The Gateway
Service Specification

National/Local Context

This specification sets out the minimum general requirements and specific requirements for high quality, GP led primary medical care services within the practice boundary of The Gateway, in Rotherham.

The Gateway service is currently provided by a social enterprise within Rotherham whose main aim has been to create community hub facilities alongside healthcare provision. NHS Rotherham CCG is keen to ensure this ethos is not lost within the re-procurement of these services particularly given that they relate more to supporting the wider needs (social and economic) which impact on health if they are not supported. This therefore includes providing facilities for voluntary and support organisations to work within the 3 practices.

Population Demographics and Health Needs

The Gateway is a collaboration of 3 practices 1 situated in the city centre (The Gate) of Rotherham, 1 in Canklow Meadows (Canklow) and 1 in Rawmarsh area of Rotherham (Rosehill).

As at July 2015 the actual list size of the practice is 6356:

- Canklow 1887
- The Gate 1802
- Rosehill 2667

<table>
<thead>
<tr>
<th>Patient Age Distribution</th>
<th>Canklow</th>
<th>Gate</th>
<th>Rosehill</th>
<th>Rotherham Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4 years</td>
<td>9.1%</td>
<td>13.6%</td>
<td>5.9%</td>
<td>6%</td>
</tr>
<tr>
<td>Under 18 years</td>
<td>31.3%</td>
<td>15.8%</td>
<td>13.1%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Over 65</td>
<td>7.6%</td>
<td>1%</td>
<td>17.2%</td>
<td>18%</td>
</tr>
<tr>
<td>Over 75</td>
<td>2.6%</td>
<td>0.4%</td>
<td>7.8%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Over 85</td>
<td>0.9%</td>
<td>0%</td>
<td>1.7%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Ethnicity

Rotherham CCG average ethnicity is 8.35%. The breakdown for the 3 practices population from BME groups is as follows:

- The Gate 66.15%
- Canklow 24.85%
- Rosehill 00.00%
Deprivation

Deprivation is higher than average in Rotherham and about 22.8% (11,300) of children live in poverty. Deprivation score of the practice population is over double that of the England average of The Index of Multiple Deprivation for the practices is below, and approximately 34% children live in poverty.

IMD Scores:
Canklow 46.5
Gate 49.6
Rosehill 30.3
Rotherham 28.7

Life Expectancy

The health of people in Rotherham is generally worse than the England average. Life expectancy for both men and women is lower than the England average. Life expectancy is 1.4 years lower for men and 1.4 years lower for women in Rotherham against the national average and life expectancy is 9.0 years lower for men and 7.0 years lower for women in the most deprived areas of Rotherham than in the least deprived areas. The practice population male life expectancy 75.5 years and female life expectancy 79.2 years.

<table>
<thead>
<tr>
<th></th>
<th>Male Life Expectancy</th>
<th>Female Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham Average</td>
<td>77.5</td>
<td>81.4</td>
</tr>
<tr>
<td>Canklow</td>
<td>75.6</td>
<td>79.3</td>
</tr>
<tr>
<td>Gate</td>
<td>74.6</td>
<td>77.9</td>
</tr>
<tr>
<td>Rosehill</td>
<td>76</td>
<td>81.8</td>
</tr>
</tbody>
</table>

Child health

In Year 6, 23.4% (671) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 29.1 per 100,000 population, better than the average for England. This represents 17 stays per year. Levels of breastfeeding and smoking at time of delivery are worse than the England average.

Adult health

In 2012, 28.5% of adults are classified as obese, worse than the average for England. The rate of alcohol related harm hospital stays was 673 per 100,000 population. This represents 1688 stays per year.

The rate of self-harm hospital stays was 161.4 per 100,000 population. This represents 406 stays per year.

The rate of smoking related deaths was 349 per 100,000 population, worse than the average for England. This represents 497 deaths per year.
Estimated levels of adult physical activity are worse than the England average. The rate of TB is better than average.

**Disability**

The practice has a higher number of patients claiming Disability Living Allowance (DLA) compared to Rotherham CCG and national mean.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Gate</td>
<td>79.3</td>
</tr>
<tr>
<td>Canklow</td>
<td>96.1</td>
</tr>
<tr>
<td>Rosehill</td>
<td>85.5</td>
</tr>
</tbody>
</table>

**Care Home residents**

1.0% of the practice population reside in a care home.

<table>
<thead>
<tr>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canklow</td>
</tr>
<tr>
<td>Gate 61</td>
</tr>
<tr>
<td>Rosehill 5</td>
</tr>
</tbody>
</table>

**Service Delivery**

Schedule 2 of the Contract provides a full breakdown of the service delivery requirements.

In addition to Schedule 2, the Gate also provides services for the public health team which are currently contracted until March 2017. These services are predominantly drugs and alcohol and sexual health. It is an expectation that these services will continue to be delivered by the provider in accordance with the relevant specifications which are available for review.
1. **Equity of Access**

1.1 The Contractor shall:

(a) Not discriminate between Patients on the grounds of age, sex, sexuality, ethnicity, disability, or any other non-medical characteristics;

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

(c) provide a dedicated telephone number for text phone users and a signing service with British Sign Language Speakers for patients who have hearing difficulties to enable them to access the Services;

(d) provide information in Braille or audio format for people with a sensory impairment of a visual nature;

(e) supply to all non-English speaking users professional translation services and establishing arrangements for both telephone based and face to face interpreting as well as translations of materials describing procedures and clinical prognosis in line with the Contractors Interpreter and Translation Policy and for the languages being the most common languages spoken by Patients who are likely to use the Services.

(f) encourage and deliver health promotion and disease prevention activities to all Patients including those from hard-to-reach groups encouraging active involvement with existing networks including a well established Equality, Diversity and Human Rights Group.

(g) The Contractor acknowledges that a hard-to-reach group shall include but not be limited to the following:

- 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;
- travelling communities
- black or minority ethnic communities;
- adolescents;
- elderly and/or housebound people;
• those who have mental illnesses;
• those who misuse alcohol or illicit drugs; and
• those who belong to a lower socio-economic class, or who are unemployed.

1.2 The Contractor acknowledges that to improve equity of access for black and minority ethnic (“BME”) Communities, it is important to collect information on ethnicity and first language due to the need to take into account culture, religion and language in providing appropriate individual care, for shared care, including secondary care, and the need to demonstrate non-discrimination and equal outcomes. The Contractor shall therefore be required to record the ethnic origin and first language of all Registered Patients.

1.3 The Contractor will, where known, flag on patient records the needs of patients who have physical, sensory or learning disabilities so that necessary arrangements are highlighted prior to consultation.

2 Patient Dignity & Respect

2.1 The Contractor shall:

(a) ensure that the provision of the Services and the environment / Practice Premises protect and preserve Patient dignity, privacy and confidentiality in line with national recommendations and the Contractors policy;

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

(c) provide a chaperone for intimate examinations to preserve Patient dignity and respect cultural preferences, in line with the Contractors’ policy; and

(d) ensure that Contractor Staff behave professionally and with discretion towards all Patients and visitors at all times and that Equality and Diversity training will be mandatory for all staff.

(e) Not discriminate on the grounds of race, religion and belief, disability, gender, age or sexual orientation, marriages / civil partnership and pregnancy and maternity

3 Informed Consent

3.1 The Contractor shall comply with NHS requirements in relation to obtaining informed consent from each Patient as notified to the Contractor by NHS England from time to time prior to commencing treatment including the following as amended from time to time:
(a) Department of Health Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2002;

(b) Health Service Circular HSC 2001/023; and

(c) Seeking Patients' Consent. The Ethical Consideration: GMC November 1998.

4 Children

4.1 The Contractor shall:

(a) provide the Services to Children who attend the Premises in accordance with the standards contained in the National Service Framework for Children, young people and maternity services, as well as local protocols notified to the Contractor, as amended from time to time;

(b) ensure that Staff who manage and treat Children are familiar with, including regular training in, local Child protection policies and Contractor Policy, annually for GPs, two years in three for Nursing staff and triennially for all other staff;

(c) ensure that all staff know how to document concerns, who the safeguarding lead in the practice is and refer on to appropriate organisations

(d) have open access to supervision, mandatory training and support from a registered Children’s nurse within the local health care community, and possess the common core competencies to:
   • carry out clinical assessments;
   • provide immediate necessary treatment required by the protocols established under paragraph 4.1(a) above; and
   • arrange onward referral to an appropriate specialist service required by the protocols referred to in paragraph 4.1(a) above.

(e) ensure the practice system has an agreed means of identifying children, patients and siblings on the Child Protection Register

(f) have ad-hoc and scheduled meetings between GPs, health visitors, practice nurses and midwives in respect of children about whom there are concerns.

5 Prescribing

5.1 Without prejudice to Clause 20 of this Agreement which shall prevail in case of conflict or ambiguity with this paragraph 5, the Contractor shall:

(a) prescribe the most clinically and cost effective medicines in accordance with national and local guidance from time to time including:
• NICE guidance and Department of Health directives relating to prescribing;
• Good Prescribing Practice as defined by BNF and the local prescribing formulary;
• shared care protocols agreed between the CCG and other secondary care NHS Contractors; and
• Patient Group Directions, such as emergency contraception, antibiotics;

(b) manage their prescribing budget and follow recommendations regarding prescribing initiatives. Should the Contractor exceed the prescribing budget, they will be expected to provide suitable justification for this position; The practice Pharmacy advisor will audit and analyse patient groups or medicines to improve quality and value for money

(c) have a prescribing rate for generic, non-branded drugs in accordance with the prescribing table set out in Schedule 6 (Performance Management);

(d) have a system that ensures regular medication review for all Patients on four or more repeat medicines;

(e) cooperate with and apply recommendations of the body responsible for medicines management;

(f) supply prescriptions using a Prescriber;

(g) where relevant, levy NHS prescription charges and collect NHS overseas visitors’ charges in accordance with the overseas visitors hospital charging regulations in accordance with guidance contained in Annex A of the Department of Health document “proposals to exclude overseas in from time to time visitors from eligibility to free NHS primary Medical Services as amended”;

(h) use NHS Prescription Forms (for dispensing in the community); and

(i) comply with guidance relating to safe and secure handling of medicines as detailed in The Safe and Secure Handling of Medicines: a team approach http://www.rpsgb.org.uk/pdfs/safsechandmeds.pdf; and adhere to the most recent safe and secure handling of medicine advice

(j) develop and implement standard operating procedures for storage, transportation, security and control of wastage.

(k) Repeat prescriptions will be available within 2 working days and can be requested online, by telephone or in consultation

5.2 The practice will work with Nursing and Residential Care homes to

(a) improve repeat prescription request systems and support staff

(b) medicines management education.
6. Clinical Safety & Medical Emergencies

6.1 The Contractor shall:

(a) Ensure that all Contractor Staff have and maintain basic life support and first aid certification with competence in Automated External Defibrillator Use, which is reviewed annually; and procure that all Contractor Staff comply with the UK Resuscitation Council guidelines on Basic Life Support and the Use of Automated External Defibrillators;

(b) Provide locums and new staff with information and training as appropriate in line with the Contractors Medical Emergencies policy;

(c) Ensure the availability of sufficient numbers of Contractor Staff with appropriate skill, training and competency and who are able and available to recognise, diagnose, treat and manage Patients with urgent conditions at all times; and that all staff are trained to respond to a panic alarm and assess the situation;

(d) Possesses the equipment and in-date emergency drugs including oxygen to treat life-threatening conditions such as anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus; and that Resuscitation equipment is kept in a secure central location where named individuals have responsibility for checking and readiness on a daily basis;

(e) Ensure that at any given time a named GP is on-call for acute medical emergencies with a second on-call rota for ensure cover at all times; Basic life support will be given where appropriate and all life threatening conditions passed to the ambulance service as soon as practicable by dialling 999 and requesting the ambulance service;

(f) Adhere to any national or local guidelines relating to clinical safety and medical emergencies in primary care as amended from time to time; and

(g) Ensure all medical emergencies are discussed as significant events within the team meetings.

7. Good Clinical Practice

7.1 Without prejudice to Clause 66 of this Agreement, the Contractor shall perform the Services in accordance with the following requirements as amended from time to time:

(a) Any Care Quality Commission Standards in force from time to time during the term of this Agreement;

(b) the “excellent GP” according to Good Medical Practice for General Practitioners (RCGP 2002);

(c) any relevant MHRA guidance, technical standards, and alert notices;

(d) the highest level of clinical standards that can be derived from the standards and regulations referred to in this paragraph 7.1 Part 1, of Schedule 2 and
8. **Equipment**

8.1 The Contractor shall provide medical and surgical equipment, medical supplies including medicines, drugs, instruments, Appliances, and materials necessary for Patient care which shall be adequate, functional and effective.

8.2 The Contractor shall establish and maintain a planned preventative programme for its equipment as referred to in paragraph 8.1 above and make adequate contingency arrangements for emergency remedial maintenance.

8.3 All goods and equipment will be registered on a database which will be used as a whole life cycle toolkit to ensure Portable Appliance Testing, contract, reactive and planned preventative maintenance schedules.

9. **Infection Control**

9.1 The Contractor shall have in place arrangements that meet the standards outlined in the NICE guidelines on infection control “Infection: Prevention and control of healthcare-associated infections in primary and community care (March 2013)”. [https://www.nice.org.uk/guidance/qs61](https://www.nice.org.uk/guidance/qs61) to maintaining a safe, hygienic and pleasant environment at the Practice Premises and shall:

(a) ensure that appropriate procedures are implemented in relation to cleaning, disinfection, inspection, packaging, sterilisation, transportation and storage of reusable medical devices;

(b) ensure that procedures implemented in accordance with paragraph 9.1(a) above shall be such as to ensure that reusable medical devices are handled safely and decontaminated effectively prior to re-use;

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

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

10. **Referrals**

10.1 The Contractor shall:

(a) monitor and minimise inappropriate referrals and hospital admissions;

(b) cooperate with and make effective use of:

(i) 111 including offering electronic booked appointments to 111 triage;

(ii) the community matron/case management team;

(iii) CCG commissioned services provided outside acute hospitals including health promotion services; and
(iv) local authority services and employment advisers;

(c) work with other service Contractors, such as A&E, Out of Hours services, Local Authority and Community Services, to ensure that care and treatment is effectively co-ordinated across Health and Social Care boundaries

(d) cooperate with service Contractors carrying out Out of Hours Services to ensure safe and seamless care for Patients including providing information on a weekly basis to the Contractor of the Out of Hours Services on Patients that may require their services or who have special clinical requirements and ensuring patients with Long Term Conditions can access this in the community wherever possible, working to an agreed care plan;

(e) provide complete and comprehensive referral information to the service the Patient is being referred to, to enable any further activity to proceed;

(f) use robust clinical pathways and build on local integrated care pilot schemes for referral, agreed with other local healthcare Contractors;

(g) routinely collect data about the appropriateness of the Contractor’s referrals;

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

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

(i) review referrals practice to ensure it is in line with latest guidance and protocols;

(j) develop and implement policies in relation to nurse and nurse specialist referrals and their extended role in treatment and investigation of patients with specified diseases; and

(k) provide community based specialist clinics for individual patient consultations with secondary care specialists.

(l) implement and operate Choose and Book at point of referral for specialist services, and provide a booking facility (in accordance with the national choice and book agenda).

(m) to avoid unplanned hospital admissions by:
   - Maintaining advanced care planning and palliative registers
   - Working closely with residential and care homes within the practice area
   - Joint mental health liaison work
   - Closer working with the Ambulance service for paramedics/ECPs to manage category C type calls to the ambulance service
- Ensuring practice opening times are well published and there is clear information with regard our facilities and services
- Maintain patients in their homes or a community setting where this meets their needs working with community health and social teams
- Monitoring referrals and unplanned admissions practice data

(o) appoint one individual who is a health care professional to act on its behalf in the dealings between the CCG to which it belongs

11. **Vision for Primary Care Services**

11.1 The Contractor shall cooperate with the CCG and other GP practices to build governance structures that ensure and are encompassed by an assurance framework; and implement all developments arising from the

- Care Quality Commission (CQC);
- NHS Next Stage Review;
- NHS Outcomes Framework;
- High Quality Care for All;
- White Paper “Our Health, Our Care, Our Say: A New Direction for Community Services” DH 2006,
- Agreed NHS Strategies for the provision of care and treatment of patients including without limitation, implementation of:
  
  a) Clinical Commissioning;
  
  b) Patient experience surveys;
  
  c) self care, expert Patient programs and self monitoring;
  
  d) NHS 111
  
  e) choice in care and treatment, including secondary Contractor; and
  
  f) an open list service.

12. **Co-operation With Other NHS Contractors**

12.1 The Contractor will provide an integrated and fully supported primary health care team to work in partnership with all other NHS and non NHS healthcare Contractors and stakeholders, (including, but not limited to, health visitors, district nurses, social services, mental health services, acute trusts and acute trust laboratories, community health Contractors, other GP practices and healthcare Contractors and local voluntary and third sector organizations) on the same basis as other GP practices;

12.2 The Contractor shall:
(a) meet with key community Health Care Professionals (particularly district nurses, health visitors, psychiatric nurses, social workers midwives and social services) with a view to accommodating them on the Practice Premises, so as to facilitate opportunities for local engagement; and

(ii) establish good information flows to/from pathology and diagnostic Contractors and NHS and non-NHS healthcare Contractors;

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

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

(d) utilise specialist services (for example drug misuse, minor surgery, dermatology, NHS dentistry) from central primary care locations and other services at local locations to avoid duplication of services, promote economies of scale, and bring practices together to plan and implement common aims for the benefit of those practices and their patients.

(e) Build on the Contractors inventory of existing community activities and area based activities and maintain their proactive partnership with the local Healthwatch, local Carers groups, and to further establish links with neighbourhood partnerships, to identify those who could become “agents of change” and community champions.

12.3 The Contractor shall be required to collaborate with the CCG in the following areas:

(a) structures - to ensure that links are maintained with key structures within the CCG and local health economy, particularly with forums dealing with Patient and Public Involvement (an NHS defined term) which is an initiative to involve Patients and the public in the planning of services, including the development of a framework for the practice;

(b) process – to ensure that similar policies and protocols are in place between the Contractor and CCG (e.g. clinical policies, workforce planning including training opportunities and structured secondment programmes subject to agreement by the Commissioner and Department of Health); and

12.4 The Contractor shall:

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

ii. develop referral protocols with local health facilities including NHS England and the CCG; and
13. **Clinical Commissioning Group (“CCG”)**

13.1 The Contractor will in relation to CCG:

(a) engage in local CCG arrangements and work in partnership to reconfigure local services to provide modernised clinical pathways;

(b) comply with any DH guidance on CCG now, or in the future;

(c) work with the CCG and other GP practices to submit practice or locality commissioning plans; and develop a strategic vision for the area in conjunction with the CCG and Health and Wellbeing Board.

(d) reflect pre-existing commissioning arrangements made by the CCG such as options for choice of referral provided by the CCG for all GP practices in the CCG’s area;

(e) involve Patients and the local community in service developments and improvements;

(f) ensure that Patients are able to exercise choice;

(g) deliver key national targets and value for money; and

(h) ensure commissioning is within the outcomes framework;

(i) Work closely to assist in prioritising patient initiatives and sharing experiences and innovative methods of engaging patients; as well as innovative services in relation to the public health challenges of the area.

14. **Quality Assurance**

14.1 The Contractor shall:

(a) comply with the Quality and Outcomes Framework (“QOF”) as indicated in Part 4 of this Schedule 2;

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

(c) operate an effective, comprehensive, System of Integrated Governance using a framework that also demonstrated compliance with CQC standards and the QOF;

(d) have medical leadership in place in accordance with Clause 50 of this Agreement which is ensured through the clinical lead;

(e) nominate a person who will have responsibility for ensuring the effective operation of the System of Clinical Governance, in line with the Contractors integrated governance framework, and who is accountable for any activity carried out on a Patient;

(f) continuously monitor clinical performance and evaluate untoward events and near misses arising from any activity and provide the Commissioner with the Records referred to in paragraph 18.4 to enable the Commissioner to assess whether standards are being met; and to
review systematically by the Organisational Medical Director and Practice Management Team.

(g) use appropriate formal methods such as root cause analysis for untoward incidents, near misses and complaints;

(h) undertake robust auditing of clinical care against clinical standards with frequent auditing of the quality of consultations in the first three months post service commencement;

(i) comply with the Commissioner’s governance requirements and inspections, and, make available on reasonable notice to the Commissioner, any and all Contractor records (including permitting the Commissioner to take copies) relating to Contractor clinical governance to enable the Commissioner to audit and verify the clinical governance standards of the Contractor;

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

(k) provide the Commissioner with a service improvement plan for the GP Practice Service; and

(l) participate in all quality and clinical governance initiatives agreed between the Commissioner and its other GP practices.

(m) commitment to work towards affiliation to approved MRCGP practice accreditation;

(n) meet all standards in the stated CQC Registration Requirements; and have reporting arrangements in place to ensure that the Contractor is discharging its responsibilities in terms of delivery of its Sustainable Development Strategy.

15. Practitioner Skill Mix/Continuity

15.1 The Contractor shall:

(a) use its reasonable endeavours to notify and consult with the Commissioner about any planned material changes to the skill mix of Clinical Staff at the GP Practice; and

(b) to maintain continuity of Clinical Staff and keep the Commissioner informed of any changes in GPs or nurse practitioners.

(c) To staff the practices using Salaried doctors who will work a 37.5 hour week in 9 nominal sessions of 4 hours 10 minutes. It is envisaged that appointments will normally be an average of 10 minutes

(d) Nurses will work a standard 37.5 hour week in 5 nominal sessions of 7.5 hours. Nurses will average 15 minute appointments and deliver specialist clinics

16. Risk Management

16.1 The Contractor shall operate:
(a) Robust and rigorous mechanisms for managing risk; and to identify and report all incidents and near misses.

(b) disaster recovery, contingency and business continuity plans;

(c) keep the Commissioner fully informed about the:
   i. Contractor’s approach to risk management (risk philosophy) including the risk the Contractor is willing to bear before taking action and what processes are implemented;
   ii. detail of the risk management structures and processes that exist and how they are implemented; and

(d) notify the Commissioner about the resource allocation to risk management (existing/planned) and to put in place individuals for the leadership roles set out in Clause 50 of this Agreement.

(e) A ‘fair blame’ incident reporting and learning culture within the practice

17. **Provision of Reception Services**

17.1 Reception services will be provided by the Contractor at the Practice Premises in accordance with the Opening Hours.

17.2 The receptionist duties will include:

(a) taking Patient details (name, time of appointment, service required, name of GP);

(b) inputting Patient details and allocating the Patient appointment on the appointment system (whether electronic or paper);

(c) reporting the Patient’s arrival to the GP;

(d) directing the Patient on arrival at the Practice Premises to the appropriate waiting room or treatment area in the Practice Premises; and

(e) answering and co-ordinating Patient queries and requests.

(f) providing privacy for patients and respecting confidentiality; and

(g) respecting and maintaining patients’ dignity at all times.

18. **Patient Records**

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

a. Good Clinical Practice;

b. this Part 1 of Schedule 2; and

c. the requirements of NHS Information Management & Technology Requirements and Technical Guidance.

18.2 The Contractor shall at its own cost retain and maintain all the clinical records in chronological order and in a form that is capable of audit.
18.3 Wherever practical, original records shall be retained and maintained in electronic form.

18.4 The Contractor shall make such records available for inspection to authorised representatives of the Commissioner and any other relevant Health Service Body where it has reasonable cause for requiring such records, on giving reasonable notice.

19. **Contractor Records**

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

(a) contract management reporting;

(b) national / data set reporting;

(c) activity reporting, including:

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

ii. preparation and submission of weekly status reports to the Department of Health and the Commissioner;

iii. activity reporting in support of quarterly monitoring returns (QMAE) to the Department of Health (as agreed with the Commissioner);

iv. by practice and host CCG;

v. requisite data for payment purposes;

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

vii. activity and outcomes data in support of service evaluation including without limitation, the Practice Performance Report (Schedule 6 Performance Management) enabling the GP Practice Service to be monitored against the Quality and Outcomes Framework in line with other practices to assess whether the threshold of 98%, (as referred to in Part 4 of this Schedule 2) has been met presenting conditions versus actual outcome, age group and gender activity data, attendance trends (day/time) and prescribing data.

19.2 The Contractor shall:

(a) on request produce the Records for inspection by the Commissioner or, on receipt of reasonable notice, allow or procure for the Commissioner and/or its authorised representatives access to any premises where any Records are stored for the purposes of inspecting and/or taking copies of and extracts from Records free of charge and for the purposes of carrying out an audit of the Contractor’s compliance with
this Agreement, including all activities of the Contractor, the Charges and the performance, and the security and integrity of the Contractor in providing the Services under this Agreement;

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

(c) prevent any corruption or loss of the Records; and

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

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

20. Information Management & Technology

20.1 Clinical System

The Contractor must put in place the information technology infrastructure and systems, plus the service management arrangements, necessary to support the Service delivery.

All clinical activity must be recorded on the IT system, including any hand written notes.

20.2 Infrastructure

The Contractor must have a secure IT infrastructure that should underpin and support all the requirements mentioned in this document. In particular:

(a) The technical infrastructure and systems should be sufficient to deliver a satisfactory and timely service to the patient regardless of level of usage, even at peak times. The Service and its technical solution should be scalable so that capacity can be added if demand increases beyond the predicted volumes.

(b) The Contractor will be responsible for the provision and management of the IT system including hardware and software, management training, implementation, refresh and support associated with the Service.

(c) Where appropriate, the Contractor must provide a telephone solution that enables them to meet the requirement of the Service.

20.3 Systems Interoperability and Integration

The Contractor should maintain an awareness of information strategy in the NHS and local health community, and to develop their systems to integrate or interoperate with NHS national systems such as C&B (Choose and Book), SCR (Summary Care Record), PDS (Personal Demographics Service), etc.
The Contractor is required to work with the local health community and IT Providers to develop and improve interoperability and integration of structured, coded information, so that electronic transfer and/or access to information is available in as simple and easy a manner as is possible.

The Contractor will consider ways in which technology can be used to improve the cost effectiveness of service delivery.

20.4 Information Requirements

The Contractor must supply a full data extract of all data items for commissioning systems; therefore:

(a) The Contractor must provide a mechanism for all data to be exported regularly from the system and transferred to any specified destination in a recognised and acceptable format. The Contractor must provide a data dictionary of all fields within the application in line with the NHS data dictionary where relevant.

(b) The Contractor must have data quality processes and checks in place to ensure that the data recorded is complete, accurate and timely, and that duplicate or empty records are managed correctly.

(c) The information systems should ideally use a recognised coding system.

(d) From April 2014 CIDS (Community Information Dataset) becomes mandatory and contractors will be expected to comply with all aspects of these standards: http://www.hscic.gov.uk/comminfodataset. Contractors would also be expected to comply with any ISNs (Information Standards Notice) that are relevant to the service specification for the duration of the contract.

20.5 Information Governance

The Contractor must have comprehensive information governance policies and procedures in place to include:

(a) Appropriate information management and governance systems and processes in place to safeguard patient confidential data and to comply with confidentiality and Data Protection laws/regulations and Confidentiality Codes of Practice. This will need to be supported by appropriate training and contracts for all staff. All information must be secure in any form or media, such as paper or electronic system. Any exchange of personal/sensitive information must be via an appropriate secure method/process;

(b) Ensuring full detailed information is available for performance management, audit trail of each activity, prevention of fraud and investigation of any complaints; and

(c) All staff must respect the confidentiality of any information relating to The Gateway, its staff, or its patients.
The Contractor will ensure that all data processing is done in the European Economic Area, or if not, that appropriate safeguards are in place, as required by the Data Protection Act 1998.

The Contractor will undertake data migration support, if appropriate, from existing systems to the new Service system to ensure a seamless transfer.

The Contractor will be responsible for the appropriate management of and secure storage of all records, including paper. At the end of the contract, these will be transferred to NHS England South Yorkshire and Bassetlaw Business Support Agency.

The Contractor or its staff must not disclose any confidential information (relating to this Service) to any person other than a person authorised in writing by [Insert Contractor] or nominated organisations working on behalf of [Insert Contractors].

The Contractor will appoint a Caldicott Guardian – this must be a senior clinician within the Contractor’s organisation, and a Senior Information Risk Owner (SIRO) – this must be a senior member within the Contractor’s organisation.

The Contractor shall have in place a completed NHS Information Governance Statement of Compliance (IGSoC).

The Contractor will identify an Information Governance lead within the Contractor's organisation.

The Contractor must complete and provide evidence that they have achieved minimum of level 2 scores in each requirement for their organisation's Information Governance Toolkit: https://nww.igt.hscic.gov.uk/.


The Contractor will participate in additional Information Governance audits agreed with the Commissioner.

The Contractor will take appropriate technical and organisational measures against any unauthorised or unlawful processing of Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the state of technological development, the nature of the data to be protected and the harm that might result from such unauthorised or unlawful processing or accidental loss, destruction or damage.

21. **Health Promotion and Disease Prevention**

21.1 The Contractor shall deliver Services that are focused heavily on health promotion and disease prevention. The Contractor acknowledges that the
Commissioner has a number of key public health challenges that it needs to address and that it shall as a result be required to support the Commissioner in meeting such challenges.

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

- smoking;
- alcohol;
- obesity;
- lack of exercise;
- dietary habits; and
- sexual behaviour.

For the purposes of this paragraph, “Long Term Conditions” shall be deemed to be those conditions that cannot at present be cured but which can be controlled by medication and other therapies (cancers, sexually transmitted infections and unwanted pregnancies).

21.3 The Contractor shall identify and proactively screen and manage Patients at risk of developing long term conditions, cancers and sexually transmitted infections as well as those more likely to have unwanted pregnancies.

21.4 Evidence based interventions and NICE guidelines will be followed in order to provide a broad range of patient centred integrated service close to home, in partnership with secondary care. The Contractor shall develop the Expert Patient Programme and work with Mental Health Teams to ensure patients with long term conditions, including Mental Health problems receive the full range of care required.

21.5 A multi-disciplinary Elderly Care team and network will be developed for the elderly to address their needs physical, mental and social.

21.6 Hard to reach groups will be targeted using social marketing to identify key groups and barriers.

21.7 Uptake of population screening and immunisation programme will be analysed to identify low uptake groups; and interventions and services will be monitored for efficacy.

21.8 The Primary Care Team will deliver lifestyle intervention programmes for overweight patients.

21.9 The Primary Care Team will be trained in the use of and to provide alcohol risk assessments; and GPs and Nurses will provide increased support and treatment opportunities for patients with identified alcohol issues.

21.10 The Primary Care Team will engage with local youth groups to encourage young people to attend local GUM/sexual health clinics for education, advice and support.
22 Adverse Incidents

22.1 The Contractor shall have in place a system for collecting data on and analysing Adverse Incidents in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to identify actions that might lead to future improvements or avoidance of further incidents.

22.2 The Contractor shall report on Adverse Incidents on request from the Commissioner.

a) The recording of all incidents, accidents, complaints and claims; and record adverse incidents under the following headings:

   I. Death occurring in practice premises
   II. New cancer diagnosis
   III. Death where terminal care took place at home
   IV. Patient complaint
   V. Patient suicide
   VI. Section under the Mental Health Act
   VII. Prescribing-related events
   VIII. Nursing-related events
   IX. Other medical incidents
   X. Other administrative incidents; and
   XI. Other incidents
   XII. All adverse incidents will be audited in line with the audit cycle and target work to be addressed.

23 Patient Experience

23.1 From 1 December 2014, it is a contractual requirement that all GP practices implement the NHS Friends and Family Test (FFT).

The full guidance can be found here: [www.nhsemployers.org/FFT](www.nhsemployers.org/FFT)

23.2 Practices must

(a) Provide an opportunity for people who use the practice to give anonymous feedback through the FFT.
(b) Use the standard wording of the FFT question and the responses exactly, as set out below. NHS England has published advice on how feedback can be collected from people who may not be able to answer the FFT question on their own.
(c) Include at least one follow up question which allows the opportunity to provide free text.
(d) Submit data to NHS England each month.
(e) Publish results locally.
Part 2

GP Practice Service

1. Services To Be Performed By The Contractor

1.1 The Contractor shall provide:

(a) GP or nurse led primary medical care services as set out in this Schedule 2 to Patients residing in the Practice Areas referred to in paragraph 7.1 of Part 2 of this Schedule 2; and

(b) A home visiting service for those patients presenting with an urgent clinical need, who live within the Practice boundary but are registered with a practice outside of Rotherham CCG boundary in accordance with GP Choice requirements.

(c) A violent patient service in accordance with the Service Agreement for violent patients (See Schedule 11). To note that this service will be provided throughout the term of the contract.

(d) The Services in accordance with the clinical service requirements set out in Part 3 of this Schedule 2.

2. Contracted Activity and Growth for the GP Practice

2.1 The Commissioner has not projected the list size for the practice throughout the period of the contract. It is the Contractor's responsibility to sustain and grow the list within a cap determined by the Commissioner.

2.2 The Contractor shall ensure that the Contractor’s List of Registered Patients in respect of the GP Practice Service is derived from the population within the Practice Area specified in Annex 1.

3. Access To Services

3.1 The Contractor must ensure as a minimum:

a) that the GP Practices, The Gate, Canklow and Rosehill, Rotherham are open for a minimum of 52.5 hours per week, providing a minimum of 9 clinical sessions (1 clinical session equates to 4 hours 10 minutes). The Contractor must deliver services in accordance with the times set out in the table below.

In addition to the specified hours below, the Contractor may choose to deliver the Directed Enhanced Service for Extended Hours at a time that is suitable to patients following consultation. Extended Hours provision will be reviewed by the Contractor to determine required hours of delivery in line with the outcome of patient consultation.
From the Commencement Date until termination or expiry of the Agreement

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(b) subject to paragraph 3.1(a) above that:

(i) Patients are able to consult an appropriate Health Care Professional within twenty-four (24) hours and a GP within forty-eight (48) hours of contacting or attending the GP Practice;

(ii) that Registered Patients are able to book appointments with a GP or appropriate Health Care Professional at the GP Practice up to four (4) weeks in advance and consult by telephone;

(iii) that in a clinical emergency a Patient is able to book an emergency appointment on the same day; and that the duty clinician will decide to triage telephone consult or call the patient into surgery

(iv) Patients are able to consult an appropriate Health Care Professional or GP of their choice within seven (7) working days;

(c) doctors surgeries will be able to be booked up to a minimum of eight weeks in advance and Nurse appointments booked up to three months in advance.

(d) that appointment lengths are tailored to the clinical needs of Patients, which for Registered Patients shall be for no less than ten (10) minutes for GP consultations and not less than fifteen (15) minutes for nurse consultations; and that surgeries are available at 24 hours notice.

(e) appointment times will be doubled for any patient requiring an interpreter, This will only be available to pre-booked patients, therefore for acute/urgent appointments an accredited telephone translation service will be employed.

(e) in respect of Registered Patients booked to see a GP at the GP Practice, consultation is commenced within thirty (30) minutes of the scheduled appointment time unless there are exceptional circumstances;

(f) treatment for 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;
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 GP Practice;

Patients will receive appointment reminders via text if requested

Registered Patients who do not attend booked appointments ("DNAs") are minimised for booked appointments at the GP Practice; First DNA will be coded, second DNA will be noted through either a call to the patients or letter, at the third DNA the patient will be invited to meet with the practice manager and discuss the problem. Patients with special needs, mental health problems and learning disabilities are exempt from this process, although their DNA rate is monitored.

to allow Patients who contact the Practice Premises by telephone to be able to do so without difficulty and allow Patients as far as possible to be able to consult the Health Care Professional that they request on making the appointment.

Information on what to do in case of an emergency and how to access treatment out of hours including information on 111, will be stored on the practice answerphone.

at busy times around public holidays, a rota system will operate to maximise the number of patient slots

the practice will have doctors on call throughout the core hours of 8.00 am – 18.30 pm and extended hours as agreed.

patients will be able to access telephone advice during opening hours from an appropriately trained individual and all GPs will have available telephone consultation slots.

Triage of same day and urgent requests will be dealt with over the phone if possible where the patient may be given advice and information and if investigations are required, the triaging clinician will arranged for these to be done at the practice and book the appointment; and

where the urgent request requires a face to face consultation, an appointment will be given with the appropriate healthcare professional and any follow up required will be booked in at the consultation. Alternatively the patient will be contacted by telephone to review their condition.

patients will be able to make follow up appointments following implementation of the 111 system

for minor ailments patients will be offered the option of obtaining treatment from the local pharmacy
3.2 The Contractor shall manage the continuity of care of Patients who:
   (a) have been recently discharged from hospital; or
   (b) require the frequent use of Out of Hours Services; or
   (c) have long term conditions.

4. General

4.1 The Contractor shall:
   (a) provide a GP Practice Service (as detailed in this Part 2 of Schedule 2) at the Practice Premises; and
   (b) provide the GP Practice Service for Registered Patients (except where stated to the contrary in respect of particular services) who have booked an appointment to see a clinician at the Practice Premises.

5. GP Practice Services

5.1 The Contractor shall provide the following clinical services as part of the GP Practice Services:
   (a) Essential Services as detailed in paragraph 1 of Part 3 of this Schedule 2;
   (b) Additional Services as detailed in paragraph 2 of Part 3 of this Schedule 2;
   (c) Directed Enhanced Services and National Enhanced Services are not embedded within the contract, the Contractor will receive remuneration for this enhanced service as per the national specification.

5.2 The Contractor shall:
   (a) provide services focusing on health promotion and disease prevention and work with the CCG, other local GP practices and other health Contractors on initiatives to promote health and prevent disease within the CCG area;
   (b) ensure it has effective strategies for health promotion and disease prevention in place and shall meet the requirement of paragraph 20 of Part 1 of this Schedule 2;
   (c) provide information about, and access to, self-management programmes for Registered Patients with long term conditions where appropriate;
   (d) identify local care pathways for Registered Patients with long term conditions to reduce inappropriate and unnecessary hospital admissions;
   (e) provide information and advice to Registered Patients on self-monitoring for long-term conditions;
   (f) participate in expert Registered Patient programmes;
(g) use computer-based disease management templates; and
(h) implement appropriate DH, NICE, MHRA and any other relevant guidelines (as amended from time to time) that apply to the provision of primary medical care services for Registered Patients.

6. **Home Visits As Part Of The GP Practice Service**

6.1 The Contractor shall ensure that in relation to visits to Registered Patients in the Practice Area other than at the Practice Premises:

(a) Registered Patients are seen as soon as practicable according to clinical need at a time agreed with the patient and in any event on the same day as the GP Practice being alerted;

(b) Registered Patients are informed of the timescale in which they will be visited if the agreed visit is delayed; and

(c) visits are made according to clinical need as determined by GP acting in accordance with Good Clinical Practice.

6.2 House calls will be available every day (Monday – Friday). A Nurse Practitioner or GP will routinely telephone housebound patients to engage in discussion and optimise care.

6.3 The Contractor shall ensure that in relation to visits to Temporary Residents, that such Temporary Residents are seen as soon as possible according to clinical need but not necessarily on the same day as the GP Practice being alerted.

7. **Patient Registration Area**

7.1 The Practice Area means the areas identified on the map attached as Annex 1 to this Schedule 2 in respect of which persons resident in it will be entitled to seek registration with the Contractor or seek acceptance by the Contractor as a Temporary Resident for the purposes of the Contractor’s List of Registered Patients at the main site and branch site.

7.2 Where this agreement

(a) specifies an area edged in blue on the map referred to in paragraph 7.1, being an area other than that referred to in paragraph 7.1, which is to be known as the outer boundary area as respect which a patient-

(i) who moves into that outer boundary area to reside; and

(ii) who wishes to remain on the contractor's list of patients,

may remain on that list if the contractor so agrees, notwithstanding that the patient no longer resides in the area referred to in clause 7.1; and

(b) specifies an outer boundary and a patient remains on the contractor's list of patients as a consequence of sub-paragraph (a) the outer boundary area is to be treated as part of the contractor's practice area.
for the purposes of the application of any other terms and conditions of the agreement in respect of that patient.

8. **Long Term Conditions Management**

8.1 The Contractor shall:

(a) have in place effective call and recall systems to manage Registered Patients with long term conditions; and remote monitoring systems will be utilised for selected patients

(b) make effective use of computer disease management templates to ensure the QOF Score is greater than the national average and in any event no less than 95% of the total maximum points available.

(c) establish systems for early identification of patients with LTC and/or palliative care needs being discharged from hospital and who attend A&E and Out of Hours services.

(d) Ensure each patient receives an initial care plan at time of diagnosis and updated as appropriate.

(e) Ensure each patient receives an individualised, written care plan which identifies their management plan and individual goals including health and social needs, which is developed and agreed by the individual and their carer; and include a “Traffic Light System” to define severity of the condition at any given time.

(f) Ensure each patient has a named key professional worker to coordinate their care.

(g) Ensure a GP or Nurse Practitioner contacts any patient with an LTC within 48 hours of discharge from hospital or out of hours services for the purpose of review of management of the LTC;

(h) Regularly review patients with an LTC. Frequency will be tailored to need but at a minimum annually; and to ensure that where it is appropriate they are seen in their own home as well in one single visit in the case of multiple conditions.

(i) The Contractor will manage LTCs by doing the following:

- Screening and targeting interventions for population wide prevention
- Managing risk factors – smoking, diet, weight, exercise, alcohol
- Positive outreach
- Self-management and patient education programmes
- Medication reviews
- Integrated pathways for common conditions and reviews
- Anticipatory care plans for patients with predefined needs
- Identification of high service users and those at risk of frequent admissions
- Proactive links with specialist teams and community matrons
- Practice based multidisciplinary teams to include community staff, social workers and pharmacists to manage patients with long term conditions
- Cancer referrals within specified target times
- Out of Hours effective interface
- Offering nurse led chronic disease clinics with the support of secondary specialist care nurses

9. **Contractor's List Of Registered Patients**

Please note that in clauses 9.1 to clause 24.1 the commissioner is NHS England Business Support Agency located at White Rose House, Ten Pound Walk, Doncaster, South Yorkshire.

9.1 The Contractor's List of Registered Patients will open on the Commencement Date and the Commissioner shall prepare and keep it up to date to reflect Registered Patients who have:

(a) been accepted by the Contractor for inclusion in the Contractor’s List of Registered Patients and who have not subsequently not been removed by the Contractor from that list; or

(b) been assigned to the Contractor by the Commissioner and whose assignment has not subsequently been rescinded; and

(c) not been removed from the Contractor’s List of Registered Patients.

10 **Application For Inclusion On The Contractor’s List Of Registered Patients**

10.1 If the Contractor's List of Registered Patients is Open, the Contractor shall accept an application for inclusion in the Contractor’s List of Registered Patients made by or on behalf of any person, resident within the Practice Area, including any person who, at the time of that application, is included on a list of Registered Patients of another Contractor or Contractor of primary medical care services.

10.2 The Contractor shall, if the Contractor's List of Registered Patients is Closed, only accept an application for inclusion in the Contractor’s List of Registered Patients from a person who is an Immediate Family Member of a Registered Patient resident within the Practice Area, including any person who, at the time of that application, is included on a list of Registered Patients of another Contractor or Contractor of primary medical care services.

10.3 Subject to paragraph 10.4(a) below, an application for inclusion in the Contractor's List of Registered Patients shall be made by delivering to the Practice Premises a Medical Card or an application signed (in either case) by the applicant or a person authorised by the applicant to sign on his behalf.

10.4 An application may be made:

(a) on behalf of any Child;

   i. by either Parent, or in the absence of both Parents, the guardian or other adult who has care of the Child;
ii. by a person duly authorised by a local authority to whose care the Child has been committed under the Children Act 1989; or

iii. by a person duly authorised by a voluntary organisation by which the Child is being accommodated under the provisions of the Children Act 1989;

iv. on behalf of any adult who lacks the capacity to make such an application, or authorise such an application to be made on their behalf, by a relative of that person, the primary carer of that person, a donee of a lasting power of attorney granted by that person or a deputy appointed for that person by the court under the provisions of the Mental Capacity Act 2005.

10.5 Where the Contractor accepts an application for inclusion in the Contractor’s List of Registered Patients, the Contractor shall notify the Commissioner in writing as soon as possible and in any case, within six (6) weeks.

10.6 On receipt of such notice, the Commissioner shall include that person in the Contractor’s List of Registered Patients from the date on which the notice is received unless the Commissioner has a reasonable objection to including such Registered Patient which discretion shall be used in exceptional circumstances (including violent patients or patients outside the Practice Area), and shall notify the applicant (or, in the case of a Child or an adult who lacks capacity, the person making the application on their behalf) in writing of the acceptance or rejection.

11. Temporary Residents

11.1 The Contractor may, if the Contractor’s List of Registered Patients is Open, accept a person as a Temporary Resident for a period of three months provided it is satisfied that the person is:

11.2 temporarily resident away from his normal place of residence and is not being provided with Essential Services under any other arrangement in the locality where he is temporarily residing; or

11.3 moving from place to place and not for the time being resident in any place.

11.4 For the purposes of paragraph 11.1(a) above, a person shall be regarded as temporarily resident in a place if, when he arrives in that place, he intends to stay there for more than twenty-four (24) hours but not more than three (3) months.

11.5 Where the Contractor wishes to terminate its responsibility for a person accepted as a Temporary Resident before the end of three (3) months or such shorter period for which it had agreed to accept him as a Registered Patient, the Contractor shall notify that person either orally or in writing and its responsibility for that person shall cease seven (7) days after the date on which the notification was given.

11.6 At the end of three (3) months, or on such earlier date as its responsibility for the Temporary Resident has come to an end, the Contractor shall notify the Commissioner in writing of any person whom it accepted as a Temporary Resident under this paragraph 11 of this Schedule 2.
12. **Refusal Of Applications For Inclusion In The Contractor's List Of Registered Patients Or For Acceptance As A Temporary Resident**

12.1 The Contractor shall only refuse an application of a person for acceptance as a Temporary Resident if it has reasonable grounds for doing so which do not relate to the applicant’s race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition, or that that the applicant does not temporarily reside in the Practice Area or lives in the outer boundary area (the area referred to in paragraph 7.2).

12.2 The Contractor shall only refuse an application of a person for acceptance as a Temporary Resident if it has reasonable grounds for doing so which do not relate to the applicant’s race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition, or that that the applicant does not temporarily reside in the Practice Area or lives in the outer boundary area (the area referred to in paragraph 7.2).

12.3 The Contractor shall keep a written record of refusals of applications and of the reasons for them and shall make this record available to the Commissioner on request.

13. **Patient Preference Of Practitioner**

13.1 Where the Contractor has accepted an application for inclusion in the Contractor's List of Registered Patients, it shall:

(a) notify the Registered Patient (or, in the case of a Child or an adult who lacks capacity, the person making the application on their behalf) of the Registered Patient’s right to express a preference to receive services from a particular performer or class of performer either generally or in relation to any particular condition; and

(b) record in writing any such preference expressed by or on behalf of the Registered Patient.

13.2 The Contractor shall endeavour to comply with any reasonable preference expressed by the Registered Patient but shall not be required to do so if the preferred performer has reasonable grounds for refusing to provide services to the Registered Patient, or does not routinely perform the service in question within the GP Practice.

14. **Removals From The Contractor’s List Of Registered Patients At The Request Of The Registered Patient**

14.1 The Contractor shall notify the Commissioner in writing of any request for removal from the Contractor’s List of Registered Patients received from a Registered Patient.

14.2 Where the Commissioner receives notification from the Contractor, or receives a request from the Registered Patient to be removed from the
Contractor’s List of Registered Patients, it shall remove that person from the Contractor's List of Registered Patients.

14.3 A removal shall take effect on the date on which the Commissioner receives notification of the registration of the person with another Contractor of Essential Services (or their equivalent) or fourteen (14) days after the date on which the notification or request respectively is received by the Commissioner, whichever is the sooner.

14.4 The Commissioner shall, as soon as practicable, notify in writing the Registered Patient and the Contractor, that the Registered Patient’s name will be or has been removed from the Contractor's List of Registered Patients on the date referred to in paragraph 14.3 above.

14.5 In this paragraph and in paragraphs 15(1)(b) and 15.5, 16.3(a) and 16.4, 18.1, and 20.2 a reference to a request received from or advice, information or notification required to be given to a Patient shall include a request received from or advice, information or notification required to be given to:

(a) in the case of a Patient who is a Child, a parent or other person referred to in paragraph 10.4(a); or

(b) in the case of an adult patient who lacks the capacity to make the relevant request or receive the relevant advice, information or notification, a relative of that person, the primary carer of that person, a donee of a lasting power of attorney granted by that person or a deputy appointed for that person by the court under the provisions of the Mental Capacity Act 2005.

15. **Removals From The Contractor's List Of Registered Patients At The Request Of The Contractor**

15.1 Where the Contractor has reasonable grounds to remove a Registered Patient from the Contractor’s List of Registered Patients, which do not relate to the applicant’s race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition, the Contractor shall:

(a) notify the Commissioner in writing that it wishes to have the Registered Patient removed; and

(b) notify the Registered Patient in writing of its specific reasons for requesting removal.

15.2 Where, in the reasonable opinion of the Contractor, the circumstances of the removal are such that it is not appropriate for a more specific reason to be given, and there has been an irrevocable breakdown in the relationship between the Registered Patient and the Contractor, the reason given may consist of a statement that there has been such a breakdown.

15.3 The Contractor shall keep a written record of removals which shall include the reason for removal given to the Registered Patient, the circumstances of the removal, and the Contractor shall make this record available to the Commissioner on request.
15.4 A removal requested in accordance with this paragraph 15 shall take effect from the date on which the person is registered with another Contractor of Essential Services, or eight (8) days after the Commissioner receives the notice, whichever is the sooner.

15.5 The Commissioner shall notify in writing the Registered Patient and the Contractor that the Registered Patient’s name has been or will be removed from the Contractor’s List of Registered Patients on the date referred to in paragraph 15.4 above.

Removals Of Violent Registered Patients From The Contractor’s List Of Registered Patients

16.1 Where the Contractor removes a Registered Patient from the Contractor’s List of Registered Patients with immediate effect on the grounds that:

(a) The Registered Patient has committed an act of violence or behaved in such a way that a reasonable person has feared for their safety; and

(b) the Contractor has reported the incident to the police;

16.2 The persons referred to in 16.1 are:

(a) the Contractor where it is an individual medical practitioner;

(b) in the case of a contract with two or more individuals practicing in partnership, a partner in that partnership;

(c) in the case of a contract with a company, a legal beneficial owner of shares in that company;

(d) a member of the Contractor staff;

(e) a person engaged by the Contractor to perform or assist in the performance of services under the contract;

(f) any another person present on the practice premises or in the place where services were provided to the patient under the contract.

16.3 The Contractor shall notify the Commissioner by any means including telephone or email but if not given in writing shall subsequently be confirmed in writing within seven (7) days (and for this purpose an email or faxed notification is not a written one). The Commissioner shall acknowledge receipt of such a request from the Contractor in writing.

16.4 A removal requested in accordance with paragraph 16.1 above shall take effect at the time the Contractor makes the telephone call to the Commissioner, or sends or delivers the notification to the Commissioner.

16.5 Where the Commissioner has removed a Registered Patient from the Contractor’s List of Registered Patients in accordance with this paragraph 16:

i) it shall give written notice of the removal to that Registered Patient; and

ii) the Contractor shall record that the Registered Patient has been removed in the Registered Patients medical records together with the circumstances leading to his removal.

16.6 Where the Contractor has notified the Commissioner of its removal of a Registered Patient from the Contractor’s List of Registered Patients, it shall inform the Registered Patient concerned unless:
17. Refusal to see Violent Patients

17.1 Contractor can refuse to see an Unregistered Patient on the grounds that:

(a) a Patient has been removed from a Contractor’s List of Registered Patients pursuant to Schedule 2 Part 2 paragraph 16; or

(b) the Patient has committed an act of violence or behaved in such a way that a reasonable person has feared for their safety; and

(c) the Contractor has reported the incident to the police; or

17.2 The persons referred to in 17.1 are:

(a) the Contractor where it is an individual medical practitioner;

(b) in the case of a contract with two or more individuals practicing in partnership, a partner in that partnership;

(c) in the case of a contract with a company, a legal beneficial owner of shares in that company;

(d) a member of the Contractor staff;

(e) a person engaged by the Contractor to perform or assist in the performance of services under the contract;

(f) any another person present on the practice premises or in the place where services were provided to the patient under the contract.

17.3 The Contractor shall notify the Commissioner by any means including telephone or fax but if not given in writing shall subsequently be confirmed in writing within seven (7) days (for this purpose a faxed notification is not a written one). The Commissioner shall acknowledge receipt of such a request from the Contractor in writing.

17.4 A removal requested in accordance with paragraph 16.1 above shall take effect at the time the Contractor makes the telephone call to the Commissioner, or sends or delivers the notification to the Commissioner.

17.5 Where the Contractor has notified the Commissioner of its refusal to see a Patient, it shall inform the Patient concerned unless:

(a) it is not reasonably practicable for it to do so; or

(b) it has reasonable grounds for believing that to do so would be harmful to the physical or mental health of the Patient or would put at risk the safety of one or more of the persons providing Services under this Agreement; or

(c) notice has already been given to the Patient under paragraph 16.
18. **Removals For The Contractor’s List Of Registered Patients Of Patients Registered Elsewhere**

18.1 The Commissioner shall reserve the right to remove a Registered Patient from the Contractor’s List of Registered Patients if he has subsequently been registered with another Contractor of Essential Services (or their equivalent) in the Practice Area or it has received notice from the Commissioner, a Health Board, a Local Health Board or a Health and Social Services Board that the Registered Patient has subsequently been registered with a Contractor of Essential Services (or their equivalent) outside the Practice Area.

18.2 A removal in accordance with this paragraph 18 shall take effect on the date on which notification of acceptance by the new Contractor was received or with the consent of the Commissioner, on such other date as has been agreed between the Contractor and the new Contractor.

19. **Removals From The Contractor’s List Of Registered Patients Who Have Moved Out Of The Practice Area**

19.1 Where the Commissioner is satisfied that a person on the Contractor’s List of Registered Patients no longer resides in the Practice Area, the Commissioner shall:

(a) inform the Registered Patient and the Contractor that the Contractor is no longer obliged to visit and treat the Registered Patient;

(b) advise the Registered Patient in writing to:

(i) obtain the Contractor’s agreement to the continued inclusion of the Registered Patient on the Contractor’s List of Registered Patients; or

(ii) apply for registration with another Contractor of Essential Services (or their equivalent); and

(iii) inform the Registered Patient that if, after the expiration of thirty (30) days from the date of the advice referred to in paragraph 18.1(b), he has not acted in accordance with the advice and informed the Commissioner accordingly, the Commissioner will remove him from the Contractor’s List of Registered Patients.

19.2 If, on the expiration of the period of thirty (30) days referred to in paragraph 18.1(b) above, the Commissioner has not been notified of the action taken by the Registered Patient, it shall remove the Registered Patient from the Contractor’s List of Registered Patients and inform him and the Contractor accordingly.

19.3 Where the address of a Registered Patient who is on the Contractor’s List of Registered Patients is no longer known to the Commissioner the Commissioner shall:

(a) notify the Contractor in writing that it intends, at the end of the period of six (6) months commencing with the date of the notice, to remove the
Registered Patient from the Contractor’s List of Registered Patients; and

(b) at the end of that period, remove the Registered Patient from the Contractor’s List of Registered Patients unless, within that period, the Contractor notifies the Commissioner that the Contractor remains responsible for providing Essential Services to that Registered Patient.

20. **Removals From The Contractor’s List Of Registered Patients Absent From The United Kingdom**

20.1 The Commissioner and the Contractor shall remove a Registered Patient from the Contractor’s List of Registered Patients where it receives notification that the Registered Patient:

(a) intends to be away from the United Kingdom for a period of at least three (3) months;

(b) is in Her Majesty’s Forces;

(c) is serving a prison sentence of more than two (2) years or sentences in excess of two (2) years in the aggregate;

(d) has been absent from the United Kingdom for a period of more than three (3) months; or

(e) has died.

20.2 The Commissioner shall notify the Contractor in writing of Registered Patients removed from the Contractor’s List of Registered Patients under this paragraph 19.

21. **Removals From The Contractor’s List of Registered Patients Accepted Elsewhere as Temporary Residents**

21.1 The Commissioner shall remove from the Contractor’s List of Registered Patients a Registered Patient who has been accepted as a Temporary Resident by another Contractor or other Contractor of Essential Services (or their equivalent) where it is satisfied, after due inquiry that the:

(a) Registered Patient’s stay in the place of temporary residence has exceeded three (3) months; and

(b) Registered Patient has not returned to his normal place of residence or any other place within the Practice Area.

21.2 The Commissioner shall notify the Contractor and, where practicable, the Registered Patient of a removal under this paragraph 21.

21.3 A notification to the Registered Patient shall inform him of:

(a) his entitlement to make arrangements for the provision to him of Essential Services (or their equivalent), including by the Contractor by whom he has been treated as a Temporary Resident; and
22. **Removals From The Contractor’s List Of Registered Patients Of Pupils Of A School**

22.1 Where the Contractor provides Essential Services under this Agreement to persons on the grounds that they are pupils at, or staff or residents of a school, the Commissioner shall remove from the Contractor’s List of Registered Patients any such persons who do not appear on particulars provided by that school.

22.2 Where the Commissioner has made a request to a school to provide the particulars referred to in paragraph 22.1 above and has not received them, the Commissioner shall consult the Contractor as to whether it should remove from the Contractor’s List of Registered Patients any persons appearing on that list as pupils, staff or residents of that school.

22.3 The Commissioner shall notify the Contractor in writing of any such Registered Patients removed from the Contractor’s List of Registered Patients under this paragraph 21.

23. **Registered Lists**

23.1 The Commissioner may assign a new Registered Patient to the Contractor’s List of Registered Patients.

23.2 In this paragraph 23, a “new” Registered Patient means a person who:

   (a) is resident (whether or not temporarily) within the Practice Area;

   (b) has been refused inclusion in a list of Registered Patients of, or has not been accepted as a Temporary Resident, by a Contractor whose premises are within the Practice Area; and

   (c) wishes to be included in the Contractor’s List of Registered Patients.

24. **Factors Relevant To Assignments**

24.1 In making an assignment to the Contractor, the Commissioner shall have regard to:

   (a) the wishes and circumstances of the Registered Patient to be assigned;

   (b) the distance between the Registered Patient’s place of residence and the GP Practice;

   (c) whether, during the six (6) months ending on the date on which the application for assignment is received by the Commissioner, the Registered Patient’s name has been removed from the list of
Registered Patients of any Contractor in the area of the Commissioner or the equivalent provision in relation to that Contractor;

(d) whether the Registered Patient’s name has been removed from the list of Registered Patients of any Contractor in the area of the Commissioner or the equivalent provision in relation to that Contractor and, if so, whether the Contractor has appropriate facilities to deal with such a Registered Patient;

(e) a fair equitable basis being applied with other local practices, such that Registered Patients who are difficult to place are not unreasonably assigned to the Contractor (when compared with other local practices); and

(f) such other matters as the Commissioner considers to be relevant.
Part 3

General Practice Clinical Service Requirements

1 Essential Services

1.1 The Contractor shall provide Essential Services and as further described in paragraphs 1.3 to 1.5 in Part 3 of this Schedule 2 at such times, within Opening Hours, as are appropriate to meet the reasonable needs of Registered Patients.

1.2 The Contractor shall have in place arrangements for Patients to access such services throughout the Opening Hours in case of emergency and in accordance with the KPI’s.

1.3 The Contractor shall provide:

(a) Essential Services required for the management of Patients and who are, or believe themselves to be:
   (i) ill with conditions from which recovery is generally expected;
   (ii) terminally ill; or
   (iii) suffering from a long term condition;
(b) Essential Services that are delivered in the manner determined by the GP Practice following discussion with the Registered Patient; and
(c) appropriate ongoing treatment and care to all Registered Patients taking account of their specific needs including:
   (i) advice in connection with the Registered Patient’s health, including relevant health promotion advice;
   (ii) the referral of the Registered Patient for other services under the Act; and
   (iii) primary medical care services required in Opening Hours for the immediately necessary treatment of any person to whom the Contractor has been requested to provide treatment owing to an accident or emergency at any place in the Practice Area.

1.4 For the purposes of paragraph 1.3(a) above, “management” includes:

(a) offering a consultation and, where appropriate, physical examination for the purpose of identifying the need, if any, for treatment or further investigation; and
(b) making available such treatment or further investigation as is necessary and appropriate, including the referral of the Registered Patient for other services under the Act and liaison with other Health Care Professionals involved in the Registered Patient’s treatment and care.
1.5 For the purposes of paragraph 1.3(c)(iii), “emergency” includes any medical emergency whether or not related to the Services provided under this Agreement.

1.6 The Contractor shall provide primary medical care services required in Opening Hours for the immediately necessary treatment of any person falling within paragraph 1.7 below who requests such treatment, for the period specified in paragraph 1.8.

1.7 A person falls within this paragraph 1.7, if he is a person:
   (a) whose application for inclusion in the Contractor’s List of Registered Patients has been refused in accordance with paragraph 6 and paragraphs 10 to 17 of Part 2 of this Schedule 2 and who is not registered with another Contractor of Essential Services (or their equivalent) in the Practice Area;
   (b) whose application for acceptance as a Temporary Resident has been rejected under paragraph 8 of Part 2 of this Schedule 2; or
   (c) who is present in the Practice Area for less than twenty-four (24) hours.

1.8 The period referred to in paragraph 1.6 above is:
   (a) in the case of paragraph 1.7(a), fourteen (14) days beginning with the date on which that person’s application was refused or until that person has been registered elsewhere for the provision of Essential Services (or their equivalent), whichever occurs first;
   (b) in the case of paragraph 1.7(b), fourteen (14) days beginning with the date on which that person’s application was rejected or until that person has been subsequently accepted elsewhere as a Temporary Resident, whichever occurs first; and
   (c) in the case of paragraph 1.7(c), twenty-four (24) hours or such shorter period as the person is present in the Practice Area.

2. Additional Services

2.1 The Contractor shall:
   (a) provide the Additional Services described in paragraph 2.2 below at such times, within Opening Hours, and to have in place arrangements for Registered Patients to access such services throughout the Opening Hours in case of emergency; and in accordance with the KPI’s; and
   (b) provide such facilities and equipment as are necessary to enable it properly to perform each Additional Service that it provides.

2.2 The Additional Services the Contractor shall provide to Registered Patients are:
   (a) Vaccinations and Immunisations including childhood, influenza, and pneumococcal as defined further in paragraph 2.3 of Part 3 of this Schedule 2;
(b) Contraceptive Services as defined in paragraph 2.4 of Part 3 of this Schedule 2;

(c) Maternity Medical Services (excluding intra-partum care) as defined in paragraph 2.5 of Part 3 of this Schedule 2;

(d) Child Health Surveillance Services as defined in paragraph 2.6 of Part 3 of this Schedule 2;

(e) Cervical Screening Services as defined in paragraph 2.7 of this Part 3 of Schedule 2;

(f) Minor surgery as defined in paragraph 2.8 of this Part 3 of Schedule 2; and

(g) Childhood Immunisations and pre-school boosters as defined in paragraph 2.9 of this Part 3 of Schedule 2.

2.3 Vaccinations and Immunisations

2.3.1 The Contractor shall:

(a)

(i) offer to provide to Registered Patients all vaccines and immunisations (other than Childhood Vaccinations and Immunisations and the combined Haemophilus influenza type B and Meningitis C booster vaccine), in accordance with “Immunisation Against Infectious Disease 2005: "The Green Book" and in the circumstances set out in the GMS Statement of Financial Entitlements;

(ii) take into account the individual circumstances of the patient, consider whether immunisation ought to be administered by the Contractor or other health professional or a prescription form ought to be provided for the purpose of the patient self-administering immunisation;

(iii) provide appropriate information and advice to Patients about such vaccinations and immunisations; and

(iv) record in the Patient’s record any refusal of the offer referred to in paragraph (a).

(b) Where the offer is accepted, and immunisations are to be administered by the contractor or other health professional, include in the Patient’s record details of:

(i) the Patients consent to the immunisation or the name of the person who gave consent to the vaccination or immunisation and that person’s relationship to the Patient;

(ii) the batch numbers, expiry date and title of the vaccine;

(iii) the date of administration;
(iv) in a case where two vaccines are administered in close succession, the route of administration and the injection site of each vaccine;

(v) any contraindications to the vaccination or immunisation; and

(vi) any adverse reactions to the vaccination or immunisation.

(c) Where the offers is accepted and the immunisation is not to be administered by the Contractor or other health professional, issue a prescription form for the purpose of self-administration by the patient.

2.3.2 The Contractor must ensure that all staff involved in the Administration of immunisations are trained in the recognition and initial treatment of anaphylaxis.

2.3.3 In this paragraph “patients record” means the record which is kept in accordance with clause 32.

2.4 Contraceptive Services

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

(i) advice about the full range of contraceptive methods;

(ii) where appropriate, the medical examination of Registered Patients seeking such advice;

(iii) the treatment of Registered Patients for contraceptive purposes and the prescribing of contraceptive substances and appliances;

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

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

(vi) initial advice about sexual health promotion and sexually transmitted infections; and

(vii) the referral as necessary for specialist sexual health services, including tests for sexually transmitted infections.
The Contractor shall cooperate with the CCG and the Commissioner and implement health improvement programs that reduce teenage conceptions.

2.5 Maternity Medical Services

(a) The Contractor shall:

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

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

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

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

(b) In paragraph 2.5(a) above:

(i) “antenatal period” means the period from the start of the pregnancy to the onset of labour;

(ii) “Maternity Medical Services” means:

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

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

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

2.6 Child Health Surveillance Services

(a) The Contractor shall, in respect of any Child under the age of five (5) years for whom it has responsibility under this Agreement:

(i) provide the services described in paragraph 2.6(b) below, other than any examination so described which the Parent refuses to allow the Child to undergo, until the date upon which the Child attains the age of five (5) years; and
(ii) maintain such records as are specified in paragraph 2.6(c) below.

(b) The services referred to in paragraph 2.6 (a)(i) above are:

(i) Monitoring:

(A) by consideration of any information concerning the Child received by or on behalf of the Contractor;

(B) on any occasion when the Child is examined or observed by or on behalf of the Contractor (whether pursuant to paragraph 2.6(b)(ii) or otherwise); and

(C) of the health, well-being and physical, mental and social development (the “development”) of the Child while under the age of five (5) years with a view to detecting any deviations from normal development; and

(ii) the examination of the Child at a frequency that has been agreed with the Commissioner in accordance with the nationally agreed evidence based programme set out in the fourth edition of “Health for all Children (David Hall and David Elliman, January 2003, Oxford University Press ISBN 0:19:85188:X) as amended from time to time.

(c) The records referred to in paragraph 2.6 (a)(ii) are an accurate record of:

(i) the development of the Child while under the age of five (5) years, compiled as soon as is reasonably practicable following the first examination of that Child and, where appropriate, updated following each subsequent examination; and

(ii) the responses (if any) to offers made to the Child’s Parent for the Child to undergo any examination referred to in paragraph 2.6 (b)(ii).

2.7 Cervical Screening Services

(a) The Contractor shall:

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

(ii) perform cervical screening tests on women who have agreed to participate in that Programme;

(iii) arrange for women to be informed of the results of the test;

(iv) ensure that test results are followed up appropriately; and

(v) ensure the records referred are an accurate record of the carrying out of a cervical screening test, the result of the test and any clinical follow up requirements.
2.8 Minor Surgery Services

(a) The Contractor shall:

(i) make available to Registered Patients where appropriate;

(A) curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery; and

(B) management of minor injuries that do not require hospital assessment and care.

(ii) The Contractor shall ensure that its record of any treatment provided pursuant to paragraph 2.8.1 (a) includes the consent of the Registered Patient to that treatment.

2.9 Childhood Immunisations and Pre-School Booster Services

(a) The Contractor shall:

(i) develop and maintain a register (its “Childhood Immunisation Scheme Register”, which may comprise electronically tagged entries in a wider computer database) of all the Children for whom the Contractor has a contractual duty to provide childhood immunisation and pre-school booster services (who may already have been immunised, by the Contractor or otherwise, or to whom the Contractor has offered or needs to offer immunisations);

(ii) undertake to offer the recommended immunisations to the Children on its Childhood Immunisation Scheme Register (with the aim of maximising uptake in the interests of Patients, both individually and collectively);

(iii) undertake to record the information that it has in Childhood Immunisation Scheme Register using any applicable national Read codes.

(iv) offer to provide to children, all vaccines and immunisations of the type and in the circumstances which are set out in the GMS Statement of Financial Entitlements;

(b) The Contractor shall:

(i) develop a strategy for liaising with and informing parents or guardians of Children on its Childhood Immunisation Scheme Register about its immunisation programme with the aim of improving uptake; and

(ii) provide information on request to those parents or guardians about immunisation.

(c) The Contractor shall take all reasonable steps to ensure that the lifelong medical records held by a Child’s general practitioner are kept up-to-date with regard to the Child’s immunisation status, and in particular include:
(i) any refusal of an offer of vaccination;
(ii) where an offer of vaccination was accepted:
   (A) details of the consent to the vaccination or immunisation
       (where a person has consented on a Child’s behalf, that
       person’s relationship to the Child must also be recorded);
   (B) the batch number, expiry date and title of the vaccine;
   (C) the date of administration of the vaccine;
   (D) where two vaccines are administered in close succession,
       the route of administration and any injection site of each
       vaccine;
   (E) any contraindications to the vaccination or immunisation;
   and
   (F) any adverse reactions to the vaccination or immunisation.

(d) The Contractor shall ensure that any Health Care Professional who is
    involved in administering a vaccine has:
    (i) any necessary experience, skills and training with regard to the
        administration of the vaccine; and
    (ii) training with regard to the recognition and initial treatment of
        anaphylaxis.

(e) The Contractor shall ensure that:
    (i) all vaccines are stored in accordance with the manufacturer’s
        instructions; and
    (ii) all refrigerators in which vaccines are stored have a
        maximum/minimum thermometer and that readings are taken
        from that thermometer on all working days.

(f) The Contractor shall supply to the Commissioner with such information
    as it may reasonably request for the purposes of monitoring the
    Contractor’s performance of its obligations;

(g) The Contractor shall have in place arrangements for an annual review
    of the service which shall include:
    (i) an audit of the rates of immunisation, which must also cover any
        changes to the rates of immunisation; and
    (ii) an analysis of the possible reasons for any changes to the rates
        of immunisation.

3. Enhanced Services

3.1 The Contractor shall provide the Directed Enhanced Services and National
    Enhanced Services Commissioned by the Commissioner within Opening
    Hours to Registered Patients
3.2 The Contractor shall:

(a) accept any changes or amendments to the Enhanced Services as other participating GP practices on the financial basis set out in Schedule 4 (Finance); and

(b) notify the Commissioner’s clinical governance lead of all emergency admissions or deaths or Registered Patients receiving Enhanced Services, where such admission or death is or may be due to usage of drug(s) or attributable to the relevant underlying medical condition within 72 hours of the information becoming known to the Contractor.

4. Specialised Services – applicable only to The Gate

The Gate: Specialist Services Specification

1. Population Needs

The Gate practice provides services to a unique cohort of patients within the Rotherham health community. These patients have complex clinical needs, in addition to social issues that are inextricably linked to their health and wellbeing. The Gate supports these patients in a number of ways; from an in-depth new patient medical to providing outreach clinics to extremely vulnerable and hard to reach groups.

This specification is designed to take account of requirements that are above and beyond the scope of core activity, and to contract and fund them effectively by acknowledging the increased resource needed to deliver and manage effective care for these groups.

No part of the specification by commission, omission or implication defines or redefines essential or additional services.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
<td>Yes</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
<td>Yes</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
<td>Yes</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td>Yes</td>
</tr>
</tbody>
</table>

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

The Gate practice has been developed specifically to provide consistency in how this
particularly vulnerable client group with additional requirements are managed across Rotherham. The following specification describes the services which have been developed to ensure the public health of patients is protected, reduce the impact of referral to alternative providers, and ensure patients receive an equitable service.

3.2 Service description/care pathway

For each of the following service descriptions electronic records using appropriate read codes in SystemOne must be maintained. The data must be collected in a way that can be easily interrogated, and an annual report providing an in-depth review of all the services delivered in each area of this specification must be submitted to NHS Rotherham CCG each year, by 30th April. The successful provider will agree a set of activity metrics with NHS Rotherham CCG in the first quarter of the contract, and these are to be submitted on a quarterly basis.

The data reporting requirements of this specification may change throughout the life of the contract, and NHS Rotherham CCG reserves the right to request additional information and data at any time in order to be able to review activity, as well as implement more regular data reporting as necessary.

3.2.1 New patient medical

In addition to the routine collection of basic patient information, all new patients at The Gate will be given an enhanced medical review in an appointment with a registered nurse lasting 45 minutes. This will include the following elements:

- Screening for blood-borne viruses i.e. Hepatitis A, B and C, leading to follow up appointments and contact tracing if needed;
- Screening for sexually transmitted infections;
- HIV screening, leading to follow up appointments and contact tracing if needed;
- Assessment of TB risk, leading to a subsequent appointment for TB screening if needed;
- Immunisations and vaccinations in line with current UK guidelines for both adults and children;
- Assessment of alcohol dependency or drug addiction;
- GP input where necessary on the day, and arrangement of any immediately necessary subsequent GP appointments;
- Referrals to secondary care where necessary;
- A discussion around any safeguarding concerns that may arise, and referrals as necessary.

3.2.2 Health related social issues

The majority of patients at The Gate also have a number of social issues that are inextricably linked to their health and wellbeing. The Gate will take an holistic approach and deliver both support and guidance in these areas to any patient in need:

- Effective interpretation facilities to enable all patients to communicate with their clinician effectively;
- Liaison with and on behalf of, and signposting to assistance for Asylum Seekers and Refugees;
- Liaison with and on behalf of, and signposting to Prison and Probation services on behalf of the patient;
- Liaison with and on behalf of, and signposting to the local health community including secondary and mental health services, community services, and drug and alcohol treatment / rehabilitation;
- Liaison and on behalf of, and signposting regarding accommodation and housing issues e.g. access to shelters, homeless services and third sector organisations;
- Liaison with and on behalf of, and signposting to Social Services;


• Guidance and support regarding food and nutrition e.g. access to food banks.

3.2.3  TB Screening

For patients that are identified as being at high risk of TB at their New Patient Medical, TB screening must be offered in a 30 minutes appointment with a registered nurse. The patient must be checked for previous BCG scarring and have a full relevant history taken as well as bloods. The patient should then attend again for the results; if negative, advice and information should be given, and if positive the patient must be referred to secondary care for assessment and treatment.

3.2.4  Shiloh Outreach

Each week The Gate is required to undertake a minimum 3 hour visit to Shiloh to provide outreach clinics to the homeless population. This requires the attendance of both a registered nurse and a Healthcare Assistant. The following services are to be provided to anyone who requires it, and not just registered patients:

• General health and welfare checks, attending to immediate health needs as necessary;
• Dressings for any and all wounds, including chronic leg ulcers;
• Administration of flu/pneumovax vaccines to both the staff and clients;
• Administration of tetanus vaccines, or other vaccinations and immunisations;
• Remote TB screening (see 3.2.3);
• Undertaking STI screening;
• Anyone who is identified as having particularly complex health needs should be given an appointment at the practice to attend for further assessment and care;
• Liaison with and signposting to other health, housing or social agencies, and the third sector.

3.2.5  Travellers Health Assessments

When notified by local authorities of their arrival The Gate will attend traveller sites with two registered nurses to provide outreach clinics. The following services are to be provided to anyone who requires it, and not just registered patients:

• General health and welfare checks for adults and children, attending to immediate health needs as necessary;
• Dressings for any and all wounds, including chronic leg ulcers;
• Administration of flu/pneumovax vaccines;
• Administration of tetanus vaccines, or other vaccinations and immunisations;
• Remote TB screening (see 3.2.3);
• Undertaking STI screening;
• Anyone who is identified as having particularly complex health needs should be given an appointment at the practice to attend for further assessment and care;
• Liaison with and signposting to other health, housing or social agencies, and the third sector.

On average these visits are to be made 10/12 times per year.

3.2.6  Rookwood Outreach

Rookwood is an approved premise responsible for individuals leaving Prison on license and under supervision in the community. The Gate will attend Rookwood with a registered nurse and a GP to provide outreach clinics. A number of the patients are classed as high risk to lone workers, women, and other individuals and therefore must not be seen on practice premises. The following services are to be provided to anyone who requires it, and not just registered patients:
• General health and welfare checks, attending to immediate health needs as necessary;
• Dressings for any and all wounds;
• Administration of flu/pnemovax vaccines to both the staff and clients;
• Administration of vaccinations and immunisations;
• Liaison with and signposting to other health, housing or social agencies, and the third sector.

On average The Gate receives 3/4 referrals per week from Rookwood. If clinically acceptable, the attendance can be limited to weekly however if dressings require more regular attendance, this is required to address the needs of the patient.

3.2.7 Corner House

Corner House is a medium secure unit for Learning Disability and those sectioned under the Mental Health Act. Patients have complex and challenging needs, and The Gate will provide outreach clinics as necessary to avoid the need and risk of patients attending the practice. The following services are to be provided to anyone who requires it, and not just registered patients:

• General health and welfare checks, attending to immediate health needs as necessary;
• Dressings for any and all wounds;
• Administration of flu/pnemovax vaccines to both the staff and clients;
• Administration of vaccinations and immunisations;
• Liaison with and signposting to other health, housing or social agencies, and the third sector.

3.2.8 Care of Leg Ulcers

The Gate has an exceptionally high incidence of chronic venous leg ulcers. Due to the personal circumstances and lifestyles of these patients they are often identified as being unsafe for the District Nursing Team to visit, and therefore have a significant gap in their care in comparison to the rest of the population. To resolve this, The Gate will care for these patients at the surgery using both a registered nurse and a Health Care Assistant.

On average clinics see approximately 25 patients per week.

3.2.9 Astrum House

The Gate will take responsibility for the residents of Astrum House, a nursing home providing care for individuals with learning disability, mental health conditions, and physical disability.

Key Principles:
• The service must be delivered by GPs. Other suitably qualified clinicians can be used to assist with the workload, but the aim of the service is that GPs see the patients for regular proactive care;
• The monitoring of the scheme is intended to be ‘light touch’. The emphasis is upon data gathering and interpretation and it is not intended that practice performance will be micromanaged. The practice will need to ensure that they use the relevant ‘read codes’.

The Key Commissioning outcomes are:
• The maintenance and improvement of quality and consistency of care;
• A reduction in the number (and length of) admissions to acute hospitals from Astrum;
• Prescribing optimisation to reduce potential harm from inappropriate prescribing and associated expenditure.
Required service elements:

1. Regular Planned GP Clinics: Regular visits/clinics (minimum monthly basis). The expectation would be that each patient is seen monthly. There should be an administrative review of the resident’s care needs with care home staff and a physical review as needed. The care plan for each resident should be kept updated.

2. Bi-Monthly review of unplanned admissions with care home manager: This should also include deaths, OOH contacts and significant events.

3. Practice Register: All new and existing patients should have the appropriate codes filled in on their record so that a practice register of patients can be generated. A read-code will also need to be identified to show where a patient has declined to move to the practice which is looking after their home.

4. Care Planning: Production of a care plan using the available templates available from the CCG. The care plan should be completed within 3 months of admission to the home.

5. Assessment of Resident on Admission to Astrum House: Within 2 weeks of admission to Astrum house
   - Comprehensive and holistic assessment- including MCA (Mental Capacity Assessment)
   - Medication review (see section 6)
   - Start of care planning process
   - Falls assessment (where appropriate)
   - Dementia assessment and diagnosis (where appropriate)

   Use of appropriate read code to record admission assessment.

6. Review of Care Plan for all residents every six months: Review of the care plan generated on admission to Astrum house, including an assessment of change in health, mobility and dependency.

   NB this may well be a ‘paper review’ if the patient has been seen on a monthly basis and the plan kept up to date. Use of appropriate read code to record review.

7. Medication Review: This should be undertaken every 6 months: Emphasis on reducing polypharmacy using appropriate guidance or systems. This can be done by the practice pharmacist or GP. Use of appropriate read code to record review.

8. Admission Episode Reviews: Significant event audit type review to be carried out by the GP working with Astrum house staff for each unscheduled admission using the template provided. Aims will be to try to identify common factors leading to admissions and issues that might prevent the need for admission, and be a reflective process suitable for GP revalidation portfolios. It is to be discussed with the Manager of Astrum House at their regular scheduled meeting, and a template to be submitted to Quality Assurance Team when completed as part of the monitoring process.

   Use of appropriate read code to record admission episode review.

9. Special Notes: A copy of the care plan with the first 2 pages on yellow paper should be easily accessible at the home, with any further information added that might help ‘out of hours’ doctors to make appropriate decisions. Astrum house staff should be encouraged to look at the care plans whenever possible.

10. Safeguarding and Mental Capacity Act Training: The Lead GP and all clinical staff should be trained in safeguarding (3-yearly). Any concerns about Astrum house should be raised through the appropriate channels.

11. Lead GP Role: At least one GP to be the Lead for Astrum house.
Other service elements

Alignment: Alignment reduces the number of GPs visiting Astrum house and helps to establish strong relationships between the practice and home. This must be fully in place prior to commencement of the enhanced service.

Commissioners’ expectations of this service with Astrum house: In order for the successful delivery of this service, it is vital that effective working relationships are fostered between the GP practice and Astrum house. It is important that each party understands what is expected of the other. A memorandum of understanding is required between the provider and Astrum house.

Minimum requirements:
1. Astrum house seeks consent from residents/relatives for their details to be kept in a care plan folder within the home.
2. The relevant paperwork will be ready prior to the GP attending the home.
3. The GP attending should be greeted promptly by a member of staff who is familiar with all of the residents to be seen at that time. In order to ensure continuity of care the person in charge should attend all the regular planned visits, the admission assessments and 6-monthly reviews, and be an active partner in the care planning process.

Accessing Unscheduled Care: Before a call is made to the GP Practice/OOH service (including a request for the GP to visit), the nurse/person-in-charge should approve the need for the call. Before a call is made to the ambulance service (unless it is clearly a medical emergency), an attempt should be made to discuss the request with the GP Practice/OOH service. The person-in-charge should make both calls.

3.2.10 The Violent Patient Scheme Designated Enhanced Service

It is a requirement of the contract that The Gate participates in and effectively delivers the NHS England Violent Patient Scheme.

4. Applicable Service Standards

For each of the service descriptions electronic records using appropriate readcodes must be maintained. The data must be collected in a way that can be easily interrogated, and an annual report providing an in-depth review of the services delivered in each area of this specification must be submitted to NHS Rotherham CCG each year, by 30th April. The data reporting requirements of this specification may change throughout the life of the contract, and NHS Rotherham CCG reserves the right to request additional information and data at any time in order to be able to review activity, as well as implement more regular data reporting as necessary.

5. Financial Information

Funding of £154,088 per year is available to resource the following:

<table>
<thead>
<tr>
<th>Area of service</th>
<th>Minimum expected activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient Medical</td>
<td>780 per year</td>
</tr>
<tr>
<td>Health Related Social Issues</td>
<td>780 per year</td>
</tr>
<tr>
<td>TB Screening</td>
<td>58 patients x 3 appointments</td>
</tr>
<tr>
<td>Shiloh Outreach Clinics</td>
<td>3 hour weekly clinic</td>
</tr>
<tr>
<td>Travellers Health Assessments</td>
<td>3 hours on 6 occasions (yearly average)</td>
</tr>
<tr>
<td>Rookwood</td>
<td>4 hour weekly (average)</td>
</tr>
<tr>
<td>Cornerhouse</td>
<td>2 hour weekly clinics</td>
</tr>
<tr>
<td>Care of Leg Ulcer patients</td>
<td>25 patient per week (average)</td>
</tr>
</tbody>
</table>
Part 4

Quality of Outcomes Framework

The Quality & Outcomes Framework is intended to measure, encourage and support clinical care and Patient experience which is constantly improving. The framework sets out a range of national standards based on the best available research evidence.

The Quality & Outcome Framework (QOF) is reviewed annually and is divided into five (5) domains.

The Contractor acknowledges that QOF changes each year and that it shall be required to meet each year’s QOF requirements to ensure patients continually receive the highest standards of clinical care.

The Contractor will be required to gain at least 98% of Quality & Outcomes Framework points each Contract Year. The Contractor will also be required to set standards over and above the QOF requirements to ensure Patients continually receive the highest standards of clinical care. The Contractor shall minimise exception and improve prevalence rates on practice registers.
Service Mobilisation / Transition Plan

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

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

This plan was proposed by the contractor as part of their successful tender bid and forms part of this contract.

*Insert Contractors Service Mobilisation / Transition Plan*
Annex 1
Patient Registration Area
Premises

Schedule 3 of the Contract provides information on the Practice Premises. From the commencement date, the Services will be provided from the practice premises to be agreed as part of the procurement process.

In the event that the service provided is required to re-locate to a site within a 3 mile radius of the vicinity of the current site, the contract will be varied in accordance with clause 57 of the contract. The provider will continue to pay no more than the existing service charge costs under the license (or sub-lease) arrangements for the current premises after transferring the service to the new centre.