APPENDIX C

QUALITY OUTCOMES INDICATORS

Quality Outcome Indicator A - Access

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Percentage of people offered an appointment, or walk-in, to GU medicine clinics within 48 hours of contacting the service	98%	BASHH Standard 1	Local determination	Remedial action plan
Percentage of people accessing GUM services to be seen within 48 hours of contacting the service	85%	BASHH Standard 1	Local determination	Remedial action plan
Percentage of users experiencing waiting times of in services of >2 hours	< 5%	Locally determined	Local data	Remedial action plan
Percentage of psychosexual clients seen within 18 weeks of referral	100%	Locally determined	Local data Quarterly performance reports	Remedial action plan
Proportion of appointments accessed online	Baseline to be set in Year 1	Locally determined	Local data	Remedial action plan
Individuals requesting advice online receiving responses within 24 hours or the next working day	Baseline to be set in Year 1	Locally determined	Local data	Remedial action plan
Percentage of women having access to and availability of the full range of contraceptive method (including choice within products)	100%	FSRH Service Standard 5	Clinical audit	Remedial action plan
Percentage of women who have access to urgent contraceptive advice and services (including emergency contraception) within 12 hours of contacting the services on a Monday to Saturday	100%	FSRH Service Standard 5	Local data	Remedial action plan
Percentage of intrauterine and subdermal implantable contraception appointments offered within 5 Business days	100%	Local determination	Quarterly performance reports Local data	Remedial action plan
Access to interpretation services	100% of service users who need this	FSRH Service Standard 2	Local data	Remedial action plan
Telephone advice will be provided by a clinician within 2 hours (during clinic times)	95%	Local data	Quarterly reports	Remedial action plan
Number of outreach sessions conducted in areas of high deprivation	Baseline to be established	Local data	Local data	Remedial action plan
Number of outreach sessions aimed at	Baseline to be established	Local data	Local data	Remedial action plan

vulnerable groups, for example those misusing drugs and alcohol, those with learning difficulties				
Number of new patients seen – data recorded by age, gender and the first 4 digits of their postcode	Baseline to be established	Local determination	Local data	Remedial action plan
Number of review patients seen – data recorded by age, gender and the first 4 digits of their postcode	Baseline to be established	Local determination	Local data	Remedial action plan
Outlets working towards achieving and maintaining 'You're Welcome' accreditation at every hub and spoke location	Baseline to be established	National expectation	Local data	Remedial action plan

Quality Outcome Indicator B - Health Promotion

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
The offer of behavioural, health or lifestyle advice, for example to smokers, drug and alcohol misusers, obese individuals	100%	Locally determined	Local data	Remedial action plan
Co-ordinate and lead health campaigns in North Tyneside, for example HIV testing week, World AIDS day, cervical screening, teenage pregnancy.....	At least 4 campaigns per year	Locally determined	Local data	Remedial action plan
Work with other agencies to increase health promotion, for example the Learning Disabilities Federation	Baseline to be set in Year 1	BASHH Standard 8	Local data	Remedial action plan
All staff trained to Making Every Contact Count (MECC)	100%	MECC Policy	Local data	Remedial action plan

Quality Outcome Indicator C - Sexually Transmitted Infections Including HIV

Quality Outcome Indicator	Threshold	Technical guidance Reference	Method of Measurement	Consequence of Breach
Routine STIs				
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment undertaken	New users 100%	BASHH Standard 2	Clinical audit	Remedial action plan
Number of attendances identified which result in full STI screen	Baseline to be established	Locally determined	Clinical audit	Remedial action plan
As a proportion of all GUM attendances the number positive for a	Baseline to be established	Locally determined	Clinical audit/ GUMCAD	Remedial action plan

STI				
Percentage of routine STI laboratory reports of results (or preliminary results) which are received by clinicians within 5 Business days of a specimen being received by the laboratory	97%	BASHH Standard 3	Clinical audit	Remedial action plan
Percentage of service users receiving results within 10 Business days from consultation date	100%	BASHH Standard 3	Clinical audit	Remedial action plan
All STIs diagnosed by coding	100%	Locally determined	GUMCAD dataset	Remedial action plan
Partner notification (PN) undertaken for all appropriate positive STI cases by diagnosis	More than 0.4 contacts per index case of gonorrhoea and 0.6 contacts per index case of Chlamydia to be seen within 4 weeks of the initial PN discussion	BASHH Standard 4	Clinical Audit	Remedial action plan
Number of dual Chlamydia/ gonorrhoea tests ordered via the website (all ages)	Baseline to be established in Year 1	Locally determined	Local data	Remedial action plan
Chlamydia Screening Programme				
Diagnostic rate of 2,300/100,000 for Chlamydia screenings in a variety of settings	100% (30% screens from outreach with vulnerable groups, 70% from core services)	Public Health Outcome Framework measure (3.02)	CTAD data PHO Framework	Remedial action plan
Percentage of all under 25 year olds screened for Chlamydia/ gonorrhoea (dual screening) broken down by venue (hub and spokes)	At least 75% of all new attendances	Contributes towards Public Health Outcome Framework measure (3.02)	Drawing on CTAD where appropriate	Remedial action plan
Percentage of all under 25 year olds offered screening for Chlamydia/ gonorrhoea (dual screening) broken down by screening venue	100%	Contributes towards Public Health Outcome Framework measure (3.02)	CTAD data/ clinical audit	Remedial action plan
Percentage of all results notified to the young person within 10 Business days (from	≥95%	NCSP Standard 4	CTAD/ local data	Remedial action plan

test date)				
Number of dual Chlamydia/ gonorrhoea tests ordered via the website	Baseline to be established	Locally determined	Local data	Remedial action plan
Percentage of individuals screened who are men	≥40%	Local data	Local data	Remedial action plan
Percentage of positive index cases treated successfully in line with NCSP guidance	≥95% treated within 6 weeks of test date	NCSP Standard 4	Local data	Remedial action plan
Percentage of positive patients screened who received treatment within 6 weeks of test dates	>95%	NCSP Standard 4	CTAD/ local data	Remedial action plan
Partner notification undertaken for all positive results	0.6 contacts per index case attend for testing within 4 weeks of PN discussion for those with a positive result	NCSP Standard 4	Quarterly report	Remedial action plan
HIV				
Monitor percentage of first time service users (of clinical based services) offered an HIV test (broken down for MSM, BME and gender)	100% offered	BASHH Standard 2	GUMCAD	Remedial action plan
Monitor percentage of first time service users (of clinical based services) accepting an HIV test (broken down for MSM, BME and gender)	80% uptake	BASHH Standard 2	GUMCAD	Remedial action plan
Number of HIV cases diagnosed late	0%	Public Health Outcome 3.04	Local data	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 of Care for People Living with HIV Standard 7	Clinical audit	Remedial action plan
Documented PN outcomes or a progress update at 12 weeks after the start of the process (for newly diagnosed HIV patients)	90%	BHIVA Standard of Care for People Living with HIV Standard 7	Clinical audit	Remedial action plan
Details of post exposure prophylaxis programme and	Baseline to be established	Local determination	Local data	Remedial action plan

numbers of administrations				
Hepatitis B				
Total number of at – risk individuals offered Hep B test	Baseline to be established	Local determination	Local data	Remedial action plan
Total number of individuals (of those who were offered) for whom Hep B tests were performed	Baseline to be established	Local determination	Local data	Remedial action plan
Total number (and total %) of Hep B positive results (specifying acute/ chronic)	Baseline to be established	Local determination	Local data. GUMCAD data	Remedial action plan
Total number of at – risk individuals offered Hep B vaccinations	Baseline to be established	Local determination	Local data	Remedial action plan
Total number of Hep B vaccination courses (full course) performed	Baseline to be established	Local determination	Local data	Remedial action plan
Total number of Hep B vaccination courses (partial course) performed	Baseline to be established	Local determination	Local data	Remedial action plan
Hepatitis C				
Total number of individuals offered Hep C test	Baseline to be established	Local determination	Local data	Remedial action plan
Total number for whom Hep C antibody tests performed	Baseline to be established	Local determination	Local data	Remedial action plan
Total number of individuals with Hep C positive antibody results	Baseline to be established	Local determination	Local data/ GUMCAD	Remedial action plan
Reporting of GUMCAD/ HARS/ CTAD/ SHRAD datasets nationally and directly to the Authority	100% data completeness 100% validation occurring 100% upload by deadlines 99% patient records completed accurately	BASHH Standard 5	Local determination	Remedial action plan
Compliance with and promotion of BHIVA standards and guidelines (and any updates)	100%	BHIVA Standards and Guidelines	Quarterly reports	Remedial action plan
Compliance with BASHH standards and guidelines	100%	BASHH Standards and Guidelines	Quarterly reports	Remedial action plan

Quality Outcome Indicator D - Contraception and Reproductive Health

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Number of females who attend the main service and outreach clinics for contraception – data recorded by age, first 4 digits of postcode and contraception type	Baseline to be established	Local data	Local data/ SHRAD	Remedial action plan
Number of females who attend their GP for contraception – data recorded by age, first 4 digits of postcode and contraception type	Baseline to be established	Local data	Local data	Remedial action plan
Number of females who attend community pharmacy for contraception – data recorded by age, first 4 digits of postcode and contraception type	Baseline to be established	Local data	Local data	Remedial action plan
Number and percentage of patients attending services and being offered a LARC method (eligible patients)	Baseline to be established	Local data	SHRAD	Remedial action plan
Percentage of LARCs prescribed as a proportion of all contraceptives by age (15-24 years, 25-49 years)	Baseline to be established	Local data	SHRAD	Remedial action plan
Condom Card				
Number of new registrants with C-card scheme	Baseline to be established	Local data	Local data	Remedial action plan
Number of venues delivering C-card by type of venue (and whether they are a registration site, a delivery site or both)	Baseline to be established	Locally agreed	Quarterly reports	Remedial action plan
Number of individuals claiming/ attendances to claim condoms, and total number of condoms distributed through C-card by age and venue	Baseline to be established	Local data	Local data	Remedial action plan
Pregnancy Options				
Number of individuals counselled regarding pregnancy options (specialist services)	Baseline to be established	FSRH Service Standard 2	Local data/ SHRAD	Remedial action plan
Contribute to the reduction of unintended conceptions for under 18 year old women	Maintain below the England average	Public Health Outcome Framework 2.04	Local data/ ONS data	Remedial action plan
Monitor the rate of abortions and repeat	Baseline target to be	Local data	Local data / ONS data	Remedial action plan

abortions for women of all ages including under 18s	established			
Automatic reporting of SHRAD datasets nationally and directly to the Authority	100% data completeness 100% validation occurring 100% upload by deadlines 99% patient records completed accurately	FSRH Service Standard 9	Local determination	Remedial action plan

Quality Outcome Indicator E - Reducing Sexual Ill Health in Vulnerable Groups

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Young People				
Full assessment of young people attending services who are at risk of, or experiencing child sexual exploitation	100% of young people under 18 years old (revisit the form at each subsequent visit to detect any new risks)	Spotting the Signs proforma	Clinical audit	Remedial action plan
Assessing those under 16 years old for Fraser competence	100%	FSRH Service Standard 8	Clinical audit	Remedial action plan
Sexual Assault				
Number of individuals who disclose an assault	Baseline to be established	Local data	Local data	N/A
Number of referrals made to SARC	Baseline to be established	Local data	Local data	N/A
Number of referrals received from SARC	Baseline to be established	Local data	Local data	N/A
Addition of a code to GUMCAD dataset to record incidence of non-consensual sexual activity	To be done within year 1	Local data	Local data	Remedial action plan

Quality Outcome Indicator F - Training and Education

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
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 7	Completion of CQC Provider Compliance Assessment tool for Outcome 12	Remedial action plan
Undertake regular audit of qualifications and training of all staff to ensure they are competent to provide the level of care they are providing and updating qualifications where necessary	Annual audit	BASHH Standard 7	Completion of CQC Provider Compliance Assessment tool for Outcome 17	Remedial action plan

Percentage of staff trained to recognise the signs of sexual exploitation, sexual violence, domestic violence, drug and alcohol misuse and how to manage other relevant safeguarding issues	100%	FSRH Service Standard 6	Local data	Remedial action plan
Percentage of clinical staff dual trained to deliver contraceptive (including LARC methods) and GUM services	100%	FSRH Service Standard 6	Local data	Remedial action plan
Number of training sessions and number of staff who attend sessions for: • Own staff (including CPD) • Subcontracted staff (e.g. GPs, pharmacists) • Wider health (including undergraduate and postgraduate training) • Non-health partners	Baseline to be established	Locally determined	Local data	Remedial action plan
Training sessions for C-card North Tyneside staff in registration/ distribution outlets	Baseline to be established	Local data	Local data	Remedial action plan

Quality Outcomes Indicator G - Service User Experience

Quality Outcome Indicator	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Evidence of at least one user experience survey bi-annually using traditional and innovative methods e.g. social media	2 per year	BASHH Standard 9	Local patient survey	Remedial action plan
Percentage of service users that feedback on surveys that rates satisfaction as good or excellent	≥70%	Local data	Local data	Remedial action plan
Evidence of improvements made to services as a result of user feedback	Demonstrable evidence of improvements and changes made to service delivery in response to feedback	FSRH Service Standard 11	Local data	Remedial action plan
Number of service users making formal complaints about the services (verbal or written) – Provider to notify The Authority in accordance with Incident Reporting Procedure – see Section 2.1.8.8)	Provider to notify The Authority	BASHH Standard 6	Completion of CQC Provider Compliance Assessment tool for Outcome 17	Remedial action plan
Number of service users complimenting the services	Provider to notify The Authority	Local data	Local data Quarterly Performance reports	Remedial action plan

APPENDIX D

SERVICE USER, CARER AND STAFF SURVEYS

Please see Appendix C - Quality Outcome Indicator G

The Provider will:

- ensure continuous service improvement through development, innovation and consultation with Service Users and the local population.
- conduct Service User experience surveys at least bi-annually (with best practice being ongoing real-time surveys) demonstrating good patient satisfaction with services, as well as demonstrating how feedback is used to improve the Service. Feedback should be collected either via paper feedback forms or online surveys.
- ensure that users are able to gain access to a sexual health appointment of choice where a holistic sexual health assessment will be provided, with services being provided in a discreet and confidential manner. Service Users should be permitted to take a friend or family member into consultations if they wish to do so.

The Provider will:

- conduct annual Staff surveys to determine the welfare of Staff.

The format of both Service User experience and Staff surveys will be agreed between the Authority and the Provider within six months of the Commencement Date.