NHS
Ashford Clinical Commissioning Group

NHS
Canterbury and Coastal
Clinical Commissioning Group

NHS

Diagnostic Tests
Direct Access Magnetic Resonance Imaging Service

Service Specification

May 2017

FINAL v1.4

Section 1

Section B –Service Specification

Section 1 INDEX

SECTION B PART 1 - SERVICE SPECIFICATION

Service: Diagnostic Services – Direct Access Magnetic Resonance Imaging Service Specification

Service Specification No.	Diagnostics
Service	Diagnostic Services – Direct Access Magnetic Resonance Imaging Service
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

B1_1.0 Population Needs

The Commissioner supports the need to continue access to diagnostic tests as part of the drive to reduce waiting times and improve choice options for patients. The need to develop community based diagnostic services is supported by the Royal College of Radiologists and Royal College of General Practitioners as part of a service strategy to improve access to tests and ensure these tests are delivered at the right stage of the patient care pathway. The overarching aims of the service are:

- To ensure patients receive the right test at the right time and in the most clinically appropriate local setting;
- To ensure diagnostic testing is integrated across pathways of care, that the report and/or images follows the patient and that there is no unnecessary duplication of investigation;
- To enable patients and referring clinicians to access a choice of provision according to Patient choice, clinical need and relevant care pathway; and
- To ensure diagnostic tests are appropriate, necessary, clinically correct, of high quality, with timely access and reporting.

To develop local service provision as part of a diagnostic commissioning plan which aims to improve access and choice for Patients.

B1_2.0 Scope

B1_2.1 Aims and objectives of service

A local, direct access MRI service with staff qualified to appropriate levels of skill and experience, using equipment which complies with the guidance set by the Royal College of Radiologists, connection to NHS image transfer solutions, the ability to integrate with the E-Referral system, robust performance management systems and stringent levels of clinical governance.

The care pathway being commissioned is pre-appointment communication with Patients, the diagnostic investigation and a report being sent to the referrer which covers not only the description of the investigation and the findings, but also covers a brief recommendation on a proposed management plan for the Patient, meeting the clinical request of the referrer. Structured reporting will be encouraged to support local referrers in their options for further clinical management. The service will need to be fully quality assured, validated and supported by the local Commissioners.

The Provider must aim to provide an excellent Patient experience during all parts of the process – to include the examination and the administrative services. In order to measure this, Providers should have in place robust mechanisms for collecting Patient feedback using approaches that reflect the diverse nature of their Patient population. This should include as a minimum, a Patient satisfaction survey, and one real time feedback mechanism. There must be a sound process for receiving and dealing with suggestions, compliments and complaints.

The aim of the service is to aid early diagnostics and avoid the need for unnecessary referral to secondary care, or to support the shift of activity in to a primary care setting. It is important that the use of MRI is governed by evidence-based guidelines for determining the diagnostic examination to optimize imaging of certain conditions and reduce radiation dose where possible.

B1_2.2 Service description/ care pathway

B1_2.2.1 Referral

- Referral should ideally be via the E-Referral system. As a minimum referrals should be sent by secure nhs.net email. Providers would be expected to aim to be connected to the E-Referral system (directly or indirectly bookable) at the earliest opportunity.
- It is anticipated that the majority of referrals will be direct from General Practitioners or a Clinical Assessment Service.

- The Provider must have a clinical triage process to ensure appropriateness of referral. The Provider will be required to agree guidance with the Commissioner on what is excluded – for example pacemakers and aneurysm clips – and will be required to monitor referrals and exclude as appropriate within 1 working day;
- The Provider must provide literature for inclusion in the CCGs guidance, to assist GPs and referrers in the decision making processes' associated with the most suitable type of diagnostic test for the Patient and the presentation that will achieve the best and quickest diagnostic outcome;
- Patients should be contacted within a maximum of 5 working days of acceptance of referral;
- The Patient should be offered a choice on day and time of appointment that is convenient to them;
- The Provider should ensure Patients have an adequate understanding of the proposed MRI scan before the appointment by providing written information in advance that explains the purpose of the scan, what it involves and when and how they can expect to receive the results. At this early contact point the provider should seek permission/consent from the patient so that in the event of a serious unexpected finding they have a contact number to phone for patient/ carer (See section on unexpected radiological findings); this information should be reinforced on arrival at the appointment consistent with the written information already received.
- The Provider shall not discriminate between or against Patients or Carers on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristics. The Provider shall provide appropriate assistance and make reasonable adjustments for Patients and Carers who do not speak, read or write English or who have communication difficulties. To ensure the provider does not inadvertently discriminate against patients who suffer with significant claustrophobia or anxiety around MRI tests; the provider shall ensure patients with anxiety claustrophobia have the opportunity to be shown around the MRI scanner and ask answer simple questions to alleviate anxieties.
- The Provider will provide to the Commissioner, detailed referral statistical information on referrers, referring organisation, service utilisation and clinical outcome to allow refinement of the clinical pathway.

B1_2.2.2 Assessment

- Scanning should be undertaken within 10 working days of acceptance of referral and at an absolute maximum of 20 working days (4 weeks);
- During the appointment, the radiographer should work in partnership with the Patient to understand their jointly agreed outcome expectations; and
- The Provider should not impart the results of the diagnostic to the Patient at the time of the investigation, but should explain that the diagnostic report will be sent to the doctor who referred the Patient.

B1_2.2.3 Report

- The provider shall provide waiting and reporting times for MRI scans monthly or a method for the CCG to obtain live wait times; for inclusion in the CCGs guidance.
- A written clinical report should be sent to the referrer within 2 working days following the MRI scan and maximum of 5 working days. The information should be communicated electronically via a secure network.
- For MRI scans requested by a GP, the provider should utilise a text alerting system to inform patients that their MRI scan has been reported and that they should now make a routine appointment with their GP to run through the findings.
- The Provider will ensure that the radiology report is produced according to the standards of the Royal College of Radiologists and as updated from time to time in the formal agreed with the Authority; and
- The report will provide the referrer with a differential diagnosis wherever possible – this will be based upon the presenting complaint described in the referral and the objective findings of the scan.
- If the radiographer requires input from a Consultant Radiologist, this should be available within 24 hours of the investigation.
- GPs or other clinical staff wishing to discuss individual cases will be provided access to the reporting radiologist through a central contact number or secure (nhs.net) email address; with response within 7 days. The Provider should ensure appropriate annual leave cover if the reporting radiologist goes on leave.
- Patients with a suspected cancer are specifically excluded from this service however there will be occasions when a diagnostic reveals a high risk Patient. In these instances the provider must ensure the report is expedited for onward communication - both referrer and the patient are to be alerted based on a risk stratification grading:

    1. ***VERY URGENT*** *– unexpected potentially life threatening finding might be pulmonary embolus, very large aortic aneurysm (>8cm)*
       Action: *Immediate notification and organisation of hospital assessment by the provider.*
    2. ***URGENT*** *– Unexpected requiring treatment or referral within days / weeks – e.g. a suspected cancer.*
       Action: *Return report and telephone GP within 3 working days. The provider is to contact the patient and request they make an urgent GP appointment.*
    3. ***Abnormal*** *– Abnormal finding requiring follow up within a number of weeks*
       Action: *Return report to GP.*
    4. ***Within physiological parameters*** *– Anomalies not likely to be of clinical significance.*
       Action: *Return report to GP.*

- The image and report is stored in electronic format, in accordance with the standards of The Royal college of Radiologists via a Picture Archiving and Communications System (PACS) system; and
- The image and report is electronically forwarded, at no charge, to other Providers of NHS funded treatment applicable to the Patient care pathway, within a maximum of a week of the request and sooner if necessary to correspond with patient care needs. This will require connection to the National Image Exchange Portal (IEP).

B1_2.3 Population Covered

Patients registered with GPs in the Canterbury and Coastal CCG & Ashford CCG catchment areas

B1_2.4 Any acceptance and exclusion criteria

B1_2.4.1 Acceptance Criteria

The MRI casemix and examinations will follow the guidelines defined in Making Best Use of Radiology Departments (MBUR6) Version 6 or as updated. The activity output should indicate the area of the body examined aggregated by the following HRG codes.

Table 1: HRG Codes

HRG Code	Description
RA01Z	Magnetic Resonance Imaging Scan, one area, no contrast agent
RA04Z	Magnetic Resonance Imaging Scan, two - three areas, no contrast agent
RA06Z	Magnetic Resonance Imaging Scan, more than three areas

B1_2.4.2 Exclusion Criteria

Clinical exclusions

Cancer – any Patient with suspected cancer should be referred through the two week wait referral pathway;

Patients with a Body Mass Index exceeding the manufacturer's health and safety guidance on weight limits for the MRI unit or couch - the provider should have a referral mechanism for patients over a certain BMI to have access to different scanning techniques.

Patients with implanted medical devices are MRI contraindicated and in certain cases MRI conditional. The referrer has a responsibility to provide information on all such devices, but the final responsibility for safety rests with the Provider in line with Provider protocols and relevant safety guidelines and resources.

Other exclusions

- Children under the age of 18;
- Patients requiring a general anaesthetic;
- Scans requiring the use of contrast;
- Hospital inpatients; and
- Non-NHS Patients.

B1_2.5 Interdependencies with other services

The Provider needs to develop their relationships with other Providers to become an integral member of the Health and Social Care Community. This includes third sector organisations providing help and support for Patients. The development of local clinical networks will be encouraged with the aim of providing parallel services, which provide complementary services allowing for further clinical services to be offered closer to home and within the community. The role of service users as key stakeholders will be

an important component of this development and Providers should ensure effective mechanisms for their involvement and develop a positive relationship with the local involvement network (Healthwatch).

The Provider will be required to be involved in local care pathway discussions and work, ensuring the best and most efficient means of treating Patients is adopted, including the electronic movement of all the relevant clinical information (i.e. images and clinical output report).

B1_3.0 Applicable Service Standards

B1_3.1 Applicable National Standards

- Right Test, Right Time, Right Place - Royal College of Radiologists and Royal College of General Practitioners (2006).
- Making the Best Use of a Department of Radiology, 6th edition (MBUR6) - Royal College of Radiologists (2007).
- Standards for the communication of critical, urgent and unexpected significant radiological findings - Royal College of Radiologists (2008).t vv
- Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use – MHRA Device Bulletin (2007).

This is intended as a non-exhaustive list. Clause [16] takes precedence

B1_3.2 Applicable Local Standards

B1_3.2.1 Staffing

The Provider shall ensure that the service is delivered by Staff who meets the following service requirements:

- UK Registered Radiologists on the GMC Specialist Register who have reported on a minimum of 1000 MRI scans in the in the last 12 months. Cases should be of the anticipated referral case mix.

Table 2: Minimum number of diagnostic reports

Subspecialty	Minimum number of diagnostic reports produced in the last year for the required anatomical area by the Reporting Clinician
Neurology	250
Head and neck	150
Abdomen and Pelvis	350

Subspecialty	Minimum number of diagnostic reports produced in the last year for the required anatomical area by the Reporting Clinician
Musculoskeletal	500
Vascular and MRA	200

- UK Registered Radiographers who have:
  - A minimum of 1 years' experience;
  - Undertaken a minimum of 900 MRI examinations per annum;
  - Assurance of competency assessment and up to date Continuous Professional Development; and
  - Meet the specification set out in the 'National Occupational Standards for Imaging' (RD5- Produce MRI images for diagnostic purposes).

Staff will have English as a first language or have passed a suitable English language examination to the level of requirement set out on the Health Professions Council website

(**http://www.hpc-uk.org/apply/international/requirements**).

B1_3.2.2 Equipment

The Provider shall provide equipment that meets or exceeds the following:

- Fixed or mobile units shall contain one full body MRI scanner with a magnetic strength of at least 1.5 Tesla;
- Complies with the Guidelines for Magnetic Resonance Equipment in clinical use, MHRA (2007) as updated, superseded and replaced from time to time.
- Is a maximum of 7 years old; and
- Electrical Safety Testing is required annually with regular maintenance and quality assurance testing;
- Details of maintenance contracts to include regular and emergency service cover must be provided; and
- Replacement schedule must be available with the maximum age of equipment of 7 years.

B1_3.2.3 IM&T

Where data is transferred from the MRI Scanner to the Provider's PACS or image store the removable media device must have encryption software. Standard operating procedures for handling the data will be implemented as required by the commissioner.

Provision of Digital Data between the Provider PACS systems should be through the Image Exchange Portal or other data sharing systems to other providers as specified by the commissioner, or in clinical circumstances that require the transfer of the image to support the safe treatment of the patient. For MRI this should be the provision of Digital Medical Image transfer to the PACS Cluster or local Data stores using DICOM V3.0, HL7 v2.3/3.0 integration profiles including the provision for images to be marked for teaching purposes as defined in IHE (UK) IP6.

The Provider should aim to work towards the ability to support the booking of appointments and receipt of referrals from local commissioners by either indirectly or directly bookable E-Referral Services

In the event of cancellation of the contract (for whatever reasons), the Provider will be required to maintain systems to allow continued access, in a timely manner, to all of the patient information, images and associated patient records.

B1_3.2.4 Facilities

- Commissioners will consider mobile or static sites.
- All facilities, including mobile units, must have a minimum of a patient reception and waiting area –either on the unit or nearby, access to a toilet and access to appropriate levels of security.

B1_3.2.5 Quality Assurance

The proposed Quality Assurance process must include, as a minimum:

- Radiographers have a duty to maintain their statutory registration – this must be renewed on a two year cycle and requires evidence of relevant Continuing Professional Development;
- Ongoing 5% blind audit of image and report review for each radiographer and radiologist - exact mechanism to be agreed with Commissioner;
- Participation in ‘errors meetings’ or similar clinical governance processes.
- The recall rates for Patients (annual report) and the reasons.
- Monthly image reject analysis (including breakdown of the reason and at what stage the rejection occurred (e.g. triage, etc).

B1_4.0 Key Service Outcomes

Table 3: Key service outcomes

Key Service Outcome	Method of Measurement
Patients reporting a good level of satisfaction of the service.	Patient Satisfaction Survey to be sent to a minimum of 95% of Patients using the service, with a minimum response rate

Key Service Outcome	Method of Measurement
	target of 30%. Target of 95% of Patients reporting good level of overall satisfaction.
Reduced referral to secondary care and improved conversion rate – as proxy for increased appropriateness of referrals.	Contract reporting dataset – using previous year as baseline.
Image and Report to follow Patient pathway – no repeat scanning without clinical rationale.	Commissioner to audit random sample – results to be extrapolated.
Improved targeting of referrals to right secondary care clinic first time – less Consultant to Consultant referrals.	Contract reporting dataset – using previous year as baseline.

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:

N/A

B1_6.0 Individual Service User Placement

N/A

SECTION B PART 2 - ESSENTIAL SERVICES

N/A

SECTION B PART 3 - INDICATIVE ACTIVITY PLAN

B3_1.0 Indicative Activity Plan

N/A

SECTION B PART 4 - ACTIVITY PLANNING ASSUMPTIONS

B4_1.0 Commissioning Ambitions based on Activity Plan

The commissioning intentions are to increase patient choice and improve the quality of service delivery across the health economy. It is not predicted that there will be an overall increase in activity or change in clinical demand.

B4_2.0 Capacity Review

N/A

B4_3.0 Prices and Payment

Table 4: Prices and payment

Providers will be paid as per national tariff, including appropriate local MFF.

SECTION B PART 5 - ACTIVITY MANAGEMENT PLAN

N/A

SECTION B PART 6 - NON-TARIFF AND VARIATIONS TO TARIFF PRICES

B6_1.0 Non-Tariff Prices

N/A

B6_2.0 Variations to Tariff Prices

N/A

SECTION B PART 7 - EXPECTED ANNUAL CONTRACT VALUES

N/A

SECTION B PART 8 - QUALITY

B8_1.0 Part 1 - Quality Requirements

Table 5: Quality Requirements

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	Patient Reported Satisfaction of an overall good experience of the service.	95% report overall satisfaction with the service.	Patient satisfaction survey to be sent out to a minimum of 95% of Patients, with a minimum response rate of 30%.	Remedial Action Plan.
	Reduced referral to secondary care and improved conversion rate as a proxy for increased appropriateness of referrals.	Previous year as baseline.	Contract reporting dataset	Remedial Action Plan.
	Improved targeting of referrals to right secondary care clinic first time – less consultant to consultant referrals.	Previous year as baseline.	Contract reporting dataset	Remedial Action Plan.
	Provider failure to ensure that 'sufficient appointment slots' are made available on the E-Referral system.	No more than 95% appointment slots booked to ensure availability.	TALs List.	Remedial Action Plan.
	Percentage of referrals received via the E-Referral	Minimum 40%	Monthly Performance Report.	Remedial Action Plan.

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	system.			
	Rejections – total number of referrals rejected by Provider.	Maximum 15%	Monthly Performance Report.	Remedial Action Plan – to work with Primary Care to improve the quality, appropriateness and completeness of referrals.
	Number of Patients who have a repeat activity as a result of any incorrectly or inadequately performed activity (expressed as a percentage of the total number of activities).	No greater than 1%	Monthly Performance Report.	Repeat activity to be provided at no cost to the NHS.
	Provider will provide triage of referrals to meet referral criteria and accept or reject a referral within 1 working day.	98%	Monthly Performance Report	Remedial Action Plan
	Initial communication to patient within 5 days of acceptance of referral.	95%	Monthly Performance Report.	Provider to provide patient scan at no cost to the NHS.
	Patient offered choice of appointment date and time that is convenient to them.	95% of patients to be offered choice.	Patient Satisfaction Survey.	Remedial Action Plan.
	Investigation undertaken within 10 working days of	Minimum 80%	Monthly Performance Report.	Remedial Action Plan.

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	acceptance of referral.			
	Investigation undertaken within 20 working days of acceptance of referral.	100%	Monthly Performance Report.	Exception reporting (patient choice/Holiday etc) and/or Remedial Action Plan.
	Report of investigation to be sent to referrer within 2 working days of investigation.	Minimum 80%	Monthly Performance Report.	Remedial Action Plan.
	Report of investigation to be sent to referrer within 5 working days of investigation.	100%	Monthly Performance Report.	Remedial Action Plan.
	Non-attendance: Percentage of referrals not completed due to patient DNA or late cancellation.	No more than 2.5%	Monthly Performance Report.	Remedial Action Plan.
	Provider cancellation of appointment for non-clinical reasons either before or after Patient arrives for investigation.	No more than 0.8%	Monthly Performance Report.	Non-payment for non-investigation.
	Patient waiting more than 30 minutes after appointment time before start of investigation activity (measured as a	No more than 5%.	Monthly Performance Report.	Remedial Action Plan.

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	percentage of all Patients scanned).			
	Complaints register to be provided every month.	No more than 5% of complaints substantiated.	Monthly Complaints Register.	Remedial Action Plan.
	A minimum of one GP satisfaction survey will be designed and sent to all referring GPs annually. 85% of GPs sampled should report overall satisfaction with service and action plan produced if response rate is below 30%.	85%	Annual Referrer Satisfaction Survey Report.	Remedial Action Plan.

B8_2.0 Nationally Specified Events

Table 6: Technical Guidance Reference - nationally specified event

Technical Guidance Reference	Nationally Specified Event	Threshold	Method of Measurement	Consequence per breach

B8_3.0 Never Events

Table 7: National Definition (part of standard contract)

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)
Projectiles/Missiles: No ferromagnetic materials are to be brought into the MRI Scanner room.	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Contraindicated implants: No patient with any of the contraindicated implants (Pacers, stimulators, clips, pins, plates etc), will pass screening and enter the MRI room.	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
RF Burns: No patient will receive a burn from an inappropriate or inappropriately positioned coil or lead.	>0	Review of reports submitted to National Patient Safety Agency (or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with applicable Guidance, recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care
Unauthorized Access: No unauthorized persons to enter	>0	Review of reports submitted to National Patient Safety Agency	In accordance with applicable Guidance, recovery of the cost

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)
restricted areas in the MRI suite.		(or successor body)/Serious Incidents reports and monthly Service Quality Performance Report	of the procedure and no charge to Commissioner for any corrective procedure or care

SECTION B PART 9 - QUALITY INCENTIVE SCHEMES

B9_1.0 Part 1 - Nationally Mandated Incentive Schemes

N/A

B9_2.0 Commissioning for Quality and Innovation (CQUIN)

Table 1: CQUIN Scheme

N/A

Table 8: Summary of goals[1]

Goal Number	Goal Name	Description of Goal	Goal weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain (Safety, Effectiveness, Patient Experience or Innovation)
1		N/A			
2					
3					
4					
etc					
		Totals:			

Table 9: Summary of indicators

Goal Number	Indicator Number[2]	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
1		N/A		
2				
3				
Etc				
		Totals:		

1 The on-line standard template on the website of the NHS Institute for Innovation and Improvement contains some additional fields to assist its automated functions. Parties may include these additional fields in the completed version of the scheme included in the contract

2 There may be several indicators for each goal

Table 10: Detail of Indicator (to be completed for each indicator)

Indicator number	
Indicator name	
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	
Numerator	
Denominator	
Rationale for inclusion	
Data source	
Frequency of data collection	
Organisation responsible for data collection	
Frequency of reporting to commissioner	
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Table 11: Milestones (only to be completed for indicators that contain in-year milestones)

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
		Total:	

Table 12: Rules for partial achievement at final indicator period/date

Final indicator value for the part achievement threshold	% of CQUIN scheme available for meeting final indicator value

1. Subject to paragraph 2, if the Provider satisfies a Quality Incentive Scheme Indicator set out in Schedule 18 Part 2 Table 1, a Quality Incentive Payment shall be payable by the Commissioners to the Provider in accordance with this Schedule 18 Part 2.

2. The Commissioners shall not be liable to make Quality Incentive Payments under this Schedule 18 Part 2 to the Provider in respect of any Contract Year which in aggregate exceed the applicable Actual Outturn Value percentage for the relevant Contract Year set out below:

Table 13: Outturn Value percentage for the relevant Contract Year

Contract Year	Maximum aggregate Quality Incentive Payment
1st Contract Year	N/A

and for the avoidance of doubt this paragraph shall limit only those Quality Incentive Payments made under this Schedule 18 Part 2, and shall not limit any Quality Incentive Payments made under any Quality Incentive Scheme set out in Schedule 18 Part 1 or Schedule 18 Part 3.

3. The Provider shall in accordance with clause [33] of this Agreement submit to the Co-ordinating Commissioner a Service Quality Performance Report which shall include details of the Provider's performance against and progress towards the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in the month to which the Service Quality Performance Report relates.

4. The provisions set out in paragraphs 5 to 13 below apply in respect of Quality Incentive Payments made by monthly instalments. The provisions set out in paragraphs 14 to 19 apply in respect of Quality Incentive Payments made by a single annual payment.

Monthly Quality Incentive Payments

5. Where the Co-ordinating Commissioner and the Provider have agreed that Quality Incentive Payments should be made on a monthly basis by any Commissioners, then in each month after the Service Commencement Date during the term of this Agreement each relevant Commissioner shall make the default Quality Incentive Payment set out below to the Provider:

Table 14: Quality Incentive Payment

Commissioners	Monthly Quality Incentive Payment – 1st Contract Year
N/A	

In addition, the Provider and the Co-ordinating Commissioner may from time to time, whether as a result of a review performed under paragraph 6 below or otherwise, agree to vary the default monthly Quality Incentive Payment for any Commissioner set out above.

6. The Co-ordinating Commissioner shall review the Quality Incentive Payments made by the Commissioners under paragraph 5 on the basis of the information submitted by the Provider under this Agreement on the Provider's performance against the Quality Incentive Scheme Indicators. Such reviews shall be carried out as part of each Review under clause [8].

7. In performing the review under paragraph 6 the Co-ordinating Commissioner shall reconcile the Quality Incentive Payments made by the relevant

Commissioners under paragraph 5 against the Quality Incentive Payments that those Commissioners are liable to pay under paragraph 1 on the basis of the Provider's performance against the Quality Incentive Scheme Indicators, as evidenced by the information submitted by the Provider under this Agreement.

8. Following such reconciliation, where applicable, the Provider shall invoice the relevant Commissioners separately for any reconciliation Quality Incentive Payments.

9. Within [10] Operational Days of completion of the review under paragraph 6, the Co-ordinating Commissioner shall submit a Quality Incentive Payment reconciliation account to the Provider.

10. In each reconciliation account prepared under paragraph 9 the Co-ordinating Commissioner:

    10.1 shall identify the Quality Incentive Payments to which the Provider is entitled, on the basis of the Provider's performance against the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in those months of the relevant Contract Year that have elapsed at the time of the review;

    10.2 shall ensure that the Quality Incentive Payments made to the Provider in respect of completed Contract Years comply with the requirements of paragraph 2;

    10.3 may correct the conclusions of any previous reconciliation account, whether relating to the Contract Year under review or to any previous Contract Year; and

    10.4 shall identify any reconciliation payments due from the Provider to any Commissioner, or from any Commissioner to the Provider.

11. Within [5] Operational Days of receipt of the Quality Incentive Payment reconciliation account from the Co-ordinating Commissioner, the Provider shall either agree, or, acting in good faith, contest such reconciliation account.

12. The Provider's agreement of the Quality Incentive Payment reconciliation account (such agreement not to be unreasonably withheld) shall trigger a reconciliation payment by the relevant Commissioner(s) to the Provider, or by the Provider to the relevant Commissioner(s), as appropriate, and such payment shall be made within [10] Operational Days of the Provider's agreement of the reconciliation account and the Provider's invoice.

13. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment reconciliation account:

    13.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting such account, and in particular identifying which elements are contested and which are not contested;

    13.2 any uncontested payment identified in the Quality Incentive Payment reconciliation account shall be paid in accordance with paragraph 12 by the Party from whom it is due; and

    13.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 13.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

    and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 13 the relevant Party shall pay any amount agreed or determined to be payable.

Single annual payment of Quality Incentive Payments

14. Where the Provider and Co-ordinating Commissioner have agreed that one single Quality Incentive Payment should be made to the Provider by any Commissioner at the end of each Contract Year, then at the end of each Contract Year during the term of this Agreement each Commissioner set out in the table in this paragraph 14 shall, subject to the Provider's performance against the Quality Incentive Scheme Indicators, make a single Quality Incentive Payment to the Provider in accordance with the procedure set out in paragraphs 15 to 19 below.

Commissioners making single annual Quality Incentive Payment at the end of the Contract Year
N/A

15. The Co-ordinating Commissioner shall, within [10] Operational Days of the end of the Contract Year to which the Quality Incentive Payments relate or its receipt of final information from the Provider on its performance against the Quality Incentive Scheme Indicators during that Contract Year (whichever is the later),

submit to the Provider a statement of the Quality Incentive Payments to which the Provider is entitled on the basis of the Provider's performance against the Quality Incentive Scheme Indicators during the relevant Contract Year, as evidenced by the information submitted by the Provider under this Agreement.

16. Within [5] Operational Days of receipt of the Quality Incentive Payment statement from the Co-ordinating Commissioner under paragraph 15, the Provider shall either agree, or, acting in good faith, contest such statement.

17. The Provider's agreement of the Quality Incentive Payment statement (such agreement not to be unreasonably withheld) shall trigger a payment by the relevant Commissioner(s) to the Provider, and such payment shall be made within [10] Operational Days of the Provider's agreement of the statement and the Provider's invoice.

18. In the event that the Quality Incentive Payment under paragraph 17 is paid before the final reconciliation account for the relevant Contract Year is agreed under clause [7] (*Prices and Payment*) of this Agreement, then if the Actual Outturn Value for the relevant Contract Year is not the same as the expected Annual Contract Value against which the Quality Incentive Payment was calculated, the Co-ordinating Commissioner shall within [10] Operational Days of the agreement of the final reconciliation account under clause [7] send the Provider a reconciliation statement reconciling the Quality Incentive Payment against what it would have been had it been calculated against the Actual Outturn Value, and a reconciliation payment in accordance with that reconciliation statement shall be made by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate, within [10] Operational Days of the submission to the Provider of the reconciliation statement under this paragraph 18.

19. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment statement under paragraph 15 or reconciliation statement under paragraph 18:

    19.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting the relevant statement, and in particular identifying which elements are contested and which are not contested;

    19.2 any uncontested payment identified in the relevant statement shall be paid in accordance with paragraph 17 by the relevant Commissioner or the Provider, as the case may be; and

19.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 19.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 19 the relevant Party shall pay any amount agreed or determined to be payable.

B9_3.0 Locally Agreed Incentive Schemes

N/A

SECTION B PART 10 - ELIMINATING MIXED SEX ACCOMMODATION PLAN

N/A

SECTION B PART 11 - SERVICE DEVELOPMENT AND IMPROVEMENT PLAN

Service Development and Implementation plans will be initiated as required.

SERVICE USER, CARER AND STAFF SURVEYS

B11_1.0 Service User, Carer and Staff Surveys

The Patient Survey will need to be aligned to the existing National patient surveys in order to provide benchmarking opportunities, as a minimum. The survey must ask questions that clearly expose a patient's true experience of a service. For example, rather than asking whether patients received information prior to their appointment, it would be preferable to ask whether the information received was helpful, relevant and in a useful format. Surveys should also include an opportunity for patient to write free text. The best providers will use surveys developed by specialist, professional companies.

Patient Experience information can only be gained through a multitude of means which includes complaints, compliments, third sector feedback, online real-time feedback, clinical incidents, etc.

The specification stipulates that Providers 'should include as a minimum, a Patient satisfaction survey, and one real time feedback mechanism'. Examples of the latter would include signing up for Patient Opinion (www.patientopinion.org.uk), the use of hand held data collection equipment, and traditional methods such as suggestion boxes and comments books. The best providers may consider an annual 'diary entry' record for patients attending that day, or Critical Incident Interview techniques, linked in with local patient user groups to support patient involvement and service improvement activities

In addition to a patient satisfaction survey and annual GP satisfaction survey should be designed and sent to all referring GP's.

Staff surveys should be carried out as per providers existing policies and procedures.

SECTION B PART 12 - CLINICAL NETWORKS AND SCREENING PROGRAMMES

N/A

SECTION B PART 13 - REPORTING AND INFORMATION MANAGEMENT

All information gathered for the purposes of reporting is subject to the requirements set out in clause [27], (*Data Protection, Freedom of Information and Transparency*) and clause [56] (*Compliance with the Law*).

B13_1.0 National Requirements Reported Centrally

1. The Provider and Commissioner shall comply with the reporting requirements of the Contract reporting dataset and UNIFY2. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs), where applicable to the service being provided.

2. The Provider shall ensure that each dataset that it provides under this Agreement contains the Organisation Data Service (ODS) code for the relevant Commissioner, and where the Commissioner to which a dataset relates is a Specialised Commissioning Group, or for the purposes of this Agreement hosts, represents or acts on behalf of a Specialised Commissioning Group, the Provider shall ensure that the dataset contains the ODS code for such Specialised Commissioning Group.

3. The Provider shall collect and report to the Commissioner on the patient-reported outcomes measures (PROMS) in accordance with applicable Guidance.

4. The Provider shall comply with the national reporting requirements in relation to Sleeping Accommodation Breaches as set out in the Professional Letter.

B13_2.0 National Requirements Reported Locally

Providers should supply information as per DM01 reporting guidelines

B13_3.0 Local Requirements Reported Locally

Diagnostic data is not a mandated Commissioning Data Set (CDS) and will therefore not flow into SUS, so a local dataset will need to be specified that will enable linkage to other mandated CDS' and aid contract monitoring.

Commissioners should consider data that will identify patient demographics, referral information, diagnostic test data and outcome results.

Table 15: Data Quality Thresholds: Expected levels of completeness/validity

Data Item	Expected level of coverage Non SUS data (diagnostics)	Expected level of coverage (SUS submissions)
DOB complete/valid	99%	99%
First attendance	100%	100%
Attended/DNA	98%	98%
NHS Number**	97%	97%
Referral source	97%	97%
Organisation code code of referrer	98%	98%
Type of diagnostic test	99%	n/a

*= complete and valid codes
Default codes (V81997/V81998/V81999) not be counted as valid codes.
** if NHS number not given then patient name must be provided

The table below suggests some information that might be useful in monitoring a diagnostic contract, but local knowledge and experience should prevail

Table 16: Information to aid in monitoring a diagnostic contract

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
Demographic	NHS Number	E	To enable linkage to other providers on pathway	*10 digit NHS Number*
Demographic	Patient Date of Birth	D	To validate NHS Number on Summary Care Record	*Date format DD/MM/YYYY*
Referral	Unique referral identifier	E	To monitor repeat activity, if another attendance offered then same referral identifier should be used in second and subsequent attendances	*Format to be confirmed by diagnostic provider, but suggest numerical /integer*
Referral	Organisation code of referrer	E	Practice Code	*6 digit national GP practice code*
Referral	Organisation code of commissioner	D	PCT Code	*3 or 5 digit national code*
Referral	Organisation code of provider	D	Provider Code	*As per NHS Data Dictionary Coding Frames*
Referral	Date sent by referrer	E	To monitor time on pathway	*Date format DD/MM/YYYY*
Referral	Date received by provider	E	To monitor time on pathway, system delays	*Date format DD/MM/YYYY* *Date of referral is date the referral was received by the service*

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
Referral	Date referral accepted by provider	E	To monitor time on pathway, system delays	*Date format DD/MM/YYYY*
Referral	Referral source	E	Taken from NHS Data Dictionary definition	*Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *01 following an emergency admission* *02 following a Domiciliary Consultation* *10 following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)* *11 other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *03 referral from a GENERAL MEDICAL PRACTITIONER* *92 referral from a GENERAL DENTAL PRACTITIONER* *2 referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)* *4 referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)*

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
				05 referral from a CONSULTANT, other than in an Accident and Emergency Department *06 self-referral* *07 referral from a Prosthetist* *13 referral from a Specialist NURSE (Secondary Care)* *14 referral from an Allied Health Professional* *15 referral from an OPTOMETRIST* *16 referral from an Orthoptist* *17 referral from a National Screening Programme* *93 referral from a Community Dental Service* *97 other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode*
Referral	Test requested	D	Reason for referral, to check referral compliance	*Text field*
Attendance	Unique activity identifier	E	To separate multiple tests on same day. This is not the same as the unique referral identifier	*Format to be confirmed by diagnostic provider, but suggest numerical /integer*
Attendance	Date and time of diagnostic test	E	To monitor time on pathway, contract activity	*Date format DD/MM/YYYY hh:mm*

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
			reconciliation	
Attendance	Duration of attendance	E	To monitor contract activity	*Numerical/integer* *Number of minutes*
Attendance	First Attendance	E	To monitor contract delivery	*1 First attendance face to face (First Diagnostic)* *Follow-up attendance face to face (Repeat Diagnostic)* *3 First telephone or telemedicine consultation (N/A)* *4 Follow-up telephone or telemedicine consultation (N/A)*
Attendance	Type of diagnostic test	E	What diagnostic test / procedure did the provider perform? To monitor contract delivery	*OPCS4 codes or locally defined list?*
Attendance	Anatomical site	D	To monitor contract delivery	*Add the area of the body requiring diagnostic*
Attendance	Staff type seeing patient	E	To monitor contract delivery	*Lead Care Professional* *Member of Care Professional team*
Attendance	Attend / DNA	E	To monitor contract delivery	*5 Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT* *6 Arrived late, after the relevant CARE PROFESSIONAL was ready to see the*

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
				PATIENT, but was seen *7 PATIENT arrived late and could not be seen* *2 APPOINTMENT cancelled by, or on behalf of, the PATIENT* *3 Did not attend - no advance warning given* *4 APPOINTMENT cancelled or postponed by the Health Care Provider* *0 Not applicable - APPOINTMENT occurs in the future **
Attendance	Seen By	E	To monitor contract delivery	*Name of person completing*
Outcome	Patient Outcome	E		*1 Discharged from CONSULTANT's care (last attendance)* *2 Another APPOINTMENT given* *3 APPOINTMENT to be made at a later date*
Outcome	Date result reported	D	To monitor time on pathway, system delays	*Date format DD/MM/YYYY*
Outcome	Date result communicated to referrer	E	To monitor time on pathway	*Date format DD/MM/YYYY*
Contract	Currency type	E	Contract monitoring and reconciliation	*PBR/nonPBR?*
Contract	HRG	E	Contract monitoring and	*Refer to list of HRGs*

Type of collection	Data Type	Essential / Desirable	Comments	Format/definition
			reconciliation	
Contract	Base HRG cost	D	Contract monitoring and reconciliation	*Numerical/Decimal*
Contract	MFF cost	D	Contract monitoring and reconciliation	*Numerical/Decimal*
Contract	Total cost of diagnostic test provided	E	Contract monitoring and reconciliation	*Numerical/Decimal* *Zero cost for DNAs/Cancellations or repeat test for non-clinical reason*

B13_4.0 Data Quality Improvement Plan

A data quality improvement plan will be initiated as required.