

Part 2 Contract - Schedule 2

West Yorkshire Urgent Primary Medical Care Services (WYUC)

Service Specification.

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1. Service overview

1.1 Vision

The West Yorkshire Urgent Primary Medical Care service will be provided in accordance with the following urgent care definition:

“Urgent care is the range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment or diagnosis. People using services should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need”.

This service schedule relates to urgent primary medical care consultation and treatment and excludes trauma patients and those patients with potentially life threatening symptoms.

The contractor shall deliver a consistent, accessible (365 days/ 366 days in a leap year), high quality, safe, effective and needs led pathway for patients living in, or visiting West Yorkshire and the Craven locality of North Yorkshire (hereafter for the purposes of this document referred to as West Yorkshire), who have an urgent primary medical care need out of hours, and cannot access their routine provider. As well as patients registered with a West Yorkshire GP practice, this requirement also includes patients who are registered with GPs outside West Yorkshire and patients who are not registered with any GP.

The contractor shall ensure the public know where and how to access services when they have an urgent primary medical care need.

The contractor will actively contribute as part of a whole system to fundamentally ensure that the clinical quality and safety of the whole urgent primary medical care pathway (including NHS 111) is duly managed within that defined area.

1.2 Core Services

The contractor shall deliver a consultation & treatment service for patients with an urgent primary medical care need, primarily in the out of hours period (6.30pm to 8am weekdays and all weekends and bank holidays and any additional public/bank holidays that maybe announced nationally), including relevant health promotion advice and referral as appropriate.

The contractor will deliver appropriate consultations for patients who:

- are referred from the 111 service (call handling and triage function)
- are referred from other services through established pathways of care some of which are in existence and others which will be developed as part of the new service.

- Self present at a primary care treatment centre without prior triage

The provider will be responsible for ensuring that patients are matched to the NHS Care Records Service spine via an NHS number.

Effective and robust clinical leadership is key to promoting patient safety and to improving quality of care. The contractor must have medical leadership at all levels of service delivery.

- *Organisational level:* there should be an Organisational Clinical Director at the highest level of the organisation whose main responsibilities are to put quality of care at the heart of the Contractor's aims, and to provide a framework for Clinical Governance (CG) and support for those delivering the Services.
- *Local level:* there should be a Local Clinical Director, whose responsibility is, to provide the medical leadership required for delivery of the Services at a local level, ensuring that key systems are in place for quality urgent care services.
- *Service delivery level:* there should be appropriate Clinical Advisors whose responsibility is to provide clinical leadership for the delivery of a particular type of clinical service, such as prescribing, whether it is provided at one or more sites. This person will have intimate knowledge of the particular clinical service and will be able to identify the key processes that should be in place to deliver the Services.

Consultations may take place via use of telephone consultations or face-to-face consultations, either in a primary medical care centre, or as a home visit. The patients' consultation format and acuity must be assessed by an appropriately trained clinician within the consult & treat provider.

The contractor shall ensure that for those patients who self present at the primary medical care centre, without prior triage, will have their urgent primary medical care needs dealt with in a manner consistent with 111 clinical assessments, i.e. seen, referred on, or sign posted.

The Contractor shall ensure that all health professionals working at its premises have the necessary skills and equipment to provide immediate life preserving treatment for patients attending as an 'un-assessed walk in'.

Patients assessed by the contractor as requiring a face to face clinical assessment in a primary medical care centre will be given an appropriate appointment time commensurate with their clinical needs and will be aware of their appointment time prior to arrival at the primary care centre. As such, these patients will not require additional formal assessment on arrival at a primary care treatment centre although if they are displaying obvious signs of distress on arrival the Contractor shall ensure that reception staff are trained to alert a clinician to this.

Where patients are assessed as requiring a home visit, the contractor will be responsible for determining the timescale of the home visit and for dispatching a visiting clinician in line with Department of Health guidelines.

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The contractor will only request investigations required to resolve the episode of care during the OOH period. Any further decisions regarding ongoing care is the responsibility of the patients own GP.

Patients who present to any urgent primary care treatment centre, who are not registered with a GP, shall be offered support by the contractor to help them to register.

Where required by Commissioners, the contractor shall work with acute providers, to develop formal pathways to facilitate transfer of patients with a primary care need from emergency departments.

The Contractor will provide a separate telephone number to enable direct contact by health and social care professionals.

Any consultation or treatment which is started before 0800 will be concluded by the contractor.

1.3 Model of care

1.3.1 Patients contacting the service shall be offered ongoing telephone based clinical assessment or face to face contact dependent upon their assessed needs.

1.3.2 Where it is assessed that a face to face appointment at the primary medical care centre is required, patients will be offered an appointment at the primary medical care centre of their choice. The contractor will provide primary medical care centres in accordance with the local service specifications contained in appropriate appendices to this document. The patient will be informed of their appointment time by the contractor. The contractor will be responsible for booking the appointment as agreed with the patient and ensuring that all the necessary administrative tasks are undertaken.

1.3.3 Where it is assessed that a home visit is required, the contractor will be responsible for agreeing the response time with the patient based on the presenting acuity. They will be responsible for arranging the home visit as agreed with the patient and ensuring that all the necessary administrative tasks are undertaken including, but not limited to, the dispatch of and contact with the visiting clinician.

1.3.4 The contractor shall ensure that telephone based and face to face consultations including the home visits are conducted by the most appropriate healthcare professional to meet the individual patient's needs.

1.3.5 The contractor is to work in partnership with the 111 contractor to ensure that patients have a smooth journey through the patient pathway without the need for them to contact multiple providers.

1.3.6 The contractor will develop systems to capture and manage information relating to frequent service users, identifying patients making repeated or inappropriate calls within information governance regulations. The Contractor will

work with the patients registered GP to conduct multi agency meetings as required to discuss each one of these patients to try to improve this situation for all those involved, particularly the patient themselves. In the event that the patient does not have a registered GP, then the contractor will be responsible for informing commissioners and subsequently facilitating meetings to address this matter.

1.3.7 The contractor will provide high level information regarding frequent callers to the service to commissioners, at practice level detail, to enable them to facilitate changing behaviours.

1.3.8 Access to transport: The contractor will provide supporting transport facilities, including:

- Sufficient suitable vehicles to facilitate all determined home visits (with due consideration of terrain or weather conditions);
- Drivers with suitable advanced driving and first aid skills, for each vehicle;
- Suitable communications equipment in each vehicle to maintain contact with the Contractor's base/operations centre;
- Suitable vehicles to facilitate, where necessary, the transportation of Patients to and from the primary care treatment centre, in accordance with clinical need.

1.4 Urgent Care improvement programmes

1.4.1 The contractor must provide staffing and management capabilities to allow for service development and improvement in line with national, regional and local priorities.

1.4.2 The contractor should be prepared in future to enable new emergent models which are not constrained by organisation or location and may be telephony or technologically based.

1.4.3 The contractor must engage fully with any future service redesign.

1.5 Principles for the service

The contractor will deliver a service based on the following principles:

1.5.1 Providing high quality, safe and effective services, with robust integrated clinical quality and continuous quality improvement that also demonstrate value for money in service delivery;

1.5.2 Active partnership with the wider health & social care economy, to own, drive and contribute to quality improvement, innovation, productivity and prevention (QIPP);

1.5.3 Active partnership with the wider health & social care economy, to own, drive and contribute to business continuity & emergency planning;

- 1.5.4 Ensuring services are accessible to all patients;
- 1.5.5 Services should guide & support patients with an urgent primary medical care need through to the most appropriate professional to meet their need (right person, right place, first time);
- 1.5.6 Contractors must have a robust system for identifying all immediate life threatening conditions and once identified, those calls must be passed to the ambulance service immediately.
- 1.5.7 Contractors must demonstrate that they have a clinically safe and effective system for prioritising and recording calls.
- 1.5.8 Enabling patients & carers to access services that they need and supporting self care and health promotion where appropriate;
- 1.5.9 Educate patients & carers in relation to appropriate future use of healthcare services, to empower them to make the right choices first time, ensuring appropriate utilisation of services;
- 1.5.10 Enabling the most vulnerable of our population (including, but not limited to, older people, children, patients with palliative care needs, Seldom Heard groups) to access appropriate healthcare.
- 1.5.11 The contractor will establish home visit and patient transport services criteria consistent with national quality standards, and subject to regular audit in conjunction with commissioners
- 1.5.12 The contractor must have robust risk stratification processes in place

1.6 Key Outcomes

- 1.6.1 Patients are not disadvantaged in terms of access (e.g. language, transport, disability etc);
- 1.6.2 Patients will receive high quality urgent primary medical care, determined by their needs, that is appropriate and timely, and meets the performance standards set out in the relevant section of this specification;
- 1.6.3 For those patients who walk into the primary medical care centre their urgent primary medical care needs will have a clinical assessment consistent with 111;
- 1.6.4 Appropriate pathways of care will be maintained, utilised and developed in conjunction with commissioners and partners;
- 1.6.5 At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescales within which further action will be taken and the location of any face-to-face consultations

1.6.6 Discharge communication should always be offered that empowers and informs patients and carers to facilitate self care and appropriate use of, and access, to healthcare services;

1.6.7 Electronic discharge communication to the patients' registered GP must be accurate with relevant level of clinical detail, completed electronically at the time of the episode by the clinician seeing the patient, sent back to the patients registered GP in a timely fashion and enhance the patients medical record to enable continuity of care.

1.6.8 It is essential that the service provider minimises the access to the patients full medical record to those staff who clinically require the access to support their assessment or to provide feedback on any contact.

1.6.9 The contractor will appropriately populate the patients primary care medical record, where available, and be responsive to requests from patients' GPs to amend data where necessary;

1.6.10 Patients will experience & report high levels of satisfaction with service provision & advice given.

1.6.11 The contractor will ensure that they respond as required to all calls warm transferred from the 111 service;

1.6.12. The contractor will ensure that, where calls are queued from the 111 service for patients requiring telephone consultation, they complete the consultation in a timely manner determined by patients assessed need.

2. Capacity Management System (CMS) and Directory of Services (DoS)

2.1 Population of a single directory of the skills and capacity of services and pathways within any given area enables the urgent primary medical care service to have a clear view of the capacity within the system to provide any set of required skills. Full details of locally available services will be maintained in the CMS DoS interface which is a web-based directory which stores details of all local services and a detailed breakdown of the specific clinical skills each service can provide. It also enables those services to register their capacity at any particular time, in the form of a red, amber and green indicator. This information will be used by the contractor to avoid referring patients to services with restricted capacity and direct them instead to services with more capacity and the same skills set.

2.2 The CMS DoS is held centrally by Connecting for Health on several web servers for resilience. This is a Commissioner owned database that will be available to the Contractor. Data within CMS is subject to robust governance and sign off by Commissioners to ensure that all parties agree that the listed services are clinically governed and that updates to the service information and capacity (Red/Amber/Green) status are a true reflection of the service. For services that are not NHS based further contractual agreements are made to ensure that data on the Directory is not shared with any other party or used for personal or professional gain.

2.3 The Contractor will provide management information to Commissioners regarding the demand, usage and performance of services in order to enable the commissioning of more effective and productive services that are tuned to meet patient needs through quarterly reporting.

2.4 The commissioner will ensure, by effective performance management that the DoS is accurately maintained, and will impose sanctions if this is not achieved.

2.5 The contractor will ensure that their entry in the directory of service is accurate and maintained.

3. Managing demand in the wider urgent care system

3.1 The contractor shall have systems and processes in place to manage and reduce the demand for inappropriate attendances at local emergency medical care services and potentially the reduction of unnecessary admissions at local NHS Acute Trusts and will be expected to work in partnership with the commissioning organisations to achieve this.

3.2 Any patients requiring secondary care attention (as determined by the clinician assessing the patient) will be directly referred according to locally agreed protocols and not sent to A&E as a default position without following local agreed procedures for admission. The Contractor will be expected to contribute to joint planning of additional pathways required as the service develops, in collaboration with Commissioners.

4. Interface with primary care and other providers

In delivering their model, the contractor will need to consider the contractual and practical interfaces and referral pathways with other contractors.

The Contractor shall ensure that referrals to and from other local services are seamless and appropriate and that there is a suitable use of urgent care services as this is vital for the effective and efficient use of local healthcare resources.

The contractor will ensure that an information sharing agreement is in place with all other services to ensure seamless transfer of information while respecting the confidentiality of patients.

In particular the Contractor will need to interface effectively with the following services:

4.1 Primary Care

4.1.1 The contractor will operate in a framework in which the patient's usual source of primary care has a central focus and responsibility.

4.1.2 The contractor will provide the patients' registered GP with electronic clinical information concerning the details of their patients' urgent primary medical care consultations and contacts by 8am on the next working day. However where the contractor has not concluded the interaction by 8am then the clinical information must be transferred immediately on completion to the patients registered GP. Where clinically appropriate there should be verbal communication with the patients GP Practice where their patients have had complex difficulties over the out of hours period.

4.1.3 Where individual patients are high users of urgent primary medical care services, the contractor will be required to have dialogue with relevant GP's and relevant others, to explore possible reasons for and solutions to this behaviour.

4.2 111 Service

4.2.1 The contractor shall ensure that the interface with the 111 service is effective and that consult and treatment services for telephone-assessed patients are timely and appropriate without any obligation for the patient to contact numerous services.

4.2.2 The contractor will ensure that assessment algorithms are consistent throughout the whole patient journey, to ensure that patients receive consistent triage and clinical assessments however they choose to access the out of hours service.

4.2.3 It will be the contractor's responsibility to maintain the information flow through all aspects of the service.

4.2.4 The contractor will establish clear *Information Handling and Sharing Protocols* to ensure that all aspects of the service have clarity around process, defined areas of responsibility and accountability in the provision of patient information and care.

4.2.5 The contractor will ensure visibility of the whole patient pathway, consistent communication to the patient and real-time interface between the 111 and treatment provider operations teams.

4.3 Community services

4.3.1 The contractor will receive referrals within specified pathways from other healthcare professionals or services such as, but not limited to, community nursing teams, ambulance service, mental health crisis teams, collaborative care teams, accident & emergency, where an urgent primary care consultation is required.

4.3.2 The contractor shall ensure that the interface with these teams is effective and that there are established pathways for appropriate onward referral. This will include effective transfer of information, transfer of accountability for patients' care, and joint understanding of roles.

4.3.3 The Contractor shall participate in joint planning of seamless pathways with the relevant community service providers & local commissioners.

4.3.4 The contractor shall ensure that it takes into account views of other healthcare professionals when reviewing service provision and performance.

4.3.5 The contractor will have a system in place to share lessons learned and actions taken resulting from feedback from fellow healthcare professionals

4.4 Secondary care services

4.4.1 Patients requiring hospital assessment or admission should have clear onward referral pathways. The contractor shall ensure that it has robust knowledge of local processes, protocols, pathways and mechanisms for referring to secondary care and will integrate this within its clinical systems to ensure knowledge is kept up-to-date.

4.4.2 The Contractor shall participate in joint planning of seamless pathways with the relevant local hospital clinicians & local commissioners.

4.4.3 The contractor shall manage the key relationships with specialists eg (but not limited to) Emergency Medicine, Acute Medicine, Mental Health, Emergency Paediatrics, Obstetrics, Gynaecology and Orthopaedics in order to achieve a level of integration which will provide the best possible clinical care to patients.

4.4.4 The contractor will work with commissioners, as required, to develop formal pathways to facilitate transfer of patients with a primary care need from emergency departments.

4.4.5 The contractor will receive referrals through a pathway from pathology laboratories in the event of grossly abnormal results processed and results made

available in the out-of-hours period. A suitably trained clinician will manage the response accordingly.

4.5 Pharmacy

4.5.1 The contractor will be required to have good working relationships with community pharmacists ensuring that they are recognised as a key part of the urgent primary medical care system and put appropriate processes in place to support this.

4.5.2 The Contractor shall work towards the development of a referral pathway to community pharmacies, out of hours, for patients with a defined range of minor ailments in line with clear agreed protocols.

5. Clinical objective and principles

5.1 Care Quality Commission (CQC)

5.1.1 The CQC sets out the level of quality that all organisations providing NHS care in England are expected to meet or aspire to and provides a common set of requirements applying across all healthcare organisations to ensure that health services that are provided are both safe and of an acceptable quality. They also provide a framework for continuous improvement in the overall quality of care that people receive.

5.1.2 From April 2010 legislation has brought a new registration system that applies to all regulated health and social care services via a phased implementation process, therefore all providers of said regulated activities must demonstrate how they comply with the requirements of Health and Adult Social Care Act 2008 (Regulated Activities) Regulations 2009, and the Care Quality Commission (Registration) Requirements 2009;

5.1.3 The contractor must demonstrate compliance with Care Quality Commission Essential Standards for Quality and Safety via an annual report. (Note - Out of Hours services are required to register with CQC).

5.1.4 The contractor shall notify the commissioners in the event of any CQC inspections, announced or unannounced, immediately, and will forward any outcome documentation. The contractor will inform commissioners of any conditions placed on registrations.

5.2 Clinical

5.2.1 The contractor will deliver “high quality clinical services”. High quality clinical services are defined as:

“Patient-centred and value for money, primary medical care services, delivered in a safe and effective manner, through a learning environment, which includes the training of doctors and other healthcare professionals.”

5.2.2 The contractor will deliver an out of hours urgent primary medical care consult and treatment service to people who require urgent primary medical care and attention by a healthcare professional. This will include where appropriate telephone consultations and also face to face delivery of urgent primary medical care treatment which will be delivered both in Patients’ homes (when clinically appropriate) and in urgent primary medical primary care centres.

5.2.3 The contractor shall ensure that, on arrival at the urgent primary medical care treatment centre, patients are greeted by a dedicated receptionist who will log their arrival electronically to ensure accuracy of performance data recording.

5.2.4 The contractor shall ensure that all clinicians are aware of all relevant pathways and are supplied with sufficient information to allow them to refer patients

to the right speciality in the right location and at the right time (see section 2 regarding the electronic directory of services that will support this.)

5.2.5 The contractor will ensure that the term “consult and treatment” is used in its broadest sense and includes providing relevant information and advice to empower the patient to self care or to support referral to a more appropriate service. The Contractor will ensure that clinicians take the opportunity to advise patients (following treatment) of what would, in the future, be a more appropriate service for them to access (e.g. patients’ own GP, self care, pharmacist). It should be recognised that the patients’ own GP practice (and associated locally provided primary and community based services) have a central role in the continuity and communication of their individual patients’ care.

5.2.6. The contractor will ensure there are special pathways (with defined timescales/acute) developed for the following groups:

- End of Life/Palliative Care
- Long Term conditions (responding to existing ‘specialised’ care plans for individuals)
- Responding to an expected death – the contractor will, where service priorities allow, attend within 2 hours to confirm death. In exceptional circumstances the clinician will issue a death certificate if indicated.
- HMS Prison responding to a death in custody – the contractor will respond to a death in custody as a priority call within 2 hours. In exceptional circumstances the clinician will issue a death certificate if indicated. The contractor will, where service priorities allow, attend urgent calls within 2 hours.

5.3 Clinical safety and medical emergencies

5.3.1 The contractor shall deal with medical emergencies safely and effectively with access to appropriately trained staff supported by suitable equipment and in-date emergency drugs.

5.3.2. The contractor shall:

- ensure the availability of appropriate staff who are able and available to recognise, diagnose, treat and manage patients with urgent or potentially life-threatening conditions at all times;
- possess the equipment and in-date emergency drugs, including oxygen, to treat life-threatening conditions such as (but not limited to) anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus;
- warm transfer of all life threatening conditions to the ambulance service immediately;

- adhere to any national or local guidelines relating to clinical safety and medical emergencies.

5.4 Self Care Promotion

5.4.1 The contractor will raise awareness and understanding of appropriate use of services and general health promotion, adapting approaches developed in other areas to produce a range of materials and methods to promote self care;

5.4.2 The contractor will ensure that reception areas provide appropriate messaging and signposting information to support patient self-care;

5.4.3 The contractor will ensure that, at the point of service delivery, health professionals will provide advice to patients about self-care options wherever appropriate and this will be reinforced by further guidance on discharge;

5.4.4 The contractor will encourage patients to seek routine care where appropriate and will also offer a comprehensive service providing health education, health promotion and self care advice to Patients;

5.4.5 The contractor will focus on changing patient behaviour in three key ways:

- Encouraging patients to use registered GP services as the first point of contact (e.g. for repeat prescriptions and non-urgent needs);
- When patients have an urgent medical need out-of-hours encouraging patients to use the 111 service;
- Avoiding A&E attendance and inappropriate use of emergency ambulance services, where appropriate.

5.5 Patient and public involvement

5.5.1 The contractor shall be required to operate a variety of effective methods for engaging with the local population in relation to new and ongoing development. This will ensure that the provision of urgent primary medical services is responsive to patients needs.

5.5.2 The contractor shall:

- identify key patient groups;
- engage and collaborate effectively with Patients and the local community to identify needs;
- develop the services to address local needs;
- share information, decisions and appropriate responsibility with patients;

- ensure the patient is comfortable with and understands what is happening at each stage of the care episode;
- offer patient choice in their treatment;
- evaluate and continually improve patient satisfaction rates.

5.5.3 To continue to improve the patient experience and user satisfaction, commissioners require evidence that the contractor demonstrates regular monitoring and reporting of views and outcomes, together with actions on how patient experience will be improved. This will include:

- How the contractor has engaged with patients/service users and sought feedback;
- Specific Service User Experience surveying. Specific themes and methodology to be agreed between providers and commissioners prior to commencement of service. Audits to be conducted quarterly, with a report on the results and action plan to address any shortfall/issues to improve service user experience. To be conducted across the whole 111 pathway and be conducted collaboratively with all NHS 111 contractors.
- The range of issues patients/service users have raised;
- What the contractor has done to address issues raised and how the providers have informed patients/service users what is to be done to improve services as a result of feedback;
- Number of PALs cases awaiting resolution at quarter end;
- Number of formal complaints awaiting resolution at quarter end.

5.6 Communication

5.6.1 The contractor will operate clear communications and have a marketing campaign, both in relation to existing and the new/changing services, to ensure maximum public awareness and understanding.

5.6.2 To improve the patient experience, the contractor will provide the following:

- Improved branding and signage, clearly showing the contractor as the provider of the services, wherever premises allow for this;
- Written information to be given to every patient attending a primary medical care centre. This will describe what the contractor does including the best way to access all services as well as opening hours;
- Further written information regarding the process to be used if symptoms change or further assistance is required

- Written information of the complaints process.

5.6.3 The contractor will ensure that robust systems are implemented to support patients with language difficulties, including the effective utilisation of translation services, where appropriate. Patients are not to be disadvantaged due to language or culture and their diversity and dignity are respected.

5.6.4 The contractor will ensure robust systems are implemented to support patients with other communication difficulties and impairment including the utilisation of loop systems, non-visual call systems and a dedicated telephone number for text phone users who have hearing difficulties to enable them to access services

5.6.5 The contractor will be an integral part of the development, implementation and maintenance of a wider health economy communications plan.

5.6.6 The contractor will supply non English speaking patients with professional translation during consultations, and translations of materials describing procedures and clinical prognosis for the most common languages spoken by users who are likely to use the services.

5.7 Marketing and engagement

5.7.1 Effective marketing and communications are essential to the success of the urgent primary medical care service. Marketing is required to ensure that the public are aware of how to 'Choose Well' or any subsequent campaigns, when requiring urgent health care. Communications are required to ensure that Stakeholders, including the media, are kept informed of developments and are supportive of NHS 111.

5.7.2 The steering group is developing a West Yorkshire-wide strategy to ensure that all Stakeholders are effectively engaged. Local Stakeholder communication and media handling strategies are also available. The previous experience of West Yorkshire Urgent Care is highly valuable in developing future campaigns and the initial evidence supports a carefully managed incremental approach to publicity that is co-ordinated across all Stakeholder Organisations.

The marketing and media handling will remain the responsibility of the Commissioners with engagement of the Contractor to support delivering the message

5.8 Patient dignity and respect

5.8.1 The contractor will deliver the services from an environment that treats every patient and carer as a valued individual, with respect for their dignity and privacy.

5.8.2 The contractor will:

- ensure that the provision of the services and the premises protect and preserve patient dignity, privacy and confidentiality;

- allow patients to have their personal clinical details discussed with them by a person of the same gender, if reasonably practicable, where required by the patient and;
- provide a chaperone for intimate examinations to preserve patient dignity and /or where requested
- ensure that all staff behave professionally and with discretion towards all patients and visitors at all times.

5.9 Equity of access

5.9.1 The contractor shall ensure that there is equity of access. The contractor shall ensure that there is no discrimination between patients on the grounds of age, sex, sexuality, ethnicity, disability, or any factor other than on clinical need.

5.10 Addressing health inequalities

5.10.1 The contractor will ensure attention is paid to Seldom Heard groups such as the needs of populations from countries with a different health care system to the UK and who do not currently access services that are available to them.

5.10.2 The contractor will ensure that any patient accessing the services who is not registered with a GP should be given the information and support to become registered, and be empowered to access routine care where at all possible.

5.10.3 The contractor must make “every contact count” and deliver health promotion and disease prevention activities and advice to all patients accessing the service, especially those from local Seldom heard groups. Seldom heard groups will include:

- those who do not understand written or spoken English;
- those who cannot hear or see, or have other disabilities;
- working single parents;
- asylum seekers or refugees;
- those who have no permanent address;
- black or minority ethnic communities;
- adolescents;
- those who are elderly and/or housebound;
- those who have learning disabilities;
- those who have mental illnesses;

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- those who misuse alcohol or illicit drugs; and
 - those who belong to a lower socio-economic class, or who are unemployed.

5.10.4 To improve equity of access, information on ethnicity should be recorded and is required to take into account culture, religion and language when planning and providing appropriate individual care, and to demonstrate non-discrimination and equal outcomes

5.10.5 The contractor shall implement Royal National Institute for the Blind, Royal National Institute for the Deaf guidance (in each case, as amended from time to time) and other relevant guidance to ensure patients who have disabilities and/or communication difficulties are able to access services.

6. Appropriate and responsive care to the most vulnerable

6.1 Principles

6.1.1 The contractor will treat patients with particular needs in line with relevant policies and procedures, including safeguarding legislation.

6.1.2 The contractor will provide appropriate care for patients who are frequent users of other local clinical services and who require continuity of care. These patients may include those who:

- have long-term conditions;
- have recently been discharged from hospital; or
- who frequently use out-of-hours services, e.g. patients requiring palliative care.

6.1.3 The contractor will have appropriate systems and processes in place to ensure that patients receive continuity of care and that this is integral to their service proposal. Key areas to be considered should include the following:

- A focus on continuity of care;
- Appropriate skill mix of clinical staff
- Appropriate systems and processes in place to identify and manage the continuity of care required by some patients.

6.2 Palliative Care

6.2.1 The contractor will meet the Gold Standard Framework and where appropriate the Liverpool Care Pathway for the provision of support to End of Life patients.

6.2.2 The contractor will have a priority phone line with clearly associated staffing resources who have been trained to understand the importance of the speed with which the calls are answered and dealt with for palliative care patients which is supported by:

- palliative care handover forms;
- Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) forms;
- specialist pharmaceutical and equipment supplies.
- Verification of death initiatives

6.3 Patients with long term conditions

6.3.1 The contractor will ensure that patients with long term conditions are supported to follow their individual care plan and ensure continuity of care through good communication channels with other providers (including carers) involved in their care.

6.4 Older people

6.4.1 The contractor will work to reduce the disadvantage in terms of access to primary medical care centres and obtaining medication, experienced by older people and work with other providers to support these patients in their own home, and from care and residential homes.

6.4.2 The Contractor shall ensure that for home visits to vulnerable elderly patients living alone, or alone at the time of the visit, information about the services will be left in a clearly visible place along with a 'calling card' stating what time the patient was visited and by whom, for the information of relatives/carers of the patient.

6.5 Children

6.5.1 The contractor shall deliver appropriate and responsive care to all children. This must be in accordance with the standards set out in the National Service Framework for Children, Young People and Maternity Services.

6.5.2 The contractor shall ensure clinical staff have appropriate paediatric skills to recognise the differences in the ways illnesses present in children, as opposed to adults, and manage children with an urgent primary medical care need. The Contractor will ensure that all clinical staff who provide care to children are trained in the local child protection policies and any other relevant processes relating to concerns about the welfare of a child.

6.6 Convenient services

6.6.1 The contractor shall ensure that the planned opening and/or closing times are clearly communicated to the public and with other urgent primary medical care providers through use of the Directory of Services.

6.6.2 The contractor will deliver a convenient service to patients.

6.6.3 The contractor will offer a comprehensive range of consultation methods that include, as a minimum, face-to-face and telephone consultations at the clinic as well as home visits when clinically appropriate. The range of consultation methods offered will enable patients, especially those from Seldom Heard groups, to access the services convenient to them.

7 Clinical quality (to be used in conjunction with schedule 10)

7.1 Regional Clinical quality and governance arrangements

7.1.1 The effective clinical quality in the provision of urgent primary medical care services presents particular challenges, especially in respect of the many different providers who all play their part in meeting a particular patients' needs. The contractor must take steps to assure the safety of the whole patient pathway including its interfaces, building and maintaining the strong and reliable relationships between partner providers which this requires.

7.1.2 In summary, while effective clinical quality will always deliver safe and improving services, the advent of a regional NHS 111 service, will present opportunities to deliver entirely new levels of understanding and trust between the many different NHS and social care providers who meet people's urgent and emergency care needs. To that extent, establishing and contributing to the development and delivery of effective clinical quality across the whole health and social care economy, will invariably serve as a powerful building block in the delivery of high quality, 24/7 integrated urgent and emergency care across the local health community.

7.1.3 Within Yorkshire and The Humber, clinical quality arrangements will be in place to ensure the clinical quality safety of the whole patient urgent primary medical care pathway is of a high standard. Clinical quality arrangements will include:

- A regional governance group, under strong clinical leadership and with clear lines of accountability to the commissioners of the service, which brings together all the NHS and social care providers to whom patients may be referred, enabling all to develop a real sense of ownership of their local service. The Y&H NHS 111 Regional Clinical Quality Steering Group (Y&H NHS 111 RCQSG) will be established to report to the Y&H NHS 111 Project Management Board (PMB). The role and remit of this group is based upon national guidance and the successful precedent of the equivalent group within the West Yorkshire Urgent primary medical care service contract. The contractor must be part of this group and respond wholly to its required ways of working;
- Clarity about lines of accountability within the service, from the Senior Responsible Officer through to individual members of staff within all partner provider organisations, and about the manner in which the clinical quality of the NHS 111 service engages with and supports the governance arrangements in other provider organisations;
- Patient safety must be critical for the Contractor. The safe delivery of clinical services is only possible when the leadership structure and governance is fit for purpose. The Contractor shall maintain clinical and organisational lines of accountability which end at the highest level within the Contractor organisation. The Contractor shall promote a culture of learning within its organisation.

- A robust policy setting out the way in which adverse and serious incidents will be identified and managed, ensuring that the clinical leadership of the contractor plays an appropriate role in understanding, managing and learning from these events, even where they have originated in a partner provider organisation.

7.2 Local Clinical Quality arrangements

7.2.1 Local clinical quality arrangements will be formally developed which will enhance and preserve the level of direct involvement from local partner provider organisations, fundamentally ensuring that the clinical quality and safety of the whole urgent primary medical care pathway is duly managed within that defined area.

7.2.2 The remit of the localised sub-regional Clinical Quality Steering Group will emulate the regional CQSG Group however membership and arrangements will be arranged locally, ensuring that local urgent primary medical care processes and progress are fed in to the Y&H NHS 111 RCQSG appropriately.

7.2.3 The contractor will provide required clinical leadership personnel to attend and contribute to all local Clinical quality meetings and relevant sub-groups convened as requested by the chair.

7.3 Quality Assurance

7.3.1 From 1st January 2005, all providers of Out of Hours (OOH) services have been required to comply with the national OOH Quality requirements. Providers of Out of Hours services have to demonstrate 100% compliance. See document http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073808.pdf

7.3.2 The contractor will be required to submit a quarterly formal quality assurance and performance assessment report that combines the various requirements of the specification and the reporting of the metrics that follow.

7.3.3 The contractor will also be required to develop a balanced scorecard approach that covers the mandatory NHS reporting, the Y&H NHS 111 RCQSG concept and the contractor's own experience of effective performance management systems. It is expected that a formal and comprehensive report is provided to inform the Y&H NHS 111 RCQSG meetings and sub-regional CQSG meetings.

7.4 Quality Assurance (QA) reporting

7.4.1 Regional Clinical Quality Steering Group will have delegated authority from Y&H NHS 111 Contract Management Board (CMB), through Sub-regional Clinical Quality review groups, to review the Quality Assurance schedule and formally agree whether the contractor has achieved the requisite quality standards. This may be through the review of quantitative data or the assessment of qualitative evidence supporting various outcome based actions. The Chair of the Sub-regional Clinical Quality Steering Groups will send a quarterly report to Regional Clinical Quality Steering Group detailing

the contractor's performance relating to quality of service delivery, which will subsequently be escalated to Y&H NHS 111 Contract Management Board to apply recommended awards/penalties in line with contractual mechanism.

7.4.2 Sub-regional Clinical Quality Steering Groups expect QA reporting schedule to be received for review on a quarterly basis, unless identified as requiring annual responses. The format will be formal reports, narrative or metric under the headings below, a RAG-rated dash-board (relating to the quality related KPIs within Schedule 7 of the contracts).

7.4.2.1. Safeguarding of Children in Vulnerable Circumstances

The Contractor will assure the Sub-regional Clinical Quality Steering Group that they follow the commissioner Safeguarding Children's Board Policies and the West Yorkshire Safeguarding Children Board Consortium procedures.

The Contractor will ensure that all of their staff are trained as per the Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate document, April 2010. Published by the Royal College of Paediatrics and Child Health and supported by the Department of Health. .
http://www.rcpch.ac.uk/doc.aspx?id_Resource=1535.

The Contractor has a duty to cooperate with and implement Section 11 of the Children's Act 2004 and provide assurance to all NHS commissioning organisations. The Contractor will evidence this through the implementation and ongoing monitoring of the West Yorkshire Safeguarding Children Board Consortium Section 11 Self Assessment Audit.

The Contractor will identify a named professional for Safeguarding Children as detailed in Working Together to Safeguard Children April 2010, paragraph 2.112 – 2.115.

Key Quality Metrics for Safeguarding Children:

- (i) 95% of all clinical and non-clinical staff are to have Level 1 Safeguarding Children training;
- (ii) 95% of all GPs (including sessional GPs), Nurses, and other eligible clinical staff are to have Level 3 Safeguarding Children training within the last 3 years;
- (iii) Annual report on outcome of the West Yorkshire Safeguarding Children Board Consortium Section 11 Self Assessment Audit with action plan to address gaps and evidence of review of risk in accordance with action plan.

7.4.2.2. Safeguarding of Adults in Vulnerable Circumstances

The Contractor will have in place systems and processes to safeguard vulnerable adults from abuse and are able to demonstrate the following:

- Adult Safeguarding policies and procedures are in place to support excellent safe guarding adults practice;
- Staff have access to appropriate training;
- Safeguarding incidents are reported to the Safeguarding Adults Board for the relevant commissioning organisation;
- Each provider will identify a named professional for Safeguarding adults

Key Quality Metrics for Safeguarding Adults:

- (i) 95% of all staff attending Basic Adult Safeguarding Training, to include updates on local policies and procedures;
- (ii) 95% of eligible staff have had a CRB check within the previous 3 years;
- (iii) 95% of new staff recorded as having received training on the awareness of the Mental Capacity Act (2005) at induction.

7.4.2.3. Evidence Based Practice/NICE guidance/NICE Quality Standards:

The Contractor will have a formal process for the management and monitoring of NICE, which includes: a Quarterly compliance report to the Sub-regional Clinical Quality Steering Group; a compliance statement in relation to all NICE guidance and Quality Standards; and can demonstrate that health care professionals make clinical decisions based on evidence based practice, and there are processes in place to monitor compliance with nationally agreed best practice as published by NICE, National Confidential Enquiries, High Level Reports and other nationally agreed guidance. Quarterly report required and to include.

- Compliance with the implementation of technology appraisals achieved within 3 months of issue (or action plans are submitted with allocated time frames when full compliance is not achieved);
- Compliance with relevant clinical guidelines and quality standards, acknowledged, disseminated and action plans submitted, within 12 months of issue
- Evidence that health care professionals make clinical decisions based on evidence based practice and there are processes in place to monitor compliance e.g through audit reports, clinical supervision, Serious Incident Investigations and complaints and any subsequent service improvements made.

7.4.2.4. Clinical Audit

The contractor is required to undertake a minimum of 2 full audit cycle clinical audits with findings used to change and improve practice which reflect national and local priorities. This must conform to the RCGP toolkit and take part in the Primary care foundation benchmarking audit developed for the National audit office. Other subjects are to be agreed with the Regional and Sub-regional Clinical Quality Steering Group and should cover quality improvement areas identified in the Quality Accounts and in response to incidents or service delivery issues.

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The Contractor will complement the Quarterly QA Schedule with

- (i) Clinical Audit Annual programme and audit outcomes for financial year;
- (ii) Annual Clinical Audit programme and audit outcomes for financial year focusing on service improvements rather than reporting results;
- (iii) Evidence of service improvements as a result of clinical audit activity to be included in quarterly audit report;
- (iv) Quarterly report on audit updates.

7.4.2.5. Patient Safety Incidents, Serious Incidents, Complaints, Compliments and Concerns

The contractor is required to have robust systems in place for the recognition and management of incidents that must include data collection mechanism, formal risk assessment, action planning and systems to share learning. Reporting shall include use of the National Reporting Learning System (NRLS). Reporting of incidents shall follow the agreed incident reporting guidelines and processes (as provided to the Contractor by the **Sub-regional Clinical Quality Steering Group** in writing from time to time)

Formal process in place for recognition and management of SIs must include data collection, formal risk assessment, action planning, collaborative working, and shared learning. 100% of SIs must have Root Cause Analysis. A full multi-provider report is expected and will be required to use Root Cause Analysis techniques, lessons learnt and action plan for all providers involved in the patient pathway and be provided within the timescales specified. Reporting of SIs shall follow the NHS Yorkshire and Humber Procedure for management of SIs Version 6 October 2010 or subsequent commissioner guidance

A sub-regional Serious Incidents, Incidents and Complaints Sub Group (subordinate to Y&H NHS 111 Clinical Quality Steering Group) will be established to review all of the contractors Serious Incidents (SIs), incidents and complaints. The group will provide: assurance that SIs, incidents and complaints are being investigated and managed appropriately; action plans are implemented and effective; and the learning is shared. This group will review categories, trends and themes of all incidents, complaints and feedback appropriately.

All patient safety incidents will be reported to the National Patient Safety Agency (NPSA) electronically via the National Reporting and Learning System (or any successor organisation or system)

Key Metrics for patient safety/SIs/complaints/compliments/concerns :

- (i) 100% of Serious Incidents should be reported onto STEIS and appropriate commissioning organisation within 24 hours of discovery;
- (ii) The contractor must provide an up-to-date report on all ongoing Serious Incidents at SI, Incident and Complaints Sub Group;

- (iii) The contractor is to report all SIs using NPSA Report template, indicating RCA process used, actions to be taken, responsible personnel, timelines and lessons learned;
- (iv) 100% of all SIs must be investigated and reported within 12 weeks or the agreed extension timeframe;
- (v) Complaints quarterly data, including:
 - Number, theme and area covered;
 - Acknowledgement/response rates against agreed timescales;
 - Analysis to identify trends or patterns;
 - Number of complaints upheld/not upheld;
 - Number of complaints investigated by Ombudsman;
 - Number of investigations upheld and overall outcomes;
 - Lessons learnt information;
 - Closing the loop data;
 - Number and type of PALs contacts quarterly;
 - Compliance against related national targets

NPSA and Medicine and Healthcare Products Regulatory Agency (MHRA) guidance, and Safety Alert Bulletins (SABs) are disseminated via the Central Alert System (CAS) including patient safety alerts and other safety solutions and products developed for the NHS are to be disseminated, implemented and evaluated in a timely manner. Where the guidance and/or alert have specified timeframes, the provider will work within these. Provider is required to have in place feedback mechanisms to demonstrate that staff have actioned these. Commissioners expect a report to give assurance regarding management of receipt, implementation and processes for managing and reporting breaches as outlined above.

7.4.2.6. Risk Management processes

The contractor will have robust systems in place to monitor and record risks using a Risk Register and impact versus probability risk assessment process and submit evidence/assurance regarding this;

The contractor is to evidence that a minimum of 98% of all staff receive induction (in year 1 and rising to 100% in year 2 onwards), which includes signposting to relevant policies and procedures, such as Risk Management, Risk Assessment, Incident Reporting, Complaints, Infections Control, Whistle Blowing and all related clinical policies, relevant to their role;

The contractor must evidence that 98% of staff receive basic Risk Management training and awareness (in year 1 and rising to 100% in year 2 onwards) which includes: Incident reporting, risk assessment and role responsibility.

The contractor is to evidence that a minimum of 98% of managers leading Root Cause Analysis (RCA) process must have received recognised RCA training in the first contract year, moving to 100% in year 2 onwards.

The contractor must evidence that all training requirements in the contract are also applied to sub-contracted staff

7.4.2.7. Infection Prevention and Control

Commissioners require adherence to infection control policies and processes. Infection prevention and control, including healthcare associated infection, is everyone's responsibility and requires cooperation and information sharing across the healthcare organisations, in order to effectively manage, monitor and reduce the incidence of infection.

The contractor will have systems and processes in place to ensure compliance with the Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on prevention and control of infections and related guidance (revised April 2010) contained within with Outcome 8, Care Quality Commission (Registration) requirements 2009 and any subsequent revisions. These services are expected to be able to demonstrate compliance with the following:

- Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them;
- produce a Healthcare Associated Infection Reduction Plan and provide commissioners with updates on the agreed plan;
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections;
- Provide suitable accurate information on infections to service users and their visitors and Inform the responsible commissioner of outbreaks/significant incidents relating to infection prevention and control as they occur, and report as per agreed incident reporting policy
- Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion;
- Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people;
- Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection;
- Provide or secure adequate isolation facilities;
- Secure adequate access to laboratory support as appropriate;
- Have and adhere to policies, designed for the individual's care and provider organisations, which will help to prevent and control infections;
- Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Key quality metrics for Infection Control:

- (i) Provide an annual report that demonstrates compliance with the Health & Social Care Act 2008, Code of Practice for the NHS on the prevention and control of healthcare associated infections 2010 (see HCAI assurance framework) with quarterly updates on amber and red factors.

7.5. Clinical prescribing and medicines management

7.5.1 The contractor will provide evidence that they comply with CQC outcome 9 (Minimum standards of quality and safety) to demonstrate that patients are adequately protected from the avoidable harms that can be caused by medicines use and that medicines are handled and prescribed in accordance with the Medicines Act 1968 (as amended, and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice identified in *The safe and secure handling of medicines: A team approach* (RPS, March 2005) should be considered and where relevant followed.

7.5.2 The contractor must submit evidence that they comply with the Medicines Code for storage and handling of medicines (this includes fridge monitoring, expiry dates, storage, etc.) for the Commissioner (or successor organisation) where based – Annual audit using Commissioner (or successor organisation) audit form (if available) or report.

7.5.3 The contractor will provide evidence that they demonstrate that controlled drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971 (and amendments), *Safer Management of Controlled Drugs: Guidance on strengthened governance arrangements* (Department of Health, Jan 2007) and *The Controlled Drugs (Supervision and Management and Use) Regulations 2006*.

7.5.4 Where urgent care primary medical care is provided – the contractor must adhere to the prescribing formularies, policies and guidelines produced by the commissioners unless there are compelling safety reasons to deviate from these. Where prescribing occurs that is not compatible, e.g. repeat prescription, justification must be provided.

7.5.5 The contractor must ensure that for all prescription requests for repeat prescriptions service users are advised in the first instance to discuss with their usual dispensing pharmacist.

7.5.6 The contractor will, wherever possible, direct the patient to a named community pharmacy, many of which have extended opening hours, for the prescription to be dispensed (refer to section 4)

7.5.7 The contractor will have a mechanism in place to identify patients requesting repeat prescriptions 2 or more times per year and will notify the service user's GP with a view to working together to prevent recurrent requests in future

7.5.8 The contractor must ensure that formal contracts / SLAs are in place where they subcontract any element of medicines management e.g. supply or

pharmaceutical advice. All relevant KPIs must be incorporated including requirements for reporting

7.5.9 The contractor must only prescribe medication for patients whose clinical condition would be adversely affected by waiting until they can access routine services (i.e. until the next working day);

7.5.10 Where access to a community pharmacy is not available, or when clinically or socially indicated, the contractor may dispense from their own stock;

7.5.11 The contractor will only issue electronic prescriptions, except in exceptional circumstances ie IT system failure.

7.5.12 The contractor shall ensure that there is safe and effective prescribing and medicines management in service delivery. The contractor shall ensure that all clinical staff who prescribe medicines prescribe in accordance with relevant national and local guidance including, but not limited to, the following:

- NICE guidance and DH directives relating to prescribing. The treatment provider should only prescribe medication when the patients' presenting clinical condition requires it and they would be adversely affected by it not being prescribed. In this case a full course of medication should be prescribed;
- Processes in place in manage repeat prescriptions
- National OOH formulary
- Local formularies
- Good Prescribing Practice as defined by British National Formulary (BNF). Medicines should be prescribed generically unless there is a good clinical reason to justify prescribing by brand name;
- The provider should comply with all relevant law relating to prescribing including the Medicines Act and Misuse of Drugs Act and subsequent amendments;
- Guidance from the department of health medicine code.¹

7.5.13 The contractor will be expected to develop and use relevant PGDs to supply and administer medicines. PGDs must be authorised by lead responsible commissioner before being used to provide care unless the contractor is a body entitled to ratify PGDs themselves.

7.5.14 The contractor shall prescribe the most clinically appropriate and cost effective medicines in accordance with both national and local guidance. The Contractor will be expected to have systems in place to ensure good quality

prescribing and work in partnership with the commissioners in relation to audit and their annual prescribing review.

7.5.15 The contractor shall ensure appropriate information and advice is given to patients about the use of the prescribed drugs.

7.5.16 The contractor will check the patient's own health record (if available) or an individual's Care Summary Record to ensure prescribed medication is not contra-indicated and input details of prescribed medication into the record if possible. If the patients' health record is not available then the prescriber will be required to ensure they are aware of other current medication to prevent interactions or duplication when prescribing new medicines.

7.5.17 If the commissioners require access for prescribing or monitoring visits then this will be accommodated and any recommendations or actions points will be undertaken.

7.5.18 The contractor will ensure that a direct telephone number is available to enable community pharmacists' direct access to contractors with any queries relating to prescriptions issued. The Contractor shall communicate the telephone number and advice on its appropriate use to community pharmacies.

7.5.19 The contractor shall ensure that prescribing and supply patterns of controlled drugs (CDs) are closely monitored and any concerns are reported to the commissioner 's Controlled Drugs Accountable Officer for appropriate management.

7.5.20 The contractor may have their own Accountable Officer (AO); if they are not a designated body for this purpose any concerns or incidents regarding CDs should be reported to the AO of the Commissioner (or successor organisation) in which patient lives.

7.5.21 The contractor will be required to have standard Operating Procedures (SOP) in place for the management of controlled drugs in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006.

7.5.22 Where the contractor is approached by patients who are requiring treatment for addiction they should be directed to in-hours services except where the service user is assessed as being at significant risk of harm. A clear and robust protocol for such situations should be developed by the contractor prior to service commencement.

7.5.3 Antibiotic Prescribing

The contractor must prescribe within the recommendations of the antimicrobial guidelines of the commissioning organisation where based; Where the prescriber deviates from the local guidance, the rationale must be documented.

The contractor must submit an antibiotic prescribing audit on a quarterly basis which will be reviewed by the sub-regional Clinical Quality Steering Group. The commissioners reserve the right to stipulate the audit which is to be conducted.

7.5.4 Benzodiazepine Prescribing

The contractor must ensure that all prescriptions for benzodiazepines and “z” drugs are for less than 72 hours duration (96 hours for 4 day Bank Holidays) and follow NICE guidance – To be included in the Quarterly Assurance report

The contractor should conduct an audit of 10% random sample of all benzodiazepine and “z” drugs prescribed over a 6 month period to include indication for prescription and duration prescribed, and provide a report to commissioner.

The contractor must inform the service user’s General practice where a request is made for benzodiazepines or “z” drugs.

7.5.5 Strong Opioids: (Morphine; Oxycodone; Diamorphine; Methadone; Fentanyl Buprenorphine)

The contractor will ensure that prescriptions for strong opioids are for less than 72 hours duration (96 hours for 4 day Bank Holidays). The contractor should demonstrate appropriate use, following risk assessment through audit.

8. Performance

8.1 Performance Management

8.1.1 The Contractor must deliver the Services in accordance with:

- Key Performance Indicators (KPIs)
- Care Quality Commission Essential standards of quality and safety;
- The Quality Assurance Schedule;
- Out of Hours Quality Requirements;
- Recommendations highlighted in Colin –Thomé / Field and Take Care now reports

8.2 Key Performance Indicators (KPIs)

8.2.1 The Contractor will deliver a service to meet the Key Performance Indicators set out in the Contract.

8.2.2 The contractor shall ensure that their Services comply, as a minimum, with all National Quality Requirements for delivering GP out-of-hours services, and all national requirements & guidance relating to the management and provision of urgent primary medical care, including, but not limited to, CQC registration. The contractor will be expected to ensure that they deliver any changes to the national quality requirements or other national guidance that may be implemented during the life of the contract.

8.3 Quality Assurance

8.3.1 Commissioners require Quality Assurance reporting to be carried out for review on a quarterly basis. The format will be narrative and metric under the headings below, a RAG-rated dash-board which is based on the quality-related Key Performance Indicators (KPI) within Schedule 7 of the contracts.

9. Workforce and development of staff

9.1 Standards

9.1.1 The Contractor shall ensure that all proposed workforce policies, processes and practices comply with all relevant employment legislation and codes of practice applicable in the UK.

9.2 Organisation

9.2.1 The Contractor shall have in place an operational management organisation structure chart, which demonstrates the key operational management roles and responsibilities, reporting relationships and accountabilities.

9.2.2 The Contractor will have a designated role responsible for Staff management and leadership and /or clinical management.

9.3 Staffing plan

9.3.1 The Contractor will have a detailed staffing plan that describes the staffing arrangements, including adequate staffing levels that will enable the delivery of the Services for the duration of the Contract and undertake TUPE transfers and Non-TUPE staff in line with all relevant policies and instructions.

9.4 Recruitment and Selection policy

9.4.1 The Contractor shall have a recruitment policy that supports delivery of the Services and focuses wherever possible on recruiting local staff and shall have a recruitment policy that supports the delivery of the Services to the local health community. The Contractor's recruitment policy, strategies and supporting processes shall promote equal opportunity and anti-discriminatory practice to enable them to attract and retain a high quality, competent workforce in adequate numbers, for the duration of the Contract.

9.4.2 The Contractor recruitment policy will include a process for ensuring that all required pre and post employment checks are implemented, and must ensure that any new staff that they propose to recruit will be suitably qualified, experienced, skilled and competent to deliver the Services safely and to a high quality.

9.5 Competency assessment

9.5.1 Prior to appointment the Contractor must demonstrate that they have an appropriate competency assessment process that includes competency assessment tools, to assess the practical competency of all Clinical Staff which includes telephone assessment and knowledge required to work out of hours.

9.5.2 The responsible commissioner reserves the right to introduce specific appropriate competency assessment tools during the term of the Contract, which the Contractor will be required to include in their recruitment/induction processes.

9.5.3 The Contractor should ensure that individual clinicians receive detailed feedback on their own performance and address any unacceptable variability in referral patterns.

9.6 Recruitment agencies

9.6.1 The Contractor must ensure that any recruitment agencies that they propose to use will comply with the Safer Recruitment and the Code of Practice for International Recruitment (where applicable)²

9.6.2 The contractor should sign agreements with preferred locum agencies, a list of which should be provided to commissioners.

9.7 Registration and qualifications

9.7.1 Clinical staff

9.7.1.1 No medical practitioner shall perform primary medical care services under this Agreement unless s/he is:

- included in a Medical Performers List for a Primary Care Trust, or successor organisations in England;
- not suspended from that list or from the Medical Register; and
- not subject to interim suspension under section 41A of the Medical Act 1983.

9.7.1.2 Clause 13.1 shall not apply in the case of:

- a person who is provisionally registered under section 15, 15A or 21 of the Medical Act 1983 acting in the course of his employment in a resident medical capacity in an approved medical practice; or
- a GP Registrar who has applied to the Commissioner (or successor organisation) to have his name included in its Medical Performers List until either the Commissioner (or successor organisation) notifies him of its decision on that application, or the end of two (2) months starting with the date on which his Vocational Training Scheme began, whichever is the sooner; or
- a medical practitioner who:
 - is not a GP Registrar;

² The Provider should be aware that for international recruitment there is a DH approved list of recruitment agencies used by the NHS that adhere to the Code of Practice. Details can be found at <http://www.nhsemployers.org>

- is undertaking a programme of post-registration supervised clinical practice supervised by the General Medical Council (a "post-registration programme");
- has notified the Commissioner (or successor organisation) that he will be undertaking part or all of a post-registration programme in its area at least twenty-four (24) hours before commencing any part of that programme taking place in that Commissioner's(or successor organisation) area; and
- has, with that notification, provided the Commissioner with evidence sufficient for it to satisfy itself that he is undertaking a post-registration programme, but only in so far as any medical services that the medical practitioner performs constitute part of a post-registration programme.

9.7.1.3 In Clause 13.2(b), "Vocational Training Scheme" has the meaning given in regulation 21(2) of the National Health Service (Performers Lists) Regulations 2004.

9.7.1.4 No Health Care Professional other than one to whom Clauses 13.1 to 13.3 apply shall perform clinical services under this Agreement unless he is registered with his relevant professional body and his registration is not currently suspended.

9.7.1.5 Where the registration of a Health Care Professional or, in the case of a medical practitioner, his inclusion in a Primary Care List is subject to conditions, the contractor shall ensure compliance with those conditions insofar as they are relevant to this Agreement.

9.7.1.6 No Health Care Professional shall perform any clinical services unless he has such clinical experience and training as are necessary to enable him properly to perform such services.

9.7.1.7 Before employing or engaging any person to assist it in the provision of the Services under this Agreement, the contractor shall take reasonable care to satisfy itself that the person in question is both suitably qualified and competent to discharge the duties for which he is to be employed or engaged.

9.7.1.8 When considering the competence and suitability of any person for the purpose of Clause 13.7, the contractor shall have regard, in particular, to:

- that person's academic and vocational qualifications;
- his education and training and
- his previous employment or work experience.

9.7.9 The contractor shall notify the responsible commissioner as soon as possible in the event that any Health Care Professional is:

- referred to the relevant professional body for alleged misconduct; or
- suspended or removed from the Relevant Register.

9.7.2 Non-registered clinical staff

9.7.2.1 If the Contractor intends to use categories of Clinical Staff who are not registered with a professional body, but who are directly involved in supporting the Services, the Contractor must ensure that these Clinical Staff have the necessary training, qualifications, experience, current competence and English language communication skills to undertake their roles:

9.7.3 Non-clinical staff

9.7.3.1 The Contractor shall ensure that all non-clinical staff have the necessary training, qualifications, experience, current competence and English language communication skills to undertake their roles.

9.8 Induction

9.8.1 The Contractor must implement a comprehensive induction programme for all staff that will support their workforce strategy and the delivery of services and which is completed before any staff work a first shift for the service.

9.8.2 The Contractor will ensure that every member of staff is trained and assessed as competent during induction to:

- Administer Basic Life Support (BLS); and
- Use Automated External Defibrillators (AED).

9.8.3 The contractor will ensure that staff induction processes are tailored according to the needs of the individual staff member, and will be more detailed for those who have not previously worked in the area with particular consideration for those who do not usually work in the UK. Consider including shadowing and mentoring.

9.9 Clinical staff supervision

9.9.1 The Contractor will ensure that appropriate arrangements are in place for the supervision of all clinical staff. For doctors, this will include the conduct of peer reviews of each other's performance on an annual basis, to assess their own work, discuss clinical outcomes and specific cases of clinical importance for the team. The Contractor must ensure that this process is conducted in line with good audit practice.

9.10 Continuing Professional Development

9.10.1 The Contractor must deliver the services in a learning environment. To this end, the Contractor must implement a continuing professional development (CPD) plan for all staff involved in delivering or supporting the delivery of the services, which will:

- promote a patient-centred approach, including the dignity of the patient, carers and relatives;
- ensure that all clinical staff involved in treating patients are appropriately skilled, trained and competent to carry out the roles required of them for the duration of the contract;
- ensure the safe, correct and up to date operation of all systems, processes, procedures and equipment;
- respond to individual training needs arising from staff performance appraisal and clinical supervision;
- respond to the individual professional development needs of staff;
- support workforce strategies
- meet the requirements of professional bodies for re-registration and revalidation.

9.10.2 Commissioners require an annual update on appraisal and personal development plans (PDP) to ensure they are fit for purpose and adhere to statutory requirements;

9.10.3 The contractor will ensure that all training requirements in the contract are applied to all staff delivering services to include;

- CPR certificate for Healthcare Professionals;
- Organisational site specific resuscitation training

9.10.4 The contractor will report and evidence their internal quality assurance processes for clinical standards, which should include telephone calls/triage, audit of clinical records and observed consultations. This report should include any action plans to address deficits and sharing of good practice. To be reported quarterly.

9.11 Training placements

9.11.1 Urgent primary medical care doctors and nurses will come from a variety of primary care, community and hospital backgrounds. The Contractor shall commit to develop a training infrastructure (taking into account the necessary obligations re: professional registration etc) to create and sustain the new type of workforce required, considering but not limited to:

- the potential for rotational/cross-organisational placements and training programmes;
- necessary involvement of senior General Practice and Emergency Medicine expertise at leadership level

9.11.2 Under the rules of the GP contract GP trainers are no longer required to work out of hours. However, the Postgraduate Deanery has a responsibility to ensure that GP specialty training provides the experience and assessment of generalist competencies including demonstrating an ability to perform competently in out of hours primary care prior to the award of the Certificate of Completion of Training (CCT).

9.11.3 The Contractor's service will support the training of GP registrars in the Out of Hours Period and be aligned to existing developments to urgent primary medical care training led by the Yorkshire Deanery.

9.12 Staff handbook

9.12.1 The Contractor shall make available to all staff at commencement of service, a staff handbook that will include details of its:

- Employment terms and conditions;
- HR policies; and
- Performance management policy.

9.12.2 The Contractor shall manage its staff based on principles of equal opportunity, anti-discriminatory practice, equity and fairness, communication and involvement and confidentiality.

9.13 Employment terms and conditions

9.13.1 The Contractor shall set its own pay rates, terms, and conditions for its staff.

9.13.2 The contractor will ensure that all clinical staff do not work excessive hours (cumulative) as many will have concurrent roles elsewhere, and that they have adequate breaks between shifts. The contractor will be expected to monitor hours worked and address any excessive hours to promote health and safety of staff and patients. Any concerns over staff working excessive hours must be shared with the commissioner immediately. This requirement must be specified in contracts with clinicians and reported to commissioners routinely within the Quality Assurance quarterly report.

9.14 Staff Performance

9.14.1 The Contractor shall ensure that the performance of all staff will promote the quality and safety of the services and the dignity and respect of patients. The Contractor shall have in place a performance management policy and a performance appraisal system that supports their proposed workforce strategy and patient-centred approach and complies with all applicable legislative and prescribed requirements. The Contractor shall ensure that their performance appraisal system is compatible with any requirements of the regulatory bodies for revalidation and re-registration.

9.14.2 The Contractor shall manage the conduct and performance issues of all staff and must ensure that all staff have regular performance appraisals. The Contractor shall be aware of the provisions for handling performance and conduct concerns of doctors in the NHS.

9.15 Workforce information

9.15.1 The Contractor shall have workforce management information systems which are capable of delivering any internal and external monitoring and workforce reporting requirements. The Contractor shall be required to provide timely and accurate workforce reports, which may include, for example, input into the annual NHS workforce census and the NHS vacancy surveys. The Contractors Staff may be required to participate in the annual NHS staff survey

9.15.2 The Contractor's workforce management information systems shall be capable of monitoring compliance with the Working Time Regulations.

9.16 Workforce transition plan

9.16.1 The Contractor will be responsible for any transition of the services and will have a transition plan in respect of the workforce requirements.

9.16.2 The Contractor will maintain an operational management plan in respect of the workforce requirements throughout the term of the Contract.

10 ICT

10.1 Standards and compliance (to be used in conjunction with Schedule 5)

The Contractor must ensure that appropriate “**ICT Systems**” are in place to support the services. “ICT Systems” means all computer hardware, software, networking, training, support and maintenance necessary to support and ensure effective delivery of the Services, management of patient care, contract management and of the treatment processes.

The Contractor’s response must state:

- Which Connecting for Health compliant systems are part of the Contractors proposal
- How the proposed systems (CfH compliant or not) comply with the CfH strategy (e.g. NHS care records strategy - summary and detailed record, Patient Demographic Service, ETP, NHS Mail) and the Yorkshire and Humber interoperability framework
- What the associated timescales are with this
- Whether changes are required to the CfH system/s to operate in the proposed Urgent Care environment
- Who the Contractors formal contacts with CfH/NPfiT
- How the supplier will integrate and share records with existing clinical systems in use within the West Yorkshire health community

10.2 Provision

The Contractor must supply such ICT systems and infrastructure as is necessary to support the delivery of urgent care services, contract management and business processes.

The Contractor must have in place appropriate, secure and well managed ICT Systems which properly support the efficient delivery of the Services and comply with specific requirements and the underpinning standards and technical specifications set out in this section.

Contractors must describe their overall ICT service proposal and approach to the provision of suitable ICT Systems, during the term of the Contract, including:

- A table showing details of all hardware to be used including manufacturer / supplier and software including version numbers and who will supply the systems (e.g. Contractor / 3rd party supplier to Contractor);

- An organisation chart of all required personnel responsible for project management and implementation;
- How they will work with the responsible commissioner as an infrastructure supplier, as a systems supplier and as a supplier of support services;
- How they will work with commercial systems suppliers;
- How they will ensure that where a mix of systems are to be used (e.g. Responsible commissioner-supplied clinical systems and infrastructure and commercially-supplied financial and reporting systems), suitable integration can be achieved;
- Where Contractors are either unable to or are choosing not to use the responsible commissioner preferred ICT systems, describe how they will manage their alternative ICT systems and integrate with the local health economy;
- Their approach to obtaining the necessary consents for the use of systems owned by other parties;
- What software licences they expect to be needed for the operation of the services and how they plan to ensure that such licences are available, especially where the software is provided through third parties; and
- How they would make provision for occasional inspection or audit of ICT systems by the responsible commissioner.

The Contractor's response must state: whether (and where) the proposed solution (or similar) is operating elsewhere within a) the NHS b) Healthcare.

The Contractor must provide Information on the infrastructure required to run the proposed system/s (e.g. network cabling, active network equipment, computer rooms, N3 connections, other wide area connections)

The contractor must state which components the Contractor (or sub contractor) intends to implement as part of their bid and which components the NHS is expected to provide.

The contractor must state how the Contractor-provided technologies will be supported, and whether technology refresh is included and, if so, what this covers.

The Contractor must state where any proposed systems are interim/tactical solution (i.e. not to be used for the duration of the contract) and if so, detail

- what long-term solutions are proposed

- What are the transition timescales
- How will transition take place e.g. data migration

Contractors must state technically and logistically, what is required to move from the current systems (supporting the group of patients covered by their proposal) to the new Contractor-provided systems, including:

- Is data migration proposed
- If so, how will this be managed

Contractors must describe the approach to purchasing, owning, maintaining and supporting the proposed Information System, response should include:

- It must be stated whether the system will be a hosted solution
- Will the system/s be on-site or remote
- How will fault calls, across the Contractors range of systems, be handled
- What operating hours will the support cover
- What processes will be put in place to support the interface between Contractor-provided and other NHS systems

In making their ICT selection the Contractor may choose the ICT Systems that it implements and uses, providing they support all requirements and adhere to the relevant standards described in the Contract.

The nature of this project means that some of the key ICT systems may be provided by and remain the property of the responsible commissioner, hence it will be necessary for the Contractor to ensure that they have agreed rights to use these ICT Systems. Similarly, other system supplier agreements may be required.

The Contractor should complete the table below to show the assumptions being by them thus far:

Description	Provided by
Hardware	
Hosted server solution	
Server supporting other clinical systems	
Local and wide area networking including N3 connection	
Hubs, switches	
Desktop - PCs, printers, scanners	
Telephony	
Software	

Compliant Clinical System	
Other clinical systems	
Virus protection	
Business applications for finance, HR/payroll, Document Management.	
Support and maintenance	
Helpdesk, desktop, email admin, network, N3	
Clinical system support	
Other clinical system support	
Any support not listed	
Training	
Clinical system training	
Other training, including desktop skills, not listed	

Proposals should be included for consulting and working with the responsible commissioner Chief Information Officers Department and Local Service Contractor (LSP), as required, to agree an implementation strategy and plan.

10.3 Testing

The Contractor must undertake testing of the ICT Systems proposed, including those supplied by the responsible commissioner, by the Contractor, by third party suppliers and also of any interfaces and inter-working arrangements between parties or systems, so as to guarantee compliance with all appropriate standards and to prove operational effectiveness.

Contractors must describe their approach to testing for standards compliance and operational effectiveness.

10.4 Patient information

10.4.1 Information governance and security

The Contractor must put in place appropriate governance and security for the ICT Systems to safeguard patient information.

The Contractor must ensure that the ICT Systems and processes comply with statutory obligations for the management and operation of ICT within the NHS, including, but not exclusively:

- Common law duty of confidence;
- Data Protection Act 1998;

- Access to Health Records Act 1990;
- Freedom of Information Act 2000;
- Computer Misuse Act 1990; and
- Health and Social Care Act 2001.

There is a statutory obligation to protect patient identifiable data against potential breach of confidence when sharing with other countries.

The Contractor must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- NHS Confidentiality Code of Practice;
- Registration under ISO/IEC 16799-2005 and ISO 27001-2005 or other appropriate information security standards;
- Use of the Caldicott principles and guidelines;
- Appointment of a Caldicott Guardian;
- Policies on security and confidentiality of patient information;
- Achievement of the data accreditation requirements of the ICT Directly Enhanced Service;
- Clinical governance in line with the NHS Information Governance Toolkit; and
- Risk and incident management system.

The Contractor is required to provide a high level assessment of their ability to meet the requirements of the Connecting For Health Information Governance toolkit, including:

- Indicate which type of toolkit they feel is appropriate to their service (e.g. commercial 3rd party complex, commercial 3rd party simple, Acute Contractor, General practice; and
- Indicate their ability to comply with the requirements therein.

The Contractor must describe how their ICT Systems will manage the security, confidentiality and quality of patient information and include in their response, use of the standards, good practice and statutory obligations listed above. Contractors must confirm that their ICT Systems do not require any patient identifiable data to be transferred outside the European Economic Area (EEA) and must list any countries outside England they plan to transfer patient identifiable data to.

10.4.2 Clinical information

To ensure the quality and safety of patient care, the ICT Systems must also support:

- Management of all clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports;
- Prescribing and where appropriate dispensing;
- Maintenance of individual electronic Patient health records;
- Inter-communication or integration between clinical and administrative systems for use of patient demographics;
- Access to knowledge bases for healthcare, such as Map of Medicine, at the point of patient contact;
- Access to research papers, reviews, guidelines and protocols; and
- Communication with Patients, including hard-to-reach groups identified within Section 5.2, to support provision of quality care, including printed materials, telephone, text messaging, website, and email.

Contractors are asked to demonstrate their processes for real-time data capture in an operational environment by providing a process flows mapped against interactions with the proposed Information Systems.

Contractors must demonstrate how the patient's routine Contractor will receive the complete patient record at the end of the care episode e.g. OOH messaging to GP systems.

Contractors must describe the perceived integration (to support real-time data flows) required between the Contractors (sub-contractors) system/s and other IT systems associated with adjoined parts of the patient pathway e.g. GP Practice systems, including

- how such integration will be achieved
- what are the related data flows
- which components/services the NHS is expected to provide to achieve this

10.5 Disaster recovery

No failure of CfH, NPfIT, the responsible commissioner or any other subcontractor supplying ICT services or infrastructure will relieve the Contractor of their responsibility for delivering Urgent care services. Therefore, the Contractor must

have an ICT Systems disaster recovery plan to ensure service continuity and prompt restoration of all ICT Systems in the event of major systems disruption or disaster.

- Contractors must describe their disaster recovery plans:

11. Contract Mobilisation

11.1 Operational Management Plan

11.1.1 The Contractor shall operate a suitable and appropriate Operational Management Plan (OMP) that:

11.1.2 Segments the overall OMP into the following sub-plans:

- Transition plan: this plan should detail the key tasks and milestones the Contractor will complete during the period up to and six months following the service commencement date in order to achieve service commencement and to deliver the services to achieve the Key Performance Indicators (KPIs) including a full risk assessment;
- Operational plan: this plan should detail the Contractors arrangements for business continuity in the event of an incident or emergency and the key tasks and milestones the Contractor will complete during the remainder of the Contract in order to deliver the services and to maintain the Key Performance Indicators; and
- Exit plan: this plan should detail the key tasks and milestones the Contractor will complete to transition the Services to an alternative provider.

11.1.3 Segments each sub-plan into work streams including:

- Clinical
- Workforce
- ICT
- Premises
- Facilities Management
- Equipment; and
- Other (as required by the Contractor)

11.1.4 Describes the key tasks and milestones and their completion dates within each work stream for each sub-plan and;

11.1.5 Identifies the human resources (e.g. number and skill mix) within the Contractor's organisation who will be responsible for implementing the OMP.

11.2 Capacity management

11.2.1 The Contractor will have sufficient and appropriate capacity to deliver the services in accordance with the requirements of the Contract.

11.3 Contingency planning

11.3.1 The contractor will actively contribute to national, regional and local Business Resilience planning.

11.3.2 The Contractor will have contingency plans in place for (but not limited to) the following circumstances (for each CCG):

- Peaks in demand such as Bank Holidays including Easter, Christmas and New Year (including any additional public/bank holidays that may be announced nationally);
- Provision of service over the transfer period, that is between the contract being awarded and the contract start date;
- Emergencies, whether due to a loss of staffing, adverse weather or major health incident including mass casualty incidents;
- Switching calls (and as a result treatment of patients) between urgent/primary care centres within the organisation or with other organisations appropriate to meet individuals' needs, and with prior agreement, in order to manage the workload
- ICT system failure

11.3.3 As a minimum the Contractor shall:

- Perform a business impact analysis and a risk assessment;
- Take steps to mitigate or eliminate risks such as ensuring mechanisms are in place to validate their contingency plans (and keep records of such tests);
- Create business continuity plans for high risks to ensure that the service will be maintained in the event of disruption to the Contractor's operations, and those of sub-contractors to the Contractor, however caused;
- Take an active role in relevant Command and Control structures
- Contribute to multi agency and health planning, training, exercises for potential emergency situations
- Exercise, debrief and review business continuity plans annually;
- Provide annual evidence of the above to the commissioners.

12. Business Continuity and Contingency Planning

The service contractor(s) shall be required to demonstrate that contingency plans are in place for the following circumstances:

- Peaks in demand
- Provision of service over the transfer period, that is between the contract being awarded and the contract start date
- Emergencies, for example due to a loss of staffing, major health incident, or malfunction of technical infrastructure, or unavailability of premises due to untoward events.

Contractors are asked to submit evidence of detailed contingency plans for all of the above scenarios.

As a minimum the contractor will;

- Perform a business impact analysis and a risk assessment.
- Take steps to mitigate or eliminate risks.
- Create business continuity plans for high risks to ensure that the service will be maintained in the event of disruption to the contractor's operations, and those of sub-contractors to the contractor, however caused.
- Exercise, debrief and review business continuity plans annually.
- Provide evidence of the above to the responsible commissioner annually

Contractors are asked to submit detailed proposals regarding how they will address all of the above requirements

13 Information Requirements

Quality and timely information across a range of data elements and indicators will be an essential part of the responsible commissioners ability to monitor the quality, performance and sustainability of the services it has commissioned. These data elements will include (as a minimum) those defined within the NHS A&E Commissioning DataSet (A&E CDS), currently used to collect urgent care data from NHS contractors in Emergency Department setting, minor injuries and walk-in centres, details found at the following links:

NHS CDS Manual XML Schema link:

CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS

(http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6/cds_v6_type_010_fr.asp?shownav=1)

Contractors are asked to demonstrate their capability to submit the A&E CDS Version 6 by submission to the NHS Secondary Uses Service (SUS) either directly or through an intermediary. Current minimum submission requirement is a monthly submission not later than 28 days following the end of the month in which the activity event took place. A future submission requirement may be the submission of an activity event not later than 5 working days following the end of the event, subject to changes in Department of Health requirements for submission to SUS.

Contractors are also asked to demonstrate their processes for providing additional information, to be agreed with the commissioner, but to include as a minimum:

- patient ethnicity, for health equality monitoring purposes
- the patients' rationale for attending the urgent care facility as opposed to any other healthcare setting
- patient experience
- complaints and incident reporting
- financial reports

The above list is not exhaustive and the process for agreeing additional reporting requirements (along with appropriate notice periods for the contractor) will be discussed at the next stage of dialogue and subsequently set out in the contract.

All data exchanged additionally must adhere to the NHS Data Model & Dictionary for format and structured codes where that element is defined in the NHS Data Dictionary.

NHS Data Model & Dictionary link:

<http://www.datadictionary.nhs.uk/index.asp>

Contractors should note that all data and information generated from these services remain the intellectual property of the responsible commissioner.

Contractor(s) will also be expected to meet information governance statutory requirements, including the stipulations set out in the Data Protection Act 1998 and the Freedom of Information Act 2000.

Contractors must describe how they will meet the above requirements to deliver accurate and timely information, including:

- how the above information (as a minimum) will be provided in a flexible manner for analysis e.g. as data, as reports or via a management information portal
- Will the Commissioner be able to interrogate performance data in an ad-hoc manner. If so, how
- Is a management reporting system or information analysis tools part of the proposal. If so, what is proposed.
- The Contractor must meet any current and future Data Set Change Notice (DSCN) applicable to Urgent Care. The approach to building these (and releasing) in to future versions of the software must be stated.
- If the proposed information system needs enhancing to produce the above dataset, how will this be developed.
- how they will monitor the quality of the data collected.

Contractors must warrant compliance with the Data Protection Act 1998 and the Freedom of Information Act 2000

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Glossary

Warm transfer	Transferring of a telephone call from one individual to another (eg call handling adviser to clinician) while the caller is still on the line. The transferrer and receiver of the call acknowledge and record the transfer of the caller prior to the transferrer backing out of the call.
Seldom heard	Those patients who are hard to reach or who would never make contact or who would have difficulty making contact/
West Yorkshire Urgent Care	Services within Leeds. Bradford and Airedale, Wakefield. Kirklees. Calderdale and Craven
The Contractor	The provider to who is contracted to provide OOH service
Primary Medical Care Centre	Location from where face-to-face appointments are provided within each area

Abbreviations

WYUC	West Yorkshire Urgent Care
CQC	Care Quality Commission
QIPP	Quality Innovation Productivity and Prevention
KPI	Key Performance Indicator
ICT	Information Communications and technology Management
CMS	Capacity Management Systems
DoS	Directory of Services
AC	Accountable Office
CD's	Controlled drugs
Y&H NHS 111 CRG	Yorkshire and Humber 111 Clinical Review Group
PMB	Project Management Board
QA	Quality Assurance
CG Review Groups	Clinical Governance Review Groups
SI's	Serious Incidents
CAS	Central Alert System
SAB's	Safety Alert Bulletins
RCA	Root Cause Analysis
HCP	Health Care Professional
OOH	Out of Hours
PALs	Patient Advocacy Liaison services
RAG rated	Red Amber Green rated
OMP	Operational Management Plan
CCG	Clinical Commissioning Group
VTS	Vocational Training Schemes

References

Colin – Thomé, D; Field S, (2010) General practice out-of-hours services; Project to consider and assess current arrangements. London.

Care Quality Commission (2010) Investigation into the out of hours services provided by Take Care Now. London

Department of Health (2006) Direction of Travel for Urgent primary medical care – Discussion Document. London

<http://www.rpsgb.org.uk/pdfs/safsechandmeds.pdf>

Appendices

5 locally specific appendices have been attached which include detail regarding:

- Any specific additional services required (eg PLT, Prisons and etc)
- Location information
- Any local detail not already covered

Schedule 2 Part 1: Service Specification Calderdale

Service/ care pathway	Calderdale Out of Hours Treatment Service
Commissioner Lead	Lucy Beeley, Gill Jones (for Safe Haven), Julie Wan-Sai-Cheong (for PLT) Dr Majid Azeb
Provider Lead	
Period	1 st April 2013
Date of Review	

Key Service Outcomes

This specification relates to the Calderdale locality and is a 'sub set of the 111 and the core WYUC treatment service specification.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this sub set document which is specific to CALDERDALE

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Calderdale locality which are in addition to those detailed in the core specification. The additional services required in Calderdale are as follows:

- Safe Haven service (appendix 1)
- Protected Learning time (appendix 2)

1.2 National/ local context and evidence base

Calderdale consists of the towns of Halifax, Elland, Brighouse, Sowerby Bridge, Hebden

Bridge and Todmorden as well as a number of villages.

It is one of the smallest metropolitan districts in terms of population, but at 140 square miles, one of the largest in terms of area. Despite being a metropolitan district, Calderdale has very distinct rural elements; most of the area is classified as rural and while definitions vary, up to a quarter of its population lives in rural areas. It faces many issues related to rurality and dispersed populations and the mix of service needs and access issues are distinctly different from a more urban area.

The Office for National Statistics groups together geographic areas according to key characteristics common to the population in that grouping. These groupings are called clusters, and are derived using census data.

The classification is used by government departments and academics for analysis and comparison, and can also be used by members of the public and school pupils for finding out about where they live and how it compares with the rest of the country.

The ONS classifies Calderdale within the centres with industry category.

Calderdale is served by 28 GP practices at variety of locations across the locality and one acute Trust (Calderdale and Huddersfield Foundation trust).

2. Service Scope

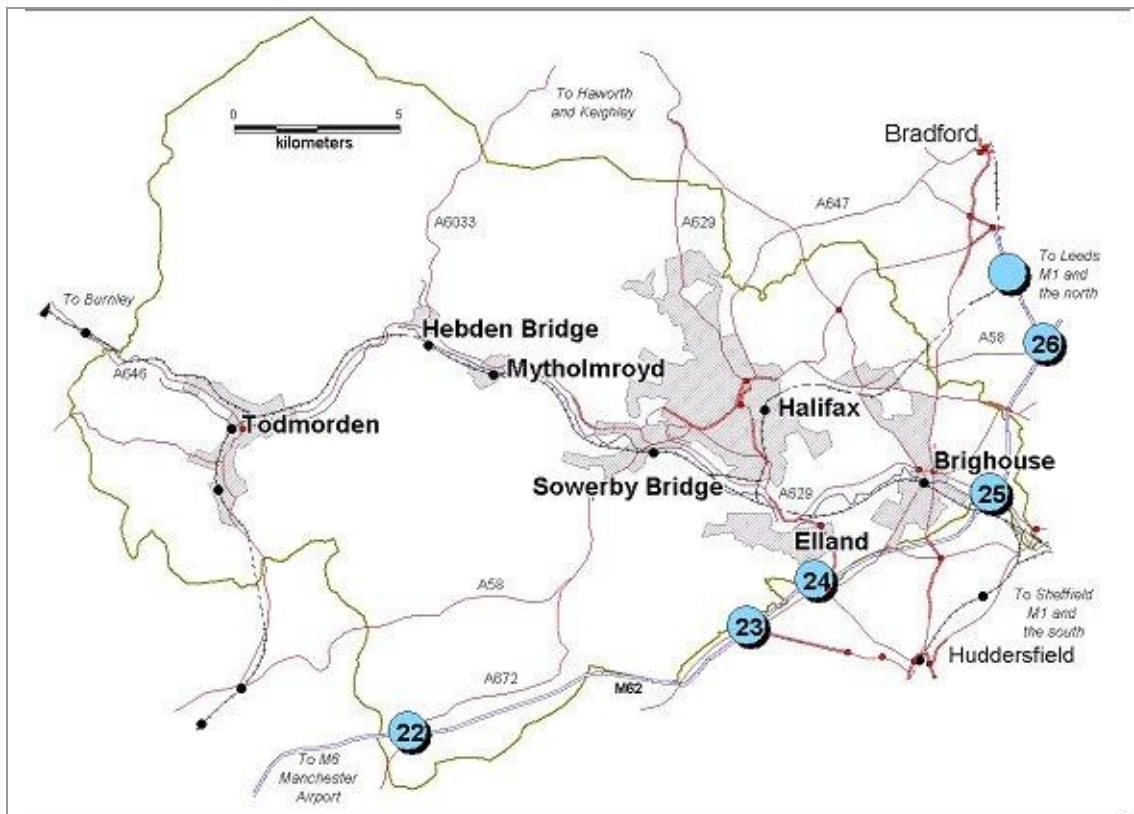
2.1 Service Description

Refer to core Specification

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries



Any patient registered at a general practice within the Calderdale locality as determined in map 1

Any out of area patients directed through the 111 service, such as temporary residents

2.4 Whole System Relationships

Refer to core specification

2.4.1 Calderdale Whole System Transformation

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the 'Transformational agenda supporting delivery of a shared vision developed by the commissioning body the Calderdale Clinical Commissioning Group and relevant stakeholders. The Contractor will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within Calderdale. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will be part of groups working to develop and then implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view of avoiding unnecessary admissions

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS Directory of Service, available electronically through a web-based computer system.

The Contractor will adhere to Calderdale locally agreed care pathways accepting and making appropriate referrals through agreed protocols. Examples include:

Emergency Care Plans for palliative patients
Integrated intermediate tier service

The Contractor will deliver a streaming service for patients from the Calderdale Royal Hospital A&E department where appropriate in accordance with the Manchester Pathway. The contractor will work with the acute trust to develop this service to ensure it is meeting patients and commissioners needs.

3.4 Location(s) of service delivery

The Contractor will deliver services from one (1) out of hours primary care centre co-located with or near to the A&E department at Calderdale Royal Hospital.

The provider is required to negotiate and fund suitable premises with Calderdale and Huddersfield Foundation Trust to deliver this service from.

The provider will be required to provide business continuity plans that detail arrangements for delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation

Monday to Friday 18.30 hours to 08.00 hours

Saturday and Sunday 08.00 to 08.00 Monday

Bank Holidays 08.00 to 08.00 next working day

3.4 Referral Criteria and sources

Patients will be referred to this service from the NHS 111 service. Patients may also access the service via the A&E streaming service at CRH. For full details of the service model and referral processes refer to Core Specification

3.5 Referral processes

Full detail of the referral processes including ICT interfaces can be found in the core specification

3.6 Discharge processes

Patients will be discharged from the service once they have completed their episode of care. The service is required to ensure that discharge communication is sent to the patients registered GP. Full details of the discharge process can be found in the core specification.

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
Please refer to core specification				

6. Activity

6.1 Indicative Activity Plan

Projected Annual Activity (estimated)

Home Visits	4507.8
A&E streamed patients	3067.9
Primary Care Centre (PCC)	8505.2
Safe Haven	234.3

NB it should be noted any activity seen occurring during the protected learning times is included in the home visits and PCC above

Please note that the current service model does not include provision of telephone consultations, these are included in the service model being procured

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating COMMISSIO NER Total	Associate COMMISSIO NER Total	Associate COMMISSIO NER Total	Associate COMMISSIO NER Total	Total Annual Expected Cost
£	£	£	£	£	£

A – Safe Haven Service Specification - Calderdale

Service/ care pathway	Calderdale Safe Haven Service
Commissioner Lead	Gill Jones
Provider Lead	
Period	1 st April 2013
Date of Review	

1. Purpose

1.1 Aims and objectives

The purpose of the Safe Haven Scheme is to provide a stable environment for the patient to receive continuing healthcare, addressing any underlying causes of aggressive behaviour and providing a safe environment for the individuals involved in providing that treatment. The ultimate aim of the scheme is to rehabilitate the patient back into mainstream general practice.

1.2 National/ local context and evidence base

A GP practice has a right, confirmed in the National Health Scheme (GMS Contracts) Regulations 2004 to remove from its list with immediate effect any patient who has committed an act of violence at the practice, where the contractor(s), any member of the contractors staff, other patients or any other bystanders present when the act is committed might have reasonable fears for their safety. Violence includes actual or threatened physical violence or verbal abuse leading to fears for a person's safety. As referred to in the The National Health Service Act 1977: The Improved Access, Quality Information Preparation and Violent Patients Schemes (England) Directions 2003

The Commissioner has a responsibility to ensure that these patients have appropriate access to limited General Medical Schemes to receive medical care and treatment.

2. Service Scope

2.1 Service Description

Referral into the scheme

Referrals into the scheme will be made directly by GP practices where the patient has been removed with immediate effect for reasons of violence and where the incident has been reported to the police. The referral process, which will be managed by West Yorkshire Central Schemes Agency (WYCSA), is shown in the flowchart attached at Annex A. Other referrals may also be made through the Safe Haven contact. WYCSA will not accept referrals from any route other than these.

Registration of patient

On receipt of the referral, if the referral meets the criteria WYCSA will notify the patient that they have been registered with Safe Haven, and invite the patient to contact Safe Haven to arrange a new patient check.

Risk assessment

The Patient will be risk assessed in their initial appointment with the Safe Haven GP unless the nature of the incident warrants a risk assessment by telephone with the referring GP Practice – the Scheme provider will use this information to inform the new patient check and appropriate security measures made for the initial appointment.

Patient contact and care

When the patient has been registered, Safe Haven will develop and administer a patient code of conduct, which will set out information on how the patient should access Schemes, and its expectations of the patient. The code will be personalised for each patient.

The scheme will provide all essential and additional services as determined within the new GMS contract to the patient. The provider will work jointly with other services as required to ensure that the patient's needs are addressed.

Review

The provision of care to patients registered with the Scheme should be subject to six-monthly reviews. This would be initiated by the provider and if it is felt that the patient is no longer a threat then he/she will be re-allocated to a mainstream general practice under the normal allocation regulations. In exceptional circumstances, and if the Provider feels it is appropriate then a patient's position may be reviewed prior to the 6 month period.

Scheme. Reviews will be supplemented by a more wide-ranging annual review where the Commissioner might seek more substantive justification for a continuance in the Scheme – for example, that the patient could not learn new behaviour because of an underlying personality disorder.

Return to mainstream General Practice

When the Scheme GP has undertaken the formal assessment and determines that the patient is suitable to return to mainstream General Practice, the patient will be allocated by WYCSA to a local practice. If a practice is made aware of a patient in Safe Haven (for example, if representation is made to the practice by the Safe Haven patient's family) and feels that it cannot manage that patient within its service, it should discuss this with the Commissioner Safe Haven contact

2.2 Any exclusion criteria

Any patients not referred by their registered GP within Calderdale: all patients must be referred via their registered GP practice.

2.3 Geographic coverage/ boundaries

As per Calderdale Commissioner boundaries, map on page 53 of this document

Any patient removed from mainstream primary care at a general practice within the Calderdale locality as determined in map 1

2.4 Whole System Relationships

The provider will liaise closely with the local out of hours and secondary care provider to ensure a healthcare provision out of normal surgery hours or in a secondary care setting as appropriate.

2.4.1 Whole System Transformation

Refer to Core Specification

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will

be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

To support the provision of care and treatment to patients registered with the scheme it is expected that the provider will provide resources and services as below:

Staffing:

- The General Practitioners providing the scheme will be practising principals on a local Commissioner's performers list.
- The provider will utilise nursing support as required.
- The provider will provide each patient within the scheme a named contact who will arrange appointments, etc, as appropriate.
- The provider is responsible for ensuring a police presence when patients are being seen by the scheme
- The provider is responsible for the health and safety of its staff and for ensuring all staff is trained in dealing with violent and aggressive behaviour.
- The provider will ensure adequate cover for staff involved in delivering the service provided within the Safe Haven Scheme in the event of annual leave and staff sickness.

Administrative support

- The provider will resource appropriate administrative and reception support.
- The provider will provide a dedicated call handling system for patients to directly access the scheme with a dedicated contact phone number for in hours use.
- The provider will develop and administer a patient code of conduct which will include expectations, patient pathways and contact numbers. This will be shared with the providers of other services, e.g. A & E as appropriate.

ICT:

- The provider will maintain electronic records for the patients registered within the scheme to a nationally outlined standard.
- The provider will work with the Commissioner ICT department to ensure compliance with Connecting for Health recommendations.
- The scheme will operate as 'paperlight' service.

Prescribing:

- The provider will supply a prescribing service to patients in line with the contractual obligations of nGMS.
- The provider will have systems in place for repeat prescribing with consideration given to the issues of patient contact and appropriateness of the involvement of local pharmacies.
- The provider will be compliant with NICE guidance.
- The provider will follow Commissioner Patient Group Directives, as appropriate.

Out of hours:

- The provider will liaise closely with the local out of hours service provider to ensure a

healthcare provision out of normal surgery hours as appropriate.

- The provider will have clear patient pathways for patients out of hours and these will be agreed with the out of hours service provider.

Confidentiality:

- The provider will be mindful of the need to protect patient confidentiality whilst encouraging the sharing of information between health and social services agencies, prison, police and other relevant bodies to build up a picture of past behaviour so that risk can be assessed and patients can be given the most appropriate level of care.

Service provision plan

The provider will be expected to submit a Service provision plan covering all the areas set out in this specification before the scheme becomes operational.

Ongoing monitoring and evaluation

The provider will be expected to work within the Performance Framework at Annex B, which sets out clinical and organisational priorities. This will provide the basis for the monitoring of the Scheme against the service level agreement.

The provider will initially be expected to attend a three-monthly review meeting with the Commissioner. The provider will be expected to report on its achievement of the indicators, and any relevant issues, providing this information to the Commissioner at least two weeks before each meeting. The frequency of the meetings will be reviewed after six months.

In addition to this, the provider will supply an agreed set of activity data to the Commissioner for each month, this information to be received within two weeks of the end of the month to which it refers.

3.2 Care pathways

The Safe Haven service will have access to all clinically appropriate secondary care pathways. The service will have the responsibility of ensuring that any referrals make clear any special requirements that may be need to support the patient in accessing this care.

3.4 Location(s) of service delivery

- The provider will source appropriate and fit for purpose premises within the boundaries of Calderdale Commissioner for the delivery of clinical appointments. These premises will be pre-agreed by the Commissioner and costs covered within the activity based allocation.
- The provider will ensure and document the agreement to the violent patient scheme operating from the premises of any other contractor who co reside within the same premises. Previous risk assessments determine that this service would not be operating from premises that house and existing GP Practice.
- The provider will have systems in place for patients to be seen at an alternative premise if deemed not appropriate for the patient to present at the pre agreed premises for example a local police station.
- The provider will establish links and formal agreements with the police and any costs linked to the police supporting the scheme will need to be met from the block fee for the contract.
- The provider will have suitable procedures and safeguards in place to ensure the safety of all staff and patients at all times.
- In exceptional circumstances the provider will make home visits only when deemed clinically appropriate ensuring the safety of provider staff and ensuring the clinician is accompanied by persons deemed appropriate following a risk assessment.
- The provider will be required to provide business continuity plans that detail arrangements for delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation

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The contractor shall provide 2 treatment sessions of 1 hour per week and 1 administrative session of 1 hour per week. Days of the week to be agreed with commissioner following appointment of provider.

The provider shall also ensure that

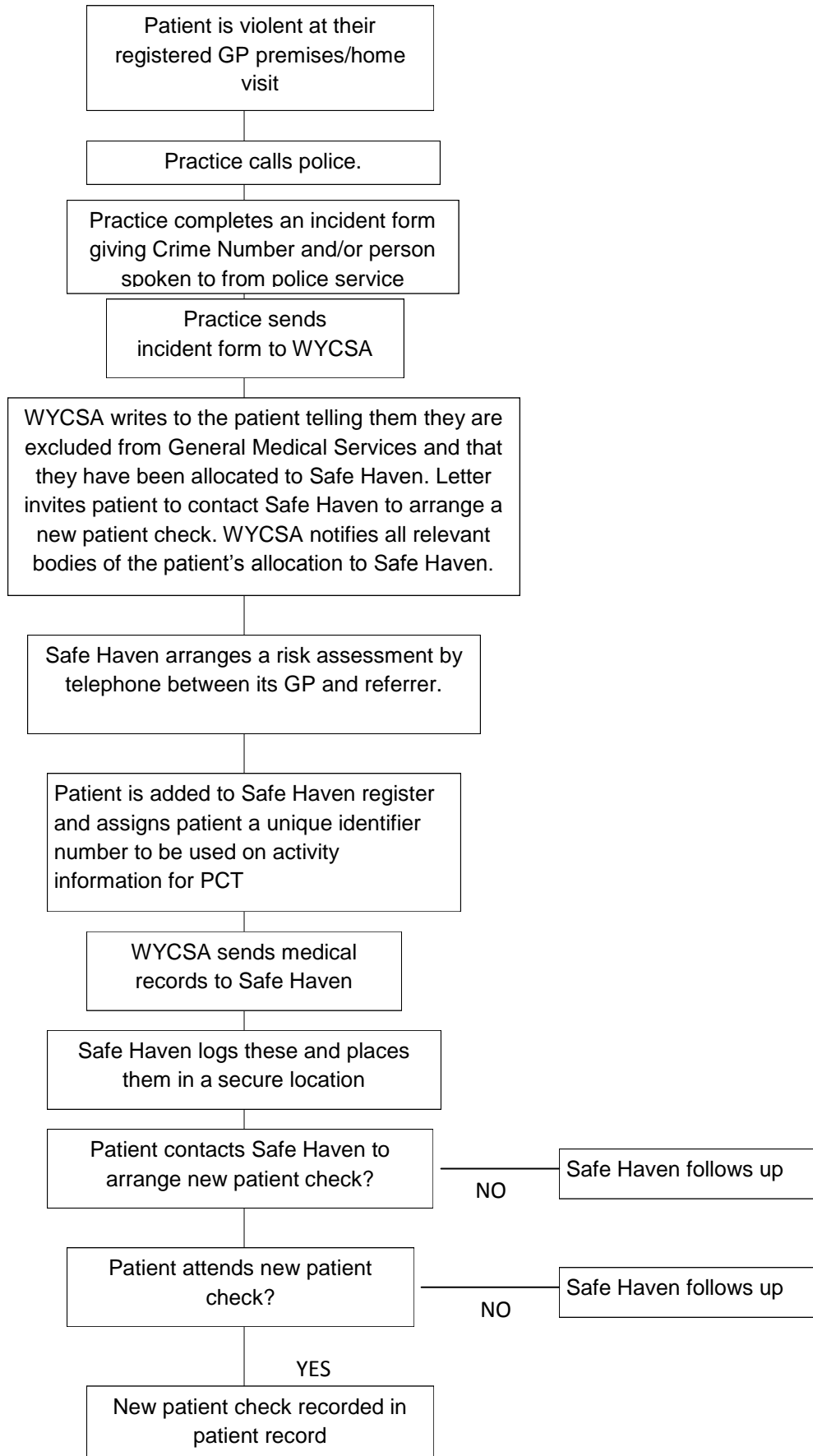
- that appointment lengths are tailored to the clinical needs of Safe Haven Patients, which shall be for no less than ten (10) minutes for GP consultations and not less than fifteen (15) minutes for nurse consultations;
- in respect of Bookable Appointments for Safe Haven Patients to see a GP at the Practice Premises, consultation is commenced within thirty (30) minutes of the scheduled appointment time unless there are exceptional circumstances;
- treatment for Safe Haven Patients suffering from immediate and life threatening conditions (as determined by a clinically trained individual at the Contractor acting reasonably) is commenced within five (5) minutes of entry to the Practice Premises;
- a full range of consultation methods are offered and utilised according to clinical need including but not limited to telephone, e-mail, and face to face consultation at the Practice Premises; and
- Safe Haven Patients who do not attend booked appointments (“DNAs”) are minimised for booked appointments at the Practice Premises.

3.4 Referral Criteria and sources

- General practices can refer patients to this service who are deemed unsuitable for mainstream primary care due to violence /aggression concerns.

3.5 Referral processes

PROCESS FOR REFERRAL TO SAFE HAVEN



3.6 Discharge processes

Return to mainstream General Practice

When the Scheme GP has undertaken the formal assessment and determines that the patient is suitable to return to mainstream General Practice, the patient will be allocated by WYCSA to a local practice. If a practice is made aware of a patient in Safe Haven (for example, if representation is made to the practice by the Safe Haven patient's family) and feels that it cannot manage that patient within its service, it should discuss this with the Commissioner Safe Haven contact

3.7 Response times and prioritisation

All Patients registered within the Safe Haven Scheme should be able to access appointments with a clinician within 48 hours.

4. Other

5. Performance Framework

	Measure	Requirement	Evidence of Measurement	Safe Haven Scheme Compliance
1	All Patients registered within the Safe Haven Scheme are able to access appointments with a clinician within 48 hours.	100%	Self Assessment	Compliance will be measured against patient complaints/complaints in relation to access to the Scheme and GP appointment availability
2.	Cancer Referrals – two week urgent referrals	100% to be faxed within 24 hours.	Commissioner/ Secondary Care data Self Assessment	Full compliance in line with national requirements.
4.	Vaccine uptake: Influenza >65s Pneumococcal (>65s)	>70% uptake > 70% uptake	Commissioner Data Self Assessment	Full compliance in line with national immunisation targets.
5.	Cervical Screening	> 80% target.	Commissioner/ WYCSA data	Full compliance in line with national cytology targets.
6.	Breast screening	>70% target	Commissioner/ WYCSA data	Full compliance in line with national breast screening targets.

7.	Clinical Patient Six Monthly Review	100% recalled to attend six monthly review. > 90% attendance at six monthly review	Self Assessment	
8.	Mental Health – Depression Screening	100% of patients to be screened for depression using a tool validated for use in primary care	Self Assessment	
9.	Anger/Behaviour Management	100% of patients to be offered anger management discussion or referral for appropriate treatment	Self Assessment	
10.	Quality Care Commission Standards - Achieve full compliance against standards and the annual declaration to be made by the contract provider)	At least 80% of standards met with acceptable evidence in year 1	Commissioner assessment of evidence	Full compliance in line with the requirements of Calderdale Commissioner
11.	Infection Control (Annual infection control audit to be undertaken)	Audit and any required action plans to be reported to and reviewed by the Commissioner annually.	Commissioner or other audit Self Assessment	Full compliance in line with the requirements of Calderdale Commissioner
12.	Complaints received / quarterly summary to include; Number of new complaints received Number of complaints ongoing Number of complaints where detailed formal response was provided within 25 working days	A detailed formal response to be provided to 100% of complaints within 25 working days.	Contractor report/Self Assessment	
13.	Complaints and	100%	Report	

	incidents to be shared 6 monthly with Commissioner, with learning points identified			
14	Number of patients referred back into mainstream GMS following GP Assessment:	10% annually	Contractor Information/W YCSA	Safe Haven Scheme Compliance

6. Activity

6.1 Indicative Activity Plan

Included in main section above. Please see page 5.

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other) *				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Total Annual Expected Cost
£	£	£	£	£	£

B Protected Learning Time Specification - Calderdale

Service/ care pathway	Calderdale Urgent Care Access & Treatment Telephone Triage for Practice Protected Time Calderdale Clinical Commissioning Groups
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

Key Service Outcomes

As per main specification

1. Purpose

To provide planned cover for telephone assessment for patients warm transferred from the NHS 111 service, appropriate advice and / or treatment for registered patients of Calderdale during General Practices protected learning time.

2. Service Scope

Urgent GP cover for practices undertaking protected learning time. The contractor will receive telephone calls appropriate for continuation of consultation via the NHS111 service from patients who would normally access their general practice.

The contractor will continue the consultation for these patients and provide advice and / or face to face treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

3. Service Delivery

Urgent GP cover for practices undertaking protected learning time. The contractor will receive redirected telephone calls from patients who would normally access their general practice.

The contractor will triage and assess these patients, provide advice and refer for urgent treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

The telephone lines will be redirected back by the practices as agreed at the conclusion of the protected learning time.

4. Other

Frequency:

Practices are given the option of either using a Wednesday or Thursday afternoon,, each month, the dates are provided by NHSC. Only these dates can be used for PLT. Time of cover: commences at 12.30 finishing at 18.30 when the phones forward calls to the out of hours provider.

Practices Covered:

All Calderdale Commissioning Group practices.

Key performance Indicators:

As indicated within the main body of the specification.

Performance and activity information will be provided to the commissioner on a quarterly basis.

The above arrangements will be reviewed on a yearly basis or more frequently if the above indicators are not being met.

5. Quality Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach

Please refer to core specification

6. Activity

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Appendix 2

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Schedule 2 Part 1: Service Specification Airedale, Wharfedale and Craven

Service/ care pathway	Airedale, Wharfedale and Craven Out of Hours Primary Medical Care 'Consultation and Treatment' Service
Commissioner Lead	Lynne Hollingsworth Dr Colin Renwick
Provider Lead	
Period	1 st April 2013
Date of Review	

Key Service Outcomes

This specification relates to the Airedale, Wharfedale and Craven (AW&C) locality and is an appendix to the Yorkshire and Humber 111 Access and Assessment service specification and the core primary medical care 'consultation and treatment' service specification for West Yorkshire.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this appendix which is specific to AW&C

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Airedale, Wharfedale and Craven locality which are in addition to those detailed in the core specification

1.2 National/ local context and evidence base

Refer to core specification

2. Service Scope

2.1 Service Description

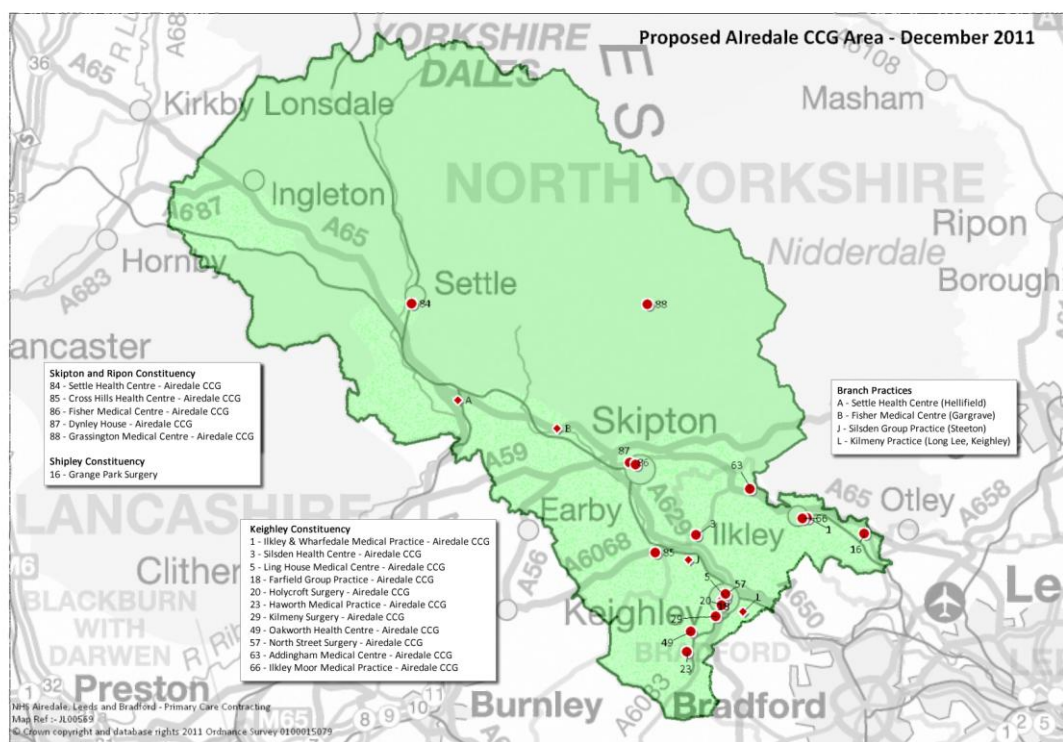
Refer to core Specification

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

Map 1



The Contractor will provide the service to any patient registered at a general practice within the Airedale, Wharfedale and Craven locality as determined in map 1

In addition the Contractor will provide the service to any out of area patients directed through the 111 service or who self present, such as temporary residents and those who may reside within the locality but be registered elsewhere.

2.4 Whole System Relationships

Refer to core specification

2.4.1 Airedale, Wharfedale and Craven Whole System Transformation

Key organisations within the local health and social care economy have developed and

signed up to a shared vision of integrated health and social care:

The right help at the right time: A shared vision and commitment to the integration of health and social care in Bradford, Airedale and Craven

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will be a member of and will actively and positively contribute to the Airedale, Wharfedale and Craven 'Transformation and Integration Group' supporting delivery of the shared vision and that of the commission body the 'Airedale, Wharfedale and Craven Clinical Commissioning Group'. The Contractor will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrate models of care, specifically within Airedale, Wharfedale and Craven. The Contractor will contribute to the development of integrated care pathways with other parts of the local system including A&E and ambulance services to ensure delivery of an integrated, efficient service

Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

Development of local pathways to support admission avoidance may include links to ANHSFT telemedicine hub. The Contractor will implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice thereby avoiding unnecessary admissions

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is understood and embedded by all staff throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

The Airedale Collaborative Care Team (ACCT) is a crucial service which supports admission avoidance. As an integrated interdisciplinary team, ACCT has access to community step up and step down beds and provide a 'virtual ward' service to patients in their own homes. The Contractor will develop key relationships with the ACCT team and will refer on any patients deemed appropriate for ACCT services

2.6 Relevant networks and screening programmes

Refer to core Specification

2.7 Training/ education/ research activities

Refer to core specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the AW&C data repository.

The Contractor will adhere to AW&C locally agreed care pathways accepting and making appropriate referrals through agreed protocols. Examples include:

- Community IV antibiotic 'Cellulitis' pathway
- Community DVT pathway
- Emergency Care Plans
- Care home clinical assessment service
- Assess to Admit (Paediatrics, Elderly, Medicine)

The contractor will develop key relationship with A&E and accept patient streaming via the Manchester pathway

3.4 Location(s) of service delivery

The Contractor will deliver services from two (2) out of hours primary care centres located within the AW&C boundary:

One will be co-located with or near to the A&E department at Airedale General Hospital

One will be located in or near to Skipton General Hospital

The Contractor will be responsible for making suitable arrangements regarding premises solutions in agreement with the Commissioner and key stakeholder Airedale NHSFT who are responsible for the two general hospital sites, or to propose alternative arrangements to the commissioners should this not be possible.

As required within the core specification the contractor is required to make business continuity plans and contingency arrangements to ensure delivery of the service from within the locality in the event of a disaster or any significant event.

3.3 Days/ hours of operation

Monday to Friday 18.30 hours to 08.00 hours

Saturday and Sunday 08.00 Saturday to 08.00 Monday

Bank Holidays and any additional Public/Bank Holidays that may be announced nationally 08.00 to 08.00 next working day

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specifications

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practice are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the patient care plans with a view of avoiding unnecessary admissions. For example by referring to ACCT for rapid and intensive intervention at home

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

Please refer to core specification

6. Activity

6.1 Indicative Activity Plan

Estimated full year effect based on actual data for Airedale and Wharfedale and full year projection for Craven based on three months actual data

Home Visits	2,611
Primary Medical Care Centre Face to Face attendances	9,033

Please note that the current service model does not include provision of telephone consultations, these are included in the service model being procured

Annual growth in demand of 1.3% based on national estimates should be factored in to forecast plans

6.2 Capacity Review

Please refer to core specification

Schedule 2 Part 1: Service Specification Wakefield and District

Service/ care pathway	Wakefield District Out of Hours 'Consultation and Treatment' Service
Commissioner Lead	Richard Sewell/Michelle Ashbridge Dr Adam Sheppard
Provider Lead	
Period	1 April 2013
Date of Review	

Key Service Outcomes

This specification relates to the Wakefield District locality and is a 'sub set of the 111 and the core WYUC treatment service specification.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this sub set document which is specific to WAKEFIELD DISTRICT

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Wakefield District locality which are in addition to those detailed in the core specification. The additional services required in Wakefield District are as follows:

- Prison Services (A – page 91)
- Protected Learning Time (B – page 96)

1.2 National/ local context and evidence base

As the former county town of West Riding, Wakefield is one of five metropolitan districts in West Yorkshire and covers some 350 square kilometres, with a resident population of 325,000. With over two thirds of the area being open countryside, it has a vibrant mix of

urban and rural communities. Apart from Wakefield City, the district includes the five major towns of Castleford, Knottingley, Featherstone, Normanton and Pontefract, as well as the towns of Hemsworth, South Elmsall and South Kirkby to the South East.

There are two significant issues for the PCT in addressing the challenge of reducing health inequalities. The Wakefield district compared to others in England has consistently poorer health outcomes than even its statistical peer group. In addition, inequalities in health across the communities within the district mean a large number of people will suffer health problems that will affect their quality of life and prospects.

The Joint Strategic Needs Assessment (JSNA) 2008/11, Health Equity Audit and Health and Lifestyle Survey confirm that 31% of the district is in the most deprived quintile in England and that 61% of the district is in the bottom two quintiles in terms of deprivation. The population demographics project that the population will increase by a further 15,000 people by 2017. Overall, health in the Wakefield district is generally worse than England as a whole, with early deaths from heart disease, stroke and cancer being particular concerns. There are also high rates compared to the England average for smoking in pregnancy, teenage pregnancy, children classified as obese and children's tooth decay. Harmful or hazardous alcohol intake is also a growing problem as is obesity and low breast feeding initiation rates.

Wakefield District is served by 40 GP practices and one acute Trust (Mid Yorkshire Hospitals NHS Trust).

2. Service Scope

2.1 Service Description

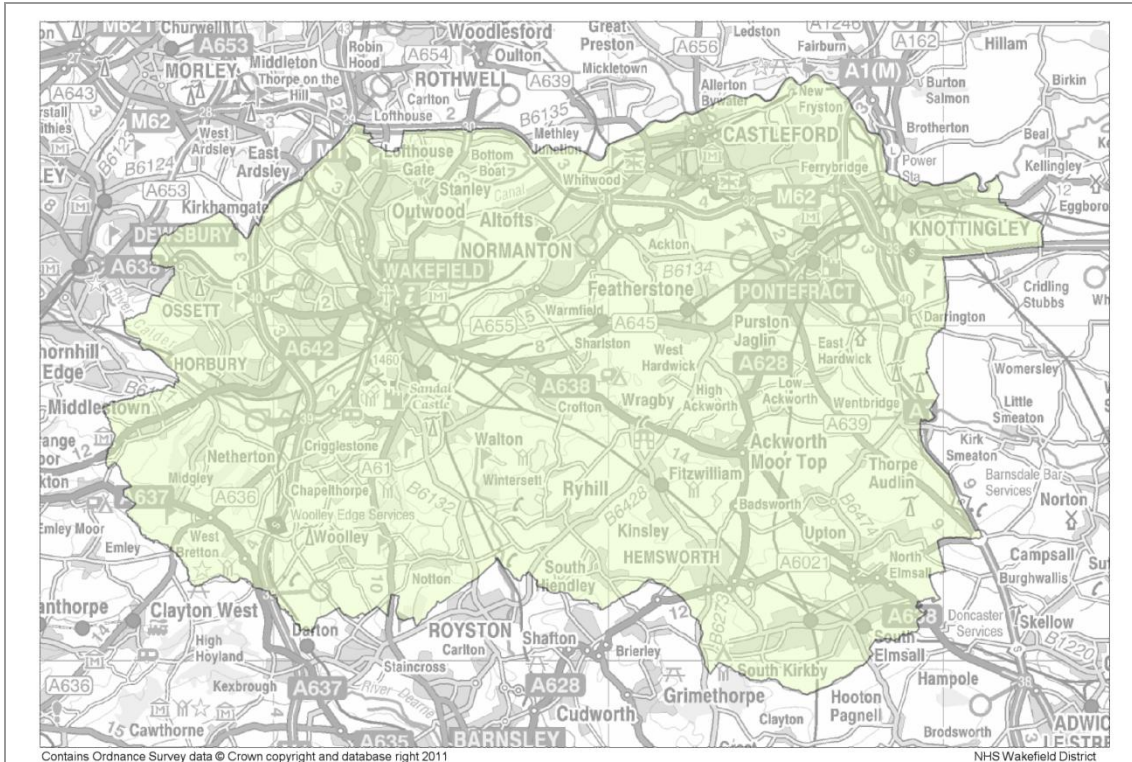
Refer to Core Specification

2.2 Any exclusion criteria

Refer to Core Specification

2.3 Geographic coverage/ boundaries

Map 1



Any patient registered at a general practice within the Wakefield District locality as determined in map 1

Any out of area patients directed through the 111 service, such as temporary residents

2.4 Whole System Relationships

Refer to Core Specification

2.4.1 Wakefield District Whole System Transformation

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the 'Transformational agenda supporting delivery of a shared vision developed by the two commissioning bodies within Wakefield District: the Wakefield Alliance and the South Wakefield Community Partnership and relevant stakeholders. The Contractor will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within Wakefield District. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will be part of groups working to develop and then implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view of avoiding unnecessary admissions

As part of the Mid Yorkshire Hospitals NHS Trust 5 Year Clinical Service Strategy a number of clinical configuration options have been identified. Each of these options proposes that a minor illness and minor injury service would be introduced at Pontefract Hospital, replacing the Emergency Department and providing services for 80% of the people who currently use it. Commissioners would expect that the successful Contractor, as a key member of the local urgent care system, would actively contribute to the development of whatever emergency/urgent care services are approved for the Pontefract Hospital site.

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

The key drivers for the Commissioner and clinical commissioners are the reduction of inappropriate attendances at the local Emergency Departments and the reduction of unnecessary admission of patients at the local NHS acute Trust.

The Contractor shall have systems and processes in place to manage and reduce the demand for these services and shall work in partnership with the future local commissioning bodies to do this. These systems and processes should not only improve patient convenience but will also optimise the use of local healthcare resources.

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS DoS (Capacity Management System Directory of Services).

The Contractor will adhere to NHSWD locally agreed care pathways accepting and making appropriate referrals through agreed protocols. Examples include:

Community IV antibiotic pathway
Community Sub-cut fluid pathway

Community Geriatrician clinical assessment service

The Contractor will deliver a streaming service for patients from the Mid Yorkshire Hospitals NHS Trusts, Pontefract General Infirmary Emergency Department where appropriate in accordance with the Manchester Pathway. The Contractor will work with the acute trust to develop this service to ensure it is meeting patients and commissioners needs.

3.4 Location(s) of service delivery

The Contractor will deliver services from two (2) out of hours primary care centres located within the Wakefield District boundary.

The anticipated locations for the primary care centres are shown below. However, please note that the opening hours and the exact locations for the out of hours primary care centres within the Wakefield District boundary are currently the subject of a public engagement exercise, which is due for completion by the 5 March 2012. Bidders will be formally informed of the outcome of the engagement and subsequent Cluster Board decision regarding the opening hours and location from where the out of hours primary care centres are to be provided by no later than 20 April 2012.

One will be located within Mid Yorkshire Hospitals NHS Trust, Pontefract General Infirmary

One will be located at Trinity Medical Centre, Wakefield

The Contractor is required to negotiate and fund suitable premises for all out of hours primary care centres.

The Contractor will also be required to provide business continuity plans that detail arrangements for delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation

Pontefract General Infirmary

Monday to Friday 18.30 hours to 23.00 hours

Saturday/Sunday/Bank Holidays 08.00 hours to 24.00 hours

Trinity Medical Centre, Wakefield

Monday to Friday 18.30 hours to 08.00am

Saturday/Sunday/Bank Holidays 24 Hours

(Whilst the above sets out the requirements regarding opening times it is expected that the Contractor will draw on its experience and knowledge of demand profiles and Patient flows to determine efficient opening hours for the Services and locations. Any proposals by the Contractor for changes to opening times must be agreed with the relevant local commissioning bodies before being implemented)

3.4 Referral Criteria and sources

It is anticipated that patients will primarily be referred to this service from the NHS 111 service however some patients may be referred directly by other services and patients may attend without an appointment at a treatment centre. The contractor will be expected to provide a clinically appropriate response and services to all patients however the make contact with the service Patients may also access the service via the Emergency Department streaming service at the Mid Yorkshire Hospitals NHS Trust, Pontefract General Infirmary. For full details of the service model and referral processes refer to Core Specification.

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

6. Activity

6.1 Indicative Activity Plan

Based on activity from 2010-11 please find below the indicative activity:

Primary Care Centre (PCC)	14,361
Home Visits	6,282

Annual growth in demand of 1.3% based on national estimations should be factored in to forecast plans.

NB. It should be noted any activity seen occurring from the primary care streaming and during the protected learning times is included in the home visits and PCC above.

Please note that this information is only provided for context to assist bidders and can only act as an indicator of future potential activity due to the fact that from April 2013 there will be a new service model based on the 111 service and the potential effects of this model on activity levels are unknown.

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Total Annual Expected Cost
£	£	£	£	£	£

A – Prison Services

1. Purpose

1.1 Aims and objectives

To set out the specific requirements for the Wakefield District prison services.

1.2 National/ local context and evidence base

Refer to Service Specification Wakefield and District

2. Service Scope

2.1 Service Description

The Contractor shall provide out of hours visits to prisoners within HMP Wakefield & HMP YOI & New Hall prisons who require urgent medical attention.

This shall include the provision of:

- GP visits to the prisons for the medical management of prisoner/patients with urgent need: includes assessment, diagnosis and treatment to meet primary care, mental health, substance misuse needs and sub-acute clinical needs;
- GP visits to the prisons pertaining to all deaths in custody;
- GP visits to high security prisoners in every event where admission to hospital is likely to be considered;
- Separate contract reporting against prison performance and quality indicators, including complaints and compliments, and access and waiting times;
- Telemedicine used to augment the clinical decision making process to prevent admission to hospital from prison

2.2 Any exclusion criteria

Refer to Core Specification

2.3 Geographic coverage/ boundaries

Refer to Service Specification Wakefield and District

2.4 Whole System Relationships

Refer to Core Specification

2.4.1 Wakefield District Whole System Transformation

Refer to Service Specification Wakefield and District

2.5 Interdependencies with other services

Refer to Service Specification Wakefield and District

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

Refer to Service Specification Wakefield and District

3.3 Location(s) of service delivery

HMP Wakefield
5 Love Lane,
Wakefield,
West Yorkshire
WF2 9AG

HMP & YOI New Hall
Dial Wood,
Flockton,
Wakefield,
Yorkshire
WF4 4XX

3.4 Days/ hours of operation

Refer to Core Specification

3.4 Referral Criteria and sources

Refer to Service Specification Wakefield and District and Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

6. Activity

6.1 Indicative Activity Plan

Refer to Service Specification Wakefield and District

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Associate Commissioner	Total Annual Expected Cost

////////////////////////////////////

				Total	
£	£	£	£	£	£

////////////////////////////////////

B – Protected Learning Time

1. Purpose

1.1 Aims and objectives

To set out the specific requirements for cover for Practice Protected Learning Time for Wakefield District (known in Wakefield District as TARGET).

1.2 National/ local context and evidence base

Refer to Service Specification Wakefield and District

2. Service Scope

2.1 Service Description

Purpose

To provide planned cover for registered patients of Wakefield District during General Practices protected learning time in the 'in hours' period. This includes telephone assessment for patients warm transferred from the NHS 111 service, appropriate advice and/or treatment

Scope

Urgent GP cover for practices undertaking protected learning time. The contractor will receive telephone calls appropriate for continuation of consultation via the NHS 111 service from patients who would normally access their general practice.

The contractor will continue the consultation for these patients and provide advice and/or face to face treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

Service Delivery

Urgent GP cover for practices undertaking protected learning time. The contractor will receive redirected telephone calls from patients who would normally access their general practice.

The contractor will assess these patients, provide advice and refer for urgent treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

The telephone lines will be redirected back by the practices as agreed at the conclusion of the protected learning time.

2.2 Any exclusion criteria

Refer to Core Specification

2.3 Geographic coverage/ boundaries

Refer to Service Specification Wakefield and District

2.4 Whole System Relationships

Refer to Core Specification

2.4.1 Wakefield District Whole System Transformation

Refer to Service Specification Wakefield and District

2.5 Interdependencies with other services

Refer to Service Specification Wakefield and District

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

Refer to Service Specification Wakefield and District

3.3 Location(s) of service delivery

Refer to Service Specification Wakefield and District

3.4 Days/ hours of operation

Frequency

The anticipated number of sessions per calendar year for all 41 local practices will be 10: i.e. 1 per month, with the exception of August and December. However, the Contractor will also be required to cover any additional PLT sessions. The sessions/hours to be covered are from 12.00 noon to 6.30 pm.

3.4 Referral Criteria and sources

Refer to Service Specification Wakefield and District and Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

6. Activity

6.1 Indicative Activity Plan

Refer to Service Specification Wakefield and District

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Associate Commissioner Total	Total Annual Expected Cost
£	£	£	£	£	£

Appendix 4

Schedule 2 Part 1: Service Specification Leeds

Service/ care pathway	LEEDS A) Out of Hours Treatment Service (page 2) B) Minor Injury Units and Practice (page 7) C) Protected Learning Time cover (page 13)
Commissioner Lead	Martin Ford
Provider Lead	
Period	1 st April 2013 (period of 5 years minus 2)
Date of Review	

Key Service Outcomes

This specification relates to the Leeds locality of the 111 and the core WYUC treatment service specification.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this document which is specific to Leeds.

This document should be viewed as additional information specific to Leeds with regard to the core services. It also describes the additional services being commissioned for Leeds only – Minor Injury Units and cover for practice protected learning time.

A OUT OF HOURS TREATMENT SERVICE

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Leeds locality which are in addition to those detailed in the core specification for the out of hours treatment service. The information specific to Leeds is set out below

1.2 National/ local context and evidence base

Refer to core specification

2. Service Scope

2.1 Service Description

Refer to core Specification

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

Leeds is the second largest metropolitan district in England with a population of over 800,000 and covers an area of 552 square kilometres.

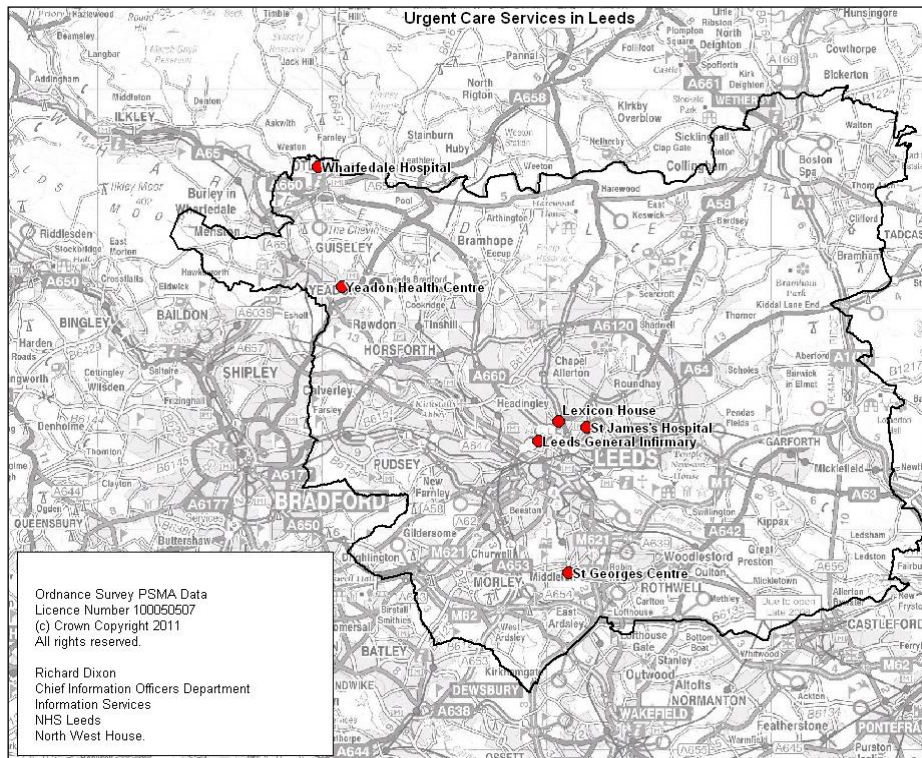
NHS Airedale, Bradford and Leeds is the organisation currently responsible for making sure that people of Leeds have all of the health services that they need and that these services are easily reached. These services include GP practices, pharmacists, optometrists, dentists and hospital services

In addition, we undertake a broad range of public health work to raise awareness and support people to improve their health and their quality of life.

Important progress has been made in improving the health of the local population, but there is still work to be done in terms of reducing health inequalities and improving access to healthcare for all local people.

Following the implementation of the draft Health and Social Care Bill in April 2013 most of the the role of NHS Airedale, Bradford and Leeds will become the responsibility of Clinical Commissioning Groups, led by local GPs.

Map 1



2.4 Whole System Relationships

Refer to core specification

2.4.1 Leeds Health and Social Care Transformation Programme

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the Transformational agenda supporting delivery of the shared vision of the Leeds local health economy whose core aim is to ensure the sustainability and safeguard of a quality NHS for the future. The provider will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within Leeds. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view of avoiding unnecessary admissions

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and

understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

Refer to core specification

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

Prison Services

The Contractor shall provide out of hours visits to prisoners within HMP Leeds, HMP Wealstun & HMYOI Wetherby who require urgent medical attention. Current activity to prisons is very low and the numbers are recorded in the overall GP OOHs indicative figures below.

This shall include the provision of:

- GP visits to the prisons for the medical management of prisoner/patients with complex needs: includes assessment, diagnosis and treatment to meet primary care, mental health and substance misuse needs in the out of hours period when in house healthcare provision is not operating.
- GP visits to the prisons pertaining to deaths in custody

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS Directory of Service, available electronically through a web-based computer system. The provider will be responsible for updating, in real time, information about the service onto the CMS DoS.

The Contractor will adhere to Leeds locally agreed care pathways accepting and making appropriate referrals through agreed protocols such as the local Diabetes pathway.

3.3 Location(s) of service delivery of GP Out of Hours

Current locations of the services are as below:

Service	Location	Opening hours
---------	----------	---------------

GP out of hours Primary Medical Care Centres (PMCC)	Lexicon House, Sheepscar, Leeds 7	6.30pm until 8.00am Monday to Thursday and then 6.30pm Friday until 8am Monday at weekends
	St George's Centre MIU, Middleton	6.30pm until 11.00pm weekdays 8.00am until 11.00pm weekends
	Wharfedale General Hospital MIU, Otley	6.30pm until 11.00pm weekdays 8.00am until 11.00pm weekends

As part of the public engagement currently underway until 4th March 2012 people are being asked to choose from one of three options for the locations of services:

OPTION A Services remain in current locations

OPTION B Services at Lexicon House to be moved to hospital sites
and Minor Injury Units to remain open

OPTION C Services at Lexicon House to be moved to an alternative
central location plus a new centre to be opened in the east Leeds area.
Minor Injury Units to remain open

Further information regarding the public engagement can be found at
www.leeds.nhs.uk/consultations

The Airedale, Bradford and Leeds Board will make a final decision regarding the future locations of services and this decision will be informed by the outcome of the public engagement.

The outcome of this decision will be uploaded onto Bravo by 20th April 2012 at the latest.

The contractor will be responsible for making and entering into all lease arrangements as necessary to deliver the required services. All costs of leasing premises plus all other costs associated with the premises are the responsibility of the contractor.

The contractor will be required to provide business continuity plans that detail arrangements for delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation of GP Out of Hours services

Monday to Friday 18.30 hours to 08.00 hours

Weekends 08.00 Saturday to 08.00 Monday

Public Holidays 08.00 to 08.00 next working day

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Risk stratification

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions

5. Quality Requirements

Refer to Core Specification

6. Activity

6.1 Indicative Activity Plan

Please find below the indicative activity for the contract year 2013-14:

Primary Medical Care Centre appointments	36,484 (including PMCC appointment based at the MIUs – around 300 per month)
Home visits	11,218

Annual growth in demand of 1.3% based on national estimations should be factored in to forecast plans.

7. Prices & Costs

Refer to Core Specification

B MINOR INJURY UNITS

1. Purpose

1.1 Aims and objectives

- To set out the specific requirements of the Leeds locality Minor Injury Units.

1.2 National/ local context and evidence base

Refer to core specification

2. Service Scope

2.1 Service Description

Purpose:

To provide walk-in services to individuals of all ages who are or believe themselves to be requiring urgent attention by a healthcare professional, such that their immediate care needs are best met by a dedicated urgent care service, and cannot appropriately be deferred to an appointment with their routine contractor.

To provide nurse-led Minor Injury services from the specified premises. In addition to provide minor illness services at the Minor Injury Units (through the GP out of hours services being available at the units – see section A above).

The majority of clauses, principles and key outcomes within the core West Yorkshire Urgent care specification apply to the Minor Injury service, but this appendix has been developed in recognition of the fact that these services are distinctly separate from GP out of hours services.

Scope:

The contractor will treat undifferentiated illness (i.e. symptoms that have yet to be placed into categories which may include minor illness/injury or major illness/injury) presenting at the Minor Injury Units located at St George's Centre and Wharfedale General Hospital. Where the clinical condition requires it, the provider will have the ability to provide a medical assessment of the patient, to the standard of a general medical practitioner.

The contractor will adhere to appropriate NICE guidelines when providing treatment to children. Additionally the contractor will meet the relevant standards developed by the Yorkshire and Humber Specialised Commissioning Group for the treatment of acutely unwell children (appendix 1).

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

Leeds is the second largest metropolitan district in England with a population of over 800,000 and covers an area of 552 square kilometres.

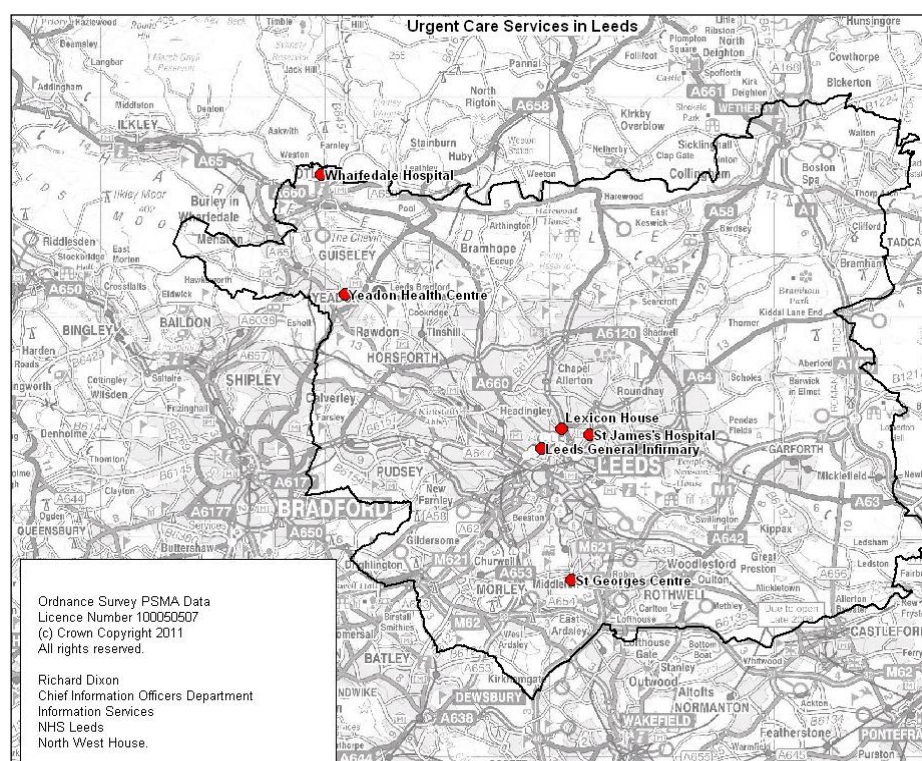
NHS Airedale, Bradford and Leeds is the organisation currently responsible for making sure that people of Leeds have all of the health services that they need and that these services are easily reached. These services include GP practices, pharmacists, optometrists, dentists and hospital services

In addition, we undertake a broad range of public health work to raise awareness and support people to improve their health and their quality of life.

Important progress has been made in improving the health of the local population, but there is still work to be done in terms of reducing health inequalities and improving access to healthcare for all local people.

Following the implementation of the draft Health and Social Care Bill in April 2013 most of the the role of NHS Airedale, Bradford and Leeds will become the responsibility of Clinical Commissioning Groups, led by local GPs.

Map 1



2.4 Whole System Relationships

Refer to core specification

2.4.1 Leeds Health and Social Care Transformation Programme

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the Transformational agenda supporting delivery of the shared vision of the Leeds local health economy whose core aim is to ensure the sustainability and safeguard of a quality NHS for the future. The provider will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within Leeds. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view of avoiding unnecessary admissions

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

Refer to core specification

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Staffing:

Nurses leading the service will be adequately supported by a medical professional so that the service will not result in an influx of referrals to A&E for patients that are outside of a nursing remit; particularly between 0800-1830hrs Monday-Friday, when there is no GP OOH service in Leeds.

Triage and Treatment process:

1.3.3 The triage process will be operated as follows:

- 1.3.4 Patients walk in to the Service, usually without prior contact with a Health Care Professional. These units do not operate an appointment system.
- 1.3.5 The Patient will be booked in by a receptionist who will be trained to recognise any immediately life threatening conditions and summon expert help.
- 1.3.6 Patients will then be triaged by a nurse. Triage will assess if the Patient is suitable to be seen in a minor injury/illness unit. Triage will be provided following protocols designed by the provider with the expert input of clinicians skilled in both primary and secondary care, and these protocols will be the same at both sites.
- 1.3.7 The triage nurse may also provide 'See & Treat', if the condition is such that quick and simple intervention will close the treatment episode. Referral directly for x-ray may also occur from triage where necessary.
- 1.3.8 Patients who require a more formal examination or diagnostics will be seen by other nurse practitioners working alongside the triage/See & Treat nurse.

During the Out of Hours Period there will be a GP in both MIUs. Where possible these will be GPs with recent or relevant Accident & Emergency experience. These GPs will be seeing patients as part of the core GP Out of Hours service, but will also be expected to work with the team of nurses to provide any back up or support required.

Note: The Contractor shall ensure that all members of staff who might deal with patient based information understood the importance of confidentiality and the basis of any record retention/archiving.

Plain X Ray:

For Patients presenting to St Georges or Wharfedale with minor injuries, provision of on-site x-ray will continue in line with current activity levels following the clinical guidelines already established within these units.

Patients attending these units with minor illness will also have access to these diagnostics but minimal additional use of xrays is anticipated.

The provider will produce detailed guidelines for clinicians, stating when the use of x-ray for Patients with minor illness would be suitable. An example would be when a Patient displays signs of serious lung pathology without being unwell enough to warrant admission. The risk of referring these Patients back to their own GP to arrange an x-ray is always that the Patient will not arrange the x-ray with the GP. In cases like these, the Contractor could provide valuable help to the Patient's own GP by facilitating rapid diagnosis.

The contractor will be required to arrange and enter into the necessary arrangements for the access and provision of the necessary plain x-ray service. All costs will be the responsibility of the contractor.

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS Directory of Service, available electronically through a web-based computer system. The provider will be responsible for updating, in real time, information about the service onto the CMS DoS.

The Contractor will adhere to Leeds locally agreed care pathways accepting and making appropriate referrals through agreed protocols such as the local Diabetes pathway.

3.3 Location(s) of service delivery of Minor Injury Units

Current locations of the services are as below:

The Minor Injury Units will be operated from:

- St George's Centre, Middleton
- Wharfedale General Hospital, Otley

The contractor will be responsible for making and entering into all lease arrangements as necessary to deliver the required services. All costs of leasing the premises plus all other costs associated with the premises are the responsibility of the contractor.

Providers should note that the GP Out of Hours service will continue to operate from the MIUs (see section A)

The provider will be required to provide business continuity plans that detail arrangements for delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation of Minor Injury Units

from 08:00 until 23:00 seven days per week including public holidays, closed Christmas Day.

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Risk stratification

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions.

Out of area patients

Charging for patients using this services will be made directly to the Responsible Commissioner as per Department of Health guidance "*Who Pays? Establishing the*

Responsible Commissioner" 18/09/07. It will be the responsibility of the provider to ensure that changing to the responsible commissioner takes place.

IM&T

IM&T arrangements for the Minor Injury Units must be as detailed in the core WYUC specification.

5. Quality Requirements

Refer to Core Specification

6. Activity

6.1 Indicative Activity Plan

Please find below the indicative activity for the contract year 2013-14:

St George's Centre MIU	33,161
Wharfedale General Hospital MIU	24,629

Annual growth in demand of 1.3% based on national estimations should be factored in to forecast plans.

7. Prices & Costs

See financial model template.

C COVER FOR PRACTICE PROTECTED LEARNING TIME

1. Purpose

1.1 Aims and objectives

- To set out the specific requirements for cover for Practice Protected Learning Time for Leeds (known in Leeds as TARGET).

1.2 National/ local context and evidence base

Refer to core specification

2. Service Scope

2.1 Service Description

Purpose:

To provide planned cover for telephone assessment for patients warm transferred from the NHS 111 service, appropriate advice and / or treatment for registered patients of Leeds during General Practices protected learning time.

Scope:

Urgent GP cover for practices undertaking protected learning time. The contractor will receive telephone calls appropriate for continuation of consultation via the NHS 111 service from patients who would normally access their general practice.

The contractor will continue the consultation for these patients and provide advice and / or face to face treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

Leeds is the second largest metropolitan district in England with a population of over 800,000 and covers an area of 552 square kilometres.

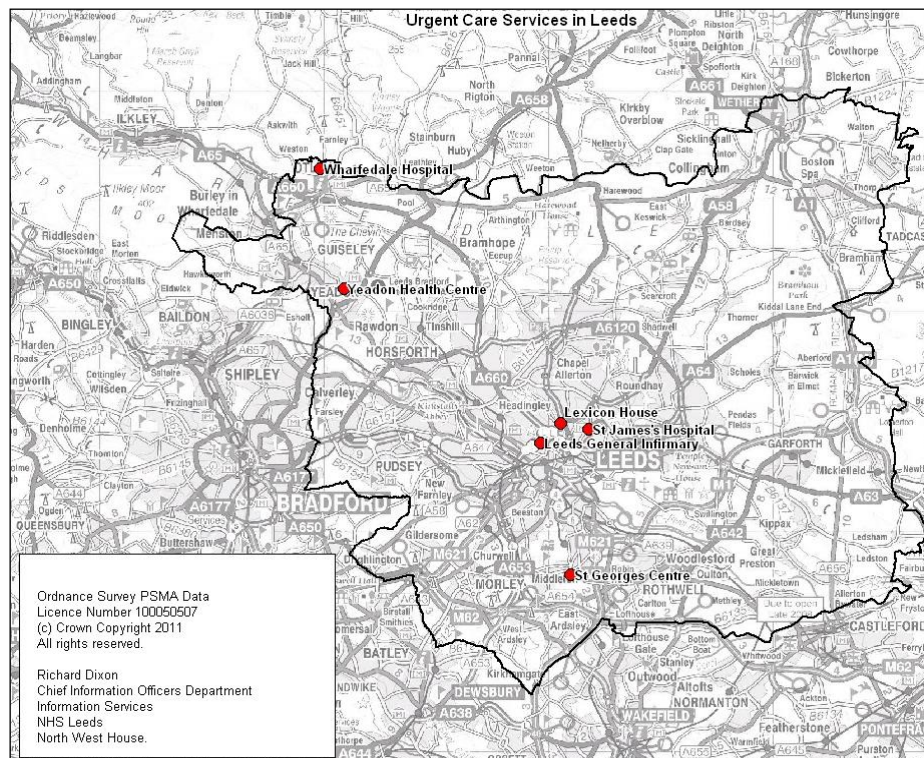
NHS Airedale, Bradford and Leeds is the organisation currently responsible for making sure that people of Leeds have all of the health services that they need and that these services are easily reached. These services include GP practices, pharmacists, optometrists, dentists and hospital services

In addition, we undertake a broad range of public health work to raise awareness and support people to improve their health and their quality of life.

Important progress has been made in improving the health of the local population, but there is still work to be done in terms of reducing health inequalities and improving access to healthcare for all local people.

Following the implementation of the draft Health and Social Care Bill in April 2013 most of the the role of NHS Airedale, Bradford and Leeds will become the responsibility of Clinical Commissioning Groups, led by local GPs.

Map 1



2.4 Whole System Relationships

Refer to core specification

2.4.1 Leeds Health and Social Care Transformation Programme

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the Transformational agenda supporting delivery of the shared vision of the Leeds local health economy whose core aim is to ensure the sustainability and safeguard of a quality NHS for the future. The provider will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within Leeds. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will

be explore and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view of avoiding unnecessary admissions

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

Refer to core specification

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to core specification

3.2 Care pathways

The provider will need to be aware of and utilise in-hours care pathways where appropriate to do so.

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS Directory of Service, available electronically through a web-based computer system. The provider will be responsible for updating, in real time, information about the service onto the CMS DoS.

The Contractor will adhere to Leeds locally agreed care pathways accepting and making appropriate referrals through agreed protocols such as the local Diabetes pathway.

3.3 Location(s) of service delivery of Protected Learning Time cover

Refer to section A above

3.3 Days/ hours of operation of PLT cover and practices covered

Frequency:

There are three Clinical Commissioning Groups (CCGs) in Leeds and practices each CCG

currently close for one half a day session per month in every month of the year except August and December.

These arrangements may change in the future. Where this change is substantial the commissioner will negotiate impact on provision by the provider.

Practices Covered:

The number of practices covered by each of the Leeds CCGs are detailed below by Leeds City Council ward to depict the geographical area covered by each CCG.

Leeds North (31 practices)	Leeds West (39 practices)	Leeds South and East (44 practices)
Wetherby Harewood Roundhay Chapel Allerton Moortown Alwoodley Adel and Wharfedale Otley and Yeadon	Guiseley and Rawdon Horsforth Calverley and Farsley Bramley and Stanningley Kirkstall Weetwood Headingley Hyde Park and Woodhouse Armley Pudsey Farnley and Wortley Morley North Morley South Ardsley and Robin Hood	Cross Green and Whinmoor Gipton and Harehills Burmantofts and Richmond Hill City and Hunslet Beeston and Holbeck Middleton Park Rothwell Temple Newsam Garforth and Swillington Kippax and Methley

These are the current arrangements and are subject to change in the future. Where this change is substantial the commissioner will negotiate impact on provision by the provider.

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Risk stratification

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view of avoiding unnecessary admissions.

IM&T

IM&T arrangements for PLT time must be as detailed in the core WYUC specification.

5. Quality Requirements

Refer to Core Specification

6. Activity

6.1 Indicative Activity Plan

Please find below the indicative activity for the contract year 2013-14:

PMCC	784
HV	294

The average activity per session is 20 PMCC appointments and 7 home visits.

Annual growth in demand of 1.3% based on national estimations should be factored in to forecast plans.

7. Prices & Costs

As for out of hours treatment service

Standards for the Care for the Acutely Unwell Child

Principles:

- The aim is to improve the standards for children presenting in emergency departments (EDs)
- This service is provided as part of a comprehensive range of services; therefore these standards should be considered within the context of overarching standards that apply to NHS provision and specific standards that apply to services for children – most notably the Children's NSF¹.
- **Standards should be met 24 hours a day, 7 days a week**

SCORE

- 5** This standard is in place and can be audited
4 This standard is in the process of being put in place
3 This standard is planned to be implemented within the next 12 months
2 This standard is planned to be in place in the next 2 years
1 This standard is not being implemented in this trust; there are no plans to implement
Note Where a standard comprises more than one requirement all must be considered

CORE STANDARDS

No.	Statement	Score 1-5	Note on compliance
1	Initial assessment of children		
1.1	Initial assessment of children takes place <u>immediately</u> by a clinician trained in the clinical assessment of children to assess serious illness (e.g. the need for airway support; critical illness) ² .		
1.2	Clinical assessment takes place, within 15m <u>or</u> there is a system of prioritisation in place for assessment if assessment time exceeds 15m ³		
1.3	The initial assessment includes a pain score ⁴		
2	Resuscitation/stabilisation		
2.1	Receiving facilities provide a suitable environment, with paediatric triage, age appropriate resuscitation facilities, equipment and appropriate drugs ⁵		
2.2	There is the ability to provide emergency treatment, initiate intensive care and stabilise critically ill children, prior to their transfer to a PICU ⁶		

2.3	Both during and following the initial stages of resuscitation of a critically ill or collapsed child, further stabilisation and management are not left within the sole remit of the anaesthetist ⁷		
2.3	A hospital resuscitation team is on duty at all times and includes practitioners who are accredited in a recognised paediatric life support courses. The team is led by clinicians with the skills and knowledge to identify the key features of life threatening illnesses and the ability to institute emergency treatments as taught on the advanced paediatric life support (APLS) ⁸		
2.4	An A&E receiving children should have someone trained in paediatric venous access on duty at all times ⁹		

No.	Statement	Score 1-5	Note on compliance
3	Supporting Staff, Structures and Facilities		
3.1	All hospitals receiving acutely ill or injured children have the facilities, equipment and staff required to establish short term high dependency care and intensive level care for airway and respiratory support ¹⁰		
3.2	All EDs are able to access child protection and safeguarding advice 24 hours a day, from a named or designated nurse or paediatrician and social services ¹¹ .		
3.3	On-site 24/7 paediatric facilities are available for children requiring admission or a short stay observation unit is available prior to transfer the main paediatric centre ¹²		
3.4	The ED has an environment appropriate for children for provision of care and safeguarding and is risk assessed in terms of security.		
3.5	There should be physical separation between children and adult patients ¹³		
3.6	The ED has a level of equipment and clinical space that is appropriate to the numbers of children seen (see 4.4)		

No.	Statement	Score 1-5	Note on compliance
4	ED Workforce (for EDs seeing children)		
4.1	EDs have a named paediatrician with designated responsibility for ED liaison ¹⁴ (Their role will involve assisting with training and giving advice on guidelines and protocols. This consultant commitment is reflected in job plans).		
4.2.	EDs have a RN (child) responsible for developing policy and practice ¹⁵		
4.3	EDs have a RN (child) lead nurse responsible for safeguarding children ¹⁶		
4.4	There is an identified lead with overall responsibility for the ED who has explicit responsibility for developing and maintaining a suitable environment for children and ensuring the provision of appropriate equipment ¹⁷ .		
4.5	EDs seeing children should have immediate access to support <i>in person</i> from an RN (child) 24/7 to provide advice/assistance		

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No.	Statement	Score 1-5	Note on compliance
5	Training and Education (training must be regularly updated, recorded and assessed in CPD)		
5.1	All trained clinical staff in EDs (including doctors, nurses and emergency care practitioners) should receive training to <ol style="list-style-type: none"> Recognise the critically sick or injured child Assess and manage pain Use paediatric medicines competently Understand the current legal and ethical issues pertaining to children including consent and confidentiality Initiate appropriate immediate treatment Communicate with children 		
5.2	Clinical staff working in facilities where children are present are compliant with the following standards relating to paediatric life support ¹⁸ : <ol style="list-style-type: none"> ED nursing staff are PILS/PLS or equivalent trained Senior trainees and consultants in EM, paediatrics & anaesthetics dealing with acutely unwell children are APLS/ EPLS trained. Medical and nursing staff are familiar with the principles of advanced airway support and induction and maintenance of anaesthesia Nursing staff have recognised additional training in paediatric skills and competencies 		
5.3	ED staff (clinical and non clinical) receive training in safeguarding children commensurate with their responsibilities and posts ¹⁹ .		
5.4	Emergency stabilisation skills for children and young people are within the remit of all anaesthetists attending EDs.		
5.5	In DGH units where the ED consultants are responsible for children with severe illness or trauma until the arrival of the retrieval team, appropriate paediatric training and CPD is in place and up to date ²⁰		

No.	Statement	Score 1-5	Note on compliance
6	Guidelines and protocols		
6.1	EDs have guidelines for safeguarding children, specific to the ED ²¹		
6.2	Hospital protocols for management of the critically ill children should be in place to include management of ^{ref 1, 6} <ul style="list-style-type: none"> a head injuries b acute upper airway obstruction c suspected meningococcal septicaemia d seizures e severe asthma f poisoning g major burns h resuscitation and stabilisation i pain management and sedation j fluid management k feverish illness l diarrhoea and vomiting m abdominal pain n indications for CT scanning 		
6.3	All ED departments that offer access to critically ill children have an Early Warning Scoring System in place within the Trust ²²		
6.4	Notification of a child's attendance at any urgent care setting is made in a timely way to their primary care team (ideally both the GP and the health visitor/school nurse) or named liaison practitioner ²³		
6.5	Guidance is in place for where a critically ill child is stabilised until their condition improves or the transport team arrives. ²⁴		
6.6	In the event of the death of a child national guidance is followed ²⁵		
7	Audit		
7.1	Hospitals subscribe to the trauma audit and research network (TARN) to assess their own outcomes for patients with major trauma ²⁶		

MEASURES OF GOOD PRACTICE – these will be for agreement between local commissioners and providers

No.	Statement	Score 1-5	Note on compliance
8	Child and Young Person Specific Facilities		
8.1	EDs have the following a food and drink available b breastfeeding areas c washing and changing facilities d safe playing facilities ²⁷		
8.2	EDs treating more than 16,000 children per year have a A waiting area dedicated to children b A route to the imaging department that avoids other areas of the ED c Provision of facilities for children of all age groups meeting 'You're Welcome Quality Criteria' ²⁸		

No.	Statement	Score 1-5	Note on compliance
9	Family		
9.1	Local arrangements for emergency care of sick or injured children, both in working hours and out of hours, are clear and well publicised locally ²⁹		
9.2	Parents/carers have access to their child at all times during their attendance at ED and related services such as radiology, except when this is not in the best interests of the child ³⁰		
9.3	Children and their parents are offered information in a format they understand to enable them to share in decisions about care. Parents are regularly updated about their child's condition and participate in the collation of the care plan. ³¹		
9.4	Parents/carers are able to be with their child in the resuscitation room unless this hampers the resuscitation. Parent witnessing resuscitation are supported by a member of staff ³²		
9.5	Families have access to support services, including bereavement support e.g. social workers, chaplains and counsellors ³³		
9.6	After the death of a child, the parent is offered a sensitively timed appointment to see a relevant consultant ³⁴		

9.7	Children and young people and their parents and carers are encouraged to participate in reviewing services and assessing the quality of existing services ³		
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³ More than source of guidance refers

No.	Statement	Score 1-5	Note on compliance
10	Workforce Development		
10.1	EDs have an HR strategy for recruitment and retention of nurses skilled and competent in nursing sick children ³⁵		
10.2	All paediatric departments supporting an on-site ED seeing more than 16,000 children per annum have a paediatrician with sub specialty training in paediatric EM ³⁶		
10.3	EDs seeing more than 16,000 children per annum employs a consultant in Emergency Medicine with sub specialty training in paediatric EM ³⁷		
10.4	EDs seeing more than 16,000 children per year employ play specialists at peak times ³⁸		

No.	Statement	Score 1-5	Note on compliance
11	Whole-System & Network-Working⁴		
11.1	EDs prevent unnecessary hospital admissions by being aware of alternative options and developing care pathways for common conditions with community and paediatric colleagues signposting to other services as appropriate ³⁹		
11.1	Services for the critically sick or injured child are planned within a clinical network comprising DGHs and a tertiary centre with a PICU and there are clear lines of communication to access appropriate emergency care teams, clinicians and advice ⁵		
11.2	Clear protocols are developed with the ambulance service to ensure that drive by policies exist if more suitable care can be provided at a hospital 10-15 minutes further away ⁴⁰		
11.3	There is a plan for clinical scenarios within the network and scenario practice is required, including the situation where a sick child turns up at the wrong place.		
11.4	Each hospital is clear what its role is with is clear local information for parents about where to take a sick child. ⁴¹		
11.5	GPs competence and confidence is maintained to manage acute paediatric cases, reflecting the Royal College of General Practitioners (RCGP) competencies ⁴² (and any updates).		
11.6	Networks on behalf of PCTs have developed criteria and pathways for referral of children from and back to primary care <ul style="list-style-type: none"> • Networks work with practices to provide paediatric training to GPs to support assessment and practice in the recognition of the acutely ill child. • Commissioners consider the use of contractual levers to ensure this is part of GP practice priorities (local) 		

⁴ This will be informed by the work to implement revised arrangements for trauma and the development of trauma networks

⁵ More than one source of guidance refers

11.7	The Paediatric Network ensures robust links between the paediatricians, emergency consultants, anaesthetists and GPs to look at issues, patient flow and training needs (local)		
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No.	Statement	Score 1-5	Note on compliance
12	Short Stay Assessment Units		
13.1	EDs have short stay paediatric assessment units or equivalent, allowing observation of children when their clinical course is uncertain, without having to resort to hospital admission.		
12.2	<p>All SSPAUs require:</p> <ul style="list-style-type: none"> • Children's nurses available on all shifts, who may also work across the emergency department and inpatient units • Senior clinical staff available 24/7 • Bed numbers in the SSPAU are sufficient for needs and can accommodate variable admission rates 		
12.3	<p>The SSPAU model complies with one of the following:</p> <ul style="list-style-type: none"> • Co location with the paediatric ward • Co location with the emergency department, run by the paediatric department and ED <p>Co location with the emergency department, run by the emergency department in a specialist paediatric hospital</p>		
12.4	Analysis of causes of intentional and unintentional injury to children is monitored by the paediatric network in liaison with safeguarding teams		

Final Version	
Agreement	Yorkshire and Humber SCG
Date	October 2011

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- ¹ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**
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- ¹ Ibid
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1 DOH (2011) **You're Welcome Quality Criteria**

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1 Ibid

1 Ibid

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1 Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

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1 Ogilvie, D., Arch Dis Child 90: 138 - 142; **Hospital Based Alternatives to Acute Paediatric Admission, A Systematic Review**

1 DOH (2006)**The Acutely or Critically Sick or Injured Child in the District General Hospital, a team response**

1 Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Department**

Schedule 2 Part 1: Service Specification Kirklees

Service/ care pathway	Kirklees Out of Hours Treatment Service
Commissioner Lead	Pat Andrewartha – Urgent Care Programme Manager Carol McKenna - Director
Provider Lead	
Period	1 st April 2013
Date of Review	

Key Service Outcomes

This specification relates to the Kirklees locality and is a 'sub set' of the 111 and the core WYUC treatment service specification.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this sub set document which is specific to KIRKLEES

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Kirklees locality which are in addition to those detailed in the core specification. The additional services required in Kirklees are as follows:

- Safe Haven service (appendix 1)
- Protected Learning time (appendix 2)

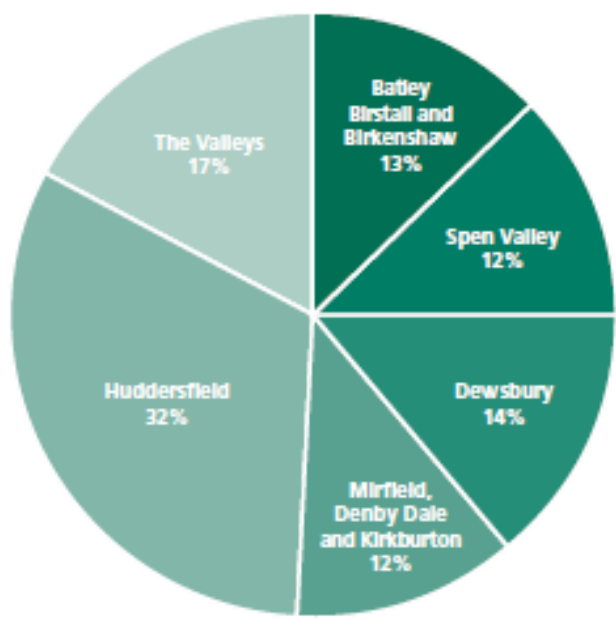
1.2 National/ local context and evidence base

Population age structure

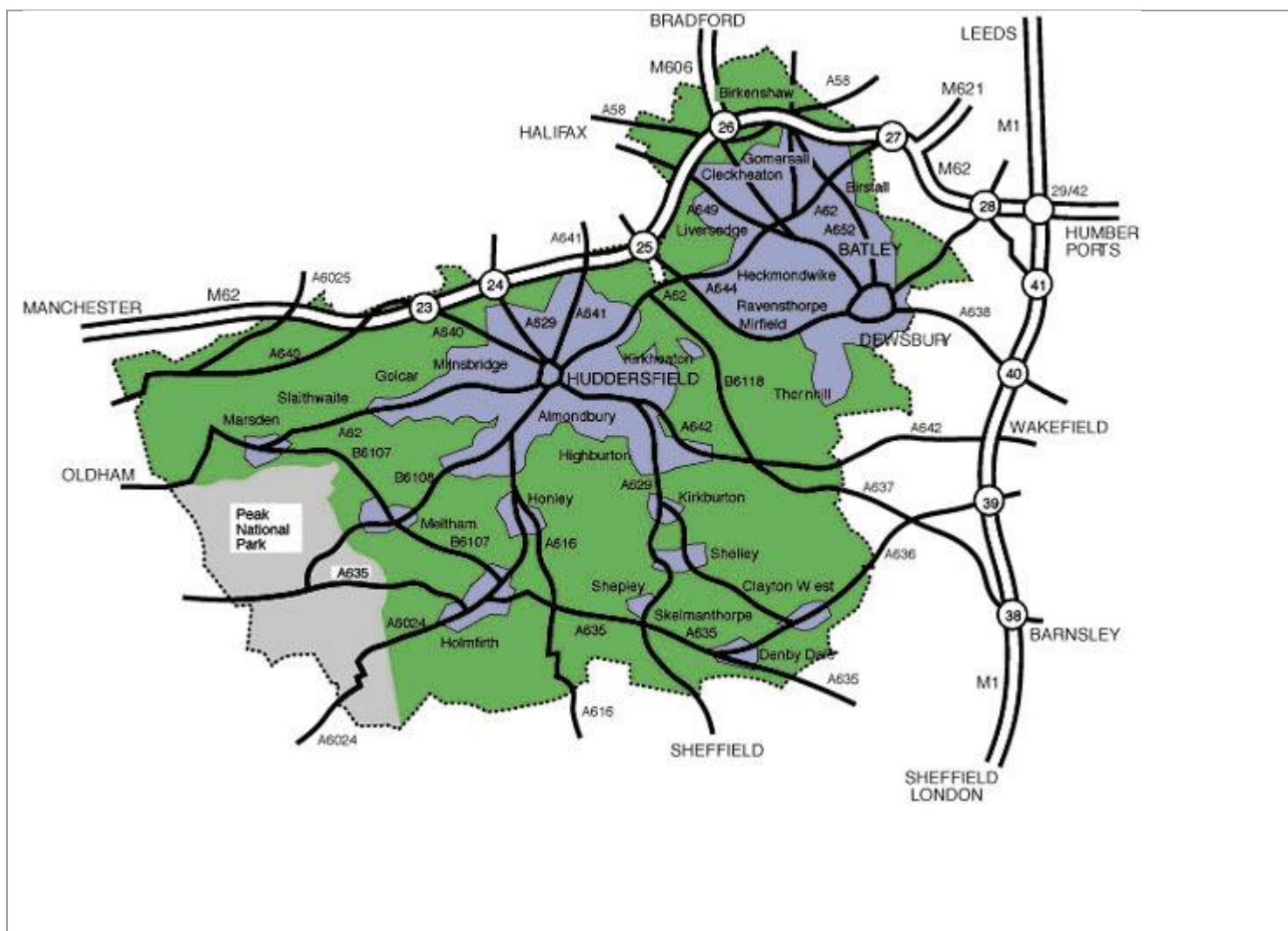
Kirklees is a mix of urban communities and rural areas. The resident population of Kirklees was 430,197 in July 2010, from GP registrations¹. The resident population (using GP registrations) at July 2010, had increased by 1% since 2008. Women aged over 75 years outnumbered men by just under 2 to 1. Otherwise, men and women were evenly split across all ages. In July 2010 Kirklees had more residents aged under 15 years than England and Wales, 21% vs. 18%, but similar

proportions of working age (63%) and aged over 65 years (16%). Nearly 1 in 4 of the Kirklees population was aged less than 19 years. Kirklees is subdivided into six Town and Valley localities. These are formed from groupings of electoral wards. They vary in population and geographical size.

Resident population for localities and Kirklees, 2010



Kirklees is served by 71 GP practices from a variety of locations across the locality and two acute Trusts (Calderdale and Huddersfield Foundation Trust and Mid Yorkshire Hospital Trust).



2. Service Scope

2.1 Service Description

Refer to core Specification

2.2 Any exclusion criteria

2.3 Geographic coverage/ boundaries

Any patient registered at a general practice within the Kirklees locality as determined in map 1 above.

Any out of area patients directed through the 111 service, such as temporary residents

2.4 Whole System Relationships

Refer to core specification

2.4.1 Kirklees Urgent Care System Transformation

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will actively and positively contribute to the Transformational agenda supporting delivery of the shared vision and that of the commissioning bodies the Greater Huddersfield Commissioning Consortia and the North Kirklees Health Alliance. The Contractor will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives working with partners and stakeholders to design and integrated models of care, specifically within the Kirklees area. Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

Through development of whole system relationships and pathways of care use of new technologies such as telehealth, telemedicine and telecare to support remote patient care will be explored and may be implemented where appropriate. The Contractor will engage in locally supported initiatives and care pathways including use of new technologies where appropriate.

The Contractor will implement any locally agreed pathways in order to access urgent specialist nursing and consultant advice with a view to avoiding unnecessary admissions.

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is embedded throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Refer to Core Specification

3.2 Care pathways

A range of locally agreed care pathways will be made available to the Contractor through access to the CMS Directory of Service, available electronically through a web-based computer system.

The Contractor will adhere to Kirklees locally agreed care pathways accepting and making appropriate referrals through agreed protocols.

The Contractor will deliver a streaming service for patients from the Huddersfield Royal Infirmary A&E department where

appropriate in accordance with the Manchester Pathway. The contractor will work with the acute trust to develop this service to ensure it is meeting patients and commissioners needs.

3.4 Location(s) of service delivery

The Contractor will deliver services from two (2) out of hours primary care centres; 1 co-located with or near to the A&E department at Huddersfield Royal Infirmary, the other to be co-located with the Dewsbury District Hospital A&E or no more distant than the centre of Dewsbury in a location which is easily accessible to the public.

The provider is required to negotiate suitable premises to deliver this service from.

The provider will be required to provide business continuity plans that detail arrangements for the delivery of services at an alternative location if the normal premises were not available. This business continuity plan requires formal agreement from the Commissioners.

3.3 Days/ hours of operation

Monday to Friday 18.30 hours to 08.00 hours

Weekends 18.30 Friday to 08.00 Monday

Bank Holidays 08.00 to 08.00 next working day

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practices are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the care plans with a view to avoiding unnecessary admissions and providing timely support.

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

6. Activity

6.1 Indicative Activity Plan

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

*delete as appropriate

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£

Annex A– Safe Haven Service Specification

Service/ care pathway	Planned Safe Haven Service for Routine GP Care
Commissioner Lead	Mark Jenkins
Provider Lead	
Period	1.4.13 For Duration of Contract
Date of Review	

Key Service Outcomes

This specification relates to the Kirklees locality and is a 'sub set of the 111 and the core WYUC treatment service specification.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this sub set document which is specific to Kirklees.

For key service outcomes refer to core safehaven specification

1. Purpose

1.1 Aims and objectives

Planned Safe Haven Service for Routine GP Care

This service will provide general primary care medical services and treatment to patients who are violent or who have particular behavioural challenges, following immediate removal from the list of a General Practice within the Kirklees boundary area. In addition, the service will cover, at the request of the PCT, patients with a history of difficult or obstructive behaviour. The aim of the service is to provide a stable environment for the patient to receive continuing health care, provide support to help the patient address any underlying cause of aggressive behaviour and provide a safe environment for the individuals involved in delivering that treatment (through the use of police escorts). Security of the premises where the service is to be delivered should, wherever possible, be discreet but effective rather than overt. As well as providing routine medical care, it is expected that the provider will work closely with the patient to support changes in behaviour in the longer term. The ultimate aim is, when appropriate, rehabilitation back to mainstream general medical practice following a comprehensive review and risk assessment.

1.2 National/ local context and evidence base

Contractual requirement for PCT's to Commission this Service

2. Service Scope

2.1 Service Description

Refer to core Safehaven Specification attached



W Y Output
Specification for Urge

2.2 Any exclusion criteria

Refer to core Safehaven Specification

2.3 Geographic coverage/ boundaries

Any patient registered at a general practice within the Kirklees locality .

2.4 Whole System Relationships

Refer to core Safehaven specification

2.4.1 Intentionally Left Blank

2.5 Intentionally left blank

2.6 Relevant networks and screening programmes

Refer to Core safehaven Specification

2.7 Training/ education/ research activities

Refer to Core Safehaven Specification

3. Service Delivery

3.1 Service model

Refer to Core Safehaven Specification

3.2 Care pathways

Refer to core safehaven Specification

3.4 Location(s) of service delivery

A location in North Kirklees and Huddersfield

3.3 Days/ hours of operation

GP appointments will be provide at each location on one day a week for a 2 hour period

3.4 Referral Criteria and sources

Refer to Core safehaven Specification

3.5 Referral processes

Refer to Core safehaven Specification

3.6 Discharge processes

Refer to Core Safehaven Specification

3.7 Response times and prioritisation

Refer to Core Safehaven Specification

4. Other

5. Quality Requirements

Performance Indicator	Indicator	Threshold	Method of Measurement	Consequence of breach

Monitoring

The provider will supply the PCT with the following information on quarterly basis.

- Numbers of patients accepted into the scheme on a quarterly basis
- Name of practice referring patients to the scheme (including number of patients)
- Removal date from mainstream GMS/PMS/APMS
- Number of patients referred back to mainstream practice
- Name of GP practice receiving a former Safe haven patient

6. Activity

6.1 Indicative Activity Plan

N/A

6.2 Capacity Review

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)

National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co- ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£

Anne B – Protected Learning Time Service Specification

Service/ care pathway	Kirklees Out of Hours Treatment Service Protected Learning Time Specification
Commissioner Lead	Jan Giles/ Jackie Holdich
Provider Lead	
Period	From 01/04/13
Date of Review	

Key Service Outcomes

This specification relates to the Kirklees locality, including Great Huddersfield CCG and North Kirklees Health Alliance CCG and the core WYUC treatment service specification.

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To provide planned cover for call handling assessment, appropriate referral and treatment for registered patients of Kirklees during General Practices protected learning time.

1.2 National/ local context and evidence base

N/A

2. Service Scope

2.1 Service Description

Refer to core Specification

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

As attached documents.

2.4 Whole System Relationships

Refer to core specification

2.5 Interdependencies with other services

N/A

2.6 Relevant networks and screening programmes

Refer to Core Specification

2.7 Training/ education/ research activities

Refer to Core Specification

3. Service Delivery

3.1 Service model

Urgent GP cover for practices undertaking protected learning time. The contractor will receive redirected telephone calls from patients who would normally access their general practice.

The contractor will triage and assess these patients, provide advice and refer for urgent treatment as appropriate.

The contractor will provide treatment for patients as required either at an agreed treatment centre or a home visit.

The telephone lines will be redirected back by the practices as agreed at the conclusion of the protected learning time.

Refer to Core Specification

3.2 Days/ hours of operation

Third Tuesday of each Month (occasional flexibility may be required)
Time of cover: commence at 13:00 and finish at 18:00

3.3 Referral Criteria and sources

Refer to Core Specification

3.4 Referral processes

Refer to Core Specification

3.5 Discharge processes

Refer to Core Specification

3.6 Response times and prioritisation

Refer to Core Specification

4. Other

Practices Covered:

GHCCG – 40 practices, 237000 population

NKHA – 31 practices, 188,000 population

Total 71 general practices 425, 000 population

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

As core specification.

Ad-hoc performance information as determined by the Commissioner

6. Activity

6.1 Indicative Activity Plan

6.2 Capacity Review

N/A

7. Prices & Costs

7.1 Price

N/A

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)	
National Tariff plus Market Forces Factor					
Reduced Tariff Prices					
Non-Tariff Price (cost per case/cost and volume/block/other)*					
Total		£		£	
*delete as appropriate					
7.2 Cost of Service by Commissioner					
Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	£	£	£	£	£

Schedule 2 Part 1: Service Specification Bradford

Service/ care pathway	Bradford Out of Hours Primary Medical Care 'Consultation and Treatment' Service
Commissioner Lead	Mike Edmondson Dr Piush Patel (Clinical Lead – Urgent Care)
Provider Lead	
Period	1 st April 2013
Date of Review	

Key Service Outcomes

This specification relates to the Bradford locality and is an appendix to the Yorkshire and Humber 111 service specification and the core urgent primary medical care 'consultation and treatment' service specification for West Yorkshire.

The Contractor will deliver all requirements as set out in the core specification and in addition those set out within this appendix which is specific to Bradford

For key service outcomes refer to core specification

1. Purpose

1.1 Aims and objectives

To set out the specific requirements of the Bradford locality which are in addition to those detailed in the core specification

1.2 National/ local context and evidence base

Refer to core specification

2. Service Scope

2.1 Service Description

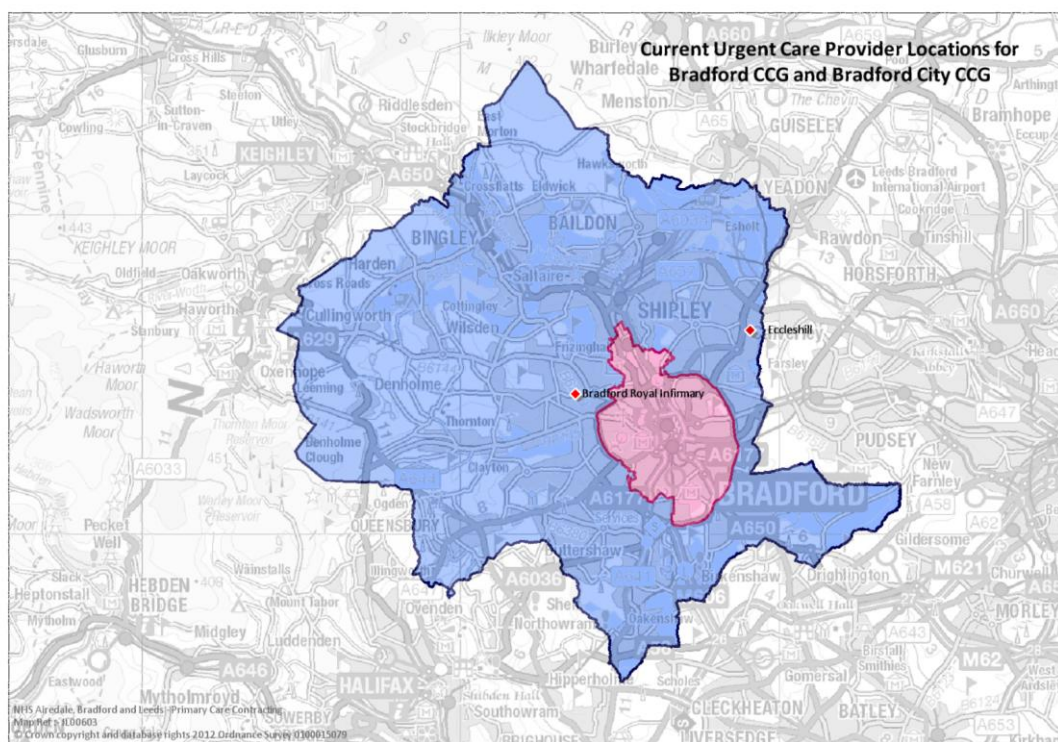
Refer to core Specification

2.2 Any exclusion criteria

Refer to core Specification

2.3 Geographic coverage/ boundaries

Map 1



The Contractor will provide the service to any patient registered at a general practice within the Bradford locality as determined in map 1

In addition the Contractor will provide the service to any out of area patients directed through the 111 service or who self present, such as temporary residents

2.4 Whole System Relationships

Refer to core specification

2.4.1 Bradford Whole System Transformation

Key organisations within the local health and social care economy have developed and signed up to a shared vision of integrated health and social care:

To ensure appropriate and timely access to urgent care across Bradford and Airedale, including improving access to primary care services, reducing the duplication of urgent care provision and ensuring patients are seen by the most appropriate clinician to meet their needs. This is to be achieved through ensuring that all parts of the system function cohesively, including primary, secondary and community-based services, as well as from the wider health and social care economy. Individuals will be able to access high quality, cost effective care services across the sector with specific services tailored to meet local needs.

As a key stakeholder the Contractor will actively engage and co-operate with service development and transformational change contributing to achievement of the shared vision.

The Contractor will be a member of and will actively and positively contribute to the Urgent Care Network, supporting delivery of the shared vision and that of both commissioning bodies within Bradford: Bradford Clinical Commissioning Group and Bradford City Clinical Commissioning Group. The Contractor will identify a senior representative who will attend relevant meetings and as an organisation will engage in transformational change initiatives, working with partners and stakeholders to design integrated models of care, specifically within Bradford. The Contractor will contribute to the development of integrated care pathways with other parts of the local system including A&E and ambulance services to ensure delivery of an integrated, efficient service, where appropriate.

Any service developments will be considered within the context of the wider health and social care economy and any contract adjustments necessary as a result of transformational change will be subject to agreement through negotiation between the Commissioner and Contractor.

The Contractor will also contribute to the local and regional Clinical Quality and Governance arrangements, specifically relating to urgent and intermediate care pathways.

2.5 Interdependencies with other services

The Contractor will ensure that the importance of extensive knowledge and understanding of the range and scope of locally commissioned services is understood and embedded by all staff throughout the service. This will be demonstrated by appropriate onward referral and signposting and the contribution the Contractor makes to avoiding unnecessary admissions to hospital.

2.6 Relevant networks and screening programmes

Refer to Master Specifications

2.7 Training/ education/ research activities

Refer to Master Specification

3. Service Delivery

3.1 Service model

Refer to Master Specifications

3.2 Care pathways

3.4 Location(s) of service delivery

The exact locations for the Primary Medical Care Centres (PMCC) within the Bradford boundary are currently the subject of an ongoing Engagement exercise with the general public, which is due for completion by 06 April 2012. Bidders will be formally informed of the outcome of the engagement and subsequent Cluster Board decision regarding the location from where PMCC's are to be provided by no later than 20 April 2012.

NHS Bradford and Airedale currently commission Primary Medical Centres:

- near to the A&E department at Bradford Royal Infirmary from 6.30pm until 8.00am Monday to Friday and then 24 hours a day on Saturday, Sunday and bank holidays;
- near to the A&E department at Airedale General Hospital from 6.30pm until 8.00am Monday to Friday and then 24 hours a day on Saturday, Sunday and bank holidays; and
- at the front of Eccleshill Community Hospital from 6.30pm until 10.30pm Monday to Friday and 7.00am until 10.30pm on Saturday, Sunday and bank holidays.

Public opinion has been sought regarding whether NHS Bradford and Airedale should commission face to face appointments to be provided from either 1 site or 2, as per the following specific options:

- a. Keep the current locations for services at, or close to, the A&E department at BRI, and further improve these services by providing more doctors to increase the number of appointments available. The limited service currently running at Eccleshill Community Hospital would be stopped in order to do this. Or
- b. Continue to provide the current level of services at, or close to, the A&E department at BRI and also continue to provide the same limited GP out-of-hours service in the community. This may move from Eccleshill Community Hospital depending on the results of an assessment of where there is most need for urgent out-of-hours care in the district.

Please note that the exact question asked to the residents of Bradford and Airedale includes reference to Airedale General Hospital. It is anticipated that this location will be commissioned as a specific aspect of the Airedale, Wharfedale and Craven CCG specification, as at Appendix x.

The Contractor will, therefore as a minimum, be expected to provide a Primary Medical Care Centres co-located with or near to the A&E department at Bradford Royal Infirmary.

The Contractor will need to make suitable arrangements to secure a sub-lease from the head lease holder for all locations.

As required within the core specification the contractor is required to make business continuity plans and contingency arrangements to ensure delivery of the service from within the locality in the event of a disaster or any significant event.

3.3 Days/ hours of operation

1. For the PMCC at, or close to, the A&E department at BRI:

- Monday to Friday 18.30 hours to 08.00 hours
- Saturday and Sunday 08.00 Saturday to 08.00 Monday
- Bank Holidays and any additional Public/Bank Holidays that may be announced nationally 08.00 to 08.00 next working day

Subject to the outcome of the engagement plan, an additional limited PMCC community based service may be required:

- Monday to Friday 18.30 hours to 22.00 hours
- Saturday and Sunday 08.00 hours to 22.00 hours
- Bank Holidays and any additional Public/Bank Holidays that may be announced nationally 08.00 hours to 22.00 hours

3.4 Referral Criteria and sources

Refer to Core Specification

3.5 Referral processes

Refer to Core Specification

3.6 Discharge processes

Refer to Core Specification

3.7 Response times and prioritisation

Refer to Core Specification

4. Other

Local practice are adopting risk profiling techniques, the Contractor will note any associated flags on patients records and will adhere, where clinically indicated, to the patient care plans with a view of avoiding unnecessary admissions. For example by referring to ACCT for rapid and intensive intervention at home

5. Quality Requirements

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>

Please refer to core specification

6. Activity

6.1 Indicative Activity Plan

OOH Home Visit: **7740**

OOOH PCC appt: **26680**

6.2 Capacity Review

Please refer to core specification

7. Prices & Costs

7.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value (for this service)
National Tariff plus Market Forces Factor				
Reduced Tariff Prices				
Non-Tariff Price (cost per case/cost and volume/block/other)*				
Total		£		£

**delete as appropriate*

7.2 Cost of Service by Commissioner

Total Cost of Service	Co-ordinating COMMISSIONER	Associate COMMISSIONER	Associate COMMISSIONER	Associate	Total Annual Expected Cost
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	Total	Total	Total	COMMISSIONER Total	
£	£	£	£	£	£

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**Annex 7 - Estates Information – West Yorkshire Urgent Care consult and treat – existing services
NHS Bradford**

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
1.	Outpatients, Airedale General Hospital	GP Out of Hours	Lease Airedale NHS Trust /LCD 30 March 2014	-	Yes	£8,770 pa	Yes
2.	Bradford Royal Infirmary	GP Out of Hours	License Bradford TH NHS FoundationTrust 30 March 2014	-	Yes	£44,000 pa	Yes
3.	Eccleshill Comm. Hospital	GP Out of Hours	Licence Bradford & Airedale Teaching PCT 30 March 2014	-	Yes	£4,300 pa licence	£3,000 pa service

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NHS Calderdale

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
	<u>Calderdale Royal Hospital</u>	GP out of hours and A&E streaming	<u>Calderdale and Huddersfield NHS Trust</u> <u>Expiry 31 March 2013.</u>	Care Uk	No	The Licence for rental of the premises is £54,962 per annum	Inclusive of rates & outgoings whatsoever

NHS KIRKLEES

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
1.	Huddersfield Royal Infirmary	GP Out of Hours/Dental	Tenancy at Will – Calderdale and Huddersfield NHS Foundation Trust/LCD Expires 31 March 2013	-	No	£86,153.00pa	All above
2.	Dewsbury Health Centre *	GP Out of Hours	Lease between Kirklees PCT and LCD	—	No	£44,500.00pa	£12.500 pa service charge
3.	Local Care Direct, Huddersfield	GP Out of Hours	LCD Owned	-	No*	-	-

*OOH PCC is run from Dewsbury Health Centre – this is covered by the EAC lease. The EAC lease was not changed to reflect the addition of OOH and so the figure noted does not reflect the true cost for the service location. Previously the OOH PCC was provided through a ‘Licence to Occupy’ with Mid Yorks Hospitals NHS Trust at a cost of £2,500pa.

NHS Leeds

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
1.	<u>St George’s Centre</u> St Georges Road Middleton Leeds	Minor Injuries Unit GP Out of Hours	<u>Leeds PCT</u> Expiry 30/03/2023 (no breaks) Landlord – Leeds	<u>Local Care Direct</u> Expires 31/03/2012 but 12 months extension agreed to 31/03/2013	No	£89,000	Includes meet and greet service charge element

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
	LS10 4UZ		City Council				
2.	<u>Lexicon House</u> Wilmington Grove Barrack Street Leeds LS7 2BQ	GP Out of Hours	<u>Leeds PCT</u> Expiry 30/04/2019 Break date 30/04/2013 (notice to be given 29/10/2012) Landlord –L and S Marten	<u>Local Care Direct</u> Expires 30/04/2012 but extension agreed to 31/03/2013	Yes	£70,000	No
3.	<u>Wharfedale Hospital</u> Otley	Minor Injuries Unit	<u>Local Care Direct</u> Expiry 31/3/2013 (TBC) Landlord - LTHT	N/A	No	£150,000	Unitary charge, rates, water, heat and light and pest control services

NHS Wakefield District

	Site	Service	Headlease	Underlease	Subject to engagement?	Cost per annum	Lease includes? (security / cleaning / council tax etc)
1.	<u>Pontefract General Infirmary</u> Friarwood Lane, Pontefract, West Yorkshire, WF8 1PL	GP Out of Hours	Licence to Occupy between Mid Yorkshire Hospitals NHS Trust and Local Care Direct Limited Expiry 31/3/2013	-	No	Licence Fee £2,814.29 (Two Thousand Eight Hundred and Fourteen Pounds Twenty Nine Pence)	All services
2.	<u>Trinity Medical Centre</u> First Floor Suite, Trinity Medical Centre, Thornhill Street, Wakefield West Yorkshire, WF1 1PG	GP Out of Hours	Lease between Primary Health Investment Properties Limited and Local Care Direct Limited Expiry 31/3/2013	—	No	£15,000 per annum	Service subject to separate agreement with facilities company

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¹ DOH (2003) **National Service Framework for Children Young People and Maternity Services**
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4067251.pdf

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[accessed Aug 2011]

² Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

³ Ibid

⁴ Ibid

⁵ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_062667.pdf

[accessed Aug 2011]

⁶ The Royal College of Anaesthetists (2010) **Guidelines for the Provision of Anaesthetic Services**

⁷ Ibid

⁸ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**

⁹ DOH (2004) **National Service Framework for Children Young People and Maternity Services**

¹⁰ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

http://www.rcgp.org.uk/pdf/Archives_Services_for_Children_in_Emergency_Departments.pdf [accessed Aug 2011]

¹¹ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

¹² Ibid

¹³ DOH (2004) **National Service Framework for Children Young People and Maternity Services**

¹⁴ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

¹⁵ Ibid

¹⁶ Ibid

¹⁷ Ibid

¹⁸ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency**

¹⁹ Ibid

²⁰ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**

²¹ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

²² CEMACE 2008

²³ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

²⁴ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**

²⁵ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in**
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Emergency Departments

²⁶ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

²⁷ Ibid

²⁸ DOH (2011) **You're Welcome Quality Criteria**

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127632.pdf [accessed Aug 2011]

²⁹ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital: A team response**

³⁰ Ibid

³¹ Ibid

³² Ibid

³³ Ibid

³⁴ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

³⁵ Ibid

³⁶ Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

³⁷ Ibid

³⁸ Ibid

³⁹ Ibid

⁴⁰ Ogilvie, D., Arch Dis Child 90: 138 - 142; **Hospital Based Alternatives to Acute Paediatric Admission, A Systematic Review**

⁴¹ DOH (2006) **The Acutely or Critically Sick or Injured Child in the District General Hospital, a team response**

⁴² Report of the Intercollegiate Committee for Services for Children in Emergency Department (2007) **Services for Children in Emergency Departments**

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