

MODEL

_____ **Primary Care Trust**

SERVICE SPECIFICATION

for the

_____ **at**
_____ **NHS Trust**

For 2010 -11

Feb 2010

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GENERAL

1. INTRODUCTION

- 1.1 This service specification forms a part of the agreement between the commissioning arm of _____PCT (the host "Commissioner") and _____NHS Trust (the "Provider") for the provision of Genito Urinary Medicine services. The specification sets out what is expected of the Provider in terms of quality and quantity of provision and the aim of providing the service. The specification also sets out the process for monitoring and reviewing the agreement.

- 1.2 The Commissioner and the Provider will operate in accordance with the DH's Payment by Results guidance (2010-11), and the London Wide Commissioning Intentions and Business Rules of London PCTs for Acute Services 20 10 -1 1 .

2 BRIEF OUTLINE OF SERVICE

Genitourinary Medicine is the medical specialty concerned with the screening, diagnosis and management of sexually transmissible infections and related genital medical conditions. This service specification covers only the GUM service. A separate service level agreement is made with the Trust as part of the London-wide specialised commissioning arrangements for HIV, led by the London Specialised Commissioning Group.

GUM services are provided on an open access basis, and are available to anyone requiring care.

The service will provide **[briefly describe what the service will provide and for how many users e.g.] [briefly describe the service] for up to a maximum of [specify the quantity of service in terms of e.g. episodes of care or number of service users]**. The service users will have **[if possible, describe the likely health care needs of potential service users]**. The Service will be provided at **[provide the name of the primary location/s of the service and its/their address]**.

Services required for all clinics (excluding specific satellite initiatives, e.g. STI testing in community settings)

- Screening and therapy for bacterial and viral STIs, common genitourinary dermatoses and infestations
- Partner notification and health education/promotion advice and information. This includes active partnership working with and referral to Pan-London HIV prevention programmes.
- HIV testing and advice; post -exposure prophylaxis site for HIV
- Cervical cytology screening
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- HPV vaccination to targeted groups may be provided if commissioned specifically by the PCT.
- DH Guidance advises that HPV vaccination status should be added to the cervical screening record on NHAIS (Exeter) System. The process for this is outlined on :
http://www.dh.gov.uk/en/publicationsandstatistics/lettersandcirculars/Dearcolleaqueletters/DH_094025
- Sexual health advice and information on STI prevention for men and women, reflecting local needs (young people/adults, drug misusers, gay men).
- Emergency contraception.

- Urgent and routine referral pathways to and from related specialties (primary care, family planning, urology, A&E, gynaecology) should be clearly defined. These may include general medicine /ID for inpatient HIV care.
 - Microbiology and Pathology - for rapid transfer of specimens and results between laboratories and clinic and advice from pathologists.
 - Imaging - ultrasound/X ray should be easily accessible; CT/MRI on site for HIV services.
- 2.2 The Service will ensure that service users are provided with **[outline the expectations of service content and its outcome/s]**.
- 2.3 The Service shall be provided by a minimum of **[give brief details of the staff to be engaged in the service e.g. the minimum number of staff/hours]** between the core hours of **[give details of the hours of operation e.g. "8.00 and 18.00 each day"]**.
- 2.4 The Service will ensure that the service users are provided with adequate health care intervention in order to enable them **[give a brief description of the overall outcome e.g. " to attain and sustain the optimum level of sexual good health and independence and quality of life]**.
- 2.5 The Service will maintain close links with allied services to enhance the quality of care delivered (e.g. microbiology services, child protection services etc).
- 2.6 The Provider shall publicise and promote its service to its local population to ensure that potential service users are aware of the provision and of how to gain access to the service.

3. UNDERLYING PRINCIPLES

Care Principles

- 3.1 The following health care principles will apply to the Service:
- i) to provide services based on sound evidence wherever possible;
 - ii) to promote the independence, choice, dignity, privacy, respect, confidentiality and participation of service users;
 - iii) to acknowledge and respect a service user's gender, sexual orientation, age, physical or mental health ability, race, religion, culture, social background and lifestyle;
 - iv) to give service users maximum possible choice of service within the resources available to meet their needs;
 - v) to recognise the right of service users to have the optimum possible control over the service they receive and so gain the most benefit from it;

- vi) to plan and provide the Service in partnership with: service users; their family, friends or lay advocates (the "Relevant People"); support workers; and other independent and statutory agencies, to ensure that the Service responds sensitively and flexibly to individual needs;
- vii) to ensure that service users' views are taken into account in the running and development of the Service;
- ix) to ensure that the service users' health is monitored and promoted;
- vii) to work in a collaborative and co-ordinated way with other providers, (both statutory and independent), of health and welfare services. This includes active involvement in:
 - Sexual Health networks
 - Pan-London initiatives such as procurement of condoms and drugs.
- viii) ***(add any other principles considered particularly important and relevant to the specific service).***

Legal Requirements

- 3.2 The Service will be delivered in accordance with, and have proper regard to, all relevant and applicable legislation relating to the provision of the Service including (in particular but without limitation) the following:
[give details of relevant legislation]

Publicity and Marketing

- 3.3 The Provider must aim to attain an activity level equivalent to its maximum capacity in order to ensure that best value is secured from the Commissioner's investment in the service. In order to realise this aim, the Provider shall produce its own publicity material to promote and publicise its service to local people.
- 3.4 The Provider shall produce each year a marketing plan which must include details of its strategy for promoting its service and details of its targets for increasing the number of service users (particularly from target groups) to whom it delivers a service. The marketing plan should link with the National Sexual Health & HIV Strategy, and where applicable, any local strategy, as well as the current identified needs of the local population. The marketing plan shall be made available to the Commissioner upon request.

4. THE SERVICE USERS

- 4.1 This is an open access service and as such will be available to all patients eligible for free NHS treatment. ***[Briefly describe the circumstances of the users in relation to the service commissioned e.g. "sexual health problems are in need of care and support within the resources provided at (service address) ("the Service Users")"]***.

- 4.2 Eligibility for the service will be based on current guidance available at <http://www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors/fs/en>

5. SPECIFIC EXCLUSIONS

- 5.1 *This agreement excludes HIV treatment and care which are subject to a separate service agreement.*

6. ACTIVITY LEVEL AND PAYMENT

- 6.1 ***(Provide details of the number of hours/places/sessions/activity profile to be provided and the number of users to receive a service.)***
- 6.2 ***(Give details of the frequency, times of operation and duration of the service.)***
- 6.3 ***(Give details of the arrangements for bank holidays or any other specific period during the year.)***
- 6.4 ***(Provide details of any transport arrangements, including the number of places available on transport provided.)***
- 6.5 First and follow-up attendances are defined in the Department of Health's PbR guidance for 2010-11. London PCTs have agreed to pay a first and follow-up ratio of 1/0.4 for GUM services. This is based on the average first to follow-up ratio achieved in many GUMs in London.
- 6.6 Out-of-London activity is funded by the PCT of residence of the patient. The provider will invoice out-of-London PCT activity directly to the PCT in line with their procedures for non-contracted activity.
- 6.7 The Provider is required to ensure that billing process is in line with DH's PbR guidance on timescales supported with patient level data (see section 11.1.2).
- 6.8 PEPSE costs are an exclusion to PbR. The Provider will use the 2010 -11 London tariffs and clinical regimen for PEPSE. The tariff for a 5 day starter pack is £122 and for the follow-up 23 day treatment is £520, including delivery charges and VAT at 17.5%. The maximum tariff cost for PEPSE treatment is, therefore, **£642** per patient. This includes the Provider's assurance to PCTs that there is clarity in PEPSE funding arrangements and monitoring to prove the costs are not being invoiced to PCTs as well as being paid for by the HIV consortium. PEPSE is funded by the PCT of residence.

Providers shall submit monthly monitoring data for PEPSE activity analysed by PCT of residence, reason for exposure (sexual exposure, non-Trust Occupational Exposure, IDU) and the ratio of the uptake of starter packs to 23 day packs. Trusts will be expected to also provide information on demographics in response to any local PCT audit requests.

7. HEALTH STANDARDS

7.1 Safety

- 7.1.1 The Provider must protect patients through systems that:
- identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and
 - patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.
- 7.1.2 The Provider must protect children by following national child protection guidance within their own activities and in their dealings with other organisations.
- 7.1.3 The Provider must protect patients by following NICE Interventional Procedures guidance.
- 7.1.4 The Provider must keep patients, staff and visitors safe by having systems to ensure that:
- the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;
 - all risks associated with the acquisition and use of medical devices are minimised;
 - all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;
 - medicines are handled safely and securely; and
 - the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.
- 7.1.5 The Provider must continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.

7.2 Clinical and Cost Effectiveness

- 7.2.1 The Provider must ensure that:
- the service conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;
 - clinical care and treatment are carried out under supervision and leadership;
 - clinicians continuously update skills and techniques relevant to their clinical work; and
 - clinicians participate in regular clinical audit and reviews of clinical services.

- 7.2.2 The Provider is required to cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.
- 7.2.3 The Provider is required to ensure that patients receive effective treatment and care that:
- conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;
 - take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;
 - are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and
 - is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

7.3 Governance

- 7.3.1 The Provider is required to:
- apply the principles of sound clinical and corporate governance;
 - actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
 - undertake systematic risk assessment and risk management;
 - ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
 - challenge discrimination, promote equality and respect human rights.
- 7.3.2 The Provider must support their staff through:
- having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and
 - organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.
- 7.3.3 The Provider is required to have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.
- 7.3.4 The Provider must:
- undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and
 - ensure that all employed professionals abide by relevant published codes of professional practice.
- 7.3.5 The Provider must ensure that staff concerned with all aspects of the provision of health care:
- are appropriately recruited, trained and qualified for the work they undertake;

- participate in mandatory training programmes; and
 - participate in further professional and occupational development commensurate with their work throughout their working lives.
- 7.3.6 The Provider must have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied when either leading or participating in research.
- 7.3.7 The Provider is required to work together with other NHS and independent health care providers to:
- ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service;
 - implement a cycle of continuous quality improvement; and
 - ensure effective clinical and managerial leadership and accountability.
- 7.3.8 The Provider is required to work together and with social care organisations to
- meet the changing health needs of their population by having an appropriately constituted workforce with appropriate skill mix across the community; and
 - ensuring the continuous improvement of services through better ways of working.
- 7.3.9 The Provider must use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.
- 7.3.10 The Provider must work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

7.4 Patient Focus

- 7.4.1 The Provider must have systems in place to ensure that
- staff treat patients, their relatives and carers with dignity and respect;
 - appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and
 - staff treat patient information confidentially, except where authorised by legislation to the contrary.
- 7.4.2 Health care organisations have systems in place to ensure that patients, their relatives and carers:
- have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;
 - are not discriminated against when complaints are made; and
 - are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.
- 7.4.3 The Provider must make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

- 7.4.4 The Provider must continuously improve the patient experience, based on the feedback of patients, carers and relatives.
- 7.4.5 The Provider must ensure that patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are:
- encouraged to express their preferences; and
 - supported to make choices and shared decisions about their own health care.
- 7.4.6 The Provider must ensure that patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

7.5 Accessible and Responsive Care

- 7.5.1 The Provider must ensure that the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.
- 7.5.2 The Provider is required to enable all members of the population to access services equally and offer choice in access to services and treatment equitably.
- 7.5.3 The Provider is required to ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.
- 7.5.4 The Provider must plan and deliver health care which:
- reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;
 - maximises patient choice;
 - ensures access (including equality of access) to services through a range of providers and routes of access; and
 - uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

7.6 Care Environment and Amenities

- 7.6.1 The Provider must ensure that the services are provided in environments which promote effective care and optimise health outcomes by being:
- a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
 - supportive of patient privacy and confidentiality.
- 7.6.2 The Provider is required to ensure that the services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and nonclinical areas that meet the national specification for clean NHS premises.

- 7.6.3 The Provider must ensure that the services are provided in well-designed environments that
- promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and
 - are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.

7.7 Public Health

- 7.7.1 The Provider is required to promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by
- co-operating with each other and with local authorities and other organisations;
 - ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and
 - making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.
- 7.7.2 The Provider is required to have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing sexually transmitted infections.
- 7.7.3 The Provider is required to protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.
- 7.7.4 The Provider is required to:
- identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role; and
 - implement effective programmes to improve health and reduce health inequalities;
 - protect their populations from identified current and new hazards to health; and
 - take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

8. QUALITY

Service Outcomes

- 8.1 The Provider must aim to achieve the following general outcomes:
- Service Users attain optimum sexual good health, independence and exercise maximum control and self management over their lives;
 - Service Users have access to, and the opportunity to use, all other relevant community health and social care services appropriate to their needs; and

- Service Users maintain an optimum level of health and general well-being.

8.2 National and London Sexual Health Targets

National and London Sexual Health Targets will be expected to be achieved and include the following:

- Improve waiting times for GUM; all clients to be *offered an appointment* within 48 hours of contacting the service.
- All GUM clinic attendees should be offered HIV testing on first STI screen (and subsequently according to risk),
- Reducing by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of infection.
- Reducing late diagnoses of HIV to support the co-ordinating PCT to achieve its target of 15% late diagnosis by 2010-11 (using 2004-5 data as baseline)

The Provider and PCT should use a quality metrics (attached) such as that developed between Islington PCT and Camden PCT provider side, which is an example of best practice.

Quality Assurance

- 8.3 The Provider shall be monitored on how the Service is being provided in relation to this Specification and, in particular, the Care Principles (paragraph 3.1) and Service Outcomes (paragraph 8.1).
- 8.4 The Provider must implement a reliable, internal quality assurance system (the "Quality Plan") in relation to standard setting, monitoring, management of the Service, Audit plan, Clinical governance plan and periodic performance review.
- 8.5 As a part of an ongoing review and assessment of sexual health services, undertaken by the PCT's Commissioner, the Provider shall be required to identify and put forward at least two quality improvements which it intends to implement and develop during the course of the following year. These improvements will be discussed and, if a cost is involved, agreed by the Commissioner, prior to the Annual Review.
- 8.6 The Provider shall ensure that all personnel it engages in the Service adhere to the PCT's Policy on Customer Care by offering:
- the highest quality of service within the resources available;
 - fairness to all Service Users; and
 - a means of making a complaint.

Equal Opportunities

- 8.7 The PCT operates within the parameters of the PCT's Equal Opportunities Policy, both at service delivery and employment level.

Service User Feedback

- 8.8 The Provider shall ensure that Service Users are given every opportunity to present their views and ideas about the future of the Service. Service User involvement must play a key part in planning how the Service develops. This shall include the provision for the active involvement of Service Users in evaluating the Service and planning service changes.
- 8.9 The Provider shall ensure that systems for consulting Service Users and Relevant People, and for monitoring Service User satisfaction, are developed and implemented. Details of the systems must be made available to the Commissioner, upon request, for consideration and approval.

Complaints

- 8.10 Service Users and their Relevant People must have access to a clearly defined written complaints' procedure, which must be implemented by the Provider to the satisfaction of the Commissioner.

9. STAFFING

- 9.1 The Provider shall provide details of their staffing arrangements for the Commissioner to consider and agree.

9.2 Staffing Levels

Staffing levels by profession are set out as follows:

	WTE in post	WTE unfilled
Consultant		
Career grade		
Clinical Assistants		
Nurse Practitioners		
Nurses - by grade		
D		
E		
F		
G		
H		
Health Advisors		
Healthcare assistants		
Management grades		

Administrators - by grade		
Lab Personnel (if applicable)		
Other		

10. POLICIES AND PROCEDURES

- 10.1 The Provider shall have in place policies and procedures as outlined in the main Contract with the Provider.

11. MONITORING ARRANGEMENTS

- 11.1.1 The clauses in the Trust's main contract that relate to monitoring and timeliness of reporting of information apply to the Sexual Health services commissioned. This includes financial penalties for delayed reporting (see relevant sections in DH's Model Foundation Trust model contract "Contract for the Provision of Health Services"

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustArticle/fs/en?CONTENT_ID=4080997&chk=lugKUe.

- 11.1.2 The Provider shall submit to the Department of Health's UNIFY system monthly the agreed minimum data subset summarising the Provider's performance during the preceding month.

The minimum dataset to be submitted will be the Phase 2/3 UNIFY dataset.

The following UNIFY reporting timelines will apply to this specification: The Provider will submit the monthly agreed data subset on the 18th day of the month (or on the next working day). The Commissioner will have access to UNIFY to sign off the return by the 25th of the month (or the next working day). If the Commissioner disagrees with the return, they will inform the Provider who will make appropriate changes to their return to UNIFY by the 25th of the month (or the next working day).

- 11.1.3 The Provider will monitor first and follow-up attendances according to the DH's PbR Guidance 2010-11 as follows:

"There are separate tariffs for first and follow-up attendances. A first attendance is the first or only attendance in respect of one referral. Follow-up attendances are those that follow first attendances as part of a series in respect of the one referral. The episode (or series) ends when the patient is not given a further appointment by the consultant or the patient has not attended for six months with no forthcoming appointment. If after discharge the condition deteriorates, a new referral occurs and the patient returns to the clinic run by the same consultant, this is a new episode and the attendance is classified as a first attendance.

The end of a financial year does not necessarily signify the end of a particular outpatient episode. If two outpatient attendances for the same course of

treatment are in two different financial years but are less than six months apart, or where the patient attends having been given a further appointment at their last attendance, the follow-up tariff applies.

In order to provide incentives to minimise follow-ups where these are not necessary, we have structured the tariff to front-load the reimbursement so that follow-ups have a relatively low reimbursement rate compared with a first attendance. As in previous years, we have set this front-loading at 10% of the follow-up costs. This means that we have added 10% of the costs of follow-up attendances to the first attendance costs making the tariff for first attendance relatively higher.

Where clinics are organised so that a patient may be seen by a different consultant team (within the same specialty and for the same course of treatment) on subsequent follow-up visits, then commissioners and providers may wish to discuss an adjustment to funding to recognise that a proportion of appointments being recognised in the data flow as first attendances are, as far as the patient is concerned, follow up visits.

We are again publishing a non-mandatory price for non face-to-face outpatient activity (paragraph 343), which commissioners and providers may wish to use to facilitate changes to outpatient pathways”.

11.2.1 Definition of multiprofessional GUM follow-up:

This is when 2 clinicians from different specialties are needed to be present at the same time to meet the needs of a patient. It excludes the situation where the patient sees different clinicians in a sequence which would attract the normal follow-up tariff.

11.2.2 When the multiprofessional tariff will apply:

The multiprofessional tariff will be rarely used. Clinical examples are:

- Conjoint clinic (sexual function) - GU consultant and Clinical health psychologist for Sex;
- Joint Gynae consultant and GU consultant session;
- GU consultant and Community paediatrician

The latter 2 are Infrequent and prompted on a case requirement basis.

11.3 The Provider shall ensure that it codes “100% of activity on a month to month basis *in line with all PbR activity*.”

11.4 The monthly Provider monitoring reports shall form the basis of discussion at monitoring meetings that shall be arranged by the Commissioner in conjunction with the Provider. The monitoring meetings will be used to:

- monitor and evaluate performance, service outcomes and targets;
- consider any financial, operational or management issues;
- review the targets and consider any proposals for amendment; and
- discuss any specific issues.

11.5 The report shall also include:

- Activity reports (first and follow-up) by PCT of residence

- Number of Service Users who have received the Service during the monitoring period, including their age, gender and ethnicity;
- Volume of the Service provided including diagnosis by STI reported in GUMCAD returns;
- GUMAM UNIFY data including waiting times.

The PCT would also like details of:

- how Service Users' views are collected;
- feedback from Service Users, Relevant People and professional carers are used to develop or enhance the services provided;
- details of all complaints and the action taken by the Provider.

Other forms of monitoring which the Commissioner will use shall include checking relevant written records maintained by the Provider; and announced and unannounced visits to the premises where the services are located.

The Provider shall make available to the Commissioner all reports of inspections of the service or premises where the service is based e.g. Environmental Health; Fire Officer etc.

- 11.6 The Provider shall be responsible for maintaining an annual audit trail of data accuracy that can be validated by the Commissioner.
- 11.7 The Provider's reference cost shall be made available to the Commissioner upon request.
- 11.8 A nominated representative of the Commissioner will be responsible for monitoring the Provider's overall performance in meeting the requirements of the Specification.
- 11.9 In order to ensure that the Service attains and maintains the quality required by the Commissioner, the Provider shall grant the Commissioner's representatives access to the Service at all reasonable times.
- 11.10 The Provider will also submit timely reporting to the HPA on newly diagnosed HIV to support the London HIV prevention performance indicator:

“The national surveillance of new HIV diagnoses, first AIDS diagnoses and deaths among HIV-infected individuals has been undertaken, by the Health Protection Agency (HPA) since 1982. These data are critical in characterising the UK epidemic and in ensuring that health promotion activities can be targeted and their success monitored. We strongly encourage you to utilise the Excel template provided (attachment A) to forward specific information to the HPA on individuals newly diagnosed with HIV, with a first AIDS diagnosis, or who have died during a six month period (period to run in conjunction with that for reporting your SOPHID return) within twenty working days of end period (*next period being January to end June 2010 with data requested by 25th July, 2010*). This information is essential in calculating and monitoring late diagnosis among newly diagnosed individuals at a PCT-specific level.”

12. Demand Management

Demand Management arrangements are to be in place between the Provider and the Commissioner, as outlined in the Department of Health's Foundation Trust model 'Contract for the Provision of Health Services.

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/NHSFoundationTrustArticle/fs/en?CONTENT_ID=4080997&chk=lugK Ue

12.1.1 Demand Management arrangements are to be in place between the Provider and the Commissioner as specified in the section **(please inset appropriate section)** of the overarching Trust Contract.

13. Finance Schedule

The following finance allocation includes GUM services at **(state Provider name)**:

	<hr/>		
	Prevention	GUMTotal	
	£'000	£'000	£'000
Start Baseline 2009/10			
Baseline 10/11			
Monthly schedule			
Total			<hr/>

February 2010

Sexual Health Services Performance Matrix - GU Medicine

Month

Domain	Metric	Monthly		Quarterly		Annual		To date		Scoring			Score	Traffic Light
		Actual	Target	Actual	Target	Actual	Target	Actual	Target	Red	Amber	Green		
Activity	Nr of 1st attendances			-	-	-	-			<95%	95-105%	>105%		
	Nr of follow up attendances			-	-	-	-			<95%	95-105%	>105%		
	% of attendances with unknown PCT		-	-	-	-	-		-	-	-	-		
	% of attendances from outside London ¹		-	-	-	-	-		-	-	-	-		
	% of attendances that are males <25 years old	-	-	-	-	-	-		-	-	-	-		

Access	% of patients offered an appointment within 48 hours			-	-	-	-	100%	<95%	95-99%	100%		
	Safety												
	Nr of incorrect results given ²	-	-			-	-	14	>24	15-24	<15		
	Infection control audit	-	-	-	-			85%	<75%	75-84%	>84%		
Clinical outcome	% uptake of HIV testing	-	-			-	-	80%	<60%	60-79%	>79%		
Patient satisfaction	% satisfied or very satisfied ³												

Specific

- Notes: 1 - Recalculated to exclude overseas, which have been included in the out of London figure as both are billed to host Commissioner
2 - Results from Q2 onwards. Target increases each quarter, i.e. Q3 will be >36, 22-36, <22.
3 - Awaiting introduction of the Dr Foster Patient Experience Tracker (PET)

Overall

Note: A metric is measured on either a monthly, quarterly or annual basis. All show a performance to date and are given a traffic light against that performance.

***EXAMPLE PERFORMANCE MATRIX**