Schedule 1 to
Contract 701162379

STATEMENT OF REQUIREMENT FOR

PROVISION OF SECONDARY HEALTHCARE SERVICES FOR BRITISH FORCES CYPRUS AND THE SOVEREIGN BASE AREA

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CONTENTS

PART 1

SECTION 1 - DEFINITIONS AND ABBREVIATIONS
SECTION 2 - POPULATION AND HISTORICAL CLINICAL ACTIVITY
SECTION 3 - GENERAL PRINCIPLES

PART 2

SECTION 1 - LEADERSHIP
SECTION 2 - SERVICE MANAGEMENT
SECTION 3 - ADMINISTRATION
SECTION 4 - CASELOAD VALIDATION AND FINANCIAL ARRANGEMENTS

PART 3

SECTION 1 - CLINICAL SERVICES – GENERAL
SECTION 2 - ADULT CLINICAL SERVICES
SECTION 3 - PAEDIATRIC CLINICAL SERVICES
SECTION 4 - CLINICAL STAFFING
SECTION 5 - CLINICAL SERVICE USER EXPERIENCE

PART 4 - GOVERNANCE AND ASSURANCE

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PART 1

SECTION 1

DEFINITIONS AND ABBREVIATIONS

1.1.1. **Introduction**. The purpose of this Statement of Requirement (SOR) is to systematically describe the minimum performance standard for the provision of Secondary Healthcare (SHC) Services and Facilities for BFC/SBAA clinical service users assigned to, and working, for Headquarters British Forces Cyprus (HQ BFC) and the Sovereign Base Area Administration (SBAA). It defines the roles and responsibilities of the Provider(s) and the Authority and signposts the underpinning legislation and national standards[1]. It is a key supporting document in the Investment Approvals Process and will be amended upon selection of the preferred Provider(s) to become the source document of Key Performance Indicators (KPIs) that will be used in the contract management process.

DEFINITIONS

1.1.2. This section sets out the main SHC definitions applicable to this Statement of Requirement (SOR) and any ensuing contract. Contractual definitions will be provided separately within the Contract Terms and Conditions.

1.1.3. It is accepted these definitions may change following downstream negotiations or over the course of the Contract. Such changes are to be agreed with the Authority and, if necessary, a revised list of definitions will be produced which will form part of the Contract between the Authority and the Provider.

1.1.4. **Agreed Treatment Plan**. A plan of treatment, that may include single or multiple attendances and/or admissions, which has been accepted by the patient and approved by the Authority. The Authority acknowledges the number of follow-up attendances may be limited after negotiation with the Provider(s) clinicians. All investigations, as authorised and/or deemed necessary by the Provider/the Authority, are to be included.

1.1.5. **Authorised Referrers (AR)**. All medical and dental practitioners working in Defence Primary Healthcare (DPHC), Defence Mental Health Practitioners, Suitably Qualified and Experienced Allied Health Professionals, and visiting Defence Medical Services (DMS) clinicians. BFC Commander Medical (Comd Med) and Regional Senior Dental Officer (RegSDO) are also ARs for the purposes of the SOR.

1.1.6. **Authority**. The Secretary of State for Defence for Defence, acting on behalf of the Crown.

1.1.7. **BFC/SBAA clinical service user**. Those serving members of HM Armed Forces, Civil Servants, and their dependants serving, either permanently or temporarily, as part of BFC or the SBAA and who are entitled to treatment under the terms of the contract.

1.1.8. **Cancellation**. A patient who, having accepted an appointment or admission, notifies the Authority or the Provider(s) of intended non-attendance at **48 hours or more** before the appointment.

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[1] In the event a single Provider cannot deliver the full range of required services or do not have sufficient specialist capabilities, there may be a requirement to utilise multiple Providers.

1.1.9. **Clinical effectiveness**. Application of knowledge derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for clinical service users.

1.1.10. **Clinical governance**. A system through which healthcare providers and partners are accountable for continuously improving the quality of their services and safeguarding high standards of treatment and/or care by creating an environment in which excellence in clinical care can flourish

1.1.11. **Clinical risk assessment**. A process used to determine risk management priorities for clinical service user treatment and/or care by evaluating and comparing the level of risk against healthcare provider standards, predetermined target risk levels or other criteria.

1.1.12. **Clinical service**. A system within, or across, healthcare provider(s) delivering prevention, diagnostics, treatment and/or care or rehabilitation to clinical service users.

1.1.13. **Clinical service leader**. A named individual of a leadership team with responsibility for leading the clinical service. May also be called the Lead Clinician.

1.1.14. **Clinical team**. Group of staff members that have the responsibility for providing and delivering a part of the clinical service.

1.1.15. **Competency**. Clinical and/or technical expertise, ability, knowledge and/or skills of a staff member or clinical team required to carry out a role.

1.1.16. **Consultant**. The term used to describe an accredited clinical specialist capable of, and responsible for, taking clinical decisions without supervision, and who is appointed to lead a team of other specialists in a given medical specialty. A DMS Consultant means a consultant employed by the Authority under separate contractual arrangements.

1.1.17. **Day Case**. An episode of hospital treatment in a ward or department where the patient is discharged on the same day as the admission.

1.1.18. **Emergency clinical service user**. Defined by the Authority as:

a. any clinical service user referred by an AR (or who self refers) requiring the services of a Clinician at the Provider(s) premises for an episode of diagnosis or treatment who does not qualify as an Outpatient or Inpatient. Care and treatment for these persons may, subject to negotiation with the Provider, include a number of follow-up appointments, or;

b. one that arrives without warning and requires clinical staff to be diverted from planned activities to assess and treat them.

1.1.19. **Ethos.** Nature, character and fundamental values of the clinical service.

1.1.20. **Failed to Attend (FTA)**. A BFC/SBAA clinical service user who, having accepted an appointment or admission, gave no or insufficient notice (less than 48 hours) of non-attendance.

1.1.21. **Fundamental Standards**. Standards of healthcare provision, enshrined in UK Law, below which care must never fall.

1.1.22. **Inpatient**. A clinical service user whose care requires a stay in hospital.

1.1.23. **Key Performance Indicator (KPI)**. Defined as an agreed benchmark against which performance can be measured.

1.1.24. **Lead clinician**. Named clinical staff member for a clinical specialty with a remit for leading the clinical staff within a clinical service.

1.1.25. **Leadership team**. Clinical and managerial staff members with responsibility for leading a clinical service.

1.1.26. **Length of Stay**. The whole number of days between admission and discharge, plus one day.

1.1.27. **Medical in Confidence**. Defined as clincial service user medical information that is not be communicated to any individual or organisation who does not have a medical or legal need to know.

1.1.28. **Outpatient**. A clinical service user who is not hospitalised overnight, but who visits a hospital, clinic, or associated facility for diagnosis or treatment

1.1.29. **Patient Safety**. Defined as the process by which an organisation aims to make patient care safer. This should involve: risk assessment; the identification and management of patient-related risks; the reporting and analysis of incidents; and the capacity to learn from and follow-up on incidents and implement solutions to minimise the risk of them recurring.

1.1.30. **Patient Safety Incident (PSI)**. Defined as any unintended or unexpected incident which could have, or did, lead to harm for one or more BFC patients[2]. (This is also referred to as an adverse event/incident or clinical error and includes near misses).

1.1.31. **Policy**. Document that states, in writing, a course or principles of action adopted by a provider and/or clinical service.

1.1.32. **Procedure**. Specified way to carry out an activity or a process.

1.1.33. **Professional body**. Association of members of the same profession.

1.1.34. **Provider(s)**. The person who, by the Contract, undertakes to supply the Contractor Deliverables, for the Authority as is provided by the Contract. Where the Contractor is an individual or a partnership, the expression shall include the personal representative of the individual or of the partners, as the case may be, and the expression shall also include any person to whom the benefit of the Contract may be assigned by the Contractor with the consent of the Authority

1.1.35. **Quality Improvement Plan**. Document, or several documents, that together specify quality requirements, practices, resources, specifications, measurable objectives, timescales and the sequence of activities relevant to a particular clinical service or project to achieve the objectives within the timescales given.

1.1.36. **Rota**. Document, usually a list, showing when each staff member has to do a particular job or different disciplines, or when an organization has a specific role.

1.1.37. **Shall**. Describes an activity or requirement that is mandatory.

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[2] http://www.npsa.nhs.uk/nrls/reporting/what-is-a-patient-safety-incident/

1.1.38. **SHC Services**. All necessary clinical and non-clinical services carried out by the Provider(s) necessary for the comprehensive care of BFC/SBAA clinical service users. This will apply to all specialties and services offered by the Provider except those specifically notified to the Authority as being excluded.

1.1.39. **Should**. Describes an activity that is considered to be good practice. If the activity is followed, then this will be considered sufficient to demonstrate compliance with a Regulated Activity. However, alternative approaches may be utilised where this produces an outcome as good as that required by the Regulated Activity.

1.1.40. **Skill mix**. Combination of different types of staff members that are employed in a clinical service that have the required skills and competencies to carry out the work of the Clinical service and deliver the clinical pathway.

1.1.41. **Staff member**. Person, clinically or non-clinically trained, working in the clinical service.

1.1.42. **Training plan.** Detailed proposal of the topics to be included within a training programme.

1.1.43. **Training programme**. Planned learning activities of the training plan.

1.1.44. **Value for money**. Maximization of quality and minimization of risk within available resources, with the intention of preventing disease and reducing the disease burden, in order to achieve the best value care practicable.

1.1.45. **Workforce**. Collective term for staff members employed and/or working in the clinical service.

1.1.46. **Workforce development plan**. Documented analysis of the current workforce and the forecasted workforce required to deliver the objectives of the clinical service strategy.

ABBREVIATIONS

1.1.47. The abbreviations listed below will be used throughout this document.

A&E	-	Accident and Emergency
AR	-	Authorised Referrer
BFC	-	British Forces Cyprus
CBF	-	Commander British Forces
CLO	-	Clinical Liaison Officer
CMH	-	Community Mental Health Team
Comd Med	-	Commander Medical
CQC	-	Care Quality Commission
CV	-	Curriculum Vitae
DCA	-	Defence Consultant Advisor
DMS	-	Defence Medical Services
DMSR	-	Defence Medical Services Regulator
DMWO	-	Defence Medical Welfare Officer
DMWS	-	Defence Medical Welfare Service
DPHC	-	Defence Primary Healthcare
ENT	-	Ear, Nose and Throat

FMed	-	Form, Medical
FTA	-	Fail To Attend
GDPR	-	General Personal Data Regulation
HCC	-	Healthcare Contracts
HLO	-	Hospital Liaison Officer
HM	-	Her Majesty
HQ	-	Headquarters
IELTS	-	International English Language Testing System
III	-	Injured, Ill or Incapacitated
IP	-	Inpatient
ISO	-	International Standards Organisation
IT	-	Information Technology
KPI	-	Key Performance Indicator
M&LM	-	Management and Liaison Meeting
MOD	-	Ministry of Defence
NHS	-	National Health Service
NOTICAS	-	Notification of Casualties
OET	-	Occupational English Test
OP	-	Outpatient
PAR	-	Population At Risk
PHC	-	Primary Healthcare
PQQ	-	Pre-Qualification Questionnaire
PSI	-	Patient Safety Incident
QA	-	Quality Assurance
QMM	-	Quarterly Management Meeting
QS	-	Quality Standard
RAF	-	Royal Air Force
RegSDO	-	Regional Senior Dental Officer
RoC	-	Republic of Cyprus
RoDs	-	Record of Decisions
SBA	-	Sovereign Base Area
SBAA	-	Sovereign Base Area Administration
SER	-	Significant Event Report
SHC	-	Secondary Healthcare
SI	-	Seriously Ill
SO2	-	Staff Officer Grade 2
SOR	-	Statement of Requirement
UK	-	United Kingdom
UKAS	-	United Kingdom Accreditation Service
VFM	-	Value for Money
VSI	-	Very Seriously Ill
WHO	-	World Health Organisation

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PART 1

SECTION 3

GENERAL PRINCIPLES.

1.3.1. **Fundamental Standards**. The standards listed below are Regulated Activities as described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 below which care **must** never fall and that the Authority has a statutory responsibility to deliver. These are reflected in the Care Quality Commission (CQC) Fundamental Standards[3] and Defence Healthcare Regulations[4].

a. **Seven Day Service**[5]. The Provider(s) shall deliver to the Authority a comprehensive and integrated SHC Service for BFC/SBAA clinical service users. The service shall be available 365 days a year and 24 hours a day. Clinical services will be Consultant-led but Multi-Disciplinary in nature.

b. **Patient-Centred Care**. All care and treatment shall be tailored to the clinical service user's needs and, where possible/practicable, preferences.

c. **Dignity and Respect**. All clinical service users will be treated with dignity and respect at all times while receiving care and treatment. The Provider(s) shall ensure that:

(1) clinical service users are given privacy when they need and want it;

(2) all clinical service users are treated as equals, and;

(3) all clinical service users are given the support they need to remain as independent as their clinical condition allows.

d. **Consent**. (See Part 4, Para 4.15) clinical service users, or their legal advocate, MUST give their consent before any care or treatment is given.

e. **Safety**. The Provider(s) shall:

(1) ensure the delivery of care and treatments are safe and risk of harm to the clinical service user is avoided;

(2) assess the risks to the health and safety of all clinical service users during care and treatment, and;

(3) ensure all staff have the qualifications, competence, skills and experience to keep clinical service users safe.

f. **Safeguarding From Abuse.** (See Part 4, Para 4.11) Clinical service users **MUST NOT** suffer any form of abuse or improper treatment while receiving care. This includes:

(1) Neglect;

(2) Degrading treatment;

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[3] CQC Fundamental Standards

[4] Defence Medical Services Regulator - DSA02 Healthcare Regulatory Policy and Healthcare Regulations

[5] https://improvement.nhs.uk/resources/seven-day-services/

(3) Unnecessary or disproportionate restraint, and;

(4) Inappropriate limits on freedom.

g. **Food and Drink**. (See Part 3, Section 5,) The Provider(s) shall ensure clinical service users have enough to eat and drink to keep them in good health while receiving care and treatment.

h. **Premises and Equipment**. The Provider(s) shall ensure all premises where care and treatment are delivered is clean, suitable and well-maintained. Similarly, all equipment used should be serviceable, clean, secure and used properly.

i. **Complaints**. (See Part 4, Para 4.12) Clinical service users **MUST** be able to lodge complaints about the care and treatment they have received. The Provider(s) and the Authority shall have an agreed system in place to handle and respond to any complaints in a timely manner. The Provider(s) and the Authority shall investigate all complaints thoroughly and take subsequent action if necessary.

j. **Good Governance**. (See Part 4) The Provider(s) shall have plans to ensure all of the above Fundamental Standards can be met. The Provider(s) shall employ effective governance and systems to check on the quality and safety of all care and treatment. The Authority shall conduct routine and frequent audits and inspections to ensure Provider(s) compliance.

k. **Staffing**. (See Part 3 Section 4) The Provider(s) shall ensure there are sufficient suitably qualified, competent and experienced staff to ensure the above Fundamental Standards are met. The Provider(s) shall have a Staff Education, Training and Continuous Professional Development Policy in place. Staff shall be given the support, training and supervision they need to help to do their job. The Provider(s) shall only employ people who can provide care and treatment appropriate to their role. The Provider(s) shall carry out relevant checks; these must include criminal records, professional body registration, certificates of qualification/competence, and work history. The Provider shall ensure only those clinicians approved by the Authority deliver care and treatment to BFC/SBAA clinical service users.

1.3.2. **Duty of Candour**. The Provider(s) and the Authority must be open and transparent:

a. with clinical service users about their care and treatment and ensure that, should something go wrong, the clinical service user is informed and given appropriate and suitable support, and;

b. with each other in relation to Service delivery challenges and expectations.

1.3.3. **Language**. Care and treatment for BFC/SBAA clinical service users shall be delivered in the English Language. The Authority will monitor compliance. The Provider(s) shall ensure:

a. Clinicians and Staff are demonstrably and sufficiently fluent in English, both verbally and in written form, to deliver care and treatment to BFC/SBAA clinical service users[6];

b. all care and treatment related correspondence and documentation is provided in English;

[6] Evidence of initial Medical, Nursing or Clinical education and training in an English-speaking country, and/or evidence of an employment history in a healthcare setting in an English-speaking country, or certification in any one of the English Language qualifications that meet the **Level B1** criteria of the Common European Framework of Reference for Languages (CEFR).

c. Managerial and Administrative Staff employed in roles where they will interact with Authority representatives are demonstrably and sufficiently fluent in English;

d. all staff are supported to improve their English Language skills and the acquisition of English language qualifications, and;

e. hospital information leaflets, approved by the Authority, are made available to BFC/SBAA clinical service users and the wider BFC /SBAA community in the English language. These leaflets will provide information to clinical service users about the Provider and the facilities that will be available to them during their planned attendance. They are to be provided to the Authority, in electronic and hard copy, for display within DPHC Medical/Dental Centres.

1.3.4. **Standards and Compliance**

a. **Legal**. (See Part 4) The Provider(s) shall be compliant with all relevant local and international legislation as it relates to the provision of SHC services in the Republic of Cyprus (RoC). Evidence of compliance and licence to operate is to be submitted to the Authority at tender submission, annually from the point of Contract Award or when there has been a significant change, whichever is sooner. The Authority acknowledges that, in the event of any inconsistency between the provisions of the UK Acts and their Cypriot equivalents, the highest standard will prevail.

b. The Authority has a Statutory duty to ensure compliance with the Regulated Activities described in Para 1.3.1 above. The Provider(s) shall demonstrate compliance, supported by the Authority to the Defence Medical Services Regulator (DMSR) Defence Healthcare Regulations.

c. **International Organisation for Standardisation (ISO)**. (See Part 4 Para 4.2) The Providers(s) shall ensure they are compliant with all ISOs listed in Part 4, Annex J, delivered by a United Kingdom Accreditation Service (UKAS) accredited organisation at **contract start**.

d. **Clinical Service Standards**. (See Part 4, Para 4.3 and 4.4) The Provider(s) shall be responsible for maintenance of Clinical Services Standards in all premises where care and treatment is delivered to BFC/SBAA clinical service users. The Authority shall monitor the clinical care and treatment delivered in the Provider(s) premises against appropriate benchmarked standards as described in Para 1.3.1 above. The Provider(s) shall take corrective action should care and treatment fall below these standards and be subsequently identified by the Authority.

1.3.5. **Entitlement to Treatment**. (See Part 3, Section 1, Para 3.1.12-3.1.17) The Authority shall ensure only BFC/SBAA clinical service users are referred to the Provider(s) for care and treatment by Authorised Referrers[7]. The Authority reserves the right, however, to refer non-BFC/SBAA clinical service users on a case by case basis and in exceptional circumstances (e.g. a migrant, humanitarian crisis, transiting Service Person (SP)).

1.3.6. **Agreed Treatment Plans**. (See Part 3, Section 1, Para 3.1.22-3.1.28) The Provider(s) shall ensure all care and treatment delivered to BFC/SBAA clinical service users has been accepted by the clinical service user and approved by the Authority AR. The Provider(s) is required to ensure only BFC approved clinicians are used in the delivery of treatment and care to BFC/SBAA clinical service users (see Part 3. Section 4, Para 3.4.2).

[7] See Part 1, Section 1 for definitions of Entitled Clinical Service Users and Authorised Referrers

1.3.7. If the Authority has concerns on safety, conduct or clinical grounds it retains the right to remove any clinician from the BFC approved list. Removal from the approved list will only be sanctioned after discussion with the Provider, however the Authority retains the right to remove regardless.

1.3.8. **Out-sourcing of Services.** The Provider(s) shall remain, at all times, responsible to the Authority for the delivery of services described in Part 3. Where a service described in Part 3 cannot be delivered by a single Provider, they shall submit a proposal to the Authority on the availability of suitable alternatives and how the service requirement could be met through out-sourcing by **contract start**.

1.3.9. Only alternative provider(s)/sources agreed by the Authority shall be used to deliver care and treatment to BFC/SBAA clinical service users. The Provider(s) shall ensure, and demonstrate to the Authority, the alternative source meets the minimum required benchmarked standard described in Part 4, Para 4.5 and shall remain responsible to the Authority for the quality and standard of care and treatment delivered through out-sourced means.

1.3.10. In the event that additional medical and health services are required during the term of the contract, the Authority reserves the right to request that the Provider(s) submit a proposal on how it can expand in order to deliver the new requirement.

1.3.11. **Pre-Existing Arrangements**. The Authority reserves the right to source alternative SHC provision as clinical and service needs dictate, including referring BFC/SBAA clinical service users to the UK for treatment under pre-existing arrangements with the UK National Health Services. In these circumstances, the Provider(s) shall:

a. liaise with the Authority in advance of such activities;

b. facilitate, as necessary, the transfer of the clinical service user to another provider, ensuring all relevant documentation (translated into English), medications and any medical equipment and/or devices are available to accompany the clinical service user, provide appropriate transport to enable the transfer;

c. be familiar with the process and assist in the preparation of the clinical service user for Aeromedical Evacuation;

d. facilitate communication and liaison with the receiving Provider, ensuring ongoing and proposed treatment plans are agreed between the Authority and the receiving Provider;

e. ensure the clinical service users' personal effects are secure and accompany the clinical service user on transfer, and;

f. where necessary, provide a clinical service user escort.

1.3.12. **Aeromedical Evacuation**

a. **To Cyprus**. There is a requirement for a small number of clinical service users to be admitted at short notice who have been evacuated by air from zones of military operations outside Cyprus. This requirement will be subject to availability of beds and the nature of the treatment required. These clinical service users will have received initial treatment and do not, in most cases, require major treatment.

b. **From Cyprus**. Where the Authority has decided a clinical service user will be transferred to the UK for further treatment, it may be necessary for the clinical service user to move to the UK by air from a hospital ward. The Provider(s) is to confirm they will co-operate with the Authority in preparing the clinical service user for movement by air. In particular, they

will provide the necessary medical documents to effect a safe transfer of clinical care, as described at para 1.3.11, and all documents will be ready to go with the clinical service user, at the time of collection by the Aeromed team.

1.3.13. **Support Services**. The Provider(s) shall ensure the environment and facilities are fit for purpose in order to provide safe, efficient and effective care for BFC/SBAA clinical service users as well as for the safety of staff members and visitors. The equipment used by staff members in the delivery of the treatment and/or care should be maintained and checked for quality.

1.3.14. **Information Systems**. The Provider(s) shall produce an Information Management Strategy and use IT systems designed to allow the collection, management and monitoring of data to support Provider(s) delivery. The Provider(s) shall have a documented procedure for the storage of data. The documented procedure shall include the provision of back-up, retention, archiving and any encryption. The Provider(s) shall ensure it is compliant with Regulation (EU) 2016/679 (General Data Protection Regulation) and all other national and international legislative requirements that may impact on BFC/SBAA clinical service users' information.

1.3.15. **Security**. It is acknowledged that Provider(s) will, most likely, be a civilian organisation providing SHC services to the local civilian population and may not have experience of treating SP subject to external threats from international terrorism and other sources. In this context, the Authority shall advise the Provider(s) of the nature of threats against BFC/SBAA clinical service users undergoing care and treatment under the terms of this SOR and on provision of security procedures to reduce risks. The Authority shall also inform the Provider(s) of any increase in the level of threat and, where necessary, provide additional security resources to the Provider(s).

1.3.16. The Provider shall confirm they will comply with the security measures described in the following paragraphs. Where this is not possible, the Provider is required to agree other such measures which will be acceptable to the Authority.

a. **Security of neonates**. The security of neonates is paramount. Conforming as a minimum to Cypriot Law, the Provider shall provide:

(1) a system of protection for infants, and;

(2) an appropriate identification tagging for use within the hospital, during the period of their IP stay.

b. **Document security**. Medical documents can contain information of particular interest, not only to hostile intelligence services but also to terrorist organisations. Medical documents must therefore be properly secured, in accordance with the requirements of Cypriot Law. Additionally BFC medical documents will be required, where possible, to be kept separate from other clinical service users' documents.

c. **Personnel security**. The Provider(s) shall ensure staff employed to deliver health care to BFC clinical service users, are subject to vetting procedures in accordance with best practice.

d. **Personal property**. The Provider shall make adequate provision for the security of a clinical service user's personal property. Details of this are to be included in the admission information.

1.3.17. **Service persons under detention**. Periodically, a Commanding Officer will deem that there is a significant risk of a SP, who has been admitted to the Provider, absconding. In such circumstances it may be necessary to place a guard upon that clinical service user and the

Authority will seek the Provider agreement to this. The Authority acknowledges such a requirement will not negatively affect the provision of services to its other clinical service users.

1.3.18. **Release of information to the press/media**. The Provider shall not disclose any information to the press or media, or publish any documents relating to the care of BFC clinical service users, unless they have the express written permission of the Authority.

1.3.19. **Communication with military authorities**. Communication, other than that between HLOs and Units relating to clinical service user care and administration, is to be conducted through, or with the approval of, HQ BFC Medical Branch.

1.3.20. **Data protection**. In respect of all personal data held, the Provider shall be responsible for the full requirements under the terms of UK Statutes, GDPR, the Medical Reports Act 1988, the Access to Health Records Act 1990 (dealing with information about the deceased) and/or Cypriot equivalents. The Authority acknowledges that, in the event of any inconsistency between the provisions of the UK Acts and their Cypriot equivalents, the highest standard will prevail. Other than at the specific request of the Authority, the Provider or their sub-contracted clinicians, will not disclose or allow access to any personal or medical data acquired or held under the terms of this agreement.

1.3.21. **Confidentiality.** clinical service user confidentiality is to remain compliant with the Data Protection Directives described in Para 1.3.14 above. Additionally, the Provider(s) shall ensure all clinical and administrative staff are familiar with and conform to Caldicott Guidelines.

1.3.22. **Accountability**. HQ BFC Commander Medical (Comd Med) is the Competent Medical Authority and is directly accountable to UK Strategic Command, via Commander British Forces (CBF)/The Administrator of the Sovereign Base Areas (SBA) and Director Overseas Bases, for the safe and effective delivery of SHC to BFC/SBAA clinical service users. The Provider(s) are accountable to Comd Med for all care and treatment delivered at their premises, at those of their clinicians and staff and those services that have been outsourced by the Provider(s).

PART 2

SECTION 1

LEADERSHIP

2.1.1. **Outline**. The Provider(s) service shall be well led, organised and delivered in order to provide safe, high quality, effective care to its BFC/SBAA clinical service users while working within its own available resources. The Provider(s) shall have in place, or appoint, a leadership team. The leadership team should adopt a collaborative approach to Provider(s) planning and delivery, so the Provider(s) operates effectively and delivers optimal value for money. The leadership team should be:

a. visible;

b. approachable, and;

c. available to all staff members.

2.1.2. The Provider(s) shall document the following:

a. members of the leadership team responsible for service provision for BFC/SBAA clinical service users;

b. roles and responsibilities of the leadership team and its members, including:

(1) a lead clinician who will have overall responsibility and accountability for the service provision;

(2) a General Manager who will have overall responsibility and accountability for Provider risk and management and administration services, and;

(3) a Clinical Liaison Officer (CLO) who will have overall responsibility and accountability for Provider/Authority clinical and clinical administrative interaction.

2.1.3. It is the expectation of the Authority that the leadership team shall be given the following responsibilities by the Provider(s):

a. leading on the development of strategic and business planning for the Provider(s) and involving stakeholders, including the Authority, in this process;

b. leading on the improvement, innovation, transformation and further development of Provider(s) delivery;

c. workforce planning, and;

d. developing staff members to become Provider(s) leaders

2.1.4. The Provider shall develop and implement an annual operating plan containing, as a minimum:

a. ethos, culture and professionalism;

b. measurable objectives, KPIs, and metrics for the clinical service delivery;

c. roles and responsibilities for staff members involved in the clinical service;

d. key relationships in the organizations involved in the clinical service;

e. organizational chart for the clinical service;

f. statement on improvement, innovation and transformation;

g. plans for development, including strategies for the development of the clinical service;

h. training and workforce development plan which includes succession planning to meet the needs of the clinical service;

i. procedures for collecting, monitoring, reviewing and analysing quantitative and qualitative data and feedback; and

j. procedure for communicating the clinical service operating plan results and outcomes to the Authority.

2.1.5. **Ethos**. The Provider(s) Leadership team shall aim to create a culture of excellence and safety, which is centred on the clinical service user and in which professional values are at the core of everything the Provider(s) does. The Provider(s) shall enable the Authority to comply with the regulated activities and Fundamental standards in Part 1 Sect 3. The leadership team shall:

a. establish a procedure for staff members that includes the following:

(1) sharing of information and raising general concerns;

(2) challenging questionable and/or poor clinical practice;

(3) manage breaches of codes of conduct and accountability;

(4) raising concerns of an ethical nature, and;

(5) providing information and support for staff members raising concerns to clarify there is no blame or adverse consequence when appropriate;

b. establish and implement a communication procedure for the Provider(s) so staff members, and, where applicable, those organizations involved in the delivery of the Provider(s) or that have an impact on the clinical pathway, are made aware of:

(1) new statutory information and other requirements that impact on the delivery of the Provider(s), and;

(2) updates on quality, safety and healthcare governance;

PART 2

SECTION 2

SERVICE MANAGEMENT

2.2.1 **Clinical service description**. The Provider(s) shall develop a Clinical Service Description that encapsulate the definition of the Clinical Service. The Provider(s) description should make it clear to the Authority what the Provider does and does not do and include high-level indicators of expected performance and aspirations for the future. Specifically, the Clinical Service Description should describe:

a. the Provider(s) clinical and non-clinical organisation;

b. the scope of the service provided (including whether research or training is undertaken);

c. the range of Provider(s)s and their location(s);

d. to whom the Provider(s) aims to provide treatment and/or care;

e. the key objectives of the Provider(s);

f. any links with other Provider(s)s and/or stakeholders;

g. the expected Provider(s) performance against key objectives, metrics and key performance indicators (KPIs), and;

h. how Provider(s) performance is to be measured and communicated.

2.2.2 **Workforce Planning**. The Provider(s) shall have a workforce development plan in anticipation of future workforce demands on the Provider(s). When unforeseen circumstances arise, which mean the required skill mix cannot be met, there shall be processes in place to safeguard Provider(s) delivery. The Provider(s) shall conduct a review of the workforce in terms of skill mix, and an impact assessment shall be undertaken a minimum of once a year, or whenever there are significant changes in the Provider(s).

2.2.3 **Managerial arrangements**. The Provider(s) shall effectively manage the provision of all hospital-based care to BFC/SBAA clinical service user. The Provider(s) shall provide:

a. a CLO who is suitably qualified, competent, and experienced and has the authority to receive and respond to clinical and administrative queries from Authority representatives, and;

b. a Contract Management Team that shall include:

(1) a named, full-time, and on-site, Contract Manager employed specifically to liaise with the Authority counterpart and to ensure all Contract and SOR provisions are being delivered. During the first 3 months of the contract the Provider Manager is to meet with the equivalent Authority appointee weekly and at mutually agreed periods thereafter, but no less than monthly.

(2) named administrative staff employed specifically for effective administration of clinical service user referrals, admissions, transfers and discharge of BFC/SBA BFC/SBAA clinical service users, and;

(3) named financial staff employed specifically for management of all BFC/SBA related financial matters.

2.2.4 The Provider is required to report all significant areas of contractual non-compliance to the Authority in the forum of the Management and Liaison Meeting (M&LM). Within its report to the M&LM concerning non-compliance, the Provider is required to present a plan to resolve these matters within 20 working days (unless otherwise agreed with the Authority), at no cost to the Authority. The Provider shall be required to provide objective, written evidence of contract compliance when given reasonable notice (a minimum of 10 working days) by the Authority.

2.2.5 In the event the Authority considers the contractual arrangements are inappropriate, the Provider shall be responsible for preparing proposals for remedial action and an estimate of the cost implications.

2.2.6 The Provider shall collaborate with Defence Primary Healthcare (DPHC)[8] to ensure a seamless service operates between PHC and SHC.

2.2.7 **Contract Management Meetings**. The Provider shall be required to facilitate regular Contract Management and Performance meetings as prescribed below:

a. **Monthly Management and Liaison Meeting (M&LM)**. The principal function of the M&LM is to consider all matters relating to the day-to-day operation and service delivery by the Provider against the contract. It is envisaged Contract Performance and Management issues will be addressed and resolved at this meeting. The M&LM will be held monthly and will be the principle vehicle for the Authority to raise concerns over contract performance, quality, clinical service user Safety, complaints and KPIs. The meeting will also provide a forum for the Provider to mitigate any identified failings and provide the QMM with details of any unresolved issues relating to Performance, Contract management and compliance. Minutes for the M&LM will be recorded and these minutes will be presented to the QMM to ensure The Authority has a complete understanding of the contract management and Service Delivery. Terms of Reference for this meeting can be found at Annex A.

b. **Quarterly Management Meeting (QMM)**. The QMM will provide assurance and oversight of the delivery of SHC for BFC/SBAA Clinical Service Users in order to ensure the Service being delivered is of the required standard and adheres to the requirements stipulated within the contract. Where innovation or best practice is identified it will be shared and where there are failings, or poor performance, remedial activity will be agreed. It is envisaged the majority of issues will have been addressed and resolved at M&LM, although outputs may also be considered at the QMM where issues remain unresolved. Terms of Reference for this meeting can be found at Annex B.

2.2.8 **Provider(s)/Authorised Referrers Clinical Meetings**. The Provider shall facilitate a programme of clinical meetings between Authority Authorised Referrers (ARs) and Provider(s) clinicians, to be held monthly for the first six months of the contract period and then quarterly thereafter. The aim of these meetings will be to develop an understanding of Cypriot/British clinical practice, to share best evidence-based practice, and to resolve any potential clinical misunderstandings and foster a spirit of clinical co-operation between the Provider and the Authority to the benefit of the Clinical Service User. In addition, the Provider is to seek to ensure the Provider clinicians communicate with ARs for the management of cases, as required.

[8] Defence Medical Services.

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PART 2

SERVICE MANAGEMENT

ANNEX A

MONTHLY MANAGEMENT AND LIAISON MEETING TERMS OF REFERENCE

2.A.1 **Purpose.** The Monthly Management & Liaison Meeting (M&LM) is a contractual requirement. The principal function of the M&LM is to consider all matters relating to contract performance, quality, clinical service user safety, complaints and KPI's. It is envisaged that Contract Performance and Management issues will be addressed and resolved at this meeting. The meeting will also provide a forum for the Provider to mitigate any identified failings and provide the QMM with details of any unresolved issues relating to Performance, Contract management and compliance. The M&LM will be minuted and these minutes will be presented to the QMM to ensure the Comd Med has as complete understanding of the status of service delivery and management of the contract.

2.A.2 This meeting will also provide an opportunity to discuss any other issues that may affect the delivery of Safe, effective and assured SHC Services to BFC/SBAA Clinical Service Users. Board membership is derived from individuals who, by virtue of their appointment are stakeholders, or have a responsibility for contract management, Quality, Assurance or delivery of SHC to BFC/SBAA Clinical Service Users.

2.A.3 The meeting will review evidence from Performance Satisfaction Surveys, concerns raised on monthly KPI Surveys, Patient Satisfaction Surveys, complaints and observations by HLO/DMWS Staff. The meeting will also discuss and review any reported areas of contract non-compliance or failure to deliver in accordance with the SOR. Any area within the SOR that is deemed below the required service delivery standard will be presented as a report by SO2 Healthcare Contracts to the QMM, showing each requirement graded green, amber red.

2.A.4 **Management Board responsibilities**. Management Board responsibilities are:

a. to provide direction on BFC SHC delivery, quality, assurance and clinical service user safety or refer to QMM;

b. to review KPIs and agree remedial action for contractual non-compliance or refer to the QMM;

c. to conduct and report outcomes/Records of Decisions (RODs) for Clinical/Sub-Committee meetings/Defence Consultant Advisor (DCA) Visits/DCA CV Approvals that take place between the Provider and Representatives of the Authority/BFC;

d. to review and report Quality Assurance benchmarking for this period;

e. to monitor high level risks and issue and provide direction as required or refer to the QMM;

f. review and investigate Significant Event Reports (SERs) and drive forward remedial actions as required or refer to QMM;

g. to review clinical service user complaints and drive forward remedial actions as required or refer to QMM. To be the decision taker on tactical/operational/and resource decisions highlighted by the Governance Committee;

h. to receive updates on key elements affecting contract delivery/performance, and;

i. ensure tasks as defined in the responsibilities (below) are met.

2.A.5 **Membership**. Permanent membership of the M&LM board are shown below:

HQ BFC	The Provider(s)
BFC SO2 Healthcare Contracts Healthcare Financial Audit, Assurance & Liaison Officer SO2 Medical Engagement HQ BFC Finance Rep HQ BFC Commercial Rep Other as required	General Manager Contract Manager Admin & Finance Manager Clinical Liaison Officer/Complaints Manager Matron Clinical Governance/Assurance Rep CLO IPC Rep Other as required

2.A.6 **Reports**. The Reports detailed at Annex C will be required for discussion at the M&LM.

2.A.7 **Agenda.** The standing Agenda is at Appendix 1 to this document.

2.A.8 **Principles**. All Members will provide representatives to attend the Board; where the normal attendee is not able to be present a replacement will be expected. Reports and papers must be with the Sec at least four clear working days in advance of all meetings in order to allow for circulation to all attendees at least three working days in advance of all meetings.

2.A.9 **Frequency of meetings**. Meetings are to be held on a monthly basis, chaired by SO2 Healthcare Contracts.

Appx 1 to
Annex A to
Part 2

BFC MONTHLY MANAGEMENT & LIAISON MEETING (M&LM) AGENDA.

Item	Subject	Lead
(a)	(b)	(c)
1	Introductions	SO2 HCC
2	Opening Remarks	SO2 HCC
3	Minutes & actions arising from the previous meeting	Sec
4	Contract Compliance Update	Provider MLO
5	Service delivery risks and issues	SO2 HCC
6	Financial Update	SO2 Q&A
7	KPI Performance Update	SO2 HCC
8	Comrcl Update	BFC Comrcl Rep
9	Financial update	BFC Fin Rep
10	Clinical Service User Safety/SERs	SO2 ME
11	Feedback	SO2 ME
12	RODs Sub Committee Clinical Meetings (Top 3 issues)	SO2 HCC
13	Any other business	All
14	Date of next meeting	All

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PART 2

SERVICE MANAGEMENT

ANNEX B

QUARTERLY MANAGEMENT MEETING (QMM) TERMS OF REFERENCE

2.B.1 **Purpose.** The QMM will provide assurance and oversight of the delivery of Secondary Healthcare (SHC) within BFC/SBAA in order to ensure the Service being delivered is of the required standard and adheres to the requirements stipulated within the contract. Where innovation or best practice is identified it will be shared and where there are failings, or poor performance, remedial activity will be agreed. It is envisaged that the majority of issues will have been addressed and resolved at Monthly Management and Liaison Meetings (MLM), although outputs may also be considered at the QMM where issues remain unresolved.

2.B.2 **Responsibilities.** The QMM will provide operational oversight and direction on BFC SHC issues and confirm performance and delivery reports from the monthly M&LM against KPI targets and contractual compliance. The meeting will also be the vehicle for the following:

a. to ensure assurance regimes and governance structures are fit for purpose, up to date and relevant whilst ensuring compliance with the Statement of Requirement (SoR) and that through life Value for Money (VFM) is achieved;

b. to provide operational oversight and direction on BFC SHC issues;

c. to identify any appropriate risks to the contracted service and assign ownership and timelines for resolution of these risks;

d. review recovery plans for performance improvement issues or referral to BFC Comrcl for consideration of non-compliance as required;

e. maintain and develop quality standards;

f. review clinical service user feedback and complaints not resolved at the monthly meetings;

g. review, and direct, action plans resulting from DCA visit reports, complaints, SERS, etc. as required;

h. review the provider(s)s monthly, quarterly and annual dataset reporting against the M&LM report, and;

i. review quantity and quality of reports.

2.B.3 **Permanent Members of the QMM Board**

a. BFC Standing members of the QMM are:

(1) Comd Med (Chair);

(2) BFC Snr Comrcl Officer;

(3) SO2 Healthcare Contracts;

(4) Healthcare Financial Audit, Assurance & Liaison Officer

(5) SO2 Healthcare, and;

(6) SO2 Medical Engagement.

b. Provider(s) Standing members of the QMM are:

(1) General Manager;

(2) Contract Manager;

(3) Clinical Liaison Officer;

(4) Complaints Manager;

(5) Clinical Service User Safety & Security;

(6) Finance Manager or representative, and;

(7) additional personnel from either the Authority or Provider(s)'s staff may attend on an as and when required basis.

2.B.4 **Reports Required for QMM.** The SO2 Healthcare Contracts will produce detailed reports as shown at Annex C to inform the Meeting. Reports and papers must be with the Sec at least **TEN** clear working days in advance of all meetings in order to allow for circulation to all attendees at least **FIVE** working days in advance of all meetings.

2.B.5 **Frequency of Meetings.** The QMM will be held Quarterly. The Standing Agenda is at Appendix 1.

Appx 1 to
Annex B to
Part 2

QUARTERLY MANAGEMENT MEETING (QMM) STANDING AGENDA.

Item	Subject	Lead
(a)	(b)	(c)
1	Introductions	Comd Med
2	Opening Remarks	Comd Med
3	Previous Minutes & Actions Arising/Action Matrix	SO2 HCC
4	Comd Med Update	Comd Med
5	Service Delivery Risks and Issues	SO2 HCC
6	Provider(s)s Annual/Quarterly Report	Provider(s) Gen Manager
7	PSM Update (clinical service user Safety, SERs, Complaints)	PSM
8	SO2 Fin Audit & Assurance Update & Report	SO2 Q&A
9	Contract Compliance Report	SO2 HCC
10	KPI Performance Report	SO2 HCC
11	Comrcl Update	Snr BFC Comrcl Rep
12	Financial Update	BFC Fin Rep
13	Any other Business	Comd Med
14	Date of Next Meeting	Sec

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PART 2

SERVICE MANAGEMENT

ANNEX C

REPORTS

REPORT NAME	FORMAT / CONTENT	AUTHOR	FREQUENCY
Contract Compliance Report	Shall include performance information against all KPIs as reported by monthly satisfaction surveys. Each requirement reported on by Practice Managers, intelligent users and/or intelligent customers as to whether the requirement is fully delivered or highlights areas that are not delivered/partially delivered etc. The report will confirm a summary of the outcome and action/recovery plans for those areas which have not achieved a 'green grading'.	SO2 HCC DPHC Practice Managers	Quarterly – to be submitted **10** working days prior to the QMM. Progress reviewed at M&LM.
Quarterly Report	The Quarterly Report shall include: a. An executive summary of service delivery. b. Summary of Clinical Activity by inpatient and outpatient episodes, procedures and consultations. c. A summary of financial activity. d. A summary of all Healthcare Governance activity, including clinical service user safety, clinical effectiveness and clinical service user experience. e. Future priorities for improvement.	The Provider	Quarterly – within 30 days of each Contract year end.
Annual Report	The Annual Report shall summarise Qs 1-4 and include: a. An executive summary of service delivery. b. Summary of Clinical Activity by inpatient and outpatient episodes, procedures and consultations. c. A summary of financial activity. d. A summary of all Healthcare Governance activity, including clinical service user safety, clinical effectiveness and clinical service user experience.	The Provider	Annual – to be submitted within 30 days of each Contract year end.

	e. Future priorities for improvement.		
Quality Assurance Reports	The format and content are to be set by the Authority.	SO2 Q&A The Provider	Quarterly and as required
Financial Report	SO2 Assurance and Quality will produce a report detailing anomalies or best practice from scrutiny of the monthly caseload for the 3 months preceding the meeting. The report will cover the numbers across the monthly caseload that were subject to scrutiny, areas of non-compliance and area of concern or persistent non-compliance.	SO2 Q&A	Quarterly
Minimum Data Set	The minimum data as specified in Contract Terms and Conditions.	The Provider	Quarterly - to be submitted within 10 working days of quarter end.
KPI Performance Report	A Provider self-assessment of performance against the agreed Key Performance Indicators.	The Provider	Quarterly – to be submitted within 10 working days of quarter end.

PART 2

SECTION 3

ADMINISTRATION

2.3.1. **Hospital Administration Office**. The Provider(s) shall ensure a Hospital Administrative Office is suitably located and manned, on-site, to support the administrative process associated with the admission and discharge of BFC clinical service users. The office will be responsible for dealing with the following:

a. administration of clinical service user referrals, admissions, transfers and discharges;

b. reception, registration and direction of BFC clinical service users as appropriate;

c. liaison with the Provider staff for all relevant matters pertaining to BFC clinical service users, including complaints;

d. liaison with PHC and other areas of the Authority and UK health authorities as appropriate, and;

e. collection and collation of data to produce statistics to inform healthcare delivery effectiveness.

2.3.2. The composition of the Hospital Administration Team will be a matter for the Provider(s) but the Authority should be consulted on the proposed arrangements should they change post any potential contract award or preferred bidder announcement.

2.3.3. **Medical Records Retention**. The detailed Medical Records relating to the care provided by the Provider(s) shall be retained in accordance with the relevant requirements of Cypriot legislation (Processing of Personal Data Laws as listed in Part 4 Annex K). The Provider(s) is to arrange for the transfer of all medical records from existing Provider(s) (should the new Provider(s) be different).

2.3.4. Where future electronic storage systems are used by the Provider(s) which are deemed compatible with that of the Authority, transfer by electronic means will be preferable. The Authority requires medical records pertaining to BFC/SBAA clinical service users are retained by the Provider(s) for the periods specified within the Records Management Code of Practice for Health and Social Care 2016[9].

2.3.5. The Provider(s) shall ensure records from externally referred providers are available and meet the Authority requirement to be in English for clarity and completeness. The Provider shall allow the Authority to access the medical records, in the circumstances described and when duly authorised in accordance with the provisions described below:

a. Where it is deemed necessary by the Authority and the clinical service user has provided consent, the Provider shall provide a full copy of all hospital notes and associated diagnostic tests, pertaining to the treatment provided;

[9] https://digital.nhs.uk/binaries/content/assets/legacy/pdf/n/b/records-management-cop-hsc-2016.pdf

b. Unless where required for clinical reasons or by statute and in all cases subject to clinical service user consent, the Provider shall only release full hospital notes when authorised, in writing, by one of the following:

(1) BFC Comd Med;

(2) SO2 Healthcare Contracts;

(3) Healthcare Financial Audit, Assurance & Liaison Officer, or;

(4) any other person authorised by Comd Med.

2.3.6. The Authority will provide the Provider with a legally valid form of consent signed by the clinical service user.

2.3.7. **Provision of Medical Reports**. There will be an occasional requirement for the Provider(s) clinicians to provide the reports listed below. In all these instances the medical report is to be provided within **10 working days** of the request.

a. legal medical reports of IP treatment on specific clinical service users. (Required for the Authority's solicitors in respect of compensation claims whilst in MOD employment).

b. medical reports on War Pensioners.

c. medical reports on clinical service users at the request of the Authority Police Services.

2.3.8. **Notification of Casualties (NOTICAS)**. The Authority has a requirement to notify military command of certain occurrences. The Authority will require a contractual obligation from the Provider(s) to ensure the Provider(s) clinicians are made aware of the need to notify the Authority immediately of the following:

a. a clinical service user dies;

b. a clinical service user becomes very seriously ill (VSI); this is regarded as occurring when the illness or injury is of such severity that there is a significant risk of death;

c. a clinical service user who is seriously ill (SI) but is responding or likely to respond to therapy;

d. a clinical service user whose illness has rendered him/her incapable, either physically or mentally, of communicating with friends or relatives (III). This includes clinical service users who have lost a limb, hand, foot, or sight of an eye or who have suffered a major disfigurement;

e. the admission of any soldier under 18 years of age, or;

f. a stillbirth, which in British law is defined as a child born after 24 weeks of gestation with no discernible signs of life.

Welfare Services. The Authority provides a contracted Welfare Service to BFC/SBAA clinical service users that are admitted to hospital. Authority-contracted Welfare Officers provide a 7-day-a-week, 24-hour contracted response to the welfare needs of clinical service users and their

relatives in accordance with the SOR laid-down by the Surgeon General and facilitated by the BFC Medical Branch[10]. Consequently, the Provider(s) shall:

g. provide access to a small meeting room to accommodate 4 - 6 persons is to be made available on request by contracted Welfare Support staff;

h. provide contracted Welfare Support staff with access to the Provider Administration System subject to GDPR requirements, and;

i. grant the right for contracted Welfare Support staff to liaise directly with medical staff on welfare matters subject to staff availability and the consent of the clinical service user.

2.3.9. **Hospital Liaison Officers**. The Hospital Liaison Officer (HLO) role is to act as an interface between the clinical service users, the hospital and other care professionals and, where appropriate, the chain of command for the purpose of ensuring effective communication. They will provide assistance to clinical service users from the time of entry to the hospital organisation until the time of departure. HLOs work as members of a multi-disciplinary team in conjunction with contracted Welfare Support staff and hospital staff.

2.3.10. The HLOs main objective is to enable the clinical service user to make informed decisions and choices on matters within the liaison remit. HLOs are therefore required to be bi-lingual and able to translate medical technical information to ensure accurate exchange of information between clinical service users and medical staff; it is therefore essential potential providers, and in particular clinicians, recognise this in order to establish the trust and confidence of all parties involved in the care of the clinical service user.

2.3.11. The Authority, HLO service and contracted Welfare Support staff accept their services are provided for the benefit of the clinical service user and that the clinical service user has the right to refuse either of these services.

[10] Future welfare provision for BFC/SBAA clinical service users may be delivered by an alternative provider. The SHC Provider(s) shall work with the Authority to facilitate access

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PART 2

ADMINISTRATION

ANNEX D

EXAMPLES/LISTS OF DOCUMENTS

2.D.1. The following forms of identification[11] will be carried by BFC personnel and may be used to confirm entitlement to treatment under Authority arrangements:

a. MOD 90 - British Forces Identity Card.

b. RAF 2185- RAF Civilian Identity Card.

c. Civilian Staff Identity card.

2.D.2. Relatives Identity Card.

a. Children's Identity Card (13 years and above).

b. Spouse Identity Card.

2.D.3. The following miscellaneous forms are listed for the information of the Provider:

a. F Med 296 - Prescription proforma.

b. F Med 85 – Notification of Infections Diseases.

c. Complaint Coding Sheet.

d. SHC Form 001 – Authority to release medical information.

[11] Examples of all documentation and Identification Cards will be provided to the Provider at contract award.

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PART 2

ADMINISTRATION

ANNEX E

SHC FORM 001

REQUEST FOR MEDICAL NOTES & RELEASE FROM THE DUTY OF MEDICAL CONFIDENTIALITY

NAME:_____

FORENAME:_____

DATE OF BIRTH:_____

ADDRESS:_____

_____

_____

I.....hereby request that [NAME OF HOSPITAL/CLINICIAN] who treated me during the period [INCLUSIVE DATES], provide a full copy of all medical notes, x rays and other scans etc., relating to this period of treatment, to [NAME OF RECIPIENT].

[I am the parent/legal guardian of the above named clinical service user and request copies of his/her medical records in that capacity]

This form of consent formally releases the [NAME OF HOSPITAL/CLINICIAN] from their duty of medical confidentiality in respect of the period set out above.

Date:_____ Signature:_____

Place:_____ Name:_____

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PART 2

SECTION 4

CASELOAD VALIDATION AND FINANCIAL ARRANGEMENTS

2.4.1. The Authority requires pricing of the Provider service to be based on the Provider's annually published price lists, minus the contractually agreed discount.

2.4.2. The Provider shall submit to the Authority separate annual costs for the accommodation, transport and other requirements of additional non-clinical staff employed specifically for the contract, such as the Provider Manager, and any additional insurance requirement of the Authority. The provider is also to submit to the Authority an annual comprehensive breakdown of the costs comprising the management fee relevant to this contract.

2.4.3. **Caseload Validation and Payment**. The Authority will be responsible throughout the contract term for ensuring claims made by the Provider(s) are valid, accord with the contractual agreements and payment is made at the agreed rates.

2.4.4. The Provider(s) shall be required to reconcile the case lists and costs submitted with the referral data and agreed price lists held by the Authority for all activity.

2.4.5. Caseload lists for the preceding month/quarter are to be with the Authority by the **10th working day** of the following month accompanied by a full list of clinical service users and associated Agreed Treatment Plan Number for which payment is claimed. Detailed requirements are set out in Part 2 Annex F.

2.4.6. The Provider shall ensure their systems of data capture are such that the use of the Agreed Treatment Plan number will allow all activity to be identified and examined if necessary, i.e. attendance, length of stay etc.

2.4.7. The Authority will audit all contracted caseload lists/Agreed Treatment Plan's submitted by the Provider and will compare them with its own data. Where discrepancies arise, the Provider may be asked to provide copies of the referral document and the Agreed Treatment Plan closure document.

2.4.8. **Contract Monitoring**. The Provider shall institute a process of case reconciliation with the Authority. The processes instituted will be used to resolve matters of contractual non-compliance and caseload validation.

2.4.9. Discrepancies or other issues of non-compliance, that cannot be resolved at a local level, will be referred for arbitration to an appropriate level within the Authority's and/or Provider(s)s management structure. ARs and Provider(s) clinicians may be requested to support the resolution of disputes.

2.4.10. **Additions/Amendments to Price List**. The Provider shall submit details of any proposed additions to the Price List using the form at Part 2 Annex G.

2.4.11. In the case of laboratory testing services, the Provider shall provide further documentation in the form of Accreditation of Laboratories Certificate issued by the Cyprus Organisation for Promotion of Quality and Ministry of Health approval for provision of the test.

2.4.12. The Provider shall present the amendments/additions, highlighting any additions to the current version in yellow, to the Price List as follows:

a. an appendix at the beginning of the Price List whereby all the changes are listed as described in Annex H, and;

b. a document-controlled version of the new proposed price schedule e.g. Version 2.

2.4.13. New procedures/services will not be undertaken until formal approval has been granted by the Authority through the processes described above. The Authority will endeavour to respond within **10 working days**, pending DCA approval, providing ***all*** supporting evidence has been submitted by the Provider(s) complete and in advance. If there is an urgent requirement to undertake a procedure permission must be obtained from BFC Comd Med or SO2 Healthcare Contracts. This should also be followed up in writing by the following day.

2.4.14. The Authority will inform the Provider in writing when the latest version of the Price List is approved, and price amendment has been accepted. Once this has taken place this version will become the extant version and will be used until the next iteration. This will be given a new version number.

PART 2

CONTRACT FINANCIAL ARRANGEMENTS AND VALIDATION

ANNEX F

PROCESS OF EVALUATION OF CASELOAD LISTS PROVIDED BY PROVIDER(S)

CASELOAD LISTS

2.F.1. **Presentation of caseload lists** The caseload lists will be separated in 3 categories:

a. invoices for services provided by Provider(s) through the referral process;

b. invoices for External Associates, and;

c. invoices for services directly requested by the Medical Centres eg. Lab tests, scans etc.

2.F.2. **Information to be provided** The minimum requirements for information provided in the caseload lists is the following:

a. clinical service user ID and Defence Medical Information Capability Programme (DMICP) number;

b. Medical Centre of AR;

c. description of treatment provided (including classification code of procedure);

d. treating clinician;

e. date of treatment;

f. agreed treatment plan number, and;

g. breakdown of costs (eg. accommodation, diagnostics, meds, op theatre charges)

2.F.3. **Caseload list invoices** Copies of invoices for External Associates/Sub-contractors should be provided with the caseload lists on submission for payment. These invoices shall be subject to scrutiny before approval for payment. Any invoices or part thereof not justifiable for payment shall be deducted from the caseload lists and the Provider shall be informed.

2.F.4. **Documents submitted with caseload lists** the Provider shall provide all documentation necessary to justify the charges raised. This shall include all invoices and full descriptions of procedures or services provided. The Authority will not accept any charges that are not in accordance with the Price List, without prior notification of such cases.

2.F.5. **Timeline for submission of caseload lists** the Provider is required to submit the caseload lists for the preceding month within the timeline outlined in paragraph 2.4.5 to Healthcare Financial Audit, Assurance & Liaison Officer (acting on behalf of the Authority).

CASELOAD VALIDATION

2.F.6. SO2 Governance & Assurance will be responsible to ensure the claims made by the Provider are valid, conform to the relevant published price lists and are in accordance with the contractual agreements in place at the time.

2.F.7. **Items on caseload list not justified for payment**. Any invoices raised for clinical service users not entitled for treatment at the Authority's expense will be considered unjustified for payment and will be deducted from the caseload lists.

2.F.8. **Requests for additional information**. During the process of validation the Provider may be requested to provide additional information or evidence to support the charges raised in the caseload lists. This information should be provided **within 2 working days** to prevent delays in the payment procedure.

2.F.9. **Timeline for validation**. The time allowance for scrutiny of invoices will span between 10 to 15 working days.

2.F.10. **Processing Of Payment**. Requires definition.

2.F.11. **Approval for Payment**. Once Healthcare Financial Audit, Assurance & Liaison Officer has completed the initial scrutiny check of the invoices, the caseload list will be approved and processed for payment through the CP & F payment system.

PART 2

CONTRACT FINANCIAL ARRANGEMENTS AND VALIDATION

ANNEX G

REQUEST FOR ADDITION TO PRICE LIST FOR SECONDARY HEALTHCARE CONTRACT

Service/ Procedure details		
Name		Charge
Brief description (to include need for anaesthesia and stay in hospital)		
Justification		
Consultant specialty that will provide the service:		
Please provide:Professional Body or Scientific/Health Dept Guidance/Direction/Regulation		
Request submitted by:		Date:

BFC Administration use only:

Further information needed		YES	NO
Request approved		YES	NO
Date of approval:		Price list version	

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PART 2

CONTRACT FINANCIAL ARRANGEMENTS AND VALIDATION

ANNEX H

SUMMARY OF CHANGES IN PRICE LIST FOR SECONDARY HEALTHCARE CONTRACT Ref. 701162379

Price list ref. & page no.	Service/Procedure description	Price list category	Amendment in price	New Service/ Procedure

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PART 3

SECTION 1

CLINICAL SERVICES - GENERAL

3.1.1. The Provider(s) shall communicate to BFC/SBAA clinical service users both what they can expect from the Provider(s) and information on their rights through a variety of methods, formats and different media in the English language. The Provider(s) shall require its staff members to involve the clinical service user when making shared decisions about all aspects of their treatment and/or care.

3.1.2. The Provider(s) shall communicate to the BFC/SBAA Clinical Service Users their responsibilities regarding:

a. keeping appointments;

b. notifying the Provider(s) of appointment changes or cancellations;

c. discussing with the Provider(s) desired changes or decisions to terminate treatment and/or care;

d. discussing with the Provider(s) where expectations of treatment and/or care are not
e. being met, and;

f. abiding by any codes of conduct (e.g. zero tolerance for aggressive behaviour) or clinical service user charters.

3.1.3. **Clinical care**. The Provider(s) shall document person-centred treatment and/or care plans, based on the needs of the individual clinical service user. The Provider(s) shall have in place a Clinical Records Management Policy that is consistent with the NHSX Records Management Code of Practice 2020 and the Professional Record Standards Body guidance on the Structure and Content of Health Care Records. All clinical records shall be maintained in a manner that is consistent with these standards. The treatment and/or care plan shall involve the clinical service user in shared decision-making, including making the informed decision to consent to treatment and/or care.

3.1.4. In the development of treatment and/or care plans, the Provider(s) shall identify and use relevant guidelines from Part 3 Section 2 & 3.

3.1.5. The Provider(s) shall identify published clinical pathways for clinical service users and compile written and visual information for clinical service users to support these clinical pathways.

3.1.6. The Provider(s) shall undertake a clinical risk assessment of individual clinical service users. The clinical risk assessment shall include:

a. the risk of harm to the clinical service user and others;

b. the clinical service user's changing risks;

c. deteriorating health and wellbeing;

d. medical emergencies, and/or;

e. challenging behaviour.

3.1.7. The results of the clinical risk assessment shall be recorded in the clinical service user medical record. Any identified risks relating to a clinical service user shall be discussed between clinical teams during handover.

3.1.8. The Provider(s) shall:

a. offer BFC/SBAA clinical service user copies of correspondence about their treatment and/or care;

b. conform to national legislation for clinical procedures that require written consent. The obtained consent shall be documented in the BFC/SBAA clinical service user record, and;

c. request consent from the BFC/SBAA clinical service user to share their clinical record with other staff members, clinical services or organizations not directly involved in their treatment and/or care.

3.1.9. The Provider(s) shall have documented information and make this available to prepare clinical service users for planned treatment and/or care, prescribed therapy, clinical procedures, and post-clinical procedure care.

3.1.10. The Provider(s) shall:

a. implement and maintain a procedure to assess, address and document BFC/SBAA clinical service user comfort, physical pain, discomfort or emotional distress;

b. implement a procedure to provide self-care support for BFC/SBAA clinical service users including:

(1) a treatment plan;

(2) information specific to the clinical service user's needs;

(3) specific guidance for emergencies;

(4) a point of contact for further information (including out of normal working hours);

(5) options for re-entering the clinical service and how to regain access into the clinical service if the need arises.

c. support carers and representatives when they are involved in BFC/SBAA clinical service users care, and;

d. provide access to information to support BFC/SBAA clinical service users treatment and/or care decisions.

3.1.11. **Entitlement to Treatment**. The majority of BFC/SBAA personnel and their dependants are entitled to Authority funded SHC. Referral letters for Non-BFC/SBAA clinical service users will carry an appropriate statement within the referral letter. On acceptance of these Non-BFC/SBAA clinical service users, it is the Providers responsibility to agree payment terms with the clinical service user prior to treatment.

3.1.12. Any BFC/SBAA clinical service users who self-refers for non-urgent, routine treatment or consultation, or presents without a referral from an Authority AR may have to bear the cost of

treatment at personal expense. The Provider(s) shall confirm entitlement prior to commencement of treatment.

3.1.13. BFC/SBAA clinical service users may "self refer" in an emergency in which case the Provider shall confirm their entitlement to treatment, subject to which; self-referrals will be treated as Authorised Referrals. The Authority acknowledges this confirmation may be retrospective.

3.1.14. The Provider is required to establish the identity of the clinical service user using the recognised forms of ID at Annex A to Part 4 and must also contact the relevant BFC medical centre to confirm entitlement and gain permission to proceed or, if out of normal working hours, the HQ BFC Med Branch Duty Officer.

3.1.15. Where treatment has been provided prior to establishment of entitlement, payment will be as follows:

a. **Entitled clinical service user with an Agreed Treatment Plan**. The Authority will pay.

b. **Entitled clinical service user without an Agreed Treatment Plan**. The Authority reserves the right to not pay.

c. **Non-Entitled clinical service user**. The Authority will not pay.

3.1.16. To support payment, and in all cases, the Provider is to demonstrate all reasonable measures were taken to confirm entitlement status of the clinical service user.

3.1.17. **Clinical Responsibility**. The Provider(s) clinician retains responsibility for the management of the clinical service user's condition until that clinical service user is discharged from IP/A&E/OP care. At the conclusion of the consultation or treatment, the clinical service user is returned to the care of the Authority AR. At this point, a summary of the treatment episode is to be provided in the English language. The Consultation Note may be supported where necessary in all complex or long-term cases with a discharge letter in the English language[12]. Should the Authority AR require additional information, the Provider(s) shall provide within **1 Working Day by telephone or within 10 Working Days by letter**. Internal correspondence between the OP clinician referring the clinical service user to the Provider(s) IP clinician for treatment does not need to be in the English language unless it is also to be copied to the Authority AR.

3.1.18. **Routine & Elective Referrals/Agreed Treatment Plan**. In consultation with the Authority, the Provider(s) shall produce adminstrative and referrals Standing Operating Procedures (SOPs). The Provider(s) shall ensure SOPs are distributed to Authority ARs and that they are reviewed, and updated if necessary, on an annual basis.

3.1.19. **Referral Authorities**. The majority of referrals will be made under the signature of a DPHC or DMS AR. Routinely, the Authority AR will include, but is not restricted, to the following:

a. General Practitioners;

b. Dental Officers;

c. DMS Consultants, and;

d. Defence Community Mental Health (DCMH) Nurses.

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[12] It is acknowledged that the type of discharge letter may depend on the clinical service user episode. Types of discharge letter will be agreed between the Provider(s) and the Authority.

3.1.20. The Authority AR will provide a written referral containing information, in English, about the presenting complaint and, where relevant, a summary of past, family, social history and drug history. The Authority requires that the Provider(s) shall provide to the AR a proposed treatment plan, written or transcribed into English, within **5 working days**. Upon receipt, the Authority AR will respond to the proposal within **5 working days**.

3.1.21. **Agreed Treatment Plans**. Once the treatment plan has been agreed, each separate episode of treatment shall be known as the Agreed Treatment Plan and shall be allocated a unique code or reference number by the Provider(s). The Agreed Treatment Plan number is to be recorded on ***all*** documents and medical records held by the Provider(s).

3.1.22. If, in the course of the treatment of a patient for the condition of referral, the Provider(s) Clinician considers a second intervention for a condition unrelated to the condition of referral is necessary, such intervention will constitute a second case and should not proceed unless approval has been sought from the Authority[13]. All such second cases will be subject to clinical review by the Authority and the process of arbitration if appropriate.

3.1.23. The necessary referral to another Provider Hospital will not be a part of the Agreed Treatment Plan, unless the case is agreed as being out of scope or a listed exception and the Agreed Treatment Plan included such transfer. The transfer to a hospital in the UK will not be the responsibility of the Provider(s).

3.1.24. If, in the course of an Agreed Treatment Plan, or for a 14 day period after discharge from the Provider, a second intervention becomes necessary and which can be reasonably considered a complication of the initial intervention, it will be undertaken and deemed to be comprised within the same Agreed Treatment Plan unless it arises as a consequence of the failure of the patient to observe the recommendations of the Provider(s) clinician.

3.1.25. Where treatment involves children, the Provider(s) shall ensure the service is provided only by appropriately trained and experienced clinicians and only those clinicians approved by the Authority treat BFC/SBAA Clinical Service Users under the age of 16.

3.1.26. In the event the Provider(s) believes a clinical service user's re-admission to hospital within 15 working days is not related to the original clinical condition and considers that the admission should be deemed a separate Agreed Treatment Plan, the case will be referred to the Authority for further consideration.

3.1.27. **Outpatient appointment booking**. the Provider(s) shall provide, during normal office hours, a booking service for all Outpatient clinics. The Provider(s) is required to provide systems to ensure that, on booking, BFC/SBAA clinical service users will be offered specific dates and times for their appointment. The offer will include the first available appointment that allows sufficient time for the referral documentation to reach the Provider(s) clinician and to allow for any additional information to be gathered.

3.1.28. BFC/SBAA clinical service users who require an urgent appointment, are to be offered an appointment on the earliest clinic that meets the clinical need of the clinical service user. the Provider(s) may also offer the clinical service user a date, but without a specific time, for an urgent appointment.

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[13] Necessary, in this context, is defined as a procedure, which, if deferred to a later admission, would adversely affect outcome

3.1.29. For all new referrals, and in addition to the referral documentation, the Provider(s) shall supply a set of self-adhesive labels or pre-printed documentation containing the following clinical service user information:

a. clinical service user surname;

b. clinical service user forename;

c. date of birth;

d. medical centre, and;

e. name of Authority AR

3.1.30. The Provider(s) is required to ensure these labels are attached to all correspondence conducted with the Authority that relates to the clinical service user and/or the Agreed Treatment Plan, originating from the referral. In particular the labels are to be used with all Discharge Notes/ Consultation Notes and other forms of discharge information produced by the Provider(s).

3.1.31. **Cancellations**. Should a BFC/SBAA clinical service user who, having accepted an appointment and/or admission, notifies intended non-attendance more than 48 hours before the appointment/dmission. The Provider(s) shall contact the Authority AR to re-arrange the appointment/admission should treatment or care still be required. The Provider(s) shall not invoice the Authority or consider this a new attendance.

3.1.32. Should the Provider(s) cancel the appointment/admission, the Provider(s) shall offer an alternative binding date within 28 days of the original appointment/admission.

3.1.33. **Fail to Attend (FTA)**. Should a BFC/SBAA clinical service user fail to attend a scheduled appointment/admission without prior notification, this should be considered a FTA and, subject to the Terms and Conditions of the Contract, the Provider(s) shall raise an invoice according to the Agreed Pricing Schedule. The Provider(s) shall contact the Authority AR to determine if treatment is still required and offer an alternative appointment/admission date. If the BFC/SBAA Clinical service user fails to attend on three separate occasions for appointments/admissions for the same clinical condition, the Provider(s) may close the Agreed Treatment Plan.

3.1.34. **Emergency Referrals**. Where possible and unless the clinical condition dictates otherwise, the process and timelines described in above should be adhered to. If this is not possible, referrals by Authority ARs can be made by telephone or any other suitable means. The Provider(s) clinical staff shall discuss the proposed treatment plan with the Authority AR and verbal agreement should be sought. **NO DEFINITIVE TREATMENT SHOULD BE STARTED WITHOUT PRIOR DISCUSSION WITH THE AUTHORITY AR**. As soon as is practicable, but no longer than **10 working days** after the clinical emergency has passed, the Provider(s) shall provide a summary of the treatment delivered, written or transcribed into English. Upon receipt, the Authority AR will respond to the summary within **10 working days**, confirming the Agreed Treatment Plan.

3.1.35. **Consultations**. All consultations will be conducted in the English language. The consultation is to include an explanation by the consultant/specialist of their conclusions and the recommended plan of action/treatment. The clinical service user should be given the opportunity to ask questions and sufficient time allowed for answers to be given.

3.1.36. The Provider(s) shall ensure all clinicians are capable of carrying out a consultation unsupervised both in terms of technical proficiency and case knowledge. The clinician shall:

a. communicate effectively with clinical service users and be prepared to liaise regularly by telephone and at meetings with the Authority representatives;

b. be sensitive to the different cultural needs of BFC/SBAA clinical service users;

c. seek to maintain good relations with the Authority ARs and representatives, and;

d. accept all proposed treatments are provisional until agreed by the referring Authority AR.

3.1.37. The waiting time for any clinical service user in attendance at a clinic for a consultation should not exceed **30 minutes,** from the time of the appointment. The clinical service user is to be given an explanation for the delay by the administrative staff at the clinic.

3.1.38. **Waiting times**. The Provider(s) shall ensure maximum waiting times between referral and start of treatment is consistent with the UK National Health Service standard as follows:

a. no longer than 18 weeks for non-urgent, consultant-led treatments, and;

b. no longer than 2 weeks for urgent cancer referrals.

3.1.39. During this time period between referral and commencement of treatment, the Provider(s) shall ensure:

a. all tests, scans and other procedures to determine appropriateness of treatment are completed;

b. symptoms are appropriately managed, and;

c. referral to any other interdependent specialites are completed.

3.1.40. The waiting time ends if a clinician decides no treatment is necessary, if the BFC/SBAA Entitled clinical service user decides they do not want to be treated, or when treatment begins.

3.1.41. For Mental Health Inpatient Services, where possible and subject to Cypriot law, the Provider(s) shall apply the NHS Access to Mental Health Services principles

3.1.42. **Admission following Outpatient Consultation**. The Provider(s) shall make the booking, and where possible confirm the details with the clinical service user prior to their departure from the OP Department. If this is not possible, details of the admission arrangements are to be forwarded to the Provider(s) Manager and the Authority appointee as soon as possible after the consultation.

3.1.43. The Provider(s) CLO is to be responsible for notifying the clinical service user's medical or dental centre who will in turn be responsible for confirming, in writing, the clinical service user's acceptance or rejection of the admission date offered. If rejected, the Provider(s) CLO will liaise with the department concerned to find a suitable alternative date.

3.1.44. Where the Provider(s) does not have a service in a specialty that meets the standards set out in this SOR the clinician is to:

a. refer to a specialist Provider(s) which has an arrangement with the Authority, or;

b. request the Authority to agree to fund a referral to another hospital, as recommended by the Provider(s) clinician.

3.1.45. **Prescribing**. The Provider shall have a Medicines Management Policy in place and ensure all aspects of this service are carried out in accordance with relevant national prescribing laws. The Provider is required to prescribe, but not dispense, medication for all BFC/SBAA clinical service users. The Provider is required to liaise and cooperate with the Authority in formulating a procedure for drug product prescribing, monitoring and auditing and to include an Authority agreed Formulary (British National Formulary) with which prescribing must adhere. Where possible, and when not in contravention to Cypriot laws and regulations, NICE principles related to medicines management are to be followed.

3.1.46. The Provider shall implement the following Authority requirements:

a. close liaison between the Authority pharmacist, GP's, SME's and the Provider clinicians. Meetings to take place at least monthly for the first six months of the contract and then at mutually agreed periods of no longer than 6 months periodicity.

b. clinicians wishing to use Cypriot licensed products for long-term therapy, or after closure of the Agreed Treatment Plan, will seek advice from the Authority pharmacist or appropriate AR beforecribing or recommending.

c. written information in English about the drug is to be available to the clinical service user and the PHC clinician responsible for ongoing monitoring.

d. Amber and Red drugs (as defined by the Authority) are to be subject to an appropriate shared care agreement between the Authority and Provider/Clinician.

3.1.47. **Safe Surgery**. The Provider(s) shall comply with NICE Guideline 45: Routine preoperative tests for elective surgery and the WHO Guidelines for Safe Surgery for all proposed surgical interventions. The Provider(s) shall demonstrate use of the WHO Safe Surgical Checklist prior to commencing any surgical procedures.

3.1.48. **Fitness for discharge**. In determining whether a BFC/SBAA clinical service user is fit to be discharged, the Provider(s) shall consider the individual circumstances of the clinical service user and discuss with the Authority AR any additional support the clinical service user may require post-discharge. The Provider(s) clinicians will be required to advise the Authority AR about the clinical service user's fitness for duties. This advice need not be specific to military tasks, but will be sufficient to guide the Authority AR. Whilst the Provider(s) clinician may recommend a limitation on activity following treatment, the Authority AR will authorise and interpret these recommendations. Provider(s) clinicians are not to discuss their recommendations in detail with the clinical service user unless it is clinically appropriate to do so. Where a limitation on activity is recommended the clinical service user is to be referred back to Authority AR after the consultation.

3.1.49. **Discharge Letter**. Once treatment is complete, the Provider(s) shall provide the Authority AR with a copy of the Discharge Letter, written or transcribed into English, within **10 working days**.

3.1.50. The Authority will be responsible for providing adequate and legible information to the Provider(s) and carry out a process of referral document validation. The Provider(s) will inform the Authority of any persistent failure of ARs to maintain an adequate standard, in terms of legibility and amount of information, in order for remedial action to be taken by the Authority.

3.1.51. The Authority will monitor the quality of the discharge information provided and where persistent illegibility or inadequacy of information provision occurs, the Provider(s) will be expected to take action to remedy the problem within **20 working days** of being so notified.

3.1.52. **Clinical appliances**. The Agreed Treatment Plan shall include all recommended appliances unless the Authority is notified to the contrary. The Provider(s) shall supply all re-useable equipment and will expect the Authority to assist in the accounting process supporting the issue and receipt of this equipment to, or by, BFC clinical service users. The Provider(s) shall put in place a system whereby such reusable equipment can be accounted for on issue and return. The Provider(s) will be responsible for managing and accounting for the reusable equipment supplied for use. The Authority will not be liable for any loss arising as a consequence of the loss by the clinical service user of any reusable equipment.

3.1.53. **Closure of Agreed Treatment Plan**. The Agreed Treatment Plan is closed by the Provider(s) clinician after a standard period of treatment or investigation. Any additional period of OP treatment may be provided within that same Agreed Treatment Plan provided it is authorised by the Authority and under the following circumstances;

a. where the requirement for follow up care is long term, as determined by the Authority AR;

b. after a clinical service user fails to attend three sequential appointments, the Provider(s) shall issue a Consultation Note (or other agreed document) to close the Agreed Treatment Plan. Any subsequent re-referral from PHC will be treated as a new the Provider(s) referral.

c. if the clinical service user wilfully, and without the benefit of medical advice from an Authority AR, fails to act in accordance with the advice given by the Provider(s) clinician.

d. if the clinical service user (or a representative) fails to book an alternative appointment within 28 days of being classed as a DNA or, is unable to agree an alternative appointment, or fails to give a clear intention to confirm one as soon as possible.

e. within 28 days of closure of the Agreed Treatment Plan, (or an alternative period to be agreed in negotiation) because the clinical service user has either; deteriorated or failed to make the expected progress.

3.1.54. Such cases will instead be subject to a review procedure to be established by the Authority and the Provider(s) and the allocation to the original or a new Agreed Treatment Plan agreed. All re-referrals after an agreed designated period will automatically be regarded as opening a new Agreed Treatment Plan.

3.1.55. Where the Authority AR remains concerned about a clinical service user's condition, they may either seek a case review meeting with the OP clinician or a second opinion. the Provider(s) is required to facilitate this requirement.

3.1.56. **Oncology Services**. The Provider(s) shall deliver a service for the diagnosis of suspected Cancers (NICE Guideline 12: Suspected cancer - recognition and referral). Should the diagnosis be confirmed, and the clinical condition allow, no treatment is to begin until the Provider(s) clinician has discussed the proposed treatment plan with the Authority AR. If an Agreed Treatment Plan is approved, any treatment and/or care shall be, as a minimum, to the UK Standard as described by NHS England[14]. The Authority reserves the right to refer BFC/SBAA clinical service user to the UK for further investigations and/or treatment.

3.1.57. **Mental Health Services**. The Authority operates a community-based mental health service which, on occasion, requires the use of suitable premises to protect and assess mentally ill clinical service users. The Provider(s) shall deliver a service that meets the following requirements:

[14] https://www.england.nhs.uk/cancer/

a. short-term inpatient care for mentally ill clinical service users in an environment that is a ligature free single room/side room;

b. assessment by a Registered Mental Health Nurse or a Consultant Psychiatrist within 6 hrs of admission, or, if assessed by a mental health nurse on admission, an assessment by a Consultant Psychiatrist within 24 hrs of admission;

c. submission of an initial report of admission sent to the Authority AR within **48 hrs;**

d. nursing observations during the admission must be overseen and directed by a registered nurse in mental health;

e. a single point and means (telephone number) of contact for admissions that can be accessed by the Authority 24 hours per day, 7 days a week;

f. telephone access, 24 hrs per day, 7 days a week, to a Duty Consultant Psychiatrist (CP). The purpose of this access is to permit direct discussion on patient admission with a referring authority;

g. a discharge report must be provided to the Authority prior to the clinical service users discharge;

h. fitness to fly assessment will be carried out prior to the discharge of the clinical service user should aeromedical evacuation be recommended by Service Liaison Officers (SLO);

i. access to the clinical service user must be granted to the SLO throughout the admission without exception;

j. the Authority retains the right to remove the clinical service user out of the facility under the direction of the SLO at any time during the admission;

k. except for emergency treatment for the management of acutely disturbed behaviour, no treatment shall be commenced without the approval of the SLO or duty clinician within the referring authority;

l. referral to additional specialists including psychology, physiotherapy, occupational therapy or other specialist outside of psychiatry must be agreed with the SLO or duty clinician within the referring authority;

m. during the admission the overseeing consultant must attend weekly ward rounds or similar multi-disciplinary team meetings, inviting the SLO to attend, and;

n. the provider and the authority will hold a minimum of 2 governance meetings per year to discuss patient care and feedback.

3.1.58. **End of Life Care**. Where possible, the Authority will repatriate BFC/SBAA Entitiled Persons who are approaching End of Life. Where this is not possible, the Provider(s) shall ensure End of Life Care is consistent with, as a minimum, the UK National Standard for both Adults (NICE Guideline 142) and Children (NICE Guideline 61) , taking into account any cultural and societal expectations and differences.

3.1.59. **Second Opinions**. There will be occasions when either the Authority AR or the clinical service user will consider the outcome of a consultation has been unsatisfactory, and the disagreement persists in spite of using the normal process of clinical liaison. In these

circumstances, the Provider(s) shall provide a second opinion service from another suitably qualified clinician.

3.1.60. **Shared care of Chronic Conditions.** The Provider(s) shall provide the long-term OP clinician monitoring of clinical service users with chronic medical conditions such as asthma, diabetes and hypertension. In collaboration with the Authority AR, the Provider is to support the development of protocols for the joint (PHC and SHC) management of these conditions and in line with NICE/SIGN guidance.

3.1.61. **Notifiable Diseases**. The Authority has a statutory duty to report incidences of Notifiable Diseases. The Provider(s) shall inform the Authority if a BFC/SBAA clinical service user presents with one of the listed diseases.

3.1.62. **Autopsies**. Non-forensic autopsies will on occasion be clinically recommended by the Provider(s) clinicians or requested by the next of kin of the deceased. In these circumstances the Authority may authorise an autopsy examination. In respect to stillbirths, the Provider(s) shall await authorisation before conducting an Autopsy. Transport of the body to the Authority mortuary at the conclusion of the examination will be the responsibility of the Authority.

3.1.63. Subject always to Cypriot legal requirements, in the event of a sudden unexpected death, an unexplained death or a death in suspicious circumstances, the matter is to be reported immediately to the Authority who in turn will issue the necessary instructions for the procedure to be followed with which the Provider(s) is requested to comply.

PART 3

SECTION 2

ADULT CLINICAL SERVICES

3.3.1. The Provider(s) shall deliver the Core Adult Clinical Services described below[15]. Links to NHS Service Specifications and various Quality Standards are provided as an **indicator** of the minimum requirement that the Provider(s) should deliver to BFC/SBAA clinical service users. Where a single Provider is unable to deliver all listed services, they shall submit a proposal to the Authority on the availability of suitable alternatives and how the service requirement could be met through out-sourcing by **contract start**.

Speciality	Description of Service	Service Quality Indicators and Delivery Guides
Major Trauma	Multi-specialty hospital care to seriously injured clinical service users, optimised for the provision of trauma care. They are the focus on the management of all types of trauma but specifically have the lead for managing candidate major trauma clinical service users, providing consultant-level care and access to tertiary and specialised level services.	NHS Service Specification - Major Trauma (All Ages) NICE Quality Standard 166: Trauma NICE Guideline 39 - Major Trauma: assessment and initial management NICE Guideline 40: Major Trauma - Service Delivery NICE Guideline 41: Spinal Injury - assessment and initial management
Orthopaedics	Orthopaedic surgery is a specialty dealing with acute injuries, congenital and acquired disorders and chronic arthritic or overuse conditions of the bones, joints and their associated soft tissues, including ligaments, nerves and muscles. The service is to provide: • assessment, diagnosis and management of all the conditions listed in the service scope.	RCS Guidelines and Quality Standards NHS Service Specification - Specialised Orthopaedics NICE Guideline 37: Fractures (Complex) - assessment and management

[15] List of Core Services arrived at through analysis of historic Clinical Service Use under previous SHC Contracts

	• provision of surgery for clinical service users with all the conditions listed in the service scope. • provision of emergency, elective and planned care. • provision of rehabilitation services and close working relationship with local rehabilitation staff e.g. community physiotherapy services.	NICE Guideline 38: Fractures (non-complex) - assessment and management NICE Clinical Guideline 124: Hip Fracture - Management BOA Standards for Trauma and Orthopaedics (BOASTs)
Emergency Surgery	The service is to provide: • emergency operations at any time, day or night. • Ongoing clinical care to post-operative clinical service users and other clinical service users being managed non-operatively, including emergency clinical service users and elective clinical service users who develop complications. • Further operations for clinical service users who have recently undergone surgery (i.e. either planned procedures or unplanned 'returns to theatre'). • Early, effective and continuous acute pain management. • Communications with clinical service users and their supporters.	RCS Guidelines and Quality Standards RCS: Emergency Surgery - standards for unscheduled care
Oral and Maxillofacial Surgery	The core OMF specialty service is the treatment of Cranio-maxillofacial trauma supported by maxillofacial technology and with important but limited input from associated specialties e.g. neurosurgery, ophthalmology. Maxillofacial surgery requires some specific input from other specialties such as Neurosurgery in the management of Craniofacial deformity / skull base tumours and orthodontics in the treatment of clinical service users with clefts of the lip/palate and jaw deformity.	RCS Guidelines and Quality Standards BAOMS QOMS Project Guide for Commissioning Oral Surgery and Oral Medicine
Vascular Surgery	Vascular surgery is a specialty dealing with diseases affecting the vascular system including diseases of arteries, veins and lymphatic vessels. The service will provide; • Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging). • OP management of clinical service users with peripheral arterial disease. • IP spells, emergency and elective activity.	RCS Guidelines and Quality Standards NHS Service Specification - Vascular Surgery Vascular Society: The Provision of Vascular Services 2015

	• Day case activity. • OP follow-up of clinical service users receiving vascular surgery/endovascular interventions. • Rehabilitation services particularly for post amputation care.	
Dermatology	Specialised dermatology services include the diagnosis and treatment of rare diseases and the management of severe diseases not suitable for, or not responding to, conventional treatment available in local dermatology departments	NHS Service Specification - Specialist Dermatology Services BAD Clinical Standards Quality Standards for Dermatology 2015
Rheumatology	Rheumatology is a multidisciplinary branch of medicine that deals with the investigation, diagnosis and management of clinical service users with arthritis and other musculoskeletal conditions. This incorporates over 200 disorders affecting joints, bones, muscles and soft tissues, including inflammatory arthritis and other multi-system autoimmune connective tissue disorders, vasculitis, soft tissue conditions, spinal pain and metabolic bone disease.	NHS Service Specification - Rheumatology NICE Guideline 100: Rheumatoid Arthritis in adults - management
Adult Critical Care	Adult Critical Care underpins all secondary and specialist adult services. Critical Care incorporates both intensive and high dependency care (ICU/HDU) stand alone or combined for adults who require care at level 2 and 3 as a component of their pathway of care.	NHS Service Specification - Adult Critical Care Core Standards for ICUs (2013) Intensive Care Society Standards NICE Clinical Guideline 50: Acutely ill adults in hospital - recognising and responding to deterioration NHS Service Specification - Extra-Corporeal Membrane Oxygenation for Respiratory Failure in Adults
Cardiology	The service will provide; • Receiving referrals • Provision of advice about possible referrals • Diagnosis and assessment • Treatment or advising on treatment • Identification of family members at risk and recommending appropriate evaluation • Prioritisation of services for clinical service user, such as access to genetic testing, according to clinical need	NHS Service Specification - Inherited Cardiac Conditions (all ages) NHS Service Specification - Cardiac Magnetic Resonance imaging NHS Service Specification - Electrophysiology and ablation services (adult) NHS Service Specification - Primary percutaneous coronary intervention (adult) NHS Service Specification - Congenital heart disease (adults)

	• Input to specialist care provided by other specialities (for example ophthalmology, rheumatology, cardiac surgery) • Input to long term monitoring, surveillance and care, including shared care arrangements with other hospitals and support provided by voluntary organisations	NHS Service Specification - Congenital heart disease (paediatrics) NICE Clinical Guideline 181: Cardiovascular disease - risk assessment and reduction, including lipid modification
Cardiothoracic Surgery	Cardiothoracic surgery is the specialty involved with the treatment of diseases affecting organs within the thorax (the chest), principally the heart, lungs and oesophagus. Thoracic Surgery is an inclusive service for all clinical service users requiring or being assessed for operative treatment of all conditions affecting the thorax, excluding the following: • Diseases of the heart and great vessels which are the remit of Cardiac Surgery • Oesophagogastric cancer Cardiac surgery is a surgical sub-specialty within the specialism of cardiothoracic surgery and includes provision of surgical interventions for coronary artery disease requiring surgical revascularisation, valve disease requiring surgical valve repair or replacement, surgery of the aorta in the thorax, both emergency and elective, surgery to deal with trauma involving the heart and a group of miscellaneous conditions such as primary surgery for cardiac arrhythmias and resections of muscular obstruction within the heart.	RCS Guidelines and Quality Standards NHS Service Specification - Thoracic Surgery
Neurology	A specialised neurology service will provide people who have a complex single need or multiple conditions with responsive specialist services using multi-disciplinary teams and disease-specific protocols and pathways.	RCS Guidelines and Quality Standards NHS Service Specification - Specialised Neurology (adult) NICE Quality Standard 26: Epilepsy in Adults NICE Quality Standard 27: Epilepsy in children and young people NICE Clinical Guideline 186: Multiple Sclerosis in adults - management NICE Guidelines related to Deep Brain Neurological care and support: framework for action 2020-2025

Neurosurgery	Neurosurgery encompasses the diagnosis, assessment and surgical management of disorders of the nervous system. The principle sub-specialties of neurosurgery are; • Paediatric neurosurgery • Neuro-oncology • Functional neurosurgery • Neurovascular surgery • Traumatology • Skull-base surgery • Spinal surgery	RCS Guidelines and Quality Standards NHS Service Specification - Neurosurgery (Adults) SBNS Quality Statement NHS Service Specification - Complex Spinal Surgery (all ages) NHS Service Specification - Spinal Cord Injury (all ages)
Ear, Nose and Throat	This speciality deals with the diagnosis, evaluation and management of diseases of head and neck and principally the ears, nose and throat. The principles sub-specialities of ENT surgery are: • Otology • Rhinology • Laryngology • Head and neck surgery • Facial plastics • Paediatrics	RCS Guidelines and Quality Standards ENT UK Guidelines
General Surgery	This speciality is wide-ranging with a number of sub-specialities as follows; • Breast • Colorectal • Endocrine • Upper Gastrointestinal • Transplant • Plastics (non-facial)	RCS Guidelines and Quality Standards ABS Guidance Platform NICE Clinical Guideline 81: Advanced breast cancer: diagnosis and treatment. NICE Clinical Guideline 164: Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer. NICE Clinical Guideline 28: Improving outcomes in breast cancer. NICE Guideline 101: Early and locally advanced breast cancer: diagnosis and management. NICE Quality Statement 12: Breast cancer NICE Guideline 45: Routine pre-operative tests for elective surgery

		RCS: Emergency Surgery - standards for unscheduled care
Urology	This speciality deals with diseases, trauma and congenital abnormalities of the kidney, bladder, genitalia and urinary tract as well as male sexual and reproductive health. Urology combines management of many non-surgical problems, such as urinary infections, and surgical problems such as the correction of incontinence, prostate problems and the treatment of cancer. Principle sub-specialities include; • Endourology • Urological oncology • Female and reconstructive urology • Andrology	RCS Guidelines and Quality Standards NICE Quality Standards related to Bladder Cancer NICE Quality Standards related to Lower Urinary Tract Symptoms NICE Quality Standard 91: Prostate Cancer NICE Quality Standard 124: Suspected Cancer
Ophthalmology	Ophthalmology services for adults encompass the investigation and management of visual, ocular and ocular adnexal disorders. Ophthalmology hospital services are provided by multidisciplinary teams (MDT) of ophthalmologists, optometrists, orthoptists, specialist nurses, and technicians. Specialised services are provided by ophthalmologists trained to fellowship standard in the appropriate subspecialty. Ophthalmic specialised services, as in most other clinical disciplines, will overlap with other specialised services. Due consideration must be given to the appropriate care of vulnerable adults.	NHS Service Specification - Specialist Ophthalmology NICE Guideline 81: Glaucoma: diagnosis and management RCOphth Clinical Guidelines RCOphth Emergency Eye Care Commissioning Guide WHO: Universal Eye Health - A Global Action Plan
Burns	Specialised burn care services provide: • Assessment • acute care (including actual care and surgical care) • rehabilitation • surgical reconstruction • on-going follow-up care To clinical service users with burn injuries that are too complex or severe to be appropriately cared for by community services or General Hospitals.	NHS Service Standards - Specialised Burn Care (all ages) BBA National Standards for Provisions and Outcomes in Adult and Paediatric Burn Care
Essential Services Laboratory (ESL)	An ESL provides a fit-for-purpose scope of pathology testing focused on time	ISO 15189: Medical Laboratory Accreditation NICE Guideline 24: Blood Transfusion

	critical, near-clinical service user tests. ESLs' work largely concerns the provision of urgent, near-clinical service user blood sciences through a mixture of point of care testing (POCT) and laboratory testing, including; • Haematology • Chemical Pathology • Microbiology • Histopathology • Cytopathology • Blood Grouping and Cross-Matching • Virology	NICE Quality Standard 138: Blood Transfusion JPAC Transfusion Handbook WHO: Laboratory Quality Standards and their implementation
Endocrinology & Diabetes	Diabetes and endocrinology is a broad-ranging specialty encompassing the diagnosis and treatment of clinical service users with conditions caused by abnormalities of hormone production or action, and the endocrine glands that produce them. This requires an understanding of the basic mechanisms of physiology and pharmacology, coupled with the ability to improve long-term outcomes for clinical service users through effective disease control, and in some conditions offer cure. Endocrine diseases and diabetes affect every physiological system of the body, so specialists need a wide range of skills and expertise.	NHS Service Specification - Specialist Endocrinology (adult) NHS Diabetes commissioning documents & guidance NICE Guideline 17: Type 1 diabetes in adults - diagnosis and management NICE Guideline 28: Type 2 diabetes in adults - diagnosis and management NICE Quality Standard 6: Diabetes in Adults NCE Quality Standard 109: Diabetes in pregnancy BAETS Guidelines SoE Emergency Guidelines
Obstetrics and Gynaecology	This service specialises in the care of women during pregnancy and childbirth and in the diagnosis and treatment of diseases of the female reproductive organs. It also specialises in other women's health issues, such as menopause, hormone problems, contraception (birth control), and infertility.	RCOG Green Top Guidelines RCOG Standards for Maternity Care RCOG Standard for Gynaecology NICE Guidelines related to Women's Health NICE Clinical Guideline 37: Postnatal care up to 8 weeks after birth

Accident & Emergency	An A&E department (also known as emergency department or casualty) deals with genuine life-threatening emergencies, such as: • loss of consciousness • acute confused state and fits that are not stopping • chest pain • breathing difficulties • severe bleeding that cannot be stopped • severe allergic reactions • severe burns or scalds • stroke	NICE Guideline 94: Emergency and acute medical care in over 16s - service delivery and organisation NICE Quality Standard 174: Emergency and acute medical care in over 16s NICE Clinical Guideline 134: Anaphylaxis - assessment and referral after emergency treatment RCEM Bes Practice Guideline: Emergency Department Care
Physiotherapy	Physiotherapists assess and treat people with physical problems caused by accident, ageing, disease or disability, using physical approaches in the alleviation of all aspects of the person's condition.	CSP Quality Standards for Physiotherapy Service Delivery NICE Quality Standards related to Rehabilitation
Diagnostic Imaging	Diagnostic imaging encompasses different imaging modalities and processes to image the human body for diagnostic and treatment purposes and therefore plays an important role in initiatives to improve public health for all population groups. Furthermore, medical imaging is frequently justified in the follow-up of a disease already diagnosed and/or treated	Quality Standard for Imaging 2019
Occupational Therapy	Occupational therapy provides practical support to empower people to facilitate recovery and overcome barriers preventing them from doing the activities (or occupations) that matter to them. This support increases people's independence and satisfaction in all aspects of life.	Hand and wrist orthoses for adults with rheumatological conditions Occupational Therapy in the prevention and management of falls in adults (2020) Occupational Therapy for people Undergoing total hip replacement (2017) Professional Standards for Occupational Therapy Practice (2017)

PART 3

SECTION 3

PAEDIATRIC CLINICAL SERVICES

3.3.1. The Provider(s) shall deliver the Core Paediatric Clinical Services described below[16]. Links to NHS Service Specifications and various Quality Standards are provided as an **indicator** of the minimum requirement that the Provider(s) should deliver to BFC/SBAA clinical service users. Where a single Provider is unable to deliver all listed services, they shall submit a proposal to the Authority on the availability of suitable alternatives and how the service requirement could be met through out-sourcing by **contract start**.

Speciality	**Description of Services**	**Service Quality Indicators and Delivery Guides**
High Dependency Care	Paediatric High Dependency Care (PHDC) is the provision of close observation, monitoring and therapies to children who are, or have a significant potential to be, physiologically unstable which is beyond the capability of a general paediatric ward as follows; • Critically ill children whose severity of illness does not require acute invasive ventilation or specialist care. • The care of long-term ventilated children, either while waiting for discharge to the community or during treatment of episodes of inter-current illness.	NHS Service Specification - Paediatric High Dependency Care PICS standards for care of critically ill children
Intensive Care	Paediatric Intensive Care (PIC) services look after children and young people whose conditions are life-threatening and need constant close monitoring and support from equipment and medication to restore and/or maintain normal body functions. PIC level 3 units provide care for children requiring intensive care and monitoring, including medically unstable clinical service users requiring intubation or ventilation, single or multiorgan support, and continuous or intensive medical or nursing supervision.	NHS Service Specification - Paediatric Intensive Care PICS standards for care of critically ill children
Endocrinology and Diabetes	Paediatric endocrinology is concerned with the diagnosis and management of children and young people with hormonal disorders	NHS Service Specification - Paediatric Endocrinology and Diabetes

[16] List of Core Services arrived at through analysis of historic Clinical Service Use under previous SHC Contracts

	(including growth and bone problems). Some of the disorders (e.g. familial short and tall stature, nutritional obesity, primary hypothyroidism, simple delayed puberty in boys) can be dealt with by general paediatricians, including those with an interest in endocrinology.	NICE Pathway: Diabetes in children and young people NICE Quality Standard 125: Diabetes in children and young adults RCPCH Standards for Paediatric Endocrinology NICE Guideline 18: Diabetes (type 1 and type 2) in children and young people - diagnosis and management
Gastroenterology, Hepatology and Nutrition	Paediatric gastroenterology is a clinical speciality comprising the investigation and management of disorders of the gastrointestinal tract including diagnostic endoscopy, inflammatory bowel disease (IBD), motility disorders, (including complex gastro-oesophageal reflux and constipation), functional disorders and conditions leading to intestinal failure. It also encompasses two related specialities: • paediatric hepatology (liver diseases) and nutritional care (complex); the nutritional • management of children with gastrointestinal and other complex diseases including • enteral and parenteral nutrition (intravenous feeding) and the provision of home parenteral nutrition.	NHS Service Specification - Gastroenterology, Hepatology and Nutrition RCPCH Quality standards for specialist paediatric gastroenterology, hepatology and nutrition
General Medicine	Paediatric Medicine deals with the prevention, diagnosis and treatment of medical conditions affecting infants, children, and adolescents, from birth to age 18.	RCPCH Facing the Future: Standards for Acute General Paediatric Services NICE Quality Standards related to Paediatric Medicine NICE Guidelines related to Paediatric Medicine
Rheumatology	Conditions managed by the specialist paediatric rheumatology team include inflammatory and non-inflammatory rheumatic conditions (ICD10- and OPCS 4.5 Codes) including JIA, Juvenile Systemic Lupus Erythematosus [JSLE], JDM, vasculitis as well as pain syndromes, unexplained fevers, complex multisystem disease, uveitis and medically unexplained physical symptoms with rheumatological manifestations and associations. In addition osteogenesis imperfecta, juvenile idiopathic	NHS Service Specification - Paediatric Rheumatology BSR Paediatric and Adolescent Guidelines

	osteoporosis, metabolic bone disease and auto- inflammatory conditions are managed by specialist rheumatology teams.	
Allergy	The Paediatric allergy service will provide diagnosis and care for children with severe or complex allergic disease, or where an allergic aetiology is suspected. In addition, it will: • Improve and maintain quality of life of children with allergic disease • Prevent acute and chronic allergic symptoms • Prevent complications and progression of disease and reduce the development of • allergic co-morbidities. • Reverse psychological damage and disability • Exclude allergic disease as a cause of illness • Provide family-centred specialist care for children with allergic disease • Minimise hospital attendance • Deliver safe and effective allergen immunotherapy	NHS Service Specification - Paediatric Allergy Services RCPCH Allergy Pathways
Respiratory	Common paediatric respiratory conditions are managed in local hospitals or primary care settings, but complex and rare conditions are managed in conjunction with a specialist paediatric respiratory centre. These children are assessed and treated on an OP, IP and day case basis by the specialised multi-disciplinary team (MDT). Treatment and follow up of many of these conditions are life-long and planned transition to adult services takes place via joint and/or hand-over clinics.	NHS Service Specification - Paediatric Respiratory Medicine NICE Guidelines related to Asthma NICE Quality Standard 25: Asthma NICE Guidelines and Quality Standards related to Tuberculosis NICE Pathways, Guidelines and Quality Standards related to Respiratory Tract Infections RCPCH Allergy Care Pathway for Asthma NICE Guidance 9: Bronchiolitis in children - diagnosis and management
Neurosurgery	This speciality deals with emergency and elective surgical interventions for a range of conditions affecting the brain and spinal cord of children under the age of 18. Conditions include; • Hydrocephalus • Central nervous system tumours,	NHS Service Specification - Paediatric Neurosurgery NICE Quality Standard 74: Head Injury

	• craniofacial disorders and • epilepsy • spinal dysraphism (forms of spina bifida) • head injury and other disorders.	
Neurology	The aim of the service is to ensure children and young people with serious neurological conditions achieve the best quality of life, through the provision of excellent diagnosis, investigation, intervention, management and information.	NHS Service Specification - Paediatric Neurology NICE Quality Standard 27: Epilepsy in children
General Surgery	General Paediatric Surgery (GPS) is defined as the surgical management of relatively common, non-specialised conditions in general surgery and urology in children who do not require complex perioperative care arrangements. This service comprises of the following elements: • Surgical/anaesthetic assessment of the referral via multidisciplinary team (MDT) or via a one-to-one consultation with the clinical service user/family • Surgical/anaesthetic pre-assessment (where appropriate) • Surgical or radiological procedure/operation • Histopathological examination of biopsies of tissues and organs removed during operation to ensure accurate diagnosis • Post-surgery/radiological IP care (including acute pain management) • OP follow up, including acute pain (as required) • Repeat surgery as part of staged pathway e.g. leg lengthening	NHS Service Specification - Paediatric Surgery and Surgical Pathology, Anaesthesia and Pain RCS Standards for Paediatric Surgery
Neonatal Surgery	Neonatal surgery will be provided by surgeons and anaesthetists who have the appropriate training accredited by the Joint Committee on Surgical Training. Similarly, the service will be led at all times by consultants who regularly anaesthetise babies/children and at all times there will be adequate, skilled assistance by trained staff. Children's surgeons/anaesthetists must demonstrate continued professional development relevant to neonatal surgery. Medical care needs will be provided by access to neonatologists or, where services are not co-located, by regular support from neonatologists (e.g. daily ward rounds)	NHS Service Specification - Paediatric Surgery - Neonates RCS Standards for Paediatric Surgery
Neonatal Critical Care	Neonatal services provide care for all babies less than 44 weeks post menstrual age that require on-going medical care. Neonatal services	NHS Service Specification – Neonatal Critical Care

	form part of an integrated pathway for high quality maternity, paediatric and family care serving a geographically defined regional population. Neonatal care services are provided in a variety of settings dependent upon the interventions required for the baby and with dedicated transport services to support babies being transferred to and from neonatal care units.	NICE Guidelines and Quality Standards related to Neonatal Critical Care
Accident & Emergency	An A&E department (also known as emergency department or casualty) deals with genuine life-threatening emergencies, such as: • loss of consciousness • acute confused state and fits that are not stopping • chest pain • breathing difficulties • severe bleeding that cannot be stopped • severe allergic reactions • severe burns or scalds • stroke	NICE Guideline 94: Emergency and acute medical care in over 16s - service delivery and organisation NICE Quality Standard 174: Emergency and acute medical care in over 16s NICE Clinical Guideline 134: Anaphylaxis - assessment and referral after emergency treatment RCEM Bes Practice Guideline: Emergency Department Care RCPCH Facing the Future: Standards for children in emergency care settings CQC Briefing: Staffing in Emergency Departments that treat children
Physiotherapy	Paediatric physiotherapy is the treatment and care of babies, children and young people from birth to 19 years. Paediatric physiotherapists bring a range of skills as physiotherapists and have additional specialist knowledge and experience of child development and of childhood conditions. Treatment should be carried out in a child-friendly environment by specialist staff. The paediatric physiotherapy team will be experienced in the assessment and treatment of a range of neuromuscular, musculoskeletal, rheumatological and orthopaedic conditions.	NICE Guidelines and Quality Standards related to Paediatric Physiotherapy CSP Quality Standards for Physiotherapy Service Delivery
Occupational Therapy	Occupational Therapists provide advice, reassurance, support, assessment and intervention to help children and young people develop their skills in everyday activities. Children and Young People's Occupational Therapists work closely with the child, their family and	Occupational therapy in neonatal services and early intervention

	members of staff from nursery/school etc to address specific functional difficulties.	

PART 3

SECTION 4

CLINICAL STAFFING

3.4.1. The Provider(s) shall, as a minimum, conform to NICE Guidance related to safe staffing.

3.4.2. The Provider(s) shall ensure only clinicians approved by the BFC Competent Medical Authority are used in the delivery of treatment and care to BFC/SBAA clinical service users. The Provider(s) shall submit to the Authority, a Curriculum Vitae, using the template at Annex I, for all Consultants and Allied Health Professionals they wish to treat BFC/SBAA clinical service users for consideration. The Authority will provide a response to a submitted CV within **30 days of receipt** of the **COMPLETED CV**, including all supporting documentation, subject to the review and availability of Defence Consultant Advisors or Defence Medical Services Subject Matter Experts.

3.4.3. At any point during the contract the Provider can propose additions and removals from the list. However, full justification must be provided to the Authority prior to assurance activity being undertaken to confirm whether the clinician is deemed suitable. The Authority may remove a clinician from the list.

3.4.4. The Provider(s) shall have a rota and a roster for staff members and the workforce according to Provider(s) activity and the skill mix required to support it. The rotas and rosters for the Provider(s) shall:

a. be made available to staff members and other Provider(s) which form part of the care pathway, emergency care or continuum of care;

b. include protected time for training and mentoring and include support by experienced staff members for any students, trainees, volunteers, locums, agency and unqualified staff members whilst on duty.

3.4.5. The Provider(s) shall have processes and tools available to monitor current numbers of staff members against the planned staff member numbers.

3.4.6. The Provider(s) shall have processes and tools available for collecting data on staff members. If applicable, these processes and tools shall be aligned to those in the organization(s) involved with the Provider(s). The data shall be used to inform the workforce development plan.

3.4.7. **Continuing professional development (CPD)**

a. **Appraisal process**. The Provider(s) shall implement an appraisal process for staff members. This shall include:

(1) information for the appraiser and the appraisee on the appraisal process;

(2) objectives and developmental goals;

(3) required supporting documentation; and

(4) outcomes from the appraisal.

b. **Feedback process (360º)**. The Provider(s) shall implement a 360° feedback process for members of the leadership team. This shall include:

(1) a procedure which provides a way for the member of the leadership team to rate their leadership

(2) performance against agreed competencies or behaviours and their raters to make their assessment on the member of the leadership team's performance confidentially;

(a) a written report;

(a) feedback; and

(a) a development plan to inform their overall professional development plan.

3.4.8. **Staff member training**. The Provider(s) shall a Staff Training Policy, training plans and training programmes in place for staff members. Training plans and related training programmes shall include:

a. Provider(s)-specific education and training;

b. principles of dignity, respect and compassion;

c. risk management;

d. Root Cause Analysis;

e. all mandatory training;

f. techniques and the use of specialist equipment;

g. additional training for new techniques, new specialist equipment or new processes; and

h. how competencies or behaviours are to be assessed, and;

i. communication skills.

3.4.9. The Provider(s) shall implement a process to assess staff members as competent before using techniques and specialist equipment. Training that requires interventions outside the Provider(s) and how this can be resourced shall be identified in the training plan.

3.4.10. The Provider(s) shall have documented procedures in place for staff members who have the responsibility for, and supervision of, students, trainees and observers.

3.4.11. The Provider(s) shall maintain outcomes and results of the training undertaken and training records of all educational and professional development activities for staff members.

3.4.12. **Development and capability to deliver high quality training**. Lessons learned and outcomes from training and education shall be shared with the staff members in the Provider(s). The Provider(s) shall identify ways of improving the efficiency and effectiveness of professional development.

3.4.13. **Teamwork and staff member involvement**. The Provider(s) shall:

a. implement processes to support staff members in team working and networking with similar clinical services;

b. have processes in place for recognizing and rewarding the achievements of the clinical team and individual staff members for outstanding performance; and

c. have a structured approach for briefing and debriefing at each team or individual handover.

3.4.14. Staff members shall be informed of the processes in place to raise concerns about any aspect of the Provider(s) or clinical team, including disrespectful, discriminatory or abusive behaviour or harassment.

3.4.15. Clinical team members shall be supported in generating and implementing ideas for improvement of the Provider(s), team, and environment.

3.4.16. The Provider(s) shall put processes in place for team members to provide informal and annually submitted formal feedback about the Provider(s).

3.4.17. The Provider(s) shall create and document action plans in response to staff member feedback indicating what it does not consider necessary to change, and why, as well as which changes can be made in response to feedback received, and how these can be achieved.

3.4.18. The Provider(s) shall present evidence of the activities described in this section to the Authority at **contract start** and annually from the point of Contract Award.

3.4.19. **Postgraduate Education (PGE)**. The Provider is required to provide support to the Authority's Postgraduate Education programme in BFC, both for the Provider clinicians to improve understanding of British clinical methods and for British PHC staff to better understand SHC and in particular the differing methods employed by UK and Cyprus healthcare systems. the Provider is not responsible for accommodation, travel and training fees. In pursuit of this the Provider shall:

a. make available to all BFC clinicians training in GP, dental, and hospital specialty issues.

b. ensure information on Postgraduate activities is sent when required to the Authority CD and any other nominated person.

c. facilitate visits of the Provider clinicians for PGE purposes where appropriate and as they arise.

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PART 3

SECTION 4

ANNEX I

CURRICULUM VITAE FOR CONSULTANTS & ALLIED HEALTHCARE PROFESSIONALS PROVIDING HEALTHCARE TO BFC/SBAA CLINICAL SERVICE USERS

SECTION A – PERSONAL DETAILS

Professional Body Registration details	Professional Body:	Reg. No:	Date of Issue & Expiry:
Health Care Professional group (Dr, Physio, Nurse, Podiatrist etc)			
Title (Dr, Mr, Mrs, Miss, Ms)			
Surname			
First name			
Gender		Date of Birth	

Contact details

Full Address		
Work telephone	Mobile telephone	Other telephone
Email address		

SECTION B – CREDENTIALS (complete either (i) or (ii))

(i) Consultant

Primary medical training	University:	Date of completion:
Speciality medical training	Location:	Date of completion:
Sub Speciality training	Location:	Date of completion:
Post Nominals (Exams/Diplomas/higher degrees)		

(ii)Allied Health Care Professional *(i.e. Podiatrist, Physiotherapist, Occupational Therapist, Nurse etc)*

Allied Health Care Speciality		
Place of study	University:	Date of completion:

SECTION C – PROFESSIONAL DEVELOPMENT & OTHER QUALIFICATIONS

Provide evidence of Continuous Professional Development for the last 5 years (*any learning outside of undergraduate education or postgraduate training that helps maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of professional practice)*

Date	Description of training course		CPD points

Level of English Language proficiency

All clinicians must be able to deliver a prognosis and treatment plan to BFC/SBAA clinical service users verbally and followed up by written confirmation within 10 days of initial consultation.		
Level of proficiency may be ascertained by one of the following: **1. A primary medical qualification that has been taught and examined in English.** **2. Recent experience of practicing in an English-speaking medical environment.** **3. Certification in any one of the English Language qualifications that meet the Level B1 criteria of the Common European Framework of Reference for Languages CEFR)[17].**		
Evidence of proficiency	**Score:**	**Date of test:**

[17] https://www.examenglish.com/examscomparison.php

Child safeguarding Training Level				
Child safeguarding Training Level	**0**	**1**	**2**	**3**
Certificate of Clear Criminal Record	Date:		Number:	

SECTION D – JOB HISTORY

Provide Job History for the last 10 years (the most recent to be listed first)

Post/Job:			
Hospital (name, address and lead consultant):			
Start date:		**End date:**	
Description of role			
Post/Job:			
Hospital (name, address and lead consultant):			
Start date:		**End date:**	
Description of role:			
Post/Job:			
Hospital			

(name, address and lead consultant):			
Start date:		**End date:**	
Description of role			
Post/Job:			
Hospital (name, address and lead consultant):			
Start date:		**End date:**	
Description of role:			
Post/Job:			
Hospital (name, address and lead consultant):			
Start date:		**End date:**	
Description of role:			

SECTION E – REFERENCES

Provide 3 referees

1.Referee name	
Job title and place of work	
Relation to you	
Phone Number	
Email Address	
2.Referee name	
Job title and place of work	
Relation to you	
Phone Number	
Email Address	
3.Referee name	
Job title and place of work	
Relation to you	
Phone Number	
Email Address	

SECTION F – ANY ADDITIONAL INFORMATION

Please include any relevant experience with treating Military Personnel

SECTION G– SUPPORTING DOCUMENTS

	Document description	√
1	Professional body registration certificate	
2	Licence to practise	
3	English language certificate	
4	Child safeguarding certificate	
5	Certificate of clear criminal record	

6		
7		
8		

SECTION H – DECLARATION

I hereby declare that the information provided is true, correct and complete. I understand any omissions or false representation may result in the termination of my services to BFC/SBAA clinical service users.

In accordance with the Data Protection Act 2018, the information provided will be stored and processed as part of the assurance process for the contract for Secondary Healthcare Provision in Cyprus and will be shared with the relevant MOD Defence Consultant Advisors as part of the assurance process. More information can be found in the MOD Privacy Notice

www.gov.uk/government/publications/ministry-of-defence-privacy-notice.

Name:

Signature:

Date:

PART 3

SECTION 5

CLINICAL SERVICE USER EXPERIENCE

3.5.1. The Provider(s) shall deliver a service that is aligned to the standards described in the NICE Quality Standard 15 – clinical service user Experience and underpinned by NICE Clinical Guidance 138. Specifically, the Provider(s) shall;

a. ensure systems are in place to give guidance to all staff in treating people with empathy, dignity and respect (QS1).

b. ensure systems are in place to deliver care by the same healthcare professional or team (whenever possible). The Provider(s) shall also ensure people using their services understand the roles of healthcare professionals involved in their care and know how to contact them about their ongoing healthcare needs (QS2).

c. ensure systems are in place to support coordinated care through clear and accurate information exchange between relevant health and social care professionals (QS3).

d. ensure systems are in place to provide opportunities to establish people's health beliefs, concerns and preferences and use them to offer individualised care. Service providers tailor care and treatment to people's needs and personal preferences, taking into account their ability to access services and their coexisting conditions. They also have systems in place to regularly assess, address and review people's physical and psychological needs (QS4).

e. ensure systems are in place to establish, respect and review people's preferences for sharing information with family members and carers (QS5)

f. ensure systems are in place to train and assess staff competency in relevant communication skills. They have systems to support people to understand relevant treatment options, actively involve them in shared decision making and support them to make fully informed choices about investigations, treatment and care. Providers make clinical service users aware of their right to choose or decline treatment, or ask for a second opinion, and make sure their staff respect these decisions (QS5).

3.5.2. **Advocacy**. The Provider(s) shall ensure each clinical service user is entitled to one advocate to attend any consultation as a matter of course. An advocate is defined as a relative or close friend who is providing support.

3.5.3. **Access**. The access route to the Provider(s) facilities will be appropriately signed, in English, and will make adequate provision for the needs of those clinical service users in wheel chairs or otherwise restricted in movement. Staff on the reception desks and the telephone operators should have sufficient knowledge of the English language to answer enquiries from BFC/SBAA clinical service users and their signifcant others. The Provider(s) shall provide assistance for clinical service users who are not able to walk unassisted or carry their own luggage.

3.5.4. **Privacy**. The Provider(s) shall ensure privacy by means of screens or curtains is offered to clinical service users during examination, consultation, diagnostic procedures, treatments involving bodily exposure, and when washing or using a commode/bed pan.

3.5.5. **Hotel Services**. Hotel services are defined as those relating to the physical/environmental facilities available and the social aspects surrounding an admission to

hospital. Whilst clinical necessity is obviously of paramount importance, care will be provided in a manner and setting that is sympathetic to the cultural, linguistic, religious, and ethnic requirements of the BFC/SBAA clinical service user. The following paragraphs set out the minimum requirements for hotel services the Provider(s) is to provide. Where it or the Authority identifies failures of compliance, the Provider(s) shall seek to rectify the problem and inform the Authority appointee of action planned and taken.

a. The Provider(s) will, wherever possible, accommodate BFC/SBAA clinical service users in the same room/ward, (subject to cross infection control limitations).

b. Accommodation for children is to be on a ward designed specifically for the hospital care of children. The Authority requires rooms for young persons aged 14 years and under are equipped with an additional bed to enable a parent/guardian to stay overnight.

c. A menu selection of meals and alternative diets for clinical service users with special medical, religious, cultural or racial requirements is to be provided.

d. BFC/SBAA clinical service users should have access to canteen or off-ward facilities for refreshments and relaxation purposes. BFC/SBAA clinical service users who wish to smoke will be subject to the Provider(s) policy on smoking, but the principle that non-smokers have a right not to be exposed to other persons' smoking is to be adhered to.

e. All wards within the hospital will provide easy access to toilet and wash/showering facilities. Wards and toilet facilities are to be single sex.

f. The Provider(s) is required to ensure secure storage, for personal possessions, is available for all clinical service users.

g. As a general principle and for security purposes the Authority requires clinical service users are accommodated in single-sex rooms and Authority clinical service users are segregated from non-Authority clinical service users, except where this requirement is over-ridden by clinical need. Additionally, there may be an occasion where the Authority requires a clinical service user to be securely separated and guarded.

h. Accommodation is to be provided for breast-feeding mothers of an admitted child and for the breast-fed child when the mother is the clinical service user, subject to clinical condition.

i. Children are to be afforded the comfort of a parent to accompany them to the entrance of the operating theatre, and as soon as possible after transfer from theatre, to the recovery area unless deemed likely to hinder the clinical care.

j. Assistance with washing or bathing and in the maintenance of oral hygiene, shaving and hair care is to be provided as necessary.

k. The changing of bed linen and waste-bin liners is to be conducted daily or more frequently as required.

3.5.6. **Visiting**. Visiting hours for family and friends of BFC clinical service users are to be as per normal hospital routine. Unit representatives, Chaplains, and DPHC practitioners are to be afforded similar access, which is at all times subject to the service users clinical needs and wishes. For clinical service users listed as "Very Seriously Ill" or "Seriously Ill" and paediatric cases, visiting access is to be unlimited, unless clinical requirements dictate otherwise.

3.5.7. **Newspapers & Television**. BFC/SBAA clinical service users are also to have access to English radio, and English language television channels. The Authority understands that technical difficulties may affect provision and, where this occurs, the Provider(s) shall make proposals for alternative solutions. The Authority requires access to a portable telephone is provided on a repayment basis. Reading material in the English language (Books, current Magazines and British national newspapers) is to be available for purchase by BFC/SBAA clinical service users.

3.5.8. **Friends and Family Test**. The Authority will introduce an anonymised Friends and Families Test as an independent indicator that will enable BFC/SBAA clinical service users to indicate their satisfaction with the service

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PART 4

GOVERNANCE AND ASSURANCE

4.1. **General.** SHC Services delivered by the Provider(s) are to complement the Authority PHC & Community Healthcare services. All these services are influenced by differing political, economic and cultural factors, professional standards and are governed by different regulatory regimes. The Authority accepts the achievement of its aspirations, with regard to quality, can only be realised:

a. within the framework of existing and future Cypriot/EU legislation and professional regulatory processes described in Annex K and,

b. through a positive partnering regime which works to the mutual benefit of both parties to ensure a continuing process of improvement to best serve BFC/SBAA clinical service users. To this end, the Authority shall provide access to extant Defence Medical Services (DMS) and UK National healthcare legislation and regulation.

4.2. **Quality Standards.** The Provider(s) shall achieve certification, issued by a UKAS-accredited organisation, to the Hospital and Care Setting International Standards, **or their equivalents**, described in Annex J **at contract start date**.

4.3. **Clinical Standards**. The Provider(s) shall have an overarching Governance and Assurance Strategy in place. All Provider(s) shall deliver care and treatment to BFC/SBAA clinical service users that is consistent with the Fundamental Standards described in Part 1, Section 3, Para 1.3.1. The Authority will utilise the CQC Key Lines of Enquiry[18] to benchmark Prover(s) service delivery against the Fundamental Standards. The Provider(s) shall accept DCA and DMSR advisory assurance visits and external assurance inspections of the provided services against the agreed requirement and described standards.

4.4. **Quality Improvement.** The Provider(s) shall operate an evidence-based system of Quality Improvement and demonstrate a robust, systematic approach to internal clinical audit. The Provider(s) shall ensure regular clinical audits, including Authority agreed clinical service user surveys, are undertaken and the results are shared and subsequently used to improve healthcare outcomes and service delivery. Provider(s) shall submit a Quality Improvement Plan (QIP) at **contract award** and annually thereafter. The QIP shall include;

a. Identified service quality improvement leads and their roles and responsibilities;

b. A description of all potential areas for improvement;

c. Identified areas of innovation;

d. Measurable objectives for improvement initiatives;

e. Key Performance Indicators;

f. Metrics for clinical effectiveness;

g. Timelines for completion of the objectives;

h. How the quality improvement plan is reviewed, monitored and evaluated; and

[18] CQC key lines of enquiry, prompts and ratings characteristics for healthcare services

i. Allocation of time, resources and staff members to achieve the above.

4.5. **Quality Breaches.** Any reasonable concerns about quality issues raised by the Authority are to be investigated by the Provider(s). The findings of any investigation and the resultant corrective measures are to be shared with the Authority at the earliest opportunity. Where corrective action is deemed insufficient by the Authority, the Provider(s) is to propose alternative arrangements for delivery of care for the affected service(s).

4.6. **Cyber Essentials Scheme**. Cyber Essentials Plus certification will be required by the Provider at the commencement of contract in line with DEFCON 658. This standard is to be maintained throughout the term of the contract by the Provider.

4.7. **Risk Management.** The Provider(s) shall have an Organisational Risk Management Strategy in place that is robust, mature and current and that is supported by;

a. a Risk Register that describes the nature of the risk, the risk owner, risk mitigation and evidence of regular review,

b. evidence of Risk Management Meetings at all levels of the organisation, and

c. evidence that all Staff are trained and understand how to apply the principles of risk management articulated in the document.

4.8. **Clinical service user Significant Event Reporting (SER).** The Provider(s) is to maintain an open and honest approach to the reporting of clinical service user safety and other reportable incidents. Reporting is to be compatible with the Authority SER system. Measures are to allow for the synthesis of data that supports a culture of 'learning from experience' within the organisation.

4.9. **Patient Safety Incidents**. Patient Safety Incidents involving BFC patients to be reported to the Authority no later than 15 days after the event outlining what measures have been taken to prevent recurrence.

4.10. **Complaints.** The Provider(s) shall have a Complaints Policy is in place. The Provider(s) shall use and demonstrate a robust complaints system that addresses concerns of the clinical service users, staff and the Authority. This complaints policy is to comply with the Authority's Complaints Policy detailed in Annex L.

4.11. **Safeguarding**. The Authority has a statutory duty to ensure the safeguarding of children, young people, and adults at risk is holistically, consistently and conscientiously applied to all care and treatment delivered by the Provider(s). To that end, the Provider(s) shall ensure a Safeguarding Strategy is in place to enable a responsive, competent and outcome focussed approach to safeguarding. The Provider(s) shall ensure all Clinical and Administrative staff who deliver treatment and/or services to BFC/SBAA clinical service users have received Safeguarding Training that is consistent with the UK Intercollegiate Adult and Child Safeguarding Standards, and that is commensurate to their role, **no later than** the contract start date and for the duration of the contract period. The BFC/SBAA protocol for safeguarding and protecting children can be found at Annex M

4.12. **Infection Prevention and Control (IPC)**. The Provider(s) IPC practices shall be consistent with NICE Quality Standards 61 (Infection Prevention and Control) and 113 (Healthcare-associated infections) and will be subject of annual Authority-lead audit to demonstrate compliance.

4.13. **Consent.** The Provider(s) shall:

(1) produce a Consent Policy and ensure use of consent forms, which comply in all respects with extant Cypriot legislation and benchmark against GMC guidelines and principles. Notwithstanding this, consent is not a snapshot but an on-going process.

(2) ensure clinical service users are provided with all information regarding the treatment that a reasonable person would likely attach significant risk. This should include alternative methods of treatment and implications of non-treatment, to enable them to make an informed decision. This information may be provided verbally or by means of relevant medical leaflets using simple English.

(3) ensure clinical service users provide informed consent in writing to surgical or other invasive procedures, unless their clinical condition prohibits this. Consent forms in the English language are to be used.

(4) ensure in the event that a clinical service user is discharged as a consequence of failing to provide consent the Authority is to be informed of the circumstances on the discharge note.

(5) ensure compliance with the General Data Protection Regulation (Regulation EU 2016/679). Any breaches are notified to the Authority without delay.

(6) ensure sufficient time is allowed between providing a clinical service user with relevant information regarding the proposed treatment plan, prior to treatment being consented by the clinical service user. Routinely, information should be provided at the initial consultation in order to allow the principle of informed consent to be evidenced.

(7) if there is evidence that informed consent has not being delivered, the Provider(s) shall conduct remedial training prior to any further referrals being made to the clinician. If a clinician is found to routinely default on informed consent the Authority retains the right to remove them from the approved list of clinicians for BFC/SBAA clinical service user.

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PART 4

ANNEX J

INTERNATIONAL STANDARDS RELATED TO HOSPITAL SERVICE DELIVERY

ISO	Description	Link
9001:2015	Quality Management	https://www.bsigroup.com/en-GB/iso-9001-quality-management/
14001	Environmental Management System	https://www.bsigroup.com/en-GB/iso-14001-environmental-management/
27001	Information Security Management	https://www.bsigroup.com/en-GB/iso-27001-information-security/
45001	Occupational Health and Safety	https://www.bsigroup.com/en-GB/Occupational-Health-and-Safety-ISO-45001/
22000	Food Safety	https://www.bsigroup.com/en-GB/iso-22000-food-safety/

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PART 4

ANNEX K

REPUBLIC OF CYPRUS LEGISLATION RELATED TO HEALTHCARE

Description	Legislation	Link
Ο περί Εγγραφής Ιατρών Νόμος	CAP. 250	http://www.cylaw.org/nomoi/indexes/250.html
Doctors Registration Law	30 / 1959	
	30 /1961	
	53 /1961	
	79 /1968	
	114 / 1968	
	14 /1974	
	18 /1979	
	72 /1991	
	66(I) /1995	
	112(I) / 1996	
	102(I) /2004	
	24(I) / 2009	
	162(I) / 2011	
	73(1) /2013	
	171(1) / 2013	
	125(1 / 2017	
Ο περί Εγγραφής Οδοντιάτρων Νόμος	CAP. 249	http://www.cylaw.org/nomoi/indexes/249.html
Dentist Registration Law	70 / 1962	
	33 / 1983	
	59 /1988	
	6. / 1992	
	64(I) / 1995	
	18(I) / 1998	
	82(I) / 2004	
	279(I) / 2004	
	25(I) / 2009	
	81 (1)/2015	
	126 (1)/2017	
	88 (1) / 2019	
	168 (1)/ 2019	
Ο περί Νοσηλευτικής και Μαιευτικής Νόμος	N. 214 /1988	http://www.cylaw.org/nomoi/indexes/1988_1_214.html
Nurses and Midwives Registration Law	131 /1991	
	154(I) / 2003	

	217(I) / 2004	
	249(I) / 2004	
	30(I) / 2006	
	43(I) / 2009	
	122(I) / 2011	
	1(I) / 2012	
	196 (1) / 2015	
	101 (1) / 2017	
Ο περί Ιδιωτικών Νοσηλευτηρίων (Έλεγχος Ίδρυσης και Λειτουργίας) Νόμος	90(I) / 2001	http://www.cylaw.org/nomoi/indexes/2001_1_90.html
Private Hospitals Registration, Control and Operations Law	193(I) /2003	
	2(I)/ 2004	
	93(I) / 2004	
	211(I) /2004	
	213(I) / 2004	
	216(I) / 2004	
	110(I) / 2005	
	19(I) / 2006	
	29(I) / 2008	
	145(I) /2009	
	129(I) / 2010	
	55(I) / 2011	
	32 (1)/2016	
	137(1)/2016	
	77(1)/2017	
	166(1)/2017	
	58(1)/2019	
Ο περί Εγγραφής Χημικών Νόμος	157 / 1988	http://www.cylaw.org/nomoi/indexes/1988_1_157.html
Chemists Registration Law	24(I) / 1992	
	20(I) /2004	
Ο περί Εγγραφής Φυσιοθεραπευτών Νόμος	140 / 1989	http://www.cylaw.org/nomoi/indexes/1989_1_140.html
Physiotherapists Registration Law	36(I) / 1998	
	76(I) / 2004	
	101(I) / 2005	
Ο περί Εγγραφής και Λειτουργίας Κλινικών Εργαστηρίων Νόμος	132 / 1988	http://www.cylaw.org/nomoi/indexes/1988_1_132.html
Clinical Laboratories Registration and Operations Law	98 / 1990	
	103(I) / 2004	

Ο περί Εγγραφής Επαγγελματιών Ψυχολόγων Νόμος	68(I) / 1995	http://www.cylaw.org/nomoi/indexes/1995_1_68.html
Professional Psychologists Registration Law	104(I) / 1996	
	17(I) / 1999	
	234(I) / 2004	
	59(I) / 2009	
	2001(1) 2014	
Ο περί Εγγραφής Επαγγελματιών Εργοθεραπευτών Νόμος	34(I) / 2006	http://www.cylaw.org/nomoi/indexes/2006_1_34.html
Occupational Therapists Registration Law	203(1) / 2014	
Ο περί Εγγραφής Λογοπαθολόγων Νόμος	136(I) / 2001	http://www.cylaw.org/nomoi/indexes/2001_1_136.html
Speech Therapists Registration Law	55(I) / 2004	
Ο περί Εγγραφής Τεχνολόγων Ακτινολόγων και Τεχνολόγων Ακτινοθεραπευτών Νόμος	23(I) / 2011	http://www.cylaw.org/nomoi/indexes/2011_1_23.html
Radiographers and Radiotherapists Registration Law		
Ο περί Εγγραφής Φυσικών Ιατρικής Νόμος	33(I) / 2008	http://www.cylaw.org/nomoi/indexes/2008_1_33.html
Medical Physicists Registration Law	45(I) / 2011	
Ο περί Προτύπων Ποιότητας και Ασφάλειας (Δωρεά, Προμήθεια, Έλεγχος, Επεξεργασίας, Συντήρηση, Αποθήκευση και Διανομή) Ανθρωπίνων Ιστών, Κυττάρων και Παράγωγων Προϊόντων Νόμος	187(I) / 2007	http://www.cylaw.org/nomoi/indexes/2007_1_187.html
Quality and Safety standards for Organ Donation and Transplant	146(1) / 2014	
	8(1) / 2017	
Ο περί Προστασίας από Ιονίζουσες Ακτινοβολίες και Πυρηνικής και Ραδιολογικής Ασφάλειας και Προστασίας Νόμος	164(I)/2018	http://www.cylaw.org/nomoi/arith/2018_1_164.pdf
Ionising Radiation Protection & Nuclear and Radiological Safety Law	153/2019	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/All/D3D926C88AAB8241C2257E2A001C88D2?OpenDocument
Ο Περί Ψυχιατρικής Νοσηλείας Νόμος	77(1) / 1997	http://www.cylaw.org/nomoi/indexes/1997_1_77.html
Mental Health Law	49(1) / 2003	
	26 (1) / 2007	
Πυρασφάλεια	2003	http://www.fs.gov.cy/fs/fs.nsf/page26_gr/page26_gr?OpenDocument
Fire Safety Law		

Η περί Ασφάλειας και Υγείας στην Εργασία νομοθεσία	89(1) 1996	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/All/1F0F98BA16BA0DA4C2257DE10030EB6C?OpenDocument
	39/1997	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/All/4C83EB8B41302EDAC2257E2100397115?OpenDocument
Health & Safety Law	158(1)/ 2001	
	25(1) /2002	
	41(1)/ 2003	
	99(1)/2003	
	33(1)/2011	
Elevators	533(1)/2012	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/pagem8_gr/pagem8_gr?OpenDocument
	170(1)/2015	
	178(1)/2015	
Η περί Πετρελαιοειδών νομοθεσία	Ch 272 of 64/1975	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/All/C2FCFB64D5E1CA26C2257DF0003FDA12?OpenDocument
Petroleum and Gas Law	138(1)/ 2004	
	7 (1)/2010	
	152(1)/2014	
Gas storage	176(1)/2010	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/pagemc_gr/pagemc_gr?OpenDocument
	530(1)/2010	
CE Marking - European Directive	765/2008	http://www.mlsi.gov.cy/mlsi/dli/dliup.nsf/pagem7_gr/pagem7_gr?OpenDocument
	2019/1020	
Ο περί Γενικού Συστήματος Υγείας Νόμος	89(I) / 2001	http://www.cylaw.org/nomoi/indexes/2001_1_89.html
General Health System Law	134 (1) /2002	-
	101 (1) / 2004	-
	62 (1) / 2005	-
	74 (1) / 2017	
	25 (1) / 2020	
Ο περί της Κατοχύρωσης και της Προστασίας των Δικαιωμάτων των Ασθενών Νόμος	1(I) / 2005	http://www.cylaw.org/nomoi/indexes/2005_1_1.html
clinical service user Rights Law		
Ο περί Επεξεργασίας Δεδομένων Προσωπικού Χαρακτήρα (Προστασία του Ατόμου) Νόμος του 2001,	125(1)/2018	http://www.dataprotection.gov.cy/dataprotection/dataprotection.nsf/all/DE97F6F59835A03AC22582DD003D895E/$file/%CE%9D%CF%8C%CE%BC%CE%BF%CF%82%20125(%CE%99)_2018.pdf?openelement

Personal Data Protection Act	EU 2016/679	https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0679&from=en
	112(1)2004	http://www.dataprotection.gov.cy/dataprotection/dataprotection.nsf/all/28791569BAED6825C2258298004007C4/$file/%CE%9D%CF%8C%CE%BC%CE%BF%CF%82%20112(%CE%99)-2004%20%CE%BC%CE%AD%CF%81%CE%BF%CF%82%2014%20.pdf?openelement

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PART 4

ANNEX L

BFC HEALTH SERVICE COMPLAINTS POLICY FOR SECONDARY HEALTH CARE

Introduction

4.L.1. The Complaints Policy is part of the commitment of the Authority to provide the best possible service to clinical service users. All complaints, arising from treatment in the Provider premises, or its subProvider(s)s, will be investigated and replied to in an efficient, courteous and sympathetic manner by staff able to investigate and, wherever possible, resolve complaints.

4.L.2. Complaints may be received from clinical service users, or their authorised representatives, such as the Chain of Command. If a complaint is received from a person other than a clinical service user himself/herself, the right of the complainant to receive responses must be authorised in writing by the clinical service user. A standard Form of Authority is attached (Appendix 1).

4.L.3. All correspondence relating to complaints will be handled as ‘medical in confidence’.

4.L.4. The Complaints Policy and Procedure is issued under the Authority of Commander Medical BFC.

4.L.5. An explanation of the Complaints Procedure will constitute part of the information given to every clinical service user and guardian.

Complaints Policy

4.L.6. Complaints are to be regarded always as an opportunity to improve the service provided and will be dealt with sympathetically without prejudging the outcome.

4.L.7. Complaints will be dealt with in a way that meets the needs of the complainant and the approach taken will be honest and fair to both the complainant and those complained against.

4.L.8. Complaints will be dealt with promptly and the process will be simple and readily understood to ensure good communication underpins all action taken.

4.L.9. The investigation of complaints will be a comprehensive enquiry into what happened, why it happened and, if the complaint is upheld, a statement of action to prevent any recurrence.

4.L.10. Complaints will be dealt with by the member of staff closest to the source of the complaint, within reasonable bounds of seriousness and risk.

4.L.11. The Authority requires all complaints are thoroughly investigated and, if appropriate, a written apology given to the complainant and processes altered to improve the service in the future.

Complaints Procedure

Verbal Complaints

4.L.12. Arrangements will be in place to ensure the Authority is made aware of the complaint and any immediate action taken to resolve it.

4.L.13. In matters relating to the social and environmental aspects of the clinical service user's experiences the Authority will liaise between the complainant and the Provider Manager to resolve the matter.

4.L.14. Verbal complaints will be dealt with as quickly as possible and in all cases within two days. They will be recorded on the Provider Manager records/log indicating the nature of the complaint, the investigation undertaken, the action taken to resolve any problems and whether the complainant was satisfied with the outcome.

4.L.15. The Provider Manager will refer any complaint outside their knowledge or sphere of experience to the appropriate Provider clinician or manager/director. Serious or unresolved complaints will be notified to Comd Med BFC for clinical matters and to the Authority appointee for contractual matters.

Written Complaints

4.L.16. On receipt of a written complaint, the Provider Manager or, in his/her absence the appointed POC, will ensure an acknowledgement is sent to the complainant within two working days of receipt.

4.L.17. A file will be opened on the complaint by the Provider Manager for all correspondence and reports. This file must be separate from the clinical service user's medical record. No copies of any documents relating to the complaint must be held on the clinical service user's medical record. This file must be available to authorised officers of the Authority or the Provider on demand.

4.L.18. An individual Complaint Coding Sheet (ICS), together with a copy of the complaint, will be sent to the Authority appointee. The ICS will be used to maintain a comprehensive Register of Written Complaints.

4.L.19. The Provider Manager will be responsible for ensuring a full and proper investigation of the complaint, as far as it relates to the services provided in the Provider or its subProvider(s)s, is carried out within the prescribed time-scales. The investigation should seek to establish the facts surrounding the complaint. Written reports are to be obtained from the staff involved, wherever possible. Where these are not available a file note is to be made by the Provider Manager.

4.L.20. The Provider is then responsible for ensuring a full and written response is made to the complainant within 28 working days of receipt of the complaint. the Provider may refer the results of the investigation of a complaint to either Comd Med for reply.

4.L.21. If a full response is not possible within this time, the Provider Manager, or in his/her absence, the designated POC must keep the complainant, or authorised representative, advised in writing about the progress of the investigation on at least a monthly basis.

4.L.22. A meeting with the complainant may be offered in appropriate circumstances. In such cases a letter confirming the outcome is to be sent to the complainant within one week of the meeting.

4.L.23. If the complainant is not satisfied with the response of the Provider Manager, the complainant will be referred to Comd Med who will investigate the complaint and its handling, and reply to the complainant within one month of its receipt. the Provider Manager will receive a copy of this response and ensure the Provider is fully aware of the outcome.

4.L.24. All correspondence, reports and other written material relating to the complaint must be copied on receipt to the Authority appointee.

Formulating Responses

4.L.25. Responses will be in plain English, sympathetic and demonstrate an appreciation of the complainant's point of view.

4.L.26. Responses will be factual and cover the outcome of the investigation, give an apology if required and include a description of the action taken as a result of the complaint.

4.L.27. Responses will not be defensive, deflect blame or responsibility, or criticise other staff or departments. Replies may be supported by extracts from records where appropriate.

4.L.28. Those aspects of complaints involving the Provider staff or services must be the responsibility of the Provider. A meeting with the complainant may be offered in appropriate circumstances and in some cases with the Provider clinician involved.

Serious Complaints

4.L.29. "**Serious complaints**" are defined by the Authority as those which concern an alleged error of clinical judgement, sexual or physical abuse, financial misconduct, criminal or military disciplinary offences, or negligence causing harm (including cases where there is thought to be any likelihood of legal action).

4.L.30. Such complaints must always be treated formally, acknowledged and passed without delay to Comd Med, to initiate action.

The Authority CD will request a formal response from the Provider and may seek specialist advice. the Provider Manager will be made aware of the action taken, as appropriate, to ensure the Provider is kept fully informed of the outcome.

Complaints About Policy

4.L.31. Complaints raising issues that are of a political or contractual nature, or concern the Authority, will be referred to the Authority appointee.

Complaints About Other SHC Providers

4.L.32. Complaints received by any office that refer to treatment received by BFC clinical service users at other Secondary Healthcare providers are to be passed directly to the Authority appointee, and copied to the Provider Manager, who will issue an acknowledgement, manage the investigation and send a response.

Complaints About The Conduct Of clinical service users By the Provider/Sub-Provider(s)s

4.L.33. Minor complaints about the conduct of clinical service users will be initially investigated by the Authority appointee; (more significant complaints will be referred to Comd Med). If the Authority appointee considers there are grounds for the complaint details will be forwarded to the Commanding Officer (CO) of the clinical service user's Unit, or equivalent for civilian staff. The Authority appointee will subsequently write to the Provider Manager to convey the CO's response and inform them of the action taken by the Unit.

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Appx 1 to
Annex L to
Part 4

Standard Form for Authority to Act on Behalf of a clinical service user in Relation to a Complaint

This is a form of Authority for the following to act on my behalf in relation to this complaint.

Date of complaint:

.....

Name and address of person acting on my behalf:

.....

.....

.....

.....

My name and address:

.....

.....

.....

.....

Signed: Dated:

....

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Appx 2 to
Annex L to
Part 4

A Brief Summary of the Procedure for the Handling of Complaints

Verbal Complaints

Respond within 2 days

Written Complaints

Acknowledge within 2 working days

Record the complaint on the Individual Complaint Coding Sheet

Aim to resolve the complaint within 28 working days

If not an interim reply is to be sent each month

If the complainant is not satisfied the complaint is referred to Comd Med for review within a month of its receipt

Serious Complaints

Acknowledge immediately

Refer to Comd Med immediately for action

Complaints about Policy

Complaints about political, contractual or Authority related issues are to be referred to the Authority appointee

Complaints about Non-the Provider and UK Hospitals

Complaints to be referred to the Authority appointee.

Complaints-related correspondence will be sent, as appropriate, to the BFC Commander Medical, the Provider Manager, and the Authority appointee.

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PART 4

ANNEX M

THE PROTOCOL FOR SAFEGUARDING AND PROTECTING CHILDREN

Introduction

4.M.1. This Annex outlines the Authority's current protocol for Safeguarding and Protecting children.

4.M.2. The Provider(s) is to ensure availability of a Safeguarding Level 4 Paediatrician. The following are seen as the minimum requirements expected of the Provider(s) when Child Protection concerns have been raised:

4.M.3. the Provider(s) clinicians must ensure comprehensive and contemporaneous notes are made of these concerns.

4.M.4. the child is not to be discharged from the Provider(s) without the Authority[19] having provided a documented plan for the future care of the child.

4.M.5. the child shall only be discharged from hospital to the care of an identified AR.

4.M.6. the Provider(s) staff must enquire about previous admissions to hospital. In the event of a positive response they must seek information about previous admissions from their own and other hospitals.

4.M.7. any child admitted to the Provider(s) must receive a full and fully documented physical examination within 24 hours of admission carried out by an appropriately trained and qualified Paediatrician to include Safeguarding Level 4. Forensic evidence should be appropriately collected, labelled and stored during such examination.

4.M.8. all the Provider(s) clinicians shall provide to BFC Social Services, if requested, a written statement of the nature and extent of their concerns.

4.M.9. the Provider(s) shall facilitate training to the Provider(s) clinicians principally involved in Child Protection, regarding the multi-disciplinary aspects of Child Protection, investigations, identification and recognition of deliberate harm to children.

4.M.10. the Provider(s) shall be prepared to provide information to those working in a liaison role between the Authority and Community Services.

4.M.11. Admission of a child at the request of a PHC clinician for investigation of non-accidental injury (NAI) and retention, as an IP if necessary, until a place of safety can be arranged.

4.M.12. Where the Provider(s) clinician suspects a child referred or seen for treatment (OP, IP and A&E) may have been subject to abuse/ NAI the Authority requires the Provider(s) shall adopt this protocol, which ensures appropriate and correct action is taken. In this respect neglect of the child's basic needs shall also be regarded as a form of non-accidental injury.

4.M.13. In the first instance, in any case of suspected child abuse where the child is already in hospital, the Provider(s) clinician shall contact the relevant PHC Duty Doctor (contact numbers will be provided).

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[19] BFC HS Consultant Paediatrician (or BFC HS personnel acting on behalf of)

4.M.14. The PHC clinician receiving the contact is responsible for notifying the relevant Agencies and ensuring the necessary action is taken for the protection of the child.

4.M.15. In any case of suspected or confirmed child abuse, where it is the Provider(s) policy to inform parents straight away, the HLOs may be called upon to act as interpreters, having notified the British Agencies/Authorities of the concern. In cases of suspected sexual abuse clinicians shall not normally inform parents at this stage.

4.M.16. The HLO has the authority to call the Service Police if parents react violently or want to remove their child before he/she can be attended to. The Service Police will liaise with the Authority or the GP in silent hours, regarding legal orders available to protect a child if necessary. The Provider(s) is to comply with Cypriot legislation in this regard.

4.M.17. When an abused child, or a child suspected of being abused, is fit for discharge, the Provider(s) shall liaise with all relevant Agencies, using the HLOs as necessary, to ensure aftercare is organised before discharging the child from hospital. The Provider(s) shall confirm the child will not be discharged unless the Provider(s) clinician is satisfied provision is in place for the care of the child.

4.M.18. The Provider(s) shall assist the Authority with cases arising in the community (within capability). The Authority will provide the Provider(s) with a clinical justification and/or a copy of its protocol for such cases and require the Provider(s) to provide the necessary support. This will not interfere with a clinician’s clinical freedom with respect to clinical service users under their care.