V27.0 – FINAL

INTEGRATED URGENT CARE (GP OOHs) SPECIFICATION 2019

Halton, Knowsley, Liverpool, South Sefton, Southport & Formby, St Helens and Warrington CCGs,

CONTENTS

1. Summary

1.1 Vision

The Clinical Commissioning Groups (CCGs) in Halton, Knowsley, Liverpool, Southport & Formby, South Sefton, St Helens and Warrington have a vision for their 'out of hours' urgent primary care medical services as part of an integrated single model of urgent care services across the whole health economy, providing a high-quality clinical service with a clear patient centred focus.

The CCGs have come together to procure a single service that will work closely alongside and integrate service delivery with the North West NHS 111 service, in line with the national expectations for an integrated 'consult & complete' delivery model. In the North West we have a delivery model whereby the NHS 111 service is delivered by the North West Ambulance Service (NWAS) at a regional level and which then works in an integrated and seamless manner with the sub-regional delivery of 'out of hours' primary care services. This pragmatic approach reflects the need to deliver an integrated solution but within the challenges of a large, complex and diverse population and geography.

The 'out of hours' Bidder(s) is expected to actively engage with the providers of urgent/unscheduled care including, but not exclusively, NHS 111, general practice in hours services, ambulance service, A&E, mental health, community integrated services, nursing, pharmacy and dental services, and where appropriate, social services. This type of approach of integration and co-ordination is required in order to make access to care as straightforward as possible for patients and carers, delivering where at all possible a 'consult & complete' model of care.

The specification focuses upon the delivery of a safe, accessible and equitable service, including the receipt of calls from NHS 111, GP telephone consultation and where a medical/clinical need has been identified, face to face consultation either in the patients' place of residence or a primary care setting. The main aim of the service is to provide evidence based urgent primary care which optimises health and wellbeing and reduces the impact of ill health during the out of hours period, avoiding where possible the need for acute care. The service will operate as part of and contribute to the wider virtual Clinical Assessment Service (CAS), supporting both 111 and 999 activity.

The CCGs wish to engage a high-quality Bidder with experienced delivery and leadership in 'out of hours' services / integrated urgent care, with demonstrable capability in managerial and clinical performance that will ensure a safe, clinically effective and affordable service for our patients.

In line with Public Contract Regulations, the CCGs are tendering their requirements with the intention to award a single core contract, supplemented by some local service variation and requirements (as outlined in Section 7)

The CCGs wish to commission from Bidders who can deliver a sustainable, integrated and high-quality service. The service must comply with NHS Policy and meet its standards for clinical and corporate governance.

1.2 Aims and objectives

1.2.1 To commission an urgent primary care medical service 'out of hours', to advise and

treat the Clinical Commissioning Groups' responsible populations, that meets all the standards identified in this document and fully integrates with other relevant 'out of hours' and urgent care services and the North West NHS 111 service.

1.2.2 The service must meet those urgent patient needs that cannot safely be deferred until the patient can access routine primary care services during core and / or enhanced or extended hours. The service must work and engage with the Clinical Commissioning Groups and act as a complementary service to primary care in-hours and maintain treatment protocols of patients, in line with in-hours arrangements.

1.2.3 The service will provide convenient and dependable care from first contact, treatment and follow-up in a suitable environment, providing a 'consult & complete' model of delivery. It shall ensure care is delivered at the right time, in the right place and by the right professional to a consistently high standard.

1.2.4 The service will support the effective management of 111 and 999 calls by providing access to GP and other Health Care Professional advice, as an essential part of the virtual CAS during the out of hours period. During the in-hours period the service will provide capacity to support the virtual CAS and calls originating from 999 and NHS 111. This in hours provision will be kept under review by commissioners and maybe subject to notice and variation during the lifetime of the contract. The cost of delivering this in-hours capacity is to be separately costed.

1.2.5 The Integrated Urgent Care Services Specification (NHSE August 2017) outlines how an integrated model of service should operate. In the North West we have a delivery model whereby the NHS 111 service is delivered at a regional level and which then works in an integrated and seamless manner with the sub-regional delivery of 'out of hours' primary care services. This pragmatic approach reflects the need to deliver an integrated solution within a large, complex and diverse population and geography. The IUCSS and associated aggregated data collection specification (NHSE December 2018) outline the core standards and requirements of this integrated service. The North and Mid Merseyside CCGs have supplemented these with 'local quality requirements' (LQRs) which are outlined in detail in Section 11.2 and which apply to this contract.

1.2.6 Support Out of hours for Public Health England: it is expected that the bidder will support PHE in the discharge of their responsibilities in managing an infectious diseases outbreak during the out of hours period. This support will include but is not limited for example to the provision of anti-virals or other prescribed medicines in the event of a flu outbreak in a residential establishment e.g. nursing, residential home or school.

1.3 NHS 111 Service Model

We expect Bidders to clearly identify in their bid how they envisage the virtually integrated service with NHS 111 operating, as the initial call handling of GP OOHs calls from members of the public is to be delivered by the NHS 111 Service and / or referral from NHS 111 online.

Bidders are required to price their bids against a service model whereby:

The 111 service directly books into the OOHs service where there is a high probability of the patient requiring a home visit and / or face to face centre appointments and where there is slot availability, currently this is estimated at 30% of total activity; for all other calls the 111 service passes the callers details, via ITK messaging, to the OOHs service who then determine the

final clinical disposition (definitive clinical management).

During the lifetime of the contract it is expected that the code set which helps determine direct bookings from NHS 111 and in the future 999 will be subject to regular review and it is likely that the volume of direct bookings will correspondingly increase.

2. Introduction

2.1 Purpose

The purpose of this document is to provide a detailed specification for the provision of Out of Hours Services to the populations of Halton, Knowsley, Liverpool, Southport & Formby, South Sefton, St Helens and Warrington.

This document sets out the core service specification for urgent Primary Care Out-of-Hours services across the seven CCG's. This ensures common standards, but still allows for local flexibilities and additional elements (where required and specified)

Individual CCG requirements over and above the common core specification are included in Section 7 and the details and costs of how these are to be met are required to be clearly and separately identified.

2.2 Contract duration

The Contract Agreement will have an initial term of 5 years (plus an option for a further 2 years) from the Commencement Date of 1st October 2020.

Bidders are required to submit their submissions and complete the Financial Management Template for providing the services for a period of 7 years from the Commencement Date.

2.3 NHS 111 Service

We expect Bidders to clearly identify in their bid how they envisage the virtually integrated service with NHS 111 as the initial call handling of GP OOHs calls is to be delivered by the NHS 111 Service and / or referral from NHS 111 online.

Bidders are required to price their bids against a service model whereby:

The 111 service directly books into the OOHs service where there is a high probability of the patient requiring a home visit and / or face to face centre appointments and where there is slot availability, currently this is estimated at 30% of total activity; for all other calls the 111 service passes the calls to 'see a clinician' to the OOHs service who then determine the final clinical disposition (definitive clinical management).

During the lifetime of the contract it is expected that the code set which helps determine direct bookings from NHS 111 and in the future 999 will be subject to regular review and it is likely that the volume of direct bookings will correspondingly increase.

2.4 Status

The final version of this document will be incorporated into the Contract as a Schedule.

Any fundamental changes to the national/local requirements of this service as a result of either development or agreed re-design will require final approval from:

- Co-ordinating Commissioner (Liverpool CCG) under the terms of the contract and

- Clinical Commissioning Groups

Local changes that are not fundamental changes to service delivery can be agreed by the Co-ordinating Commissioner and Commissioning Leads from each CCG

3. Local context

3.1 Local Context

3.1.1 Local A&E providers, Community Health organisations and North West Ambulance Service are under considerable pressure with rising demand for urgent care/emergency services. The CCGs are committed to ensuring that only appropriate patients are referred to A&E Departments for assessment and treatment. The Bidder(s) of 'out of hours' services is required to build effective relationships with regional and local providers in the effective management of urgent care.

3.1.2 It is the intention of the CCGs to achieve a situation where, wherever possible and clinically sound, patients will be managed at home or in the community and outside of A&E services, by maximising the opportunity for 'hear & treat' and / or 'see & treat' management of patients.

3.1.3 The Bidder(s) must demonstrate in its operational management plan its commitment and capacity to provide an integrated 'out of hours' primary care service. This must include supporting directly transferable communication links between patients and the Bidder to NHS 111, NHS Trusts, North West Ambulance Service, Social Services, Mental Health, Palliative Care, Community Nursing, Specialist Nursing, Pharmacies, Dental and any other services deemed appropriate by the CCGs - all of whom can aid the Bidder in supporting patients outside hospital.

3.1.4 It is important the Bidder(s) is involved in a whole system integrated approach to urgent and unscheduled care service development and engages with the CCGs and other stakeholders in forums to review and develop services. The Bidder is expected to pay a full role in for example AED Delivery Boards, urgent care networks, urgent/emergency care and adverse weather planning.

3.1.5 The Bidder(s) must outline systems to support and encourage the regular exchange of up to date and comprehensive information (including, where appropriate an anticipatory care plan, or 'special patient notes'), including electronic communications / submissions between all those who may be providing care to patients with predefined needs. It is also expected that the Bidder(s) will have access to the summary care record or equivalent and where possible direct access to patient records.

3.2 Innovation and Integration

3.2.1 The Bidder(s) must demonstrate an on-going commitment to service development and innovation, including the use of technology such as video consultations and telehealth. They are expected to describe and demonstrate how they will adopt new technologies during the lifetime of the contract as the use of online access, apps, telehealth and medicine develops, changing the way in which patients access the service and consultations are delivered, although not all patients will be able or appropriate for management via the likes of telehealth / video consultation.

The Bidder(s) must demonstrate how they plan to contribute to reducing fragmentation and enhance partnership working and integration across urgent care, primary care, secondary and

social care as well as across organisational boundaries.

The Bidder(s) shall work in partnership with the Clinical Commissioning Groups to reduce unnecessary hospital admissions and prevent avoidable A&E attendances, deliver cost effective prescribing and provide accessible care closer to home. They are expected to integrate within the local place (currently seven CCG footprints) and work collaboratively with Primary Care Networks to ensure out of hours services are integrated within local systems.

4. Core Principles

4.1 Summary

The service must meet those urgent patient needs that cannot safely be deferred until the patient can access routine primary care services during core and / or extended / enhanced hours. The service must work and engage with the Clinical Commissioning Groups and act as a complementary service to primary care in-hours and enhanced / extended hours services and maintain treatment protocols of patients, in line with in-hours arrangements.

The service provided shall be equitable in terms of access and quality of provision, no matter where it is provided or to whom it is provided.

Patient access shall be as simple and straightforward as possible, with the majority of initial contacts made via NHS 111 (telephony and online), supplemented by direct health care professional (HCP) contact.

The service is an integral part of the delivery of 24-hour urgent care and as such must work in close partnership with other urgent care stakeholders and the CCGs to deliver integrated patient centred care, making the most appropriate use of resources.

Patients shall have access to an appropriate health care professional and a GP where clinically necessary, in the appropriate place in a timely manner, in accordance with assessed clinical priority.

The service delivered shall be evidence based and meet all the national, local quality and clinical governance requirements. Regular monitoring of outcomes shall be utilised to ensure continuous improvements are made to the service.

Repetitive information gathering from the patient shall be minimised and mechanisms shall be in place to ensure timely and efficient flows of information to ensure continuity of care. All interoperability requirements with NHS 111 and 999, including direct booking must be met.

The service shall be patient focused and have in place mechanisms to involve patients in their own care and in the future developments of the service

Services shall be provided based on patient / clinical need.

Services shall make full use of and promote the effective use of ‘special patient notes’, anticipatory care plans and access to the patient’s own records (where possible and subject to consent) to support the delivery of effective and appropriate patient care.

5. Scope

5.1 Service Description

The core specification for each CCG is identical. Section 7 identifies any additional services or requirements which are specific to an individual CCG(s).

The 'out of hours' period is defined as from 1830 hours to 0800 hours on weekdays and the whole of weekends, bank holidays and public holidays.

The provision of GP "Out of Hours" Integrated Urgent Care Service, for the GP responsible populations of Halton, Knowsley, Liverpool, Southport & Formby, South Sefton, St Helens and Warrington CCGs' i.e. patients registered with a GP within the CCGs', or unregistered patients' resident within the defined area. This will include temporary residents and immediately necessary treatment to patients, where required. It will be provided to patients of all age groups. It is a requirement that where clinically necessary the face to face service will be delivered by GPs.

The bidder must meet The Equality Act 2010 and Public Sector Equality Duty in provision of the service. This includes meeting national NHS Accessible Information Standards and making other reasonable adjustments to provide high quality care for people with physical disability, sensory disability or loss, learning disability and mental ill health. Spoken language and BSL interpretation services must be made available for patients, where required to facilitate good quality care. Written communication must also meet the needs of the patient in either language or format, for example Easy Read, Large print etc. in accordance with the Accessible Information Standards.

Contractual arrangements for interpretation and translation services are in place for GP practices in the local CCGs and consideration should be given to integrating communication services provided, with that provision. All arrangements must, as a minimum, meet the Quality Standards for Interpreter/translation services attached as Appendix C.

A schedule of the individual CCG GP Practices to be covered is attached as Appendix A. The total registered GP populations of the CCG are as follows:

Halton	132,847
Knowsley	149,978
Liverpool	541,895
Southport & Formby	125,496
South Sefton	156,393
St Helens*	53,597
Warrington	219,010
TOTAL	**1,379,216**

*Note partial St Helens CCG coverage only

The potential (GP Registered) population for the whole service is therefore approximately 1.4 million (unweighted).

From the present contract information, the following level of activity (1st April 2018 to 31st March 2019) is shown:

	Total Contacts
Halton	12,530
Knowsley	12,012
Liverpool	40,494
Southport & Formby	10,829
South Sefton	11,205
St Helens	5,124
Warrington	27,980
Total	**120,174**

* Please note that the St Helens CCG data is an estimate only based upon July – Sept 2019 actuals.

Contacts were completed either by telephone advice, face-to-face consultations in a primary care centre or by a home visit.

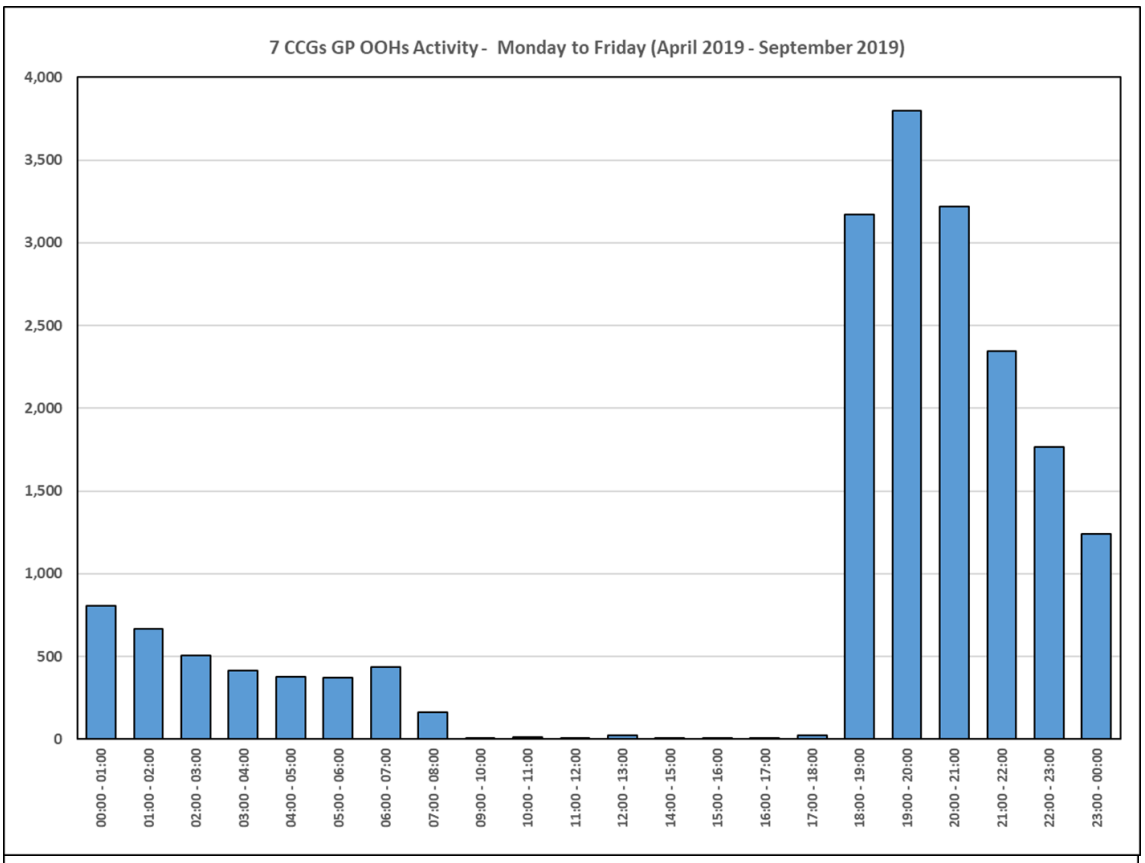
Information from the current 'out of hours' contract performance shows the profile of calls completed, based on 1st April 2018 to 31st March 2019, as follows:

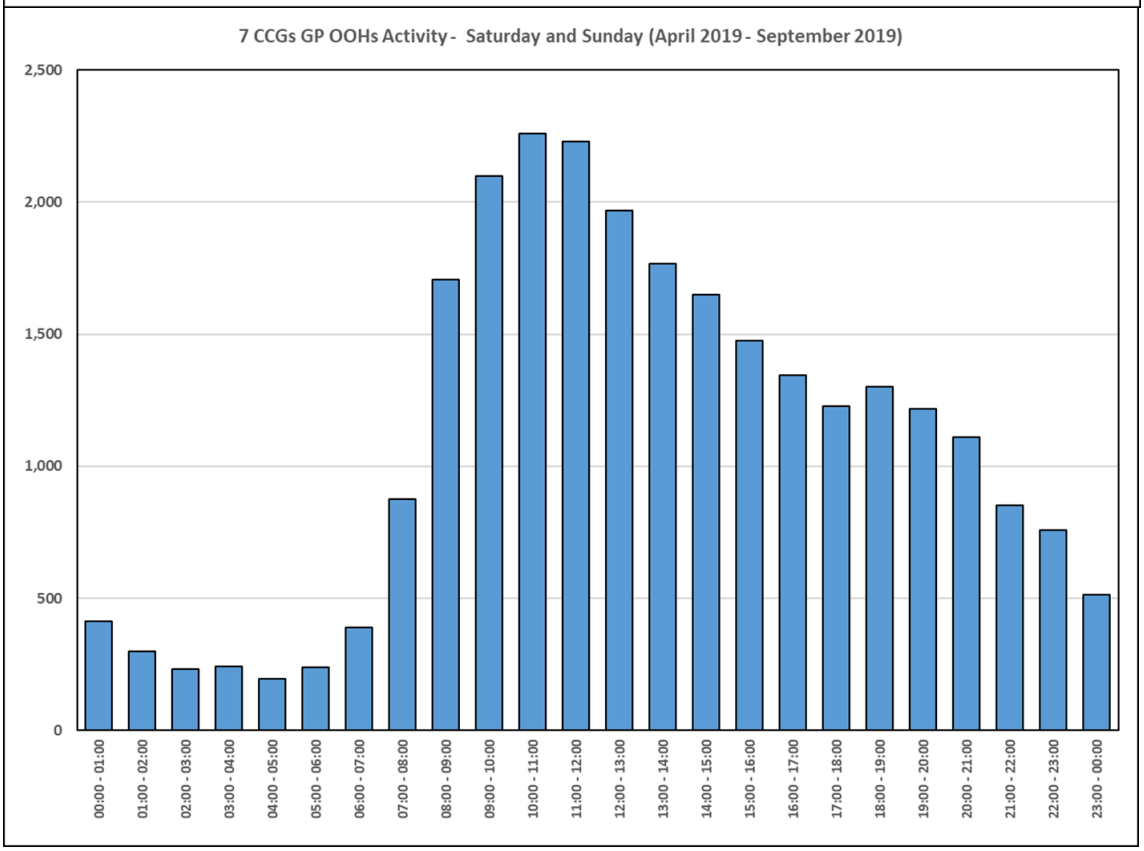
	Telephone Advice	Face to Face at UCC	Home Visits
Halton	6,469	4,461	1,530
Knowsley	6,487	3,849	1,623
Liverpool	23,666	11,796	5,032
Southport & Formby	4,192	4,547	2,090
South Sefton	4,801	4,449	1,955
St Helens*	2,508	1,964	652
Warrington	11,752	13,710	2,518

* Please note that the St Helens CCG data is an estimate only based upon July – Sept 2019 actuals.

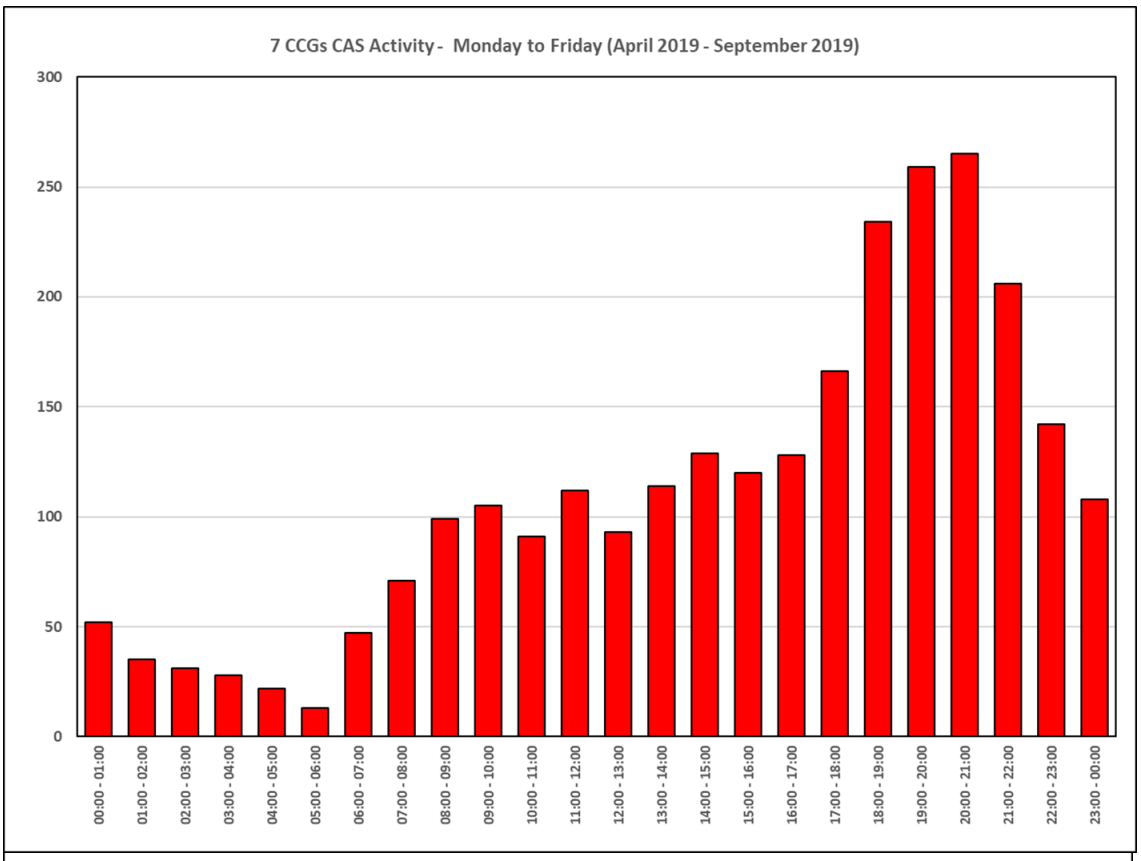
To assist bidders an hourly profile of activity by day of the week is provided in Appendix B to illustrate the current profile of demand. This profile is provided for Halton, Knowsley, Liverpool and Warrington CCGs only, as data for the two Sefton CCGs was not available at the time of publication. This profile should be considered as illustrative of the likely demand profile across the seven CCGs.

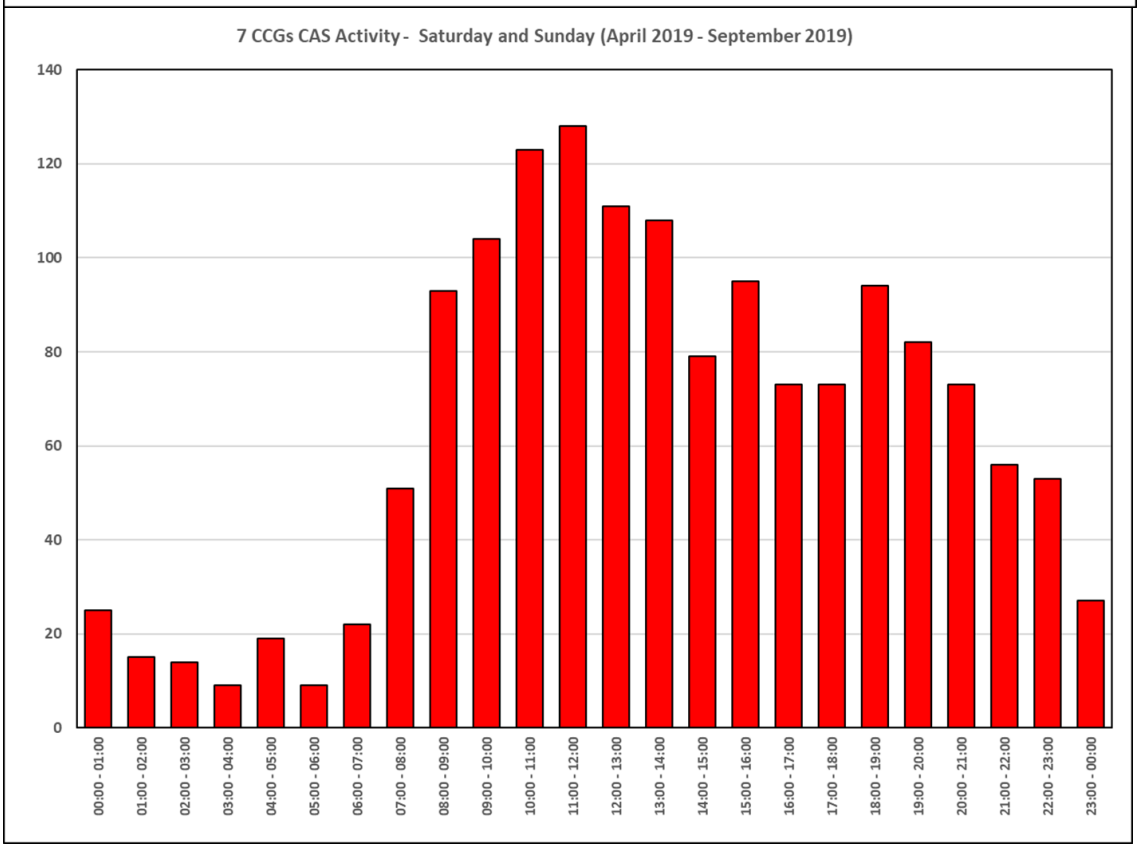
To further inform the profiling of demand, the following charts present the aggregated demand profile from NHS 111 dispositions for OOHs services and separately the CAS demand passed into the OOHs services for both weekdays and weekends for the seven CCGs:





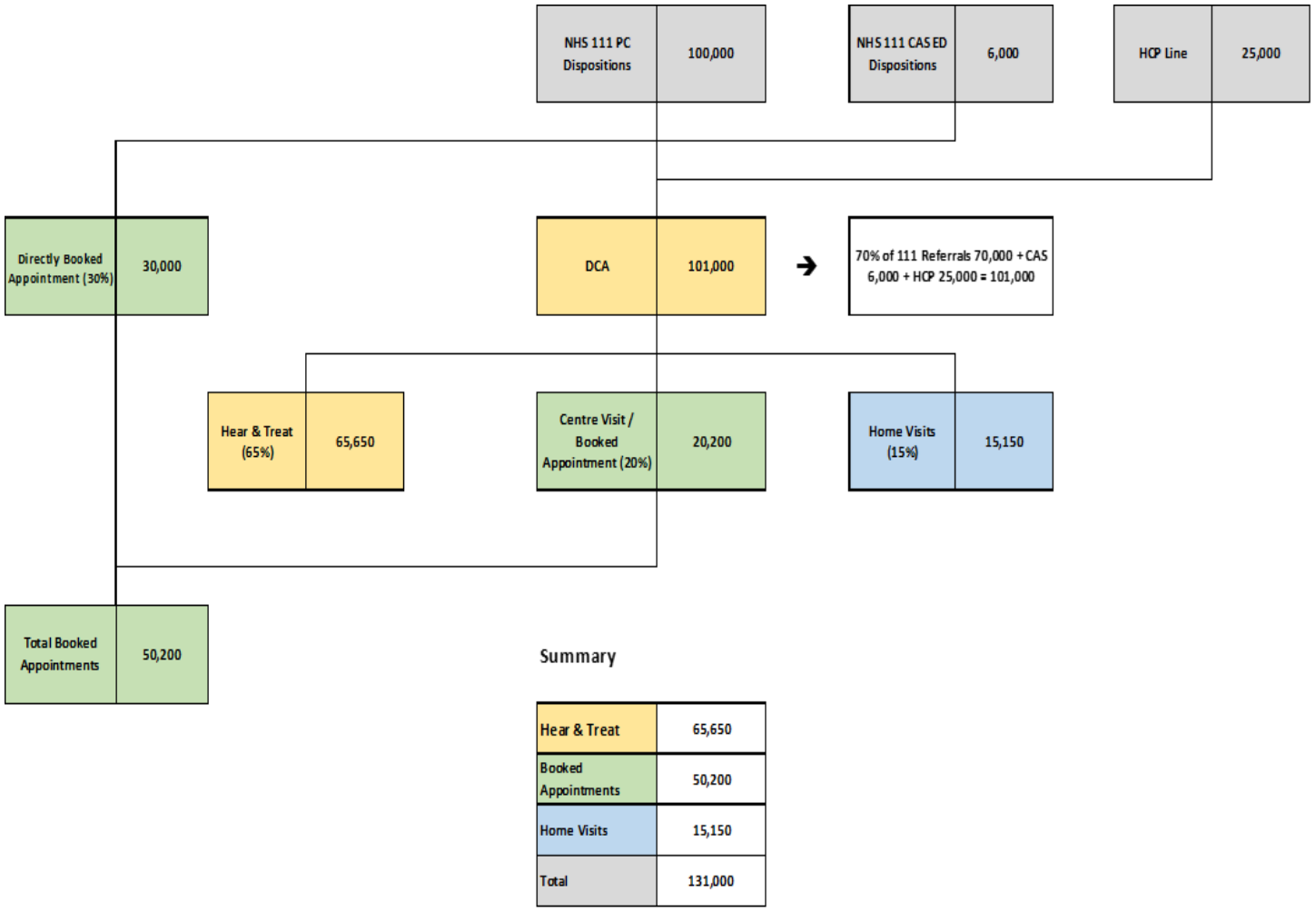
For the CAS element of the service, the following hourly profile is provided:





The CCG's anticipate, but make no representations, assurances or commitment as to the volume of calls that the Bidder(s) will receive. The Bidder(s) is obliged to deal with all calls made by patients during the 'out of hours' period, pursuant to the services set out in this specification. The above volumes are illustrative only.

Considering the expected balance of activity overall, the following profile of activity is anticipated, showing the flow of directly booked patients from NHS 111 and the expected outcomes, post DCA, for calls completed by the OOHs service, including HCP line activity.



Summary

Hear & Treat	65,650
Booked Appointments	50,200
Home Visits	15,150
Total	131,000

5.2 Location of Service Delivery

The CCGs require the following sites and hours to be available where face to face consultations will occur, listed in Table 1.

We require a suitable skill mix of appropriately qualified staff / clinicians to meet the demands of the service and that a minimum of 1 GP during centre opening times is to be physically available in each CCG area (2 in the case of Liverpool, as a consequence of higher baseline population), who can be either mobile or based in one of the static locations.

During the overnight period 23:00 to 08:00 the following minimum number of GPs are expected to be available within the area covered by the contact:

	Summer	Winter
Monday to Thursday	4	5
Friday	4	6
Saturday	4	6
Sunday	4	5

It is expected that not less than 15-minute bookable appointments will be scheduled, including completion of clinical record and necessary data input will be provided for.

Table 1 – Out of Hours Centre Locations for face to face consultations and minimum operational hours.

CCG Area	**Sites used for 'Out of Hours' Face to Face Consultations**	**Hours of Operation**	
		Monday - Friday	**Weekends/ Bank Holidays**
Halton	Halton Hospital	19.00-08.00	09.00 – 08:00
	Widnes HCRC	19.00-08:00	07.00 -22.00
Knowsley	Knowsley Nutgrove Villa (Huyton)	18:30-08:00	09.00-08:00
	Knowsley NHS Walk-in Centre (Kirkby)	19.00-21.00	10.00-21.00
Liverpool	Royal Liverpool Hospital (Fri to Mon ONLY) *	19.00-23.00	10.00-22.00
	Aintree University Hospital *	19.00-23.00	10.00-22.00
	Old Swan Neighbourhood Centre	19.00-08.00	09.00-08.00
	South Liverpool NHS Treatment Centre	20.00-23.00	08.00-2300
Sefton	Litherland NHS Treatment Centre	18.30-23.00	08.00-23.00
	Southport District General Hospital	18.30-23.00	08.00-23.00
	Philips Lane, Formby	2300-08.00	23.00-0800
St Helens	Lowe House, Primary Care Resource Centre.	19:00-08:00 Mon – Thurs; 19:00 Friday to 08:00 Mon	08:00-23:00
Warrington	Bath Street	19:30–00:30	08:00-01:00

NB: * at these two sites the face to face clinical capacity will also receive referrals direct from AED, i.e. patients will be triaged by AED staff and where their principle presenting need is one of urgent primary care they may be directed to the service (subject during mobilisation to an agreed ‘cap’ to protect and balance the needs of patients ‘booked’ following an NHS 111 call / online contact and / or DCA and those referred from AED).

The Commissioner reserves the right to alter these locations at any point throughout the contract. It is expected that the locations of some of these centres will particularly change over time as the final delivery model and distribution of Urgent Treatment Centres across the seven CCGs is determined and implemented.

Please note that whilst it will be for the Bidder(s) to agree with the respective owners / landlords of the specified premises access to and utilisation of the accommodation (with the support of the commissioning CCGs) during mobilisation, the direct ‘accommodation’ charges levied by the owners / landlords for the space utilised will be re-charged and reimbursed by the commissioning CCGs and not form part of the contract price submission. The Bidder(s) will however remain responsible for equipping at their own cost the nominated clinical and non-clinical rooms / space required to meet their needs, where equipment cannot be shared. The costs associated with the headquarters/control room shall be included in the tender price as these remain the responsibility of the Bidder(s).

The Bidder(s) must be able to supplement and enhance clinical and non-clinical staff cover at times of expected pressure e.g., Bank / Public Holidays. Current planning guidance requires that Bidder(s) shall plan for surges in patient demand at key or peak times e.g. between Christmas and New Year.

5.3 Geographic coverage/boundaries

5.3.1 Areas

Individual CCG maps are provided in Appendix D.

5.4 Patients to whom services will be provided

The service will be provided to all patients registered and/or temporary resident with practices in Halton, Knowsley*, Liverpool, Southport & Formby, South Sefton, St Helens* and Warrington CCGs APPENDIX A.

*only those Practices identified in Appendix A(i)

6. Service model

Specifications have been prepared for 4 definitive areas:-

Call Management post 111 call/data transfer
Definitive Clinical Management
Clinical Services
Transport

NB: Patients will access the service primarily via 111, telephone or online contact. No patients will access the service as 'Walk-In' patients unless it is an extreme emergency i.e. collapsing in or just outside of the premises. The Bidder(s) will agree with the CCG's a protocol for managing such unforeseen instances. The only exception to this will be where the OOHs service shares hospital, urgent treatment centre or walk-in centre accommodation. Here the direct referral of patients into the service may be required from another health care professional / service, as services co-operate to deliver seamless clinically appropriate care to patients.

The Bidder(s) is also required to provide access to designated health care professionals, via a by-pass number (thus avoiding an initial NHS 111 call). Current activity across the CCGs indicates that between 18-20% of all contacts into the service are made directly by HCPs.

6.1 Core Service

During the out of hours period the Bidder is required to provide the Essential and Additional services specified in the GMS/PMS/APMS regulations as applicable to a patient if, in the contractor's reasonable opinion having regard to the patient's medical condition, it would not be reasonable in all the circumstances for the patient to wait to obtain those services. All areas of service provision shall comply with the relevant standards and key performance indicator as outlined in the following document: Integrated Urgent Care Key Performance Indicators published by NHSE on 25th June 2018.

Core services must stand alone and have no cross funding or subsidisation from the additional services detailed in section 7. All Bidder(s) must be prepared to deliver the core specification plus the additional services as they apply in each CCG area, although the commissioning CCGs reserve the right to commission the core service elements only.

6.2 Access into the Service

There will be a single primary route into the service for patients by initially ringing the 111 service directly or via NHS 111 online. Other local providers wishing to transfer a patient to the service or seek advice from one of the clinicians including a GP will ordinarily arrange this by contacting the service via the Healthcare Professional Line (sometimes referred to as the "by-pass" line) including referrals from the integrated 111 and 999 services.

6.3 Telephony, Call Handling and Call Management

In order to achieve an effective, 'customer focused' service, the Bidder(s) is to ensure they have appropriate mechanisms in place to deal with enquiries by telephone, i.e. 'speak to a clinician' to provide high quality clinical prioritisation and assessment. This includes being able to respond to patients with needs, such as those with impaired hearing or language

difficulties.

Callers will usually be directed to the service after first having called 111 directly or via NHS 111 online.

The Bidder(s) must ensure it has in place a comprehensive, robust electronic call handling system that can interface completely with a fit-for-purpose electronic call management system (using latest version of supplier's software). These systems must be able to record the necessary patient demographics and presenting condition; the clinical details from the definitive clinical assessment and the outcome of the consultation following either the provision of telephone advice, face-to-face encounter or home visit. The Bidder(s) must also be able to use the system to send details of all 'out of hours' consultations to the Practices where the patient is registered by 0800 hours the next working day. Any solution must fit into the local IM&T strategy and NHS111 interoperability requirements. Appropriate business continuity plans and measures must be in place, should the primary clinical systems be unavailable or interrupted (the use of fax machines should NOT form part of these plans). It is expected that these contingency arrangements will centre around the use of NHS.net accounts to securely send information between partners and agencies.

All telephony call handling/call management systems must be able to capture all necessary date/time stamps and patient data required for the monitoring of the nationally mandated integrated aggregated data collection specification, as it applies to this contract. The Bidder(s) is required to obtain all new version releases (beta tested) of software utilised in call handling/management systems as soon as offered by their software suppliers and reasonably practicable and must keep such systems up to date, supported and maintained throughout the lifetime of the contract.

Once the contract is awarded the Bidder(s) must obtain the agreement of the contracting CCGs prior to any significant proposed changes to the electronic call management systems or software used to deliver the contracted 'out of hours' primary care service. Such agreement will not be unreasonably withheld.

Technology utilised for call handling must be capable of the latest developments to allow the clinical assessment of patients from either a central location; remotely at designated primary care sites; in a vehicle whilst the clinician is being driven to a home visit or at a patient's place of residence. The technology must allow the recording of, in real time, any clinical assessment undertaken remotely. This to ensure the clinical details are available for any subsequent assessment/consultation undertaken by an 'out of hours' primary care clinician and to ensure that the patient's in-hours GP Practice can be advised of the clinical detail by 0800 hours the next working day.

The Bidder(s) is required to detail their systems and processes to deliver the above, this to include the availability of access to a clinician for the whole 'out of hours' period for necessary control room staff and details of the audit trails created. This is to include how the appropriate electronic audit trail will be provided for instances where the consultation does not follow through to normal completion e.g. request for prescriptions; patient referred to A&E for non-life-threatening condition etc.

The Bidder(s) must comply with the following:

Control centre and reception staff will be polite, helpful and efficient, and will be trained to respond to callers, via protocols, and take information accurately.

The Bidder must ensure that before the call is terminated the patient understands the process, what help is being offered to them and what their next steps are.

The call handling system will flag immediate life-threatening calls and respond according to the national standards.

Records of all calls, including the requirement for all messages to be voice recorded, must be maintained and stored in line with NHS Records Management policies and procedures.

Digital Voice Recording is essential for all telephone communications.

The call handling system must flag repeat callers in order to alert clinicians of a possible reprioritisation being required.

6.4 Definitive Clinical Management

6.4.1 Definitive Clinical Management is an assessment carried out by an appropriately trained and experienced GP / health care professional verified by and accountable to the Medical Director of the Bidder(s), who delegates this authority on the telephone or face-to-face. In practice, it is the assessment that will result either in reassurance and advice or in a face-to-face consultation, either in a centre or in the patient's own home. The definitive clinical assessment must be recorded in such a way on the Bidder(s) call management system that it identifies when the assessment started, when it was completed, and the priority allocated following assessment.

The Bidder(s) to ensure that clinicians undertaking telephone clinical management are well trained and undergo regular performance review.

6.4.2 The Bidder(s) must explain their processes and protocols for delivering definitive clinical management. The 'out of hours' Bidder(s) will agree any decision support or assessment tools, computer or paper based, the Bidder(s) intends to use, with the CCGs. Alternatively, where there is to be a reliance on GP / health care professional knowledge and training to provide definitive clinical assessment, the CCG clinical governance leads must be provided with evidence of appropriate training, working methods and programme of regular review.

6.4.3 Definitive clinical management will determine whether it is necessary for a patient to:

- see a clinician face to face in a primary care setting
- receive a home visit
- contact their GP Practice or other appropriate clinician the next working day
- have their condition reprioritised to Immediate and Life Threatening and an emergency ambulance called.

6.4.4 Each call will be allocated a priority and outcome as described within the Performance and Quality Requirements that will determine the patient pathway. The process may end at this point if the clinical assessment does not identify the need for further clinical input 'out of hours'. However, at the close of the call, the person taking the call must always check that the caller is happy with the advice given and shall be advised to call again, if the condition deteriorates, or gives rise to further concern.

6.4.5 The Bidder(s) must ensure that all time frames for response, i.e.

Emergency – 1 Hour
Urgent – 2 Hours
Less Urgent – 6 Hours

are notified to the patient, and patients are provided with an appointment time at the Bidder(s) 'out of hours' centre, closest to the patient's home address, or other location by agreement, or when to expect a home visit. They must always be contacted if a home visit or appointment is delayed.

6.4.6 The CCGs will require verification of the effective prioritisation of calls through audit undertaken by the Bidder(s) as part of the agreed service audit programme the Out of Hours Clinical Audit Toolkit. The CCG reserve the right to independently re-examine raw data and audit results by designated third parties independent of the Bidder(s) and the CCGs.

6.4.7 The Bidder(s) must explain processes and protocols for ensuring consistency of data input, housekeeping of data and the capability of their call management system to operate an easily retrievable master record for the patient. Systems will then easily identify where callers have recently contacted the service.

6.4.8 It is important that patients making more than one call to the 'out of hours' call centre can be identified as repeat callers, and their situation reviewed and reprioritised. This will require close liaison and agreement of operational protocols with the NHS111 service.

6.4.9 The Bidder(s) must ensure that they have appropriate systems in place to manage an effective two-way flow of information and communications with the NHS 111 service.

6.5 Clinical Services

6.5.1 This specification details the requirements for the clinical service provision aspect of the 'out of hours' service.

6.5.2 The Bidder(s) must ensure that there is always a sufficient level of accredited medical and other clinical staffing per head of population and the appropriate medication, appliances and quality assured equipment, available to provide a safe and accessible service taking into account both patient and staff safety.

We require a suitable skill mix to meet the demands of the service and a minimum of 1 GP during centre opening times to be physically available in each CCG area (2 in the case of Liverpool, because of higher baseline population), who can be either mobile or based in one of the static locations.

During the overnight period 23:00 to 08:00 the following minimum number of GPs are expected to be available within the clinical skill deployed:

	Summer	Winter
Monday to Thursday	4	5
Friday	4	6
Saturday	4	6
Sunday	4	5

6.5.3 The CCG's are committed to a policy of restricted appropriate home visiting to only those patients with a clinical need who cannot reasonably attend one of the 'out of hours' centres and will work with the appointed Bidder(s) to achieve a common policy across the CCG's.

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6.5.4 The Bidder(s) will provide a copy of their clinical guidelines, with clear reasons and criteria that indicate when home visits are considered appropriate. This to include details of how they plan to transport clinicians making home visits, including the number of vehicles to be provided and their base, driver assistance and associated training and qualification assurance.

6.5.5 Appropriately qualified health care professionals undertaking home visits to confirm and/or certify deaths when they occur 'out of hours' will be expected to undertake such visits in a reasonable time frame, cognisant of the impact upon families and relatives at such a difficult time.

6.5.6 Where patients self-present at the 'out of hours' centre in an emergency and have not contacted the NHS 111 service prior to attending, an initial assessment must be undertaken to ascertain whether they need to see an appropriate professional urgently. Full patient demographic, assessment and consultation details must be fully recorded in the electronic call management system including 'priority' on initial contact, 'priority' following definitive clinical assessment and 'priority' on completion. It is expected that self-presenting patients will be the rare exception, with almost all patients making an initial contact by telephone. The Bidder(s) protocol for managing such self-presenters must be agreed in advance with the Commissioners.

6.6 Transport.

In exceptional circumstances the Bidder(s) may consider it appropriate to provide patient transport, typically via a taxi, to enable patients without access to their own transport and where they cannot make reasonable alternative arrangements to attend the nearest 'out of hours' centre for a consultation and to avoid professionals providing 'out of hours' services from making inappropriate home visits. The costs of any such transport are the responsibility of the Bidder(s).

Transport could be required for: patients from their home to the nearest 'out of hours' centre and then from the 'out of hours' centre back home where no other practical means exists.

6.6.1 Criteria for Transport

The use of the patient transport is strictly on the basis of assessed need. The service must only be used by exception if the patient is unable to reasonably arrange their own transport to the nearest 'out of hours' centre. The professional taking the call must explore other options such as a friend/neighbour's car, patient calls own taxi etc. to transport the patient to the 'out of hours' centre.

The transport service shall only be offered to patients who are fit to travel and not as a substitute for a home visit to seriously ill patients.

Where possible, a family member should accompany the person being transported to the out-of-hours centre. All children transported to the 'out of hours' centre must be accompanied by a parent/guardian.

6.7 Collaborative Working and Admission Avoidance

The Bidder(s) must be involved in a whole system approach to urgent and unscheduled care service development and engage with the CCGs and other stakeholders in forums to review and develop services.

6.8 Palliative Care

The condition of those reaching the end of life can change rapidly, thereby requiring an urgent response. The Bidder(s) will deliver end of life care services in line with the recommendations of the End of Life Care Strategy 'Promoting high quality care for adults at the end of life' Department of Health, July 2008.

The Bidder(s) will work to NICE Guidance:

NG31 Care of the Dying Adult in Last Days of Life (2015)
NG61 End of life care for infants, children and young people with life-limiting conditions: planning and management
CG140 Palliative care for adults: strong opioids for pain relief

Clinicians shall make Home Visits to these patients outside of the normal home visiting policy with an express view of managing these patients at home, except in exceptional circumstances, and only after advice from the Specialist Palliative Care team once the GP or DN has made a clinical assessment or where Special Patient Notes direct an alternative.

The Bidder(s) will work in partnership with local providers of end of life care to ensure that they have processes in place, to access the most up-to-date information about vulnerable patients, their needs and preferences. They will also ensure that the out of hours service database/ register is kept updated with relevant information i.e. anticipatory care plans, special patient notes etc.

The Bidder(s) will have protocols in place to ensure that when these patients or their carers call they are not required to go through the normal routine assessment of needs, but are put through to a clinician in a timely manner, who can respond quickly and effectively to their needs

The Bidder(s) will have systems in place to ensure that the identification of people who may be in their final stages of life using a recognised tool (such as the Gold Standards Framework Proactive Identification Guidance), which is monitored and that a timely personalised care and supportive care plan is documented and shared electronically. This will include but not be limited to identifying needs and expressed preferences of patients at the end of life, including preferred place of death. The development and implementation of a robust system of communication between the Bidder(s) and the GP practices using special patient notes is vital in ensuring that the needs of patients are met.

Systems will need to be in place to ensure patients at the end of life have access to timely and appropriate medication, in line with CCG palliative care formularies, and equipment as agreed with CCGs and palliative care teams e.g. syringe drivers and catheters, during the OOH period.

The Bidder(s) will work with CCGs and community palliative care teams to align the paperwork e.g. 'pink sheet' that is to be used to authorise administration of end of life medication.

All clinicians and control room staff must receive relevant training in end of life care to ensure patients are appropriately managed within an agreed care pathway and where possible enabled to remain at home. Unnecessary calls to the ambulance service and admissions to hospital shall be reduced. This training shall include: symptom management, Individual Plan of Care for End of Life (IPOC), DN'A'CPR, communication skills specific to the needs of this patient group and their carers

The Bidder(s) will ensure compliance and support of any telehealth systems in use, including staff training.

The Bidder(s) will ensure use of the Electronic Palliative Care Co-Ordination Systems (EPaCCS)

The Bidder(s) will have in place systems and suitably qualified staff to undertake verification of death.

6.9 Mental Health

Bidder(s) must ensure:

Adherence to the principles of the Mental Health Crisis Care Concordat – Improving Outcomes for People Experiencing Mental Health Crisis (https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353).

For patients requiring urgent specialist mental health input (inpatient, community or home support), contact will be made with the local mental health services for the area. The out of hours service will provide appropriate and timely clinical information to the mental health service to facilitate the swift referral of the patient.

For those patients who have urgent physical health issues e.g. have taken an overdose, referral will be made to A&E or if required an emergency ambulance will be called, as appropriate.

The Bidder(s) will ensure that they are aware of the range of services in place to support mental health for children and adults in each CCG area and be familiar with the DoS. The service will be expected to work, as an active partner in local mental health networks, with all local providers of mental health services, including the voluntary sector, to ensure that patients are kept safe, including those services providing alternatives to admission. In addition, the Bidder will ensure that their service response is maintained with reference to developments relating to NHS111 and Mental Health.

6.10 Clinical, Professional and Management Leadership

Strong managerial and clinical leadership is vital to establish an effective culture of staff and patient engagement. Staff involved in leadership, managerial and supervisory roles must receive appropriate training and development to ensure they can undertake the range of tasks and responsibilities expected of them.

6.11 Potentially Violent Patients

The Bidder(s) will see those patients who are on the Special Allocations Scheme across the

CCG's and subsequently liaise with the local service / Practice. The Bidder(s) shall have adequate and appropriate measures in place to manage such patients, whilst at the same time maintaining staff safety.

6.12 Infection Control

The Bidder(s) will ensure that it has appropriate arrangements for infection control and decontamination. The Bidder(s) is required to provide the services in accordance with the Code of Practice on the Prevention and control of infections under the Health and Social Care Act 2008.

The Bidder(s) will:

Have systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance (See Section 9.0 Medicines Management)

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Have systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control and control infections

Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Ensure the environment and equipment used for patient care is fit for purpose and where required decontaminated in line with national and local policies.

Ensure all staff receive suitable and sufficient training to ensure they are complying with local and national recommendations and are able to reduce the risk of transmission of infection by good clinical practice and treatment.

The Bidder(s) will be required to participate with annual infection control audits carried out by the local NHS infection control nurses and random unannounced audits' if required by the commissioner's e.g. environmental cleanliness and infection prevention and control. They must comply in full with all recommendations made subsequent to these visits.

The Bidder(s) shall demonstrate good infection control and hygiene practice and must ensure

evidence-based policies and guidelines in place to facilitate this. All staff will facilitate and co-operate with the Commissioners' Infection Control Teams in monitoring, audit and investigation (including Root Cause Analysis) of the environment, patient outcomes and practices to ensure high standards are maintained.

6.13 Patient Dignity and Respect

The Bidder(s) must deliver the Services in such a way that treats every Patient and Carer as a valued individual, with respect for their dignity and privacy.

The Bidder(s) must:

- ensure that the provision of the Services and the Premises protect and preserve patient dignity, privacy and confidentiality;
- allow patients to have their personal clinical details discussed with them by a person of the same gender, where required by the Patient and if reasonably practicable;
- provide a chaperone for intimate examinations to preserve patient dignity; and
- ensure that all staff always behave professionally and with discretion towards all patients and visitors.

6.14 Patient, Public and Professional Engagement

The CCGs are committed to ensuring that services genuinely meet the needs of people from all communities, and the CCGs actively promote race equality, disability equality, and gender equality. The Bidder(s) will include proposals for patient communication, for example, patient groups, newsletters, focus groups, social media, so to highlight how patient participation in service development and delivery will be achieved. In addition, information about service availability and location, how to access services and the appropriate use of out of hours urgent care services shall be provided to patient/service users.

Quarterly the Bidder(s) must provide to the CCGs for distribution to Practices a summary of activity and dispositions over the last quarter, including a quality commentary by exception against the contractual standards and any service delivery messages for GPs information and / or action. The format of these reports to be agreed with the co-ordinating commissioner.

6.15 Health and Safety

The Bidder(s) must have in place a Health and Safety policy which will ensure the health and safety of their employees, patients and relevant others.

6.16 Service Mobilisation

The Bidder(s) will be responsible for the mobilisation of the Services and will be required to propose an outline Mobilisation Plan in respect of the workforce requirements and submit this plan as part of your Invitation to Tender. This plan will form part of the agreed contract.

The Bidder(s) will be required to maintain a Business Continuity Plan in respect of the service delivery, workforce and IM&T/telephony requirements throughout the term of the Contract Agreement.

7.0 Additional Services

In addition to the core 'out of hours' services, common to all the CCG's, some have additional local specific services that they wish the Bidder(s) to respond to under the proposed contract arrangements.

7.1 ALL CCGs – in hours Clinical Assessment Service (CAS) Capacity

The seven commissioning CCGs require the Bidder(s) to provide in hours CAS clinical capacity between the hours of 08:00 – 18:30 Monday to Friday to receive and manage calls from NHS 111 and the 999 emergency ambulance service (including elements of Cat 3 & 4 activity that could benefit from primary care 'hear & treat' intervention) as part of the wider virtual CAS offering across urgent and emergency care. NB this requirement covers the whole of St Helens CCG population.

Bidder(s) should price within their model the provision of at least 3 GPs and associated support staff to meet the expected level of demand for in hours 'hear & treat' support as part of the wider virtual CAS.

The cost of this in hours CAS is to be included within the overall bid price but separately identified as an element within the total bid price submitted. CAS support during the out of hours period will be included within the overall service demand and activity envelope.

7.2 Protected Learning Time (PLT) Cover.

The seven commissioning CCGs require the Bidder(s) to provide varying levels of in hours PLT cover as defined below. This should include the provision of direct call handling, 'hear & treat' and if required face to face consultation. A specific cost per CCG specific request is to be provided. The exact dates of the programme of each CCGs PLT event is to be agreed with the individual CCGs as part of mobilisation e.g. to avoid weeks with a Public Holiday or school half term.

7.2.1 Halton Clinical Commissioning Group

Protected Learning Time (PLT) – the Bidder(s) will be required to provide OOH telephone advice and face to face contact during core hours from 1.00pm - 6.30pm one afternoon per month for 10 months per annum (excluding August and December) to provide cover for PLT. It is expected that these days will fall on a Wednesday / Thursday.

7.2.2 Knowsley Clinical Commissioning Group

Protected Learning Time (PLT) – the Bidder(s) will be required to provide OOH telephone advice and face to face contact during core hours from 1.00pm - 6.30pm on 6 occasions per annum. Please note that the provision of PLT cover in Knowsley is for all Practices in the CCG, with PLTs ordinarily scheduled to take place on a Thursday.

7.2.3 Liverpool Clinical Commissioning Groups

Protected Learning Time (PLT) – the Bidder(s) will be required to provide OOH telephone advice and face to face contact during core hours from 12 noon - 6.30pm on 10 occasions (twenty half days) per annum to provide cover for PLT, with Practices opting to 'book' their

event on either the last Wednesday or Thursday of the month ie on each of the ten occasions per annum some of the Practices will wish to close on the Wednesday, others on the Thursday, with some variation from one event or occasion to another.

7.2.4 South Sefton and Southport & Formby Clinical Commissioning Groups

The CCGs require the Bidder(s) to run OOH cover for all Sefton practices for 12 Professional Forum days a year, these are typically, half day, afternoon sessions once a month and take place on a Wednesday from 12 noon to 6:30pm. The CCGs will provide the Bidder(s) with the schedule.

7.2.5 Warrington CCG

Protected Learning Time (PLT) – the Bidder(s) will be required to provide OOH telephone advice and face to face contact during core hours from 12 noon - 6.30pm 14 afternoons per annum to provide cover for PLT. It is expected that these days will fall on a Thursday.

7.2.6 St Helens CCG

Protected Learning Time (PLT) – the Bidder(s) will be required to provide OOH telephone advice and face to face contact during core hours from 12 noon - 6.30pm 7 afternoons per annum to provide cover for PLT. It is expected that these days will fall on an alternating Wednesday or Thursday. Please note that the provision of PLT cover in St Helens is for all Practices in the CCG.

NOTE: the continuation of the current arrangements for half day PLT events is currently under review. In the event that these events cease, the contract will be subject to variation and the service obligation removed.

7.3 In-hours support to Public Health England.

The seven commissioning CCGs require the Bidder to provide an hourly cost for the provision of a GP / nurse and driver to assist in the management of an infectious diseases outbreak, year round, such as an incidence of flu in a residential or nursing home setting requiring the provision of anti-virals or other prescribed medicines, where the CCG(s) require additional clinical capacity in hours to supplement available primary care and / or community health services.

7.4 HM Prisons / Secure Accommodation.

Within the area covered by this contract there are four prison establishments. Whilst NHSE commission prison medical services, urgent out of hours primary care only provision falls under the remit of this specification, whereby telephone advice and /or a visit may be required, in circumstances where an individuals need cannot reasonably and safely wait until the resumption of prison health care services and where the request is for urgent primary care. It is expected that the cost of carrying out this work will be **included** within the core service element price. In addition, there is one secure accommodation unit for young people in St Helens that requires a similar level of service to the prisons.

The four prison establishments are as follows:

HMP Liverpool:

Address: 68 Hornby Road
Liverpool
L9 3DF

Operational capacity: 1300

Accommodation: Constructed in 1855 with eight wings, all of which have integral sanitation. HMP Liverpool has commenced a programme of refurbishment which includes full refurbishment of accommodation.

Reception criteria: Standard local prison criteria. Remand/Trial and Convicted as directed by the courts.

HMP Altcourse:

Address: Higher Lane
Fazakerley
Liverpool
L9 7LH

Operational Capacity: 1033 from April 2013

Accommodation: Healthcare, 6x accommodation units, 3 x Vocational Training residential units

Reception Criteria: HMP Altcourse is a Category B local prison receiving prisoners from the courts in Merseyside, Cheshire and North Wales. The prison accepts young offenders and adult male prisoners who are both sentenced and remanded by the courts.

HMP Risley:

Address: Warrington Road
Risley
WARRINGTON
Cheshire
WA3 6BP

Accommodation: Modern three-tiered single cell accommodation units with integral sanitation, showers on all landings, purpose-built Serveries and association facilities. In-cell mains power and in-cell TVs installed throughout the prison. PIN phones on all units with access reported as good.

Operational capacity: 1095

Reception criteria: Risley is a Male category C training prison with an integrated VP (Vulnerable Prisoner) regime with access to the Sex Offender Treatment Programme.

HMP Thorn Cross:

Address: Arley Road

Appleton Thorn
Warrington
Cheshire
WA4 4RL

Operational capacity: 381

Accommodation: Single and double rooms, own key.

Reception criteria: Less than 2 years left to serve.

'Out of Hours' cover will be required from 1830 to 0800 daily and from 0800 to 1830 on Saturdays, Sundays and bank holidays.

An important point is that any doctors / clinicians visiting the prison MUST carry photographic ID to ensure smooth and timely entry to the prison. Failure to do so can result in entry being refused and patient care being compromised.

Secure Accommodation: St Catherine's.

St Catherine's is a secure centre providing residential care and education to young people of both genders in St Helens Borough. Residents are not registered with local practices as in hours care is provided in house but may require a 'home visit' to the accommodation rather than residents attending a clinic, as a consequence of the secure nature of the young people's placement in the centre.

St Catherine's Secure Centre
Blackbrook Road
Blackbrook
St Helens
Merseyside
WA11 9RJ

7.5 Primary Care Streaming – Southport & Formby (Southport Hospital AED site).

In order to further develop partnership working and integration across urgent care, Southport and Formby CCG require the Bidder(s) to provide a cost for the provision of a daily GP streaming service in Southport Hospital AED in the out of hours period. This will be in the form of a 4 hour session Monday to Friday 18:30 to 22:30 and weekends between the hours of 16:00 to 20:00. The Bidder(s) would be required to develop a model and governance arrangements with Southport & Ormskirk Trust to ensure that any process of streaming would be designed so that patient safety is paramount. Any initial assessment process should improve the overall quality of care provided for patients and add value to the patient's experience by providing early information and ensuring that the patient sees the most appropriate clinician to address their need. The Service would be located in the Southport Hospital AED. Alongside this the Bidder(s) would be expected to work with local stakeholders in the redesign of urgent care services as part of the Acute Sustainability Programme.

8.0 Contingency Planning

Robust contingency plans must be in place to ensure the level of 'out of hours' primary care service is always routinely delivered as stipulated within the contract.

The Bidder(s) must also ensure robust contingency policies exist for extraordinary circumstances in which Services are challenged to meet unexpected demand. These may include plans that support the various health economies in the management of Major Incidents, Hospital Escalation, Winter Pressures, Influenza & Flu Pandemic and Heat Wave contingency.

The Bidder(s) are additionally specifically required to have plans in place to administer anti-virals to nursing, residential, educational or other establishments upon direction from Public Health England upon determination of an outbreak in any such establishment and / or pandemic scenario all year round.

These functions would not discharge the Bidder(s) of any obligation and legal responsibility for the management of such events. To ensure compliance with The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, escalation and activation under these circumstances would have to be agreed between the CCGs and the Bidder(s). This would include functions aligned to the anticipation, assessment, prevention, preparation, response and recovery of such events. To facilitate this, it is expected that the 'normal' command and control arrangements for 'out of hour' services would be suspended, and the Bidder(s) would fully co-operate with the reasonable directions and instructions of NHSE and/or CCGs, and fully support the CCGs in the discharge of their Civil Contingencies Act responsibilities.

In particular, contingency plans must be developed that ensure business continuity in the event of any evacuation, flood, fire or IMT / power failure. To ensure this occurs operational considerations are required in respect of Human Resources, Information Technology, Telephony, Medical Devices, Medicines Management, Transportation and Estates.

The Bidder(s) shall demonstrate contingency plans that it will put in place for failure of or breakdown in the Service (or their part thereof). As a minimum, contingency plans shall cover:

- Capacity and capability to manage peaks in demand (escalation plan);
- Emergencies, whether due to a loss of staffing or major health incident (contingency plan); and
- Disaster recovery plans (e.g. loss of IT systems or premises).
- Details of their contingency plans should the main telephone line be inoperable for any reason
- Adverse weather

These plans must show evidence of how service recovery will be sustained after an incident.

The Bidder(s) shall input into the CCG planning processes for emergency planning and capacity planning (including winter planning) as required. Representation from the Bidder(s) at local major incident planning forum will be required. This will include a requirement to respond in the event of a major or untoward incident e.g. disease outbreak or major accident.

8.1 Response in a Major Incident

The CCGs, with other NHS and statutory agencies, have an incident and major emergency plan to support response to emergency situations, as well as a pandemic influenza contingency plan.

The Bidder(s) must have its own enhanced emergency response plan and take part in multi-agency planning, training and exercising of plans as appropriate and requested.

The Bidder(s) must become fully conversant with local emergency planning arrangements including pandemic influenza preparedness and participate and respond as required in exercises and real emergencies as required by the CCG and partner agencies.

8.2 Involvement in Business Continuity Plans within the Wider Health & Social Care Economy

At times of significant demand and pressure across the health system there may be occasions where the out of hours Bidder(s) is asked to support the health economy by seeing appropriate patients with primary care needs who may be redirected from the local AEDs. Typically, this might be where the health economy declares a high OPEL level escalation which requires whole system support.

The Bidder(s) will be required to fully assist with business continuity plans within the wider Health & Social Care economy. For example, in adverse weather conditions or at times of increased demand in the system, Bidder(s) will be required to ensure flexibility in opening/closing times of the OOH service as well as providing assistance in acute settings and carrying out additional home visits.

9.0 Medicines Management and Prescribing Formulary

The Bidder(s) will be responsible for providing the following:

A supply of stock medicines for use or administration as part of immediate treatment or assessment. This stock will need to be comprehensive and align with the clinical pathways agreed for care in the out of hours period, this includes Controlled Drugs (CDs). The stock formulary and any future changes to it will need to be agreed with the CCGs as well as via the Bidder(s) own clinical governance processes.

If PGDs are to be used - A supply of pre-labelled stock medicines for supply under a Patient Group Direction (PGD) in line with the Pan Mersey Area Prescribing Committee (APC) formulary, recommendations and guidelines. The use of PGDs will need to be agreed with the CCGs and must be aligned with the clinical pathways agreed for care in the out of hours period.

Access to FP10 prescriptions for use by medical and non-medical prescribers where clinically appropriate, including the use of EPS where available. The Bidder(s) will be expected to adhere to the APC formulary, recommendations and guidelines as agreed by the CCGs. This is available via the APC website.

9.1 Formulary

All CCGs included in this are part of the Pan Mersey Area Prescribing Committee (APC). All prescribing should be in line with the Pan Mersey APC formulary, guidance and recommendations. Any deviation from this formulary must be agreed by the CCGs in advance. Prescribing of antibiotics is likely to be a common intervention within the out of hours setting and as such it is essential that the Bidder(s) adheres to the Pan Mersey APC antimicrobial guidance to support effective antimicrobial stewardship and reduce antimicrobial resistance. It will be expected that the Bidder(s) will carry out a full antibiotic audit twice a year working as agreed with CCG medicines management teams and will be able to demonstrate activities that support good antimicrobial stewardship.

9.2 Clinical governance

The Bidder(s) is responsible for clinical governance and compliance with applicable national legislation and guidance for all aspects of medicines management, including prescribing and supply. Bidder(s) must engage and participate in any prescribing audits when deemed necessary by the CCGs.

The Bidder(s) must ensure compliance with all legal, clinical and governance procedures regarding the use of PGDs.

Any incidents related to medicines and prescribing, including use of PGDs, must be investigated by the Bidder(s), with outcomes reported following the Bidder(s) and commissioner reporting processes along with shared learning as a result of the investigations.

9.3 Supply of Medication

The Bidder(s) is expected to have a mechanism available through which a full course of medicines can be supplied or administered where clinically appropriate.

The Bidder(s) should also implement a mechanism for reporting all medicines prescribed and provided as part of the OOH service to the CCG on a regular basis.

Although not routinely recommended the OOH Bidder(s) can issue repeat prescriptions, where this is deemed appropriate as determined by clinical assessment.

9.4 Medicines policies

The Bidder(s) is expected to have in place a full set of policies and protocols relating to safe use of medicines and safe management of controlled drugs within the service. These policies must be audited on a regular basis to support adherence to legislation and best practice.

The Bidder(s) will be required to designate an executive member to be the responsible lead for medicines management. Appropriate management time shall be assigned to this post. In addition, a lead manager for medicines management shall support this post and provide a further point of contact for the CCGs on medicines matters.

9.5 Basic Requirements of Medicines Supply

Based on the National 'Out of Hours' Formulary (see attached document) the Bidder(s) will operate within an agreed local formulary approved by the Medicines Management Committees of each of the CCGs or the pan Merseyside Medicines Management Committee.

All medicines shall be supplied in appropriate quantities for the condition being treated (i.e. full courses of treatment and **not** starter packs), and comply with all relevant legislation regarding packaging, labelling and the use of patient information leaflets (PILs).

Manufacturers' original packs shall be used wherever possible. Any pre-packed items shall only be obtained from a fully licensed supplier who complies with the relevant legislation. A full audit trail to track movements of drugs identifying the prescriber (or supplier) at the point of issue will be required. The Bidder(s) is responsible for the supply of essential medicines in the 'out of hours' period. The responsibility for locating a source of medicines does not rest with the patient or their representative.

Where a supply of oxygen is deemed necessary in the out of hours period the Bidder(s) shall comply with arrangements in place to furnish an appropriately completed Home Oxygen Order Form (HOOF)[1] to the regional home oxygen services without delay.

Where medicines are supplied by the Bidder(s) directly to patients, i.e. not for dispensing by a pharmacy, prescribers must complete a non FP10 supply form (FP10P-REC form). Completed forms must be stored securely and all completed forms returned to the Prescription Pricing Authority of the NHS Business Services Authority in Newcastle by the 5th working day of each calendar month.

FP10 prescriptions are classed as controlled stationary and must be stored and transported in line with 2018 Counter Fraud Authority Control and Management of prescription forms

9.6 Access to Palliative Care Drugs including Controlled Drugs

The Bidder(s) will be expected to stock palliative care drugs including controlled drugs as

[1] http://www.bprs.co.uk/documents/oxygen/HOOF.pdf

agreed with the commissioning CCGs. The commissioning CCGs will endeavour to standardise this list but where there are differences in the lists between the CCGs the range and quantity of drugs specified by the appropriate CCG shall be available from the Bidder(s) in that area. The carer should in no case be expected to leave the patient to collect a necessary medicine or be responsible for locating a source of supply of an essential medicine in the 'out of hours' period, neither is this the responsibility of the district nurse. This responsibility lies with the 'out of hours' Bidder(s).

9.7 Controlled Drugs

The Bidder(s) must comply with all requirements related to the strengthened governance arrangements now in operation in the NHS related to handling of controlled drugs. There must be a full audit trail for all aspects of handling of controlled drugs including patients own controlled drugs. Patients own controlled drugs should not be removed from the patient's home by the Bidder(s), unless in an exceptional case on the grounds of patient or public safety. In this case the organisations-controlled drugs Accountable Officer shall be informed of the details on the next working day at the latest.

The Bidder(s) will link into the Local CD intelligence Network and to report CD incidents to the Cheshire & Merseyside CDAO in line with the reporting requirements.

9.8 Medicines Management –Reporting Arrangements

The Bidder(s) will co-operate with the CCGs Heads of Medicines Management in relation to medicines. They will establish regular meetings to monitor performance and issues related to medicines and to discuss local guidance, links to Area Prescribing Committee, local developments that may affect them etc. Information will be specific to each CCG. Such meetings will take place at least quarterly.

The Bidder(s) will co-operate with the CCGs to establish systems that will (i) enable prescribing costs to be attributed appropriately by CCG and (ii) establish a system for collection of prescription charges from patients as appropriate.

9.9 Medicines Managements – Sources of Information

Legislation, policies and standards relevant to medicines management include:

- All relevant CCG Medicines, Policies and Guidelines

Where possible these will be standardised across the patch but where a different policy exists for each CCG the Bidder(s) must comply with each CCG's requirements in the relevant locality e.g. palliative care drugs stocked.

National standards/guidelines relating to medicines management:

- Delivering the Out of Hours Review: Securing Proper Access to Medicines in the Out of Hours Period; A Practical Guide for CCGs and Organised Bidders (Includes National Drug Formulary): Department of Health 2004[2].
- The Safe and Secure Handling of Medicines: A Team Approach, Royal Pharmaceutical

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134235

Society Great Britain, 2005[3]

- Safer Management of Controlled Drugs: Guidance on Strengthened Governance Arrangements, Department of Health 20062[4]

9.10 Prescribing Budget / Costs.

The CCGs acknowledge the complexity of the Bidder(s) providing a service across the populations of seven CCGs, within the constraints of the current prescribing / budget system. It is therefore proposed that initially the service is set up with a single prescribing code across the whole service, avoiding the need for multiple CCG codes or a single code being attributed to one CCG, thereby adversely affecting their prescribing data quality. The costs of the prescribed drugs etc would then be retrospectively apportioned and met by the CCGs across the seven CCG areas.

It is suggested that we monitor the prescribing budget and spend for a minimum period of six months, with the intention of exploring and establishing a realistic prescribing budget for the service in due course, which could be transferred to the Bidder(s) to manage going forward, within a to be agreed risk / gain sharing arrangement.

9.11 Legislation and Regulations – Medicines Management

The Medicines Act 1968, London: HMSO
The Misuse of Drugs Act 1971, London: HMSO
The Misuse of Drugs (Safe Custody) Regulations 1973
The National Health Service Act (1977), London: HMSO
The Primary Care Trusts Out of Hours Services (Supply of Medicines, etc.) Directions; 2005
The Misuse of Drugs Regulations 2001 (February 2002)
The Controlled Drugs (Supervision of Management and Use) Regulations 2006

[3] http://www.sld.cu/galerias/pdf/servicios/medicamentos/the_safe_and_secure_handling_of_medicines.pdf
[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_064460

10. Staffing

10.1 Clinical Staffing

Demand for services is variable throughout the year with seasonal peaks, particularly over public holiday weekends and during the winter months. The Bidder(s) will be required to describe their staffing and delivery model, clinical skill mix and its approach to capacity and demand modelling to deliver the required activity.

The Bidder(s) must demonstrate they have the capability to use activity data to forecast demand in line with times of day (by hour of the day), days of the week and seasonal variations.

The Bidder(s) is to provide details of a sample weeks rota that shows the distribution and allocation of staff, by clinical grade and function across the service for a weekday (summer & winter) and for a weekend (summer & winter)

In addition, they must describe their approach and arrangements for the following:

- The arrangements for the provision of additional capacity (standby doctors / clinical staff) and the protocol for their deployment at times of increased demand

- The provision of substitute clinicians should the rostered clinicians(s) be unavailable for their shift. (It will be the responsibility of the Bidder(s) to arrange locum / agency staff.)

- Details of the management structure and responsibilities, including on-call and shift lead arrangements

10.2 Qualifications and Mandatory Training

All staff must be appointed in line with professional qualifications / standards as appropriate and continue to update skills in line with professional codes of conduct.

No health care professional shall perform any clinical service unless he/she has such clinical experience and training as are necessary to enable him/her properly to perform such services.

The Bidder(s) shall be responsible for ensuring that their staff:

- have relevant professional registration and enhanced DBS checks undertaken prior to seeing patients alone

- have, prior to starting in post, provided two references (clinical if applicable), relating to two recent posts (which may include any current post) as a health care professional which lasted for three months without a significant break, or where this is not possible, a full explanation and alternative referees.

- all access robust induction training applicable to their individual role,

- have access to, safeguarding training and development in line with their professional bodies' recommendations

- undertake annual audit to ensure compliance with the above.

If the staff member is a GP they must:

- be included in a Medical Performers List for a CCG
- not be suspended from that List or from the Medical Register; and
- not be subject to interim suspension under section 41A of the Medical Act 1983.
- be included in the GMC specialist register with a licence for General Practice and evidence of active participation in revalidation.
- provide evidence of professional indemnity insurance, if not covered under the auspices of the national indemnity scheme

If the staff member is a nurse or other regulated health care professional, they must be appropriately registered by the relevant professional regulatory body.

The Bidder(s) must provide evidence of membership / eligibility for membership of the national NHSE indemnity scheme and / or professional indemnity insurance

10.3 General Practitioner Registrar Training

The Bidder(s) must provide training and education for doctors, including ST1's, ST2's and ST3's. The Bidder(s) will be expected to facilitate training opportunities for GP registrars, every 6 months, who will be supernumerary, and therefore separate from the practitioners delivering 'out of hour' services. This will be negotiated in liaison with their designated GP Trainer who has responsibility for the educational and clinical experience of the Registrar. A certificate of attendance detailing cumulative hours attended to be issued for each registrar to their registered trainer.

The numbers of trainees can vary and the current number of training Practices across the seven CCGs is as follows (at October 2019):

CCG	**Number of training Practices / placements.**
Halton	8
Knowsley	6
Liverpool	33
South Sefton	10
Southport & Formby	9
St Helens	2 (6 further currently serviced by St Helens Rota)
Warrington	14

The Bidder(s) will be required to provide verification of attendance with evidence of exposure to, and competency gained in, the delivery of urgent medical care in line with the recommendations of HEE and individual GP Trainers.

The Bidder(s) must ensure that it complies with the requirements of HEE, Royal College of General Practitioners (RCGP), and any other relevant training bodies, to take on training

placements. The training must fulfil the needs of the RCGP curriculum especially Curriculum Statement 7 – Care of Acutely Ill People.

The Bidder(s) must also have in place:

- Sufficient clinical supervisors who are always trained and accredited to teach/supervise to a level approved by HEE to provide adequate supervision of trainees.
- Systems to ensure patient safety and the service are not adversely affected by training.
- Training available across the OOH contract and not restricted to certain hours
- Quality control systems to ensure training are being provided to the standards expected by the CCGs.

The Bidder(s) must meet the local general practice training accreditation criteria to take on GP training placements within 1 month of their Commencement Date and / or notification.

10.4 Workforce Requirements

The Bidder(s) must have in place a comprehensive, coherent, robust plan for recruitment, management and development of staff with the principle objectives to:

- meet the essential day to day staff leadership, management and supervisory needs of the contract during its lifetime, including during mobilization and, if appropriate, contract termination
- adhere to TUPE legislation
- support the provision of safe, high quality clinical services
- ensure through appropriate audit, training and continuous professional development that all staff involved in treating NHS patients are and remain qualified and competent to do so.
- support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice.
- maintain an effective working partnership with local NHS employers to continuously develop and maintain best people management practices and ways of working

The Bidder(s) must have in place a recruitment and retention strategy. This must:

- be capable of attracting and retaining high quality job applicants
- optimise individual skill levels and potential
- fully harness available skills and commitment and
- encourage and engender support for new ways of working.

This policy must also cover the working hours of clinical staff outside of the OOH service, and in particular, the Bidder(s) must ensure they have a mechanism in place which supports them in reviewing and monitoring the hours worked by clinical staff and assuring themselves that the service they provide is safe.

The Bidder(s) must have in place a staffing strategy to meet specified levels of service that identifies the requirements for supporting ancillary staff services. The strategy shall include contingency plans for times of high demand and/ or high levels of staff absence. The Bidder(s) must have in place mechanisms for keeping the commissioner informed when staffing capacity is unlikely to meet demand and the actions that will be taken to address this. It is expected that the Bidder(s) will have in place mechanisms to actively review and monitor the working hours of all staff members.

10.5 The Transfer of Undertakings (Protection of Employment) Regulations (TUPE)

The Bidder(s) shall be responsible for all TUPE obligations occurring under this contract from the existing providers of the services (see table below) and shall include for all associated costs within their tender and pricing of the services. The CCG's cannot warranty the accuracy or completeness of this information provided by the current service providers.

Current service providers:

CCG	**Name of current service Bidder(s)**
Halton	Primary Care 24 (PC24)
Knowsley	Primary Care 24 (PC24) / St Helens Rota *
Liverpool	Primary Care 24 (PC24)
South Sefton	gtd healthcare
Southport & Formby	gtd healthcare
St Helens	Primary Care 24 (PC24) / St Helens Rota *
Warrington	Bridgewater NHS Foundation Trust

Notes:

Knowsley * 3 practices currently remain outside of this procurement and receive their services under direct contracting by the Practices from St Helens Rota

St Helens * 26 practices currently remain outside of this procurement and receive their services under direct contracting by the Practices from St Helens Rota; 8 practices currently receive services from PC24.

10.6 Workforce Strategy

The Bidder(s) must provide a comprehensive workforce strategy that includes:

- a description which will support the effective achievement of the service delivery solution;
- a management organisation structure chart and summary of key individuals' relevant management experience;
- a proposed staffing plan to deliver the service delivery solution, detailing staff numbers, whole time equivalents (WTEs) and staffing assumptions including contingency arrangements to cover planned and unplanned increases in workload or staff absence patterns;

- details of how suitably qualified, experienced and competent staff will be sourced and retained in the numbers required to deliver safe and high-quality services;

- details of key support staff and the processes for providing support services;

- details of how a positive employee relations environment will be achieved and maintained

10.7 Recruitment Policy

The Bidder(s) must ensure recruitment processes for all staff are linked to clear competency-based job roles and person specifications and they have access to effective occupational health support prior to interview, and subsequently, to support managers and staff on an on-going basis. Systems must be in place to ensure professional staff are appropriately registered and that where necessary pre-employment DBS checks are undertaken.

The Bidder(s) must have a recruitment policy that supports its service delivery solution. The Bidder(s) recruitment policies, strategies and supporting processes must enable it to attract, retain and ensure a high quality, competent workforce.

The Bidder(s) is required to have a competency assessment process for all clinical staff that must include competency assessment tools. The assessment process should be appropriate to the grade of staff and the process/ consultation being undertaken.

The Bidder(s) must ensure staff are provided with an appropriate working environment. Evidence is required of the mechanisms that show compliance with all employment legislation, the working time directive.

Bidder(s) must ensure that any recruitment, including that via agencies that they propose to use comply with the Code of Practice for International Recruitment as relevant.

The Bidder(s) must ensure compliance with all specified pre- and post-employment checks including the verification of identities of prospective recruits.

The Bidder(s) shall ensure that staff comply with best practice standards with regards to pre-employment checks including Hep B status.

10.8 Registration of Staff

10.8.1 Professionally Registered Personnel

The Bidder(s) must ensure that all clinical staff engaged in delivering the Services are appropriately registered with the relevant UK regulatory bodies and have the necessary training, qualifications, experience, current competence and English language communication skills to undertake their clinical roles.

The Bidder(s) must ensure that the registration requirements for each category of staff are met and that appropriate compliance records are maintained and may be subject to inspection by the CCGs at any reasonable time.

10.8.2 Non-Registered Personnel

Where the Bidder(s) intends to use categories of staff who are not registered to a professional body, but who are directly involved in supporting the clinical services then information regarding roles, competency levels and management structures must be provided as part of their bids.

10.9 Staff Training and Development

10.9.1 Induction

Bidder(s) must propose and subsequently implement, a comprehensive induction programme for all staff. Induction modules shall support the Bidder(s) key workforce strategies and service delivery objectives. Where applicable, the Bidder(s) should be aware of the NHS employers' best practice guidelines.

Clear processes for induction, training and development, which maintain and improve skills and competencies of the workforce in the field of urgent care, are essential.

A shortened induction process shall be in place for the use of any temporary, agency or locum staff that ensures that they are competent and familiar with key local policies and procedures before they undertake any duties.

10.9.2 Continuing Professional Development (CPD)

The Bidder(s) must ensure that all clinical and non-clinical staff involved in managing patients remain appropriately skilled, trained and competent to carry out the roles required of them for the term of the GP 'Out of Hours' Integrated Urgent Care Services Contract Agreement and that all Clinical Staff have undertaken appropriate CPD as specified by their professional bodies and the Royal Colleges.

Bidders must propose and subsequently implement a comprehensive training plan for all clinical and non-clinical staff. Training modules must include items which demonstrate how the Bidder(s) will:

- support its workforce strategies;
- ensure the safe, correct and up-to-date operation of all systems, processes, procedures and equipment used in each facility;
- promote the dignity and respect of, and the quality of care to, the patient;
- ensure all staff are up to date with adult and children's safeguarding procedures and requirements;
- respond to individual training needs arising from staff performance appraisal and clinical supervision;
- meet any requirements for re-registration and re-validation;
- comply with the provisions of 'Standards for Better Health'; and
- comply with all applicable law.

10.10 Staff Management

10.10.1 Employment Terms and Conditions

The Bidder(s) will be expected to set its own conditions for staff it employs. Bidder(s) must

provide a Staff Handbook that will provide details of their:

- employment terms and conditions;
- existing or proposed HR policies in relation to their service delivery solution;
- existing or proposed health and safety policies in relation to their service delivery solution; and
- existing processes that are in place for resolving any employee relations issues which may arise.

Bidder(s) must demonstrate that their employment terms and conditions and HR policies and processes will encourage the retention of high quality, competent staff and will promote a positive workforce environment.

10.10.2 Performance Management of Staff

The Bidder(s) must ensure that the performance of all staff and service delivery teams promotes the quality and safety of the services and the dignity and respect of the patient. The Bidder(s) will manage the conduct and performance issues of all its directly employed clinical and non-clinical staff and will be expected to conduct regular performance appraisals for all categories of staff. The Bidder(s) must demonstrate that they have processes in place for handling conduct and performance management concerns of staff.

All staffs have an annual appraisal, which, if applicable, shall include reflection on performance in the urgent care setting. The Bidder(s) of GP Out of Hours Integrated Urgent Care Services will be expected to illustrate how a reflection of the staff's performance will be achieved in the 'out of hours' period.

The Bidder(s) is to identify their protocols and arrangements for highlighting, assessing and handling concerns regarding staffs' performance. The Bidder(s) will also be required to illustrate knowledge and use of the regulatory systems that exist to deal with clinical performance and fitness to practice. In this regard they are expected to maintain close and effective relations with the Director of Commissioning and Medical Director in NHSE Cheshire & Merseyside.

Bidder(s) must propose a performance management policy and a performance appraisal system that supports their proposed workforce strategy and complies with all applicable legislative and prescribed requirements.

Bidder(s) must ensure that proposed performance appraisal systems are compatible with any requirements of the external professional regulatory bodies for revalidation and re-registration.

10.11 Workforce Information Requirements/Management Information Systems

The Bidder(s) is required to have workforce management information systems which support the workforce requirements, and which are capable of delivering any internal and external monitoring and workforce reporting requirements.

The Bidder(s) will be required to provide timely and accurate workforce data returns, which will include input into the annual NHS Workforce Census and the NHS Vacancy Surveys. The Bidder(s) staff may be required to participate in the annual NHS Staff Survey.

The Bidder(s) workforce management information systems will be required to monitor

compliance with the Working Time Regulations as appropriate.

11. Performance management

11.1 Principles of Performance management

The Bidder(s) shall provide each CCG with individual datasets for each consultation undertaken by the service in the preceding month i.e., telephone advice, face-to-face consultations and home visits. The submission of data is to be provided within 15 working days from the end of the month to be reported upon. The content in terms of required fields for the dataset will be agreed with the CCG (s).

The Bidder(s) must comply with a CCG request for repeat data downloads for months, or downloads of data for an aggregated period, where unexpected difficulties with data housing may have been experienced, or to assess where amendments to data by the Bidder have occurred.

The CCGs expect the Bidder(s), as per the reporting schedule, to routinely deliver full compliance against the National Quality Requirements[5], Local Quality Requirements and National Standards for Better Health[6] at an individual CCG and contract level. The Bidder(s) is invited to describe reporting formats available from its own internal monitoring systems and final schedules will be agreed during the mobilisation period.

The CCG may also require other monitoring information relating to any additional services commissioned or other local circumstances.

The CCG may benchmark the Bidder against other 'out of hours' Bidders' information to compare the quality, scope and pricing of the service being offered by the Bidder(s). The Bidder(s) is required to co-operate with such benchmarking activity and provide data as required

The CCG, in its absolute discretion, will work with the Bidder(s) to address inappropriate use of the Service by Patients/Practices.

A monthly Contract Management Board(s) will be held to review the data and service provided. These will comprise, as a minimum, of:

From the Commissioners – Lead Clinician(s)
Lead Commissioner(s)
Lead Finance Manager(s)

From the Bidder – Medical Director
Director of Operations or equivalent
Director of Performance or equivalent
Director of Finance or equivalent

Actual membership will be agreed during mobilisation.

It is expected that for the first twelve months of the new contract that meetings will be held monthly and then reviewed with the intention of reducing to bi-monthly.

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137271
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

11.2 Performance and Quality Requirements

Bidder(s)s are required to monitor and provide data against the following national indicators and local performance and quality indicators:

IUC KPIs

The national IUC KPIS and metrics are detailed in '*The Integrated Urgent Care Key Performance Indicators and Quality Standards 2018'*. The IUC KPIs apply to parts or the whole of the patient journey and data needs to be compiled to allow them to be measured, managed and reported irrespective of any organisational boundaries. All Bidder(s)s of Primary Care Out of Hours Services and 111 will need to comply with The Integrated Urgent Care KPIs.

It is a requirement that the bidder(s) will co-operate with the North West Bidder(s) of the NHS 111 service, currently NWAS, in the provision of and access to data that is required to be submitted to meet the national IUC data requirements (as outlined below).

Integrated Urgent Care Key Performance Indicators.

KPI	Title	Domain	Freq.	%
1	Calls abandoned after at least 30 seconds	Safety	Monthly	≤5%
2	Calls answered within 60 seconds	Pt Experience	Monthly	≥95%
3	Patients called back within 10 minutes	Pt Experience	Monthly	≥50%
4	95% of Primary Care Cases booked to an IUC Treatment Centre or Extended Hours GP Service	Pt Experience	Monthly	≥95%
5	50% of Primary Care Cases booked to an Urgent Treatment Centre	Pt Experience	Monthly	≥50%
6	50% of calls with an initial category 3 and 4 ambulance dispositions are revalidated	Effectiveness	Monthly	≥50%
7	50% of calls with an initial ED disposition are revalidated	Effectiveness	Monthly	≥50%
8	15% of Calls Recommended as self-care by a Non-Clinician	Effectiveness	Monthly	≥15%
9	40% of Calls Closed as Self-care by a Clinician	Pt Exp./ Effectiveness	Monthly	≥40%
10	80% of patients who require a prescription medication required can obtain it via a prescription issued within IUC or the NUMSAS service	Pt Experience	Monthly	≥80%
11	Directory of Service catch-all occurs for less than 3% of calls	Effectiveness	Monthly	≤3%
12	Average time to Assessment Outcome	Effectiveness	Monthly	N/A
13a/ b/c	95% of Patients receive a Face to Face Consultation in an IUC Treatment Centre within the specified period	Effectiveness	Monthly	≥95%
14a/ b/c	95% of Patients receive a Face to Face Consultation within their Home Residence within the specified period	Effectiveness	Monthly	≥95%
15	50% of Calls receive Clinical Input	Pt Exp./ Effectiveness	Monthly	≥50%

NHS England have mandated that Bidder(s) delivering IUC services, typically OOH and 111 services, must collect and submit Integrated Urgent Care (IUC) metrics relevant to their service and submit them into an Aggregate Data Collection (ADC).

The metrics listed below support the publication of the 15 NHS England IUC Key Performance Indicators (KPIs). A consistent approach has been agreed for IUC ADC submissions in the North West to enable effective reporting in line with NHS England's key performance indicators and quality standards. This data will also be used by the commissioning organisations to effectively monitor performance of the service.

The IUC data metrics for GP OOH are broadly in line with old NQRs. However, they are no longer standalone metrics and contribute to the wider picture of IUC service delivery across the North West. During the mobilisation period the successful bidder is expected to work to the agreed approach for the submission of IUC ADC metrics. Mechanisms for submission and deadlines will be agreed with the successful bidder during the service mobilisation period.

Bidder(s) must provide the data listed below on a monthly basis, to be submitted to the North West NHS 111 provider NWAS, who currently co-ordinate the aggregated data collection for the north west.

The IUC data items listed below are in line with the national IUC service specification August 2017 however they may be subject to review and change as the service evolves to meet the needs of patients and any national mandated changes will need to be implemented.

Activity:

- Number of cases direct booked by 111
- Number of cases received from 111 that have DCA applied
- Number of CAS cases
- Number of HCP line requests to include NWAs Crew pathfinder activity
- Number of urgent prescriptions issued
- Number of unscheduled IUC attendances (in the unlikely event that a person is acutely ill nearby)
- Number of HCP calls received broken down by role: District Nurse, Paramedic, Care home nurse, Community specialist nurse, social worker i.e. EDT, Other
- Number of HCP calls responded to in 30 mins or less
- Percentage of health and social care professionals called back within 30 minutes

Bidder(s) must have a robust system for identifying all immediate life-threatening conditions, following any clinician input (face to face or telephone).

- Number of emergency ambulances requested
- Number of patients recommended to attend an ED
- Number of patients recommended to attend a UTC / Walk in Centre
- Number of patients recommended to contact primary care services
- Number of patients recommended to contact a dentist
- Number of patients recommended self-care

- Number of calls where person triaged by a clinician through DCA broken down by calls assessed by role: General Practitioner, Advanced Nurse Practitioner, Mental Health Nurse, Nurse, Paramedic, Dental Nurse, Pharmacist, another type of clinician

Face to face consultations:

Bidder(s) must ensure that patients are treated by an appropriate clinician, in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

- Number of IUC centre appointments available
- Number of IUC centre appointments utilised through direct booking
- Number of IUC centre appointments utilised following Definitive Clinical Assessment
- Number of IUC centre appointments provided within: 1 hour (emergency); 2 hours (urgent); 6 hours (less urgent); Any other timescale
- Number of patients receiving a face to face consultation within their home residence
- Number of face to face consultations in their home residence delivered within:1 hour (emergency); 2 hours (urgent); 6 hours (less urgent); Any other timescale
- Number of face to face consultations broken down by clinician: General Practitioner, Advanced Nurse Practitioner, Mental Health Nurse, Nurse, Paramedic, Dental Nurse, Pharmacist, another type of clinician

In addition to data covering those IUC metrics that are relevant to OOHs, it is expected that Patient level data, including NHS number and key identifiers to allow linkage to the NHS111 dataset (Case Number) and other IUC data sets, must also be provided on a monthly basis (or agreed frequency) to the organisation and / or agency tasked with compiling and submitting the aggregated data set for the North West (currently NWAS). Mechanisms for submission and deadlines will be agreed with the successful bidder, during mobilisation.

Local Quality Reporting

LQR 1: Quality indicators; Bidder(s) must regularly report to CCGs on their compliance with the Quality Requirements to include:

Compliances against % of notifications from OOHS to patients own GP sent by 8am (target 100%)
Compliance against % of abandoned HCP calls (maximum 5% threshold)
Number of complaints received - total and a as a % of all activity
Number of compliments received – total and as a & of all activity
Number of incidents total and as a % of all activity

Data required - monthly reports to be submitted to CCG within 10 working days of month end, supported by monthly face-to-face meetings with Bidder(s). For all areas where performance is rated as partial compliance or non-compliant then a breach analysis must be reported, including reasons for the breach and any action plans to prevent recurrence.

LQR 2: Bidder(s) must send details of all consultations (including appropriate clinical information) to the practice where the patient is registered by 08.00 the next working day. Where more than one organisation is involved in the provision of services, there must be

clearly agreed responsibilities in respect of the transition of patient data.

Data required – monthly total activity numbers, number of records transferred within specified timeframe, number of patients who do not want information transferred to their GP.

LQR 3: Bidder(s) must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the commissioners. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance, including the appropriateness of disposition, of each individual working within the service. This audit must be led by a clinician with suitable experience in providing care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

Bidder(s) must cooperate fully with CCGs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one Bidder(s) organisation. All categories of staff to be included in the audit process (e.g. non clinical call handlers).

Data required – copies of audit reports and actions taken as a result, quarterly.

LQR 4: Bidder(s) must regularly audit a random sample of patients' experiences (note – experience is different from satisfaction) of the service (for example 1% per quarter) and appropriate action must be taken on the results of these audits. Regular reports of these audits must be made available to the contracting CCG.

Data required – copies of patient experience audits, quarterly (total number of patients in quarter, number in audit).

LQR 5: Bidder(s) must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint and the manner in which it has been dealt with, to the contracting CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

Data required – quarterly number of complaints and PALS queries received, number of complaints and PALS queries dealt with within specified timeframes, details of each complaint and PALS query, manner in how complaint and PALS query dealt with, lessons learned (including timescales to implement actions), results of audit. Number of SUIs in period, number of SUIs reported to CQC and CCG within one working day of receipt within Bidder. This may be presented as a quarterly Complaints, Litigation, Incidents and Patient Advice and Liaison (CLIP) report.

LQR 6: Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact (90% compliance threshold). The service must also make appropriate provision for patients with impaired hearing or impaired sight.

Data required –interpretation services are available within 15 minutes of initial contact and evidence to support this, confirmation of the provisions for patients with impaired hearing, confirmation of the provisions for patients with impaired vision, monthly, number of patients requiring interpretation service, number of patients receiving interpretation service within 15 minutes of initial contact.

LQR 7: Bidder(s) must demonstrate the online completion of the annual assessment of the IG Toolkit at level 2 (satisfactory) or above and that this is audited on an annual basis by Internal Auditors using the national framework.

Data required – annual online submission of assessment by deadline (31st March) each year and Internal Audit report.

LQR 8: Bidder(s) must demonstrate that they are complying with the Department of Health Information Governance and Serious Untoward Incident Guidance on reporting of IG incidents appropriately.

Data required – quarterly and annual reports of IG incidents and SUI's including action plans and outcomes for any level 3 incidents or above. Level 3 + incidents must be reported to the commissioners and CQC within the stated timescales (e.g. 24 hours).

LQR 9: Bidder(s) must ensure that Frontline staff and advisors receive training in recognition of safeguarding issues for adults and children to an appropriate level in line with the CQC registration requirements and Local Safeguarding Board. An annual statement of compliance/performance will be required within 4 weeks of the year end.

Data required – annual submission of compliance against safeguarding training requirements.

LQR 10: Bidder(s) must have a process in place to identify frequent users (who call OOH more than 4 times a month) whose use is immediately highlighted to their registered GP and an action plan agreed with the practice as to their future care management and reported quarterly.

Data required- quarterly and annual reports of frequent users and evidence of action plans and multiagency working to address the issue.

LQR 11: Workforce Information

Data required- Quarterly summary return showing the number of GPs employed broken down by Performers List and ethnicity.

LQR 12: Practice Information

Data required - Quarterly, the number, time and destination of calls broken down by practice

11.3 Data Sharing with Public Health England

The Bidder(s) will be expected to work with the Public Health England in times of a pandemic or outbreak of any sort to ensure appropriate action out of hours is taken, including the administration of anti-virals if directed.

11.4 Quality Improvement/Audit

A programme of quarterly audits will be agreed with the CCG, and the results of the audits must be available to the CCG, including findings and Action Plans.

The programme will include regular audits of:

- A random sample of patient contacts to allow review of the clinical performance of each individual working within the service.
- Patients' experiences of the service (1% per quarter)
- Complaints in relation to individual staff so appropriate action is taken
- Patients contacting the service requiring an interpretation service; with impaired hearing or impaired sight.

The Bidder(s) must describe how they will deliver:

Effective quality improvement processes that include collection, review and action in relation to patient feedback, and this must include regular audit of patient experience and the audit arrangements to understand the clinical quality of the service they provide by auditing the work of each individual working within the organisation who contributes to clinical care.

11.5 Complaints

The Bidder(s) must have complaints procedures that are consistent with national NHS Complaints Procedures and must comply with the NHS complaints policy timelines. Bidder(s) are directed to consider "Handling Complaints in the NHS – good practice toolkit for local resolution". All staff must understand the complaints procedure and are easily able to supply the information to patients, if asked. There must be mechanisms in place to record, manage and audit complaints so to analyse trends and amend service delivery in line with the learning outcomes.

The Bidder(s) are required to ensure that patients are aware of:

- The complaints procedure
- The role of the CCG and other bodies in relation to complaints about services commissioned by the CCG from the Bidder(s)
- The right to assistance with any complaint from independent advocacy services provided under section 185 of the Health and Social Care Act 2012
- How to access the complaints procedure, particularly where there are language and communication needs.

The Bidder(s) shall provide a monthly summary to the commissioning CCGs of all complaints and commendations received, together with the progress, outcome and actions taken.

11.6 Legal Claims

Any legal or insurance claims against the Bidder(s) in connection with the delivery of the service shall be notified to the CCGs as swiftly as reasonably practicable, including if required 'out of hours'. Such claims shall be included within the monthly performance reports presented to the CMB and regular updates provided. Upon conclusion of a claim a summary of the outcome shall be provided along with any lessons learnt and changes to service delivery/operating policy.

12. INFRASTRUCTURE AND PROPERTY REQUIREMENTS

12.1 Site provision

This section describes the requirements relating to infrastructure and property and provides information with regards to the service delivery solutions for this scheme.

The bidder will deliver services face to face from the specified sites in Section 5.2

Bidders should note that where existing NHS facilities and infrastructure are used by the Bidder(s) on an on-going basis, the operational responsibilities and liabilities of the Bidder(s) and the site owner and/or site operator must be discrete and clearly distinguishable.

In their bids, Bidders must, in describing their service delivery solution, include location details of their headquarters and control room(s) that support delivery of the service.

All facilities must meet all relevant legislation, utility supply company requirements, mandatory NHS standards relevant to the procedures being carried out and, where the provision of services must be registered by CQC.

The Bidder(s) will have sole responsibility for ensuring that all sites, are appropriate and equipped to support the delivery of the services.

As a consequence of the current uncertainty surrounding the future management and financial model associated with the use of the NHS sites specified in section 5.2 the property costs of the Bidder(s) using these premises should be excluded from the tender price. This includes any rent, or lease costs, utility costs, maintenance and facilities management costs. These will be met directly by the Commissioners outside of the tendered price. The costs associated with the headquarters/control room shall be included in the tender price as these remain the responsibility of the Bidder.

12.2 Site Investigations and Surveys

The condition of the site(s) used by the Bidder(s) will be at the sole risk of the Bidder(s) who will be responsible for all necessary surveys and investigations appropriate to any proposed use of the site(s).

12.3 Planning Permissions - Current and Proposed Use

The Bidder(s) will be responsible for obtaining all necessary consents required for any proposed use of the site(s).

Where Bidders wish to benefit from previously granted consents, they are at all times responsible for ensuring that their use of such information causes no breach of copyright or infringement of consents and/or intellectual property rights.

Bidders must make clear their approach to obtaining consents, where relevant, including:

- whether or not they plan to benefit from any existing approval;

- describe the impact of their approach to obtaining consents on their project and mobilisation plans; and
- include an assessment of the risk associated with their proposed approach and, if intending to make use of any existing consents, that they have acquired the right to do so without infringement of copyright or intellectual property rights.

12.4 Fit Out - Furnishings and Fittings

Bidders must provide a statement confirming those works and services to be provided by the Bidder(s) in addition to and following completion of any building works including the installation of built-in equipment, furnishings, fittings, general fit out and commissioning works to deliver a fully operational facility meeting Care Quality Commission requirements.

12.5 Availability and Capacity of Infrastructure Services

The Bidder must clearly state any infrastructure, utility and other services, and the terms of supply, which they are assuming will be provided by site owners and/or site operators, and identify the implications of providing those services directly, should the Facilities Management or other support services assumed to be provided by the site owner and/or site operator prove not to be available.

Ownership, Encumbrances, Restrictive Covenants and Other Impairments to Development

In proposing any site and/or facility, the Bidder must, in relation to such sites and/or facilities, provide details of: the current ownership of the site and/or any access to it plus evidence of the site owner's agreement in principle to consider either the Bidder's use or acquisition of the site and/or facility, and any known encumbrances, restrictive covenants or other impairments to its use.

12.6 Supplied services

Bidders are required to provide all Facilities Management services and other support services that are appropriate for their service delivery solution and the patient experience. Bidders must provide in their bids sufficient detail to describe the standard and scope of relevant Facilities Management services and other support services.

12.6.1 Procurement of Facilities Management and Other Support Services

All necessary Facilities Management and other support services will be assumed to be provided by the Bidder.

The Bidder(s) will be responsible for the provision of services and the management of its subcontractors, including, where relevant, NHS subcontractors.

For all sites, Bidders are expected to negotiate the service specifications for these services with individual site owners, where not directly provided themselves.

13 Information Management and Technology

The Bidder(s) IM&T services are an integral part of the clinical and business operation that will be delivered. The Bidder(s) must therefore demonstrate how their proposed IM&T solution will support and optimise the delivery of the GP 'Out of Hours' Integrated Urgent Care Services.

Bidder(s) are required to put forward proven and robust proposals for IM&T, which underpin both the delivery of care within their facilities and proper integration with the NHS both locally and nationally. In addition, the Bidder(s) must ensure all IM&T Services are compliant with the underpinning standards, technical specifications, governance requirements and strategies within the NHS locally and nationally. This includes NHS Digital standards for Fast Healthcare Interoperability Resources (FHIR), Transfer of Care, GP Connect and the Local Health and Care Record Exemplar (LHCRE) Target Architecture.

The CCGs' IM&T strategy and vision is to ensure that high quality clinical information is accessible, in an integrated shared clinical record in real time, at the point of care: to ensure that IM&T programmes are fully aligned to enable the clinical business needs of clinical commissioning groups. This includes clinical data sharing via systems interoperability and electronic clinical correspondence, this covers Primary Care to Bidder(s) and Bidder(s) to Primary Care.

Bidder(s) will work with CCGs to implement and develop the appropriate clinical information systems to support the local care delivery model for this service. The Bidder(s) will identify a lead position within the service responsible for the effective operational use of the information system and to act as Bidder Lead in meetings and liaison with the Commissioning CCGs.

13.1 Clinical Information Management System

Bidder(s) are responsible for providing and managing a clinical information management system that is capable of performing ALL the processes and functions listed in section 13.1.3. Bidder(s) are required to provide the following specifications for the chosen clinical information management system.

Clinical system Supplier, Product name and version.
Number of user licenses and system capacity to deal with high volumes of GP out of hours cases simultaneously.
Infrastructure hosting the clinical system. Include information security standards.
How access the clinical information management system in the Call/Command HQ, GP lead centres and cars will be controlled.
Support and maintenance arrangements for the clinical system. (SLA with suppliers)
Disaster recovery and business continuity plans
Workstation/Computer specifications used to access the clinical system. Include operating systems, antivirus, and encryption software.
A system level security policy and data privacy impact assessment.

13.1.1 Clinical Information System Interoperability

The Bidder(s) Clinical Information System should conform or be working towards conformance with the Interoperability Toolkit (ITK). This should include the adoption of current and future Fast Healthcare Interoperability Resources (FHIR) specifications along with other defined

frameworks and specifications published under IHE and HL7

The Bidder(s) Clinical Information System should have the ability to produce and consume messages using the following standards (FHIR, HL7). The bidder should document which of these standards they currently conform to and which they are working towards.

The Bidder(s) Clinical Information System must provide interfaces to NHS standard systems. Confirmation should include a list of APIs they currently have available with the purpose and specification of each API attached as an addendum to the response. This should include GP Connect:

View a patient's GP practice record with Access Record: HTML
Manage GP appointments with Appointment Management
Import or download data on a patient's medicines and allergies with Access Record: Structured

The Bidder(s) should indicate where their Clinical Information System supplier already have examples where their system integrates into other NHS systems.

The Bidder(s) should describe how they ensure information is replayed in the event of interface errors and/or downtime

The Bidder(s) should demonstrate the willingness of their Clinical Information System supplier to work with third party suppliers. This should include examples of previous projects undertaken with other suppliers to provide additional functionality.

It is crucial for cases that are referred to the GP 'Out of Hours' Integrated Urgent Care Service from the North West 111 service are seamlessly processed. The Bidder(s) clinical information management system must receive the clinical assessment data from the North West 111 service's Adastra 111 system electronically and automatically match the referred case to the patient's record, if the patient already has a record. If the patient does not have an existing record in the Bidder(s) clinical information management system, then the Bidder(s) clinical information management must automatically create a record for the patient by automatically populating the clinical information management system with the patient's demographics. The clinical assessment data recorded by the North West 111 service will be attached to the patient's health record.

The Bidder(s) clinical information management system must have the functionality to make appointments for face to face contact available to the North West 111 service so that the North West 111 service can directly book appointments into the Bidder(s) appointment system.

Bidder(s) are required to provide the details via a narrative and appropriate schematic of how the clinical information management system will receive and process referrals and the clinical assessment data from the North West 111 service's Adastra 111 system.

13.1.2 Transfer of Electronic Health Records

If the GP out of hours functions transfer to a new Bidder, the existing GP out of hours electronic health records and audit trial will also transfer. The successful Bidder(s) will have the responsibility of Data Controller for the transferred electronic health records. Bidder(s) will nominate their Senior Information Risk Officer and Information Governance Lead who will be accountable for overseeing the transfer of all health records.

The Bidder(s) clinical information management system must be capable of receiving and controlling appropriate access to the transferred electronic health records in line with information governance standards. The transferred electronic health records must also be available at the point of contact with patients, thus providing the GP out of hours GPs with access to the full health record to support clinical decision making.

The CCGs' will direct the transfer of the GP out of hours electronic health records from the existing Bidder(s)s GP out of hours clinical information management system to the Bidder(s) chosen clinical information management system during the mobilisation period.

It is the Bidder(s) responsibility to ensure the integrity of the data contained within those electronic health records is not compromised during the transfer process and as they are copied to the receiving live clinical information management systems database. The Bidder(s) is expected to provide a risk assessment and report back to commissioners if limitations or assumption are made for data migration and transfer mechanism

The transfer of electronic health records between systems is complex. It is recognised that there is a risk of data errors occurring within receiving clinical information management system. Therefore Bidder(s) are required to check 0.5% of records or 750 unique patient records (whichever metric is smallest), including clinical review of data mapping. (For the purposes of data checking one patient record can be made up of many cases/calls). If errors are found, the Bidder(s) will resolve them prior to the service commencing across all migrated data.

Data checking must be completed using the same version of the clinical information management system that will receive the transferred health records at the start of the contract. If the Bidder(s) clinical information management system requires version update(s) between the data checking sign off and the final transfer of health records, the Bidder(s) must provide assurances that the version update(s) do not cause errors in the transferred health records and any fixes applied to resolve the data issues identified during the data checking.

To prevent unauthorised access and to protect the health records the clinical information management system used for data checking must benefit from the same hosted secure network and access controls as the clinical information management system that will be used at the start of the contract. All members of staff who will be involved in the transfer of health records and data checking process shall be trained and be aware of their legal responsibilities and the information governance standards and procedures.

No later than one month prior to the successful Bidder(s) contract commencing the Bidders are required to demonstrate that all the electronic health records can be transferred into their chosen live clinical information system without errors.

For the transfer of the electronic health records Bidder(s) shall provide costs along with a detailed plan, schematics and narrative including risks and how the risks will be mitigated.

The table below provides the details of the existing GP out hours Bidder(s), the existing clinical information management system.

CCG	Existing GP OOH supplier	*Electronic Health Record System	Estimated Disk Space Required to accept records and audit trail.
South Sefton and Southport & Formby	Go to Doc	Adastra v3.28	100GB
Liverpool	Primary Care 24	Adastra v3.24	220GB
Knowsley	Primary Care 24	Adastra v3.24	(Shared with LCCG)
Halton	Primary Care 24	Adastra v3.24	(Shared with LCCG)
St Helens	Primary Care 24	Adastra v3.24	(Shared with LCCG)
Warrington	Bridgewater NHS FT	System One	100GB
**Version number correct as of 18/11/2019. Subject to change through system upgrades and updates.*			

At the end of the contract period Bidder(s) must support the commissioning CCGs' to transfer the electronic health records to the CCGs' chosen clinical information management system. Therefore, the Bidder(s) chosen clinical information management system must be capable of safely and securely extracting the electronic health records to be transferred. Bidder(s) are required to submit the details of how their chosen clinical information management system will extract cases health records and user audit trial so that they are ready to be transferred.

13.1.3 Clinical Information System Processes and Functions

The Bidder(s) will implement the following processes in relation to the operation of their clinical information management system:

The Bidder(s) chosen clinical management system must integrate with the North West 111 Services as described in section 13.1.1.

Interoperate with national services and applications at the point of contact with the patient:

- Patient Demographic Service
- Summary Care Record
- Electronic Prescription Service
- NHS Digital standards for Fast Healthcare Interoperability Resources (FHIR)
- Transfer of Care
- GP Connect and the Local Health and Care Record Exemplar (LHCRE) Target Architecture.

Integrate with GP clinical systems using the Healthcare Gateway Ltd Medical Interoperability Gateway (MIG) and Graphnet to access patients GP electronic primary medical GP records.

Access to Share2care e-Xchange as part of the Local Health and Care Record Exemplar (LHCRE) Programme

Access to patients GP electronic primary care records will be subject to local CCG sharing agreements.

Contemporaneously record all patient encounters electronically at the point of contact to support patient care and reporting. To achieve this users must have the ability to:

- Retrieve and record NHS numbers via PDS.
- Retrieve and record the patients registered GP Practice.
- Record the patient's home address including post code.
- Record the patients preferred contact telephone number.
- Record patient's current location including post code (if different to their home address).
- Record the caller's details if calling on behalf of the patient
- Record callers full Name
- Record callers contact telephone number
- Record caller's relationship to the patient
- SNOMED clinical information to support reporting requirements.
- SNOMED clinical information utilising a structured template.
- Record medications using a drug dictionary.
- Print medication prescriptions from the clinical information management system in Call/Command Centre HQ, GP out of hours centres and Cars.
- Record clinical assessments and outcomes.

Prioritise patient cases based upon defined response time frames for in bound NHS 111 cases and other.

At the point of contact with the patients, alerts prompting the call handlers and clinicians of the existence of previous contacts with the service within the last 5 days.

Record Special Patient Notes and Anticipatory Care Plans for patients.

At the point of contact with the patients, system alerts prompting the call handlers and clinicians of existing Special Patient Notes and Anticipatory Care Plans.

Instantly dispatch and forward cases data to appropriate personnel within the out of hours service. The receiving personnel must have access to the relevant case information within the clinical information system to enable them to process the case safely and efficiently.

Maintain appointment systems for the GP out of hours centres.

Provide a reporting suite to support the analysis of contract performance.

All patient encounter reports to be transmitted electronically (using the minimum data set Appendix E) directly into the patients registered GP practice GP system using Message Exchange for Social Care and Health (MESH), and Doc Man EDT messaging. The system must also have the option of emailing using nhs.net, if required by the GP practices and as part of system business continuity planning and resilience.

The Bidder(s) must confirm support for the use of Microsoft Office suite and state which versions are supported (e.g. Office 2010, 2013, 2016 in 32 and 64 bit Mode and Office 365 Online Office). The Bidder(s) will also state if any Add-Ons for Microsoft Word are required.

13.1.4 Clinical Information System Development

The Bidder(s) Clinical Information System Bidder(s) should provide regular updates in respect of system development and offer the opportunity for the service to have sight into system development roadmaps and the opportunity to input into these to support the development of the services.

The Bidder(s) should outline planned adoption for use of Video consultations for clinical interactions with patients.

The Bidder(s) should outline planned adoption for use of mobile app solutions to support clinical interactions with patients.

13.2 Control Room Telephony

Bidder(s) must provide details of their chosen telephony system detailing the following:

- Supplier, product and version
- Number of user licenses and system capacity
- Network and infrastructure requirements at the GP lead centres
- Call recording software and version
- Call recording storage
- Resilience and business continuity
- The management of incoming lines and call queuing
- Facilities to manage
- Calls in other languages
- Calls from patients with hearing and speech disabilities
- Reporting suite to support the analysis of contract performance as outlined in section 11

13.3 Local Network and IT Suppliers

The technical connectivity between 'out of hours' centres is provided via the Sefton and Liverpool, Knowsley, Halton and St Helens COINs (Community of Interest Networks) which are supported 24/7 by Informatics Merseyside and St Helens & Knowsley Health Informatics Service (STHKHIS). The Warrington CCG IT network is provided and managed by the Midlands & Lancashire CSU.

Bidder(s) requiring a new HSCN / N3 connection will require the commissioning CCGs' Senior Information Risk Owner (SIRO) to sponsor the service. The prerequisites for sponsorship are;
Bidder(s) must be providing a service for or on behalf of the commissioning CCG.
Bidder(s) must provide the relevant information security and information governance assurances.

Bidder(s) who already have access to HSCN / N3 are required to disclose the existing sponsoring SIRO and the details of HSCN / N3 access.

Bidder(s) will be responsible for all costs associated with gaining and maintaining access to N3 throughout the contract duration.

13.4 Hardware and Software

13.4.1 Bidder(s) Call/Command Centre HQ

Bidder(s) are responsible for providing and managing the hardware and supporting software and associated costs throughout the life of the contract. Bidder(s) shall liaise with commissioners and local IT Bidder(s)s to ensure hardware and software is compatible with the out of hours centres infrastructure.

Bidder(s) are required to provide evidence of an approved Connection Agreement. Prior to Bidder(s) being able to connect to the COIN and HSCN / N3 networks Bidder(s) are required to have obtained an approved Connection Agreement for the organisation type and sponsorship from the CCGs Senior Information Risk Officer.

Bidder(s) who do not have access to the CCGs COIN and HSCN / N3 networks are required to demonstrate how they will obtain timely access to the COIN and HSCN / N3 networks to support the requirements of the mobilisation period.

Bidder(s) who already have access to the COIN and HSCN / N3 networks must demonstrate they have obtained an approved Connection Agreement and have achieved the minimum level of compliance against all key requirements identified in the Information Governance Toolkit[7] for the Bidder(s) organisation type.

13.4.2 Out of Hours Centres

In line with local information security policies the commissioning CCGs' will provide the consultation rooms and reception workstations and printers at the out of hours centres that will be shared with existing services. Bidder(s) will be responsible for providing workstations and printers in consultation rooms and reception that are exclusively used by the Bidder(s), elsewhere it is expected that agreement can be reached to share such equipment.

Bidder(s) will supply at their own expense all telephony handsets in the GP out of hours centres.

Bidder(s) are required to detail the number of workstations, mobile devices, printers, telephone handsets they require for each GP out of hours centre.

Throughout the contract period Bidder(s) are required to liaise with the local IT Bidder(s)s responsible for the ICT infrastructure at the out of hours centres to ensure connectivity to the chosen clinical information management and telephony systems.

13.4.3 Mobile Devices

Bidder(s) must use mobile devices that provide access to the patient's health record and case details to support home visits etc. Bidder(s) are required to provide the following information about the mobile device(s).

- Hardware.
- Software and version for operating system and clinical system.
- Outline approach for mobile device connectivity to wireless and wired networks.
- User access controls.
- How patient information is processed between the mobile devices and the clinical information management system, including approach to managing disconnected working and synchronisation.
- Description of the encryption capabilities between mobile devices and the clinical information system.

The Bidder(s) Clinical Information System shall provide a secure connection that allows staff to use Android, Windows or IOS devices for mobile working and provide real time access to

[7] https://nww.igt.connectingforhealth.nhs.uk/

the system. The proposed solution shall offer functionality to match their role-based access permissions and include full audit trails.

The application must also have a time out feature that forces users to log in again following a period of inactivity.

Controls should be in place to limit access to the application through mobile devices

13.5 Data Security Standards (including Cyber security)

The Bidder(s) Clinical Information System should conform to the relevant NHS standards and requirements as determined by the Health and Social Care Information Centre (or any new body with equivalent national responsibility, such as NHS Digital) and facilitate the implementation of full electronic health record keeping.

The Bidder(s) should have completed the Data Security and Protection Toolkit (DSPT) achieving a minimum level) compliance. Where the Bidder(s) Clinical Information System Bidder(s) has not yet achieved accreditation, they should be working towards this and must achieve it by the system go live date.

If the Bidder(s) Clinical Information System is cloud based, then the service Bidder(s) should provide assurances the solution is hosted according to NHS Security standards. This should include specifying the locations of the datacentres and how they abide by current applicable data protection legislation.

The Bidder(s) Clinical Information System shall have test and quality processes in place to ensure continued compliance with IG standards and processes in place to deal with erroneous information/incorrectly merged records or duplicate records.

System Bidder(s) shall have formal security policies and procedures in place (ideally to ISO27001 standard), formal data protection registration, and formal business continuity arrangements.

The Bidder(s) Clinical Information System supplier should describe and demonstrate the data backup, restore and partial restore procedures; ideally, the system should be capable of backup and restore whilst the system is live

The Bidder(s) Clinical Information System Bidder(s) must provide details of a configuration to provide maximum resilience.

The Bidder(s) Clinical Information System Bidder(s) must highlight any additional configurations required with relation to NHS Firewalls and proprietary antivirus software.

The software must be able to run side by side with the trust's antivirus products. Suppliers will need to supply any directories that need excluding from real time scanning during the implementation phase.

Bidder(s) Clinical Information System suppliers must provide system management tools that will allow the Trust Technical staff to manage day-to-day tasks of data security monitoring. Requirements

Bidder(s) Clinical Information System suppliers must provide configuration tools, which will

allow the Trust technical staff to manage password access, and user rights.

Any system management tasks should be installed on the server not external pc workstations and the suppliers should specify if additional servers are needed to allow for this to take place.

Bidder(s) Clinical Information System should provide a fully documented Disaster Recovery plan that will be tested. It should be possible to test this plan during the implementation stage and again within a year of full implementation

The Bidder(s) Clinical Information System should only be accessible from only Trust issued devices. The system should be inaccessible from staff's own personal devices

The Bidder(s) Clinical Information System Bidder(s) should be registered with Information Commissioners Office (ICO) and should provide registration number Equipment/Software

13.6 Local Infrastructure at Call Centre HQ and 'Out of Hours' Centres

Bidder(s) are required to submit detailed plans for the Call/Command Centre HQ and 'out of hours' centres. The plans provided must include, but not limited to, the following specifications:

- Storage of paper and electronic health care records. How access controlled at each location?
- Network infrastructure (provided by the Bidder(s)).
- Support and maintenance arrangements.
- Workstation client specifications.

Bidder(s) who choose to use a Call/Command Centre HQ outside the boundaries of the local COINs must detail how the call centre will be technically linked to the local COINs including arrangements for support/maintenance and resilience.

Bidder(s) are also required to provide evidence of the following:

- Formal business continuity and disaster recovery arrangements for IM&T (so that in the event of a major system failure, there is minimal disruption to the service)
- Data Protection registration.
- Current or proposed support service arrangements
- Current security practices adopted.
- Complete IG Toolkit

The Bidder(s) should provide minimum and recommended hardware specification to achieve optimum performance and screen size for the application to run. Operating Systems must support Windows 10 1803 channel or above (32 bit and 64 Bit). The supplier should also specify any client software or supporting components, which need to be installed on individual PCs/ laptops/IPAD and indicate if the software is available in MSI / Install Shield for a centralised deployment to PCs/laptops

The Bidder(s) must provide details of any versions of software and features which need to be in place on a Windows based endpoint (Examples include JAVA, .NET, Silverlight, Internet Explorer Zone changes) that are required, to allow the system to co-exist on existing PC workstation build. The Supplier should ensure that software dependencies are in full support of the vendor.

If NHS Smartcards are to be used, the supplier will advise which versions of HSCIC identity agent are supported.

The Bidder(s) must provide the minimum and recommended screen resolutions (e.g., 1024x768) and must indicate if the software is capable of rendering on high resolution displays where application scaling is in place.

The Bidder(s) must provide a specification for recommended printers and indicate if it is able to support the use of print queues mapped via Windows based servers

The Bidder(s) must state if server components can be hosted in a virtual environment e.g. VMware

Resilience/failover must be provided, Bidder(s)should provide a solution for this and the specification of equipment/software needed i.e. clustering, shadow server etc.

The Bidder(s)configuration must incorporate servers for Live, Backup, Testing, and Training.

The Bidder(s)must provide the paths to any files/folders that should be excluded from Anti-Virus scanning.

The Bidder(s)must provide the system start-up and shutdown sequence.

The Bidder(s)must state if there are any special requirements for standard Microsoft patches.]

The Bidder(s) Clinical Information System Bidder(s) will provide on- going maintenance of the system, including support for system fixes, system developments/upgrades, and other statutory changes including Data Change Board notifications and Information Standard Notices (DCB's/ISN's which are instigated by NHS Digital as part of the Health and Social Care Act.).

The Bidder(s) Clinical Information System Bidder(s) will also provide a response to system failure within an agreed timescale,

The Bidder(s) Clinical Information System Bidder(s) must provide help desk facilities for technical triage, diagnostic testing, plus advice and support for the system. There should be the ability to log jobs either via phone or electronically.

13.7 IM&T Training

The Bidder(s) are required to ensure that all members of staff are adequately trained in the use of the information system including 'update training' for new modules and versions. Evidence of staff of training plans must be included in the application.

The Bidder(s) shall provide a full training and support plan to support go live and system implementation activities

The Bidder(s) should be able to provide a mix of onsite training and E Learning training along with comprehensive documentation covering:

- End user usage of the system
- Technical components including any installation and configuration instructions
- System Administration

When necessary the Bidder(s) should provide on-going training and support when upgrades or new functionality is applied to the system.

The Bidder(s) should be able to offer on-going support and advice for system super users and system administrators

14. Statutory duties

This section highlights the key statutory requirements that the OOH Service will need to comply with.

14.1 Protection and retention of information

All NHS organisations / Bidder(s)s have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. In addition, NHS organisations are required to have robust records management procedures in place to meet the requirements set out under the Data Protection Act 1998 and the Freedom of Information Act 2000 (Detailed guidance on all aspects of record keeping and protection of information can be found in Records Management: Code of Practice available at www.dh.gov.uk).

14.2 Safeguarding Children and Safeguarding Adults

The Bidder(s) will be required to be responsible for ensuring that procedures for Safeguarding Children, Safeguarding Adults and for the application of requirements within the Mental Capacity Act (2005), are always in place and adhered to during the period of the contract. They will be expected to follow the terms and conditions and agreements as set out in the paragraphs below.

14.2.1 Safeguarding Children

The Bidder(s) has a specific responsibility within the terms and conditions of the 'out of hours' service to ensure that the following arrangements are in place within their organisation. These arrangements are required for the CCGs to fulfil their statutory obligations to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.

All organisations commissioned to provide services on behalf of the CCGs, including private and voluntary organisations, must take the statutory guidance under section 11 of the Children Act 2004 into account in the provision of the services.

Senior management within the Bidder organisation must demonstrate a clear commitment to the importance of safeguarding and promoting the welfare of children.

A clear statement of the Bidder(s) responsibilities towards children must be available to and understood by all staff within the Bidder organisation/s.

The Bidder(s) must have formal/established links to and liaison with the CCGs Local Safeguarding Partnerships.

The Bidder(s) must have a named professional responsible for safeguarding children who can work with and liaise with the CCGs designated nurse and/or doctor. A clear line of accountability must exist within the Bidder organisation/s for work on safeguarding and promoting the welfare of children.

The Bidder(s) must ensure that the named professional's duties are discharged effectively, and that the named professionals are allowed adequate time to fulfil their duties. The contracted organisation must provide evidence that this requirement is being met, on request.

The Bidder(s) must have in place comprehensive safeguarding children policies and procedures. The Bidder(s) must ensure that internal policies and procedures are in line with those of the Local Safeguarding Partnerships in Halton, Liverpool, Knowsley, Sefton and Warrington. Local Safeguarding Partnership procedures and / or manuals must be easily accessible for staff at all levels within the Bidder(s) organisation/s.

The Bidder(s) must ensure that appropriate safeguarding children training is available for all staff in line with the RCPCH Intercollegiate Document – Roles and Competencies for Health Care Staff 2019. The frequency of training provision must be in line with national guidance

The Bidder(s) must ensure they have safe recruitment policies and practices in place, including enhanced DBS checks for staff, including agency staff, students and volunteers who work with children and staff who have access to children's data on IT systems. The safer recruitment policies and practice must be in accordance with the requirements of NHSE , CCGs and Local Safeguarding Partnerships.

The Bidder(s) must comply with the LSCB procedures for dealing with allegations of abuse by a professional employed by or contracted with the organisation and work with the relevant Designated Nurse and/or Doctor when implementing these procedures.

14.2.2 Safeguarding Adults

The Bidder(s) will be expected to be familiar with each CCG's Safeguarding Adult Assurance Framework and comply with their policies and procedures as necessary.

The Bidder(s) will be expected to provide a quarterly compliance and activity report using the agreed Safeguarding Assurance Framework to the commissioning CCGs as part of the routine contract quality monitoring process to be agreed during mobilisation.

Social Care Services are the lead agency in working with those who are vulnerable to abuse and protecting adults from harm. The Bidder(s) must ensure that it operates in line with the local authority adult safeguarding policy and procedures for the relevant local authority it operates services from. Its policy and procedures must reflect this.

The Bidder(s) must:

Be alert to potential indicators of abuse and neglect

Understand their responsibility to alert other agencies of adults they feel are at risk or who are suffering abuse in any form

Share and assist in analysing information in order that a comprehensive assessment of the situation can be carried out

Contribute to whatever actions are needed to safeguard the person who is at risk

The Bidder(s) must comply with the Safeguarding Adults procedures and in particular the North West PIPOT (persons in a position of trust) for dealing with allegations of abuse by a professional employed by or contracted with the organisation.

The Bidder(s) must have arrangements in place to enable full compliance with the legislation

governing safeguarding adults (Care Act 2014). The Bidder(s) must ensure that Service Users as well as staff are protected from abuse and improper treatment in accordance with the law and must take appropriate action to respond to any allegation of abuse.

This includes, but is not limited to the following:

Have an established leadership and accountability framework for safeguarding adults within the organisation that meets the statutory requirements for safeguarding adults, Prevent and Mental Capacity Act. This includes having Board Level leads and named professionals in place to cover these aspects of care.

Have up to date policies and procedures in place for staff to follow in relation to safeguarding, Prevent and Mental Capacity Act (MCA)

Have clear systems in place for ensuring that staff are able to recognise adults at risk and respond appropriately in line with the relevant local authority Adult Safeguarding Procedures and Care Act 2014.

Arrange, deliver and monitor the training of staff in relation to adult safeguarding, Prevent and MCA in line with the Intercollegiate Competency Framework 2018- adult safeguarding.

Compliance with the Local Safeguarding Adult Board in safeguarding enquiries and safeguarding adult reviews and other Multi Agency Safeguarding meetings.

If OOHs staff are aware of a patient with a Learning Disability who has died they must report the death on the national reporting system on the following link:
http://www.bristol.ac.uk/sps/leder/notify-a-death/

The Bidder(s)s information systems should enable the flagging adults at risk and high risk victims of domestic abuse. Systems should allow the flagging of reasonable adjustments to enable equal access to the service for patients.

14.3 Public Sector Equality Duty

14.3.1 Covering Employment & Service Delivery

As with other organisations, the CCG's must not discriminate on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation

CCG's are responsible for meeting their duties and complying with legislation even where external suppliers carry functions out all, or in part. CCGs therefore expect this duty to be transferred under this contract to the Bidder(s) who will be expected to promote equal opportunities, comply with Equality Act 2010, where a Bidder(s) of services is a private company or a charity sector organisation then particular attention to section 149 sub-section 2 of the Equality Act 2010 needs to be made. The service Bidder(s) must be able to demonstrate that all reasonably practicable steps to allow access and equal treatment in employment and service delivery are undertaken for all.

14.3.2 Equality

The Bidder(s) must also undertake to comply with relevant provisions contained within the Equality Act 2010 The Bidder(s) must ensure, and be able to clearly demonstrate compliance with the Act if a Bidder(s) is unclear on what section of the Equality Act 2010 apply to it as an employer and service Bidder(s) then it must immediately take advice or contact the CCG for more information.

Without prejudice to, or limitation of, its obligations the Bidder(s) will additionally comply with the following requirements in discharging its obligations under this Agreement.

The Bidder(s) will not discriminate directly or indirectly against any person on the grounds of age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

The Bidder(s) will not treat a person less favourably for a reason relating to that person's disability, nor fail to comply with the duty to make reasonable adjustments for disabled people under the Equality Act 2010The Bidder(s) will ensure that it complies with current and future Codes of Practice as published by the Equality & Human Rights Commission.

The Bidder(s) will comply with the Accessible Information Standard as outlined by NHS England guidance.

The Bidder(s) will notify the CCGs as soon as it becomes aware of any complaint or proceedings against the Bidder(s) alleging discrimination or any investigation of the Bidder(s)'s performance of this agreement. In the event of any such complaint, proceedings or investigation the Bidder(s) will co-operate fully and promptly with the body undertaking the investigation or bringing the proceedings, and will indemnify the CCGs against all costs, charges and expenses (including legal and administrative expenses and any compensation that the CCGs are required to pay) arising out of such investigation of proceedings.

The Bidder(s) will provide to the CCGs such information as the CCGs may reasonably request in relation to meeting the duties under the Equality Act 2010 and in any assessment relating to potential negative impacts that the service Bidder(s) or provision may have on protected characteristics. The CCG will expect, where necessary, for the Bidder(s) to undertake Equality Analysis reports showing how the Bidder(s) has identified any discriminatory tendencies, forces or barriers that may affect protected characteristics and what the Bidder(s) of the service is doing to mitigate any disadvantage.

If the Bidder(s) subcontracts any of its obligations under this contract it will impose obligations on its sub-contractor that are substantially similar to those imposed on the Bidder(s) by way of this contract. Any sub-contractor must equally apply all relevant duties under the Equality Act 2010 to delivering its service.

The CCG reserves the right to require the Bidder(s), by written request, to remove any person involved in the performance of the contract where in the CCG reasonable opinion such person is acting contrary to the requirements of this clause.

The Bidder(s) will discharge its obligations under this contract without infringing the human rights of any person, as defined by the Human Rights Act 1998.

14.3.3 Diversity

As part of the NHS drive for race equality the Bidder(s) will, have due regard to the need to eliminate unlawful racial discrimination, and to promote equality of opportunity. The Bidder(s) must keep focus on eliminating any discrimination that is suffered by people of different protected characteristics, whether within the work place, or to the recipients of the delivered of service.

The Bidder(s) will comply with any equal employment and/or equal service delivery targets set as part of the contract having regard to the CCG procedures for equality monitoring.

In order to help marginalised groups, engage with the service, the service Bidder(s) should make every attempt to employ a workforce that is reflective of the Merseyside and Warrington communities.

The Bidder(s) will monitor representation amongst its staff of race, gender and disability as a minimum (which shall mean groups of persons classified as “ethnic groups” in the most recent official census by the Office of National Statistics or successor body), and where it appears to the Bidder(s) that any racial group is under-represented in its staff by comparison with the proportion of members of a racial group undertake the following actions as may be appropriate:

The placing of job advertisements must be affected such that they reach out to minority and underrepresented groups and to encourage their applications.

The inclusion in job advertisements of the following slogan (or a slogan carrying the same or a similar meaning) “We are an equal opportunities employer and encourage applicants from under-represented groups.”

The use of employment agencies and careers offices in areas where members of underrepresented groups live and work.

The promotion of recruitment schemes for school-leavers designed to reach members of underrepresented groups.

The provision of appropriate training and encouragement to members of the Bidder(s)’s staff from underrepresented groups, such as racial groups, to apply for promotion or transfer to positions where such racial groups are under-represented.

The Bidder(s) shall supply the CCG, on a quarterly basis, with details of how it is staffing the service in order to ensure that the local community is represented.

14.3.4 Equality and Diversity Monitoring

The Bidder(s) will, (12 months) from the date of this agreement and (annually) thereafter submit a report statement to the CCG’s demonstrating its compliance with this clause and its delivery of an accessible and appropriate service, fairly and without unlawful discrimination to all groups irrespective of age (where appropriate) disability, gender reassignment marriage and civil partnership, sex, sexuality, race, religion and belief, .

This report should include:

- Equality Objectives and Action Plan updates including.

- Detailed monitoring, surveys and data analysis – e.g. of levels of satisfaction by ethnic background, gender and disability; as a minimum, consultation with users or the community at large; consultation with the Bidder(s)'s staff.

- How the Bidder(s) has developed and changed the services to reflect demographic or environmental changes, or previous poor equality performance and/or under representation.

- How the Bidder(s) is to take positive action – e.g. to make regular contact with disadvantaged or under-represented communities to encourage greater take-up of services.

- How the Bidder(s) will specify inputs, where these are relevant to the equality outputs required – e.g. arrangements for equality training, consultation, monitoring, recording.

- Translation and Interpretation Usage

- Workforce Reporting Workforce Race Equality Standard, Workforce Disability Standard.

Non-Compliance with any of the relevant requirements of the Equality Act 2010 will be a breach of the conditions of this agreement.

The Bidder(s) is also required to submit equality related information to the CCG in line with local quality compliance reporting requirements including:

- Evidence of lawful decision making in the event of Service Change/ Redesign/ Transformation.

- Evidence of compliance with Reasonable Adjustments and Accessible Information Standard Bidder(s) attention is brought to the Equality and Human Rights Commission web site

14.4 Sustainability & Social Value

Our approach to sustainable development across the health and care landscape seeks to achieve a more sustainable NHS and one which maximises social value. Locally CCGs have strategies in place to support this and delivery of the Social Value Act 2012, in line with the Social Value Charter for Cheshire & Merseyside which can be found at https://www.cheshireandmerseysidepartnership.co.uk/news-and-publications/publications/52-social-value-charter-digital/file. Bidders will be required to demonstrate how they will minimize environmental impact from the delivery of the contract and maximize social and economic wellbeing for residents of the contract area in support of national and local strategies for health, sustainability and social value.

Key goals which we expect as a minimum to be addressed by bidders include:

- Supporting employment of local residents and good working conditions
- Ensuring a Living Wage Foundation Living Wage for all employees and any subcontracts
- Supporting education skills and training for local residents
- Maximise benefit to the local economy through purchasing decisions and investment in local communities
- Increase public, patient and carer empowerment, health literacy and self-care
- Reduce social isolation
- Reduce carbon emissions
- Reduce travel, maximise walking and cycling and reduce emissions from any vehicle travel

Tenders shall incorporate within them details of the bid which relate to the relevant elements.

In addition, this policy guidance should incorporate considerations raised in equality and diversity, above,

14.5 Care Quality Commission

Bidders of the OOH Service must be registered with the Care Quality Commission and will be required to provide evidence of their registration.

14.6 Record keeping

All calls to OOH must to be voice recorded. Calls from adults will be retained for 8 years and calls from or about children will be retained until their 26th birthday. OOH Bidders are also required to ensure that systems are in place to comply with regulations concerning child protection and vulnerable adults.

15 Governance Framework

The Bidder(s) are required to have clear and transparent governance frameworks in place, which sets out structures, processes and responsibilities in relation to corporate and clinical governance for all aspects of the service, which are acceptable to the CCG Commissioners. CCGs require the Bidder(s) to identify a clinical governance lead to provide leadership and staff engagement within the organisation in relation to complaints, patient incidents, quality and risk management. The clinical governance lead can then work with other clinical governance leads across the local health system to ensure there is a seamless approach to governance and the management of incidents.

CCGs require the Bidder(s) to describe their full clinical governance management structure to include committees, terms of reference and reporting mechanisms within their own organisation and to commissioning CCGs.

The Bidder(s) must, as a minimum, meet the clinical governance standards as stated by the Care Quality Commission building on the National Standards for Better Health[2] and any new national standards that may emerge.

CCGs are committed to ensuring Bidder(s) have in place comprehensive policies and systems for identifying, assessing and managing clinical risk, including compliance with the controls assurance standards. The Bidder(s) is required to detail their risk management policies to cover clinical governance; action plans and strategies to handle identified risk with documented review periods and the establishment and maintenance of a risk register (clinical and non-clinical).

CCGs will support the Bidder(s) to become appropriately linked into the integrated risk management systems across the health economies.

15.1 Patient Safety

The Bidder(s) must detail the policy and procedure that staff, and the organisation, must follow for handling patient safety incidents and Serious Untoward Incidents, and in doing so identify the criteria used to categorise a Serious Untoward Incident. All incidents need to be thoroughly investigated, trends analysed, and lessons learnt. Detail to be provided of how the learning outcomes will translate into changes in service delivery. A description is also required of the process for the Bidder(s) to engage with related partners across the patient's journey to share lessons arising from safety incidents to improve service delivery. All staff must have access to patient safety notices.

The Bidder(s) must comply with all health and safety standards contained in Health and Safety at Work Act 1974 and are requested to provide a copy of their health and safety policy as per section 2 of the Act. The Bidder(s) must have written polices in line with national guidance/legislation and these policies must be satisfactory to the CCGs.

15.2 Reporting Serious Incidents

Reporting of SIs will follow national guidance and shall be known/ available to all staff. The LOCAL CCG must be informed of such occurrences as soon as is practicable. Arrangements for reporting and starting an investigation shall be clearly set out and adhered to by the Bidder(s). The clinical and managerial leadership roles for investigations should be stated and

clear to all concerned. SIs must be responded to immediately, to prevent any recurrence. All reports, investigations and action plans will be provided to the CCGs as part of performance reporting.

15.3 Information Governance and Records

The Bidder(s) will be required to demonstrate compliance with relevant NHS Information Governance Standards for the management and use of service user information. Bidder(s)s must protect personal data in accordance with the provisions and principles of the 'Data Protection Act' 1998 / 2008, General Data Protection Act (GDPR) 2018 and 'Confidentiality: NHS Code of Practice'. They must ensure compliance with the Commissioner's security arrangements and ensure the reliability of its staff that has access to any personal data held by them. In addition, if Bidder(s)s are required to access or process personal data held by the commissioner, they shall keep all such personal data always secure and shall only process such data in accordance with instructions received from the Commissioner's

Evidence of compliance with such requirements where deemed appropriate by the commissioner shall be provided by completing a Data Security and Protection Toolkit (DSPT) submission for your relevant organisational type.

Bidder(s)s shall achieve the minimum level of compliance against all key requirements identified in the DSPT as set by the commissioning organisation. Bidder(s)s must sign the Information Governance Statement of Compliance (IGSoC) to provide assurance that they are meeting these key requirements and must have robust improvement plans to address any shortfalls against other requirements. Bidder(s)s must baseline their performance within the DSPT by the end of March each year and shall update the assessment with improvements at end of October to enable performance and actions to be tracked by monitoring bodies. Bidder(s)s may be asked to provide evidence of compliance against any requirement within the DSPT should it be requested. Full details of the DSPT is available via www.dsptoolkit.nhs.uk.

Details of serious untoward incidents involving actual or potential loss of personal data or breach of confidentiality must be published in annual reports and reported to the commissioning organisation and where appropriate to the Information Commissioner as soon as is reasonably practicable and reported to the next CMB Meeting.

15.4 Freedom of Information

In accordance with the Freedom of Information Act 2000 the CCGs may be required to release information it holds, subject to certain exemptions. Consultation with third parties may be appropriate and the CCG will comply with the law in considering whether exemptions apply, particularly those relating to confidentiality. The CCGs may consider informing contractors or obtaining their views on the release of information. However, ultimately the decision to disclose information rests with the CCGs.

15.5 Confidentiality Agreement

The Bidder(s) must protect personal data in accordance with the provisions and principles of the Confidentiality: NHS Code of Practice11. They must ensure compliance with the CCG's security arrangements and ensure the reliability of its staff who have access to any personal data held by them. In addition, the Bidder(s) should keep all such personal data always secure and shall only process such data lawfully.

15.6 Health Records

The Bidder(s) must ensure that health records are managed in accordance with the Records Management – NHS Code of Practice and the Public Records Act 1958 and Record Management Code of Practice for Health and Social Care 2016, which imposes a statutory duty of care directly upon all individuals who have direct responsibility for any such records. The Bidder(s) must ensure that they adhere to the minimum retention periods for each class of record and that any disposal is managed in line with professional body requirements and national policy/legislation. Bidder(s) should monitor standards of record keeping within their organisation in accordance with the commissioning CCG's records audit arrangements. Subject Access Requests must be processed in accordance with current legislation i.e., the Data Protection Act 1998 / 2008, GDPR 2018 and the Access to Health Act 1990.

It is an expectation of this contract that health records will be kept electronically, utilising the full potential of the clinical information system in operation.

The Bidder(s) should provide details of management arrangements, systems and processes for the protection of personal data

16 Contract Management and Finance

16.1 Contract Management Structure

16.1.1 Regulatory Framework

The Bidder(s) must comply with the same regulatory framework and standards associated with the provision of clinical services as the NHS

16.1.2 Governance

The contract management arrangements for this service are designed to encapsulate a clear commitment to partnership working, where local health service bodies are fully and regularly consulted by the Bidder(s) and an appropriate level of assurance and scrutiny is in place. In support of this, following Contract Signature, the CCG's will work with the Bidder(s) to ensure collaborative, robust governance arrangements both during mobilisation and throughout the term of the GP "Out of Hours" Integrated Urgent Care Services Contract Agreement. The governance and oversight will be managed through the establishment and operation of a Contract Management Board (CMB) prior to and for the duration of the Contract. The CMB is expected to meet monthly to review the contractual performance of the successful bidder(s) and will include Clinical and Management representatives from the provider (as notified in the contract), alongside senior commissioner representatives from the CCG's. The CMB will have clear agreed terms of reference and a collaborative commissioning agreement will underpin the commissioner participation in the group. Meeting frequency may change during the term of the contract subject to a contract variation in year

NHS Liverpool CCG will act as the co-ordinating or lead commissioner for this contract.

16.2 Legal Requirements.

16.2.1 Overview

The requirements set out in this document have been developed by the CCG's in consultation with local health service bodies.

Within the submission of their tenders' Bidders are required to confirm their acceptance of all the provisions of the GP "Out of Hours" Integrated Urgent Care Services APMS Contract Agreement;

16.3 Key Provisions of the APMS Contract Agreement

16.3.1 Insurance Requirements

The levels and types of insurance that the CCGs require the Bidder(s) to carry during the term of the GP "Out of Hours" Integrated Urgent Care Services Contract Agreement are set out in Clause 51 and 52

16.3.2 Change Procedure

The GP "Out of Hours" Integrated Urgent Care Services Contract Agreement contains a

procedure for the identification, costing, funding and agreement of changes to the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement. The GP “Out of Hours” Integrated Urgent Care Services Contract Agreement identifies several categories of change, for which the treatment varies according to the nature of the change involved.

16.3.3 Intellectual Property Rights

As set out in Clause 86 of the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement, The CCGs and the Bidder(s) will each licence the other, for the purpose of the performance of the services, to use its intellectual property that exists at the time the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement is signed and that is relevant to the services. Any intellectual property that is created subsequently and jointly by the parties will be owned by the CCGs and the Bidder(s) will assign any rights it has in such intellectual property to the CCGs. NHS parties will have the right to inspect the Bidder’s practices and procedures and be shown by the Bidder(s) how to operate procedures, services or facilities delivered as part of the services.

16.3.4 Data Protection, Confidentiality, Freedom of Information

The Bidder(s) and the CCGs are required to comply with data protection and freedom of information legislation. The Bidder(s) is also required to recognise that the CCGs are subject to codes of practice, in on freedom of information and information governance. The Bidder(s) will be expected to use reasonable endeavours to assist and co-operate with the CCGs to enable the CCGs to comply with its disclosure obligations.

16.4 Commercial Requirements

This section describes the commercial requirements pertaining to this Scheme and must be read in conjunction with the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement. This contract will take the form of the national APMS contract.

16.5 Pricing and Performance

16.5.1 Overview of Pricing and Payment

Bidders’ prices should be inclusive of all input costs whether supplied directly by the Bidder(s) or subcontracted from other organisations, including the NHS. Pass through costs identified in this specification should be excluded.

The annual contract value will be the total Net Present Value (NPV) price submitted in the successful bid split equally over 7 years. From April 2021 annual contract values will be adjusted each year for inflation in line with National APMS contract uplifts that are applicable to Out of Hours providers.

Payment will be monthly based on the annual contract value divided into 12 equal parts.

The unit price will remain unchanged in real terms throughout the term of the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement, regardless of the level of activity, although the price is indexed for inflation using the annual uplift in line with National APMS contract uplifts that are applicable to Out of Hours providers.

At the time of publication, there are 29 GP Practices which remain outside of this

procurement, 26 within St Helens CCG and 3 within Knowsley CCG. Therefore, the Upper Affordability Threshold Limit, Target Price and Price Evaluation excludes these practices. Should, at any time from procurement publication date to the end of the contract, any of the 29 practices 'opt-in' it will be the responsibility of the successful bidder with sufficient notice to deliver a GP “Out of Hours” Integrated Urgent Care Service to the patients registered at these practices in accordance with the specification.

Furthermore, should any of the GP Practices currently included within this procurement ‘opt-out’ at any time from procurement publication date to the end of the contract the successful bidder with sufficient notice will cease to deliver a GP “Out of Hours” Integrated Urgent Care Service to the patients registered at these practices under this specification.

The contract value will be updated to reflect any increases or reductions in the number of patients the service will be expected to cover due to practices ‘opting in’ or ‘opting out’.

The contract variation value will be updated based upon:

Successful bidder price, divided by 7 years, divided by weighted patient population detailed in the Service Specification = unit cost per year.

The unit cost will then be multiplied by the weighted patient population of the patients registered at the practices that ‘opt in’ or ‘opt out’.

16.5.2 Funds Flow

The Bidder(s) will invoice each CCG 1 twelfth of the annual contract value at the end of each calendar month for the duration of the GP “Out of Hours” Integrated Urgent Care Services Contract Agreement. The CCG(s) will check the invoice for accuracy against the provision of services.

The CCG(s) will calculate any applicable performance deductions and will settle the adjusted invoice. Invoice payments and associated reconciliations will be settled on a monthly basis with payments being made on the 15th day of the month following receipt of the invoice from the Bidder(s).

16.6 Performance

Contractual arrangements with the Bidder(s) will establish processes for the reporting, investigation, audit and delivery of action plans in response to Serious Untoward Incidents and Adverse Patient Incidents.

Performance will be monitored against all targets set out in this tender document. The KPIs are set at group level and must be delivered across all CCG’s included in the specification. If KPIs are not delivered at group level, all CCG’s have the right to reclaim their share of funds up to a maximum of 2% of the total contract value (annual contract value is inclusive of KPIs as outlined in the APMS contract). The 2% will be split equally between the national IUC KPIs at 1% and then the LQRs a further 1% (specifically LQRs 2, 6 and 8). The performance measures are listed in Section 11 of this specification.

16.7 NHS and Independent Sector Co-branding

All NHS services should be clearly branded NHS, regardless of who the provider is, so that it’s

clear to the patient that it is an NHS funded service which meets NHS quality standards. Branding must meet the requirements set out in the NHS identity guidelines: https://www.england.nhs.uk/nhsidentity/identity-guidelines/service-branding/. Further information regarding the NHS identity is available from communications@liverpoolccg.nhs.uk

16.8 VAT

Bidders are required to state their assumptions and expectations regarding VAT for the bid prices. Although it will be the Bidder's responsibility to determine the VAT liability of their services, it is anticipated that the supply of services under the GP "Out of Hours" Integrated Urgent Care Services Contract Agreement is likely to be VAT exempt under the provisions of Group 7 to Schedule 9 of the 1994 VAT Act. The Bidder(s) should therefore ensure that all VAT assumptions are clearly set out in the pricing pro forma and that if the Bidder(s) concludes that it will incur irrecoverable VAT, all such is included in its costs, and is identifiable as irrecoverable VAT. Bidders are advised to take independent VAT advice as no future adjustments will be allowed to the bid prices for incorrect assumptions made in the pricing pro forma.

16.9 Service Costs

The Bidder(s) is to complete the Financial Model Template (FMT), embedded within ITT Document 3. Instructions on how this will be evaluated are set out in the Bid Response Questionnaire, embedded within ITT Document 3. Details on how to complete the FMT are available on the "instructions" worksheet of the FMT (embedded within ITT Document 3)

Any Bidder that fails to complete all the requested information on the FMT the bid will be deemed as non-compliant and the Bidder and their Bidder Members may be excluded from further consideration.

Bidders should use 2019/20 prices for all 7 years. The price paid will be the Net Present Value (NPV) price submitted in the successful bid and adjusted each year for inflation from April 2021 in line with National APMS contract uplifts that are applicable to Out of Hours providers.

References

1 National Quality Requirements in the Delivery of Out-of-Hours Services, DOH October 2004 & Reissued July 2006

2 National Standards for Better Health, DOH July 2004

3 NHS 1977 Act - The Primary Medical Services (Out of Hours Services) Directions 2006

4 Take Care Now Review

5 Commentary on the National Out-of-Hours Quality Requirements and their Performance Management, DOH October 2004

6 Telephone access to out-of-hours care Supporting CCGs Commissioning Call Handling and Telephone Clinical Assessment Services, DOH January 2004

7 Raising Standards for Patients - New Partnerships in Out-of-Hours Care, DOH October 2000

8 Out of Hours Clinical Audit Toolkit, RCGP 2007: Gateway No. 7790

9 (CAMIDOC Report) The Report of the Panel Overseeing the Serious Untoward Incident Investigation into the Death of Penny Campbell, Islington CCG, May 2007

10 Health and Safety at Work Act 1974, Statutory Instrument 2001 No. 2127

11 Freedom of Information Act 2000, London: HMSO

12 NHS Code of Practice, DOH 2003

13 Records Management – NHS Code of Practice (Parts 1 & 2), DOH 2006

14 The Public Records Act 1958, London: HMSO

15 The Data Protection Act 1998 (c.29), London: HMSO

16 Access to Health Records Act 1990, London: HMSO

17 NHS Complaints Procedure: NHS (Complaints) Regulations 2004:2006

18 Handling Complaints in the NHS – good practice toolkit for local resolution April 2005

19 Health and Social Care Act 2001, Chapter 15, The Stationery Office

20 The Mental Capacity Act 2004 (c.9), London: HMSO

21 The Children Act 2004 (c.36), London: HMSO

22 Delivering the Out-of-Hours Review: Securing Proper Access to Medicines Out-of-Hours: A Practical Guide for CCGs and Organised Bidders: Gateway Number 4107, DOH

23 The Safe and Secure Handling of Medicines: A Team Approach, Royal Pharmaceutical Society, Great Britain, 2005

24 Safer Management of Controlled Drugs: Guidance on Strengthened Governance Arrangements, DOH 2006

25 The Medicines Act (1968), London: HMSO

26 The Misuse of Drugs Act (1971), London: HMSO

27 The Misuse of Drugs (Safe Custody) Regulations 1973 & Amendments

28 NHS Act (1977), London: HMSO

29 The Primary Care Trusts Out of Hours Services (Supply of Medicines, etc) Directions; 2005

30 The Misuse of Drugs Regulations 2001 (February 2002), HMSO, Statutory Instrument 2001 No. 3998

31 The Controlled Drugs (Supervision of Management and Use) Regulations, 2006

32 The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005

33 Safer Recruitment – A Guide for NHS Employers, Issue 02, DOH, May 2005

34 The Code of Practice for the International Recruitment of Healthcare Professionals, DOH, December 2004

35 The NHS Plan: A plan for investment, a plan for reform, DOH, July 2000

36 Maintaining High Professional Standards in the Modern NHS: A framework for the initial handling of concerns about doctors and dentists in the NHS, HSC 2003/012, DOH, 2003/2005

37 Developing Medical Regulation: A Vision for the Future, General Medical Council, April 2005

38 Care Standards Act 2004 (c.14), London: HMSO

APPENDIX A (i)

Practice	CCG	ACTUAL	WEIGHTED
ORMSKIRK HOUSE SURGERY	St Helens	7,635	9,059.76
BERRYMEAD FAMILY MEDCTR	St Helens	8,301	9,489.92
MILL STREET MEDICAL CTR	St Helens	11,136	12,746.57
FOUR ACRE HEALTH CENTRE	St Helens	8,457	9,869.94
CENTRAL SURGERY ST HELENS	St Helens	6,519	7,575.57
DR RAHILS SURGERY	St Helens	2,919	3,228.67
NEWHOLME SURGERY	St Helens	3,450	3,840.13
MARSHALLS CROSS MC	St Helens	5,180	6,172.73
	Total	**53,597**	61,983
CAUSEWAY MEDICAL CENTRE	Warrington	8,256	7,911
FOLLY LANE MEDICAL CENTRE	Warrington	10,183	10,498
GUARDIAN MEDICAL CENTRE	Warrington	10,484	10,707
SPRINGFIELDS MEDICAL CENTRE	Warrington	6,959	7,398
CHAPELFORD MEDICAL CENTRE	Warrington	5,018	3,823
PENKETH MEDICAL CENTRE	Warrington	14,314	15,025
WESTBROOK MEDICAL CENTRE	Warrington	10,599	9,533
FAIRFIELD SURGERY	Warrington	3,299	3,262
GREENBANK SURGERY	Warrington	8,821	9,583
HELSBY STREET SURGERY	Warrington	8,426	9,024
HOLES LANE SURGERY	Warrington	10,430	10,819
MANCHESTER ROAD MEDICAL CENTRE	Warrington	3,098	3,190
BIRCHWOOD MEDICAL CENTRE	Warrington	11,175	11,277
FEARNHEAD CROSS MEDICAL CENTRE	Warrington	14,201	14,843
PADGATE MEDICAL CENTRE	Warrington	6,663	6,555
CULCHETH MEDICAL CENTRE	Warrington	12,226	12,754
ERIC MOORE PARTNERSHIP	Warrington	10,654	10,569
COCKHEDGE MEDICAL CENTRE	Warrington	3,002	2,813
4 SEASONS MEDICAL CENTRE	Warrington	2,581	2,539
DALLAM LANE MEDICAL CENTRE	Warrington	2,755	3,032
PARKVIEW MEDICAL PRACTICE	Warrington	5,835	5,489
BROOKFIELD SURGERY	Warrington	8,897	8,516
LAKESIDE SURGERY	Warrington	10,628	9,937
LATCHFORD MEDICAL CENTRE	Warrington	7,023	7,273
STOCKTON HEATH MEDICAL CENTRE	Warrington	16,051	15,469
STRETTON MEDICAL CENTRE	Warrington	7,432	6,953
	Total	**219,010**	**218,792**
DR VITTY F & PARTNERS	NHS South Sefton CCG	9845	10154.35
SAPRE S.S & PARTNER (S2S HEALTH LTD)	NHS South Sefton CCG	2575	2846.03
THOMSON & PARTNERS	NHS South Sefton CCG	10826	11558.97
GLOVERS LANE	NHS South Sefton CCG	7668	8377.51
MISRA & BIRD	NHS South Sefton CCG	5615	6308.06
SAPRE S.S (S2S HEALTH LIMITED)	NHS South Sefton CCG	4650	4804.81
HUGHES & PTNRS	NHS South Sefton CCG	6679	6871.92
STEPHENSON & PARTNERS	NHS South Sefton CCG	6033	7116.32
ROBERTS & PARTNER	NHS South Sefton CCG	6458	7689.43
TCG MEDICAL SERVICES LTD	NHS South Sefton CCG	6261	7354.51
TONG & GILLESPIE	NHS South Sefton CCG	10342	10370.06
VICKERS & PARTNERS	NHS South Sefton CCG	7258	7970.38
WESTWAY MEDICAL CENTRE	NHS South Sefton CCG	8136	8799.42
CROSBY VILLAGE SURGERY	NHS South Sefton CCG	3131	3022.03
PITALIA	NHS South Sefton CCG	4222	4167.39
OLIVER & PARTNERS	NHS South Sefton CCG	7467	8561.17
FORD MEDICAL PRACTICE	NHS South Sefton CCG	6056	6566.41

Practice	CCG	ACTUAL	WEIGHTED
PARK STREET SURGERY	NHS South Sefton CCG	5768	6527.96
MC ELROY & PTNRS	NHS South Sefton CCG	4423	5216.46
DR GOLDBERG	NHS South Sefton CCG	5662	6543.8
30 KINGSWAY	NHS South Sefton CCG	4711	4711.96
SEAFORTH VILLAGE SURGERY	NHS South Sefton CCG	2076	2206.08
LITHERLAND PRACTICE	NHS South Sefton CCG	3483	3654.01
PITALIA S	NHS South Sefton CCG	2632	2958.11
THORNTON PRACTICE	NHS South Sefton CCG	2851	3032.34
SAPRE S S (S2S HEALTH LIMITED)	NHS South Sefton CCG	912	864.73
HIGHTOWN SURGERY	NHS South Sefton CCG	1975	2214.75
CROSSWAYS PRACTICE	NHS South Sefton CCG	2671	2729.65
NETHERTON PRACTICE	NHS South Sefton CCG	2744	2795.1
MAGHULL PRACTICE	NHS South Sefton CCG	3263	3282.34
	Total	**156393**	**169276.06**
CUMBERLAND House	NHS Southport And Formby CCG	10605	11361.78
JACKSON & PARTNERS	NHS Southport And Formby CCG	7975	8796.33
NORWOOD SURGERY	NHS Southport And Formby CCG	9732	10454.44
AINSDALE MEDICAL	NHS Southport And Formby CCG	12371	13483.82
CHRISTIANA HARTELY	NHS Southport And Formby CCG	5614	6236.29
MCCLELLAND & PARTNER	NHS Southport And Formby CCG	3311	3417.16
CHURCHTOWN MEDICAL	NHS Southport And Formby CCG	9850	11111.11
REDDINGTON & PARTNERS	NHS Southport And Formby CCG	12780	13725.65
ST MARKS MEDICAL CENTRE	NHS Southport And Formby CCG	17620	18465.13
KILSHAW & PARTNERS	NHS Southport And Formby CCG	9624	11530.84
LINCOLN HOUSE SURGERY	NHS Southport And Formby CCG	2085	2134.69
ROE LANE SURGERY	NHS Southport And Formby CCG	3996	4498.87
MULLA & PARTNERS	NHS Southport And Formby CCG	4061	4441.75
MARSHSIDE SURGERY	NHS Southport And Formby CCG	2860	3173.98
OBUCHOWICZ H	NHS Southport And Formby CCG	3957	3831.69
THE HOLLIES	NHS Southport And Formby CCG	4839	4839.48
FAMILY SURGERY	NHS Southport And Formby CCG	4216	3787.84
	Total	**125496**	**135290.85**
BEVAN GROUP	Halton CCG	14,841	15,716.16
CASTLEFIELDS	Halton CCG	12,843	14,857.22
APPLETON VILLAGE SURGERY	Halton CCG	9,847	10,855.94
THE BEECHES MEDICAL CTR	Halton CCG	8,543	9,277.57
PEELHOUSE MEDICAL PLAZA	Halton CCG	14,529	16,079.70
WEAVER VALE PRACTICE	Halton CCG	9,107	10,181.95
TOWER HOUSE PRACTICE	Halton CCG	13,023	14,869.92
NEWTOWN SURGERY	Halton CCG	7,268	7,985.89
GROVE HOUSE PRACTICE	Halton CCG	14,085	15,630.49
MURDISHAW	Halton CCG	7,951	8,048.19
BROOKVALE PRACTICE	Halton CCG	8,539	9,194.56
HOUGH GREEN HEALTH PARK	Halton CCG	5,068	5,182.46
OAKS PLACE MEDICAL CENTRE	Halton CCG	3,536	3,592.96
UPTON ROCKS PRIMARY CARE	Halton CCG	3,667	3,272.37
	Total	**132,847**	**144,745**
N82001MARGARET THOMPSON MEDICAL CENTRE	Liverpool CCG	5,635	6,859
N82002 YEW TREE MEDICAL CENTRE	Liverpool CCG	4,174	4,761
N82003 DOVECOT MEDICAL CENTRE	Liverpool CCG	3,743	4,306
N82004 DR JUDE GARSTON	Liverpool CCG	3,225	3,563
N82009 GRASSENDALE MEDICAL CENTRE	Liverpool CCG	8,224	8,748
N82011 PRIORY MEDICAL CENTRE	Liverpool CCG	11,182	13,175
N82014 LANCE LANE MEDICAL CENTRE	Liverpool CCG	6,702	6,495
N82018 ELLERGREEN MEDICAL CENTRE	Liverpool CCG	13,132	14,288
N82019 LANGBANK MEDICAL CENTRE	Liverpool CCG	4,745	5,396

Practice	CCG	ACTUAL	WEIGHTED
N82024 WEST DERBY MEDICAL CENTRE	Liverpool CCG	12,979	13,765
N82026 PENNY LANE	Liverpool CCG	6,035	5,918
N82033 DINGLE PARK	Liverpool CCG	5,213	6,306
N82034 DR BROOKES AND LEE	Liverpool CCG	5,917	7,367
N82035 MATHER AVENUE	Liverpool CCG	9,281	10,010
N82036 DR JUDE NETHERLEY	Liverpool CCG	3,797	4,754
N82037 WESTMORELAND GP CENTRE	Liverpool CCG	12,155	13,448
N82039 STORRSDALE MEDICAL CENTRE	Liverpool CCG	3,650	3,688
N82041 OAK VALE MEDICAL CENTRE	Liverpool CCG	11,020	11,439
N82046 SEFTON PARK MEDICAL CENTRE	Liverpool CCG	8,560	9,261
N82048 WALTON MEDICAL CENTRE	Liverpool CCG	6,714	8,059
N82049 WESTMINSTER MEDICAL CENTRE	Liverpool CCG	6,132	7,401
N82050 GATEACRE MEDICAL CENTRE	Liverpool CCG	2,382	2,727
N82052 TOWNSEND MEDICAL CENTRE	Liverpool CCG	5,371	6,519
N82053 AINTREE GROUP PRACTICE	Liverpool CCG	16,328	17,082
N82054 ABERCROMBY MEDICAL CENTRE	Liverpool CCG	6,769	7,755
N82058 ROCK COURT	Liverpool CCG	5,005	5,644
N82059 GREENBANK DRIVE	Liverpool CCG	5,402	5,557
N82062 FULWOOD GREEN	Liverpool CCG	7,119	7,889
N82065 EARLE ROAD	Liverpool CCG	4,177	4,499
N82066 WOOLTON VILLAGE	Liverpool CCG	8,891	9,667
N82067 BENIM MEDICAL CENTRE	Liverpool CCG	3,881	4,566
N82070 THE ELMS	Liverpool CCG	8,765	10,522
N82073 THE ASH	Liverpool CCG	6,559	7,194
N82074 OLD SWAN	Liverpool CCG	9,968	10,849
N82076 BROWNLOW HEALTH AT PRINCES PARK	Liverpool CCG	7,123	8,307
N82077 DR JUDE	Liverpool CCG	2,800	3,441
N82078 DR JUDE	Liverpool CCG	3,471	4,263
N82079 GREENBANK ROAD	Liverpool CCG	6,454	6,159
N82081 ISLINGTON MEDICAL CENTRE	Liverpool CCG	4,570	6,898
N82082 ST JAMES	Liverpool CCG	5,262	6,138
N82083 JUBILLEE MEDICAL CENTRE	Liverpool CCG	9,112	9,581
N82084 GATEACRE BROW	Liverpool CCG	6,992	7,824
N82086 ABINGDON MEDICAL CENTRE	Liverpool CCG	3,413	4,027
N82087 GILMOSS MEDICAL CENTRE	Liverpool CCG	2,486	2,769
N82089 PICTON GREEN	Liverpool CCG	3,461	3,533
N82090 GREEN LANE	Liverpool CCG	9,645	10,701
N82091 GP PRACTICE RIVERSIDE (DR JUDE)	Liverpool CCG	2,322	2,641
N82092 THE VALLEY	Liverpool CCG	8,099	8,585
N82093 DERBY LANE	Liverpool CCG	3,388	3,768
N82094 BELLE VALE	Liverpool CCG	7,831	8,877
N82095 ALBION MEDICAL CENTRE	Liverpool CCG	4,935	7,105
N82097 THE GREY ROAD SURGERY	Liverpool CCG	8,367	8,795
N82099 MERE LANE	Liverpool CCG	7,931	9,685
N82101 KIRKDALE	Liverpool CCG	2,750	3,557
N82103 ANFIELD GROUP PRACTICE	Liverpool CCG	7,273	8,627
N82104 STONEYCROFT MEDICAL CENTRE	Liverpool CCG	4,404	5,109
N82106 THE VILLAGE	Liverpool CCG	3,711	3,901
N82107 EDGE HILL AT MOSSLEY HILL	Liverpool CCG	1,519	1,653
N82108 RUTHERFORD	Liverpool CCG	7,521	7,181
N82109 DR THAKUR SC & PARTNER	Liverpool CCG	3,238	3,996
N82110 LONG LANE	Liverpool CCG	7,918	8,544
N82113 FAIRFILED	Liverpool CCG	6,584	7,155
N82115 VAUXHALL HEALTH CENTRE	Liverpool CCG	7,604	10,391
N82116 HILLFOOT HEALTH	Liverpool CCG	6,428	6,881
N82117 BROWNLOW GROUP PRACTICE	Liverpool CCG	43,447	40,738

Practice	CCG	ACTUAL	WEIGHTED
N82621 DR MANGARAI KR & PARTNER	Liverpool CCG	2,567	2,861
N82633 KNOTTY ASH	Liverpool CCG	2,570	3,098
N82641 DR J MAHADANAARACHCHI	Liverpool CCG	7,252	7,695
N82645 BROWNLOW HEALTH AT KENSINGTON PARK	Liverpool CCG	5,640	6,524
N82646 HEGDE AND JUDE'S PRACTICE	Liverpool CCG	9,850	10,331
N82648 POULTER ROAD	Liverpool CCG	1,547	1,634
N82650 DRS A SINGH & S BICHA	Liverpool CCG	2,727	2,993
N82651 DR JUDE STANLEY MEDICAL CENTRE	Liverpool CCG	4,648	5,945
N82655 MOSS WAY	Liverpool CCG	2,461	3,194
N82662 DUNSTAN VILLAGE	Liverpool CCG	6,653	7,203
N82663 HORNSPIT	Liverpool CCG	3,738	4,203
N82664 ROCKY LANE	Liverpool CCG	3,219	2,938
N82668 WALTON VILLAGE	Liverpool CCG	2,588	2,891
N82669 GREAT HOMER STREET	Liverpool CCG	3,243	4,485
N82670 DR JUDE PARK VIEW	Liverpool CCG	2,869	3,114
N82671 BIGHAM ROAD	Liverpool CCG	2,417	2,831
N82676 DR JUDE FIR TREE MEDICAL CENTRE	Liverpool CCG	4,346	4,539
N82678 STOPGATE MEDICAL CENTRE	Liverpool CCG	2,890	3,144
Y00110 DR JUDE WEST SPEKE	Liverpool CCG	1,986	2,195
	Total	**541,895**	**600,532**
WINGATE MC	Knowsley CCG	12,097	15,053.64
THE HEALTH CENTRE	Knowsley CCG	5,056	5,507.00
DINAS LANE	Knowsley CCG	10,109	11,453.01
BLUEBELL MEDICAL PRACTICE	Knowsley CCG	4,278	5,099.10
STOCKBRIGDE VILLAGE	Knowsley CCG	8,769	10,701.14
CORNERWAYS	Knowsley CCG	9,125	10,760.10
ASTON	Knowsley CCG	27,202	30,519.04
PILCH LANE	Knowsley CCG	5,180	5,861.00
ROSEHEATH MC	Knowsley CCG	2,513	2,631.53
MILLBROOK	Knowsley CCG	11,339	13,285.45
ST LAURENCES	Knowsley CCG	6,024	7,475.62
LONGVIEW	Knowsley CCG	4,035	4,785.70
TARBOCK	Knowsley CCG	4,282	4,687.69
TRENTHAM	Knowsley CCG	5,617	6,473.84
MACMILLAN	Knowsley CCG	5,313	6,305.68
HOLLIES MC	Knowsley CCG	4,967	5,045.68
TOWERHILL	Knowsley CCG	10,489	10,904.58
COLBY MC	Knowsley CCG	2,386	2,837.14
ROBY	Knowsley CCG	2,072	2,209.32
HILLSIDE	Knowsley CCG	2,885	3,377.02
PRIMROSE	Knowsley CCG	2,517	2,649.90
NUTGROVE SURGERY	Knowsley CCG	3,723	4,472.94
	Total	**149,978**	**172,096**
	Total for all CCG's	**1,379,216**	**1,502,714**

APPENDIX A(ii)

Practices excluded from the procurement in St Helens and Knowsley CCGs:

Please note the following Practices in St Helens and Knowsley are currently excluded from the procurement, as the Practices retain individuality responsibility for OOHs primary care. As described it is envisaged that over time some or all of these Practices could wish to migrate into the procured service and details of how this would be accommodated in the pricing structure are outlined in Section 16.5.1

Excluded St Helens Practices:

Practice	01/07/2019 Actual	01/07/2019 Weighted
PHOENIX MEDICAL CENTRE	3,370	3,828.18
LINGHOLME HEALTH CENTRE WA10 2HT	2,394	2,770.04
HALL STREET MEDICAL CENTRE	4,366	5,599.39
PARKFIELD SURGERY	2,612	3,154.48
BILLINGE MEDICAL PRACTICE	9,509	10,579.54
RAINFORD HEALTH CENTRE	4,848	5,608.40
KENNETH MACRAE MED CENTRE	3,884	4,621.00
BETHANY MEDICAL CENTRE	4,079	4,340.02
SANDFIELD MEDICAL CENTRE	3,127	3,397.26
GARSWOOD SURGERY	5,046	5,038.86
PATTERDALE LODGE MED CTRE	12,304	13,520.24
VISTA ROAD	7,818	9,241.11
HAYDOCK MEDICAL CENTRE	7,459	8,627.10
LIME GROVE SURGERY	7,779	9,019.10
NEWTON MEDICAL CENTRE	4,706	4,951.97
NEWTON COMMUNITY HOSPITAL PRACTICE	3,876	4,078.59
RAINBOW MEDICAL CENTRE	14,443	16,204.19
PARK HOUSE SURGERY WA9 1LN	6,673	8,034.09
THE SPINNEY MEDICAL CTR	7,313	8,329.74
THE BOWERY MEDICAL CENTRE	3,948	4,405.95

LONGTON MEDICAL CENTRE	5,350	5,680.08
HOLLY BANK SURGERY	3,639	4,553.21
ECCLESTON MEDICAL CENTRE	3,714	3,993.18
THE VILLAGE SURGERY PRESCOT	6,926	7,961.11
THE CROSSROADS SURGERY	2,708	2,994.22
CORNERSTONE SURGERY WA9 1LN	2,595	3,058.56

TOTAL	**144,486**	**163,590**

Excluded Knowsley Practices:

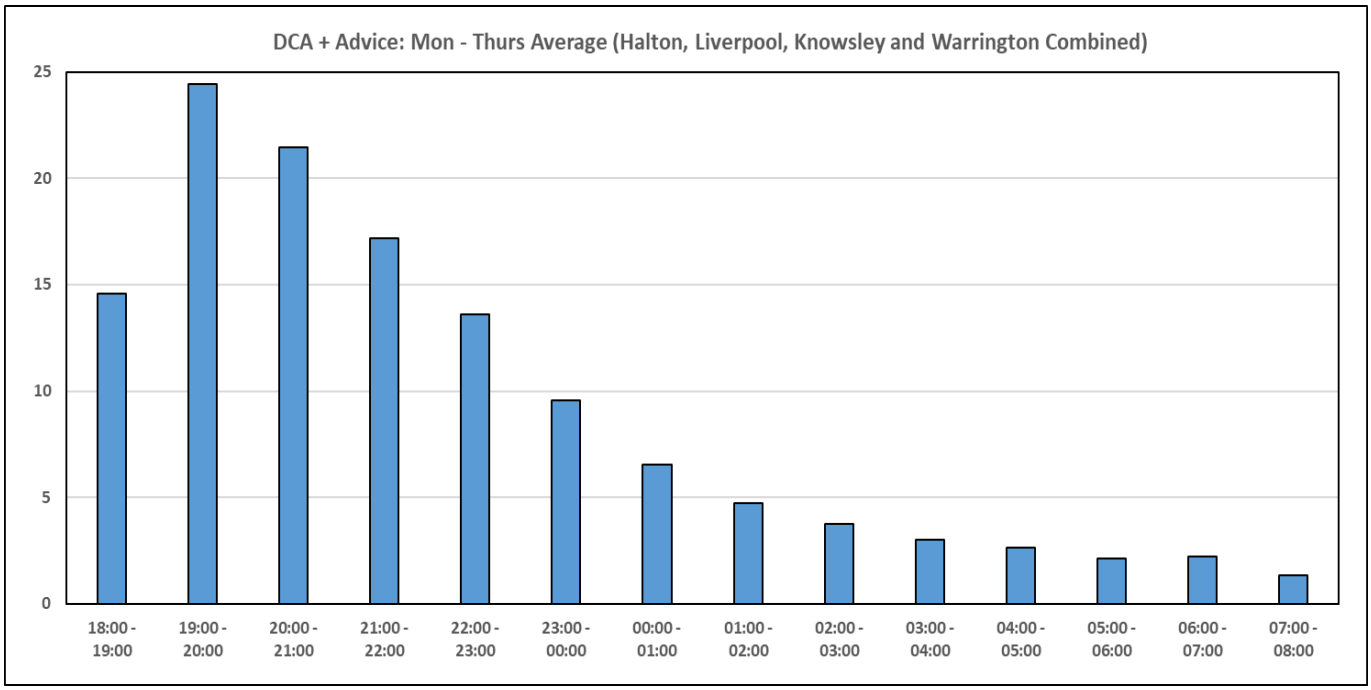
Code	Practice	Actual	Weighted
N83024	PARK HOUSE	7,438	8,452.75
N83603	PRESCOTT MC	5,793	6,567.56
N83609	CEDAR CROSS	3,715	3,865.30
Totals		16,946	18,886

APPENDIX B: Hourly Profile Data

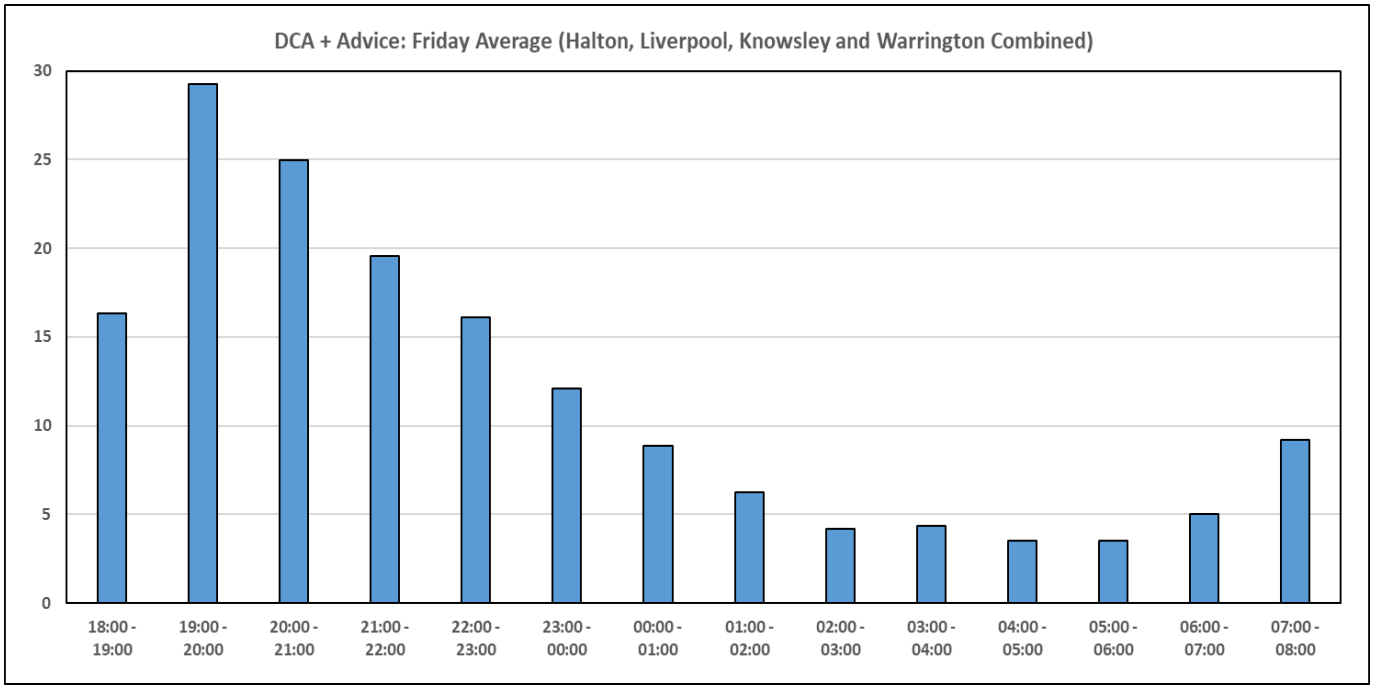
Data for Appendix

Hourly activity data for DCA, Face-to-Face Appointments and Home Visits was only provided for Halton, Liverpool, Knowsley and Warrington. Total figures only have been provided for the other CCGs.

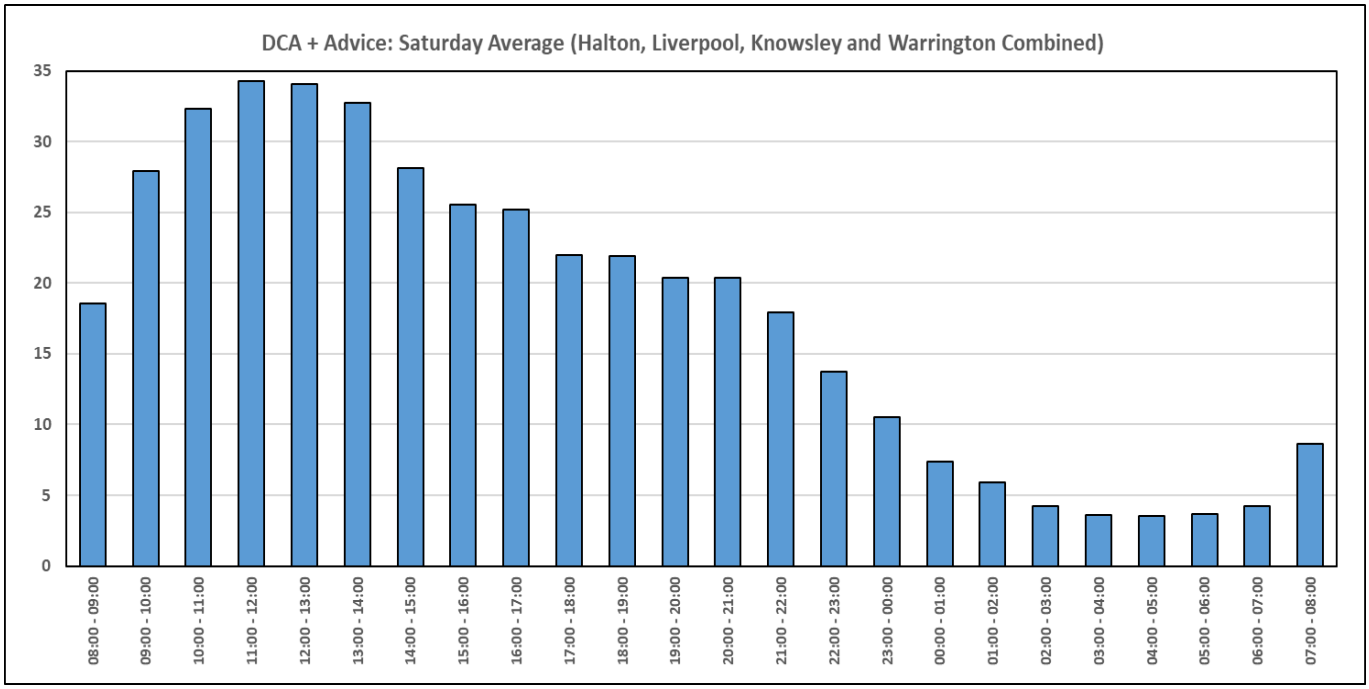
DCA + Advice: Mon to Thurs (Halton, Liverpool, Knowsley and Warrington Combined)



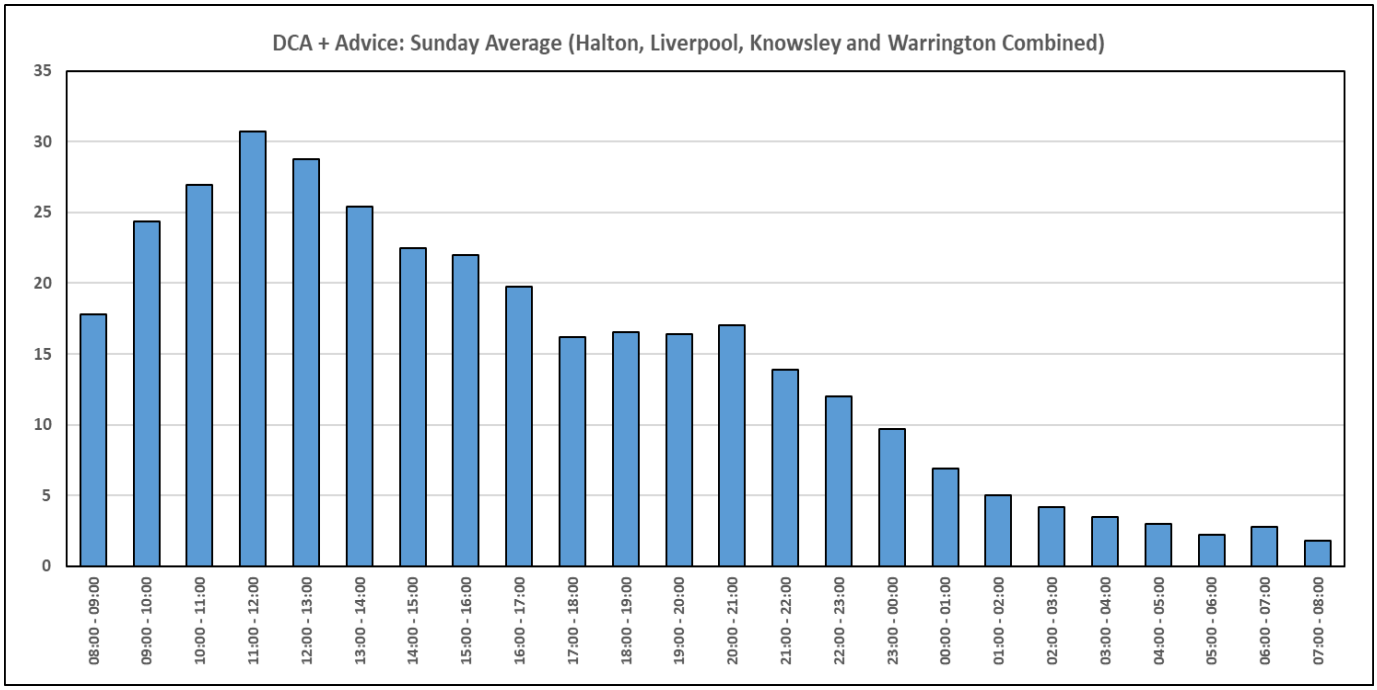
DCA + Advice: Friday (Halton, Liverpool, Knowsley and Warrington Combined)



DCA + Advice: Saturday (Halton, Liverpool, Knowsley and Warrington Combined)

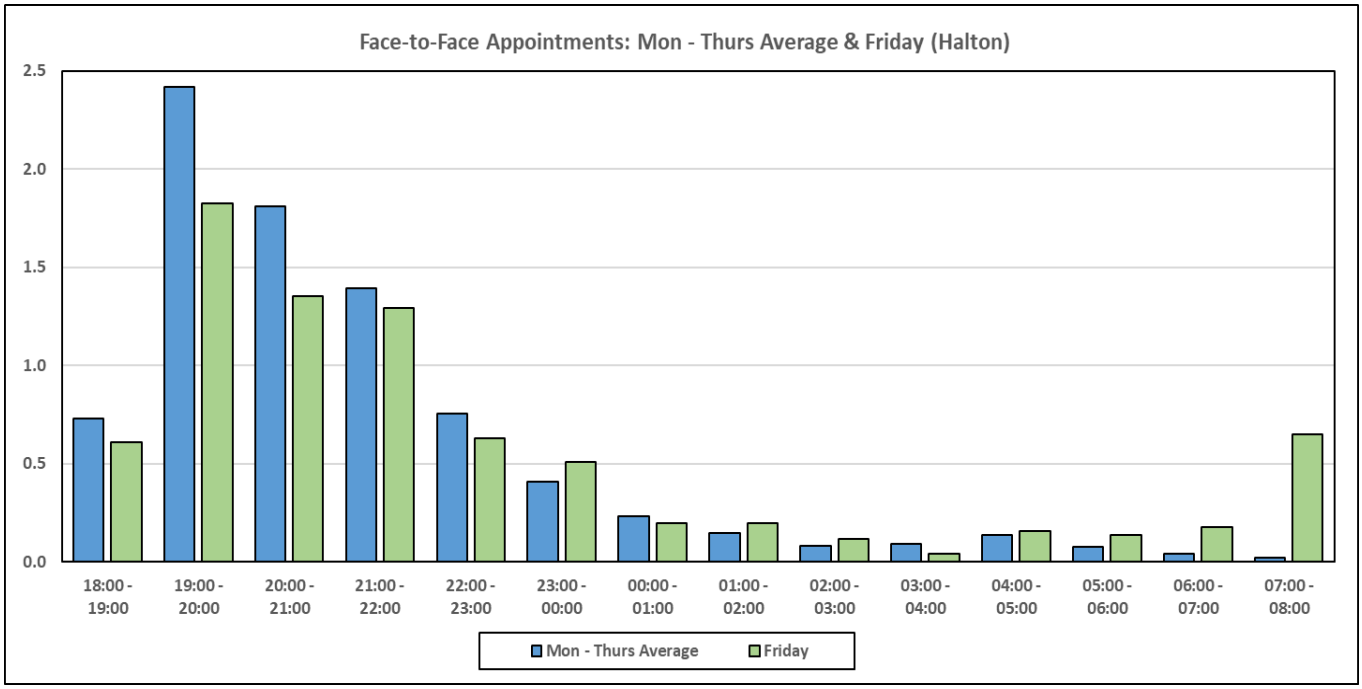


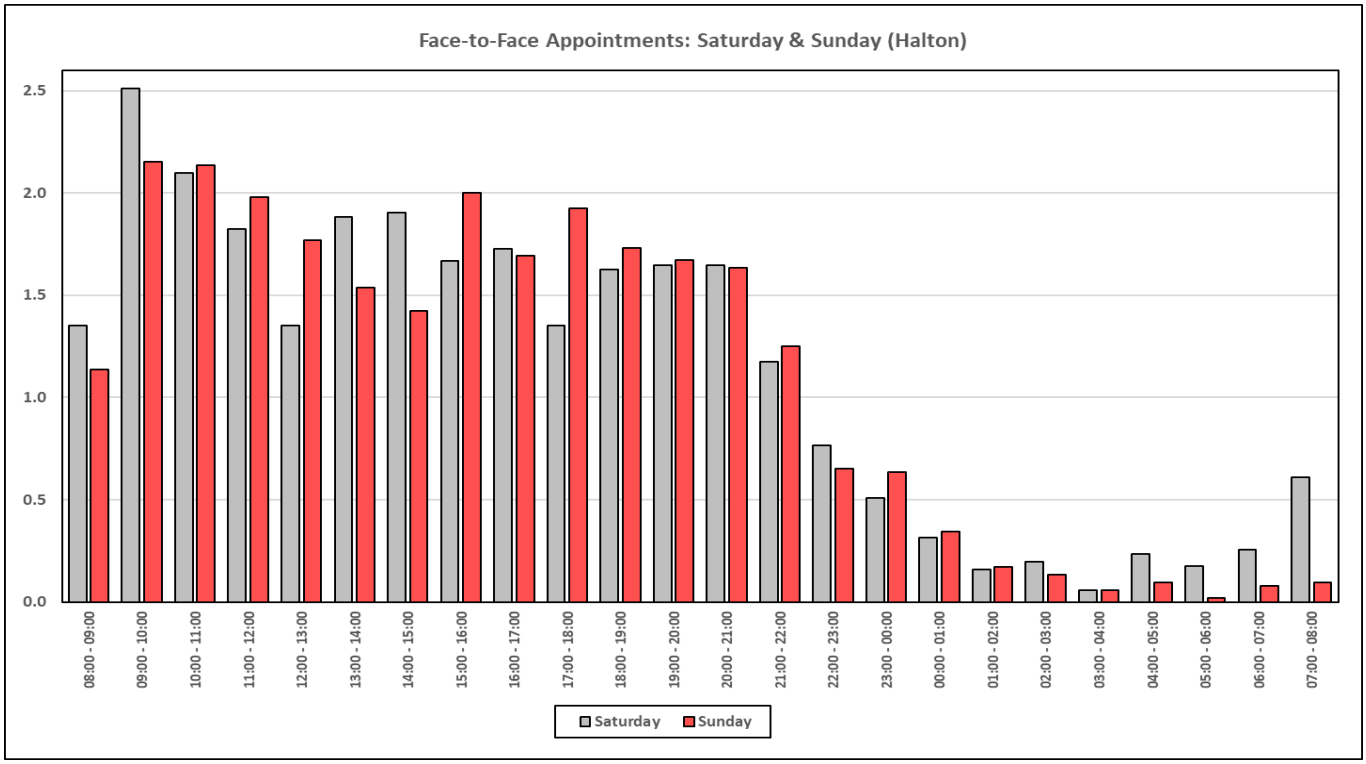
DCA + Advice: Sunday (Halton, Liverpool, Knowsley and Warrington Combined)



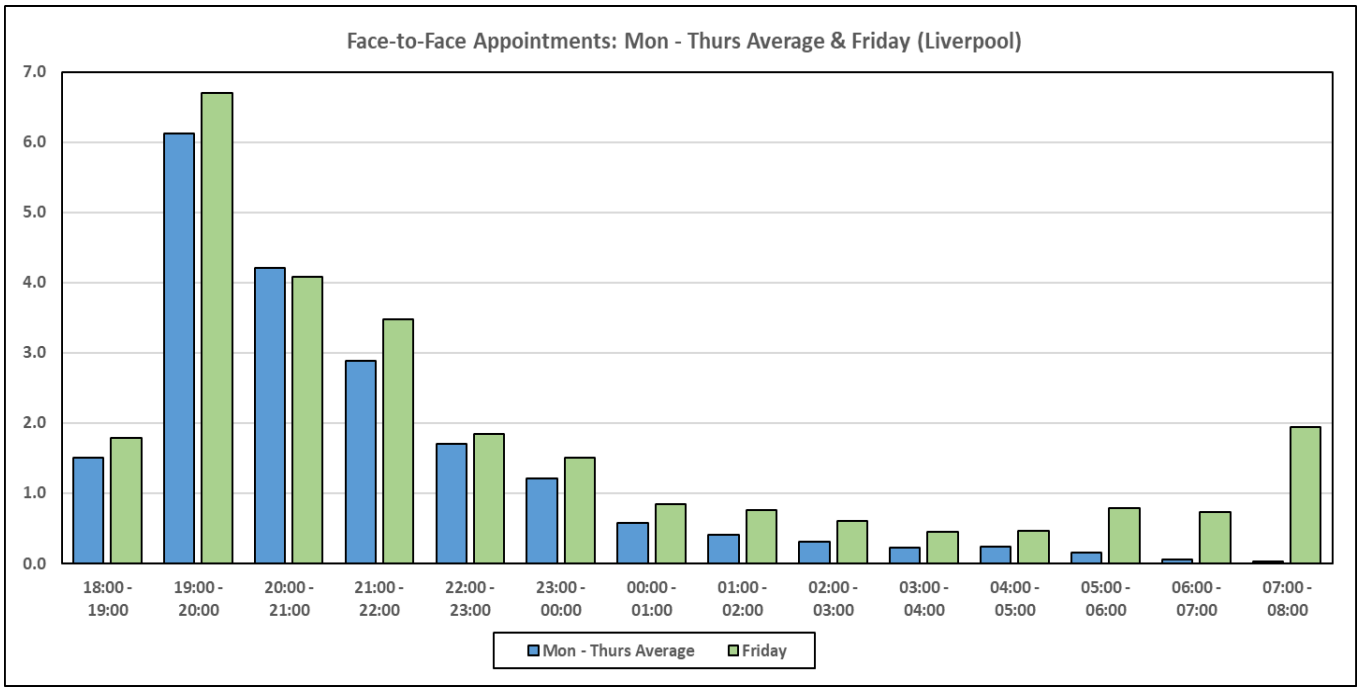
Face-to-Face Appointments (by Individual CCG)

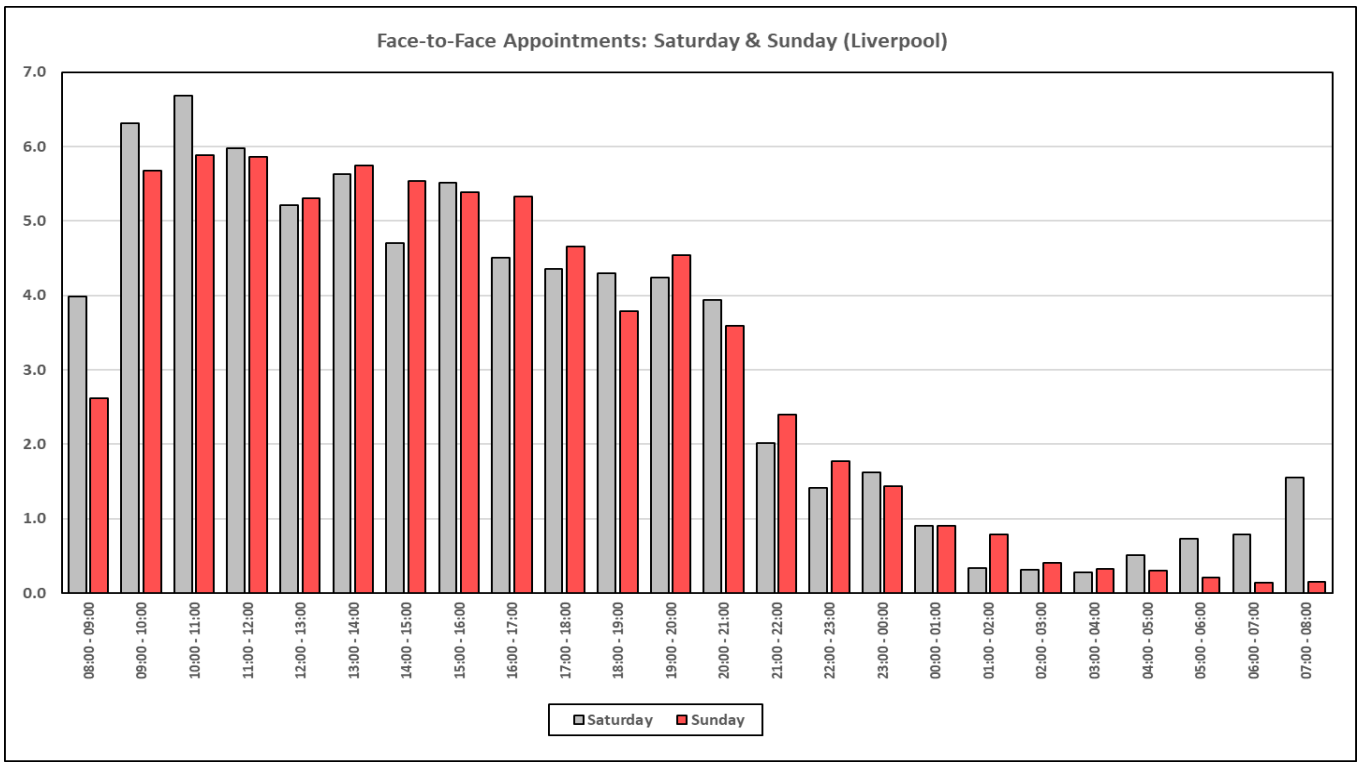
Halton



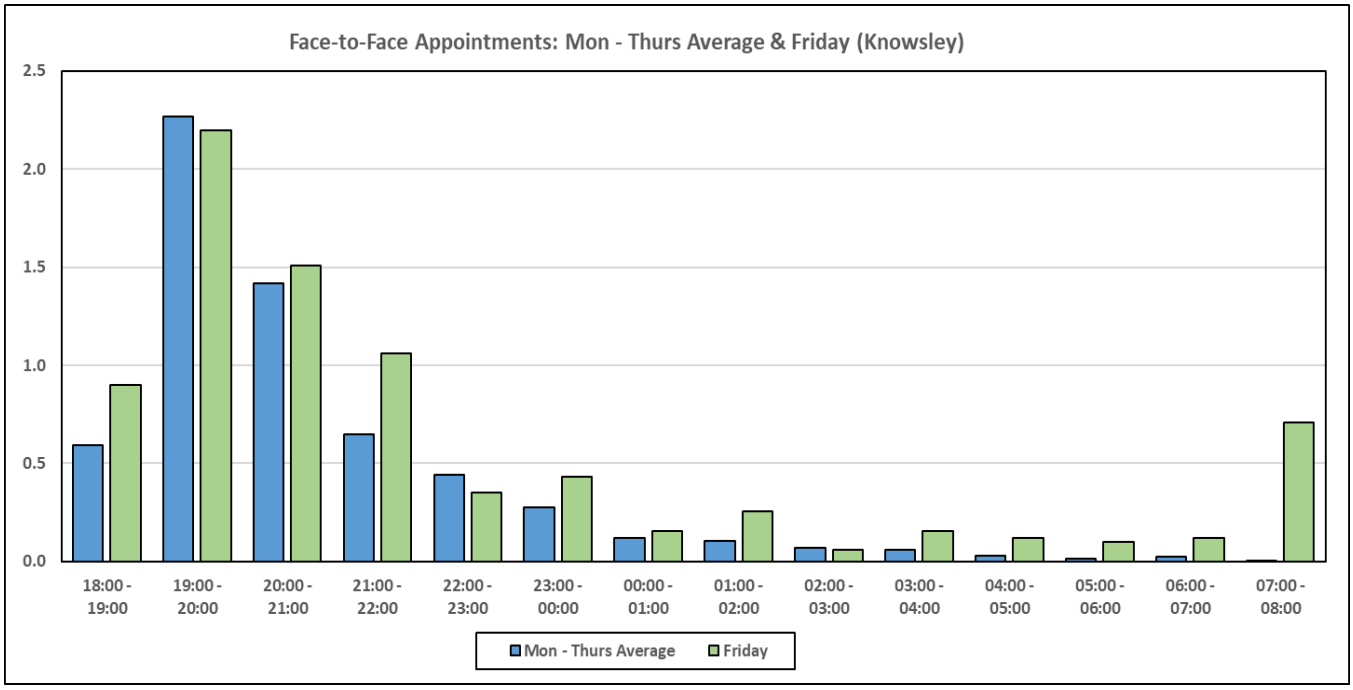


Liverpool


Face-to-Face Appointments: Mon - Thurs Average & Friday (Liverpool)
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
18:00 - 19:00
19:00 - 20:00
20:00 - 21:00
21:00 - 22:00
22:00 - 23:00
23:00 - 00:00
00:00 - 01:00
01:00 - 02:00
02:00 - 03:00
03:00 - 04:00
04:00 - 05:00
05:00 - 06:00
06:00 - 07:00
07:00 - 08:00
Mon - Thurs Average
Friday


Face-to-Face Appointments: Saturday & Sunday (Liverpool)
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
08:00 - 09:00
09:00 - 10:00
10:00 - 11:00
11:00 - 12:00
12:00 - 13:00
13:00 - 14:00
14:00 - 15:00
15:00 - 16:00
16:00 - 17:00
17:00 - 18:00
18:00 - 19:00
19:00 - 20:00
20:00 - 21:00
21:00 - 22:00
22:00 - 23:00
23:00 - 00:00
00:00 - 01:00
01:00 - 02:00
02:00 - 03:00
03:00 - 04:00
04:00 - 05:00
05:00 - 06:00
06:00 - 07:00
07:00 - 08:00
Saturday
Sunday

Knowsley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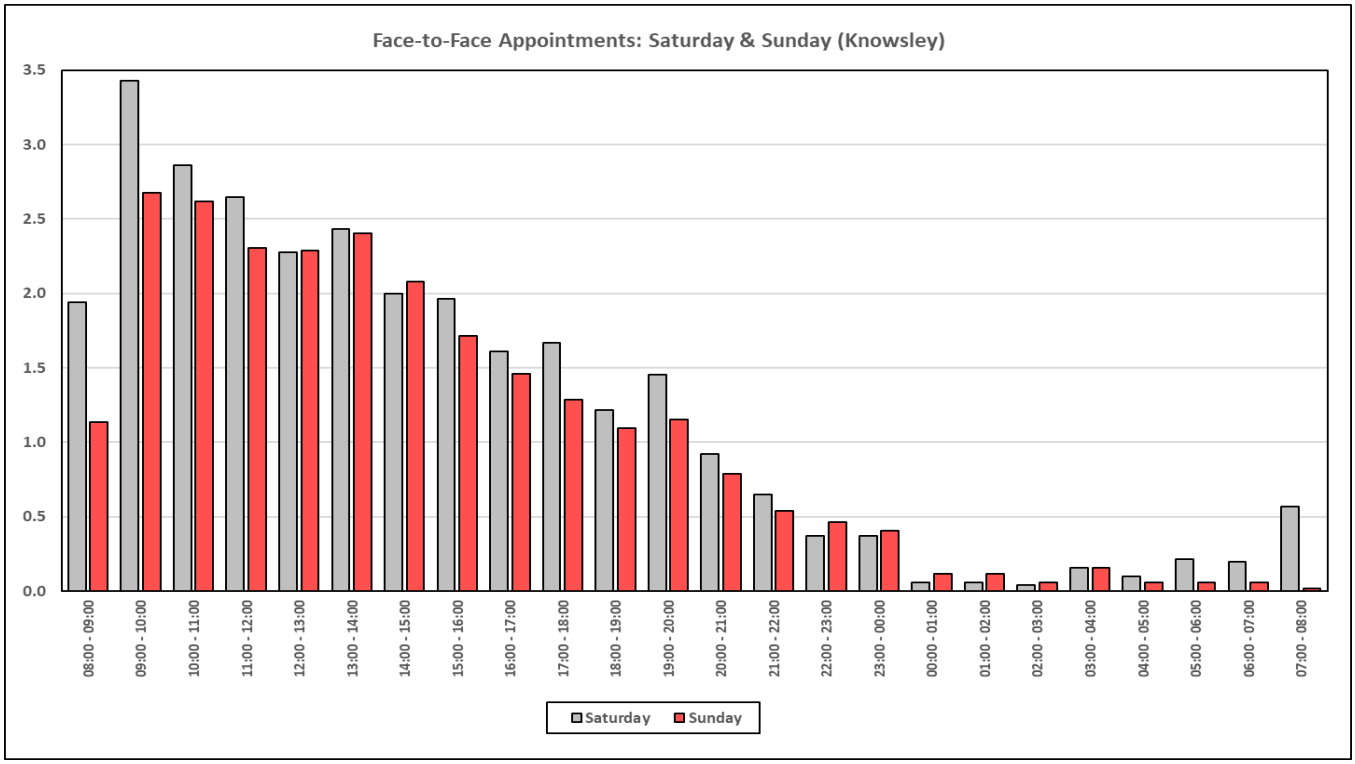
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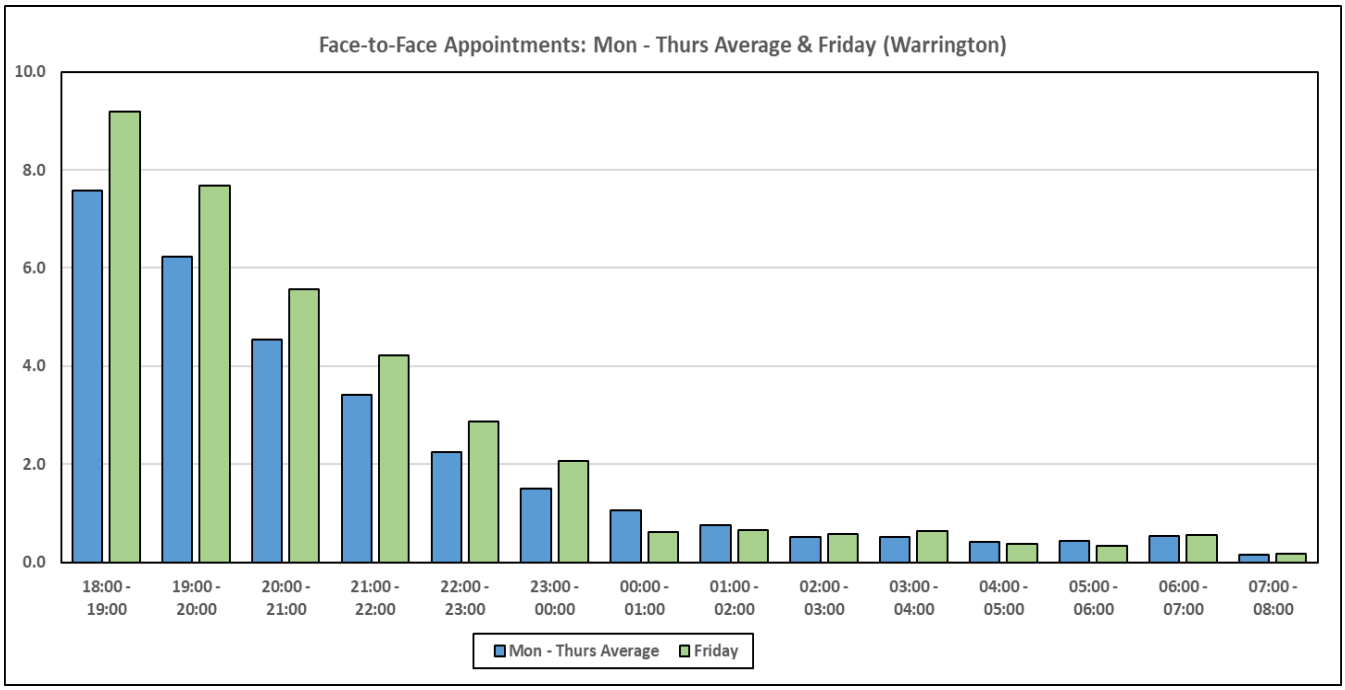
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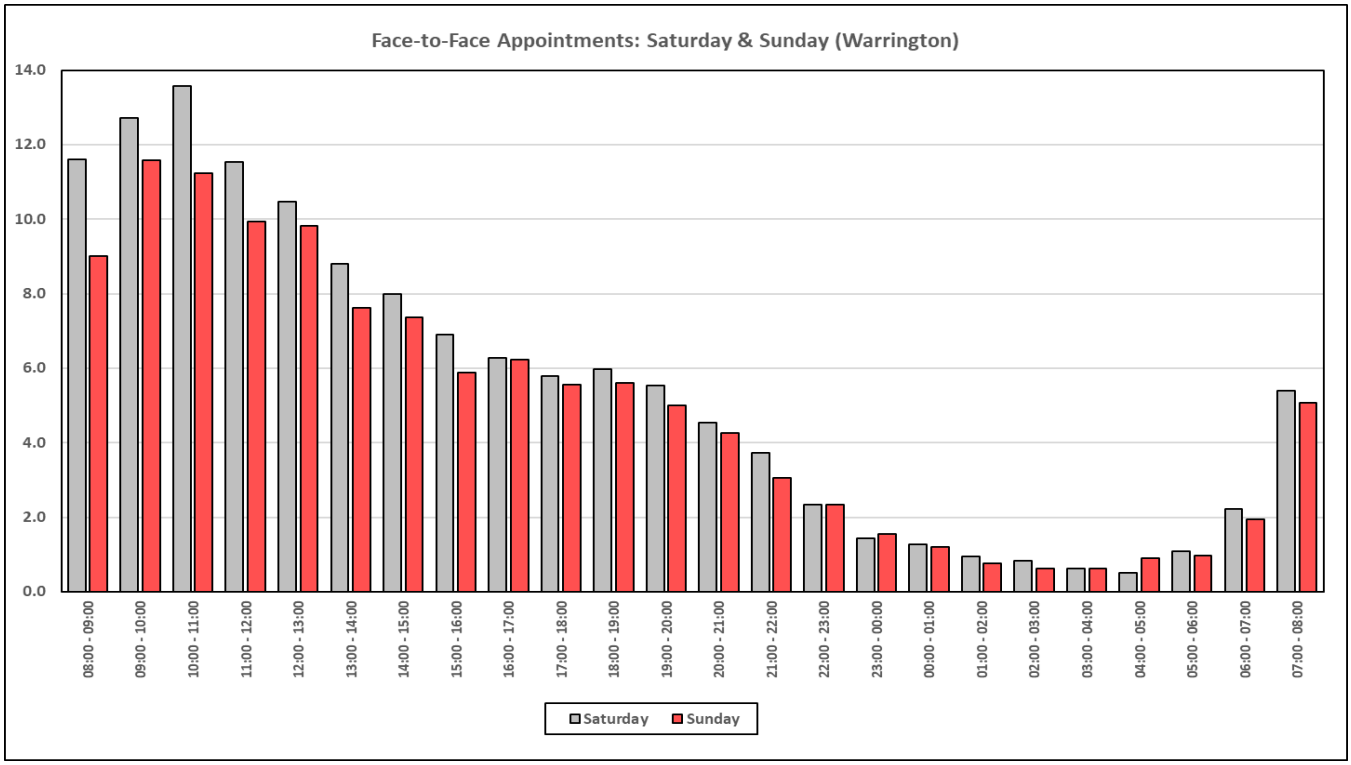
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Home Visits

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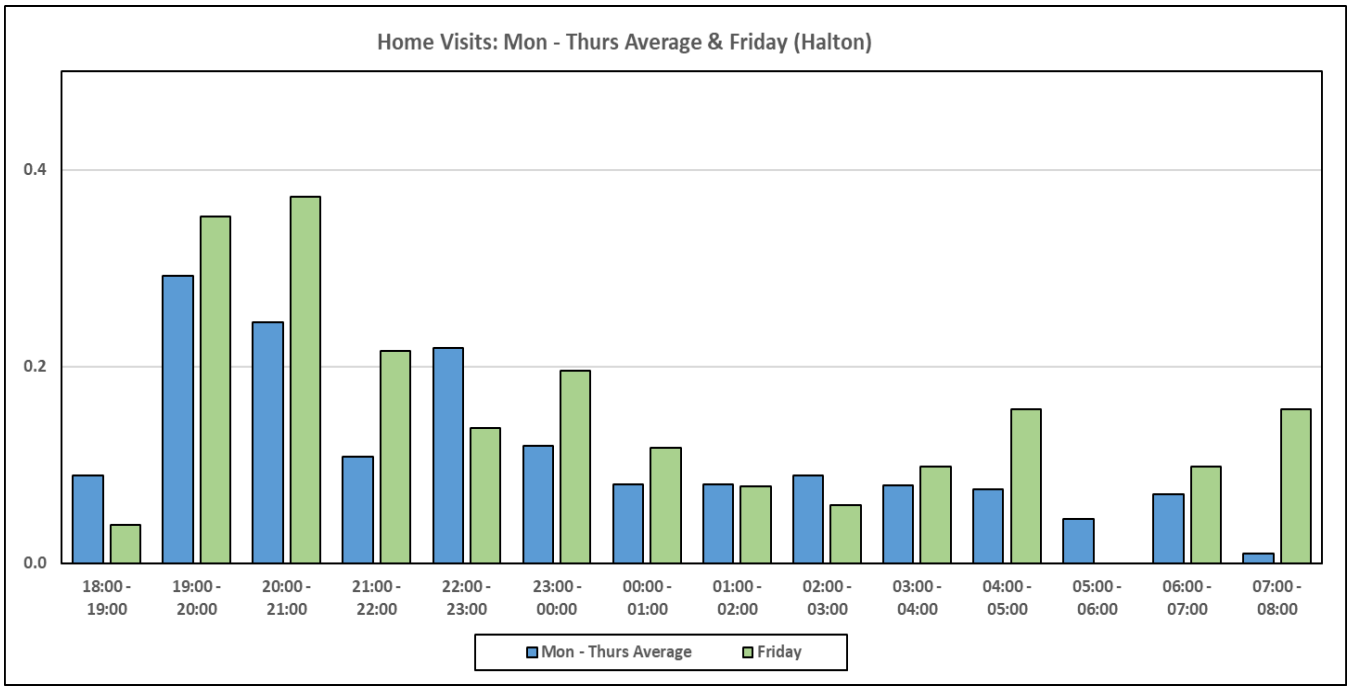

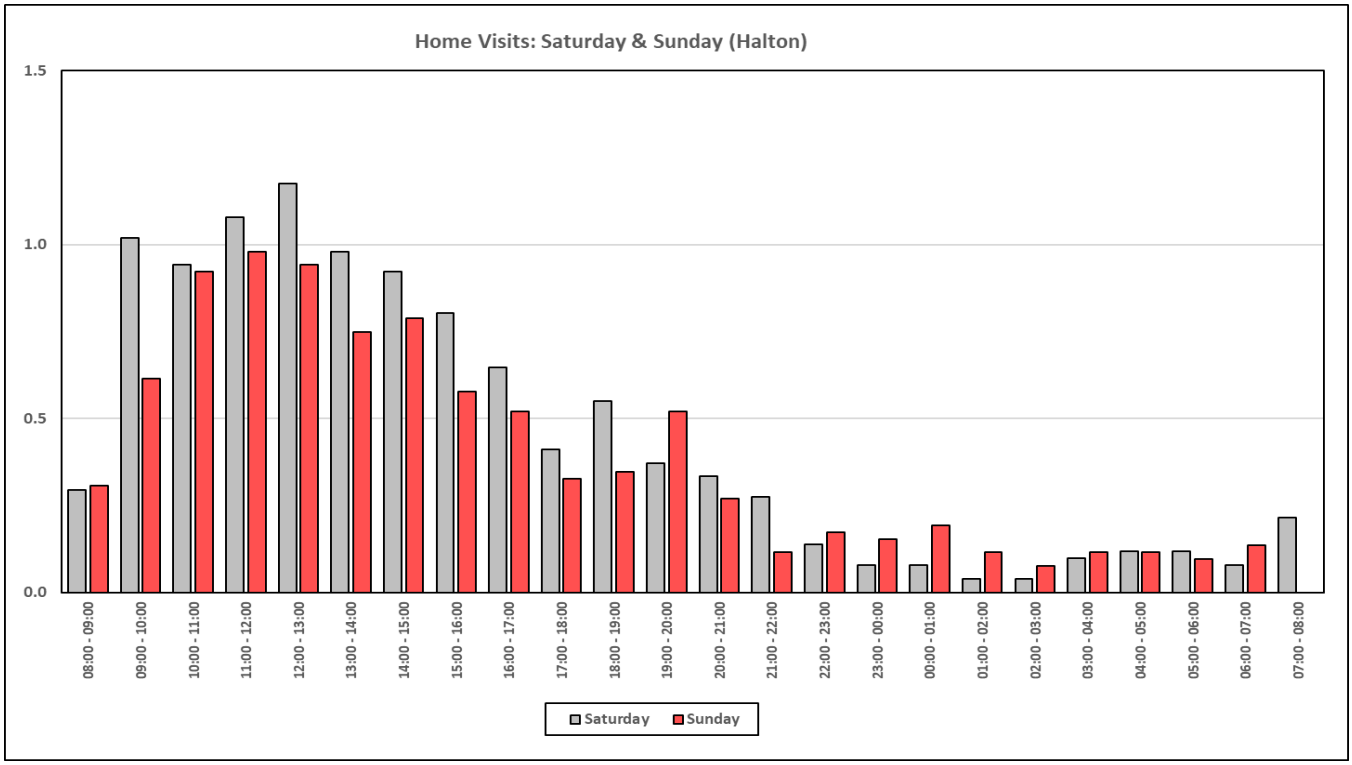

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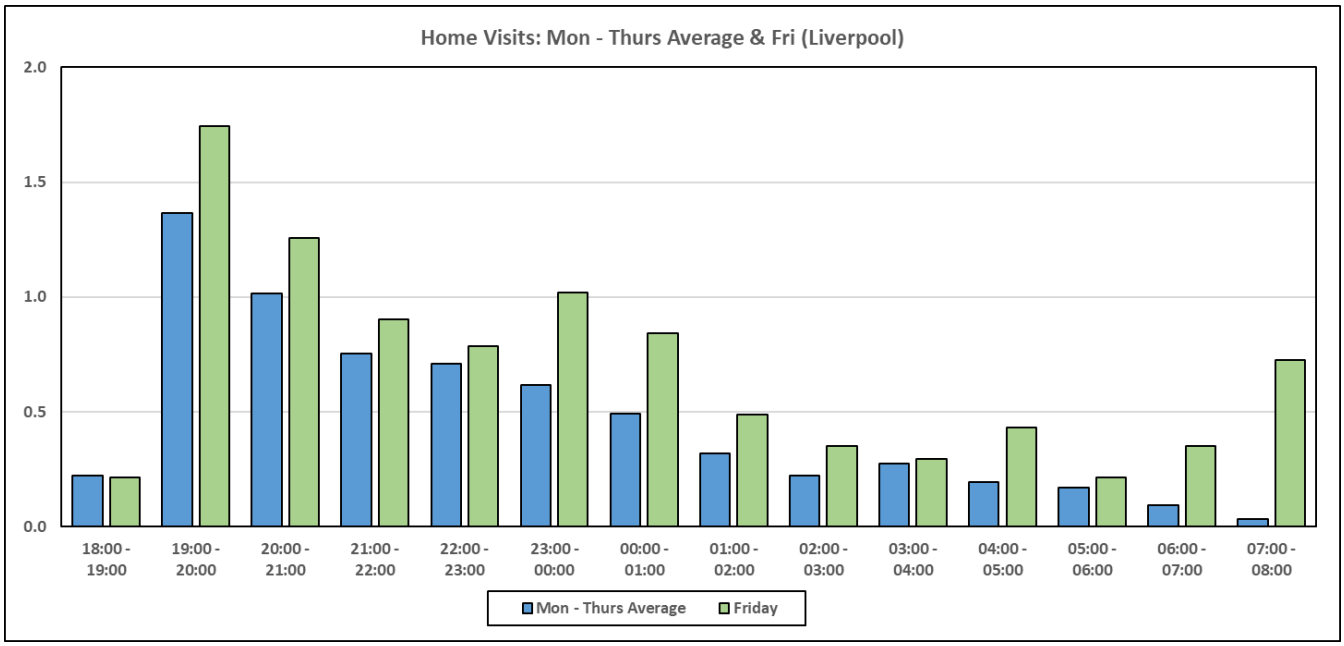
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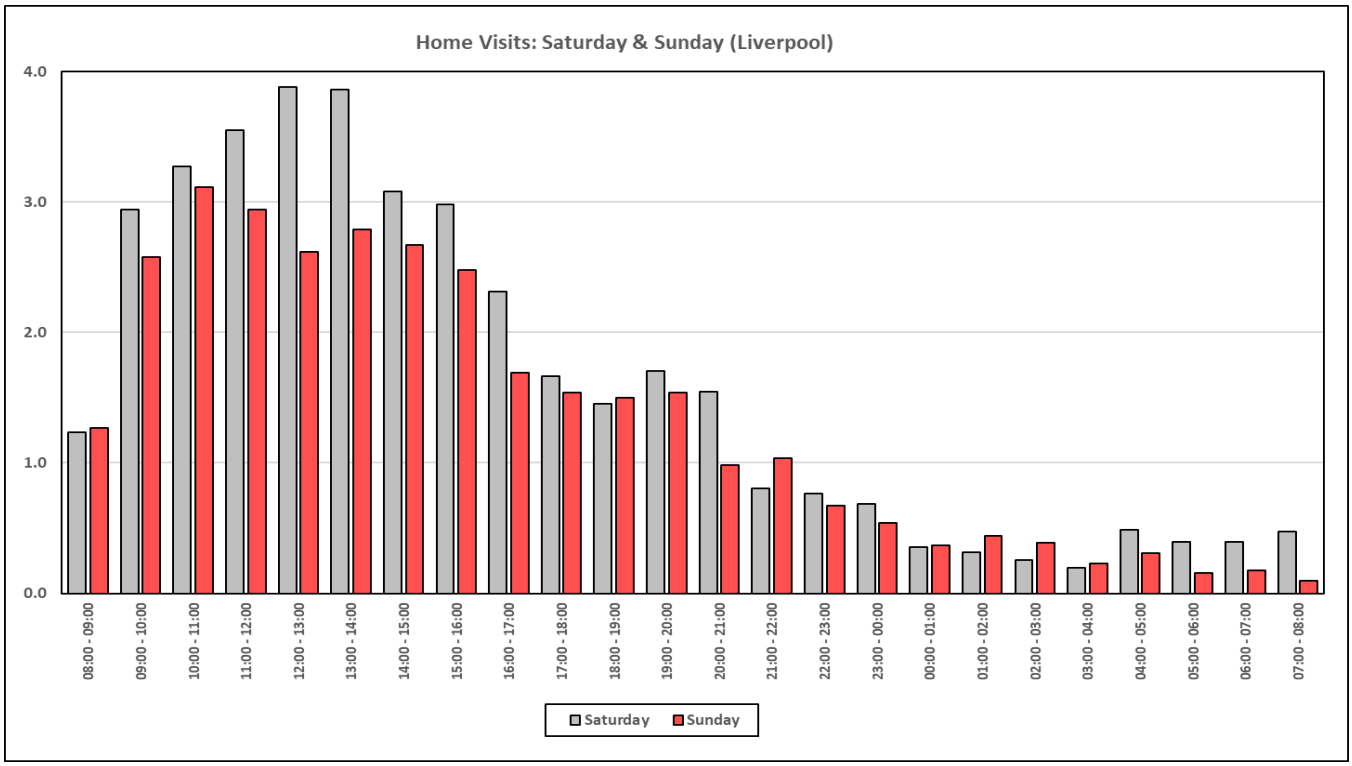
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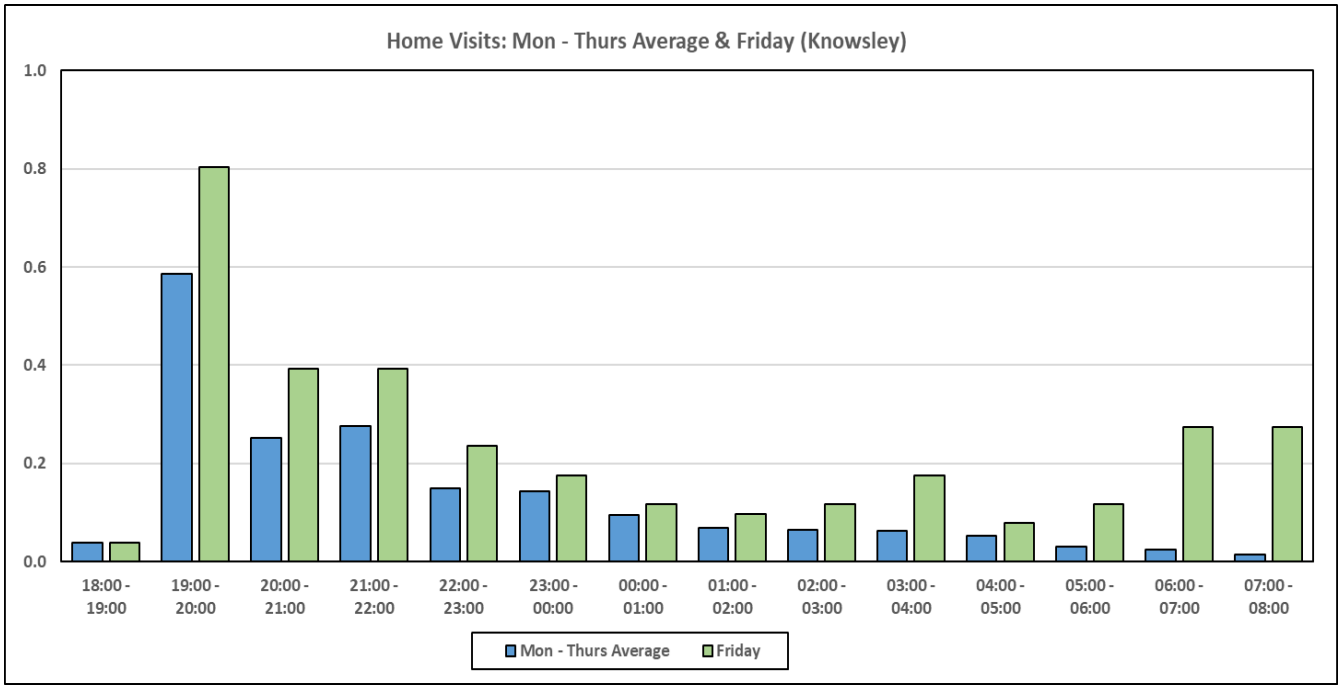
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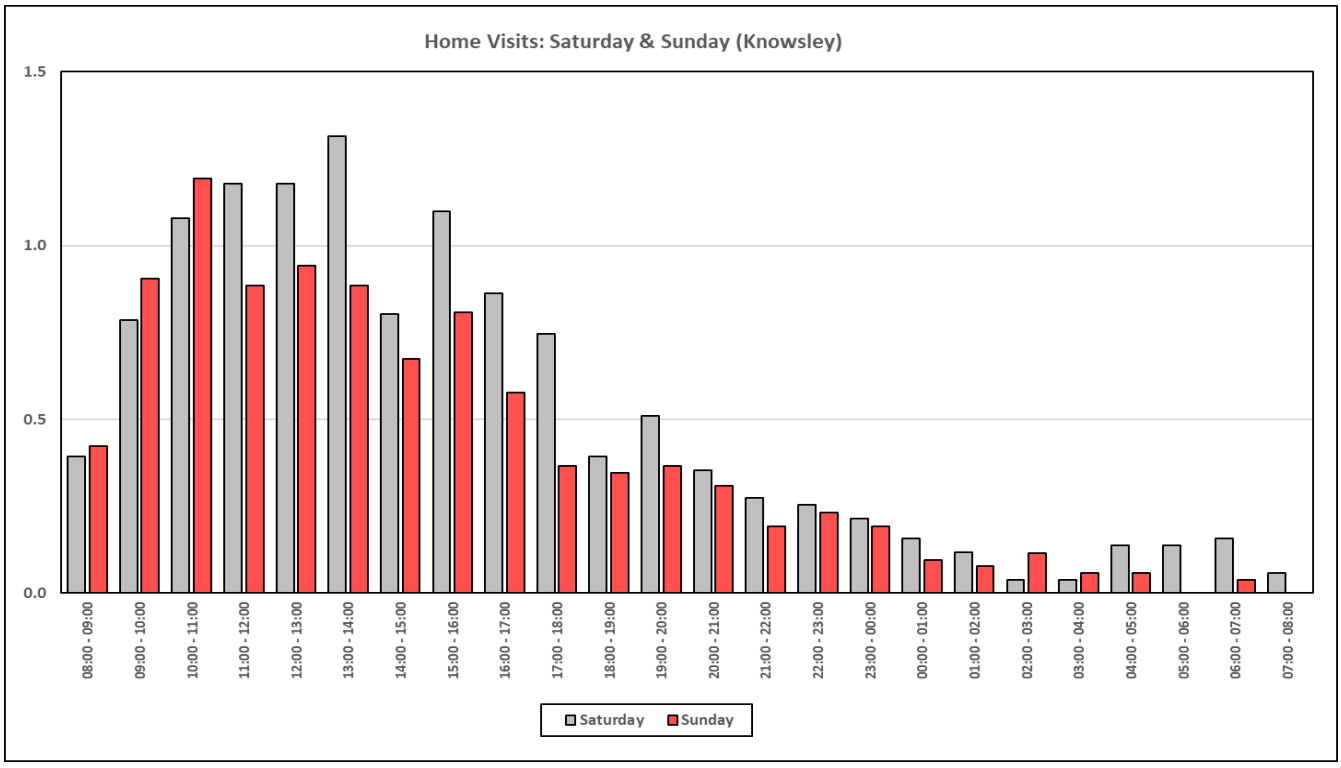
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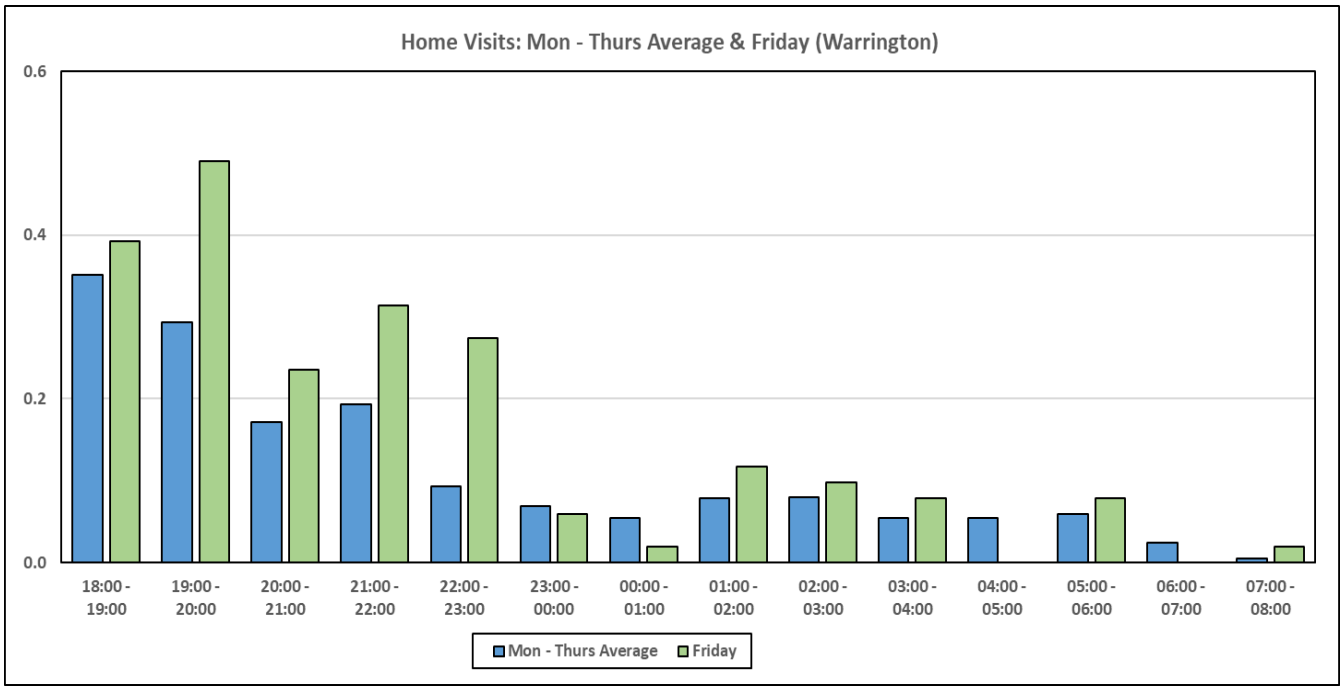
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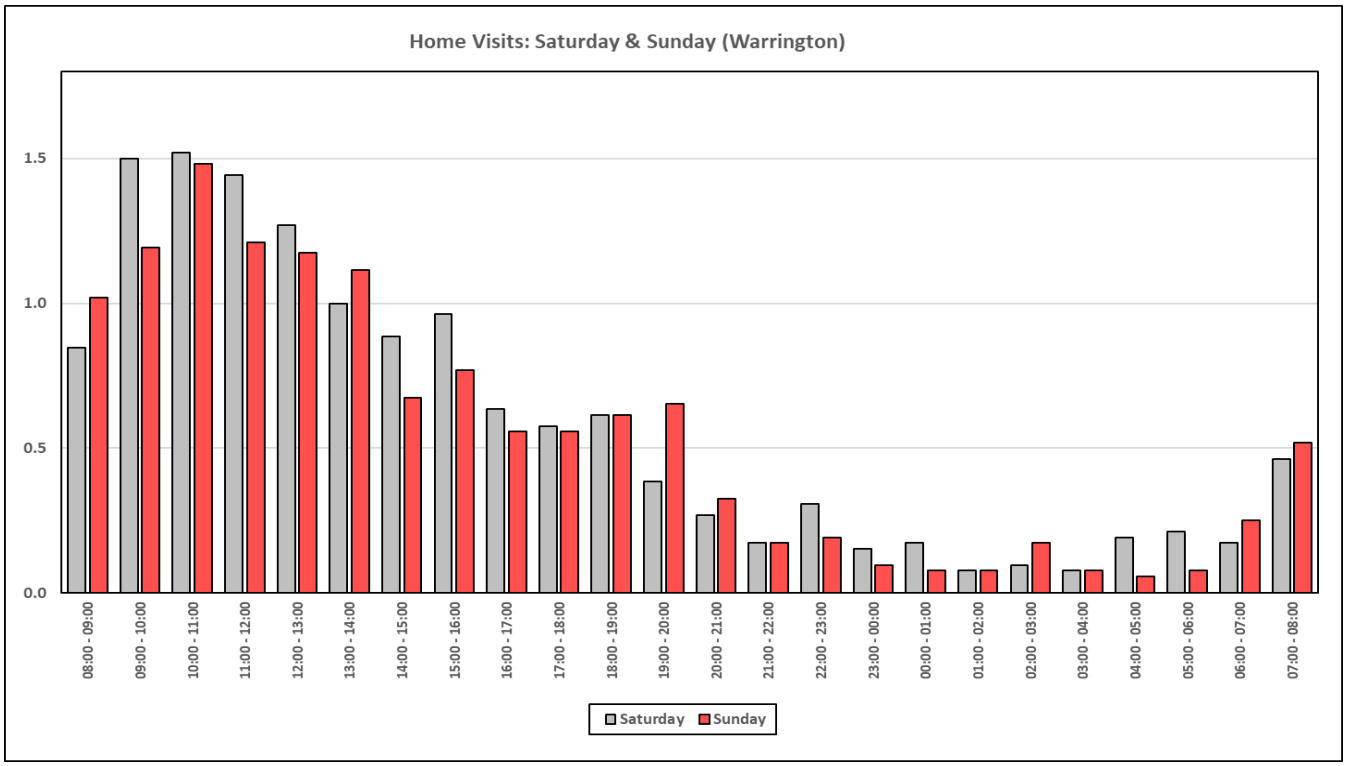
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APPENDIX C

Quality Standards: Translation and Interpretation Services

Table of Contents

Executive Summary

1.1 Purpose

The purpose of this document is to set out quality standards to ensure that people who have limited ability to communicate in English are able to access and receive high quality healthcare. The quality standards aim to ensure a consistent approach to commissioning Translation and Interpretation services across the Merseyside healthcare system, to remove unwarranted variation in quality and to ensure quality drives future procurement and commissioning decisions. Considerations for procurement, contracting and commissioning can be viewed in (see Appendix 1)

1.2 Background

Communication presents a major barrier to accessing healthcare services for people who have limited ability to communicate in English due to impairment or because their first language is not English. Equally, communication difficulties present healthcare staff with barriers to the delivery of safe, effective, patient focused care. This has significant implications for healthcare quality, governance and risk management.

Merseyside has diverse populations and increasing demographic pressures associated with age and increasing disabilities and impairments.

1.3 Introduction

Clinical Commissioning Groups (CCGs) and Providers who deliver NHS healthcare services across Merseyside are committed to commissioning and providing excellent healthcare services that are responsive to all patients' needs.

This document is an adaptation of NHS England's Guidance for Commissioners: Interpreting and Translation Services in Primary Care (September 2018) which incorporates further national guidance, national and local reports and recommendations and other local intelligence to ensure that Quality and Equality are at the centre of Translation and Interpretation services.

This document highlights best practice for Translation and Interpreting services for NHS patients and carers, specifically:

- Quality standards
- Legal position
- Commissioning and contracting considerations.

Equality of access to health services is highlighted within several documents including:

- European Convention for the Protection of Human Rights and Fundamental Freedoms 1950
- United Nations Convention on the Rights of the Child 1989
- Human Rights Act 1998
- United Nations Convention on the Rights of Persons with Disabilities 2005
- Equality Act 2010
- The NHS Constitution 2012
- Health and Social Care Act 2012
- Social Value Act 2013
- Accessible Information Standard (SCCI1605) 2016.

1.4 Definitions

Clinical Commissioning Group (CCG): a clinically-led statutory body responsible for the planning and commissioning of health care services for their local area.

Health Care Provider: is an organisation acting as a direct provider of health care services. A Health Care Provider is a legal entity, or a sub-set of a legal entity, which may provide health care under NHS Service Agreements, it may operate on one or more sites within and outside hospitals.

Commissioner: a commissioner is defined as the organisation responsible for the planning and commissioning of services. In the context of planning and commissioning Translation and Interpretation Services the Health Care Provider also acts as a commissioner and they sub-contract the service.

Interpreting: Interpreting is where a conversation or discussion (for example, between a nurse and a patient) is re- produced in another language. This might be from Farsi to English and vice versa. Or, from British Sign Language (BSL) in to English, and vice versa. This may be done face-to-face or using remote methods such as telephone interpreting or video or visual relay interpreting.

Translation: Translation is where a written source document (for example, a letter) is re-produced in another language. This can involve translating a document from one spoken language to another, such as Spanish in to English or transcribing a document from English in to braille.

Telephone interpreters: a professional who is available over the phone to convey spoken information from one language into another.

Face to face interpreters: a professional who in person conveys spoken information from one language into another or sign language into spoken English and vice versa. They can also act as “cultural mediators” taking into account potential cultural differences between patients and staff.

Immediate and Necessary: circumstances to save a patient’s life; or. to prevent a condition from becoming immediately life-threatening; or. to prevent permanent serious damage from occurring either to themselves or, in the British Medical Association’s (BMA) view, to the wider community.

Quality Standards

Quality Standard 1: Access to services

Patients should be able to access NHS services in a way that ensures their language and communication requirements do not prevent them receiving the same quality of healthcare as others

1. Interpreting and Translation services should be provided free at the point of delivery, be of high quality, accessible, and responsive to a patient's linguistic needs. Patients should not be asked to pay for interpreting services or to provide their own interpreter.
2. Where organisations have a contract with a particular Provider for Interpreting and Translation services there should be clear guidance on the use of alternative provision/ contingency arrangements e.g. use of voluntary organisations/ non-framework providers.
3. Organisations should look at how systems can be adapted to meet the needs of patients who require language support e.g. providing British Sign Langauge (BSL) videos, and indicating the need for an interpreter to be booked.
4. When an interpreter is required, additional time will be needed for the patients appointment (typically double that of a regular appointment) and should be reflected in Provider policies.
5. A highly visible alert should be used to ensure staff are aware of the needs of the patient in time for them to book appropriate support This should record specific requirements such as those detailed in Quality Standard 4, to ensure the correct service is booked. Language preferences and communication needs should be recorded in the patient's record and shared with other services when the patient is referred on to other services as outlined in the Accessible Information Standard[8].
6. When supporting children who require an interpreter, every effort should be made to respect the rights of the child (any person under the age of 18 years and especially those under 16 years of age) and support them in ensuring that interpreting services are provided to them under the principles of Gillick competency. Further guidance on Gillick can be found on the NSPCC website[9]
7. The rights of the child to receive healthcare services independently of parental control or decision making must be considered and respected and every effort should be made to empower the child to have an independent consultation if requested.
8. Where the patient has an identified carer (i.e. someone who provides regular, unpaid care and support (defined by ISB 1580: End of Life Care Co-ordination: Core Content) then the carer should be able to access language support to understand the discussion between the clinician and patient, with the patient's consent.

[8] https://www.england.nhs.uk/ourwork/accessibleinfo/

[9] The full address for further guidance on Gillick is: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

Quality Standard 2: Booking of Interpreters

Staff working in provider services should be aware of how to book interpreters across all languages, including BSL, and book them when required

1. Where an interpreter is required the provider is responsible for ensuring one is booked.
2. For Unaccompanied Asylum Seeking Children attending Initial Health Assessments it is the Local Authority's responsibility to book interpreters. Healthcare organisations and Interpreters should be aware of the Unaccompanied Asylum Seeking Children guidance.[10]
3. It is good practice for the provider to confirm to the patient, in advance of the appointment, the name and gender of the interpreter (if known) that has been booked.
4. Interpreters must be registered with an appropriate regulator (see Appendix 2), and should be experienced and familiar with medical and health-related terminology.
5. All staff within services should be offered training to raise awareness of the role of interpreting, the positive impact on patients and clinicians of high quality interpreting, and appropriate types of interpreting for specific situations. This training should include contact details of the organisation providing interpreting and translation services, how to book appointments and how to make complaints or provide feedback.

[10] http://www.uaschealth.org/resources/

Quality Standard 3: Timeliness of Access

Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access

1. Providers should use appropriate formats and languages to raise awareness that interpreters are available and work with the service provider for support materials.
2. Providers must take reasonable measures to ensure that patients are not disadvantaged by waiting unnecessarily longer for appointments to access services because an interpreter is required though it is recognised that access to interpreting is affected by availability of suitable interpreters.
3. At first contact with a service (or subsequently if their needs change), patients requiring language support should be made aware of the different types of interpreting available to them (e.g. face-to-face, telephone, video remote interpreting / video relay services).
4. Staff within organisations should ensure that patients with specific language or communication needs are called to their appointment by staff in a way which eliminates the opportunity for appointments to be missed (for example directly approaching a d/Deaf patient in the waiting area when the appointment is called, instead of using a public address (PA) system).

Quality Standard 4: Personalised Approach

Patients should expect a personalised approach to their language and communication requirements recognising that "one size does not fit all"

1. Patients should be asked about their language requirements and communication needs at first contact (or subsequently should their needs change) and this should be indicated clearly in their patient record. This should include:
    - Language requirements, language preferences, including dialect, and communication needs
    - Preference regarding gender of interpreter (if they wish to express one)
    - Cultural identity where this is relevant to the provision of interpreting

    Where patients have requested specific support to meet their needs, this will need to be recorded by the organisation. As such, it may be sensitive personal data and the organisations would need to handle it appropriately (see the information governance section).
2. Special circumstances may necessitate one form of interpretation over another (for example, specific circumstances may mean it is more appropriate for a patient to always have a face-to-face interpreter).
3. Good practice indicates that where a patient requires continuity of care, systems are in place to enable them to access the same interpreter where this is practicable.
4. Interpreters should complete their assignment and role to the satisfaction of the patient and the healthcare professional and to the standards set out by their professional body.
5. The organisation delivering the patient's care should consider how the service can support patients so that ideally the whole episode of care is facilitated, (for example booking future appointments at the reception desk immediately after the appointment).
6. The organisation delivering the patient's care should consider how the service can support inpatients.
7. Professionals and staff may use their language and communication skills to assist patients in making appointments or identifying communication requirements, (language brokering) but should not, other than where immediate and necessary treatment is required, take on the role of an interpreter unless this is part of their defined job role and they are qualified to do so. Staff trained and used as interpreters must be covered by indemnity insurance.
8. Where staff share the same first language with a patient they should use their professional judgement to decide whether they are able to competently communicate with the patient. Conversations should be limited to topics not related to the individuals specific care.
9. Patients should always be offered a registered interpreter. Reliance on family, friends or unqualified interpreters is not recommended and presents patient safety and legal risks to the organisation delivering the patient's care. For details of recommended qualifications please see Appendix 2.
10. If a patient expressly desires a family member or friend to act as their 'interpreter', the patient should give informed consent in their own language, sought from them independently of the family member/ friend. The consent must be noted in the patient's record.
11. The use of anyone under the age of 18 for interpretation is not acceptable in any circumstance other than when immediate and necessary treatment is required. This must be an exceptional occurrence as safeguarding and competency are serious concerns (refer to Gillick competency guidance outlined in Quality Standard 1).

Quality Standard 5: Professionalism and Safeguarding

High ethical standards, a duty of confidentiality and Safeguarding responsibilities are mandatory for Providers and this duty extends to interpreters

1. Interpreters must be registered with an appropriate regulator, be suitably qualified and should have the skills and training to work in health care settings.
2. Interpreters must have undergone appropriate checks and clearance in line with Disclosure and Barring Service guidelines. See Appendix 4.
3. Interpreters should be trained annually in safeguarding both children and adults. The level of training required will be determined by the Safeguarding Lead of the organisation delivering the patient's care.
   Any interaction requires the interpreters to be trained to an advanced level. Interpreting agencies are responsible for ensuring that staff and contractors have access to this training and development free-of-charge. All safeguarding training must be evidenced on request and be completed prior to any patient contact.
4. All Interpreters should be made aware of the Mental Capacity Legislation.
5. Interpreters should be aware of the safeguarding children and adults reporting procedures for the organisation. They must comply to the statutory duties to refer any concerns to the relevant agencies as per the organisation's procedures.
6. Interpreting service agencies are responsible for ensuring that staff and contractors have access to annual Information Governance training.
7. To safeguard and maintain the confidentiality of personal data, the interpreting agency should find a way to meet all information governance requirements when providing interpreting staff information about assignments. A secure online access system may be preferable.
8. All interpreters and staff of the organisation delivering the patient's care are responsible for ensuring that any interaction is conducted in a secure environment and cannot be overheard or interrupted.
9. Interpreters should introduce themselves along with their Identity badge (yellow badge for BSL interpreters) to all parties at the start of their assignment and explain the purpose of the role (the Interpreter's Declaration). An interpreter's role is to facilitate communication between two or more people who use different languages, being either spoken or signed.The interpreter is not responsible for what is said by either party, but is responsible for ensuring that everything that is said is communicated accurately in the other language.
10. The interpreter is present only to facilitate communication during the appointment. They should not be asked to undertake additional/ ancillary duties.
    during the appointment (e.g. those which may be delivered by a carer or advocate). There should not be physical contact or support with intimate or clinical procedures and any such procedures should not be performed in view of the interpreter.
11. Interpreters are present to interpret for everyone in that appointment including the patient, parents or carers, any representative / chaperone and healthcare professionals.
12. Any conflict of interest or issues that may arise within the interaction must be declared to the lead healthcare worker supporting the patient.
13. Any actions identified by healthcare professionals that are deemed unsafe, of a safeguarding concern or a breach of confidentiality should be reported to the interpreting agency and where relevant registering body.
14. Healthcare organisations should alert their Interpreter service provider if they suspect the interpreting agency is being intercepted by traffickers with the aim of trafficking service users into modern slavery.
15. Interpreters should be aware of how to raise concerns and how to alert agencies to any concerns regarding clinical conduct and unsafe practices.
16. Where a safeguarding concern is raised about a registered interpreter, the interpreter should self-declare the concern. The healthcare organisation also has a duty to make a

declaration to the registration body.

Quality Standard 6: Compliments, Comments, Concerns and Complaints

Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their first or preferred language and formats (written, spoken, signed etc.)

1. Easy-to-follow procedures which maintain confidentiality should be in place to enable positive and negative feedback about the interpreting service. The feedback procedure should be available in appropriate languages and formats including written, spoken and BSL signed video.
2. Any response to patients' comments should be in a language they understand. Patients should be able to give feedback directly to the interpreting service. To do this patients will need to know the interpreter's full name, be made aware of who is the provider agency and/ or details of the registering body.
3. Interpreting agencies should collate and publish data on feedback and outcomes in a service satisfaction report. The service satisfaction report should be made available to commissioners, providers and patients on their website at a locally agreed frequency.
4. Monitoring of themes and trends should be undertaken to understand if an individual or agency poses a risk to patient and their families.

Quality Standard 7: Translation of documents

Documents which help professionals provide effective health care or that supports patients to manage their own heath should be available in appropriate formats when needed

1. Documents which are usually available free to patients which may help them to take more control of their health and wellbeing must be available on request, in community languages or alternative formats (e.g. braille) at no additional charge to the patient (practices may wish to engage directly with organisations that provide such literature). Organisations are not required to have 'stocks' of information in different community languages and formats (e.g. braille) in anticipation of requests. However, organisations must have an identified process for obtaining information in alternative formats (including those which are not able to be produced in-house) if needed by a patients. Such processes should ensure minimum delay in receipt of accessible information by the patient. Good practice would be for organisations to have a limited number of the most commonly used patient-facing documents / information readily available

   (i.e. 'in stock') in the most commonly required alternative formats.
2. Documents translated for the benefit of patients must be translated by competent and appropriately trained translators and not by staff.
3. Patients should be able to request a translation of their summary care record into their preferred language and format (including easy read, Braille and other accessible formats) at no cost to themselves over and above the standard cost of accessing their patient record. See the Accessible Information Standard (SCCI1605) for further information.
4. Translation of documents can include reading information to the patient in the language required by them – known as sight translation. This also applies to BSL.
5. Where patients are in possession of documents in languages other than English which relate to their health, these should be translated into English as soon as possible where there is an identified clinical need. The documents should be included in the patient record in both languages where this is deemed necessary.
6. Where patients have an identified need for language or communication support, consideration should be given to the best way to contact them. For some people, a letter in English will not be an effective way to communicate. Alternatives could include: text messages; 'phone calls; or translated / transcribed letters.
7. Automated online translating systems or services such as "Google-translate" should be avoided as there is no assurance of the quality of the translations.

Quality Standard 8: Quality Assurance and Continuous Improvement

The interpreting service should be systematically monitored as part of commissioning and contract management procedures and users should be engaged to support quality assurance and continuous improvement and to ensure it remains high quality and relevant to local needs

1. Clear lines of accountability must be in place between the organisation delivering the patient's care, the agency, the interpreter and healthcare professionals using the service set out.It must be clear who the commissioner is, who the providing agency is, who the clients / recipients of the service are and a clear trail of which service has been provided and when. Any data shared will need to be done so in line with NHS information governance protocols (see Appendix 3 section)

2. Once commissioned, the service should be subject to regular performance monitoring against the service specification to ensure that it continues to meet patient needs. This may include for example, checks to ensure that interpreters are suitably qualified and registered, review of vetting and barring, review of safeguarding training, appointments are being kept, governance is effective, costs are being monitored and the level of compliments, comments, concerns and complaints recorded. The service may be asked to deliver training to the Provider as part of the Contract arrangement. The service may be asked to provide assurance in regards to due diligence in relation to mitigating the risks against modern slavery and human trafficking. Regular audits should be carried out to support service improvement. Monitoring of themes and trends should be undertaken to understand if an individual or agency poses a risk to patient and their families

3. Information governance, confidentiality and data protection are significant features of a high quality and effective service. All agencies will be expected to comply with the information governance requirements set out in Appendix 3

4. Monitoring of information governance and governance issues must be undertaken monthly and action taken where concerns are raised.

Legal position

There is a legal obligation to ensure that people who have limited ability to communicate in English are not disadvantaged in accessing and receiving high quality healthcare.

- NHS Constitution – basic principle is that the NHS is available to everyone and therefore equitable accessible. Another principle is that individuals, families and carers are consulted on and involved with decisions regarding their treatment. This may require the removal of language barriers.
- The Equality Act 2010 and Public Sector Equality Duty (PSED) – places a legal requirement for providers to give 'due regard' to the need to advance equality of opportunity. Failure to provide interpretation for clinical assessments and treatment when necessary equates to discrimination under sections 13, 19 and 149 of the Equality Act 2010.
- Health and Social Care Act 2012 – legal duty to tackle health inequalities in regards to access to health services and improved outcomes for all patients.
- Failure to provide appropriate professional interpreting and translation services presents serious safeguarding issues (e.g. not using friends or family as interpreters) and increases the risk of failing to meet a healthcare professional's duty of care.
- The Equality Act 2010 places an additional duty on public sector bodies who are subject to the 'public sector equality duty' including independent contractors.
- NHS Standard Contract states that providers must comply with the Accessible Information Standard (SC12.3) – this applies to disabled patients and patients with impairment or sensory loss. All Acute, Community, Mental Health Trusts and Independent Sector Organisations are monitored on their implementation of the standard via the Quality Schedule compliance.

Appendix 1 - Procurement, Commissioning and Contracting Considerations

It is essential that these Quality Standards are incorporated into any future procurement, commissioning, contracting and performance management processes and that quality is the focus of Intepreter provision.

Assessing needs and reviewing current service provision

 Consider the specific language needs of the population (for both BSL and community languages) using:

- Locally available data including data collected as part of the Accessible Information Standard
- NHS England data set combining ONS Census data with Local Super Output Area (LSOA) data (available separately for commissioners by e-mailing the Primary Care Commissioning Team)

 Consider the legal position and whether this is being met by current service provision

 Consider the financial position. The cost of any services commissioned or recommissioned would need to be met from within existing allocations.

 Consider how communication difficulties can prevent people accessing services and how this can be overcome (for example *Sick of It* published by *SignHealth* and Liverpool CCG's report recommendations following engagement event with D/deaf community https://www.liverpoolccg.nhs.uk/media/3391/liverpool-nhs-final-report-and-actions-deaf-hearing-loss-final.pdf).

1.1 Deciding priorities

 Demography may have changed since services were first commissioned

 Health inequalities are the driver to considering priorities for groups of patients who require interpreting services

 Consider the range of health services to be covered and ensure that any commissioning plans cover these and avoid disadvantaging specific patient groups

 Consider the organisation's current policy on translation of documents to support people with an impairment (e.g. learning disability, blindness) or who speak community languages (for example, translation of foreign medical documents).

1.2 Designing services

 Commissioners may find it helpful to separate community languages from BSL / braille and address each separately as the legal position for the two differs

 Consider cost-effective and efficient ways to provide services (for example telephone interpreting or app-based support (noting that these must meet commissioners' governance, quality and procurement guidelines if purchased on behalf of the NHS)

 Consider what support is in place or needs to be in place to support d/Deaf or deafblind people, referring to the Accessible Information Standard as necessary.

1.3 Shaping structure of supply

 The Quality Standards outlined in this document should be translated into the procurement and form part of the weighting and evaluation process also ensuring that Quality, Equality and Patient Experience officers of the organisation procuring the service are engaged and involved.

 Consider commissioning options. The Crown Commercial Service has a procurement framework. Commissioners could review this to see if it meets their needs or whether alternative arrangements are preferable. Contact NHS England's Commercial Team for guidance and support on the procurement of interpreting and translation services to ensure adherence to NHS England's Standing Financial Instructions (nhsengland.commercial@nhs.net)

 Commissioning with neighbouring organisations may be preferable if it reduces transaction and administrative costs and represents best value.

1.4 Managing performance

The Quality Standards outlined in this document should be translated into Key Performance Indicators for discussion at Quality Assurance and Contract Review meetings between the Interpreter agency and Activity and Finance, Quality, Equality and Patient Experience Officers of the organisation delivering the patient's care.

Data monitoring should include measurements that support future service planning for example:

- Number of appointments provided broken down by type including:
  - Language provided (broken down by community language and BSL)
  - Type of interpreting provided (face-to-face, telephone, video)
  - Where the service was provided (e.g. GP surgery, pharmacy)
  - Reason for interpreting (e.g. to book appointment, to attend appointment)
  - Patient demographic (e.g. age, gender, language required)
- Missed appointments and reason (both by interpreter and patient / carer)
- Feedback from patients broken down by type e.g. compliments, comments, concerns, complaints
  - Themes and trends analysis to review issues and complaints
- NUBSLI compliant for BSL
- Use of local Interpreters for BSL (to prevent dialect issues).
- Registered Sign Language Interpreter (RSLI)
- Continuity – use of same interpreters both Language and BSL
- Encouraging ongoing feedback as part of service provision can lead to more timely feedback and enables a timely response to emerging issues.

Appendix 2 - Qualifications and Regulators

Interpreting is a specific skill which requires expertise and training. The qualifications below recognise this. At the present time there are limited numbers of suitably qualified interpreters for both BSL and spoken languages.

Qualifications and Regulators for Interpreters for Deaf People

Organisations must ensure that the communication and language professional holds relevant interpreting qualifications and, in the case of British Sign Language (BSL) the interpreter must be a Registered Sign Language Interepreter (RSLI). Those working in health and social care settings should have sufficient knowledge of medical terminology in order to communicate information effectively.

Registration with NRCPD confirms interpreters hold suitable qualifications, are subject to a code of conduct and complaints process, have appropriate insurance, hold an enhanced disclosure from the Disclosure and Barring Service and engage in continuing professional development.

Qualifications and Regulators for Interpreters for Spoken Languages

Spoken language interpreters should be registered with the National Register of Public Service Interpreters (NRPSI) and hold a Diploma in Public Sector Interpreting (Health).

Where an interpreter does not hold a DPSI (Health) it may be acceptable to use an interpreter who either:

- Is a native speaker in English and another language who also has a minimum of NVQ level 3 in interpreting, or,
- In addition to their own native language has ILETS level 7.5 (English) and also has a minimum of NVQ level 3 in interpreting.

These interpreters should also have training in medical terminology in order to communicate information effectively.

- **Translators**

People used to translate written documents should hold at least one of the following qualifications:

- An honours degree in the relevant language and / or a degree in translation
- Qualifications and Credit Framework Level 7 qualification in translation such as the Institute of Linguists Educational Trust (IoLET) Diploma in Translation
- A masters level qualification in translation
- A recognised post-graduate qualification in translation.

Appendix 3 - Information Governance

The interpreting service agency and individual interpreters will be required to comply with information governance requirements. They must demonstrate they can process personal data and sensitive personal data in a secure, confidential manner, giving assurance to patients, clinicians and commissioners about the way they handle patient information.

1. Where patient data is to be shared electronically the interpreting service will be required to have and maintain an N3 network connection (the national network for the NHS), to enable safe transfer of patient data between organisations providing NHS services. This may be facilitated by the provision of an NHS.net email account or a .gsi.gov.uk email account.

2. All persons acting as interpreters must complete annual Information Governance (IG) Training, compliant with NHS Information Governance standards.

3. Interpreting service agencies must find a way to enable staff to find out details of assignments in a way which meets all information governance requirements. Where interpreters or translators need access to confidential information, such as the patient's needs, there must be an appropriate way of accessing and managing these data. For example this could be a secure online portal for interpreting staff to access their appointments and the information they need to support the patient effectively.

4. Parties handling personal data must comply with data protection legislation: the General Data Protection Regulation (GDPR) and Data Protection Act (DPA) 2018. The following principles must be applied to the management of patient information.

- Be used lawfully; any sharing of personal data by the controller must have a contract in place which sets out clearly the legal basis for processing of personal data and the responsibilities each party has in relation to the data and its protection. A data sharing contract forming part of the wider supplier contract would look to ensure the following areas are addressed:
- That personal data is used fairly in a way that the patient would reasonably expect and that they have been informed about prior to its use
- That personal data is not kept longer than necessary- a retention period should be applied within the contract
- That personal data is used for the purpose intended, and specified by the controller, with the minimum necessary used to achieve that purpose
- That personal data is accurate (subject to best endeavours of the contractor)
- That personal data is kept securely and disposed of securely when no longer required - copies of secure destruction should be provided to the controller
- That personal data is not processed outside of the European Economic Area (EEA). Any proposed processing outside of the EEA should be reviewed with the controller and written permission given before any processing of personal data outside the EEA is undertaken

- That personal data is processed in accordance with the patient's rights. With data subjects informed about how to exercise their rights.

5. In order to comply with data protection legislation, patients must be provided with a Fair Processing Notice. This means that they should be provided with information regarding the service and how any data sharing will be facilitated :

- Who the data controller is for their data
- The contact details of the controller's Data Protection Officer (DPO)
- The purposes for processing the data including the legal basis
- With whom their data may be shared and why
- How to exercise their rights under the data protection legislation (i.e. right of access)
- Outline how long the information will be retained
- How to contact the Information Commissioner's Office (ICO- the ICO is the UK's independent body set up to uphold information rights) in the event of a complaint.

Please note that the needs of patients using translation services will need to considered and material that is accessible provided.

6. Contracted agencies will be required to report annually to their commissioner(s) in line with the current expectations set out in:

- Their contract
- By standards set by NHS Digital or the Information Governance Alliance
- By the Information Commissioners' Office.

7. Identifiable data should only be shared with the commissioner when appropriate and there is a lawful basis to do so, which includes the patient being aware of that flow of data.

8. Where the interpretation service is acting as data processor, the contract will outline how they will support the data controller(s) in answering Data Subject Rights Requests (i.e. right of access)from patients. Where the contractor is a data controller in their own right, they are responsible for meeting these data protection obligations in their own right.

Appendix 4 - Information Sources

National and Local Reports

- National Frameworks Dossier of Disgrace. https://nubsli.com/resources/national-frameworks-dossier-of-disgrace/#fullreport
- Sick Of It Report https://www.signhealth.org.uk/health-information/sick-of-it-report/
- Liverpool CCG hosted event in relation to D/deaf Access May 2018 https://www.liverpoolccg.nhs.uk/media/3248/liverpool-nhs-final-report-and-actions-deaf-hearing-loss-v1.pdf

National Guidance

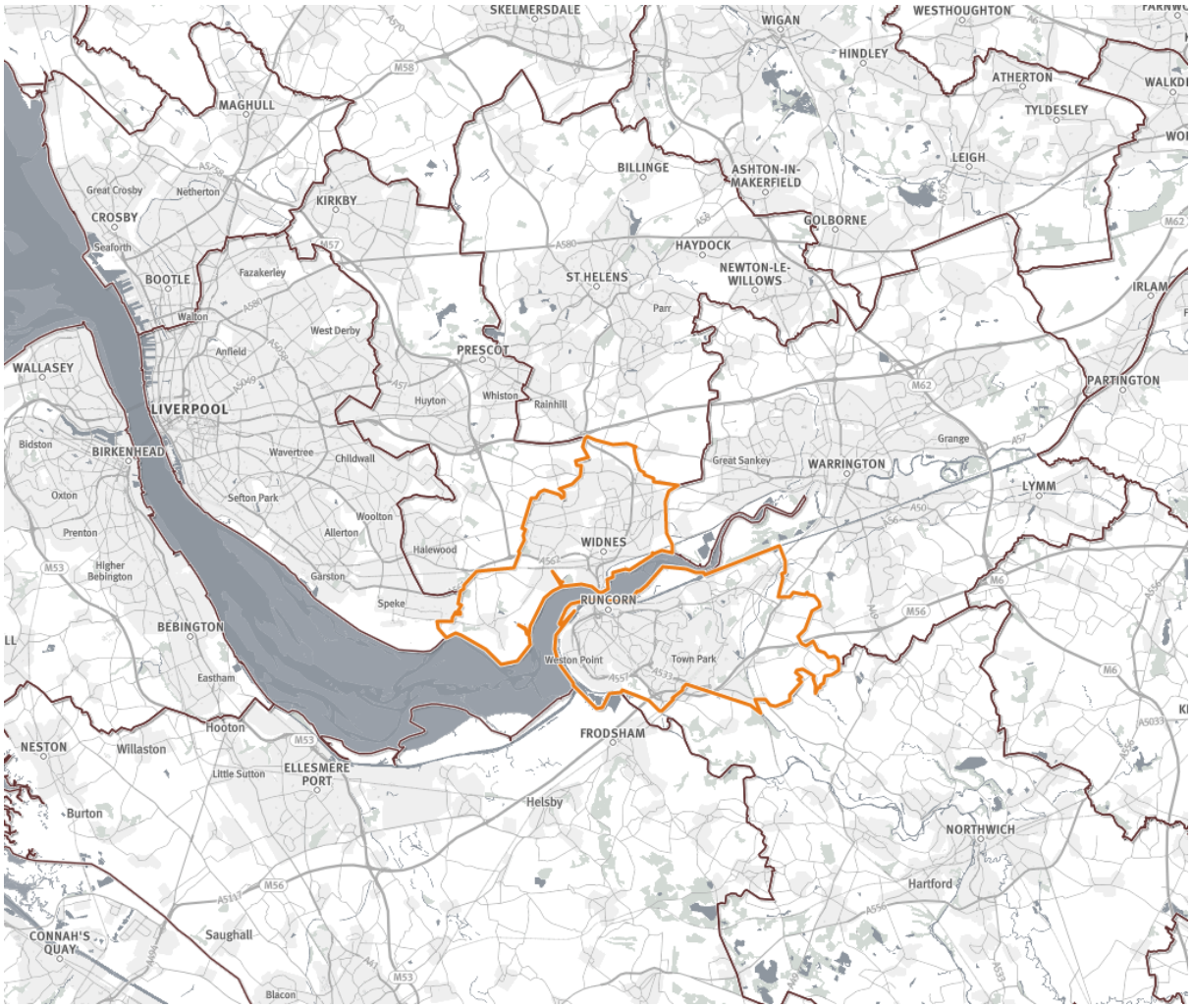
- NHS England Principles for High Quality Interpreting and Translation Services https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/it_principles.pdf
- NHS England Guidance for commissioners interpreting and translation services in primary care. https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf
- NHS England and Race Equality Foundation: Draft Scope for Community Language Information Standard: https://www.england.nhs.uk/about/equality/equality-hub/community-languages/
- DBS Guideline https://www.gov.uk/government/publications/dbs-update-service-employer-guide/dbs-update-service-employer-guide

Local Intelligence

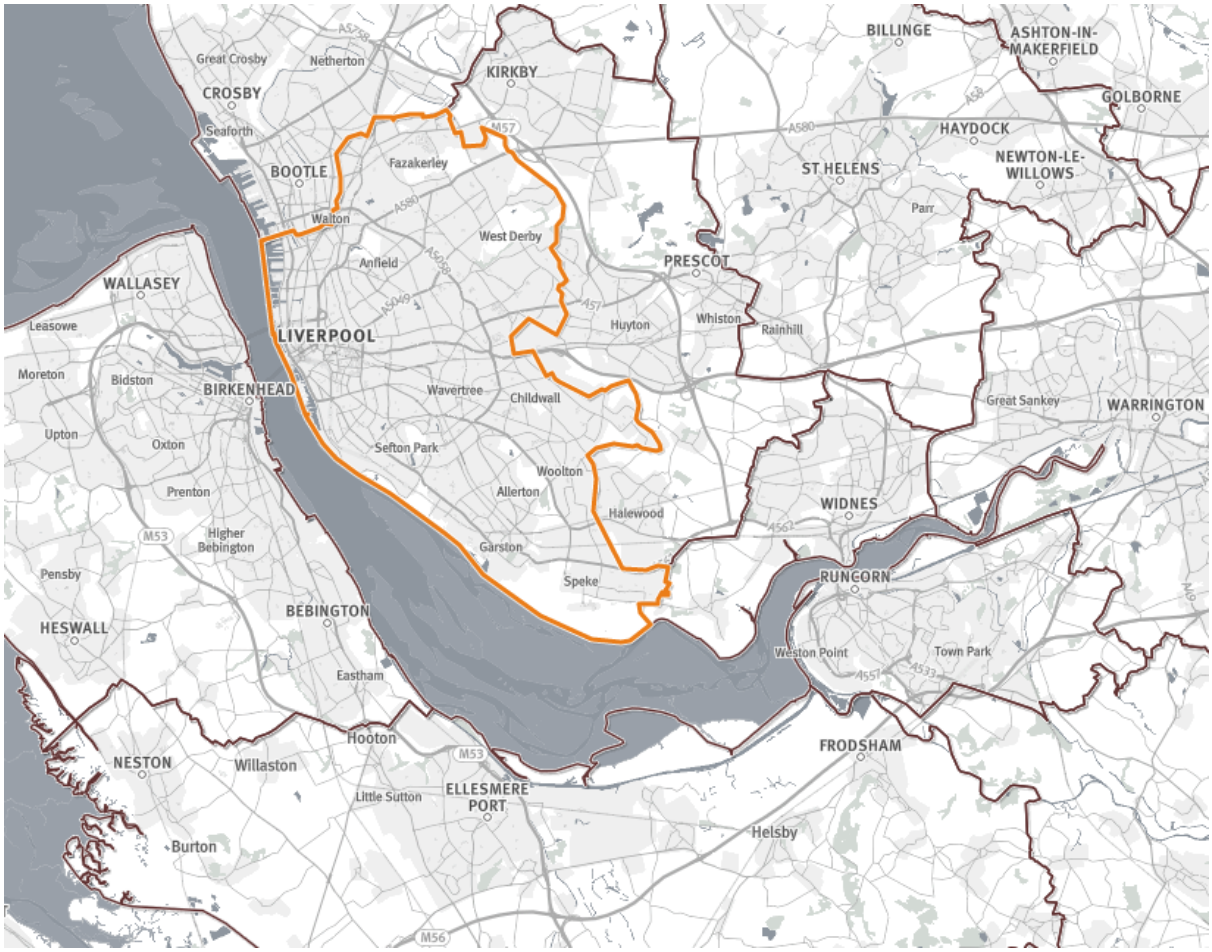
- Merseyside CCGs and Providers Equality Delivery System 2 (EDS2) Working Group: barriers matrix - accessible via CCG and Trust websites.

APPENDIX D: CCG MAPS

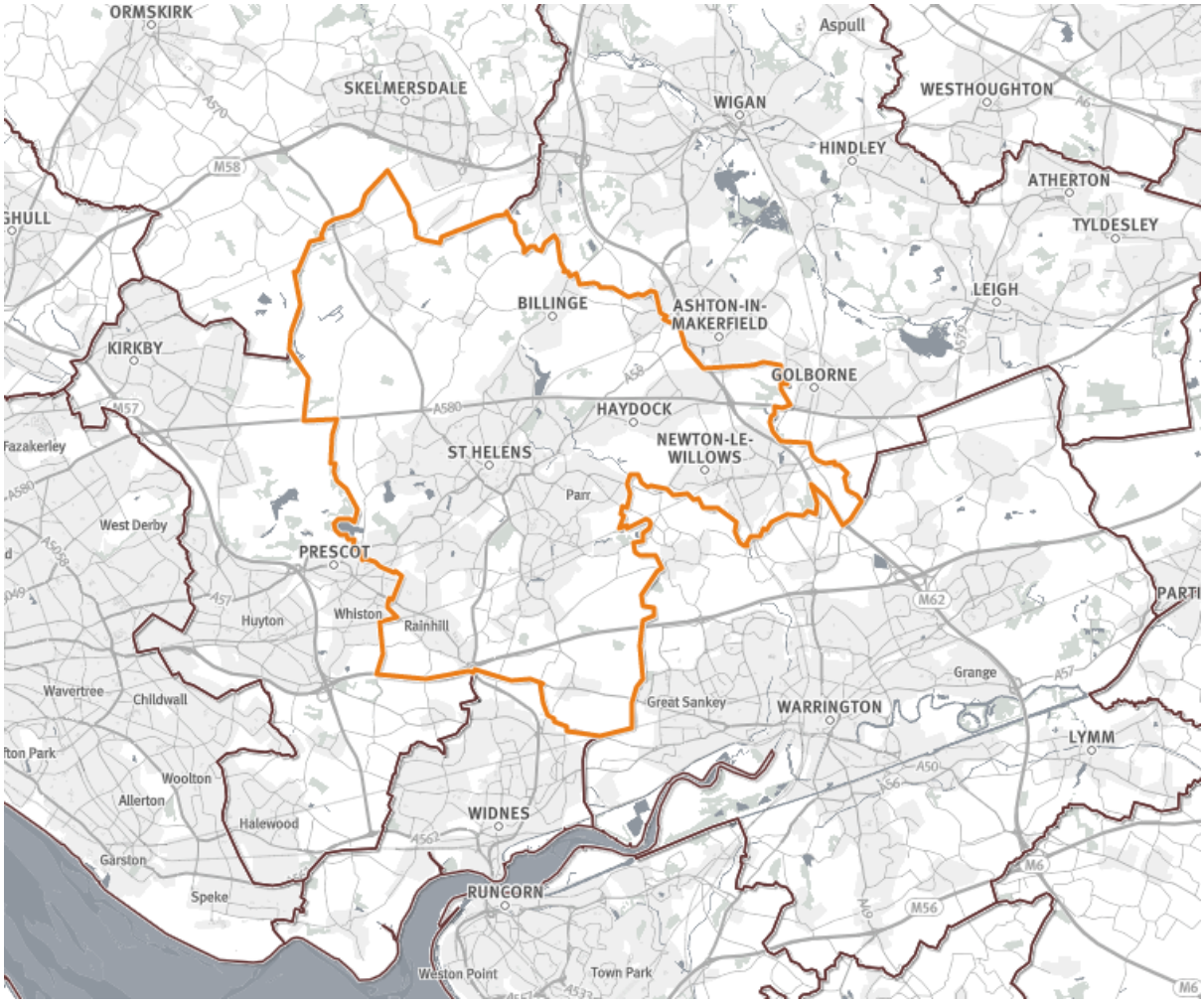
Halton CCG



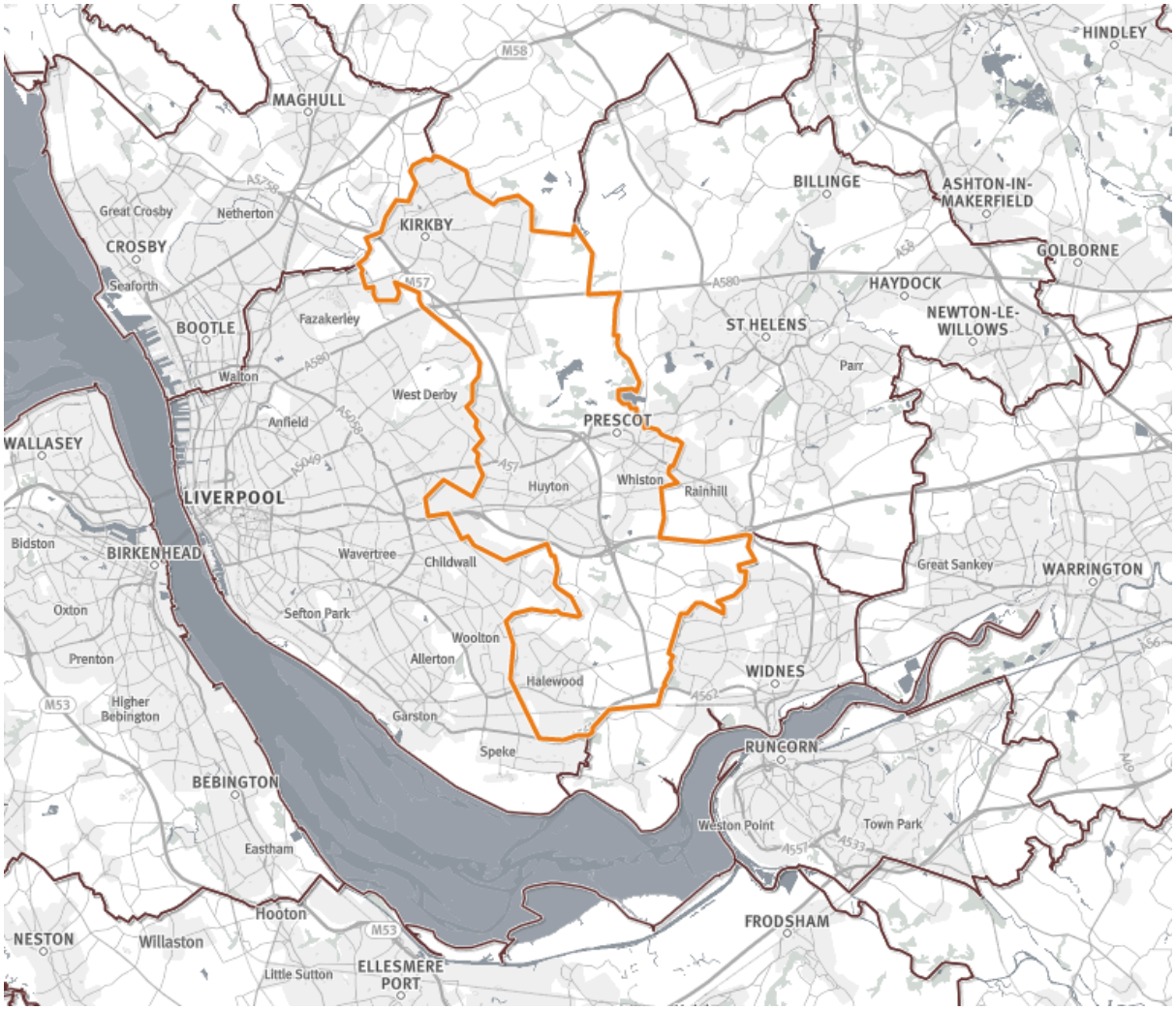
Liverpool CCG



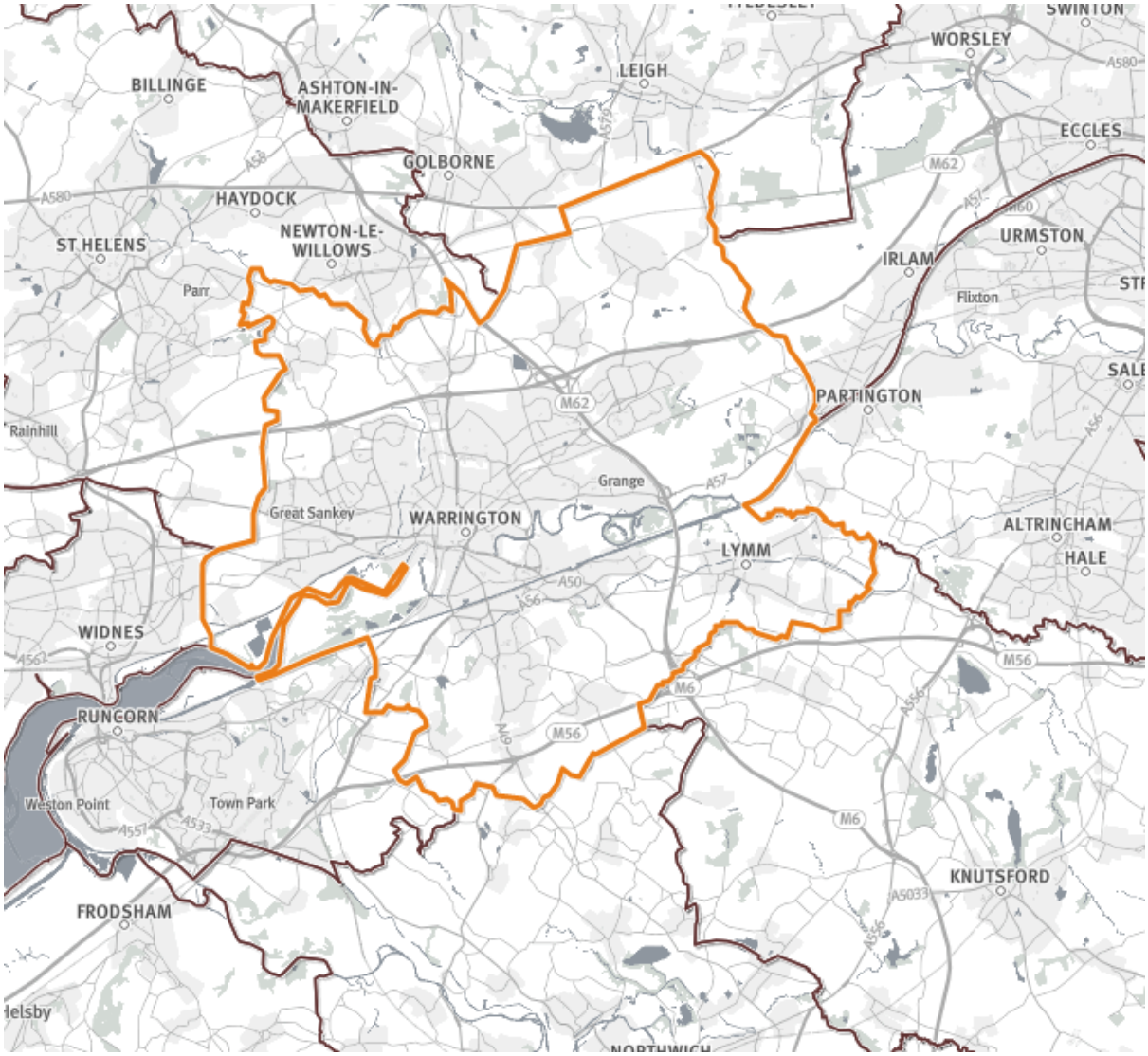
St Helens CCG



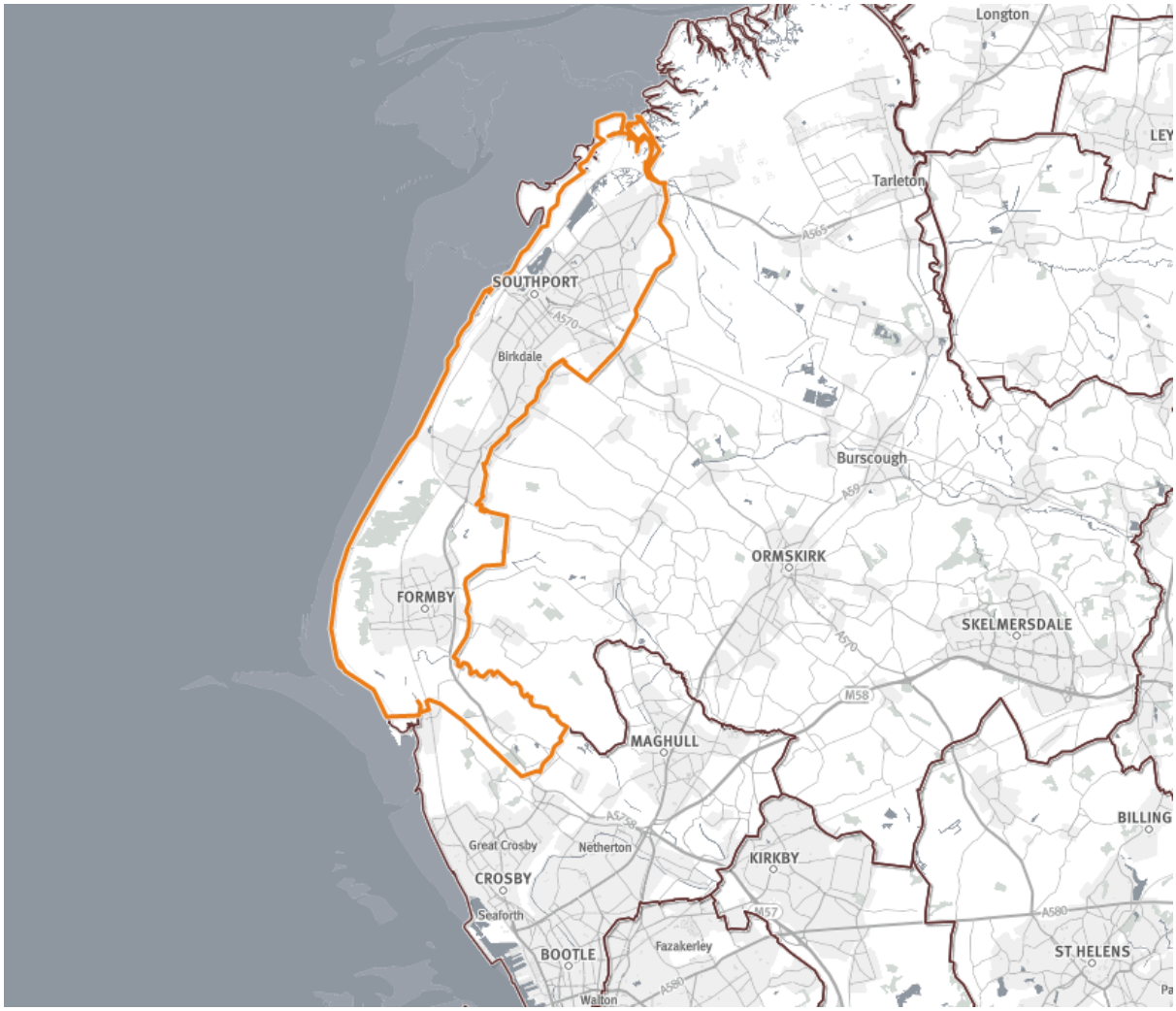
Knowsley CCG



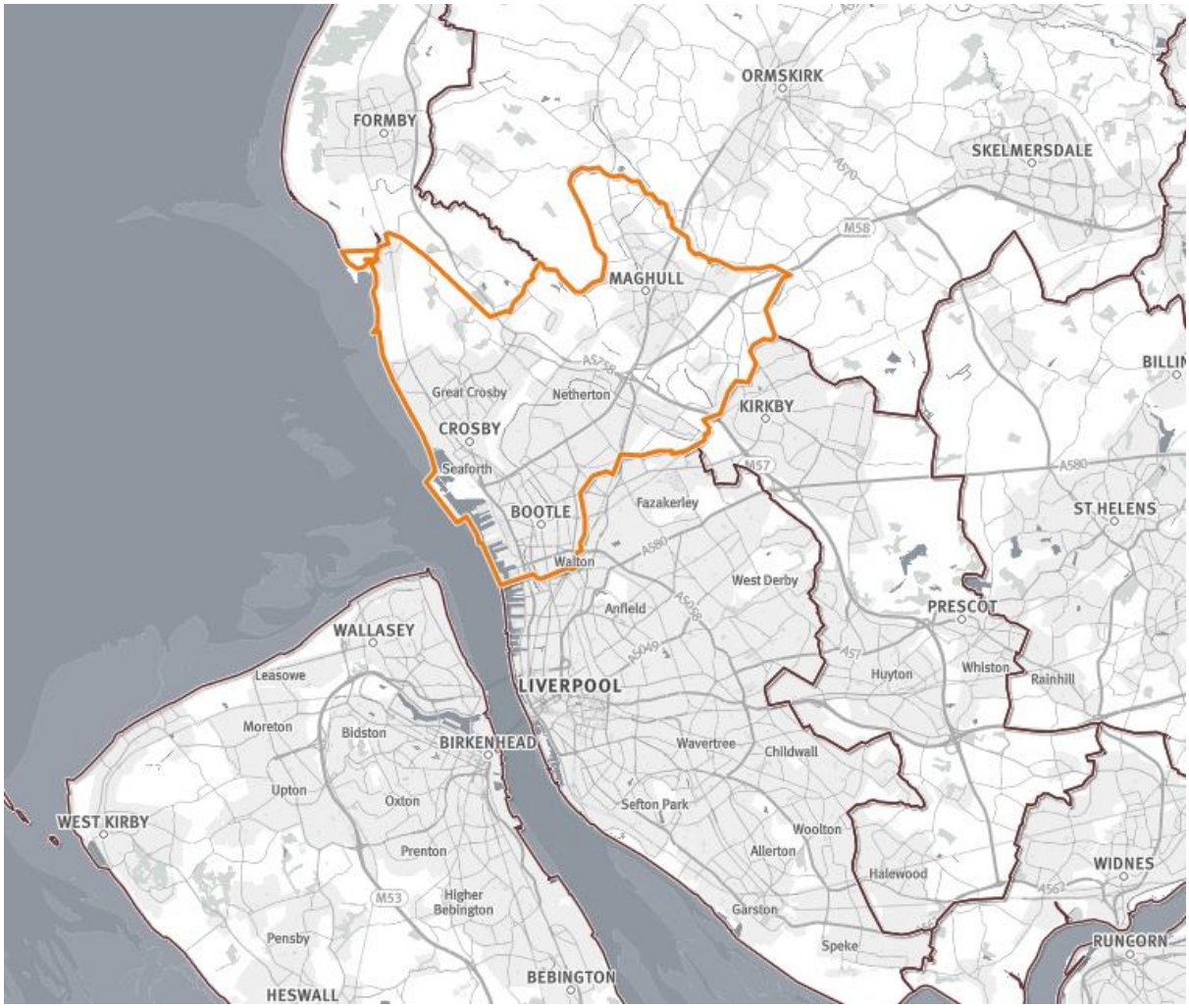
Warrington CCG



Southport & Formby CCG



South Sefton CCG



APPENDIX E

(LOGO Name of Provider) OOH Call Incident Report	
OOH Case number:	Receive Date and Time:
Patient's Full Name:	
NHS №	
Date of birth:	Gender:
Home Address:	Current Address:
Home Postcode:	Current Address Postcode:
Return Contact Tel No:	
Tel No:	
Mobile No:	
Case Priority:	Call Origin:
Received:	Call Type:
Advised:	Arrived PCC:
Cons start:	Cons End:
OOH Consulting Doctor:	Own doctor:
111 Clinical Assessment	
GP OOH Clinical Assessment	
History: Examination:	
GP OOH Consultation	
History: Examination: Diagnosis: Treatment: Prescriptions: Follow Ups: Clinical Codes:	