Meeting: Primary Care Commissioning Committee

Meeting Date	23 May 2018	**Action**	Approve
Item No.	8	**Confidential**	No
Title	Special Allocation Scheme (Zero Tolerance/Violent Patient Scheme)		
Presented By	Zoe Alderson, Head of Primary Care		
Author	Zoe Alderson, Head of Primary Care		
Clinical Lead	Jeffery Schryer, Chair of Bury CCG and Primary Care Clinical Lead		

Executive Summary

Following the recently published Primary Medical Services PMS policy book https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/ all CCGs were required to review their processes in regards to their Special Allocation Schemes (previously known as violent patient or zero tolerance schemes).

The purpose of this paper is therefore to:

a) Present the key changes between the old and the new requirements
b) Seek approval of the proposed service specification
c) Seek approval of the intended process and proposed panel
d) Seek approval to remain with the existing provider until 31st March 2019 or such time were either party wishes to change that agreement

Recommendations

It is recommended that the Primary Care Commissioning Committee:

- Note the contents of the paper
- Approve the Service Specification attached
- Approve the intended process and propose panel
- Approve the recommendation to remain with the existing provider until 31st March 2019 or such time were either party wishes to change that agreement

Links to CCG Strategic Objectives

To empower patients so that they want to, and do, take responsibility for their own healthcare. This includes prevention, self-care and navigation of the system.	☒
To deliver system wide transformation in priority areas through innovation	☐
To develop Primary Care to become excellent and high performing commissioners	☐
To work with the Local Authority to establish a single commissioning organisation	☐
To maintain and further develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning.	☐
To deliver long term financial sustainability in partnership with all stakeholders through innovative investment which will benefit the whole Bury economy.	☐
To develop the Locality Care Organisation to a level of maturity such that it can consistently deliver high quality services in line with Commissioner's intentions.	☐
Supports NHS Bury CCG Governance arrangements	☐

Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	Choose an item.
GBAF *[Insert Risk Number and Detail Here]*	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
This service focuses on providing care for patients in an appropriate environment and protects other service users/staff from potential harm.						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☒	No	☐	N/A	☐
These will not be known until a full understanding of the requirements has been mapped against current delivery model						
Has a Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is a Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
Primary Care Workstream	03/01/2018	A more detailed paper which included the findings from the internal review was presented to the Primary Care Workstream Group. It was agreed that due to the newly published guidance it would be necessary to complete further exploratory work before presenting PCCC with a proposal to consider.
PCCC	24/01/2018	A holding statement was presented to PCCC at the end of January with a view to presenting a revised proposal in May 2018

Special Allocation Scheme
(Previously known as Violent Patient or Zero Tolerance Scheme)

1. Introduction and Background

1.1 Following the recently published Primary Medical Services PMS policy book https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/ all CCGs were required to review their processes in regards to their Special Allocation Schemes (previously known as violent patient or zero tolerance schemes).

1.2 This work has now been completed and the purpose of this paper is therefore to:

a) Present the key changes between the old and the new requirements
b) Seek approval of the proposed service specification
c) Seek approval of the intended process and proposed panel
d) Seek approval to remain with the existing provider until 31st March 2019 or such time were either party wishes to change that agreement

2. Key Changes Between the Old and New Requirements

2.1 Although the requirements laid out in the draft specification provided by NHS E are considerably more detailed than current provider service agreement the actual service needs have not changed a great deal other than:

- The need to have a liaison team that would receive data on a quarterly basis and act as a point of contract for any patient disputes.
- The need for the CCG to establish and be part of a review panel that would meet every 6 months and/or following any patient disputes.
- The provider will review patients every 6 months

3. Proposed Service Specification

3.1 Attached as Appendix 1 is the proposed Service Specification for the Bury SAS.

3.2 It is intended that the reimbursement of this contract would remain as was:

Element	Cost
Retainer Fee	£8,000 per annum
Contact Fee	£80 per patient contact (maximum 2 contacts per day)
Out of Area Patients	£20 additional payment per contact

3.3 The agreement would provide service delivery for up to 20 patients, should this maximum be exceeded the provider and commissioner would review.

4. Panel and Dispute Process

4.1 As required under the new PMS policy book guidance an SAS Liaison Team and Review Panel Process will be established. This has been localised from Manchester CCGs Process and is described in Appendix 2.

5. Risks

Access – The provider has highlighted that the change in Bury Walk in Centre Hours and BARDOCs relocation to Fairfield is impacting on the ability to offer the appropriate numbers of appointments at Moorgate Primary Care Centre.

Prescribing – the provider currently uses Electronic Prescription Service (EPS) for most of the prescribing against this scheme which allocates their usual practice prescribing code rather than the dedicated code for this service. An audit of prescribing activity and cost will therefore form part of the 6 month review.

6. Recommendations

6.1 It is recommended that the Primary Care Commissioning Committee:

- Note the contents of the paper
- Approve the Service Specification attached (Appendix 1)
- Approve the intended process and proposed panel (Appendix 2)
- Approve the recommendation to remain with the existing provider until 31st March 2019 or such time were either party wishes to change that agreement

Zoe Alderson
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May 2018

SERVICE SPECIFICATION FOR THE PROVISION OF PRIMARY CARE MEDICAL SERVICES FOR THE SPECIAL ALLOCATION SCHEME

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Schedule 1

Service Specification

Part A
General Service Delivery Requirements

The Contractor shall provide GP led primary medical care services as set out in this Schedule 1, Part B to patients registered on the Special Allocation Scheme (SAS), in accordance with the requirements set out in this Schedule 1 - Part A.

1. Equity of Access

1.1 The Contractor shall:

1.1.1. not discriminate between Patients on the grounds of medical condition, age, sex, sexuality, ethnicity, disability, or any other non-medical characteristics;

1.1.2. not discriminate as per the requirements set out in the APMS contract clause 78;

1.1.3. utilise the available professional translation services currently commissioned by the Commissioner (or where this is no longer available, source own professional translation services):

i. as required for all non-English speaking Patients during all consultations;
ii. to provide appropriate translations of materials describing procedures and clinical prognosis, where it is normal procedure to provide such materials in English, for the languages most commonly spoken by Patients who are likely to use the Services; and

1.1.4. take reasonable steps to proactively deliver health promotion and disease prevention activities to all Patients including those from hard-to-reach groups. The Contractor acknowledges that a hard-to-reach group shall include but not be limited to the following:

i. those who do not understand written or spoken English;
ii. those who cannot hear or see, or have other disabilities;
iii. working single parents;
iv. asylum seekers or refugees;
v. those who have no permanent address;
vi. seasonal migrant workers and immigrants;
vii. gypsy travellers;
viii. black or minority ethnic communities;
ix. adolescents;
x. elderly;
xi. those who have mental illnesses;
xii. those who misuse alcohol or illicit drugs; and
xiii. those who are unemployed.

1.2 The Contractor acknowledges that to improve equity of access for black and minority ethnic (**"**BME**"**) Communities, it is important to collect information on ethnicity and first language due to the need to take into account culture and language in providing appropriate care packages and the need to demonstrate non-discrimination and equality of access to service provision. The Contractor shall therefore be required to record the ethnic origin and first language of all Registered Patients.

2 Patient Dignity and Respect

2.1 The Contractor shall:

2.1.1 ensure that the provision of the Services and the Practice Premises protect and preserve Patient dignity, privacy and confidentiality at all times;

2.1.2 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;

2.1.3 provide a trained chaperone who will work in accordance with the most up-to-date chaperone good practice guidance for intimate examinations (of the same gender where requested and if reasonably practicable) if requested by the patient to preserve Patient dignity and respect cultural preferences;

2.1.4 ensure that patients are aware of their right to a chaperone and how to request one; and

2.1.5 ensure that the Contractor's staff and anyone acting on behalf of the Contractor behaves professionally and with discretion towards all Patients and visitors at all times.

3 Informed Consent

3.1 The Contractor shall comply with NHS requirements in relation to obtaining informed consent from each Patient as notified to the Contractor by the Commissioner from time to time prior to commencing treatment, including the Department of Health (DH) Good Practice in Consent Implementation Guide: Consent to Examination or Treatment 2001 or any superseding guidance.

4 Safeguarding Adults at Risk and Safeguarding Children and Looked After Children

4.1 The Contractor shall:

4.1.1 Ensure they have a named professional that takes a lead and is appropriately trained in relation to adults at risk and children safeguarding as set out in Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework 2015, and in line with Working Together (2015), Care Act (2015), Children Act (1989) and Children Act (2004);

4.1.2 Have policies and procedures in place that meet the requirements set out in current guidance and legislation pertaining to Adults at Risk, Safeguarding Children and Looked After Children (LAC) as well as specific and local arrangements as prescribed by the 3 Local Safeguarding Adult Boards (LSABs) and the three Local Safeguarding Children Boards (LSCBs) of Southend, Essex and Thurrock (SET). The policies must include domestic violence, honour-based abuse, PREVENT, Modern Slavery, managing allegations against staff and the chaperoning of children, young people and adults at risk. Policies must comply with legislation that underpins safeguarding adults at risk, e.g. Mental Capacity Act (MCA) 2005, Deprivation of Liberty (DoLS);

4.1.3 Contribute to serious case reviews (SCRs), Safeguarding Adult Reviews (SARs), domestic homicide reviews (DHRs) and multi-agency case reviews as requested by the SET LSABs and SET LSCBs and Child Death Review Process, including provision of information to the Child Death Overview Panel (CDOP) and the rapid response team when a child dies unexpectedly. The Contractor is expected to have a safeguarding lead within the organisation. The Contractor will actively seek and accept support from the named professional leads for safeguarding within the CCG;

4.1.4 Ensure that records are retained of incidents relating to allegations made against staff working with children, young people and adults at risk. This will include details of referrals/discussions with the Local Authority Designated Officer (LADO) and outcome of the allegation;

4.1.5 Use appropriate SET LSAB/SET LSCB/local authority endorsed systems to make safeguarding referrals and ensure that such information is appropriately flagged within the health care record; and

4.1.6 Ensure that all staff have access to training and development in relation to all aspects of safeguarding children (including Looked After Children) and adults at risk, including PREVENT, MCA and DoLS and will ensure that in-house training packages/resources used are in line with professional body recommendations, requirements of the SET LSABs, additionally for children as per Working Together to Safeguard Children 2015 and the Intercollegiate Document (Safeguarding Children: Roles and Competences for Health Care Staff 2014; Looked After Children, knowledge, skills and competencies of healthcare staff 2015).

5 Prescribing

5.1 Without prejudice to Clause 29 of this Contract (which shall prevail in case of conflict or ambiguity with this Section 5), the Contractor shall prescribe the most clinically safe and cost effective medicines in accordance with national and local guidance from time to time including:

5.1.1 National Institute for Health and Care Excellence (NICE) guidance and DH directives relating to prescribing;

5.1.2 Good Prescribing Practice as defined by the latest edition of the British National Formulary (BNF);

5.1.3 Shared care protocols agreed between the Commissioner and other secondary care NHS Contractors;

5.1.4 Patient Group Directions, such as emergency contraception and antibiotics; and

5.1.5 Meet all requirements of the prescribing or medicines optimisation work plan agreed with the CCG.

6 Clinical Safety and Medical Emergencies

6.1 The Contractor shall:

6.1.1 ensure that all Contractor Staff have and maintain basic life support certification with competence in defibrillation and ensure that all the Contractor's staff comply with the UK Resuscitation Council guidelines on Basic Life Support and the Use of Automated External Defibrillators;

6.1.2 ensure the availability of sufficient numbers of the Contractor's staff with appropriate skill, training and competency and who are able and available to recognise, diagnose, treat and manage Patients with urgent conditions at all times Core Hours and Additional Hours (where applicable);

6.1.3 possess the equipment (which is routinely assessed) and in-date emergency drugs including oxygen to treat life-threatening conditions such as anaphylaxis, meningococcal disease, suspected myocardial infarction, status asthmaticus and status epilepticus;

6.1.4 pass all life threatening conditions to the ambulance service as soon as practicable by dialling 999 and requesting the ambulance service; and

6.1.5 adhere to any national or local guidelines relating to clinical safety and medical emergencies in primary care as amended from time to time.

7 Good Clinical Practice

7.1 Without prejudice to Clause 50 of this Contract, the Contractor shall perform the Services in accordance with the following requirements as amended from time to time:

7.1.1 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009 (Part 4) including the Care Quality Commission's Fundamental Standards;

7.1.2 the "excellent GP" according to Good Medical Practice for General Practitioners (RCGP 2008);

7.1.3 any relevant MHRA guidance, technical standards, and alert notices;

7.1.4 the highest level of clinical standards that can be derived from the standards and regulations referred to in this Section 7.1 of Part A of this Schedule 1; and

7.1.5 the General Medical Council guidance on Good Medical Practice (2013).

7.2 The Contractor shall ensure that clinical meetings are convened for all clinicians working in the Practice a minimum of once each calendar month.

8 Equipment

8.1 The Contractor shall provide all medical and surgical equipment, medical supplies including medicines, drugs, instruments, Appliances, and materials necessary for the delivery of services under this Agreement; which shall be adequate, functional and effective.

8.2 The Contractor shall establish and maintain a planned maintenance programme for the equipment referred to in paragraph 8.1 above in line with the manufacturer's guidance, and make adequate contingency arrangements for emergency replacement or remedial maintenance.

9 Infection Control and Prevention

9.1 Without prejudice to clause 12 of this Contract, the Contractor shall have in place arrangements that meet criterions within the Health and Social Care Act (2008), Code of practice for the control and prevention of infection and associated guidance and the standards outlined in the NICE guidelines on infection control "Prevention of healthcare associated infections in primary and community care (March 2012)", to maintain a safe, hygienic and pleasant environment at the Practice Premises, and the NHS England Standard Operating Procedure Infection Prevention and Control Audit requirements (or any new/revised requirements/legislation), and shall:

9.1.1 use only disposable medical supplies including instruments and materials;

9.1.2 ensure adequate provision is made for hand washing and disinfection in all clinical areas and that appropriate guidance is clearly displayed;

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

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

9.1.5 follow appropriate guidelines to the management of hospital; acquired infections;

9.1.6 conduct regular (annual as a minimum) infection control audits where appropriate; and

9.1.7 ensure an Infection Control Policy is in place, available to all staff and annually reviewed.

9.1.8 ensure that a named Infection Control Lead is identified.

10 Referrals

10.1 The Contractor shall:

10.1.1 ensure that all staff act in the patient's best interests when making referrals;

10.1.2 ensure that, whenever possible, referrals are made via the NHS e-Referrals Service;

10.1.3 record all referrals in the patient record using the appropriate SNOMED clinical terms;

10.1.4 ensure that any healthcare professional to whom Clinical Staff refer a Patient is accountable to a statutory regulatory body or is employed within a managed environment, and where this is not the case the transfer of care is to be regarded as a delegation (and not a referral) and the Contractor shall remain responsible for the overall management of the Patient and shall be accountable for the decision to delegate;

10.1.5 monitor secondary care activity relating to registered patients and minimise inappropriate referrals, A&E attendances and hospital admissions in line with the relevant CCG(s) annually agreed priorities and Practice specific work plan;

10.1.6 co-operate with service contractors carrying out Out of Hours Services to ensure safe and seamless care for Patients;

10.1.7 provide complete and comprehensive information to support any Referral made and comply with, where appropriate, any directions provided by the relevant CCG(s) concerning the format or composition of Referrals including, where relevant, instruction to direct Referrals to a third party for clinic booking and/or clinical triage;

10.1.8 use robust clinical pathways for referral, where these are agreed with other local healthcare Contractors and/or issued by the relevant CCG;

10.1.9 implement local and national referral advice including Referral Guidelines for Suspected Cancer and NICE guidance;

10.1.10 ensure urgent suspected cancer Referrals are sent electronically and received by the relevant trust within twenty-four (24) hours; and

10.1.11 review access and care for patients who are using out of hours services rather than core services.

11 Co-operation with Other NHS Contractors

11.1 The Contractor will provide an integrated and fully supported primary health care team to work in partnership with all other NHS and non-NHS healthcare contractors and stakeholders (including, but not limited to, CCGs, health visitors, district nurses, social services, mental health services, acute trusts and acute trust laboratories, community health Contractors, other GP practices and healthcare Contractors and local voluntary and third sector organisations). This will include participating in any local collaborative models of working.

11.2 The Contractor shall:

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

11.2.2 sign up to multi-agency information sharing agreements as agreed with the Commissioner; and

11.2.3 have a policy in place for information sharing relating to safeguarding.

12 Clinical Governance and Quality Assurance

12.1 The Contractor shall:

12.1.1 have medical leadership in place in order to operate an effective, comprehensive, system of Clinical Governance with clear channels of accountability, supervision and reporting, and effective systems to reduce the risk of clinical system failure;

12.1.2 continuously monitor and report on clinical performance and evaluate Serious Incidents, significant events, near misses and complaints. The Contractor must ensure that records and reports are available to the Commissioner on request;

12.1.3 use appropriate formal methods such as root cause analysis for Serious Incidents, significant events, near misses and complaints;

12.1.4 have in place a system for collecting data on Serious Incidents, significant events, near misses and complaints in a systematic and detailed manner to ascertain any lessons learnt about the quality of care and to indicate changes that might lead to future improvements. Furthermore, the Contractor shall have in place a system for adopting such changes into practice and processes going forward;

12.1.5 receive and respond to relevant CAS (central alert system) Patient Safety Alerts and messages. The central alert system is a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations;

12.1.6 ensure contractual compliance against the Information Governance Toolkit and any future returns requested by the Commissioner, implementing suitable action plans until all standards are achieved;

12.1.7 operate robust auditing of clinical care against clinical standards and in line with CQC Fundamental standards;

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

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

12.1.10 provide the Commissioner with a service improvement plan where appropriate; and

12.1.11 participate in all quality and clinical governance initiatives agreed with the Commissioner and the CCG where appropriate.

13 Contractor Workforce: Recruitment and Competence

13.1 The Contractor must have a comprehensive, robust plan for recruitment, selection and employment procedures in place that are compliant with employment legislation and European directives.

13.2 The principle objectives of the Contractor must:

13.2.1 Reflect the local community and range of languages spoken to support access to services;

13.2.2 Meet the essential day-to-day staff leadership, management and supervisory needs of the contract during its lifetime, including during mobilisation and, if appropriate, contract termination;

13.2.3 Support the provision of safe, high quality clinical services;

13.2.4 Aim to provide continuity of care for patients and minimise use of locum staff;

13.2.5 Ensure that every member of the staff has a job description and appropriate contracts of employment setting out their terms and conditions, and roles and obligations as well as their rights;

13.2.6 Ensure that, where appropriate any transference of employees to its employment must comply with TUPE regulations;

13.3 The Contractor must specify arrangements to ensure that all mandatory pre-employment checks are implemented for all staff working in the organisation, including ensuring compliance with Disclosure and Barring Service (DBS) requirements for all staff before they start employment.

13.4 The Contractor shall not employ or engage a health care professional to perform services under this contract unless:

i. a minimum of two written clinical references have been received relating to two recent posts, covering a minimum of three years
ii. the received references have been checked, validated and are satisfactory

13.5 Where the employment or engagement of a medical or health care professional is urgently needed and it is not possible to obtain and check the references in accordance with clause 13.4 before employing or engaging the person, the person may be employed or engaged

on a temporary basis for a single period of up to 14 days whilst references are checked and considered, and for an additional single period of a further 7 days if the Contractor believes the person supplying those references is ill, on holiday or otherwise temporarily unavailable.

13.6 Where the Contractor employs or engages the same person on more than one occasion within a period of three months, they may rely on the references provided on the first occasion, provided that those references are not more than twelve months old.

13.7 If a Contractor uses a third party to assist with recruitment and recruitment checks, the Contractor is responsible for ensuring the relevant checks have been undertaken and documentary evidence of this is available on request by the Commissioner.

13.8 Ensure, through appropriate audit, training and continuous professional development, that all staff involved in treating patients are and remain qualified and competent to do so.

13.9 Support the implementation of all relevant statutory and non-statutory NHS standards, regulations, guidelines and codes of practice.

13.10 Ensure there are systems in place to monitor that clinicians do not work excessive shifts or hours to the detriment of patient safety and their own welfare.

13.11 The Contractor should provide details of their staffing structure highlighting the persons that are to have responsibility for the operation of the contract.

13.12 The Contractor should provide details of the management structure and the escalation procedures for resolving problems. Also how during periods of annual leave, sickness, industrial dispute or any other absence the service will be delivered.

13.13 The Contractor must ensure:

13.13.1 All Clinical Staff are registered with all appropriate regulatory bodies;

13.13.2 All medical provider staff performing specialist procedures, are suitably qualified, competent and experienced and are registered in the GMC Specialist Register in respect of the specialty in which they perform specialist procedures.

13.13.3 All GPs:

i. Are registered with the GMC and on the GMC GP register.
ii. Hold appropriate certificates confirming their eligibility to work in general practice in the UK including current membership on the Medical Performers List;
iii. Are fully licensed to practice; and
iv. Have undergone a revalidation process as appropriate.

13.13.4 All Nursing Staff are:

i. Registered on the Nursing and Midwifery Council and, if they are to prescribe drugs and/or medicine, that the corresponding entry in the register indictes that they hold a prescribing qualification; and
ii. Subject to robust procedures for re-registering and monitoring subsequent re-registration for Health Care Professionals as appropriate.
iii. Subject to revalidation.

14 Risk Management

14.1 The Contractor shall:

14.1.1 Operate mechanisms for assessing and managing clinical and general business risk including the maintenance of a suitable risk register that is reviewed, as a minimum by the Contractor on a monthly basis;

14.1.2 Prepare disaster recovery, contingency and business continuity plans that should be available for inspection by the Commissioner at any time;

14.1.3 Keep the Commissioner fully informed about any significant risks that have been identified that could impact on the performance of the contract;

14.1.4 Notify the Commissioner of the person responsible for risk management within the Contractor's organisation.

Service Specification

Part B

Services

1. Scope of Services

1.1 The Contractor shall deliver primary medical services (Essential and Additional) to Patients who have been removed from general practice due to exhibiting violent or aggressive behaviour and are registered with the Special Allocation Scheme (SAS).

1.2 The Contractor shall provide support for rehabilitation of Registered Patients in order to address the underlying causes of violent or aggressive behaviour and encourage and support facilitation of return to general practice.

2. Access To Services

2.1 Core Hours

2.1.1 The Service shall be contactable by telephone during Core Hours, as defined below (excluding Bank Holidays):

Monday	Tuesday	Wednesday	Thursday	Friday
8am 6.30pm	8am 6.30pm	8am 6.30pm	8am 6.30pm	8am 6.30pm

2.1.2 The Services may be offered during Core Hours, or Out of Hours if preferred, equating to a minimum of one session per week (three hours).

2.1.3 The Services must be offered flexibly throughout Core Hours, or Out of Hours if preferred.

2.1.4 The Service hours must be determined by and meet Patient need.

2.1.5 The Contractor shall not be required to provide Out of Hours Services.

2.2 Provision of Reception Services

2.2.1 The Contractor must provide a call handling service throughout Core Hours. Call handling services will include but not be limited to:

i. Answering the telephone by a staff member;
ii. Booking appointments;
iii. Answering and co-ordinating Patient queries and requests;
iv. Signposting Patients to services, including appropriate third sector organisations; and
v. Prescription services.

2.2.2 In the instance of this contract this will be via BARDOC our Out of Hours Contractor.

2.3 Appointments

2.3.1 The Contractor shall offer a full range of consultation methods according to clinical need and patient preference including, but not limited to, telephone, e-mail, video consultation and face-to-face consultation.

2.3.2 The Contractor shall explore opportunities to improve access to Services through the use of technology, including but not limited to, telephone consultations, video consultations, mobile apps and expanding online booking.

2.3.3 The Contractor shall ensure that it has measures in place to minimise the number of Patients who do not attend booked appointments (DNAs).

2.3.4 Telephone triage must be undertaken by a GP or appropriately qualified Advanced Nurse Practitioner.

2.4 Booking an Appointment

2.4.1 The Contractor shall ensure that upon contacting the Service during Core Hours by telephone;

2.4.1.1 Patients should normally be required to only make one call in order to make an appointment and not be asked to call back;

2.4.1.2 Patients are able to book a routine appointment with a GP within forty-eight (48) hours of contacting the Service;

2.4.1.3 Patients are able to book a telephone consultation with a GP within twenty-four (24) hours of contacting the Service;

2.4.1.4 Patients are able to book an appointment with the GP or other appropriate Health Care Professional of their choice at the Service Premises up to and including four (4) weeks in advance;

2.4.1.5 Patients are able to speak with a GP on the same day of contacting the Service if they consider the need is urgent; and will be offered an urgent appointment within 24 hours if clinically justified following triage.

2.4.1.6 The Contractor shall issue passwords and verify the identity of registered patients wishing to access the Contractor's online services.

2.5 Availability of Appointments

2.5.1 The Contractor shall undertake continuous assessment of its appointment system and access, monitoring demand and supply and taking action to address gaps in provision.

2.6 Length of Appointments

2.6.1 Appointment length shall be tailored to the clinical needs of the patient.

2.7 Punctuality of Appointments

2.7.1 Consultations shall aim to commence within ten (10) minutes of the scheduled appointment time unless there are exceptional circumstances. This is to reduce anxiety for the patient.

2.7.2 Treatment for patients suffering from immediate and life threatening conditions (as determined by a clinically trained individual acting reasonably) shall commence immediately as necessary.

2.8 Home Visits

2.8.1 The Contractor shall not conduct home visits, unless in exceptional circumstances and in agreement with the Commissioner.

3. Patient Registration

3.1 The Contractor shall:

3.1.1 Deliver Services to all patients referred by Practices in the borough of Bury, including any existing patients;

3.1.2 Receive and assess patient information from the Referring Practice and be responsible for notifying the Commissioner of any referrals which do not meet GMS Regulations and the referral criteria detailed in Annex 3;

3.1.3 Ensure that the incident has been reported to the police. A police incident number is not mandatory, however the Referring Practice must be able to provide details of the date, time and mechanism (i.e. 999, 111, local number) via which the incident was reported to the police;

3.1.4 Provide all patients with clear information (in a method appropriate to the patient) about the Service, including the limitations and timescales for review (see Annex 6 for a template letter);

3.1.5 Require the patient to complete a registration form, which includes patient consent for data sharing with other appropriate organisations;

3.1.6 Inform relevant local health services including but not limited to 111, Accident and Emergency, and local GP practices of new Patient Registration to the Service; and

3.1.7 Securely hold SAS patient details and notes on a register that is maintained independently of any main Patient register (if the Contractor already holds a GMS/APMS list).

3.2 Patient engagement/ rehabilitation

3.2.1 The Contractor shall encourage patients to engage with the Services;

3.2.2 Undertake an initial assessment of the patient at first appointment and develop a care plan as required;

3.2.3 Engage with patients to provide a holistic service to address the underlying causes of violent/ aggressive behaviour and return to general practice as soon as is practicable;

3.2.4 As appropriate, work with or refer to other specialist services, such as substance misuse or mental health services; and

3.2.5 Promote an understanding of the NHS health service to encourage patients to use services in a responsible, safe and appropriate way in the future.

3.2.6 Patients shall be deemed ‘active’ if they attend the Service on one or more occasion in a year. Patients shall be deemed ‘inactive’ if they do not engage or attend the Service for 1 year or more.

3.2.7 For registration, performance monitoring and payment purposes these patients must be recorded and remain on the register as ‘inactive’.

3.2.8 The Contractor must attempt to contact the patient on at least three separate occasions using varying communication methods (letter, telephone call, email) per year of registration.

3.3 Prison or long-term hospital stay

3.3.1 Where a patient has been sent to prison or admitted for a long-term hospital stay the Patient must stay on the SAS but have their registration suspended and be recorded as 'inactive' (for registration, performance monitoring and payment purposes).

3.3.2 A flag must be added to the Patient notes to highlight their registration with the Service.

3.3.3 Once a patient is released from prison or long-term hospital stay the Patient's registration with the Service shall change from 'inactive' to active.

3.3.4 The Contractor shall invite the Patient for an immediate review to determine if registration is appropriate.

3.4 Out-of-area referrals

3.4.1 On an exceptional basis, the Contractor shall accept referrals from other Essex SAS Services on the grounds of patient choice only.

3.4.2 The Contractor must inform the Commissioner if an out-of-area referral has been made from another Essex SAS Service or if the Contractor wishes to refer to another Essex SAS Service.

3.4.3 The reason for the referral must be recorded.

3.4.4 A financial re-numeration will be attached to out-of-area referrals.

4. Safe Delivery of Services

4.1 The Contractor shall:

4.1.1 Complete a thorough risk assessment for each Registered Patient to determine the level of security and safety measures required;

4.1.2 Ensure appropriate safety measures are in place to protect staff, patients and visitors from untoward incidents;

4.1.3 Ensure staff undertake specific training in risk assessment, personal safety and dealing with challenging behaviour/ conflict resolution;

4.1.4 When required, employ professional security guards to be present on the premises, be present within the consulting room (not anticipated to be routinely), or escorting the patient on/off the premises;

4.1.5 Ensure patient confidentiality is maintained at all times, particularly in respect to the employment of security guards, who should be subject to a confidentiality agreement;

4.1.6 Give consideration to the layout of the waiting and consultation rooms, access to the premises, and security cameras within the premises.

5. Prescribing

5.1 On registration to the SAS, the Contractor shall request the Registered Patient to nominate a pharmacy from which they will access pharmaceutical services.

5.2 The Contractor shall advise the Registered Patient that they should only use the agreed pharmacy and have agreed expectations of behaviour.

5.3 When a prescription is issued, the Contractor shall contact the nominated pharmacy to ensure the necessary medication is in stock and processed for when the Registered Patient collects it.

6. Patient Discharge

6.1 The Contractor shall:

6.1.1 Invite patients for review a minimum six monthly basis and complete a discharge form to determine whether they can return to general practice;

6.1.2 Invite patients for interim reviews as deemed necessary and beneficial for the patient;

6.1.3 Be responsible for identifying the need for and actively participating in Exceptional Discharge Panels (EDP) (see Annex 5) to review active patients that have been on the scheme for more than two years. Panel members may include the Commissioner, relevant CCG(s), mental health services, police and social services;

6.1.4 Facilitate patients registering with a new general practice. The Contractor shall work with Primary Care Support England and the Commissioner to ensure patients can be discharged within three months of a positive review;

6.1.5 Provide a comprehensive handover to the receiving Practice, including but not limited to:

6.1.5.1 ensuring patients have sufficient medication as required, normally 3-4 weeks' supply, but less if appropriate for clinical or risk reasons.

6.1.5.2 ensuring the receiving practice is aware of any referrals in progress or follow up required by the new GP; and

6.1.6 After three months patients who have not registered with another practice should be discharged via a deduction down the link process. The Contractor must ensure a note is placed on the patient's file to notify any new provider of the patient's registration with the SAS.

6.2 In exceptional circumstances it may be appropriate to discharge a patient on the grounds of the Service no longer meeting the needs of the patient. The Contractor must notify the Commissioner and the decision to return to general practice will be made by the EDP (see Annex 5).

6.3 If a patient moves out of the area and registers with another GP, the Contractor shall notify the new provider of the patient's registration with the SAS.

7. Location of Services

7.1 It is the responsibility of the Contractor to secure and fund appropriate and safe location(s) from which to deliver the Services.

7.2 The location shall be;

7.2.1 Suitable for the delivery of primary medical services;

7.2.2 Appropriately registered with the Care Quality Commission (CQC);

7.2.3 Safe for staff, Registered Patients and other patients;

7.2.4 Accessible for Registered Patients within the Bury area; and

7.2.5 A stable environment which actively reduces anxiety for Registered Patients.

8. Essential Services

8.1 The Contractor shall provide Essential Services at such times, within Core Hours, as are appropriate to meet the reasonable needs of Registered Patients.

8.2 The Contractor shall have in place arrangements for Patients to access such services throughout the Core Hours if clinically urgent.

8.3 The Contractor shall provide:

8.3.1 Essential Services required for the management of Patients who are, or believe themselves to be:

i. ill with conditions from which recovery is generally expected;
ii. terminally ill; or
iii. suffering from a long term condition.

8.3.2 Essential Services that are delivered in the manner determined by the Contractor following discussion with the Registered Patient; and

8.3.3 Appropriate ongoing treatment and care to all Registered Patients taking account of their specific needs including:

i. advice in connection with the Registered Patient's health, including relevant health promotion advice
ii. the referral of the Registered Patient for other services under the Act; and
iii. primary medical care services required in Core Hours for the immediately necessary treatment of any person to whom the Contractor has been requested to provide treatment owing to an accident or emergency at any place in the Practice Registration Area.

8.4 For the purposes of the above section, "management" includes:

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

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

9. Additional Services

9.1 The Contractor shall provide Additional Services as defined in the GMS Contracts Regulations as amended from time to time.

9.2 The Contractor shall provide Additional Services at such times, within Core Hours, as are appropriate to meet the reasonable needs of Registered Patients.

9.3 The Contractor shall provide such facilities and equipment as are necessary to enable it properly to perform each Additional Service that it provides.

9.4 The Additional Services the Contractor shall provide to Registered Patients are:

i. Vaccinations and Immunisations;
ii. Contraceptive Services;
iii. Maternity Medical Services (excluding intra-partum care);
iv. Cervical Screening Services; and
v. Minor Surgery

9.5 Vaccinations and Immunisations

9.5.1 The Contractor shall:

9.5.1.1 offer to provide to Registered Patients all clinically necessary vaccinations and immunisations, in accordance with the national immunisation schedule and "Immunisation Against Infectious Disease 2005: "The Green Book" (online, as periodically amended;

9.5.1.2 provide appropriate information and advice to Registered Patients and, where appropriate, their Parents about such vaccinations and immunisations;

9.5.1.3 record in the Registered Patient's record any refusal of the offer of all clinically necessary vaccinations and immunisations; and

9.5.1.4 record all vaccinations and immunisations given by other healthcare providers in the Registered Patient's record.

9.5.2 Where the offer referred to above is accepted, the Contractor shall administer the vaccinations and immunisations, and include in the Patient's record details of:

i. the Patient's consent to the vaccination or immunisation or the name of the person who gave consent to the vaccination or immunisation and their relationship to the Patient;
ii. the batch numbers, expiry date and title of the vaccine;
iii. the date of administration;
iv. in a case where two or more vaccines are administered in close succession, the route of administration and the injection site of each vaccine;
v. any contraindications to the vaccination or immunisation; and
vi. any adverse reactions to the vaccination or immunisation.

9.5.1 The Contractor shall ensure that all staff involved in administering vaccines have any necessary experience, skills and training with regard to the administration of the vaccine and are trained in the recognition and initial treatment of anaphylaxis and any adverse reactions to the vaccination or immunisation.

9.5.2 The Contractor must provide the Commissioner with such information as it may reasonably request for the purposes of monitoring the Contractor's performance. The Contractor must;

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

9.5.3 The Contractor shall ensure that a policy is in place and accessible to all staff members that incorporates the necessary requirements in section 7.5.

9.6 Contraceptive Services

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

9.6.1.1 advice about the full range of contraceptive methods;

9.6.1.2 where appropriate, the medical examination of Registered Patients seeking such advice;

9.6.1.3 the treatment of Registered Patients for contraceptive purposes and the prescribing of contraceptive substances and appliances;

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

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

9.6.1.6 initial advice about sexual health promotion and sexually transmitted infections;

9.6.1.7 the referral as necessary for specialist sexual health services, including tests for sexually transmitted infections.

9.6.1.8 in addition to the specific requirements of the GMS Contract Regulations the Contractor shall co-operate with the Commissioner, CCG and/or relevant Local Authority and implement any reasonable initiative that reduces teenage conceptions.

9.7 Maternity Medical Services

9.7.1 The Contractor shall:

9.7.1.1 provide (and or ensure) that Registered Patients who are pregnant, are receiving all necessary Maternity Medical Services throughout the antenatal period;

9.7.1.2 provide referrals to the Smoking Cessation Service for Registered Patients who are pregnant and who smoke, or any other relevant health promotion programmes;

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

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

9.7.2 In this section:

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

ii. “Maternity Medical Services” means:

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

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

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

9.8 Cervical Screening Services

9.8.1 The Contractor shall:

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

9.8.1.2 perform cervical screening tests on women who have agreed to participate in that Programme;

9.8.1.3 arrange for women to be informed of the results of the test;

9.8.1.4 ensure that test samples are sent off promptly and test results are followed up appropriately;

9.8.1.5 ensure the records referred are an accurate record of the carrying out of a cervical screening test, the result of the test and any clinical follow up requirements;

9.8.1.6 ensure all sample taking staff are appropriately trained; and

9.8.1.7 participate in any audits relating to cervical screening as determined by the Commissioner.

9.9 Minor Surgery

9.9.1 The Contractor shall make available to Registered Patients where appropriate:

9.9.1.1 curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery; and

9.9.1.2 management of minor injuries that do not require hospital assessment and care.

9.9.1.3 The Contractor shall ensure that its record of any treatment provided pursuant to Section 7.11 includes the consent of the Registered Patient to that treatment.

10. Enhanced Services

10.1 The Contractor shall provide all clinically appropriate Enhanced Services and Locally Enhanced Services, as directed by the Commissioner and relevant CCG(s), to all Registered Patients.

10.2 The Commissioner shall provide the Contractor, with a list(s) of the Enhanced Services (the "Enhanced Services List") that the Commissioner wishes the Contractor to provide. The Enhanced Services List shall contain the service specification, service levels, any financial remuneration and limits or targets that must be reached in order to obtain such remuneration.

11. Health Promotion and Disease Prevention

11.1 The Contractor shall:

11.1.1 provide services focusing on health promotion and disease prevention and work with the Commissioner, other commissioning bodies, other local GP practices and other health contractors on initiatives to promote health and prevent disease within the Commissioner's area;

11.1.2 ensure it has effective strategies for health promotion and disease prevention in place. These shall include but not be limited to

i. alcohol;
ii. smoking;
iii. obesity;
iv. lack of exercise;
v. dietary habits;
vi. sexual health; and
vii. mental health and well being
viii. domestic abuse

11.1.3 identify and proactively screen and manage Patients at risk of developing physical and mental long term conditions, cancers and sexually transmitted infections as well as those more likely to have unwanted pregnancies;

11.1.4 provide information about, and access to, self-management programmes for Registered Patients with long term conditions where appropriate;

11.1.5 identify local care pathways for Registered Patients with long term conditions to reduce inappropriate and unnecessary hospital admissions;

11.1.6 provide information and advice to Registered Patients on self-monitoring for long-term conditions;

11.1.7 participate in Expert Patient Programmes;

11.1.8 use computer-based disease management templates; and

11.1.9 implement appropriate DH, NICE, Medicines and Healthcare products Regulatory Agency (MHRA) and any other relevant guidelines (as amended from time to time) that apply to the provision of primary medical care services for Registered Patients.

11.2 The Contractor shall support relevant stakeholders in the delivery of Public Health services including but not limited to:

i. bowel screening
ii. breast screening
iii. diabetic eye screening
iv. abdominal aortic aneurism (AAA) screening

11.3 The Contractor shall notify the appropriate diabetic eye screening programme of patients newly diagnosed with diabetes and actively participate in routine data validation exercises to ensure the register is valid.

12. Monitoring

12.1 The Contractor shall attend, with appropriate representation, six monthly performance monitoring meetings.

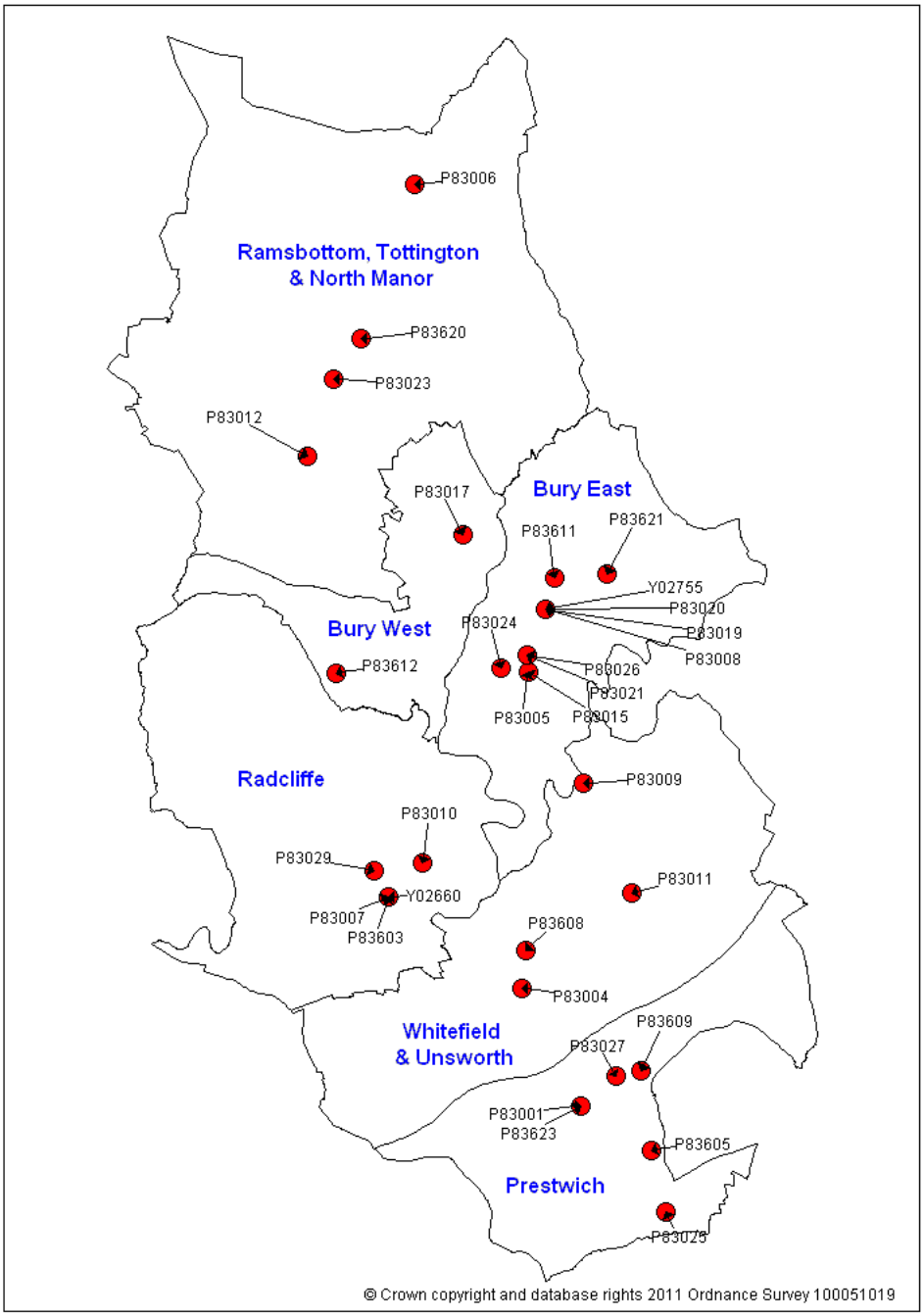
12.2 The Contractor shall provide Service data on a quarterly basis, at the request of the Commissioner. The information to be provided per patient shall include, but is not limited to, the following:

12.2.1 Number of face-to-face consultations
12.2.2 Number of telephones/ internet consultations
12.2.3 Number of telephone prescription requests
12.2.4 Number of DNAs
12.2.5 Number of A& E and Out-of-Hours attendances
12.2.6 Length of time on SAS
12.2.7 Number of referrals by referring practice

12.3 The Contractor shall inform the Commissioner of the number of new patients, the number reviewed and the number discharged in the reporting quarter.

12.4 The Commissioner shall review referrals on a six monthly basis in order to ensure all referrals meet the referral criteria (Annex 3).

Schedule 1, Annex 1 – Practice Registration Area



Schedule 1, Annex 2

List of Enhanced Services

1. Pertussis (pregnant women) Vaccination Programme
2. Seasonal Influenza and Pneumococcal Polysaccharide Vaccination Programme
3. Shingles (catch up) Vaccination Programme

Schedule 1, Annex 3
Criteria for SAS placement - Guidance from the BMA (August 2016)

1. Removal of patients from GP lists

1.1 A good patient-doctor relationship, based on mutual respect and trust, is the cornerstone of good patient care. The removal of patients from practice lists should continue to be an exceptional and rare event, and a last resort in an impaired patient-practice relationship. When trust has irretrievably broken down, it is in the patient's interest, just as much as that of the practice, that they should find a new practice.

1.2 Practices have the right to ask for a patient to be removed from their list. These provisions require that a reason should be given to the patient by the practice and that normally a warning should have been given by the practice within the past year.

1.3 Primary Care Support England (PCSE) or NHS England must be informed in writing of the request and the removal will not take effect until the eighth day after the request is received by PCSE or NHS England or, if the practice is treating the patient at intervals of less than seven days, eight days after treatment ceases unless the patient is accepted by, allocated or assigned to another practice sooner than this. The patient is always notified by the PCSE or NHS England. There is an exception to this: immediate removal on the grounds of violence e.g. when the police are involved.

2. The General Practitioners Committee's advice

2.1 The General Practitioners Committee (GPC) will defend vigorously the rights of both practices and patients to terminate a relationship that is not working and offers the following advice.

3. Breakdown of relationship

3.1 Normally the sole criterion for removal should be an irretrievable breakdown of all or part of the patient-practice relationship, usually that between patient and doctor. Violence or threatening behaviour by the patient is a special case. It usually implies a total abrogation by the patient of any responsibility towards the doctor or other members of the practice and will normally result in removal from the list. As well as having a right to protect themselves GPs have a duty as employers to protect their staff, and as providers of a public service those with reason to be on their premises.

3.2 Since 1994 it has been possible to request the immediate removal of any patient who has committed an act of violence or caused a doctor to fear for his or her safety. In April 2004 these provisions were extended to make it clear that the provisions extend to anyone else on the premises. The police must have been informed of the patient's behaviour and the doctor must notify PCSE or NHS England, and, other than in exceptional circumstances, the patient of the removal in writing. In such circumstances, PCSE or NHS England can be initially notified by the practice by any means including telephone and fax; however this needs to be followed up by confirmation in writing within seven days. The removal will take effect from the time the practice phones, sends or delivers notification to PCSE or NHS England.

3.3 The GPC believes that practices will use their clinical judgement to determine the appropriate course of action in those rare cases where a patient's violent behaviour results from their medical condition. It should be noted that if practices do not remove a violent patient under these provisions, and instead use the normal removal process, they may find themselves being asked to justify why they did not do so if a violent

patient subsequently registers with another practice, and potentially at risk of action should an untoward incident then take place.

3.4 The NHS England Area team, for its part, also has a legal responsibility and a duty of care to ensure that it commissions services to ensure that all patients removed under this regulation can only access NHS primary medical care through appropriately secure arrangements.

4. Complaints and removals

4.1 The GPC neither supports nor condones the removal of patients solely because they have made a complaint.

4.2 The current NHS complaints procedure requires that all practices have an in-house complaints procedure. Patients should normally raise a complaint with their practice in the first instance. There is public concern that patients may be removed from the list simply for making a complaint. However, complaints made in a reasonable and constructive manner can help practices to improve services to patients.

4.3 It is also perfectly possible to use the practice-based complaints procedure to discuss any instances where a patient is felt to be behaving inappropriately. This gives patients early notification of a possible problem in their relationship with their doctor along with an opportunity to discuss ways of preventing further difficulties. As well as preventing the need for removals, this procedure should reduce the number of incidents where patients appear to have been removed without any prior indication that the relationship with the doctor was less than satisfactory.

4.4 The GPC believes, however, that complaints that take the form of a scurrilous personal attack on members of the practice or contain allegations which are clearly unfounded usually indicate a serious breakdown in the patient-doctor relationship.

4.5 It is a breakdown of the relationship rather than a complaint per se which must form the basis of any decision to remove a patient from the list; it may then be in the patient's best interest to seek care at another practice.

- Practices should never remove patients from their list because their treatment is too costly. There are never any grounds for removing patients because of cost. Where the costs of treating an individual patient are higher than anticipated, adequate mechanisms exist to enable doctors to seek and be granted an increase in their prescribing budget
- Practices should never remove patients because they are suffering from a particular clinical condition
- Practices should never remove patients on grounds of age. Looking after patients "from the cradle to the grave" is the essence of general practice. Some, but by no means all, elderly patients may have an increased need for medical attention. This is recognised in higher capitation weighting for older patients and normally also in the formula for allocating prescribing budgets.

4.6 Sometimes it is not the patients themselves but carers, particularly staff of private nursing and residential homes, who can generate excessive and inappropriate demand for services from the doctor or practice. In these cases the GPC recommends that the practice attempts to resolve the problems through the in-house procedure or using the help of the LMC and PCSE or NHS England

- Practices should never remove patients on grounds of race, gender, social class, religion, sexual orientation or appearance.

5. What to do if removal appears to be necessary

5.1 In cases other than violence and abuse, the GPC recommends that the decision to remove a patient from the list should only be made after careful consideration. Alternatives, short of removal, should be considered such as transferring the patient's care to a partner (with the consent of both parties) or persuading the patient that it would be better for all concerned for them to go to another practice.

5.2 The GPC believes that many patients who are misusing services can alter their behaviour if this is brought to their attention and the regulations normally require a warning to be given within the 12 months prior to removal.

5.3 If all else fails the GPC believes that it is not in the best interests of either patient or doctor for an unsatisfactory relationship to continue and it will be necessary to remove the patient from the list.

6. What constitutes a warning and when is a warning not necessary

6.1 A patient must be warned that they are at risk of removal, together with an explanation of the reasons for this, within the period of 12 months before the date of the request to PCSE. Whilst warnings do not have to be in writing it is good practice for them to be so as this allows for carefully considered reasons to be given.

6.2 A permanent record of the warning, including the date and reason for the warning, must be made and retained as PCSE or NHS England may require sight of them. Copies of such records must therefore be retained after the patient has left the list.

6.3 However no warning is required if:

- The removal is on the grounds of change of address
- The practice has reasonable grounds for believing that the issue of such a warning would be harmful to the physical or mental health of the patient
- The practice has reasonable grounds for believing that the issue of such a warning would put at risk the safety of members of the practice or those entitled to be on the practice premises
- It is, in the opinion of the contractor, not otherwise reasonable or practical for a warning to be given.

6.4 If no reason is given an explanation in writing should be made and retained for potential future inspection by PCSE or NHS England.

7. How to remove a patient from the list if necessary

7.1 Where practices intend to remove a patient because of the irretrievable breakdown of the doctor-patient relationship, they should first consider discussing the problem confidentially with an independent party, such as their LMC secretary.

7.2 Practices should issue a warning, preferably in writing, giving the reasons for the possibility of removal. Warnings are valid for 12 months and a written record must be retained. Practices should send a written notice to PCSE or NHS England, giving the patient's name, address, date of birth, and NHS number. They should state that they wish to have the patient removed from their list under the terms of their agreement or contract.

7.3 If the removal is on grounds of violence or threatened violence the police must have been informed; there is no obligation to ask them to pursue the matter. The practice must notify the patient of the removal with an explanation for the removal. The GPC recommends that this should be in the form of a letter to the patient briefly outlining the reasons. A copy of the letter should be retained.

8. Removing other members of the household

8.1 If the behaviour of one member of a household or family has led to their removal, this does not mean that the removal of other family members should automatically follow. An explicit discussion, whilst protecting the confidentiality of the removed patient, with other family members about the problem and the doctor's concerns will often obviate the need for any further action.

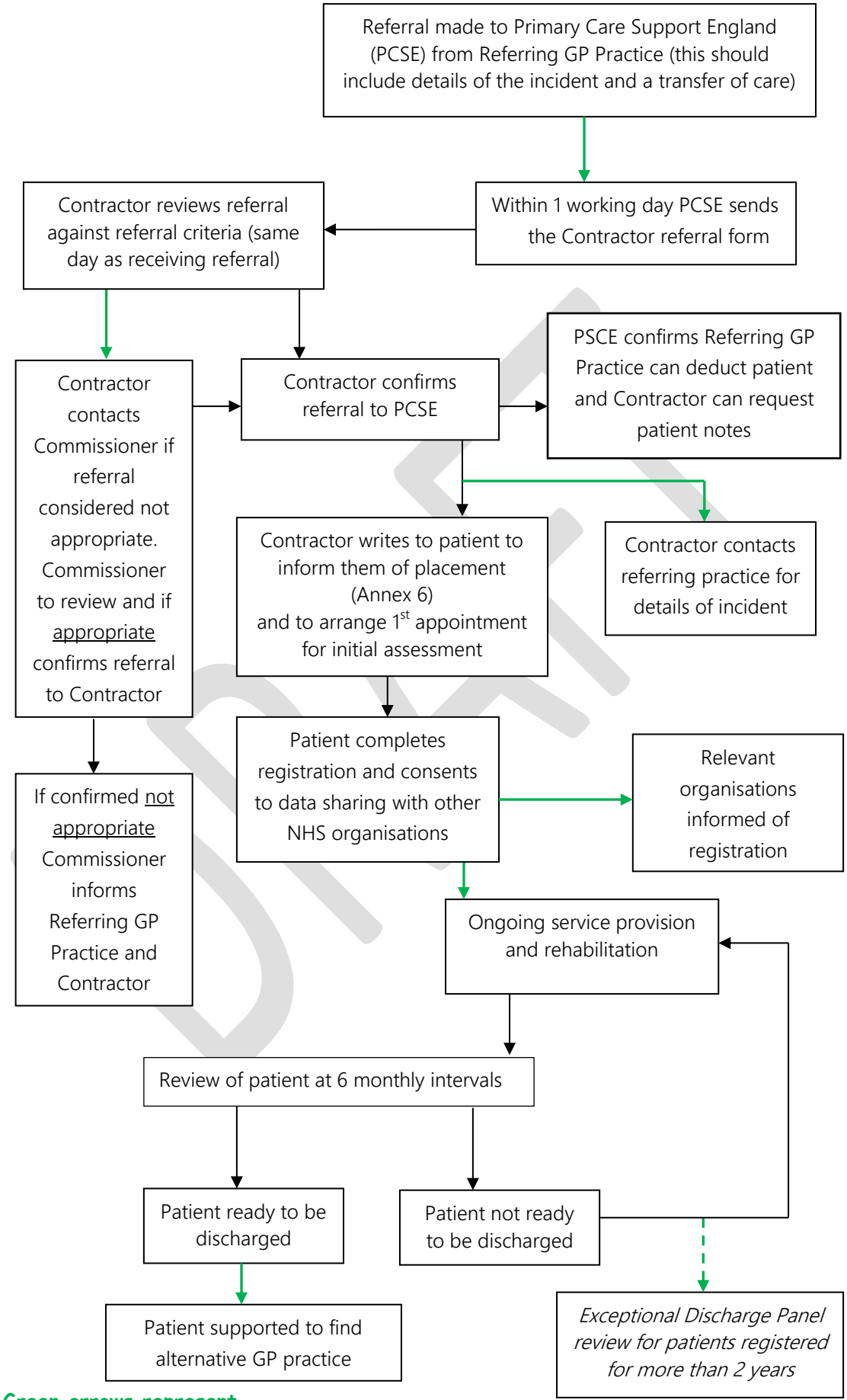
8.2 In rare cases, however, because of the possible need to visit patients at home it may be necessary to terminate responsibility for other members of the family or the entire household. The prospect of visiting patients where a relative who is no longer a patient of the practice by virtue of their unacceptable behaviour resides, or being regularly confronted by the removed patient, may make it too difficult for the practice to look after the whole family. This is particularly likely where the patient has been removed because of violence or threatening behaviour and keeping the other family members as patients could put doctors or their staff at risk.

8.3 Again the GPC would suggest that reasons are given clearly in the case of a removal. The practice should always consider how it would look to outside observers if a family were to be summarily removed from the list in haste and without explanation for a single misdemeanour or disagreement with one family member.

9. Practice leaflets

9.1 It may be helpful if practices set out in their practice leaflets the arrangement for removal of patients from the list, and their policy for dealing with threats or incidents of violent behaviour.

PATIENT PATHWAY



Green arrows represent data transfer flows

Schedule 1, Annex 5

Responsibilities of Primary Care Support England (PCSE) and the Commissioner

PCSE Responsibilities:

1. To process the removal notification from the Referring Practice and within one working day place the patient on the SAS.
2. To notify the Commissioner of the patient placement.
3. To put an alert on all SAS registered patients' notes to make all local practices aware (where appropriate).

Commissioner Responsibilities:

Exceptional Discharge Panel

In exceptional circumstances, at the request of the Contractor, hold an Exceptional Discharge Panel (EDP) meeting to determine the discharge of a patient on the grounds of the Service no longer meeting the needs of the patient.

Members of the EDP may include representatives from the Commissioner (e.g. Medical Directorate, Nursing Directorate and Commissioning), the referring Practice, the Local Medical Committee and any other relevant stakeholders (e.g. social care or mental health services).

EDPs must be convened when an active patient has been registered for two or more years. This is to enable multi-organisation discussions about what is needed to facilitate patient rehabilitation into general practice.

Return to General Practice

In exceptional circumstances the Commissioner will support the Contractor to return a patient to general practice (i.e. where a patient does not register elsewhere and needs to be allocated or where the only practice in the patient catchment is the Referring practice).

Template Letter for Patient Registration

Ref:

Primary Care Support Services England
3 Caxton Road
Fulwood
Preston
PR2 9ZZ
Tel: 0300 311 22 33

PRIVATE & CONFIDENTIAL

Date

[Patient Name]

[Patient Address]

Dear (Patient Name)
Immediate Removal from Routine General Practice/GP List of (**Practice Name & Address)**

In accordance with NHS Regulations, the above named GP Practice has requested the immediate removal of your name from their list of patients. You have been removed from routine General Practice because of your recent behaviour towards a member of the GP practice team/NHS staff. Behaviour that threatens the safety or well-being of any National Health Service staff will not be tolerated**.**

Your behaviour has compromised your right to have access to normal arrangements and locations for receiving primary care general medical services. I must make it clear, however, that you are not being excluded from receiving primary care medical services.

NHS Bury Clinical Commissioning Group has established a Special Allocation Scheme at Moorgate Primary Care Centre. The aim of this service is not only to provide you with temporary primary care medical services, but it is hoped that you will eventually return to mainstream General Practice with an understanding that any form of unacceptable behaviour will not be tolerated.

You and your doctor will work together, to not only provide you with medical services, but to identify any other problems you might have which may contribute to violent or aggressive behavior. This may involve referring you other Health Services for advice and treatment.

In return, I would ask that you use this opportunity to address the issues that have led to you being removed from the list of <**Surgery Name**> practice.

Please note that NHS England may, in certain circumstances share information such as details of your current state of health and treatment that you are receiving. NHS England is authorised to share this information with the police, probation services and other health authorities and professionals. This is pursuant to the Crime and

Disorder Act 1998. The purpose of this Act is to tackle crime and disorder and help create safer communities. NHS England reserves the right to use its powers under the Act as necessary.

When you next need to make an appointment to see a GP please contact:-

Moorgate Primary Care Centre
22 Derby Way
Bury
BL9 0NJ

Telephone Number 0161 763 4242

Your care will be provided by Dr Paul Jackson, who will be your allocated GP and should be your first point of contact if you feel you need medical attention. You should not routinely contact either the local Accident and Emergency Department or the Ambulance Service unless your medical problem is a life-threatening emergency.

Please give at least 48 hours' notice for a routine appointment. You will be asked to give sufficient details in order that the GP can assess the urgency of your condition. The doctor will then make arrangements for an appointment at Moorgate Primary Care Centre and you will be notified of the date and time of the appointment. Please note the surgery will not be attended by a GP outside of the agreed appointment time.

I have enclosed two contracts detailing the requirements of your registration. Please retain one for future reference and sign and return the other at your first appointment with the practice.

Bury CCG hopes that by taking part in this service your health and well-being will benefit from maintaining a relationship with this practice for the foreseeable future.

Should you wish to appeal against the decision to be placed on the Special Allocation Scheme, please write to: Zoe Alderson, Head of Primary Care, 21 Silver St, Bury BL9 0EN or email buccg.primarycareteam@nhs.net

Your letter should clearly state 'Special Allocation Scheme Appeal', any appeal has to be in writing and made within 14 days of the notification of the referral. Please include any supporting evidence you wish to be presented to the review panel.

Your right to complain is not affected by being on this scheme. For more information about complaints, telephone NHS England National Team Customer Contacts Centre on 0300 311 2233, england.contactus@nhs.net, NHS England, PO Box 16738, Redditch B97 9PT.

Yours sincerely

Registrations Department
Primary Care Support England

NHS Bury Clinical Commissioning Group

NHS Bury CCG Primary Care Special Allocation Scheme

Liaison Team and Panel

In November 2017, NHS England published the Primary Medical Care Policy and Guidance Manual which superseded the policy book for primary medical services which had been published in January 2016.

Click here to read the full policy https://www.england.nhs.uk/wp-content/uploads/2017/11/primary-medical-care-policy-guidance-manual-final.docx

The policy refers to a number of recommendations regarding the commissioning of a robust Special Allocation Scheme[1] (SAS) which is currently provided by Dr Jackson of Peel GPs (SAS Provider) and delivered from Moorgate Primary Care Centre on behalf of NHS Bury CCG.

Whilst the service specification appears significantly different due to the level of detail included there are no material service changes for the provider. What has changed is the role the CCG will play as the new policy states that CCG's must set up a Special Allocation Scheme Liaison Team and a Review Panel.

It is therefore proposed that Members of the Primary Care Team will act as the SAS Liaison team who will be the main contact for NHS Bury CCG with regards to any action, communication, information and notifications regarding the SAS from the Primary Care Services England (PCSE) team.

It is proposed that the SAS Liaison team will consist of the following people:

- Rachele Schofield, Primary Care Manager
- Karen Keen, Primary Care Administrator

The Primary Care Manager will report aggregated data to the Primary Care Workstream Group on a quarterly basis as part of routine contract monitoring

The SAS Liaison team will form part of an SAS Panel which is required to review all requests, allocations and appeals[2]. The panel will monitor the on-going appropriateness of the removal, allocation and rehabilitation of the patient on a 6 monthly basis using the information provided by the SAS provider. This is with a view to safely returning choice to the patient in a timely way and reintegration to mainstream Primary Care.

It is proposed that the SAS Panel consists of the following people:

- Rachele Schofield, Primary Care Manager
- Karen Keen, Primary Care Administrator
- Paul Jackson, GP and SAS provider
- Lay member TBC
- A member of the Safeguarding Team

[1] Previous referred to as Violent Patient or Zero Tolerance Schemes

[2] The process for a patient appeal is outlined on page 2

The role of the SAS Provider is to review the status of each SAS patient every 6 months and co-ordinate a report to be reviewed at an SAS Patient Review Panel also held at 6 month intervals.

The SAS scheme itself will be reviewed annually and this will be undertaken by the Primary Care Team as part of the contract monitoring and performance.

Patient Appeals Process

When a patient is referred to the SAS, PCSE informs the SAS Liaison team and provides the patient with a letter detailing why they have been referred and the process that will take place. (see Appendix 1 for a copy of the patient letter)

Here is an outline of the SAS process that takes place:

- The referring GP practice notifies the commissioner via PCSE by telephone and email that a patient is to be removed from the practice list.
- The referring GP practice must ensure that if the patient has children also registered at the practice that there appropriate delegate responsibilities are in place.
- The referring GP practice preferably within 24 hours but no more than 7 days provides a written report and this is shared with the commissioner as well as PCSE.
- The referring GP practice notifies the patient that it has requested their removal from the patient list, as set out in the regulations.
- PCSE starts the patient removal process. Following patient removal from the referring GP practice list and in conjunction with commissioners, decide on best arrangement to ensure continuity of primary care service for the patient. This may include allocation to the SAS. A flag is placed on the patient record.
- PCSE will write to the patient within 24 hours of the initial notification.
- After removal, all requests and allocations to the SAS will be reviewed by the SAS panel.
- The panel will monitor on-going appropriateness of the removal, allocation and rehabilitation of the patient, with a view to safely return choice to the patient in a timely way.
- Patients allocated to the SAS will be identified via their NHS number and not by name or any other patient identifiable information.
- Once notified by PCSE by letter, the patient has 14 days of the notification of the referral to appeal in writing or by email to the SAS Liaison team at NHS Bury CCG.
- The SAS Liaison team then notifies the GP practice of the appeal and invites them to provide any supplementary information. GP practice will be advised to contact Local Medical Committee for advice and support if needed.
- If an appeal is received it needs to be reviewed by the SAS Panel. A decision will be made by the panel (this can be done by an actual face to face meeting, telephone conference call or virtually by email). All decisions will be presented in a written form and shared with the Primary Care Workstream Group as part of a governance audit trail.
- The appeals process does not delay the immediate removal of a patient following an incident that has been reported to the police, the commissioner and PCSE.
- The SAS Liaison team will notify the patient of the decision in writing within 14 days of the SAS Panel but the outcome needs to be discussed with the referring GP practice first.
- It is the role of the SAS Panel to review the evidence provided by the patient in support of their appeal. The panel can uphold or reject the appeal where it has reasonably considered if a removal under the regulations was made in error, or inappropriately.
- Pending the outcome of the appeals process, should the patient need to access primary care medical services these would have to be provided by the SAS.

A recording mechanism for the SAS Panel will be developed to ensure there is an appropriate governance trail for decisions made.

Contact details

NHS Bury CCG: 0161 762 3070
Special Allocation Scheme Liaison Team buccg.primarycareteam@nhs.net
21 Silver Street, Bury, BL9 0EN

NHS England / Greater Manchester Health and Social Care Partnership
Primary Care Support Services England pcse.registrations-preston@nhs.net

Customer Support Centre: 0333 014 2884
Address: Primary Care Support England, PO Box 350, Darlington, DL1 9QN
Website: www.pcse.england.nhs.uk

SAS Provider: 0161 762 4242
Dr P Jackson
Moorgate Primary Care Centre, Derby Way, Bury BL9 0NJ

Appendix 1

FINAL Bury CCG SAS
Letter to Patient 2018(