

**SERVICE SPECIFICATION**

**SCHEDULE 2**

**THURMASTON HEALTH CENTRE**

**573A Melton Rd, Thurmaston, Leicester LE4 8EA**

1 The Service Specification must specify who the Contractor is to provide services to under the Contract, including where appropriate by reference to an area within which a person resident would be entitled to receive services under the Contract. This is a requirement of the APMS Directions.

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**PART 1 – AIMS & GENERAL SERVICE DELIVERY**

* 1. **AIMS OF THE SERVICE**
		1. The Commissioner recognises that Primary Care has a significant and strategic part to play in supporting the NHS Long Term Plan and therefore wants services provided at Thurmaston Health Centre to reflect and meet the ambitions of national and local strategy.
		2. The Commissioner is therefore seeking innovation in the provision of integrated primary care services, which align to both the national and local strategic plan, i.e.:

### ‘Do things differently’

* + - * + develop new ways to improve access and service delivery for our diverse population;
				+ improve and embed the ethos of integration and collaborative working with local health and social care providers, including ‘Primary Care Networks;
				+ embed a culture of co-design with patients in the development of integrated primary care services ensuring the patient has more control over their own health and the care they receive;

### Preventing illness, tackle health inequalities;

* + - * + Understand and adopt a population health management approach to tackling health inequalities
				+ Enable a service model that increases equity of both access and outcomes for our different cohorts of populations
				+ Promote physical and psychological well-being and self- care in a holistic model;

### ‘Provide world class care for major health problems’

Through the use of:

* + - * + improved continuity of care
				+ clinical audit,
				+ appropriate risk assessment to promote early diagnosis of chronic disease;
				+ Understand and act upon population health management data to identify, delay and / or manage multi morbidity
				+ improved long term condition management;

### Making better use of data and digital technology

* + - * + The Contractor must support the ‘digital first’ approach and use clinically safe, NHS approved digital technology to improve access, increase equity of outcome, increase patient choice, and improve quality of care

### Backing the workforce:

* + - * + The Contractor must provide a GP Led service with appropriate clinical oversight to support the multi- dimensional practice team;
				+ The Contractor must provide and support all staff holistically, ensuring personal development, promote confidence and greater staff satisfaction.

## High quality, appropriate and responsive care

* + 1. The Contractor must be able to mobilise all services from commencement of the contract term.
		2. The Contractor must provide a GP Led service ensuring there is a robust process for clinical oversight throughout core hours to support a multi- disciplined practice team.
		3. To deliver a patient-centered service, the Contractor must engage and co-design service with patients (including carer’s where appropriate) in the design and development of the services.
		4. Service delivery must ensure that Patients (and their families and carers where appropriate) are involved in and consulted on all decisions about their care and treatment.
		5. In addition the Contractor must carefully consider and cross reference current Department of Health Guidance when developing, reviewing and implementing their service delivery.
		6. Access and convenience are important aspects of a patient-centered service; however, it is vital that the services are delivered flexibly and appropriately, in response to the needs of the patient(s).
		7. The Contractor must utilise new technology, including but not limited to telephone triage and remote consultation and other innovative systems in the provision of services, providing they have received prior agreement from the Commissioner and the support of patients.

## Patient and Public Involvement

* + 1. It is important that patients and the public have a key voice in how integrated health and social care services are delivered and the contractor will has a statutory obligation to consult and engage with patients and the public under Section 242 of the Health and Social Care Act 2012.
		2. The contractor must improve and embed engagement and communication with patients throughout the term of this contract to develop services and communicate any changes made in patient services, having regard for Part 3 paragraphs 3.5 and 3.6 of this Schedule 2.

## Patient Dignity, Privacy & Respect

* + 1. The Contractor must:
			1. Ensure that all aspects of Service provision protect and preserves Patient dignity, privacy and confidentiality regardless of the location;
			2. Allow Patients to have their personal clinical details discussed with them by an appropriate clinician, where possible maintaining continuity of care
			3. As far as reasonably practicable, patients should be offered choice in who they see, for example, if a patient would prefer a female doctor for intimate examinations.
			4. Ensure that a trained chaperone is available for intimate examinations. The Contractor must ensure that that they preserve patient dignity, respect and cultural preferences at all times.
			5. Ensure that all Staff behaves professionally and with discretion, compassion and sensitivity towards all Patients, staff and families at all times.
			6. Develop policies, processes and procedures which support the safe implementation of referrals to and from nurses, including nurse specialists. These will incorporate the identification and description of extended nursing roles in treatment and investigation of patients.

## Equity of Access, Equality and Non-Discrimination

* + 1. The Contractor must ensure equity of care, access and outcome across the whole health and social care community. The contractor must maintain integrated working between acute units, emergency treatment services, ambulance services, community hospitals, primary care, social services and the voluntary and independent sectors.
		2. The Contractor must:
			1. Meet the needs of all patients with protected characteristics covered by the Equality Act 2010 (age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics)
			2. The Contractor must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral, sight/visual or learning impairments). This may include professional interpretation and translation services during all consultations, telephone, remote or face to face, and translations of materials describing procedures and clinical prognosis for the languages recommended by the Commissioner as being the most common languages spoken by Patients who are likely to use the Services. The contractor must be able to access interpreters and for non-English speaking patients and deaf patients from the service commissioned on behalf of primary care by NHS England/the CCG and;
			3. Patient and/or their families and carers, where appropriate, must be involved and consulted on all decision about their care and treatment. Subject to its obligations under the Data Protection Legislation, record details of any Patients who have special requirements in relation to accessing the Services;
		3. The Contractor acknowledges the need to improve equity of access and health outcomes for all patients. Some individuals and groups sharing one or more protected characteristics do not currently experience easy access to general practice services, and subsequently do not experience the same health outcomes as the rest of the population. The contractor needs to demonstrate how these will be managed and overcome. This includes improving access and considering the needs of:
			1. Those living in deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment).
			2. Vulnerable groups of society, or ‘inclusion health’ groups: e.g. migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; sex workers and faith groups. Additionally, people with mental health problems, learning disabilities, low health literacy, and drug and alcohol problems may be similarly challenged. Those not registered with practices might also be subsequently ‘invisible’ in the primary care system (some of these groups and more are listed in the section below in section 1.6)
			3. People affected differently due to geography e.g. urban, rural.
			4. There is a particular requirement to consider the needs of the BAME community and other vulnerable groups affected disproportionately by COVID-19.
			5. Regarding people with protected characteristics , providers must also collect information on patient’s ethnicity, religion, first language, age, disability, gender reassignment, pregnancy or maternity, sex and sexual orientation due to the need to take into account a patient’s background, culture, religion or belief and communication needs in providing appropriate individual care, for shared care, including secondary care, and the need to demonstrate non- discrimination. The contractor must take all reasonable measures to ensure that its services are fully accessible in respect of physical access to the building, digital access and in terms of all communication and contact with its patients.
			6. Providers are asked to familiarize themselves with the document enclosed at the link below. It is designed to support you in understanding whether any groups within your local community are experiencing barriers in accessing those services and provide resources to help you address those barriers as improvements in access to general practice services are rolled out.

<https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-sep-2018.pdf>

* + 1. The Contractor acknowledges that to improve equity of access and health outcomes for all patients with protected characteristics that it must collect information on patient’s ethnicity, religion, first language, age, disability, gender reassignment, pregnancy or maternity, sex and sexual orientation due to the need to take into account a patient’s background, culture, religion or belief and communication needs in providing appropriate individual care, for shared care, including secondary care, and the need to demonstrate non- discrimination. The contractor must take all reasonable measures to ensure that its services are fully accessible in respect of physical access to the building, digital access and in terms of all communication and contact with its patients.
		2. The Contractor must ensure that it complies with the obligations contained under sec 149 – public sector equality duty, of the Equality Act 2010, the Equality Act 2010 (Specific Duties) Regulations and complies fully with all relevant articles of the Human Rights Act 1998 in the provision of services to patients.

## Services for vulnerable and hard to engage groups

* + 1. The Contractor must recognise that access is a multi-dimensional concept that is not only about open hours and appointments, but also includes making services flexible and available to groups of the population that traditionally do have difficulty making use of the health service or public services generally.
		2. These groups are often the most vulnerable, and might have different expectations of health services, to the majority (these are referred to above in paragraph 5.1.3. in terms of people who can experience poorer outcomes). In particular, they may have difficulty in;
		- making or keeping appointments
		- they might have difficulties making their needs understood
		- there might be cultural, practical or social barriers that affect their ability to follow treatment regimes
		- challenges might be faced in organising systematic follow-up because of age, mobility, lifestyle, mental health and wellbeing and practical issues such as transport.
		1. The provision of primary care services for socially excluded groups is included under the terms of all existing contractual arrangements (GMS/PMS & APMS contracts), as a minimum, the successful Contractor must be able to demonstrate how provision for unscheduled care, continuing care and health protection must be achieved for all registered patients registered who may fall within some of the following socially excluded and vulnerable groups including but not limited to:
			1. Patients who do not understand written or spoken English;
			2. Patients with identified with Learning Disability;
			3. Working single parents
			4. Those who have no permanent address
			5. Patients who might have a history of violence or aggression including those with a forensic history and who might transit into and out of the prison system.
			6. Patients with drugs and alcohol problems, or mental illness, or combinations of these, including homeless or transient persons.
			7. Patients who have a mental illness;
			8. Asylum seekers or refugees, who may have special needs related to experiences in their country of original and recent immigrants and their families, for whom English is not their first language;
			9. Travellers and their families, in whom there may be social, cultural and practical barriers to the provision of health and social care.
			10. Black and minority ethnic communities;
			11. Disabled people, including people with sensory impairments, brain injury, people with learning / physical disabilities and disfigurements;
			12. Adolescents;
			13. People aged 16-24 outside education and work, especially those with chronic illness, mental health and serious social challenges;
			14. Patients who are elderly and/or housebound.
			15. Child carers;
		2. The Contractor must develop and implement innovative approaches to provide a robust follow up and health protection plan for these groups, for example, the use of digital technology, specialist nurse support, community services, and the voluntary sector.

## Violent Patients

* + 1. The Contractor must operate a robust process and ensure that staff are appropriately trained and supported to manage violent, aggressive or abusive behaviour from patients attending the surgery. The Contractor must adhere to the commissioned service Leicester, Leicestershire & Rutland Violent Patient Scheme (LLR VPS) in accordance with local guidance and policy.
		2. Where patients behaviour does not meet the criteria for referral into the LLR VPS, i.e. swearing or verbal abuse which is unthreatening; the Contractor must manage this appropriately; i.e. the patient should be notified in writing and warned that their behaviour is unacceptable and could result in removal from the registered list if the patient repeats the behaviour in the future. Removal of such patients thereafter must adhere to the regulated process identified in paragraph 60 to this APMS Contract.

## Interpretation Services and translation

* + 1. The Contractor must ensure compliance of locally agreed pathways and ensure that patients have appropriate access to interpretation and translation services to support patients during consultations in line with national and local guidance:
		2. The Contractor must have an awareness of what the common languages that are spoken at the practice by the patients.
		3. The Contractor must ensure that British Sign Language interpretation is made available for Deaf patients;

## Informed Consent

1.9.1. The contractor must comply with all Legal/Information Commissioners Office/NHS/CCG Requirements in relation to obtaining consent from each Patient as notified to the contractor by the Commissioner from time to time prior to commencing treatment.

* + 1. Consent is the approval or agreement for something to happen after consideration. For consent to be legally valid, the individual must be informed, must have the capacity to make the decision in question and must

give consent voluntarily. This means individuals should know and understand how their information is to be used and shared (there should be ‘no surprises’) and they should understand the implications of their decision, particularly where refusing to allow information to be shared is likely to affect the care they receive. This applies to both explicit and implied consent.

* + 1. Explicit consent is unmistakable. It can be given in writing or verbally, or conveyed through another form of communication such as signing. A patient may have capacity to give consent, but may not be able to write or speak. Explicit consent is required when sharing information with staff that are not part of the team caring for the individual. It will also be required for a use other than that for which the information was originally collected, or when sharing is not related to an individual’s direct health and social care.
		2. Implied consent is applicable only within the context of direct care of individuals. It refers to instances where the consent of the individual patient can be implied without having to make any positive action, such as giving their verbal agreement for a specific aspect of sharing information to proceed.
		3. It is important when obtaining either explicit or informed consent that the contractor records the patient's decision within their clinical records, which may be subject to auditing.
		4. The contractor must also make it clear to patients that they may withdraw their consent, at any time, without detrimental effect on their care or treatment and have appropriate mechanisms in place to ensure they comply with the wishes of each patient.
		5. The contractor must ensure compliance with Mental Capacity Act (MCA) and where it is suspected that a patient does not have capacity to consent this is recorded through MCA assessment, Best Interests Assessments (BIA), Best Interest Decision and thorough records kept on file.

## Referrals

* + 1. The contractor must use the NHS e-Referral Service (e-RS) (Para 31.124A of this APMS Agreement refers); ensuring patients are offered appropriate choice of service provider for any referrals.
		2. The contractor must:
			1. Monitor and peer review all referrals, with the aim of minimising inappropriate referrals and hospital admissions; participate in local initiatives to audit and review when required by the commissioner.
			2. Co-operate with and make effective use of existing services available as appropriate and in line with care needs.
			3. Cooperate with other service Providers Services to ensure safe and seamless care for Patients via access to the Summary Care Record (para 32 to APMS Agreement refers) and including providing information via Special Patient Notes (SPN) or equivalent as clinically appropriate. This is also includes complying with any temporary changes/additions to SCR, for example inclusion of Covid-19 codes.
			4. Provide complete and comprehensive referral information to the service the Patient is being referred to, to enable any further activity to proceed
			5. Use robust clinical pathways for referral, agreed with other local healthcare providers;
			6. Routinely collect, record and analyse data about the appropriateness of the contractor’s referrals;
			7. Implement national referral guidance such as Referral Guidelines for Suspected Cancer and NICE guidance, but no limited to;
			8. Ensure 2 week wait (2WW) and urgent suspected cancer referrals, are sent electronically and received by the relevant trust within twenty-four (24) hours;
			9. All referrals must go through PRISM (Pathway and Referral Implementation SysteM) where applicable or where the pathway is available.
			10. Develop and implement policies in relation to nurse and nurse specialist referrals and their extended role in treatment and investigation of Patients with specified diseases;
			11. Implement and operate Electronic Referral at point of referral for specialist services, and provide a booking facility (in accordance with the national choice and book agenda); and
1. Except where specifically stated otherwise in respect of particular services, the Contractor must provide Services under the Contract to:
	* Registered Patient’s;
	* Temporary Residents;
	* Persons to whom the Contractor is required to provide emergency or immediately necessary treatment;
	* Any other person to whom the Contractor is responsible under arrangements made with another Contractor; and
	* Any other person to whom the Contractor has agreed to provide Services under the Contract
		+ 1. All elective referrals to consultant led out-patient services to be made electronically and that service providers must comply with the national and or local arrangements for return of any non-ERS referrals to primary care.

## Duty of Co-Operation

### The Contractor must:

* + - 1. become an active member practice in West Leicestershire CCG (the Commissioner) (or any succeeding body);
			2. adhere to the CCG constitution;
			3. adhere to all national or local priorities/targets;
			4. engage with the Commissioner performance monitoring process identified in Schedule 6 to this Agreement.
			5. discuss and develop policies and procedures to ensure there is compatibility and alignment with other local policies and procedures, including clinical and non-clinical issues;
			6. audit and monitor outcomes to ensure that key clinical indicators are in place to allow benchmarking with other services and contribute towards the Commissioner’s own performance indicators.

### GP Federation/Localities

Thurmaston Health Centre is a member of the South Charnwood Locality which is part of The North & South Charnwood GP Federation. The Contractor must maintain membership of a federation throughout the duration of the contract.

### Primary Care Networks

* + - 1. For the purposes of this paragraph, "primary care network" means a network of contractors and providers of other services that have been approved by the Board, serving an identified geographical area with a minimum population of 30,000 people.
			2. Thurmaston Health Centre is a member of The Watermead Primary Care Network (PCN); The Contractor must maintain membership of a PCN and must comply and adhere to the requirements of the Network Contract Directed Enhanced Service throughout the duration of the contract.

### Local Integration

* + - 1. The contractor must participate and send appropriate representation to meetings determined by the Commissioner, the GP Federation, the PCN and/or other local community services/stakeholders; to support improved integration and service development. This may include but not be limited to:
1. Protected Learning Time (PLT) (or equivalent events);
2. PCN meetings
3. General Practitioner Locality Meetings;
4. Practice manager and Nursing forums;
5. Multi-disciplinary meetings with community services/stakeholders;
6. Any other health and social care providers meetings which will support improved patient care, new care pathways and whole system integration.
	* + 1. Foster good working relationships and gain mutual understanding of systems, policies and procedures with key local stakeholders;
			2. Establish links to local information resources and foster a good understanding of the local Patient care pathways to promote effective referrals and to participate in the local Active Signposting Initiative;
			3. Utilise specialist services (for example drug misuse, minor surgery, dermatology, NHS dentistry) from central primary care locations and other services at local locations to avoid duplication of services, promote economies of scale, and bring practices together to plan and implement common aims for the benefit of those practices and their patients.
			4. Implement robust structures – to maintain key relationships and ensure that links are maintained with key structures within the local health economy, particularly with but not limited to: Acute and Community Services, Local Authority, forums dealing with Patient and Public Involvement and the voluntary sector.

## IM&T & Information Governance

* + 1. The Contractor must comply with:
			1. This Agreement;
			2. All relevant Law and best practice guidance in relation to NHS records management and IM&T in the NHS; and
			3. The Caldicott Principles; and
			4. All relevant provisions under the General Data Protection Regulations/Data Protection 2016
		2. The Contractor must ensure that their IM&T Services conform to the relevant standards and submit documents to the Commissioner defining how it will put in place and operate the following:
			1. An incident management system allowing for the identification, impact assessment and reporting of all actual or suspected incidents;
			2. Procedures for maintaining all systems provided by the Provider are up to date and in line with any cyber security-related patches and advice from their suppliers;
			3. Procedures for any transfer or storage of NHS Patient data according to standards specified.
			4. Procedures for risk assessment of particular risks to information security, and the agreement of and completion of mitigation works within agreed timescales; and
			5. an acceptable user policy for access and use of IM&T systems and equipment;
		3. The Contractor must verifiably collect accurate data for and submit to the NHS England or the Commissioner on request. Such requests to include but not limited to:
			1. Clinical data sets as stipulated in the regulations;
			2. Data relating to the performance of services under this agreement which are necessary for its effective monitoring and management;
			3. Other clinical data sets required by this Agreement.
		4. The Contractor will be supplied with the following IT support (covered under the GP IT operating framework);
			1. Hardware support
			2. Software support
			3. Network support
			4. Rolling Replacement Programme
			5. RA services
			6. Training
		5. IT support will be contracted by the Commissioner on behalf of the supplier. It will be delivered through Leicestershire Health Informatics Service (LHIS) under existing SLA contracts. Any additional requirements and costs outside of SLA must be supported by the Contractor
		6. The Contractor must sign a Practice / Commissioner agreement prior to commencement of services; this agreement will set out all parties responsibilities under the Local IM&T framework, and adhere to all responsibilities as set out the agreement.
		7. The Contractor must adopt the clinical system set up for this service (Namely, TPP SystmOne, GPSOC accredited clinical system). Project Management, Business Change, RA smartcard set up and training for the clinical system are provided by LHIS.
		8. The Contractor is responsible for ensuring that all clinical notes regarding the patient are captured in the clinical system in line with paragraph 32 of this APMS Agreement and have the ability to interoperate in accordance with local protocols, and share data within the community.
		9. The Contractor must only use clinical system templates developed by LHIS.
		10. Configuration set up of services will be delivered by LHIS. These services include all IM&T modules currently utilised by GP Practices in the CCG area, the list below is not exhaustive, i.e.
			1. Sunquest ICE
			2. Electronic Referrals
			3. Summary Care Record including capturing of consents for enhanced SCR
			4. Electronic Prescription (EPSr4)
			5. PRISM
			6. Eclipse
			7. GP2GP
			8. ARISTOTLE
			9. GP Wi-Fi
		11. As and when services/modules/template changes are agreed by the Commissioner these will be automatically included in the LHIS and the relevant CSU SLA agreements.
		12. The Contractor must sign up to an Information Sharing Agreement (ISA), allowing for patient data to be viewed and shared for clinical use in line with data protection legislation and patient opt-out preferences. The clinician accessing the patient record is required to gather explicit consent from the patient in accessing the clinical record. It is the responsibility of the Contractor to ensure that patients are fully aware of their records being accessed and who will have access to the information once information has been captured.
		13. The Contractor must adhere to the locally implemented EPACCS solution to support high quality care planning, effective once this solution is brought in to effect.
		14. The Contractor must ensure that appropriate security measures are in place to cover IM&T. This will include procedures for any security breaches or loss of data. The Contractor should ensure that IT equipment is stored safely.
		15. The following hardware will be supplied to the Contractor under existing GP IT services:
			1. Desktops
			2. Printers
			3. Scanner
		16. The cost of any additional devices will be borne by the Contractor; i.e.:
			1. Laptops / Toughbook
			2. Tablets
			3. Mobile phone devices
			4. 3G/4G dongle or Wi-Fi devices
			5. Patient Arrival systems
			6. Patient Call Board systems
		17. For purposes of clarity, telephone systems are outside the scope of GP IT and will not be provided.
		18. The Contractor will require a HSCN connection at its base location, which will be provided by the CCG. All clinicians will require an N3/HSCN connection to access the clinical system. The Contractor will have access to the Leicester, Leicestershire and Rutland (LLR) shared Wi-F that is currently available in NHS buildings, Council buildings and most care homes across the area. The LLR Shared Wi-Fi will allow them to have direct access to HSCN.
		19. Where a direct or wireless connection to HSCN is not possible the Contractor will be required to provide alternative secure means of accessing the N3 connection. This can include accessing N3 via a VPN when an internet connection is available. An internet connection can be established using alternative methods such as Wi-Fi hotspots or 3G/4G access but must be arranged as secure to NHS standards.
		20. The Contractor will ensure that they do not use their own laptop to carry out NHS work unless they have the appropriate NHS security standards, and have been approved by the CCG.
		21. Contingency plans need to be in place for IM&T unavailability. This needs to be built into the Contractor’s business continuity plans.
		22. The Contractor must provide detailed plans for mobilisation of IT and telephony services. The Contractor should ensure that all IM&T equipment is in place and ready to use at the start of the contract go live. This will include the training staff on the clinical system in advance of go live.

## Disaster Recovery and Business Continuity

* + 1. The contractor must produce a business continuity plan (BCP) on or before the Commencement Date which must set out how the contractor will ensure that the service continues for patients in the event of a disaster which may include a power cut, flood, etc. As a minimum the business continuity plan must state what arrangement will be put in place to have secure access to patient records held on the clinical system, and the arrangements for patients to continue to access the service, e.g. relocation or replacement of telephone lines, and/or any temporary relocation information.
		2. The Contractor must ensure the BCP incorporates a disaster recovery plan (DRP) which sets out how items such as patient records and other clinical data held by the Contractor in relation to Patients who are or may be the subject of services, will be backed-up, verified, safely stored, recovered and made securely available to the Contractor, the commissioner or a third party providing other services in the event that a disaster causes the Services or any part of them to no longer be performed by the Contractor or from the Practice Premises.
		3. As a minimum the DRP in para 1.13.2 above must state that appropriate back up procedures are in place for all Practice data, other than the GPSOC provided clinical system, to ensure minimal data loss. The contractor must comply with such disaster recovery plan and must provide a copy of such disaster recovery to the Commissioner. The disaster recovery plan must not contain any obligations on the Commissioner.
		4. It is vital that workforce succession is fully prepared in the case of a localised or regional major incident, unexpected emergencies, pandemic(s) and planned or unplanned increases in workload, and also staff absences. Therefore the contractor must include in their BCP dedicated staffing levels for both clinical and administration staff as part of a workforce succession plan that ensures services will not be affected and continue in the event of such risks. This plan must include the provision of office and administration services, provision of reception services and the provision of appropriate clinical mix and be in line with any communication that is required to manage and successfully execute workforce succession.

# PART 2: CORE MANDATORY SERVICES

## Services to be provided

* + 1. The Contractor must provide all services detailed within this specification and adhere to any changes to the national contract and/or national guidance:
			1. For all patients registered with the practice at the point of commencement; and
			2. For all new patients and temporary residents who reside within the agreed practice area identified in Schedule 3 of this Agreement; who apply to register after commencement.

## Contracted Activity and Growth

* + 1. The Contractor must ensure the contractor’s List of Registered Patients in respect of the Services remains **OPEN** to new registration for the duration of this Agreement.
		2. The Contractor must ensure that growth of the contractor’s List is derived from the population which resides within the agreed practice boundary.

## Opening Hours

* + 1. From commencement the Contractor must provide:
			1. **Core hour opening**, ensuring the practice is open and fully operational (with appropriate levels of administration and clinical staff) 8am-6.30pm Monday to Friday, 52 weeks per year except agreed Public and Statutory Bank Holidays;

Patients would like appointments outside of the core hour provision; the contractor

must develop and implement innovative plans in agreement with the Commissioner to support patient needs;

## Clinical Team

* + 1. The clinical team must be a multi-disciplinary team (MDT). The clinical team should include a combination of General Practitioners, Advanced Nurse Practitioners, Nurses, Health Care Assistants, Phlebotomist, Practice Pharmacist, etc. (NB: this list is not exhaustive) and the Contractor must ensure
			1. that there is appropriate GP clinical leadership and oversight to support safe care throughout core hours. A GP must therefore be accessible throughout core hours and for any services provided by the Contractor outside of Core hours; providing leadership and support to the multi-disciplinary team (MDT) ensuring there is appropriate on site cover arrangements for dealing with a medical emergency at all times;
			2. an effective and safe clinical triage system is to be developed and implemented to ensure patients receive the most appropriate clinical intervention, advice or referral at the point of their first contact with the surgery; Clinical triage must be provided by an appropriately qualified clinician and not receptionists;

## Flexible Access

* + 1. Access and convenience are important aspects of a patient-centered service, but it is also vital that the services are appropriate and responsive to the needs of the local population. In the event of local and national pandemics, the Contractor must use telephone triage and remote consultations when and where appropriate.
		2. The Contractor must use other online patient-facing services, e.g. GP Connect, repeat prescription ordering and access to medical records.
		3. The Contractor must design services around the health and social care needs of patients and their carers (if applicable);
		4. In developing an access model which provides the above requirements, the Contractor must ensure:
			1. a robust appointment system to provide flexible access and delivery of appointments across core hours ensuring full range of consultation methods are offered, according to clinical need. This will include but not limited to
				1. telephone – The Contractor must provide telephone clinical triage and remote consultation but not use this to substitute face to face clinical time where this is required
				2. Video Consultation – The Contractor must have the ability to carry out video consultations between patients and clinicians. The Contractor must use an NHS-approved videoconferencing solution
				3. On line (in line with para 32.15 to 32.22 of this APMS agreement and national guidance).
				4. face to face consultation at the Practice or in the patient’s home when clinically necessary, adhering to the principles of cohorting and complying with PPE and IPC guidance.
			2. the number of appointments available for each clinical group to be reviewed regularly and aligned according to patient need;
			3. treatment for any patients potentially suffering from an immediate and life-threatening condition are identified as soon as they contact or present to the practice;
			4. in the case of clinical urgency there are sufficient on the day appointments available to ensure a patient is able to book an urgent appointment on the same day, at the point of their first contact with the surgery; (i.e. the patient must not be asked to call back at another time to book.);
			5. there are sufficient pre-bookable appointments available to patients;
			6. i.e. for routine/non-urgent care, which are bookable at least 4 weeks in advance; and that such appointments are made available in line with patients’ clinical need and made available on the patients’ first request; (i.e. the patient must not be asked to call back at another time to book.);
			7. patients must have the ability to book and cancel appointments, or order repeat prescriptions, via the telephone, on-line or in person throughout core hours;
			8. a robust process, for managing Repeat Prescriptions, including electronic, must be developed, implemented and aligned to Paragraph 19 of this APMS Agreement; In addition the Contractor must ensure
	+ communication with patients and local pharmacies is effective to support a robust process.
	+ that patients do not wait longer than 2 working days for their repeat prescription;
	+ that there is facility for a fast turnaround for any urgent prescription requests if these are clinically appropriate (no longer than 24 hours).
		- 1. Patients must have access to co-located services within the health community, e.g. community midwives, district nurses, counsellors, physiotherapists etc. as appropriate to clinical need.

## Provision of Reception and Administration Services

* + 1. Reception services and telephone access must be available to patients, carers and other stakeholders throughout the Core Hours.
		2. Receptionists must not be responsible for clinical triage. Triage should only be conducted by an appropriately trained clinician to assess the appropriate clinical action. Receptionists may support a GP patient call back type service; however, there must be appropriate clinical oversight and protocols in place to ensure patients with urgent clinical need are sign posted to an appropriate clinician on their first contact with the service.
		3. Reception staff should ensure that when speaking to patients they are kind, courteous, and respectful at all times.
		4. The Contractor must ensure reception staff have appropriate clinical support and receive training in the following key areas,
1. Customer Service
2. Conflict Resolution
3. Active Signposting
4. Safeguarding
5. Learning Disability Awareness
6. Infection Prevention and Control
7. PPE

The above list is not exhaustive and training should be aligned to appraisal and personal development process. (Para 14 of this Agreement)

* + 1. Appropriate office management and robust administration processes will be required to fully support this service
		2. The contractor must utilise innovative use of technology subject to the appropriate prior approvals from the Commissioner and in consultation with patients. Digital consultations must be available for patients, where clinically appropriate, in order to increase patient choice and access. The use of new technology platforms should not be made compulsory for patients.

## Essential Services

* + 1. The Contractor must ensure all Essential and Additional Services, as defined in the National Health Service (General Medical Services Contracts) Regulations 2015, are provided to registered patients and temporary residents, throughout core and extended hours.

## Directed Enhanced Services by NHS England

* + 1. The Contractor must provide **all** *Directed Enhanced Services* (DES) as commissioned by Commissioners during the term of this Agreement as; such services to be provided within Core Hours to patients in accordance with patients’ needs.
		2. The Contractor will be funded as per the agreed DES specification for each service.
		3. The Contractor must:
			1. Comply with all compliance and accreditation criteria as detailed within each individual service specification;
			2. Accept any changes or amendments to *Directed Enhanced Services* as they apply from time to time; and
			3. Notify the Commissioner clinical governance lead of all emergency admissions or deaths of patients receiving Enhanced Services, where such admission or death is or may be due to usage of drug(s) or attributable to the relevant underlying medical condition within 72 hours of the information becoming known to the Contractor.

## Directed Enhanced Services - Public Health England

* + 1. The Contractor will be expected to provide **all** *Directed Enhanced Services* (PHDES) commissioned by Public Health England (national and local) during the term of this contract as commissioned at such times; such services to be provided within *Core Hours*, to patients in accordance with patients’ needs.
		2. Public Health England commission all national immunisation programmes.
		3. The full range of nationally negotiated Immunisation Enhanced Services can be found here:

<https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/>

* + 1. Please also note that there are a number of additional services that receive a fee for activity (paid via CQRS) that don’t equate to enhanced services since they have been nationally negotiated into the vaccine programme.
		2. Contractors are asked to note that Childhood Immunisations Directed Enhanced Services will require the Contractor to submit the relevant immunisation activity data in the manner and format required NHS England and Primary Care Support England (PCSE) to generate payments. i.e. in this instance to the use the Open Exeter (or any successor system) upload process for PCS England to calculation using NHAIS.

## Locally commissioned Community Based Services:

* + 1. Where services are not detailed within this service specification and there is an identified need within the registered population, the Contractor must ensure that registered patients have access to services commissioned locally, including but not limited to those commissioned by:
			1. The Clinical Commissioning Group;
			2. The Primary Care Network or Federation;
			3. Public Health England;
			4. The Local Authority; and
			5. Local NHS Providers.
		2. The Contractor will be required to adhere to all accreditation and service requirements of each service as agreed with the commissioner and any changes made to respective services from time to time.

## Home visits

* + 1. The Contractor must ensure that home visits are made available to all Registered Patients (including Temporary Residents). Patients should have access to home visiting services as soon as practicably possible and in accordance with clinical need. The Contractor must ensure;
			1. Registered Patients are informed of the timescale in which they will be visited if the agreed visit is delayed; and
			2. Visits are made in a timely manner, according to clinical need as determined by GP acting in accordance with Good Medical Practice.

## Phlebotomy Services

* + 1. The Contractor must provide a practice based phlebotomy service, ensuring that:
			1. there are sufficient appointments available each week to meet the clinical needs of the patients;
			2. all samples taken are handled appropriately and are transported to clinical lab within identified timeframes.
			3. that the results are reviewed by a clinician and communicated to the patient in a timely manner, appropriate to the clinical need;
			4. that the patient’s electronic record is updated appropriately to record the type of blood test undertaken, the result and any follow up treatment offered or required;

## Long Term Condition Care

* + 1. For the purpose Long Term Condition Management the Contractor must provide care to patients who have been diagnosed as suffering from one or more chronic disease; and those services::
			1. to be delivered in the manner determined by the Contractor’s

*practice* in discussion with the patient;

* + - 1. appropriate ongoing treatment and care management including:
				1. advice in connection with the patient’s individual health and relevant health promotion advice; and
				2. the referral of a patient for other services under the *2006 Act*;
			2. “management” includes:
				1. offering a consultation and, where appropriate, physical examination for the purposes of identifying the need, if any, for treatment or further investigation; and
				2. making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the *2006 Act* and liaison with other *health care professionals* involved in the patient’s treatment and care.

# PART 3 – APMS PREMIUM SERVICES

## AIMS

* + 1. As detailed in Parts 1 and 2 of this Schedule, the Commissioner is committed to reducing health inequalities, improving patient outcomes and access to primary medical services in line with the NHS Long Term Plan and local commissioning intentions which include:
			1. Improved appointment access;
			2. Innovative use of digital technology to increase patient choice, improve access, and improve quality and outcomes
			3. Health promotion including regular patient engagement and appropriate signposting to increase patient awareness and promote self-care;
			4. Targeted clinical audit and risk assessment to identify at risk patients, early diagnosis, improved intervention and improved patient outcomes;
			5. Increased services within Primary Care to provide care closer to home;
			6. Improved management of Long Term Conditions;
			7. Improved patient engagement and communication;
			8. Monitoring, review and improvement of patient and staff satisfaction;

## Improved Appointment Access

### Demand and Capacity:

The Contractor must

* + - 1. Undertake a demand and capacity audit within 2 months from commencement date and will be required to report back on the results at the first Contract Review Meeting set up in line with Schedule 6 to this Agreement.
			2. Thereafter the contractor must repeat such audits at regular intervals (to be no more than 6 months apart) to understand the changing needs of the registered population.
			3. Ensure that clinical provision across the

identified core hours is adjusted and aligned to meet the changing needs of the registered population accordingly.

## Health Promotion to prevent disease and improve self-care

* + 1. The NHS Long Term Plan recognises that the NHS will need to increase its contribution to tackling some of the most significant causes of ill health. This will require new actions to help support people address ‘wider determinants of health’ and to improve lifestyle modification to further mitigate the risk arising from patient behaviour on their long-term health. The programme should focus on the communities and groups of people most affected by these challenges.
		2. Primary care is well placed to promote healthy lifestyles through their interactions with local people. This is sometimes referred to as MECC – making every contact count.
		3. West Leicestershire CCG acknowledges that without supporting changes in lifestyle, in conjunction with the increase of multimorbidity and an aging population, the demand on all areas of the healthcare system will continue to increase. The Contractor should be able to demonstrate an effective approach to supporting lifestyle modification, which would result in a reduction in disease severity, and the use of medication. Areas of attention might include (but not limited to);
			1. Onset of avoidable disease
			2. Addictive behaviour - with focus on those that smoke, drink alcohol to excess, and use drugs to modify response to life’s stress.
			3. Help to manage stress, including insomnia using e.g. ‘Five Ways to Wellbeing’ (<https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/>)
			4. Nutrition & weight management with focus on the pre-diabetic and malnourished
			5. Improved identification of early disease through uptake of screening programmes
			6. Improved health in children and adolescents to include increased uptake of vaccination programmes, early identification of those ‘at risk’ and management of childhood development.
			7. Attention to education and support in respect of sexual health is also be a point of focus.
			8. Falls avoidance programmes
		4. The Contractor must work with its registered population, the Commissioner, the Federation, Primary Care Network, Public Health England, Community Services, health and social care and other local stakeholders including the Voluntary Sector; to develop and implement initiatives which promote healthier lifestyles, increase patient’s knowledge and self-care. This can include (but not limited to):
			1. Advice & guidance provided to the patient during or after consultation;
			2. Patient communications, via: Website, letter, leaflets, SMS etc.
			3. Invitation to health-promotion clinics or health promotion events held in the practice;
			4. Appropriate signposting to other healthcare providers and into community schemes to support learning and self-care.
		5. Primary care also has huge potential to help address the ‘wider determinants of health’ i.e. those non-medical causes of ill-health e.g. debt, poor housing, unemployment. This can be facilitated through ‘social prescribing’ and linking health services to wider community assets.
		6. Social prescribing is designed to support people with social, emotional or practical needs, and schemes often target vulnerable groups, involving various activities that are typically provided by statutory, voluntary and community sector organisations including the local authority (for advice on housing, debt, unemployment etc.), arts groups, gardening, cookery and sports groups.
		7. Social prescribing link workers embedded in primary care can empower people to take control of their health and wellbeing through referral to non-medical interventions and services, connecting people to community groups and statutory services for practical and emotional support.
		8. Support services as commissioned by councils and grant funders mean that partnership working between councils, other funders and the NHS is essential to ensure these services can deal with increases in demand due to population growth associated with new developments.

## Clinical Audit and Risk Assessment

* + 1. The Commissioner recognises that an aging population is increasing the numbers of patients being diagnosed with chronic disease in middle age. To support improved patient outcomes the Commissioner is currently working with its member practices to develop effective strategies for early risk assessment and integrated care. In 2019/20 the CCG has focussed on the following key areas.
			1. Diabetes
			2. Respiratory
			3. Hypertension
			4. Cardiology
			5. Obesity.
		2. The contractor will be expected to work with patients, the Commissioner, the Federation, the Primary Care Network (PCN), local practices and other local healthcare stakeholders; to develop effective and robust strategies which must include clinical audit and appropriate risk assessment to increase the accurate assessment of prevalence, promote earlier diagnosis and improve patient outcomes in line with National guidance and local strategy, and provide evidence of the effect of their strategy.

### Clinical Audit

* + - 1. In addition to the core requirement for National Diabetes audit (paragraph 34A of the APMS Agreement) the Contractor must agree a programme of clinical audits throughout the term of the contract. Audits to be undertaken as a minimum of one per 3-month reporting period.
			2. The suggested programme of clinical audits to include:

|  |  |
| --- | --- |
| 1st Reporting Period | End of Life/Palliative Care |
| 2nd Reporting Period | Prescribing |
| 3rd Reporting Period | Respiratory/COPD |
| 4th Reporting Period | Hypertension |
| 5th Reporting Period | Cardiology |
| 6th Reporting Period | Obesity |

* + - 1. The Contractor will be required to report back to the Commissioner on the outcomes of each audit and any actions taken as a result at the next scheduled Contract/KPI review meeting (as detailed in Schedule 6).
			2. By month 3 of the contract the Contractor and Commissioner will agree a 1 year programme of clinical audits and there after agree a clinical audit programme by the last quarter for the preceding year.
			3. The identification of Clinical Audits in para 3.4.3.2 above will be agreed with the Contractor prior to commencement. The inclusion of this programme does not prevent the Contractor from undertaking additional clinical audit to support service delivery, robust process and safe patient care.

### Risk Assessment & Early Intervention

* + - 1. The Contractor must undertake early identification of ‘at risk’ patients using a mixture of clinical judgement supported by outputs from a number of data sources such as QoF registers and any approved risk stratification tool, ensuring:
				1. Implementation of a robust recall process for those defined as ‘at risk’;
				2. Early intervention is provided in line with appropriate DH, NICE, MHRA and any other relevant guidelines (as amended from time to time) that apply to the provision of primary medical care services for Patients.
				3. Patients are provided with appropriate Healthy living advice and health education to promote and increase awareness and self-care;
				4. Patients are made aware of the appropriate use of NHS services, their sector and other providers;
				5. That any necessary referrals to other healthcare providers are made in line with local and national strategy, i.e.: 2 week wait supporting reduction in cancer mortality rates;
				6. That the practice provides flexible service provision and longer appointments for vulnerable patient groups;
				7. Ensure a joint and integrated care plan is agreed with the patient and local health and social care systems;
				8. Provide support for carers including the establishment and maintenance of a register of carers which includes evidence of regular review of the register
				9. That the patients summary care record / Special Note Record and Electronic Patient Record is kept updated in line with national guidance and paragraphs 32 to this agreement.
			2. The contractor must ensure they provide clinical input into wider healthcare oversight meetings to support integrated care plans.

## Improved patient engagement and communication;

* + 1. The Contractor must work with the Commissioner from contract award and throughout the contract mobilisation period, to ensure effective communication and engagement is implemented to support patients through the transition.
		2. The Contractor must engage patients in the design, development and delivery of the services. They should deliver a patient centered service that responds both to the immediate needs of the patient and their ongoing health support. The service should be responsive to patient feedback in a manner that can be evidenced.
		3. The Contractor must therefore manage patient expectations by ensuring they have a robust and effective communication process in place to inform patients on all changes in service provision, confirming any changes in how and when they can access those services.
		4. From commencement and throughout the term of this Agreement the Contractor must have systems in place to consistently engage with patients, particularly vulnerable groups and those with protected characteristics. This should include digital mechanisms. Activities can include, but not be limited to:
			- 1. Engagement with the patient participation group (PPG virtually or face-to-face),
				2. By letter, leaflets, posters or the practice website, or waiting area display screen;
				3. At patient health promotional events (virtual or face-to-face);
				4. Appropriate digital mechanisms including social media, SMS text messaging, email
		5. Work collaboratively and effectively to:
			- 1. Provide partnership working with patients and where appropriate, system partners to ensure they have the opportunity to influence and inform service design and delivery, ensuring services continue to be appropriate and responsive to clinical need.
				2. Provide partnership working with patients and where appropriate, system partners to ensure an effective, open and transparent process to monitor, review and act on patient feedback;
				3. Provide partnership working with patients and where appropriate system partners to ensure engagement with the specific local community groups, community leaders and system partners involved in support of vulnerable patients and those with protected characteristics.
				4. Provide partnership working with patients and where appropriate system partners to ensure engagement with the specific local community groups, community leaders and system partners involved in the support of hard to reach groups
				5. Develop knowledge of local resources and foster a good understanding of the local Patient care pathways to promote effective referrals and to participate in the local Active Signposting Initiative;
				6. Provide analysis in the form of a report at each reporting period, on all patient engagement undertaken and the outcomes in line with Schedule 6 to this Agreement.

## Improved Patient Satisfaction

* + 1. The Contractor must monitor and evidence improved patient satisfaction with service delivery throughout the term of the contract and must demonstrate what processes are in place to do this. The Contractor must monitor and take action to improve against the following measures:
			- 1. Patient Experience Survey (PES) (or its equivalent)
				2. Friends and Family Test
				3. Patient complaints
				4. General patient feedback/satisfaction
		2. In order to monitor, promote and measure patient satisfaction, the Contractor must work with its Patient Participation Group (PPG).
		3. In line with Schedule 6 to this Agreement the Contractor will be required to:
			- 1. Discuss planned patient engagement at Reporting Period KPI Review meetings; and
				2. Prepare and submit an annual report detailing the type and outcome of all engagements within the preceding year; The Annual Report should include a thematic analysis, organisational/individual learning and improvements implemented to improve patient care and must be published on the practice website.
		4. The Commissioners at its discretion may undertake patient engagement which could include ‘drop-in’ type listening booth sessions with patients held within the practice waiting room.

## Staff development & satisfaction:

* + 1. The Commissioners engagement with patients identified that they value practice staff who:
* display empathy for patients
* have a cultural awareness of patients
* show patients respect
* understand the patient’s needs
* act professionally at all times
	+ 1. The National Plan identifies a key priority of ‘*Backing the Workforce’.* The Commissioner recognises that a valued, supported and developed multi- skilled workforce is required to meet the requirements of this APMS Agreement.
		2. The Commissioner recognises that a time-limited APMS Agreement includes transfer and change for staff at regular intervals which can be unsettling. Similarly service delivery can be significantly affected by a reduction in staff satisfaction.
		3. In line with paragraph 13 of this Agreement the contractor must ensure that all staff have access to appropriate training and development to undertake their individual duties.
		4. The Contractor must develop and implement a programme to support all staff holistically, to promote greater satisfaction and confidence, including but not limited to:
			1. Transfer of employment on commencement and at end of the contract term (TUPE);
			2. Personal Development and Appraisal;
			3. Improved customer services management;
			4. Improved conflict resolution, i.e.: dealing with difficult situations/patients;
			5. Improved support to vulnerable patients, i.e. Learning Disability;
			6. Improved management of complaints and Investigations
			7. Improved Active Signposting
		5. The contractor must have an effective process to engage and involve staff in all changes to service delivery within the practice; Staff should have opportunities to comment on changes, both in person and anonymously if they prefer.
		6. The contractor must ensure regular practice wide staff meetings are held and that discussions are recorded via minutes, with Complaints & Significant Event Learning included as key agenda items;
		7. The contractor must implement a process to monitor staff satisfaction commencement ensuring that the outcomes, analysis and actions taken following the process are discussed with the commissioner at Annual Review (Schedule 6 applies).

# PART 4: QUALITY, GOVERNANCE & ASSURANCE

## Quality Assurance

### The must:

* + - 1. Operate an effective, comprehensive, System of Clinical Governance with clear channels of accountability for risk management, supervision and effective systems to reduce the risk of clinical system failure;
			2. Operate an effective, comprehensive, System of Integrated Governance;
			3. Have General Practitioner leadership in place
			4. Nominate a Senior GP Lead who will have responsibility for ensuring the effective operation of the System of Clinical Governance and who is accountable for any activity carried out on a Patient;
			5. Continuously monitor clinical performance and evaluate serious incidents, other incidents or untoward events and near misses arising from any activity and update the Commissioner within 24 hours of the incident,
			6. Use appropriate formal methods such as root cause analysis for untoward incidents, near misses and complaints;
			7. Undertake regular and robust auditing of clinical care against clinical standards with frequent auditing of the quality of consultations to ensuring appropriate reporting is available for discussion at performance monitoring meetings in line with Schedule 6 to this Agreement.
			8. Comply with the Commissioner’s governance requirements and inspections, and, make available on reasonable notice to the Commissioner, any and all Contractor records (including permitting the Commissioner to take copies) relating to Contractor clinical governance to enable the Commissioner to audit and verify the clinical governance standards of the Contractor;
			9. Participate and comply with all quality and clinical governance initiatives agreed between the Commissioner and member GP practices.
			10. Participate and comply with CQC visits, notifying the Commissioner of any required actions.

## Due Diligence

* + 1. The Contractor must undertake its own due diligence review following commencement of the contract to ensure the appropriate quality and safety of patient care is maintained. The Contractor must notify the Commissioner of any issues highlighted and provide action plan for mitigation of all risks.
		2. The Contractor will be required to establish and implement robust protocols and processes to ensure patient safety, safe system and clinical management in line with national and local standards; however, specific priority and written assurance must be given on the following:
			1. Management of Pathology results;
			2. Repeat prescribing process;
			3. Management of long-term conditions;
			4. Medicine Review
			5. Public Health Immunisation and Screening Services;;
			6. Continuity of clinical care and choice of Provider;
			7. Provision of home visiting;
			8. Provision of services to care homes;
			9. Management of the registered list;
			10. Mental Health;
			11. Palliative Care, including cooperation/liaison with HM Coroner;

## Safeguarding

* + 1. The Contractor must deliver appropriate and responsive care to all children and vulnerable adults in line with all national legislation, guidance and local policy and procedure:
		2. The Contractor must have a named safeguarding practitioner for the practice;
		3. The Contractor must maintain a robust and safe recruitment process, ensuring all staff have appropriate up-to-date job descriptions and person

specifications which are specific to individual roles and which identify the level of safeguarding training required for that role.

* + 1. All clinical staff must have received training appropriate to their role; Contractor must implement robust process for monitoring training needs for all staff,
		2. The contractor must have a clearly defined and understood policy in place regarding safeguarding children; young people and adults at risk that also addresses issues of domestic abuse and Prevent and the Mental Capacity Act. These policies must be in accordance with the local multi-agency policies and procedures as per paragraph 4.3.6. All policies must be reviewed and updated in line with national policy / local requirements.
		3. The Contractor must adhere to Local Safeguarding Children’s Board/Safeguarding Adults Board Policies found at:

<http://llrscb.proceduresonline.com/index.htm> &

[www.llradultsafeguarding.co.uk](http://www.llradultsafeguarding.co.uk/)

* + 1. The Contractor must provide the Commissioner with full assurance on its safeguarding process in line with the locally agreed principles and by completing and submitting the Safeguarding Assurance Tool (SAT) confirming it is compliant with all standards required, within 4 weeks from commencement of services:

## Good Clinical Practice

* + 1. The Contractor must perform the Services in accordance with this Agreement and the following requirements as amended from time to time:
			1. Care Quality Commissions ‘Essential Standards of Quality & Safety’ found at:

<http://www.cqc.org.uk/content/guidance-providers>

* + - 1. The ‘Good Medical Practice for General Practitioners’ RCGP (2008) Found at:

[http://www.rcgp.org.uk](http://www.rcgp.org.uk/)

* + - 1. Any relevant MHRA guidance, technical standards, and alert notices;
			2. The General Medical Council guidance on Good Medical Practice (2013). Found at:

<http://www.gmc-uk.org/guidance/good_medical_practice.asp>

* + 1. The Contractor will deliver healthcare to nationally consistent quality and safety standards as lie out in statute from time to time, and must achieve registration with the CQC (Care Quality Commission) for the service.
		2. The Contractor will do this in a way that makes best use of its financial resources by following good business practice to ensure it can respond to the unexpected without jeopardising services, and introduce changes where services need to be improved.
		3. The Contractor must comply with the Essential Standards of Quality and Safety (Section 20 of the Health and Social Care Act 2012) and NHS England, Social Care England and Public Health England Registration Regulations. The Contractor will be required to meet and deliver on these Standards and will be monitored against them as well as any updated national monitoring matrices.

## Clinical Governance

* + 1. The Contractor will ensure all procedures are carried out in line with the Commissioning authority guidelines. Every primary care NHS organisation in England is responsible for ensuring that it is complying with the Department of Health’s core standards, as detailed above 3.5.1(a). Also refer to the CQC GP Provider Handbook.

<https://www.cqc.org.uk/guidance-providers/gps>;

* + 1. The Contractor must carry out clinical audits to ensure compliance with national and local standards and guidance, the achievement of patient treatment outcomes and any other reasonable requests for clinical audits made by the Commissioners.
		2. Clinical governance is about ensuring all health care Contractors are able to deliver high quality care, able to learn from audit and errors, and where all practitioners and staff are encouraged to develop their skills and expertise. The must identify a clinical governance lead from Commencement and demonstrate how clinical governance will be maintained. The clinical governance lead will be responsible for maintaining key patient safety mechanisms including:
			1. Health Care acquired infections
			2. Safeguarding children and vulnerable adults
			3. Accident reporting
			4. Clinical Incident reporting and management
			5. Risk management
			6. Clinical effectiveness
			7. Compliance with Safety Alert Broadcasts
			8. Clinical supervision
			9. Whistle blowing
			10. Mechanism for patient complaints, concerns and experience
			11. Identification of a Caldecott Guardian
		3. The Contractor will ensure that robust clinical governance processes are in place to include:
			1. Clinical governance lead
			2. Incident reporting – including the notification of all incidents to the Commissioner and other bodies in line with the NHS serious incident framework;
			3. Infection control
			4. Significant Incident/event analysis
			5. Complaints
			6. Managing alerts
			7. Quality assurance
		4. The Clinical Governance lead must put in place a system which is defined by the level of risk and manages incidents in an appropriate timeframe; ensuring that procedures and protocols are being effectively applied (with evidence) and that, if not, effective rectification action is taken. Records in relation to on-going clinical governance activity must be made available to the Commissioner must ensure that Health and Safety and Clinical Risk Assessments are carried out within 1 month from commencement and at determined intervals thereafter to ensure effective risk management; and that a risk management plan is fully documented and discussed at Commissioner Review Meeting.

## Unwarranted Clinical Variation/Efficiency

* + 1. The Commissioner and the other local CCGs are committed to strengthening and improving the quality of general practice and reducing variation to tackle the challenges that lie ahead. It is critical that both practice and system wide resources, such as population health management, risk stratification tools etc., are used effectively on behalf of registered patients and that this becomes a core element of general practice, and is not viewed as an optional extra.
		2. The provision of consistent, high quality primary care is essential to reduce costs and improve efficiency, and sets the standard for the whole health economy.
		3. The Contractor must have appropriate clinical systems and processes in place for acting on diagnostic information in a timely and appropriate manner.

## Quality and Outcomes Framework (QOF)

* + 1. The Contractor must comply with the Quality & Outcomes Framework which is intended to measure, encourage and support clinical care and Patient experience which is constantly improving. The framework sets out a range of national standards based on the best available research evidence.
		2. The Contractor must participate in the current and any future Quality and Outcomes Framework (QOF), as laid out in the APMS contract, in line with national guidance.
		3. Contractor must implement robust systems to achieve an overall improvement Qof Achievement annually throughout the term of the Contract term; achieving no less than **97%** minimum of the agreed Quality & Outcomes Framework points annually.
		4. The Contractor must minimise exception reporting and improve prevalence rates on practice registers.
		5. The Quality & Outcome Framework (QOF) is reviewed annually via the Calculating Quality Reporting Service (CQRS). The Contractor will be expected to comply with the QOF validation process and Post Payment Verification Process as required.

## Complaints

4.8.1 The Contractor must ensure that complaints are dealt with in accordance with Schedule 5 to this agreement.

4.8.3 The Contractor must report on number of complaints received within the preceding Reporting Period and must publish annually an overview of the patient complaints themes/actions taken in line with Schedule 6 of this Agreement. The Annual Report must demonstrate analysis, organisational/individual learning and improvements in care.

## Serious Incident reporting

* + 1. All patient safety incidents and near misses must be reported using the incident reporting process via the NRLS website: <https://report.nrls.nhs.uk/nrlsreporting/>To ensure and contribute to National learning
		2. All aspects of the NHSE SI framework must be adhered to as well as the local LLR policy

([https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-](https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf) [upd.pdf](https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf))

* + 1. The Contractor must adhere to NHSI Never events policy which can be found at:

<https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf>

* + 1. If a Serious Incident (definition according to the national SI policy) occurs it will be reported immediately to the patient safety lead lcrsi@nhs.net
		2. The Contract must comply with paragraph 55 to this Agreement in its co- operation with investigations. A full investigation must take place using a recognised investigation methodology. A full report of this including analysis and recommendations to reduce the risk of recurrence must be submitted to the Commissioners at their request. Patients and their relatives must be invited to input in line with best practice.
		3. Duty of Candour must comply with CQC regulation 20 and any breaches reported to the Commissioner.
		4. The Contractor must have a system in place to analyse the type, frequency and severity of incidents, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt to mitigate the risk of recurrence and to indicate changes that might lead to future improvements. This must be discussed at performance reviews in line with Schedule 6 to this Agreement.
		5. Most problems affecting patient safety and information safety occur as a result of weaknesses in systems and processes, rather than the acts of individuals. The Contractor must ensure that incidents are, investigated and analysed so that lessons are learned and that actions identified are followed up/evidenced. This should include using ‘just culture methodology’ avoiding individual blame

## Care Quality Commission (CQC)

* + 1. The contractor must apply to register with the Care Quality Commission prior to commencement of services and provide the Commissioner with evidence of CQC registration as soon as this is achieved.
		2. The Contactor must comply with paragraph 45 to this Agreement and allow entry to the premises by the Care Quality Commission. Notifying the Commissioner thereafter of any issues raised during the visit and any identified actions required to address such issues.
		3. Following publication by the Care Quality Commission of the outcome from the visit the Contractor is required to display the inspection outcome prominently in their waiting room(s) and on the practice website.

## Infection Prevention and Control

* + 1. The Contractor must have in place robust infection prevention and control (IPC) procedures in line with the Health and Social Care Act 2008 and the Code of Practice on the Prevention and Control of Infections.

[https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/44904](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf) [9/Code\_of\_practice\_280715\_acc.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf)

* + 1. Regular Infection Control Audits must be carried out by the Contractor for each service/premises and appropriate actions must be implemented. The Contractor will be required to report and evidence on the audits undertaken and all actions implemented under the performance monitoring process detailed in Schedule 6 to this Agreement.

## Risk Management

* + 1. The Contractor must:
			1. Develop and implement robust mechanisms for the identification and management of risk;
			2. Develop and implement robust disaster recovery, contingency and business continuity plans, including succession planning;
			3. Keep the Commissioner fully informed during mobilisation and Reporting Period Review meetings about the:
				1. Contractor’s approach to risk management (risk philosophy) including the risk the contractor is willing to bear before taking action and what processes are implemented;
				2. detail of the risk management structures and processes that exist and how they are implemented; and
				3. Notify the Commissioner about the resource allocation to risk management (existing/planned) and to put in place individuals for the leadership roles set out in Clause 4.5.5 of this Agreement.

## Health and safety at work

* + 1. The Contractor must have a health and safety policy that complies with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1992). The contractor must ensure that the health and safety policy includes:
			1. The written statement (as required by section 2(3) of the Health and Safety at Work Act 1974 and regulation 4 of the Management of Health and Safety at Work Regulations 1992) (or EU member state equivalent) of the organization
			2. The name and status of the person responsible for the implementation of the organisation’s health and safety policy
			3. A description of how the contractor will manage its obligations in respect of health and safety at work
			4. A description of how health and safety responsibilities are allocated within the organization
			5. The contractor must provide an overview of their approach to health and safety which includes a description of its approach to managing
			6. Health and safety risks and improvement measures
			7. Working Time Regulations and safe systems of work
			8. Staff consultation and counselling
			9. Safety audit
			10. Accident reporting
			11. Health and safety record keeping and reporting.