SCHEDULE 2

SERVICE SPECIFICATION

The Centre Surgery
Hill Street
Hinckley
Leicestershire LE10 1DU

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

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1. PART 1 - GENERAL SERVICE DELIVERY REQUIREMENTS

1.1 High quality, appropriate, convenient and responsive care

1.1.1 The Contractor must be able to mobilise from commencement of the contract.

1.1.2 The Contractor must ensure services are appropriate to local need, access and convenience are important aspects of a patient-centred service but it is also vital that the services are appropriate and responsive to the needs of the local population.

1.1.3 The Contractor will need to design the services around the needs of patients and their carer's. Patients with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

1.1.4 To deliver a patient-centred service, the Contractor will need to engage patients in the design and development of the services. It must also ensure that the services continue to be appropriate and responsive by involving patients during the delivery of the services.

1.1.5 The Contractor must have a system and processes in place to evaluate and continually improve patient and staff satisfaction rates.

1.1.6 In addition to the specification, the Contactor may wish to carefully consider and cross reference current Department of Health Guidance when developing, reviewing and implementing their service delivery of a patient-centred service.

1.1.7 The commissioner requires the provider to meet the key principles and values set out in the NHS Constitution.

1.2 Equity of Access

1.2.1 The Contractor must ensure equity of care and access across the whole health and social care community. The Contractor must maintain integrated working between acute units, emergency treatment services, ambulance services, NHS 111, community hospitals, primary care, social services and the voluntary and independent sectors.

1.2.2 The Contractor shall:

a) Not discriminate between patients, including all people with protected characteristics covered by the Equality Act 2010 (Age disability, gender reassignment, pregnancy or maternity, race, religion or belief, sexual orientation and sex)

b) Implement Royal National Institute for the Blind and Royal National Institute for the Deaf guidance as amended from time to time to ensure Patients who have relevant disabilities and/or communications difficulties are able to receive the Services:

c) Provide a dedicated telephone number for text phone users who are Deaf or hard of hearing to enable them to access the Servicesd)

d) Supply to all non-English speaking users professional translation services during all consultations and translations of materials describing procedures and clinical prognosis for the languages recommended by the Commissioner as being the most common languages spoken by Patients who are likely to use the Services Subject to its obligations under the Data Protection Legislation, record details of any Patients who have special requirements in relation to accessing the Services;

1.2.3 The Contractor acknowledges that to improve equity of access for all patients with protected characteristics that it will collect information at the point of registration a patient's ethnicity, religion and first language due to the need to take into account culture, religion and language in providing appropriate individual care, for shared care, including secondary care, and the need to demonstrate non-discrimination and equal outcomes.

1.2.4 In addition the provider will also be required to collect other relevant protected characteristics of patients such as their age, disability, gender reassignment, pregnancy or maternity, sex and sexual orientation.

1.3 Services for vulnerable and hard to engage groups

1.3.1 The Contractor will need to recognise that access is a multidimensional concept that is not only about open hours and appointments, but also includes

making services available to groups of the population that traditionally do have difficulty making use of the health service or public services generally.

1.3.2 These groups are often the most vulnerable, and might have different expectations of health services, to the majority. In particular, they may have difficulty making or keeping appointments, they might have difficulties making their needs understood, there might be cultural, practical or social barriers that affect their ability to follow treatment regime's and challenges might be faced in organising systematic follow-up because of age, mobility, lifestyle, mental health and wellbeing and practical issues such as transport.

1.3.4 Ensure that patients who have disabilities and/or communication difficulties are able to receive the services by implementing the relevant principles and guidance organisations such as: Royal National Institute for the Blind, Royal National Instittute for the Death Guidance and NHS Accessible Information Standard which will be mandated from July 2016. Guidance and resources for Contractors can be found at:

http://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

1.3.5 The provision of primary care services for socially excluded groups is included under the terms of all existing contractual arrangements (GMS/PMS & APMS contracts), as a minimum, the successful Contractor must be able to demonstrate how provision for unscheduled care, continuing care and health protection will be achieved for all registered patients registered who may fall within some of the following socially excluded and vulnerable groups:

a) Patients who do not understand written or spoken English;
b) Working single paretns
c) Those who have no permanent address
d) Patients who maight have a history of violence or aggression including those with a forensic history and who might transit into and out of the prison system.
e) Patients with drugs and alcohol problems, or mental illness, or combinations of these, including homeless or transient persons.
f) Patients who have a mental illness;

g) Asylum seekers or refugees, who may have special needs related to experiences in their country of origina and recent immigrants and their families, for whome English is not their first language;

h) Travellers and their families, in whom there may be social, cultural and practical barriers to the provision of health and social care.

i) Black and minority ethnic communities;

j) Disabled people, including people with sensory impairments, brain injury, people with learning / physical disabilities and disfigurements;

k) Adolescents;

l) People aged 16-24 outside education and work, especially those with chronic illness, mental health and serious social challenges;

m) Patients who are elderly and/or housebound.

n) Child carers;.

1.3.6 The Contractor will need to consider innovative approaches to providing follow up and health protection in these groups, such as SMS texting, outreach visits and specialist public health nurse support, as integral to service provision or through effective working with other contractors.

1.3.7 RESERVED

1.3.8 The Contractor acknowledges that to improve equity of access for black and ethnic ('BME') Communities it shall collect information on ethnicity and first language due to the need to take into account culture, religion and language in providing appropriate individual care, for shared care, including secondary care, and the need to demonstrate non-discriminiation and equal outcomes. The Contractor shall therefore be required to record the ethnic origin and first language of all new patients at the point of registration

1.4 Zero Tolerance Policy

The Contractor must ensure that a policy is developed to manage violent, aggressive or abusive behaviour from patients to healthcare staff. This will

include referring patients into the commissioned Leicester, Leicestershire & Rutland Violent Patient Scheme in accordance with local guidance and criteria. The Contractor is expected to adhere to the local guidance on when and how to make referrals on to the scheme.

1.5 Interpretation Services and Translation Service

1.5.1 The Contractor will be required to ensure patients appropriate access to interpretation and translation services to support patients during consultations in line with national and local guidance:

1.5.2 The Contractor will be able to access interpreters and for non-English speaking patients and deaf patients from the service commissioned on behalf of primary care by NHS England/the CCG.

1.6 Patient Dignity, Privacy & Respect

1.6.1 The Contractor shall:

a) Ensure that all aspects of Service provision protects and preserves Patient dignity, privacy and confidentiality;

b) Allow Patients to have their personal clinical details discussed with them by a a person of the same gender, where required by the Patient and if reasonably practicable.

c) provide a trained chaperone for intimate examinations to preserve Patient dignity and respect cultural preferences; and

d) Ensure that Contractor Staff behave professionally and with discretion towards all Patients, staff and visitors at all times.

1.7 Informed Consent

1.71. The Contractor shall comply with NHS Requirements in relation to obtaining consent from each Patient as notified to the Contractor by the Commissioner

from time to time prior to commencing treatment including the following as amended from time to time:

a) Department of Health Reference Guide to Consent for Examination or Treatment; 2009 second addition;

b) Consent: patients and doctors making decisions together (GMC 2008)

1.8 Referrals

1.8.1 The Contractor will be required to utilise the e-Referral Service (NHS Electronic Referral Service) as the preferred method of referral, where eligible; andother clinical appropriate pathways.

1.8.2 The Contractor will ensure patients are offered appropriate choice of service provider.

1.8.3 The Contractor shall:

a) Monitor all referrals and minimise inappropriate referrals and hospital admissions; participate in local initiatives to audit and review when required by the commissioner

b) Co-operate with and make effective use of existing services available as appropriate including but not limited to:

i. The Local Ambulance Service ensuring arrangements are in place for Paramedics to have access to GP's to perform telephone based GP Triage to prevent unnecessary conveyance to secondary care;
ii. NHS 111 telephone triage system integrating with the service as it develops under the Integrated Urgent Care national agenda;
iii. The community matron/case management team/Specialist Long term Management Team if available and appropriate
iv. Palliative care team where applicable
v. Locally commissioned services provided outside of acute hospitals, including health promotion services; and
vi. Local Authority services and employment advisers;

c) Cooperate with service Providers of Out of Hours (OOH) Services to ensure safe and seamless care for Patients including providing information via Special Patient Notes (SPN) or equivalent as clinically appropriate to the Provider of the Out of Hours Services on Patients that may require their services or who have special clinical requirements;

d) Provide complete and comprehensive referral information to the service the Patient is being referred to, to enable any further activity to proceed; ideally using any locally agreed referral protocols, templates and proformas;

e) Abide by any locally set/agreed policies covering Individual Funding Requests (IFR) and requests for Procedures of Limited Clinical Effecgtiveness (PoLCE)

f) Use robust clinical pathways for referral, agreed with other local healthcare providers;

g)Routinely collect data about the appropriateness of the Provider's referrals;

h) Implement national referral advice including Referral Guidelines for Suspected Cancer and NICE guidance;

i) Ensure urgent suspected cancer referrals, are sent electronically via the e-referral Service or faxed (if no e-RS slots) and received by the relevant trust within twenty-four (24) hours;

j) Ensure that the practices use PRISM to do an appropriate referral

k) Review referrals practice at least every six (6) months to ensure it is in line with latest guidance and protocols;

l) Develop and implement policies in relation to nurse and nurse specialist referrals and their extended role in treatment and investigation of Patients with specified diseases;

m) Implement and operate Electronic Referral at point of referral for specialist services, and provide a booking facility (in accordance with the national choice and book agenda); and

n) Except where specifically stated otherwise in respect of particular services, the Contractor must provide Services under the Contract to:

i. Registered Patient's;
ii. Temporary Residents;
iii. Persons to whom the Contractor is required to provide emergency or immediately necessary treatment;
iv. Any other person to whom the Contractor is responsible under arrangements made with another Contractor; and
v. Any other person to whom the Contractor has agreed to provide Services under the Contract.

1.9 NHS West Leicestershire Clinical Commissioning Group

a) The Provider is required to join and become an active member in West Leicestershire CCG (the CCG) and will be expected to adhere to the CCG constitution.

b) The Provider will be allocated a locality based on the geographical location. The provider will be required to participate in locality meetings.

c) The Provider will be expected to adhere to all local priorities/targets as identified by the CCG ensuring clinical efficiency and quality is monitored and maintained.

d) The provider will be required to engage with the CCG in formal annual practice visits.

e) The provider will be required to participate in Protected Learning Time (PLT), General Practitioner, practice manager and nursing forums and any other health and medical meetings as required, to ensure appropriate integration of service delivery and whole system thinking.

1.10 Duty of Co-Operation with Other NHS Providers, Local Authority & Community Services

1.10.1 The Contractor is expected to deliver services where the patient is at the centre of the service delivery. The nature of the service should be designed around the patient's need and not the organisation's business needs.

1.10.2 All practice staff must be courteous and respectful towards the patients registered at the practice. The service should be tailored to meet the needs of the patients at all times.

1.10.3 All practice staff are expected to demonstrate the following:

a) Empathy for patient
b) Having a cultural awareness of patients
c) Showing patients respect
d) Understanding the patient's needs

https://www.england.nhs.uk/commissioning/primary-care-comm/interpreting/

1.10.4 The Contractor is expected to have an awareness of what the common languages are spoken at the practice by the patients.

1.10.5 The Contractor will need to ensure that British Sign Language interpretation is made available for the patients who need this.

1.10.6 The Contractor shall:

a) Foster good working relationships and gain mutual understanding of systems, policies and procedures with key local stakeholders;

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

c) 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.

d) Structures - to ensure that links are maintained with key structures 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;

e) Process – to ensure that similar policies and protocols are in place between the Provider 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

f) Outcomes – to ensure that key clinical indicators are in place to allow benchmarking with other services and contribute towards the Commissioner's own performance indicators.

1.10.7 The Contractor shall:

a) Discuss and develop policies and procedures with the CCG to ensure there is compatibility with other local policies and procedures, including clinical and non-clinical issues;
b) Develop referral protocols with local health commissioners and providers, including the local NHS England team; and
c) Offer training opportunities for staff (including nursing and medical training and training for local Health Care Professionals in order to meet appropriate accreditation and regulatory requirements) and comply with the provisions required.

1.11 Patient and Public Involvement

1.11.1 It is important that patients and the public have a key voice in how their health and social care services are delivered and the Provider will have a statutory obligation to consult and engage with patients and the public under Section 242 of the Health and Social Care Act 2012.

1.11.2 Access and convenience are important aspects of a patient-centered service, but it is also vital that the services are appropriate and responsive to the needs of the local population. The Contractor should design the services around the needs of the patients and their carers, wherever possible; The contractor should offer patients more choice and a greater say in their treatment.

1.11.3 To deliver a patient-centered service, the Contractor will need to demonstrate and ensure;

a) Partnership working with patients and the public to ensure they have the opportunity to influence and inform service design and delivery
b) Ensure that the services continue to be appropriate and responsive by involving patients during the delivery of the services.
c) Patient feedback on services acting on that feedback to further improve service quality
d) The continued support of the Practice Patient Participation Group ensuring that membership is open to all patients.
e) The PPG is consulted about any service changes that the provider is looking to introduce and are central to the practice's service delivery
f) Working with local community groups and community leaders, particularly hard to reach groups
g) It can demonstrate to the commissioner how the service has been improved based on patient feedback

1.12 Patient Experience

1.12.1 The Contractor will be required to monitor and evidence improved patient experience throughout the term of the contract and must demonstrate what processes are in place to do this.

1.12.2 This should include but be not limited to:

a) Patient surveys including

i. Patients confidence in the GP
ii. Satisfaction with opening hours
iii. Telephone Access
iv. Access to appointments

v. The Friends and Family Test;

` b) Complaints

c) Customer services management

1.12.3 RESERVED

1.12.4 Patient surveys should be available in appropriate languages to ensure equitable consultation with Black, Minority and Ethnic Groups. It is the intention that the Practice Participation Group (PPG) agrees the survey

1.12.5 The Contractor must give all patients who use the Contractors practice the opportunity to provide feedback about the service received from the practice through the friends and family test.

1.12.6 The Contractor must:

a) Report the results of the completed friends and family tests to the Board; and

b) Publish the results of such completed Tests, in the manner approved by the Board.

1.13 IM&T & Information Governance

1.13.1 The Contractor shall comply with:

a) This Agreement;
b) All relevant Law and best practice guidance in relation to NHS records management and IM&T in the NHS; and
c) The Caldicott Principles; and
d) All relevant provisions under the Data Protection Act 1998

1.13.2 The Contractor shall ensure that their IM&T Services conform to the relevant standards and submit documents to the Commissioner defining how it will put in place and operate the following:

a) An incident management system allowing for the identification, impact assessment and reporting of all actual or suspected incidents;

b) Procedures for maintaining all systems provided by the Provider are up to date and in line with any security-related patches and advice from their suppliers;

c) Procedures for any transfer or storage of NHS Patient data according to standards specified.

d) Procedures for risk assessment of particular risks to information security, and the agreement of and completion of mitigation works within agreed timescales; and

e) an acceptable user policy for access and use of IM&T systems and equipment;

1.13.3 The Contractor shall verifiably collect accurate data for and submit to the Commissioner or Clinical Commissioning Group on request. Such requests to include but not limited to:

a) Clinical data sets as stipulated in the regulations;

b) Data relating to the performance of services under this agreement which are necessary for its effective monitoring and management; and

c) Other clinical data sets required by this Agreement.

1.13.4 The provider will be supplied with the following IT support (covered under the GP IT operating framework);

a) Hardware support
b) Software support
c) Network support
d) Rolling Replacement Programme
e) RA services
f) Training

1.13.1 IT support referenced in section 1.14.4 will be contracted by the CCG on behalf of the supplier. It will be delivered through Leicestershire Health Informatics Service (LHIS) under existing SLA contracts. Any additional requirements outside of SLA support will be at an additional cost to the provider.

1.13.2 The provider will be required to sign a Practice / CCG agreement, which set out all parties responsibilities under the GPSOC framework, and adhere to all responsibilities as set out within.

1.13.3 The provider will be required to adopt the clinical system set up for this service (Namely, TPP SystmOne, GPSOC accredited clinical system). Migration of this service to the provider will be delivered by LHIS. Project Management, Business Change, RA smartcard set up and training for the clinical system are provided by LHIS.

1.13.4 The provider is responsible for ensuring that all clinical notes regarding the patient are captured in the clinical system and have the ability to interoperate in accordance with local protocols, and share data within the community.

1.13.5 Configuration set up of services will be delivered by LHIS and Arden & GEM CSU under existing SLA agreements. These services include all IM&T modules

currently utilised by GP Practices in the CCG area, the list below is not exhaustive, i.e.

a) Sunquest ICE
b) Electronic Referrals
c) Summary Care Record
d) Electronic Prescription
e) PRISM
f) Medical interoperable gateway (MIG)
g) GP 2 GP
h) Calculating Quality Results Service
i) GEMIMA

1.13.6 As and when services/modules change these will be automatically included in the LHIS and Arden & GEM CSU SLA agreements.

1.13.7 The provider will require a secure website to allow patients to access a summary of their care records, book appointments and request repeat prescriptions. It should also provide information to patients such as access for the service, contacts, newsletters, patient leaflets etc.

1.13.8 The provider will be required to sign up to an Information Sharing Agreement (ISA), allowing for patient data to be viewed and shared for clinical use. The clinician accessing the patient record is required to gather explicit consent from the patient in accessing the clinical record. It is the responsibility of the provider to ensure that patients are fully aware of their records being accessed and who will have access to the information once information has been captured.

1.13.9 The provider will be required to adhere to the locally implemented EPACCS solution to support high quality care planning, effective once this solution is brought in to effect.

1.13.10 LHIS will provide IT support for this service under existing SLA agreements. Staff will require IT support services during operating hours. Where such support is not available the supplier will be required to make an agreement through LHIS as an addition to the SLA.

1.13.11 The provider must ensure that appropriate security measures are in place to cover IM&T. This will include procedures for any security breaches of loss of data. The provider should ensure that IT equipment is stored safely.

1.13.12 The following hardware will be supplied to the provider under existing GP IT services:

a) Desktops
b) Printers
c) Scanner

1.13.13 The cost of any additional devices will be borne by the provider; here is an example of devices list;

- Laptops / Toughbooks
- Tablets
- Mobile phone devices
- 3G/4G dongle or Wi-Fi devices
- Patient Arrival systems
- Patient Call Board systems

1.13.14 For purposes of clarity, telephone systems are outside the scope of GP IT and will not be provided.

1.13.15 The provider will require an N3 connection at its base location, which will be provided by the CCG. All clinicians will require an N3 connection to access the clinical system. The provider will have access to the Leicester, Leicestershire and Rutland (LLR) shared Wi-F that is currently available in NHS buildings, Council buildings and most care homes across the area. The LLR Shared Wi-Fi will allow them to have direct access to N3.

1.13.16 Where a direct or wireless connection to N3 is not possible the provider will be required to provide alternative secure means of accessing the N3 connection. This can include accessing N3 via a VPN when an internet connection is available. An internet connection can be established using alternative methods such as Wi-Fi hotspots or 3G/4G access but must be arranged as secure to NHS standards.

1.13.17 The provider will ensure that they do not use their own laptop to carry out NHS work unless they have the appropriate NHS security standards, and have been approved by the CCG.

1.13.18 Contingency plans need to be in place for IM&T unavailability. This needs to be built into the provider's business continuity plans.

1.13.19 The supplier must provide detailed plans for mobilisation of IT and telephony services. The provider should ensure that all IM&T equipment is in place and ready to use at the start of the contract go live. This will include the training staff on the clinical system in advance of go live.

1.14 Disaster Recovery and Business Continuity

1.14.1 The Contractor shall produce a disaster recovery plan which must set out how items such as patient records and other clinical data held by the Contractor in relation to Patients who are or may be the subject of services, will be backed-up, verified, safely stored, recovered and made securely available to the Contractor, the commissioner or a third party providing other services in the event that a disaster causes the Services or any part of them to no longer be performed by the Contractor or from the Practice Premises.

1.14.2 As a minimum the disaster recovery plan must state that appropriate back up procedures are in place for all Practice data, other than the GPSOC provided clinical system, to ensure minimal data loss. The Provider must comply with such disaster recovery plan and must provide a copy of such disaster recovery to the Commissioner. The disaster recovery plan must not contain any obligations on the Commissioner.

1.14.3 The Provider must produce a business continuity plan which must set out how the Provider will ensure that the service continues for patients in the event of a disaster which may include a power cut, flood, etc. As a minimum the business continuity plan must state what arrangement will be put in place to have secure access to patient records held on the clinical system, and the arrangements for

patients to continue to access the service, e.g. relocation or replacement of telephone lines, and/or any temporary relocation information.

PART 2: ACCESS & MANDATORY SERVICES TO BE PROVIDED

2.1 Services to be provided

2.1.1 The Contractor must provide all services detailed within this specification to:

a) all patients registered with the practice at the point of commencement regardless of whether they reside within the practice identified area (Schedule 3);

b) all new patients and temporary residents residing within the practice identified area (Schedule 3) after commencement;

2.2 Contracted Activity and Growth

2.2.1 The Contractor must ensure that the Provider's List of Registered Patients in respect of the Services remains **open** to new registration for the duration of this Agreement. 2.2.2 The Contractor must ensure that the Provider's List of Registered Patients, in respect of the Services, is derived from the population at the point of commencement and of patients that falls within the practice boundary thereafter.

2.3 Essential Services

2.3.1 The Contractor must ensure all Essential and Additional Services, as defined in regulation 15(3), (5), (6) and (8) the National Health Service (General Medical Services Contracts) Regulations 2004 are provided to registered patients and temporary residents, throughout core and extended hours.

2.3.2 The Contractor shall have in place arrangements for Patients to access such services throughout the Core and Extended Opening Hours, where relevant in case of emergency. 2.3.3

2.3.3 The Contractor must provide:

a) Services required for the management of the registered patients and temporary residents, who are, or believe themselves to be:
    i. ill with conditions from which recovery is generally expected;
    ii. Terminally ill; or
    iii. Suffering from chronic disease

b) Delivered in the manner determined by the Provider in discussion with the Patient, or, where appropriate (e.g. where power of attorney exists), the patient's next of kin or legal guardian;
c) Appropriate on-going treatment and care to all registered patients and temporary residents taking account of their specific needs including:
d) the provision of advice in connection with the patient's health, including relevant health promotion advice;The referral of the patient for other services under the 2006 Act
e) Primary medical services required in core hours and extended core hours, for the immediately necessary treatment of any person to whom the Provider has been requested to provide treatment owing to an accident or emergency at any place in the Practice Area.

2.3.4 For the purposes of paragraph 2.3.3(a) above, "management" includes:

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

b) Making available of such treatment or further investigation as is necessary and appropriate, including the referral of the Patient for other services under the 2006 Act and liaison with other Health Care Professionals involved in the Patient's treatment and care.

2.3.5 For the purposes of paragraph 2.3.3(c) (iii), "emergency" includes any medical emergency whether or not related to the services provided under this Agreement.

2.3.6 The Contractor must provide primary medical services required in core hours for the immediate and necessary treatment of any person falling within clause 2.3.7 who requests such treatment, for the period specified in clause 2.3.8.

2.3.7 A person falls within this clause if he is a person –

a) Whose application for inclusion in the registered list of patients has been refused in accordance with paragraph 31.17 of this APMS Agreement and who is not registered with another Provider of essential services (or their equivalent);

b) Whose application for acceptance as a temporary resident has been rejected under paragraph 31.17 of this Agreement; or

c) Who is present in the Contractors practice area for less than 24 hours but no more than three months.

2.3.8 The period referred to in paragraph 2.3.7 is:

a) In the case of paragraph 2.3.7(a), 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;

b) In the case of paragraph 2.3.7(b), 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

c) In the case of paragraph 2.3.7(c), 24 hours or such shorter period as the person is present in the Provider's practice area.

2.3.9 The Provider does not have to provide the services described in paragraph 2.3.3 and 2.3.6 during any period in respect of which the Care Quality Commission has suspended the Provider as a service Provider under section 18 of the Health and Social Care Act 2008.

2.4 Additional Services

2.4.1 The Provider must provide the additional services set out below and described in the (General Medical Services Contract Regulations 2004 to:

a) Contraception Services
b) Vaccinations and Immunisations including childhood, influenza, and pneumococcal.
c) Childhood vaccines and pre-school boosters;
d) Child Health Surveillance Services
e) Maternity Medical Services (excluding intra-partum care); and
f) Minor surgery (Level 1);

2.5 Directed Enhanced Services by NHS England

2.5.1 The Contractor will be expected to provide all Directed Enhanced Services commissioned by NHS England during the term of this contract as commissioned at such times, within opening hours, in accordance with patients' needs.

2.5.2 The Contractor will be funded as per the agreed specification for each service.

2.5.3 The Contractor must:

a) Comply with all compliance and accreditation criteria as detailed within each individual service specification;
b) Accept any changes or amendments to Directed Enhanced Services as they apply from time to time; and
c) Notify the Commissioner clinical governance lead of all emergency admissions or deaths or Patients receiving Enhanced Services, where such admission or death is or may be due to usage of drug(s) or attributable to the relevant underlying medical condition within 72 hours of the information becoming known to the Contractor.

2.6 Directed Enhanced Services - Public Health England

2.6.1 The Contractor will be expected to provide all Directed Enhanced Services commissioned by Public Health England during the term of this contract as

commissioned at such times, within opening hours, in accordance with patients' needs.

2.6.2 Public Health England commission all national immunisation programmes and two locally commissioned services (NIPE and active call of Men ACWY for teenagers not yet in the aged 18 cohort).

2.6.3 The full range of nationally negotiated Immunisation Enhanced Services can be found here:

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

2.6.4 Please also note that there are a number of additional services that receive a fee for activity (paid via CQRS) that don't equate to ES since they have been nationally negotiated into the vaccine programme. It may help to refer bidders to the Immunisation Audit and Guidance document which covers the national services (whether additional or enhanced services) and just give them our Local ES details?

- http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/V%20and%20I/V%20and%20I%20Home%20Page/2016-17%20VI%20guidance.pdf

further clarification can be found at:

- http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/V%20and%20I/V%20and%20I%20Home%20Page/2016%2017%20Vaccination%20programmes%20enhanced%20and%20additional%20services.pdf

2.6.5 Contractors are asked to note that Childhood Immunisations Directed Enhanced Services will require The Practice to submit the relevant immunisation activity data in the manner and format required NHS England and Primary Care Support England (PCSE) to generate payments. i.e. in this instance to the use the Open Exeter upload process for PCS England to calculation using NHAIS

2.7 Locally commissioned Community Based Services:

2.7.1 Where there is an identified need within the registered population, the Contractor will ensure within 3 months from commencement, that registered patients have access to services commissioned locally, including but not limited to those commissioned by:

a) The Clinical Commissioning Group;
b) Public Health England; and
c) The Local Authority;
d) Local NHS Providers.

2.7.2 The Contractor will be required to adhere to all accreditation and service requirements of each service as agreed with the commissioner and any changes made to respective services from time to time.

2.8 Home visits

2.8.1 The Contractor must ensure that in relation to visits to Registered Patients in the Practice Area other than at the Practice Premises that Registered Patients are seen as soon as practicable according to clinical need, and in any event on the same day as the Contractor is alerted;

a) Registered Patients are informed of the timescale in which they will be visited if the agreed visit is delayed; and
b) Visits are made according to clinical need as determined by GP acting in accordance with Good Clinical Practice.

2.8.2 The Contractor must ensure that in relation to visits to Temporary Residents, that such Temporary Residents are seen as soon as possible according to clinical need.

2.9 Provision of Reception Services

Reception services must be provided by the Contractor at the Practice Premises throughout all the Opening Hours detailed in this document

2.10 Opening Hours

2.10.1 At the point of commencement the Contractor will be expected to provide:

a) Core hour opening, ensuring the practice is open (with appropriate levels of admin and clinical staff) 8am-6.30pm 5 days a week, 52 weeks per year except agreed Public and Statutory Bank Holidays;

b) To facilitate access, the contractor must provide patients with an online option to book appointments, order prescriptions, access summary care records and any other online incentive.

2.10.2 Within the term of the contract, the Contractor shall be required to work with practice staff and the commissioner with a view to implementing extended opening hour clinics (through the Directed Enhanced Service); as appropriate to the registered population preference.

2.10 Out of Hours Access

2.10.1 The service is currently commissioned from commencement by the Clinical Commissioning Group on behalf of the Provider.

a) The Provider must ensure there is an appropriate telephone message and automatic transfer to the OOH Provider in place during the identified Out of Hours period

b) The Provider must have appropriate process in place to monitor the quality of services provided by the Out of Hours Provider and report any concerns they may have.

2.10.2 The provider must have robust processes in place to hand-over details of any high risk cases to the OOH service after 18.30 to ensure continuity of care as outlined in the patients care plan.

2.11 Improving Access to Services

2.11.1 The Commissioner wants to ensure patient access to GP services is amongst the best in the country for all patients and not just for those who are lucky enough to live within the boundary of a high performing practice.

2.11.2 The Commissioner is seeking innovative provision of primary care services, which aligns with the CCG's strategic plans. Providers may utilise new technology and other innovative systems in the provision of services.

2.11.3 The Contractor must evidence increased access and improved patient satisfaction.

2.11.4 The Contractor will be required to undertake regular capacity and demand audits and evidence that clinical provision across the identified core hours is meeting the needs of the registered list.

2.11.5 The commissioner will monitor patient satisfaction across a number of areas, including satisfaction with response times appointments and telephone access.

2.11.6 The Contractor must ensure patients have access to high quality care throughout all service hours' opening times, ensuring:

a) a minimum provision (within 3 months from commencement) of
   i. 90 GP appointments per 1000 registered patients per week either face to face or telephone consultation;and
   ii. 40 face to face Nurse appointments per 1000 registered patients per week should be provided.

b) that appointments are made available to appropriate clinicians throughout core hours; Contractors are asked to use flexible systems for booking appointments at the right time both during core hours and extended hour clinics.
c) a full range of consultation methods are offered an utilised according to clinical need, including but not limited to telephone, email, Skype (or alternative) and face to face consultation at the GP Practice;
d) appointment lengths are tailored to meet the clinical needs of patients.

e) that booked consultations commence within 20 minutes of the scheduled appointment time.
f) treatment for Patients potentially suffering from immediate and life-threatening conditions are identified as soon as they present to the practiced and that there is appropriate GP cover throughout core opening hours to deal with such medical emergencies
g) Ensure in a clinical Emergency a patient is able to book an urgent appointment on the same day. (The practice may embargo some appointments for on the day/emergency demand and advise patients accordingly.)
h) Ensure there are suffificent pre-bookable appointments across the week for routine/non-urgent and that such appointments are made available and booked on the patients first contact/request to the surgery, ie the patient must not be asked to call back at another time or day to pre-book a routine/non-urgent appointment.
i) a multi-disciplinary team (MDT) is provided, led and supported by GPs, as part of the integrated service delivery. The clinical team may include a combination of General Practitioners, Advanced Nurse Practitioner, Nurses, Health Care Assistant, Phlebotomist, Practice Pharmacist, etc (this list is not exhaustive).
j) patients have the ability to pre - book an appointment at least 4 weeks in advance
k) there is adequate clinical staffing/skill mix to ensure the most appropriate clinician (in line with patients' needs) is available to attend a patient within no more than 48 hours of the need being identified.
l) a demand and capacity audit is undertaken within one month of commencement to understand patient demand and need, and appropriate adjustments are made to service provision to meet such demand.
m) patients have the ability for patients to book and cancel appointments on-line, via telephone and in person
n) implement a robust process for actioning repeat prescriptions, which should normally be available within 2 working days, however, the Contractor should also have the facility in place to turnaround urgent requests if these were clinically appropriate to meet the needs of the patient

o) an effective and safe clinical triage system is provided to ensure patients receive the most appropriate clinical intervention and advice on their first contact with the surgery; including referal to NHS 111, local pharmacy and other appropriate services (such as adult social care and voluntary sector services etc.); NB: Telephone triage must not substitute face-to-face clinical appointments.

p) patients have access to co-located services within the health community, eg. community matrons, district nurses, etc.

q) patients have access to an interpreter / translation;booked and made available for patients for when they arrive for pre-booked appointments

r) all patients, including children, have a named accountable GP, ensuring newly registered patients are notified within 21 days of registration and that all registered patients know how to find out who their named accountable GP is.

2.12 Health Promotion and Disease Prevention

2.12.1 The Provider must deliver Services that are focused on health promotion and disease prevention and work with the Commissioner, other local GP practices and other commissioners or health Providers on initiatives to promote health and prevent disease.

2.12.2 The Provider acknowledges that the burden of long term conditions are increasing and that it must ensure it has effective strategies for health promotion and disease prevention in place to tackle the lifestyle issues that underlie some of these diseases. These must include but not be limited to:

a) Smoking;
b) Alcohol;
c) Obesity;
d) Healthy weight
e) Poor dietary habits
f) Sexual behaviour and
g) Mental health

2.12.3 The provider must work to improve the health and wellbeing of its patients and reduce health inequalities. This must include but not be limited to the:

a) Early identification of ‘at risk’ patients using a CCG approved risk stratification tool;
b) Early intervention for those defined as ‘at risk’;
c) Healthy living advice and health education and appropriate on ward referral to health promotion services.
d) Promote and increase self-care;
e) Ensure patients are aware of appropriate use of NHS services;
f) Focus on Long Term conditions, especially vascular diseases;
g) Reduction in cancer mortality rates;
h) Culturally appropriate services, including the need to consider the provision of women-only clinics;
i) Services for children and young people;
j) Services for hard to reach groups;
k) Outreach services;
l) Joint working with social care
m) Support for carers including the establishment and maintenance of a register of carers which includes evidence of regular review of the register

2.12.4 The Provider must where appropriate:

a) Use computer-based disease management templates; and
b) 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 Patients.

2.13 Cervical Screening Services

2.13.1 The Provider must:

a) Provide the services described in paragraph 2.11.2; and
b) Make such records as are referred to in paragraph 2.11.3.

2.13.2 The services referred to in paragraph 2.15.1 are to:

a) ensure that all staff who undertake sample taking have appropriate initial training and achieve and maintain the necessary competencies. This must include regular updates on policy and technology;

b) record all cervical tests and ensure sample taker access to all previous test results ;
c) ensure that all women are appropriately informed of their test result in writing
d) counsel women before the screening test, and also after, where the result is abnormal and this is requested by the woman
e) ensure that follow-up/ treatment/ referral is recommended and initiated, and verify direct referral.
f) comply fully and promptly with non-responder and failsafe procedures
g) provide specified data for national and local audits and other agreed purposes
h) audit the data of all individuals taking cervical samples individually and for the practice as a whole on a quarterly basis.

2.14 Long Term Condition Management

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

2.14.2 The provider must proactively manage all long term conditions.

2.14.3 The Provider must proactively identify and manage patients at risk of developing long term conditions.

2.14.4 The Provider must:

a) Ensure LTC management aligns with care pathways and any new care pathways that are being developed by the Commissioners.
b) Ensure all LTC patients have a named clinician, who will be responsible for ensuring care is co-ordinated and where appropriate an agreed integrated care plan is in place and regularly reviewed.
c) Have in place effective call and recall systems to manage Registered Patients with long term conditions.
d) Make effective use of Clinical System disease management templates.
e) Provide information about, and access to, self-management programmes for Patients with long term conditions where clinically appropriate.
f) Provide information and advice to Patients on self-monitoring for long-term conditions where this is clinically appropriate

g) Ensure provision of Diabetic control and monitoring.
h) Ensure that patients have access to Anticoagulation Near Patient Testing, dosing and monitoring as provided under shared care agreements.
i) Ensure access to specialist End of Life care and advice.
j) Ensure access to community mental health services.
k) Provide a primary care Phlebotomy service ensuring all samples taken are handled appropriately and are transported to clinical lab within identified timeframes.
l) Ensure access to and co-ordination with District nursing services.
m) Ensure that patients are able to access all necessary Vaccination services - Cold Chain Transportation Service (for transportation of blood samples and vaccinations).
n) Learning and Disabilities Health Check.
o) liaise with the Local Authority in order to establish which of the patients should be included on the health-check Learning disability register in order to validate that the patients are known to the LA and that they have access to the most appropriate care for their disability.

2.14.5 The Provider must engage with the locally arranged learning disability nurse to help with the delivery of the Learning Disability service.

2.15 Palliative Care

2.15.1 The Provider must ensure the identification of patients who are in their last year of life with Palliative Care needs (including cancer), and apply Gold Standards Framework or its equivalent in their end of life care programme, ensuring each patient has an up to date Personalised Care Plan Deciding Right (PCPDR) care plan or the most current method of care plan generation within the CCG. The provider must ensure that for each patient, this has been shared with all the relevant partners involved in the delivery of the agreed care plan, including but not limited to:

a) Patient (or patients next of kin e.g. where Power of attorney exists)
b) Ambulance service
c) NHS 111
d) OOH service

e) Community health care services
f) Acute trust – emergency and other relevant departments
g) Care home staff

2.15.2 The care plan should be reviewed on a regular basis and any updates shared with the Patient and Partners.

2.15.3 The Provider must hold a Multi-Disciplinary Care review carried out monthly for all patients on the practice palliative care register and this should be undertaken face to face. These meetings should be appropriately documented. The Special Patient Note (SPN) for each patient must be updated on the same day as the review and shared with the relevant out of hours providers.

PART 3: QUALITY, GOVERNANCE & ASSURANCE

3.1 Quality Assurance

3.1.1 The Contractor shall:

a) Operate an effective, comprehensive, System of Clinical Governance with clear channels of accountability, supervision and effective systems to reduce the risk of clinical system failure;

b) Operate an effective, comprehensive, System of Integrated Governance;

c) Have clinical/medical leadership in place

d) 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;

e) Continuously monitor clinical performance and evaluate untoward events and near misses arising from any activity and provide the Commissioner with the Records to enablethe Commissioner to assess whether standards are being met;

f) Use appropriate formal methods such as root cause analysis for untoward incidents, near misses and complaints;

g) Undertake regular and robust auditing of clinical care against clinical standards with frequent auditing of the quality of consultations to enable appropriate reporting at performance monitoring meetings.

h) 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;

i) Participate in all quality and clinical governance initiatives agreed between the Commissioner and its other GP practices of the contract.

j) Engage with the CCG's annual practice appraisal visit;as required by the commissioner; and

k) participate in CQC visits and work with the commissioner to complete any necessary CQC action plans.

3.2 Due Diligence

3.2.1 The Contractor must undertake its own due diligence review following commencement of the contract to ensure the appropriate quality and safety of patient care is provided.

3.2.2 The Contractor will be required to establish and implement robust protocols and processes to ensure patient safety, safe system and clinical management within all areas; however, specific priority and written assurance must be given on the following:

a. Management of Pathology results;
b. Repeat prescribing process;
c. Management of long-term conditions;
d. Medicine Review every 6 months at least for patients who are on four or more types of medication otherwise yearly is sufficient
e. Process for maintaining immunization targets;
f. Continuity of clinical care and choice of Provider;
g. Provision of home visiting;
h. Provision of services to care homes;
i. Management of the registered list;
j. Cooperation and liaison with HM Coroner as required.

3.3 Safeguarding

3.3.1 The Contractor must have a named safeguarding practitioner for each premises/surgery on behalf of the provider;

3.3.2 All staff will have appropriate up-to-date job descriptions and person specifications which are specific to individual roles.

3.3.3 Ensure that all clinical staff have access to safeguarding supervision fron an appropriately skilled person.

3.3.4 The Contractor must deliver appropriate and responsive care to all children and vulnerable adults in line with all national legislation and guidance and local policy and procedure:

3.3.5 The Contractor must adhere to The Safeguarding Policy found at:

a) Htt/ps://www.england.nhs.uk/ourwork/safeguarding/policies/

b) Leicester, Leicestershire and Rutland Safeguarding Children Board Inter Agency Child Protection Procedures: http://llrscb.proceduresonline.com/index.htm

c) Leicester, Leicestershire and Rutland Safeguarding Adults Board (SAB) Safeguarding Adults: Multi- agency Policy and Procedures:

www.llradultsafeguarding.co.uk

3.3.5.1 The contractor must have clearly defined and understood policy in place regarding safeguarding children; young people and adutls at risk that also addresses issues of domestic abuse and Prevent and the Mental Capacity Act. These policies must be in accordance with the local multi-agency policies and procedures.3.3.5.2 The Contractor must ensure all staff are aware of national and local guidance for safeguarding children and adults, domestic abuse, Prevent and the Mental Capacity Act and that the information is readily available.

3.3.6 The Contractor must ensure appropriate training is in place:

a) an expectation that all practice staff undertake safeguarding and appropriate domestic abuse training and are familiar with safeguarding and domestic abuse reporting protocols;

b) ensure that all staff are trained to an appropriate level, that is congruent with their role and responsibilities and must ensure all training is regularly updatged and is in line with the Intercollegiate Guidance on safeguarding training.

3.3.7 The Contractor will ensure the workforce is compliant with Safer Recruitment process:

a) That appropriate pre-employment checks including taking up previous employment references and Disclosure and Barring Service (DBS) checks at an enhanced level (formerly Criminal Records Bureau CRB checks) have been conducted and risk assessed where staff deliver care to children and vulnerable adults.

b) Ensure there are robust arrangements in place for managing allegation against staff and where this relates to safeguarding children, that procedures relating to referral to Local Authority Designated Officer are followed.

c) Ensure that staff understand their roles and responsibilities in accordance with professional standards and national guidance including

i. Working Together to Safeguarding Children 2015
ii. Promoting the health and Well Being of Looked After Children Statutory Guidance 2015;
iii. Care Act 2014 and Care Act Statutory Guidance (as revised 2016)
iv. Mental Capacity Act 2005
v. Deprivation of Liberty Safeguards 2007
vi. Prevent Strategy
vii. Domestic Abuse
viii. Local protocols

3.3.8 The contractor should demonstrate effective governance of safeguarding arrangements in their service through use of a safeguarding assurance framework, as agreed with the commissioner.

3.3.9 The Contractor should hold multi-professional safeguarding meetings at regular intervals to ensure safeguarding information is conveyed appropriately in a timely fashion in order to assess and respond to risk as part of a multi-agency response.

3.3.10 The Contractor should conduct audits and reviews to ensure staff are adhering to required safeguarding standards and this should include:
a) Safeguarding referrals and notifications in accordance with local safeguarding boards agreed procedures.
b) Responses to case of domestic violence.
c) Contribution to multi-agency procedures such as reports to case conferences.

3.3.11 The Contractor must contribute to statutory reviews including Serious case reviews; Safeguarding Adult Reviews and Domestic Homicide Reviews.

3.3.12 The Contractor must adhere to mandatory reporting requirements including HSCIC reporting for Female Genital Mutilation.

3.4 Good Clinical Practice

3.4.1 The Contractor shall perform the Services in accordance with this Agreement and the following requirements as amended from time to time:

a) Care Quality Commissions 'Essential Standards of Quality & Safety' found at: http://www.cqc.org.uk/content/guidance-providers
b) The 'Good Medical Practice for General Practitioners' RCGP (2008) Found at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Good_Medical_Practice_for_GPs_July_2008.ashx
c) Any relevant MHRA guidance, technical standards, and alert notices;
d) The General Medical Council guidance on Good Medical Practice (2013). Found at: http://www.gmc-uk.org/guidance/good_medical_practice.asp

3.5 Clinical Governance

3.5.1 The Contractor will ensure all procedures are carried out in line with the Commissioning authority guidelines. Every primary care NHS organisation in

England is responsible for ensuring that it is complying with the Department of Health's core standards, as detailed above 3.5.1(a). Also refer to the CQC GP Provider Handbook.

http://www.cqc.org.uk/sites/default/files/20160127_gp_practicfes_provider_handbook_jan16.pdf

3.5.2 The Contractor will carry out clinical audits to ensure compliance with national and local standards and guidance, the achievement of patient treatment outcomes and any other reasonable requests for clinical audits made by the Commissioners.

3.5.3 Clinical governance is about ensuring all health care Contractors are able to deliver high quality care, able to learn from audit and errors, and where all practitioners and staff are encouraged to develop their skills and expertise. The Contractor will be responsible for identifying a clinical governance lead and demonstrate how clinical governance will be maintained. The clinical governance lead will be responsible for maintaining key patient safety mechanisms including:

a) Health Care acquired infections
b) Safeguarding children and vulnerable adults
c) Accident reporting
d) Clinical Incident reporting and management
e) Risk management
f) Clinical effectiveness
g) Compliance with Safety Alert Broadcasts
h) Clinical supervision
i) Whistle blowing
j) Mechanism for patient complaints, concerns and experience
k) Identification of a Caldecott Guardian

3.5.4 The Provider will ensure that robust clinical governance processes are in place to include:

a) Clinical governance lead
b) Incident reporting – including the notification of all incidents to the Commissioner and other bodies as required

c) Infection control
d) Significant Incident/event analysis
e) Complaints
f) Managing alerts
g) Quality assurance

3.5.5 It will be the clinical governance lead's responsibility to manage the above and ensure that procedures and protocols are being effectively applied (with evidence) and that, if not, effective rectification action is taken. Records in relation to on-going clinical governance activity should be made available to the Commissioner on request.

3.5.6 The Contractor will ensure that Health and Safety and Clinical Risk Assessments are carried out and a risk management plan is documented.

3.5.7 The Contractor will ensure continued professional development of all their staff delivering to this contract and Continuing Professional Development (CPD)

3.6 Clinical Variation /Efficiency

3.6.1 The Commissioner and the local CCGs are committed to strengthening and improving the quality of general practice and reducing variation to tackle the challenges that lie ahead. It is critical that effective use of resources by practices on behalf of their patients becomes a core element of general practice, and is not viewed as an optional extra.

3.6.2 The provision of consistent, high quality primary care is essential to reduce costs and improve efficiency, and sets the standard for the whole health economy.

3.6.3 The Contractor must have systems and processes in place for acting on diagnostic information in a timely and appropriate manner.

3.6.4 As part of the the CCG's strategy to reduce clinical variation the provider must ensure that:

a) The Provider attends all locality meetings
b) Actively engage at contribute to locality meetings
c) Implement and embed the learning within practices as identified from the locality meetings.

3.7 Quality and Outcomes Framework (QOF)

3.7.1 The Centre Surgery achieved 96.92% / 541.78 of the 559 points available in 2015/16. The Contractor will be expected to comply with the Quality & Outcomes Framework which is intended to measure, encourage and support clinical care and Patient experience which is constantly improving. The framework sets out a range of national standards based on the best available research evidence.

3.7.2 The Contractor acknowledges that QOF changes each year and that it must be required to meet with the Commissioner to agree each year's QOF requirements to ensure patients continually receive the highest standards of clinical care.

3.7.3 The Contractor will be required to participate in the current and any future Quality and Outcomes Framework (QOF), as laid out in the APMS contract, in line with other practices.

3.7.4 Contractor will be required to work towards maintaining current achievement ensuring no less than 90% minimum of the agreed Quality & Outcomes Framework points within the Contract year. The Contractor will also be required to set standards over and above the QOF requirements to ensure Patients continually receive the highest standards of clinical care.

3.7.5 The Contractor shall minimise exception and improve prevalence rates on practice registers.

3.7.6 The Provider should note that Key Performance Indicator Targets may require standards over and above the national QOF requirements to ensure Patients continually receive the highest standards of clinical care.

3.7.7 The Quality & Outcome Framework (QOF) is reviewed annually via the Calculating Quality Reporting Service (CQRS)3.7.8 Providers will be expected to comply with the QOF validation process and inspection visits as required.

3.8 Complaints

3.8.1 The Contractor will ensure that complaints are dealt with in accordance with Schedule 5 to this agreement and the NHS complaints procedure, as detailed below which can be found at:

https://www.england.nhs.uk/wp-content/uploads/2015/01/nhs-complaints-procedures.pdf

3.8.2 Contractors are required to comply with the NHS complaints procedure and guide 'Listening, Improving, Responding ' (2009). Pending NHS England issuing new guidance.

3.8.3 The service will publish annually an overview of the patient complaints that will demonstrate analysis, organisational/individual learning and improvements in care.

3.9 Serious Incident reporting

3.9.1 All adverse incidents (significant events) and near misses must be reported using the incident reporting process via the NRLS webnsite:

http://www.nrls.npsa.nhs.uk/

3.9.2 A record of the incident investigation and changes made as a result and learning outcomes should be documented y the service and a coy sent to the Commissioner.

3.9.3 If a serious untoward incident (definition according to the national policy) occurs it should be reported immediately to the patient safety lead via england.hsmlat.sui@nhs.net and to the CCG Contracts Manager using the reporting forms supplied.

3.9.4 Ensure Duty of Candor is applied in line with CQC regulation 20;

3.9.5 The Contractor will be expected to undertake a thorough investigation (Root Cause Analysis) and share lessons learned from all adverse incidents and complaints.

3.9.6 The Contractor must adhere to NHS England Serious Incidents Framework

https://www.england.nhs.uk/patientsafety/serious-incident/

3.9.7 The Contractor must adhere to NHS England Never events policy which can be found at

https://www.england.nhs.uk/patientsafety/never-events/

3.10 Care Quality Commission (CQC)

3.10.1 The Contractor will deliver healthcare to nationally consistent quality and safety standards as lie out in statute from time to time, and will achieve registration with the CQC (Care Quality Commission) for the service. The Contractor will do this in a way that makes best use of its financial resources by following good business practice to ensure it can respond to the unexpected without jeopardising services, and introduce changes where services need to be improved.

3.10.2 The Contractor must comply with the Essential Standards of Quality and Safety (Section 20 of the Health and Social Care Act 2012) and meet the NHS England, Social Care England and Public Health England Registration Regulations from 1st April 2013. The Contractor will be required to meet and deliver on these Standards and will be monitored against them as well as any updated national monitoring matrices.

3.10.3 The Contractor must comply with all relevant legislation and relevant guidance issued by NHS England, Clinical Commissioning Groups or the Secretary of State.

3.10.4 The Provider must achieve registration with the Care Quality Commission prior to commencement and provide the Commissioner with evidence of CQC registration.

3.10.5 Practices will be required to display the inspection outcome in their waiting room(s) and on the practice website..

3.11 Infection Control

3.11.1 The Contractor must have in place strict infection prevention and control procedures in line with adherence to CQC Essential Standards.

3.11.2 Annual Infection Control Audits will be carried out by the Contractor for each service/premises and evidence will be provided of any actions taken as a result of the completed audits.

3.11.3 The Contractor shall:

a) Ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of reusable medical devices, including complying with the Commissioner policy
b) Ensure that reusable medical devices are handled safely and decontaminated effectively prior to re-use
c) Make arrangements for the ordering, recording, handling, safe keeping, safe administration and disposal of medicines used in relation to the Services; and
d) Make arrangements to minimise the risk of infection and toxic conditions and the spread of infection between Patients and Staff, (including any Health Care Professional which the Provider has asked to carry out clinical activity).

3.11.4 The Provider should demonstrate good infection control and hygiene practice. All staff will facilitate and co-operate with the Commissioner Infection Control Team in monitoring, audit and investigation (including Root Cause Analysis) of

the environment, patient outcomes and practices to ensure high standards are maintained.

3.12. Risk Management

3.12.1 The Contractor must operate:

a) Mechanisms for managing risk;
b) Disaster recovery, contingency and business continuity plans;
c) Keep the Commissioner fully informed about the:

i. Provider's approach to risk management (risk philosophy) including the risk the Provider is willing to bear before taking action and what processes are implemented;
ii. detail of the risk management structures and processes that exist and how they are implemented; and
iii. Notify the Commissioner about the resource allocation to risk management (existing/planned) and to put in place individuals for the leadership roles set out in Clause 46.3 of this Agreement.

3.13 Health and safety at work

3.13.1 The Provider must have a health and safety policy that complies with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1992). The Provider must 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 regulation 4 of the Management of Health and Safety at Work Regulations 1992) (or EU member state equivalent) of the organization
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 Provider will manage its obligations in respect of health and safety at work

d) A description of how health and safety responsibilities are allocated within the organization
e) The Provider must provide an overview of their approach to health and safety which includes a description of its approach to managing
f) Health and safety risks and improvement measures
g) Working Time Regulations and safe systems of work
h) Staff consultation and counselling
i) Safety audit
j) Accident reporting
k) Health and safety record keeping and reporting.

3.14 Performance Management

3.14.1 The Commissioner will monitor service provision via the process identified within Schedule 6 of this Agreement;