to submit data extracts in line with local and national requirements.

Should at any time the contracted laboratory not adhere to the specified clinic governance structure within this contract, the Provider will notify the commissioner, in writing, immediately.

Sexual Health Clinical Outreach to Vulnerable Young People and Adults

The Provider will deliver targeted clinical contraception and sexual health outreach services to vulnerable young people and adults at high risk of unintended pregnancy and poor sexual health who are not effectively accessing mainstream services.⁴ High risk defined as (but not limited to):

- *Looked After Children (LAC);*
- *Care Leavers;*
- *Erratic school attenders;*
- *Pupil Referral Units (PRUs);*
- *Youth Offending Service (YOS);*
- *Substance Misuse;*
- *Young people identified as vulnerable through risk taking behaviour;*
- *Young people accessing termination services;*
- *BME groups at risk of poor sexual health;*
- *NEET (Not in formal education employment or training)*
- *Gypsy and traveller communities; and*
- *MSM populations at risk of poor sexual health.*⁵

The Provider shall offer the following services from suitable venues of the young person or vulnerable adults' choice,⁶ where they feel comfortable and therefore are more likely to engage:

⁵ MSM populations at risk of poor sexual health as a result of not accessing mainstream services is a local priority

⁶ The provider shall adhere to the following guidance: Premises for the provision of clinical based services must be fit for purpose, see Department of Health guidance *Out-patient care. Healthy Building note 12:01: Consulting, examining and treatment facilities. Supplement A: Sexual and reproductive health clinics*

- fitting of contraceptive implants;
 - administering of contraceptive injections;
 - prescribing of oral contraception;
 - issuing emergency contraception;
 - providing treatment for Chlamydia as a non-medical prescriber
- Provision of a domiciliary contraception/STI service for those with special needs (e.g. those with a severe physical or learning disability) who are unable to attend a GP practice or community-based sexual health clinic
 - Service Users who are not suitable for any of the above forms of contraception shall be supportively fast-tracked to specialist provision

The Provider will ensure all provision of this service element is strictly in line with safeguarding legislation, guidance, policies and procedures specified in service specification

Activities and interventions shall be age appropriate (for those aged 16 and over, and those under 16 years).

Sexual Health Outreach in Schools, Colleges, educational and training institutes

The Provider will lead on establishing relationships and collaborating with schools, colleges, educational and training institutes to encourage a joint-approach in supporting the sexual health needs of young people.

The Provider will be expected to liaise closely with the School Nursing Service (5-19 Healthy Child Programme) and other key stakeholders (e.g. GPs) in developing and implementing accessible and equitable sexual health prevention and outreach services and care pathways for young people.

The Provider will deliver a range of age appropriate prevention activities, support and training within settings accessed by school/college aged pupils, including those who are attending other educational and training institutes:

- 1:1 and group sessions with service users on Prevention and Self-management;
- Referrals to more supported sexual health services e.g. brief intervention, level 1 services etc;
- Identify and train key staff e.g. health and wellbeing advisors, pastoral advisors, to deliver Prevention and Self-management as a means of developing a workforce that will compliment and support the sexual health agenda; and

Activities and interventions shall be age appropriate (for those aged 16 and over, and those under 16 years).

The Provider will also liaise with the NEET tracking and research team and schools, to identify

children, at risk groups or schools who may benefit from specific advice, activities and interventions.

The Provider shall prepare a biannual plan of interventions and activities to be delivered within schools, colleges, education and training institutes and shall have been approved by the Commissioner. Plans shall be monitored during the quarterly monitoring meetings.

Local health economy sexual health provider training

The Provider shall:-

- Support undergraduate, postgraduate and specialist training for medical staff. A charge may be levied for this.
- Work with Post-graduate GP Education to deliver Sexual and Reproductive Health teaching and updating to GPs and GP registrars. A charge may be levied for this.
- Provide annual FSRH theory training for local level 1 and 2 practitioners plus practical training to achieve Letters of Competence in IUDs/IUS, Sub-Dermal Implants and Medical Education and Special Skills Modules of the Faculty of Sexual and Reproductive Healthcare; updating and changing training to provide learning that is up to date with that currently recommended by the FRSB including maintenance of a register of professionals trained.
- Provide annual BASHH STIF training for local level 1 and 2 practitioners plus practical training to achieve STIF Level 2 competency. A charge may be levied for this.
- Provide training and support for level 1 and 2 practitioners involved in the delivery of local sexual health services (including local enhanced services) for emergency contraception, Chlamydia screening & treatment, HIV testing, STI screening, condom distribution, pregnancy testing, brief interventions and Making Every Contact Count
- Create and maintain a training register of all courses provided, attendees and pass rates where appropriate.
- Contribute to the delivery of Sexual Health Promotion training programmes as agreed with the commissioner.
- Work in partnership with the Local Authority Public Health Children and Young People Team as providers of the local Condom distribution Scheme, the local Chlamydia Screening Programme and the local Relationships and Sex Education programmes to ensure consistent services and messages are delivered to Service Users.
- Training for health professionals in primary and secondary care in prescribing of Post Exposure Prophylaxis following Sexual Exposure (PEPSE) including:-
 - the development of a protocol and patient pathway for issue and prescribing in primary and secondary care
 - maintenance of a register of professionals trained to issue/prescribe PEPSE
 - development of a 'fail safe' mechanism for referral of patients to GUM for follow up

Shropshire sexual health clinical network co-ordination

The provider will coordinate and support the delivery of sexual health care across a locality through expert clinical advice, clinical governance and clinical networks. The Provider shall co-ordinate a County-wide multi-agency and multi-disciplinary Sexual Health Network of level 1, 2 and 3 practitioners to:

- Identify, collect and share information on local sexual health needs and concerns.
- Share information on local sexual health services, activity and planned service developments.
- Identify gaps in local provision and agree priorities for service improvement and development.
- Maximise resources and work across organisational boundaries to improve access and deliver high quality, effective services.
- Share and develop good practice and identify opportunities to improve service uptake and user experience.
- Develop, agree and promote agreed care pathways for core sexual health services and vulnerable groups.
- Support the co-ordination and delivery of local sexual health workforce development and education.
- Share information on the availability of national and local funding opportunities.
- Ensure all services are well advertised; and the public understand the entire 'sexual health offer' in the area – including services provider and commissioned by all partners
- Network lead to be a member of the Sexual Health Commissioning Partnership (or equivalent) and provide updates on the work of the network via that route.

- **Safeguarding**

The Provider shall have primary regard for the safety and wellbeing of any child/young person or vulnerable adult in their care. Procedures exist for escalating cases and providers are expected to be aware of, conversant with and able to put into operation the local protocols.

The Provider and all sub-contractors will ensure that when working with service users under the age of 16 years, adherence to the Department of Health's guidance document *Best practice guidance for doctors and other health professional on the provision of advice and treatment to young people under the age of 16 on contraception, sexual reproductive health*.⁷ Practitioner will also be aware of the specific responsibilities that they have for young people aged 13 – 15 years and for those under the age of 13 years.

Services who see Service Users less than 16 years of age must comply with Gillick competency and FRASER guidelines, and with the Children Acts (1989 and 2004).

The Provider shall ensure all staff are aware of, trained to a level appropriate to their role and abide by guidance and legislation on safeguarding (children and adults) and the standards below. This should include understanding safeguarding referral procedures and referral pathways to social care (see below).

In any cases where a child is aged 13 years or under, it should be discussed with a nominated

⁷ DoH (2004): *Best practice guidance for doctors and other health professional on the provision of advice and treatment to young people under the age of 16 on contraception, sexual reproductive health* <http://www.bashh.org/documents/1993.pdf>

professional responsible for safeguarding in that service or locality. It is also recommended that **all** young people under 16 have a risk assessment for sexual abuse or exploitation.

The Service Provider will ensure that people who use the service, workers and others who visit are as safe as they can be and that risks are managed. They will also ensure that the human rights and dignity of people who use services are respected and identify and respond when people are in vulnerable situations. Service Providers will ensure that the premises and equipment they use to provide care, treatment & support are safe and suitable. Service Providers will comply with guidance for safeguarding people who use services from abuse, cleanliness and infection control, management of medicines, safety & suitability of premises and safety and suitability of equipment.

All staff working with children, young people and vulnerable adults will have been recruited in line with Shropshire Local Safeguarding Board Standards for Safer Recruitment 2012 and will be subject to a Disclosure and Barring Service (DBS) check. (This is the new system that has replaced Enhanced CRB check)

The provider or any subcontractor will comply with the local inter-agency Safeguarding Children and Young People and Adults Procedures and Practice guidelines. These are available from Shropshire Local Safeguarding Children's Board LSCB websites. These guidelines relate to the protection of all children and young people and vulnerable adults residing within Shropshire and Telford and Wrekin. The Board definition of a vulnerable child:-

Is any child **under the age of 18** including the unborn baby. However some children are more vulnerable than others. These include:

- "Looked after" children already in the care system
- Children with disabilities
- Homeless children
- Teenage mothers
- Children in custodial settings
- Children who live with parental drug and alcohol abuse or domestic violence.

The broad definition of a "vulnerable adult", is a person (aged 18+) who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him/herself, or unable to protect him or herself against significant harm or exploitation.

The websites contains a number of useful tools and procedures including escalation processes and the Provider shall demonstrate familiarity with these.

Children and Young People Safeguarding

Building on the partnership work to date the new provider will need to develop positive working relationships with Children and Family services from Early Help through to Child Protection to ensure the needs of children and young people are met appropriately. All practitioners should be familiar with local safeguarding processes and understand their responsibility to ensure their functions are discharged having regard for the need to safeguard and promote the welfare of the child. All practitioners should be trained and fully competent in safeguarding.

Adults Safeguarding

The new provider will need to be familiar with the Adult Safeguarding processes and protocol to support the safeguarding of adults within the county of Shropshire. Relationships should be built with the Adult Safeguarding team and all practitioners should be competent in recognising and managing issues in respect of vulnerable adults whether as a user of services or their

care/family members.

3.3 Interdependencies with other Services

The Integrated Sexual Health Service will maintain efficient working relationships with allied services, agencies and stakeholders to enhance the quality of care delivered and ensure the holistic nature of the Service. Specifically, linkages will be maintained with, GPs, wider Local Authority services, Health Promotion, other sexual health and secondary health service providers as part of an integrated and coordinated sexual health system.

The Service cannot work in isolation and is required to work with partners to address the needs of service users and increase the opportunity for service users to achieve optimum sexual health outcomes.

As a priority the Provider will have developed robust referral pathways with the following services at start of delivery for this contract:

- Psychosexual problems;
- Female Genital Mutilation (FGM);
- Male and Female sterilisation;
- Termination of pregnancy;
- Antenatal and post-natal services;
- Sexual Assault Referral Centre;
- HIV treatment and Care
- Local Safeguarding services;
- Laboratory services

Partners will include:

- SURE Chlamydia screening programme
- Shropshire Child Health Development Team
- Cervical Screening Programme
- Child, adolescent and adult mental health services
- Community pharmacy
- Drug, alcohol, obesity and smoking intervention services
- General practice
- Gynaecology
- Male and female sterilisation services
- Other healthcare service areas including 3rd sector organisations
- Pathology and laboratory services
- Prisons and youth offenders institutions
- Criminal justice system including probation services
- School, colleges, universities and education services
- Social Care Support
- Community health services, including Health Visitors and Family Nurse Partnership
- Youth services
- Paediatric services

The Provider is expected to actively participate in local, regional and national clinical networks, relevant trials, training, research and audit programmes where applicable

The Provider will ensure Service Users receive consistent and continuous care through the

establishment of data and care pathways.

The Service will need to interface with local specialised HIV services, local sexual health services as well as locally driven campaigns and activities.

To achieve the abovementioned, the Service is dependent upon up to date lists of local sexual health services and specialised HIV services within and beyond commissioned localities

Relevant Organisations

- Public Health England
- NHS England
- Clinical Commissioning Groups

The Provider is expected to actively participate in local, regional and national networks, relevant trials, training, as well as research and audit programmes where applicable.

3.4 Staffing arrangements

To deliver the service, the staff will need to be competent and able to demonstrate they are appropriately qualified to undertake the roles they do. Across the whole service, the staffing skill mix and levels must reflect, relate to and justify the functions of the Service required. It is expected to achieve these, the provider will ensure that:

- All staff are appropriately qualified to undertake their role and provision is in place for training updates where necessary
- Ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enabled to progress through supported learning.
- There is a register of all courses provided, attendees and pass rates where appropriate
- Staff are supported for undergraduate, postgraduate or specialist training
- To maintain quality of delivery and good practice all employees should have in place an individual personal development plan, which is reviewed every 12 months.
- Staff attend appropriate education and training programmes to maintain their level of competency and comply with their professional body requirements.
- All staff has the relevant professional qualifications and operates within their scope of competency, their professional body's standards, regulations and codes of conduct.
- They manage the process of managing and recruiting the team needed to provide the Service
- All staff have a current DBS check
- That during periods of staff absence such as sickness and holidays, the Provider will do everything in its power to ensure that the Service will not be adversely affected and that arrangements for cover are made which enable the Service to continue in line with this specification
- Workforce development plan is in place that is reviewed and amended annually.
- Contribute to the delivery of sexual health promotion training as agreed with the commissioner.
- Appropriate skill mix is in place, or plans in place to improve skill mix.
- Professional leadership is provided.
- An appropriate management structure is in place that supports service delivery and development.
- Staff work to their employing organisational policies.
- Provider maintains a record of dates and types of training provided to all staff involved in

this service. Written evidence of training and development plans and arrangements for staff support will be kept and records should be immediately available to the Authority on request for audit purposes.

- There is a formal, comprehensive and coordinated training plan covering all aspects necessary to deliver and maintain the quality of the Service provided.

The Provider will carry out professional registration checks before a team member commences employment and in advance of that registration expiring will carry out checks to ensure that registration has not been removed (as appropriate). If a team member has failed to renew their registration in time, the Provider will not allow them to work in their substantial role until such time as the registration has been renewed and verified.

3.4.1 Training and workforce development

As above

3.5 Clinical Governance

The Provider will be required to demonstrate that they have systems, processes and plans to ensure sound clinical governance. These systems, processes and plans should be in line with and adhere to NHS Clinical Governance Frameworks

3.5.1 Risk management arrangements

The Provider will ensure that there is in place a documented risk management policy / plan that will include:

- Incident reporting, investigation, resolution and audit to inform learning and service development

The Provider shall provide quarterly risk management reports to the Authority or more frequently if appropriate, in exceptional circumstances.

The Provider will ensure that they have an appropriate incident reporting policy in place.

3.6 Any Acceptance and Exclusion Criteria and Thresholds

- **Population Covered**

As an integrated sexual health service, the service must operate an open access policy regardless of residence of the patient.

- **Any Acceptance and Exclusion Criteria and Thresholds**

This agreement excludes:

- HIV treatment and care, which is subject to separate service agreements. (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to national service specifications. This will include a preferred access to NHS list prices in the Commercial Medicines Unit (CMU) tender)

- Any costs incurred for undertaking opportunistic cervical smears which is subject to a separate service agreement with the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to the service specification as detailed in appendix 6.
- Services that should be provided by General Practice under the terms of the GMS contract.
- Psychosexual services as a result of:
 - Sexual practices that would be the subject of action under the criminal justice system
 - Sexual addictions and paraphilia requiring psychiatric input
 - Psychological therapies requiring pharmacological treatment
 - Services required as a result of dysfunctions that are organic in origin – such as non-sexual health aspects of psychosexual counselling
 - Services required for the assessment and management of gender dysphoria. However the service will facilitate appropriate referral.

The Provider has the right to refuse service provision to the users:

- Who are unsuitable for treatment under the conditions of this service specification
- Who have not validly consented to the treatment provided under the Services
- For any unreasonable/ unacceptable behaviour towards staff or others attending the service.

Where staff do not wish to provide sexual health and contraception service i.e. EHC services to under 16 year olds, due to religious or moral reasons, they are required to refer to another health professional/service that can offer the intervention and the Provider shall inform the Commissioner immediately.

Patient inclusion and exclusion criteria, i.e. under the PGD, young person specific intervention, will be applied during provision of the specified services.

The Summary of Product Characteristics should be consulted for clinical information on the licensing of the drug (www.medicines.org.uk). The Provider shall ensure that those patients, who are excluded on the grounds of inclusion thresholds, are referred to the integrated community-based sexual health service.

For service users whose needs are not met at a service, it is the responsibility of that service to make a direct onward referral to another sexual health service that can meet the service user's need. Where it is not possible for that service to make a direct referral the service user will be provided with clear information (opening hours and service information) for other sexual health providers. The Provider shall be expected to provide details of onward referrals made to the same level of service.

The Provider has the right to refuse service provision to those users:*

- Who are unsuitable for treatment under the conditions of this service specification;
- Who have not validly consented to the treatment provided under the services; and
- For any unreasonable behaviour unacceptable to the Provider, its staff, or the named professional clinically responsible for the care of the patient.

*The Provider must immediately inform the Commissioner in writing of any service complaints or serious or untoward incidents.

The service must comply with the Equality Act 2010

The service should be sensitive to the cultural needs and backgrounds of people in its local population and its service users.

There are a number of groups mentioned within this specification who are at greater risk of sexual ill-health. Services should be specifically targeted to these groups to reduce inequalities.

3.7 Equality and diversity

The Service is to be provided free from discrimination where all individuals are treated fairly, with dignity and respect, appropriate to their need. The appointed Provider will undertake Equality Impact Assessments to ensure that no population targeted under this Service Specification are disadvantaged through chosen delivery model(s).

3.8 Any Activity Planning Assumptions

Service planning and improvement should always include Service Users and public engagement.

4. Applicable Service Standards

4.1 The Service is to be underpinned by the following national standards and guidelines:

Delivering effective quality treatment needs to be underpinned by the evidence base. It is the expectation of the Partnership providers will be able to demonstrate how they will contribute to the achievement of national and local priorities and targets using the best evidence available.

The following are the minimum required standards that the Provider is required to meet wherever a service schedule indicates that the function listed is part of that service

- Service Standards for Sexual and Reproductive Healthcare (FSRH 2013)
- British HIV Association Standards of Care for People Living with HIV (BHIVA 2013)
- Clinical Guidance – Emergency Contraception (FSRH 2012)
- UK National Guideline on Safer Sex Advice (BASHH & BHIVA 2012)
- National Chlamydia Screening Programme Standards (7th Edition 2014)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (2012)
- Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE 2012)
- Standards for psychological support for adults living with HIV (British Psychological Society, BHIVA & MEDFASH 2011)
- UK Guideline for the use of Post-Exposure Prophylaxis for HIV following Sexual Exposure (BASHH 2011)
- PH34 Increasing the uptake of HIV testing among men who have sex with men (NICE 2011)
- PH33 Increasing the uptake of HIV testing among black Africans in England (NICE 2011)
- The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline

Number 7 (RCOG 2011)

- Standards for the Management of Sexually Transmitted Infections (BASHH & MEDFASH 2010)
- UK National Guidelines for HIV Testing (BHIVA 2008)
- Progress and Priorities - Working Together for High Quality Sexual Health (MEDFASH 2008)
- PH3 One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups (NICE 2007)
- CG30 Long-acting reversible contraception (NICE 2005)
- Recommended Standards for Sexual Health Services (MEDFASH 2005)
- Research Governance Framework for Health and Social Care (Department of Health 2005)
- Male and Female Sterilisation , Evidence-based Clinical Guideline Number 4 (RCOG 2004)
- Guidance for managing STI outbreaks & incidents (HPA 2010)
- Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.
- Essential standards of quality and safety (CQC 2010)
- Sexually Transmitted Infections in Primary Care (RCGP/BASHH 2013)
- PH51 Contraceptive Services with a focus on young people up to the age of 25 (NICE 2014)
- UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault (BASHH 2011)
- A Quality Standard for Contraceptive Services (FSRH 2014)
- Sexual Health Services : Key principles for cross charging (DH 2013)
- Sexual Health Clinical Governance (DH 2013)
- Working Together to Safeguard Children (DfE 2013)
- UK Medical Eligibility Criteria for Contraceptive Use (FRSH 2009)
- All related NICE Guidance

Relevant UK clinical guidance covering the specialities of Sexual & Reproductive Healthcare and Genitourinary Medicine can be found at www.fsbh.org and www.bashh.org Providers must ensure services reflect updates in guidance and recommendations as and when produced.

The Service will use the Department of Health's *You're Welcome* quality criteria⁸ and local resources where available, as guiding principles when planning and implementing changes and improvements, in order for the service to become young people friendly where appropriate.

Service planning and improvement should always include consultation with service users and local populations.

The Provider will comply with all relevant legislation, regulations, statutory circulars and National Quality requirements in so far as they are applicable to the service. Services will have robust processes for assessing, implementing and monitoring NICE technology appraisals, guidance and interventional procedures as appropriate. Outcomes of any non-compliance are to be made available to SC with an appropriate Action Plan and timelines for compliance.

Department of Health 2011; Quality criteria for young people friendly health services

<https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services>

The service will have a clear and written complaints procedure in place which complies with both Local Authority and NHS standards. It will be made available to service users and their friends and family at commencement of engagement with the service. Where a service user or their friend or family member has a complaint or concern about the service offered, the provider will make efforts to address the issue as soon as possible at the local level. If the issue is not resolved to the satisfaction of the service user or their friend or family member, there should be an open and transparent process to escalate the complaint to a higher level within the organisation, informing the commissioner of this action.

The Provider will log all complaints and will return a quarterly collated report of the complaints received and resulting actions taken.

Applicable Local Standards:

Sexual health promotion in all care pathways

- 100% of all patients attending services receive sexual health promotion and brief advice to enable them to tackle their risk taking behaviours and avoid future sexual health problems.
- 100% of service staff are trained to give sexual health promotion messages/ information and to give brief advice

Data Requirements

The Service is required to generate a quarterly data extract of all patient attendances and associated diagnoses and services at GUM and non-GUM clinics in accordance with PHE (Public Health England) Genitourinary Medicine Clinic Activity Dataset (GUMCADv2). In addition to GUMCADv2, the Service is also required to utilise Sexual and Reproductive Health Activity Dataset (SRHAD) to capture contraception and other sexual and reproductive health activities.

Following a new HIV diagnosis, the Service is required to generate a data extract to the HIV and AIDS Reporting Section (HARS) in Public Health England. This extract can either be through the new HIV diagnosis reporting template or reported quarterly through the HIV and AIDS Reporting System which is being rolled out during 2013/14.

The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for all NHS and NHS-commissioned chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through measurement of population screening coverage, proportion of all tests that are positive and diagnosis rates.

It is the responsibility of the sexual health service provider to ensure the core CTAD data requirements are provided to the laboratory for each chlamydia test, in particular, postcode of residence of the patient and testing service type.

SRHAD and HARS, together with GUMCADv2 will form the basis for a standardised sexual health dataset collected from sexual health clinic settings (plus CTAD from laboratories). The Service is expected to discuss with commissioners quarterly GUMCADv2 and SRHAD data analysis from PHE to enable informed commissioning decisions relating to GUM attendances, activity and STI trends.

The Provider must have a clear confidentiality and data handling policy, which is understood by all members of staff. The purpose of this policy is to prevent patient details being inappropriately disclosed when consent is given.. The policy may be outlined in the form of a simple leaflet and / or notice displayed within the provider.

Circumstances of information sharing and when confidentiality may be breached must be explained to service users on entry to the service.

The Provider will develop clear and robust information sharing protocols with relevant partner agencies across the county. This will ensure the development of good working relationships with relevant partners and make the transfer of client information easier and safer to facilitate optimal treatment gains and recovery for service users. Agreed protocols must be in place for commencement of the service

Data and information and reporting arrangements

The accurate, clear and concise recording of all activities is a requirement of this contract. The Provider shall comply with this requirement and also demonstrate how they will be able to establish a two-way flow of information and data with partners which is safe and secure and does not breach the appropriate legislation in respect of data protection.

The local authority and the Provider will be separate Data controllers and therefore each responsible for upholding requirements of the Data Protection Act 1998.

The Provider shall ensure the following:

- Data collected as part of this agreement shall be processed solely to perform the obligations outlined in this agreement and no other purposes;
- Have in place appropriate retention and disposal policies and upon completion of termination of the agreement, should return any data deemed to belong to the local authority and/or with local authority consent securely destroy in line with above disposal policies;
- Allow the commissioning authority access to patient level non-identifiable data throughout the course of the Contract (within 10 working days) and for 5 years from completion or termination of the Contract (within 21 working days);
- Requests for information, including, but not limited to Freedom of Information and Subject Access Requests shall be dealt with by the Provider (where they are subject to the Freedom of informational Act 2000) in line with their normal Information Governance structures;
- All staff and sub-contractors are made aware of their obligations with regard to the security and protection of data and shall require that they enter into binding obligations with regards with the Provider in order to maintain the level of security and protection specified;
- Appropriate technical and organisational measures to safeguard the data from unauthorised or unlawful processing or accidental loss, destruction or damage and shall have a process in place for managing potential or actual security incidences;
- Service user data will not be divulged to any person, business or organisation except to those of its employees, agents and sub-contractors who are engaged in the processing

of the data or where there is a legal obligation to do so; and

- All staff are adequately trained to understand and comply with their individual responsibilities under the Data Protection Act, the Common Law of Duty of Confidentiality and this Agreement.

The Provider shall have the capability to generate, and will submit relevant data extracts in line with the following reports:

- National data submission requirements
- Indicators specified in Appendix III: section 6.8.20 *Quality and Performance indicator*
And Appendix IV: section 6.9.20 *Quality and Performance Indicator*

5. Location of Provider Premises

Locations and settings:

Services are to be situated in easily accessible convenient locations with good public transport links. Their location also needs to be guided by public health intelligence to ensure that the greatest needs are met across Shropshire.

As minimum, services must be provided in:

**Shrewsbury (Town centre),
Oswestry, Whitchurch,
Ludlow,
Market Drayton and
Bridgnorth**

Premises Quality:

The Provider must ensure that all clinical space complies with the DH guidance⁹. The provider is responsible for securing premises for the services and all related matters.

6. Required Insurances

See the main contract body

⁹ Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.

CONDOM DISTRIBUTION SCHEME

Condom distribution

The Provider is responsible for developing and delivering a condom distribution scheme in the county for young people aged 14 – 25 years of age (up to the age of 25 years for those with a learning disability). The service aims to provide quick and confidential access to condoms, supported by evidence based, accurate contraceptive and sexual health information, and signposting to sexual health services as per the core service specification.

The Provider is responsible for operating a community condom distribution scheme. They are responsible for coordinating the scheme, supporting and providing training and quality assurance and delivering the scheme through a range of clinical and community outlets.

In line with guidance from Public Health England and Brook 'C-Card distribution schemes – why, what and how' the service will share these three fundamental principles:

1. **Timely information and advice:** young people need access to timely information advice about all aspects of relationships, sex and sexuality.
2. **Easy access to condoms:** the young person should be able to get condoms easily once they have been properly assessed and supported to ensure that they know how to use condoms safely.
3. **Trusting young people:** once they have their c-card the young person must be trusted and helped to get condoms free and easily.

Provider responsibilities:

- To coordinate and manage the local condom distribution service
- Identifying registration and distribution outlets through engagement with young people
- Establishing core policies and procedures and the quality framework
- Develop a review process so that young people's sexual health can be re-assessed so that their need for the service can be determined and that positive behaviour conversations around sexual health be reinforced
- Training staff in all outlets and ensuring they are kept updated with any developments or changes to the scheme
- Developing the brand and service publicity (including developing and purchasing marketing materials – online and offline)
- Developing a condom selection process at outlets so that it allows young people to receive kits that are relevant to their personal sexual health needs e.g. latex free condoms, large condoms.
- Providing supplies (ordering, purchasing and delivering)
- Coordinating data
- Monitoring and evaluation
- Identifying inappropriate use of cards and taking appropriate action
- Overseeing the role of all outlets

Role of registration outlets:

- Provide staff who are trained to carry out the initial registration, assessment of the person, and the review process
- Act as distribution outlets, providing supplies as defined by the scheme
- Work within policies and procedures, including promotion of the scheme
- Provide data to the Provider
- Ordering and storage of condoms from the Provider
- Checking that condoms are stored correctly and regularly checking that they are within expiration dates
- Ensuring that all monitoring forms are returned or entered on a mechanism such as PharmOutcomes

Role of distribution outlets:

- Provide staff who are trained to provide condom packs and signposting to other services as defined by the scheme
- Working within policies and procedures, including promotion of the scheme
- Provide data to the Provider
- Ordering and storage of condoms from the Provider
- Checking that condoms are stored correctly and regularly checking that they are within the expiration date
- Ensuring that all monitoring forms are returned or entered on a mechanism such as PharmOutcomes

6.9.1 Sexual Health Clinical Network

Should this service be sub-contracted, it will be expected for the lead sub-contractor to attend all network meetings as and when required.

6.9.2 Laboratory Services

N/A

6.9.3 Interdependencies and joint working

Success of the scheme is dependent on a wide range of organisations promoting the condom distribution service to young people, registering young people with the c-card and providing sufficient number of access points to distribute condoms.

Although the scheme is a community based scheme the Provider is able to utilise Level 1, 2 and 3 clinical services as per the core service specification. The service must build on and offer a range of clinical and community outlets.

6.9.4 Activity

The provider will demonstrate access to the scheme through:

- Quarterly increases in the number of Registration and Distribution outlets available to young people

- Quarterly monitoring data reporting to the commissioner, showing; access within service types e.g. schools and colleges, pharmacies and sexual health services, access by gender, access by age and access for registration and/or distribution of C-card and condoms.
 - Evidence of liaison with condom distribution service outlets
- The Provider shall develop an overall plan to show how they will make progress towards this in year. Evidence of progress will be presented to the commissioner at quarterly meetings.

6.9.5 Population covered

Shropshire residents aged 14–25 years

6.9.6 Acceptance and exclusion criteria

Shropshire residents aged 14 up to the age of 25 years are eligible to receive the service. The service should be targeted towards young people who are particularly vulnerable or at risk; this includes but is not exclusive to:

- Young men
- Young people with learning disabilities and / or physical impairment
- Young people from black or ethnic minority communities
- Young people in or leaving care
- Lesbian, gay, bisexual, transgender (LGBT) young people
- Young people living in socially disadvantaged areas
- Young people in rural areas
- Young women who have previously had one or more pregnancies
- Young people who practice unsafe sex practices

6.9.7 Care pathways and referrals

The Provider is responsible for building in a review process into the service. This will allow for young people to be re-assessed and for continual positive sexual behavioural conversations to be reinforced. The Provider is responsible for determining the period of when young people are due for a review based on age and need e.g. after 6 condom visits, every 6 months and building this into the care pathway. Reviews and re-registrations should only be undertaken by a qualified and trained worker at a registration outlet.

The Provider is responsible for developing a condom selection process which allows young people to receive kits that are relevant to their personal sexual health needs at condom distribution outlets e.g. latex free condom kits.

1. In order for a young person to register onto the scheme the young person must go to a 'Registration' point (a level 1, 2, 3 service or an alternative community outlet as identified by the Provider).
2. The young person will then go through an induction process with a trained worker who has assessed their suitability for the scheme. This induction process must cover Fraser competence (under 16's); delay; safer sex advice; sexually transmitted infections; contraception including emergency contraception; condom demonstration and service provision / signposting advice. The assessment and induction should take approximately 20 minutes.

3. Young people who are not suitable for the scheme e.g. outside acceptance criteria will be signposted to an alternative provider. Please see service specification for details
4. Eligible young people will then receive their condom card with a personal registration number, entitling them to free condoms at any of the outlets (registration or distribution) displaying the logo.
5. Outlets shall only issue condom packs on production, by the young person, of a valid condom card that is in date. If a card is out of date a 2 condom pack may be given however the cards expiry must be recorded on the monitoring form. The young person must also be informed that they need to return to a registration outlet for their check in order to get future supplies.
6. If a young person presents without a card, they must be directed to their nearest registration outlet to obtain a new card in order to receive supplies.

Ordering and maintenance of supplies

The Provider shall provide outlet sites with all supplies necessary to deliver the service free of charge.

The Provider will ensure effective systems for ordering and maintenance of appropriate supplies. It is the responsibility of each outlet to ensure sufficient continuous supplies. 7 working days for delivery of supplies should be allowed from receipt of order from the Provider. All orders, once placed, will be delivered within 7 working days.

6.9.8 Service location, premises and opening times

The service is to be free from a variety of community and clinical venues such as higher education based venues; L1, 2 and 3 clinical services; community centres, local pharmacies. All venues must be young people friendly and be selected through engagement and consultation with young people. All venues must comply or be working towards Department of Health 'You're Welcome' criteria.

As a minimum, services shall be located in each market town and in wards that have been identified as young people 'Hot-Spot' areas, and wards in those priority areas for schools, college, educational and training institutes.

Service users should be able to access services every weekday morning, afternoon and evening and Saturdays. As a minimum services shall be open for 8 hours a day on weekdays and for 4 hours on a Saturday.

Opening times should be reflective of demand, which the Provider shall demonstrate to the Commissioner through intelligence data of service uptake and service user surveys.

Registration venues must have a private and confidential area for condom demonstration and sexual health discussion.

The Summary of Product Characteristics should be consulted for storage and distribution of all supplies.

6.9.9 Equality of access

As per main service specification section **3.7: Equality of Access**

6.9.10 Service Transformation

The Provider will conduct an annual service user satisfaction survey and mystery shopper service in order to determine user satisfaction and areas for improvement and development. This will be presented to the Commissioner in the form of an annual report.

6.9.11 Incident managing and reporting

In the event of an adverse incident occurring, the Provider is required to report this immediately to the Commissioner.

The Provider will adhere to incident managing and reporting specified in section B: *Incident Requiring Reporting* and Appendix G: *Incident Reporting Procedures* in this Contract

6.9.12 Social marketing

The Provider is responsible for promoting the service online and offline to the eligible target population. The Provider must develop and implement an annual marketing plan.

6.9.13 Safeguarding

In cases of unrestricted age (14 up to 16 years), the Provider is required to ensure that effective care pathways are in place. As soon as it become evident that a young person is under 16 years of age a suitably trained professional must liaise with the young person in line with national guidance, local safeguarding procedures and ensure that competency against the Fraser guidelines can be established. In any cases of a child under 14 years it should be discussed with a nominated professional responsible for safeguarding in that service or locality. It is also recommended that all young people under 16 have a risk assessment for sexual abuse or exploitation.

For more information, please refer to the main service specification

6.9.14 Local Standards and Training

The Provider shall develop two local training programmes (one for registration venues and one for distribution venues) in order for staff and outlets to become accredited. Training outcomes are to include (not an exhaustive list):

Outcome	Venue to be trained
An understanding of the aims and objectives of the condom distribution scheme	Registration Distribution
A thorough understanding of Fraser competence, safeguarding and safeguarding procedures, confidentiality, child exploitation and the law	Registration Distribution
Skills and knowledge on how to assess Fraser Competence	Registration

Skills and knowledge on how to initiate safeguarding procedures	Registration Distribution
An understanding of safer sex practices, delay, sexual readiness, sexually transmitted infections, contraception including emergency contraception and have skills in discussing these with young people.	Registration
An understanding of the different types of condoms and how to conduct condom demonstrations	Registration
A thorough understanding of condom distribution scheme guidance and processes (registration, distribution, ordering of stock)	Registration Distribution
An understanding of Making Every Contact Count (MECC) and skills in discussing Information and Brief Advice (IBA), especially around alcohol	Registration Distribution
An understanding of the available sexual health services in Shropshire and how to signpost young people to those services	Registration Distribution

Staff will not be able to undertake or deliver this service unless they have successfully completed the training. The Provider shall also ensure that regular CPD is made available and therefore refresher training must be provided on an annual basis.

The Provider will ensure that all outlets have sufficiently qualified and experienced staff

The Provider is responsible for holding an up to date register of all staff and outlets delivering the service and their accreditation status.

6.9.15 Data and information and reporting arrangements

The Provider is responsible for developing data reporting and monitoring processes for the service (including registration and distribution outlets).

The following categories (as a minimum) should be captured on the data monitoring form at registration visits:

- Date of visit
- New or returning user
- Condom Card number
- Registration visit (new user, review, lost card)
- Age (not date of birth)
- Part postcode
- Ethnicity
- Gender
- Sexual orientation
- Disability / impairment
- Risk assessment and Fraser competence assessed and completed
- Competency completed
- Type and quantity of condoms and lubricant

Distribution outlets:

- Date of visit
- Condom card number
- Type of condom pack issued
- Name of person issuing kit

Confidential data must not be disclosed to anyone other than the person conducting the condom transaction and the Provider (including Provider staff handling the data).

Please refer to the main service specification and contract body

6.9.16 Applicable service standards and Evidence Base

The service must comply with the following service standards:

- Local safeguarding policies and procedures
- Data Protection Act 1998
- Department of Health 'You're Welcome' Criteria
- Public Health England and Brook guidance 'C-Card distribution schemes – why, what and how'

6.9.17 Waiting times / waiting list management

The service is to be delivered via a walk-in service, therefore there are to be no waiting times. The Provider is responsible for developing mechanisms to monitor this.

6.9.18 Financial model

As specified in tender bid submission

6.9.19 Glossary

As per main service specification section 9: *Glossary*

6.9.20 Quality and Performance Indicator

Performance / quality indicator	Threshold	Method of measurement	Consequence of breach
Total number of eligible young people issued a condom distribution card	100% of eligible population that comes into contact with distribution worker	Quarterly performance report to Commissioner	Remedial Action Plan
Total number of new registrations versus repeat users	Year 1 as Baseline. Expected year on year increase to achieve and maintain 15% coverage of eligible	Quarterly performance report to Commissioner	Remedial Action Plan

	population		
% of staff trained	100%	Quarterly performance report to Commissioner	Remedial Action Plan
% of staff trained and delivering the service	100%	Quarterly performance report to Commissioner	Remedial Action Plan
% of staff completed annual refresher training	Baseline will be established at the end of Year 1 and will be based on quality and performance measures + professional feedback	Quarterly performance report to Commissioner	Remedial Action Plan
Supplies delivered to outlets with 7 working days of receipt of order	100%	Quarterly performance report to Commissioner	Remedial Action Plan

Appendix 2: HIV prevention & support services in Shropshire

HIV Prevention

The provider is required to deliver HIV prevention and support services in Shropshire. These will be targeted at groups at increased vulnerability to the Human Immune Deficiency Virus (HIV) within Shropshire. These key groups include: men who have sex with men (MSM); Black African communities; sex workers; lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people; lesbian, gay, bisexual, transgender (LGBT) adults; and others. Further, support will be offered and available to anyone in Shropshire living with HIV.

The requirement is for the provision of a set of Local Engagement services targeting Black African groups and/or MSM, the population groups that remain most at risk of HIV in Shropshire, and other at risk groups. These services will need to be able to be delivered to fit in with and enhance the impact of nationally delivered super campaign media work, locally delivered online/digital engagement, and locally delivered Development & Engagement work, thereby enabling the programme to provide a coordinated set of HIV Prevention work with maximum local impact. Delivery will need to be to an agreed volume of activity and to an agreed quality standard.

All Local Engagement services will be geared to achieving the following two overarching health outcomes which have been established nationally in partnership between HIV Prevention England and the Department of Health:

- A reduction in the level of undiagnosed and late diagnosed HIV
- An increase in precautionary behaviours, especially condom use

The HIV Prevention and Support Service will have objectives to:

- Increase awareness of STIs and HIV, routes of transmission, testing, treatment, post-exposure prophylaxis following sexual exposure (PEPSE), safer sex and locally accessible sexual health services
- Increase access to free condoms, lubricants and other safer sex resources
- Increase access to STI and HIV testing and repeat testing in non-GUM settings
- Increase testing, repeat testing and treatment for Chlamydia in under 25s in non-GU settings
- Increase awareness of Hepatitis B & C, testing, repeat testing and access to Hepatitis A&B vaccinations
- Increase access to STI and HIV treatment and management
- Increase access to other health and social care services
- Proactively improve health outcomes
- Reduce health inequalities

Provider responsibilities

The general responsibilities of the provider will include:

- Co-ordinate and manage the local HIV Prevention and Support Service
- Establishing core policies, procedures and the quality framework

- Train staff and ensure all training is up-to-date, in all settings for the service
- Develop the brand and service publicity (including developing and purchasing marketing materials – online and offline)
- Provide supplies for the service (ordering, purchasing and delivering)
- Coordinate data from the service
- Monitor and evaluate
- Provide targeted HIV prevention with high risk groups
- Provide targeted sexual health promotion with high risk groups, and with other priority groups in collaboration with partner agencies
- Support people living with HIV, and their carers and families

The HIV Prevention and Support Service will be expected to deliver, in an innovative and culturally sensitive manner, the following:

1. Advice, counselling and information on STIs and HIV, routes of transmission, testing, treatment, post-exposure prophylaxis following sexual exposure (PEPSE), safer sex and locally accessible sexual health services by:
 - The production and dissemination of public awareness resources (e.g. leaflets, posters, DVDs, websites, social media or public events, etc.)
 - Training on STI and HIV awareness, routes of transmission, treatment, PEPSE, safer sex (e.g. healthcare professionals, social care workers, the ambulance service, the police, schools etc.)
 - Maintaining an interactive service website and using other social media
 - Establishing HIV prevention networks with other sexual health providers
 - Providing a targeted counselling service for individuals at increased vulnerability to HIV

2. Provide counselling and support for the complex social needs for people living with HIV, including but not restricted to:
 - Support those with a new diagnosis, to come to terms with the diagnosis, including help with feelings of social isolation (especially around fears of disclosing to friends and family, who would otherwise be providing much needed social support), mental ill-health, distress, and difficulties coping
 - Help to combat and cope with stigma and discrimination
 - Highlight what is available and signpost those in need to the social care support additional to, and supportive of, that provided by medical and clinical services
 - Assist people with HIV to find ways to cope and manage complex symptoms and co-morbidities which affect their ability to work, socialise, cope and function
 - Generally introduce services that are preventive and advisory, supporting positive health and employment outcomes, including adherence to medication, disclosure of status and safer sex

- Provide care and case management service to PLWHIV including assessment planning
 - Provide support and information to PLWHIV so they can make better use and understand the range of social and health care services available across the clinical, voluntary sector and public sectors, developing and promoting clear healthcare pathways
 - Provide access to counselling services (within the BACP Ethical Framework)
 - Provide guidance and advice on the use of Post Exposure Prophylaxis (PEP)
 - Provide relevant leaflets and other printed resources regarding living with HIV to PLWHIV via Level 3 provider, HIV Clinical Nurse Specialist and the service's centre and workers
3. Increased access to free condoms, lubricants and other safer sex resources by:
- Demonstrations of good condom use to reduce the occurrences of condom failure
 - Provision of free condoms, lubricants and other safer sex resources
 - Participation in the free condom distribution scheme, providing a registration and distribution venue
 - Distribute free condoms, femidoms and lubricant to people living with HIV, through targeted outreach to vulnerable communities and as part of general health improvement/prevention campaign activities including by post
4. Increased access to STI and HIV testing and repeat testing in non-GUM settings by:
- Sexual health outreach in locally accessible settings and public sex environments (PSEs)
 - Using the HIV Point of Care Tests (POCT) to increase the early identification and treatment of HIV
 - Referrals to integrated sexual health providers in primary care including Level 3 HIV provision
 - Support for partner notification, testing and treatment or referral
 - Support, signposting and referral for those who have self-tested for HIV
 - Proactively encouraging annual repeat testing for HIV-negative people at increased vulnerability to HIV
5. Increased testing, repeat testing and treatment for Chlamydia in under 25s in a range of settings by:
- Opportunistically testing for Chlamydia in under 25s and older adults
 - Referrals to integrate community sexual health providers with primary care
 - Supporting partner notification, testing, treatment or referral
6. Increased awareness of Hepatitis A, B & C, testing, repeat testing and access to Hepatitis A& B vaccinations by:

- Advice and information on Hepatitis B and Hepatitis B vaccinations
 - Opportunistically testing for Hepatitis in those most at risk
 - Targeted outreach in locally accessible settings and public sex environments
 - Support for partner notification, testing and treatment or referral
 - Referrals to integrated sexual health providers in primary care including specialist HIV/Hepatitis provision
7. Increased access to STI and HIV treatment, health and social care services by:
- Encouraging and supporting people with STIs and HIV-positive service users to access STI and HIV treatment services
 - Supporting service users, their partners, carers or families to access other services (e.g. health and social care support services)
8. The HIV Prevention and Support Service will be expected to provide sexual health prevention interventions that will include:
- The production and dissemination of resources for public awareness-raising about STIs and HIV (leaflets, posters, DVDs, websites, social media, etc.).
 - Participate in media campaigns on STIs and HIV (e.g. World AIDS Day, PEPSE, etc.).
 - Training on STI and HIV awareness, routes of transmission, safer sex, treatment, PEPSE.
 - An interactive service website about STIs and HIV and other social media.
 - Any training required to support new innovations/advances and interventions i.e. home care tests
9. Point of Care Testing
- Deliver point of care testing at a variety of venues including the service's centre, African Community & MSM venues where appropriate
10. Provide a volunteering scheme and Training Programme for local Professionals / others
- Recruit and train local volunteers to support people living with HIV including peer support, counsellors and community support volunteers
 - Provision of HIV training to professionals including statutory and voluntary services to increase awareness of HIV and reduction in HIV stigma amongst target professionals and increase awareness of specialist HIV support available
11. Provide outreach services BME communities with particular focus on African Communities and Eastern European Communities; to MSM Communities and sex workers
- Deliver HIV prevention campaigns and evaluate the impact on targeted groups within BME communities

- Interactive distribution of information, resources and signposting people to local sexual health services
- Promote safer sexual practices with individuals and support them to use local sexual health services
- Deliver HIV prevention campaigns and evaluate the impact on targeted groups within MSM communities
- Interactive distribution of information, resources and signposting people to local sexual health services
- Non-clinical targeted outreach either via the commercial gay scene, PSE sites or the internet
- Promote safer sexual practices with individuals and support them to use local sexual health services
- Promote safer sex practice and provide free condoms and information on local sexual health services to sex on the premises venues so that staff can signpost their workers and peers to local health services. Support individuals to use local services where necessary.
- Promote safer sex practice and availability of local sexual health services to private sex workers. Support individuals to use local services where necessary.

12. Proactively reducing health inequalities

It is the responsibility of the Service Provider to proactively reduce health inequalities in supplying this service. Health inequalities are the result of a complex and wide-ranging network of factors. People who experience material disadvantage, poor housing, lower educational attainment, insecure employment or homelessness, are among those more likely to suffer poorer health and an earlier death, compared with the rest of the population. As part of the strategy to reduce health inequalities, the Service Provider must provide evidence of engagement and collaborative working practices with all relevant organisations, to promote and improve health equalities within the relevant population.

All partners are required to work in compliance with NICE guidelines PH 9 on Community Engagement, in order to deliver the legal obligations on the 'Duty to Involve' legislation. It is expected that all engagement processes are adequately resourced, long term and embedded within service delivery.

Equality monitoring for all Service Users, including referrals and those who did not attend (DNAs) where appropriate, should also be recorded and reported typically as monthly, but no less than quarterly. Equality monitoring should include physical, sensory or learning disabilities as appropriate and the Commissioner will agree specific data returns with the Service Provider in addition to those listed here.

The Service Provider shall not discriminate unlawfully within the meaning and scope of any law, enactment, order, regulation or similar instrument relating to discrimination (whether in relation to race, gender, disability, religion, age or otherwise) in employment or in relation to the performance of the services. The Service Provider will meet all its statutory responsibilities in this area.

The Service Provider will identify and implement continual improvements with evidence of progress against Standards for Better Health, also demonstrating an ability to adapt programmes to meet the requirements of local commissioners.

Every contact with a Service User provides an opportunity for a health promoting discussion and brief intervention. The Service Provider will ensure that staff are effectively trained and supported to ensure 'Every Contact Counts'.

Sexual Health Clinical Network

Should this service be sub-contracted, it will be expected for the lead sub-contractor to attend all network meetings as and when required.

Interdependencies and joint working

Joint working and strong relationships will be central to the success and quality of the HIV Prevention and Support Service. The service will establish partnerships or referral pathways with national and local NHS-led, non-NHS and Independent agencies that will include:

- Abortion services
- Counselling services
- HIV support services
- Primary care providers or general practitioners (GPs)
- Schools and school nursing teams
- Social Care Providers
- The Adult Safeguarding Team (Shropshire Council)
- The Children Safeguarding Team (Shropshire Council)
- The Drugs and Substance Misuse Team
- The Local Sexual Health Service
- The Sexual Assault Referral Centre (SARC)
- The Youth Service

Activity

The provider will demonstrate access to the service and activity through:

- Quarterly monitoring data reporting to the commissioner showing at least the provision of one-to-one counselling; outreach events and clients contacted (the BME, MSM and sex worker groups); condom distribution, chlamydia testing and point-of-care testing activity; and local training provided.
- The Provider will develop a plan to show how they will progress towards the objectives of the service. Evidence of progress will be presented to the commissioner at quarterly meetings.

Population covered

All Shropshire residents

Acceptance and exclusion criteria

There are no exclusion criteria. The HIV Prevention and Support Service will be accessible to all members of the community resident within Shropshire irrespective of age, disability, ethnicity, faith, gender, sexuality, marital status or civil partnership, status of residence or language spoken (speakers of other languages) including:

- BME groups
- LGBT adults
- LGBTQ young people
- Migrant workers
- MSM
- Sex Workers

Care pathways and referrals

The HIV Prevention and Support Service will be an open-access service with no specific referral criteria. However, the Service Provider will ensure the Service has clear assessment and referral criteria for Service Users accessing counselling.

The HIV Prevention and Support Service will establish clear referral mechanisms and protocols with locally accessible sexual health/HIV services. It will establish partnerships or referral pathways with national and local NHS-led, non-NHS and Independent agencies, both for referral into the service and onward referrals, which will include:

- Termination services
- Counselling services
- HIV support services
- Primary care providers or general practitioners (GPs)
- Schools and school nursing teams
- Social Care Providers
- The Adult Safeguarding Team (Shropshire Council)
- The Children Safeguarding Team (Shropshire Council)
- The Drugs and Substance Misuse Team
- The Local Sexual Health Service
- The Sexual Assault Referral Centre (SARC)
- The Youth Service

Service location, premises and opening times

The HIV Prevention and Support Service will be provided within the boundaries of Shropshire County. It will include a targeted outreach service for communities at increased vulnerability to HIV

and resident within the boundaries of Shropshire County; as well as outreach to all groups living with HIV.

The service shall be provided from a variety of outreach locations targeting vulnerable communities across Shropshire County; outreach at events in Shropshire (especially those relevant to vulnerable groups). A facility to signpost service users to other alternative providers 'out of hours' and during closures of planned service/clinics shall be in place at all times. The HIV Prevention and Support Service will operate as follows:

- A minimum of 4 hours a day on weekdays (Mondays through Fridays)
- Flexibly in the evenings (on weekdays) and weekends i.e. the Service will operate to the requirements of Service Users

Equality of access

The integrated sexual health services provided in Shropshire are open access to anyone in the area. Services will be targeted to those at highest risk of poor sexual health to reduce inequalities in health. In particular services will be targeted at men who have sex with men (MSM), vulnerable young people including gay, lesbian, bisexual and transgendered young people, people moving in from abroad from high risk countries including Black African communities, sex workers and people living with HIV.

In addition to the targeted groups there are a number of other priority groups, which include substance misusers, people living with mental health problems, people with learning disabilities, homeless people, military, older people and migrant communities.

A number of these target and priority groups have Protected Characteristics.

The specifications for the new services clearly identify the need to work with all of these groups. The Targeted HIV Prevention, Targeted Sexual Health Promotion and Support for People Living with HIV service is specifically tasked with using a range of methods to outreach to each of these groups, and to improve appropriate access to the sexual health clinical services.

Service Transformation

The Provider will conduct an annual service user satisfaction survey in order to determine user satisfaction and areas for improvement and development. This will be presented to the Commissioner in the form of an annual report.

The Service Provider will identify, implement and demonstrate continuous improvements to the quality of the Service as part of their quality framework. Evidence of action plans, monitoring progress and improvements / outcomes achieved will be reported to the Commissioner at regular intervals. These reports will be reviewed as part of the monitoring of the Service.

Incident managing and reporting

In the event of an adverse incident occurring, the Provider is required to report this immediately to the Commissioner.

The Provider will adhere to incident managing and reporting specified in section B: *Incident Requiring Reporting* and Appendix G: *Incident Reporting Procedures* in this Contract

Social marketing

The Provider is responsible for promoting services online and offline to the eligible target population. The Provider must develop and implement an annual marketing plan. Not only will the services be promoted online, aspects of the service will be provided online and through social media, such as the outreach, educational messages, and others.

Safeguarding

In cases of unrestricted age (under 16 years), the Provider is required to ensure that effective care pathways are in place. As soon as it becomes evident that a young person is under 16 years of age a suitably trained professional must liaise with the young person in line with national guidance, local safeguarding procedures and ensure that competency against the Fraser guidelines can be established. In any cases of a child under 13 years it should be discussed with a nominated professional responsible for safeguarding in that service or locality. It is also recommended that all young people under 16 have a risk assessment for sexual abuse or exploitation.

The Service Provider will ensure that people who use the service, workers and others who visit are as safe as they can be and that risks are managed. They will also ensure that the human rights and dignity of people who use services are respected and identify and respond when people are in vulnerable situations. Service Providers will ensure that the premises and equipment they use to provide care, treatment & support are safe and suitable. Service Providers will comply with guidance for safeguarding people who use services from abuse, cleanliness and infection control, management of medicines, safety & suitability of premises and safety and suitability of equipment.

All staff working with children, young people and vulnerable adults will have been recruited in line with Shropshire and Telford and Wrekin Local Safeguarding Board Standards for Safer Recruitment 2012 and will be subject to a Disclosure and Barring Service (DBS) check. (This is the new system that has replaced Enhanced CRB check)

The provider or any subcontractor will comply with the local inter-agency Safeguarding Children and Young People and Adults Procedures and Practice guidelines. These are available from Shropshire and Telford and Wrekin Local Safeguarding Children's Board LSCB websites. These guidelines relate to the protection of all children and young people and vulnerable adults residing within Shropshire and Telford and Wrekin. The Board definition of a vulnerable child

Is any child **under the age of 18** including the unborn baby. However some children are more vulnerable than others. These include:

- "Looked after" children already in the care system
- Children with disabilities
- Homeless children
- Teenage mothers
- Children in custodial settings

- Children who live with parental drug and alcohol abuse or domestic violence.

The broad definition of a "vulnerable adult", is a person (aged 18+) who is or may be in need of community care services by reason of mental or other disability , age or illness; and who is or may be unable to take care of him/herself, or unable to protect him or herself against significant harm or exploitation.

For more information, please refer to the main service specification

Local Standards and Training

The Service Provider will ensure that they have the right staff with the right skills, qualifications, experience and knowledge to support people. Service Providers will comply with guidance relating to staffing and supporting workers.

Data, information and reporting arrangements

As a minimum, data returns submitted should include the broad nature of the service users encounter, actual age, gender, ethnicity and full postcode if feasible, using standard classification systems where possible. Equality monitoring for all Service Users, including referrals and those who did not attend (DNAs) where appropriate, should also be recorded and reported typically as monthly, but no less than quarterly. Equality monitoring should include physical, sensory or learning disabilities as appropriate and the Commissioner will agree specific data returns with the Service Provider in addition to those listed here.

The Service Provider will also notify the CQC about incidents that affect the health, safety and welfare of people who use services including injuries to people, making an application to deprive someone of their liberty, allegations of abuse and police investigations.

The Service Provider will provide an Annual Quality Report to give the Commissioner assurance that care is safe; clinically effective; and provides service users with the most positive service user experience. This report will be used to assure the Commissioner of the quality of the Service delivered. The Service Provider will demonstrate compliance with best practice and improved outcomes through undertaking relevant clinical audits as part of an annual audit programme.

Applicable service standards and Evidence Base

The Service Provider will manage risk in order to ensure that essential standards of quality and safety are maintained and have systems in place to assess and monitor the quality of service provision. Service Providers will also take account of comments and complaints, investigations into poor practice and advice from and reports by the CQC. The Service Provider will improve the service by learning from adverse events, incidents, errors and near misses, the outcome from comments and complaints and the advice from expert bodies.

The Service Provider must be able to demonstrate current registration with the Care Quality Commission (CQC) for the Service to be delivered where this is applicable to the Service or Service Provider. The Service Provider must notify the Commissioner of registration renewal dates and of any amendments, variations or applications. The Service Provider must also notify the Commissioner of any penalties imposed for non-registration (services can no longer provide a service if not registered as this is a legal requirement), CQC inspections (planned or unannounced) and

enforcements for delivery of poor quality. The Service Provider should make available all inspection reports, CQC periodic and special reviews, national audit reports, and national patient and staff surveys as applicable.

The Service must be able to demonstrate compliance with all generic and service specific Registration Requirements, Regulations of the CQC. The regulations and outcomes ensure that the care people receive meets essential standards of quality and safety. Where CQC registration is not currently a requirement of the provider or service, the Service Provider should be able demonstrate compliance with them. The regulations and outcomes cover:

Involvement and Information – the Service Provider will ensure that service users and carers are involved in making decisions about their care, treatment and support. They will also ensure that the views of people who use services are taken into account when making decisions about how services are delivered and improved. Service Providers shall make information available so that people can make informed choices about their care, treatment and support.

Personalised Care, Treatment and Support – the Service Provider will ensure that people who use services receive effective, safe and appropriate care, treatment and support that meets their individual needs. Service Providers will assess health needs, develop care plans, take account of published research and best practice, cooperate with other agencies involved in the care, treatment and support of a person and share information in a confidential manner with all relevant services, teams or agencies.

Safeguarding and Safety – the Service Provider will ensure that people who use the service, workers and others who visit are as safe as they can be and that risks are managed (see Safeguarding – above).

The HIV Prevention and Support Service will also be expected to be compliant with national sexual health policy, guidelines and clinical procedures produced by the:

- British Association of Sexual Health and HIV (BASHH)
- British HIV Association (BHIVA)
- Care Quality Commission (CQC)
- Department of Health (DH)
- Medical Foundation for AIDS and Sexual Health (MedFASH)
- National AIDS Trust (NAT)
- National Institute of Health and Clinical Excellence (NICE)
- HIV Prevention England

Financial model

As specified in tender bid submission

Appendix 3; Shropshire - Sexual health Needs Assessment epidemiology

Shropshire – the people and the place

Shropshire is a large county in the West Midlands, with a population of approximately 309,000 people of mainly White British ethnicity (~95%) and a high proportion of people aged over 50 years old. Like many rural areas, Shropshire is expecting an increase in the future population of people aged 65 years and over.

Overall the county is more affluent than the English average – although there are less of the most affluent areas than would be expected. There are areas of deprivation, notably rural deprivation which create issues with access to services. Shropshire has a low earnings rate compared with England, although it benefits from low unemployment rate and child poverty.

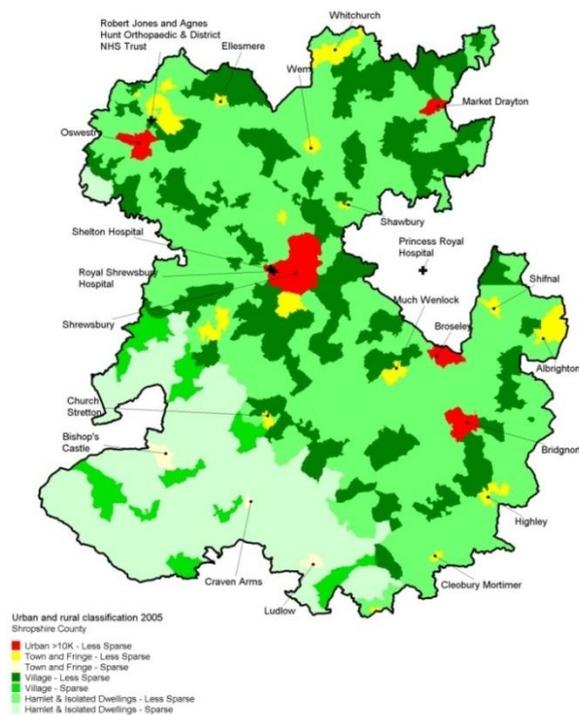


Figure 1; Shropshire population density using the ONS urban/rural classification 2006
(Source: Rural and urban classification, ONS)

Shropshire's geography is an important consideration. It is the sixth most sparsely populated area in England, covering a large area of 1235 square miles and with only approximately 6% comprising suburban and rural development and continuous urban land. The geography of Shropshire is diverse (Figure 1). The southern and western parts of the county are generally more remote; approximately 25 percent of the population live in Shrewsbury and a further 20 percent in the five main market towns. Shropshire is entirely inland and its borders also have importance for the people living at the edges of the county, with connections to its bordering areas.

Generally the health of the population in Shropshire is good and both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all age all-cause

mortality for males and females are significantly lower. Life expectancy has increased in Shropshire in the last decade and all age all-cause mortality has decreased. However, inequalities in health persist in Shropshire and the increases in life expectancy and reductions in all age all-cause mortality have not had equal impact across all sections of the population. In the most deprived fifth of areas in Shropshire, for example, there has been no significant increase in life expectancy in either males or females. There are also significantly lower rates of life expectancy in the most deprived fifth of areas compared to the most affluent fifth for both males and females, and this gap appears to be increasing.

Sexually Transmitted Infections in Shropshire

Shropshire has been consistently in recent years, and remains to be, a low transmission area for all sexually transmitted infections (STIs). Figure 2 presents the rate of any STI diagnosis in Shropshire, compared with national rates and Shropshire’s statistical neighbours. Statistical neighbours are areas in England of comparable sociodemographic profiles. Shropshire has significantly lower STI diagnosis rates than all these areas, and well under half the national rate, with 362 diagnoses per 100,000 resident population.

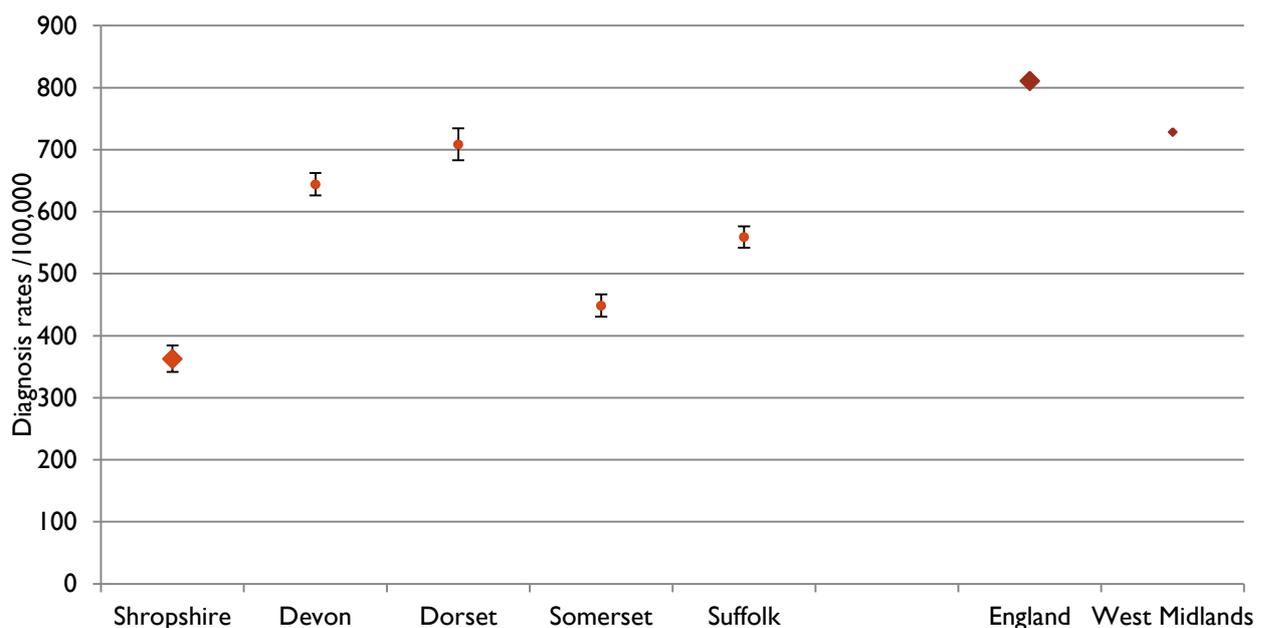


Figure 2; combined STI diagnosis rates in Shropshire and its statistical neighbour areas in 2013
 (Source: Public Health England. Sexually transmitted infections (STIs): annual data tables 2014)

This was the same for all individual STIs (Figure 3). Syphilis diagnoses were low, with fewer than 8 cases in 2014. This equates to a rate of 2.6 per 100,000 respectively – significantly lower than the 7.8 per 100,000 in England. Although there was some variation due to small numbers, rates were stable over the last 5 years. Gonorrhoea diagnosis rates are also lower than England and the West Midlands at 13.3 per 100,000 and Shropshire has not had the recent increase seen across England (Figure 4). There were 27.5 cases of herpes diagnosed

in Shropshire in 2014 per 100,000 population (lower than the 50.7 in England). The area has seen a significant reduction in herpes since 2009, with a 21.4 percent relative reduction. The second most common STI in 2014 was genital warts, with 95.6 cases diagnosed per 100,000 population in, which was significantly lower than the rate in England of 118.7 per 100,000.

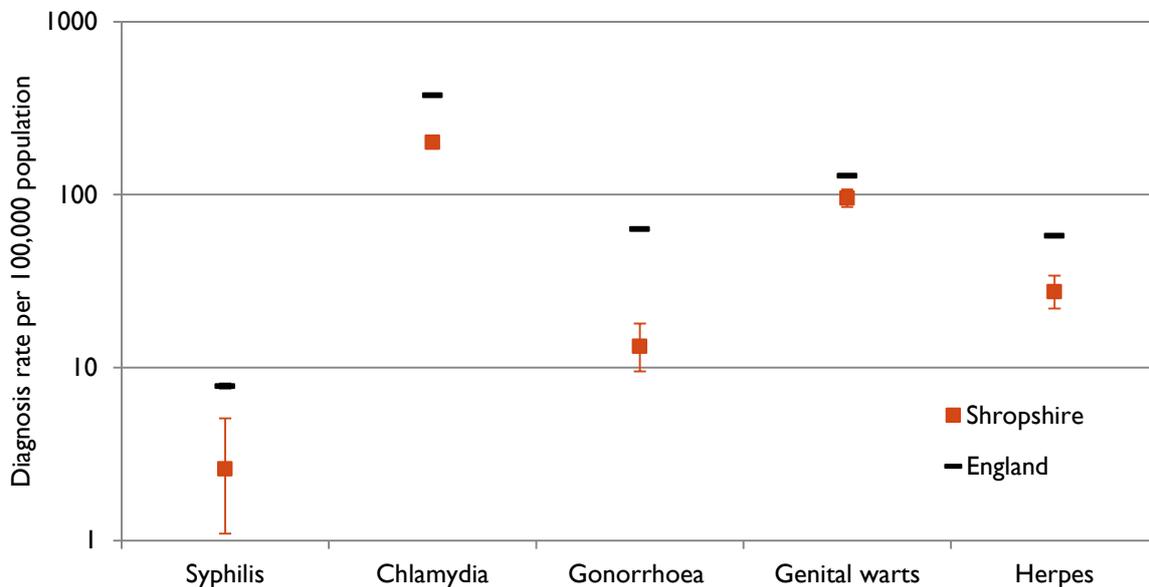


Figure 3; STI diagnosis rates in Shropshire and England in 2014 – data presented are rates per 100,000 population, with 95% confidence intervals

NB y-axis is presented on a logarithmic scale; direct comparisons cannot be made between the STIs – but between local and national rates

(Source: Public Health England. Sexually transmitted infections (STIs): annual data tables 2014)

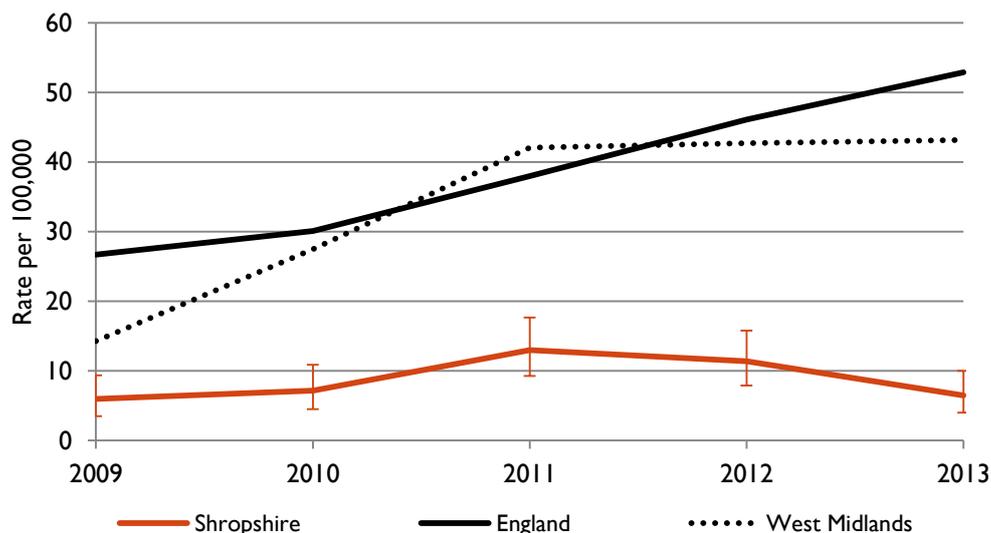


Figure 4; Gonorrhoea diagnosis rates per 100,000 resident population

(Source: Public Health England. Sexually transmitted infections (STIs): annual data tables 2014)

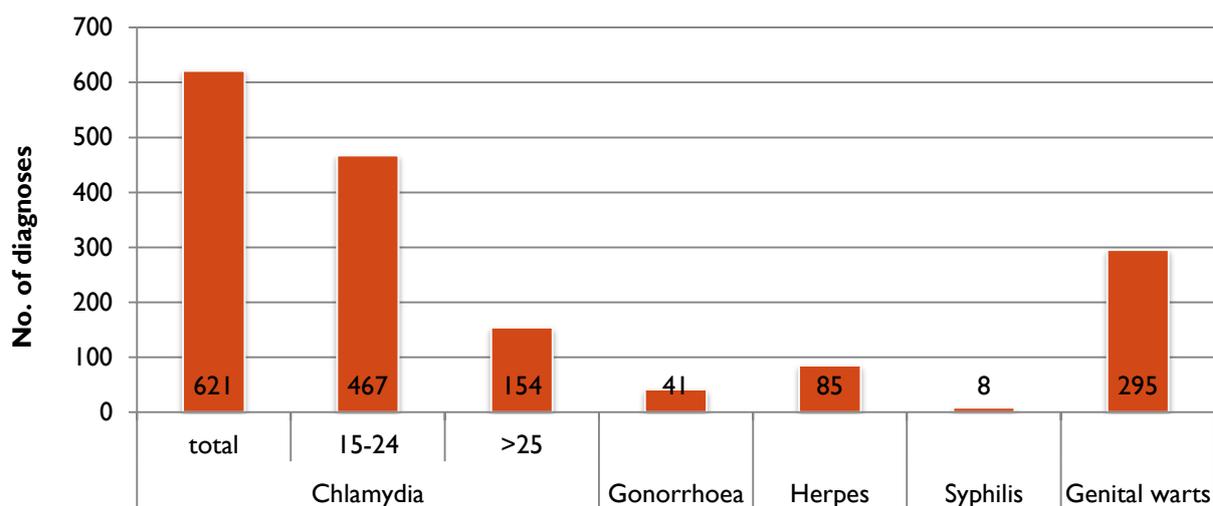


Figure 5; counts of STI diagnoses in Shropshire in 2014

(Source: Public Health England. Sexually transmitted infections (STIs): annual data tables 2014)

Chlamydia was the most common STI in 2014 with 621 cases in Shropshire. The majority (75%) of these cases were in those aged 15 to 24 years old. Just under half of the cases of chlamydia were diagnosed in the sexual health service (349 cases in the 2013-14 financial year - Table 1). Chlamydia rates in Shropshire have remained constant over the last three years, although it is not possible to examine any longer term trends due to changes in data recording around chlamydia in 2012. Figure 5 presents the numbers of cases of each STI in Shropshire in 2014; whilst Table 1 presents the counts of diagnoses in the sexual health services alone in the 2013/14 financial year.

Table 1; STI diagnoses in sexual health services 2013-14

	Shropshire
Anogenital warts	252
Candidosis	148
Chlamydia	349
Gonorrhoea	19
Hep C	<5
Herpes	91
HIV	9
Molluscum contagiosum	25
Syphilis	6
Urinary Tract Infection	12
Vaginosis/vaginitis/balanitis	174
Total	317

(Source: Staffordshire and Stoke-on-Trent Partnership. Sexual health service activity 2013-14)

Both pelvic inflammatory and ectopic pregnancy are recognised as multi-factorial in cause, but STI infections – notably chlamydia – are strong risk factors. Shropshire has the second lowest rate of ectopic pregnancy in the West Midlands (Telford & Wrekin lowest), with a rates of 55.2 hospital admissions per 100,000 population. This is significantly lower than England (94.7 per 100,000) and the West Midlands (94.0 per 100,000). Pelvic inflammatory

admission rates are also lower than both regional and national averages, at 177.4 per 100,000 compared with 228.3 in England and 228.5 in the West Midlands. Finally, although not STIs, gynaecological cancers have important health impacts on sexual and reproductive systems, whilst cervical cancer is strongly related to human papilloma-virus infection. Directly standardised cervical cancer incidence rates for women aged 75 years and under (standardised to the European standard population –data from the national cancer registry 2010-12) were 10.3 per 100,000 women (95% CI 7.4-14.0) in Shropshire compared with 9.0 (95% CI 8.8-9.2) in England. Mortality rates were 3.1 per 100,000 (95% CI 1.6-5.3) in Shropshire compared with 2.3 (95% CI 2.2-2.4) in England.

STI testing and prevention in Shropshire

There were 5,269 chlamydia tests carried out in Shropshire in those aged 15 to 24 years, an estimated coverage of 14.9 percent in 2013: this is significantly lower than the estimate of 24.9 percent across England. The majority of tests were amongst women (78%), with coverage with chlamydia testing varying by both age and sex (Table 2). As well as the national rate of coverage, there is also a benchmark for positivity rates (positive tests per number of tests carried out). This benchmark states that there should be a rate of 1,900 positive tests per 100,000 resident population aged 15 to 24 years. Diagnosis rates (in those aged 15 to 24 years) were significantly lower than both the national benchmark and the English rate, with a rate of 1,149 per 100,000 compared with the English rate of 2,016 per 100,000. Positivity rates differed by age and sex (Table 2), for example higher in men. Thirty four percent of all chlamydia tests were carried out in sexual health services, with 11.1 percent of tests positive there compared with 6.0 percent from elsewhere.

Table 2; Chlamydia testing coverage and positive rates by age and sex in 2013

		Shropshire	
		Male	Female
15-19	Coverage	4.0%	20.4%
	+ve	10.1%	7.5%
20-24	Coverage	8.0%	31.7%
	+ve	12.6%	5.9%
Total	N	1,140	4,123
	Coverage	5.9%	25.5%
	+ve	11.8%	6.6%

(Source: Public Health England. CTAD data - local detailed chlamydia report (2013-14))

In sexual health services there were 3,712 STI tests for Shropshire residents in the 2013/14 financial year, with the types of tests undertaken presented in Table 3. There were more tests carried out for women and for young adults, with 16 to 24 years old the age group receiving most testing (Figure 7). In Shropshire, 1,853 tests were carried out for STIs in general practice in the 2013-14 financial year, with all but two GPs offering testing (Figure 6). Of these, 129 tested positive for an STI (7.0%). Testing varied between practices in absolute number from 0 (in 4 practices) to 153 tests in the year (0 to 16.9 per 1,000 registered population).

Table 3; types of STI tests offered in sexual health services in the 2013/14 financial year

	Shropshire
Chlamydia only	260
Chlamydia and gonorrhoea	1,038
Chlamydia, gonorrhoea and syphilis	9
Chlamydia, gonorrhoea, syphilis & HIV	2,393

(Source: Staffordshire and Stoke-on-Trent Partnership. Sexual health service activity 2013-14)

Figure 6; a summary of STI testing in Shropshire general practice in the 2013/14 financial year

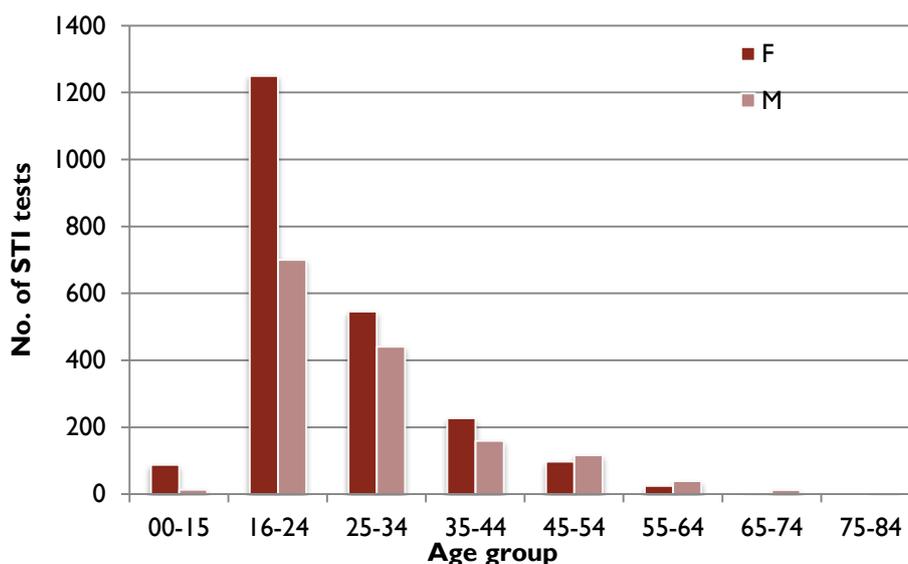


Figure 7; Age and sex profile of STI testing in sexual health services for Shropshire in the 2013-14 financial year
(Source: Shropshire sexual health commissioner GP activity data)

Table 4; SURE Chlamydia Screening Programme: A summary of programme indicators 2012 to 2014

Shropshire			
Negative†	1554	(92.9%)	
Positive†	118	(7.1%)	
Void‡	44	(2.6%)	
Total	1716		
Treatment (of positives)	58	(49.2%)	
Partners	Number	77	
	Notified	71	(92.2%)
	Treated	27	(36.0%)

† Percentage of all valid tests; ‡ Percentage of all returned tests

NB Partner notification and treatment counts only those known to the service, treatment may be more if received and the service is not informed

(Source: Shropshire Council. SURE screening programme activity data. 2014)

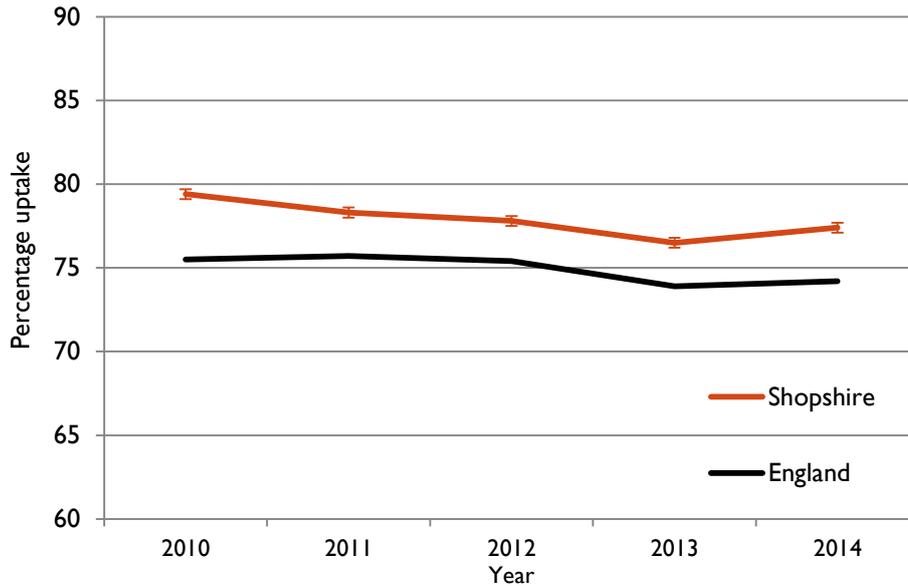


Figure 8; trends in cervical screening coverage from 2010 to 2014 in females aged 25-64 years old
 (Source: Public Health England. Sexual & Reproductive Health Profiles)

The national chlamydia screening is undertaken through the SURE screening programme in Shropshire. In the 2013/14 financial year, 746 were screened in Shropshire, with 76.3 percent female (Table 4) – this equates to 14.1 percent of the total chlamydia testing in the two areas. The population coverage from SURE alone is approximately 2.1 percent of the population aged 15 to 24 years old.

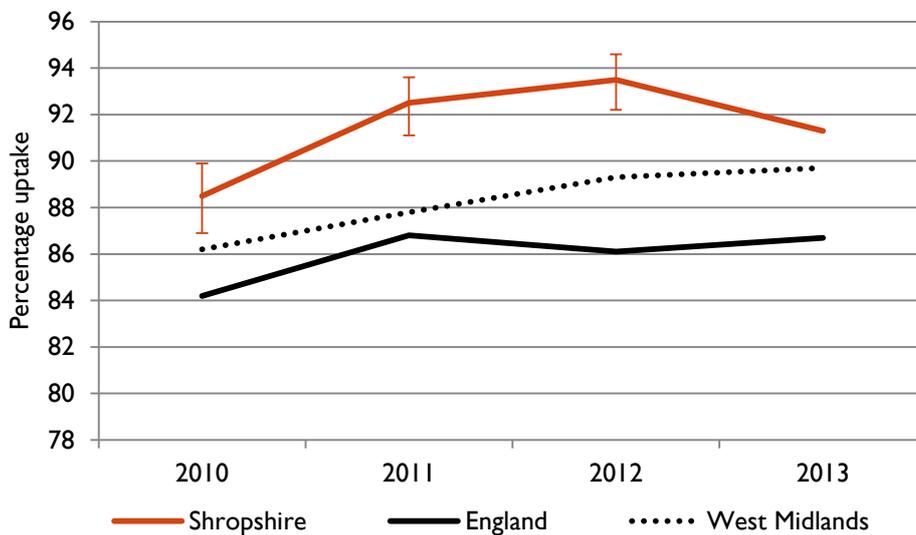


Figure 9; HPV vaccination coverage (females 12-13) from 2010 to 2013 in Shropshire
 (Source: Public Health England. Sexual & Reproductive Health Profiles)

Cervical screening is offered at general practices and sexual health services in Shropshire: it is offered every three years to women aged 25 to 49 years and every 5 years to women aged 50 to 64 years. In 2014 cervical screening coverage was 77.4 percent in Shropshire, significantly higher than the 74.2% in England. There was a significant reduction in coverage

from 2010 to 2014 (Figure 8), although it improved between 2013 and 2014. Coverage was 74.8 percent in Shropshire in women aged 25 to 49 years old, but higher in women aged 50 to 64 years at 77.6 percent. Human Papilloma Virus (HPV) vaccination is part of the NHS childhood vaccination programme, and is offered to all girls aged 12 to 13 years. HPV vaccination uptake has increased slightly since 2010 and in 2012, although may have levelled off in 2013 (Figure 9): coverage is significantly higher than England.

The HIV profile of Shropshire

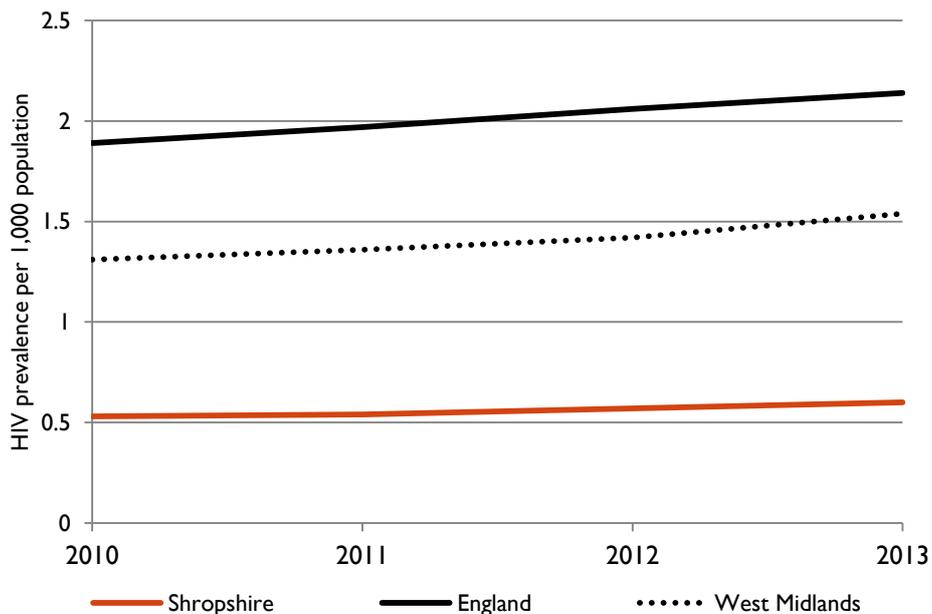


Figure 10; trend in HIV prevalence per 1,000 registered population aged 15 to 59 years for 2010 to 2013
 (Source: Public Health England. Survey of Prevalent HIV Infections Diagnosed (SOPHID). 2013)

In 2013 there was a diagnosed HIV prevalence of 0.60 per 1,000 (aged 15-59 years) in Shropshire (127 residents accessing care), compared with 2.14 per 1,000 in England and 1.54 in the West Midlands (statistically significantly lower than both). There was been no significant change recently in HIV prevalence (Figure 10). Taking estimates from England & Wales, there is an expected 22 percent (95% CI = 18-27) on top of the diagnosed population with undiagnosed HIV – this would leave 28 more cases in Shropshire – although local undiagnosed rates may differ.

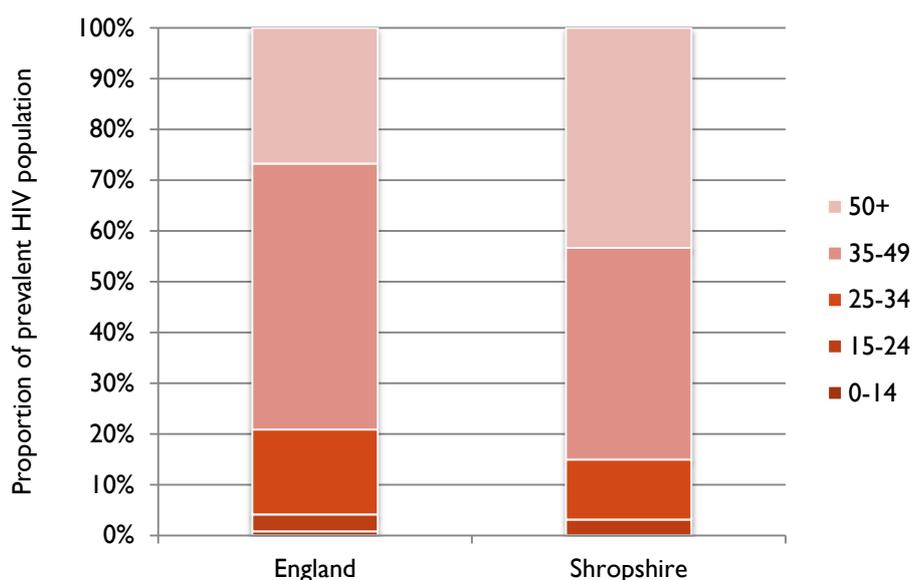


Figure 11; proportion of the population with diagnosed HIV by age group in Shropshire and England in 2014
 (Source: Public Health England. Survey of Prevalent HIV Infections Diagnosed (SOPHID). 2014)

The population living with HIV in Shropshire were mostly male, 82.6 percent; whilst the prevalent population was older in Shropshire than in England (Figure 11 – e.g. 43.3% were aged 50 years and over, compared with 27% in England). That said, Shropshire has an older population than England, although the age standardised proportions are more similar. The majority of the prevalent population were from White ethnic groups. A large proportion of the probable exposure was from sex between men (59.1% compared with 44.5% nationally).

Table 5; characteristics of residents in Shropshire with a new HIV diagnosis - 2009 to 2013

		Shropshire	England
Sex	Male	76.6%	74.6%
	Female	23.4%	25.4%
Route of transmission	Heterosexual contact	42.2%	41.5%
	Sex between men	55.6%	54.2%
Age	0-14	0.0%	0.6%
	15-24	14.9%	12.3%
	25-34	25.5%	32.6%
	35-49	40.4%	38.4%
	50+	19.1%	16.2%
Ethnic group†	Black African	12.3%	21.0%
	White	78.8%	53.7%
Number		47	

† Summarises data from 1981-2013

(Source: Public Health England. Survey of Prevalent HIV Infections Diagnosed (SOPHID) 2013.)

In 2013 there were 8 new cases of HIV in Shropshire. Table 5 summarises the transmission profile of HIV presenting the characteristics of new HIV diagnoses in the last five years (a total of 47 cases in Shropshire), and compares these with new diagnoses in England. New diagnoses were largely male in Shropshire; aged 35 to 49 years and of a White ethnic

background. Transmission was mostly from sex between men, but a large proportion was from heterosexual contact.

Table 6; percentage of late and very late diagnosis of HIV by age in Shropshire (2004-13)

Age group	Shropshire		England
	% diagnosed late	% diagnosed very late	% diagnosed late
15-24	13%	13%	28%
25-34	71%	43%	31%
35-49	41%	33%	43%
50+	79%	57%	58%
Total	52%	38%	42%

(Source: Public Health England. Survey of Prevalent HIV Infections Diagnosed (SOPHID) 2013.)

NB There were a total of 94 new diagnoses in this time period

Timely diagnosis with HIV is critical to care and prognosis. A diagnosis of HIV with a CD4 cell count of less than 350 cells/mm³ is the accepted marker of late diagnosis. From 2004 to 2013, 52 percent were diagnosed late in Shropshire compared to 45 percent in England. Thirty-eight percent of the total were diagnosed very late – with a CD4 count less than 200 cells/mm³. Late diagnosis rates differed by age Table 6 – late diagnosis was more common in those aged 50 years and older and also in those 25 to 34 years.

HIV – testing & treatment

All first time attendees at sexual health services should be offered HIV testing. In 2014 there were similar levels of tests offered to first time attendees to sexual health services in Shropshire compared with England (Figure 12) – although below the 85 percent national target. Actual coverage – accounting for take up was also similar to England, with 60 percent of all first time attendees taking up the test. Previously, there had been a significant drop in testing between 2012 and 2013. This is likely due to a real fall due to the change in sexual health provider, in conjunction with a problem in data capture (there were difficulties in differentiating between contraception and GU attendances). In addition to universal testing in first time attendees, high risk areas and groups should be targeted. In 2013, 95.8 percent of men who have sex with men (MSM) attending sexual health services took up an HIV test. Rates increased significantly in the last five years, from 88.6 percent respectively.

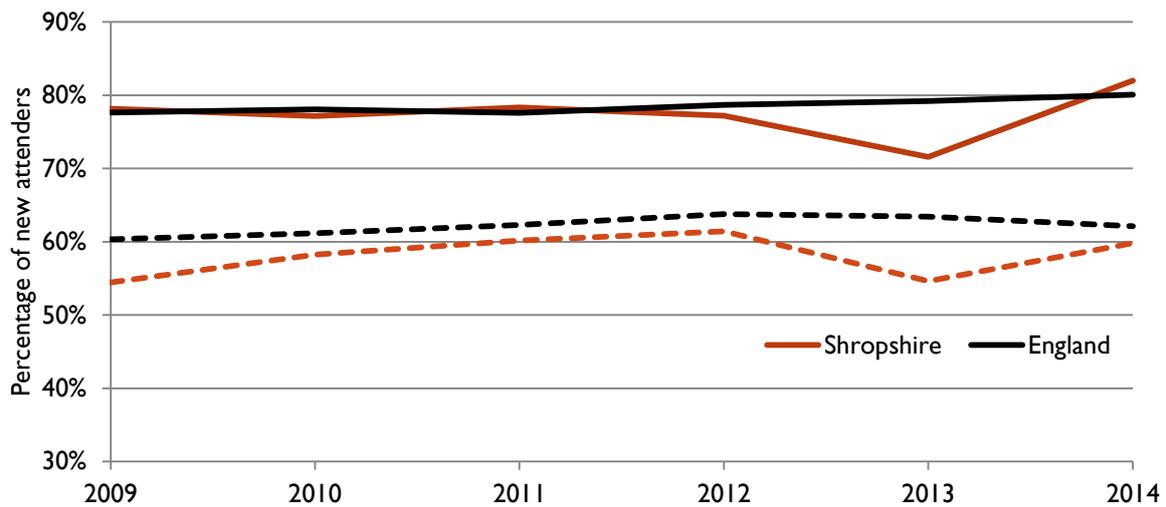


Figure 12; HIV testing offered and coverage in new attendees to the sexual health services
 solid line represents the percent of eligible offered and the dashed line those offered who had a test

(Source: Public Health England. Genitourinary medicine clinic activity dataset (GUMCAD) 2014)

There are a number of metrics for the quality of HIV care. The first metric is retention into care, which is defined as the proportion of people testing positive for HIV going into care. Between 2012 and 2013, 91 percent of patients in Shropshire were retained in care compared with 95 percent nationally. The speed at which a patient gets their first recorded CD4 count recorded is another metric for linkage into specialist HIV care. Table 7 shows the majority of new diagnoses receive fast CD4 testing: that said 20 percent of new diagnoses do not have a record of a CD4 test. A low CD4 cell count in patients with HIV is a marker that the virus is damaging the immune system. In the prevalent population control of the CD4 count above 350 cells/mm³ is sought both clinically and as a metric of good care. In Shropshire, 22.8 percent of those accessing care have a CD4 count of <350 cells/mm³, higher than the 15.9 percent nationally. Table 7 shows the treatment received by the patients with HIV and a CD4 count of <350 cells/mm³. The majority of patients receive 3 or more ARTs, but this combination therapy is less common in Shropshire than other areas in the West Midlands (data not presented due to small numbers). Shropshire also has a higher proportion (31%) of patients with a CD4 count of <350 cells/mm³ not on ART than in England (8%). Viral load (the amount of HIV in a blood sample) is another measure of the control of the virus. Two measures are used, a viral load of <50 cells per mm³ is defined as undetectable (very well controlled) whilst a level of <200 cells per mm³ indicates no need to modify the current ART regimen that a patient is on. Figure 13 summarises control of viral load: of those living with HIV in 2013 who had a recorded viral load (100% of those accessing care), 86 percent in Shropshire had a viral load <200 cells per mm³ and 84 percent <50 cells per mm³. Ninety percent in England of those with a recorded viral load achieve control to <200 cells per mm³.

Table 7; care metric for HIV in Shropshire (2013); the top row presenting CD4 testing after diagnosis and the bottom antiretroviral therapy and control of CD4

	Number of new diagnoses	Number of new diagnoses with a reported CD4 test	Percentage of new diagnoses who have had a test reporting a CD4 test < 1 month of diagnosis	Percentage of new diagnoses who have had a test reporting CD4 test < 3 months of diagnosis
Shropshire	25	20	100%	100%
England			90%	98%
	Percentage not receiving ART	Percentage receiving 1-2 drugs	Percentage receiving 3 or more drugs	No. with CD4 count <350 cells/mm ³
Shropshire	31%	15%	54%	26
England	8%	92%		12,609

(Source: Public Health England. Survey of Prevalent HIV Infections Diagnosed (SOPHID) 2013.)

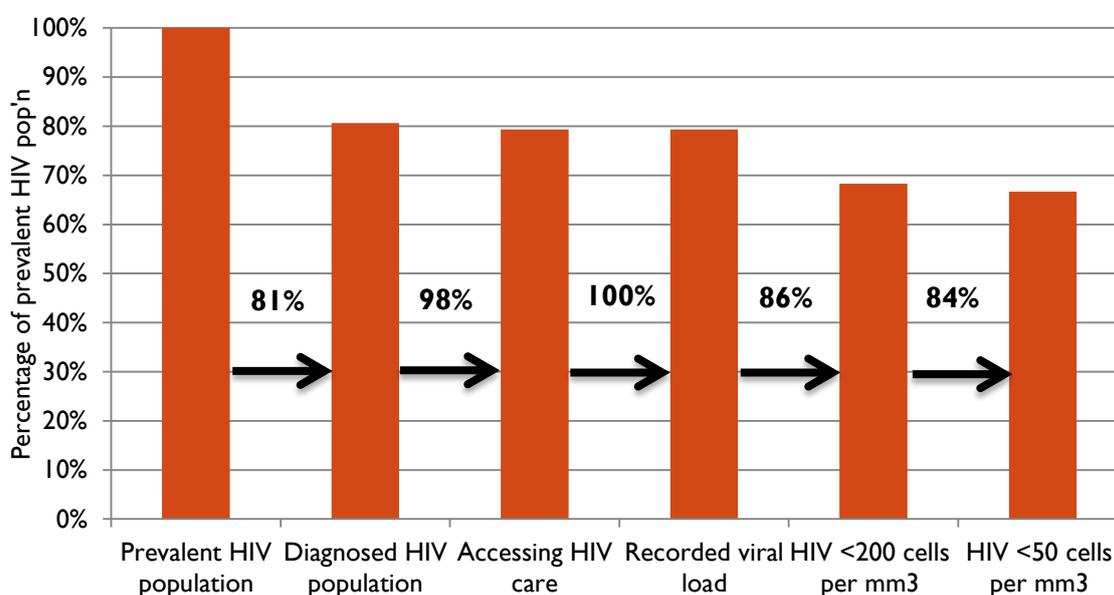


Figure 13; HIV treatment cascade in Shropshire in 2013

prevalent population is modelled using PHE undiagnosed estimate (24%), other data are from local SOPHID extracts. Percentages on the diagram represent each step in the cascade as a percentage of the previous stage – except for HIV control to <200 and <50 cells per mm³ which are both a percentage of those with recorded viral load

(Source:

Figure 13 summarise the treatment cascade for HIV in Shropshire, estimating the prevalent population including the undiagnosed, then the proportions that reach successive steps in care, namely diagnosis, access to care, viral load recoding and viral load control. This model of a treatment cascade shows the importance of a sustainable model for improved access to testing and all aspects of care. This is both for improved treatment outcomes, but also given the proportion with uncontrolled viral loads can spread disease to improve prevention

Conception in Shropshire

The conception rate in Shropshire was 67.7 per 1,000 in 2013, giving 3,391 births. The rate in Shropshire was considerably and significantly lower than England (78.0 per 1,000).

Conception rates have remained similar in recent years. In 2013 there were 107 conceptions in girls aged 18 years and under, a rate of 19.1 per 1,000. Shropshire has a significantly lower rate than West Midlands, but no difference from England – the latter has only been the case in recent years, with English rates converging (Figure 14). There has been a reduction in under-18 conceptions between 1998 and 2012, but not equal to that across England. Conception rates in under-16 are also lower in Shropshire than England (4.5 compared with 6.1 per 1,000) – and reductions in recent have been greater than England.

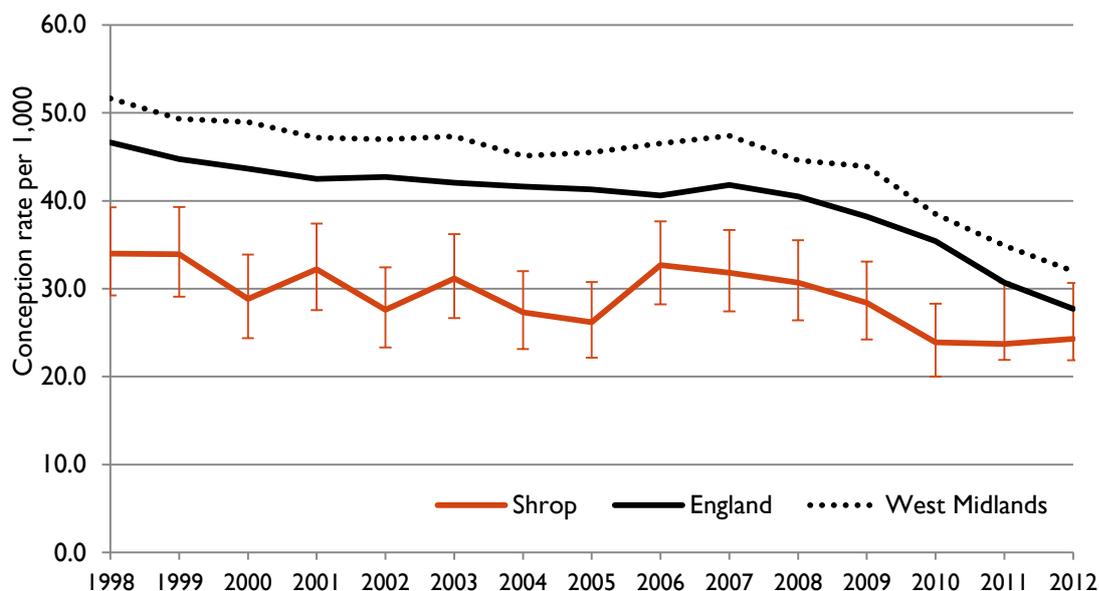


Figure 14; Under-18 conception rate in Shropshire from 1998 to 2012
 (Source: Office for National Statistics. Conceptions in England and Wales, 2012)

Terminations

In 2013 there were a total of 626 terminations of pregnancy in Shropshire, an age standardised rate of 12.6 per 1,000 women aged 15-44 years (compared with 15.9 per 1,000 in England). This equates to 18.9 percent of the total conceptions. Over the last decade, termination rates have remained constant (Figure 15). The regions had considerably fewer terminations carried out directly by the NHS compared with England (6% compared with 34%). Most (93%) were NHS funded but carried out by the independent sector.

There are a similar proportion of ‘early’ terminations (carried out before 10 gestational weeks) in Shropshire to England – 80 compared with 79 percent; and no differences in late terminations (carried out after 13 gestational weeks – 8% for both). There has been an increase over the last decade in the proportion of early terminations (Figure 16). Between 2002-4 and 2011-3 there was a 34 percent relative increase in the proportion of terminations before 10 gestational weeks; this was greater in Shropshire at 53 percent. Figure 16 suggests these increases might now have ceased, with a plateau reached of approximately 75 percent of terminations carried before 10 weeks.

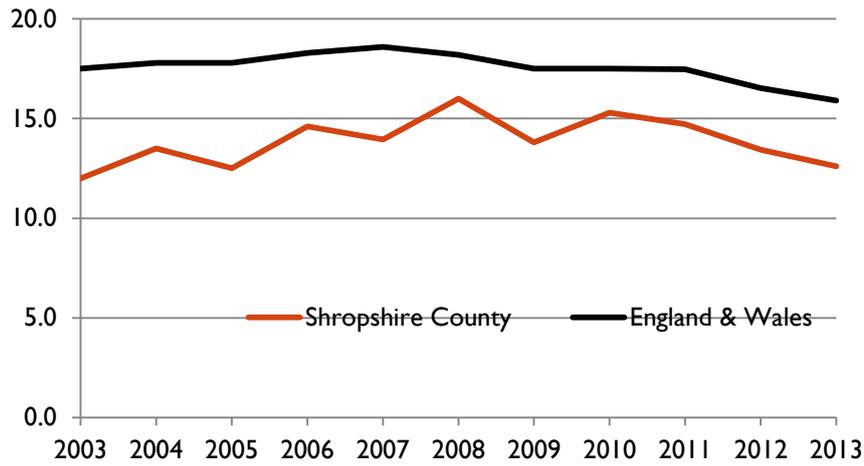


Figure 15; Age standardised termination rates between 2003 and 2013 in Shropshire
 (Source: Department of Health. Abortion Statistics, England and Wales. 2014)

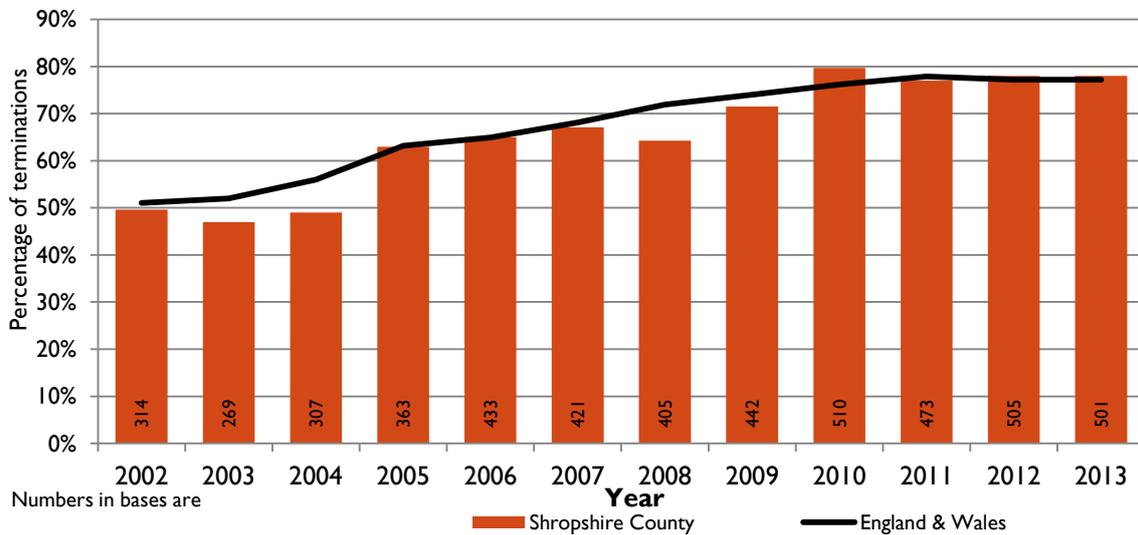


Figure 16; early terminations in NHS funded abortions (3-9 weeks)
 (Source: Department of Health. Abortion Statistics, England and Wales. 2014)

There has been a decrease in late terminations, with reductions from 16.0 to 10.0 percent (three year means from 2002-4 and 2011-3 respectively). This is marginally larger relative reductions than in England with a 12.5 to 8.7 percent fall over the same period.

The overall lower termination rate in Shropshire is found across all ages (Figure 17), but particularly in women aged 20-29 years. Despite no change in the overall rates of terminations, shown above, there have been reductions in rates in under-18s. Rates in girls aged 18 years and under fell from 13.7 to 10.5 per 1,000 between 2003-5 and 2011-3, a relative reduction of 23.3 (6.5-37.1) percent, compared with 26.4 percent in England.

In 2012, 52.6 percent of conceptions in girls under-18 years resulted in a termination which is similar to England (with 49.1%). In girls under 16 years, there is a no of difference

between local and national proportions of conceptions proceeding to a termination (62.2% and 61.2% respectively). Despite the overall reduction in termination rates in girls aged 18 years and younger shown above, there has been a stable trend (a slight but no-significant increase) in the proportion of conceptions resulting in a termination (Figure 18).

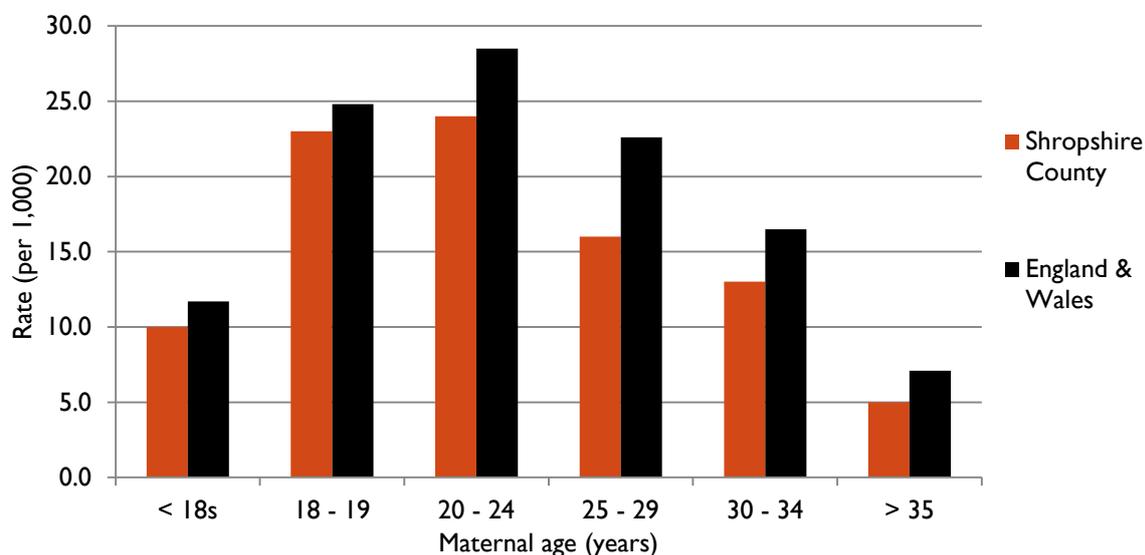


Figure 17; Age standardised rate of termination by maternal age in 2013 in women aged 15 to 44.
(Source: Department of Health. Abortion Statistics, England and Wales. 2014)

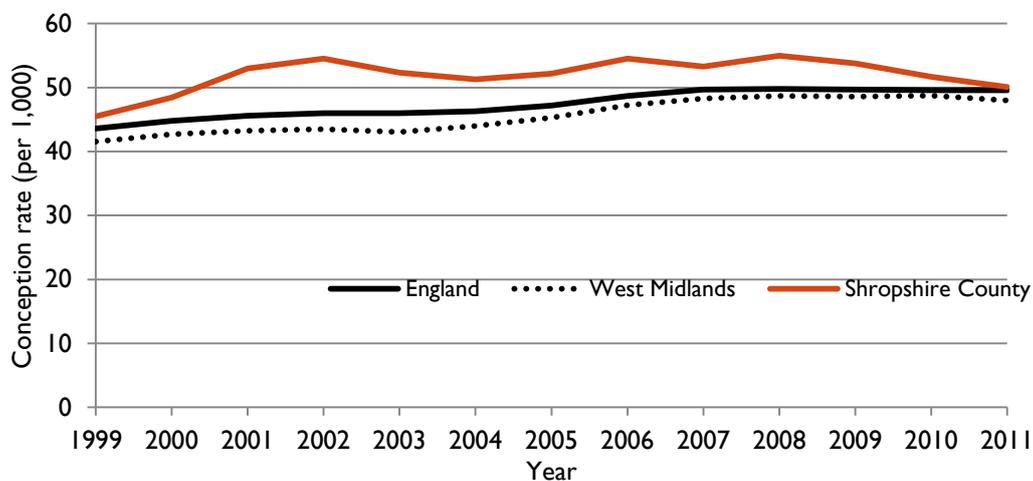


Figure 18; Under-18 conceptions resulting in termination - three year rolling mean for 1999 to 2011
(Source: Department of Health. Abortion Statistics, England and Wales. 2014)

The gestational age of terminations in girls aged 18 years and younger was higher than in the whole population. In this age group only 65 percent of terminations were early (compared with 77% in total) and 14 percent were late (compared with 6% in total). Repeat terminations are associated with greater health risks to women. Further, repeat terminations by their very nature occur in women who have had previous contact with services – therefore represent either a missed or a failed opportunity to prevent the

unwanted conception. Shropshire shows a lower but not statistically significantly different rate compared with England (Figure 19), and is not different from its ‘statistical neighbour’ local authorities.

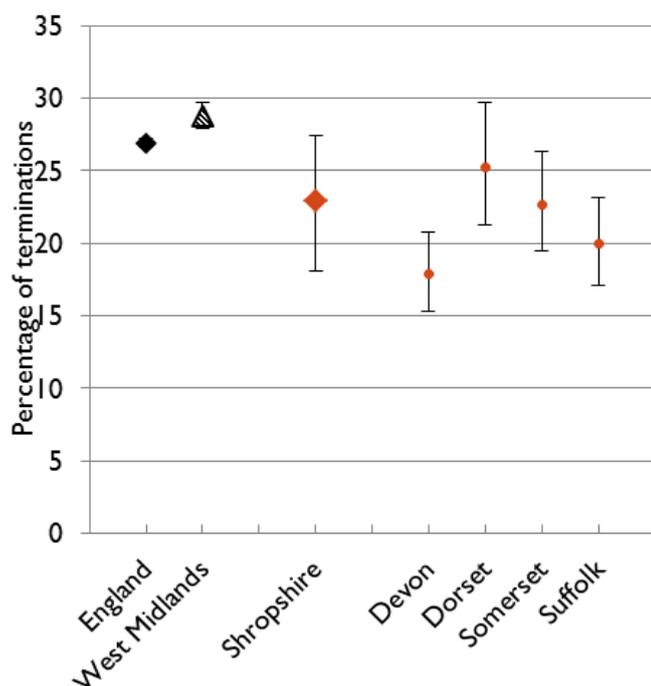


Figure 19; Percentage of repeat terminations in women aged 25 years and under in 2013
 (Source: Department of Health. Abortion Statistics, England and Wales. 2014)

Contraception

In 2013-14 there were 57 instances of women accessing emergency contraception in sexual health services, with all offered it on the same working day. Here, 22 percent of emergency contraception was prescribed to under-17 year olds. No women were prescribed emergency contraception more than once in sexual health services. There were 799 consultations held concerning EHC in pharmacies (from 31 pharmacies – as of January 2015, 37 pharmacies prescribe EHC), with 766 prescriptions (61 – 7.9% - in girls aged 16 years and under). Dispensing ranged from 175 prescriptions in one Shrewsbury pharmacy to 16 with fewer than 10.

In Shropshire in 2013-14 there were 4,080 consultations in sexual health services that dispensed contraceptives: 3,133 were for women and 947 for men. This equated to 45.4 percent of all attendances at the service. Of these, 79.7 percent were repeat-dispenses, 14.2 percent were a change in method and 6.1 percent were starting contraception. Sexual health services dispensed most contraceptives in the 15 to 19 years age group (37.5% - Figure 20). For women, oral contraceptives were most often dispensed (39% - compared with 33% LARC and 35% male condoms), although this varied with age. Oral contraceptives were most common in those aged 15 to 29 years, with LARCs most common aged 30 to 54 years. Of the women receiving a LARC, a contraceptive implant was most common overall

(52%), although intrauterine systems (IUSs) were most often used in women aged 30 to 59 years. LARCs are the most commonly dispensed contraceptives overall in England.

Table 8; the number and type of contraception and the percentage of the total contraception prescribed in general practice: 2013 in Shropshire

Choice	Method	LA (n)	LA (%)	PHE Centre (n)	PHE Centre (%)	England (n)	England (%)
LARCs	IU Device	163	0.3	4313	0.5	42466	0.5
	IU System	1556	3.1	12656	1.5	132876	1.6
	Injectable Contraceptive‡	5739	11.6	109332	13.1	979573	11.4
	Implant	1145	2.3	16899	2.0	158092	1.8
	TOTAL LARCs	8603	17.3	143200	17.2	1313007	15.3
UDM	Oral Contraceptives*	40619	81.9	680178	81.6	7150537	83.6
	Contraceptive Patch	294	0.6	8998	1.1	70407	0.8
	Other±	73	0.1	1325	0.2	24383	0.3
	TOTAL UDM	40986	82.7	690501	82.8	7245327	84.7
TOTAL CONTRACEPTION		49589	100.0	833701	100.0	8558334	100.0

‡ Excludes Norethisterone Enantate under LARC numbers but included under total contraception. Number of individual DMPA doses prescribed reported, divided by 4.3 (estimated that to supply one woman with DMPA for one year requires 4.3 injections) for adjusted numerator (same as Sexual Health Profiles) – method adopted based on that undertaken for the London Sexual Health Needs Assessment mapping exercise 2008).

* Includes combined pill and progesterone only pill

± Includes vaginal ring, cap/diaphragm and spermicides

NB PHE centre = West Midlands

Reproduced with permission of Centre for Infectious Disease Surveillance and Control (CIDSC), Public Health England; Source - Prescribing and Analysis Cost Tabulation (PACT) data, NHS Prescription Services' Database, NHS Business Services Authority

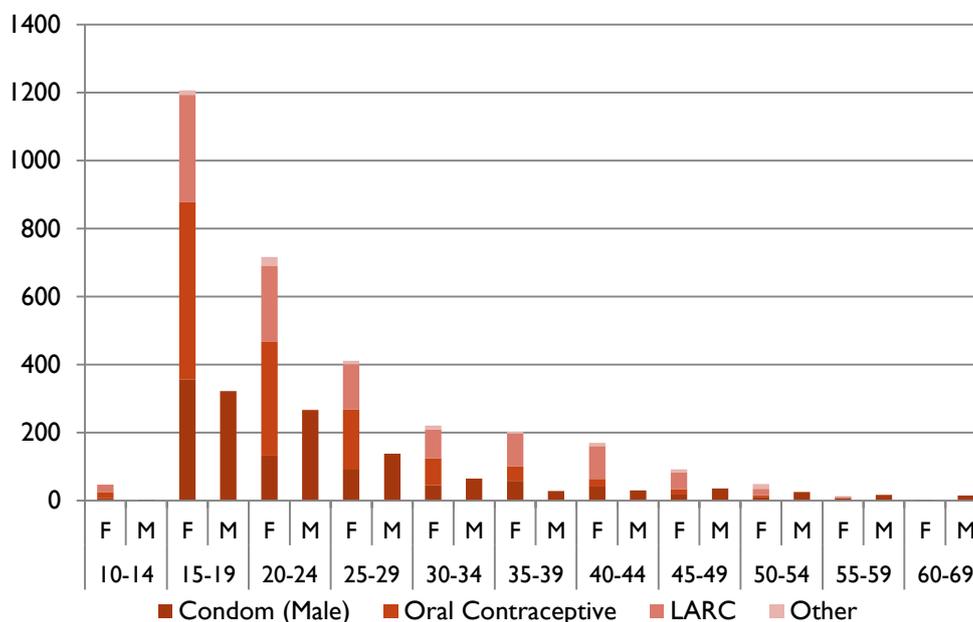


Figure 20; Types of contraceptives dispensed by age in sexual health services in Shropshire (Source: Staffordshire and Stoke-on-Trent Partnership. Sexual health service activity 2013-14)

Prescribing Analysis and Cost (PACT) gives an estimate of contraceptives prescribed in primary care. PACT data contains all items that have been prescribed by general practice or

prescribing pharmacists, and have been dispensed. These data (Table 8) are reproduced, with permission from Public Health England, from the 2013 LASER report. In 2013 in Shropshire there were 49,589 dispenses of contraception – these are however not indicative of the number of women prescribed to, simply the number of prescriptions. A breakdown of the types of contraceptives prescribed in general practice is given in Table 8. Note, the percentages do not represent the relative use of the types of contraception in women because, for example, a LARC will be dispensed once to cover many years, in which time a woman would have many oral contraceptive prescriptions.

The Framework for Sexual Health Improvement in England states the objective to increase access to all methods of contraception, including LARC methods as central to its ambition to reduce unwanted pregnancies. Shropshire has significantly higher rates of LARC prescribing in general practices than in England. The rate of LARC prescribing in sexual health services was, however, significantly lower in Shropshire compared with the West Midlands and England. In 2013, the rate of LARCs prescribed here per 1,000 women aged 15 to 44 years was 15.4 for Shropshire, 28.6 for West Midlands and 32.3 for England. In 2013-4, 25.8 percent of women consulting about contraception were prescribed a LARC method in sexual health services.

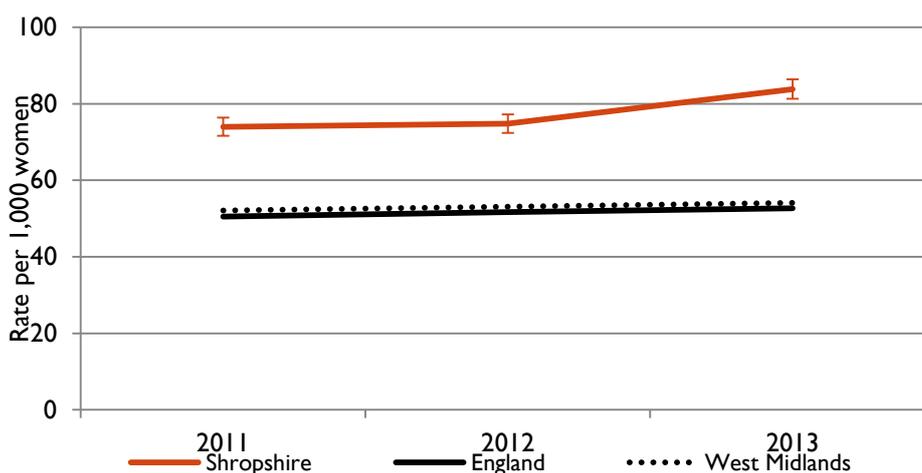


Figure 21; General practice prescribed LARC rate resident female population aged 15-44 years
 (Source: Shropshire Sexual health commissioner GP activity data 2013)

In the 2013-14 financial year, general practices in Shropshire conducted 2,190 consultations about Intrauterine Contraceptive Device (IUCDs), with 1,046 fittings, 686 removals and 458 refits. Between the 44 practices, activity varied from 0 to 178 fittings (0 to 1.46 per 100 registered population).

Summary points

- Shropshire is a rural county with a population that is on average older than England and aging further.
- The area has low STI transmission, with well under half the national rate of diagnosis with any STI.

- Chlamydia was the most common STI in 2014 with 621 cases in Shropshire: the majority (75%) of these were in those aged 15 to 24 years.
- There is an estimated coverage with chlamydia testing of 14.9 percent in 2013: this is significantly lower than the estimate of 24.9 percent across England.
- The diagnosis rate for chlamydia was 1,149 per 100,000 in those aged 15 to 24 years. This was significantly lower than both the national benchmark (1,900 positive tests per 100,000) and the English rate (2,016 per 100,000).
- In sexual health services there were 3,712 STI tests for Shropshire residents in the 2013/14, in 8,990 attendances and resulting in 1,087 diagnoses
- In 2013 there was a diagnosed HIV prevalence of 0.60 per 1,000 (aged 15-59 years) in Shropshire (127 residents accessing care), significantly lower than the 2.14 per 1,000 in England
- The prevalent population with HIV is older in Shropshire than in England, for example 43.3 percent were aged 50 years and over, compared with 27 percent in England.
- There is a higher rate of late HIV diagnosis in Shropshire compared with England, for example 52 percent diagnosed late in Shropshire compared to 45 percent in England.
- Rates conceptions in girls aged 18 years and under are similar to England – the latter has only been the case in recent years, with English rates converging, There has been a reduction in under-18 conceptions between 1998 and 2012, but not equal to that across England.
- Termination rates match those in England 12.6 per 1,000 women aged 15-44 years (compared with 15.9 per 1,000 in England), 18.9 percent of the total conceptions.
- There has been an increase over the last decade in the proportion of early terminations, whilst the proportion is similar to that in England (at 80%).
- Twenty-three percent of terminations in Shropshire are repeat terminations.
- In Shropshire in 2013-14 there were 4,080 consultations in sexual health services that dispensed contraceptives, 45 percent of the total: 3,133 were for women and 947 for men
- For women, oral contraceptives were most often dispensed (39% - compared with 33% LARC and 35% male condoms), although this varied with age: this differs from England as a whole where LARCs are the most commonly dispensed
- Shropshire has significantly higher rates of LARC prescribing in general practices than in England.

Appendix 4 – Shropshire Sexual Health Needs Assessment - Consultation

In 2015 Shropshire and Telford & Wrekin Councils undertook a needs assessment for sexual health, which included a consultation of the public and professionals. Although the exercise covered both areas; the majority of respondents were from Shropshire, whilst there were no noticeable differences in finding between the areas. The results presented here are for the two areas combined. Four different consultation exercises covered the general public, young people, sexual health service providers and LAC providers – a summary of the key themes from the whole exercise is shown in Figure 1.

General public

The general public questionnaire was completed by 61 respondents across the two areas. Of those accessing services, general practice provided a large proportion of the services to respondents, notably contraception, sexual health advice, pregnancy testing and cervical screening. Sexual health services provided the majority of STI testing and treatment and a large amount of contraception. Significant strengths of the current provision included friendliness/ helpfulness of staff; the quality of information/service offered once accessed and flexibility of walk-in services.

Following barriers to access were highlighted:

Despite some praise for drop-in session, a number wanted more fixed appointments. Although not common, another theme was repeated – namely that there was no privacy in the reception area of services. Opening times were the commonest barrier to services, whilst 58 percent said ability to book appointments (potentially online) would promote use. Better promotion of services was also important, including what was offered and where – whilst the current “all in one” clinic was popular. General practice was more often the preferred site for STI treatment and contraception, although a large number did chose sexual health clinics, with supermarkets popular for the latter. Sexual health services and after every new partner were popular for HIV testing.

Young people

There were 186 responses to the young person’s consultation. In terms of the services used, the majority accessed contraception advice in general practice or at school/ college, contraception was provided in sexual health service, pharmacy and general practice; and chlamydia screening and STI testing/ treatment were most common in sexual health service. There were three main areas that services were seen to be good, the quality of the information offered; the polite and welcoming staff; and the non-judgemental/ confidential service.

Following areas for improvement were highlighted in the survey:

- Access (opening hours, location and waiting time). Generally, services “open at a time and place that is easy for us to access” were important for young people.
- Other factors that would promote the use of services, with “Less embarrassing to attend”; “more confidential”; “available without appointment” and “available at more

convenient times” the most commonly mentioned although other options were frequent.

- A significant proportion also wanted to know what service they could get, from where.
- The internet, as with the general population was the preferred method to find out about services, and leaflets/ posts in schools or GPs were also high.
- General practice was the preferred setting for receiving STI treatment/ testing, with a large proportion selecting sexual health services, whilst pharmacy was the most popular place to access contraception.
- A substantial minority had not heard of the condom distribution scheme, whilst a number felt there were not enough places to register and confidentiality when signing up was seen as a gap.

In addition to this, workshop sessions highlighted access as critical to sexual health services, whether in times (for example weekends) or locations (for example town centre). There was repetition of above in that young people needed to know what was offered, whilst personal aspects of staff were vital. Confidentiality was important – as it was in the wider consultation. It is possible those not using services fear lack of confidentiality, but those who use them are very happy with this aspect. There was a lot of support for accessing services in their GP, whilst waiting times were a final barrier. It was felt that good RSE revolved around the environment, including not feeling judged, being confidential, having separate sessions in schools and having suitable staff. School/ college was seen as the best setting.

	General Public	Young People	Sexual Health Providers	Vulnerable Group Providers
Suggestions				
Need to increase provision of RSE in FE		✓	✓	
Access for YP a problem- YP specific service needed		✓	✓	✓
Confidentiality critical to a good service		✓		
Make more use of GP for sexual health services	✓	✓	✓	✓
Strengths				
High quality care received	✓	✓		
Excellent personal qualities of current staff	✓	✓		
Some like the flexibility offered by drop-in clinics	✓	✓		
Areas for improvement				
Better promote service - "what and where"	✓	✓	✓	
Clinic timings need improving for access	✓	✓	✓	
Waiting times too long	✓	✓		✓
Privacy /confidentiality of reception area needs improving	✓	✓		✓
Improve access the HIV care in lieu of aging prevalent cohort	✓		✓	
Some feel insufficient fixed appointments affect access	✓		✓	✓
Recent significant loss /lack of outreach by sexual health services		✓	✓	✓
LAC receive poorer RSE			✓	✓
Access issues due to service location of & rurality, notably town centre venue required		✓	✓	

Figure 1; summary of the themes for the SHNA consultation in Shropshire and Telford & Wrekin

Sexual health providers

Providers of sexual health service providers were also consulted. In school nurse services, the CHAT service, the CDS and drop-in session at school were seen as good; in pharmacy, providing EHC and the CDS in pharmacies, and the long opening hours were working well. The most coherent criticism of current services was access for young people. A second theme was around the needs for increased provision of booked appointments. Wider barriers to services included the rurality (especially Shropshire), access in town centres, the information about what is offered, lack of bookable appointments and elements of specialist training. In terms of the comments to improve services, themes from the providers covered taking services to schools and colleges – and outreach in general; focus on prevention; advertising about what is provided; use of pharmacies (which pharmacy respondents said they were happy to do) and better training were all mentioned. The Looked After Children (LAC) care providers largely saw LAC receive poorer sexual health services and RSE. These stem from the reliance on schools and LAC nurses. Knowledge to LAC to overcome the barriers, and training to the providers were seen as priorities.

Lastly, in depth work ascertained the views of those involved in the care of looked after children and sexual assault counselling services. In short, long waits/ the use of drop-in services for these most vulnerable was a huge barrier, effectively stopping service use in groups including LAC, sexual assault victims and the women. Outreach to young people, especially the vulnerable, was also a priority and unmet need described by these stakeholders, LAC service provides and other sexual health service providers.

Conclusions

A summary of the recommendations from the recent sexual health needs assessment, including those from the consultation work can be see below.

Missed opportunities ‘Making every contact count’ must be embedded across sexual health, so that every opportunity to promote appropriate contraception use is seized.

Although not explicitly covered in the needs assessment, widening the attitude of ‘making every contact count’ outside of sexual health services is also important. Contacts with other services, notably alcohol and substance misuse services, accident and emergency, elsewhere in the hospital trust and the wider primary care teams – and others too – can be used to promote contraception and sexual health.

There were a number of **positives about the sexual health services** offered across he two areas, notably in the integrated sexual health service. The big positive was the staff. The personal attributes of the staff were praised across the consultation, including their friendliness, helpfulness – and that they were non-judgmental and maintained confidentiality. These personal aspects seem particularly valued by young people, and a vital part of making a service work for them. The quality of the service in terms of information and care given was also praised. There were no problems from a public perspective in integrating sexual health services; in fact having a “one-stop shop” for sexual health was seen as a major factor in promoting attendance.

Communication							
Formulate a clear definition of the entire SH offer							
Produce a single, coherent communications strategy for SH							
Informatics							
Improve provision of metrics around the quality of care for STIs							
Monitor repeat EHC use in pharmacy							
Build knowledge & resilience among young people	Rapid access to high quality services	People remain healthy as they age	Prioritise prevention	Reduce rates of STIs among people of all ages	Reduce onward transmission of HIV & avoidable deaths from it	Reduce unintended pregnancies among all women of fertile age	Continue to reduce the rate of U16 & U18 conceptions
<p>Review the RSE provision in Schools and colleges in both areas</p> <p>Provision of RSE in further education needs to be strengthened</p> <p>Provide greater training about SH for those involved in the care of LAC</p> <p>Put measures in place to prevent over-reliance on the LAC nurses for SH provision</p> <p>RSE for looked after children needs strengthening</p>	<p>Interventions are needed to reduce late HIV & further work to examine why diagnosis</p> <p>Work towards making the fullest use of existing SH encounters</p> <p>Improve the timings of SH clinics to allow better access for users</p> <p>Provide a balance of drop-in & appointments in SHSs, with more appointments than currently</p> <p>Consider town centre services in both Shrewsbury and Telford</p> <p>Continue the roll out of some elements of SH services into pharmacies</p> <p>Consider the role of general practice in the provision of SH care</p> <p>Ensure there is confidentiality at all times that an attendee is within a service</p> <p>Access to appointment slots for all services that deal with vulnerable groups</p> <p>Consider young people specific service</p> <p>Significantly strengthen the provision of outreach SH services</p>	<p>Ensure HIV on-going care is suited to an older population</p>	<p>Promote HIV testing as a means to reduce late diagnosis</p> <p>Revitalise preventive work in SH, embedding it across all services and partners</p> <p>Significantly strengthen the provision of outreach SH services</p>	<p>Improve access to contraception & SH care for women accessing terminations and EHC</p> <p>Significantly strengthen the provision of outreach SH services</p> <p>Consider young people specific service</p>	<p>Promote HIV testing as a means to reduce late diagnosis</p>	<p>Increase the rate of LARC provision in SH services in Shropshire</p> <p>Improve access to contraception & SH care for women accessing terminations and EHC</p> <p>Work towards making the fullest use of existing SH encounters</p> <p>Significantly strengthen the provision of outreach SH services</p> <p>Work towards making the fullest use of existing SH encounters</p>	<p>Increase the rate of LARC provision in SH services in Shropshire</p> <p>Improve access to contraception & SH care for women accessing terminations and EHC</p> <p>Consider young people specific service</p> <p>Significantly strengthen the provision of outreach SH services</p> <p>Work towards making the fullest use of existing SH encounters</p>

Confidentiality is a concern for users and the public, especially young people, although not straightforward. Firstly, there may be a misunderstanding in what exactly people (particularly young people) think of as confidential. Generally people are confident the consultation with the clinician will be confidential but it is the whole encounter with the

service that they worry about. This includes attending, talking in waiting area and speaking at reception. A number of young people do not access services because they fear that it would not be confidential, but interesting all of those who have actually accessed service do not report this as a problem – in fact many praise the confidentiality. This leads to a potential for peer lead communication. Young people may also demand “complete” confidentiality, which cannot always be offered. The ‘waiting room/ reception’ aspect of confidentiality was repeated through the consultation as a major issue, not only affecting sexual health services but C-card registration as well. It may be a particular issue for vulnerable groups, and for example came up as a barrier to stop attendance at sexual health service in the Changing Futures project.

Specific to the integrated sexual health services, **access** to service is a significant issue with opening hours and town centre locations of services highlighted in the consultation. A lack of Shrewsbury town centre services was highlighted as a major barrier. Lack of a central Shrewsbury town clinic on a Saturday was seen by some a significant step towards improving access for young people. Opening times were also a major barrier –nearly 25 percent of adult consultation respondents were prevented from accessing services; whilst young people saw better opening times as a major factor to promote use. After school or weekend service (in town centre) were a priority for a young person designed service.

A number of young people, health professionals and those involved in the care of LAC called for more young person specific clinics. This was highlighted by professionals working with LAC. One specific issues is the shared waiting room, with young people – especially the most vulnerable feel reluctant to attend services if they have to wait with adults.

Another strong theme for the consultation was the lack of **outreach** and community work, both for all young people, but especially for vulnerable people (including LAC, children with disabilities, learning difficulties). When considering outreach and young people’s services, school nurses should be seen as a major asset to use. Greater use of this asset might be warranted, whilst the focus group work indicated that having different school nurse offers between schools was noticed by the young people and was not liked.

A second theme for the integrated sexual health services, which also covers all sexual health provision, was the public are not aware of where services are and what is available to them. This theme of **advertising** services was repeated by most stakeholders. The clinical quality and personal qualities of the staff should be central to this message. In terms of method of promotions, the internet and general practice or school posters/ leaflets were preferred. A coherent **communication** strategy is needed for all aspects of sexual health. As a baseline, this must start with a clearly defined sexual health offer that is available for the two populations, combining all services across different providers and commissioners.

There is stark split in preferences for **drop-in versus bookable appointments**. In adults nearly 60 percent of consultation respondents stated bookable appointments would increase the chance of attendance. That said, although drop-in clinics was reported by a

significant minority as a positive of the current service, and this flexibility of drop-ins was a theme from free text comments. Young people mostly stated that drop-in clinics would improve use but a large minority wanted appointments. From a staff perspective, they see the lack of booked appointments as a significant barrier for patients particularly the vulnerable groups. Whether following the trauma of sexual assault, the SARC and AXIS Counselling services highlighted drop-in clinic were a terrible prospect for their clients due to recent trauma. The LAC providers said that LAC were more likely to attend with appointments, and would be discouraged by long waits for a drop-in. A balance between appointments needs to be struck, although it is likely more appointments need to be available for adults. There must be an appointment system for the most vulnerable groups, otherwise sexual health service are inaccessible for them. In the consultation of professionals, some who work with vulnerable groups and young people reported their service was able to directly contact sexual health services and get guaranteed appointments for their clients. Some, however, reported this as a gap, therefore this opportunity and knowledge of this opportunity needs to be rolled out to all who need it.

The importance and power of **general practice** may be underestimated in the provision of sexual health care. Although, general practice is currently involved in sexual health services – for example the major source of contraception – this current status might be underestimated. . General practice was a popular option in the consultation for receiving sexual health services, including STI testing and contraception. This was not only in adults, but also young people where general practice was the most popular setting for sexual health provision for all but contraception (where pharmacy was preferred, although GP well supported). The young person's focus group also highlighted one's own general practice as a good setting, with the group suggesting if the expertise was not there a specialist team could run regular clinics there. This exact same suggestion was repeated in the professional consultation. General practice was also seen as an ideal venue from the LAC providers. They described how young people – but especially vulnerable ones take a long time to build relationship. As a result the general practice was the best, possibly only place some of these groups would access care.

Pharmacies was seen as a positive and their opening times as a major strength – whilst some providers thought this should be used more with pharmacists stating they would be happy for this. However, pharmacy, although popular for contraception, was not a preferred option for other aspects of sexual health services, such as treatment and testing. The exact role of pharmacy needs to be found in sexual health, providing services that the public want. Forcing too many services unto pharmacy may not be acceptable to the public, therefore not effective.

Finally, **embarrassment** and culture remain a problem in sexual health. Both the general public and young people's consultations marked embarrassment as a major barrier to services, whilst making services less embarrassing was seen as factor to promote attendance. This, of course, is a major cultural issue and is never going to be easily rectified by a single intervention, indeed this has been an objective nationally for many years. That said, further efforts can be made in this area, for example normalising attending a service for sexual ill-health.

Appendix 5; current sexual health services and premises in Shropshire

Integrated sexual health services

The sexual health service in Shropshire has been integrated, combining both GU and contraceptive services, through the commissioning process since April 2013. There is currently a countywide hub and spoke model of service delivery. The service provides for both adults and young people; and in summary provides simple and complex contraceptive care; simple and complex GU care; HIV care and testing; sexual health counselling; psychosexual services and outreach to further education venues and vulnerable /high risk groups. Currently the integrated sexual health service is provided by Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP).

Currently, sexual health services are offered across seven locations in Shropshire (Figure 1/ Table 1). The hub, Severn Fields in Shrewsbury offer services Monday to Saturday, with the remaining spokes offering one half day session per week (except Claremont Bank in Shrewsbury with two). Spoke services are located in Bridgnorth, Ludlow, Market Drayton, Oswestry, Shrewsbury (central) and Whitchurch. Patients can attend any of the venues, which can all provide most of the simple (level 1 and 2) contraception and sexual health services, although attendees at the service spokes will be provided with a follow-up appointment and the hub if they required complex (level 3/ consultant lead) care.

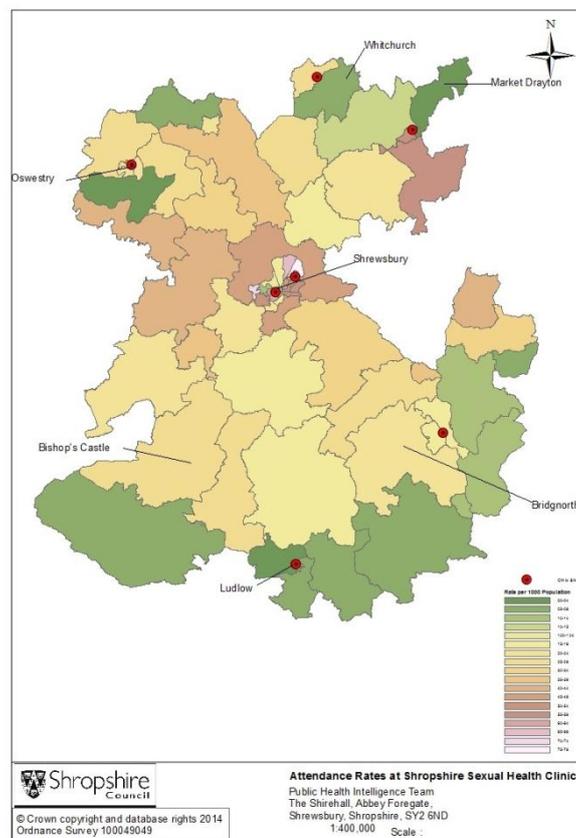
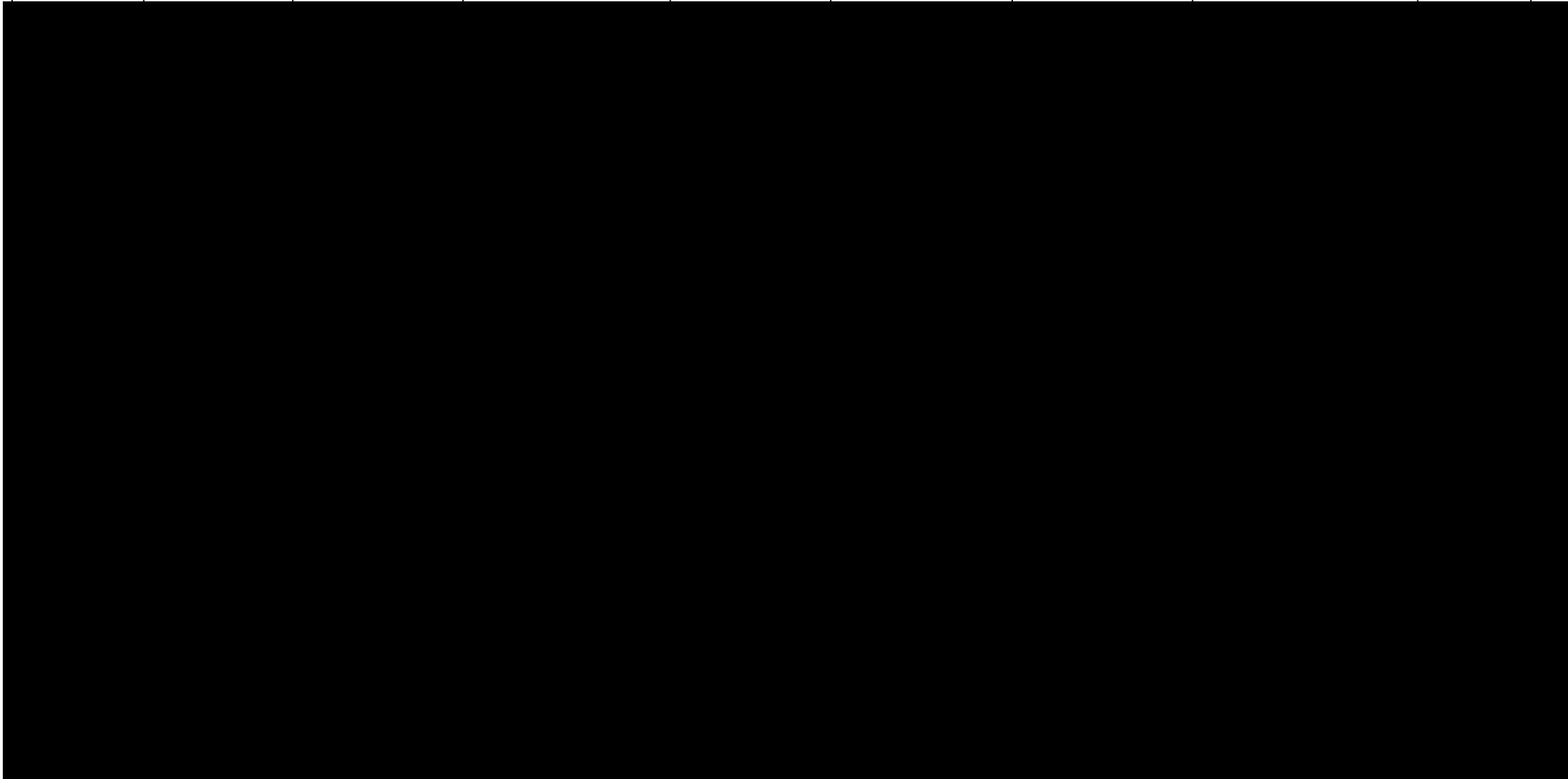


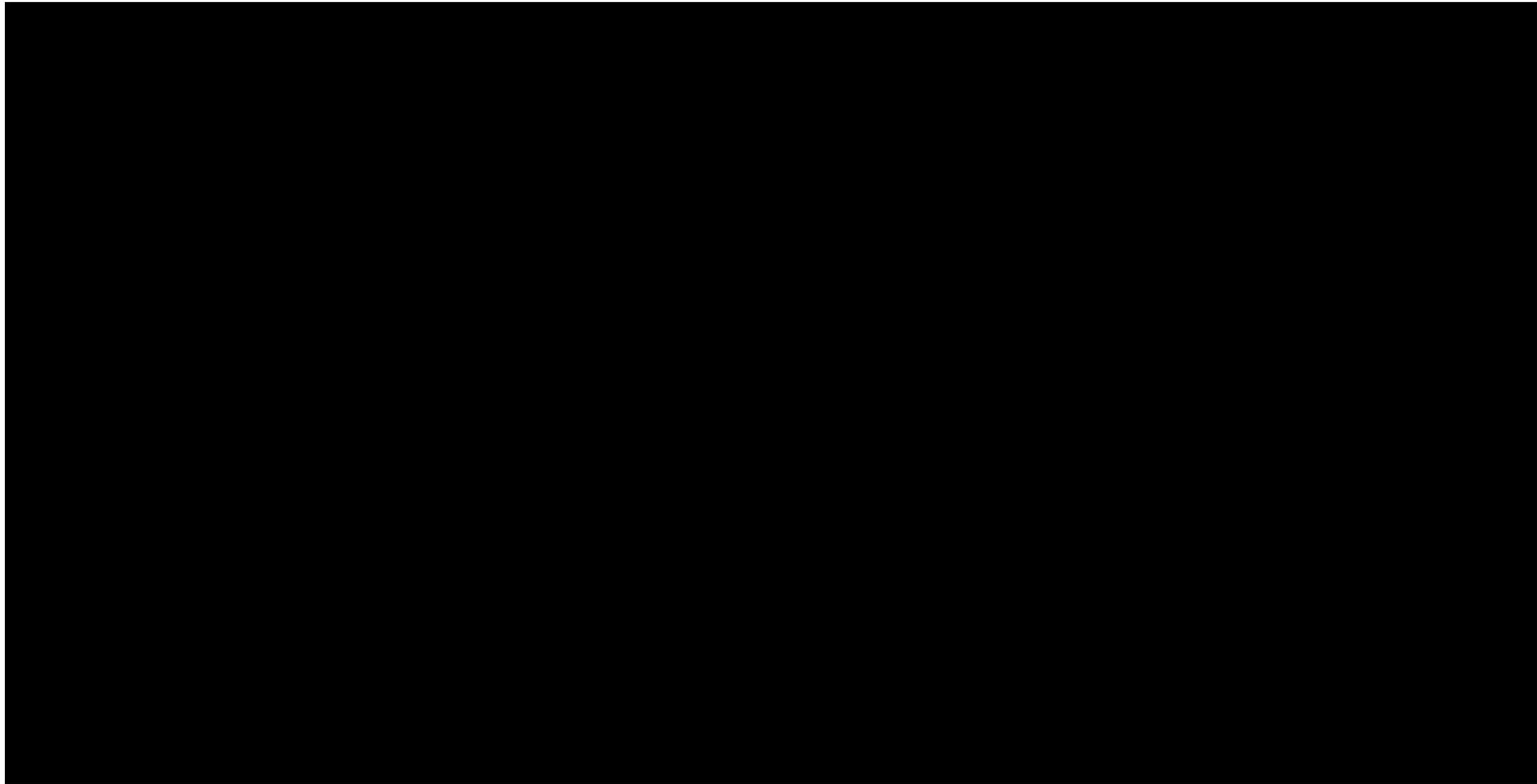
Figure 1; Attendance rates at Sexual Health Services per resident population a) in Shropshire

commercial info

Table 1; Details of current locations for provision of integrated sexual health services

Location	Property	Address	Description	Formal occupancy agreement	Details of agreement	2014/15 estates charges	Days of use	Current Provider
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In 2014/15, there were 9,242 attendances at sexual health services by 6,350 patients. These were grouped into 7,893 episodes of care, whilst 64.5 percent were new appointments and 35.5 percent were follow-up appointments. 81.2 percent of attendances were level 1 or 2 sexual health attendances, whilst 10.7 percent (961) were level 3 sexual health and 8.1 percent (730) were level 3 HIV attendances. In total 76.7 percent of attendances were walk-ins (6,572). Of the 8,990 attendances in the 2013/14 financial year there were 3,712 tests for STIs, with 1,087 diagnoses and 4,080 that dispensed contraceptives.

Of all attendances, 60.7 percent were by women. Numbers of attendances differ dramatically by age and gender (data from 2013/14 – Figure 2). The most common age group for women is 15 to 19 year olds, whilst for men was 20 to 24 years. Aged younger than 45 years old, women attended more than men, whilst men attended more aged 45 years and over. Attendance rates were 30.4 per 1,000 resident population in Shropshire in 2013-14. Attendance rates vary geographically (Figure 1).

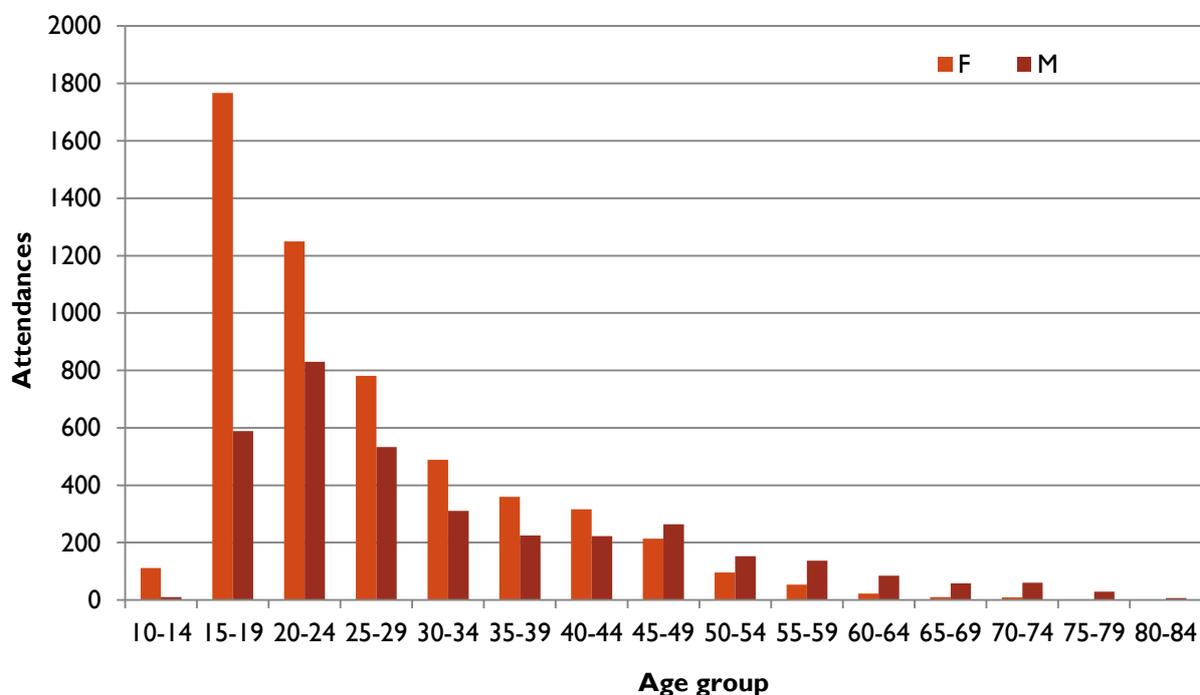


Figure 2; Sexual health services attendances in Shropshire in the 2013-14 financial year by age and gender

Psychosexual services are offered at the hub of the sexual health services. In the 2014 to 2015 financial year there were 321 attendances from Shropshire residents in the psychosexual service. The none-attendance rate at this service was 3.1 percent over the year, although ranged from 0 to 15 percent in a month.

In addition to the HIV testing commissioned by Shropshire Council – for example in sexual health clinics – treatment and care for HIV are commissioned by NHS England. NHS England currently commissions the provider for sexual health services in Shropshire to provide HIV care, with SSOTP providing the service for Shropshire at their hub – notably

the specialist HIV clinic held at Severn Fields. There is currently a separate contract and service provider for outreach, support and counselling for HIV (see below).

Other services involved in sexual health, in addition to the ones discussed below, include:

All 43 general practices offer LARC prescribing in Shropshire. Forty-one general practices are signed up to an enhanced scheme for chlamydia testing and treatment, with payment per activity. Other STI testing in Shropshire general practice is offered in 41 of the 43 practices, although as described above, some practices report no activity.

- 42 of the 53 community pharmacies supplying emergency hormonal contraception
- Termination services, at the time of writing, are provided largely by one provider, with one consultation venue in Shrewsbury and early terminations provided in Welshpool in neighbouring Powys. Surgical abortions are offered in Chester and Cannock – as well as a number of locations in Birmingham; whilst a second provider delivers a small number of services to Shropshire residents at a Birmingham venue. At the time of writing, the commissioner of these services (Shropshire CCG) has the termination services out to tender.
- Relationship and sex education is provided through an enhanced programme called *Respect Yourself* by the Public Health, Healthy Child programme 5-19. The programme is widely adopted in Shropshire: 75 percent of primary schools are delivering summer 2015 and 19 out of the 21 secondary schools. *Respect Yourself* is provided by the Shropshire Public Health, Healthy Child 5-19 programme.
- The school nurses provide a range of services around, from health information and signposting for all; to universal access to some care; to more targeted complex interventions and safeguarding. The specific services offered depend on the school. Within sexual health the potential services include: information and advice in a confidential drop-in service; CDS registration & distribution (15 Schools in Shropshire); LARC provision and fitting (not currently used in any Shropshire school); emergency contraception; pregnancy testing; and chlamydia screening; and STI testing and treatment (not currently used in any Shropshire school). The school nurse service is provided by Shropshire Community Health NHS Trust, and commissioned by the Shropshire Public Health, Healthy Child programme.
- CHAT is a free, confidential service for young people, aged 11 to 19 years in Shropshire. It includes services in secondary schools, GP practices who display the CHAT logo, and some Youth Service buildings. It includes sexual health advice. CHAT is not a specific service, provided by a specific provider, but is an umbrella term for services
- Shropshire is covered by the Glade Sexual Assault Referral Centre (SARC) which covers the footprint of West Mercia Police. The Glade has two sites, with its Telford venue the primary source of support for the residents of Shropshire. Between November 2013 and October 2014 the Glade saw 35 clients with a Shropshire postcode. The SARC is commissioned by NHS England.

- In addition to the SARC there are other services available to victims of rape, sexual assault and other sexual abuse, notably the AXIS counselling service. These are provided by third sector and charity organisations.
- A multi-agency child sexual exploitation (CSE) panel operates, by Shropshire Council Children's Social Care and Police, is in operation to provide oversight of CSE cases and develop and implement appropriate responses to CSE.

SURE Chlamydia screening

The SURE screening programme is the local iteration of the national chlamydia screening programme in Shropshire. The programme offers postal testing, which can be accessed by phone, text message or from a range of venues (including pharmacies, school nurses, youth services and other outreach events); and testing at venues such as general practice of the SHSs. All data presented from here come from the SURE screening provider. In the 2013/14 financial year, 746 were screened in Shropshire with 76.3 percent female – this equates to 14.1 percent of the total chlamydia testing in the area. The population coverage from SURE alone is approximately 2.1 percent of the population aged 15 to 24 years old. Quarterly trends in the SURE activity show a constant rate of activity in Shropshire between 2012 and 2014. Of the tests received that were valid between, 7.1 percent were positive, with 2.6 percent of all tests void. Treatment rates of positive cases were 49 percent, with 92 percent of all partners notified and 36 percent treated, a large loss to follow up between partner notification and treatment. The SURE programme is provided by Telford & Wrekin Council public health, and commissioned by Shropshire Council public health.

CDS

As of March 1st 2015 there were 36 sites set up as registration centres for all young people (which also distribute condoms), including 27 general practices, the walk-in centre, 7 SHS venues and the Terence Higgins trust venue. Additionally 43 pharmacies (81.1% of the Shropshire pharmacies), three minor injury units and three housing projects were distribution points open to all young people. There are also closed venues which only provide registration and distribution to clients of the host service; these include 15 CHATs, the family nurse partnership in central Shropshire, Teenage Identified Midwives, Young People's Substance Misuse Team, 16+ Leaving Care Team, the Looked After Children's nurse, County Training, youth offending service, and learning mentors in 3 further education settings. The CDS is currently provided by Shropshire Public Health, Healthy Child programme, although will come under the responsibility of the new integrated sexual health service provider after the current recommissioning.

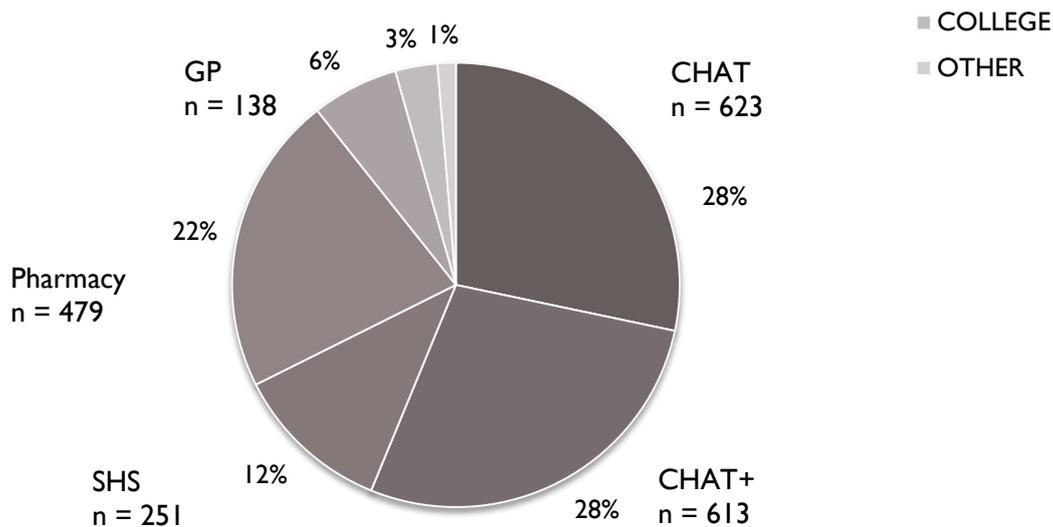


Figure 3; Service access to the condom distribution scheme in Shropshire (2013-14)

The 2013-14 annual report for the CDS in Shropshire collated data on the use and workload of the service. There were a total of 2,200 contacts with the service – a rise of 211 from the previous year. Forty-one percent were registrations, 57 percent repeat issues and 2 percent upgrading cards. Of the contacts with recorded age and sex, 70.0 percent were aged 15-17 years, with 26 visits in 13 year olds and 58.2 percent were female. Figure 3 shows where the CDS was accessed from in Shropshire. The majority of contacts were made through schools (28% through the CHAT programme – see below) and further education collages (28% through CHAT+ - this was the further education version of CHAT, now decommissioned in Shropshire). A large proportion was also through pharmacies, but relative few were through clinical settings, especially general practice.

HIV prevention, outreach and counselling

A large amount of HIV testing is commissioned alongside the integrated sexual health services, with the testing provided in the sexual health clinics at the seven sites across Shropshire. There is currently a separate contract and service provider for outreach, support and counselling for HIV. This service includes:

- One-to-one advice, information, case management and counselling for people living with HIV to support them in effective long term condition management
- Provision of outreach services BME communities with particular focus on African Communities and Eastern European Communities
- Provision of outreach services to MSM Communities
- Provision of outreach services to Sex Workers
- Distribution of condoms (including Condom Distribution Scheme) and Chlamydia screening
- Point of Care Testing
- Peer support
- Training of professionals

The current provider is Terence Higgins Trust, commissioned by Shropshire Council public health – although this will come under the responsibility of the new integrated sexual health service provider after the current recommissioning. THT provides HIV prevention, outreach and counselling out of their Shrewsbury base, outreach and campaigns delivered across the area. There are currently targets for the number of local outreach activities carried out every month and the number of clients seen at these events; the number of national or local health promotion campaigns delivered per year and for point-of – care testing clinic per week (with associated minimum tests per session). Service currently reach a range of venues, including night clubs and venues, especially in Shrewsbury, LGBT events, hair salons, markets, known public sex areas, housing providers, town centre sessions in Shrewsbury, hospital events, and an online presences (especially on media such as Grindr and Gaydar).

A summary of activity from the 2014/15 annual report shows:

One-to-one services for people living with HIV

In 2014/15 the provider of HIV Prevention and Support Service offered one-to-one support which could be summarised into the topics of family issues, health maintenance, hardship and emotional support. The service saw approximately 20 percent of its total clients in contact with the service every quarter, with a total of 46 interventions offered, with 18 counselling sessions.

Provision of outreach services BME communities

The provider offered 53 outreach sessions to BME groups (targeting Black African groups), with a total of 684 attendees at the sessions. They ran three health promotion campaigns for this group and one community testing clinic.

Provision of outreach services to MSM Communities

The provider offered 133 outreach sessions to MSM groups, with a total of 1866 people seen by the service (and safe ex promoted to). This covered four public sex areas; 2 MSM outreach venues; and electronic outreach on four web-based platforms.

Provision of outreach services to Sex Workers

In 2014/15 there were 6 outreach sessions for sex workers, with 32 individual contacts seen across the sessions.

Distribution of condoms, chlamydia screening and point-of-care testing (POCT)

The provider acted as both a registration and a distribution point for the condom distribution scheme in Shropshire, offering these at their service's base and distribution at the outreach venues and events that the service attended. The service registered 23 users and distributed approximately 5,600 condoms. The service ran 73 POCT sessions, conducting 56 HIV tests, 11 hepatitis B and 15 hepatitis C tests.

Volunteering Scheme and local training

There were 10-15 volunteers registered with the service in Shropshire in each quarter in 2014/15, with between 8 and 12 active. They offered 6 training sessions for local

professionals, with a total of 69 attendances; examples of training included an infection control study day and basic HIV training /information for Shropshire Mind.

Service	National Health Service Cervical Screening Programme – Opportunistic Sample Taker Services Outside of a GP Primary Care Setting.
Commissioner Lead	NHS England North Midlands
Provider Lead	
Period	

1.0. Aims and objectives

NHS England (the commissioner) on behalf of Public Health England (PHE) are responsible for commissioning and performance managing services to ensure that their populations are offered NHS screening programmes of high quality which meet national standards. NHS England on behalf of PHE have to ensure that services commissioned for NHS screening meets national quality and safety standards, local service requirements and values of the NHS.

This service specification has been adapted by the NHS England North Midlands Screening & Immunisation Teams (SIT) from the NHS England Yorkshire and Humber / Bassetlaw Health Partnership version. It should be read in conjunction with the current NHS Cervical Screening Programme (NHSCSP) guidance and recommendations. These can be found on the cancer screening website: www.cancerscreening.nhs.uk

This service specification should also be read in conjunction with the relevant Department of Health (DH) documents:

- Integrated Sexual Health Services: National Service Specification (DH, June 2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210726/Service_Specification_with_covering_note.pdf
- Commissioning Sexual Health services and interventions – *Best practice guidance for local authorities* (DH, March 2013):
<https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities>
- Sexual Health Services: key Principles for Cross Charging (DH, August 2013):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226325/Sexual_Health_Key_Principles_for_cross_charging.pdf

The aim of the NHSCSP is to reduce the incidence of and mortality from cervical cancer by delivering a systematic, quality assured population based screening programme for eligible women.

This will be achieved across the whole programme, as per the NHS England / DH National Service Specification No. 25 Cervical Screening (Dec 2014) by delivering evidence-based interventions that:

- Identify the eligible population and ensure efficient delivery with maximum coverage.
- Are safe, effective, of a high quality, equitable, externally and independently monitored and quality assured
- Lead to early detection of cervical abnormalities, appropriate subsequent treatment of cervical intraepithelial neoplasia (CIN) and improved outcomes.
- Are delivered in suitably equipped accommodation and supported by suitably trained competent and qualified clinical and non-clinical staff who, where relevant participate in recognised ongoing continuous medical education (CME), continuous professional development (CPD) and external quality assurance (EQA) schemes.
- Meet all published national standards.
- Have audit and failsafe embedded in the service.

1.1. Programme Information

All elements of the programme must operate strictly within existing published national guidance, including any updated or new documentation. See the NHS England / DH national service specification No. 25 Cervical Screening (Dec 2014) by clicking on link below:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383199/1516_No25_Cervical_Screening_Programme_FINAL.pdf

Further detailed information on the NHSCSP is available at www.cancerscreening.nhs.uk and www.csp.nhs.uk

1.2. General Overview

This specification outlines the commissioning arrangements for the NHSCSP at a primary care or acute hospital clinic level, but outside of a GP primary care setting (e.g. Contraceptive and Sexual Health Services (CaSH), Sexual Health Services (SHS), Integrated Sexual Health Services (ISHS) and Genital-Urinary Medicine (GUM) clinics to be delivered opportunistically by the provider.

1.3. Definition

Opportunistic cervical screening in CaSH / SHS / ISHS / GUM is where a visit to those services also includes cervical screening for non-attenders of the NHSCSP. This opportunistic offer will improve access to cervical screening for hard to reach or seldom seen women when attending for other examinations where their cervical screening is due, overdue or lapsed; it is not for routine cervical screening.

The specification:

- Identifies the quality standards appropriate to the NHSCSP and will provide a structure within which the recommendations of quality audits can be addressed.
- Stimulates providers to put forward proposals for improving services.
- Offers information to other commissioners of care and consumer organisations of the NHSCSP commissioned.
- Requires providers to comply with the compulsory service principles of the NHSCSP.

The specification is an integral part of the planning and delivery of services. As such, it is clearly linked to the local delivery plans of NHS England/PHE and the wider service specifications for screening programmes.

The specification should be viewed in conjunction with any separate provider specifications across the NHSCSP care pathway.

1.4. Expected Outcomes

- A reduction in the number of women who develop invasive cervical cancer and the number of women who die from invasive cancer.
- Early identification of abnormalities and rapid referral for further assessment and management within an appropriate clinical environment.
- Equity of access to all groups in society, minimising the adverse physical, psychological clinical aspects of screening (e.g. anxiety, unnecessary investigation).
- Submission of data to the relevant reporting bodies within the agreed timeframes.
- Maintenance of minimum standards, whilst aiming for achievable standards.

2.0. Service Scope

2.1. Service description

The provision of an opportunistic cervical screening service, as recommended by the NHSCSP to eligible women via CaSH / SHS / ISHS / GUM Services.

2.2. Accessibility / acceptability

The provider should be able to demonstrate what systems are in place to ensure equity of access to the service including timely and sufficient access to appropriately trained health professionals and follow up of women as appropriate.

The provider should be able to demonstrate how the (CaSH / SHS / ISHS / GUM) services are designed to ensure that there are no obstacles to access on the grounds of race, culture, physical or learning disabilities. Equality Impact Assessments undertaken by the provider to facilitate service improvements will be shared with the commissioner.

2.3. Whole system relationships & referral

The service is part of high quality NHSCSP provision for the eligible population within Staffordshire area, but it is also an integral part of national screening programmes for

England. The provider will need to work with other services (see interdependencies below) and the national office of the NHSCSP within PHE and with the UK National Screening Committee (UKNSC) to deliver national standard services.

The provider is required to adopt a whole system relationship throughout the service. This should include excellent and appropriate referral processes with failsafe mechanisms to ensure that women with abnormal cytology results are referred appropriately and where an inadequate or rejected cervical sample is notified, the woman is followed up appropriately by the provider and a repeat sample arranged for 3 months hence.

2.3.1. Direct referral with abnormal cervical screening results

Women with abnormal cervical screening results are referred to the local colposcopy unit directly by the cytology laboratory, unless the result report states otherwise.

2.3.2. Provider referral action required

The provider must initiate appropriate follow-up, treatment or referral after an abnormal result as follows:

- Where a result of cervical screening requires action beyond the NHSCSP, the provider must ensure it is acted upon. For example: When abnormal results require diagnostic assessment, management and/or follow-up within another service i.e. for suspected non-cervical cancer which can be detected inadvertently for endometrial cancer. Please note that in this scenario the woman will receive a normal cervical cytology result as the abnormality detected is not cervical.
- The direct lab referral to colposcopy for abnormal cervical cytology results also includes the urgent two-week-wait for suspected cervical cancer; the provider (CaSH / SHS / ISHS / GUM Services) is required to contact the woman for the result to be given on a personal basis. The GP should also be informed promptly that an urgent two-week-wait referral has been initiated and the woman should be made aware to expect this result and encouraged to attend.
- The laboratory operates a direct referral system for colposcopy in conjunction with the local colposcopy units, but the responsible clinician or cervical sample taker at CaSH / SHS / ISHS / GUM still has a responsibility to ensure that colposcopy appointment was attended or if the woman has declared her GP the responsible

clinician, the cervical sample taker should inform the woman's GP to follow up as appropriate.

- Ensure that arrangements for referral are made if a woman requests colposcopy at an alternative colposcopy unit.

The provider will ensure that the service is delivered in the context of other current national relevant guidelines, including:-

- Colposcopy and Programme Management: Guidelines for the NHS Cervical Screening Programme NHSCSP Publication 20 version 2, 2010 (For note these are currently under review)
<http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp20.pdf>
- Clinical Practice Guidance for the Assessment of Young Women aged 20-24 with Abnormal Vaginal Bleeding (DH, 2010):
<http://www.cancerscreening.nhs.uk/cervical/publications/doh-guidelines-young-women.pdf>
- Guidelines on Failsafe Actions for the Follow-up of Cervical Cytology Reports NHSCSP Publication 21, 2004.
<http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp21.pdf>

2.4. Interdependencies

The NHSCSP is dependent on strong functioning working relationships, both formal and informal, between primary care, the colposcopy service, the screening laboratory, diagnostics, and appropriate clinical services, including gynaecology and CaSH / SHS / ISHS / GUM. The provider will ensure that appropriate communication systems are in place to support an interagency approach to the quality of the services.

This will include, but is not limited to:

- Agreeing and documenting roles and responsibilities relating to all elements of the screening pathway across organisations to assure appropriate handover arrangements are in place between services.
- Providing strong clinical leadership and clear lines of accountability.
- Developing and participating in joint audit and monitoring processes.

- Agreeing jointly on what failsafe mechanisms are required to ensure safe and timely processes across the whole screening and management pathway.
- Compliance with the screening incident handling guidance developed by national office of the NHS CSP (see section 3.5. pages 11-12 for the incident documents and forms).
- Contributing to initiatives in screening pathway development in line with NHSCSP/UKNSC expectations.
- Facilitating, providing or supporting education and training both inside and outside the provider organisation.

Excellent communication between the laboratory and the provider is essential to ensure an effective NHSCSP.

This is to ensure that:

- Cervical samples are taken and sent within appropriate timescales to achieve a 14 day turnaround time (TAT).
- Batching of samples does not occur.
- Cervical sample test results are received and acted upon where appropriate by an appropriately trained individual, within the required timescales.
- Missing samples and / or results are identified and followed up.
- Unacceptable samples/forms are identified and followed up.

2.5. Relevant networks and screening programmes

The provider will ensure that there is appropriate internal clinical oversight of the service contributing to programme quality and development. The provider will participate in a care pathway group with appropriate membership from all elements of the care pathway, which should meet at least quarterly. Representatives from this group should also attend one of the commissioner led NHS England, North Midlands Cervical Screening Programme Board.

3.0. Service Delivery

3.1. Service model

The provider has a responsibility to deliver the service in accordance with NHSCSP and will:

- Ensure women are provided with the necessary information and advice to assist in making an informed choice about whether to participate or not in the NHSCSP.
- Ensure that all cervical sample takers within the service are appropriately trained in line with NHSCSP guidance:

INTERIM Good practice guidance for cervical sample takers - A reference guide for primary care and community settings in the NHS Cervical Screening Programme (NHSCSP Good practice guide No 2, July 2011)

<http://www.nwscgarc.org.uk/private/Good%20practice%20guidance%20for%20cervical%20sample%20takers.pdf>

Taking Samples for Cervical Screening Publication 23, April 2006:

<http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp23.html>

- Ensure that new starter staff in the service if required to offer cervical sampling, access and successfully complete the new sample taker two-day training course *Cervical Screening for Health Care Professionals*, which complies with NHSCSP Guidelines.
- Ensure that all cervical sample takers are registered on the Cervical Sample Taker Database (CSTD) or equivalent sample taker register and obtain a PIN from relevant Laboratory, NHS Shared Business Services or sample taker register provider.
- Ensure sample takers have their own individual sample taking code, participate in annual self-audit and complete a three yearly update session, either by attending a half-day face to face training event or by completing an accredited online e-learning package.
- Have a nominated Cervical Sample Taker Coordinator with administrative support (see pages 10-11 for details of the roles and responsibilities).

- Provide information about the test in relevant languages and in other formats as well as other health promotion materials, utilise interpreter services where appropriate.
- Maintain a register of cervical sample tests showing when the cervical sample was taken, when the result was received back from the laboratory and recorded on the CaSH / SHS / ISHS / GUM system records accordingly.
- Ensure that all cervical sample takers have access to Open Exeter and the results (e.g. paper copies of lab reports or via electronic pathology links where available) for all of the cervical samples taken.
- Support the follow-up of non-responders.
- Ensure that all women understand the importance of notifying their GP practice and the CaSH / SHS / ISHS / GUM service of any change of address.
- Ensure that arrangements are made for women who fall outside the routine call and recall system (e.g. temporary residents, HIV positive women having annual screening, women not registered with a GP and women requesting no correspondence to registered address) to be given their cervical sample test results.
- Contribute towards 14 day TAT e. g. timely sending of cervical samples to the laboratory via transport or pathology courier service.
- Ensure cervical samples are taken in an appropriate setting within the service
- Act on the non-responder notification from the colposcopy unit for women who have not attended an appointment following their colposcopy referral.
- Cooperate with failsafe enquiries about a woman who requires further investigation and treatment.
- Respond to failsafe enquiries by laboratory in a timely manner (within a maximum of two weeks).
- Ensure completion of or involvement in regular audits of cervical samples taken, including (but not exclusively) inadequate rates, abnormal rates, HMR101 request form completion error rates or mismatches between sample form and specimen.

This information is available through the CSTD, cytology laboratory or Screening & Immunisation Team.

- Respond to requests from Hospital Based Programme Coordinators (HBPC) to support the completion of the audit of screening history for those women who go onto develop cervical cancer (Cancer Research UK (CRUK) Invasive Cancer Audit).
- Participate in the wider management and development of the NHSCSP.
- Ensure processes are in place for the woman to be informed of her cervical sample test result, and appropriate follow-up recommended. The responsible clinician or cervical sample taker has a responsibility to check that all of the relevant information on the woman, including her address is up to date and entered correctly on the cervical sample test request form.
- The Open Exeter pre-populated electronic HMR101 request form (version 2009 A5 printed copy) should be used (where possible); the barcode is auto-read by the cytology lab service which minimises transcription errors and reduces the rejected sample rate.
- Provide counselling before and after the cervical sample test and to discuss all abnormal results if required.
- Ensure arrangements for the woman's GP to be notified of the cervical sample test result unless a woman attending a GUM clinic has requested anonymity.

3.2. Anonymity

Where a woman has requested anonymity at a CaSH / SHS / ISHS / GUM clinic the responsible clinician or sample taker must:

- Ensure that the cervical sample test result is followed up appropriately.
- Ensure that there is a system in place for notifying women of their cervical sample test results in writing.
- Refer the woman for further investigation and treatment when necessary
- Check that all cervical sample test results have been received for samples taken as part of the service.

3.2. Sample Taker Coordinator

Within each clinic/department delivering the service there will be an appropriately trained individual responsible for all aspects of the cervical screening service referred to as a sample taker coordinator. Responsibilities will include communication with external parties in respect of the service, service performance and development of clinic / department guidelines (where applicable); monitoring sample taking competencies, management of patient safety concerns, incidents or serious incidents and failsafe systems; audit, data collection and workforce development.

In order to support other cervical sample takers the coordinator must be a current practising cervical sample taker with an adequate training history (>20 self-audited cervical screening samples per year for 3 years and attended a half-day face-face update training session in the last 3 years).

3.3. Cervical screening administrator

Within each clinic/department delivering the service there should be an appropriately trained individual responsible for all aspects of the service administration. Responsibilities should include Open Exeter access and coordination, laboratory failsafe letters and enquiries, call and recall enquiries, non-responder cards and in-house failsafe procedures. This individual's workload should be monitored by the Sample Taker Coordinator to ensure the completion of these tasks is undertaken in line with the NHSCSP guidelines.

3.4. Safety, confidentiality and safeguarding

The provider must ensure that all staff delivering any element of the service are aware of and comply with the relevant NHSCSP guidance together with the provider's safety, data protection, confidentiality and safeguarding policies which will reflect all appropriate legislation.

The provider will take prompt action where standards are lower than expected to identify the causes and improve the service, informing the commissioner and PHE QA Team (as applicable).

3.5. Patient safety concerns, incidents and serious incidents

A screening incident is any unintended or unexpected incident that could have or did lead to harm to one or more persons who are eligible for NHS screening, or to staff working in an NHS screening programme. It can affect populations as well as individuals and be the result of an actual or possible failure in the screening pathway, or of a problem at the interface between screening and the next stage of care.

Although the level of risk to an individual may be low, because of the large numbers of people offered screening, this may equate to a high corporate risk. It is important to ensure that there is a proportionate response based on an accurate investigation and assessment of the risk of harm.

Potential SIs or patient safety concerns in screening programmes should be investigated with the same level of priority as actual SIs. The decision whether an SI should be declared should be taken jointly by key stakeholders including the commissioner (informed by advice from experts) and the QA Team. In distinguishing between an incident and an SI consideration should be given to whether individuals, the public or staff would suffer unavoidable severe (e.g. permanent) harm or death if the problem is unresolved.

The provider must ensure that failsafe mechanisms are in place across the whole of the screening pathway and have a policy, which has been agreed with the commissioner, relating to defining and dealing with patient safety concerns, incidents and SIs.

When a potential or actual patient safety concern, incident or SI is identified the provider will comply with UKNSC, NHSCSP and NHS England incident management as outlined in the documents below:

- Managing Safety Incidents in NHS Screening Programmes – updated interim guidance (March 2015)
<https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes>
- **Screening incident assessment form:**
<http://www.screening.nhs.uk/getdata.php?id=18382>
- NHS England's Serious Incident Framework (April 2015)
<http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/>

- NHS England's Serious Incident Framework FAQs:
<http://www.england.nhs.uk/wp-content/uploads/2015/03/serious-incident-framwrk-15-16-fags-fin.pdf>

The provider will complete the NSC screening incident assessment form (see link above) within 5 days of a patient safety concern or incident and within 24 hours of an SI (actual or suspected). A copy should be sent to the regional Screening Quality Assurance Service (SQAS) and the local Screening & Immunisation Team (SIT) and the provider must give reasonable assistance to the commissioner in investigating and dealing with the SI.

3.6. Procedures and protocols

The provider will be able to demonstrate that written procedures and protocols are in place and adhered to, to ensure best practice is consistently applied for all elements of the service. This will include policy based on best practice for the care of women who have declined to take part in the NHSCSP (as described in section 4).

Where the provider undertakes the service on more than one site, they will ensure consistency of procedures and protocols across all sites, including policies for onward referral.

The provider will use nationally developed and agreed letters, leaflets and templates (as applicable).

3.7. Clinical and corporate governance

The provider should ensure that there is regular monitoring and audit of the service in line with national and regional guidance and standards.

3.8. User experience

The commissioner requires assurance that the service is accessible equitably to all groups within the eligible population.

The provider should be able to demonstrate they have processes in place to collect the views of the service users and for ensuring that these views inform service planning and delivery. User experience is important to the quality of healthcare and this applies to all elements of the NHSCSP. The provider will be required to act upon

any actions identified as part of that process specific to its service provision and will be able to demonstrate how user views have influenced service developments.

3.9. Premises and equipment

The provider will ensure that suitable premises and equipment are provided for the service and will have appropriate policies in place to ensure service sustainability. The provider should provide an environment that meets the expectation of NHSCSP guidance including:

- Appropriate national leaflets are available in the waiting area along with all cervical sample taking rooms.
- Adequate equipment for cervical sample taking should be available for all women.
- Availability of an assortment of speculum sizes.
- Provision of adequate stock management to ensure sufficient LBC kits are available and wastage is minimised.
- Adherence to national/regional/local policies for sterilisation and infection control.

The provider will ensure that appropriate IT systems and internet access are in place to support service delivery including audit and monitoring functions.

All cervical sample takers should use (where possible) the appropriate electronic HMR101 Open Exeter form (A5 version 2009 folded to display bar code on outside of double pocket sample bag) and to avoid use of staples on request forms. Gripper bags can be ordered from the usual consumable Pathology Supplies in the specific areas. These bags have a sealable pocket for the sample vial and a separate pocket for the form.

The provider will therefore require access to Open Exeter. There is a user guide available from NHS SBS or the local SIT plus telephone support for trainees. Where this is not currently in place the commissioner will advise how this can be facilitated.

4.0. Referral, access and acceptance criteria

4.1 Geographic coverage / boundaries

This is a universal screening programme and should be opportunistically offered to all eligible women whom are not accessing cervical screening via the routine NHSCSP.

4.2. Location(s) of service delivery

The provider will ensure accessible service provision for all eligible women while assuring that all locations fully comply with the policies, standards and guidelines referenced in this service specification. Consideration should be given to the public transport links and car parking facilities.

4.3. Days / hours of operation

The provider will ensure that days and hours of operation of the service are sufficient to meet the demand for the service within the timescales indicated in relevant standards and guidelines.

The provider should be able to demonstrate efficient and effective use of resources.

4.4. Screening criteria

All women between the ages of 24.5 and 65 are eligible for a free cervical screening test every 3 to 5 years and annually for women who are HIV positive.

- 25 years - first invitation (the first actual invitation will be at 24 ½ years)
- 25-49-invitation every 3 years
- 50-64-invitation every 5 years
- 65 plus - Only screen those who have not been screened since age 50 or have had recent abnormal tests

4.5. Routine call / recall

Eligible women registered with a GP are invited via the NHSCSP call and recall system.

4.6. Exclusion criteria

Women are normally excluded from the programme if:

- They are under the age of 24 ½ (unless they are already in the programme via a symptomatic / treatment pathway).
- The woman's next test is due when she is over 64, and she has a suitable normal screening history (these women are automatically ceased from the system).
- Aged 65 without ever attended for a test, but may request screening.
- Ceased from the programme at own request by returning a signed disclaimer to the call / recall office.
- They have no cervix (which should be recorded / documented).
- They are symptomatic and should be managed according to NHS guidance with the appropriate referral dependant on symptoms.
- They decline screening at a particular offer, or are non-responders to routine invitations, but this is a deferment of screening, the woman is not ceased from the programme and the next test due date will be moved forward the relevant screening interval (i.e. 1, 3 or 5 years depending on age and screening history). The woman should be informed that she may access screening at any time in the interim period.

5.0. Care obligations, information and consent

5.1. Care obligations.

Exclusion status only applies to the categories outlined in section 4.6 above. The provider will retain care obligations for the woman regardless of outcome of screening if the woman has requested anonymity or has asked for her GP not to be contacted.

Women participating in cervical screening should do so with the knowledge of the inherent benefits and disadvantages. This is to enable women to make an informed choice about whether or not to take up the offer of screening.

5.2. Information

Effective information and communication to women is crucial to reducing anxiety. All women, including those with special requirements, should be fully informed of the

choices regarding the NHSCSP and informed consent to screening recorded appropriately.

The provider will ensure that a trained interpreter is available during appointments for women whose functional language is not English, along with appropriate written information.

The provider will provide appropriate support for women with physical disabilities and ensure that women with learning disabilities are provided with easy read / DVD materials and support to enable them to understand all processes and results. These are available in different formats via the following links:

[http://www.easyhealth.org.uk/listing/cervical-screening-\(leaflets\)](http://www.easyhealth.org.uk/listing/cervical-screening-(leaflets))

<http://www.easyhealth.org.uk/sites/default/files/null/Having%20a%20smear%20test%20-%20What%20is%20it%20about%3F.pdf>

<http://www.jostrust.org.uk/videos/smear-test-film>

Where an abnormal result or diagnosis is identified appropriate further information should be provided. Information and resources are available via the following links to websites:

www.cancerscreening.nhs.uk

<http://www.easyhealth.org.uk/>

5.3. Consent

The provider will comply with NHSCSP guidance *Consent to Cancer Screening Publication Number 4 January 2009 second edition*. This guidance also offers information in respect of cancer screening for individuals who lack the mental capacity to consent. The guidance can be accessed via www.cancerscreening.nhs.uk or by clicking on the link below:

<http://www.cancerscreening.nhs.uk/publications/cs4.pdf>

6.0. Quality Requirements

6.1. Quality standards and quality assurance (QA)

To ensure full compliance with the NHSCSP guidance the provider will:

- The provider will be expected to fully engage in external QA measures and reviews (as applicable) including submission of QA review visit returns and all audits to the required timeframes detailed by the QA Team.
- Where recommendations for action have been made as a result of an external QA process, the provider will develop action plans with defined timescales and responsibilities in liaison with the commissioner and report on progress as requested.
- Deliver on a continuous basis a service that adheres to national policy guidance, quality standards and protocols for the NHSCSP.
- Ensure that all staff involved in the delivery of the service are involved in/participate (as applicable) QA activities including QA reviews and visits.
- Be required to act upon any actions identified as part of that QA process.
- Where national recommendations and core and/or developmental standards are not currently fully implemented the provider will be expected to indicate in service plans what changes and improvements will be made over the course of the duration of the service specification.
- Participate in the CRUK audit and review of Invasive Cancers.
- Work collaboratively to develop and improve the service based on evidence from national office of the Cancer Screening Programmes within PHE, DH audits and internal audits. This may include advice on human papilloma virus (HPV) Triage, Test of Cure (ToC) and future service developments e.g. Primary HPV screening. The algorithms for current HPV Triage and ToC pathways are available at the link below:

<http://www.cancerscreening.nhs.uk/cervical/hpv-triage-test-flowchart-201407.pdf>
- Strive to achieve or exceed the minimum standards set by the NHSCSP as part of the overall NHSCSP and with other partners across the care pathway.
- Ensure that all staff working in the service are familiar with the relevant current QA guidelines published by the NHSCSP.

- Ensure that all staff participate in the regional QA scheme. This includes the collection and review of data for QA purposes, co-operation with the relevant professional member of the SQAS Team, participation in quality QA visits (as applicable) and attendance (if appropriate) at meetings of the regional QA groups.
- Work in partnership with the commissioner and other partners across the care pathway including those undertaking national programme initiatives in order to achieve a seamless care pathway to maintain minimum standards and strive continually for excellence.
- Meet any other quality standards agreed with the commissioner.

6.2. Quality principles

The provider will be expected to adhere to the general governance and quality principles as described below:

6.2.1. Keeping patients safe

- Incident reporting.
- Serious incidents.
- Failsafe procedures.
- Health and safety.
- Insurance and liability.
- Ongoing risk management.

6.2.2. Clinical and cost effectiveness

- Quality indicators.
- Expectations of clinical audit participation.
- Effectiveness of reporting.

6.2.3. Governance

- Clinical/corporate governance expectations.
- Compliance with DH Policy Standards.
- Equality and human rights legislation.
- Staff experience surveying.
- Staff training and development expectations.
- Compliance with NHSCSP Standards.

- Compliance with NHSCSP/NHS Information Governance requirements relating to the confidentiality and disclosure of person identifiable information and system/information security.
- Equality and diversity as defined by the Equality Act 2010.

6.2.4. Patient Experience and Engagement

- Dignity and respect expectations.
- Public and patient engagement expectations.
- Confidentiality.
- User involvement, experience and complaints.

6.2.5. External Reporting Requirements

- Expected clinical governance arrangements.
- Clinical audit.

7.0. Performance and monitoring arrangements

The provider will:

- Complete / submit national data collection as required
- Provide reports on activity including statistical activity as requested by the commissioner, the national office of the Cancer Screening Programmes within PHE, the QA Team within PHE or the laboratory provider.
- Provide a quarterly report on the above standards to the commissioner on dates as agreed.
- Include in the quarterly report a general update on service provision and issues affecting the service provision

7.1. Key Performance Indicators (KPI)

In addition to the required information outlined previously, the commissioner requires the KPI data below to be reported quarterly. This is in addition to any minimum KPIs that may be defined nationally. KPIs will be reviewed annually to ensure they reflect the requirements of the NHSCSP. Performance reports may be required quarterly or annually as determined by the commissioner and may be available at different population levels (e.g. by GP Practice / SIT).

7.2. KPI data requirement:

- Number of eligible women offered cervical screening as part of their initial or ongoing CaSH / SHS / ISHS / GUM care management
- Number and % of women who take up the offer
- Number and % of women who decline the offer
- Number of cervical samples taken by each of the cervical sample takers within the service by sample taker code
- Number of complaints
- Number of incidents/details of each incident
- Patient engagement activity and details of that activity

7.3. Workforce / professional standards & training

The provider will:

- Ensure the provision of a range of clinical and administration support staff appropriate for the safe and effective delivery of the service in line with NHSCSP guidance.
- Ensure that sufficient numbers of staff are available to deliver the service in accordance with this service specification in times of holidays, absences, anticipated demand and actual peaks in demand.
- Be involved in regular multi-disciplinary meetings led by the commissioner to review the performance against the NHSCSP standards together.
- Ensure that all staff participate in an annual personal development review process. Part of which will be the identification of specific training needs. Regular training and updating of skills and knowledge are vital to the success of the service.
- Ensure access and equity issues are addressed; all staff should participate in relevant training particularly for 'seldom seen' or 'hard to reach' groups including BME communities.
- Ensure training provision applies to all staff groups and a service training budget should always be accessible.

- Be able to show evidence of workforce development in year, as requested by the commissioner and will have a workforce plan in place designed to maintain a sustainable service.
- Ensure that all clinical and administrative staff working in the service attend appropriate training courses and receive update training as appropriate.
- Ensure that all staff undertaking cervical screening have successfully completed accredited training, are trained in the appropriate technique (e.g. ThinPrep or SurePath) and are up to date in accordance with national and regional requirements. Evidence of which must be submitted to the commissioner, QA and/or sample taker register holder as requested.
- Ensure that all professional staff delivering the service are registered with appropriate professional bodies, adhere to professional codes of practice/standards (including the need to undertake a recommended minimum of 20 cervical samples per year) to monitor and audit their personal practice.
- Ensure that all cervical sample takers undertake an update training session every 3 years in line with the regional and national guidance.
- Support attendance of staff at local, regional or national training and development events relating to NHSCSP.
- Ensure that all cervical sample takers review and maintain their inadequate / rejected sample rate record. The Sample Taker Co-ordinator should regularly review records of all cervical sample takers within their clinic/department to ensure that training is up to date and performance is being reviewed.
- The national office of the Cancer Screening Programmes within PHE supports health professionals in their endeavour to meet the standards of the NHSCSP and deliver a high quality service. A number of resources to support health professionals are available on the NHSCSP website:
www.cancerscreening.nhs.uk

7.4. Failsafe

The provider is expected to adhere to the relevant NHSCSP guidance, standards and recommendations in respect of failsafe as outlined in *Guidelines on Failsafe Actions for the Follow-up of Cervical Cytology Reports NHSCSP Publication Number 21* (NHSCSP Dec 2004):

<http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp21.pdf>

The provider will ensure that there is a clear and appropriate care pathway for such women to ensure that they are not lost to follow up.

7.5. Performance

The provider will:

- Participate in the regional audits undertaken by the QA Team including annual audit and patient satisfaction questionnaire.
- Accept responsibility for monitoring and validating the activity data on behalf of the commissioner.
- The provider will produce/publish an Annual Report of its activities and submit to the commissioner.
- After considering the Annual Report the commissioner will identify issues for discussion at a relevant review, the dates of which to be agreed with the commissioner.
- Monitoring arrangements will be expected to comply with clinical governance requirements.
- The provider will be monitored against the latest NHSCSP standards and the standards set out in this service specification.
- The provider may also be monitored by the regional PHE QA Team on behalf of the commissioners. Monitoring data may be collected by the PHE QA Team which will provide reports to commissioners at agreed intervals for the purposes of benchmarking the service with other comparable services.
- A copy of this service specification and any subsequent amendments will be made available to the PHE QA Team on request.

7.6 Information management and technology

The provider will:

- Use the NHSCSP IT systems to capture key screening data/outcomes promptly and accurately, supporting local and national QA cancer registration processes and NHSCSP evaluation.
- Ensure the provision of a high quality Information Management and Technology (IM&T) system to support all elements of the NHSCSP. This will include all computer hardware, software, networking, training supporting and maintenance necessary to support the effective delivery of the specified services.

The provider must ensure their IM&T systems comply with the following standards:

- NHS Terminology Service, NHS Classifications Service and Healthcare Resources Groupings.
- Information Governance and Security.
- Have an IM&T disaster recovery plan to ensure service continuity and prompt restoration of all IM&T systems in the event of a major system disruption or disaster. No failure of any subcontractor supplying IM&T services or infrastructure will relieve the provider of their responsibility for delivering services.
- Have a detailed business continuity plans to ensure and manage the continuity of the service, in the event of any significant disruption whether major or minor, in addition to Disaster Recovery Plans.
- Provide such IM&T Systems infrastructure as is necessary to support the delivery of the specified services, contract management and business processes.
- Have a nominated data quality lead and agree to abide by the data quality standards as agreed with the commissioner.

- Comply with the National Patient Safety Agency Safer Practice Notice NPSA/2008/SPN001 'Risk to patient safety of not using the NHS number as the national identifier for all patients'. In particular the provider must use the NHS Number as the national patient identifier; OR the NHS Number as the national patient identifier in conjunction with a local numbering system.
- Comply with all elements in respect of data protection and confidentiality.
- Undertake audits as required to ensure data quality, consistency and accuracy.
- Ensure all patient related information flows are electronic.

8.0. Activity

N/A

9.0. Prices and costs

N/A

**2013/14
PUBLIC HEALTH SERVICES CONTRACT**

**SHROPSHIRE COUNCIL (1)
AS AUTHORITY**

AND

**CONTRACT FOR THE
PROVISION OF PUBLIC HEALTH SERVICES**

**2013/14
PUBLIC HEALTH SERVICES CONTRACT**

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SECTION A
THE PARTICULARS

**2013/14
PUBLIC HEALTH SERVICES CONTRACT**

This Contract is made on

2014

PARTIES

- (1) **SHROPSHIRE COUNCIL** of Shirehall, Abbey Foregate, Shrewsbury, Shropshire SY2 6ND (the **Authority**); and
- (2) [xxxxxxxxxxxxxx] a company incorporated in England and Wales under company number [xxxxxxxxxxxxxx] and whose registered office is at [xxxxxxxxxxxxxx] (the **Provider**).

BACKGROUND

- (A) The Authority must exercise a number of health service functions set out in section 2B of the NHS Act 2006 and the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations. In order to satisfy these obligations the Authority wishes to secure the provision of the Services and the Provider wishes to provide the Services.
- (B) The Parties have agreed for the Provider to provide the Services in accordance with the terms and conditions of this Contract.

IT IS AGREED

A1. CONTRACT

A1.1. This Contract comprises of:

- a) these Particulars (Section A);
- b) the General Terms and Conditions (the **General Conditions**) (Section B); and
- c) the Special Terms and Conditions (the **Special Conditions**) (Section C), where any such terms have been agreed,

as completed and agreed by the Parties and as varied from time to time in accordance with clause B22 (*Variations*) of the General Conditions (this **Contract**).

A2. INTERPRETATION

A2.1. This Contract shall be interpreted in accordance with Appendix O (*Definitions and Interpretation*), unless the context requires otherwise.

A2.2. If there is any conflict or inconsistency between the provisions of this Contract, such conflict or inconsistency must be resolved according to the following order of priority:

- a) Section C;
- b) Section B; and
- c) Section A.

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A3. COMMENCEMENT AND DURATION

- A3.1. This Contract shall take effect on the date it is executed by or on behalf of the Parties (the **Commencement Date**).
- A3.2. The Provider shall, subject to having satisfied the Conditions Precedent where applicable, provide the Services from [xxxxxxxxxxxx] (the **Service Commencement Date**).
- A3.3. This Contract shall expire automatically on [xxxxxxxxxxxx] (the **Initial Expiry Date**), unless it is extended or terminated earlier in accordance with the provisions of this Contract.
- A3.4. It is agreed between the Parties that the Authority may extend this Contract at the expiry of the Initial Term for further periods of twelve months up to a maximum of two extensions from the Initial Expiry Date.
- A3.5. If the Authority decides to extend the Initial Term it shall notify the Provider in writing at least 3 months in advance of the expiry date of the Initial Term. Where such notification is given under this sub-clause A3.5 the definitions of Initial Expiry Date and Initial Term shall be deemed to be amended to reflect the extension to the Initial Term.
- A3.6. If the Authority decides that it does not wish to extend the Contract then this Agreement shall terminate on the Initial Expiry Date and the provisions of B33 (Consequences of Expiry or Termination) shall apply.

A4. REPRESENTATIVES

- A4.1. The person set out below is authorised from the Commencement Date to act on behalf of the Authority on all matters relating to this Contract (the **Authority Representative**).

Name:
Title:
Contact Details:

- A4.2. The person set out below is authorised from the Commencement Date to act on behalf of the Provider on all matters relating to this Contract (the **Provider Representative**).

Name:
Title:
Contact Details

- A4.3. The Provider may replace the Provider Representative and the Authority may replace the Authority Representative at any time by giving written notice to the other Party.

A5. NOTICES

- A5.1. Any notices given under this Contract shall be in writing and shall be served by hand or post by sending the same to the address for the relevant Party set out in clause A5.3.

- A5.2. Notices:

- a) by post and correctly addressed shall be effective upon the earlier of actual receipt, or 5 Business Days after mailing; or
- b) by hand shall be effective upon delivery.

- A5.3. For the purposes of clause A5.2, the address for service of notices on each Party shall be as follows:

- a) For the Authority:

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A5.4.

Address: The Shirehall, Abbey Foregate, Shrewsbury, Shropshire SY2 6ND
For the attention of:
Tel:

b) For the Provider:
Address:]

For the attention of:
Tel:

A5.4. Either Party may change its address for service by serving a notice in accordance with this clause A5.

A6. ENTIRE CONTRACT

This Contract constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Contract, except for any contract entered into between the Authority and the Provider which relates to the same or similar services to the Services and is designed to remain effective until the Services are provided under this Contract.

A7. COUNTERPARTS

This Contract may be executed in counterparts each of which when executed and delivered shall constitute an original but all counterparts together shall constitute one and the same instrument. No counterpart shall be effective until each Party has executed at least one counterpart.

IN WITNESS WHEREOF the Parties have signed this Contract on the date shown below

**SIGNED by and on behalf of
the AUTHORITY**

**Claire Porter
Name**

.....
Signature - Head of Legal and Democratic Services

.....
Date

**Tim Collard/Helen Powell
Name**

.....
Signature - Legal Services Manager

.....
Date

2013/14
PUBLIC HEALTH SERVICES CONTRACT

SIGNED by and on behalf of
the PROVIDER

.....Director

.....(Print Name)

.....Director/Company
Secretary

.....(Print Name)

.....
Date

DRAFT

**2013/14
PUBLIC HEALTH SERVICES CONTRACT**

**SECTION B
GENERAL TERMS AND CONDITIONS**

DRAFT

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B1. SERVICES

- B1.1. The Provider shall provide the Services in accordance with the Service Specification(s) in Appendix A (*Service Specifications*), including any service limitations set out in them, and in accordance with the provisions of this Contract.
- B1.2. The Provider shall satisfy any Conditions Precedent set out in Appendix B (*Conditions Precedent*) prior to commencing provision of the Services.

B2. WITHHOLDING AND/OR DISCONTINUATION OF SERVICE

- B2.1. Except where required by the Law, the Provider shall not be required to provide or to continue to provide Services to any Service User:
- a) who in the reasonable professional opinion of the Provider is unsuitable to receive the relevant Service, for as long as such unsuitability remains;
 - b) who displays abusive, violent or threatening behaviour unacceptable to the Provider acting reasonably and taking into account the mental health of that Service User);
 - c) in that Service User's domiciliary care setting or circumstances (as applicable) where that environment poses a level of risk to the Staff engaged in the delivery of the relevant Service that the Provider reasonably considers to be unacceptable; or
 - d) where expressly instructed not to do so by an emergency service provider who has authority to give such instruction, for so long as that instruction applies.
- B2.2. If the Provider proposes not to provide or to stop providing a Service to any Service User under clause B2.1:
- a) where reasonably possible, the Provider must explain to the Service User, taking into account any communication or language needs, the action that it is taking, when that action takes effect, and the reasons for it (confirming that explanation in writing within 2 Business Days);
 - b) the Provider must tell the Service User of the right to challenge the Provider's decision through the Provider's complaints procedure and how to do so;
 - c) the Provider must inform the Authority in writing without delay and wherever possible in advance of taking such action;

provided that nothing in this clause B2.2 entitles the Provider not to provide or to stop providing the Services where to do so would be contrary to the Law.

B3. SERVICE AND QUALITY OUTCOMES INDICATORS

- B3.1. The Provider must carry out the Services in accordance with the Law and Good Clinical Practice and must, unless otherwise agreed (subject to the Law) with the Authority in writing:
- a) comply, where applicable, with the registration and regulatory compliance guidance of CQC and any other Regulatory Body;
 - b) respond, where applicable, to all requirements and enforcement actions issued from time to time by CQC or any other Regulatory Body;
 - c) consider and respond to the recommendations arising from any audit, death, Serious Incident report or Patient Safety Incident report;
 - d) comply with the recommendations issued from time to time by a Competent Body;

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- e) comply with the recommendations from time to time contained in guidance and appraisals issued by NICE;
- f) respond to any reports and recommendations made by Local HealthWatch; and
- g) comply with the Quality Outcomes Indicators set out in Appendix C (*Quality Outcomes Indicators*).

B4. SERVICE USER INVOLVEMENT

- B4.1. The Provider shall engage, liaise and communicate with Service Users, their Carers and Legal Guardians in an open and clear manner in accordance with the Law, Good Clinical Practice and their human rights.
- B4.2. As soon as reasonably practicable following any reasonable request from the Authority, the Provider must provide evidence to the Authority of the involvement of Service Users, Carers and Staff in the development of Services.
- B4.3. The Provider must carry out Service User surveys (and Carer surveys) and shall carry out any other surveys reasonably required by the Authority in relation to the Services. The form (if any), frequency and method of reporting such surveys must comply with the requirements set out in Appendix D (*Service User, Carer and Staff Surveys*) or as otherwise agreed between the Parties in writing from time to time.
- B4.4. The Provider must review and provide a written report to the Authority on the results of each survey carried out under clause B4.3 and identify any actions reasonably required to be taken by the Provider in response to the surveys. The Provider must implement such actions as soon as practicable. If required by the Authority, the Provider must publish the outcomes and actions taken in relation to such surveys.

B5. EQUITY OF ACCESS, EQUALITY AND NO DISCRIMINATION

- B5.1. The Parties must not discriminate between or against Service Users, on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other non-medical characteristics except as permitted by the Law.
- B5.2. The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, who do not speak, read or write English or who have communication difficulties (including without limitation hearing, oral or learning impairments).
- B5.3. In performing this Contract the Provider must comply with the Equality Act 2010 and have due regard to the obligations contemplated by section 149 of the Equality Act 2010 to:
 - a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by the Equality Act 2010;
 - b) advance equality of opportunity between persons who share a relevant protected characteristic (as defined in the Equality Act 2010) and persons who do not share it; and
 - c) foster good relations between persons who share a relevant protected characteristic (as defined in the Equality Act 2010) and persons who do not share it,

and for the avoidance of doubt this obligation shall apply whether or not the Provider is a public authority for the purposes of section 149 of the Equality Act 2010.

- B5.4. As soon as reasonably practicable following any reasonable request from the Authority, the Provider must provide the Authority with a plan detailing how it will comply with its obligations under clause B5.3.

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- B5.5 The Provider and any Sub-Contractor will take all reasonable steps to observe as far as possible the Codes of Practice produced by Equality and Human Rights Commission, which give practical guidance to Local Authorities on the elimination of discrimination.
- B5.6 In the event of any finding of unlawful discrimination being made against the Provider and any Sub-Contractor during the contract period, by any court or employment tribunal, or any adverse finding or formal investigation by the Equality and Human Rights Commission over the same period, the Provider and any Sub-Contractor shall inform the Authority of this finding and shall take appropriate steps to prevent repetition of the unlawful discrimination.
- B5.7 The Provider and any Sub-Contractor employed by the Provider will provide a copy of its policies to the Authority at any time upon request. In addition, the Authority may reasonably request other information from time to time for the purpose of assessing the Provider's compliance with the above conditions.
- B5.8. The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, who do not speak, read or write English or who have communication difficulties (including without limitation hearing, oral or learning impairments) whether by provision of a translation service or referral to an appropriate service provider.
- B5.9. The Provider must provide to the Authority as soon as reasonably practicable, any information that the Authority reasonably requires to:
- a) monitor the equity of access to the Services; and
 - b) fulfil their obligations under the Law.

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B6. MANAGING ACTIVITY

B6.1. The Provider must manage Activity in accordance with any activity planning assumptions and any caseloads set out in a Service Specification and must comply with all reasonable requests of the Authority to assist it with understanding and managing the levels of Activity for the Services.

B7. STAFF

B7.1. At all times, the Provider must ensure that:

- a) each of the Staff is suitably qualified and experienced, adequately trained and capable of providing the applicable Services in respect of which they are engaged;
- b) there is an adequate number of Staff to provide the Services properly in accordance with the provisions of the applicable Service Specification;
- c) where applicable, Staff are registered with the appropriate professional regulatory body; and
- d) Staff are aware of and respect equality and human rights of colleagues and Service Users.
- e) it can provide a clear DBS Certificate (Standard, Enhanced or Enhanced and DBS Barred List at the Provider's discretion) for each of the Staff engaged in the Services

B7.2. If requested by the Authority, the Provider shall as soon as practicable and by no later than 20 Business Days following receipt of that request, provide the Authority with evidence of the Provider's compliance with clause B7.1.

B7.3. The Provider must have in place systems for seeking and recording specialist professional advice and must ensure that every member of Staff involved in the provision of the Services receives:

- a) proper and sufficient continuous professional and personal development, training and instruction; and
- b) full and detailed appraisal (in terms of performance and on-going education and training),

each in accordance with Good Clinical Practice and the standards of any applicable relevant professional body.

B7.4. Where applicable under section 1(F)(1) of the NHS Act 2006, the Provider must co-operate with and provide support to the Local Education and Training Boards and/or Health Education England to help them secure an effective system for the planning and delivery of education and training.

B7.5. The Provider must carry out Staff surveys in relation to the Services at intervals and in the form set out in Appendix D (*Service User, Carer and Staff Surveys*) or as otherwise agreed in writing from time to time.

B7.6. Subject to clause B7.7, before the Provider engages or employs any person in the provision of the Services, or in any activity related to, or connected with, the provision of the Services, the Provider must without limitation, complete:

- a) the Employment Checks; and
- b) such other checks as required by the DBS.

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- B7.7. Subject to clause B7.8, the Provider may engage a person in a Standard DBS Position or an Enhanced DBS Position (as applicable) pending the receipt of the Standard DBS Check or Enhanced DBS Check or Enhanced DBS & Barred List Check (as appropriate) with the agreement of the Authority.
- B7.8. Where clause B7.7 applies, the Provider will ensure that until the Standard DBS Check or Enhanced DBS Check or Enhanced DBS & Barred List Check (as appropriate) is obtained, the following safeguards will be put in place:
- a) an appropriately qualified and experienced member of Staff is appointed to supervise the new member of Staff; and
 - b) wherever it is possible, this supervisor is on duty at the same time as the new member of Staff, or is available to be consulted; and
 - c) the new member of Staff is accompanied at all times by another member of staff, preferably the appointed supervisor, whilst providing services under this Contract; and
 - d) any other reasonable requirement of the Authority.
- B7.9. Where the Authority has notified the Provider that it intends to tender or retender any of the Services, the Provider must on written request of the Authority and in any event within 20 Business Days of that request (unless otherwise agreed in writing), provide the Authority with all reasonably requested information on the Staff engaged in the provision of the relevant Services to be tendered or retendered that may be subject to TUPE.
- B7.10. The Provider shall indemnify and keep indemnified the Authority and any Successor Provider against any Losses incurred by the Authority and/or the Successor Provider in connection with any claim or demand by any transferring employee under TUPE.
- B7.11. The Parties agree that the provisions of Section C (TUPE) shall apply to any Relevant Transfer of staff under this Contract

B8. CHARGES AND PAYMENT

- B8.1. Subject to any provision of this Contract to the contrary (including without limitation those relating to withholding and/or retention), in consideration for the provision of the Services in accordance with the terms of this Contract, the Authority shall pay the Provider the Charges.
- B8.2. The Parties shall to the extent reasonably practicable agree the Charges in a transparent and equitable manner and the Charges shall be set out at Appendix E (*Charges*).
- B8.3. The Provider shall invoice the Authority in arrears for payment of the Charges on a quarterly basis or such other frequency agreed between the Parties in writing) which the Authority shall pay within 30 Business Days of receipt.. In the event of late payment, interest thereon shall be charged at 4% above the base rate of National Westminster Bank further to the Late Payment of Commercial Debts (Interest) Act 1998. Such interest shall accrue on a daily basis from the due date until actual payment of the overdue amount, whether before or after Judgement.
- B8.4. The Charges are stated exclusive of VAT, which shall be added at the prevailing rate as applicable and paid by the Authority following delivery of a valid VAT invoice.
- B8.5. In its performance of this Contract the Provider shall not provide or offer to a Service User any clinical or medical services for which any charges would be payable by the Service User (other than in accordance with this Contract, the Law and/or Guidance).

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- B8.6. If a Party, acting in good faith, contests all or any part of any payment calculated in accordance with this clause B8:
- a) the contesting Party shall within 5 Business Days notify the other Party, setting out in reasonable detail the reasons for contesting the requested payment, and in particular identifying which elements are contested and which are not contested;
 - b) any uncontested amount shall be paid in accordance with this Contract.
- B8.7. If a Party contests a payment under clause B8.6 and the Parties have not resolved the matter within 20 Business Days of the date of notification under clause B8.6, the contesting Party may refer the matter to dispute resolution under clause B30 (*Dispute Resolution*) and following the resolution of any dispute referred to dispute resolution, where applicable the relevant party shall pay any amount agreed or determined to be payable in accordance with clause B8.3.
- B8.8. Subject to any express provision of this Contract to the contrary each Party shall be entitled, without prejudice to any other right or remedy it has under this Contract, to receive interest at the Default Interest Rate on any payment not made from the day after the date on which payment was due up to and including the date of payment.
- B8.9. Each Party may retain or set off any sums owed to the other Party which have fallen due and payable against any sum due to the other Party under this Contract or any other agreement between the Parties.

B9. SERVICE IMPROVEMENTS AND BEST VALUE DUTY

- B9.1. The Provider must to the extent reasonably practicable co-operate with and assist the Authority in fulfilling its Best Value Duty.
- B9.2. In addition to the Provider's obligations under clause B9.1, where reasonably requested by the Authority, the Provider at its own cost shall participate in any relevant Best Value Duty reviews and/or benchmarking exercises (including without limitation providing information for such purposes) conducted by the Authority and shall assist the Authority with the preparation of any Best Value performance plans.
- B9.3. During the term of this Contract at the reasonable request of the Authority, the Provider must:
- a) demonstrate how it is going to secure continuous improvement in the way in which the Services are delivered having regard to a combination of economy, efficiency and effectiveness and the Parties may agree a continuous improvement plan for this purpose;
 - b) implement such improvements; and
 - c) where practicable following implementation of such improvements decrease the price to be paid by the Authority for the Services.
- B9.4. If requested by the Authority, the Provider must identify the improvements that have taken place in accordance with clause B9.3, by reference to any reasonable measurable criteria notified to the Provider by the Authority.

B10. SAFEGUARDING CHILDREN AND VULNERABLE ADULTS

- B10.1. The Provider shall adopt Safeguarding Policies and such policies shall comply with the Authority's safeguarding policy as amended from time to time and may be appended at Appendix F (*Safeguarding Policies*).

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- B10.2. At the reasonable written request of the Authority and by no later than 10 Business Days following receipt of such request, the Provider must provide evidence to the Authority that it is addressing any safeguarding concerns.
- B10.3. If requested by the Authority, the Provider shall participate in the development of any local multi-agency safeguarding quality indicators and/or plan.
- B10.4. The Parties acknowledge that the Provider is a Regulated Activity Provider with ultimate responsibility for the management and control of the Regulated Activity provided under this Contract and for the purposes of the Safeguarding Vulnerable Groups Act 2006.
- B10.5. The Provider must fulfil its commitment to safeguard and promote the welfare of vulnerable adults and children and shall have the following in place:
- a) clear priorities for safeguarding and protecting vulnerable adults and children explicitly stated in strategic policy documents and Safeguarding Policies;
 - b) a clear commitment by the Provider's senior management to the importance of safeguarding and protecting vulnerable adults and children
 - c) a clear line of accountability within the Provider's organisation for overseeing safeguarding and protecting vulnerable adults and children and that roles and accountability for taking action and reporting internally and in accordance with the Authority's Multi Agency Adult Protection Policy and Procedure and Shropshire Safeguarding Children's Board Procedures are properly defined and understood by those involved
 - d) recruitment and human resources management procedures to take account of the need to safeguard and protect vulnerable adults including safe recruitment policies and practices and enhanced DBS checks for all Staff including agency staff students and volunteers working with vulnerable adults and children.
 - e) procedures for instigating the Authority's Multi Agency Adult Protection Policy and Shropshire Safeguarding Children's Board Procedures and for dealing with allegations of abuse against members of Staff and volunteers.
 - f) arrangements to ensure that all Staff receive supervision and undertake training in respect of safeguarding in order to equip them to carry out their safeguarding responsibilities effectively. Refresher training must be provided at regular intervals and all Staff including temporary Staff and volunteers who work with vulnerable adults and children must be made aware of the organisations arrangements for protecting vulnerable adults and children.
 - g) policies to safeguard and protect vulnerable adults and children and procedures that are in accordance with the Authority's Multi Agency Protection Policy and Shropshire Safeguarding Children's Board Procedures.
 - h) arrangements to work effectively with other organisations involved in the delivery of services to vulnerable adults and children in order to protect vulnerable adults and children including arrangements for sharing information.
 - i) a culture of listening to and engaging in dialogue with vulnerable adults and children in ways appropriate to their understanding and seeking their views and taking account of those views both in individual decisions and the establishment or development of services.
 - j) ensuring appropriate whistle blowing procedures are in place and there is a culture that enables issues about safeguarding and protecting vulnerable adults and children to be raised. A copy of the Authority's Speaking Up About Wrongdoing "Whistleblowing" Policy can be found on the Authority's website at www.shropshire.gov.uk.

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- B10.6. The Provider shall ensure that all policies required by the Authority are implemented in respect of the Services.
- B10.7. Where the Service or activity being undertaken in this Contract is a Regulated Activity the Service Provider shall:
- a) comply with the requirements of clause B7.6; and
 - b) monitor the level and validity of the checks under this clause B10.7 for each member of the Provider's Staff.
- B10.8. The Provider warrants that at all times for the purposes of this Contract it has no reason to believe that any person who is or will be employed or engaged by the Provider in the provision of a Service or activity that is a Regulated Activity is barred from the activity in accordance with the provisions of the Safeguarding Vulnerable Groups Act 2006 and any regulations made thereunder, as amended from time to time.
- B10.9. The Provider shall immediately notify the Authority of any information that it reasonably requests to enable it to be satisfied that the obligations of this clause have been met.
- B10.10. The Provider shall refer information about any person carrying out the Services or the activity to the DBS where it removes permission for such person to carry out the Services or activity (or would have, if such person had not otherwise ceased to carry out the Services or the activity) because, in its opinion, such person has harmed or poses a risk of harm to the Service Users, children or vulnerable adults.
- B10.11. The Provider shall not employ or use the services of any person who is barred from, or whose previous conduct or records indicate that he or she would not be suitable to carry out Regulated Activity or who may otherwise present a risk to Service Users.

B11. INCIDENTS REQUIRING REPORTING

- B11.1. If the Provider is CQC registered it shall comply with the requirements and arrangements for notification of deaths and other incidents to CQC in accordance with CQC Regulations and if the Provider is not CQC registered it shall notify Serious Incidents to any Regulatory Body as applicable, in accordance with the Law.
- B11.2. If the Provider gives a notification to the CQC or any other Regulatory Body under clause B11.1 which directly or indirectly concerns any Service User, the Provider must send a copy of it to the Authority within 5 Business Days or within the timescale set out in Appendix G (*Incidents Requiring Reporting Procedure*).
- B11.3. The Parties must comply with the arrangements for reporting, investigating, implementing and sharing the Lessons Learned from Serious Incidents, Patient Safety Incidents and non-Service User safety incidents that are agreed between the Provider and the Authority and set out in Appendix G (*Incidents Requiring Reporting Procedure*).
- B11.4. Subject to the Law, the Authority shall have complete discretion to use the information provided by the Provider under this clause B.11 and Appendix G (*Incidents Requiring Reporting Procedure*).

B12. CONSENT

- B12.1. The Provider must publish, maintain and operate a Service User consent policy which complies with Good Clinical Practice and the Law.

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B13. SERVICE USER HEALTH RECORDS

- B13.1. The Provider must create, maintain, store and retain Service User health records for all Service Users. The Provider must retain Service User health records for the periods of time required by Law and securely destroy them thereafter in accordance with any applicable Guidance.
- B13.2. The Provider must:
- a) use Service User health records solely for the execution of the Provider's obligations under this Contract; and
 - b) give each Service User full and accurate information regarding his/her treatment and Services received.
- B13.3. The Provider must at all times during the term of this Contract have a Caldicott Guardian and shall notify the Authority of their identity and contact details prior to the Service Commencement Date. If the Provider replaces its Caldicott Guardian at any time during the term of this Contract, it shall promptly notify the Authority of the identity and contact details of such replacements.
- B13.4. Subject to Guidance and where appropriate, the Service User Health Records should include the Service User's verified NHS number.
- B13.5. Where relevant and subject to compliance with the Law, the Provider shall at the reasonable request of the Authority promptly transfer or deliver a copy of the Service User health Record held by the Provider for any Service User for which the Authority is responsible to a third party provider of healthcare or social care services designated by the Authority.
- B13.6. The Provider undertakes to implement and maintain security standards, processes, procedures, practice and controls to the same standard which they apply to personal confidential identifiable data and in accordance with the 'Community Health Provider' NHS Information Governance Toolkit standards to a minimum of Level 2 compliance.

B14. INFORMATION

- B14.1. The Provider must provide the Authority the information specified in Appendix H (*Information Provision*) to measure the quality, quantity or otherwise of the Services.
- B14.2. The Provider must deliver the information required under clause B14.1 in the format, manner, frequency and timescales specified in Appendix H (*Information Provision*) and must ensure that the information is accurate and complete.
- B14.3. If the Provider fails to comply with any of the obligations in this clause B14 and/or Appendix H (*Information Provision*), the Authority may (without prejudice to any other rights it may have under this Contract) exercise any consequence for failing to satisfy the relevant obligation specified in Appendix H (*Information Provision*).
- B14.4. In addition to the information required under clause B14.1, the Authority may request from the Provider any other information it reasonably requires in relation to this Contract and the Provider must deliver such requested information in a timely manner.

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B15. EQUIPMENT

B15.1. The Provider must provide and maintain at its own cost (unless otherwise agreed in writing) all Equipment necessary for the supply of the Services in accordance with any required Consents and must ensure that all Equipment is fit for the purpose of providing the applicable Services.

B16. TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS

B16.1. The Provider must comply with any Transfer of and Discharge from Care Protocols agreed by the Parties set out in Appendix I (*Transfer of and Discharge from Care Protocols*).

B17. COMPLAINTS

B17.1. The Provider must at all times comply with the relevant regulations for complaints relating to the provision of the Services.

B17.2. If a complaint is received about the standard of the provision of the Services or about the manner in which any of the Services have been supplied or work has been performed or about the materials or procedures used or about any other matter connected with the performance of the Provider's obligations under this Contract, then the Authority may take any steps it considers reasonable in relation to that complaint, including investigating the complaint and discussing the complaint with the Provider, CQC or/and any Regulatory Body. Without prejudice to any other rights the Authority may have under this Contract, the Authority may, in its sole discretion, uphold the complaint and take any action specified in clause A.B28 (*Default and Failure to Supply*).

B18. SERVICE REVIEW

B18.1. The Provider must each of this Contract deliver to the Authority a Service Quality Performance Report against the factors set out in Appendix J (*Service Quality Performance Report*).

B18.2. The Provider must submit each Service Quality Performance Report in the form and manner specified in Appendix J (*Service Quality Performance Report*).

B19. REVIEW MEETINGS

B19.1. The Parties must review and discuss Service Quality Performance Reports and monitor performance of the Contract and consider any other matters reasonably required by either Party at Review Meetings which should be held in the form and intervals set out in Appendix K (*Details of Review Meetings*).

B19.2. Notwithstanding clause B19.1, if either the Authority or the Provider:

- a) reasonably considers a circumstance constitutes an emergency or otherwise requires immediate resolution; or
- b) considers that a JI Report requires consideration sooner than the next scheduled Review Meeting,

that Party may by notice require that a Review Meeting be held as soon as practicable and in any event within 5 Business Days following that notice.

B20. CO-OPERATION

B20.1. The Parties must at all times act in good faith towards each other.

B20.2. The Provider must co-operate fully and liaise appropriately with:

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- a) the Authority;
- b) any third party provider who the Service User may be transferred to or from the Provider;
- c) any third party provider which may be providing care to the Service User at the same time as the Provider's provision of the relevant Services to the Service User; and
- d) primary, secondary and social care services,

in order to:

- e) ensure that a consistently high standard of care for the Service User is at all times maintained;
- f) ensure a co-ordinated approach is taken to promoting the quality of Service User care across all pathways spanning more than one provider;
- g) achieve a continuation of the Services that avoids inconvenience to, or risk to the health and safety of, Service Users, employees of the Authority's or members of the public.

B21. WARRANTIES AND REPRESENTATIONS

B21.1. The Provider warrants and represents that:

- a) It has full capacity and authority to enter into this Contract and all necessary Consents have been obtained and are in full force and effect;
- b) its execution of this Contract does not and will not contravene or conflict with its constitution, any Law, or any agreement to which it is a party or which is binding on it or any of its assets;
- c) in entering this Contract it has not committed any Fraud;
- d) all reasonably material information supplied by it to the Authority during the award procedure leading to the execution of this Contract is, to its reasonable knowledge and belief, true and accurate and it is not aware of any material facts or circumstances which have not been disclosed to the Authority which would, if disclosed, be likely to have an adverse effect on a reasonable public sector entity's decision whether or not to contract with the Provider substantially on the terms of this Contract;
- e) to the best of its knowledge, nothing will have, or is likely to have, a material adverse effect on its ability to perform its obligations under this Contract;
- f) it has the right to permit disclosure and use of Confidential Information for the purpose of this Contract;
- g) in the 3 years prior to the Commencement Date:
 - (i) It has conducted all financial accounting and reporting activities in compliance in all material respects with the generally accepted accounting principles that apply to it in any country where it files accounts;
 - (ii) It has been in full compliance with all applicable securities and tax laws and regulations in the jurisdiction in which it is established; and
 - (iii) It has not done or omitted to do anything which could have a material adverse effect on its assets, financial condition or position as an ongoing business concern or its ability to fulfil its obligations under this Contract; and

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- h) No proceedings or other steps have been taken and not discharged (nor, to the best of its knowledge are threatened) for the winding up of the Provider or for its dissolution or for the appointment of a receiver, administrative receiver, liquidator, manager, administrator or similar officer in relation to any of the Provider's assets or revenue.
- i) the Provider warrants that the signing of this Contract on its behalf has been validly authorised and the obligations expressed as being assumed by the Provider under this Contract constitute valid legal and binding obligations of the Provider enforceable against the Provider in accordance with their terms.
- j) The Provider acknowledges and confirms that:
 - (i) it has had an opportunity to carry out a thorough due diligence exercise in relation to the Services and has asked the Authority all the questions it considers to be relevant for the purpose of establishing whether it is able to provide the Services in accordance with the terms of this Contract;
 - (ii) it has received all information requested by it from the Authority pursuant to sub-clause B.21.1j(i) to enable it to determine whether it is able to provide the Services in accordance with the terms of this Contract;
 - (iii) it has made and shall make its own enquiries to satisfy itself as to the accuracy and adequacy of any information supplied to it by or on behalf of the Authority pursuant to sub-clause B.21.1.j(ii);
 - (iv) it has raised all relevant due diligence questions with the Authority before the Commencement Date; and
 - (v) it has entered into this Contract in reliance on its own diligence
 - (vi) as at the Commencement Date, the Provider warrants and represents that all information contained in the Tender remains true, accurate and not misleading, save as may have been specifically disclosed in writing to the Authority prior to execution of the Contract AND shall promptly notify the Authority in writing if it becomes aware during the performance of this Contract of any inaccuracies in any information provided to it by the Authority during such due diligence which materially and adversely affects its ability to perform the Services
 - (vii) The Provider shall not be entitled to recover any additional costs from the Authority which arise from, or be relieved from any of its obligations as a result of, any matters or inaccuracies notified to the Authority by the Provider in accordance with sub-clause B.21.1.j.(vi) save where such additional costs or adverse effect on performance have been caused by the Provider having been provided with fundamentally misleading information by or on behalf of the Authority and the Provider could not reasonably have known that the information incorrect or misleading at the time such information was provided.

B21.2 The Provider agrees that where requested in writing during the term of this Contract it will ensure that an appropriately authorised representative of the Provider shall attend a Committee meeting of the Authority upon being invited to do so by the Authority

B21.3. The Authority warrants and represents that:

- a) it has full power and authority to enter into this Contract and all necessary approvals and consents have been obtained and are in full force and effect;
- b) its execution of this Contract does not and will not contravene or conflict with its constitution, any Law, or any agreement to which it is a party or which is binding on it;

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- c) it has the right to permit disclosure and use of Confidential Information for the purpose of this Contract; and
- d) to the best of its knowledge, nothing will have, or is likely to have, a material adverse effect on its ability to perform its obligations under this Contract.

B21.4. The warranties set out in this clause B21 are given on the Commencement Date and repeated on every day during the term of this Contract.

B22. VARIATIONS

B22.3. This Contract may not be amended or varied other than in accordance with this clause B22.

B22.4. Either Party may from time to time during the term of this Contract, by written notice to the other Party, request a Variation. A Variation Notice must set out in as much detail as is reasonably practicable the proposed Variation(s).

B22.5. If a Variation Notice is issued, the Authority and the Provider must enter into good faith negotiations for a period of not more than 30 Business Days from the date of that notice (unless such period is extended by the Parties in writing) with a view to reaching agreement on the proposed Variation, including on any adjustment to the Charges that, in all the circumstances, properly and fairly reflects the nature and extent of the proposed Variation. If the Parties are unable to agree a proposed Variation within such time period (or extended time period), the proposed Variation shall be deemed withdrawn and the Parties shall continue to perform their obligations under this Contract.

B22.6. No Variation to this Contract will be valid or of any effect unless agreed in writing by the Authority Representative (or his nominee) and the Provider Representative (or his nominee) in accordance with clause A5 (*Notices*). All agreed Variations shall form an addendum to this Contract and shall be recorded in Appendix L (*Agreed Variations*).

B23. ASSIGNMENT AND SUB-CONTRACTING

B23.3. The Provider must not assign, delegate, transfer, sub-contract, charge or otherwise dispose of all or any of its rights or obligations under this Contract without the Authority in writing:

- a) consenting to the appointment of the Sub-contractor (such consent not to be unreasonably withheld or delayed); and
- b) approving the Sub-contract arrangements (such approval not to be unreasonably withheld or delayed).

B23.4. The Authority's consent to sub-contracting under clause B23.1 will not relieve the Provider of its liability to the Authority for the proper performance of any of its obligations under this Contract and the Provider shall be responsible for the acts, defaults or neglect of any Sub-contractor, or its employees or agents in all respects as if they were the acts, defaults or neglect of the Provider.

B23.5. Any sub-contract submitted by the Provider to the Authority for approval of its terms, must impose obligations on the proposed sub-contractor in the same terms as those imposed on it pursuant to this Contract to the extent practicable.

B23.6. The Authority may assign, transfer, novate or otherwise dispose of any or all of its rights and obligations under this Contract without the consent of the Provider.

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B24. AUDIT AND INSPECTION

- B24.3. The Provider must comply with all reasonable written requests made by, CQC, the National Audit Office, any Authorised Person and the authorised representative of the Local HealthWatch for entry to the Provider's Premises and/or the premises of any Sub-contractor for the purposes of auditing, viewing, observing or inspecting such premises and/or the provision of the Services, and for information relating to the provision of the Services. The Provider may refuse such request to enter the Provider's Premises and/or the premises of any Sub-contractor where it would adversely affect the provision of the Services or, the privacy or dignity of a Service User.
- B24.4. Subject to Law and notwithstanding clause B24.1, an Authorised Person may enter the Provider's Premises and/or the premises of any Sub-contractor without notice for the purposes of auditing, viewing, observing or inspecting such premises and/or the provision of the Services. During such visits, subject to Law and Good Clinical Practice (also taking into consideration the nature of the Services and the effect of the visit on Service Users), the Provider must not restrict access and must give all reasonable assistance and provide all reasonable facilities to the Authorised Person.
- B24.5. Within 10 Business Days of the Authority's reasonable request, the Provider must send the Authority a verified copy of the results of any audit, evaluation, inspection, investigation or research in relation to the Services, or services of a similar nature to the Services delivered by the Provider, to which the Provider has access and which it can disclose in accordance with the Law.
- B24.6. The Authority shall use its reasonable endeavours to ensure that the conduct of any audit does not unreasonably disrupt the Provider or delay the provision of the Services.
- B24.7. During any audit undertaken under clause B24.1 or B24.2, the Provider must provide the Authority with all reasonable co-operation and assistance in relation to that audit, including:
- a) all reasonable information requested within the scope of the audit;
 - b) reasonable access to the Provider's Premises and/or the premises of any Sub-contractor; and
 - c) access to the Staff.

B25. INDEMNITIES

- B.25.1 The Provider shall indemnify the Authority against all liabilities, costs, expenses, damages and losses (including any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal and other reasonable professional costs and expenses) suffered or incurred by the Authority arising out of or in connection with:
- (a) The performance, defective performance or otherwise of this Contract by the Provider or its Staff
 - (b) Any claim made against the Authority for actual or alleged infringement of a third party's Intellectual Property Rights arising out of, or in connection with the provision of the Services
 - (c) Any claim made against the Authority by a third party arising out of, or in connection with, the supply of the Services, to the extent that such claim arises out of the breach, negligent performance or failure or delay in performance of this Contract by the Provider or the Staff; and

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- (d) Any claim made against the Authority by a third party for death, personal injury or damage to property arising out of, or in connection with the delivery of the Services and performance of this Contract to the extent that the defective performance is attributable to the acts or omissions of the Provider or the Staff

B.25.2 The Authority shall indemnify the Provider against all reasonable claims, costs and expenses which the Provider may incur and which arise, directly from the Authority's breach of any of its obligations under this Contract.

B.25.3 Nothing in this Contract shall limit or exclude the liability of either Party for:

- (a) death or personal injury resulting from negligence; or
- (b) fraud or fraudulent misrepresentation; or
- (c) the indemnities given in this clause B25

B26. LIMITATION OF LIABILITY

B26.1 Each Party must at all times take all reasonable steps to minimise and mitigate any Losses for which it is entitled to be indemnified by or bring a claim against the other Party pursuant to this Contract.

B27. INSURANCE

B27.1 The Provider shall effect and maintain with a reputable insurance company a policy or policies of insurance providing an adequate level of cover, or in accordance with any legal requirement for the time being in force, in respect of all legal liability which may be incurred by the Provider, arising out of the Provider's performance of this Contract, including death or personal injury, loss of or damage to property or any other loss, and unless otherwise agreed with the Authority such policy or policies of Public Liability and Employers Liability insurance shall provide for a minimum indemnity limit of **5MILLION POUNDS (£5000000.00)**

B27.2 If appropriate and requested in Writing, the Provider may also be required to provide Product Liability insurance of at least **10 MILLION POUNDS (£10,000000.00)** cover for any one claim.

B27.3 the Provider shall hold and maintain professional indemnity insurance cover and shall ensure that all professional consultants or Sub-Contractors involved in the provision of the Services hold and maintain policy cover which indemnifies the contractor for negligent acts arising out of the performance of this Contract. To comply with its obligations under this clause, and as a minimum, the Provider shall ensure professional indemnity insurance held by the Provider and by any agent, Sub-Contractor or consultant involved in the performance of Services has a limit of indemnity of not less than **5 MILLION POUNDS (£5000000.00)** in respect of each and every claim.

B27.4 The Provider shall hold and maintain the insurances required under this Contract for a minimum of 6 years following the expiration or earlier termination of this Contract

B27.5 The Provider warrants that it has complied with this clause B27 and shall provide the Authority with certified copies of the relevant policy documents (including any warranties or exclusions) together with receipts or other evidence of payment of the latest premiums due under those policies prior to the commencement of this Contract and annually thereafter throughout the duration of this Contract.

B27.6 The Provider shall:

- (a) do nothing to invalidate any insurance policy
- (b) notify the Authority if any policy is (or will be) cancelled or its terms are (or will be) subject to any material change

B27.7 For the avoidance of doubt, the terms of any insurance or the amount of cover shall not relieve the Provider of any liabilities under this Contract.

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- B27.8 Where the minimum limit of indemnity required in relation to any of the insurances is specified as being "in the aggregate":
- B27.9 if a claim or claims which do not relate to this Contract are notified to the insurers which, given the nature of the allegations and/or the quantum claimed by the third party(ies), is likely to result in a claim or claims being paid by the insurers which could reduce the level of cover available below that minimum, the Provider shall immediately submit to the Authority:
- (i) details of the policy concerned; and
 - (ii) its proposed solution for maintaining the minimum limit of indemnity specified; and
- B27.10 if and to the extent that the level of insurance cover available falls below that minimum because a claim or claims which do not relate to this Contract are paid by insurers, the Provider shall:
- (i) ensure that the insurance cover is reinstated to maintain at all times the minimum limit of indemnity specified for claims relating to this Contract; or
 - (ii) if the Provider is or has reason to believe that it will be unable to ensure that insurance cover is reinstated to maintain at all times the minimum limit of indemnity specified, immediately submit to the Authority full details of the policy concerned and its proposed solution for maintaining the minimum limit of indemnity specified.

B28. DEFAULTS AND FAILURE TO SUPPLY

- B28.3. In the event that the Authority is of the reasonable opinion that there has been a Default which is a material breach of this Contract by the Provider, then the Authority may, without prejudice to any other rights or remedies it may have under this Contract including under clause B29 (*Contract Management*), consult with the Provider and then do any of the following:
- a) require the Provider to submit a performance improvement plan detailing why the material breach has occurred and how it will be remedied within 10 Business Days or such other period of time as the Authority may direct;
 - b) without terminating this Contract, suspend the affected Service in accordance with the process set out in clause B31 (*Suspension and Consequences of Suspension*);
 - c) without terminating the whole of this Contract, terminate this Contract in respect of the affected part of the Services only in accordance with clause B32 (*Termination*) (whereupon a corresponding reduction in the Charges shall be made) and thereafter the Authority may supply or procure a third party to supply such part of the Services.
- B28.4. If the Authority exercises any of its rights under clause B28.1, the Provider must indemnify the Authority for any costs reasonably incurred (including reasonable professional costs and any reasonable administration costs) in respect of the supply of any part of the Services by the Authority or a third party to the extent that such costs exceed the payment which would otherwise have been payable to the Provider for such part of the Services and provided that the Authority uses its reasonable endeavours to mitigate any additional expenditure in obtaining replacement Services.

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B28.5.

B29. CONTRACT MANAGEMENT

B29.3. If the Parties have agreed a consequence in relation to the Provider failing to meet a Quality Outcomes Indicator as set out in Appendix C (*Quality Outcomes Indicators*) and the Provider fails to meet the Quality Outcomes Indicator, the Authority may exercise the agreed consequence immediately and without issuing a Contract Query, irrespective of any other rights the Authority may have under this clause B29.

B29.2 The provisions of this clause B29 do not affect any other rights and obligations the Parties may have under this Contract.

B29.3 Clauses B29.19, B29.23, B29.24 and B29.26 will not apply if the Provider's failure to agree or comply with a Remedial Action Plan (as the case may be) is as a result of an act or omission or the unreasonableness of the Authority.

Contract Query

B29.4 If the Authority has a Contract Query it may issue a Contract Query Notice to the Provider.

B29.5 If the Provider has a Contract Query it may issue a Contract Query Notice to the Authority.

Excusing Notice

B29.6 The Receiving Party may issue an Excusing Notice to the Issuing Party within 5 Business Days of the date of the Contract Query Notice.

B29.7 If the Issuing Party accepts the explanation set out in the Excusing Notice, it must withdraw the Contract Query Notice in writing within 10 Business Days following the date of the Contract Query Notice.

Contract Management Meeting

B29.8 Unless the Contract Query Notice has been withdrawn, the Authority and the Provider must meet to discuss the Contract Query and any related Excusing Notice within 10 Business Days following the date of the Contract Query Notice.

B29.9 At the Contract Management Meeting the Authority and the Provider must agree either:

- a) that the Contract Query Notice is withdrawn; or
- b) to implement an appropriate Remedial Action Plan; or
- c) to conduct a Joint Investigation.

B29.10 If a Joint Investigation is to be undertaken:

- a) the Authority and the Provider must agree the terms of reference and timescale for the Joint Investigation (being no longer than 4 weeks) and the appropriate clinical and/or non-clinical representatives from each Party to participate in the Joint Investigation.
- b) the Authority and the Provider may agree an Immediate Action Plan to be implemented concurrently with the Joint Investigation.

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Joint Investigation

- B29.11 On completion of a Joint Investigation, the Authority and the Provider must produce and agree a JI Report. The JI Report must include (without limitation) a recommendation to be considered at the next Review Meeting that either:
- a) the Contract Query be closed; or
 - b) Remedial Action Plan be agreed and implemented.
- B29.12 Either the Authority or the Provider may require a Review Meeting to be held at short notice in accordance with the provisions of this Contract to consider a JI Report.

Remedial Action Plan

- B29.13 If a Remedial Action Plan is to be implemented, the Authority and the Provider must agree the contents of the Remedial Action Plan within:
- a) 5 Business Days following the Contract Management Meeting; or
 - b) 5 Business Days following the Review Meeting in the case of a Remedial Action Plan recommended under clause B29.11.
- B29.14 The Remedial Action Plan must set out:
- a) milestones for performance to be remedied;
 - b) the date by which each milestone must be completed; and
 - c) subject to the maximum sums identified in clause B29.23, the consequences for failing to meet each milestone by the specified date.
- B29.15 The Provider and the Authority must implement or meet the milestones applicable to it within the timescales set out in the Remedial Action Plan.
- B29.16 The Authority and the Provider must record progress made or developments under the Remedial Action Plan in accordance with its terms. The Authority and the Provider must review and consider that progress on an ongoing basis and in any event at the next Review Meeting.
- B29.17 If following implementation of a Remedial Action Plan:
- a) the matters that gave rise to the relevant Contract Query Notice have been resolved, it must be noted in the next Review Meeting that the Remedial Action Plan has been completed;
 - b) any matter that gave rise to the relevant Contract Query Notice remains in the reasonable opinion of the Authority or the Provider unresolved, either may issue a further Contract Query Notice in respect of that matter.

Withholding Payment for Failure to Agree Remedial Action Plan

- B29.18 If the Authority and the Provider cannot agree a Remedial Action Plan within the relevant period specified in clause B29.13, they must jointly notify the Board of Director of the Provider and the Chief Executive of the Authority.
- B29.19 If, 10 Business Days after notifying the Board of Director and Chief Executive, the Authority and the Provider still cannot agree a Remedial Action Plan, the Authority may withhold up

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to 2% of the monthly sums payable by it under clause B8 (*Charges and Payment*) for each further month the Remedial Action Plan is not agreed.

- B29.20 The Authority must pay the Provider any sums withheld under clause B29.19 within 10 Business Days of receiving the Provider's agreement to the Remedial Action Plan. Unless clause B29.25 applies, those sums are to be paid without interest.

Exception Reports

- B29.21 If a Party breaches a Remedial Action Plan and does not remedy the breach within 5 Business Days of its occurrence, the Provider or the Authority (as the case may be) may issue a First Exception Report to that Party's Chief executive and/or Board of Directors. If the Party in breach is the Provider, the Authority may withhold payment from the Provider in accordance with clause B29.23.

- B29.22 If following issue of the First Exception Report, the breach of the Remedial Action Plan is not rectified within the timescales indicated in the First Exception Report, the Authority or the Provider (as the case may be) may issue a Second Exception Report to:

- a) the relevant Party's Chief Executive and/or Board of Directors; and/or;
- b) CQC or any other Regulatory Body,

in order that each of them may take whatever steps they think appropriate.

Withholding of Payment at First Exception Report for Breach of Remedial Action Plan

- B29.23 If the Provider breaches a Remedial Action Plan:

- a) the Authority may withhold, in respect of each milestone not met, up to 2% of the aggregate monthly sums payable by the Authority under clause B8 (*Charges and Payment*), from the date of issuing the First Exception Report and for each month the Provider's breach continues, subject to a maximum monthly withholding of 10% of the aggregate monthly sums payable by the Authority under clause B8 (*Charges and Payment*) in relation to each Remedial Action Plan;
- b) the Authority must pay the Provider any sums withheld under clause B29.23(a) within 10 Business Days following the Authority's confirmation that the breach of the Remedial Action Plan has been rectified. Subject to clause B29.25, no interest will be payable on those sums.

Retention of Sums Withheld at Second Exception Report for Breach of Remedial Action Plan

- B29.24 If the Provider is in breach of a Remedial Action Plan the Authority may, when issuing any Second Exception Report retain permanently any sums withheld under clause B29.23.

Unjustified Withholding or Retention of Payment

- B29.25 If the Authority withholds sums under clause B29.19 or clause B29.23 or retain sums under clause B29.24, and within 20 Business Days of the date of that withholding or retention (as the case may be) the Provider produces evidence satisfactory to the Authority that the relevant sums were withheld or retained unjustifiably, the Authority must pay those sums to the Provider within 10 Business Days following the date of the Authority's acceptance of that evidence, together with interest at the Default Interest Rate for the period for which the sums were withheld or retained. If the Authority does not accept the Provider's evidence the Provider may refer the matter to Dispute Resolution.

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Retention of Sums Withheld on Expiry or Termination of this Contract

- B29.26 If the Provider does not agree a Remedial Action Plan:
- B29.26.1 within 6 months following the expiry of the relevant time period set out in clause B29.13; or
- B29.26.2 before the Expiry Date or earlier termination of this Contract,
- whichever is the earlier, the Authority may retain permanently any sums withheld under clause B29.19.
- B29.27 If the Provider does not rectify a breach of a Remedial Action Plan before the Expiry Date or earlier termination of this Contract, the Authority may retain permanently any sums withheld under clause B29.23.

B30. DISPUTE RESOLUTION

- B30.1. If there is any dispute between the Parties arising out of or in connection with this Contract (the "Dispute") the Authority Representative and Provider Representative (the "Authorised Representatives") shall work together in good faith to resolve the Dispute to the mutual satisfaction of the Parties.
- B30.2. If the Authorised Representatives cannot resolve the Dispute within ten (10) Business Days of it being referred to the Authorised Representatives the Dispute shall be referred to the Chief Executive of each Party, who shall attempt in good faith to resolve the Dispute to the mutual satisfaction of the Parties within 21 days of receipt of such notice.
- B30.3. If the Dispute cannot be resolved in accordance with the preceding sub-clause then it shall be referred to a single arbitrator to be agreed between the Parties and failing such agreement within 14 days of the request by one Party to the other in writing that the matter be referred to arbitration either Party may apply in writing to CEDR for the appointment of an expert to settle the dispute. The other Party may make representations to CEDR regarding the expertise of the expert to settle the matter. The person nominated by CEDR will be appointed as the Expert. Any reference to arbitration under this clause shall be deemed to be a reference to arbitration within the meaning of the relevant Arbitration Acts and it is further agreed that if any matter is referred to arbitration then each Party will bear its own costs of such referral
- B30.4. The provisions of this clause B30 shall survive termination or expiry of this Contract.

B31. SUSPENSION AND CONSEQUENCES OF SUSPENSION

- B31.1 A suspension event shall have occurred if:
- a) the Authority reasonably considers that a breach by the Provider of any obligation under this Contract:
 - (i) may create an immediate and serious threat to the health or safety of any Service User; or
 - (ii) may result in a material interruption in the provision of any one or more of the Services; or

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- b) clause B31.1 does not apply, but the Authority, acting reasonably, considers that the circumstances constitute an emergency, (which may include an event of Force Majeure) affecting provision of a Service or Services; or
- c) the Provider is prevented, or will be prevented, from providing a Service due to the termination, suspension, restriction or variation of any Consent,

(each a **Suspension Event**).

B31.2 Where a Suspension Event occurs the Authority:

- d) may by written notice to the Provider and with immediate effect suspend any affected Service, or the provision of any affected Service, until the Provider demonstrates to the reasonable satisfaction of the Authority that it is able to and will perform the suspended Service, to the required standard; and
- e) must where applicable promptly notify CQC and/or any relevant Regulatory Body of the suspension.

B31.3 During the suspension of any Service under clause B31.2, the Provider must comply with any steps the Authority reasonably specifies in order to remedy the Suspension Event, including where the Authority's decision to suspend pursuant to clause B31.2 has been referred to dispute resolution under clause B30 (*Dispute Resolution*).

B31.4 During the suspension of any Service under clause B31.2, the Provider will not be entitled to claim or receive any payment for the suspended Service except in respect of:

- f) all or part of the suspended Service the delivery of which took place before the date on which the relevant suspension took effect in accordance with clause B31.2; and/or
- g) all or part of the suspended Service which the Provider continues to deliver during the period of suspension in accordance with clause B31.5.

B31.5 The Parties must use all reasonable endeavours to minimise any inconvenience caused or likely to be caused to Service Users as a result of the suspension of the Service.

B31.6 Except where suspension occurs by reason of an event of Force Majeure, the Provider must indemnify the Authority in respect of any Losses directly and reasonably incurred by the Authority in respect of that suspension (including for the avoidance of doubt Losses incurred in commissioning the suspended Service).

B31.7 Following suspension of a Service the Provider must at the reasonable request of the Authority and for a reasonable period:

- h) co-operate fully with the Authority and any Successor Provider of the suspended Service in order to ensure continuity and a smooth transfer of the suspended Service and to avoid any inconvenience to or risk to the health and safety of Service Users, employees of the Authority or members of the public; and
- i) at the cost of the Provider:
 - (i) promptly provide all reasonable assistance and all information necessary to effect an orderly assumption of the suspended Service by an alternative Successor Provider; and
 - (ii) deliver to the Authority all materials, papers, documents and operating manuals owned by the Authority and used by the Provider in the provision of the suspended Service.

B31.8 As part of its compliance with clause B31.7 the Provider may be required by the Authority to agree a transition plan with the Authority and/or any alternative Successor Provider.

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B31.9 If it is determined, pursuant to clause B30 (*Dispute Resolution*), that the Authority acted unreasonably in suspending a Service, the Authority must indemnify the Provider in respect of any Loss directly and reasonably incurred by the Provider in respect of that suspension.

B31.10 During any suspension of a Service the Provider where applicable will implement the relevant parts of the Business Continuity Plan to ensure there is no interruption in the availability to the relevant Service.

B32. TERMINATION

B32.1. Either Party may voluntarily terminate this Contract or any Service by giving the other Party not less than 3 months' written notice at any time after the Service Commencement Date.

B32.2. The Authority may terminate this Contract in whole or part with immediate effect by written notice to the Provider if:

- a) the Provider is in persistent or repetitive breach of the Quality Outcomes Indicators;
- b) the Provider is in persistent breach of its obligations under this Contract;
- c) the Provider:
 - (i) fails to obtain any Consent;
 - (ii) loses any Consent; or
 - (iii) has any Consent varied or restricted,
the effect of which might reasonably be considered by the Authority to have a material adverse effect on the provision of the Services;
- d) the Provider has breached the terms of clause B39 (*Prohibited Acts*);
- e) any of the Provider's necessary registrations are cancelled by the CQC or other Regulatory Body as applicable;
- f) the Provider materially breaches its obligations in clause B37 (*Data Protection*);
- g) two or more Second Exception Reports are issued to the Provider under clause B29.22 (*Contract Management*) within any rolling 6 month period which are not disputed by the Provider, or if disputed, are upheld under Dispute Resolution;
- h) the Provider breaches the terms of clause B23 (*Assignment and Sub-contracting*);
- i) a resolution is passed or an order is made for the winding up of the Provider (otherwise than for the purpose of solvent amalgamation or reconstruction) or the Provider becomes subject to an administration order or a receiver or administrative receiver is appointed over or an encumbrancer takes possession of any of the Provider's property or equipment;
- j) the Provider ceases or threatens to cease to carry on business in the United Kingdom; or
- k) the Provider has breached any of its obligations under this Contract and that breach materially and adversely affects the provision of the Services in accordance with this Contract, and the Provider has not remedied that breach within 14 Business Days following receipt of notice from the Authority identifying the breach.

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B32.3. Either Party may terminate this Contract or any Service by written notice, with immediate effect, if and to the extent that the Authority or the Provider suffers an event of Force Majeure and such event of Force Majeure persists for more than 30 Business Days without the Parties agreeing alternative arrangements.

B32.4. The Provider may terminate this Contract or any Service with immediate effect by written notice to the Authority if the Authority is in material breach of any obligation under this Contract provided that if the breach is capable of remedy, the Provider may only terminate this Contract under this clause B32.4 if the Authority has failed to remedy such breach within 14 Business Days of receipt of notice from the Provider to do so.

B33. CONSEQUENCE OF EXPIRY OR TERMINATION

B33.1. Expiry or termination of this Contract, or termination of any Service, will not affect any rights or liabilities of the Parties that have accrued before the date of that expiry or termination or which later accrue.

B33.2. On the expiry or termination of this Contract or termination of any Service for any reason the Authority, the Provider, and if appropriate any successor provider, will agree a Succession Plan and the Parties will comply with the provisions of the Succession Plan.

B33.3. On the expiry or termination of this Contract or termination of any Service the Provider must co-operate fully with the Authority to migrate the Services in an orderly manner to the successor provider.

B33.4. In the event of termination or expiry of this Contract, the Provider must cease to use the Authority's Confidential Information and on the earlier of the receipt of the Authority's written instructions or 12 months after the date of expiry or termination, return all copies of the Confidential Information to the Authority.

B33.5. If, as a result of termination of this Contract or of any Service in accordance with this Contract (except any termination under clauses B32.1 or B32.3 (*Termination*)), the Authority procures any terminated Service from an alternative provider, and the cost of doing so (to the extent reasonable) exceeds the amount that would have been payable to the Provider for providing the same Service, then the Authority, acting reasonably, will be entitled to recover from the Provider (in addition to any other sums payable by the Provider to the Authority in respect of that termination) the excess cost and all reasonable related professional and administration costs it incurs (in each case) for a period of 6 months following termination.

B33.6. The provisions of clauses B7 (*Staff*), B8 (*Charges and Payment*), B11 (*Incidents Requiring Reporting*), B13 (*Service User Health Records*), B14 (*Information*), B23 (*Assignment and Sub-contracting*), B24 (*Audit and Inspection*), B27 (*Insurance*), B33 (*Consequence of Expiry or Termination*), B36 (*Confidentiality*) and B38 (*Freedom of Information and Transparency*) and C3 (TUPE) will survive termination or expiry of this Contract.

B34. BUSINESS CONTINUITY

B34.1. The Provider must comply with the Civil Contingencies Act 2004 and with any applicable national and local civil contingency plans.

B34.2. The Provider must, unless otherwise agreed by the Parties in writing, maintain a Business Continuity Plan and must notify the Authority as soon as reasonably practicable of its activation and in any event no later than 5 Business Days from the date of such activation.

B35. COUNTER-FRAUD AND SECURITY MANAGEMENT

B35.1. The Provider must put in place and maintain appropriate counter fraud and security management arrangements.

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- B35.2. The Provider must take all reasonable steps, in accordance with good industry practice, to prevent Fraud by Staff and the Provider in connection with the receipt of monies from the Authority.
- B35.3. The Provider must notify the Authority immediately if it has reason to suspect that any Fraud has occurred or is occurring or is likely to occur.
- B35.4. If the Provider or its Staff commits Fraud in relation to this or any other contract with the Authority, the Authority may terminate this Contract by written notice to the Provider with immediate effect (and terminate any other contract the Provider has with the Authority) and recover from the Provider the amount of any Loss suffered by the Authority resulting from the termination, including the cost reasonably incurred by the Authority of making other arrangements for the supply of the Services for the remainder of the term of this Contract had it not been terminated.

B36. CONFIDENTIALITY

- B36.1. Other than as allowed in this Contract, Confidential Information is owned by the Party that discloses it (the “**Disclosing Party**”) and the Party that receives it (the “**Receiving Party**”) has no right to use it.
- B36.2. Subject to Clauses B36.3 and B36.4, the Receiving Party agrees:
- a) to use the Disclosing Party’s Confidential Information only in connection with the Receiving Party’s performance under this Contract;
 - b) not to disclose the Disclosing Party’s Confidential Information to any third party or to use it to the detriment of the Disclosing Party; and
 - c) to maintain the confidentiality of the Disclosing Party’s Confidential Information and to return it immediately on receipt of written demand from the Disclosing Party.
- B36.3. The Receiving Party may disclose the Disclosing Party’s Confidential Information:
- a) in connection with any dispute resolution under clause B30 (*Dispute Resolution*);
 - b) in connection with any litigation between the Parties;
 - c) to comply with the Law;
 - d) to its staff, consultants and sub-contractors, who shall in respect of such Confidential Information be under a duty no less onerous than the Receiving Party’s duty set out in clause B36.2;
 - e) to comply with a regulatory bodies request.
- B36.4. The obligations in clause B36.1 and clause B36.2 will not apply to any Confidential Information which:
- a) is in or comes into the public domain other than by breach of this Contract;
 - b) the Receiving Party can show by its records was in its possession before it received it from the Disclosing Party; or
 - c) the Receiving Party can prove that it obtained or was able to obtain from a source other than the Disclosing Party without breaching any obligation of confidence.
- B36.5. The Receiving Party shall indemnify the Disclosing Party and shall keep the Disclosing Party indemnified against Losses and Indirect Losses suffered or incurred by the Disclosing Party as a result of any breach of this clause B36.

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- B36.6. The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause B36 by the Receiving Party, and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause B36.
- B36.7. This clause B36 shall not limit the Public Interest Disclosure Act 1998 in any way whatsoever.
- B36.8. The obligations in clause B36.1 and clause B36.2 shall not apply where the Confidential Information is related to an item of business at a board meeting of the Authority or of any committee, sub-committee or joint committee of the Authority or is related to an executive decision of the Authority and it is not reasonably practicable for that item of business to be transacted or that executive decision to be made without reference to the Confidential Information, provided that the Confidential Information is exempt information within the meaning of Section 101 of the Local Government Act 1972 (as amended), the Authority shall consider properly whether or not to exercise its powers under Part V of that Act or (in the case of executive decisions) under the Local Authorities (Executive Arrangements) (Access to Information) (England) Regulations 2000 as amended to prevent the disclosure of that Confidential Information and in doing so shall give due weight to the interests of the Provider and where reasonably practicable shall consider any representations made by the Provider.

B37. DATA PROTECTION

- B37.1. The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.
- B37.2. To the extent that the Provider is acting as a Data Processor on behalf of the Authority, the Provider shall, in particular, but without limitation:
- a) only process such Personal Data as is necessary to perform its obligations under this Contract, and only in accordance with any instruction given by the Authority under this Contract;
 - b) put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in clause B37.3 below, the state of technical development and the level of harm that may be suffered by a Data Subject whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;
 - c) take reasonable steps to ensure the reliability of Staff who will have access to such Personal Data, and ensure that such Staff are properly trained in protecting Personal Data;
 - d) provide the Authority with such information as the Authority may reasonably require to satisfy itself that the Provider is complying with its obligations under the DPA;
 - e) promptly notify the Authority of any requests for disclosure of or access to the Personal Data;
 - f) Promptly notify the Authority of any breach of the security measures required to be put in place pursuant to this clause B37;
 - g) ensure it does not knowingly or negligently do or omit to do anything which places the Authority in breach of the Authority's obligations under the DPA.
- B37.3. To the extent that any Authority data is held and/or processed by the Provider, the Provider

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shall supply that Authority data to the Authority as requested by the Authority.

- B37.4. The Provider and the Authority shall ensure that Personal Data is safeguarded at all times in accordance with the Law.

Data Security

- B37.5 Subject to clauses B37.6. to B37.10., the Provider shall be liable to the Authority for loss or corruption of any Authority Data, if and to the extent that such loss or corruption results from an act or omission of the Provider or from any default of the Provider.
- B37.6 In the event of loss or corruption of Authority Data resulting from an act or omission of the Provider or a default of the Provider, the Provider shall return such data and software to a fully operational state as soon as is reasonably practicable thereafter. The Provider shall promptly notify the Authority (via the Authority's ICT Helpdesk) within one (1) Business Day if at any time the Provider becomes aware, suspects or has reason to believe that Authority Data has or may become corrupted, lost or sufficiently degraded in any way for any reason, and inform the Authority of the remedial action the Provider proposes to take.
- B37.7 If the Provider fails to comply with clause B37.6, and within any reasonable period notified to the Provider, the Provider fails to take any remedial action in respect of its breach of clause B37.6 as required by the Authority, the Authority may itself restore or procure the restoration of Authority Data, and shall be repaid by the Provider any reasonable expenses incurred in doing so including the restoration of the Authority Data

Audit

- B37.8 For the duration of this Contract and for a period of 6 years after the Expiry Date or date of termination if earlier, the Authority may conduct or be subject to an audit for the following purposes:
- (a) to verify the accuracy of Charges (and proposed or actual variations to them in accordance with this Contract) and/or the costs of all suppliers (including Sub-Contractors) of the Services at the level of detail agreed in Appendix E (Charges);
 - (b) to review the integrity, confidentiality and security of any data relating to the Authority or any Service Users;
 - (c) to review the Provider's compliance with the DPA, the FOIA, in accordance with this clause B37 (Data Protection) and clause B38 (Freedom of Information) and any other legislation applicable to the Services;
 - (d) to review any records created during the provision of the Services;
 - (e) to review any books of account kept by the Provider in connection with the provision of the Services;
 - (f) to carry out the audit and certification of the Authority's accounts;
 - (g) for the purposes of the Local Government Finance Act 1982 (and any other Law relating to the inspection, examination and auditing of the Authority's accounts)
 - (h) to carry out an examination pursuant to the Authority's Best Value Duty;
 - (i) to verify the accuracy and completeness of the reports delivered or required by this Contract.
- B37.9 Except where an audit is imposed on the Authority by a regulatory body or further audits are required as a result of any non-compliance by the Provider with their obligations under this Contract, the Authority may not conduct an audit under this clause B37 more than twice in any calendar year
- B37.10 The Authority shall use its reasonable endeavours to ensure that the conduct of each audit does not unreasonably disrupt the Provider or delay the provision of the Services
- B37.11 Subject to the Authority's obligations of confidentiality, the Provider shall on demand provide the Authority and any relevant regulatory body (and/or their agents or representatives) with all reasonable co-operation and assistance in relation to each audit, including:

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- (a) all information requested by the above persons within the permitted scope of the audit, to include examining such documents as reasonably required which are owned, held or otherwise within the control of the Provider and any Sub-Contractor and may require the Provider and any Sub-Contractor to produce such oral or written explanations as the Authority or relevant regulatory body considers necessary;
- (b) reasonable access to any sites controlled by the Provider and to any equipment (including, but not limited to, any software, IT systems, materials, data or information stored on, accessed by or used to operate the equipment) used (whether exclusively or non-exclusively) in the performance of the Services; and
- (c) access to the Provider's Staff.

B37.12 The Authority shall endeavour to (but is not obliged to) provide at least 5 Business Days' notice of its or, where possible, a regulatory body's, intention to conduct an audit.

B37.13 For the purposes of this clause B37 any reference to the Authority carrying out an audit shall include the ability for that audit to be carried out by the District Auditor, the Authority's internal auditor or any external auditor appointed by the Authority.

B37.14 The parties agree that they shall bear their own respective costs and expenses incurred in respect of compliance with their obligations under this clause, unless the audit identifies a material failure to perform its obligations under this Contract in any material manner by the Provider in which case the Provider shall reimburse the Authority for all the Authority's reasonable costs incurred in the course of the audit.

B37.15 If an audit identifies that:

- (a) the Provider has failed to perform its obligations under this Contract in any material manner, the parties shall agree and implement a Remedial Action Plan. If the Provider's failure relates to a failure to provide any information to the Authority about the Charges, proposed Charges or the Provider's costs, then the Remedial Action Plan shall include a requirement for the provision of all such information;
- (b) the Authority has overpaid any Charges, the Provider shall pay to the Authority the amount overpaid within 20 days. The Authority may deduct the relevant amount from the Charges if the Provider fails to make this payment; and

the Authority has underpaid any Charges, the Authority shall pay to the Provider the amount of the under-payment less the cost of audit incurred by the Authority if this was due to a default by the Provider in relation to invoicing within 20 days

DATA AND INFORMATION

B37.16 The Provider acknowledges that the Authority's Data is the property of the Authority and the Authority reserves all IPRs which may, at any time, subsist in the Authority's Data. To the extent that any IPRs in any of the Authority's Data vest in the Provider by operation of law, such IPRs shall be assigned by the Provider to the Authority by operation of this clause 26 immediately upon the creation of such Authority's Data.

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B37.17 The Provider shall:

- (c) not delete or remove any proprietary notices or other notices contained within or relating to the Authority's Data;
- (d) not alter, store, copy, disclose or use the Authority's Data, except as necessary for the performance by the Provider of its obligations under this Contract, the Strategic Contract, or as otherwise expressly authorised by this Contract in compliance with the provisions of this Contract;
- (e) preserve, so far as possible, the integrity of the Authority's Data and prevent any loss, disclosure, theft, manipulation or interception of the Authority's Data, to include ensuring that where the Authority has notified the Provider that Authority's Data is required to be stored in an encrypted format, such Authority Data is not stored on any portable device or media, unless the device or media is encrypted;
- (f) make secure back-up copies of the Authority's Data on such regular basis as is reasonable for the particular data concerned as required by the Disaster Recovery Plan, or as otherwise instructed by the Authority, and in any event at such regular intervals appropriate to the frequency of the revision of the data; and
- (g) immediately notify the Authority if any of the Authority's Data is lost, becomes corrupted, is damaged or is deleted accidentally.
- (h) At contract start date receive and be responsible for all data transferred into the service including any legacy records

B37.18 The Authority hereby grants to the Provider, for the Term, a non-exclusive, non-transferable, royalty-free licence to use the Authority's Data solely for the purpose of meeting, and to the extent necessary to meet, its obligations under this Contract. The Provider shall not:

- (a) modify, amend, alter, remove, delete or enhance the Authority's Data without the prior written consent of the Authority;
- (b) use any form of cloud computing or similar data storage measures without the prior written consent of the Authority or as specifically permitted within the Security Policy; or
- (c) make any copies of the Authority's Data without the prior written permission of the Authority.

B37.19 To the extent that any Authority Data is held or processed by the Provider, the Provider shall supply such Authority Data to the Authority as may be requested by the Authority from time to time in the format specified by the Authority.

B37.20 On receipt or creation by the Provider of any Authority Data and during any collection, processing, storage and transmission by the Provider of any Authority Data, the Provider shall take, and shall procure that each of the Provider's Personnel shall take, all precautions necessary to preserve the security and integrity of the Authority's Data and to prevent any corruption or loss of the Authority's Data.

B37.21 The Provider acknowledges that the Authority is under transparency obligations stemming from the DCLG Code of Practice on Data transparency and the Provider shall assist the Authority in complying with its obligations in respect of data transparency.

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B38. FREEDOM OF INFORMATION AND TRANSPARENCY

- B38.1. Where the Parties are both Public Authorities within the meaning of the FOIA, the Parties acknowledge their respective duties under the FOIA and must give all reasonable assistance to each other where appropriate or necessary to comply with such duties.
- B38.2. If the Provider is not a Public Authority, the Provider acknowledges that the Authority is subject to the requirements of the FOIA and will assist and co-operate with the Authority to enable the Authority to comply with its disclosure obligations under the FOIA. Accordingly the Provider agrees:
- a) that this Contract and any other recorded information held by the Provider on the Authority's behalf for the purposes of this Contract are subject to the obligations and commitments of the Authority under the FOIA;
 - b) that the decision on whether any exemption to the general obligations of public access to information applies to any request for information received under the FOIA is a decision solely for the Authority;
 - c) that if the Provider receives a request for information under the FOIA, it will not in any event respond to such request (unless expressly directed to do so by the Authority) and will promptly (and in any event within 2 Business Days) transfer the request to the Authority;
 - d) that the Authority, acting in accordance with the codes of practice issued and revised from time to time under both section 45 of the FOIA, and regulation 16 of the Environmental Information Regulations 2004, may disclose information concerning the Provider and this Contract either without consulting with the Provider, or following consultation with the Provider and having taken its views into account; and
 - e) to assist the Authority in responding to a request for information, by processing information or environmental information (as the same are defined in the FOIA) in accordance with a records management system that complies with all applicable records management recommendations and codes of conduct issued under section 46 of the FOIA, and providing copies of all information requested by a Authority within 5 Business Days of such request and without charge.
- B38.3. The Parties acknowledge that, except for any information which is exempt from disclosure in accordance with the provisions of the FOIA, the content of this Contract is not Confidential Information.
- B38.4. Notwithstanding any other provision of this Contract, the Provider hereby consents to the publication of this Contract in its entirety including from time to time agreed changes to this Contract subject to the redaction of information that is exempt from disclosure in accordance with the provisions of the FOIA.
- B38.5. In preparing a copy of this Contract for publication pursuant to clause B38.4 the Authority may consult with the Provider to inform its decision making regarding any redactions but the final decision in relation to the redaction of information shall be at the Authority's absolute discretion.
- B38.6. The Provider must assist and co-operate with the Authority to enable the Authority to publish this Contract.

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- B38.7. In order to comply with the Government's policy on transparency in the areas of contracts and procurement the Authority will be disclosing information on its website in relation to monthly expenditure over £500 (five hundred pounds) in relation to this Contract. The information will include the Provider's name and the monthly Charges paid. The Parties acknowledge that this information is not Confidential Information or commercially sensitive information.
- B38.8. The Authority shall in no event be liable for any loss, damage, harm or detriment, howsoever caused, arising from or in connection with the reasonable disclosure under FOIA or any other law, of any information (including exempt information) whether relating to this Contract or otherwise relating to any other party.
- B38.9. The Provider shall ensure that all Information required to be produced or maintained under the terms of this Contract, or by law or professional practice or in relation to the Contract is retained for disclosure for at least the duration of the Contract plus one year together with such other time period as required by the Contract, law or practice and shall permit the Authority to inspect such records as requested from time to time.

B39. PROHIBITED ACTS

B39.1. Neither Party shall do any of the following:

- a) offer, give, or agree to give the other Party (or any of its officers, employees or agents) any gift or consideration of any kind as an inducement or reward for doing or not doing or for having done or not having done any act in relation to the obtaining of performance of this Contract or any other contract with the other Party, or for showing or not showing favour or disfavour to any person in relation to this Contract or any other contract with the other Party; and
- b) in connection with this Contract, pay or agree to pay any commission, other than a payment, particulars of which (including the terms and conditions of the agreement for its payment) have been disclosed in writing to the other Party,

(together "**Prohibited Acts**").

B39.2 The Provider:

- a) shall not, and shall procure that all Staff shall not, in connection with this Contract commit a Prohibited Act
- b) warrants, represents and undertakes that it is not aware of any financial or other advantage being given to any person working for or engaged by the Authority, or that an agreement has been reached to that effect, in connection with the execution of this Contract, excluding any arrangement of which full details have been disclosed in writing to the Authority before execution of this Contract
- c) shall notify the Authority immediately if any breach of this clause B39 is suspected or known. Where such notification has been given to the Authority, the Provider must respond promptly to the Authority's enquiries, co-operate with any investigation and allow the Authority to audit books, records and any other relevant documentation. This obligation shall continue for two years following the expiry or termination of this Contract.

B39.3 If either Party or its employees or agents (or anyone acting on its or their behalf) commits any Prohibited Act or commits any offence under the Bribery Act 2010 with or without the knowledge of the other Party in relation to this Contract, the non-defaulting Party shall be entitled:

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- c) to exercise its right to terminate under clause B32.2 (*Termination*) and to recover from the defaulting Party the amount of any loss resulting from the termination; and
 - d) to recover from the defaulting Party the amount or value of any gift, consideration or commission concerned; and
 - e) to recover from the defaulting Party any loss or expense sustained in consequence of the carrying out of the Prohibited Act or the commission of the offence.
- B.39.4 The Provider must provide the Authority upon written request with all reasonable assistance to enable the Authority to perform any activity required for the purposes of complying with the Bribery Act 2010.
- B39.5 The Provider must have in place an anti-bribery policy for the purposes of preventing any of its Staff from committing a prohibited act under the Bribery Act 2010. Such policy must be disclosed to the Authority within 5 Business Days of the Authority requesting it and enforced by the Provider where applicable.
- B.39.6 Should the Provider become aware of or suspect any breach of this clause B39, it will notify the Authority immediately. Following such notification, the Provider must respond promptly and fully to any enquiries of the Authority, co-operate with any investigation undertaken by the Authority and allow the Authority to audit any books, records and other relevant documentation.
- B39.7 The Provider shall, within 10 Working Days of a request from the Authority, certify to the Authority in writing (such certification to be signed by an authorised officer of the Provider) the Provider's compliance with this clause B39.
- B39.8 Despite clause B30 (Dispute Resolution), any dispute relating to:
a) the interpretation of this clause B39; or
b) the amount or value of any gift, consideration or commission
Shall be determined by the Authority and its decision shall be final and conclusive
- B39.9 Any termination under this clause B39 shall be without prejudice to any right or remedy which has already accrued or subsequently accrues to the Authority

B40. FORCE MAJEURE

- B40.1. Subject to the remaining provisions of this clause B40, neither party to this Contract shall be liable to the other for any delay or non-performance of its obligations under this Contract to the extent that such non-performance is due to a Force Majeure Event.
- B40.2. In the event that either party is delayed or prevented from performing its obligations under this Contract by a Force Majeure Event, such party shall:
- a) promptly give notice in writing of such delay or prevention to the other party as soon as reasonably possible, stating the commencement date and extent of such delay or prevention, the cause thereof and its estimated duration;
 - b) use all reasonable endeavours to mitigate the effects of such delay or prevention on the performance of its obligations under this Contract;
 - c) use reasonable endeavours to carry out its obligations under this Contract in any way that is reasonably practicable; and
 - d) resume performance of its obligations as soon as reasonably possible after the removal of the cause of the delay or prevention.
- B40.3. A party cannot claim relief if the Force Majeure Event is attributable to that party's wilful act, neglect or failure to take reasonable precautions against the relevant Force Majeure Event.

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- B40.4. The Provider cannot claim relief if the Force Majeure Event is one where a reasonable service provider should have foreseen and provided for the cause in question.
- B40.5. As soon as practicable following the affected party's notification, the parties shall consult with each other in good faith and use all reasonable endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and to facilitate the continued performance of this Contract. Where the Provider is the affected party, it shall take and/or procure the taking of all steps to overcome or minimise the consequences of the Force Majeure Event in accordance with Good Clinical Practice.
- B40.6. The affected party shall notify the other party as soon as practicable after the Force Majeure Event ceases or no longer causes the affected party to be unable to comply with its obligations under this Contract. Following such notification, this Contract shall continue to be performed on the terms existing immediately before the occurrence of the Force Majeure Event unless agreed otherwise by the parties.
- B40.7. The Authority may, during the continuance of any Force Majeure Event, terminate this Contract by written notice to the Provider if a Force Majeure Event occurs that affects all or a substantial part of the Services and which continues for more than 25 Business Days.

B41. THIRD PARTY RIGHTS

- B41.1. No term of this Contract is intended to confer a benefit on, or to be enforceable by, any person who is not a party to this Contract.

B42. CAPACITY

- B42.1. Without prejudice to the contractual rights and/or remedies of the Provider expressly set out in this Contract, the obligations of the Authority under this Contract are obligations of the Authority in its capacity as a contracting counterparty and nothing in this Contract shall operate as an obligation upon the Authority or in any way fetter or constrain the Authority in any other capacity, nor shall the exercise by the Authority of its duties and powers in any other capacity lead to any liability on the part of the Authority under this Contract (howsoever arising) in any capacity other than as contracting counterparty.

B43. SEVERABILITY

- B43.1. If any provision or part of any provision of this Contract is declared invalid or otherwise unenforceable, the provision or part of the provision as applicable will be severed from this Contract and this will not affect the validity and/or enforceability of the remaining part of that provision or other provisions of this Contract.

B44. WAIVER

- B44.1. Any relaxation or delay by either Party in exercising any right under this Contract will not be taken as a waiver of that right and will not affect the ability of that Party subsequently to exercise that right.

B45. PUBLICITY

- B45.1. Without prejudice to clause B38 (*Freedom of Information and Transparency*), except with the written consent of the Authority, (such consent not to be unreasonably withheld or delayed), the Provider must not make any press announcements in relation to this Contract in any way.
- B45.2. The Provider must take all reasonable steps to ensure the observance of the provisions of clause B45.1 by all its staff, servants, agents, consultants and sub-contractors.

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B46. TRANSFER OF UNDERTAKINGS (PROTECTION OF EMPLOYMENT REGULATIONS 2006 (TUPE))

The Parties agree that the provisions of Section C (TUPE) shall apply to any Relevant Transfer of Staff under this Contract

B47 INTELLECTUAL PROPERTY

B47.1 In the absence of prior written agreement by the Authority to the contrary, all Intellectual Property created by the Provider or any employee, agent or sub-contractor of the Provider:

- (i) in the course of performing the Services; or
- (j) exclusively for the purpose of performing the Services,
- (k) shall vest in the Authority on creation.

B47.2 The provisions of clause B47.1 shall not override any pre-existing binding contractual terms with agents or Sub-Contractors in respect of Intellectual Property which reserve rights of ownership to the agent or Sub-Contractor which the Provider entered into prior to the Commencement Date and which were within the knowledge of the Authority at the Commencement Date.

B47.3 The Provider shall indemnify the Authority against all claims, demands, actions, costs, expenses (including legal costs and disbursements on a solicitor and client basis), losses and damages arising from or incurred by reason of any infringement or alleged infringement (including the defence of such alleged infringement) of any Intellectual Property Right by the availability of the Services, except to the extent that they have been caused by or contributed to by the Authority's acts or omissions.

B47.4 This provision shall survive the expiration or termination of the Contract

B48. EXCLUSION OF PARTNERSHIP, JOINT VENTURE OR AGENCY

B48.1.

B48.2.

B48.3. Nothing in this Contract creates a partnership or joint venture or relationship of employer and employee or principal and agent between the Authority and the Provider.

B49. GOVERNING LAW AND JURISDICTION

B49.1. This Contract will be governed by and interpreted in accordance with English Law and will be subject to the exclusive jurisdiction of the Courts of England and Wales.

B49.2. Subject to the provisions of clause B30 (*Dispute Resolution*), the Parties agree that the courts of England have exclusive jurisdiction to hear and settle any action, suit, proceeding or dispute in connection with this Contract.

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**APPENDIX A
SERVICE SPECIFICATIONS**

Service Specification No.	AMC006
Service	Integrated Sexual Health Service
Authority Lead	
Provider Lead	
Period	1st April 2016 to 31st March 2019 (+1+1)
Date of Review	15th September 2016

1. Population Needs

Introduction:

Shropshire Council (SC) is transforming how it commissions services with a greater focus on delivering outcomes that positively impact on people's health and well-being. The provision of an integrated sexual health service will support local ambitions to reduce health inequalities, support people to make positive choices to improve health and wellbeing. This specification has been developed to set out Shropshire Council's ambition to develop a service that is reflective and responsive to the needs of service users.

Outcome based commissioning puts the service user at the forefront of the commissioning process and over the course of the contract it is expected the role of service users will develop in the co-production of service design and delivery. By commissioning for outcomes it is anticipated this will allow providers to be innovative in their approach, to respond to local needs to improve outcomes and maximise value for money. We will underpin this with key quality standards, values and principles which we expect to be adopted into the new system to support the development of the ethos of partnership working with key stakeholders of the local health economy and co-production with service users.

This specification has been written in accordance with the principles and expectations outlined within national and local policies (Please see section 4). All system elements and services will be developed in line with these expectations and will also need to be delivered in line with the forthcoming local or national frameworks.

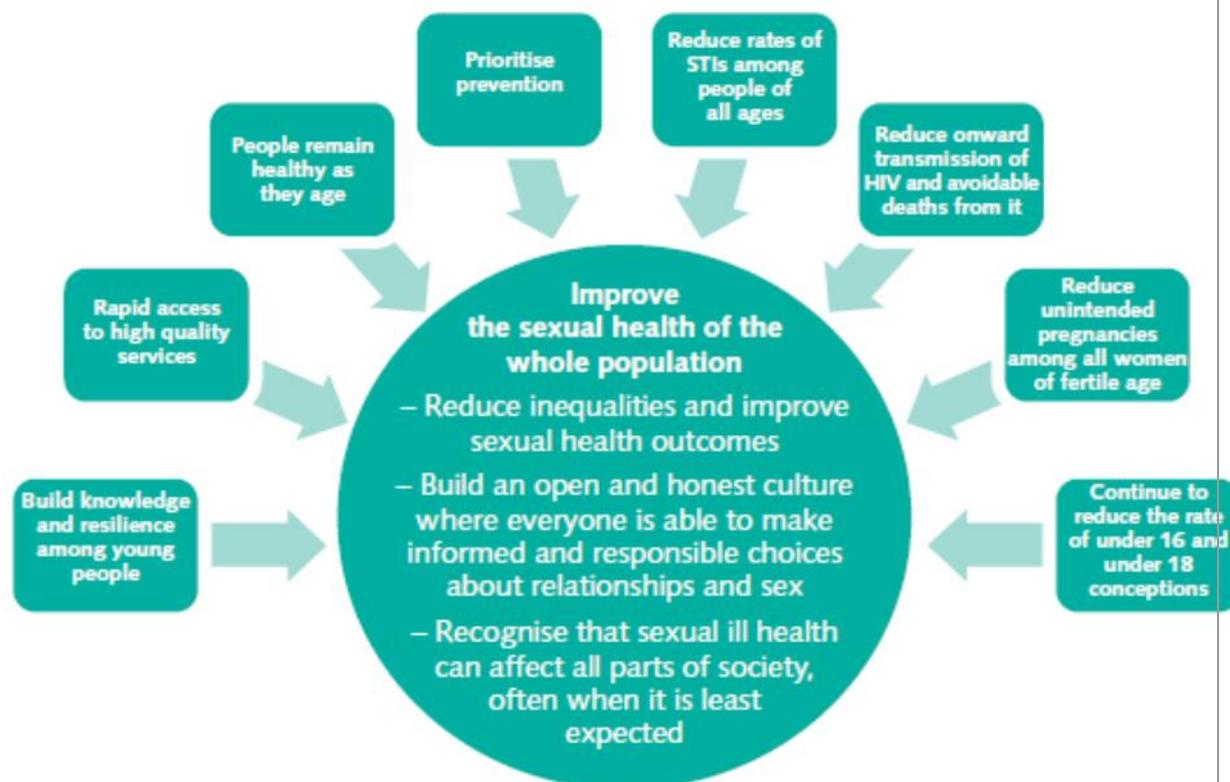
Where there is ambiguity regarding the content or meaning of any part of this specification interpretation will favour service delivery in line with these guidelines.

National Context

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

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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



Poor sexual 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.

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 contraception) and the Department of Health has produced guidance to assist Local Authorities to commission these and other sexual health interventions. The Public Health outcomes framework measures for sexual health include:

- Reducing under 18 conceptions
- Increasing the effectiveness and diagnosis of Chlamydia (15-24 year olds) as part of the National Chlamydia Screening Programme (NCSP)
- Reducing the number of people presenting with HIV at a late stage of infection

It is recognised that with these latest NHS reforms, providers of integrated sexual health services will need to work collaboratively across a number of organisations, responsible for commissioning different elements of care – Local Authority, NHS England and Clinical Commissioning Groups.

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

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An integrated sexual health service model aims to improve sexual health by providing easy access to services through open access 'one stop shops', 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. To do this effectively and affordably, it will require:

- An appropriately qualified workforce that can provide integrated sexual health services
- Health promotion through all care pathways to support service users in tackling underlying causes of risk taking behaviours leading to poor sexual health
- Services primarily delivered in accessible community settings.
- Services to be provided on a "drop in" and appointment system
- Service provision to be confidential (conforming to local Safeguarding policies) and welcoming
- Services to be available "out of hours" to include evenings and weekends as required

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, SSHA 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.

However, this model largely relies upon the individual realising that they may have a sexual health problem or that they need some help or resources in order to maintain their sexual health. People have to realise that something is wrong or that they need help before they might consider accessing sexual health services. For many conditions such as HIV infection or certain sexually transmitted infections (STIs) such as Chlamydia, people may be completely unaware of their infection as they can be asymptomatic. This may lead to an individual not accessing service as they believe there is nothing wrong with them until symptoms start to appear some time later. With both HIV and certain STIs, failure to have treatment early can lead to severe health problems and premature death.

We must therefore look to ways in which the service can reach out to the most vulnerable groups to enable them to make informed choices about their sexual health. A coordinated outreach service working in partnership with local 3rd sector organisations and other health and wellbeing services can take services to vulnerable priority groups that might be otherwise unable or unlikely to access sexual health services.

The system will contribute locally to the delivery of the Public Health Outcome Framework outcomes to increased healthy life expectancy and reduced differences in life and healthy life expectancy between communities, through the six indicators directly pertinent to sexual health and others where improving sexual health can contribute to other positive outcomes.

Local Context

Shropshire Council is committed to achieving social value outcomes through maximising the social, economic and or environmental impact of all its procurement activity in line with the Public Service (Social Value) Act 2012. Accordingly it is expected delivery of this specification will contribute to providing social value benefits to individuals, families and the wider community.

<http://www.shropshire.gov.uk/doing-business-with-shropshire-council/social-value/>

The new system will also support delivery of the local Health and Wellbeing Board's strategic outcomes:

Outcome 1: Health Inequalities are reduced

Outcome 2: People are empowered to make better lifestyle and health choices for their own, and their family's health and well being

Outcome 3: Better emotional and mental health and well-being for all

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Outcome 4: People with long-term conditions and older people will remain independent for longer
Outcome 5: Health, social-care and well-being services are accessible, good quality and seamless

<http://www.shropshiretogether.org.uk/health-wellbeing-board/>

Local Need

Shropshire is situated in the West Midlands, with a population of approximately 309,000, of which 34,800 are aged 15-24 years. Shropshire remains a low transmission area for sexually transmitted infections (STIs), with total diagnosis rates 45 percent of the national rate.

The demographic factors most important to sexual health are that Shropshire has an older population than England, especially over 45s, therefore sexual health services need to ensure services are appropriate for all age groups. The major factor affecting the provision of any service in Shropshire, is the rurality/ sparseness of the population and services need to meet the needs of a large proportion of the population who live away from towns or any other great populous, with poor/ no public transport.

The Public Health England Sexual Health Profile for Shropshire (2013) highlights key areas of sexual health and compares local performance in Shropshire against the national average for England and also compares against the performance of other neighbouring local authorities in the West Midlands. For further information, please see the Public Health England Sexual & Reproductive Health Profile for Shropshire <http://fingertips.phe.org.uk/profile/sexualhealth/data#gid/8000057/pat/6/ati/102/page/1/par/E12000005/are/E06000051>. A snapshot of the indicators for Shropshire is presented below:

In summary, the key issues for Shropshire include:

- Chlamydia screening in Shropshire is not reaching large numbers of young people and only 14.9% of young people were tested which is lower than the West Midlands and England average in terms of diagnostics/ screening young people for Chlamydia.
- Teenage conceptions are reducing, at a lower rate than in England and the West Midlands, but are at a much lower rate. In 2014 19.1 per 1,000 compared to 28.9 in West midlands and 24.3 in the England
- GP prescribing of LARC methods is much higher than the National and West Midlands average
- Numbers of women having abortions is 626 in 2013, and the numbers having repeat abortions is 23 percent
- There are low numbers of diagnosed sexually transmitted infections, chlamydia being the commonest STI diagnosed in young people in Shropshire.
- 50% of HIV infection is diagnosed late in the disease, compared with 40% in England

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Compared with benchmark: ● Better ● Similar ● Worse ● Lower ● Similar ● Higher
○ Not Compared

• a note is attached to the value, hover over to see more details

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Shropshire		Region England		England		Best/ Highest
		Count	Value	Value	Value	Worst/ Lowest	Range	
Syphilis diagnosis rate / 100,000	2014	8	2.6	3.6	7.8	132.1		0.7
Gonorrhoea diagnosis rate / 100,000	2014	41	13.3	51.2	63.3	633.9		8.7
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02)	2014	463	1,330	1,852	2,012	945		4,270
Chlamydia proportion aged 15-24 screened	2014	5,300	15.2%	20.7%	24.3%	10.9%		48.7%
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	2014	733	383	718	829	3,190		383
HIV testing coverage, total (%)	2014	2,928	65.3%	71.1%	68.9%	20.8%		86.1%
HIV late diagnosis (%) (PHOF indicator 3.04)	2011 - 13	10	50.0%	53.5%	45.0%	77.3%		25.9%
HIV diagnosed prevalence rate / 1,000 aged 15-59	2013	103	0.60	1.54	2.14	0.37		14.70
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii)	2013/14	1,434	91.3%	89.7%	86.7%	51.1%		96.6%
Abortions under 10 weeks (%)	2013	497	80.2%	78.4%	79.4%	55.6%		87.4%
Under 25s repeat abortions (%)	2013	69	22.4%	28.8%	26.9%	49.2%		13.9%
GP prescribed LARC rate / 1,000	2013	4,199	83.8	54.1	52.7	7.5		96.3
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	2013	107	19.1	28.9	24.3	43.9		9.2
Under 18s conceptions leading to abortion (%)	2013	62	57.9%	48.0%	51.1%	35.2%		83.3%
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	2013/14	230	0.75	1.04	1.01	0.38		2.43

The New Sexual Health System for Shropshire

The future system will be outcome based. Shropshire Council requires a new sexual health model/system; one that is coordinated and will be responsible for ensuring that sexual health prevention, promotion and treatment services, provided through a range of qualified providers from the statutory and 3rd sectors, are delivering high quality, effective and value for money services that conform to recognised national standards and are delivered consistently across Shropshire.

The provision of sexual health services are mandated to be “open access”; this means they are free at the point of delivery for anyone who seeks to use them, irrespective of any characteristic such of age, gender or sexual orientation. Simply, anyone within an area can use services in that area, therefore care has to be available to patients/ service users who are not residents of Shropshire or who are not registered with a general Practice in Shropshire. This extends to individuals living in devolved nations within the UK but outside of England, and indeed any other overseas visitor. NHS regulations state that family planning services (provision of contraceptive products and devices to prevent pregnancy) and STI treatment should be free to all, regardless of place of residency.

The Provider will be responsible for all aspects of delivery within the system including by:

- Establishing a single clinical governance system across all providers.
- Standardising protocols and procedures.
- Identifying and delivering the training needs within each organisation.
- Performance management of all provision against key performance indicators.
- Ensuring consistency in the promotion of good sexual health and enabling of patients/ service users to tackle the underlying causes of sexual health risk taking and coercion.

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- Establishing quicker and easier access to comprehensive sexual health services for the most vulnerable groups through targeted outreach and rapid referral pathways to specialist services as required.
- Creating active partnerships with key local organisations such as drug and alcohol services, to ensure vulnerable/ at risk individuals receive the treatment, care and support to enable them to achieve good health and wellbeing.
- Ensuring that services are delivered in easily accessible locations with good public transport links, and that services are open 6 days per week, at times that are convenient to service users and at regular and predictable times.

2. Key Service Outcomes

The service will support the outcomes as outlined by “A framework for Sexual Health In England” and three main sexual health Public Health Outcome Framework measures

A framework for Sexual Health In England

- Reducing inequalities and improve sexual health outcomes
- Building an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognising that sexual ill health can affect all parts of society, often when it is least expected

Public Health Outcome Framework measures

Sexual health directly features in six of the indicators in the current public health outcomes framework (see below); whilst it has indirect impacts on many others:

- 1.12iii** – Crude rate of sexual offences per 1,000 population
- 2.04** – Rate of conceptions per 1,000 females aged 15-17
- 2.21i** – HIV pregnant women (new in February 2015)
- 3.02** – Crude rate of chlamydia screening detection per 100,000 young adults aged 15-24
- 3.03xii** – Percentage of girls aged 12-13 who have received all 3 doses of the HPV vaccine
- 3.04** – Percentage of adults (aged 15+) newly diagnosed with HIV with a CD4 count <350 cells per mm

Local Service Outcomes

The recent sexual health needs assessment is summarised in Appendices 3 and 4. Appendix 3 presents the current epidemiological information on sexual health in Shropshire.

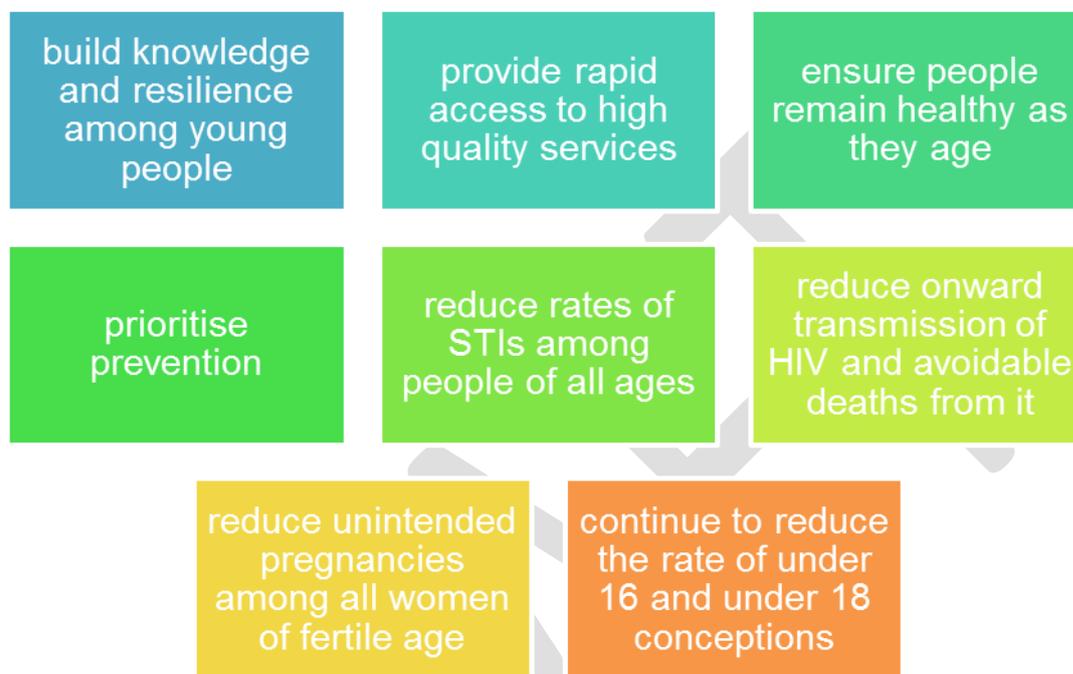
The needs assessment highlighted a number of priority areas that we have developed into local service outcomes:

- The proportion of the population aged 15 to 24 years old covered by chlamydia testing
- The diagnosis rates for of chlamydia in those tested in the population aged 15 to 24 years
- The rate of late diagnosis of HIV
- Proportion of terminations that are a repeat termination
- The rates of prescribing long-acting reversible contraceptives in local sexual health services

3. Scope

3.1 Aims and Objectives of Service

The aim of the procurement is to commission an integrated sexual health system across Shropshire; **which provides a care model for the delivery of good quality, easily accessible, value for money and effective sexual health services to meet the following ambitions for sexual health** in Shropshire (those set out in 'A Framework for Sexual Health Improvement in England'):



Scope:

This service specification describes the services to be made available to all people (depending on need) who attend sexual health services in Shropshire. The services are open access which means that people that do not reside in Shropshire are still able to use them; services provided will be subject to charging to the Local Authority of residence for each individual. The specification further covers the provision of the condom distribution scheme in Shropshire (appendix 1); and the HIV prevention and support services (appendix 2)

Services are to be provided for people of all ages that require them. Practitioners must be aware of their specific responsibilities for all vulnerable groups including children under 13 and those between 13 to 15 years of age. Integrated sexual health care are to be offered and provided in all relevant and appropriate settings by appropriately qualified workforce. The provider will deliver the following elements, set out in detail below:

- A core service offer comprising of Prevention (including HIV Prevention) and Self-management, which will underpin delivery of services and activities;
- An equitable Basic and Intermediate (level 1 and 2) community-based contraception and sexual health service across Shropshire;
- An equitable integrated community-based sexual health service, in Shrewsbury, that will bring together all sexual health and contraception provision, including Prevention and Self-management, levels 1/2/3, HIV testing, counselling, outpatients (including collaboration of HIV treatment and care with NHSE)
- Health promotion/prevention planned outreach campaigns
- A local condom distribution scheme (CDS), see Appendix 1: *Condom Distribution Scheme*
- An HIV prevention and support programme, see Appendix 2

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- Sexual health clinical outreach to vulnerable young people and adults
- Sexual health outreach facilitation in schools, colleges, educational and training institutes
- Additional Training for health professionals
- A Sexual Health Clinical network
- Laboratory services

Service values & aims

The new sexual health service in Shropshire will have to meet and adhere to some overarching values aims:

- Continuously improve service through development and innovation and consultation with service users and the local population
- Offer open access, confidential, integrated sexual health system across Shropshire that is welcoming to all that need to use it, regardless of gender, ethnicity, sexuality and physical or learning disabilities.
- Improve access to services – understanding the broadest meaning and connotations of the word access, including addressing physical, temporal barriers to services, and psychological barriers, such as perceived confidentiality.
- Create a sexual health economy that provides a comprehensive service with clear referral pathways between providers; enables effective planning through clinical leadership and clinical networks; train and educate staff, trainees and students
- Provide treatment free of charge
- Provide a 'one stop shop', where the majority of sexual health and contraceptive needs can be met at one site, usually within a single consultation
- Improving the sexual health of people living with HIV
- Reduce late HIV diagnoses in Shropshire
- Develop a sexual health system of care across Shropshire, working in partnership with general practice, local community groups/ 3rd Sector Organisations and linking into local outreach to facilitate collaboration and service development
- Ensure that Sexual health promotion as a key, embedded component of all care pathways
- Provide a service tailored to the needs of service users and potential service users, especially those most vulnerable to poor sexual health
- Reduce unwanted pregnancies
- Multidisciplinary working, in partnership with local service providers (statutory and non-statutory) and other services supporting and working with vulnerable and at risk groups such as drugs and alcohol services.

Objectives:

This will be achieved through the following objectives:

- Proactively promote, publicise and raise awareness of the services offered to the local population.
- Ensure that interventions have a robust evidence base for their effectiveness
- Lead and participate in the local sexual health clinical network
- Provide evidence based care centred on recognised national best practice guidance where this exists (this should include participation in audit and service evaluations and may include research).
- Delivering training to wider workforce involved in Provide sexual health services; and develop the sexual health workforce
- Engage key services to participate in the screening and treatment of young people for Chlamydia

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(15-24) in Shropshire.

- Increase diagnosis and effective management of STIs, with rapid and easy access to services for prevention, detection and management (treatment and partner notification), to reduce prevalence and transmission.
- Increased uptake of HIV testing with particular emphasis on first time service users and repeat testing of those that remain at risk
- Provide a comprehensive range and choice of contraception including long acting methods (LARC) – increasing the uptake of this method; emergency contraception; condoms and support to reduce the risk of unwanted pregnancy; giving the methods most appropriate for the age.
- Offer and provide (as required) on-going support and guidance to women choosing LARC methods to avoid premature or unnecessary removal of contraceptive implants or intra uterine devices.
- Increase the uptake of effective methods of contraception, including LARC (Long Acting Reversible Contraceptive) for all appropriate age groups in line with national guidelines
- Facilitate and manage the local condom distribution scheme
- Reducing the number of abortions and repeat abortions
- Provide free pregnancy tests and appropriate rapid onward referral to abortion services or maternity care with an individualised future contraception plan agreed wherever possible in advance.
- Provide sexual health information and advice in order to develop increased knowledge and skills, especially in high-need individuals and communities.
- Work towards making the fullest use of existing sexual health encounters to promote effective contraception and sexual health, especially in the most vulnerable groups.
- Ensure that services are acceptable and accessible to people disproportionately affected by unwanted pregnancy and sexual ill health based on up to date sexual health needs assessment and equity impact assessment.
- Ensure there is confidentiality at all times that an attendee is within a service, including at reception, registration and all other times outside of the consultation room, as well as in.
- Promote access to service, through timings, locations and other facets – including the correct balance of walk-in and appointment clinics, and evenings and weekends
- Ensure that services are situated in easily accessible locations with good public transport links and that all premises comply with the DH guidance
- Implement “You’re Welcome” quality standard accreditation to ensure provision is welcoming to young people and encourages them to access services.
- Strengthen the provision of outreach sexual health services specific to young people. These should be for all young people, and with some outreach focused at vulnerable groups such as looked-after-children,
- Provide opportunities for people to manage their own sexual health either independently or with support, including increased availability and provision of self-testing kits, condoms and sexual health promotion information and referral on to other services as appropriate.
- Ensure those services currently engaged and delivering the local condom distribution scheme receive annual updates as a minimum. Providers currently engaged with the scheme consist of School Nurses, Pharmacists, Sexual Health Services, Supported Housing, GP Practice nurses, Further Education, Health Visitors, Family Nurse Partnership, Teenage Identified Midwives, Walk-in Centre, Minor Injury Units and the Youth Offending Service.

3.2 Service Description/Pathway

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The Service will provide a range of interventions via clinics and outreach provision to meet the needs of the community based on Shropshire's sexual health needs assessment. As part of this agreement, providers will ensure and demonstrate that pathways of care within the sexual health economy are formally agreed.

Whilst the intention is not to be too prescriptive to allow for innovation within the system, it is anticipated it will need to provide, as a minimum, the following service elements:

NB A service description and further detail of the condom distribution scheme in Shropshire is provided in appendix 1; and the HIV prevention and support services in appendix 2

- **Accessibility:**

The service will be on an open access basis. Provision of the service must be accessible. There is a limited rural transport network in Shropshire; therefore the service should be accessible within the main market towns of **Shrewsbury (Town centre), Oswestry, Whitchurch, Ludlow, Market Drayton and Bridgnorth** as a minimum. Ensuring that services are situated in easily accessible locations with good public transport links and that all premises comply with the DH guidance²

The service will offer greater flexibility in access, with evenings and weekend availability to meet people's needs.

The service will implement "You're Welcome" quality standard accreditation to ensure provision is welcoming to young people and encourages them to access services

The service will provide interpretation services for clients whose first language is not English and who require interpretation and to people who have a sensory impairment and/ or learning disability etc.

- **Single Main Point of Contact**

There will be a single main point of contact for the entire system. This will be available to anyone who wants to make contact or access the service, However, service users should be able to contact other available services and other contacts within the service where appropriate.

- **Prevention**

Prevention interventions should follow best practice and NICE guidance. As part of the wider local agenda to reduce health inequalities the provider is also expected to deliver to Making Every Contact Count (MECC) principles and ensure personnel possess appropriate skills and knowledge to MECC activity to give appropriate brief opportunistic advice to service users and support them to adopt healthier lifestyles actively sign-posting patients into relevant local lifestyle-risk management services e.g. smoking cessation support services.

- **Self-Managed Care**

Service users 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. 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 onwards.

² Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142892/HBN_12-01_SuppA_DSSA.pdf

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	Method of access		
	Internet	By phone	In person
Health information <ul style="list-style-type: none"> • Generic information on pregnancy, STIs including and HIV prevention/safer sex advice • Information on the full range of contraceptive methods and their availability 	X	X	X
Primary prevention initiatives to improve overall sexual health to the community	X	X	X
Condoms and lubricants		X	X
Chlamydia and gonorrhoea testing kits		X	X
Pregnancy testing kits		X	X
HIV point of care test kits		X†	X†

• **Service elements:**

Sexual health promotion and prevention

Sexual health promotion and prevention will be embedded in all aspects of the sexual health services – with the service elements of this spread through the other six elements below.

Basic and Intermediate Care (Level 1 and 2)

- Prevention and Self-management
- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)
- Pregnancy testing and expedient referral to antenatal or termination services as appropriate;
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device 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 IUS 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/IUD/IUS removal
- Natural family planning
- Young people's (13 to 25 years old) brief and focused counselling service, for issues such as pre- and post- termination support; and onward referral to a secondary service as appropriate
- Direct referral for antenatal care
- Direct referral for abortion care and to support self-referral
- Counselling and direct referral for male and female sterilisation
- Non prescribing brief and focused psychosexual counselling/interventions for service users aged 16 and over for the management of lack/loss of libido, non-consummation, orgasm problems, vaginismus, dyspareunia, erectile dysfunction, ejaculatory problems and other penile problems

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such as pain and anxiety.

- Screening service users (all practitioners) and referral for signs of domestic abuse, sexual coercion/ exploitation and violence etc., identifying clients at risk and complying with local Safeguarding policies and procedures.
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- Opportunistic cervical screening and onward referral to GP for routine follow-up thereafter.
- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women excluding:
 - Men with dysuria and/or genital discharge
 - Symptoms at extra-genital sites e.g. rectal or pharyngeal
 - Pregnant women (except women with uncomplicated infections requesting abortion)
 - Genital ulceration other than uncomplicated genital herpes
- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- Management of results notification and partner notification for young people (under 16) testing positive for chlamydia as part of the National Chlamydia Screening Programme, in line with local safeguarding policies and procedures
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- Screening for asymptomatic women and men (including Men who have sex with Men) for STIs
- Initiation of Post Exposure Prophylaxis following sexual exposure with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Ensuring opportunistic health promoting interventions across all service delivery to include, in particular: smoking, obesity, alcohol and mental health.
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of HIV/syphilis/LGV (Lymphogranuloma Venereum)
- Treatment of uncomplicated genital warts (plus referral to Level 3 service for recalcitrant/ keratinised warts and warts in pregnancy)
- Management of women with contraceptive related abnormal bleeding and abdominal pain
- Verbal assessment and referral of sexual assault cases to sexual assault referral centres (SARCs)
- Holistic sexual health care for all ages including risk assessments for protection/safeguarding/exploitation and coercion.
- Clinical outreach services offering prevention, STI testing and treatment, and offer all methods of contraception but not limited to e.g. higher and further education settings.
- Nurse-delivered outreach service to under-19s in further education and college; and other young person settings on a regular basis

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- Provide structured one-to-one sessions (in accordance with NICE guidance) to individuals at high risk of STIs, structured on the basis of behavioural change theories, in order to reduce sexual risk taking, and improve self-efficacy and motivation.
- Management of heterosexual men with urethral/urinary symptoms
- Management of problems with choice of contraceptive methods, including missing threads, menorrhagia, abdominal pain
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /respiratory/infectious diseases departments for inpatient HIV care
- Opportunistic cervical smear tests (responsible commissioner NHSE) and onward referral to GP (see NHSE specification appendix 6)
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines
- HIV prevention and support services following diagnosis
- Interpretation services for clients whose first language is not English and who require interpretation and to people who have a sensory impairment and/ or learning disability etc.
- Any samples taken from clients who subsequently disclose as victims and/or complainants in suspected sexual assault/ abuse/coercion cases must be handled with high quality forensic integrity and a robust chain of evidence for all samples taken should be in place

Complex (Level 3) Service Provision in addition to Levels 1 and 2 in the “hub” of the model/system

- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC),
- 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)
- Management of complicated STIs in high risk groups, including MSM, people living with HIV and commercial sex workers
- Providing rapid referral to HIV treatment and care services, (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to national service specifications. This will include a preferred access to NHS list prices in the Commercial Medicines Unit (CMU) tender)
- Interface with specialised HIV services as commissioned by NHS England (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East)
- Management of HIV partner notification
- Same day HIV test to be available for any service user requesting HIV test
- Increasing the uptake of HIV testing by offering
 - HIV testing to be routine (opt out) in clinical services with particular emphasis on first time service users and repeat testing of those that remain at risk
 - Point of care (POC) tests and clinical outreach to vulnerable groups
- Providing HIV PEPSE (Post Exposure Prophylaxis following Sexual Exposure) as clinically appropriate in line with national guidance.
- Management of sexual health aspects of psychosexual dysfunction
- Coordination of outreach clinical services including point of care testing for high risk groups

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- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this, under direction of a consultant /clinical lead qualified to provide such care
- Referral to imaging, ultrasound or x-ray service when appropriate
- Coordination of clinical contraceptive and STI care across a network including:
 - Clinical leadership of contraceptive and STI management
 - Co-ordination of clinical governance
 - Co-ordination and oversight of training in SRH and GUM
 - Co-ordination of pathways across clinical services
 - Co-ordination of partner notification for STIs and HIV
 - Development of clinical guidelines
 - Development and implementation of Patient Groups Directions (PGDs) including sign off
 - Provision of quarterly clinical network meetings

Laboratory Services

This specification is inclusive of the management and delivery of all sexual health laboratory testing activities. It is mandatory that the laboratory providing such local services is accredited and compliant to the Clinical Pathology Accreditation 'Standards for the Medical Laboratory' and in line with its transfer to the new UKAS accredited CPA standards.³

The laboratory must be enrolled in a nationally recognised quality assurance scheme (e.g. Quality Control molecular Diagnostics (QMD) and National External Quality Assessment Service in laboratory medicine (NEQAS)). Where the laboratory is to provide results directly to the patients e.g. Internet-based Chlamydia screening programme, the laboratory shall adhere to the appropriate national standards i.e. BAASH, NCSP etc. and sections within this specification for result notification time, information governance and clear pathways for the transfer of data into sexual health services for treatment and partner notification.

The laboratory must have the capacity to submit data extracts in line with local and national requirements.

Should at any time the contracted laboratory not adhere to the specified clinical governance structure within this contract, the Provider will notify the commissioner, in writing, immediately.

Sexual Health Clinical Outreach to Vulnerable Young People and Adults

The Provider will deliver targeted clinical contraception and sexual health outreach services to vulnerable young people and adults at high risk of unintended pregnancy and poor sexual health who are not effectively accessing mainstream services.⁴ High risk defined as (but not limited to):

- Looked After Children (LAC);

³ UKAS is currently managing the transition of all CPA accredited laboratories to UKAS accreditation to the internationally recognised standard ISO 15189:2012, *Medical Laboratories – particular requirements for quality, competence* and the transition of CPA accredited External Quality Assurance Providers (EQA) to ISO/IEC 17043:2010, *Conformity Assessment – General requirements for proficiency testing* http://www.ukas.com/services/CPA/Clinical_Pathology_Accreditation_CPA.asp

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- Care Leavers;
- Erratic school attenders;
- Pupil Referral Units (PRUs);
- Youth Offending Service (YOS);
- Substance Misuse;
- Young people identified as vulnerable through risk taking behaviour;
- Young people accessing termination services;
- BME groups at risk of poor sexual health;
- NEET (Not in formal education employment or training)
- Gypsy and traveller communities; and
- MSM populations at risk of poor sexual health.⁵

The Provider shall offer the following services from suitable venues of the young person or vulnerable adults' choice,⁶ where they feel comfortable and therefore are more likely to engage:

- fitting of contraceptive implants;
 - administering of contraceptive injections;
 - prescribing of oral contraception;
 - issuing emergency contraception;
 - providing treatment for Chlamydia as a non-medical prescriber
- Provision of a domiciliary contraception/STI service for those with special needs (e.g. those with a severe physical or learning disability) who are unable to attend a GP practice or community-based sexual health clinic
 - Service Users who are not suitable for any of the above forms of contraception shall be supportively fast-tracked to specialist provision

The Provider will ensure all provision of this service element is strictly in line with safeguarding legislation, guidance, policies and procedures specified in service specification

Activities and interventions shall be age appropriate (for those aged 16 and over, and those under 16 years).

⁵ MSM populations at risk of poor sexual health as a result of not accessing mainstream services is a local priority

⁶ The provider shall adhere to the following guidance: Premises for the provision of clinical based services must be fit for purpose, see Department of Health guidance *Out-patient care. Healthy Building note 12:01: Consulting, examining and treatment facilities. Supplement A: Sexual and reproductive health clinics*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142892/HBN_12-01_SuppA_DSSA.pdf

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Sexual Health Outreach in Schools, Colleges, educational and training institutes

The Provider will lead on establishing relationships and collaborating with schools, colleges, educational and training institutes to encourage a joint-approach in supporting the sexual health needs of young people.

The Provider will be expected to liaise closely with the School Nursing Service (5-19 Healthy Child Programme) and other key stakeholders (e.g. GPs) in developing and implementing accessible and equitable sexual health prevention and outreach services and care pathways for young people.

The Provider will deliver a range of age appropriate prevention activities, support and training within settings accessed by school/college aged pupils, including those who are attending other educational and training institutes:

- 1:1 and group sessions with service users on Prevention and Self-management;
- Referrals to more supported sexual health services e.g. brief intervention, level 1 services etc;
- Identify and train key staff e.g. health and wellbeing advisors, pastoral advisors, to deliver Prevention and Self-management as a means of developing a workforce that will compliment and support the sexual health agenda; and

Activities and interventions shall be age appropriate (for those aged 16 and over, and those under 16 years).

The Provider will also liaise with the NEET tracking and research team and schools, to identify children, at risk groups or schools who may benefit from specific advice, activities and interventions.

The Provider shall prepare a biannual plan of interventions and activities to be delivered within schools, colleges, education and training institutes and shall have been approved by the Commissioner. Plans shall be monitored during the quarterly monitoring meetings.

Local health economy sexual health provider training

The Provider shall:-

- Support undergraduate, postgraduate and specialist training for medical staff. A charge may be levied for this.
- Work with Post-graduate GP Education to deliver Sexual and Reproductive Health teaching and updating to GPs and GP registrars. A charge may be levied for this.
- Provide annual FSRH theory training for local level 1 and 2 practitioners plus practical training to achieve Letters of Competence in IUDs/IUS, Sub-Dermal Implants and Medical Education and Special Skills Modules of the Faculty of Sexual and Reproductive Healthcare; updating and changing training to provide learning that is up to date with that currently recommended by the FRSB including maintenance of a register of professionals trained.
- Provide annual BASHH STIF training for local level 1 and 2 practitioners plus practical training to achieve STIF Level 2 competency. A charge may be levied for this.
- Provide training and support for level 1 and 2 practitioners involved in the delivery of local sexual health services (including local enhanced services) for emergency contraception, Chlamydia screening & treatment, HIV testing, STI screening, condom distribution, pregnancy testing, brief interventions and Making Every Contact Count
- Create and maintain a training register of all courses provided, attendees and pass rates where appropriate.

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- Contribute to the delivery of Sexual Health Promotion training programmes as agreed with the commissioner.
- Work in partnership with the Local Authority Public Health Children and Young People Team as providers of the local Condom distribution Scheme, the local Chlamydia Screening Programme and the local Relationships and Sex Education programmes to ensure consistent services and messages are delivered to Service Users.
- Training for health professionals in primary and secondary care in prescribing of Post Exposure Prophylaxis following Sexual Exposure (PEPSE) including:-
 - the development of a protocol and patient pathway for issue and prescribing in primary and secondary care
 - maintenance of a register of professionals trained to issue/prescribe PEPSE
 - development of a 'fail safe' mechanism for referral of patients to GUM for follow up

Shropshire sexual health clinical network co-ordination

The provider will coordinate and support the delivery of sexual health care across a locality through expert clinical advice, clinical governance and clinical networks. The Provider shall co-ordinate a County-wide multi-agency and multi-disciplinary Sexual Health Network of level 1, 2 and 3 practitioners to:

- Identify, collect and share information on local sexual health needs and concerns.
 - Share information on local sexual health services, activity and planned service developments.
 - Identify gaps in local provision and agree priorities for service improvement and development.
 - Maximise resources and work across organisational boundaries to improve access and deliver high quality, effective services.
 - Share and develop good practice and identify opportunities to improve service uptake and user experience.
 - Develop, agree and promote agreed care pathways for core sexual health services and vulnerable groups.
 - Support the co-ordination and delivery of local sexual health workforce development and education.
 - Share information on the availability of national and local funding opportunities.
 - Ensure all services are well advertised; and the public understand the entire 'sexual health offer' in the area – including services provider and commissioned by all partners
 - Network lead to be a member of the Sexual Health Commissioning Partnership (or equivalent) and provide updates on the work of the network via that route.
-
- **Safeguarding**

The Provider shall have primary regard for the safety and wellbeing of any child/young person or vulnerable adult in their care. Procedures exist for escalating cases and providers are expected to be aware of, conversant with and able to put into operation the local protocols.

The Provider and all sub-contractors will ensure that when working with service users under the age of 16 years, adherence to the Department of Health's guidance document *Best practice guidance for doctors and other health professional on the provision of advice and treatment to young people under the age of 16 on contraception, sexual reproductive health.*⁷ Practitioner will also be aware of the specific responsibilities that they have for young people aged 13 – 15 years and for those under the age of 13 years.

Services who see Service Users less than 16 years of age must comply with Gillick competency and FRASER guidelines, and with the Children Acts (1989 and 2004).

⁷ DoH (2004): *Best practice guidance for doctors and other health professional on the provision of advice and treatment to young people under the age of 16 on contraception, sexual reproductive health* <http://www.bashh.org/documents/1993.pdf>

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The Provider shall ensure all staff are aware of, trained to a level appropriate to their role and abide by guidance and legislation on safeguarding (children and adults) and the standards below. This should include understanding safeguarding referral procedures and referral pathways to social care (see below).

In any cases where a child is aged 13 years or under, it should be discussed with a nominated professional responsible for safeguarding in that service or locality. It is also recommended that **all** young people under 16 have a risk assessment for sexual abuse or exploitation.

The Service Provider will ensure that people who use the service, workers and others who visit are as safe as they can be and that risks are managed. They will also ensure that the human rights and dignity of people who use services are respected and identify and respond when people are in vulnerable situations. Service Providers will ensure that the premises and equipment they use to provide care, treatment & support are safe and suitable. Service Providers will comply with guidance for safeguarding people who use services from abuse, cleanliness and infection control, management of medicines, safety & suitability of premises and safety and suitability of equipment.

All staff working with children, young people and vulnerable adults will have been recruited in line with Shropshire Local Safeguarding Board Standards for Safer Recruitment 2012 and will be subject to a Disclosure and Barring Service (DBS) check. (This is the new system that has replaced Enhanced CRB check)

The provider or any subcontractor will comply with the local inter-agency Safeguarding Children and Young People and Adults Procedures and Practice guidelines. These are available from Shropshire Local Safeguarding Children's Board LSCB websites. These guidelines relate to the protection of all children and young people and vulnerable adults residing within Shropshire and Telford and Wrekin. The Board definition of a vulnerable child:-

Is any child **under the age of 18** including the unborn baby. However some children are more vulnerable than others. These include:

- "Looked after" children already in the care system
- Children with disabilities
- Homeless children
- Teenage mothers
- Children in custodial settings
- Children who live with parental drug and alcohol abuse or domestic violence.

The broad definition of a "vulnerable adult", is a person (aged 18+) who is or may be in need of community care services by reason of mental or other disability , age or illness; and who is or may be unable to take care of him/herself, or unable to protect him or herself against significant harm or exploitation.

The websites contains a number of useful tools and procedures including escalation processes and the Provider shall demonstrate familiarity with these.

Children and Young People Safeguarding

Building on the partnership work to date the new provider will need to develop positive working relationships with Children and Family services from Early Help through to Child Protection to ensure the needs of children and young people are met appropriately. All practitioners should be familiar with local safeguarding processes and understand their responsibility to ensure their functions are discharged having regard for the need to safeguard and promote the welfare of the child. All practitioners should be trained and fully competent in safeguarding.

Adults Safeguarding

The new provider will need to be familiar with the Adult Safeguarding processes and protocol to support the safeguarding of adults within the county of Shropshire. Relationships should be built with the Adult Safeguarding team and all practitioners should be competent in recognising and managing issues in respect of vulnerable adults whether as a user of services or their care/family members.

3.3 Interdependencies with other Services

The Integrated Sexual Health Service will maintain efficient working relationships with allied services, agencies and stakeholders to enhance the quality of care delivered and ensure the holistic nature of the Service. Specifically, linkages will be maintained with, GPs, wider Local Authority services, Health Promotion, other sexual health and secondary health service providers as part of an integrated and coordinated sexual health system.

The Service cannot work in isolation and is required to work with partners to address the needs of service users and increase the opportunity for service users to achieve optimum sexual health outcomes.

As a priority the Provider will have developed robust referral pathways with the following services at start of delivery for this contract:

- Psychosexual problems;
- Female Genital Mutilation (FGM);
- Male and Female sterilisation;
- Termination of pregnancy;
- Antenatal and post-natal services;
- Sexual Assault Referral Centre;
- HIV treatment and Care
- Local Safeguarding services;
- Laboratory services

Partners will include:

- SURE Chlamydia screening programme
- Shropshire Child Health Development Team
- Cervical Screening Programme
- Child, adolescent and adult mental health services
- Community pharmacy
- Drug, alcohol, obesity and smoking intervention services
- General practice
- Gynaecology
- Male and female sterilisation services
- Other healthcare service areas including 3rd sector organisations
- Pathology and laboratory services
- Prisons and youth offenders institutions
- Criminal justice system including probation services
- School, colleges, universities and education services
- Social Care Support
- Community health services, including Health Visitors and Family Nurse Partnership
- Youth services
- Paediatric services

The Provider is expected to actively participate in local, regional and national clinical networks, relevant trials, training, research and audit programmes where applicable

The Provider will ensure Service Users receive consistent and continuous care through the establishment

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of data and care pathways.

The Service will need to interface with local specialised HIV services, local sexual health services as well as locally driven campaigns and activities.

To achieve the abovementioned, the Service is dependent upon up to date lists of local sexual health services and specialised HIV services within and beyond commissioned localities

Relevant Organisations

- Public Health England
- NHS England
- Clinical Commissioning Groups

The Provider is expected to actively participate in local, regional and national networks, relevant trials, training, as well as research and audit programmes where applicable.

3.4 Staffing arrangements

To deliver the service, the staff will need to be competent and able to demonstrate they are appropriately qualified to undertake the roles they do. Across the whole service, the staffing skill mix and levels must reflect, relate to and justify the functions of the Service required. It is expected to achieve these, the provider will ensure that:

- All staff are appropriately qualified to undertake their role and provision is in place for training updates where necessary
- Ensure that training requirements and competencies are monitored through regular assessment and staff appraisal and that staff are enabled to progress through supported learning.
- There is a register of all courses provided, attendees and pass rates where appropriate
- Staff are supported for undergraduate, postgraduate or specialist training
- To maintain quality of delivery and good practice all employees should have in place an individual personal development plan, which is reviewed every 12 months.
- Staff attend appropriate education and training programmes to maintain their level of competency and comply with their professional body requirements.
- All staff has the relevant professional qualifications and operates within their scope of competency, their professional body's standards, regulations and codes of conduct.
- They manage the process of managing and recruiting the team needed to provide the Service
- All staff have a current DBS check
- That during periods of staff absence such as sickness and holidays, the Provider will do everything in its power to ensure that the Service will not be adversely affected and that arrangements for cover are made which enable the Service to continue in line with this specification
- Workforce development plan is in place that is reviewed and amended annually.
- Contribute to the delivery of sexual health promotion training as agreed with the commissioner.
- Appropriate skill mix is in place, or plans in place to improve skill mix.
- Professional leadership is provided.
- An appropriate management structure is in place that supports service delivery and development.
- Staff work to their employing organisational policies.
- Provider maintains a record of dates and types of training provided to all staff involved in this service. Written evidence of training and development plans and arrangements for staff support will be kept and records should be immediately available to the Authority on request for audit purposes.
- There is a formal, comprehensive and coordinated training plan covering all aspects necessary to deliver and maintain the quality of the Service provided.

The Provider will carry out professional registration checks before a team member commences employment and in advance of that registration expiring will carry out checks to ensure that registration has not been removed (as appropriate). If a team member has failed to renew their registration in time, the

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Provider will not allow them to work in their substantial role until such time as the registration has been renewed and verified.

3.4.1 Training and workforce development

See section 3.3 and 3.4 above including:

- Support undergraduate, postgraduate and specialist training for medical staff. A charge may be levied for this.
- Work with Post-graduate GP Education to deliver Sexual and Reproductive Health teaching and updating to GPs and GP registrars. A charge may be levied for this.
- Provide annual FSRH theory training for local level 1 and 2 practitioners plus practical training to achieve Letters of Competence in IUDs/IUS, Sub-Dermal Implants and Medical Education and Special Skills Modules of the Faculty of Sexual and Reproductive Healthcare; updating and changing training to provide learning that is up to date with that currently recommended by the FRSR including maintenance of a register of professionals trained.
- Provide annual BASHH STIF training for local level 1 and 2 practitioners plus practical training to achieve STIF Level 2 competency. A charge may be levied for this.
- Provide training and support for level 1 and 2 practitioners involved in the delivery of local sexual health services (including local enhanced services) for emergency contraception, Chlamydia screening & treatment, HIV testing, STI screening, condom distribution, pregnancy testing, brief interventions and Making Every Contact Count
- Create and maintain a training register of all courses provided, attendees and pass rates where appropriate.
- Contribute to the delivery of Sexual Health Promotion training programmes as agreed with the commissioner.

3.5 Clinical Governance

The Provider will be required to demonstrate that they have systems, processes and plans to ensure sound clinical governance. These systems, processes and plans should be in line with and adhere to NHS Clinical Governance Frameworks

3.5.1 Risk management arrangements

The Provider will ensure that there is in place a documented risk management policy / plan that will include:

- Incident reporting, investigation, resolution and audit to inform learning and service development

The Provider shall provide quarterly risk management reports to the Authority or more frequently if appropriate, in exceptional circumstances.

The Provider will ensure that they have an appropriate incident reporting policy in place.

3.6 Any Acceptance and Exclusion Criteria and Thresholds

- **Population Covered**

As an integrated sexual health service, the service must operate an open access policy regardless of

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residence of the patient.

- **Any Acceptance and Exclusion Criteria and Thresholds**

This agreement excludes:

- HIV treatment and care, which is subject to separate service agreements. (NHS England will commission HIV as a prescribed specialised service through the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to national service specifications. This will include a preferred access to NHS list prices in the Commercial Medicines Unit (CMU) tender)
- Any costs incurred for undertaking opportunistic cervical smears which is subject to a separate service agreement with the relevant Commissioning Hub (West Midlands) Region (Midlands and East) in line with a standard NHS contract and compliance to the service specification as detailed in appendix 6.
- Services that should be provided by General Practice under the terms of the GMS contract.
- Psychosexual services as a result of:
 - Sexual practices that would be the subject of action under the criminal justice system
 - Sexual addictions and paraphilia requiring psychiatric input
 - Psychological therapies requiring pharmacological treatment
 - Services required as a result of dysfunctions that are organic in origin – such as non-sexual health aspects of psychosexual counselling
 - Services required for the assessment and management of gender dysphoria. However the service will facilitate appropriate referral.

The Provider has the right to refuse service provision to the users:

- Who are unsuitable for treatment under the conditions of this service specification
- Who have not validly consented to the treatment provided under the Services
- For any unreasonable/ unacceptable behaviour towards staff or others attending the service.

Where staff do not wish to provide sexual health and contraception service i.e. EHC services to under 16 year olds, due to religious or moral reasons, they are required to refer to another health professional/service that can offer the intervention and the Provider shall inform the Commissioner immediately.

Patient inclusion and exclusion criteria, i.e. under the PGD, young person specific intervention, will be applied during provision of the specified services.

The Summary of Product Characteristics should be consulted for clinical information on the licensing of the drug (www.medicines.org.uk). The Provider shall ensure that those patients, who are excluded on the grounds of inclusion thresholds, are referred to the integrated community-based sexual health service.

For service users whose needs are not met at a service, it is the responsibility of that service to make a direct onward referral to another sexual health service that can meet the service user's need. Where it is not possible for that service to make a direct referral the service user will be provided with clear information (opening hours and service information) for other sexual health providers. The Provider shall be expected to provide details of onward referrals made to the same level of service.

The Provider has the right to refuse service provision to those users:*

- Who are unsuitable for treatment under the conditions of this service specification;
- Who have not validly consented to the treatment provided under the services; and
- For any unreasonable behaviour unacceptable to the Provider, its staff, or the named professional clinically responsible for the care of the patient.

*The Provider must immediately inform the Commissioner in writing of any service complaints or serious

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or untoward incidents.

The service must comply with the Equality Act 2010

The service should be sensitive to the cultural needs and backgrounds of people in its local population and its service users.

There are a number of groups mentioned within this specification who are at greater risk of sexual ill-health. Services should be specifically targeted to these groups to reduce inequalities.

3.7 Equality and diversity

The Service is to be provided free from discrimination where all individuals are treated fairly, with dignity and respect, appropriate to their need. The appointed Provider will undertake Equality Impact Assessments to ensure that no population targeted under this Service Specification are disadvantaged through chosen delivery model(s).

3.8 Any Activity Planning Assumptions

Service	Indicative Activity 2016-17
Level 3 sexual health	500 episodes of care
Level 3 complex contraception	150 episodes of care
Levels 1 and 2 (Contraception and Sexual Health)	6500 attendances
Sexual Health Clinical Outreach	
Vulnerable/At risk	220 Service Users
FE/College settings	350 attendances

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Sexual Health Counselling	120 attendances
Non Prescribing Psychosexual Clinic	260 attendances
Health Promotion/Prevention Planned Outreach Campaigns	Minimum 12 planned campaigns per year
Training for local sexual health providers	As per service specification
Condom distribution Scheme	To be determined
HIV prevention service	To be determined

4. Applicable Service Standards

4.1 The Service is to be underpinned by the following national standards and guidelines:

Delivering effective quality treatment needs to be underpinned by the evidence base. It is the expectation of the Partnership providers will be able to demonstrate how they will contribute to the achievement of national and local priorities and targets using the best evidence available.

The following are the minimum required standards that the Provider is required to meet wherever a service schedule indicates that the function listed is part of that service

- Service Standards for Sexual and Reproductive Healthcare (FSRH 2013)
- British HIV Association Standards of Care for People Living with HIV (BHIVA 2013)
- Clinical Guidance – Emergency Contraception (FSRH 2012)
- UK National Guideline on Safer Sex Advice (BASHH & BHIVA 2012)
- National Chlamydia Screening Programme Standards (7th Edition 2014)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (2012)
- Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE 2012)
- Standards for psychological support for adults living with HIV (British Psychological Society, BHIVA & MEDFASH 2011)
- UK Guideline for the use of Post-Exposure Prophylaxis for HIV following Sexual Exposure (BASHH 2011)
- PH34 Increasing the uptake of HIV testing among men who have sex with men (NICE 2011)
- PH33 Increasing the uptake of HIV testing among black Africans in England (NICE 2011)
- The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7 (RCOG 2011)
- Standards for the Management of Sexually Transmitted Infections (BASHH & MEDFASH 2010)
- UK National Guidelines for HIV Testing (BHIVA 2008)
- Progress and Priorities - Working Together for High Quality Sexual Health (MEDFASH 2008)
- PH3 One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups (NICE 2007)
- CG30 Long-acting reversible contraception (NICE 2005)
- Recommended Standards for Sexual Health Services (MEDFASH 2005)

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- Research Governance Framework for Health and Social Care (Department of Health 2005)
- Male and Female Sterilisation , Evidence-based Clinical Guideline Number 4 (RCOG 2004)
- Guidance for managing STI outbreaks & incidents (HPA 2010)
- Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.
- Essential standards of quality and safety (CQC 2010)
- Sexually Transmitted Infections in Primary Care (RCGP/BASHH 2013)
- PH51 Contraceptive Services with a focus on young people up to the age of 25 (NICE 2014)
- UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault (BASHH 2011)
- A Quality Standard for Contraceptive Services (FSRH 2014)
- Sexual Health Services : Key principles for cross charging (DH 2013)
- Sexual Health Clinical Governance (DH 2013)
- Working Together to Safeguard Children (DfE 2013)
- UK Medical Eligibility Criteria for Contraceptive Use (FRSH 2009)
- All related NICE Guidance

Relevant UK clinical guidance covering the specialities of Sexual & Reproductive Healthcare and Genitourinary Medicine can be found at www.fsrh.org and www.bashh.org. Providers must ensure services reflect updates in guidance and recommendations as and when produced.

The Service will use the Department of Health's *You're Welcome* quality criteria⁸ and local resources where available, as guiding principles when planning and implementing changes and improvements, in order for the service to become young people friendly where appropriate.

Service planning and improvement should always include consultation with service users and local populations.

The Provider will comply with all relevant legislation, regulations, statutory circulars and National Quality requirements in so far as they are applicable to the service. Services will have robust processes for assessing, implementing and monitoring NICE technology appraisals, guidance and interventional procedures as appropriate. Outcomes of any non-compliance are to be made available to SC with an appropriate Action Plan and timelines for compliance.

The service will have a clear and written complaints procedure in place which complies with both Local Authority and NHS standards. It will be made available to service users and their friends and family at commencement of engagement with the service. Where a service user or their friend or family member has a complaint or concern about the service offered, the provider will make efforts to address the issue as soon as possible at the local level. If the issue is not resolved to the satisfaction of the service user or their friend or family member, there should be an open and transparent process to escalate the complaint to a higher level within the organisation, informing the commissioner of this action.

The Provider will log all complaints and will return a quarterly collated report of the complaints received and resulting actions taken.

Applicable Local Standards:

Sexual health promotion in all care pathways

- 100% of all patients attending services receive sexual health promotion and brief advice to enable

Department of Health 2011; Quality criteria for young people friendly health services
<https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services>

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- them to tackle their risk taking behaviours and avoid future sexual health problems.
- 100% of service staff are trained to give sexual health promotion messages/ information and to give brief advice

Data Requirements

The Service is required to generate a quarterly data extract of all patient attendances and associated diagnoses and services at GUM and non-GUM clinics in accordance with PHE (Public Health England) Genitourinary Medicine Clinic Activity Dataset (GUMCADv2).

In addition to GUMCADv2, the Service is also required to utilise Sexual and Reproductive Health Activity Dataset (SRHAD) to capture contraception and other sexual and reproductive health activities.

Following a new HIV diagnosis, the Service is required to generate a data extract to the HIV and AIDS Reporting Section (HARS) in Public Health England. This extract can either be through the new HIV diagnosis reporting template or reported quarterly through the HIV and AIDS Reporting System which is being rolled out during 2013/14.

The completion of the Chlamydia Testing Activity Dataset (CTAD) is mandatory for all NHS and NHS-commissioned chlamydia testing carried out in England. CTAD is submitted by laboratories and enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through measurement of population screening coverage, proportion of all tests that are positive and diagnosis rates.

It is the responsibility of the sexual health service provider to ensure the core CTAD data requirements are provided to the laboratory for each chlamydia test, in particular, postcode of residence of the patient and testing service type.

SRHAD and HARS, together with GUMCADv2 will form the basis for a standardised sexual health dataset collected from sexual health clinic settings (plus CTAD from laboratories). The Service is expected to discuss with commissioners quarterly GUMCADv2 and SRHAD data analysis from PHE to enable informed commissioning decisions relating to GUM attendances, activity and STI trends.

The Provider must have a clear confidentiality and data handling policy, which is understood by all members of staff. The purpose of this policy is to prevent patient details being inappropriately disclosed when consent is given.. The policy may be outlined in the form of a simple leaflet and / or notice displayed within the provider.

Circumstances of information sharing and when confidentiality may be breached must be explained to service users on entry to the service.

The Provider will develop clear and robust information sharing protocols with relevant partner agencies across the county. This will ensure the development of good working relationships with relevant partners and make the transfer of client information easier and safer to facilitate optimal treatment gains and recovery for service users. Agreed protocols must be in place for commencement of the service

Data and information and reporting arrangements

The accurate, clear and concise recording of all activities is a requirement of this contract. The Provider shall comply with this requirement and also demonstrate how they will be able to establish a two-way flow of information and data with partners which is safe and secure and does not breach the appropriate legislation in respect of data protection.

The local authority and the Provider will be separate Data controllers and therefore each responsible for upholding requirements of the Data Protection Act 1998.

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The Provider shall ensure the following:

- All data transferred into the service will include all open, closed and legacy patient records including paper based and electronic.
- Data collected as part of this agreement shall be processed solely to perform the obligations outlined in this agreement and no other purposes;
- Have in place appropriate retention and disposal policies and upon completion of termination of the agreement, should return any data deemed to belong to the local authority and/or with local authority consent securely destroy in line with above disposal policies;
- Allow the commissioning authority access to patient level non-identifiable data throughout the course of the Contract (within 10 working days) and for 5 years from completion or termination of the Contract (within 21 working days);
- Requests for information, including, but not limited to Freedom of Information and Subject Access Requests shall be dealt with by the Provider (where they are subject to the Freedom of Information Act 2000) in line with their normal Information Governance structures;
- All staff and sub-contractors are made aware of their obligations with regard to the security and protection of data and shall require that they enter into binding obligations with regards with the Provider in order to maintain the level of security and protection specified;
- Appropriate technical and organisational measures to safeguard the data from unauthorised or unlawful processing or accidental loss, destruction or damage and shall have a process in place for managing potential or actual security incidences;
- Service user data will not be divulged to any person, business or organisation except to those of its employees, agents and sub-contractors who are engaged in the processing of the data or where there is a legal obligation to do so; and
- All staff are adequately trained to understand and comply with their individual responsibilities under the Data Protection Act, the Common Law of Duty of Confidentiality and this Agreement.

The Provider shall have the capability to generate, and will submit relevant data extracts in line with the following reports:

- National data submission requirements
- Indicators specified in Appendix C *Quality and Performance indicator*

5. Location of Provider Premises

Locations and settings:

Services are to be situated in easily accessible convenient locations with good public transport links. Their location also needs to be guided by public health intelligence to ensure that the greatest needs are met across Shropshire.

As minimum, services must be provided in:

**Shrewsbury (Town centre),
Oswestry, Whitchurch,**

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**Ludlow,
Market Drayton and
Bridgnorth**

Premises Quality:

The Provider must ensure that all clinical space complies with the DH guidance⁹. The provider is responsible for securing premises for the services and all related matters.

6. Required Insurances

See Main Contract Section B27

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⁹ Out-patient care. Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics. London: The Stationary Office.

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APPENDIX B

CONDITIONS PRECEDENT

1. Provide the Authority with a copy of the Provider's registration with the CQC where the Provider must be so registered under the Law

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APPENDIX C

QUALITY OUTCOMES INDICATORS¹⁰

Quality Outcomes Indicators	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Clinical Management				
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment undertaken ¹¹	100%	BASHH Standard 1 ¹²	Clinical Audit	Remedial Action Plan
Monitor percentage of first time service user (of clinical based services) offered and accepting an HIV test	For local determination ¹³	For local determination (To support Public Health Outcome Framework 3.4)	GUMCAD	Remedial Action Plan
Percentage of routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within seven working days of a specimen being taken	100%	BASHH Standard 4	Clinical Audit	Remedial Action Plan
Ratio of contacts per gonorrhoea index case, such that the attendance of these contacts at a Level 1, 2 or 3 service was documented as reported by the index case, or by a HCW, within four weeks of the date of	At least 0.6 contacts per index case, and documented within four weeks of the date of the first PN discussion ^{14 15}	BASHH Statement on Partner Notification for Sexually Transmissible Infections ²⁵	Clinical Audit	Remedial Action Plan

¹² BASHH (British Association Sexual Health & HIV) and MEDFASH (2010). *Standards for the Management of Sexually Transmitted Infections* (<http://www.medfash.org.uk/publications>)

¹³ Cross reference BHIVA (2008) *UK National Guidelines for HIV Testing 2008* (<http://www.bhiva.org/HIVTesting2008.aspx>)

¹⁴ Corrigendum *BASHH Statement on Partner Notification for Sexually Transmissible Infections*, May 2013 (<http://www.bashh.org/documents/Corrigendum%20BASHH%20Statement%20on%20Partner%20Notification%20for%20Sexually%20Transmissible%20Infections.pdf>)

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the first PN discussion (within 12 weeks for HIV)				
Ratio of contacts of chlamydia index cases whose attendance at a Level 1, 2 or 3 service was documented as reported by the index case, or by a HCW, within four weeks of the date of the first PN discussion	At least 0.6 contacts per index case for all clinics and documented within four weeks of the date of the first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections NCSP Standard 4	Clinical Audit	Remedial Action Plan
The ratio of all contacts of chlamydia index case whose attendance at a Level 1, 2, or 3 sexual health service was documented as verified by a HCW, within four weeks of first PN discussion	At least 0.4 contacts per index case for all clinics and documented within four weeks of date of first PN discussion	BASHH Statement on Partner Notification for Sexually Transmissible Infections NCSP Standard 4	Clinical Audit	Remedial Action Plan
Documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk	90%	BHIVA Standard 7 ¹⁶	Clinical Audit	Remedial Action Plan
Documented PN outcomes or a progress update at 12 weeks after the start of the process	90%	BHIVA Standard 7	Clinical Audit	Remedial Action Plan
Monitor period of time from consultation to receipt of results by service user	100%/10 days	BASHH Standard 5	Clinical Audit	Remedial Action Plan
Percentage of women having access to and availability of the full	100%	FSRH Standard 2 ¹⁷	Clinical Audit	Remedial Action Plan

¹⁶ British HIV Association (2013). *Standards of Care for People Living with HIV* <http://www.bhiva.org/documents/Standards-of-care/BHIVStandardsA4.pdf>

¹⁷ Faculty of Sexual & Reproductive Healthcare (2013). *Service Standards for Sexual and Reproductive Healthcare* (http://www.fsrh.org/pdfs/All_Service_standards_January_2013.pdf)

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range of contraceptive method (including choice within products)				
Monitor percentage of LARCs prescribed as a proportion of all contraceptives by age	Baseline will be in line with national average. The provider will demonstrate year on year increase from baseline year 1	For local determination	Quarterly reporting	Remedial Action Plan
Percentage of women who have access to urgent contraceptive advice and services (including emergency contraception) within 24hours of contacting the service ¹⁸	100%	For local determination	Quarterly reporting	Remedial Action Plan
Percentage of women who have access to LARC method of choice within 4 weeks of contacting service ³²	100%	For local determination	Quarterly reporting	Remedial Action Plan
Improving Productivity				
Percentage of staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant update requirements	100%	BASHH Standard 2	For local determination	Remedial Action Plan
Percentage of nurses dual trained to deliver contraceptive (including LARC methods) and GUM services	Year 1 baseline formed in-year. To reach 100% dual trained by end of year 2.	For local determination	Quarterly reporting	Remedial Action Plan
Chlamydia Screening				
Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	100%	Public Health Outcome Framework measure (3.2)	CTAD Data	Remedial Action Plan

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Percentage of all under 25 year olds screened for chlamydia	At least 75% of new attendances ¹⁹	Contributes towards Public Health Outcome Framework measure (3.2)	Quarterly reporting	Remedial Action Plan
Percentage of all results notified to the young person within 10 working days (from test date)	At least 90%	NCSP Standard 4	Quarterly reporting	Remedial Action Plan
Percentage of positive patients who received treatment within six weeks of test dates	At least 95%	NCSP Standard 4	Quarterly reporting	Remedial Action Plan
Service User Experience				
Maintain/achieve <i>You're Welcome</i> accreditation	100%	National Expectation	Quarterly reporting	Remedial Action Plan
Evidence of at least one real time user experience survey annually	100%	For local determination	Annual service report	Remedial Action Plan
Percentage of service user feedback on surveys that rates satisfaction as good or excellent	70%	For local determination	For local determination	Remedial Action Plan
Feedback from target groups who are at greatest risk of sexual ill health to ensure services are attractive and accessible	Target group to be agreed with the commissioner at start of year	Local indicator	Quarterly reporting	Remedial action plan
Evidence of improvements made to service as a result of user feedback	Demonstrable evidence of improvements and changes made to service delivery in response to feedback	BASHH Standard 9	For local determination	Remedial Action Plan
Number of service users making formal complaints about the service (verbal or written)	Provider to notify Commissioner in accordance with <i>Incidents Requiring Reporting Procedure Section - Appendix G</i>	BASHH Standard 9	Quarterly reporting	Remedial Action Performance
Number of service users	Year 1: Baseline	BASHH	Quarterly	Remedial

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complimenting the service	formed in year Year 2: 90% Year 3:90%	Standard 9	reporting	Action Plan
Reducing Inequalities				
An Equality Impact Assessment (EIA) is undertaken and outcomes utilised to inform forward year planning	Completion of EIA	Locally Determined	Annual service report	Remedial Action Plan
Provider to demonstrate that all functions and policies are equality impact assessed	100% compliance	Locally Determined	Annual service report	Remedial Action Plan
Number of outreach sessions conducted in areas of high deprivation or aimed at vulnerable groups	Year 1: baseline formed in year. Year 2-3:maintain baseline as a minimum	Locally Determined	Quarterly reporting	Remedial Action Plan
Access				
Percentage of clients accessing service to be seen within 48 hours of contacting the service	85%	Locally Determined	Quarterly reporting	Remedial Action Plan
Percentage of people offered an appointment, or walk-in, within 48 hours of contacting a provider	98%	BASHH Standard 1	Quarterly reporting	Remedial Action Plan
Percentage of users experiencing waiting times in clinics of > 2 hours	Less than 10%	Locally determined	Quarterly reporting	Remedial Action Plan
Percentage of clients waiting longer than (<i>to be agreed locally</i>) from booking to appointment	Less than 10%	Locally Determined	For local determination	Remedial Action Plan
Increase in the number of men accessing services	Baseline of 35% in year 2015/16: year on year increase from baseline	Locally Determined	For local determination	Remedial Action Plan
Care pathways with other organisations to include	Pathways established	BASHH Standard 7	Quarterly reporting	Remedial Action Plan

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partner notification and/or linked services (e.g. alcohol, mental health etc.) are clearly defined				
Percentage of specialist SRH referrals from general practice seen within 18 weeks of referral	100%	Locally Determined	Quarterly reporting	Remedial Action Plan
Percentage of psychosexual clients seen within 18 weeks of referral ²⁰	100%	Locally Determined	Quarterly reporting	Remedial Action Plan

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Performance Indicators	Threshold	Method of Measurement	Consequence of breach
Percentage of HIV testing uptake (as a proportion of all HIV tests) in MSM	Maintain 97%	Quarterly performance report to Commissioner	Remedial Action Plan
Proportion of service users presenting at sexual health services taking up STI testing	70%	Quarterly performance report to Commissioner	Remedial Action Plan
Proportion of services users taking up a chlamydia test (under 25 years)	100% offer 80% uptake	Quarterly performance report to Commissioner	Remedial Action Plan
Proportion of service users (first-time attendees) switching to LARC from other contraceptive methods	Year 1: 10% increase from user dependent methods using 2014/15 Baseline Year 2: 20% increase from 2014/15 Baseline Year 3: 30% increase from 2014/15 Baseline	Quarterly performance report to Commissioner	Remedial Action Plan
Percentage of all service users who did not meet the service criteria and were referred to another sexual health services	% of service users that did not meet service criteria % of service users who were referred and that presented at referred service as verified by a	Quarterly performance report to Commissioner	Remedial Action Plan

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	HCW		
Proportion of activity at Level 1 -2 within the Integrated community-based sexual health service	Year 1: Baseline formed in year Year 2: Baseline formed in year Start of Year 3: 75% :25% split between level 3: level 1 and 2 activity	Quarterly performance report to Commissioner	Remedial Action Plan
Proportion of service users receiving Prevention – Information & Education and Self-management And Proportion of those service users receiving brief intervention after being referred from brief advice Proportion of those service users receiving one to one support after being referred from brief intervention	100% And 100% of those referred after brief advice And 100% of those referred after brief intervention	Quarterly performance report to Commissioner	Remedial Action Plan
Proportion of sexual health staff trained in Prevention and self-management	Year 1: Baseline for capacity of achieving delivery to 100% of service users formed at start of	Quarterly performance report to Commissioner	Remedial Action Plan

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At level 1-	service delivery		
At level 2-	Year 2 and 3: Maintain/ Rebalance Baseline capacity to continue to achieve delivery to 100% of service users		
At level 3-			

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APPENDIX D

SERVICE USER, CARER AND STAFF SURVEYS

1. The service provider is required to carry out regular surveys with service users to understand their experience of the service, from invitation through to delivery of the Sexual Health Service and how follow up is managed. Providers will work with the commissioner to identify and implement any improvements from the patient experience feedback.
2. The format of the feedback can be decided by the provider and will be reviewed 6 monthly but will include real time surveys.
3. The service provider is required to carry out regular surveys with staff delivering services to understand any problems, good practice and service improvements, which need to be fed back to the Council's Commissioners.

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APPENDIX E

CHARGES

Financial Model

Total annual contract value for the 3 year period - £2,664,000

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APPENDIX F

SAFEGUARDING POLICIES

1.0 SAFEGUARDING REQUIREMENTS

- 1.1 The Provider shall adopt the Council's procedures for dealing with allegations or suspicions of Abuse including the **West Midlands Multi-Agency Safeguarding Adults Policy and Procedure** (July 2012) (as amended from time to time during the Term).and the **West Mercia Consortium Inter-Agency Child Protection Procedures for Safeguarding Children** (February 2013) (as amended from time to time during the Term).
- You can report your concerns online via the '[Report child abuse online - NSPCC website](#)' or phone **the Initial Contact Team on 0345 678 9021**.
 - If you need to report concerns **out of office hours** then please contact **the Emergency Duty Team on 0345 678 9040**.
 - You can also speak to:
Protecting Vulnerable People (West Mercia Police): 0300 333 3000
NSPCC: 0800 800 5000
Childline: 0800 1111
- 1.2 In cases of actual or suspected abuse to a Service User who is a Vulnerable Adult the Provider must ensure strict adherence to the West Midlands Multi-Agency Safeguarding Adults Policy and Procedure in order to protect the Service User, and in so doing shall comply with requirements of any investigation carried out by the Council or other appropriate agency.
- 1.3 The Council's Representative must be notified immediately in writing by the Provider of all instances of suspected Abuse of any Service User which comes to the attention of the Provider by any means pursuant to the operation of this Agreement. For the avoidance of doubt this includes instances which do not relate to any member of Staff or other persons engaged in the provision of the Services.
- 1.4 The Provider shall immediately notify the Council in writing of any information that is required under this clause or it reasonably requests to enable it to be satisfied that the obligations of this clause have been met.

APPENDIX G

INCIDENTS REQUIRING REPORTING PROCEDURE

Pursuant to clause B11 (Incidents Requiring Reporting) procedure for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) reportable Patient Safety Incidents; and (3) Non-Service User incidents]

Incidents in relation to adult of child Safeguarding

Incidents relating to Equipment

An adverse incident is an event that causes, or has the potential to cause, unexpected or unwanted effects involving the accuracy and/or safety of device users (including patients) or other persons. Examples would include but not be limited to:

- patient, user, carer or professional is injured as a result of a medical device failure or its misuse
- patient's treatment is interrupted or compromised by a medical device failure
- misdiagnosis due to a medical device failure leads to inappropriate management and treatment
- a patient's health deteriorates due to medical device failure

Any adverse incidents involving medical equipment should be reported to the manufacturer as well as the Medicines and Healthcare products Regulatory Agency (MHRA).

Adverse incidents should be managed according to the providers' governance arrangements.

Any adverse incident must be reported in writing by the Provider to the contractor within 48 hours of the incident occurring.

The written notification should detail what actions the provider proposes, and plans to share learning with the contractor and other providers of the service.

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APPENDIX H

INFORMATION PROVISION

Activity Plan

On a quarterly basis, the Provider will be required to report on progress against all the Quality and Performance Indicators outlined in Appendix C.

The Provider will also report on a range of activity to the Commissioner on a quarterly basis. The Provider will meet quarterly with the Commissioner to review performance.

Reports to include:

- Number of first and follow up clients
- Number of clients by:
 - Age (Bands)
 - Gender
 - Ethnicity
 - LA and out of area residents
- Number of chlamydia screens offered and accepted (in under 25 year olds)
- Number of positive chlamydia diagnoses (in under 25 year olds)
- All STI tests by coding: positive and negative
- All HIV antibody tests positive and negative
- Contraceptive methods:
 - Number of patients (male & female) receiving condoms
 - Number of IUD's fitted and removed
 - Number of IUS' fitted and removed
 - Number of contraceptive injections administered
 - Number of hormonal contraceptive implants fitted and removed
 - Number of contraceptive pills prescribed (COC & POP)
 - Numbers of clients provided with emergency contraception (oral & device)
- Number of referrals to abortion services
- Details of training provision including course information, number of delegates and delegate details (including job title and organisation)
- Number of outreach sessions undertaken, including details of venue
- Number of opportunistic cervical smears offered and undertaken
 - Age of woman
 - Period since last smear taken

The above provision of data is in addition to national reporting mechanisms i.e. GUMCADv2, SRHAD and CTAD.

APPENDIX I

TRANSFER OF AND DISCHARGE FROM CARE PROTOCOLS

Sexual health patients are not formally discharged from the Service. However, it is recognised that patients may choose not to attend the service in future, or may attend another service provider for their continuing care e.g. GUM for Level 3 services or referral to providers abortion support.

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APPENDIX J

SERVICE QUALITY PERFORMANCE REPORT

Annual reports

- Annual service user satisfaction report;
- Annual calendar for health promotion/ prevention planned Outreach campaigns;
- Annual 'Additional Training' plan;

Biannual reports

- Workforce + qualification + training + accreditation + professional training;
- Plan of activities and interventions within schools, colleges, education and training settings.

Quarterly reports

- Quality outcomes indicators report;
- Performance indicators report;
- Activity indicators report;
- Information indicators report;
- Workforce metrics report; and
- Service user feedback report.

In Year 1, the Provider shall monitor, generate and submit monthly activity data against the planned indicative activity to the Commissioner.

Meetings between the Provider and commissioner will be held on a quarterly basis for at least 3 hours each, and will be used to discuss service performance and service development. Electronic reports for local performance and quality monitoring shall be submitted to the commissioner a week in advance of the meetings, in the format specified by the commissioner. Data will be submitted in the Quality and performance tables specified.

Where appropriate, the Council shall request that sub-contractors and/or other stakeholders (including service users) attend to support contract management, as a means of sharing service experience. This will not be with reference to any activities relating to performance monitoring or the details of contracts/sub-contracts, which will remain the sole responsibility of the Provider.

In the event of breaching a threshold, the Council may request that the Provider submit a remedial action plan for tackling the causes of the breach.

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Activity indicators	Method of Measurement
Number of Chlamydia screens offered and accepted (in under 25 years)	Quarterly performance report to Commissioner
Contraceptive methods <ul style="list-style-type: none"> • Number of service users (male and female) receiving condoms • Number of IUD's fitted and removed • Number of IUS' fitted and removed for contraceptive purposes / menorrhagia • Number of contraceptive implants fitted and removed • Number of service users prescribed a contraceptive pills • Number of service users provided with emergency contraception (oral and device) 	Quarterly performance report to Commissioner
Number of repeat use of EHC (self-reported when obtained from other provider)	Quarterly performance report to Commissioner
Number of service users of repeat oral contraception	Quarterly performance report to Commissioner
Number of DNAs	Quarterly performance report to Commissioner
Details of training provision including course information, number of delegates and delegate details (job title and organisation)	Quarterly performance report to Commissioner
Prevention	
Number of service users that have received Prevention- Information & Education and Self-management	Quarterly performance report to Commissioner
Number of service users that have received brief intervention	Quarterly performance report to Commissioner
Number of service users that have received one to one support	Quarterly performance report to Commissioner
Number of service users referred from other services for behavioural change (please provide breakdown of agencies and numbers referred)	Quarterly performance report to Commissioner
Contraception Basic and Intermediate community-based L1&2	
Number of new and repeat attendances	Quarterly performance report to Commissioner
Proportion of new attendances at Level 1 and 2 sexual health services	Quarterly performance report to Commissioner
Proportion of repeat attendances at Level 1 and 2 sexual health services	Quarterly performance report to Commissioner
Proportion of new attendances at Level 1 and 2 contraception services	Quarterly performance report to Commissioner
Proportion of repeat attendances at Level 1 and 2 contraception services	Quarterly performance report to Commissioner
Number of attendees receiving behaviour change intervention	Quarterly performance report to Commissioner
Integrated community-based sexual health services L1,2&3	

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Number of new and repeat attendances	Quarterly performance report to Commissioner
Proportion of new attendances at Level 3 sexual health services	Quarterly performance report to Commissioner
Proportion of follow up attendances at Level 3 sexual health services	Quarterly performance report to Commissioner
Proportion of new attendances at Level 3 contraception services	
Proportion of follow up attendances at Level 3 contraception services	
Proportion of new attendances at Level 1 and 2 sexual health services	Quarterly performance report to Commissioner
Proportion of follow up attendances at Level 1 and 2 sexual health services	Quarterly performance report to Commissioner
Number of attendees receiving behaviour change intervention	Quarterly performance report to Commissioner
Local Condom Distribution Scheme	
Breakdown of the number outlets and number of service users registered and number of packs distributed	Quarterly performance report to Commissioner
% of services users that have been using this service for 1 year 2 years 3 years	Quarter 4 performance report to Commissioner
Number of outlets in market towns Number of outlets in young people hot-spot areas Number of outlets in priority areas Number of outlets in areas of deprivation	Quarterly performance report to Commissioner
Number of attendees receiving behaviour change intervention	
Number of service users 'flagged' as using the card 'inappropriately'	
Sexual Health Clinical Outreach to Vulnerable Young people and adults	
Location ²¹ of venues and frequency of visits/intervention	Quarterly performance report to Commissioner
Number of EHC issued	Quarterly performance report to Commissioner
Number of contraceptive implants	Quarterly performance report to Commissioner
Number of contraceptive injections	Quarterly performance report to Commissioner
Number of oral contraception prescriptions issued	Quarterly performance report to Commissioner
Number of home interventions	Quarterly performance report to Commissioner
Number of service users referred to other sexual health services	Quarterly performance report to Commissioner

²¹ Location – where possible please provide physical address and as a minimum the town clinical venue is located in.

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Number of attendees receiving behaviour change intervention	
Sexual Health Outreach in schools, colleges, education and training institutes	
List of schools, colleges, educational and training institutes currently engaged Please breakdown the below by setting:	Quarterly performance report to Commissioner
Number of 1:1 interventions delivered + Number of attendances	Quarterly performance report to Commissioner
Number of group sessions delivered + Number of attendances	Quarterly performance report to Commissioner
Number of referrals into sexual health services	Quarterly performance report to Commissioner
Number of Schools the Provider is collaborating with to support, prioritise and standardise SRE	Quarterly performance report to Commissioner
Number of attendees receiving behaviour change intervention	
Laboratory services	
Total number of laboratory tests broken down by type of test and location provider	Quarterly performance report to Commissioner
Total number of tests broken down by type and positive and negative results	Quarterly performance report to Commissioner
All HIV tests positive and negative	Quarterly performance report to Commissioner
Referrals	
Number of direct referral pathways in place with other agencies (please list agencies)	Quarterly performance report to Commissioner
Number of referrals to other services	Quarterly performance report to Commissioner
Breakdown of referring agencies + number of referrals for Prevention/behavioural change for Level 1 /2 services for Level 3 services	Quarterly performance report to Commissioner
Proportion of referrals (out of total referrals) into services that were made at the appropriate level	Quarterly performance report to Commissioner
Number of referral to SARC	Quarterly performance report to Commissioner
Number of referrals to termination of pregnancy services	Quarterly performance report to Commissioner

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Information Indicators	Method of Measurement
Number of contact by type (face to face, over the phone)	Quarterly performance report to Commissioner
Number of service users by <ul style="list-style-type: none"> • Age (bands) • Gender • Ethnicity • Clinic/Sites • LA LSOA of residence • LA and out of area residents • Sexual orientation • Disability • Religion/ belief • Gender reassignment (where appropriate) 	Quarterly performance report to Commissioner

Workforce Metrics	Method of Measurement
Staff in post	Quarterly performance report to Commissioner By sub-contractors
Vacancies / locum rates	
Staff turnover	
Sickness / absence Clinical	

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APPENDIX K

DETAILS OF REVIEW MEETINGS

Reporting & Meeting Schedule

Monthly Contract Implementation Meeting Schedule: 1st April – 31st June 2016

Meeting Date	Meeting Time	Meeting Venue
9 th May 2016	9.30 – 11.00	TBC
2 nd June 2016	9.30 – 11.00	TBC
26 th July 2016	9.30 – 11.00	TBC
Future dates TBC		

Quarterly Contract and Performance Meeting Schedule: 1st April 2016– 31st March 2017

Quarter	Period	All Reports Submission to Commissioners	Meeting Date	Meeting Time	Meeting Venue
Q1	April - June	14 th July 2016	28 th July 2016	9.00 – 12.00	TBC
Q2	July - September	13 th October 2016	27 th October 2016	9.00 – 12.00	TBC
Q3	October - December	12 th Jan 2017	26 th Jan 2017	9.00 – 12.00	TBC
Q4	January - March	17 th March (this report will need to include as much data as possible)	10 th April 2017	9.00 – 12.00	TBC

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**APPENDIX L
AGREED VARIATIONS**

Not applicable

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APPENDIX M

DISPUTE RESOLUTION

Part 1 of Appendix M – Dispute Resolution Process

1. ESCALATED NEGOTIATION

1.1 Except to the extent that any injunction is sought relating to a matter arising out of clause B36 (*Confidentiality*), if any Dispute arises out of or in connection with this Contract, the Parties must first attempt to settle it by either of them making a written negotiation offer to the other, and during the 15 Business Days following receipt of the first such offer (the “**Negotiation Period**”) each of the Parties shall negotiate in good faith and be represented:

1.1.1 for the first 10 Business Days, by a senior person who where practicable has not had any direct day-to-day involvement in the matter that led to the Dispute and has authority to settle the Dispute; and

1.1.2 for the last 5 Business Days, by its chief executive, director, or board member who has authority to settle the Dispute,

provided that no Party in Dispute where practicable shall be represented by the same individual under paragraphs 1.1.1 and 1.1.2.

2. MEDIATION

2.1 If the Parties are unable to settle the Dispute by negotiation, they must within 5 Business Days after the end of the Negotiation Period submit the Dispute to mediation by CEDR or other independent body or organisation agreed between the Parties and set out in Part 2 of this Appendix M.

2.2 The Parties will keep confidential and not use for any collateral or ulterior purpose all information, whether given orally, in writing or otherwise, arising out of or in connection with any mediation, including the fact of any settlement and its terms, save for the fact that the mediation is to take place or has taken place.

2.3 All information, whether oral, in writing or otherwise, arising out of or in connection with any mediation will be without prejudice, privileged and not admissible as evidence or disclosable in any current or subsequent litigation or other proceedings whatsoever.

3. EXPERT DETERMINATION

3.1 If the Parties are unable to settle the Dispute through mediation, then either Party may give written notice to the other Party within 10 Business Days of closure of the failed mediation of its intention to refer the Dispute to expert determination. The Expert Determination Notice must include a brief statement of the issue or issues which it is desired to refer, the expertise required in the expert, and the solution sought.

3.2 If the Parties have agreed upon the identity of an expert and the expert has confirmed in writing his readiness and willingness to embark upon the expert determination, then that person shall be appointed as the Expert.

3.3 Where the Parties have not agreed upon an expert, or where that person has not confirmed his willingness to act, then either Party may apply to CEDR for the appointment of an expert. The request must be in writing, accompanied by a copy of the Expert Determination Notice and the appropriate fee and must be copied simultaneously to the other Party. The other Party may make representations to CEDR regarding the expertise required in the expert. The person nominated by CEDR will be appointed as the Expert.

3.4 The Party serving the Expert Determination Notice must send to the Expert and to the other Party within 5 Business Days of the appointment of the Expert a statement of its case

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including a copy of the Expert Determination Notice, the Contract, details of the circumstances giving rise to the Dispute, the reasons why it is entitled to the solution sought, and the evidence upon which it relies. The statement of case must be confined to the issues raised in the Expert Determination Notice.

- 3.5 The Party not serving the Expert Determination Notice must reply to the Expert and the other Party within 5 Business Days of receiving the statement of case, giving details of what is agreed and what is disputed in the statement of case and the reasons why.
- 3.6 The Expert must produce a written decision with reasons within 30 Business Days of receipt of the statement of case referred to in paragraph 1.9, or any longer period as is agreed by the Parties after the Dispute has been referred.
- 3.7 The Expert will have complete discretion as to how to conduct the expert determination, and will establish the procedure and timetable.
- 3.8 The Parties must comply with any request or direction of the Expert in relation to the expert determination.
- 3.9 The Expert must decide the matters set out in the Expert Determination Notice, together with any other matters which the Parties and the Expert agree are within the scope of the expert determination. The Expert must send his decision in writing simultaneously to the Parties. Within 5 Business Days following the date of the decision the Parties must provide the Expert and each other with any requests to correct minor clerical errors or ambiguities in the decision. The Expert must correct any minor clerical errors or ambiguities at his discretion within a further 5 Business Days and send any revised decision simultaneously to the Parties.
- 3.10 The Parties must bear their own costs and expenses incurred in the expert determination and are jointly liable for the costs of the Expert.
- 3.11 The decision of the Expert is final and binding, except in the case of fraud, collusion, bias, or material breach of instructions on the part of the Expert at which point a Party will be permitted to apply to Court for an Order that:
- 3.11.1 the Expert reconsider his decision (either all of it or part of it); or
- 3.11.2 the Expert's decision be set aside (either all of it or part of it).
- 3.12 If a Party does not abide by the Expert's decision the other Party may apply to Court to enforce it.
- 3.13 All information, whether oral, in writing or otherwise, arising out of or in connection with the expert determination will be inadmissible as evidence in any current or subsequent litigation or other proceedings whatsoever, with the exception of any information which would in any event have been admissible or disclosable in any such proceedings.
- 3.14 The Expert is not liable for anything done or omitted in the discharge or purported discharge of his functions, except in the case of fraud or bad faith, collusion, bias, or material breach of instructions on the part of the Expert.
- 3.15 The Expert is appointed to determine the Dispute or Disputes between the Parties and his decision may not be relied upon by third parties, to whom he shall have no duty of care.

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Part 2 of Appendix M - Nominated Mediation Body

If any dispute or difference shall arise between the parties as to the construction of this Agreement or any matter or thing of whatever nature arising under this Agreement or in connection with it then the same shall be dealt with as follows:-

- a) In the first instance a special meeting of both the Parties shall be arranged on 14 days written notice to the other party and the matter shall be discussed and the representatives shall use their reasonable endeavours to resolve the dispute
- b) If the dispute cannot be resolved in accordance with the preceding sub-clause then either one of the Parties may serve the Council's Chief Executive and the Provider or other authorised officer whose details have been notified to the Council, with notice of the dispute and those officers shall then appoint their representative to adjudicate and use their reasonable endeavours to resolve the dispute within 21 days of receipt of such notice
- c) If the dispute cannot be resolved in accordance with the preceding sub-clause then it shall be referred to a single arbitrator to be agreed between the Parties and failing such agreement within 14 days of the request of one Party to the other in writing that the matter be referred to arbitration such reference shall be to a single arbitrator appointed for that purpose on the written request of either Party by the President for the time being of the Law Society of England and Wales and any reference to arbitration under this clause shall be deemed to be a reference to arbitration within the meaning of the relevant Arbitration Acts and it is further agreed that if any matter is referred to arbitration then each Party will bear its own costs of such referral

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Part 3 of Appendix M - Recorded Dispute Resolutions

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**APPENDIX N
SUCCESSION PLAN**

To be agreed within the contract period

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APPENDIX O

Definitions and Interpretation

1. The headings in this Contract shall not affect its interpretation.
2. References to any statute or statutory provision include a reference to that statute or statutory provision as from time to time amended, extended or re-enacted.
3. References to a statutory provision shall include any subordinate legislation made from time to time under that provision.
4. References to Sections, clauses and Appendices are to the Sections, clauses and Appendices of this Contract, unless expressly stated otherwise.
5. References to any body, organisation or office shall include reference to its applicable successor from time to time.
6. Any references to this Contract or any other documents includes reference to this Contract or such other documents as varied, amended, supplemented, extended, restated and/or replaced from time to time.
7. Use of the singular includes the plural and vice versa.
8. The following terms shall have the following meanings:

Activity means any levels of clinical services and/or Service User flows set out in a Service Specification

Authorised Person means the Authority and any body or person concerned with the provision of the Service or care of a Service User

Authority Representative means the person identified in clause A4.1 (*Representatives*) or their replacement

Best Value Duty means the duty imposed by section 3 of the Local Government Act 1999 (the **LGA 1999**) as amended, and under which the Authority is under a statutory duty to continuously improve the way its functions are exercised, having regard to a combination of economy, efficiency and effectiveness and to any applicable guidance issued from time to time

Board of Directors means the executive board or committee of the relevant organisation

Business Continuity Plan means the Provider's plan referred to in Clause B34.2 (*Business Continuity*) relating to continuity of the Services, as agreed with the Authority and as may be amended from time to time

Business Day means a day (other than a Saturday or a Sunday) on which commercial banks are open for general business in London

Caldicott Guardian means the senior health professional responsible for safeguarding the confidentiality of patient information

Care Quality Commission or CQC means the care quality commission established under the Health and Social Care Act 2008

Carer means a family member or friend of the Service User who provides day-to-day support to the Service User without which the Service User could not manage

CEDR means the Centre for Effective Dispute Resolution

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Charges means the charges which shall become due and payable by the Authority to the Provider in respect of the provision of the Services in accordance with the provisions of this Contract, as such charges are set out in Appendix E (*Charges*)

Commencement Date means the date identified in clause A3.1 (*Commencement and Duration*)

Competent Body means any body that has authority to issue standards or recommendations with which either Party must comply

Conditions Precedent means the conditions precedent, if any, to commencement of service delivery referred to in clause A3.2 (*Commencement and Duration*) and set out in Appendix B (*Conditions Precedent*)

Confidential Information means any information or data in whatever form disclosed, which by its nature is confidential or which the Disclosing Party acting reasonably states in writing to the Receiving Party is to be regarded as confidential, or which the Disclosing Party acting reasonably has marked 'confidential' (including, without limitation, financial information, or marketing or development or work force plans and information, and information relating to services or products) but which is not Service User Health Records or information relating to a particular Service User, or Personal Data, pursuant to an FOIA request, or information which is published as a result of government policy in relation to transparency

Consents means:

- (i) any permission, consent, approval, certificate, permit, licence, statutory agreement, authorisation, exception or declaration required by Law for or in connection with the performance of Services; and/or
- (ii) any necessary consent or agreement from any third party needed either for the performance of the Provider's obligations under this Contract or for the provision by the Provider of the Services in accordance with this Contract

Contract has the meaning given to it in clause A1.1 (*Contract*)

Contract Query means:

- (i) a query on the part of the Authority in relation to the performance or non-performance by the Provider of any obligation on its part under this Contract; or
- (ii) a query on the part of the Provider in relation to the performance or non-performance by the Authority of any obligation on its part under this Contract,

as appropriate

Contract Query Notice means a notice setting out in reasonable detail the nature of a Contract Query

Contract Management Meeting means a meeting of the Authority and the Provider held in accordance with clause B29.8 (*Contract Management*)

CQC Regulations means the Care Quality Commission (Registration) Regulation 2009

Data Processor has the meaning set out in the DPA

Data Subject has the meaning set out in the DPA

DBS means the Disclosure and Barring Service established under the Protection of Freedoms Act 2012

Default means any breach of the obligations of the Provider (including but not limited to fundamental breach or breach of a fundamental term) or any other default, act, omission, negligence or statement

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of the Provider or the Staff in connection with or in relation to the subject-matter of this Contract and in respect of which the Provider is liable to the Authority

Default Interest Rate means LIBOR plus 2% per annum

Disclosing Party means the Party disclosing Confidential Information

Dispute means a dispute, conflict or other disagreement between the Parties arising out of or in connection with this Contract

DPA means the Data Protection Act 1998

Employment Checks means the pre-appointment checks that are required by law and applicable guidance, including without limitation, verification of identity checks, right to work checks, registration and qualification checks, employment history and reference checks, criminal record checks and occupational health checks

Enhanced DBS & Barred List Check means an Enhanced DBS & Barred List Check (child) or Enhanced DBS & Barred List Check (adult) or Enhanced DBS & Barred List Check (child & adult) (as appropriate)

Enhanced DBS & Barred List Check (child) means a disclosure of information comprised in an Enhanced DBS Check together with information from the DBS children's barred list

Enhanced DBS & Barred List Check (adult) means a disclosure of information comprised in an Enhanced DBS Check together with information from the DBS adult's barred list

Enhanced DBS & Barred List Check (child & adult) means a disclosure of information comprised in an Enhanced DBS Check together with information from the DBS children's and adult's barred list

Enhanced DBS Check means a disclosure of information comprised in a Standard DBS Check together with any information held locally by police forces that it is reasonably considered might be relevant to the post applied for

Enhanced DBS Position means any position listed in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended), which also meets the criteria set out in the Police Act 1997 (Criminal Records) Regulations 2002 (as amended), and in relation to which an Enhanced DBS Disclosure or an Enhanced DBS & Barred List Check (as appropriate) is permitted

Equipment means the Provider's equipment, plant, materials and such other items supplied and used by the Provider in the performance of its obligations under this Contract

Excusing Notice means a notice setting out in reasonable detail the Receiving Party's reasons for believing that a Contract Query is unfounded, or that the matters giving rise to the Contract Query are:

- (i) due wholly or partly to an act or omission by the Issuing Party; or
- (ii) a direct result of the Receiving Party following the instructions of the Issuing Party; or
- (iii) due to circumstances beyond the Receiving Party's reasonable control but which do not constitute an event of Force Majeure

Expert means the person designated to determine a Dispute by virtue of paragraphs 1.6 or 1.7 of Appendix M (*Dispute Resolution*)

Expert Determination Notice means a notice in writing showing an intention to refer Dispute for expert determination

Expiry Date means the date set out in clause A3.3 (*Commencement and Duration*)

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First Exception Report means a report issued in accordance with clause B29.21 (*Contract Management*) notifying the relevant Party's chief executive and/or Board of Directors of that Party's breach of a Remedial Action Plan and failure to remedy that breach

FOIA means the Freedom of Information Act 2000 and any subordinate legislation made under this Act from time to time together with any guidance and/or codes of practice issued by the Information Authority or relevant government department in relation to such legislation and the Environmental Information Regulations 2004

Force Majeure means any event or occurrence which is outside the reasonable control of the Party concerned and which is not attributable to any act or failure to take preventative action by that Party, including fire; flood; violent storm; pestilence; explosion; malicious damage; armed conflict; acts of terrorism; nuclear, biological or chemical warfare; or any other disaster, natural or man-made, but excluding:

- (i) any industrial action occurring within the Provider's or any Sub-contractor's organisation; or
- (ii) the failure by any Sub-contractor to perform its obligations under any Sub-contract

Fraud means any offence under the laws of the United Kingdom creating offences in respect of fraudulent acts or at common law in respect of fraudulent acts or defrauding or attempting to defraud or conspiring to defraud the Authority

General Conditions has the meaning given to it in clause A1.1(b) (*Contract*)

Good Clinical Practice means using standards, practices, methods and procedures conforming to the Law and using that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced clinical services provider, or a person providing services the same as or similar to the Services, at the time the Services are provided, as applicable

Guidance means any applicable local authority, health or social care guidance, direction or determination which the Authority and/or the Provider have a duty to have regard to including any document published under section 73B of the NHS Act 2006

Immediate Action Plan means a plan setting out immediate actions to be undertaken by the Provider to protect the safety of Services to Service Users, the public and/or Staff

Indirect Losses means loss of profits (other than profits directly and solely attributable to the provision of the Services), loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis

Initial Term means one year commencing on the Service Commencement Date and expiring on the Initial Expiry Date.

Issuing Party means the Party which has issued a Contract Query Notice

JI Report means a report detailing the findings and outcomes of a Joint Investigation

Joint Investigation means an investigation by the Issuing party and the Receiving Party into the matters referred to in a Contract Query Notice

Law means:

- (i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;
- (ii) any enforceable EU right within the meaning of Section 2(1) of the European Communities Act 1972;

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- (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;
- (iv) National Standards;
- (v) Guidance; and
- (vi) any applicable industry code

in each case in force in England and Wales

Legal Guardian means an individual who, by legal appointment or by the effect of a written law, is given custody of both the property and the person of one who is unable to manage their own affairs

Lessons Learned means experience derived from provision of the Services, the sharing and implementation of which would be reasonably likely to lead to an improvement in the quality of the Provider's provision of the Services

LIBOR means the London Interbank Offered Rate for 6 months sterling deposits in the London market

Local HealthWatch means the local independent consumer champion for health and social care in England

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges whether arising under statute, contract or at common law but, excluding Indirect Losses

National Institute for Health and Clinical Excellence or **NICE** means the special health authority responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health (or any successor body)

National Standards means those standards applicable to the Provider under the Law and/or Guidance as amended from time to time

Negotiation Period means the period of 15 Business Days following receipt of the first offer

NHS Act 2006 means the National Health Service Act 2006

Parties means the Authority and the Provider and "Party" means either one of them

Patient Safety Incident means any unintended or unexpected incident that occurs in respect of a Service User that could have led or did lead to, harm to that Service User

Personal Data has the meaning set out in the DPA

Prohibited Acts has the meaning given to it in clause B39.1 (*Prohibited Acts*)

Provider Representative means the person identified in clause A4.2 (*Representatives*) or their replacement

Provider's Premises means premises controlled or used by the Provider for any purposes connected with the provision of the Services which may be set out or identified in a Service Specification

Public Authority means as defined in section 3 of the FOIA

Quality Outcomes Indicators means the agreed key performance indicators and outcomes to be achieved as set out in Appendix C (*Quality Outcomes Indicators*)

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Receiving Party means the Party which has received a Contract Query Notice or Confidential Information as applicable

'Regulated Activity' in relation to children, as defined in Part 1 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006, and in relation to vulnerable adults, as defined in Part 2 of Schedule 4 to the Safeguarding Vulnerable Groups Act 2006.

'Regulated Provider' as defined in section 6 of the Safeguarding Vulnerable Groups Act 2006

Regulatory Body means any body other than CQC carrying out regulatory functions in relation to the Provider and/or the Services

Remedial Action Plan means a plan to rectify a breach of or performance failure under this Contract specifying targets and timescales within which those targets must be achieved

Required Insurances means the types of policy or policies providing levels of cover as specified in the Service Specification(s)

Restricted Person means any person: (i) other than an Institutional Investor who has a material interest in the production of tobacco products or alcoholic beverages; or (ii) whom the Co-ordinating Commissioner reasonably believes is inappropriate for public policy reasons to have a controlling interest in the Provider or in a Material Sub-contractor

Review Meeting means a meeting to be held in accordance with clause B19 (*Review Meetings*) or as otherwise requested in accordance with clause B19.2 (*Review Meetings*)

Safeguarding Policies means the Provider's written policies for safeguarding children and adults, as amended from time to time, and as may be appended at Appendix F (*Safeguarding Children and Vulnerable Adults*)

Second Exception Report means a report issued in accordance with clause B29.22 (*Contract Management*) notifying the recipients of a breach of a Remedial Action Plan and the continuing failure to remedy that breach

Serious Incident means an incident or accident or near-miss where a patient (whether or not a Service User), member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death on the Provider's Premises or where the actions of the Provider, the Staff or the Authority are likely to be of significant public concern

Service Commencement Date means the date set out in clause A3.2 (*Commencement and Duration*)

Service Specification means each of the service specifications defined by the Authority and set out at Appendix A (*Service Specifications*)

Service User means the person directly receiving the Services provided by the Provider as specified in the Service Specifications and includes their Carer and Legal Guardian where appropriate

Service Quality Performance Report means a report as described in Appendix J (*Service Quality Performance Report*)

Services means the services (and any part or parts of those services) described in each of, or, as the context admits, all of the Service Specifications, and/or as otherwise provided or to be provided by the Provider under and in accordance with this Contract

Special Conditions has the meaning given to it in clause A1.1(c) (*Contract*)

Staff means all persons employed by the Provider to perform its obligations under this Contract together with the Provider's servants, agents, suppliers and Sub-contractors used in the performance of its obligations under this Contract

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Standard DBS Check means a disclosure of information which contains certain details of an individual's convictions, cautions, reprimands or warnings recorded on police central records and includes both 'spent' and 'unspent' convictions

Standard DBS Position means any position listed in the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as amended) and in relation to which a Standard DBS Check is permitted

Sub-contract means a contract approved by the Authority between the Provider and a third party for the provision of part of the Services

Sub-contractor means any third party appointed by the Provider and approved by the Authority under clause B23.1 (*Assignment and Sub-contracting*) to deliver or assist with the delivery of part of the Services as defined in a Service Specification

Succession Plan means a plan agreed by the Parties to deal with transfer of the Services to an alternative provider following expiry or termination of this Contract as set out at Appendix N (*Succession Plan*)

Successor Provider means any provider to whom a member of Staff is transferred pursuant to TUPE in relation to the Services immediately on termination or expiry of this Contract

Transfer of and Discharge from Care Protocols means the protocols set out in Appendix I (*Transfer and Discharge from Care Protocols*)

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

VAT means value added tax in accordance with the provisions of the Value Added Tax Act 1994

Variation means a variation to a provision or part of a provision of this Contract

Variation Notice means a notice to vary a provision or part of a provision of this Contract issued under clause B22.2 (*Variations*).

SECTION C
SPECIAL TERMS AND CONDITIONS

[Local Authority Pension Scheme]

TUPE

1. Definitions and Interpretation:

The definitions and rules of interpretation in this Schedule apply in this Agreement:

Admission Agreement: the agreement to be entered into in accordance with regulation 3 of the Local Government Pension Scheme Regulations 2013, as amended, by the Administering Authority, the Council and the Provider or Sub-Contractor, as appropriate in the Administering Authority's standard form

Administering Authority: means Shropshire Council

Appropriate Pension Provision: in respect of Eligible Employees, either:

- (a) membership, continued membership or continued eligibility for membership of their Legacy Scheme; or
- (b) membership or eligibility for membership of a pension scheme, which is certified by the Government Actuary's Department (GAD) as being broadly comparable to the terms of their Legacy Scheme.

Bond: the bond to be executed in the Council's standard form to the value of [VALUE] under paragraph 5.4.

Provider's Final Staff List: the list of all the Provider's and Sub-Contractor's personnel engaged in, or wholly or mainly assigned to, the provision of the Services or any part of the Services at the Service Transfer Date.

Provider's Provisional Staff List: the list prepared and updated by the Provider of all the Provider's and Sub-Contractor's personnel engaged in, or wholly or mainly assigned to, the provision of the Services or any part of the Services at the date of the preparation of the list.

Data Protection Legislation: the Data Protection Act 1998, the Data Protection Directive (95/46/EC), the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Electronic Communications Data Protection Directive (2002/58/EC), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003) and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner.

Effective Date: the date(s) on which the Services (or any part of the Services), transfer from the Authority [or any Third Party Employer] to the Provider or Sub-Contractor, and a reference to the Effective Date shall be deemed to be the date on which the employees in question transferred or will transfer to the Provider or Sub-Contractor.

Eligible Employees:

- (a) the Transferring Employees who are active members of (or are eligible to join) the LGPS on the date of a Relevant Transfer including the Effective Date; and/or
- (b) the Third Party Employees who are former employees of the Authority and who were active members of (or who were eligible to join) the LGPS on the date of a previous Relevant Transfer of the Services.

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Employee Liability Information: the information that a transferor is obliged to notify to a transferee under regulation 11(2) of TUPE:

- (a) the identity and age of the employee;
- (b) the employee's written statement of employment particulars (as required under section 1 of the Employment Rights Act 1996);
- (c) information about any disciplinary action taken against the employee and any grievances raised by the employee, where a Code of Practice issued under Part IV of the Trade Union and Labour Relations (Consolidation) Act 1992 relating exclusively or primarily to the resolution of disputes applied, within the previous two years;
- (d) information about any court or tribunal case, claim or action either brought by the employee against the transferor within the previous two years or where the transferor has reasonable grounds to believe that such action may be brought against the Provider arising out of the employee's employment with the transferor;
- (e) information about any collective agreement that will have effect after the Effective Date or the Service Transfer Date, as the case may be, in relation to the employee under regulation 5(a) of TUPE.

Employment Liabilities: All claims, including claims without limitation for redundancy payments, unlawful deduction of wages, unfair, wrongful or constructive dismissal compensation, compensation for sex, race, disability, age, religion or belief, gender reassignment, marriage or civil partnership, pregnancy or maternity, or sexual orientation discrimination, claims for equal pay, compensation for less favourable treatment of part-time workers, and any claims (whether in tort, contract, statute or otherwise), demands, actions, proceedings and any award, compensation, damages, tribunal awards, fine, loss, order, penalty, disbursement, payment made by way of settlement and costs and expenses reasonably incurred in connection with a claim or investigation (including any investigation by the Equality and Human Rights Commission or other enforcement, regulatory or supervisory body), and of implementing any requirements which may arise from such investigation, and any legal costs and expenses.

Legacy Scheme: the pension scheme of which the Eligible Employees are members, or are eligible for membership of, or are in a waiting period to become a member of, prior to the Relevant Transfer.

LGPS: Local Government Pension Scheme

LGPS Regulations: the Local Government Pension Scheme Regulations 2013 (SI 2013/2356)

Redundancy Costs: statutory redundancy payments, contractual redundancy payments and contractual notice pay payable by the Provider to the Redundant Transferring Employees, but excluding any payments or liabilities arising from any claim as to the fairness of the dismissal and/or unlawful discrimination.

Redundant Transferring Employees: Transferring Employees whom the Provider has dismissed following a lawful redundancy within [NUMBER] months of the Effective Date.

Relevant Employees: those employees whose contracts of employment transfer with effect from the Service Transfer Date to the Authority or a Replacement Provider by virtue of the application of TUPE.

Relevant Transfer: a relevant transfer for the purposes of TUPE.

Replacement Services: any services that are fundamentally the same as any of the Services and which the Authority receives in substitution for any of the Services following the termination or expiry of this agreement, whether those services are provided by the Authority internally or by any Replacement Provider.

Replacement Provider: any third party supplier of Replacement Services appointed by the Authority from time to time.

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Service Transfer Date: the date on which the Services (or any part of the Services), transfer from the Provider or Sub-Contractor to the Authority or any Replacement Provider.

Staffing Information: in relation to all persons detailed on the Provider's Provisional Staff List, in an anonymised format, such information as the Authority may reasonably request including the Employee Liability Information and details of whether the personnel are employees, workers, self-employed, contractors or consultants, agency workers or otherwise, and the amount of time spent on the provision of the Services.

Sub-Contractor: the contractors or Contractors engaged by the Provider to provide goods, services or works to, for or on behalf of the Provider for the purposes of providing the Services to the Authority.

Third Party Employees: employees of Third Party Employers whose contracts of employment transfer with effect from the Effective Date to the Provider or Sub-Contractor by virtue of the application of TUPE.

Third Party Employer: a Contractor engaged by the Authority to provide [some of the] Services to the Authority before the Effective Date and whose employees will transfer to the Provider on the Effective Date.

Transferring Employees: employees of the Authority whose contracts of employment transfer with effect from the Effective Date to the Provider by virtue of the application of TUPE. A list of the Transferring Employees, as at the date of execution of the Agreement, is attached at Appendix[1].

TUPE: the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246).

2. TRANSFER OF EMPLOYEES TO THE PROVIDER ON THE EFFECTIVE DATE

2.1 The Authority and the Provider agree that where the identity of the provider of any of the Services changes, this shall constitute a Relevant Transfer and the contracts of employment of any Transferring Employees [and Third Party Employees] shall transfer to the Provider or Sub-Contractor. The Provider shall comply and shall procure that each Sub-Contractor shall comply with their obligations under TUPE. The [first] Relevant Transfer shall occur on the [Effective Date OR [DATE]].

2.2 The Authority shall be responsible for all remuneration, benefits, entitlements and outgoings in respect of the Transferring Employees, including without limitation, all wages, holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions, pension contributions and otherwise, up to the Effective Date. The Authority shall provide and, where necessary, update the Employee Liability Information for the Transferring Employees to the Provider, as required by TUPE. The Authority shall warrant that such information is complete and accurate as it is aware or should reasonably be aware as at the date it is disclosed.

2.3 Subject to paragraph 2.4, the Authority shall indemnify and keep indemnified the Provider against any losses, except indirect losses incurred by the Provider or any relevant Sub-Contractor in connection with any claim or demand by any Transferring Employee arising out of the employment of any Transferring Employee. This indemnity shall apply provided that it arises from any act, fault or omission of the Authority in relation to any Transferring Employee prior to the Effective Date (except where such act, fault or omission arises as a result of the Provider or any relevant Sub-Contractor's failure to comply with regulation 13 of TUPE) and any such claim is not in connection with the transfer of the Services by virtue of TUPE on the Effective Date.

2.4 The Provider shall be liable for and indemnify and keep indemnified the Authority [and any Third Party Employer] against any Employment Liabilities arising from or as a consequence of:

- (i) any proposed changes to terms and conditions of employment the Provider or Sub-Contractor may consider taking on or after the Effective Date;

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- (ii) any of the employees informing the Authority [and any Third Party Employer] they object to being employed by the Provider or Sub-Contractor; and
 - (iii) any change in identity of the Transferring Employees' [and Third Party Employees'] employer as a result of the operation of TUPE or as a result of any proposed measures the Provider or Sub-Contractor may consider taking on or after the Effective Date.
- 2.5 The Provider shall be liable for and indemnify and keep indemnified the Authority [and any Third Party Employer] against any failure to meet all remuneration, benefits, entitlements and outgoings for the Transferring Employees,[the Third Party Employees], and any other person who is or will be employed or engaged by the Provider or any Sub-Contractor in connection with the provision of the Services, including without limitation, all wages, holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions, pension contributions, termination costs and otherwise from and including the Effective Date.
- 2.6 The Provider shall immediately on request by the Authority [and/or the Third Party Employer] provide details of any measures that the Provider or any Sub-Contractor of the Provider envisages it will take in relation to any Transferring Employees [and any Third Party Employees], including any proposed changes to terms and conditions of employment. If there are no measures, the Provider will give confirmation of that fact, and shall indemnify the Authority [and any Third Party Employer] against all Employment Liabilities resulting from any failure by it to comply with this obligation.

3. EMPLOYMENT EXIT PROVISIONS

- 3.1 This Agreement envisages that subsequent to its commencement, the identity of the provider of the Services (or any part of the Services) may change (whether as a result of termination of this Agreement, or part or otherwise) resulting in a transfer of the Services in whole or in part (Subsequent Transfer). If a Subsequent Transfer is a Relevant Transfer then the Authority or Replacement Provider will inherit liabilities in respect of the Relevant Employees with effect from the relevant Service Transfer Date.
- 3.2 The Provider shall and shall procure that any Sub-Contractor shall on receiving notice of termination of this Agreement or otherwise, on request from the Authority and at such times as required by TUPE, provide in respect of any person engaged or employed by the Provider or any Sub-Contractor in the provision of the Services, the Provider's Provisional Staff List and the Staffing Information together with any additional information required by the Authority, including information as to the application of TUPE to the employees. The Provider shall notify the Authority of any material changes to this information as and when they occur.
- 3.3 At least 28 days prior to the Service Transfer Date, the Provider shall and shall procure that any Sub-Contractor shall prepare and provide to the Authority and/or, at the direction of the Authority, to the Replacement Provider, the Provider's Final Staff List, which shall be complete and accurate in all material respects. The Provider's Final Staff List shall identify which of the Provider's and Sub-Contractor's personnel named are Relevant Employees.
- 3.4 The Authority shall be permitted to use and disclose the Provider's Provisional Staff List, the Provider's Final Staff List and the Staffing Information for informing any tenderer or other prospective Replacement Provider for any services that are substantially the same type of services as (or any part of) the Services.
- 3.5 The Provider warrants [and the Replacement Provider] that the Provider's Provisional Staff List, the Provider's Final Staff List and the Staffing Information (the TUPE Information) will be true and accurate in all material respects and that no persons are employed or engaged in the provision of the Services other than those included on the Provider's Final Staff List.
- 3.6 The Provider shall and shall procure that any Sub-Contractor shall ensure at all times that it has the right to provide the TUPE Information under Data Protection Legislation.

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- 3.7 The Authority regards compliance with this paragraph 3 as fundamental to the Agreement. In particular, failure to comply with paragraphs 3.2 and 3.3 in respect of the provision of accurate information about the Relevant Employees shall entitle the Authority to suspend payment of the Charges until such information is provided, or indefinitely. The maximum sum that may be retained under this paragraph 3.7 shall not exceed an amount equivalent to the Charges that would be payable in the [three] month period following the Provider's failure to comply with paragraphs 3.2 or 3.3, as the case may be.
- 3.8 Any change to the TUPE Information which would increase the total employment costs of the staff in the [six] months prior to termination of this Agreement shall not (so far as reasonably practicable) take place without the Authority's prior written consent, unless such changes are required by law. The Provider shall supply to the Authority full particulars of such proposed changes and the Authority shall be afforded reasonable time to consider them.
- 3.9 In the [six] months prior to termination of this Agreement, the Provider shall not and shall procure that any Sub-Contractor shall not materially increase or decrease the total number of staff listed on the Provider's Provisional Staff List, their remuneration, or make any other change in the terms and conditions of those employees without the Authority's prior written consent.
- 3.10 The Provider shall indemnify and keep indemnified in full the Authority and each and every Replacement Provider against all Employment Liabilities relating to:
- (a) any person who is or has been employed or engaged by the Provider or any Sub-Contractor in connection with the provision of any of the Services; or
 - (b) any trade union or staff association or employee representative
- arising from or connected with any failure by the Provider and/or any Sub-Contractor to comply with any legal obligation, whether under regulation 13 or 14 of TUPE or any award of compensation under regulation 15 of TUPE, under the Acquired Rights Directive or otherwise and, whether any such claim arises or has its origin before or after the Service Transfer Date.
- 3.11 The parties shall co-operate to ensure that any requirement to inform and consult with the employees and or employee representatives in relation to any Relevant Transfer as a consequence of a Subsequent Transfer will be fulfilled.
- 3.12 The parties agree that the Contracts (Rights of Third Parties) Act 1999 shall apply to clause 3.2 to clause 3.11, to the extent necessary to ensure that any Replacement Provider shall have the right to enforce the obligations owed to, and indemnities given to, the Replacement Provider by the Provider or the Authority in its own right under section 1(1) of the Contracts (Rights of Third Parties) Act 1999.
- 3.13 Despite clause 3.12, it is expressly agreed that the parties may by agreement rescind or vary any terms of this Agreement without the consent of any other person who has the right to enforce its terms or the term in question despite that such rescission or variation may extinguish or alter that person's entitlement under that right.

4. PENSIONS

- 4.1 The Provider shall or shall procure that any relevant Sub-Contractor shall ensure that all Eligible Employees are offered Appropriate Pension Provision with effect from the Effective Date
- 4.2 The provisions of clause 4 and clause 5 and clause 6 shall be directly enforceable by an affected employee against the Provider or any relevant Sub-Contractor and the parties agree that the Contracts (Rights of Third Parties) Act 1999 shall apply to the extent necessary to ensure that any affected employee shall have the right to enforce any obligation owed to such employee by the Provider or Sub-Contractor under those paragraphs in his own right under section 1(1) of the Contracts Rights of Third Parties Act 1999..

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5. ADMITTED BODY STATUS TO THE LOCAL GOVERNMENT PENSION SCHEME

- 5.1 Where the Provider or Sub-Contractor wishes to offer the Eligible Employees membership of the LGPS, the Provider shall or shall procure that it and/or each relevant Sub-Contractor shall enter into an Admission Agreement to have effect from and including the Effective Date or, if the Relevant Transfer occurs after the Effective Date, from and including the date of that Relevant Transfer. [The Provider or Sub-Contractor will bear the cost of any actuarial assessment required in order to assess the employer's contribution rate [and Bond value] in respect of any Eligible Employee who elects to join the LGPS [on or after] the Effective Date.]
- 5.2 [For the purposes of calculating the employer's contribution rate, any termination payment, and any other sums due to the administering Authority under the Admission Agreement, the Authority shall ensure that the Eligible Employees' past service benefits accrued prior to the Effective Date are fully funded as at the Effective Date, as determined by the Fund's actuary.]
- 5.3 The Provider shall indemnify and keep indemnified the Authority and/or any Replacement Provider and, in each case, their Providers, from and against all direct losses suffered or incurred by it or them, which arise from any breach by the Provider or Sub-Contractor of the terms of the Admission Agreement, to the extent that such liability arises before or as a result of the termination or expiry of this Agreement.
- 5.4 The Provider shall and shall procure that it and any Sub-Contractor shall prior to the Effective Date or, if the Relevant Transfer occurs after the Effective Date, from and including the date of that Relevant Transfer, obtain any indemnity or Bond required in accordance with the Admission Agreement. [The Provider or Sub-Contractor will bear the cost of any actuarial assessment required in order to assess the value of the Bond or guarantee.]
- 5.5 The Provider shall and shall procure that any relevant Sub-Contractor shall award benefits (where permitted) to the Eligible Employees under the LGPS Regulations in circumstances where the Eligible Employees would have received such benefits had they still been employed by the Authority. The Provider shall be responsible for meeting all costs associated with the award of such benefits.

6. PROVIDER PENSION SCHEME

- 6.1 Where the Provider or Sub-Contractor does not wish to or is otherwise prevented from offering [all or some of] the Eligible Employees membership or continued membership of the LGPS, the Provider shall or shall procure that any relevant Sub-Contractor shall offer the Eligible Employees membership of an occupational pension scheme with effect from the Effective Date or, if the Relevant Transfer occurs after the Effective Date, from and including the date of that Relevant Transfer. Such an occupational pension scheme must be:
- (a) established no later than [three months] prior to the date of the Relevant Transfer; and
 - (b) certified by the GAD as providing benefits that are broadly comparable to those provided by the Legacy Scheme,
- and the Provider shall produce evidence of compliance with this clause 6 to the Authority prior to the date of the Relevant Transfer.
- 6.2 The Authority's actuary shall determine the terms for bulk transfers from the LGPS to the Provider's scheme following the Effective Date and any subsequent bulk transfers on termination or expiry of this Agreement.
- 6.3 The Provider shall and shall procure that each relevant Sub-Contractor shall:
- (a) maintain such documents and information as will be reasonably required to manage the pension rights of and aspects of any onward transfer of any person engaged or employed by the Provider or any Sub-Contractor in the provision of the Services on

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the expiry or termination of this Agreement (including without limitation identification of the Eligible Employees);

- (b) promptly provide to the Authority such documents and information mentioned in paragraph 6.3(a) which the Authority may reasonably request in advance of the expiry or termination of this Agreement; and
- (c) fully cooperate (and procure that the trustees of the Provider's scheme shall fully cooperate) with the reasonable requests of the Authority relating to any administrative tasks necessary to deal with the pension rights of and aspects of any onward transfer of any person engaged or employed by the Provider or any Sub-Contractor in the provision of the Services on expiry or termination of the Agreement.

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[
[For use with Staff transfers from Public Authority (**other than Local Government**)]

1. Definitions

In this Schedule, the following definitions shall apply:

Admission Agreement: The agreement to be entered into by which the supplier agrees to participate in the Schemes (in the form contained in Schedule 1);

Eligible Employee: any Fair Deal Employee who at the relevant time is an eligible employee as defined in the Admission Agreement;

Employee Liabilities: all claims, actions, proceedings, orders, demands, complaints, investigations (save for any claims for personal injury which are covered by insurance) and any award, compensation, damages, tribunal awards, fine, loss, order, penalty, disbursement, payment made by way of settlement and costs, expenses and legal costs reasonably incurred in connection with a claim or investigation related to employment including in relation to the following:

- (a) redundancy payments including contractual or enhanced redundancy costs, termination costs and notice payments;
- (b) unfair, wrongful or constructive dismissal compensation;
- (c) compensation for discrimination on grounds of sex, race, disability, age, religion or belief, gender reassignment, marriage or civil partnership, pregnancy and maternity or sexual orientation or claims for equal pay;
- (d) compensation for less favourable treatment of part-time workers or fixed term employees;
- (e) outstanding employment debts and unlawful deduction of wages including any PAYE and national insurance contributions;
- (f) employment claims whether in tort, contract or statute or otherwise;
- (g) any investigation relating to employment matters by the Equality and Human Rights Commission or other enforcement, regulatory or supervisory body and of implementing any requirements which may arise from such investigation;

Employment Regulations: the Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) as amended or replaced or any other regulations implementing the Acquired Rights Directive;

Fair Deal Employees: those Transferring Authority Employees who are on the Relevant Transfer Date entitled to the protection of New Fair Deal[and any Transferring Former Supplier Employees who originally transferred pursuant to a Relevant Transfer under the Employment Regulations (or the predecessor legislation to the Employment Regulations), from employment with a public sector employer and who were once eligible to participate in the Schemes and who at the Relevant Transfer Date become entitled to the protection of New Fair Deal];

[Former Supplier: a supplier supplying services to the Authority before the Relevant Transfer Date that are the same as or substantially similar to the Services (or any part of the Services)

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and shall include any sub-contractor of such supplier (or any sub-contractor of any such sub-contractor);]

New Fair Deal: the revised Fair Deal position set out in the HM Treasury guidance: "*Fair Deal for staff pensions: staff transfer from central government*" issued in October 2013;

Notified Sub-contractor: a Sub-contractor identified in *Annex C* to whom Transferring Authority Employees and/or Transferring Former Supplier Employees will transfer on a Relevant Transfer Date;

Replacement Services: any services which are the same as or substantially similar to the Services following the expiry or termination of Partial Termination of this Agreement, whether those services are provided by the Authority internally and/or by any third party;

Replacement Sub-contractor: a sub-contractor of the Replacement Supplier to whom Transferring Supplier Employees will transfer on a Service Transfer Date (or any sub-contractor of any such Sub-contractor);

Replacement Supplier: any third party service provider of Replacement Services appointed by the Authority from time to time (or where the Authority is providing Replacement Services for its own account, the Authority);

Relevant Transfer: a transfer of employment to which the Employment Regulations apply;

Relevant Transfer Date: in relation to a Relevant Transfer, the date upon which the Relevant Transfer takes place;

Schemes: the Principal Civil Service Pension Scheme available to employees of the civil service and employees of bodies under the Superannuation Act 1972, as governed by rules adopted by Parliament; the Partnership Pension Account and its (i) Ill health Benefits Scheme and (ii) Death Benefits Scheme; the Civil Service Additional Voluntary Contribution Scheme; and the 2015 New Scheme (with effect from a date to be notified to the Supplier by the Minister for the Cabinet Office);

Service Transfer: any transfer of the Services (or any part of the Services), for whatever reason, from the Supplier or any Sub-contractor to a Replacement Supplier or a Replacement Sub-contractor;

Service Transfer Date: the date of a Service Transfer;

Staffing Information: in relation to all persons identified on the Supplier's Provisional Personnel List or Supplier's Final Personnel List, as the case may be, such information as the Authority may reasonably request (subject to all applicable provisions of the DPA 1998), but including in an anonymised format:

- (a) their ages, dates of commencement of employment or engagement and gender;
- (b) details of whether they are employed, self employed contractors or consultants, agency workers or otherwise;
- (c) the identity of the employer or relevant contracting Party;
- (d) their relevant contractual notice periods and any other terms relating to termination of employment, including redundancy procedures, and redundancy payments;
- (e) their wages, salaries and profit sharing arrangements as applicable;

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- (f) details of other employment-related benefits, including (without limitation) medical insurance, life assurance, pension or other retirement benefit schemes, share option schemes and company car schedules applicable to them;
- (g) any outstanding or potential contractual, statutory or other liabilities in respect of such individuals (including in respect of personal injury claims);
- (h) details of any such individuals on long term sickness absence, parental leave, maternity leave or other authorised long term absence;
- (i) copies of all relevant documents and materials relating to such information, including copies of relevant contracts of employment (or relevant standard contracts if applied generally in respect of such employees); and
- (j) any other "employee liability information" as such term is defined in regulation 11 of the Employment Regulations;

Supplier's Final Personnel List: a list provided by the Supplier of all Supplier Personnel who will transfer under the Employment Regulations on the Relevant Transfer Date;

Supplier Personnel: all directors, officers, employees, agents, consultants and contractors of the Supplier and/or any Sub-contractor engaged in the performance of the Supplier's obligations under this Agreement;

Supplier's Provisional Personnel List: a list prepared and updated by the Supplier of all Supplier Personnel who are engaged in or wholly or mainly assigned to the provision of the Services or any relevant part of the Services which it is envisaged as at the date of such list will no longer be provided by the Supplier ;

Transferring Authority Employees: those employees of the Authority to whom the Employment Regulations will apply on the Relevant Transfer Date [as contained in *Annex B*, and accurate as at the date on which this Agreement is signed by both Parties];

[Transferring Former Supplier Employees: in relation to a Former Supplier, those employees of the Former Supplier to whom the Employment Regulations will apply on the Relevant Transfer Date; and]

Transferring Supplier Employees: those employees of the Supplier and/or the Supplier's Sub-contractors to whom the Employment Regulations will apply on the Service Transfer Date.

2. Interpretation

Where a provision in this Schedule imposes an obligation on the Supplier to provide an indemnity, undertaking or warranty, the Supplier shall procure that each of its Sub-contractors shall comply with such obligation and provide such indemnity, undertaking or warranty to the Authority, [Former Supplier,] Replacement Supplier or Replacement Sub-contractor, as the case may be.

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TRANSFERRING AUTHORITY EMPLOYEES AT COMMENCEMENT OF SERVICES

3. Relevant Transfers

3.1 The Authority and the Supplier agree that:

- (a) the commencement of the provision of the Services or of each relevant part of the Services will be a Relevant Transfer in relation to the Transferring Authority Employees; and
- (b) as a result of the operation of the Employment Regulations, the contracts of employment between the Authority and the Transferring Authority Employees (except in relation to any terms disapplied through operation of regulation 10(2) of the Employment Regulations) will have effect on and from the Relevant Transfer Date as if originally made between the Supplier and/or any Notified Sub-contractor and each such Transferring Authority Employee.

3.2 The Authority shall comply with all its obligations under the Employment Regulations and shall perform and discharge all its obligations in respect of the Transferring Authority Employees in respect of the period arising up to (but not including) the Relevant Transfer Date (including the payment of all remuneration, benefits, entitlements and outgoings, all wages, accrued but untaken holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions and pension contributions which in any case are attributable in whole or in part to the period up to (but not including) the Relevant Transfer Date) and any necessary apportionments in respect of any periodic payments shall be made between: (i) the Authority; and (ii) the Supplier and/or any Notified Sub-contractor (as appropriate).

4. Authority indemnities

4.1 Subject to paragraph 4.2, the Authority shall indemnify the Supplier and any Notified Sub-contractor against any Employee Liabilities in respect of any Transferring Authority Employee (or, where applicable any employee representative as defined in the Employment Regulations) arising from or as a result of:

- (a) any act or omission by the Authority occurring before the Relevant Transfer Date;
- (b) the breach or non-observance by the Authority before the Relevant Transfer Date of:
 - (i) any collective agreement applicable to the Transferring Authority Employees; and/or
 - (ii) any custom or practice in respect of any Transferring Authority Employees which the Authority is contractually bound to honour;
- (c) any claim by any trade union or other body or person representing the Transferring Authority Employees arising from or connected with any failure by the Authority to comply with any legal obligation to such trade union, body or person arising before the Relevant Transfer Date;

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- (d) any proceeding, claim or demand by HMRC or other statutory authority in respect of any financial obligation including, but not limited to, PAYE and primary and secondary national insurance contributions:
 - (i) in relation to any Transferring Authority Employee, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising before the Relevant Transfer Date; and
 - (ii) in relation to any employee who is not a Transferring Authority Employee and in respect of whom it is later alleged or determined that the Employment Regulations applied so as to transfer his/her employment from the Authority to the Supplier and/or any Notified Sub-contractor as appropriate, to the extent that the proceeding, claim or demand by the HMRC or other statutory authority relates to financial obligations arising before the Relevant Transfer Date.
- (e) a failure of the Authority to discharge, or procure the discharge of, all wages, salaries and all other benefits and all PAYE tax deductions and national insurance contributions relating to the Transferring Authority Employees arising before the Relevant Transfer Date;
- (f) any claim made by or in respect of any person employed or formerly employed by the Authority other than a Transferring Authority Employee for whom it is alleged the Supplier and/or any Notified Sub-contractor as appropriate may be liable by virtue of the Employment Regulations and/or the Acquired Rights Directive; and
- (g) any claim made by or in respect of a Transferring Authority Employee or any appropriate employee representative (as defined in the Employment Regulations) of any Transferring Authority Employee relating to any act or omission of the Authority in relation to its obligations under regulation 13 of the Employment Regulations, except to the extent that the liability arises from the failure by the Supplier or any Sub-contractor to comply with regulation 13(4) of the Employment Regulations.

4.2 The indemnities in paragraph 4.1 shall not apply to the extent that the Employee Liabilities arise or are attributable to an act or omission of the Supplier or any Sub-contractor (whether or not a Notified Sub-contractor) whether occurring or having its origin before, on or after the Relevant Transfer Date including any Employee Liabilities:

- (a) arising out of the resignation of any Transferring Authority Employee before the Relevant Transfer Date on account of substantial detrimental changes to his/her working conditions proposed by the Supplier and/or any Sub-contractor to occur in the period from (and including) the Relevant Transfer Date; or
- (b) arising from the failure by the Supplier or any Sub-contractor to comply with its obligations under the Employment Regulations.

4.3 If any person who is not identified by the Authority as a Transferring Authority Employee claims, or it is determined in relation to any person who is not identified by the Authority as a Transferring Authority Employee, that his/her contract of employment has been transferred from the Authority to the Supplier and/or any Notified

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Sub-contractor pursuant to the Employment Regulations or the Acquired Rights Directive then:

- (a) the Supplier shall, or shall procure that the Notified Sub-contractor shall, within five Working Days of becoming aware of that fact, give notice in writing to the Authority; and
- (b) the Authority may offer (or may procure that a third party may offer) employment to such person within 15 Working Days of receipt of the notification by the Supplier and/or any Notified Sub-contractor, or take such other reasonable steps as the Authority considers appropriate to deal with the matter provided always that such steps are in compliance with Law.

4.4 If an offer referred to in paragraph 4.3(b) is accepted, or if the situation has otherwise been resolved by the Authority, the Supplier shall, or shall procure that the Notified Sub-contractor shall, immediately release the person from his/her employment or alleged employment.

4.5 If by the end of the 15 Working Day period specified in paragraph 4.3(b):

- (a) no such offer of employment has been made;
- (b) such offer has been made but not accepted; or
- (c) the situation has not otherwise been resolved,

the Supplier and/or any Notified Sub-contractor may within five Working Days give notice to terminate the employment or alleged employment of such person.

4.6 Subject to the Supplier and/or any Notified Sub-contractor acting in accordance with the provisions of paragraph 4.3 to paragraph 4.5 and in accordance with all applicable proper employment procedures set out in applicable Law, the Authority shall indemnify the Supplier and/or any Notified Sub-contractor (as appropriate) against all Employee Liabilities arising out of the termination pursuant to the provisions of paragraph 4.5 provided that the Supplier takes, or procures that the Notified Sub-contractor takes, all reasonable steps to minimise any such Employee Liabilities.

4.7 The indemnity in paragraph 4.6:

- (a) shall not apply to:
 - (i) in any case in relation to any alleged act or omission of the Supplier and/or any Sub-contractor, any claim for: (A) discrimination, including on the grounds of sex, race, disability, age, gender reassignment, marriage or civil partnership, pregnancy and maternity or sexual orientation, religion or belief; or (B) equal pay or compensation for less favourable treatment of part-time workers or fixed-term employees; or

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- (ii) any claim that the termination of employment was unfair because the Supplier and/or Notified Sub-contractor neglected to follow a fair dismissal procedure; and
 - (b) shall apply only where the notification referred to in paragraph 4.3(a) is made by the Supplier and/or any Notified Sub-contractor (as appropriate) to the Authority within six months of the Effective Date.
- 4.8 **If any such person as is referred to in paragraph 4.3 is neither re-employed by the Authority nor dismissed by the Supplier and/or any Notified Sub-contractor within the time scales set out in paragraph 4.5 such person shall be treated as having transferred to the Supplier and/or any Notified Sub-contractor and the Supplier shall, or shall procure that the Notified Sub-contractor shall, comply with such obligations as may be imposed upon it under applicable Law.**

5. Supplier indemnities and obligations

- 5.1 **Subject to paragraph 5.2, the Supplier shall indemnify the Authority against any Employee Liabilities in respect of any Transferring Authority Employee (or, where applicable any employee representative as defined in the Employment Regulations) arising from or as a result of:**
- (a) any act or omission by the Supplier or any Sub-contractor whether occurring before, on or after the Relevant Transfer Date;
 - (b) the breach or non-observance by the Supplier or any Sub-contractor on or after the Relevant Transfer Date of:
 - (i) any collective agreement applicable to the Transferring Authority Employees; and/or
 - (ii) any custom or practice in respect of any Transferring Authority Employees which the Supplier or any Sub-contractor is contractually bound to honour;
 - (c) any claim by any trade union or other body or person representing any Transferring Authority Employees arising from or connected with any failure by the Supplier or any Sub-contractor to comply with any legal obligation to such trade union, body or person arising on or after the Relevant Transfer Date;
 - (d) any proposal by the Supplier or a Sub-contractor made before the Relevant Transfer Date to make changes to the terms and conditions of employment or working conditions of any Transferring Authority Employees to their material detriment on or after their transfer to the Supplier or the relevant Sub-contractor (as the case may be) on the Relevant Transfer Date, or to change the terms and conditions of employment or working conditions of any person who would have been a Transferring Authority Employee but for their resignation (or decision to treat their employment as terminated under regulation 4(9) of the Employment Regulations) before the Relevant Transfer Date as a result of or for a reason connected to such proposed changes;

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- (e) any statement communicated to or action undertaken by the Supplier or any Sub-contractor to, or in respect of, any Transferring Authority Employee before the Relevant Transfer Date regarding the Relevant Transfer which has not been agreed in advance with the Authority in writing;
- (f) any proceeding, claim or demand by HMRC or other statutory authority in respect of any financial obligation including, but not limited to, PAYE and primary and secondary national insurance contributions:
 - (i) in relation to any Transferring Authority Employee, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising on or after the Relevant Transfer Date; and
 - (ii) in relation to any employee who is not a Transferring Authority Employee, and in respect of whom it is later alleged or determined that the Employment Regulations applied so as to transfer his/her employment from the Authority to the Supplier or a Sub-contractor, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising on or after the Relevant Transfer Date;
- (g) a failure of the Supplier or any Sub-contractor to discharge or procure the discharge of all wages, salaries and all other benefits and all PAYE tax deductions and national insurance contributions relating to the Transferring Authority Employees in respect of the period from (and including) the Relevant Transfer Date; and
- (h) any claim made by or in respect of a Transferring Authority Employee or any appropriate employee representative (as defined in the Employment Regulations) of any Transferring Authority Employee relating to any act or omission of the Supplier or any Sub-contractor in relation to their obligations under regulation 13 of the Employment Regulations, except to the extent that the liability arises from the Authority's failure to comply with its obligations under regulation 13 of the Employment Regulations.

5.2 The indemnities in paragraph 5.1 shall not apply to the extent that the Employee Liabilities arise or are attributable to an act or omission of the Authority whether occurring or having its origin before, on or after the Relevant Transfer Date including, without limitation, any Employee Liabilities arising from the Authority's failure to comply with its obligations under the Employment Regulations.

5.3 The Supplier shall comply, and shall procure that each Sub-contractor shall comply, with all its obligations under the Employment Regulations (including its obligation to inform and consult in accordance with regulation 13 of the Employment Regulations) and shall perform and discharge, and shall procure that each Sub-contractor shall perform and discharge, all its obligations in respect of the Transferring Authority Employees, from (and including) the Relevant Transfer Date (including the payment of all remuneration, benefits, entitlements and outgoings, all wages, accrued but untaken holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions and pension contributions which in any case are attributable in whole or in part to the period from and including the Relevant Transfer Date) and any necessary

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apportionments in respect of any periodic payments shall be made between the Authority and the Supplier.

5.4 The parties agree that the Contracts (Rights of Third Parties) Act 1999 shall apply to this *paragraph 5*, to the extent necessary to ensure that any Replacement Supplier shall have the right to enforce the obligations owed to, and indemnities given to, the Replacement Supplier by the Supplier or the Authority in its own right under section 1(1) of the Contracts (Rights of Third Parties) Act 1999.

5.5 Despite *paragraph 5.4*, it is expressly agreed that the parties may by agreement rescind or vary any terms of this Agreement without the consent of any other person who has the right to enforce its terms or the term in question despite that such rescission or variation may extinguish or alter that person's entitlement under that right.

6. Information

The Supplier shall, and shall procure that each Sub-contractor shall, promptly provide to the Authority in writing such information as is necessary to enable the Authority to carry out its duties under regulation 13 of the Employment Regulations. The Authority shall promptly provide to the Supplier and each Notified Sub-contractor in writing such information as is necessary to enable the Supplier and each Notified Sub-contractor to carry out their respective duties under regulation 13 of the Employment Regulations.

7. Principles of good employment practice

7.1 The Parties agree that the Principles of Good Employment Practice issued by the Cabinet Office in December 2010 apply to the treatment by the Supplier of employees whose employment begins after the Relevant Transfer Date, and the Supplier undertakes to treat such employees in accordance with the provisions of the Principles of Good Employment Practice.

7.2 The Supplier shall, and shall procure that each Sub-contractor shall, comply with any requirement notified to it by the Authority relating to pensions in respect of any Transferring Authority Employee as set down in:

- (a) the Cabinet Office Statement of Practice on Staff Transfers in the Public Sector of January 2000, revised 2007;
- (b) HM Treasury's guidance, Staff Transfers from Central Government: A Fair Deal for Staff Pensions, of 1999;
- (c) HM Treasury's guidance "Fair deal for staff pensions: procurement of Bulk Transfer Agreements and Related Issues" of June 2004; and/or
- (d) the New Fair Deal.

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- 7.3 Any changes embodied in any statement of practice, paper or other guidance that replaces any of the documentation referred to in paragraph 7.1 or paragraph 7.2 shall be agreed in accordance with [the Change Control Procedure].

PENSIONS

8. Protection of Pensions

- 8.1 The Supplier shall, and shall procure that each of its Sub-contractors shall, comply with the pensions provisions in paragraph 9 to paragraph 15.

- 8.2 [The provisions of paragraphs 8 to 15 shall be directly enforceable by an affected employee against the Supplier and any Notified Sub-contractor and the parties agree that the Contracts (Rights of Third Parties) Act 1999 shall apply to the extent necessary to ensure that any affected employee shall have the right to enforce any obligation owed to such employee by the Supplier or Notified Sub-contractor under those paragraphs in his own right under section 1 of the Contracts (Rights of Third Parties) Act 1999.]

9. Participation in the public sector pension scheme

- 9.1 The Supplier undertakes to enter into the Admission Agreement.
- 9.2 The Supplier and the Authority undertake to do all such things and execute any documents (including the Admission Agreement) as may be required to enable the Supplier to participate in the Schemes in respect of the Fair Deal Employees.
- 9.3 The Supplier shall bear its own costs and all costs that the Authority reasonably incurs in connection with the negotiation, preparation and execution of documents to facilitate the Supplier participating in the Schemes.

10. Future service benefits

- 10.1 The Supplier shall procure that the Fair Deal Employees, shall be either admitted into, or offered continued membership of, the relevant section of the Schemes that they currently contribute to, or were eligible to join immediately prior to the Relevant Transfer Date and the Supplier shall procure that the Fair Deal Employees continue to accrue benefits in accordance with the provisions governing the relevant section of the Schemes for service from (and including) the Relevant Transfer Date.
- 10.2 The Supplier undertakes that should it cease to participate in the Schemes for whatever reason at a time when it has Eligible Employees, that it will, at no extra cost to the Authority, provide to any Fair Deal Employee who immediately prior to such cessation remained an Eligible Employee with access to an occupational pension scheme certified by the Government Actuary's Department or any actuary nominated by the

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Authority in accordance with relevant guidance produced by the Government Actuary's Department as providing benefits which are broadly comparable to those provided by the Schemes at the relevant date.

- 10.3 **The Parties acknowledge that the Civil Service Compensation Scheme and the Civil Service Injury Benefit Scheme (established pursuant to section 1 of the Superannuation Act 1972) are not covered by the protection of New Fair Deal.**

11. Funding

- 11.1 **The Supplier undertakes to pay to the Schemes all such amounts as are due under the Admission Agreement and shall deduct and pay to the Schemes such employee contributions as are required by the Schemes.**

- 11.2 **The Supplier shall indemnify and keep indemnified the Authority on demand against any claim by, payment to, or loss incurred by, the Schemes in respect of the failure to account to the Schemes for payments received and the non-payment or the late payment of any sum payable by the Supplier to or in respect of the Schemes.**

12. Provision of information

The Supplier and the Authority respectively undertake to each other:

- (a) to provide all information which the other Party may reasonably request concerning matters (i) referred to in paragraphs 7 to 15 and (ii) set out in the Admission Agreement, and to supply the information as expeditiously as possible; and
- (b) not to issue any announcements to the Fair Deal Employees prior to the Relevant Transfer Date concerning the matters stated in paragraphs 7 to 15 without the consent in writing of the other Party (not to be unreasonably withheld or delayed).

13. Indemnity in respect of Fair Deal Employees

The Supplier undertakes to the Authority to indemnify and keep indemnified the Authority on demand from and against all and any Losses whatsoever arising out of or in connection with any liability towards the Fair Deal Employees arising in respect of service on or after the Relevant Transfer Date which relate to the payment of benefits under an occupational pension scheme (within the meaning provided for in section 1 of the Pension Schemes Act 1993) or the Schemes.

14. Employer obligation under pensions legislation

The Supplier shall comply with the requirements of [Part 1 of] the Pensions Act 2008, sections 257 and 258 of the Pensions Act 2004, and the Transfer of Employment (Pension Protection) Regulations 2005.

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15. Subsequent transfers

The Supplier shall:

- (a) not adversely affect pension rights accrued by any Fair Deal Employee in the period ending on the date of the relevant future transfer;
- (b) provide all such co-operation and assistance as the Schemes and the Replacement Supplier and/or the Authority may reasonably require to enable the Replacement Supplier to participate in the Schemes in respect of any Eligible Employee and to give effect to any transfer of accrued rights required as part of participation under New Fair Deal; and
- (c) for the period either
 - (i) after notice (for whatever reason) is given, in accordance with the other provisions of this Agreement, to terminate the Agreement or any part of the Services; or
 - (ii) after the date which is [two (2) years] prior to the date of expiry of this Agreement,

ensure that no change is made to pension, retirement and death benefits provided for or in respect of any person who will transfer to the Replacement Supplier or the Authority, no category of earnings which were not previously pensionable are made pensionable and the contributions (if any) payable by such employees are not reduced without (in any case) the prior approval of the Authority (such approval not to be unreasonably withheld). Save that this sub-paragraph shall not apply to any change made as a consequence of participation in an Admission Agreement.

EMPLOYMENT EXIT PROVISIONS

16. Pre-service transfer obligations

16.1 The Supplier agrees that within 20 Working Days of the earliest of:

- (a) receipt of a notification from the Authority of a Service Transfer or intended Service Transfer;
- (b) receipt of the giving of notice of early termination or any Partial Termination of this Agreement;
- (c) the date which is 12 months before the end of the Term; and
- (d) receipt of a written request of the Authority at any time (provided that the Authority shall only be entitled to make one such request in any six month period),

it shall provide in a suitably anonymised format so as to comply with the DPA 1998, the Supplier's Provisional Personnel List, together with the Staffing Information in relation to the Supplier's Provisional Personnel List and it shall provide an updated Supplier's Provisional Personnel List at such intervals as are reasonably requested by the Authority.

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- 16.2 **At least 28 days prior to the Service Transfer Date, the Supplier shall provide to the Authority or at the direction of the Authority to any Replacement Supplier and/or any Replacement Sub-contractor:**
- (a) the Supplier's Final Personnel List, which shall identify which of the Supplier Personnel are Transferring Supplier Employees; and
 - (b) the Staffing Information in relation to the Supplier's Final Personnel List (insofar as such information has not previously been provided).
- 16.3 **The Authority shall be permitted to use and disclose information provided by the Supplier under paragraph 16.1 and paragraph 16.2 for the purpose of informing any prospective Replacement Supplier and/or Replacement Sub-contractor.**
- 16.4 **The Supplier warrants, for the benefit of the Authority, any Replacement Supplier, and any Replacement Sub-contractor that all information provided pursuant to paragraph 16.1 and paragraph 16.2 shall be true and accurate in all material respects at the time of providing the information.**
- 16.5 **From the date of the earliest event referred to in paragraph 16.1(a), paragraph 16.1(b) and paragraph 16.1(c), the Supplier agrees, that it shall not, and agrees to procure that each Sub-contractor shall not, assign any person to the provision of the Services who is not listed on the Supplier's Provisional Personnel List and shall not without the approval of the Authority (not to be unreasonably withheld or delayed):**
- (a) replace or re-deploy any Supplier Personnel listed on the Supplier Provisional Personnel List other than where any replacement is of equivalent grade, skills, experience and expertise and is employed on the same terms and conditions of employment as the person he/she replaces;
 - (b) make, promise, propose or permit any material changes to the terms and conditions of employment of the Supplier Personnel (including any payments connected with the termination of employment);
 - (c) increase the proportion of working time spent on the Services (or the relevant part of the Services) by any of the Supplier Personnel save for fulfilling assignments and projects previously scheduled and agreed;
 - (d) introduce any new contractual or customary practice concerning the making of any lump sum payment on the termination of employment of any employees listed on the Supplier's Provisional Personnel List;
 - (e) increase or reduce the total number of employees so engaged, or deploy any other person to perform the Services (or the relevant part of the Services); or
 - (f) terminate or give notice to terminate the employment or contracts of any persons on the Supplier's Provisional Personnel List save by due disciplinary process,

and shall promptly notify, and procure that each Sub-contractor shall promptly notify, the Authority or, at the direction of the Authority, any Replacement Supplier and any Replacement Sub-contractor of any notice to terminate employment given by the Supplier or relevant Sub-

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contractor or received from any persons listed on the Supplier's Provisional Personnel List regardless of when such notice takes effect.

16.6 During the Term, the Supplier shall provide, and shall procure that each Sub-contractor shall provide, to the Authority any information the Authority may reasonably require relating to the manner in which the Services are organised, which shall include:

- (a) the numbers of employees engaged in providing the Services;
- (b) the percentage of time spent by each employee engaged in providing the Services; and
- (c) a description of the nature of the work undertaken by each employee by location.

16.7 The Supplier shall provide, and shall procure that each Sub-contractor shall provide, all reasonable cooperation and assistance to the Authority, any Replacement Supplier and/or any Replacement Sub-contractor to ensure the smooth transfer of the Transferring Supplier Employees on the Service Transfer Date including providing sufficient information in advance of the Service Transfer Date to ensure that all necessary payroll arrangements can be made to enable the Transferring Supplier Employees to be paid as appropriate. Without prejudice to the generality of the foregoing, within five Working Days following the Service Transfer Date, the Supplier shall provide, and shall procure that each Sub-contractor shall provide, to the Authority or, at the direction of the Authority, to any Replacement Supplier and/or any Replacement Sub-contractor (as appropriate), in respect of each person on the Supplier's Final Personnel List who is a Transferring Supplier Employee:

- (a) the most recent month's copy pay slip data;
- (b) details of cumulative pay for tax and pension purposes;
- (c) details of cumulative tax paid;
- (d) tax code;
- (e) details of any voluntary deductions from pay; and
- (f) bank/building society account details for payroll purposes.

17. Employment regulations exit provisions

17.1 The Authority and the Supplier acknowledge that subsequent to the commencement of the provision of the Services, the identity of the provider of the Services (or any part of the Services) may change (whether as a result of termination or Partial Termination of this Agreement or otherwise) resulting in the Services being undertaken by a Replacement Supplier and/or a Replacement Sub-contractor. Such change in the identity of the supplier of such services may constitute a Relevant Transfer to which the Employment Regulations and/or the Acquired Rights Directive will apply. The Authority and the Supplier further agree that, as a result of the operation of the Employment Regulations, where a Relevant Transfer occurs, the contracts of employment between the Supplier and the Transferring Supplier Employees (except in

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relation to any contract terms disapplied through operation of regulation 10(2) of the Employment Regulations) will have effect on and from the Service Transfer Date as if originally made between the Replacement Supplier and/or a Replacement Sub-contractor (as the case may be) and each such Transferring Supplier Employee.

- 17.2 **The Supplier shall, and shall procure that each Sub-contractor shall, comply with all its obligations in respect of the Transferring Supplier Employees arising under the Employment Regulations in respect of the period up to (and including) the Service Transfer Date and shall perform and discharge, and procure that each Sub-contractor shall perform and discharge, all its obligations in respect of all the Transferring Supplier Employees arising in respect of the period up to (and including) the Service Transfer Date (including the payment of all remuneration, benefits, entitlements and outgoings, all wages, accrued but untaken holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions and pension contributions which in any case are attributable in whole or in part to the period ending on (and including) the Service Transfer Date) and any necessary apportionments in respect of any periodic payments shall be made between: (i) the Supplier and/or the Sub-contractor (as appropriate); and (ii) the Replacement Supplier and/or Replacement Sub-contractor.**
- 17.3 **Subject to paragraph 17.4, the Supplier shall indemnify the Authority and/or the Replacement Supplier and/or any Replacement Sub-contractor against any Employee Liabilities in respect of any Transferring Supplier Employee (or, where applicable any employee representative as defined in the Employment Regulations) arising from or as a result of:**
- (a) any act or omission of the Supplier or any Sub-contractor whether occurring before, on or after the Service Transfer Date;
 - (b) the breach or non-observance by the Supplier or any Sub-contractor occurring on or before the Service Transfer Date of:
 - (i) any collective agreement applicable to the Transferring Supplier Employees; and/or
 - (ii) any other custom or practice with a trade union or staff association in respect of any Transferring Supplier Employees which the Supplier or any Sub-contractor is contractually bound to honour;
 - (c) any claim by any trade union or other body or person representing any Transferring Supplier Employees arising from or connected with any failure by the Supplier or a Sub-contractor to comply with any legal obligation to such trade union, body or person arising on or before the Service Transfer Date;
 - (d) any proceeding, claim or demand by HMRC or other statutory authority in respect of any financial obligation including, but not limited to, PAYE and primary and secondary national insurance contributions:
 - (i) in relation to any Transferring Supplier Employee, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising on and before the Service Transfer Date; and

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- (ii) in relation to any employee who is not a Transferring Supplier Employee, and in respect of whom it is later alleged or determined that the Employment Regulations applied so as to transfer his/her employment from the Supplier to the Authority and/or Replacement Supplier and/or any Replacement Sub-contractor, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising on or before the Service Transfer Date;
- (e) a failure of the Supplier or any Sub-contractor to discharge or procure the discharge of all wages, salaries and all other benefits and all PAYE tax deductions and national insurance contributions relating to the Transferring Supplier Employees in respect of the period up to (and including) the Service Transfer Date);
- (f) any claim made by or in respect of any person employed or formerly employed by the Supplier or any Sub-contractor other than a Transferring Supplier Employee for whom it is alleged the Authority and/or the Replacement Supplier and/or any Replacement Sub-contractor may be liable by virtue of this Agreement and/or the Employment Regulations and/or the Acquired Rights Directive; and
- (g) any claim made by or in respect of a Transferring Supplier Employee or any appropriate employee representative (as defined in the Employment Regulations) of any Transferring Supplier Employee relating to any act or omission of the Supplier or any Sub-contractor in relation to its obligations under regulation 13 of the Employment Regulations, except to the extent that the liability arises from the failure by the Authority and/or Replacement Supplier to comply with regulation 13(4) of the Employment Regulations.

17.4 The indemnities in paragraph 17.3 shall not apply to the extent that the Employee Liabilities arise or are attributable to an act or omission of the Replacement Supplier and/or any Replacement Sub-contractor whether occurring or having its origin before, on or after the Service Transfer Date, including any Employee Liabilities:

- (a) arising out of the resignation of any Transferring Supplier Employee before the Service Transfer Date on account of substantial detrimental changes to his/her working conditions proposed by the Replacement Supplier and/or any Replacement Sub-contractor to occur in the period on or after the Service Transfer Date); or
- (b) arising from the Replacement Supplier's failure, and/or Replacement Sub-contractor's failure, to comply with its obligations under the Employment Regulations.

17.5 If any person who is not a Transferring Supplier Employee claims, or it is determined in relation to any person who is not a Transferring Supplier Employee, that his/her contract of employment has been transferred from the Supplier or any Sub-contractor to the Replacement Supplier and/or Replacement Sub-contractor pursuant to the Employment Regulations or the Acquired Rights Directive, then:

- (a) the Authority shall procure that the Replacement Supplier shall, or any Replacement Sub-contractor shall, within five Working Days of becoming aware of that fact, give notice in writing to the Supplier; and

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- (b) the Supplier may offer (or may procure that a Sub-contractor may offer) employment to such person within 15 Working Days of the notification by the Replacement Supplier and/or any and/or Replacement Sub-contractor or take such other reasonable steps as it considers appropriate to deal with the matter provided always that such steps are in compliance with Law.

17.6 If such offer is accepted, or if the situation has otherwise been resolved by the Supplier or a Sub-contractor, the Authority shall procure that the Replacement Supplier shall, or procure that the Replacement Sub-contractor shall, immediately release or procure the release of the person from his/her employment or alleged employment.

17.7 If after the 15 Working Day period specified in paragraph 17.5(b) has elapsed:

- (a) no such offer of employment has been made;
- (b) such offer has been made but not accepted; or
- (c) the situation has not otherwise been resolved

the Authority shall advise the Replacement Supplier and/or Replacement Sub-contractor, as appropriate that it may within five Working Days give notice to terminate the employment or alleged employment of such person.

17.8 Subject to the Replacement Supplier and/or Replacement Sub-contractor acting in accordance with the provisions of paragraph 17.5 to paragraph 17.7, and in accordance with all applicable proper employment procedures set out in applicable Law, the Supplier shall indemnify the Replacement Supplier and/or Replacement Sub-contractor against all Employee Liabilities arising out of the termination pursuant to the provisions of paragraph 17.7 provided that the Replacement Supplier takes, or shall procure that the Replacement Sub-contractor takes, all reasonable steps to minimise any such Employee Liabilities.

17.9 The indemnity in paragraph 17.8:

- (a) shall not apply to:
 - (i) in any case in relation to any alleged act or omission of the Replacement Supplier and/or Replacement Sub-contractor, any claim for: (A) discrimination, including on the grounds of sex, race, disability, age, gender reassignment, marriage or civil partnership, pregnancy and maternity or sexual orientation, religion or belief; or (B) equal pay or compensation for less favourable treatment of part-time workers or fixed-term employees; or
 - (ii) any claim that the termination of employment was unfair because the Replacement Supplier and/or Replacement Sub-contractor neglected to follow a fair dismissal procedure; and
- (b) shall apply only where the notification referred to in paragraph 17.5(a) is made by the Replacement Supplier and/or Replacement Sub-contractor to the Supplier within six months of the Service Transfer Date.

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- 17.10 If any such person as is described in paragraph 17.5 is neither re-employed by the Supplier or any Sub-contractor nor dismissed by the Replacement Supplier and/or Replacement Sub-contractor within the time scales set out in paragraph 17.5 to paragraph 17.7, such person shall be treated as a Transferring Supplier Employee and the Replacement Supplier and/or Replacement Sub-contractor shall comply with such obligations as may be imposed upon it under applicable Law.
- 17.11 The Supplier shall comply, and shall procure that each Sub-contractor shall comply, with all its obligations under the Employment Regulations and shall perform and discharge, and shall procure that each Sub-contractor shall perform and discharge, all its obligations in respect of the Transferring Supplier Employees before and on the Service Transfer Date (including the payment of all remuneration, benefits, entitlements and outgoings, all wages, accrued but untaken holiday pay, bonuses, commissions, payments of PAYE, national insurance contributions and pension contributions which in any case are attributable in whole or in part in respect of the period up to (and including) the Service Transfer Date) and any necessary apportionments in respect of any periodic payments shall be made between:
- (a) the Supplier and/or any Sub-contractor; and
 - (b) the Replacement Supplier and/or the Replacement Sub-contractor.
- 17.12 The Supplier shall, and shall procure that each Sub-contractor shall, promptly provide to the Authority and any Replacement Supplier and/or Replacement Sub-contractor, in writing such information as is necessary to enable the Authority, the Replacement Supplier and/or Replacement Sub-contractor to carry out their respective duties under regulation 13 of the Employment Regulations. The Authority shall procure that the Replacement Supplier and/or Replacement Sub-contractor, shall promptly provide to the Supplier and each Sub-contractor in writing such information as is necessary to enable the Supplier and each Sub-contractor to carry out their respective duties under regulation 13 of the Employment Regulations.
- 17.13 Subject to paragraph 17.14, the Authority shall procure that the Replacement Supplier indemnifies the Supplier on its own behalf and on behalf of any Replacement Sub-contractor and its sub-contractors against any Employee Liabilities in respect of each Transferring Supplier Employee (or, where applicable any employee representative (as defined in the Employment Regulations) of any Transferring Supplier Employee) arising from or as a result of:
- (a) any act or omission of the Replacement Supplier and/or Replacement Sub-contractor;
 - (b) the breach or non-observance by the Replacement Supplier and/or Replacement Sub-contractor on or after the Service Transfer Date of:
 - (i) any collective agreement applicable to the Transferring Supplier Employees; and/or

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- (ii) any custom or practice in respect of any Transferring Supplier Employees which the Replacement Supplier and/or Replacement Sub-contractor is contractually bound to honour;
- (c) any claim by any trade union or other body or person representing any Transferring Supplier Employees arising from or connected with any failure by the Replacement Supplier and/or Replacement Sub-contractor to comply with any legal obligation to such trade union, body or person arising on or after the Relevant Transfer Date;
- (d) any proposal by the Replacement Supplier and/or Replacement Sub-contractor to change the terms and conditions of employment or working conditions of any Transferring Supplier Employees on or after their transfer to the Replacement Supplier or Replacement Sub-contractor (as the case may be) on the Relevant Transfer Date, or to change the terms and conditions of employment or working conditions of any person who would have been a Transferring Supplier Employee but for their resignation (or decision to treat their employment as terminated under regulation 4(9) of the Employment Regulations) before the Relevant Transfer Date as a result of or for a reason connected to such proposed changes;
- (e) any statement communicated to or action undertaken by the Replacement Supplier or Replacement Sub-contractor to, or in respect of, any Transferring Supplier Employee on or before the Relevant Transfer Date regarding the Relevant Transfer which has not been agreed in advance with the Supplier in writing;
- (f) any proceeding, claim or demand by HMRC or other statutory authority in respect of any financial obligation including, but not limited to, PAYE and primary and secondary national insurance contributions:
 - (i) in relation to any Transferring Supplier Employee, to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising after the Service Transfer Date; and
 - (ii) in relation to any employee who is not a Transferring Supplier Employee, and in respect of whom it is later alleged or determined that the Employment Regulations applied so as to transfer his/her employment from the Supplier or Sub-contractor, to the Replacement Supplier or Replacement Sub-contractor to the extent that the proceeding, claim or demand by HMRC or other statutory authority relates to financial obligations arising after the Service Transfer Date;
- (g) a failure of the Replacement Supplier or Replacement Sub-contractor to discharge or procure the discharge of all wages, salaries and all other benefits and all PAYE tax deductions and national insurance contributions relating to the Transferring Supplier Employees in respect of the period from (and including) the Service Transfer Date; and
- (h) any claim made by or in respect of a Transferring Supplier Employee or any appropriate employee representative (as defined in the Employment Regulations) of any Transferring Supplier Employee relating to any act or omission of the Replacement Supplier or Replacement Sub-contractor in relation to obligations under regulation 13 of the Employment Regulations.

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- 17.14 **The indemnities in paragraph 17.13 shall not apply to the extent that the Employee Liabilities arise or are attributable to an act or omission of the Supplier and/or any Sub-contractor (as applicable) whether occurring or having its origin before, on or after the Relevant Transfer Date, including any Employee Liabilities arising from the failure by the Supplier and/or any Sub-contractor (as applicable) to comply with its obligations under the Employment Regulations.**

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Annex A. Admission Agreement

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Annex B. Transferring Authority Employees

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Annex C. List of Notified Sub-contractors

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Tender Response Document

**AMC 006
INTEGRATED SEXUAL HEATH SERVICES**

Name of TENDERING
ORGANISATION
(please insert)

**South Staffordshire & Shropshire
Healthcare NHS Foundation Trust**

Shropshire Council Tender Response Document

Instructions for the completion of this document

1. This document must be completed in its entirety with responses being given to all questions. If you are unsure of any section and require further clarification, please contact via our Delta Tenderbox. You are recommended to keep a copy of all tender documents and supporting documents for your own records.
2. Tenderers must also complete and sign the four certificates in Sections A1 to A4. These must be signed;
 - a) Where the tenderer is an individual, by that individual;
 - b) Where the tenderer is a partnership, by two duly authorised partners;
 - c) Where the tenderer is a company, by two directors or by a director and the secretary of the company, such persons being duly authorised for the purpose.
3. All questions require specific responses from you relating to the organisation named in Section B Question 1.1. All information supplied must be accurate and up to date. The Council reserves the right to refuse to consider your application if the Tender Response Document is not fully completed or is found to be inaccurate.

Contents

Section	Description	Page
A1	Form of Tender	4
A2	Non-Canvassing Certificate	5
A3	Non-Collusive Tendering Certificate	6
A4	Declaration of Connection with Officers or Elected Members of the Council	7
You must sign all 4 certificates in sections A1 to A4		
B	Tender Schedule	8

Award Criteria

Tenders will be evaluated on the answers provided in this Tender Response Document against the criteria shown in the table below. The following award criteria is made up of 'Quality' and 'Price' and shows how each criteria is to be weighted against each other.

Section / Question No.	Award Criteria	Weighting / Max Marks Available
Price 40% (400 marks)		
Pricing Schedules	Price	40 / 400 max marks
Total for price		40 / 400 max marks
Quality 60% (600 marks)		

B 1.	1.Service Delivery & Clinical	18 / 180 max marks
B 2.	2.Workforce Development & HR	14 / 140 max marks
B.3	3. Partnerships	7/ 70 marks
B 4.	4.Clinical Governance & Quality	7 / 70 max marks
B 5.	5.Information Governance & Data Management	7/ 70 max marks
B 6	6. Contract Management & Implementation	7/ 70 max marks
Total for quality		60 / 600 max marks

Please note that each question within each of the above quality criteria sections is weighted against the other questions only within that section. The individual question weightings are indicated against each question in section B 1-5.

Each question will be marked out of 10 using the scheme below and the total mark received for each quality section (B1 – B5) will then be used in the final calculation. The tender receiving the highest initial mark overall in each of the quality sections will receive the full maximum marks available for that quality criteria as shown in the table above. Other tenders will receive a final mark that represents a % of the maximum marks for each quality section that reflects the difference in the initial marks between those tenders and the tender receiving the highest mark for each of the quality sections.

For example:- If the best scoring tender in relation to Section B 1 scores a total of 280 then their final mark will be 180 for that section. If the second highest mark bidder scores 200 then they would receive a final mark of 128 for that section (200 divided by 280 x 100 = 71% x 180 = 128)

Or for example:- If the best scoring tender in relation to Section B 4 scores a total of 120 then their final mark will be 80 for that section. If the second highest mark bidder scores 60 then they would receive a final mark of 40 (60 divided by 120 x 100= 50% x 80 = 40)

There is one pass /fail question at 6.6.

Quality Questions/ Scoring Scheme

Questions within the quality sections shown above will be scored using the following scoring scheme. Each answer from the questions identified below will be given a mark between 0 and 10 with the following meanings:

Assessment	Mark	Interpretation
------------	------	----------------

Excellent	10	<i>Exceeds the requirement. Exceptional demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures. Response identifies factors that demonstrate added value, with evidence to support the response.</i>
	9	
Good	8	<i>Satisfies the requirement with minor additional benefits Above average demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures. Response identifies factors that demonstrate added value, with evidence to support the response.</i>
	7	
Acceptable	6	<i>Satisfies the requirement. Demonstration by the Tenderer of how they will meet this requirement by their allocation of skills and understanding, resources and quality measures, with evidence to support the response.</i>
	5	
Minor Reservations	4	<i>Satisfies the requirement with minor reservations Some minor reservations regarding how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with limited evidence to support the response.</i>
	3	
Serious Reservations	2	<i>Satisfies the requirement with major reservations. Considerable reservations regarding how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with little or no evidence to support the response.</i>
	1	
Unacceptable	0	<i>Does not meet the requirement Does not comply and/or insufficient information provided to demonstrate how the Tenderer will meet this requirement by their allocation of skills and understanding, resources and quality measures, with little or no evidence to support the response.</i>

The use of odd numbers indicates an answer's allocated mark lies between definitions.

Price Evaluation

Price has an overall weighting of 40% of the total evaluation criteria. Please complete the pricing schedule attached. The price that will be evaluated will be the average annual price as shown in cell C19 on the 'Summary of all the Costs' worksheet.

The most competitively priced tender will receive the maximum marks of 400 Less competitive tenders will receive a mark that is a % of the maximum mark available that represents the difference in cost or reduction between that tender and the most competitively priced tender.

The winning tender will be the highest scoring tender overall when the final quality and price marks are combined.

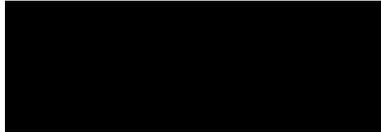
Section A:
1. Form of Tender

Form of Tender

Shropshire Council
Tender for **Sexual Health Services**

We confirm that this, our tender, represents an offer to Shropshire Council that if accepted in whole, or in part, will create a binding contract for the Sexual Health Services at the prices and terms agreed and subject to the terms of the invitation to tender documentation and the Terms and Conditions, copies of which we have received.

Signed:



Name:



Date: 5th November 2015

Designation: Head of Business & Commercial Development

Company: South Staffordshire & Shropshire NHS Foundation Trust

Address: Trust Headquarters, St George's Hospital, Corporation St, Stafford

Post code: ST16 3SR

Tel No: 0300 790 7000

Fax No: n/a

E-mail address:



Web address: www.sssft.nhs.uk

Section A:
2. Non-Canvassing Certificate

Non-Canvassing Certificate

To: Shropshire Council (hereinafter called “the Council”)

I/We hereby certify that I/We have not canvassed or solicited any member officer or employee of the Council in connection with the award of this Tender or any other Tender or proposed Tender for the Services and that no person employed by me/us or acting on my/our behalf has done any such act.

I/We further hereby undertake that I/We will not in the future canvass or solicit any member officer or employee of the Council in connection with the award of this Tender or any other Tender or proposed Tender for the Services and that no person employed by me/us or acting on my/our behalf will do any such act.

Signed (



tatus: Head of Business & Commercial Development

Signed (2)

tatus: Business Development & Service Improvement

(For and on behalf of: South Staffordshire & Shropshire NHS Foundation Trust)

Date: 4th November 2015

Section A:
3. Non-Collusive Tendering Certificate

Non-collusive Tendering Certificate

To: Shropshire Council (hereinafter called “the Council”)

The essence of selective tendering is that the Council shall receive bona fide competitive Tenders from all persons tendering. In recognition of this principle:

I/We certify that this is a bona fide Tender, intended to be competitive and that I/We have not fixed or adjusted the amount of the Tender or the rates and prices quoted by or under or in accordance with any agreement or arrangement with any other person.

I/We also certify that I/We have not done and undertake that I/We will not do at any time any of the following acts:-

- (a) communicating to a person other than the Council the amount or approximate amount of my/our proposed Tender (other than in confidence in order to obtain quotations necessary for the preparation of the Tender for insurance); or
- (b) entering into any agreement or arrangement with any other person that he shall refrain from Tendering or as to the amount of any Tender to be submitted; or
- (c) offering or agreeing to pay or give or paying any sum of money, inducement or valuable consideration directly or indirectly to any person for doing or having done or causing or having caused to be done in relation to any other Tender or proposed Tender for the Services any act or omission.

Signed (1)



Status: Head of Business & Commercial Development

Signed (2)
Manager

Status: Business Development & Service Improvement

Section A:

4. Declaration of Connection with Officers or Elected Members of the Council

Are you or any of your staff who will be affected by this invitation to tender related or connected in any way with any Shropshire Council Elected Councillor or Employee?

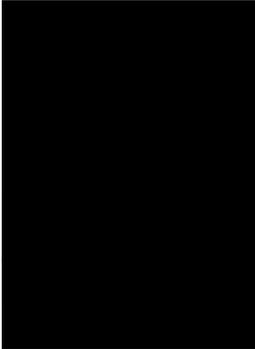
No

If yes, please give details:

Name	Relationship

Please note:

This information is collected to enable the Council to ensure that tenders are assessed without favouritism. Whether or not you have a connection with elected members or employees will have no bearing on the success of your tender, but your tender will not be considered unless this declaration has been completed.

Signed (1)		Status: Head of Business & Commercial Development
Signed (2) Manager		Status: Business Development & Service Improvement

(For and on behalf of: South Staffordshire & Shropshire NHS Foundation Trust)

Date: 4th November 2015

Section B:

commercial info

Tender Schedule

(Please provide responses to all of the following questions under each section keeping within the maximum word counts for each.)

Question No.	1.Service Delivery & Clinical Questions	Question Weighting Within Section
1.1	<p>Based on the specification please describe your overarching proposed service model for providing Integrated community based Sexual health Services in Shropshire. Your response should give consideration to the resources, including staff you will apply in order to deliver the service, and cite appropriate evidence.</p> <p>Please also include in your answer your proposed model in relation to the delivery of:</p> <ul style="list-style-type: none"> • The range, scale and approach to delivering: <ul style="list-style-type: none"> • Prevention and self-management services • Shifting the focus from reactive to preventive services • Management of community based contraception and sexual health services. • Management of community based level 1,2 and 3 testing, diagnosis and treatment services <ul style="list-style-type: none"> • Integrated patient delivery pathways across the healthcare system • Implementation of service re-design models • Working with service users and patients with complex sexual health needs in terms of assessment and referral to Level 3, and secondary care including maternity services, substance misuse services, mental health services, the voluntary sector organisations and partnership working • Promoting a proactive equal opportunities culture in the planning, design and delivery of services. <p><i>(max 1500 words)</i></p> <p><u>Introduction</u></p> <div style="background-color: black; height: 40px; width: 100%;"></div>	5

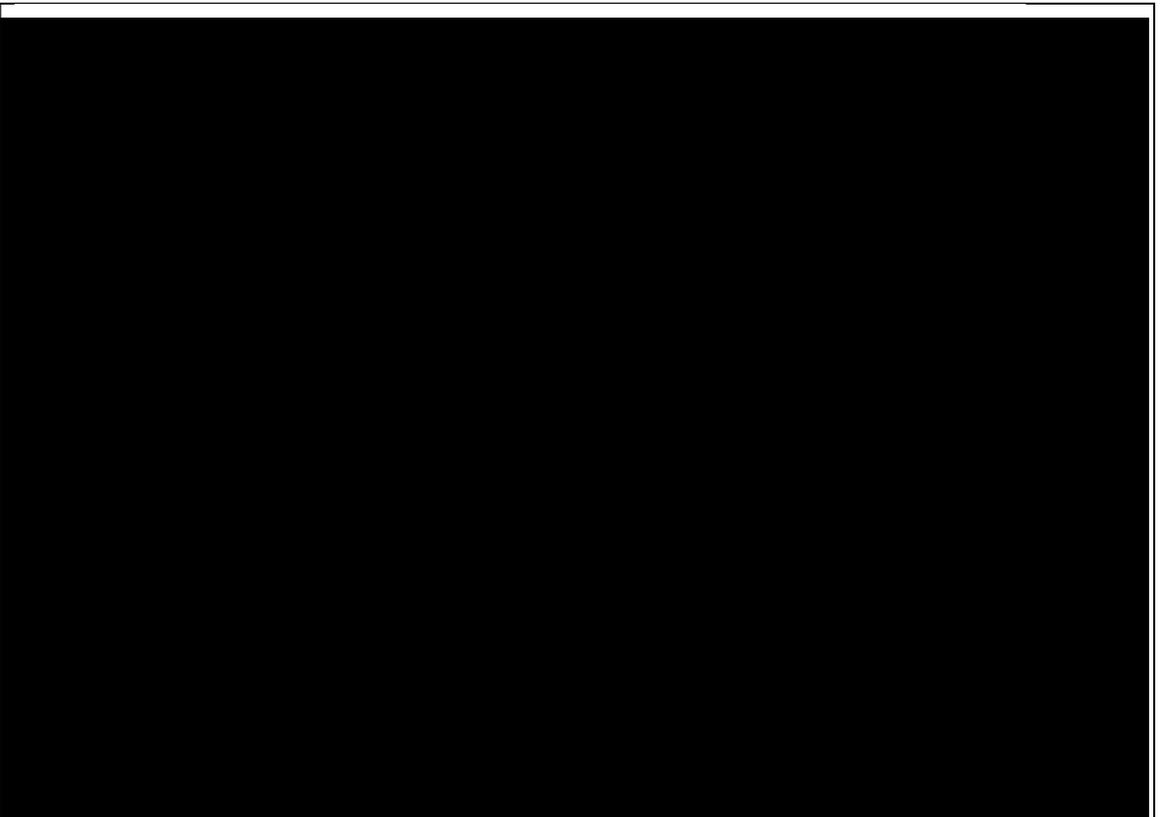
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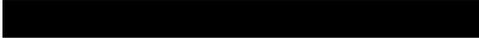
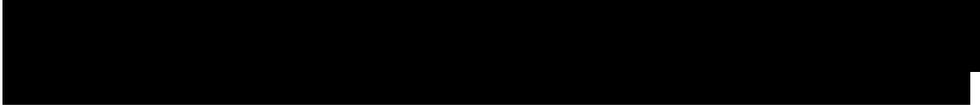
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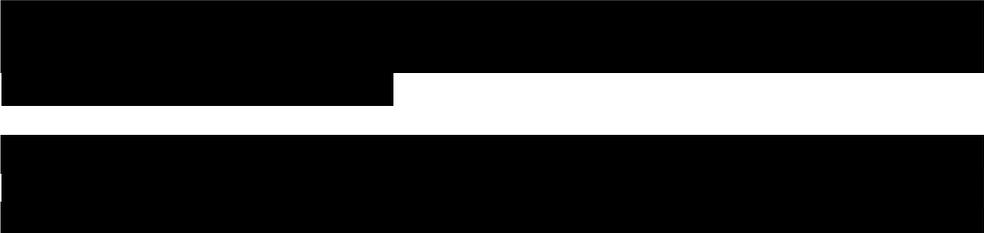
																			
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1.2	<p>One of the key priorities of the Shropshire Health and Wellbeing Strategy is that all health, social care and wellbeing services in Shropshire are accessible to the residents.</p> <p>Please describe how your organisation will ensure that the sexual health services you will provide are accessible in Shropshire; and the challenges delivering services to a rural county. Your answer should reflect the service requirements set out within the specification including out of hours/ weekends provision? (<i>max 400 words</i>).</p>        	5

	<p>[Redacted]</p>	
1.3	<p>In the context of this contract think about access in its broadest sense:</p> <ul style="list-style-type: none">• How will you map opening times to the demand of service users?• How might there be a conflict between offering appointment slots and drop-in clinics when it comes to access to and provision of sexual health services• How might you make your service accessible to the most vulnerable people in Shropshire (<i>max 500 words</i>) <p>[Redacted]</p>	3

	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <ul style="list-style-type: none">[Redacted][Redacted][Redacted][Redacted][Redacted]	
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	<p>[REDACTED]</p>	
1.5	<p>Nationally there has been an increase in the numbers of men who have sex with men diagnosed with HIV late in the disease, this is reflected locally.</p> <p>Please describe how you will manage a preventive approach to support this Public Health Outcome Indicator (<i>max words 400</i>).</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	3

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1.6	<p>Please outline your marketing plan and expertise (internal and external) that you will utilise to support promotion of the service to other organisations, professionals, service users, and the general population across Shropshire (<i>max 500 words</i>)</p>  Two horizontal bars of redacted content are located below the text in this row.	4

	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <ul style="list-style-type: none">[Redacted][Redacted][Redacted] <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
1.7	<p>How would you demonstrate that your service would meet the needs of young people within this contract and monitor that these needs are continuously met. (<i>max 500 words</i>)</p> <p>[Redacted]</p> <ul style="list-style-type: none">[Redacted]	4

<p>1.8</p>	<p>Why do you consider monitoring C-card activity is important and how will you do this within this contract? (<i>max 400 words</i>)</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	<p>3</p>
<p>1.9</p>	<p>Safeguarding children is everyone’s responsibility. As a contractor providing a public service on behalf of a Shropshire Council, we expect that you will be familiar and committed to the local safeguarding children procedures as set by statutory guidance and by Shropshire’s Safeguarding Children Board (SSCB)</p> <p>http://www.safeguardingshropshireschildren.org.uk/scb/index.html</p>	<p>4</p>

Please describe how your organisation will ensure that it can meet this requirement from the start and throughout the contract.

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

- [Redacted]

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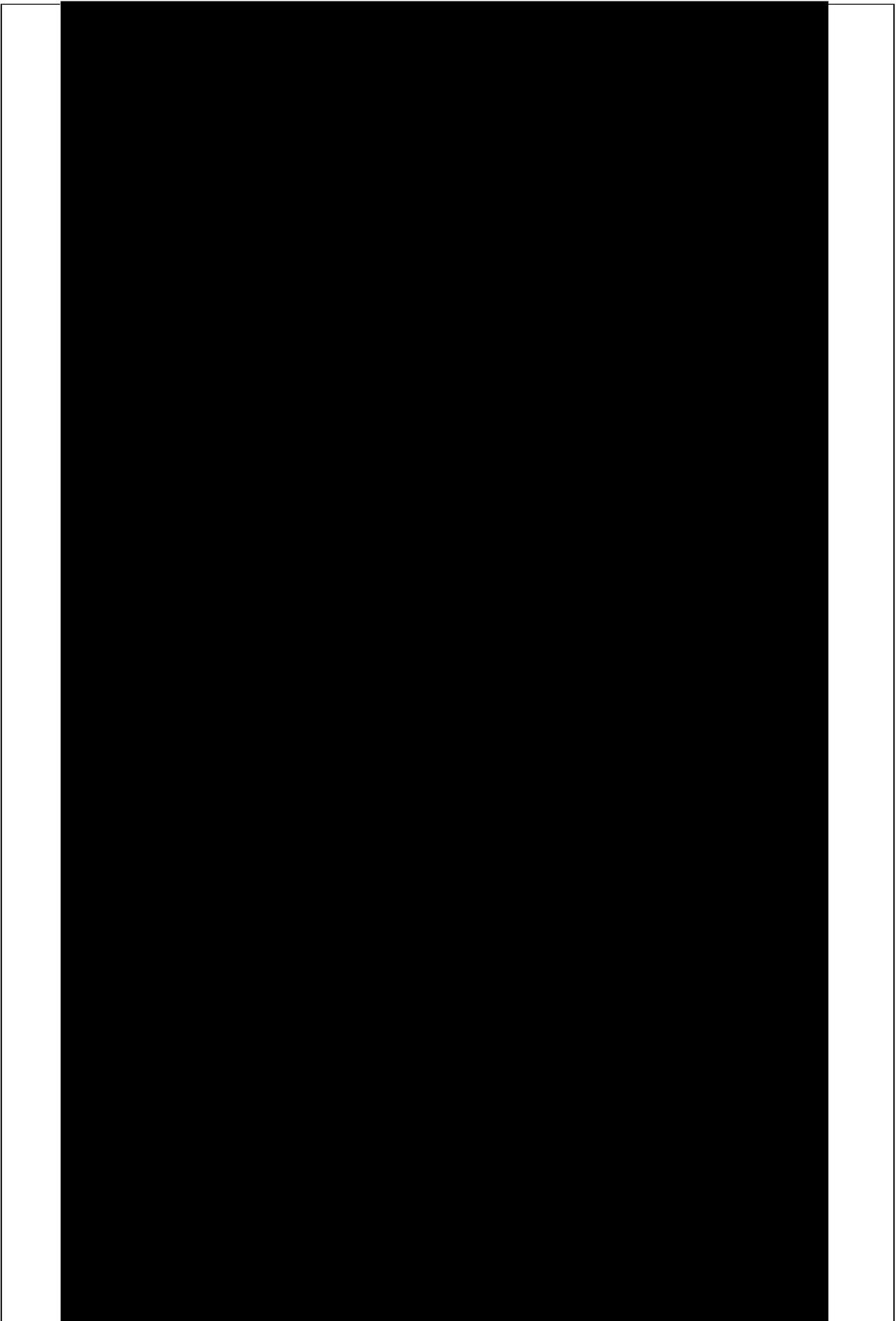
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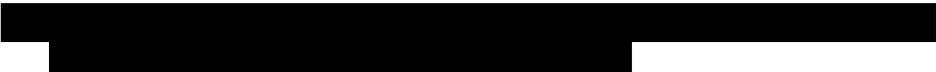
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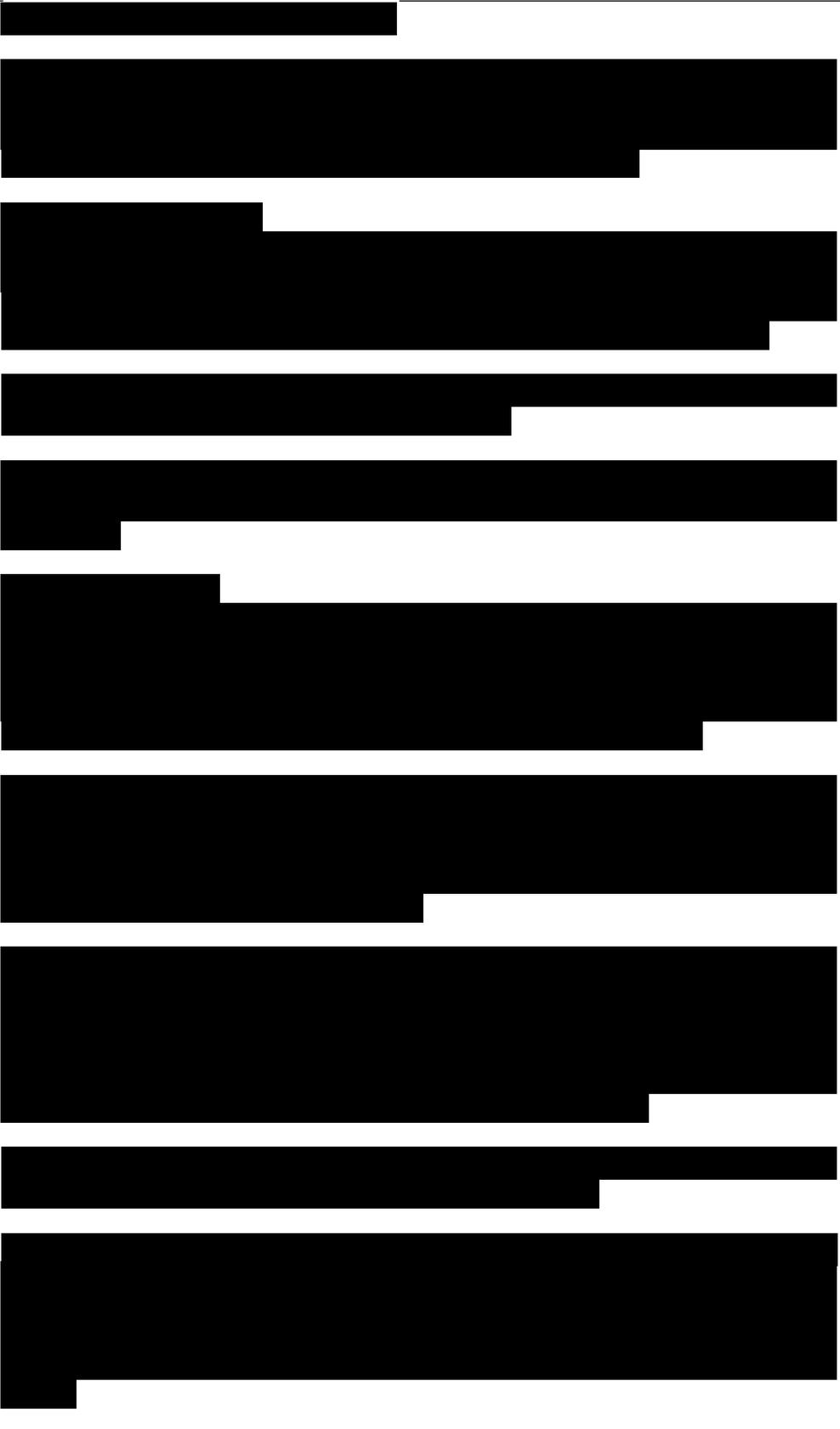
	 	
Question No.	2. HR & Workforce Proposals	Question Weighting Within Section
2.1	<p>Please attach your proposed staffing model for full service operation. This should include detail of all professions, roles, qualifications and pay bands and whole time equivalents.</p>   	5
		

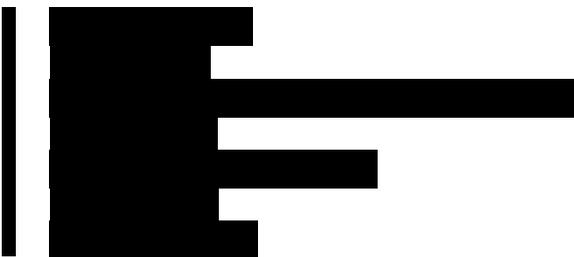


		
2.2	<p data-bbox="295 622 1284 728">Please describe how you arrived at your workforce plan and how it links with the service specification. The answer should detail how the workforce compliments the service requirements (<i>max 500 words</i>).</p>          	5

	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
2.3	<p>Please describe your proposed retention strategy. This should detail how staffing requirement is assessed, monitored and maintained (<i>max 400 words</i>).</p> <p>[Redacted]</p> <ul style="list-style-type: none">[Redacted] <p>[Redacted]</p> <p>[Redacted]</p> <ul style="list-style-type: none">[Redacted]	3

	<p>█ [REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>█ [REDACTED]</p> <p>█ [REDACTED]</p> <p>[REDACTED]</p> <p>█ [REDACTED]</p>	
2.4	<p>How will you maintain service delivery during periods of annual leave, staff sickness (long term) or other absence. Please ensure your answer addresses planning, policies and resources (<i>max 400 words</i>).</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	3

		
2.6	<p>Please describe how you plan to provide training for your staff, maintaining a competent and up-to-date workforce, including:</p> <ul style="list-style-type: none">• How you deliver staff appraisal and CPD• How you ensure that staff engage positively in clinical supervision• How will you deliver joint-training and education, using examples of undertaking this type of training (<i>max 500 words</i>)	3

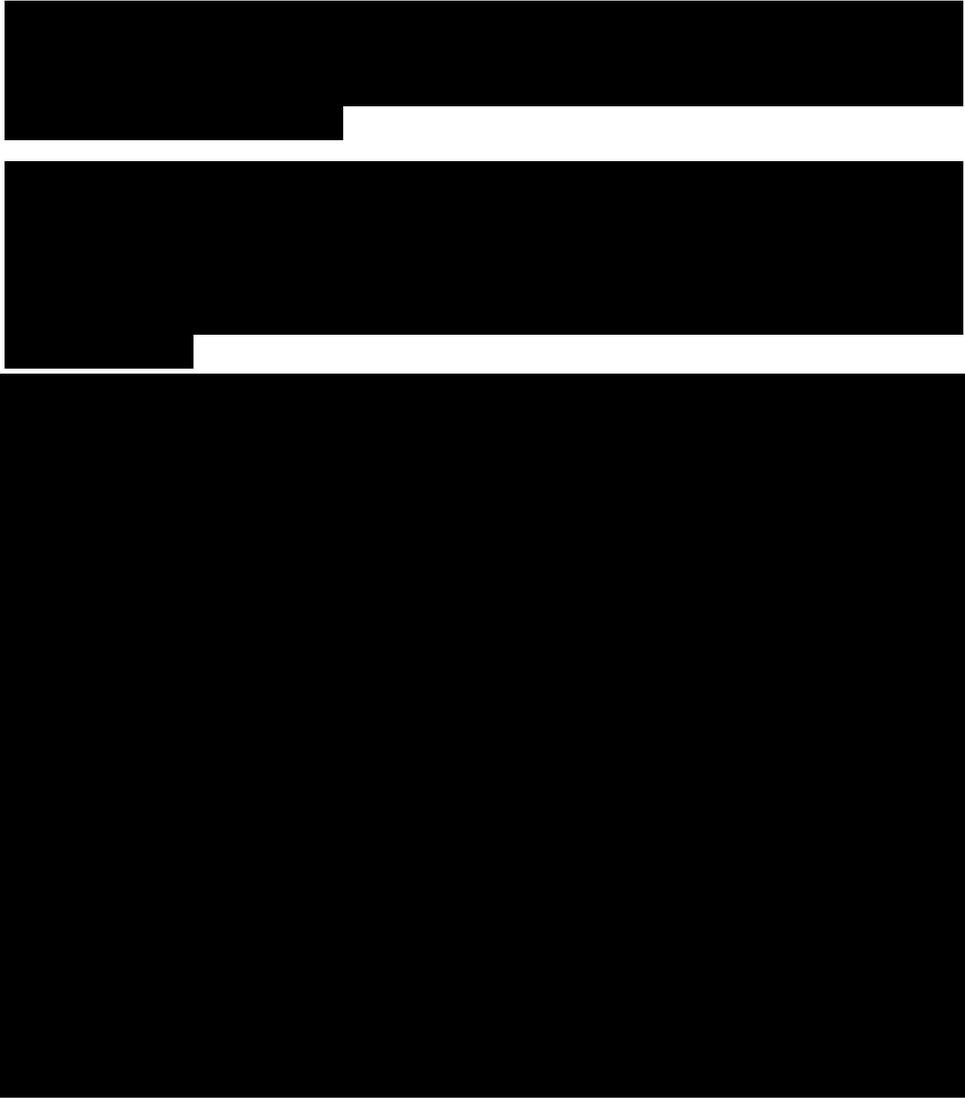
	<ul style="list-style-type: none">• Workplace Risk Awareness, Manual Handling     	
2.7	<p>How will you fulfil your role leading the training of the wider sexual health workforce in Shropshire, including staff in general practice, school nurses etc. Include how you will offer training, teaching, support medical education and placements, and maintain a training register (<i>max 400 words</i>)</p>     	3

	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
2.8	<p>How will you maximise the use of pre-existing skills within Shropshire for those services specified in Interdependencies in section 3.3 - in order to preserve local skills e.g. primary care, school nursing etc. <i>(max 500 words)</i></p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	3

		
<p>Question No.</p>	<p style="text-align: center;">3. Partnerships</p>	<p>Question Weighting Within Section</p>
<p>3.1</p>	<p>With reference to Sexual Health Outreach in Schools, colleges, educational and training settings, how do you propose on utilising human resources within schools to the delivery of prevention and positive messages as it related to sexual reproductive health (<i>max 400 words</i>)</p> 	<p>5</p>

	[REDACTED]	

	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
3.3	<p>How will you ensure effective engagement, collaboration and partnership working with other services and specialisms in relation to HIV treatment and care services? (<i>max 400 words</i>)</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	5

		
3.4	<p>How do you propose to work with primary care providers in delivering prevention and positive messages as it relates to sexual reproductive health (<i>max 400 words</i>)</p> 	5

	<p>[REDACTED]</p> <ul style="list-style-type: none"> ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] <p>[REDACTED]</p> <ul style="list-style-type: none"> ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] ■ [REDACTED] 	
<p>Question No.</p>	<p>4. Clinical Governance & Quality</p>	<p>Question Weighting Within Section</p>
<p>4.1</p>	<p>Describe the clinical governance structure of your organisation for the undertaking of this service? Please address the following questions in</p>	<p>5</p>

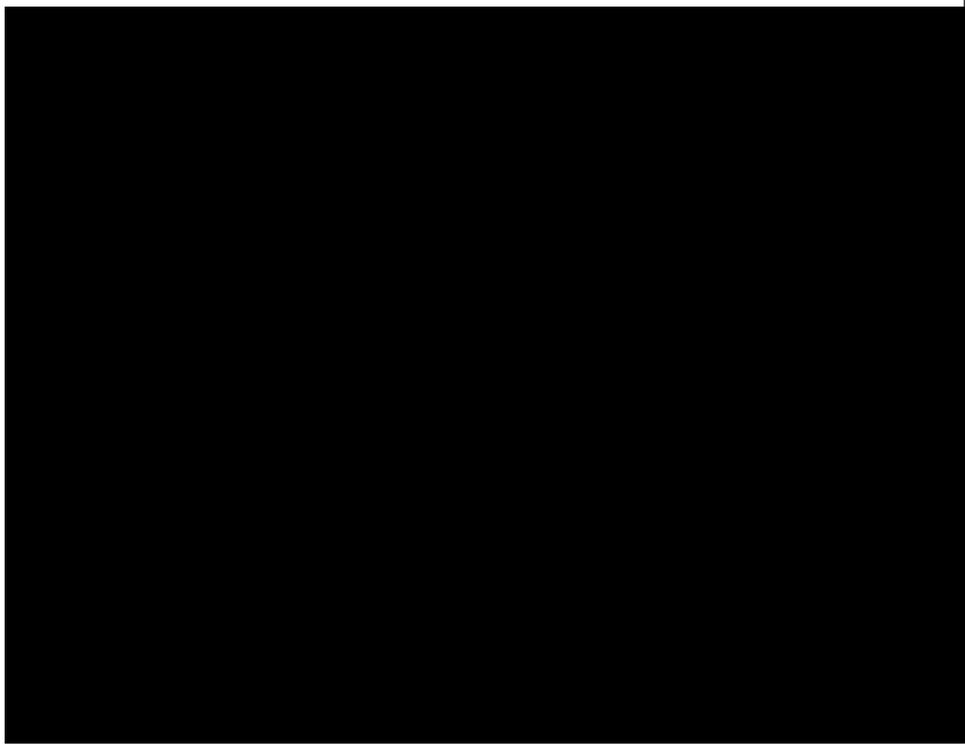
	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
4.2	<p>Do you have a CG policy for your organisation to be used in relation to this contract? If yes, please provide the copy of your latest CG policy.</p> <p>[Redacted]</p> <p>[Redacted]</p>	5
4.3	<p>Do you have an infection, prevention and control policy for your organisation for use within this service? If yes, please provide the copy of your latest infection, prevention and control policy</p> <p>[Redacted]</p>	3

	[REDACTED]	
4.4	<p>Do you have an incident management policy for your organisation for use within this service? If yes, please provide the copy of your latest incident management policy</p> <p>[REDACTED]</p>	3
4.5	<p>Describe your complaints management system for use within this service. Please provide a copy of your complaints management policy.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	3
4.6	<p>Describe your risk assessment, risk management and risk communication systems for use within this service? Does your</p>	3

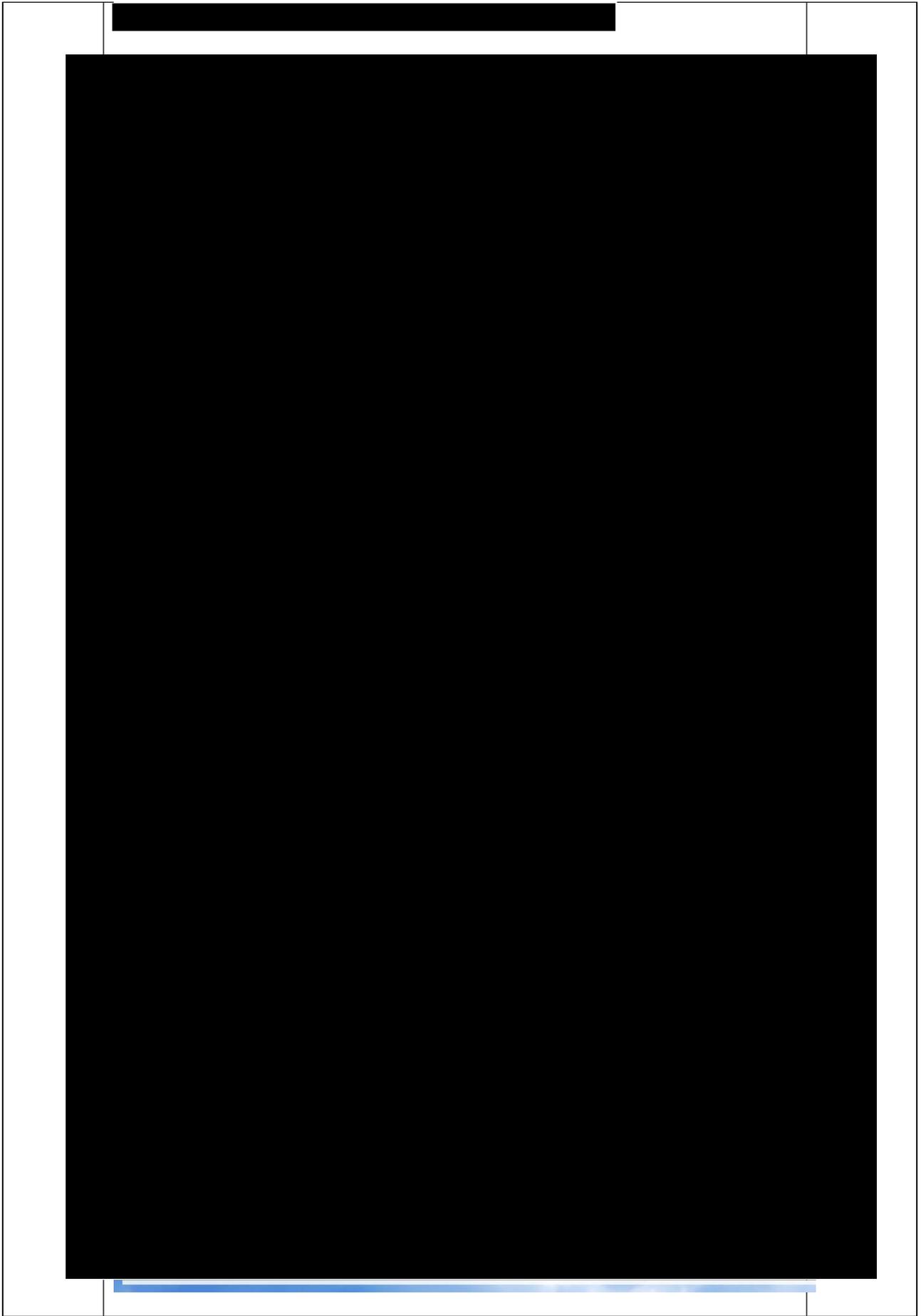
	<p>organisation keep a risk register? Does it have a risk assessment lead (<i>Max 600 words</i>)</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
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	[REDACTED]	

	<p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>	
4.7	<p>In the context of this service, describe what you and your service would consider as 'core' aspects of quality – those of high importance to all potential service user groups; are there any markers of quality that might differ between user groups, if so describe them and how you will meet these needs <i>(Max 400 words)</i></p> <p>[REDACTED]</p> <p>[REDACTED]</p>	4

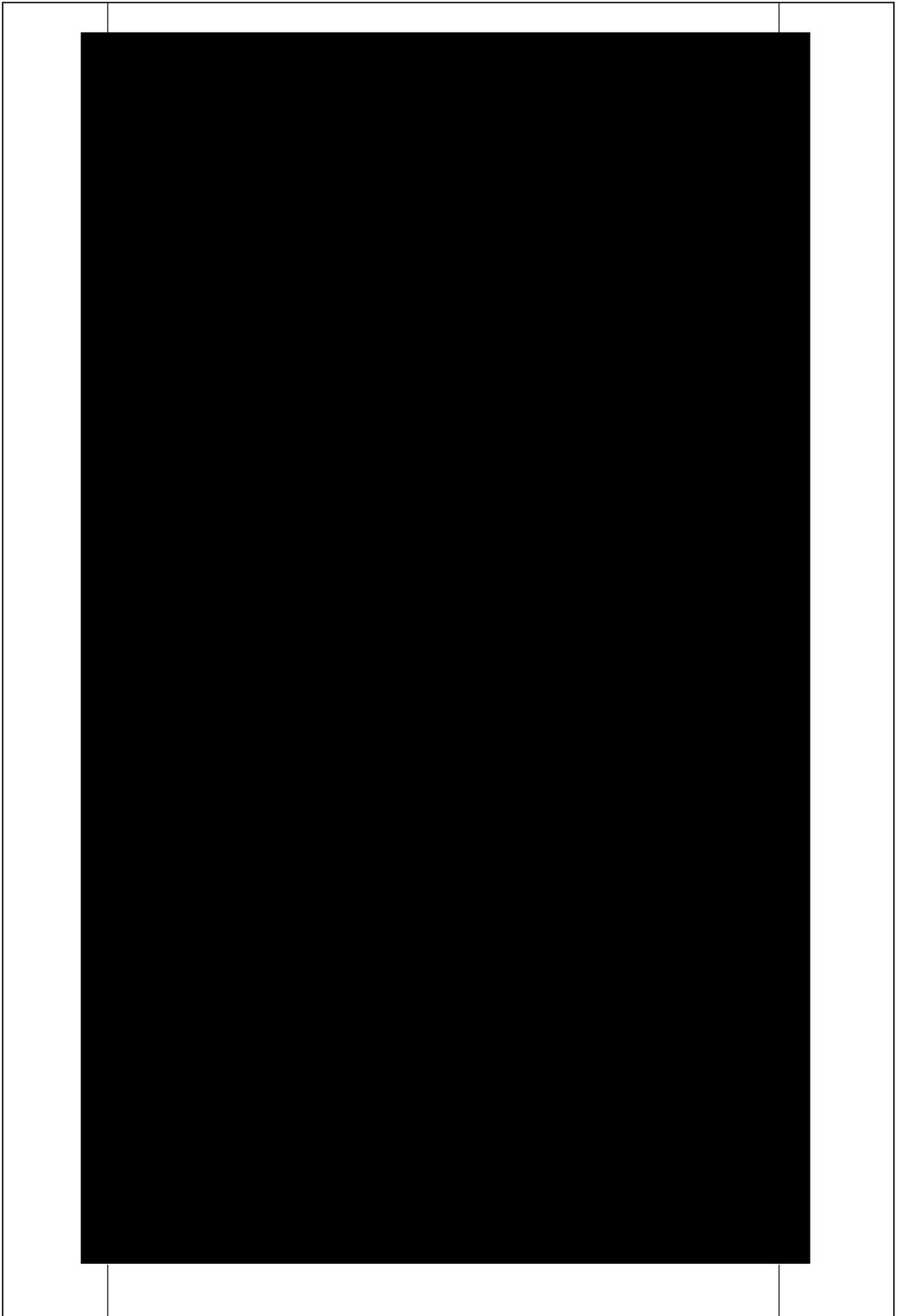
	       	
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	<p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	
4.8	<p>Shropshire Council expects service providers to have in place a range of approaches to ensure high levels and the development of customer service. How will you, in the context of this service:</p> <ul style="list-style-type: none">• Ensure a customer/patient satisfaction led culture is embedded within your organisation and service delivery.• Use recommendations of patient satisfaction surveys, learning from complaints and other sources of feedback? Please provide an example of how you have done this previously• Ensure and enable full involvement of service users in service planning, improvement and quality control, using examples <p><i>(Max 500 words)</i></p> <p>[Redacted]</p>	4



<p>4.9</p>	<p>Do you have policy/procedures in place on clinical audits for use within this service? Do you carry out clinical audits regularly? If yes, please provide a copy of your latest clinical audit report (<i>Max 400 words</i>)</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	<p>3</p>
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<p>4.10</p>	<p>How will you operate system-wide integrated care pathways for patients within this service? Please provide a copy of one such pathway used previously. (Max 300 words)</p> <p>Our model will create a single service underpinned by robust care</p> <p>[REDACTED]</p>	<p>3</p>
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Question No.	5. Information Governance & Data Management Questions	Question Weighting Within Section
5.1	<p>Demonstrate how you will meet or exceed the NHS Information Governance Toolkit standards required for your organisation type/s, It is critical to provide appropriate supporting evidence. If responding as a partnership, demonstrate how compliance is consistently achieved across all partners. (Max 500 words).</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p> <p>[Redacted]</p>	4

5.2

[REDACTED]

[REDACTED]

[REDACTED]

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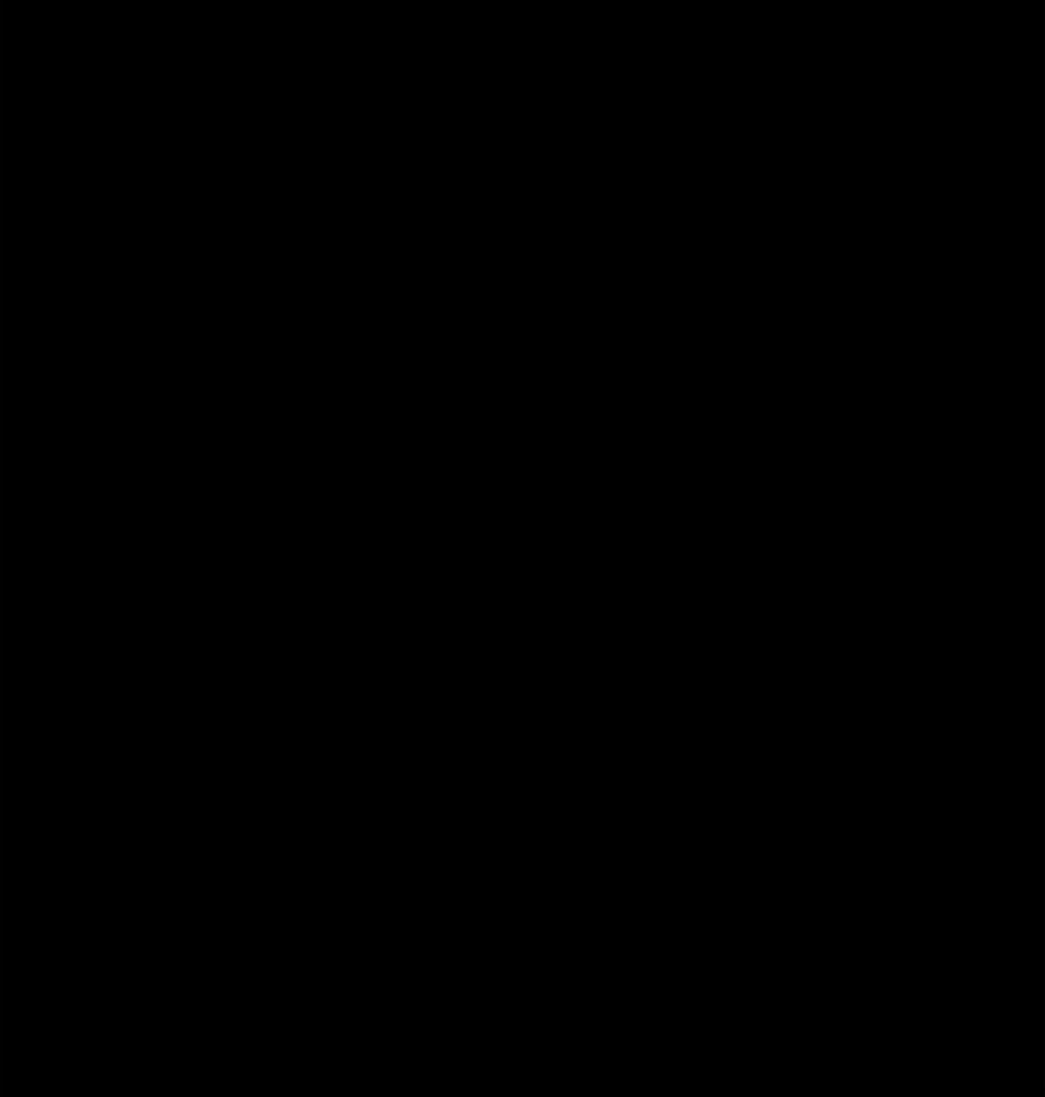
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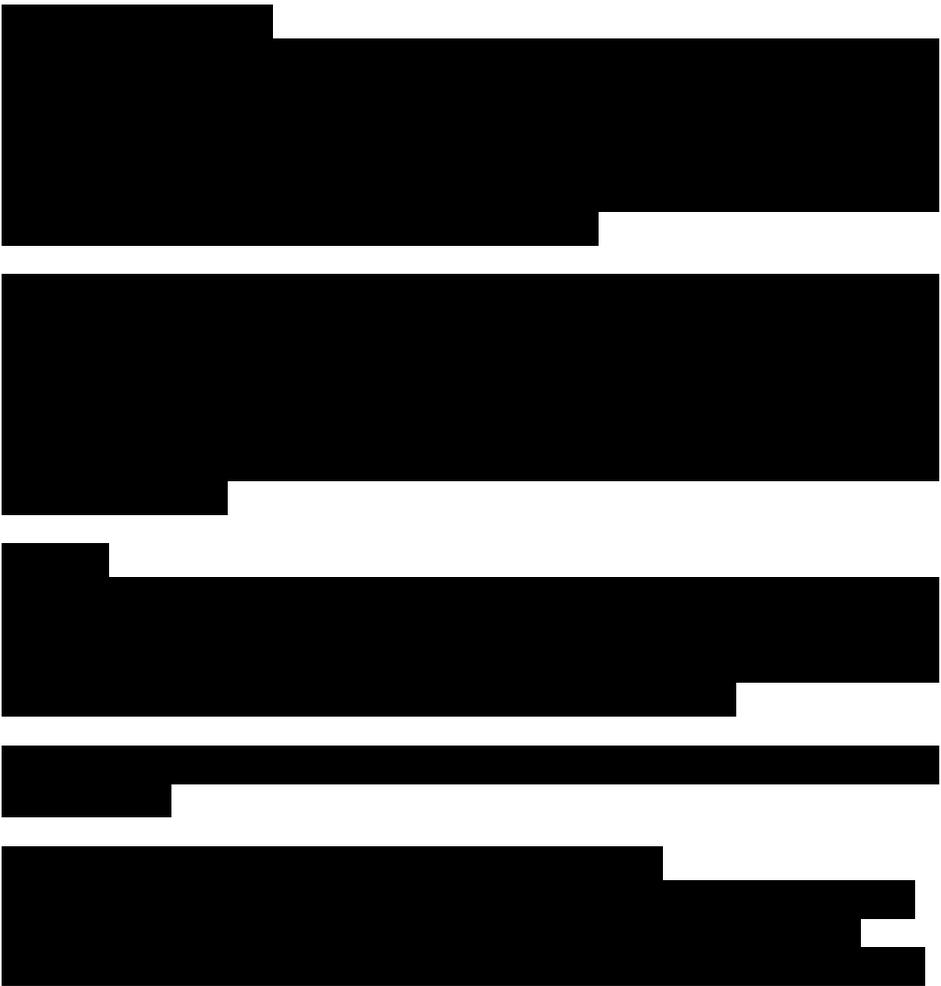
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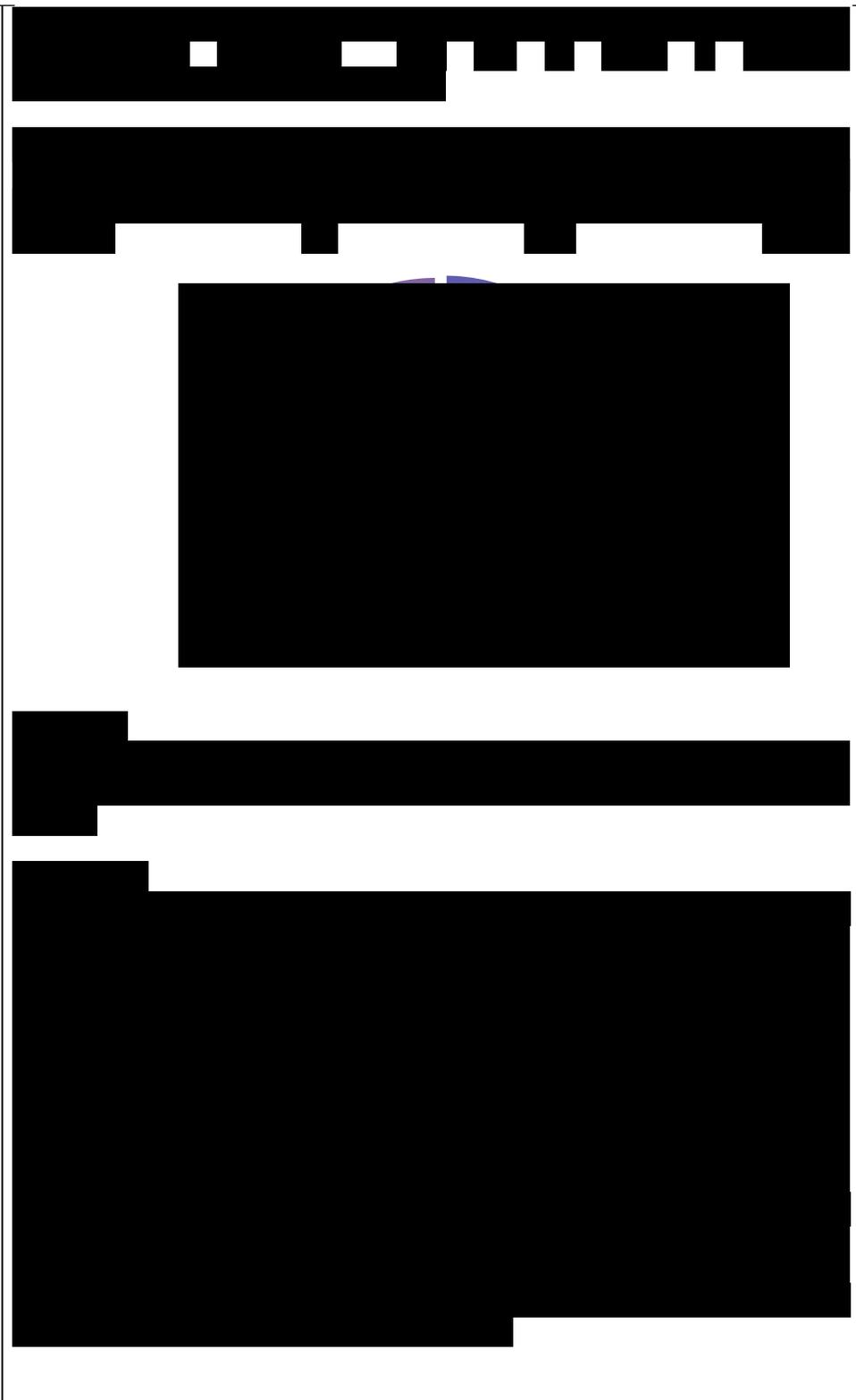
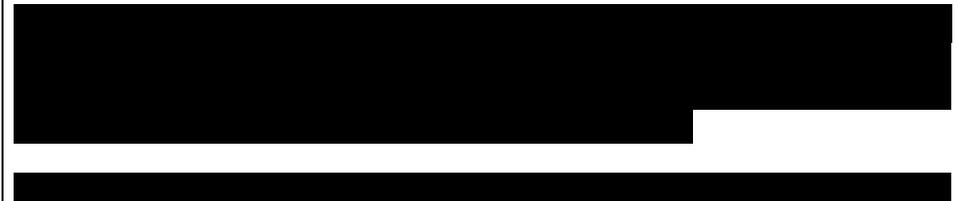
[REDACTED]

[REDACTED]

5

		
6.2	<p>Please attach a copy of your proposed implementation plan starting at contract award and working through to service start date on the 1 April 2016.</p> 	4
6.3	<p>Describe your risk assessment, risk management and risk communication systems? <i>(Max 500 words)</i></p>  	 4

		
6.4	<p>Please give details of the assistance you will provide to ensure that changes to the system are communicated appropriately and effectively to service users, families and carers, stakeholders, partners and the general public. Such communication should encourage engagement with the service and allay public concerns over delivery of a sexual health service (<i>max 400 words</i>).</p> 	4

		
6.5	<p>How will you ensure performance targets are achieved and what action you will take for poor performance (if responding as a consortium please detail how this will be managed internally (<i>max 400 words</i>)).</p> 	4

		
<p>6.6</p>	<p>Please confirm your agreement to the Performance Management method and indicators described in the service specifications and contract.</p> 	<p>PASS \ FAIL</p>
<p>6.7</p>	<p>Please indicate how your approach to service delivery will reduce non-service costs including management and overheads in this service (max 400 words)</p>       	<p>3</p>
<p>6.8</p>	<p>The transition to a new service model carries a number of risks.</p> <p>Please describe what you consider to be the potential risks during the transition period and beyond.</p>	<p>4</p>

Please describe how you would mitigate these risks, giving examples to support your response. (max 400 words)

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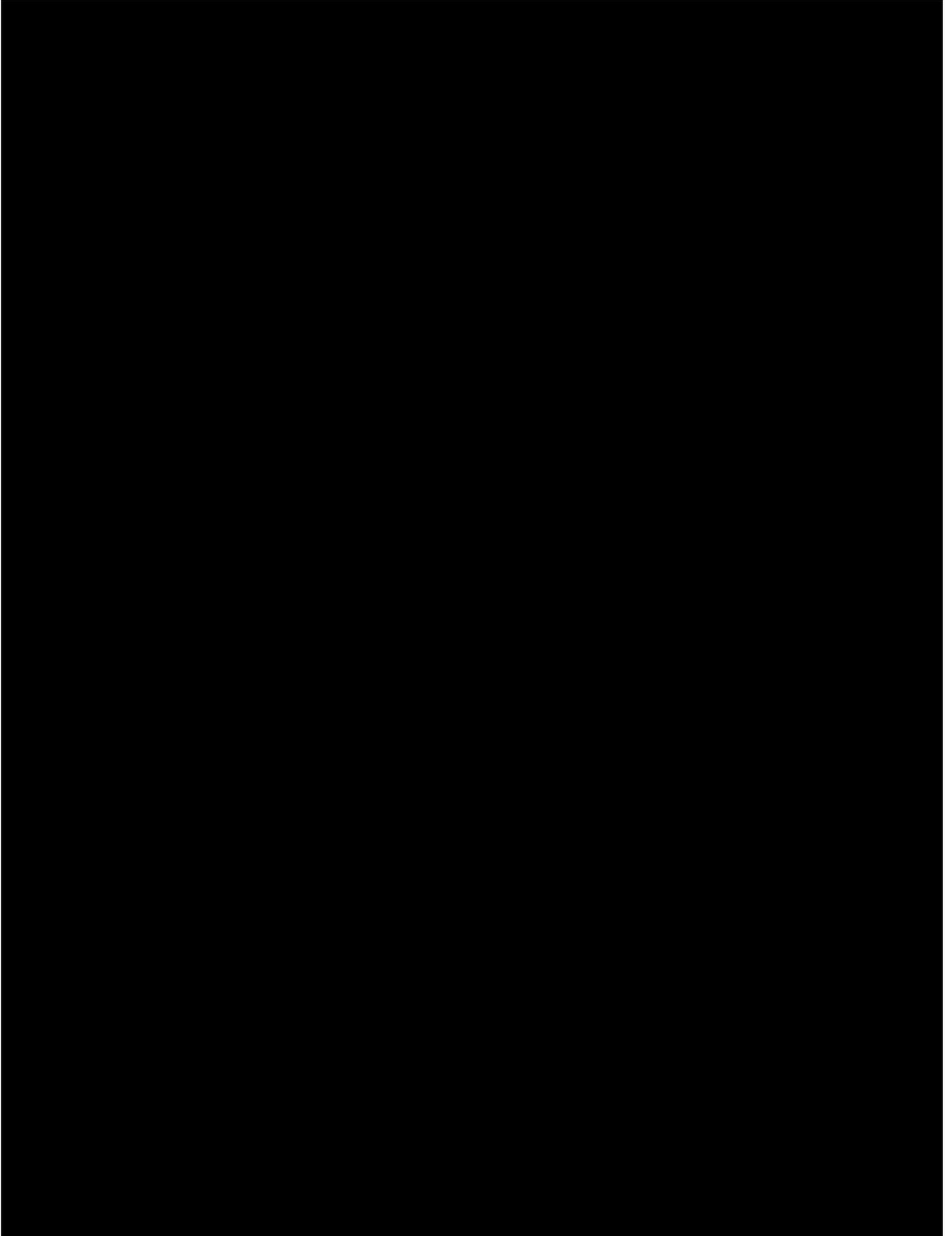
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personal & commercial info

South Staffordshire & Shropshire NHS Foundation
Trust
Trust Headquarters
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Corporation St
Stafford
ST16 3SR

Shropshire Council
Shirehall
Abbey Foregate
Shrewsbury
Shropshire SY2 6ND

Date: 27 January 2016



Dear Bidder

**RE: AMC 006 – INTEGRATED SEXUAL HEALTH SERVICES
SHROPSHIRE COUNCIL**

SUBJECT TO CONTRACT

This is an Award Decision Notice pursuant to The Public Contracts Regulations (the "Regulations").

We are pleased to inform you that, following the evaluation process and after negotiations with you, Shropshire Council proposes to accept your offer in relation to the above Contract. This acceptance is subject to:-



Subject to Shropshire Council receiving no notice during the standstill period of any intention to legally challenge the award process, the Council aims to conclude the award of the contract after the expiry of the standstill period.



personal info

We will be in touch with you again at the end of the standstill period but in the meantime we wish to continue working with you to mobilise the contract in time for commencement on the 1 April 2016.

Yours faithfully


Director of Public Health
Shropshire Council


Consultant in Public Health
Shropshire Council