**Extended Access Service Specification (DRAFT)**

**(January 2018)**

**NHS Crawley CCG**

**NHS Horsham & Mid Sussex CCG**

Extended Access Service Specification

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**SERVICE SPECIFICATION**

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| **Service Specification No.** |  |
| **Service** | Extended hours access to primary care |
| **Commissioner Lead** | Clare Allcock |
| **Provider Lead** |  |
| **Period** | Service to be provided from 1st October 2018 |
| **Date of Review** | March 2019 |

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| **Introduction:** |
| * 1. **Overview of The Clinical Commissioning Groups/The Commissioners**   Horsham and Mid Sussex (HMS) CCG has 23 member GP practices and it commissions on behalf of a current population of approximately 236,000 patients. Crawley CCG has 12 member GP practices and it commissions on behalf of a current population of approximately 131,000 patients. The CCGs (the Commissioners) are run by local GPs and have been given the stewardship of significant resources to be spent on improving the health of the populations of Horsham and Mid Sussex and Crawley and on delivering health services that meet our population needs.  CCGs, which have responsibility for two thirds of health service funding, are well placed to implement flexible solutions that benefit the local population and embrace the opportunities offered through partnership working with social care and other organizations. |
| The CCGs have growing populations with significant increases in the over 65s. **Horsham & Mid Sussex** has an older age structurethan the national average and the population is projected to increase within the next 20 years and will be living longer with complex needs. In 20 years there is an expectation that there will be a 72.1% increase in the female population and 101.2% increase in the male population over the age of 75. In Horsham & Mid Sussex 74% of those over 65 have at least one long term condition, compared with 27% of those under 65. Whilst deprivation is lower than the national average there is inequity in life expectancy. If we do nothing, the effects of demography and new housing on non-elective bed days for over 75s for example, are predicted to be an increase of 163% for male bed days and an increase of 108% for female bed days by 2035.  **Crawley** has a younger age structure and higher proportion of BAME population than the national average. 79% of those 65+ have at least one LTC compared with 28% of those under 65. Whilst deprivation is lower than the national average there is inequity in life expectancy. Over the next 20 years we expect a 54.5% increase in females and 89.7% increase in males over 75. If we do nothing, the effects of demography and new housing on non-elective bed days for over 75s for example, are predicted to be an increase of 77% by 2035.  There are significant housing developments planned in Horsham & Mid-Sussex and Crawley. This will have a major impact on the service planning as older people are more likely to experience disability and long-term conditions and therefore have greater need for health and social care provision in the future.  By the year 2022 it is anticipated that the population living to the age of 85 in Crawley, Horsham and Mid-Sussex localities will be 2.5 times greater than the current number. The table below shows the population increase aged over 65 since 2001   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Area** | **2001 Census** | **2011 Census** | **Change** | **% Change** | | **Horsham** | **20,600** | **25,600** | **5,000** | **24.3%** | | **Mid-Sussex** | **21,600** | **25,300** | **3,700** | **17.2%** | | **Crawley** | **14,600** | **13,500** | **-1,100** | **-7.5%** |   The table below shows the population aged over 85 has increased significantly since 2001 and is predicted that the population will almost double by 2030   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Area** | **2001 Census** | **2011 Census** | **Change** | **% Change** | | **Horsham** | **2,900** | **3,700** | **800** | **27.6%** | | **Mid-Sussex** | **3,100** | **3,900** | **800** | **25.8%** | | **Crawley** | **1,400** | **2,000** | **600** | **42.9%** |   Whilst people are living longer, healthy life expectancy is not increasing proportionately and we are facing a developing burden of avoidable illness from unhealthy lifestyles – the cost of meeting this demand is rising more quickly than we can afford. At the same time, locally, general practices and community-based services are increasingly struggling to meet the current demands, with greater pressure from high levels of staffing vacancies that are difficult to recruit to, and increasing workload due to patients with ever more complex needs. It is clear that we cannot continue to deliver services in the way we always have. The CCGs intend to commission a new model of care which addresses the three gaps set out in the Five Year Forward View and delivers on the triple aim – improving the health of the population; enhancing the patient care experience; and reducing per capita cost of care.   * 1. **Strategic vision:**   As CCGs we want to invest to develop a system of healthcare for our local population that is less reactive and less hospital bed-based. It will deliver a great start in life and continue to promote people’s wellbeing, their ability to stay healthy, to self-care and be cared for at home. Primary and community care services are the first point of contact with the NHS for most people; to this end we see primary care as the system leaders within this vision, firmly at the centre of a proactive, locally delivered, integrated service, providing more accessible care and services closer to patients’ homes.  To deliver this vision we need to create a fundamental change in the way urgent and emergency care services are provided to all ages, improving out-of-hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions. We need a system that is safe and sustainable and one that provides high quality care consistently. Improving access to primary care through the delivery of Extended Access needs to be part of a broader urgent care offer that provides a highly responsive service, delivering care as close to home as possible, minimising disruption and inconvenience for patients, carers and families. This then would allow the freeing-up of emergency care for those people with more serious or life-threatening emergency care needs.  As set out by NHS England in their paper ‘Transforming Urgent and Emergency Care Services in England’ (issued August 2015): ***“urgent care in general practice matters”***. Primary care clinicians have many more interactions with patients than any other part of the NHS. Early diagnosis and treatment in primary care reduces harm and distress for patients. Effective and timely responses can prevent the need for unwell adults and children to use emergency departments. Our overall aim is that no patient should have to attend A&E as a walk-in because they have been unable to get an urgent appointment with a GP.  Supporting a sustainable general practice for the future is a key priority for our CCGs and we are actively supporting general practice across our five towns (Horsham, East Grinstead, Haywards Heath, Burgess Hill and Crawley) to work more collaboratively together to be able to deliver a wider range of services.   * 1. **Confidentiality and Intellectual Property Rights (IPR)**   The confidentiality and IPR clauses stated within NHS standard terms and conditions (APMS Contract) shall apply.   * 1. **Interpretation of this Service Specification**   Any conflict, perceived or actual, adduced within this Service Specification and/or within any referenced documents and/or between this Service Specification and any referenced documents shall be referred to the Commissioners for resolution. The Commissioners’ decision(s) shall be final.   * 1. **Status of this Service Specification**   This Specification is a draft version and may be subject to change(s) by the Commissioners at any time in order, *inter alia*, that they may deliver on the intent and purposes of the GPFV and NHS(E). |
| **2. National and local context for Extended Access** |
| * 1. **National context for Extended Access**   Nationally, the public’s satisfaction with general practice remains high but increasingly patients are reporting more difficulty in accessing services and there has been a decline in patients reporting a ‘good’ overall experience of making an appointment’ over the last four years. The General Practice Forward View (GPFV) published by NHS England on 21 April 2016 aims to support the sustainability of primary care and to improve access for patients. The five year plan (part of the GPFV) includes an increase in funding to expand the workforce, improve the infrastructure and support a major programme of improvements to strengthen and redesign primary care. The GPFV allocates investment to support delivery, the largest pot of money available nationally being for Extended Access, with £500 million committed for the period ending 2020/21; this is intended to enable CCGs to commission and fund additional capacity across England to ensure that everyone has access to GP services including sufficient routine appointments at evenings and weekends, alongside effective access to Out-of-Hours and urgent care services. The 2017/19 NHS Shared Planning Guidance sets out the funding trajectory for this work, supporting CCGs to deliver Extended Access as part of delivering the GP Forward View.  NHS England have developed 7 core national requirements for the delivery of Extended Access in order to bring parity to the Extended Access offer across the country; these are reflected throughout this Service Specification:  **Timing of appointments:**   * Weekday provision of access to pre-bookable and same day appointments to general practice services during evenings (after 6:30pm) – to provide an additional 1.5 hours a day; * Weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays; * Ensure proposed distribution of Services is based on utilization rates that reflect the need for Services across the week.   **Capacity:**   * A minimum additional 30 minutes consultation capacity per 1000 head of population, rising to 45 minutes.     **Measurement:**   * A new tool, nationally commissioned by NHS England to automatically measure appointment activity, shall be used by the Provider(s) from the time of its availability. If necessary, the Commissioners and the Provider(s) shall discuss and agree any interim arrangements pending availability of the new tool.   **Advertising and ease of access:**   * The Provider(s) shall ensure that Services are advertised effectively to patients, including but without limitation, notification on practice websites, notices in local urgent care services and publicity in the community, so that it is clear to patients how they can access these appointments and the Service. * Patients shall be offered a choice of evening or weekend appointments on an equal footing to core in-hours primary care appointments. * The Provider(s) shall ensure ease of access for patients including enabling all practice receptionists to direct patients to the Service and to offer appointments to Services on the same basis as standard appointments to non-extended hours services.   **Digital:**   * Use of digital approaches to support new models of care in general practice.   **Inequalities:**   * Issues of inequalities in patients’ experience of accessing general practice shall be identified by local evidence and actions to resolve put in place.   **Effective Access to wider whole-system services:**   * Effective connection to other system services enabling patients to receive the right care from the right professional including access from and to other primary care and services such as urgent care.   To deliver their commissioning vision the CCGs recognize that the provision of Extended Access within primary care is not just about delivering additional appointments in general practice; it also provides the opportunity to link Extended Access with the vision for developing primary care at scale as part of a wider set of integrated services including, where possible and appropriate to do so, integration of Extended Access with Out-of-Hours services and urgent care services, including reformed 111 and local Urgent Treatment Centres. The Provider(s) shall support the CCGs in their commitment to ensuring that the Extended Access Service addresses the requirements of the national Urgent and Emergency Care Delivery Programme and maximize the opportunities presented to deliver a safe, high quality service, responsive to local needs and systems which demonstrate excellent value for money.  **2.2 Local Context for Extended Access**  The CCGs recognise that there are significant challenges across local general practice including practices struggling to meet the current access demands. The CCGs are also seeing a decrease in the number of practices providing the Extended Hours Directed Enhanced Service (DES), creating an inconsistent access offer and fewer opportunities for patient access outside current core GMS contracted hours. It is believed that there is not enough capacity in local general practice to deal with both on-the- day demand and to deliver high quality proactive care to complex patients who are extensive users of primary and specialist services. It is also known that there are significant housing developments in progress or planned across most of the CCGs’ localities over the coming years, bringing with them population growth which will increase demand. A range of organisations provides the current urgent care system across North West Sussex, offering a number of different options for people to use the system. It is recognised that some of these options duplicate each other which makes it difficult for the public to be sure they are using the right service to meet their needs. Commissioners across North West Sussex are taking a whole system approach to urgent care redesign, which will include robust alternatives in the community.  A pan-Sussex NHS111/Clinical Advice Service (CAS) will provide a consistent and resilient route for patients to access urgent telephone and face-to-face assessment in the community, along with a home visiting service.  Work is also taking place to develop Urgent Treatment Centres (UTCs) where appropriate across the CCGs’ localities.  There is currently an established UTC at Crawley Hospital which fulfils national standards regarding operational hours and service provided and the CCGs are in the options appraisal phase for the transformation of current local Minor Injuries Units into UTCs and consideration of whether more urgent care support is required at Acute sites such as Princess Royal Hospital.  **Local commissioning plan:**  As described above the need is to align the available commissioning opportunities to deliver improved access in primary care, and simplify pathways into the local urgent and emergency care system. There is an opportunity to improve patients’ experience of urgent care and perceptions of access to primary care by redesigning the current local urgent care system, increasing the functions of NHS111/CAS, realigning some of activity that is currently provided under an Out of Hours contract and introducing the Extended Access Service functions as described in this Specification. The Out of Hours contract activity that is realigned and introduced as part of the Extended Access Service will carry with it the appropriate funds disaggregated from the current Out of Hours contract, funding additional capacity to enable direct booking from NHS111/CAS into the Extended Access service.  **Current urgent care system:**  **Future state:**  The CCGs intend to develop this model further in dialogue with prospective providers of the Services, including the following developments to be delivered through a phased planned approach to be agreed between the Provider(s) with Commissioners and other service providers:   * Delivery of current weekend Out-of-Hours base face-to-face activity, occurring between 18.30-20.00 weekdays and 08.00-20.00 at weekends, through Extended Access. * Extended Access Hubs aligned/co-located with UTCs and emergent UTCs within the CCG localities, working in an integrated way to deliver booked appointments at weekends in partnership as part of the urgent care weekend offer. * Offering a booking system via the patient’s registered practice and NHS111/CAS that requires only one call on the patient’s behalf. * Development of pathways between ambulance services, emergency departments, acute services, NHS111/CAS into the Extended Access Service for patients deemed unsuitable for an emergency response that could be managed appropriately in a primary care environment. * The introduction of a range of alternative forms of consultation, including telephone and, potentially, video, email and online after further development work. * Online booking capability for patients. * Development of the range of services delivered by Extended Access by diversifying and expanding the workforce as appropriate to need.   **2.3 Geographical Coverage**  The CCGs intend to commission Extended Access based around delivery to the local populations across Horsham, East Grinstead, Haywards Heath, Burgess Hill and Crawley for patients registered with the CCGs’ GP member practices.  The Extended Access service shall be responsive to local circumstance, including geography, population spread and need, as well as the configuration of local urgent care such as UTCs.   * 1. **Managing Conflicts of Interest**   Acknowledging the unique position of actual and potential relationships within the CCGs, it will be critical to carefully manage all conflicts of interest, whether real or perceived, throughout the process to procure and commission the Extended Access Services. The CCGs have developed a Conflict of Interest management plan (‘COI Management Plan’) that follows the principles of the CCGs’ Procurement Policy, ensuring all aspects are managed accordingly so as to not prejudice the procurement process. In developing this COI Management Plan the CCGs have recognised that the clearly stated national direction on the use of the Extended Access funding (vide GPFV) already provides a level of mitigation against Conflicts of Interest as the CCGs are clearly fulfilling a national directive. All GPs working on the project have been made aware of, and have confirmed they will abide by, the agreed management plan. |
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| **3. Scope of the Extended Access Service:** |
| **3.1 Aims and objectives of the Extended Access Service:**  The overall aim, as expressed in the GPFV, is that no patient should have to attend A&E as a walk-in patient as a result of being unable to get an appointment, urgent or otherwise, with a GP.  Extended Access Services will improve access and experience for patients by:   * Providing additional capacity for pre-bookable, urgent on the day appointments and appointments booked 5 days in advance ahead, which are more convenient for patients and offer shorter waits, both during and outside traditional general practice hours. * Providing the technical capabilities required to deliver Extended Access including the appropriate solutions to communicate interventions and outcomes with core hours’ primary care providers and the local urgent care system. * Ensuring services are advertised throughout the local community including local general practice and urgent care facilities so that it is clear to patients how they can access the Services. This shall include actions that address inequalities of access identified by local evidence. * Working in close partnership with providers of in-hours primary care and all parts of the urgent care system to ensure effective, efficient service delivery. * Freeing up time during in-hours primary care service hours that enables local general practice to provide more proactive care to patients with complex conditions, for example the management of long-term conditions. * Developing the range of services offered by the wider primary care team, such as Practice Nurses, Advanced Nurse Practitioners and Paramedic Practitioners. * Reducing variation in access to general practice. * Supporting wider systems’ resilience by providing additional primary care capacity.   **3.2 Implementation:**  From 1st October 2018, the Provider(s) shall fulfill the Commissioners’ requirement for 100% population coverage by the Extended Access Service, at a minimum of 30 minutes’ additional consultation capacity per 1,000 head of population. Additionally, the Provider(s) shall use best endeavours to support the Commissioners’ ambition to increase this to 45minutes by/from 1st April 2019.  **3.3 Service description/care pathway**  As a minimum, the Provider(s) shall operate the Extended Access Services between the hours of 16.00 -20.00 weekday evenings, 08.00 – 20.00 Saturday’s, Sunday’s and on Bank Holidays and public holidays, 365 days per year. Pre-bookable appointments shall be available for urgent on-the-day and routine appointments, up to 5 days in advance of needs. Appointments shall be pre-booked via the patient’s registered practice (with only one call necessary on the patient’s behalf) and by the NHS 111/CAS at a date to be mutually agreed.  The Provider(s) shall be afforded access to the patients’ records as necessary, sufficient to be able to deliver the Services.  **Nature of the Services:**  The Extended Access Service, when realised, will provide a Service equivalent in all material respects to a full General Practice service to the registered populations of East Grinstead, Horsham, Haywards Heath, Burgess Hill and Crawley. The Provider(s) may supply Services using team(s) of health professionals including GPs, Nurses, Health Care Assistants and emerging roles in primary care for example Pharmacists, Paramedics or Physiotherapists all of which can be included in the 30 minutes per 1000 population capacity required. Other services may be offered, for example care navigators, but such roles shall not be counted towards the 30 minutes per 1000 population capacity requirements. The Provider(s) should aspire to ensure services are provided where possible by local GPs and staff who have a good knowledge of the local health and social care system.  **Location of Services:**  Commissioners aspire to establish 5 (five) Extended Access Hubs across the CCGs’ geography, (in East Grinstead, Horsham, Haywards Heath, Burgess Hill and Crawley) providing Extended Access Services to GP-registered populations across both CCGs. The Extended Access Services shall be provided from Hubs sited at recognisable and accessible locations convenient for the local population with transport links and available parking, enabling colocation/integration with the related local urgent care services. Provider(s) shall ensure strong links to community care services such as mental health, community pharmacy, social care and the voluntary sector which will be beneficial in providing an effective and integrated service.  **Capacity Plan:**  Services delivered from the Extended Access Hubs shall comprise a minimum of 4 hours of additional consultation capacity on weekdays between 16.00-20.00 and 12 hours on Saturday, Sunday and Bank Holidays between the hours of 08.00-20.00. The Service shall deliver a minimum additional 30 minutes consultation capacity per 1000 head of population equating to the following number of hours per week in each locality. As previously stated, the CCGs’ ambition is to increase this capacity to 45 minutes by/from April 2019 and the Provider(s) shall use best endeavours to support the CCGs in this.   |  |  |  | | --- | --- | --- | | **Locality** | **30mins consultation capacity per 1,000 head of population** | **45mins consultation capacity per 1,000 head of population** | | **Crawley** | **66hrs p/w** | **99hrs p/w** | | **Burgess Hill** | **27hrs p/w** | **40.5hrs p/w** | | **Haywards Heath** | **32.5hrs p/w** | **48.75hrs p/w** | | **East Grinstead** | **20.5hrs p/w** | **30.75hrs p/w** | | **Horsham** | **39hrs p/w** | **58.5hrs p/w** | |  |  |  |   The Provider(s) shall deliver the Services so as to offer the maximum appointment capacity possible within the stated hours of operation, improving access to general practice services across the week for both urgent and routine needs. The Service ‘go live’ pattern of capacity across the week will be based on robust evidence of utilization rates available at the time in order to deliver the minimum 30 additional minutes of consultation capacity required per 1,000 head of population from 1st October 2018, with the aim of increasing this to 45mins by/from 1st April 2019. The Provider(s) shall be responsible for managing capacity and ensuring prioritisation of appointments for patients with urgent care needs. The Provider(s) shall have robust contingency policies/plans and systems in place for managing unexpected surges in demand. This may include the provision of patient education and advice on self–care management. Any proposed changes to capacity at Hubs shall be pre-agreed between Provider(s) and Commissioners via reviews of utilisation across the Hubs, demand patterns and opportunities to create efficiencies.  **Pathways and appointment booking:**  The Extended Access Service should be an extension to general medical services and patients should experience this when they book and attend extended access appointments.  The Extended Access Services shall operate in an integrated way with general practice across the CCGs, NHS 111/CAS, Out-of-Hours and local A&E departments.  Provider(s) shall avoid the introduction to the public of new telephone numbers for the Extended Access Service.  The Provider(s) shall ensure that the contact details, location and operational delivery times of each Extended Access Hub are included in the NHS 111 Directory of Services.  All consultations at the Extended Access Hub shall be booked appointments; Extended Access shall not be a walk-in service where patients arrive and queue.  Entry points into the Extended Access Hub shall only be via the patient’s registered practice and/or NHS 111.  Appointments shall be booked via the patient’s registered practice following the appropriate triage process, if the practice does not have available appointments at suitable times, or the patient requests an appointment during the Extended Access Service operational hours. Practice receptionists shall offer appointments within the Extended Access Services on an equal footing to standard appointments at the registered practice. Some appointments shall be pre-bookable up to 5 days in advance; some shall be pre-booked on the day to meet urgent needs.  The Provider(s) shall ensure that NHS 111, following the appropriate triage process, shall have access to a number of bookable urgent on-the-day appointments and appointments up to 5 days in advance. The number of these appointments shall be subject to local demand according to utilisation and need. Patients triaged by NHS 111 as requiring/seeking routine appointments beyond 5 days shall be re-directed to their registered practice.  The Provider(s) shall ensure the adequacy of appropriate triage/decision-making processes at patients’ registered practices and via NHS111 in order to ensure equity of access and maximum use of available capacity.  The Provider(s) shall ensure pathways are in place to support onward referrals to secondary care specialists (excluding 2 week wait) and diagnostics either directly from the Service or from the registered GP as per the CCGs’ demand management process; the Provider(s) shall ensure this is efficient and effective. Governance arrangements in place shall support and secure smooth effective Services which reflect core GMS. The Provider(s) shall be responsible for ensuring comprehensive governance structures are in place for the implementation of pathways and ensure that adequate responsibility and accountability is transparent and clear. The Extended Access Service shall support access to Pharmacists and Pharmacies, where necessary, to ensure that access to medication is prompt and easy. The Service shall also seek and support integration with pharmacy services, particularly with local community pharmacies and ‘100 hours’ pharmacies.  **3.4 Inclusions in and Exclusions from the Services**  The following table makes explicit a number of inclusions and exclusions:   |  |  | | --- | --- | | **Service Offering** | **Available** | | **WHO** |  | | 1. For patients on the registered lists of GP practices within the CCGs | Yes | | 2. For patients on the registered lists of GP practices outside the CCGs | **No** | | 3. For temporary residents | Yes | | 4. For unregistered patients (Immediate and Necessary patients) | Yes | | 5. For vulnerable / homeless patients | Yes | | 6. For hard-to-reach patients | Yes | | **HOW** |  | | Pre-booked appointments – up to 5 days in advance | Yes | | On-the-day urgent appointments | Yes | | Face-to-face consultations | Yes | | Walk-in consultations | **No** | | Further alternative forms of consultation: Video, email and online | YES - To be tested and implemented via a Service Delivery Improvement Plan (SDIP) at time to be agreed by Commissioners & Provider(s) | | Appointment bookable via own practice on phone or in person | Yes | | Appointment bookable on phone via NHS 111/CAS | Yes | | Appointment bookable by attendance in person at an Access Hub | **No** | | Appointment bookable on phone by patient ringing Access Hub | **No** | | Appointment bookable online | YES - To be tested and implemented as appropriate via an SDIP at time to be agreed by Commissioners & Provider(s) | | Appointment bookable via UTC and local A&E departments | **Not directly.** | | Hub arranges follow-up appointment with patient’s own GP practice | **No**  Patient contacts own practice | | **WHAT** |  | | Urgent or Unscheduled Care | Yes | | Routine care | Yes | | Essential services including management of patients who believe themselves to be ill | Yes | | Appropriate assessment, diagnosis, treatment (including prescribing of presenting complaints), care, and health promotion | Yes | | Diagnostics requests - as available to GPs in a CCG GP practice - with a process for results to be seen and actioned by the patient’s own GP | Yes | | Referrals–on to other services as necessary and appropriate, to the same standards, protocolsand pathways as in Horsham & Mid Sussex CCG/Crawley CCG GP practices | No  All referrals, excluding 2 week wait, to be worked up and sent to the registered practice for review and final action as per CCG demand management process. | | Working in partnership with the patient’s own GP and other services for on-going holistic care. | Yes | | Accurate record keeping with a summary included in the patient’s record. Use of appropriate digital solution to enable safe and high quality patient care to be delivered. | Yes | | Basic sexual health services | Yes | | Cervical screening (follow-up with registered GP Practice) | Yes | | Flu Immunisation | Yes | | Childhood Immunisation | Yes  but only a limited number of routine slots, and for hard-to-reach groups | | IUCD & Implanon fitting | **Not routinely**  Only opportunistic emergency contraception | | Maternity Medical Services (registered GP Practice) | **Yes**  Pregnant women to be offered Extended Access appointments **ONLY** if clinically appropriate to do so. | | Substance misuse | **No** | | Minor surgery | **No** | | Home visiting | **No** | | Phlebotomy (blood taking) | **No** | | Repeat Prescriptions | **To be decided (requires access to full medical record)** | | Private provision | **No** |   **3.5 Interdependencies in Service delivery**  The Provider(s) shall establish operational practices that ensure a seamless patient experience, based on productive integrated working which in turn requires continual focus on making communication and front line processes the best they can be for patients and interdependent professionals. An indicative (but not necessarily exhaustive) list of key partner agencies to ensure the outputs outlined in this Specification are achieved includes:  GP practices: It is key that advice and treatment provided outside core hours is integrated with routine care and patient care plans. The Provider(s) shall work with all GP practices to promote the Service and ensure that patients are given the choice of an appointment in the evening or over the weekend if this is their preference. The Provider(s) will develop robust processes to ensure the effective handover of patient care between services where clinically appropriate.  NHS 111/CAS: The Provider(s) shall work with NHS 111/CAS to ensure that there are clear pathways in place for directing patients to the Extended Access Service for both routine and urgent appointments, through comprehensive use of the Directory of Services (DoS), and that robust processes are in place to ensure effective handover of patients between services.  GP out of hours (OOH) service: As noted in section 2.2 of this draft Specification, the Commissioners intend to realign some current OOH activity into the Extended Access Service. However an interface will remain with the current OOH provision beyond the planned operational hours of the Extended Access Service. In view of this the Provider(s) will work in close partnership with the OOH provider(s)’ current arrangements to ensure robust process for effective handover and operate clear pathways for arranging a home visit out of hours should a patient need one.  Urgent Treatment Centre (UTC): The Provider(s) shall work with the local existing and emergent UTCs to ensure that there are clear pathways in place for directing patients to the Extended Access Service. It is expected that the Extended Access Service will co-locate with local UTCs where this make sense locally and provide improved access to routine and urgent appointment provision.  Community pharmacies: The Provider(s) shall work with community pharmacies to ensure there are clear pathways in place for directing patients who require pharmacy services and work towards integration of extended hours and pharmacy services.  Mental health services: The Provider(s) shall work with Sussex Partnership NHS Foundation Trust to ensure clear pathways are in place for patients with routine and urgent needs.  Voluntary services: The Provider(s) shall work with the third sector to ensure promotion of the Extended Access Service and also to ensure the voluntary sector supports the service in appropriate ways, such as supporting care navigation.  Secondary care providers: The Provider(s) shall work with local acute trusts in the area, especially the Emergency Department/s, to ensure there are clear pathways and protocols in place for redirecting patients to the Extended Access Service.  Care Quality Commission (CQC): The Provider(s) shall ensure that the Service has adequate registration with the CQC, who will regulate and monitor the Provider(s)’ activities where appropriate. |
| **4. Outcomes** |
| **4.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **✓** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **✓** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **✓** | | **Domain 4** | **Ensuring people have a positive experience of care** | **✓** | | **Domain 5** | **Treating and caring for people in a safe environment and protecting them from avoidable harm** | **✓** |   **4.2 Local defined outcomes**   |  |  | | --- | --- | | **Outcome** | **Measure** | | The Extended Access Hubs support the delivery of access to general practice 8am – 8pm, 7 days per week, and 365 days per year. | Opening hours of the 5 Access Hubs across both CCGs meet the specified demand for Services whilst delivering the core requirements regarding consultation capacity and timing of appointments. | | As a minimum in the first phase, the Extended Access Hubs shall deliver an additional 30 minutes additional consultation per 1,000 head of population capacity across the week starting from 1st October 2018 to give 100% population coverage.  A second phase plan to further increase consultation capacity to 45 minutes per 1,000 head of population from 1st April 2019 will be particularised in consultation between Commissioners and the Provider(s). | Additional capacity shall be created both within and outside of core general practice hours based on local needs, but minimally shall offer appointments between 1600-20.00 on weekdays and appointments between 0800-2000 on Saturdays/Sundays/Bank Holidays  100% of the GP-registered population of both CCGs shall have access to the Extended Access Service from October 2018.  The disposition of Hub operational hours shall reflect demand for Services across the week. | | Patients with urgent care needs shall be offered an on-the-day appointment, subject to capacity. | Capacity & Demand audits at Hubs, using the Extended Access Measurement Tool.  Data on the utilisation of urgent appointments included as a data-reporting requirement of the Extended Access Service dashboard, to be provided by the Provider(s). | | Patients with non-urgent needs shall be offered a convenient appointment up to 5 days in advance subject to capacity. | Capacity & Demand audits at Hubs, using the Extended Access Measurement Tool.  Data on utilisation of the in-advance appointments in relation to meeting patient demand for convenient Extended Access appointments shall be included as a data reporting requirement of the Extended Access Service dashboard, to be provided by the Provider(s). | | Patients will know how to access the Service | Data on utilisation and uptake of Services as measured through the Extended Access Service dashboard and use of the Extended Access Measurement Tool.  The Provider(s) shall ensure the Service is widely advertised to include (but not be limited to) practice websites, local urgent care services and within the wider community. The Provider(s) shall develop marketing and communication plans in response to any change in utilisation. | | Services provided by the Extended Access Hubs shall address local issues of inequality of access. | The Provider(s) shall utilise all information available to them to ensure that local issues regarding inequality of access issues are addressed and resolved via an action plan to be created and maintained by the Provider(s) and made available to the Commissioners.  Data sets capture the demographic profile of patients using the Extended Access Service.  Patient satisfaction plans to be designed and implemented by the Provider(s) to measure and report patient satisfaction with the Service.  Data on the distribution and utilisation of appointments across practices shall be included as a data reporting requirement of the Extended Access Service dashboard/report, to be provided by the Provider(s). | | The Extended Access Hub shall provide effective connection to other system services such as the local urgent care system. | Direct booking capability for NHS111/CAS into the Extended Access Service and data set regarding number of appointments booked via that route.  Colocation of Extended Access Hubs with/within existing Urgent Treatment Centre facilities except where it is agreed to be inappropriate to do so.  The Provider(s) shall participate as required by the Commissioners in the development of the local urgent care system. | | The associated costs of dispensing medication prescribed shall be managed by the Provider(s) within the Contract value. | Each Extended Access Hub shall have a separate prescribing code to allow for reporting and monitoring as required.  The Provider(s) shall manage associated dispensing costs within the Contract value. | | NHS 111 has the capability to book appointments within the Extended Access hubs. | Demonstrate plan to introduce and soft test NHS 111 direct booking capability to the Extended Access Hubs in the period 1st October 2018-31st March 2019.  NHS 111 has direct booking capability into Extended Access Hubs from 1st April 2019. | |
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| **5. Applicable Service Standards** |
| **5.1 Applicable national standards (e.g. NICE)**  The Provider(s) shall follow best practice in relation to NICE guidelines and any other national standard that is or becomes applicable to the Services.  **5.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**  The Provider(s) shall adhere to all standards as laid out by the GMC, RCGPs, RCN, and HPC (as appropriate).   |  | | --- | |  |   **5.3 Applicable local standards**  **Clinical Governance**  The Service shall be compliant with the APMS Contract quality requirements and have these reported as per Contract conditions. The Provider(s) shall ensure for the Services that:   * There is a named governance lead with a clinical governance supporting structure; and * There is a clinical governance audit programme and processes to monitor clinical standards (this shall be linked to the Royal College GP audit toolkit or equivalent so that there is a systemic approach to measuring outcomes).   The Provider shall establish a robust internal clinical governance structure with an identified senior clinical lead. The clinical lead shall be responsible for assuring the clinical quality of the Service and ensuring that this is supported by a suite of robust policies and procedures (and any subsequent amendments to the CCGs’ Clinical Group during mobilization and afterwards via the Clinical Quality Review Group (CQRG) for review and approval. A range of metrics will be agreed to monitor Service quality and these shall be reported to Commissioners by the Provider(s) formally at CQRG and upon request by the Commissioner.  The Provider shall ensure that:   * A named Clinical Lead is appointed to the Service to provide clinical leadership; and that a substantial and sufficient part of the Clinical Lead’s role is spent at the Services providing clinical leadership to staff; * The Clinical Lead shall be an experienced senior medical doctor who has the authority and responsibility to make decisions relating to the clinical direction of the Service; * The Clinical Lead has sufficient time and capacity to undertake their duties (part of the role of the Clinical Lead will be to link with local primary care, community based services and local urgent care providers to promote and maintain a whole system integrated response); and * The Clinical Lead, as part of their role, engages with and participates in work to develop ongoing understanding of the health needs of the local population and of local healthcare services. * The Clinical Lead, as part of their role, participates and works collaboratively with other urgent care providers in the area to ensure high quality and seamless integrated care for patients with urgent care needs.   The Provider(s)’ Clinical Lead shall be heavily involved in the development of the Provider(s)’ mobilization planning and roll out of the new Service.  The Provider(s) shall produce a monthly integrated quality report to the Commissioner. This shall form the basis of the Clinical Quality Review Group (CQRG) meeting. The Provider(s) shall produce a monthly report to the Commissioner, using data captured from electronic systems wherever possible, no later than the third Friday of the following month to which is applies.  The monthly report shall include, but not be limited to:   * Details of all KPIs within contract; * Safeguarding issues; * Incidents; * Significant incidents – both reported and concluded within period; * Complaints – divided by theme; * Health Advisor, Clinical Advisor and Clinical call and case audits; * Shift fill by clinician (including details of agency staff used); * Clinician involvement in case; * Outcome of consultation (telephone and face to face contacts) * Patient satisfaction survey; * Additional audits as agreed by CQRG (for non-exhaustive examples, infection control, antibiotic prescribing, ambulance non-conveyance reviews and drugs of potential misuse prescribing).   The report shall be prefaced with a high level summary detailing:   * Significant incidents; * Complaints; * Clinician involvement in case   The Commissioners may request audit(s)/report(s) specifically on the Extended Access Service to inform service improvement/development and the Provider(s) shall comply promptly with such request(s), within a reasonable timescale agreed with the Commissioners.  The Provider(s) shall implement a suite of standard operating procedures that comply with relevant primary and secondary legislation and relevant regulations. As a minimum this suite of procedures shall cover:  Medicines management  Staffing – appraisal, competency, training, lone working  Delivering equity of access to the Service  Communications and engagement  Information Governance  Infrastructure management – premises, technology and equipment  Patient safety  Incident reporting  Safeguarding – adults and children  Emergency planning  Complaints  Infection prevention and control  The Provider(s) shall provide copies of the standard operating procedures to the Commissioners.  The Provider(s) shall 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.  The Provider(s) shall continuously monitor and report on clinical performance in a systematic and detailed manner and evaluate serious incidents, near misses and complaints arising from activity under the Services. The Provider(s) shall use appropriate formal methods such as root cause analysis for serious incidents, near misses and complaints in order that lessons can be learnt as appropriate. This shall include robust audits of clinical care against clinical standards and in line with CQC essential standards.  The Provider(s) shall use this clinical governance framework to continuously improve the quality of its Services and safeguard high standards of care by creating an environment in which clinical excellence can flourish.  The Provider(s) shall demonstrate compliance with these clinical governance requirements to the satisfaction of the Commissioners.   |  | | --- | | **Minimum clinical governance requirements**     * Patients who require further case management/follow-up after receiving treatment during extended hours shall be discharged back into the care of their registered GP. * If any clinical and safeguarding concerns arise in relation to a patient seen by the Service, the Provider(s) staff delivering care shall notify the patient’s registered GP by the earliest working day (via telephone and email correspondence). The details of the consultation shall be updated on the patient’s electronic record. If the registered GP is not operating on an inter-operable clinical system, the details of the consultation shall be made available to the registered GP in the appropriate format. * The Provider(s) shall deliver, manage and report on services at a CCG level as well as at an individual hub point of delivery. * The Provider(s) shall ensure that all Hubs meet CQC requirements for the delivery of medical services which, as a minimum, shall be those required for the delivery of general medical services. * The Provider(s) shall ensure that all standards of communication adhere to Caldicott and Data Protection guidelines. * Data generated in the course of delivering the Services shall be available to the Commissioners on request. The Commissioners will have due regard to data protection and confidentiality requirements. * The Provider(s) shall comply promptly with Commissioner requests for clinical audit. | |
| **6. Applicable quality requirements** |
| **6.1 Applicable quality requirements**  **Quality Assurance**  The Provider(s) shall ensure that the Extended Access Services adhere to the principles and standards of the Care Quality Commission as laid out below:   |  |  | | --- | --- | | Safety | Ensure that people are protected from abuse and avoidable harm. | | Effective | Ensure that people’s care, treatment and support achieve good outcomes, promote a good quality of life and is based on the best available evidence. | | Caring | Ensure that staff involve and treat people with compassion, kindness, dignity and respect. | | Responsive | Ensure that services are organised so that they meet people’s needs. | | Well Led | Ensure that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture. |   **Information Governance and technical capabilities required**  The Provider(s) shall ensure that the appropriate Information Governance policy, processes, practice and assurances are in place to legally, safely and effectively manage all data in accordance with the Data Protection Act (1998) and General Data Protection Regulations (GDPR) Post May 2018.  The Provider(s) shall demonstrate:   * Appropriate registration with the Information Commissioner’s Office * Achievement of Data Security and Protection Toolkit (DSP Toolkit) level 2, or NHS Digital Toolkit V14.1 for current assurance, and update annually as required.  Alternatively the Provider(s) shall show evidence of plan in-place towards achieving DSP Toolkit level 2. * The appropriate data sharing agreements are in place between the Service and local general practice providers.   The Provider(s) shall provide and be responsible for a system that provides interoperability with primary care providers and other services as appropriate. The Provider(s) shall ensure that the system for the provision of Services is in place that can:   * Monitor performance outcomes * Support performance review and improvement * Develop processes to ensure confidentiality of information about patients via a Shared Data Agreement * Ensure data quality * Provide direct booking capabilities for local practices * Record and log Extended Access appointment booking via appropriate process * Accept direct bookings from the NHS 111 service * Utilise the Extended Access Measurement Tool to automatically measure appointment activity * Utilise Electronic Prescribing (EPS) * The Prescribing Support System Optimise Rx, with Crawley/Horsham & Mid Sussex profile loaded to the Provider(s) clinical system, along with the CCGs’ formulary.   Delivery of the Extended Access Service to general practice services shall embrace technology. The Provider(s) shall demonstrate that access will be improved by providing a number of alternative appointment modes such as telephone and online consultations and the promotion and use of health apps as a series of developments agreed with the Commissioners.  As a basis, the Provider(s) shall be required to have IT infrastructure in place to support the growth of technology. This shall include - but is not limited to - broadband, appropriately trained staff, electronic systems for training and multi-route communications.  The Provider(s) shall support and embrace the use of a single patient record in primary care and patient care shall be supported through the use of electronic case management systems. There shall be effective connectivity to all general practice IT systems to enable timely access to patient records and electronic transfer of patient information back to the patient’s registered practice. The Provider(s) shall support the move towards full integration of clinical systems and one patient record.  The use of technology to support new innovative ways of improving access shall also be considered. This shall include use of online consultation, remote appointments, telecare and telehealth equipment.  **Medicines Management**  The Provider(s) of the Extended Access Service shall demonstrate robust processes to ensure the safe and secure handling of medicines and medicines-related processes (including prescribing, supply and administration) in accordance with the Interface Prescribing Policy and mandatory requirements that appear in **Appendix One** of this Specification. Provider(s) shall set up as Independent Health Sector Providers as required by the NHS Business Authority. The Provider(s) shall ensure that prescribing follows the current formulary and recommendations of the CCGs. The Extended Access Service shall also comply with any other national medication policies and guidelines that are appropriate to medicines management, including infection control guidelines.  The Provider(s) shall demonstrate to the Commissioners that robust, auditable systems are in place to cover responsibility, reconciliation, record keeping and disposal requirements for the drugs for which the Provider(s) is responsible as per the mandatory requirements laid out in Appendix One. Medicines handling activities (e.g. procurement, storage, prescribing, dispensing and disposal of medicines) shall be covered by the Provider(s) standard operating procedures and shall be safe and in line with current legislation, licensing requirements and good practice. The CCGs may review the Standard Operating Procedures as part of ongoing engagement with the CCGs Medicines Management Teams. The Provider(s) shall demonstrate regular risk assessments of all processes used in medicines handling and supplying medicines to patients. The Provider(s) shall ensure that all staff involved in medicines handling and supply of medicines to patients have regular education and training needs assessments, and the Provider(s) shall be able to demonstrate that identified education and training needs of staff are met.  The Provider(s) shall gather expenditure and qualitative prescribing information from the CCGs based on FP10 prescriptions to ensure that it is prescribing/supplying medicines in a cost-effective manner according the CCGs’ Formulary and pathways to demonstrate effective budget management. The Provider(s) shall undertake regular monitoring of prescribing safety, costs, trends and formulary adherence. The Provider(s) shall highlight variances of unusual drugs prescribed/supplied outside of formulary and if there is a cost variance of more than 5% on the predicted FP10 prescribing budget the Provider(s) shall work with the CCGs’ Medicines Management Team to understand the cause of the variance and take the agreed course of action to address as appropriate.  **Workforce:**  Clinical leadership is essential to ensure that Services are configured in the most appropriate way and that staff feel that they are operating in an appropriate and safe system. It is important that clinical leaders capable of developing and maintaining the Extended Access Service are clearly identified and are part of the Provider organisation’s governance and Executive Board arrangements, with clear and identifiable management accountability (both clinical and operational) for the delivery of the Service. The Provider(s) shall have in place an operational management organisation structure chart, which demonstrates the key operational management roles and responsibilities, reporting relationships and accountabilities.  The Commissioners require robust resource plans from prospective Provider(s) that demonstrate effective use of healthcare professionals and administrators, capable of delivering timely and effective assessment and advice to patients. The overall staffing profile shall demonstrate effective use of a multi-disciplinary approach and shall be considered and mapped onto the operational and demand profile of the Service. The Provider(s) shall develop the skill mix of staff delivering the Service over time to widen the Service offer; this could include the use of Paramedic Practitioners, Advanced Nurse Practitioners and Physiotherapists. The Service shall provide primary care clinicians whose appointments count towards the capacity of minutes per 1000 population required capacity. Other services can be offered, for example by care navigators or by the voluntary sector, but these shall not count towards the required capacity. All staff involved in delivering the Extended Access Service shall have an appropriate level of competence to deliver Services, demonstrate the appropriate registration and competence against their relevant professional body and training must be updated regularly in response to changes. The Provider(s) shall undertake all relevant staff appraisal processes.  **Minimum workforce competency:**   * The Provider(s) shall provide the full complement of staff during Service operating hours. This shall include a GP and reception/support staff as a minimum requirement. The reception/support staff shall be sufficiently competent to work within the Extended Access Service environment. The staffing and skill mix may be flexed, according to circumstances. * The Provider(s) shall ensure that there are appropriately competent, qualified and trained staff to deliver the specified level of Service in each Hub. * Staff delivering the Service shall be trained on all appropriate policies relating to the delivery of the Service and be able to demonstrate the appropriate evidence of training. This shall include but is not limited to Annual Information Governance and Safeguarding training. * The Provider(s) shall ensure that staff are CPR trained (adults and paediatrics) when they start to provide the Service and attend annual refresher training thereafter. * The Provider(s) shall ensure that staff employed to deliver the Service have undergone the relevant DBS check before commencing delivery of the Service. * The Provider(s) shall ensure the continuity of Service by providing staff sickness and leave cover. * The Provider(s) shall ensure the safety of staff during the operation of Extended Access.   **Ease of access and patient engagement:**  The Provider(s) shall ensure that the Extended Access Service is advertised to patients within each locality, utilizing general websites, notices in local urgent care services and appropriate publicity into the community, so that it is clear to patients how they can access Extended Access appointments.  The Provider(s) shall meet the needs of the whole population including those within protected characteristic groups; this shall be reflected across the suite of standard operating procedures, making it clear to staff and patients of the Service whose needs shall be met. The Provider(s) shall, in conjunction with Commissioners, regularly monitor the uptake of appointments in relation to the equality assessment to ensure issues of local quality of access are addressed satisfactorily.  The Provider(s) shall collaborate with the Commissioners regarding the communication of any proposed Service amendmentsto all staff and key stakeholders including patients. The Provider(s) shall also ensure that patients are involved in any Service developments and that it has mechanisms in place to obtain regular feedback from patients and key stakeholders in order to inform and assist in the development of the Service over the period of the Contract.   * 1. **Data Sets and Key Performance Indicators**   **Activity and Data:**  A range of contact, referral and other patient and clinician activity shall be made available by the Provider(s) (see minimum data set). A flexible and a collaborative approach shall be required between Provider(s) and Commissioners, to identify and develop appropriate activity and data metrics that demonstrate improving quality and effectiveness outcomes for the CCGs’ populations; for example:   * Quality metrics such as Service thresholds being met. * Metrics that can demonstrate effectiveness and strategic impact. * Metrics that demonstrate patient satisfaction.     **Key Performance Indicators:**  Reporting on the KPIs and draft dataset below shall be furnished by the Provider(s) to the Commissioners on a monthly basis via dashboard, reporting on Service utilisation for each Extended Access Hub. The Provider(s) shall provide further information where captured, including through use of the Extended Access Measurement Tool. The Provider(s) shall work with Commissioners in developing, by the Contract start date, additional datasets to be delivered.   |  |  |  |  | | --- | --- | --- | --- | |  | **KPI Description** | **Applicable Data Set** | **Target** | | 1. | Extended Access Service offers the maximum number of appointments possible during all periods of operation, based on 4 appointments per hour | * Total number of appointments offered * Total number of in advance appointments as % of total offer * Total number of urgent appointments as % of total offer | 70%-100% during 0-3 months following Service ‘go-live’ date.  90%-100% month 4 following Service ‘go-live’ date onwards. | | 2. | Utilisation of Extended Access Service appointments is maximised as far as possible during each week | * Total number of appointments filled as a % of total appointments offered | Hub appointments’ utilisation measured across a week will exceed 70% for 0-3 months and 80% thereafter | | 3. | The appropriate number of appointments are reserved for direct booking by NHS 111 on weekdays and at weekends according to demand patterns | * Total number of in advance appointments booked via NHS111 per Hub, per month * Total number of urgent appointments booked via NHS111 per Hub, per month | No target – just reporting required | | 4. | The Provider(s) shall work with practices to ensure utilisation of appointments is in line with fair usage across the practices. | * Allocated number of appointments per practice based on registered populations. * Referring practices represented from highest to lowest | No target – just reporting required | | 5. | Reduction in number of A&E attendances with a primary care applicable HRG code. | * Primary care applicable HRG codes | No target set for Provider as this KPI will be monitored internally by the CCGs to assess any overall system impact. | | 6. | Monthly submission of dashboard representing activity data as per the agreed data sets that provide information on demand for Services at each Access Hub | * As per data sets above | Submission of dashboard data to be agreed by Commissioner and Provider(s) | | 7. | Monthly submission of suite of quality reports covering staffing performance, all training, appraisal, induction, professional registrations | * Content of report to cover areas outlined in KPI (additions to be developed collaboratively) | Date(s) for submission of reports to be agreed by Commissioners and Provider(s) | | 8. | Monthly submission of suite of quality reports covering complaints, SI’s, patient satisfaction. | * Content of report to cover areas outlined in KPI (additions to be developed collaboratively) | Date(s) for submission of reports to be agreed by Commissioners and Provider(s) | |
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| **GLOSSARY**   |  |  | | --- | --- | | **Term** | **Definition** | | **APMS** | Alternative Provider Medical Services – a contracting route available to NHS commissioners of Primary Care, comprising standard contracting terms and conditions – the APMS Contract | | **CCG(s)/the CCGs** | Means, as the context admits, Horsham & Mid-Sussex Clinical Commissioning Group and/or Crawley Commissioning Group | | **Commissioners** | The CCGs | | **Conflict(s) of Interest** | A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. | | **Contract(s)** | The APMS Contract(s) signed between the Commissioners and the Provider(s) | | **Contract(s) Start Date** | Means 1st October 2018 | | **Extended Access** | Means Extended Access to Primary Care as set out in the GPFV and more specifically as detailed in the Specification | | **Extended Access Hub(s)** | Physical hubs from which the Services shall be delivered | | **Extended Access Measurement Tool** | A new tool, nationally commissioned by NHS England to automatically measure Extended Access appointment activity (or/and such alternative or interim measure(s) as may be agreed for use by the Commissioners and Provider(s)) | | **Five Year Forward View** | The NHS document first issued in October 2014 outlining plans for improvements in the NHS | | **General Practice Forward View (GPFV *or* GP Forward View)** | The document issued by NHS England on 21st April 2016 entitled General Practice Forward View | | **Hub(s)** | Extended Access Hub(s) | | **MIU** | Minor Injuries Unit | | **Mobilization Date** | Means the date upon which the Provider(s) shall commence mobilization of the Services | | **Service ‘go live’ (date)** | Means 1st October 2018 | | **Specification** | This Extended Access Service Specification | | **The Provider(s)** | The organisation(s) appointed by the Commissioners to deliver the Services in accordance with the Contract(s) | | **The Service(s)/Services** | Means the Services described in this Extended Access Service Specification | | **UTC** | Urgent Treatment Centre | |
| **Appendix One – Interface Prescribing Policy and Medicines Management Mandatory requirements** |
| **Interface Prescribing Policy**  The Department of Health requires that NHS providers establish, document and maintain an effective system to ensure that medicines are handled in a safe and secure manner. The policy attached here has been adapted from the NHS Surrey Interface Prescribing Policy for providers of NHS services commissioned to deliver services which include prescribing and drugs. The aim is to facilitate consistent prescribing policies in the National Standard NHS Contracts across Surrey and the CCGs’ localities. CCGs and providers to which this policy applies will jointly monitor compliance with this policy through regular review via their routine interface and contracting mechanisms.    **Net formulary link** - <http://www.chmsformulary.nhs.uk/>  **Mandatory requirements**  The Provider(s) shall ensure that it has in place and can demonstrate robust processes to ensure the safe and secure handling of medicines and medicines-related processes (including prescribing, supply and administration) in accordance with the following:   * All prescribers shall adhere to legal, professional and good practice guidance on prescribing and medicines management in line with relevant medicines legislation and regulations e.g. Medicines Act 1968, Misuse of Drug Act 1971 etc. * Any medications or consumables to be held as stock by the Provider(s) shall be stored, handled and disposed of safely and securely, including controlled drugs in accordance with the relevant medicines legislation and regulations e.g. Medicines Act 1968, Misuse of Drug Act 1971 etc. * All prescribing and/or recommendations under the Contract shall be in accordance with national recommendations i.e. NICE, Healthcare Commission Standards etc. Mandatory NICE guidance shall be implemented within 90 days of being formally issued, and the Provider(s) shall inform the CCGs of their intention to implement. **GPs shall not be asked to prescribe outside of NICE recommendations unless locally agreed.** * All prescribing and/or recommendations shall be in accordance with the Red Amber Blue Green ‘traffic light’ classification system and local recommendations i.e. local joint formulary and Interface Prescribing Policy. **GPs shall not be asked to prescribe non-formulary drugs and/or indications and doses**. * Suitable medicines management for patients to ensure they are taking only appropriate medications(s) for their needs, with a commitment to de-prescribing where beneficial and safe. * New medications/treatment pathways entering the market shall be reviewed and approved by the local Prescribing Committees, and ratified by the CCGs’ governance processes for medicines. * If the Provider(s) wishes to use a medicine outside of national or local recommendations then they shall approach the CCGs’ Medicines Management Lead BEFORE any prescribing commences. * All ‘specials’ (specially formulated, unlicensed medications), unlicensed medicines, named patient medications and clinical trials shall NOT to be prescribed or recommended, unless approved by the CCGs’ governance processes for medicines. * Applications for National Tariff excluded (NTe) medications (i.e. specialist commissioning) shall be initiated by a consultant, and applications shall be submitted using either Blueteq or a locally agreed data set. * All pharmaceutical company involvement/sponsorship/patient access schemes to be approved by the CCGs governance process for medicines. * All service level agreements with home care providers or third party contractors to be in line with NHS Terms and Conditions, Purchasing and Supply Agency (PASA guidance), and local Prescribing Committee arrangements. * The Service shall support the development of shared care protocols for ‘AMBER’ drugs, and participate in shared care to enable monitoring of patients with stable well-controlled disease to take place safely and effectively in primary care. All shared care arrangements shall be approved by the CCGs’ governance process for medicines before implementation. * The Service shall have robust systems in place to manage and report medication errors, near misses and adverse reactions utilizing the ‘yellow card’ reporting system and/or patient incident reporting software e.g. Datix. * The Provider(s) shall demonstrate to the Commissioners’ satisfaction that they have processes to manage patient safety and governance e.g. compliance with any relevant patient safety alerts i.e. NPSA/MHRA and drug recall notices, policies in place for all aspects of medicines and data protection. * All staff shall be appropriately trained and be deemed competent in medicines use e.g. Patient group directions. The Provider(s) shall be responsible for the development of Patient Group directions and associated training of, and a robust internal governance process shall be in place to ratify medicine related documents. * If the Provider(s) shall provide their prescribing data at any time, as requested by the CCGs. * The Provider(s) shall conduct patient experience surveys and satisfaction questionnaires in order to improve the Services. * The Provider(s) shall provide a patient helpline number to all patients for medicines related enquiries. * The Provider(s) shall be responsible for the ordering and secure storage of FP10s. * The prescribing budget (except NTe medications) shall be fully attributable to the Provider(s), unless the patient is managed under a shared care agreement or discharged from the Service. The budget shall include all medications or consumables held as stock. |