Schedule 2

Service Specification

Part 1 - General Service Delivery Requirements

Reference: Clause 3.1

The following words shall have those meanings as described below for the purposes of this Schedule 2.

"Frontline Staff" means any staff or other persons engaged by the Contractor that have direct contact with patients.

"BNF" means British National Formulary.

1.0 Introduction and Overview

1.0.1 Significant progress has been made nationally to improve health outcomes for the population as a whole however; health inequalities remain for many socially excluded groups. Health inequalities amongst the homeless population are evidenced at both a National and Local Level, with evidence of significantly lower life expectancy and poorer health outcomes amongst people who are homeless[1].

1.0.2 Those who find themselves homeless are often extremely vulnerable with complex health and care needs and high levels of comorbidity including: physical, mental health and substance misuse needs.

1.0.3 They may be excluded from services or have difficulty engaging with mainstream services, relying instead on emergency or urgent care services such as: Accident & Emergency.

1.1 National context

1.1.1 The current Government has set a vision of an NHS modelled on integration, asking Health and Local Authorities to work more closely across the barriers of Primary and Secondary Care to provide seamless services for the population. This necessitates making the very best use of resources to improve health and

[1] https://www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2931869-X

wellbeing outcomes for the whole population. Part of this agenda is redesign of services to better support people with multiple or complex needs and through this it is anticipated there will be a reduction in reliance on emergency and urgent care services.

1.1.2 Another key element is to support patients to have more control over their care by empowering them to live independently, with the ability to make choices about the way their care is administered. There has also been an emphasis on collective leadership and joint working with a call for leaders from across Health, Social Care and the third[2] sector to jointly deliver solutions appropriate to their own communities.

1.1.3 Addressing Health Inequalities, supporting early identification of housing need and actively intervening to prevent homeless are all important national priorities.

1.2 London Context

1.2.1 In 2021/22 over 8,329 people were seen sleeping rough at some point in London. This is only the second time in the last ten years that there has been a year on year decrease in the total number of people seen rough sleeping[3].

1.2.2 52% of the people seen sleeping on the streets were not UK nationals, many of whom would have no recourse to public funds.[4] However all of these people are entitled to register with a GP practice and receive immediate treatment if it is necessary.

1.2.3 The Pan-London London Homeless Health Programme has published commissioning guidance for London for health services for people who are affected by homelessness. This includes 10 Commitments[5] listed below which will underpin the model of delivery of services for people who experience homelessness. The Commissioning Guidance was developed in response to issues identified by people who were homeless in London as reported in *More than a Statistic*[6]*;* a research and consultation exercise carried out by Groundswell using peer researchers.

[2] Non statutory voluntary sector partners
[3] https://data.london.gov.uk/dataset/chain-reports
[4] For more information about statutory duties to migrants with care needs who have no recourse to public funds see the information provided by the network of local authorities and partner organisations https://www.nrpfnetwork.org.uk/information-and-resources/rights-and-entitlements
[5] https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Commissioning_guidance_for_London_-_Homeless_health.pdf
[6] https://www.healthylondon.org/wp-content/uploads/2017/10/More-than-a-statistic.pdf

1	***People experiencing homelessness receive high quality healthcare***
2	***People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce***
3	***Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models***
4	***Data recording and sharing is improved to facilitate outcome-based commissioning for the homeless population of London***
5	***Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness***
6	***People experiencing homelessness are never denied access to Primary Care***
7	***Mental Health Care Pathways, including Crisis Care, offer timely assessment, treatment and continuity of care for people experiencing homelessness***
8	***Wherever possible people experiencing homelessness are never discharged from hospital to the street or to unsuitable accommodation***
9	***Homeless Health advice and signposting is available within all Urgent and Emergency Care Pathways and Settings***
10	***People experiencing homelessness receive high quality, timely and co-ordinated End of Life Care***

1.3 Local Context

1.3.1 North West London has the largest homeless population in London, and Westminster is the borough with the largest homeless population;

- 1,698 people were seen rough sleeping in the borough in 2021/22. This represents a 21% decrease when compared to 2020/21. 50% of people seen rough sleeping in the borough during the year were new rough sleepers (flow),

while 33% fell into the stock category, and 17% were returners. [CHAIN Westminster annual report 2021-22].

- A recent snapshot shows 'tri morbidity' of poor physical health (60%) poor mental health (53%) and alcohol/ substance misuse (43%)[4]
- A&E attendances 6x as high, admissions 4x as often and stays 3x longer than the general population.
- Stark health inequalities. The average age of death is 43 years old (women) and 46 (men) compared with 83 and 79 in the general population.[4]
- Many unregistered homeless patients sleeping out or otherwise NFA in Central London are high users of both Emergency Departments and unplanned health care.

2. Commissioning Intentions

2.1 The service is required to provide in line with the following delivery principles and outcomes areas:

- Preventing avoidable secondary care;
- Integration with 'mainstream' practices as part of developing primary care at scale- including transfer of skills and expertise for clinicians in other practices operating in a primary care at scale framework to build their capability in supporting homeless/ formerly homeless patients and those with complex needs;
- Integration with the specialist community nursing service (through co-location, staff secondment and joint CLCH/ practice management);
- Safe and person centred transition of patients to mainstream practices in a care planned and managed way;
- The service will develop and sustain a model of access that is suitable for homeless patients, including rough sleepers and those with complex needs- favouring a direct access model over appointments based primary care;
- The service is in a position to support the establishment of local connection and related data for rough sleepers through working with CHAIN registered agencies- important for housing and related needs, and cooperation with this wider network of services is therefore critical in meeting whole needs of homeless people
- Using homelessness support services to enhance access to health services
- Taking services to where homeless people are- day centres and hostels
- Joint working with an established range of primary and community physical and mental health providers;
- Model of multidisciplinary integrated care, including MDT case management and joint assessment/ support for complex cases;
- Use of peer advocacy;
- Shifting patient care from unplanned and secondary care into primary and community setting where possible
- A personalised and person centred approach to planning and providing health and care

- Social prescribing to make best use of voluntary sector resources and opportunities to secure optimal outcomes for patients
- A prevention based approach that also focusses on self-care, empowerment and self-management of health and wellbeing
- Making use of Right Care approaches
- Optimising use of technology for efficient means of health delivery to patients and self-management
- Progressing a population-health based approach– using available intelligence to deliver the best care for homeless patients and people with complex needs
- Medicines optimisation
- Management of continuing healthcare processes

3. Target Population

3.1.1 Adults of aged 16 and over.

3.1.2 For this service specification, the definition of homelessness is broad by design and includes:

- People living in hostels or supported accommodation;
- The hidden homeless i.e. people in 'squats' or 'sofa surfers';
- Rough sleepers and;
- Those who spend a significant amount of time on the street or in other public areas.

In order to target health services appropriately, it is necessary to consider a wider range of clients. Groups to consider are:

- People who are entrenched rough-sleepers and homeless in Westminster as identified by Westminster City Council Rough Sleepers Team (previously known as the Westminster 150);
- People who have a significant history of rough sleeping;
- People who are currently rough-sleeping in Westminster, and likely to become entrenched;
- Hostel, refuge and night shelter residents in Westminster or boundary areas;
- Failed asylum seekers in Westminster;
- Irregular and undocumented migrants;
- People who have a link to Westminster and who have recently left institutions such as local authority care, the armed forces or prison and who are at risk of rough-sleeping.

3.1.3 However, not every new patient who falls into these groups should be considered for intensive care and support. They should be supported to gain access and support

in their home boroughs, including registration with relevant 'mainstream' practices. Options for time-limited medical care should be offered, and a referral to a housing advice worker for support in their home boroughs

3.1.4 1,698 people were seen rough sleeping in the borough in 2021/22. This group makes up the majority of patients that use the homeless practice.

3.2 Emergency/Temporary Accommodation

3.2.1 There is limited emergency and temporary accommodation within Westminster. Most people are housed within accommodation outside of the Borough. The locality currently has a number of hostel places for single homeless people.

3.3 Hostels

3.3.1 Across Westminster, there are 415 beds for rough sleepers alongside an additional 600 units for people with severe and enduring mental health issues, young people leaving care etc.

3.4 Homeless Health Needs Assessment

This was carried out in February 2013 but is still relevant today. The full health needs assessment is available at https://www.jsna.info/document/rough-sleepers

The main issues identified by the assessment were:

- Rough sleepers use more secondary health services, and therefore cost more. National estimates show that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year. The 933 rough sleepers analysed in inner North West London used secondary care at a cost of £2.4 million. Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital as emergencies, which costs four times more than elective inpatients.

- Rough sleepers have more health needs. When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases.

- There are specific barriers to accessing services for rough sleepers. Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant barriers.

- But there are things that can be done. Interventions and models of care have been developed, and are being used, to provide a better system of care for rough sleepers.

4. The Overall Model

The overall model that is being commissioned is one that works in an integrated way with other providers to ensure patients have the best care possible in a 'one-stop-shop' environment. This will also involve taking care directly to patients where that it is necessary and appropriate and getting hard to reach patients registered with the service. The model also ensures that patients are mainstreamed as soon as they are ready and actively identified and deducted from the list once they have left the area. The services provided should also contribute to the reduction in A&E attendances and emergency admissions by homeless people.

5. Overall Outcomes from the Contract

5.1 The overall outcomes to be secured from the contract are:

- Improved identification of homeless patients in primary care and acute services
- A shift in health and care activity away from reactive and unplanned usage wherever possible, towards delivery of preventative approaches and services, and planned care where this is required. This shift will result in a measurable reduction in A&E attendances and avoidable hospital admissions
- The facilitation of service users to take increasing responsibility for their own health and well-being- meaning increased levels of self-management of health and care needs for homeless patients
- Reduction in Delayed Discharges
- Improvement of patient experience
- Reduction of readmission to hospital within 7 and 28 days
- The timely mainstreaming of patients in a personalised way that supports transition into non-specialist primary care at the point when the patient's care can be managed in this setting

- Increased competencies and confidence across ‘mainstream’ general practices to manage the health and care needs of patients on their registered lists or otherwise receiving services who are homeless or have a history of homelessness

Additionally, the service will ensure the following:

- A ‘one stop’ service model through an integrated approach with multiple service providers that enables access to the range of co-located services needed by homeless patients (podiatry, counselling, psychiatry, dentistry, hepatology)
- Working with expertise around homeless health and prevalence of issues and needs across this population segment- for example high levels of adverse childhood experiences (ACE) and Acquired Brain Injuries (ABI
- The proactive identification and deduction of patients who have left the area from the practice list through a regular exercise of auditing and updating the list to ensure the most accurate possible list at any point in time
- Management of complex cases using established care planning, case management and MDT working arrangements
- Clinical leadership around homeless health across primary care and other health and care services for this patient group
- Integrated working as part of primary care at scale- this includes delivery of services as part of a wider group of practices as well as close working with the south Westminster specialist homeless practice
- Increasing clinical skills and capacity in other ‘mainstream’ practices as part of primary care at scale, enabling registration and the transfer and good management of care for homeless patients with a threshold of need and complexity that can be supported in these ‘mainstream’ practices
- Being an active part of primary care at scale and ensuring an integrated offer for patients through joined up delivery of primary and community services around the registered list of patients
- Actively working with other providers to enable the registration of patients who are otherwise hard to reach (such as the homeless health team who provide street outreach) - enabling access to primary care across the whole homeless population.
- Good working relationships and strengthened integrated working practices (e.g. delivery of joint assessment and clinics, utilisation and hosting of specialist services, and smooth transitions of care between e.g. acute units, emergency treatment services, ambulance services, intermediate care, primary care, social services and the voluntary and independent sector).

- Housing needs are taken into account in assessment, care planning and review of patient needs
- Delivery of person centred services
- The provision of safe environments that promote physical and psychological well-being for all patients and service users
- Integration of care delivery across health, social care and homeless services through strongly managed co-ordination of services and partnership working

5.2 The provider must demonstrate an understanding of the key challenges that face homeless people and of the wider health and care determinants which impact upon patient health and wellbeing and engagement. The provider will provide high quality, accessible and responsive specialist homeless primary medical services to address the often complex health and care needs affecting people who are homeless including:

- Long term conditions
- Acquired brain injuries
- Physical injury
- Premature death
- Premature disability
- Mental health - psychiatric and psychological
- Physiological issues
- Trauma including childhood abuse and torture
- Sexual health and education issues
- High rates of infectious disease and blood borne viruses and sepsis
- Substance misuse including drug and alcohol
- Alcohol related illness
- Drug related illness
- Smoking related illness
- Dermatological conditions such as scabies
- Complex wound care including tissue viability.
- Chronic leg ulcers
- Oral health problems.
- Stress
- Cultural and lifestyle issues
- Sleep problems
- Sexual health education
- Pregnancy
- Musculoskeletal
- Neurological – cognitive impairment, brain acquired injury
- Chronic Pain
- Tuberculosis and respiratory complications
- Need for social care intervention including complex family relationships
- Communication including language difficulties
- Learning Difficulties
- Safeguarding of children and vulnerable adults

The provider must:

- Be innovative and creative in the delivery of primary health care to drive improvements in health and care outcomes
- Ensure primary medical services are aligned with the overall model described and are delivered within the principles and duties for services as outlined above in sections 2 -5.
- Evidence good working relationships and strengthened integrated working practices (e.g. delivery of joint assessment and clinics, utilisation and hosting of specialist services, drop ins and outreach/in-reach, reduced handoffs and smooth transitions of care between e.g. acute units, emergency treatment services, ambulance services, intermediate care, primary care, social services and the voluntary and independent sector)

6. Equity of Access

6.1 The Contractor shall:

6.1.1 implement Royal National Institute of Blind People and Royal National Institute of Deaf People guidance as amended from time to time to ensure Patients who have relevant disabilities and/or communications difficulties are afforded appropriate access to the Services;

6.1.2 utilise available professional translation services:

i. as required for all non-English speaking Patients during all consultations.

ii. to provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English, for the languages recommended by the Commissioner as being the most common languages spoken by Patients who are likely to use the Services; and

6.1.3 take reasonable steps to proactively deliver health promotion and disease prevention activities to all Patients including those from hard-to-reach groups. The Contractor acknowledges that a hard-to-reach group shall include but not be limited to the following:

i. those who do not understand written or spoken English;
ii. those who cannot hear or see, or have other disabilities;
iii. asylum seekers or refugees;

iv. those who have no permanent address;
v. black or minority ethnic communities;
vi. elderly and/or housebound people;
vii. those who have mental illnesses;
viii. those who misuse alcohol or illicit drugs;
ix. those who are unemployed; and
x. those on probation in bail hostels and approved premises
xi. those with no recourse to public funds
xii. sex workers

6.2 The Contractor acknowledges that to improve equity of access for black and minority ethnic (**"BAME"**) Communities, it is important to collect information on ethnicity and first language due to the need to take into account culture and language in providing appropriate care packages and the need to demonstrate non-discrimination and equality of access to service provision. The Contractor shall therefore be required to record the ethnic origin and first language of all Registered Patients.

6.3 Initial Health Assessments will be offered to all those who register with the practice and will include a thorough review of medical history and cover the following areas:

- Conduct a general physical health assessment
- Provide patient education/self-care advice.
- Explanation of health and care services available both within and outside the practice that are relevant for the patient and refer appropriately.
- Provide overview of how services should be accessed by patients mentioning use of A&E, NHS 111 and urgent care.
- Record different agencies already involved with the person's care
- Undertake a thorough review of medicines.
- Develop a care plan if required and ensure this is shared with all relevant agencies, subject to patient consent.
- Provide vaccinations if required.
- Identify the housing status.
- Identify ethnic origin, sexual orientation and gender identity.
- Record smoking status.
- Undergo drug and alcohol screening assessment.
- Conduct a sexual health screen including chlamydia screening assessment where appropriate.
- Identify any communication issues including: need for an Interpreter service, literacy issues and learning difficulties.
- Conduct mental health / dementia assessment.
- Check foot care needs.
- Check dental needs.
- Screen for blood borne viruses including HIV and risk of TB and provide interventions as necessary.

- Regularly review housing status and when appropriate support transition to other services including registration with other GP practices.

The above list is not an exhaustive list as the initial health assessment must be relevant for the patient's needs and it may not be possible to deliver the entire assessment within a single appointment.

7 Patient Dignity & Respect

7.1 The Contractor shall:

7.1.1 ensure that services are delivered within a Psychologically Informed Environment or Trauma Informed Care framework in recognition of the trauma often experienced by those who are homeless and challenges for staff in working with complex needs

7.1.2 ensure that the provision of the Services and the Practice Premises protect and preserve Patient dignity, privacy and confidentiality;

7.1.3 allow Patients to have their personal clinical details discussed with them by a person of the same gender, where required by the Patient and if reasonably practicable;

7.1.4 provide a chaperone for intimate examinations if requested by the patient to preserve Patient dignity and respect cultural preferences; and

7.1.5 ensure that the Contractor Staff and anyone acting on behalf of the Contractor behaves professionally and with discretion towards all Patients and visitors at all times.

8 Informed Consent

8.1 The Contractor shall comply with NHS requirements in relation to obtaining informed consent from each Patient as notified to the Contractor by the Commissioner from time to time prior to commencing treatment including the following as amended from time to time:

8.1.1 Department of Health Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2001;

8.1.2 Health Service Circular HSC 2001/023; and

8.1.3 Seeking Patients' Consent - The Ethical Consideration: GMC November 1998.

Guidance on the application of the Mental Capacity Act with people who are sleeping rough can be found at https://www.pathway.org.uk/publication/mental-health-service-interventions-for-people-sleeping-rough/

9 Prescribing

9.1 Without prejudice to Clause 29 of this Contract (which shall prevail in case of conflict or ambiguity with this paragraph 5), the Contractor shall:

9.1.1 prescribe the most clinically and cost effective medicines in accordance with national and local guidance from time to time including:

i. NICE guidance and Department of Health directives relating to prescribing;

ii. Good Prescribing Practice as defined by BNF;

iii. shared care protocols agreed between the Commissioner and other secondary care NHS Contractors; and

iv. patient group directions, such as emergency contraception and antibiotics;

9.1.2 Meet all requirements of the prescribing or medicines management work plan agreed with NHS NW London.

10 Clinical Safety & Medical Emergencies

10.1 The Contractor shall:

10.1.1 ensure that all Contractor Staff have and maintain basic life support certification with competence in defibrillation and ensure that all the Contractor Staff comply with the UK Resuscitation Council guidelines on basic life support and the use of automated external defibrillators;

10.1.2 ensure the availability of sufficient numbers of the Contractor Staff with appropriate skill, training and competency and who are able and available to recognise, diagnose, treat and manage Patients with urgent conditions at all times when the surgery is open;

10.1.3 possess the equipment and in-date emergency drugs including oxygen to treat life-threatening conditions such as anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus;

10.1.4 pass all life threatening conditions to the ambulance service as soon as practicable by dialling 999 and requesting the ambulance service; and

10.1.5 adhere to any national or local guidelines relating to clinical safety and medical emergencies in primary care as amended from time to time.

11 Good Clinical Practice

11.1 Without prejudice to Clause 50 of this Contract, the Contractor shall perform the Services in accordance with the following requirements as amended from time to time:

11.1.1 Care Quality Commission Essential Standards in force from time to time during the term of this Contract;

11.1.2 the "excellent GP" according to Good Medical Practice for General Practitioners (RCGP 2008);

11.1.3 any relevant Medicines and Healthcare Products Regulatory Agency (MHRA) guidance, technical standards, and alert notices;

11.1.4 the highest level of clinical standards that can be derived from the standards and regulations referred to in this paragraph 7.1 of Part 1 of Schedule 2; and

11.1.5 the General Medical Council guidance on Good Medical Practice (2013).

11.1.6 The Care Quality Commission's guidance on primary care for people who are homeless[7]

11.1.7 The Faculty for Homeless and Inclusion Health's Standards[8]

[7] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-29-looking-after-homeless-patients-general-practice

[8] https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf

11.2 The Contractor shall ensure that clinical meetings are convened for all clinicians working in the practice to agreed minimum standards

12 Equipment

12.1 The Contractor shall provide all medical and surgical equipment, medical supplies including medicines, drugs, instruments, Appliances, and materials necessary for the delivery of services under this Agreement; which shall be adequate, functional and effective.

12.2 The Contractor shall establish and maintain a planned maintenance programme for the equipment referred to in paragraph 8.1 above in line with the manufacturer's guidance, and make adequate contingency arrangements for emergency replacement or remedial maintenance.

13 Infection Control

13.1 Without prejudice to clause 12 of this Contract, the Contractor shall have in place arrangements that meet the standards outlined in the NICE guidelines on infection control "Prevention of healthcare associated infections in primary and community care (June 2003)", to maintain a safe, hygienic and pleasant environment at the Practice Premises, and the NHS England Standard Operating Procedure Infection Prevention & Control Audit requirements, and shall:

13.1.1 use only disposable medical devices;

13.1.2 make arrangements for the ordering, recording, handling, safe keeping, safe administration and disposal of medicines used in relation to the Services; and

13.1.3 make arrangements to minimise the risk of infection and toxic conditions and the spread of infection between Patients and staff (including any clinical practitioners which the Contractor has asked to carry out clinical activity).

14 Referrals

14.1 The Contractor shall:

14.1.1 record all referrals in the patient record using the appropriate Read Codes;

14.1.2 monitor and minimise inappropriate referrals and hospital admissions in line with NHS NW LONDON annually agreed priorities and practice specific work plan;

14.1.3 co-operate with and make effective use of:

i. 111, including making 111/IUC bookable slots available at a ratio of a minimum of 1:3000 via a worklist;

ii. the community matron/case management team;

iii. Commissioner - commissioned services provided outside acute hospitals, including health promotion services; and

iv. local authority services and employment advisers;

14.1.4 co-operate with service contractors carrying out Out of Hours Services to ensure safe and seamless care for Patients, including providing information on, as a minimum, a weekly basis and, where relevant, daily to such contractors carrying out Out of Hours Services on Patients that may require their services or who have special clinical requirements;

14.1.5 provide complete and comprehensive information to support any referral made and comply with, where appropriate, any directions provided by the relevant ICB concerning the format or composition of referrals including, where relevant, instruction to direct referrals to a third party for clinic booking and/or clinical triage;

14.1.6 use robust clinical pathways for referral, where these are agreed with other local healthcare Contractors and/or issued by the relevant ICB;

14.1.7 routinely collect and assess data about the appropriateness of the Contractor's referrals, using audit and peer review to share learning;

14.1.8 implement national referral advice including Referral Guidelines for Suspected Cancer and NICE guidance;

14.1.9 ensure urgent suspected cancer referrals are or sent electronically and received by the relevant trust within twenty-four (24) hours;

14.1.10 review referrals practice every six (6) months as a minimum to ensure it is in line with latest guidance and protocols;

14.1.11 develop and implement policies in relation to nurse and nurse specialist referrals where nurses have an extended role in the treatment and investigation of Patients with specified diseases;

14.1.12 the Contractor is required to use the commissioned pathways for making referrals. All referrals should be made via the Referral Wizard;

14.1.13 all secondary care referrals should be made directly to the appropriate provider through e-RS

14.1.14 all community care referrals should be made directly to the appropriate provider through SystmOne (unless the community care provider is not commissioned to use SystmOne)

15 Co-operation with Local Authority and Third Sector Services

The Contractor shall have regard to all primary care commissioning policies (as updated from time to time at both local and national levels and including the 'Call To Action' deliverables), and ensure that co-commissioning arrangements are implemented and amended from time to time (including arrangements for co-commissioning or joint commissioning with clinical commissioning groups).

15.1 The Contractor will provide an integrated and fully supported primary health care team to work in partnership with all other NHS and non-NHS healthcare contractors and stakeholders on the same basis as the majority of other GP Practices in NHS NW London area. This will include participating in any local collaborative models of working.

Key interfaces will include:

- Acute Care, including hospital discharge teams
- Advocacy including peer advocacy
- Outreach teams
- Community Health Services.

- Dental, Pharmacy and Optometry services
- Doctors of the World.
- Housing assessment services/Housing Options
- Temporary and Emergency accommodation including winter night shelters, CRISIS at Christmas
- Wellbeing and primary mental health services.
- Adult Social Care assessment
- Adult Social Care services
- Housing Related Support services for single homeless people services which include:
  - Rough Sleepers Service
  - Supported accommodation
- Community Safety and police
- Public Health and health improvement services
- Substance Misuse Services
- Mental Health services
- Voluntary and Community services (including Money Advice and Employment Support) day centres and food banks
- Prisoner and ex-offender services
- Forensic services
- Local Authority Access Point for Safeguarding queries and concerns
- Community Safety Partnership and subgroups
- Home Office and Reconnection teams
- Find & Treat – conducting screening TB and BBV – notification system
- EoLC – hospices, palliative care teams, St Mungo's EoLC Co-ordinator
- Social prescribing providers

15.2 The Contractor shall, together with the Commissioner:

15.2.1 establish good information flows to/from pathology and diagnostic Contractors and NHS and non-NHS Healthcare Professionals;

15.2.2 foster good working relationships and gain mutual understanding of systems, policies and procedures with key local stakeholders;

15.2.3 establish a directory of information regarding local resources and foster a good understanding of the local Patient care pathways to promote effective referrals; and

15.2.4 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.

15.3 The Contractor shall collaborate with the Commissioner in the following areas:

15.3.1 structures - to ensure that links are maintained with key individuals, departments, forums, groups and organisations within the Commissioner and local health economy, particularly with forums dealing with Patient and Public Involvement (an NHS defined term) which is an initiative to involve Patients and the public in the planning of services;

15.3.2 process – to ensure that similar policies and protocols are implemented by all Contractors and the Commissioner (e.g. clinical policies, workforce planning including training opportunities and structured secondment programmes subject to agreement by the Commissioner and Department of Health); and

15.3.3 outcomes – to ensure that key clinical indicators are in place to allow benchmarking with other equivalent services commissioned by the Commissioner and contribute towards the Commissioner's own performance indicators.

15.3.4 For the purposes of this paragraph 11.3 above, the Contractor will, if requested by the Commissioner, nominate representatives for key planning forums such as the Commissioner Local Care Network, the Commissioner's Local Delivery Plans, Health Improvement Programmes, Strategic Service Development Delivery forums and nominate representatives for the Clinical Governance Committee and local Reforming Emergency Committees and ensure that service plans link with the plans of the Commissioner and local authorities.

15.4 The Contractor shall:

15.4.1 discuss and develop policies and procedures with local ICBs to ensure there is compatibility with local policies and procedures, including clinical and non-clinical issues;

15.4.2 sign up to multi-agency information sharing agreements as agreed with the Commissioner.

16 Clinical Governance & Quality Assurance

16.1 The Contractor shall:

16.1.1 show a commitment to achieve maximum points on the Quality and Outcomes Framework (QOF) and/or any future National Quality Framework;

16.1.2 show a commitment to achieve the highest banding across the range of indicators on the NHS England Assurance Framework and/or any future quality scorecard by preparing and implementing suitable action plans until the standard is achieved;

16.1.3 comply with any NHS England (London Region) Quality Standards that may be introduced during the term of the contract, subject to the agreement of additional funding should it be reasonably required;

16.1.4 operate an effective, comprehensive, System of Clinical Governance with clear channels of accountability, supervision and reporting, and effective systems to reduce the risk of clinical system failure;

16.1.5 have medical and nursing leadership in place;

16.1.6 nominate a person 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;

16.1.7 continuously monitor and report on clinical performance and evaluate Serious Incidents, near misses and complaints arising from any activity including 'learning the lessons' and provide the Commissioner with the records of such to assist the Commissioner in assessing whether standards are being met;

16.1.8 use appropriate formal methods such as root cause analysis for Serious Incidents, near misses and complaints;

16.1.9 have in place a system for collecting data on Serious Incidents, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements. Furthermore, the Contractor shall have in place a system for adopting such changes into practice and processes going forward;

16.1.10 operate robust auditing of clinical care against clinical standards and in line with CQC essential standards;

16.1.11 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;

16.1.12 where appropriate, fully implement any recommendations following Commissioner clinical governance inspections within three (3) months of notification by the Commissioner of the recommendations;

16.1.13 provide the Commissioner with an annual report and service improvement plan on a template to be provided by the Commissioner;

16.1.14 participate in all quality and clinical governance initiatives agreed between the Commissioner and its other GP Practices.

16.1.15 comply with the Pan-London Safeguarding policies and procedures for Children and Adults

16.1.16 cooperate fully with NHS Trusts to support their requirements to learn from deaths and to report all deaths judged as likely to have been caused by problems in care. [9]

17 Practitioner Skill Mix/Continuity

17.1 The Contractor shall:

17.1.1 notify the Commissioner about any planned material changes to the skill mix of Clinical Staff at the GP Practice;

17.1.2 keep the Commissioner informed of any changes in the permanently employed GPs or nurse practitioners; and

17.1.3 take all reasonable steps to keep the use of locum GPs or nurses to a minimum.

[9] The first edition of National Guidance on Learning from Deaths for Trusts was published by the National Quality Board (NQB).

18 Risk Management

18.1 The Contractor shall:

18.1.1 Operate mechanisms for assessing & managing clinical and general business risk including the maintenance of a suitable risk register that is reviewed, as a minimum by the business owners on a monthly basis;

18.1.2 prepare disaster recovery, contingency and business continuity plans that should be available for inspection by the Commissioner at any time;

18.1.3 keep the Commissioner fully informed about any significant risks that have been identified that could impact on the performance of the contract;

18.1.4 notify the Commissioner of the person responsible for risk management within the contractor's organisation.

18.1.5 comply with the requirements of the "Sign up to Safety" initiatives https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/08/su2s-induction-300715.pdf

19 Patient Records

19.1 The Contractor shall at its own cost retain and maintain all the clinical records in accordance with:

19.1.1 Good Clinical Practice; and

19.1.2 this Part 1 of Schedule 2.

19.2 The Contractor shall at its own cost retain and maintain all the paper based clinical records in chronological order and in a form that is capable of audit.

19.3 The Contractor shall institute a programme of audit of individual clinicians' electronic medical records on at least an annual basis for all clinicians engaged to work at the practice on the contractor's behalf.

20 Contractor Records

20.1 The Contractor shall during the term of this Contract and for a period of six (6) years thereafter, maintain at its own cost such records relating to the provision of the Services, the calculation of the Charges and/or the performance by the Contractor of its obligations under this Contract as the Commissioner may reasonably require in any form (the **"Records"**), including information relating to:

20.1.1 contract management reporting;

20.1.2 national data set reporting. (This shall include full compliance by the Contractor with all of the requirements necessary for the operation of CQRS and GPES);

20.1.3 activity reporting, including:

i. monthly activity reporting to the Department of Health and Commissioner;

ii. activity reporting in support of quarterly monitoring returns to the Department of Health (as agreed and advised by the Commissioner);

iii. requisite data for payment purposes;

iv. KPI measures (where not covered elsewhere); and

v. activity and outcomes data in support of service evaluation

vi. any management information relating to management information counts defined in the Technical Requirements for GMS Contract Changes as issued and updated from time to time.

20.2 The Contractor shall, subject always to the provisions of relevant legislation and Directions:

20.2.1 on request produce the Records for inspection by the Commissioner or, on receipt of reasonable notice, allow or procure for the Commissioner and/or its authorised representatives access to any premises where any Records are stored for the purposes of inspecting and/or taking copies of and extracts from

Records free of charge and for the purposes of carrying out an audit of the Contractor's compliance with this Contract, including all activities of the Contractor, the Charges and the performance, and the security and integrity of the Contractor in providing the Services under this Contract;

20.2.2 preserve the integrity of the Records in the possession or control of the Contractor and Contractor Staff and all data which is used in, or generated as a result of, providing the Services;

20.2.3 prevent any corruption or loss of the Records, including keeping a back-up copy; and

20.2.4 provide any assistance reasonably requested by the Commissioner in order to interpret or understand any Records.

20.2.5 take reasonable measures to ensure that the Records are updated using appropriate Read codes, using where applicable those Read codes required by the Commissioner and / or as required by the Technical Requirements for GMS Contract Changes.

20.3 The Contractor shall ensure that during any Records inspection the Commissioner and/or its authorised representatives receive all reasonable assistance and access to all relevant Contractor staff, premises, systems, data and other information and records relating to this Contract (whether manual or electronic).

21. Contract Length

21.1 The contract is for a period of TBC.

21.2 The contract may be terminated by any of the parties on giving six months' written notice of intention to terminate the arrangement to the other parties.

Part 2 – Services

1. Services To Be Provided By The Contractor

The Contractor shall provide:

1.1 GP led primary medical care services as set out in this Schedule 2 Part 2 to patients residing in the Patient Registration Area and Outer Boundary Area, and/ or patients registered with the practice as temporary patients

1.2 the Services in accordance with the requirements set out in this Schedule 2 Part 2 to those standards set out in the Key Performance Indicators set out in Schedule xx

2. Access To Services

Opening Hours

The Contractor must:

2.1.1 Provide the services described at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and have in place arrangements for its patients to access such services throughout core hours in case of emergency.

2.1.2 Deliver services at agreed times and intervals to best meet the needs of patients and, where appropriate, include the use of outreach and drop-in-clinics to improve patient access.

2.1.3 Demonstrate how the delivery of patient care will be managed and set this out in an appropriate access plan.

2.1.4 Deliver a service that is over the entire specified period of opening, with a clinician available at all times

2.1.5 Demonstrate that Premises will be open and reception staffed for face to face contact and telephone access (not voicemail) to the practice between 9 a.m. until 5 p.m. Monday to Friday

2.1.6 Have non-clinical staff that are appropriately trained and skilled to provide a high quality service and good user experience to this client group

2.1.7 Utilise practice skill mix and clinical rooms effectively to foster integrated working. This should be set out in the access plans and updated routinely in line with list size growth

2.1.8 Enable patients to consult an appropriate health care professional on the day of request or at an agreed future appointment time appropriate to the clinical need

2.1.9 Where practicable, ensure patients have an opportunity to be seen by a practitioner of their preference, whether this be a named member of staff or a gender specific member of staff

2.1.10 Offer patients flexible access and ways of communicating with the service

2.1.11 Offer and utilise a full range of consultation methods according to clinical need including, but not limited to, web-enabled communication, telephone, e-mail, and face to face

2.1.12 Where possible utilise triage to support the management and demand of the service to ensure the service delivers with maximum efficiency to patients

2.1.13 Ensure a minimum level of drop in-appointment capacity during opening hours so as to ensure that appointment lengths are tailored to the clinical needs of patients. It is expected extended appointments will be made available to patients to meet their health and support needs in a proactive and reactive manner

2.1.14 Conduct home visits according to clinical need as determined by GP acting in accordance with Good Clinical Practice. This will include in-reaching to other homeless services such as local hostels or temporary emergency accommodation, day centres and drop-ins.

2.1.15 The Contractor must at all times have provision for a clinician to see and visit patients at the patient's home or sleep site if they are rough sleeping. The Contractor shall ensure that patients are informed of the timescale in which they will be visited

2.2 The Contractor shall adhere to the GP Registration Standard Operating Principles for Primary Medical Care (General Practice) (as the same may be amended or replaced from time to time). A copy of the version of the Policy in force can be requested by contractor from NHS England (London Region) at any time. A copy of the version of the policy in force at the contract commencement date is attached at Schedule 2 Annex 1 Part 2;

2.3 The Contractor shall register patients as permanent rather than with temporary status.

Length of Appointments

2.4 Appointment length shall be tailored to the clinical needs of the patient.

Improving Access Through Use of Technology

2.4 The Contractor shall implement the following Digital Primary Care schemes according to a timetable agreed with the Commissioner and as appropriate for the model of care delivered by the specialist practice:

2.4.1 Online Patient access to records;

2.4.2 Online ordering of repeat prescriptions;
The Contractor shall make Electronic Prescription Services (EPS) the default method for prescribing, unless the patient asks for a paper prescription or the necessary legislative or technical enablers are not in place.

2.4.3 Online and Video consultations.

2.4.4 Electronic receipt of Secondary Care Provider discharge summaries and subsequent post-event messages.

2.5 The Contractor shall proactively offer registered patients access to the services referred to in paragraph 2.4.1 – 2.4.4 above, providing clear information necessary to do so.

2.6 The Contractor shall issue passwords and verify the identity of registered patients wishing to access the services in 2.14 above, as recommended by guidance from the Royal College of General Practitioners (RCGP).

2.7 The Contractor shall ensure that its pages on NHS Choices are updated regularly, and at all times provide complete and accurate information regarding the practice.

2.8 The Contractor will seek to maximise digital inclusion by actively promoting and encouraging digital access to the practice's patients and participating in any relevant initiatives that support this objective.

Discharge

2.9 The Contractor will support discharge planning from local acute and mental health hospital discharge teams including specialist homelessness discharge arrangements where these are in place and ensure continuity of care between hospital and out of hospital care.

Mainstreaming and Management of List Size

2.10 The Contractor will ensure that patients, other than those that are street homeless, registering with the practice transitioned to a mainstream practice within, **on average, 18 months of initial registration where appropriate.**

2.11 Specific periods for registering patients with mainstream practices will depend on the personal and clinical circumstances of each patient. The Contractor shall develop appropriate procedures and processes that ensure:

2.11.1 Patients do not remain registered with the practice for more than 24 months unless there are exceptional clinical and/or personal circumstances;

2.11.2 There is appropriate support provided to transitioning patients to other practices balanced against patient referrals received directly, from third sector organisation and/or community groups;

2.11.3 The average time for patients remaining registered with the practice is at or below 18 months; and

2.11.4 That appropriate procedures are developed to support street homeless patients registering with mainstream practices wherever possible.

2.12 The Contractor will ensure that homeless patients are supported into primary care registration and where clinically appropriate will support those patients into mainstream practice. These patients will often feel uncomfortable attending GP practices and the Contractor will need to provide outreach targeted clinical treatment whilst encouraging and facilitating patients to attend the practices and drawing on peer advocacy contracts that are available within either the Contractor's locality or the locality where the patient is registering with a mainstream practice.

2.13 The Contractor will ensure that practice documentation including webpages and leaflets clearly sets out the practice's policy on managed transfers of care.

<u>System wide leadership</u>

2.14 The Contractor will have a system wide leadership role to drive improvements in health and care outcomes for homeless people

2.15 This will include working within a Primary Care Network (PCN): raise awareness and understanding of the health and care needs of the homeless, the barriers to care that people who are homeless

often face and to develop skills in working with the homeless amongst clinical and non-clinical front line staff

2.16 The Contractor must:

2.16.1 Provide care planning support and guidance to mainstream GPs and PCNs for their homeless and vulnerably housed patients (this is critical in managing current and future demand and ensuring best use of resources);

2.16.2 Agree shared protocols and pathways with partners to integrate care, assessment, planning, review and risk management;

2.16.3 Create sustainable support structures and work in a planned way to support individuals move on at the end of their period of support;

2.16.4 Develop good relationships with relevant services to ensure effective delivery of care within the PCNs;

2.16.5 Deliver education and training to both clinical and non-clinical frontline staff including e.g.: GPs and GP clusters medical school and undergraduate and postgraduate training, shared GP Protective Learning Time (PLT), practice manager and nursing forums, and any other health and medical meetings);

2.16.6 Promote inclusion health as a career path;

2.16.7 Work in conjunction with other agencies to prevent and reduce anti-social behaviour and crime;

2.16.8 Work in conjunction with other agencies to support people to access and maintain suitable accommodation.

2.17 The Contractor will encourage and enable staff to participate in London and national homeless health clinical and practice networks.

Deducting Patients

2.18 The Contractor will conduct a bi-monthly audit to check the list for patients who they believe have left the area and deduct these accordingly;

2.19 The contractor needs to be assured that the patient definitely doesn't reside in their catchment area and that they have made every possible attempt to contact the patient. If it isn't appropriate or possible to write to the patient, then alternative means of communication should be employed such as text or engagement with key worker.

A&E and Emergency Admissions Avoidance

2.20 The practice needs to use the WSIC dashboard to proactively manage patients who are most likely to attend A&E and make avoidable use of unscheduled secondary care, including intelligence on the highest frequency users who comprise a small proportion of the patient cohort but a disproportionately high and high cost consumption of health and care

2.21 Reducing the rates of unscheduled A&E attendances and unplanned care by rough sleepers and homeless people is a strategic priority for the local health and care system and this is a key outcome area that will be monitored on an on-going basis through the contract

2.22 The contractor will determine how best approaches to preventing and avoiding unscheduled care can be managed with appropriate input from patients, partners and commissioners

2.23 Risk stratification, clinical auditing, proactive management of care needs and multi-disciplinary approaches are likely to support these aims.

Use of Premises

2.24 It's essential that the practice work alongside a range of other services such as dentistry, counselling, housing advice services etc. to provide a one stop shop to ensure that they can access all the holistic care in one place.

Care Planning

2.25 Care planning should be done through the medium chosen by the patient and must take a holistic approach to a patient's multiple care needs, both clinical and social.

2.26 The output is a personalised care plan developed collaboratively between a patient, carer, and GP (or other appropriate and competent registered care professional). It will be entered into the commissioners' approved template, which is available on the clinical systems. It must be discussed and shared with patients in order to encourage their ownership of the plans.

2.27 The care plan should include agreed, measurable, patient-determined goals and actions, recorded in a patient's own words.

2.28 The care planning consultation and the content of the care plan will focus on how the patient's care will be managed to meet the patient's own goals, as described by the patient.

2.29 It will enable effective management of all care needs, including through supported self-management, to avoid avoidable escalation or crisis and unplanned hospital admission and show understanding of the patient's interactions with other care agencies and plan a holistic approach across all services;

3. Patient Voice

The Contractor will establish and encourage Patient Participation arrangements that support the second commitment of the London Commissioning Guidance for health services for people who are homeless. *People with a lived experience of homelessness are pro-actively included in patient and public engagement activities, and supported to join the future healthcare workforce.*

Patient Participation Group (PPG)

3.1 The Contractor shall establish and encourage on an on-going basis an active Patient Participation Group. The PPG shall meet regularly at times determined by its members but the general guidance is (4) times per Contract Year, once in each three-month period. Areas for discussion shall be determined by the members and should include, but not be limited to:

- 3.1.1 Access, including opening hours, telephone access, availability of appointments
- 3.1.2 Clinical services
- 3.1.3 Reception services
- 3.1.4 Practice performance
- 3.1.5 How patient feedback is being used to improve clinical standards
- 3.1.6 How patient feedback is being used to improve patient experience

Patient Surveys

3.2 The practice will establish an appropriate method for surveying patients such as feedback cards available in reception.

4. Practice Clinical Services

The Contractor shall:

4.1 Provide Essential Services and Additional Services to all Registered Patients, including patients registered as Temporary Residents;

4.2 Only be required to provide services during the hours specified in this contract.

4.3 Provide Enhanced Services appropriate to the provision of care required by the health needs of the Contractor's List of Registered Patients and directed by the Commissioner;

4.4 Participate, where relevant, in the Quality and Outcomes Framework (QOF);

4.5 Implement the Gold Standards Framework and co-ordinate My Care for patients requiring end of life care;

4.6 Participate in and support Health Promotion and Disease Prevention programmes

5. Essential Services

5.1 The Contractor shall provide Essential Services at such times, within the agreed hours, as are appropriate to meet the reasonable needs of Registered Patients, including patients registered with the practice as Temporary Residents.

5.2 The Contractor shall have in place arrangements for Patients to access such services throughout the Opening Hours if clinically urgent and in accordance with the KPIs.

5.3 The Contractor shall provide:

5.3.1 Essential Services required for the management of Patients who are, or believe themselves to be:

i) ill with conditions from which recovery is generally expected;

ii) terminally ill; or

iii) suffering from a long term condition.

5.3.2 Essential Services that are delivered in the manner determined by the GP Practice following discussion with the Registered Patient; and

5.3.3 Appropriate on-going treatment and care to all Registered Patients taking account of their specific needs including:

i) advice in connection with the Registered Patient's health, including relevant health promotion advice;

ii) the referral of the Registered Patient for other services under the relevant Act; and

iii) primary medical care services required in Opening Hours for the immediately necessary treatment of any person to whom the Contractor has been requested to provide treatment owing to an accident or emergency at any place in the Patient Registration Area.

5.4 For the purposes of the above section, "management" includes:

5.4.1 offering a consultation and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and

5.4.2 making available such treatment or further investigation as is necessary and appropriate, including the referral of the Registered Patient for other services under the relevant Act and liaison with other Health Care Professionals involved in the Registered Patient's treatment and care.

6. Immediately Necessary Treatment

6.1 The Contractor shall provide primary medical care services required in Opening Hours for the immediately necessary treatment of any person falling within the following conditions described below who requests such treatment, for the period specified

6.2 A person falls within this paragraph if he is a person:

6.2.1 whose application for inclusion in the Contractor's list of Registered Patients has been refused and who is not registered

with another contractor of Essential Services (or their equivalent) in the Practice Area;

6.2.2 whose application for acceptance as a Temporary Resident has been rejected;

6.2.3 who is present in the Practice Area for less than twenty-four (24) hours.

6.3 The period referred to in 6.1 above is:

6.3.1 in the case of 6.2.1 above, fourteen (14) days beginning with the date on which that person's application was refused or until that person has been registered elsewhere for the provision of Essential Services (or their equivalent), whichever occurs first;

6.3.2 in the case of 6.2.2 above, fourteen (14) days beginning with the date on which that person's application was rejected or until that person has been subsequently accepted elsewhere as a Temporary Resident, whichever occurs first; and

6.3.3 in the case of 6.2.3 above, twenty-four (24) hours or such shorter period as the person is present in the Practice Area.

6.4 For the avoidance of doubt, Essential Services provided by the contractor are deemed to include wound care and suture removal.

7. Additional Services

7.1.1 The Contractor shall provide Additional Services as defined in the GMS contracts regulations as amended from time to time.

7.1.2 The Contractor shall provide Additional Services at such times, within the agreed Hours, as are appropriate to meet the reasonable needs of Registered Patients.

7.1.3 The Contractor shall have in place arrangements for Patients to access such services throughout the Opening Hours if clinically urgent and in accordance with the KPIs.

7.1.4 The Contractor shall provide such facilities and equipment as are necessary to enable it properly to perform each Additional Service that it provides.

7.1.5 The Additional Services the Contractor shall provide to Registered Patients are:

i) Vaccinations and Immunisations;
ii) Contraceptive Services;
iii) Maternity Medical Services (excluding intra-partum care);
iv) Cervical Screening Services;
v) Minor surgery;

<u>7.2 Vaccinations and Immunisations</u>

The Contractor shall:

7.2.1 offer to provide to Registered Patients all clinically necessary vaccinations and immunisations in accordance with “Immunisation Against Infectious Disease 2005: "The Green Book" (as amended from time to time);

7.2.2 provide appropriate information and advice to Registered Patients; and

7.2.3 record in the Registered Patient’s record any refusal of the offer of all clinically necessary vaccinations and immunisations.

7.2.4 Where the offer referred to above is accepted, the Contractor shall administer the vaccinations and immunisations, and include in the Patient's record details of:

i) the Patient's consent to the vaccination or immunisation or the name of the person who gave consent to the vaccination or immunisation and his relationship to the Patient;
ii) the batch numbers, expiry date and title of the vaccine;
iii) the date of administration;
iv) in a case where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine;
v) any contraindications to the vaccination or immunisation; and
vi) any adverse reactions to the vaccination or immunisation.

7.2.5 The Contractor shall ensure that all staff involved in administering vaccines are trained in the recognition and initial treatment of anaphylaxis and any adverse reactions to the vaccination or immunisation.

7.3 Contraceptive Services

The Contractor shall make available the following Contraceptive Services to all of its Registered Patients who request such services:

7.3.1 advice about the full range of contraceptive methods;

7.3.2 where appropriate, the medical examination of Registered Patients seeking such advice;

7.3.3 the treatment of Registered Patients for contraceptive purposes and the prescribing of contraceptive substances and appliances;

7.3.4 advice about emergency contraception and where appropriate, the supplying or prescribing of emergency hormonal contraception or, where the Contractor has a conscientious objection to emergency contraception, prompt referral to another Contractor of primary medical care services who does not have such conscientious objections;

7.3.5 the provision of advice and referral in cases of unplanned or unwanted pregnancy, including advice about the availability of free pregnancy testing in the Practice Area and, where appropriate, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another Contractor of primary medical care services who does not have such conscientious objections;

7.3.6 initial advice about sexual health promotion and sexually transmitted infections; and

7.3.7 the referral as necessary for specialist sexual health services, including tests for sexually transmitted infections.

7.3.8 In addition to the specific requirements of the GMS Contract Regulations the Contractor shall co-operate with the Commissioner, ICB and/or relevant Local Authority and implement any reasonable initiative that that reduces teenage conceptions.

7.4 Maternity Medical Services

The Contractor shall:

7.4.1 provide Registered Patients who are pregnant, with all necessary Maternity Medical Services throughout the antenatal period;

7.4.2 provide referrals to the Smoking Cessation Service for Registered Patients who are pregnant and who smoke;

7.4.3 provide female Registered Patients and their babies with all necessary Maternity Medical Services throughout the postnatal period other than neonatal checks; and

7.4.4 provide all necessary Maternity Medical Services (see paragraph 7.4.6 below) to Registered Patients who are pregnant if their pregnancy has terminated as a result of miscarriage or abortion or, where the Contractor has a conscientious objection to the termination of pregnancy, prompt referral to another Contractor of primary medical care services, who does not have such conscientious objections.

7.4.5 an important area of focus will be women who are pregnant and whose unborn child may need to be identified for safeguarding as per the Children Act 1989 and the Children Act 2004

In this section:

7.4.6 “antenatal period” means the period from the start of the pregnancy to the onset of labour;

7.4.7 “Maternity Medical Services” means:

i) in relation to female Registered Patients (other than babies), all primary medical care services relating to pregnancy, excluding intra partum care; and

ii) in relation to babies, any primary care medical services necessary in their first fourteen (14) days of life; and

7.4.7 “postnatal period” means the period starting from the conclusion of delivery of the baby or the Registered Patient’s discharge from secondary care services, whichever is the later, and ending on the fourteenth day after the birth.

7.5 Cervical Screening Services

The Contractor shall:

7.5.1 supply any necessary information and advice to assist women identified by the Commissioner as recommended nationally for a cervical screening test in making an informed decision as to participation in the NHS Cervical Screening Programme (the “Programme”);

7.5.2 perform cervical screening tests on women who have agreed to participate in that Programme;

7.5.3 arrange for women to be informed of the results of the test;

7.5.4 ensure that test results are followed up appropriately; and

7.5.5 ensure the records referred are an accurate record of the carrying out of a cervical screening test, the result of the test and any clinical follow up requirements.

7.5.6 In addition to the specific requirements of the GMS Contract Regulations the Contractor shall aim to meet the performance standard specified in Schedule 6 or achieve at least a 5% improvement of performance against the previous year’s performance.

8. Enhanced Services

8.1 The Contractor shall provide all clinically appropriate Enhanced Services subject to 8.2, as directed by the Commissioner, to patients registered at the Practice Premises

9. Quality and Outcomes Framework (QOF)

With regard to the Quality and Outcomes Framework (QOF) as defined in the GMS Contract Regulations and/or any future National Quality Framework, the Contractor shall:

9.1 participate in the QOF Scheme each year;

9.2 work towards gaining the maximum QOF points for each Contract Year securing the minimum standards set out in 12.1.1 of Part 1 of this Schedule 2;

9.3 take all reasonable steps to minimise exception reporting and improve prevalence rates on practice registers;

9.4 set standards over and above the QOF requirements to ensure Patients continually receive the highest standards of clinical care

10. Health Promotion and Disease Prevention

The Contractor shall:

10.1 provide services focusing on health promotion and disease prevention and work with the Commissioner, ICBs, Local Authority, other local GP Practices and other health contractors on initiatives to promote health and prevent disease within the Commissioner's area;

10.2 ensure it has effective strategies for health promotion and disease prevention in place. These shall include but not be limited to:

10.2.1 smoking;

10.2.2 alcohol and drugs;

10.2.3 obesity;

10.2.4 lack of exercise;

10.2.5 dietary habits; and

10.2.6 sexual activity.

10.3 identify and proactively screen and manage Patients at risk of developing Long Term Conditions (see paragraph 10.10 below), cancers and sexually transmitted infections as well as those more likely to have unwanted pregnancies;

10.4 provide information about, and access to, self-management programmes for Registered Patients with long term conditions where appropriate;

10.5 identify local care pathways for Registered Patients with Long Term Conditions to reduce inappropriate and unnecessary hospital admissions;

10.6 provide information and advice to Registered Patients on self-monitoring for Long Term Conditions;

10.7 participate in expert Registered Patient programmes;

10.8 use computer-based disease management templates; and

10.9 implement 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 Registered Patients.

10.10 For the purposes of this paragraph 10, “Long Term Conditions” shall be deemed to be those conditions that cannot at present be cured but which can be controlled by medication and other therapies.

10.11 The Contractor shall, at the minimum, be expected to achieve those standards in the key Public Health Targets, where there is an eligible cohort of patients, including but not limited to:

10.11.1 flu vaccine uptake

10.11.2 covid-19 vaccine uptake

10.11.3 pneumococcal vaccine uptake

10.11.4 shingles vaccine uptake

10.11.5 cervical cytology screening

10.11.6 bowel screening

10.11.7 breast screening

10.11.8 diabetic retinopathy screening

10.11.9 abdominal aortic aneurism (AAA) screening

10.11.10 smoking cessation

10.11.11 obesity

10.11.12 consumption of alcohol and drugs

10.12 Unless otherwise advised the minimum expected achievement standard for the Public Health Targets in 10.11 will be the Minimum Performance Level (Band C) of the KPIs as defined in Schedule 6 Part 7 or Schedule 6 Part 9. Where a Public Health Target is not defined in Schedule 6 Part 7 or Schedule 6 Part 9, the minimum standard will be:

equal to or exceeding the median value established for all the GP Practices located in the local area for the previous year.

10.13 For those standards in 10.11 and 10.12 above that relate to cancer screening, the Contractor shall refer to the Transforming Cancer Services Team for London guidance document “Good Practice Guide for Bowel Breast and Cervical Cancer Screening in Primary Care” https://www.healthylondon.org/wp-content/uploads/2016/09/Screening-Good-Practice-Guide-2018.pdf

11 Services Specific to Central London (Westminster)

NHS NW London will retain the right during the course of this contract to introduce further service specifications and KPIs to ensure equality of service

provision to the patients registered with this practice compared to other GMS and PMS practices within NHS NW London area. Where such further services specifications and KPIs are introduced, the Commissioner will make further payments over and above those specified in Schedule 4, Part 1 Paragraph 3 to the contractor in line with those payments made to other GMS and PMS contractors within NHS NW London Area.

Part 3 – Staffing & Registration

1. Employment, Registration, Permits, and Vetting

1.1. The Contractor shall comply with:

(a) the relevant human resources provisions in the NHS Plan applicable to the Contractor and, where not directly applicable to the Contractor, the Contractor shall comply with the principles and spirit of the relevant human resources provisions in the NHS Plan;

(b) the following policies and guidance as amended, updated or replaced from time to time:

(i) NHS Employment Check Standards, March 2008 (revised September 2012 or from time to time thereafter);

(ii) the Code of Practice for the International Recruitment of Healthcare Professionals (December 2004) (the "Code of Practice");

(iii) Standards for Better Health (available on https://webarchive.nationalarchives.gov.uk/ukgwa/20050418193452/http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086665&chk=jXDWU6 and www.cqc.org.uk;

(iv) the Criminal Records Bureau Code of Practice for Registered Persons and other recipients of Disclosure Information published by the Home Office under the Police Act 1997 (revised April 2009) ("Code of Practice on Disclosure");

(v) the DH's guidance on the employment or engagement of bank staff, if any;

(vi) Any guidance and/or checks required by the Independent Safeguarding Authority (or success organisation) or any other checks

which are to be undertaken in accordance with current and future national guidelines and policies;

(vii) All guidance issued by the Care Quality Commission including the guidance entitled "Compliance: Essential Standards of Quality and Safety (March 2010)" and any other guidance issued by the Care Quality Commission from time to time;

(viii) Cabinet Office Statement entitled "Principles of Good Employment Practice (December 2010);"

(ix) The Cabinet Office Statement (as defined in Schedule 1 to this Contract); and

(x) all relevant employment legislation and codes of practice applicable in the UK.

1.2. The Contractor shall ensure that all Contractor Staff:

(a) have all necessary permits and/or entitlements to work in England in relation to the provision of the Services;

(b) are able to communicate in English at a level appropriate to their role so that they are able to communicate effectively with Patients and other persons in relation to the Services, including (where relevant) IELTS/PLAB tests as detailed in the Code of Practice for NHS Employers as amended from time to time in relation to the international recruitment of Health Care Professionals;

(c) are registered with all appropriate regulatory bodies including without limitation the following:

(i) for medical Contractor Staff, the GMC;

(ii) for nursing Contractor Staff, the Nursing and Midwifery Council; and

(iii) for Contractor Staff who are other Health Care Professionals (including Allied Health Professionals and Health Care Scientists (where appropriate)), the Health Professions Council.

1.3. The Contractor shall ensure that:

(a) medical Contractor Staff performing specialist procedures, are suitably qualified, competent and experienced and are registered in the GMC Specialist Register in respect of the specialty in which they perform specialist procedures;

(b) GPs are:

(i) registered with the GMC; and

(ii) hold appropriate certificates confirming their eligibility to work in general practice;

(c) nursing Contractor Staff are registered on the Nursing and Midwifery and Health Professional Council Register and, if they are to prescribe drugs and/or medicine, that the corresponding entry in the register indicates they hold a prescribing qualification; and

(d) appropriate arrangements are in place for re-registering and monitoring subsequent re-registration for Health Care Professionals as appropriate.

2. Workforce Strategy

2.1. The Contractor shall ensure that:

(a) its staffing arrangements (as may be amended or updated from time to time by prior written agreement between the parties) are sufficient to mobilise and manage the provision of the Services during any change period and throughout the term of this Contract taking into account estimated growth and Patient numbers (where appropriate); and

(b) there are, at all times, sufficient numbers of Contractor Staff engaged in the provision of the Services with the requisite level of skill and experience to

cover Contractor Staff absences (for example, holidays and sickness) and to cope with planned or unplanned increases in workload.

2.2. Subject to the Contractor's obligations to comply with Clause 67 of this Contract, the Contractor shall (and shall procure that any of its sub- Contractors shall), allow the Commissioner full access, on an open book basis, to any information or data in respect of all employees or other persons employed or engaged in the provision of the Services, or in relation to any recruitment or any other matter concerning this Contract, which the Commissioner considers relevant.

2.3. The Contractor shall:

(a) implement workforce management information systems which are capable of delivering any internal and external monitoring and workforce reporting requirements and of monitoring compliance with the Working Time Regulations 1998;

(b) provide timely and accurate workforce reports including, if required, input into the annual NHS workforce census and the NHS vacancy surveys; and

(c) if requested by the Commissioner, use its best endeavours to procure that Contractor Staff participate in the annual NHS staff survey.

2.4 The Contractor shall have an operational management organisation structure chart which demonstrates the key operational management roles and responsibilities, reporting relationships and accountabilities. The Contractor shall inform the Commissioner within five (5) working days if they make any material changes to this chart.

2.5 The Contractor shall have a designated role responsible for Staff management, leadership and practice management, known as "the Practice Manager".

3. Contractor Staff Recruitment

3.1. The Contractor shall ensure that:

(a) any recruitment agency partners used for recruitment or engagement in the UK are compliant with NHS Employers Code of Practice for NHS Employers as amended from time to time;

(b) in employing or otherwise engaging Clinical Staff it complies with the agreed person specifications as minimum requirements in terms of qualifications, knowledge, skills and experience;

(c) all Clinical Staff are covered by appropriate indemnity insurance;

(d) interviews of Clinical Staff take place with a suitably qualified interview panel, that proper references are sought and that professional qualifications are verified; and

(e) its recruitment policy, strategies and supporting processes must promote equal opportunity and anti-discriminatory practice to enable them to attract and retain a high quality, competent workforce in adequate numbers, for the duration of the Contract.

4. Appointment of Contractor Staff

4.1. The Contractor shall:

(a) comply with the rules and requirements regarding employment checks as set out in the NHS Employment Check Standards, March 2008 (as amended in September 2012 and as may be further amended from time to time);

(b) comply with the Cabinet Office Statement entitled "Principles of Good Employment Practice (December 2010);"

(c) ensure that all Contractor Staff receive Training, supervision, necessary induction and are competent and fit for purpose to ensure the proper performance of the Services in accordance with this Contract and any NHS Requirements of which the Contractor is notified from time to time;

(d) ensure that it will not use any individual for the performance of the Services in respect of whom an Alert Letter has been issued as amended by the Secretary of State's guidance of November 2006 (at Gateway 7147);

(e) ensure that it is (and at all times during the term of this Contract shall be) a Registered Person within the meaning of the Police Act 1997 and the Police Act 1997 (Criminal Records)(Registrations) Regulations 2006 and an Umbrella Organisation within the meaning of the Code of Practice on Disclosure (for the purposes of applications made in relation to any sub-contractors of the Contractor) and that it complies at all times with the provisions of the Rehabilitation of Offenders Act 1974, the Police Act 1997, the Police Act 1997 (Criminal Records)(w) Regulations 2006 and the Code of Practice on Disclosure as amended from time to time;

(f) ensure that it shall not (and shall procure that its sub-Contractors shall not) employ or engage any person in relation to the Services unless the highest form of available Disclosure is obtained by the Contractor as follows:

(i) if such person would be employed or engaged in an ERC Position or CRC Position, unless and until such person provides the Contractor with Enhanced Disclosure and the relevant Standard Disclosure as appropriate; and

(ii) unless and until such person to whom paragraph 4.1(f)(i) would not apply provides the Contractor with Standard Disclosure and, for the avoidance of doubt, if it is not possible to obtain Enhanced Disclosure from the Disclosure and Barring Service (DBS) (formerly the Criminal Records Bureau) in respect of such person, unless and until such person provides the Contractor with a copy of the information supplied by the relevant Data Controller in response to a subject access request by such person in respect of Personal Data held on the Police National Computer in relation to that person;

(g) ensure that it shall not (and shall procure that its sub-contractors shall not) employ or engage any Overseas Person in relation to the Services unless and until the Contractor and/or any sub-contractor of the Contractor and/or

the Overseas Person (as the case may be in each relevant country) provide(s) Overseas Disclosure in respect of:

(i) each country outside the United Kingdom of which the Overseas Person is a citizen;

(ii) each country outside the United Kingdom of which the Overseas Person holds a relevant professional qualification; and

(iii) each country outside the United Kingdom of which the Overseas Person has worked;

save in circumstances in which it is not possible for the Contractor and/or any sub-contractor of the Contractor and/or the Overseas Person using best endeavours to obtain Overseas Disclosure in or in relation to a particular country. For the avoidance of doubt, Overseas Persons shall also be subject to the DBS provisions set out in paragraph 4.1(f) and the Contractor shall obtain, or procure the obtaining of by any sub- Contractor of the Contractor /or the Overseas Person, as appropriate, (in respect of any country where Overseas Disclosure is available) the highest form of available Overseas Disclosure. In circumstances in which it is not possible in respect of an Overseas Person for the Contractor and/or any sub-contractor of the Contractor and/or the Overseas Person using best endeavours to obtain Overseas Disclosure in relation to a particular overseas country, the Contractor shall (and shall procure that any sub-contractor of the Contractor shall) not employ or engage any such person in relation to the Services by the Contractor or any sub- Contractor of the Contractor, without the Commissioner's prior written consent;

(h) procure that no person (which shall for the purposes of this paragraph include any Overseas Person) who discloses any Convictions, or in respect of whom any other matter is revealed following Disclosure or Overseas Disclosure, in either case, of which the Contractor is aware or ought to be aware, is employed or engaged in the provision of the Services or any activity related to or connected with the provision of the Services by the Contractor or any sub- Contractor of the Contractor, without the Commissioner's prior written consent; and

(i) ensure that the Commissioner is kept informed at all times of any person employed or engaged by the Contractor or any of its sub-contractor s in relation to the Services who, subsequent to his/her commencement of such employment or engagement, receives a Conviction of which the Contractor or any sub- contractor of the Contractor becomes aware or whose previous Convictions become known to the Contractor or any sub-contractor of the Contractor:

4.2. The Contractor shall implement an appropriate competency assessment process that includes competency assessment tools, to assess the practical competency of all Clinical Staff on recruitment. The Commissioner reserves the right to introduce specific appropriate competency assessment tools at any time during this Contract, and require the Contractor to include them in its recruitment and induction process.

4.3. The Contractor must implement a comprehensive induction programme and shall ensure that every member of Contractor Staff is trained and assessed as competent during induction to:

(a) administer basic life support; and

(b) use automated external defibrillators.

4.4. The Contractor shall have in place contingency arrangements to ensure adequate, available cover in the case of any:

(a) planned or unplanned increases in workload;

(b) Contractor Staff absences; and

(c) medical emergencies.

4.5. The Contractor shall make available to all Contractor Staff as soon as reasonably practicable, a staff handbook that will include details of its:

(a) employment terms and conditions;

(b) HR policies; and

(c) performance management policy.

4.6. The Contractor shall manage the Contractor Staff based on principles of equal opportunity, anti-discriminatory practice, equity and fairness, communication and involvement and confidentiality.

4.7. The Contractor shall have a comprehensive health and safety policy that complies with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999). The Contractor shall ensure that the health and safety policy includes:

(a) the written statement (as required by section 2(3) of the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999, if applicable) (or EU member state equivalent) of the organisation;

(b) the name and status of the person responsible for the implementation of the organisation's health and safety policy;

(c) a description of how the Contractor will manage its obligations in respect of health and safety at work; and

(d) a description of how health and safety responsibilities are allocated within the organisation.

5. Terms and Conditions and Employee Relations

5.1. The Contractor shall:

(a) ensure that all monies, salary, benefits, tax and national insurance contributions due to be paid to any Contractor Staff or the Inland Revenue, relating to the provision of Services by the Contractor, shall be paid up in full by the Contractor and the Contractor shall fully indemnify the Commissioner in respect of any losses incurred by the Commissioner as a result of the Contractor 's breach of this paragraph 5.1(a); and

(b) ensure that its human resources and workforce policies and procedures do not conflict with the aims and objectives of the HR strategy elements in the

NHS Plan, adhere to best employment practice in the NHS contained in the document entitled "Improving Working Lives" (available on https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelemployer/Improvingworkinglives/index.htm and the "Agenda for Change" and "Pay Modernisation" initiatives.

6. Staff Performance Management

6.1. The Contractor shall:

(a) put in place a performance management policy and suitable arrangements for handling concerns about the conduct and performance of all Contractor Staff;

(b) comply with the requirements of the regulatory bodies for revalidation and re-registration;

(c) put in place processes to ensure robust clinical governance and perform appropriate clinical audits for the continuing professional development of Contractor Staff needs following regular appraisals of Contractor Staff; and

(d) ensure that Contractor Staff are aware of the needs of those working in a health service environment, observe the highest standards of hygiene, customer care, courtesy and consideration, and keep confidential all confidential information and information relating to any Patient.

6.2. The Commissioner shall have the right to order the removal from the performance of the Services, or prohibit from further involvement in the provision of the Services any person employed or engaged by (or acting on behalf of) the Contractor whose presence and/or involvement, (in the opinion of the Commissioner) is likely to have a material adverse effect on the performance of the Services or is otherwise undesirable. The decision of the Commissioner in this regard shall be final and conclusive and the Contractor shall immediately comply with such instruction. Any such instruction shall not give rise to any liability whatsoever on the part of the Commissioner to the Contractor or any other party and shall not affect in any way the obligations of the Contractor to

carry out the Services to the Specifications. Where any such person is removed, the Contractor shall, as soon as it is reasonably practicable thereafter, supply a replacement where, as agreed between the parties, this is required to ensure the proper performance of the Services and/or to ensure that the Contractor complies with its obligations to carry out the Services to the Specifications.

6.3. The Contractor shall ensure that appropriate arrangements are in place for the supervision of all Clinical Staff. For GPs, this will include the conduct of peer reviews of each other's performance once a month, to assess their own work and discuss clinical outcomes and specific cases of clinical importance for the team. The Contractor shall ensure that this process is conducted in line with good audit practice.

7. Contractor Staff Training and Development

7.1. The Contractor shall:

(a) ensure that all Contractor Staff involved in treating Patients are appropriately trained and competent to carry out the roles required of them for the duration of this Contract;

(b) facilitate and provide access to the training and continuing professional development of Contractor Staff and ensure that all Contractor Staff receive such training, supervision and induction as is necessary to ensure the proper performance of the Services in accordance with this Contract;

(c) develop and implement a training plan for all Contractor Staff to ensure the safe and correct operation of all systems and equipment and adherence to processes and procedures in order to meet mandatory/statutory training requirements;

(d) implement a continuing professional development (CPD) plan for all Contractor Staff which will:

(i) promote a patient-centred approach, including the dignity of the Patient, carers and relatives;

(ii) ensure that all Clinical Staff involved in treating patients are appropriately skilled, trained and competent to carry out the roles required of them for the duration of the Contract;

(iii) ensure the safe, correct and up to date operation of all systems, processes, procedures and equipment;

(iv) respond to individual training needs arising from Contractor Staff performance appraisal and clinical supervision;

(v) respond to the individual professional development needs of Contractor Staff;

(vi) support workforce strategies;

(vii) comply with the provisions of Standards of Better Health and equal opportunities and anti-discriminatory employment legislation;

(viii) meet the requirements of professional bodies for re-registration and revalidation; and

(e) ensure that clinical supervision for GPs includes the conduct of peer reviews of performance no less than once every month to discuss the work of the GP, clinical outcomes and specific cases of clinical importance to the team.

(f) The Contractor will encourage and enable staff to participate in London and national homeless health clinical and practice networks.

8. Consequences of Termination

8.1. The Contractor shall:

(a) for a reasonable period both before and after the termination of this Contract, fully co-operate with the Commissioner and any successor providing services similar to the Services (or any part of them) in order to achieve a smooth transfer of the delivery of such services and to avoid any inconvenience or any risk to the health and safety of Patients and/or of employees of the Commissioner and/or members of the public, including

continuing to provide the Services (which shall be paid for by the Commissioner in accordance with this Contract) until otherwise directed by the Commissioner; and

(b) fully co-operate with the Commissioner in the event that the Commissioner conducts a competition prior to the Expiry Date with a view to entering into a contract for the provision of services (which may or may not be the same as, or similar to, the Services or any of them) following the expiry of this Contract, including providing any information which the Commissioner may reasonably require to conduct the competition (such as information relating to the terms and conditions of employment or engagement of Contractor Staff and numbers and job descriptions of Contractor Staff involved), although the Contractor shall not be required to provide information which is commercially sensitive (i.e. information which would, if disclosed to a competitor of the Contractor, give that competitor a competitive advantage over the Contractor and thereby prejudice the business of the Contractor).

8.2. The Contractor shall:

(a) ensure that it adheres to Data Protection Legislation, particularly in respect of personal information relating to individuals employed by the Contractor; and

(b) comply with all relevant Laws and Codes of Practice relating to employment in relation to all Contractor Staff.

9. Equal Opportunities

9.1. The Contractor shall:

(a) not unlawfully discriminate against any person within the meaning of the Part Time Workers (Prevention of Less Favourable Treatment) Regulations 2000, the Fixed Term Employees (Prevention of Less Favourable Treatment) Regulations 2002 and the Equality Act 2010 including on the grounds of, without limitation, age, race, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation;

(b) comply with all current equality legislation including, without limitation, the Equality Act 2010 and any other Law relating to discrimination in the provision of the Services and, without limitation, any obligations contained within such legislation and Law to have due regard to the need to eliminate unlawful discrimination and harassment and to promote equality of opportunity in employment;

(c) adopt policies to comply with their statutory obligations under the Equality Act 2010 and any other Law relating to discrimination in the provision of the Services, and confirm to the Commissioner details of such policies;

(d) take all necessary steps (and deliver to the Commissioner full details of the steps taken) to prevent recurrence of unlawful discrimination designated as such by any court or tribunal, or Commission for Racial Equality ("CRE"), the Equal Opportunities Commission ("EOC"), the Disability Rights Commission ("DRC") or the Equality and Human Rights Commission ("EHRC") or any successor body to the CRE, EOC, DRC or EHRC;

(e) comply with all Codes of Practice (as amended or replaced from time to time) issued by the CRE, the DRC, the EOC or the EHRC (or any successor organisations) for the elimination of discrimination and harassment and the promotion of equal opportunity in employment and provide such information as the Commissioner may reasonably request for the purposes of ascertaining compliance with this paragraph 9.1(e); and

(f) comply with any other requirements and instructions which the Commissioner reasonably imposes in connection with any statutory equality obligations imposed on the Commissioner at any time.

10. Blood Borne Viruses

10.1. The Contractor shall:

(a) in respect of Contractor Staff (but excluding Exempt Staff) that are or may be engaged on Exposure Prone Procedures, comply with BBV Guidelines;

(b) ensure that all Contractor Staff are kept fully aware of their professional, Contractual and statutory obligations (as applicable to their speciality) to disclose, or seek testing for Blood Borne Viruses following any incident which carries a risk of infection or exposure to infection (including needlestick injuries) or which become known to staff members as a result of any medical examination or testing;

(c) ensure that occupational health services are available to support the Contractor in complying with the requirements in this paragraph 10.1;

(d) ensure the Contractor's recruitment and health and safety policies include and are implemented to give effect to the requirements in this paragraph 10.1;

(e) comply with all circulars, instructions, directions, guidance, regulations, codes and/or requirements of the NHS and/or the Authority in respect of any Contractor Staff in connection with Blood Borne Viruses and Exposure Prone Procedures;

(f) ensure for each and every member of Exempt Staff prior to his or her engagement on Exposure Prone Procedures that the Contractor has received (subject to Law) written confirmation from the NHS Body that employs such person that the engagement of the relevant member of Exempt Staff on Exposure Prone Procedures does not or would not breach BBV Guidelines and ensure that the relevant employing NHS Body notifies the Contractor immediately if any member of Exempt Staff that is or may be engaged by the Contractor on Exposure Prone Procedures should or would be required under BBV Guidelines to cease to or not perform Exposure Prone Procedures. If the Contractor receives such notification it shall if appropriate and in accordance with BBV Guidelines, ensure that the member of Exempt Staff who is the subject of the notification ceases to or does not perform Exposure Prone Procedures.

Service Mobilisation / Transition Plan

The contractor shall ensure that those services and requirements described in this contract are implemented in accordance with the timetable and plan described below.

For the avoidance of doubt where any service or requirement is not specified in the Service Mobilisation / Transition Plan this shall be deemed to have been implemented by the contract commencement date.

This plan was proposed by the contractor as part of their successful tender bid and forms part of this contract agreed between the Commissioner and Contractor as part of the negotiations

Insert Contractors Service Mobilisation / Transition Plan

Annex 1 (of Schedule 2)

Part 1

Patient Registration Area and Outer Boundary Area

Reference: Clause 31.2

[INSERT DETAILS / MAP HERE]

Part 2 –

GP Patient Registration Standard Operating Principles for Primary Medical Care (General Practice)

Reference: Schedule 2 Part 2 Paragraph 2.5

See Schedule 2, Part 2, Annex 1