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NHS DORSET CLINICAL COMMISSIONING GROUP

REPORT FOR THE DORSET HEALTH SCRUTINY COMMITTEE REGARDING

NON-EMERGENCY PATIENT TRANSPORT SERVICES

Date of the meeting	24/06/2014
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Sponsoring Board Member	J Pike – Director of Review Design and Delivery P Vater – Director of Finance
Purpose of Report	Report for the Dorset Health Scrutiny Committee in regard to Non-Emergency Patient Transport Services
Recommendation	The Committee is asked to **Note** the report.

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1. Introduction

1.1 Following the presentation of a report to the Dorset Health Scrutiny Committee on 10 March 2014, NHS Dorset Clinical Commissioning Group (DCCG) welcomes the opportunity to present more detailed information to explain the process of the commissioning and procurement of the new Non-Emergency Patient Transport Service provided by E-zec Medical Transport Services Ltd.

2. Contextual Information

2.1 Historically, Non-Emergency Patient Transport (NEPTS) has been provided by South West Ambulance NHS Foundation Trust (SWAST) formerly Dorset Ambulance Service for patients registered with a Dorset General Practitioner.

2.2 The Service Specification for this service had not changed over a number of years to reflect the changes within the NHS such as, longer hours of operation and weekend clinics.

2.3 Earlier attempts at going out to the market to commission a new NEPTS service were prevented from proceeding by the Strategic Health Authority (SHA) and Member of Parliament (MP) recommendations.

Table 1 – Comparison Specification

PRIOR TO 1 OCTOBER 2013	FROM 1 OCTOBER 2013
Monday to Friday 08:00 to 18:00. Call Centre for this area of work.	24/7, 7 days a week, 365 days a year including Bank Holidays and call centre.
Provision of transport only to NHS sites	Provision of transport to any contracted NHS healthcare facility/clinic (including private, community settings, primary care locality clinics, Nursing Homes)
5 Lots contracted as an extra resource to PTS contract. • Timed Response • Out Of Hours • Long Distance Transfers and Repatriation • Bariatric/Complex Manual Handling Patients	All mobility's and all categories of vehicles provided, including the 5 lots criteria; escorts; qualified crew; bariatric; mental health – specialist. Contract includes boundary to Dorset out of area transport Repatriation OOA provision – subject to demand

• Short Notice Trusts contracting independently to supplement transport need.	
Multiple contracts	Single contract

2.4 Commissioning responsibility for NEPTS for the whole of the South West lay with Torbay Care NHS Trust who contract managed all NEPTS contracts. In light of the above mentioned changes within the NHS and the fact Dorset could not go out to commission a new NEPTS service, the South West subsequently commissioned a 5 Lots contract which covered:

- Timed Response
- Out Of Hours
- Long Distance Transfers and Repatriation
- Bariatric/Complex Manual Handling Patients
- Short Notice

2.5 The 5 Lot service was to cover any deficiencies in the NEPTS contract with SWAST however, the 5 Lot contract was found not to be fit for purpose as Trusts found they frequently had to source their own transport so, individual Acute Trusts commissioned multiple private providers of ambulance and taxi services to meet their transportation needs for patients.

2.6 In 2011 the Department of Health (DH) indicated that Clinical Commissioning Groups (CCGs) would be responsible for commissioning NEPTS services and with the move towards CCGs, Torbay Trust informed DCCG they would no longer be contracting on behalf of the South West.

2.7 Following consultation with the South West Commissioners, each Primary Care Trust (PCT)/Clinical Commissioning Group (CCG) cluster, decided on the most appropriate route they would follow for procurement of NEPTS.

2.8 Bournemouth and Poole & Dorset PCT in conjunction with our Acute and Community providers opted to test the market for a county wide NEPTS service for Dorset. This information was previously submitted to the Health Oversee Scrutiny Committee (HOSC) in August 2012 (Appendix A).

2.9 DCCG policy and procedures regarding commissioning and procurement operate to and include:

- Dorset CCG Standard Financial Instructions (Appendix B)

- European Procurement Law
- Department of Health/NHS England/Monitor Guidelines
- Health and Social Care Act 2012

2.10 The business model which formed the basis with which the service was tendered was based on the type of journey, the mobility of the patient, the volume of journeys, the journey distance and call data volume. This information was provided from a wide range of resources.

2.11 Data received could in some cases be validated, but in the case of many small, private providers, who undertook multiple journeys, the data was not previously collected and therefore an estimate of the criteria in 2.10 was calculated. Contingency provision was placed within the business model to reflect the risk anticipated with this lack of defined knowledge.

3 Service Specification

3.1 As per standard CCG commissioning and procurement process, consultation on the service specification and design was carried out in consultation with NHS partners, patient groups, County and Local Authorities and service user groups.

- Service Specification Call Centre (Appendix C)
- Service Specification NEPTS (Appendix D)

4 Information regarding the selection process

4.1 DCCG followed standard procurement processes following European procurement law. This was a type A procurement which required advertising in the official Journal of the European Union and was also advertised on the NHS Supply2health website.

4.2 A Board Report of the process and selection of the preferred provider is attached at Appendix E.

5 Contract Monitoring Policy and Procedures

5.1 DCCG followed standard Contract Monitoring processes and holds regular monthly contract monitoring meetings. (Appendix F)

5.2 Due to the high level of data involved in NEPTS, DCCG additionally hold a Finance and Information Group (FIG) meeting at which data provided by E-zec is scrutinised, challenged and planned against, to help support operational development and financial and budgetary impact on the service. (Appendix G)

5.3 DCCG also holds regular Assurance meetings with our NHS provider Trusts to discuss operational concerns and developments. (Appendix H)

6 Mobilisation and Implementation

6.1 Following on from the previous report submitted to the Dorset Health Scrutiny Committee (DHSC) on 10 March 2014, the information below is to provide extra detail.

6.2 Although the plan was to award the contract and ”go live” by 1 April 2013, none of the Trusts in the South West were in a position to meet that date. It was therefore agreed to extend SWASTs contract to 30 September 2013.

6.3 One week before the new tendered bids for the NEPTS were due in, Unison and SWAST appeared on BBC South news discussing the South West tender and the need to renegotiate terms and conditions of staff. This caused concerns for the bidders in the Dorset tender and as a result DCCG made the decision to delay the process for 4 weeks to allow clarity on the situation and for bidders to reflect it within their bids.

6.4 The result of the aforementioned was E-zec had 4 months to mobilise the service after award, as opposed to the planned 6 months.

6.5 The month before going live (end of August 2013) SWAST provided notice to cease services with immediate effect, which the CCG understood was part of the 5 Lot contract and SWAST understood it was not contracted activity. As a result DCCG asked E-zec to respond and assist in providing this service prior to the official implementation date of 1 Oct 2013. E-zec responded unreservedly.

6.6 During the mobilisation phase, DCCG discovered there was an increased level of activity within the majority of NHS Trusts against the activity which was indicated by them prior to tender and on which the business model was based as described in 2.10 and 2.11.

6.7 The business model produced by DCCG based on data and information received did not reflect the level of demand received, despite the planned contingency. All partner agencies worked together with E-zec to anticipate the increase in need.

6.8 Due to information governance issues the data transfer of booked patient level information could not be transferred from SWAST and the multiple other providers, including Taxi services, until 48 hours before.

6.9 The quality and accuracy of that information was of varying quality and due to technical issues there was corruption of data on transfer to E-zec’s system - CLERIC. Added to this, the sheer volume of pre booked journey information transferred to E-zec complicated the process eg:

- there was multiple duplications;
- bookings that should have been cancelled but weren’t;
- some bookings up to a year in advance;
- incomplete bookings.

6.10 Regular mobilisation meetings were held with E-zec and the Trusts. All were reacting to new or changing information on a daily basis.

7 "Go Live"

7.1 In the first week of the contract being operational, the volume of calls received into the booking centre exceeded planned activity by approximately 400%.

7.2 Over a period of time the calls into the booking centre have stabilised but still substantially exceed planned demand.

7.3 Upon reflection, it was felt the strong marketing campaign by DCCG and E-zec to advise the public and clinicians of the service change to a new provider and informing patients of the availability of transport for patients attending NHS appointments who met a medical criteria, prior to the launch and in the first few weeks of the service being live, led to a substantial increase in demand as well as highlighting an unmet need.

7.4 Similarly call centre demand was excessive due to patients calling to check the new provider had their contact details, appointment times. Likewise, clinical staff were also doing the same. Meanwhile new bookings were having difficulty obtaining a line to book their appointment and the system was falling over with the demand.

7.5 E-zec consistently responded to this problem by putting in new lines, extra resources, streaming the calls and monitoring the demand process pro-actively.

7.6 As with any launch of a complex logistical service, where both new and transferred staff will be operating together, there were some initial operational and service issues relating to staff working to new or changed practices.

7.7 There were also issues related to the planning and control of transport. A significant amount of which related to, the quality of the data transferred from the Trusts, the utilisation of E-zec's fleet and a number of subcontractors E-zec were using to assist in the initial peaks in demand.

7.8 Due to the volume of bookings the anticipated number of vehicles required to service the contract did not reflect the actual situation on the ground, therefore E-zec relied on a number of parties to help service the contract which brought with it other operational issues of control, planning and quality.

7.9 Daily evening meetings were organised by DCCG for all organisations to highlight issues and propose solutions to support the development and progress of the service.

7.10 By the end of week 2, DCCG, having consulted with the providers and feedback received from patients, met with E-zec to agree a course of action to improve and refine the service in light of the increased activity.

7.11 By mid November 2013, it was clear that whilst the level of calls and transport activity had not risen dramatically, the nature and composition of the activity was causing issues for E-zec, patients and providers.

7.12 E-zec was asked to provide a plan of what they required from DCCG to help them to meet the challenges being experienced.

7.13 During November and December, E-zec and DCCG met on a number of occasions and agreed a plan which would enable E-zec to resource the service efficiently to provide the service effectively. DCCG agreed with E-zec to provide further substantial financial resource to enable the contract to be resourced to capacity.

7.14 During January and February 2014, E-zec placed orders for new vehicles and recruited more staff for areas across the whole contract. By the middle of March the new fleet and staff started to arrive and were at full resource capacity by the end of March 2014. Whilst there is evidence of improvement in the service, DCCG are closely monitoring the situation to ensure the service is fit for purpose.

7.15 DCCG recognises there are ongoing problems and have agreed a further Service Development Improvement Plan with E-zec, (with measurable performance structure to be agreed) to be monitored via the Contract Review meetings and the Finance Information Group (FIG). (Appendix I).

8 Compliments and Complaints

8.1 DCCG anticipated there would be a high level of complaints at the start of this contract due to the implementation of the key aspect of the contract being all patients must meet the medical eligibility criteria (Appendix J).

8.2 All organisations have kept a log of the complaints, incidences and compliments attributed to the service.

8.3 The service, over time, has received a number of compliments via patient verbally and through discussions with patients when receiving informal concerns.

8.4 As part of the Contract Monitoring process of DCCG, the quality directorate actively monitor and review the complaints received by the organisations and agree any appropriate action necessary. They are currently working with E-zec on their complaints policies and procedures, developing support strategies to assist E-zec. (Appendix K).

8.5 The Care Quality Commission (CQC) contacted DCCG to inform them they would be doing an unannounced visit to E-zec during January 2014. The CQC report, Reference INS1-984377643 is in the public domain for accessibility and E-zec is working to an improvement plan to meet the recommendations of the report.

8.6 The complaints, in relation to NEPTS, fall into two main categories. Formal and Incidence information. A short table has been provided to outline the volume of complaints, queries, and incidences, received by Dorset CCG. It does not reflect

complaints received by E-zec Medical Ltd or any of the Trusts. The quality department from DCCG and E-zec use this information as a learning tool to develop the service. (Appendix L).

9 Current Situation

9.1 Following feedback from the April Contract Monitoring meeting with E-zec and the April Assurance meeting, the indication from providers is there is a noticeable reduction in the number of complaints/incidences being raised and the service is slowly improving.

9.2 Key Performance Indicators for April and May would also indicate the service is moving in the right direction. (Appendix M)

9.3 However, DCCG and E-zec are not complacent and will continue to work together with our partners to improve the level of service to our patients.

10 Conclusion

10.1 DCCG recognises it has not been the easiest of mobilisations. There were a number of factors which contributed which were experienced by patients, E-zec, providers and the CCG.

10.2 All parties have worked hard to resolve the issues. With the commitment of DCCG to support the additional resources being provided by E-zec it is anticipated the service will continue to improve.

10.3 It should be noted that where other services have transferred from NHS to a private provider for NEPTS, similar issues have been experienced to a greater or lesser extent across the country, as those in Dorset.

10.4 DCCG recognises the commitment of E-zec to work in partnership with the CCG and its NHS partners to deliver a service which will meet the service specifications and over the life of the contract, improve quality, data and efficiencies but most importantly provide a safe, reliable and responsive service for the patients of Dorset.

NHS Dorset

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APPENDIX A

BRIEFING FOR HEALTH OVERVIEW AND SCRUTINY MEMBERS

AUGUST 2012

PATIENT TRANSPORT SERVICES

1. INTRODUCTION

1.1. A number of different providers deliver patient transport services (PTS) in Dorset. Patients who meet the Department of Health eligibility criteria are able to access these services.

1.2. The main service provider is currently South Western Ambulance NHS Foundation Trust (SWAST) and this contract is managed by Torbay Care Trust on behalf of the South West PCTs and PCT clusters covering Dorset, Somerset, Cornwall and Devon.

1.3. Other providers of transport include, for example, Poole Radio Cabs and Bob's Cars in Dorchester.

2. BACKGROUND

2.1. Commissioning arrangements for PTS are as follows:

- Torbay Care Trust leads on contracting SWAST;
- The cluster pays each acute trust a set amount of money to provide care and taxi PTS services to its eligible patients in addition to the regionally contracted SWAST PTS services. These trusts choose who they would like to contract with and these are often taxi firms. The cluster is not involved in these commissioning decisions or contract management.

2.2. The SWAST contract was limited with the following services not being commissioned under the regional umbrella:

Type	Definition
Timed response	Timed response patients are those patients who are leaving an NHS healthcare facility to return to their home environment. When leaving the NHS healthcare facility the patient may need to be met by one or more agencies so that their living needs can be assessed on their homecoming. This is to ensure that a patient is able to return home and cope in their home environment and to assess

	whether support is required from other agencies to allow the patient to remain in their own home following a stay at an NHS healthcare facility. Sometimes after assessment it is felt that patients cannot remain in their home environment at that time and may need to be taken to another convalescent facility, which may be an NHS Trust or care home.
Short notice	Short Notice Bookings are defined as any request for the provision of patient transport where the request has been received by the provider with less than 24 hours' notice from pick up. A Short Notice Booking will be on the day bookings.
Long distance/repatriation	There are two different types of transport requirement within this specification but they are similar in the fact that they require the provider to leave the boundaries of the four south west counties (Cornwall, Devon, Somerset and Dorset): **Long Distance Transfers** The provider will transport a patient(s) to a different NHS or provider site to allow a patient to access a specialist service. This could be a scheduled care episode or the continuation of a related unscheduled care episode. **Repatriation** Repatriations specifically refer to sending a patient back to their home PCT. This would be following an unscheduled episode of care e.g. an accident or incident requiring treatment whilst temporarily away from their home PCT (Physical or Mental Health).
Bariatric/complex handling	A bariatric patient is defined as anyone regardless of age or gender, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environmental access with one or more of the following areas: - has a Body Mass Index (BMI) of more than

	40kg/m squared and/or are 40kg above ideal weight for height (NICE 2004); - exceeds the Working load limit (WLL) and dimensions of the support service such as a bed, chair, wheelchair, couch, trolley, toilet, mattress. A complex manual handling patient is a patient who may have specialist handling needs due to their size or shape. This may through height or width or both. It is possible that some patients may have a combination of requirements and may be bariatric with additional complex manual handling needs and fit into one of the generic mobility strategies.
Out of hours	The provider will deliver PTS between the hours of 18.00 and 8.00 Monday to Friday, weekends and bank holidays. The requirements may be planned, ad-hoc or specific hour coverage e.g. PTS transport cover for A&E discharges on a Friday and Saturday night etc.

2.3. Historically these services would be contracted on a need only basis and therefore it was difficult to hold providers to account and also allow commissioners to seek value for money when journeys were commissioned on an individual basis.

2.4. In 2010/11 it was agreed regionally that these services would be procured. The lead commissioner undertook this process on behalf of the PCTs in the South West and a range of providers were successful. Contracts were put in place in 2011/12. Performance management arrangements were shared between the commissioners; Dorset and Bournemouth & Poole performance manages two providers.

2.5. Patients who are medically eligible for PTS are transported in vehicles appropriate to their medical condition. Historically, SWAST used to provide car transport but wished to terminate this arrangement in 2008/09. For this reason there is not consistency in approach across the county; the acute trusts in the east primarily procure car transport through taxi firms and the acute trust in the west of the county continued to contract voluntary car drivers through SWAST.

2.6. The development of these commissioning arrangements was in part driven by the Department of Health's decision to take PTS out of the national tariff paid to acute hospitals for patients attending hospital appointments. As a result of this, a 'block' of funding was allocated to each acute trust in Dorset and each organisation now holds

their own contracts with a range of PTS providers and the contracting arrangements vary.

3. CURRENT POSITION

3.1. Due to the mix of patient transport service provision it was felt that there was a need to review the current PTS arrangements for patients in Dorset to see if a more modern and responsive service could be procured. This would also enable the NHS commissioning organisation to performance manage the entire network of PTS providers consistently and assure strict adherence governance requirements.

3.2. Notice to terminate the current contracts has been given to SWAST and all other providers where there were contracts in place.

3.3. Torbay Care Trust agreed that each county should lead their own procurement process to enable it to reflect local needs more effectively. It would also ensure direct accountability for the performance of a patient transport service. The NHS Bournemouth & Poole and NHS Dorset cluster procurement process aims to have contracts in place by 1 May 2013. The funding for the re-procurement of these services is the same as at present. Evaluation of tenders submitted by interested providers will take place in October with provider presentations being schedule for November. Patients of the services will be invited to attend the provider presentations to comment on proposals.

3.4. The cluster has worked with local service providers and used feedback from meetings with scrutiny panels and committees and the LINKs to agree the procurement process and objectives of the procurement exercise. These are:

Criteria	Definition
Quality	Patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This includes keeping journey times low and ensuring promptness of arrival and pick-up.
Flexible and responsive	Service must provide flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends. There will also be a need for some enhanced PTS related to specialist vehicle equipment or crew training to meet particular patient requirements.
Communication and performance information	High-quality communication with commissioners to discuss flexible and innovative approaches. Clear and complete information must be provided regularly on activity, finance and quality of service provision.
Efficiency savings	Public sector organisations are required to make efficiency savings whilst maintaining and improving quality of service. Savings can be made by improved productivity, performance and/or innovative service delivery redesigns. Providers will be required to demonstrate innovations to achieve the

	commissioner's objectives. Any initiatives which impact on service delivery will be agreed prior to implementation with the commissioner.
Value for money	Service must be affordable and provide value for money.
Green	Service must take action to reduce the carbon footprint of patient journeys wherever possible.
Innovation and use of Information Technology	Service must be innovative in its approach using best practice to respond to future needs. It needs to make the most effective use of technology for the scheduling of journeys and for the provision of management information.

4. PTS PROCUREMENT

4.1. Dorset has structured the procurement process into seven lots. These are:

- Patient Help Centre
  The Help Centre will take patient and clinical professional bookings for transport, apply the medical eligibility consistently, help to signpost patients where necessary and centrally collate performance management information to provide intelligence on all PTS services.

- Ambulance transport
  Ambulance transport will take patients who cannot travel by car or other means, between the hours of 8.00 and 20.00 (to be agreed with successful providers). This could include patients who need to lie down and may need assistance in doing so.

- Car transport
  Car transport will take patients including those on wheelchairs between the hours of 8.00 and 20.00 (to be agreed with successful providers).

- Qualified crew
  Provide an enhanced level of service to cover all the needs of high dependency patients such as those with complex needs and infectious/communicable conditions/diseases, where a higher level of crew skills will be needed. Specific examples include (but not limited to)

  - patients whose medical conditions may require cardiac/pulmonary resuscitation;

  - patients transferring after attending the A&E department who have a variety of conditions such as head or trauma injuries, or pregnancy related issues;

  - children with a variety of conditions from neurological, meningitis, oncology or terminal conditions.

Other areas could include (but are not limited to) pre-transplant transfers, the return of patients following complex surgery such as cardiothoracic, post-fall patients, trauma and orthopaedic injury transfer.

- Bariatric patient / or patient requiring complex manual handling
  A bariatric patient will be defined as anyone regardless of age, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environment access with one or more of the following areas:

  - has a body mass index (BMI) >40 kg/m^2 and or are 40 kg above ideal weight for height (NICE 2004) and/or exceed the working load limit and dimensions of the support service such as a bed, chair, wheelchair, couch , trolley, toilet mattress.

- High risk mental health patients
  Patients will present with complex presentations i.e. physically violent, aggressive and detained under a section of the Mental Health Act.

- Out of area
  This would relate to transport not within the local area. Local providers have been determined to be providers based in Poole, Bournemouth, Taunton, Exeter, Southampton and Dorchester.

4.2. The PTS procurement will not change the current medical eligibility criteria for transport so patient access will remain the same as at present. The cluster and the emerging Dorset Clinical Commissioning Group will still be required to adhere to the Department of Health guidelines that were written in 2007.

4.3. The vision for PTS service is that there will be a help centre that patients and carers can call to book transport and that this centre will liaise with transport and health providers in the county to facilitate these requests. This centre will also be able to apply the eligibility criteria consistently across Dorset to ensure equality of access to services and it will be able to signpost patients, if they are not medically eligible, to voluntary transport schemes as well as public transport routes.

4.4. The cluster will update the HOSCs once the outcome of the procurement process is known in December 2012.

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APPENDIX B

STANDING FINANCIAL INSTRUCTIONS

1. 10. INTRODUCTION

2. 10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in support of the Prime Financial Policies contained in the Constitution. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the CCG. They are designed to ensure that the CCG's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Governing Body and the Scheme of Reservation and Delegation adopted by the CCG.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the CCG. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Financial Officer must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the CCG's Standing Orders.

10.1.5 **The failure to comply with Standing Financial Instructions and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

10.1.6 **Overriding Standing Financial Instructions**–If for any reason these Standing Financial Instructions are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Quality Committee for referring action or ratification .All members of the Governing Body and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.

10.1.7 In addition to the Interpretation and Definitions in the Constitution and Standing Financial Instructions, these definitions will apply to the Standing Financial Instructions:

(a) wherever the term **"Legal Advisor"** is used, means the properly qualified person appointed by the Primary Care Trust to provide legal advice.

(b) wherever the title **"Accountable Officer "**, **"Chief Financial Officer"**, or other nominated officer is used in these Standing Financial Instructions, it shall be deemed to include such other Directors or employees who have been duly authorized to represent them.

(c) wherever the term **"employee"** is used and where the context permits, it shall be deemed to include employees of third parties contracted to the CCG when acting on behalf of the CCG.

10.2 Responsibilities and delegation

10.2.1 The CCG Body

The Governing exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) Defining specific responsibilities placed on members of the Governing Body and employees as indicated in the Scheme of Reservation and Delegation document.

10.2.2 The Governing Body has resolved that certain powers and decisions may only be exercised by the Governing Body in formal session. These are set out in the 'Schedule of Matters Reserved to the Group' document.

10.2.4 The Accountable Officer and Chief Financial Officer

The Accountable Officer and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Accountable Officer is ultimately accountable to the Governing Body, and as Accountable Officer, to the Secretary of State, for ensuring that the Governing Body meets its obligation to perform its functions within the available financial resources. The Accountable Officer has overall executive responsibility for the CCG's activities; is responsible to the Chair and the Governing Body for ensuring that its financial obligations and targets are met and has overall responsibility for the CCG's system of internal control.

10.2.5 It is a duty of the Accountable Officer to ensure that Members of the Governing Body and employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.6 The Chief Financial Officer

The Chief Financial Officer is responsible for:

(a) implementing the CCG's financial policies and for co-coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the CCG's transactions, in order to disclose, with reasonable accuracy, the financial position of the CCG at any time;

and, without prejudice to any other functions of the CCG, and employees of the CCG the duties of the Chief Financial Officer include:

(d) the provision of financial advice to other members of the Governing Body and employees;

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the CCG may require for the purpose of carrying out its statutory duties.

10.2.7 **Governing Body Members, and Employees**

All members of the Governing Body and employees, severally and collectively, are responsible for:

(a) The security of the property of the CCG;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources; and

(d) Conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.8 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the CCG to commit the CCG to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Accountable Officer to ensure that such persons are made aware of this.

10.2.9 For all members of the Governing Body and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Governing Body and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

11. AUDIT

11.1 Audit and Quality Committee

11.1.1 An independent Audit Committee (whether stand-alone or is part of an Audit and Quality committee) is a central means by which a Governing Body ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Governing Body. In accordance with Standing Orders the Governing Body shall formally establish an Audit Committee, with clearly defined terms of reference and to perform the following tasks:

(a) Ensuring there is an effective internal audit function established by management, that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and Governing Body;

(b) Reviewing the work and findings of the external auditor appointed by the Audit Commission and considering the implications of and management's responses to their work;

(c) Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and considering the implications for the governance of the organisation;

(d) ensuring that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body;

(e) Reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(f) Reviewing the establishment and maintenance of an effective system of Audit, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(g) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(h) Reviewing schedules of losses and compensations and making recommendations to the Governing Body;

(i)

(j) Review the annual report and financial statements prior to submission to the Governing Body focusing particularly on;

(i) the wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
(ii) changes in, and compliance with, accounting policies and practices;
(iii) unadjusted mis-statements in the financial statements;
(iv) major judgmental areas;
(v) significant adjustments resulting from audit.

(k) Reviewing the annual financial statements and recommend their approval to the Governing Body;

(l) Reviewing the external auditors report on the financial statements and the annual management letter;

(m) Conducting a review of the CCGs major accounting policies;

(n) Reviewing any incident of fraud or corruption or possible breach of ethical standards or legal or statutory requirements that could have a significant impact on the CCGs published financial accounts or reputation;

(o) Reviewing any objectives and effectiveness of the internal audit services including its working relationship with external auditors;

(p) Reviewing major findings from internal and external audit reports and ensure appropriate action is taken;

(q) Reviewing 'value for money' audits reporting on the effectiveness and efficiency of the selected departments or activities;

(r) Reviewing the mechanisms and levels of authority (e.g. Standing Orders, Standing Financial Instructions, Delegated limits) and make recommendations to the CCG Governing Body;

(s) Reviewing the scope of both internal and external audit including the agreement on the number of audits per year for approval by the CCG Governing Body;

(t) Investigating any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation;

(u) Reviewing waivers to Standing Orders;

(v) Reviewing hospitality and sponsorship registers;

(w) Reviewing the information prepared to support the controls assurance statements prepared on behalf of the Governing Body and advising the Governing Body accordingly.

11.1.2 The minutes of the Audit Committee meetings shall be formally recorded by the CCG Secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action. The Committee will report to the Governing Body annually on its work in support of the Statement of Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organization and, the integration of governance.

11.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of Audit Committee should raise the matter at a full meeting of the Governing Body.

11.2 Chief Financial Officer

11.2.1 The Chief Financial Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit function is adequate and meets the NHS mandatory audit standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of Internal Audit recommendations;

(iv) progress against plan over the previous year;

(iv) strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

11.2.2 The Chief Financial Officer or designated internal or external auditor is entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Governing Body or employee of the CCG;

(c) the production of any cash, stores or other property of the CCG under a member of the Governing Body or an employee's control; and

(d) explanations concerning any matter under investigation.

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11.3 Role of Internal Audit

11.3.1 Internal Audit is an independent and objective appraisal service within an organisation which provides:

(1) an independent and objective opinion to the Accountable Officer, the Governing Body, and the Audit Committee on the degree to which risk management, control and governance, support the achievement of the organisation's agreed objectives;

(2) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

11.3.2 Internal Audit will review, appraise and report upon policies, procedures and operations in place to;

(a) establish and monitor the achievement of the organisation's objectives; ;

(b) identify, assess and manage the risks to achieving the organisation's objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioral and ethical expectations), procedures, laws and regulations;

(e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

11.3.3 The Head of Internal Audit will provide to the Audit Committee;

(a) A risk-based plan of internal audit work, agreed with management and approved by the Audit Committee, based upon the management's Assurance Framework that will

enable the auditors to collect sufficient evidence to give an opinion on the adequacy and effective operation of the organisation;

(b) Regular updates on the progress against plan;

(c) Reports of management's progress on the implementation of action agreed as a result of internal audit findings;

(d) An annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This opinion is used by the Governing Body to inform the SIC and by Strategic Health Authority as part of its performance management role;

(e) A report supporting CCG assurances to the Healthcare Commission on compliance with Standards for Better Health;

(f) Additional reports as requested by the Audit Committee.

11.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

11.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Accountable Officer of the CCG.

11.3.6 The Head of Internal Audit reports to the Audit Committee and is managed by the Chief Financial Officer. The reporting system for Internal Audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.3.7 The appointment and termination of the Head of Internal Audit and/or the Internal Audit Service must be approved by the Audit Committee.

11.4 External Audit

11.4.1 The External Auditor is appointed by the Audit Commission and paid for by the CCG. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Audit Commission if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the CCG Accountable Officer and Chief Financial Officer shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

11.5.2 The CCG shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, and guidance.

11.5.3 The LCFS shall report to the CCG Chief Financial Officer and shall work with staff in the NHS Counter Fraud Service (NHS CFS) and the Operational Fraud Team (OFT) in accordance with the NHS Counter Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the CCG.

11.6 Security Management

11.6.1 In line with their responsibilities, the CCG Accountable Officer will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The CCG shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS Security Management.

11.6.4 The Accountable Officer has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. RESOURCE LIMIT CONTROL

12.1.1 The CCG is required by statutory provisions not to exceed its Resource Limit. The Accountable Officer has overall executive responsibility for the CCG's activities and is responsible to the CCG for ensuring that it stays within its Resource Limit.

12.1.4 The Chief Financial Officer will:

(a) provide monthly reports in the form required by the Secretary of State;

13. ALLOCATIONS, LOCAL DELIVERY PLAN, BUDGETS, BUDGETARY CONTROL AND MONITORING

13.1 Allocations

13.1.1 The Chief Financial Officer of the CCG will:

(a) periodically review the basis and assumptions used by the National Commissioning Board for distributing allocations and ensure that these are reasonable and realistic and secure the CCG's entitlement to funds;

(b) prior to the start of each financial year submit to the CCG Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

(c) regularly update the CCG Governing Body on significant changes to the initial allocation and the uses of such funds.

13.2 Preparation and Approval of Budgets

13.2.2 Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Accountable Officer, prepare and submit budgets for approval by the Governing Body. Such budgets will:

(a) be in accordance with the aims and objectives set out in the CCG strategy;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

13.2.3 The Chief Financial Officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body.

13.2.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

13.2.5 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

13.3 Budgetary Delegation

13.3.1 The Accountable Officer may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose(s) of each budget heading;

(c) individual and group responsibilities;

(d) authority to exercise virement;

(e) achievement of planned levels of service;

(f) the provision of regular reports.

13.3.2 The Accountable Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the Governing Body.

13.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Accountable Officer, subject to any authorised use of virement.

13.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Accountable Officer, as advised by the Chief Financial Officer.

13.4 Budgetary Control and Reporting

13.4.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Governing Body in a form approved by the Governing Body containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Accountable Officer's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers.

13.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Governing Body;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorized, subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Accountable Officer other than those provided for within the available resources and manpower establishment as approved by the Governing Body .

13.4.3 The Accountable Officer is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Local Delivery Plan and a balanced budget.

13.5 Capital Expenditure

13.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. .

13.6 Monitoring Returns

13.6.1 The Accountable Officer is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

14. ANNUAL ACCOUNTS AND REPORTS

14.1 The Chief Financial Officer, on behalf of the CCG, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the CCG's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to the Department of Health certified in accordance with current guidelines;

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

14.2 The CCG's annual accounts must be audited by an auditor appointed by the Audit Commission. The CCG's audited annual accounts must be presented to a public meeting and made available to the public.

14.3 The CCG will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts.

15. BANK ACCOUNTS

15.1 General

3. 15.1.1 The Chief Financial Officer is responsible for managing the CCG's banking arrangements and for advising the CCG Governing Body on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health.

The Government Banking Service (GBS) changed its main provider of banking transaction services from the Bank of England to Citibank and the Royal Bank of Scotland Group (RBSG). Two banks have been engaged so that no single entity can see the full picture of the Government's overnight cash position.

15.1.2 The Governing Body shall approve the banking arrangements.

15.2 Bank and Office of the Paymaster General (OPG) Accounts

15.2.1 The Chief Financial Officer is responsible for:

(a) bank accounts;

(b) establishing separate bank accounts for the CCG's non-exchequer funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Governing Body all arrangements made with the CCG's bankers for accounts to be overdrawn;

(e) monitoring compliance with DH guidance on the level of cleared funds.

15.3 Banking Procedures

15.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the CCG's accounts.

15.3.2 The Chief Financial Officer must advise the CCG's bankers in writing of the conditions under which each account will be operated.

15.4 Tendering and Review

15.4.1 The Chief Financial Officer will review the banking arrangements of the CCG at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the CCG's banking business.

15.4.2 Competitive tenders should be sought at least every 5 years.. The results of the tendering exercise should be reported to the Governing Body.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

16.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

16.2 Fees and Charges

16.2.1 The CCG shall follow the Department of Health's advice in the "Costing" Manual in setting prices for NHS service agreements.

16.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

16.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

16.3 Debt Recovery

16.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

16.3.2 Income not received should be dealt with in accordance with losses procedures.

16.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4 Security of Cash, Cheques and other Negotiable Instruments

16.4.1 The Chief Financial Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the CCG.

16.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

16.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the CCG is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the CCG from responsibility for any loss.

17. TENDERING AND CONTRACTING PROCEDURE

17.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the CCG shall comply with these Standing Orders and Standing Financial Instructions.

17.2 European Union Directives Governing Public Procurement

(a) Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.3 Reverse eAuctions

The CCG should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

17.4 Capital Investment Manual and other Department of Health Guidance

The CCG shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions.

17.5 Formal Competitive Tendering

17.5.1 General Applicability

The CCG shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

17.5.2 Health Care Services

Where the CCG elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering.

17.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed **£100,000**;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Accountable Officer OR Chief Financial Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate CCG record;

(e) where the requirement is covered by an existing contract;

(f) where Government Procurement Service agreements are in place and have been approved by the Governing Body;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the CCG is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate CCG record and reported to the Audit Committee.

17.5.4. **Fair and Adequate Competition**
4.
5. Where any exceptions set out in Standing Orders applies, the CCG shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/ individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.
6.
7. 17.5.5 **List of Approved Firms**
8.
9. The CCG shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are assessed for their competency and capability prior to the award of any contract.

17.5.6 **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

17.5.7 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Accountable Officer, and be recorded in an appropriate CCG record.

17.6 Contracting/Tendering Procedure

17.6.1 **Invitation to tender**

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

- submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the CCG (or the word "tender" followed by the subject to which it related) and the latest date and time for the receipt of such tender addressed to the Accountable Officer or nominated Manager;

- that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

- Where an e-tendering software package is used the suppliers' response will be completed on-line and uploaded into a secure electronic mailbox until the opening time.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract

recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

(v) Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practice.

17.6.2 **Receipt and safe custody of tenders**

The Accountable Officer or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

Except where an electronic tendering package is used, the date and time of receipt of each tender shall be endorsed on the tender envelope/package. Where an electronic tendering package is used the tender documents will be stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer documents are received.

17.6.3 **Opening tenders and Register of tenders**

(i) Except where an electronic tendering package is used, as soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Accountable Officer and not from the originating department. Where an electronic tendering package is used the tender documents will be opened electronically by two officers independent from the originating department.

(ii) A member of the CCG Governing Body will be required to be one of the two approved persons present for the opening of tenders estimated above **£100,000**. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the CCG's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Financial Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Director/Secretary/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The CCG's Secretary will count as a Director for the purposes of opening tenders.

(vi) Except where an electronic tendering package is used, every tender received shall be marked with the date of opening and initialled by those present at the opening. Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening.

(vii) A register shall be maintained by the Accountable Officer, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;

- the names of firms individuals from which tenders have been received;

- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender and suitably initialed.
- Where an electronic tendering package is used all actions are recorded within the system audit reports and shall act as the tender register.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

17.6.4 **Admissibility**

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Accountable Officer.

(ii) Where only one tender is sought and/or received, the Accountable Officer and Chief Financial Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the CCG.

17.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Accountable Officer or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Accountable Officer or his/her nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Accountable Officer or his/her nominated officer.

(iv) Accepted late tenders will be reported to the Governing Body.

17.6.6 **Acceptance of formal tenders (See overlap with SFI No. 17.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the CCG, or the highest, if payment is to be received by the CCG, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and which is not in accordance with these Instructions except with the authorisation of the Accountable Officer.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All Tenders should be treated as confidential and should be retained for inspection.

17.6.7 **Tender reports to the CCG Governing Body**

Reports to the CCG Governing Body will be made on an exceptional circumstance basis only.

17.6.8 **List of approved firms (see SFI No. 17.5.5)**

(a) **Responsibility for maintaining list**

A manager nominated by the Accountable Officer shall on behalf of the CCG maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the CCG is satisfied. All suppliers must be made aware of the CCG's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970,

the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Chief Financial Officer may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/ medical competence.

17.6.9 **Exceptions to using approved contractors**

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11. If in the opinion of the Accountable Officer and the Chief Financial Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Accountable Officer should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

12. 17.7 Quotations: Competitive and non-competitive

17.7.1 **General Position on quotations**

13. Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed **£10,000** but not exceed **£100,000**.

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15. 17.7.2 **Competitive Quotations**

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17. (i) Quotations should be obtained from at least **three** firms/ individuals based on specifications or terms of reference prepared by, or on behalf of, the CCG or PEC.

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19. (ii) Quotations should be in writing unless the Accountable Officer or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

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21. (iii) All quotations should be treated as confidential and should be retained for inspection.

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23. (iv) The Accountable Officer or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the CCG, or the highest if payment is to be received by the CCG, then the choice made and the reasons why should be recorded in a permanent record.

17.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the Responsible Officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

(v) Where Government Procurement Services agreements are in place and have been agreed by the Governing Body.

17.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Accountable Officer or Chief Financial Officer.

17.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Chief Financial Officer	up to	**£750,000**
Accountable Officer	up to	**£1,500,000**
CCG Governing Body	over	**£1,500,000**

These levels of authorisation may be varied or changed and need to be read in conjunction with the CCG Governing Body's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the CCG Governing Body this shall be recorded in their minutes.

17.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required, the CCG should adopt one of the following alternatives:

(a) the CCG shall use the Government Procurement Service Framework Contracts for procurement of all goods and services unless the Authorised Officer or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) if the CCG does not use the Government Procurement Service Framework Contracts - where tenders or quotations are not required, because expenditure is

below the prescribed limit, the CCG shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

17.10 Private Finance for capital procurement (see overlap with SFI No. 23)

The CCG should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Governing Body proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Accountable Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Governing Body of the CCG.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.11 Compliance requirements for all contracts

The Governing Body may only enter into contracts on behalf of the CCG within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The CCG's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) Such of the NHS Standard Contract Conditions as are applicable;

(d) 'Standards for Better Health';

(e) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

(g) In all contracts made by the CCG, the Governing Body shall endeavour to obtain best value for money by use of all systems in place. The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of the CCG.

17.12 Personnel and Agency or Temporary Staff Contracts

The Accountable Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.13 Disposals (See overlap with SFI No. 25)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Accountable Officer or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with any supplies policy of the CCG;

(c) items to be disposed of with an estimated sale value of less than **£100,000** for tendering and **£10,000** for quotations, these figures to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

17.14 In-house Services

17.14.1 The Accountable Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The CCG may also determine from time to time that in-house services should be market tested by competitive tendering.

17.14.2 In all cases where the Governing Body or PEC determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Accountable Officer or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Accountable Officer and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer representative. For services having a likely annual expenditure exceeding **£1,000,000**, a non-officer member should be a member of the evaluation team.

17.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.14.4 The evaluation team shall make recommendations to the Governing Body or PEC.

17.14.5 The Accountable Officer shall nominate an officer to oversee and manage the contract on behalf of the CCG.

17.15 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 28)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the CCG's trust funds and private resources.

18. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 17.13)

18.1 Service Level Agreements (SLAs)

18.1.1 The Accountable Officer, as the Accountable Officer, is responsible for ensuring the CCG enters into suitable contracts with service commissioners for the provision of NHS services.

All contracts should aim to implement the agreed priorities contained within the Local Delivery Plan (LDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Accountable Officer should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing Joint Investment Plans;
- that contracts are based on integrated care pathways.

18.2 Involving Partners and jointly managing risk

A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Accountable Officer to ensure that the CCG works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the CCG can jointly manage risk with all interested parties. Due consideration in all provider/purchaser arrangements must be observed as the NHS moves toward a 'Patient-led NHS'.

18.3 A 'Patient Led NHS' and 'Practice Based Commissioning'

The Department of Health has published its document 'Creating a patient–led NHS' and 'Practice Based Commissioning' setting out the basis upon which the Government's major reform agenda will be carried forward.

A 'Patient-led NHS'

Every aspect of the new system is designed to create a service which is patient-led, where:

- people have a far greater range of choices and of information and guidance to help make choices;
- there a stronger standards and safeguards for patients;
- NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

What services will look like

In order to be patient-led, the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible;
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care;
- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

Securing services

The NHS will develop the way it secures services for its patients. It will:

- promote more choice in acute care by offering choice to the patient both in number and type of provider;
- encourage development of new community and primary services alongside new practices;
- strengthen existing networks for emergency, urgent and specialist services;
- build on current practices in shared commissioning to create a far simpler contract management and administration system that can be professionally managed.

Changing the way the NHS works

The NHS needs a change of culture as well as of systems to become truly patient-led, where:

- everything is measured by its impact on patients and type of provider
- the NHS is as concerned with health promotion and prevention as with sickness and injury;
- frontline staff have more authority and autonomy to better support the patient;
- barriers which create rigidity and inflexibility are tackled and codes of conduct and shared values are instilled into the culture.

Making the changes

A Patient-led NHS needs effective organisations and incentives, with:

- a new development programme to help NHS Trusts become NHS Foundation Trusts;
- a similar structured programme to support CCGs in their development of 'Practice Based Commissioning';
- further development of Payment by Results to provide appropriate financial incentives for all services;
- greater integration of all the financial and quality incentives along with full utilisation of new human resources and IT programmes.

Commissioning a Patient-led NHS and Practice Based Commissioning are being rolled out by the Department of Health and full support and latest guidance may be accessed at http://www.dh.gov.uk

18.4 Reports to Governing Body on contracts

The Accountable Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure against the contracts. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for across the range of contracts.

18.5 The CCG will reach decisions on whether it is legally required to (or best practice dictates that it should) procure health services through formal tendering and market testing

exercises, or whether a more informal approach would be justifiable in the circumstances in accordance with the CCG Contestability Framework.

19. COMMISSIONING

19.1 Role of the CCG in Commissioning Secondary Services

19.1.1 The CCG has responsibilities for commissioning secondary services on behalf of the resident population. This will require the CCG to work in partnership with the National Commissioning Board, local NHS Trusts, CCGs, and FTs, local authority, users, carers and the voluntary sector.

19.2 Role of the Accountable Officer

19.2.1 The Accountable Officer as the Accountable Officer has responsibility for ensuring secondary services are commissioned in accordance with the priorities agreed. This will involve ensuring contracts are put in place with the relevant providers, based upon integrated care pathways.

19.2.2 Contracts will be the key means of delivering objectives and therefore they need to have a wider scope. The CCG Accountable Officer will need to ensure that all SLAs;

- Meet the standards of service quality expected;
- Fit the relevant national service framework (if any);
- Enable the provision of reliable information on cost and volume of services;
- Fit the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing Joint Investment Plans;
- that contracts are based upon cost-effective services;
- that contracts are based on integrated care pathways.

19.2.3 The Accountable Officer, as the Accountable Officer, will need to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.

19.2.4 Where the CCG makes arrangements for the provision of services by non-NHS providers it is the Accountable Officer, as the Accountable Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and cost-effectiveness of services provided. Before making any agreement with non-NHS providers, the CCG should explore fully the scope to make maximum cost-effective use of NHS facilities.

19.3 Role of the Chief Financial Officer

19.3.1 A system of financial monitoring must be maintained by the Chief Financial Officer to ensure the effective accounting of expenditure under the contract. This should provide a suitable audit trail for all payments made under the agreements, but maintains patient confidentiality.

19.3.2 The Chief Financial Officer must account for Out of Area Treatments/ Non Contract Activity financial adjustments in accordance with national guidelines

20. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE CCGGOVERNING BODY AND EXECUTIVE COMMITTEE AND EMPLOYEES

24. 20.1 Remuneration and Terms of Service (see overlap with SO No. 4)

20.1.1 In accordance with Standing Orders the Governing Body shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

20.1.2 The Committee will:

(a) Determine appropriate remuneration and terms of service for the Accountable Officer, other officer members employed by the CCG and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Governing Body on the remuneration and terms of service of officer members of the Governing Body and PEC members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the CCG - having proper regard to the CCG's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

20.1.3 The Committee shall report in writing to the Governing Body the basis for its recommendations. The Governing Body shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration. Minutes of the Governing Body's meetings should record such decisions.

20.1.4 The Governing Body will consider and need to approve proposals presented by the Accountable Officer for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

20.1.5 The CCG will pay allowances to the Chairman and non-officer members of the Governing Body in accordance with instructions issued by the Secretary of State for Health.

20.2 Funded Establishment

20.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

20.2.2 The funded establishment of any department may not be varied without the approval of the Accountable Officer.

20.3 Staff Appointments

20.3.1 No officer, or Member of the CCG Governing Body or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Accountable Officer; and

(b) within the limit of their approved budget and funded establishment.

20.3.2 The Governing Body will approve procedures presented by the Accountable Officer for the determination of commencing pay rates, condition of service, etc, for employees.

20.4 Processing Payroll

20.4.1 The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

20.4.2 The Chief Financial Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the CCG of sums of money and property due by them to the CCG.

20.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

20.4.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable

arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.

20.5 Contracts of Employment

20.5.1 The Governing Body shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Governing Body and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

21. NON-PAY EXPENDITURE

21.1 Delegation of Authority

21.1.1 The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers.

21.1.2 The Accountable Officer will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

21.1.3 The Accountable Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

21.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

21.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the CCG. In so doing, the advice of the CCG's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Accountable Officer) shall be consulted.

21.2.2 **System of Payment and Payment Verification**

The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

21.2.3 **The Chief Financial Officer will:**

(a) advise the Governing Body regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Governing Body and PEC members/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

21.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%)..

(b) The appropriate officer member of the PECmust provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the CCG if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Accountable Officer if problems are encountered.

21.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Financial Officer;

(c) state the CCG's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Accountable Officer.

21.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6 and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff"; the Code of Conduct for NHS Managers 2002); and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Accountable Officer;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Accountable Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the CCG to a future uncompetitive purchase;

(j) changes to the list of members/employees and officers authorised to certify invoices are notified to the Chief Financial Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

(l) petty cash records are maintained in a form as determined by the Chief Financial Officer.

21.2.7 The Accountable Officer and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Concode and Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

21.3 Joint Finance Arrangements with Local Authorities, Private and Voluntary Bodies (see overlap with Standing Order No. 9.1)

21.3.1 Payments to local authorities, private and voluntary organisations made under the powers of section 28A of the NHS Act 1977**shall** comply with procedures laid down by the Chief Financial Officer which shall be in accordance with that Acts. (See overlap with Standing Order No. 9.1)

22. FINANCIAL FRAMEWORK

22.1 The Chief Financial Officer should ensure that members of the Governing Body and the PEC are aware of the Financial Framework. This document contains directions which the CCG must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to CCGs. The Chief Financial Officer should also ensure that the direction and guidance in the framework is followed by the CCG.

23. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

23.1 Capital Investment

23.1.1 The Accountable Officer:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

23.1.2 For every capital expenditure proposal the Accountable Officer shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements;

(b) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

23.1.3 For capital schemes where the contracts stipulate stage payments, the Accountable Officer will issue procedures for their management, incorporating the recommendations of Estatecode.

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

23.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Accountable Officer shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.5);

(c) approval to accept a successful tender (see overlap with SFI No. 17.5).

The Accountable Officer will issue a scheme of delegation for capital investment management in accordance with Estatecode guidance and the CCG's Standing Orders.

23.1.5 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

23.2 Private Finance (see overlap with SFI No. 17.10)

23.2.1 The CCG should normally test for PFI when considering capital procurement. When the CCG proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Governing Body.

23.3 Asset Registers

23.3.1 The Accountable Officer is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

23.3.2 Each CCG shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Accounting Manual* as issued by the Department of Health.

23.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

23.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

23.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

23.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Accounting Manual* issued by the Department of Health.

23.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Accounting Manual* issued by the Department of Health.

23.3.8 The Chief Financial Officer of the CCG shall calculate and pay capital charges as specified in the *Capital Accounting Manual* issued by the Department of Health.

23.4 Security of Assets

23.4.1 The overall control of fixed assets is the responsibility of the Accountable Officer.

23.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

23.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

23.4.4 Whilst each employee and officer has a responsibility for the security of property of the CCG, it is the responsibility of Governing Body members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Governing Body. Any breach of agreed security practices must be reported in accordance with agreed procedures.

23.4.5 Any damage to the CCG's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Governing Body members and employees in accordance with the procedure for reporting losses.

23.4.6 Where practical, assets should be marked as CCG property.

23.5 NHS LIFT

23.5 A Primary Care Trust planning involvement with LIFT projects should access guidance from the joint DH and Partnerships UK website at www.partnershipsforhealth.co.uk.

24. STORES AND RECEIPT OF GOODS

24.1 General position

24.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

24.2 Control of Stores, Stocktaking, condemnations and disposal

24.2.1 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Accountable Officer. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

24.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

24.2.3 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

24.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

24.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

24.2.6 The designated Manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

24.3 Goods supplied by NHS Logistics

24.3.1 For goods supplied via the NHS Logistics central warehouses, the Accountable Officer shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

25. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

25.1 Disposals and Condemnations

25.1.1 **Procedures**

The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

25.1.2 When it is decided to dispose of a CCG asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

25.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

25.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

25.2 Losses and Special Payments

25.2.1 **Procedures**

The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

25.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Accountable Officer and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and/or Accountable Officer. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform the relevant LCFS and Operational Fraud Team (OFT) in accordance with Secretary of State for Health's Directions.

25.2.3 **Suspected fraud**

The Chief Financial Officer must notify the NHS CFS and the External Auditor of all frauds.

25.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify:

(a) the Governing Body, and

(b) the External Auditor.

25.2.5 Within limits delegated to it by the Department of Health, the Governing Body shall approve the writing-off of losses.

25.2.6 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the CCG's interests in bankruptcies and company liquidations.

25.2.7 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

25.2.8 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

25.2.9 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

25.2.10 All losses and special payments must be reported to the Audit Committee at every meeting.

26. INFORMATION TECHNOLOGY

26.1 Responsibilities and Duties of the Chief Financial Officer

26.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the CCG, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the CCG's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

26.1.2 The Chief Financial Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

26.1.3 The Head of Information Governance shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our CCG that we make publicly available.

26.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

26.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of CCG in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

26.3 Contracts for computer services with other health bodies or outside agencies

The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

26.4 Requirements for computer systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Financial Officer staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

27. PATIENTS' PROPERTY

27.1 The CCG has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

27.2 The Accountable Officer is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- Notices and information booklets **(subject to sensitivity guidance)**;
- Hospital admission documentation and property records;
- The oral advice of administrative and nursing staff responsible for admissions.

that the CCG will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

27.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

27.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

27.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

27.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

27.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

28. FUNDS HELD ON TRUST

28.1 Corporate Trustee

(1) Standing Order No. 2.9 outlines the CCG's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.9.4 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the CCG's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Chief Financial Officer shall ensure that each trust fund which the CCG is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

28.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the CCG's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Schedule of Matters Reserved to the Governing Body and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All CCG Governing Body members and CCG officers must take account of that guidance before taking action.

28.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No. 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

29. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Chief Financial Officer shall ensure that all staff are made aware of the CCG policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct

for NHS Staff'; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

30. PAYMENTS TO INDEPENDENT CONTRACTORS

30.1 Role of the CCG

The CCG will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received shall be dealt with equitably, within any time limits laid down in the contractors NHS terms and conditions of service.

30.2 Duties of the Accountable Officer

The Accountable Officer shall:

(a) ensure that lists of all contractors, for which the CCG is responsible, are maintained in an up to date condition;

(b) ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service.

30.3 Duties of the Chief Financial Officer

The Chief Financial Officer shall:

(a) ensure that contractors who are included on a Primary Care Trust's approved lists receive payments;

(b) maintain a system of payments such that all valid contractors' claims are paid promptly and correctly, and are supported by the appropriate documentation and signatures;

(c) ensure that regular independent verification of claims is undertaken, to confirm that:

(i) rules have been correctly and consistently applied;

(ii) overpayments are detected (or preferably prevented) and recovery initiated;

(iii) suspicions of possible fraud are identified and subsequently dealt with in line with the Secretary of State for Health's Directions on the management of fraud and corruption.

(d) ensure that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

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31. RETENTION OF RECORDS

31.1 The Accountable Officer shall be responsible for maintaining archives for all records required to be retained in accordance with NHS Code of Practice - Records Management 2006.

31.2 The records held in archives shall be capable of retrieval by authorised persons.

31.3 Records held in accordance with NHS Code of Practice - Records Management 2006 shall only be destroyed at the express instigation of the Accountable Officer. Detail shall be maintained of records so destroyed.

32. RISK MANAGEMENT AND INSURANCE

32.1 Programme of Risk Management

The Accountable Officer shall ensure that the CCG has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Governing Body.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of internal control within the Annual Report and Accounts as required by current Department of Health guidance.

32.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Governing Body shall decide if the CCG will insure through the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks covered by the risk pooling schemes. If the Governing Body decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

32.3 Insurance arrangements with commercial insurers

32.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when CCGs may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) for **insuring motor vehicles** owned by the CCG including insuring third party liability arising from their use;

(2) where the CCG is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into;

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the CCG for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in

the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a CCG's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

32.4 Arrangements to be followed by the Governing Body in agreeing Insurance cover

(1) Where the Governing Body decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

(2) Where the Governing Body decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Governing Body is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**02/GMS/0037**
Service	**Patient Transport Managed Call Centre**
Commissioner Lead	**CCP for General Medical & Surgical**
Provider Lead	
Period	**1 October 2013 to 30 September 2018**
Date of Review	**January 2016**

1. Population Needs

1.1 National/local context and evidence base

The PTS service is for NHS non-emergency patients and their escorts who meet the eligibility criteria. These are journeys between their place of residence and healthcare facilities, and between hospitals. The place of residence is defined as any address specified at the time of booking, e.g. home, nursing home, hospice, hospital or treatment centre. There may be a requirement for patients to be taken to non NHS establishments e.g. Private Hospitals; however this will only be the case when they are going to receive NHS Funded treatment at that establishment.

It is recognised that PCTs will no longer exist after 2013. However, this service will still remain and continue to exist for the GP practices that formally belonged to NHS Bournemouth and Poole and NHS Dorset. Further clarification will be given nearer the time as to the lead contract arrangements.

NHS Bournemouth and Poole and NHS Dorset will be known as the 'Commissioner'; Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Poole Hospital NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University Foundation Trust will be known as 'Commissioning Agents'.

This service specification is underpinned by the following documents:

Department of Health – Finance Arrangements for ambulance services
Department of Health – Guidance for the commissioning of Ambulance Services
Department of Health – Eligibility Criteria for non-emergency patient transport

The Provider and Commissioner will agree any future amendments in view of changes to national policy, guidance or survey results.

The service is primarily for patients and their escorts who are GP registered in Dorset (including Bournemouth and Poole) and who meet the agreed eligibility criteria for PTS. The eligibility criteria have been determined using national and local guidance.

The current national guidance states that the PCT in which a patient is registered (referred to in this guidance as the "home PCT") is responsible for funding their PTS needs, provided they meet the eligibility criteria set out in the 2008 guidance and any supplementary local criteria. The national guidance states eligible patients for PTS are those where:

The medical condition of the patient is such that they require the skills or support of

PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.

The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.

Full details of the national eligibility guidance are in http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373.

The Healthcare Travel Costs Scheme (HTCS) is a separate scheme and provides guidance on reimbursement of journey expenses for patients meeting low-income criteria. See www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_075759

The journeys will mainly be in or around the South West area but there will be a requirement for transport to anywhere within England, Scotland or Wales.

There may also be a requirement to transport some patients who are not GP registered in geographical area covered – this will primarily be for returning patients who are being discharged from an inpatient stay. It will not generally be for outpatient or day hospital appointments. A charge will need to be made to the responsible commissioner organisation. The Provider will be responsible for raising invoices with the relevant commissioner.

2. Scope

2.1 Aims and objectives of service

The purpose of this service is to ensure that there is an equitable and accessible service to all eligible patients based on their medical need. The model is based on a central point of contact where journey requests are made directly by all patients, unless they form part of the clinical discharge process or pre-determined social care and mental health pathways.

This specification describes the Help Centre functions and should be read in conjunction with the PTS specification as the Provider of the Help Centre will need to have a comprehensive understanding of the PTS service in order to provide a high quality service to meet the needs of Dorset, Bournemouth and Poole patients who are eligible for treatment. The successful provider of the Help Centre will have an overarching remit in relation to any other providers providing transport services and the Help Centre will act as a central coordination and facilitation service for PTS in respect of the other lots.

This specification describes the required service but does not specify how the provider is to manage its service or where the service should be located, although it is important that there is an understanding of the Dorset geography and the needs of patients in relation to PTS. The Provider must meet specified outcomes and relevant performance indicators as described in Section B of the contract and these elements will form the basis of performance management.

The Help Centre Provider and Commissioner must agree and comply with any future changes in view of changes to national policy, guidance or survey results and where appropriate, review this specification to reflect any changes required.

The levels of expected activity for the patients are in the Contract – Section B Part 3. These figures are mainly based on 2011/2012 levels carried out by the current main Provider and various other suppliers. As the activity data was not collected in the same format from all suppliers, the levels are indicative and for guidance only.

The objectives of the specification are to ensure the following:

 Quality – Patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This includes the consistent application of the relevant eligibility criteria (including continual assessment for each journey of the same patient), keeping journey time's low and ensuring promptness of arrival and pick-up.
 Flexible and Responsive – Service must provide flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends. There will also be a need for some enhanced PTS related to specialist vehicle equipment or crew training to meet particular patient requirements.
 Communication and Performance Information – High-quality communication with commissioners to discuss flexible and innovative approaches. Clear and complete information must be provided regularly on activity, finance and quality of service provision.
 Efficiency Savings - Public Sector organisations are required to make efficiency savings whilst maintaining and improving quality of service. Savings can be made by improved productivity, performance and/or innovative service delivery redesigns. Providers will be required to demonstrate innovations to achieve the Commissioners objectives. Any initiatives which impact on service delivery will be agreed prior to implementation with the Commissioner.
 Value for Money – Service must be affordable and provide value for money.
 Green – Service must take action to reduce the carbon footprint of patient journeys wherever possible.
 Innovation and use of Information Technology – Service must be innovative in its approach using best practice to respond to future needs. It needs to make the most effective use of technology for the scheduling of journeys and for the provision of management information.

The following are also essential requirements of the Help Centre Provider:

- Booking information to enable the Provider to schedule the journeys must be provided electronically, direct from the Help Centre.
- Key performance indicators with proposed incentives and deductions for the Provider are set out in the standard contract documentation. The Provider and Commissioner must agree and comply with any future changes in view of changes to national policy, guidance or survey results.
- The Provider must consider the implementation of robust systems to support service redesign.
- Robust relationships must be established with all Commissioning Agents to reflect clinical views on a patient's medical condition.

2.2 Service description/care pathway

The key elements to be provided are:

- To provide an office based within the UK from which it will manage the service.
- To be the first point of access for PTS requests
- To enable bookings to be made efficiently as possible including electronic links with current healthcare providers to allow compatibility between IT systems.
- To ensure calls answered effectively and efficiently.
- To be accessible through means of a single point of contact (using a single telephone number), where patients are not required to repeat personal information to different providers.

- To enable block booking of regular journeys to minimise individual requests (for example, renal, oncology treatments or other regular bookings).
- To provide access to booking requests from healthcare professionals and patients. This may be either via the single point of contact (As above) or via an alternative method to be agreed with the Commissioner.
- To provide a robust eligibility screening service to identify the entitlement to non-emergency transport services for NHS patients.
- To provide a resource to support 'on the day 'discharge requests form healthcare providers which must include the screening of eligibility criteria.
- To collate and process requests from patients/discharge co-ordinators for PTS transport.
- To ensure that premises access issues at either the pick-up or destination are established in order to determine whether a risk assessment is undertaken by the Provider.
- To provide an appropriate response without undue delay or duplication.
- To ensure that when the Help Centre has confirmed a request for a journey that the journey confirmation is forwarded to the appropriate transport providers in a timely manner in accordance with agreed protocols to ensure patients know time of collection.
- To answer queries from healthcare professionals in accordance with agreed protocols.
- To be compliant with the Department of Health guidance, legal requirements and best practices.
- To offer transport advice and assistance to passengers who do not meet the eligibility criteria which must include alternative transport options available to them in their area, access to HTCS scheme for reimbursement of travel costs, voluntary services and other means of transport.
- To be able to reconcile activity with provider invoices to assist in processing of payments and allowing a common currency to be developed; including any claims to commissioners and/or commissioning agents for HTCS using as an example HC5(T) forms.
- To become a key interface with the transport provider to solve any issues regarding bookings.
- To establish robust relationship with Commissioning Agent Staff ensuring that clinical views are considered if a patient's medical conditions has changed.
- To ensure Help Centre staff understand local needs and conditions to offer knowledgeable local information and demonstrate an excellent knowledge of the geography and infrastructure of the areas covered by Bournemouth and Poole and Dorset.
- To ensure good systems of communication exist that contribute to collaborative working with healthcare services, social care and mental health services to ensure continuity.
- To ensure the service is easily accessible by all patients including those who have learning difficulties, are vulnerable, with special needs, whose first language is not English or who have impaired haring.
- To ensure a Help handling system is staffed by appropriately trained personnel, supervised by competent persons and supported by appropriate software.
- To ensure appropriate access to professional/clinical advice is available to support eligibility criteria decisions.
- To ensure that minimum data requirements are obtained for each booking request in line with the approved booking system.
- To ensure that an appropriate and timely appeals process is available in the event of any eligibility disputes.
- Production of management information to assess performance of all transport providers, as well as Help centre performance targets.

Cancelled Journeys

Where Help Centre staff have been notified that a journey is no longer required they must inform the Transport Provider as soon as possible to minimise the number of aborted journeys.

The Help Centre Provider must record and action cancellations received by reason code.

Operational Planning and Booking

The Provider will be able to proactively plan on a 'live' basis to allow capacity to be flexed according to need. In effect this will allow a floating fleet of vehicles to be able to respond to patient demand in an efficient manner maximising resources e.g. less down time for crews but also response times to patients.

The Provider will have data migration support from the existing booking/record systems to ensure a seamless transfer of journey scheduling to the new provider system. The new system will be designed to allow for migration of data to future systems, should this become necessary. This should include the ability to prove the data migration process via test or trial loads.

The Provider's system must have the ability to handle electronic transfer and the import of an electronic data file of transport bookings, for example from a Commissioning Agent's PAS system.

The Provider must ensure requests can be received by alternative methods in the event of system failure.

The Provider will predominately receive bookings by electronic transfer of data or telephone from the Commissioning Agents or the Help Centre via an agreed data system approved by the Commissioner. The Provider will electronically confirm bookings to the booker of the transport request.

The electronic booking system will have all the details necessary to schedule the patient journey and any additional information to provide to the relevant crew. Where a journey falls outside the core contract the pricing for the journey will be determined at the time of booking, based on the Postcodes of the pick-up and drop-off points, tier of service and mobility. If further adaptations are needed, these will be agreed between the Provider and the Commissioner.

The booking system must be able to make post-travel enquiries in order to investigate complaints, accidents or potential disciplinary matters.

The Provider must establish relationships such that the system is mangled effectively. The Commissioner will support this by endeavouring to ensure that care provider's book routine transport well in advance of the day of expected travel.

The Provider must provide storage of all paper and electronic records.

The Provider must provide appropriate staff to manage the contract on a daily basis and to receive a daily workload.

The Provider must have an alternative back-up system if there is a fault with the equipment. This must be clearly stated as part of the business continuity plan.

The Provider is expected to contribute to reducing cancelled journeys. There must be an agreed system between the Provider and Commissioner to achieve this objective.

The Commissioner shall have the right to full access to the Help Centre Providers computer information.

The Provider must prioritise responses for unplanned 'on the day' requests where outside the expected levels.

The Provider must ensure any variations in the route or timetable requested by the Commissioner are implemented. In this event the Commissioner and Provider will have the right to negotiate the rate charged.

In the event of the Transport Provider not being able to perform a journey (other than in the case of a special needs contract), the Help Centre staff must arrange as an emergency measure, for a replacement operator to provide the journey at the Transport Providers expense and must notify the Commissioner accordingly at the earliest opportunity as per Section E, core legal cause and definitions. Such a replacement operator must fulfil all statutory requirements in the same way as the provider.

The majority of journey requests will be received during normal working hours re 8am – 6pm Monday to Friday. However, there will be some short-notice, same day requests for out of hours and weekend journeys that must be received, assessed and processed by the Help Centre. Extended routine hours within 24 hour emergency access is therefore required. The Help Centre operating hours are to be agreed but consideration must be given to how evening and weekend journey requests are handled.

Patient Groups covered including exclusion criteria

The Help Centre Provider must establish the appropriate mode of transport once eligibility criteria have been fulfilled. There are a number of mobility categories which will determine the type of vehicle needed for the patient.

The Help Centre must record when an NHS patient will be accompanied to/from their appointment by a carer, relative or a healthcare professional due to the patient having a health need for an escort.

The mobility categories' of Patients/Passengers are shown below and this information must be contained on the booking request form for the Provider.

Name	Description
Vehicle 1	Patients who are able to walk with limited assistance and require no lifting or moving – one person assistance.
Vehicle 2	Patients who require two persons' assistance to board or alight from the vehicle, or to be lifted in a chair.
Wheelchair 1	Patients who require to travel in their own wheelchair for the journey, with one person's assistance, requiring no lifting or moving.
Wheelchair 2	Patients who require to travel in their own wheelchair for the journey, with two persons' assistance to board and alight from the vehicle.
Electric Wheelchair 1	Patients who require to travel in their own electric wheelchair for the journey, with one person's assistance, requiring no lifting or moving.
Electric Wheelchair 2	Patients who require to travel in their own electric wheelchair for the journey, with two persons' assistance to board and alight from the vehicle.
Stretcher (ST)	Patients who require to lie down for at least part of the journey, with the assistance of two persons' required.

Escort (ESC)	Healthcare patients who have a medical need to be accompanied to/from their appointment by carer/relative/healthcare professional or guide/aid assistance dogs. This may also include a nurse, clinical team or carer may accompany any of the above categories if the patient's condition is such that they require constant attention. This includes patients who have severe communication difficulties such as profound deafness or speech and language difficulties. Such escorts and the escort's mobility will be notified to the Provider at the time of booking. A return journey may be required for clinical escorts accompanying patients being transferred or discharged.
Qualified Crew (High Dependency) [Crew to include a minimum of one Paramedic trained member of staff on the vehicle and the other must be trained in 'Blue Light' emergency driving]	Provide an enhanced level of service to cover all the needs of high dependency patients such as those with complex needs and infectious/communicable conditions/diseases, where a higher level of crew skills will be needed. Specific examples include (but not limited to): - Patients whose medical conditions may require cardiac/pulmonary resuscitation. - Patients transferring after attending the A&E Department who have a variety of conditions such as head or trauma injuries, pregnancy related issues. - Children with a variety of conditions from neurological, meningitis, oncology or terminal conditions. Other areas could include (but are not limited to) pre-transplant transfers, the return of patients following complex surgery such as cardiothoracic, post-fall patients, trauma and orthopaedic injury transfer.
Bariatric (BAR)	A bariatric patient will be defined as anyone regardless of age, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environment access with one or more of the following areas: Has a body mass index (BMI) >40kg/m^2 and or are 40kg above ideal weight for height (NICE 2004) and/or exceed the working load limit and dimensions of the support service such as a bed, chair, wheelchair, couch , trolley, toilet mattress.
Mental Health - specialist inter-unit transfers	Patients will present with complex presentations i.e. physically violent, aggressive and detained under a section of the mental health Act.

- ❖ For all categories patients with additional needs will be clearly identified at the time of requesting. This may include the following:

Clinical requirements of the patient

Patients may have a number of clinical requirements of varying levels of complexity. These include:

- Oxygen required (intermittent and continuous) at varying levels of concentration.
- Infusion drips and drains, and pumps in situ (where possible, these will be disconnected for the journey but some may be required to be continued).

- Patients who require ongoing monitoring during the journey, for example cardiac or other equipment.
- Immunocompromised patients or, due to other health issues, patients required to travel without other patients.
- Patients may also require the specialist skills of trained crew including spinal injury management.

NB. Due to the complexity of patient medical conditions, a nurse or doctor escort may be required to manage the patient's condition during the journey and crew support may also be necessary.

The following risks will also need to be considered by the Provider to ensure that patients are conveyed appropriately and in a timely manner. These include:

- If the patient has been treated for, or is currently experiencing symptoms of, an infectious disease such as norovirus, MRSA, C Diff or Swine Flu.
- Whether the patient's weight and mobility needs require specialist equipment and/or the support of extra personnel.
- Whether there are any access issues at either the pick-up or destination which require a full risk assessment due to patient's mobility. This includes steps and narrow corridors.
- Whether the patient is considered at risk of cardiac or respiratory arrest during the journey and whether a Do Not Resuscitate (DNR) position has been confirmed for the journey.

Other Special Requirements:

Request for a male or female crew member

Escorts: A parent or other responsible adult must accompany all children under the age of 18 years. Patient escorts will be transported only when an authorised request is made at the time of booking, and this includes escorts for end-of- life patients. The definition of who is eligible as an escort is included in the PTS eligibility criteria. Escorts are not subject to journey charging.

Registered Disability Dogs are essential for some patients and accepted by Health Providers for outpatient appointments. The Provider will need to be able to accommodate these transport requests.

Exclusions

1. Patients who need emergency transport. The Emergency Ambulance Service provides call handling and prioritisation of 999 calls from the general public, and other calls and requests from healthcare professionals and other emergency services. There are four types of calls covered by the A&E agreement:

a) Emergency calls from members of the public and healthcare professionals.

b) Urgent requests for ambulance transport from other healthcare professionals defined as being required within 1 to 4 hours.

c) Inter-hospital transfers of an urgent or emergency nature where the patient is moving to a higher level of care.

d) Mental health patients who are under the care of any of the Mental Health partnership Trusts who are assessed as high risk (e.g. sectioned patients) and are not suitable for PTS. A risk assessment tool will be agreed for use.

2. Transport to primary care services provided under the following NHS contract; General Medical

Services/Personal Medical Services/General Dental Services/ Personal Dental Services, e.g. routine appointments to GPs/health centres and dental surgeries.

3. Prisoners – Transport is provided by the prison service.

4. Paediatric intensive care retrieval.

5. Neonatal intensive care retrieval (NICU). (This is a two-way journey to collect a specialist team and transport them to the patient)

6. Non NHS-funded patients.

7. Patients assessed to be not eligible for NHS funded transport.

8. Conveyance of supplies, mail or any other goods unless previously agreed between the Provider and the Commissioner or Commissioning Agent.

9. Patients who require transport outside England, Scotland and Wales. NB: These journeys, if and when they occurred, would be agreed on an individual pricing basis.

2.3 Population covered

The service is primarily for patients registered with a GP in Bournemouth and Poole and Dorset

and who meet the eligibility criteria.

The journeys will mainly be in or around Dorset, Hampshire, Wiltshire, Somerset and Devon areas but there will be a requirement for transport to anywhere within England, Scotland or Wales.

There may also be a requirement to transport some patients who are not GP registered in geographical area covered – this will primarily be for returning patients who are being discharged from an inpatient stay. It will not generally be for outpatient or day hospital appointments. The Provider must engage with the Commissioner in developing a process to manage the repatriation of patients where they are registered with a non Bournemouth and Poole and Dorset GP. A charge will need to be made to the responsible commissioner organisation. The Provider will be responsible for raising invoices with the relevant commissioner and mechanisms will need to be developed to support this process.

2.4 Any acceptance and exclusion criteria

Please refer to section 2.2 Service Description

2.5 Interdependencies with other services

The Provider will work proactively and jointly with Commissioning Agents to ensure the adherence to Eligibility Criteria. To underpin this, the Provider will give regular information on potential misuse of the service so that issues can be quickly resolved. Where there is thought to be blatant disregard for the criteria the Provider is empowered to refer the request to the authorised transport co-ordinator within the Commissioning Agency, or if necessary escalate to the relevant Commissioner.

Communication with Commissioner, Commissioning Agents, Health Staff and Patients

The Authorised Officer of the Commissioner is named in the contract.

The Commissioner expects the Provider's staff to have a proactive, friendly, solution-focussed style of communication. A key objective is to have high-quality communication processes to discuss flexible and innovative approaches.

The Provider shall establish a proactive communications/customer relations policy with the Commissioner. The aim shall be to:

- Ensure public awareness of the access to the service, e.g. via an effective website and information sheets.
- Encourage proper use of the criteria by service users within the Commissioner and Commissioning Agents, e.g. via an effective website, information sheets and face-to-face meetings with key departments.
- Encourage understanding of the system and co-operation from all Healthcare professionals/patients who are requesting transport.
- Ensure the highest standards of communication with Healthcare professionals/patients so there can be a proactive improvement programme.
- Eliminate abuse of the service and minimise abortive journeys and cancellations.

Incidents & Complaints Processes

Please refer to Clause 25 of Section E, core legal clauses and definitions, "Incidents Requiring Reporting" and 27 "Complaints" and Section C, Service Matters part 7.3.

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

The Provider must comply with all relevant current and future legislation, national standards and evidence base set out within this Service Specification and required in the provision of this Service.

In developing this specification the following documents have been drawn upon:

Department of Health – Finance Arrangements for ambulance services
Department of Health – Guidance for the commissioning of Ambulance Services
Department of Health – Eligibility Criteria for non-emergency patient transport

3.2 Applicable local standards

Local Standards are throughout the specification but are shown in full in Section B part 8, part 12 and part 14.

4. Key Service Outcomes

The outcomes of this specification are to deliver an efficient, responsive, equitable and accessible service to all eligible patients measured through the key quality standards as set out in Section B part 8.

The Provider must provide Commissioners with an implementation plan, as part of the tender documentation. This will demonstrate how they will achieve a seamless take-over of undertaking all requests for transport without adversely affecting the quality and reliability of the service. The implementation plan must include a detailed timed program for achieving certain key identified milestones. It must be updated and reported to commissioners during the mobilisation period. As a minimum this must include:

- Launching of the service to ensure that from day one, patient care comes first.
- The establishment of a booking service for patient transport
- The implementation of computer and other systems
- The implementation of communications systems, including media coverage to notify the public/ patients and local NHS and unitary authority staff regarding the new booking process.
- A staff training programme
- Recruitment and transfer of staff
- Management of TUPE responsibilities
- Appointment of managers
- The provision of policies, procedures and reporting standards

5. Location of Provider Premises

The Provider's Premises are located at:

[Name and address of the Provider's Premises **OR** details of the Provider's Premises **OR** state "Not Applicable"]

6. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	**02/GMS.0036**
Service	**Patient Transport Services (PTS)**
Commissioner Lead	**CCP for General Medical & Surgical**
Provider Lead	
Period	**1 October 2013 to 30 September 2018**
Date of Review	**January 2016**

1. Population Needs

1.1 Strategic context

The Department of Health defines non-emergency Patient Transport Services (PTS) as the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients' medical needs. Eligible patients are those:

- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.

- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.

- Recognised as a parent or guardian where children are being conveyed.

Full details of the national eligibility guidance can be found: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373. Eligibility criteria for accessing PTS across the south west can be found in appendix 2.

PTS is only available for patients with a **clear and genuine medical need** – this is assessed by the agreed eligibility criteria (Appendix 2).

The PTS service is for NHS non-emergency patients and their escorts who meet the eligibility criteria. These are journeys between their place of residence and healthcare facilities, and between hospitals. The place of residence is defined as any address specified at the time of booking, e.g. home, nursing home, hospice, hospital or treatment centre. There may be a requirement for patients to be taken to non NHS establishments e.g. Private Hospitals; however this will only be the case when they are going to receive NHS Funded treatment at that establishment.

It is recognised that PCTs will no longer exist after 2013. However, this service will still remain and continue to exist for the GP practices that formally belonged to NHS Bournemouth and Poole and NHS Dorset. Further clarification will be given nearer the time as to the lead contract arrangements.

NHS Bournemouth and Poole and NHS Dorset will be known as the 'Commissioner'; Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Poole Hospital NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University Foundation Trust will be known as 'Commissioning Agents'.

This service specification is underpinned by the following documents:

Department of Health – Finance Arrangements for ambulance services
Department of Health – Guidance for the commissioning of Ambulance Services
Department of Health – Eligibility Criteria for non-emergency patient transport

The Provider and Commissioner will agree any future amendments in view of changes to national policy, guidance or survey results.

1.2 Evidence Base

- The levels of expected activity for the patients are in the Contract – Section B Part 3. These figures are mainly based on 2011/2012 levels carried out by the current main Provider and various other suppliers. As the activity data was not collected in the same format from all suppliers, the levels are indicative and for guidance only.
- The majority of the workload will be notified in sufficient time to enable the activity to be planned; however the workload for short-notice/ same-day requests will fluctuate from day to day.
- The Provider should be aware that there will be daily and seasonal peaks and troughs in demand.
- The Provider will assist the Commissioner and Commissioning Agents in actively managing demand. This will include providing systematic feedback on patients who, it is thought, may not be eligible to NHS funded transport, discussing modifications to existing procedures, and piloting new or innovative schemes.
- Activity levels for this contract cannot be guaranteed.

1.3 General Overview

The service is primarily for patients and their escorts who are GP registered in Dorset (including Bournemouth and Poole) and who meet the agreed eligibility criteria for PTS. The eligibility criteria have been determined using national and local guidance.

The current national guidance states that the PCT in which a patient is registered (referred to in this guidance as the "home PCT") is responsible for funding their PTS needs, provided they meet the eligibility criteria set out in the 2008 guidance and any supplementary local criteria. The national guidance states eligible patients for PTS are those where:

> The medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
>
> The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
>
> Full details of the national eligibility guidance are in http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373.

The Healthcare Travel Costs Scheme (HTCS) is a separate scheme and provides guidance on reimbursement of journey expenses for patients meeting low-income criteria. See www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/DH_075759

The journeys will mainly be in or around the South West area but there will be a requirement for

transport to anywhere within England, Scotland or Wales.

There may also be a requirement to transport some patients who are not GP registered in geographical area covered – this will primarily be for returning patients who are being discharged from an inpatient stay. It will not generally be for outpatient or day hospital appointments. A charge will need to be made to the responsible commissioner organisation. The Provider will be responsible for raising invoices with the relevant commissioner.

1.4 Expected Outcomes

A high quality, patient focused service that is cost effective, innovative and provides value for money.

2. Scope

2.1 Aims and Objectives of the Service

It is the aim of the procurement exercise to allocate a lead provider through supplier tiering to allow each of the procurement lots to be managed (not provided) by one primary supplier.

The Provider will be responsible for the safe, timely and comfortable transport of patients between their place of residence and the healthcare facility and between healthcare facilities and from the healthcare facility to their place of residence and will deliver a managed PTS service for all patients registered with a GP Practice who belong to the Lead or Associate Commissioners and who meet the agreed eligibility criteria for PTS. The Provider will manage the entire PTS journey requirements for patients including out of area transfers, patients defined as bariatric, specialist mental health needs or as having complex manual handling needs. The eligibility criteria referred to above has been determined using national and local guidance.

The Provider will ensure there is adequate data collection down to GP and Commissioner level to monitor this contract on behalf of all the Commissioners and in preparation for future GP commissioning consortiums.

Responsible commissioner rules will apply for patients who live in the geographical area covered by this contract but have no history of being registered with a GP.

Below are discrete services in recognition that more services are being delivered closer to a person's home or as part of their Health Care needs or as a result of patient choice.

- Independent private sector hospitals through local standard acute contracts providing NHS treatment
- Nursing homes transfer requests
- Hospices
- Intermediate care step up/down beds
- Falls clinics in the community
- Any satellite consultant or rehabilitation sessions in the community

In all cases the patients must meet the eligibility criteria.

The objectives of the specification are to ensure the following:

 Quality – Patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This includes keeping journey times low and ensuring promptness of arrival and pick-up.
 Flexible and Responsive – Service must provide flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends. There will also be a need for some enhanced PTS related to specialist vehicle equipment or crew training to meet particular patient requirements.
 Communication and Performance Information – High-quality communication with commissioners to discuss flexible and innovative approaches. Clear and complete information must be provided regularly on activity, finance and quality of service provision.
 Efficiency Savings - Public Sector organisations are required to make efficiency savings whilst maintaining and improving quality of service. Savings can be made by improved productivity, performance and/or innovative service delivery redesigns. Providers will be required to demonstrate innovations to achieve the Commissioners objectives. Any initiatives which impact on service delivery will be agreed prior to implementation with the Commissioner.
 Value for Money – Service must be affordable and provide value for money.
 Green – Service must take action to reduce the carbon footprint of patient journeys wherever possible.
 Innovation and use of Information Technology – Service must be innovative in its approach using best practice to respond to future needs. It needs to make the most effective use of technology for the scheduling of journeys and for the provision of management information.

2.2 Service Description

The Department of Health gives guidance on the type of service provision which is covered. It is about treatment, outpatient appointment or diagnostic services, i.e. procedures that were traditionally solely provided in hospital, but are now available in a hospital (NHS or Private) or community setting.

The main types of NHS funded services to and from which patients are transported are:

- Any health care appointment at any treatment centre (these clinics cover a wide variety of treatments from oncology, where patients can have daily appointments, renal dialysis where patients will have regular sessions each week to surgical procedures).
- Day case and inpatient.
- Transfer of cardiac patients between treatment centres.
- Discharges from hospitals/treatment centres. This will consist of an element of planned discharges but will include a significant number of unplanned discharges on the day.
- Inter-hospital transfers – some of which are time essential. NB: Also included are Neonatal Intensive Care Unit patients who need inter-hospital transfers within the catchment, and will be transported with their own medical attendees.
- Accident and Emergency – patients going home after attending the department.
- End of life patients. Due to the nature of the patient's condition these may need to be fast tracked through the system.

There is a requirement for the following journey planning and provision:

- Providing services at differing times and days. (There is an intention to extend outpatient and operating sessions in some new premises to between 07.00 and 22.00, 7 days a

week).

- To allow for specific provision of services for renal patients who will require transport at varying times depending on treatment plan. The Provider will need to make arrangements for allowing patients to attend at various times including 6am clinic starts as well as pick up at 10pm at night.
- Providing services for outpatient appointments, admissions and discharges, same-day, transfers, timed response and short-notice requests.
- Providing a service for escorts where required.
- Providing a preset time slot where packages of care are being organised or where bed swaps are being organised at a specific time. Further examples of timed responses are for the day hospitals and rehabilitation units where arrival and return times for each session are critical to ensure patients receive maximum benefit from their attendance and home visits where a number of specialist services have been co-ordinated.
- Providing services to respond to new locations, e.g. new treatment centres and premises providing community based services.
- Changing services to reflect population trends, such as an ageing population.
- Providing an enhanced level of service to cover all the needs of high-dependency patients such as those with complex medical needs and infectious/communicable conditions/diseases, where a higher level of crew skills will be needed. Specific examples include:
    - Cardiac patients who have had treatment for cardiac surgery, angioplasty, cardiac failure.
    - Patients going home after attending the Emergency Department who have a variety of conditions such as head or trauma injuries, pregnancy related issues.
    - Children with a variety of conditions e.g. neurological, meningitis, oncology or terminal conditions should be transported safely in appropriate seating restraints for normal seats and stretchers.
    - Other areas could include pre-transplant transfers; the return of patients following complex surgery such as cardiothoracic; post-fall patients, trauma and orthopaedic injury transfer.
    - Providing a service for same-day discharges which would otherwise lead to the need for an extended use of a hospital bed.
    - Responding to a request for transport ‘out of hours’. This will necessitate provision of a service 24/7 365 days of the year to include all statutory and discretionary Bank and Public Holidays.
    - Availability of resources to undertake long distance and repatriation work. This will normally be a pre-planned request; however there will be a requirement for on the day requests as well. These are not anticipated to be significant in numbers.
    - Provide a liaison office for each acute health care site (to be discussed and agreed with each commissioning agent) to work in partnership to facilitate the management of transport provision.

Exclusions

1. Patients who need emergency transport. The Emergency Ambulance Service provides call handling and prioritisation of 999 calls from the general public, and other calls and requests from healthcare professionals and other emergency services. There are four types of calls covered by the A&E agreement:

a) Emergency calls from members of the public and healthcare professionals.

b) Urgent requests for ambulance transport from other healthcare professionals defined as being required within 1 to 4 hours.

c) Inter-hospital transfers of an urgent or emergency nature where the patient is moving to a higher level of care.

d) Mental health patients who are under the care of any of the Mental Health partnership Trusts who are assessed as high risk (e.g. sectioned patients) and are not suitable for PTS. A risk assessment tool will be agreed for use.

2. Transport to primary care services provided under the following NHS contract; General Medical Services/Personal Medical Services/General Dental Services/ Personal Dental Services, e.g. routine appointments to GPs/health centres and dental surgeries.

3. Prisoners – Transport is provided by the prison service.

4. Paediatric intensive care retrieval.

5. Neonatal intensive care retrieval (NICU). (This is a two-way journey to collect a specialist team and transport them to the patient)

6. Non NHS-funded patients.

7. Patients assessed to be not eligible for NHS funded transport.

8. Conveyance of supplies, mail or any other goods unless previously agreed between the Provider and the Commissioner or Commissioning Agent.

9. Patients who require transport outside England, Scotland and Wales. NB: These journeys, if and when they occurred, would be agreed on an individual pricing basis.

Patient Mobility and Escorts

Mobility categories of patients are shown below. This information will be indicated on the booking request to the Provider.

Name	Description
Vehicle 1	Patients who are able to walk with limited assistance and require no lifting or moving – one person assistance.
Vehicle 2	Patients who require two persons' assistance to board or alight from the vehicle, or to be lifted in a chair.
Wheelchair 1	Patients who require to travel in their own wheelchair for the journey, with one person's assistance, requiring no lifting or moving.
Wheelchair 2	Patients who require to travel in their own wheelchair for the journey, with two persons' assistance to board and alight from the vehicle.
Electric Wheelchair 1	Patients who require to travel in their own electric wheelchair for the journey, with one person's assistance, requiring no lifting or moving.
Electric Wheelchair 2	Patients who require to travel in their own electric wheelchair for the journey, with two persons' assistance to board and alight from the vehicle.
Stretcher (ST)	Patients who require to lie down for at least part of the journey, with the assistance of two persons' required.

Escort (ESC)	Healthcare patients who have a medical need to be accompanied to/from their appointment by carer/relative/healthcare professional or guide/aid assistance dogs. This may also include a nurse, clinical team or carer may accompany any of the above categories if the patient's condition is such that they require constant attention. This includes patients who have severe communication difficulties such as profound deafness or speech and language difficulties. Such escorts and the escort's mobility will be notified to the Provider at the time of booking. A return journey may be required for clinical escorts accompanying patients being transferred or discharged.
Qualified Crew (High Dependency) [Crew to include a minimum of one Paramedic trained member of staff on the vehicle and the other must be trained in 'Blue Light' emergency driving]	Provide an enhanced level of service to cover all the needs of high dependency patients such as those with complex needs and infectious/communicable conditions/diseases, where a higher level of crew skills will be needed. Specific examples include (but not limited to): - Patients whose medical conditions may require cardiac/pulmonary resuscitation. - Patients transferring after attending the A&E Department who have a variety of conditions such as head or trauma injuries, pregnancy related issues. - Children with a variety of conditions from neurological, meningitis, oncology or terminal conditions. Other areas could include (but are not limited to) pre-transplant transfers, the return of patients following complex surgery such as cardiothoracic, post-fall patients, trauma and orthopaedic injury transfer.
Bariatric (BAR)	A bariatric patient will be defined as anyone regardless of age, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environment access with one or more of the following areas: Has a body mass index (BMI) >40kg/m^2 and or are 40kg above ideal weight for height (NICE 2004) and/or exceed the working load limit and dimensions of the support service such as a bed, chair, wheelchair, couch , trolley, toilet mattress.
Mental Health - specialist inter-unit transfers	Patients will present with complex presentations i.e. physically violent, aggressive and detained under a section of the mental health Act.

- ❖ For all categories patients with additional needs will be clearly identified at the time of requesting. This may include the following:

Clinical requirements of the patient

Patients may have a number of clinical requirements of varying levels of complexity. These include:

- Oxygen required (intermittent and continuous) at varying levels of concentration.
- Infusion drips and drains, and pumps in situ (where possible, these will be disconnected

for the journey but some may be required to be continued).

- Patients who require ongoing monitoring during the journey, for example cardiac or other equipment.
- Immunocompromised patients or, due to other health issues, patients required to travel without other patients.
- Patients may also require the specialist skills of trained crew including spinal injury management.

NB. Due to the complexity of patient medical conditions, a nurse or doctor escort may be required to manage the patient's condition during the journey and crew support may also be necessary.

The following risks will also need to be considered by the Provider to ensure that patients are conveyed appropriately and in a timely manner. These include:

- If the patient has been treated for, or is currently experiencing symptoms of, an infectious disease such as norovirus, MRSA, C Diff or Swine Flu.
- Whether the patient's weight and mobility needs require specialist equipment and/or the support of extra personnel.
- Whether there are any access issues at either the pick-up or destination which require a full risk assessment due to patient's mobility. This includes steps and narrow corridors.
- Whether the patient is considered at risk of cardiac or respiratory arrest during the journey and whether a Do Not Resuscitate (DNR) position has been confirmed for the journey.

Other Special Requirements:

Request for a male or female crew member

Escorts: A parent or other responsible adult must accompany all children under the age of 18 years. Patient escorts will be transported only when an authorised request is made at the time of booking, and this includes escorts for end-of- life patients. The definition of who is eligible as an escort is included in the PTS eligibility criteria. Escorts are not subject to journey charging.

Registered Disability Dogs are essential for some patients and accepted by Health Providers for outpatient appointments. The Provider will need to be able to accommodate these transport requests.

Transportation and Care of Patients/Escorts

PTS is only for patient transport and ideally a single piece of patient luggage/personal belongings (dependent on need of patient in relation to healthcare equipment or devices).

The Commissioner and Commissioning Agent will:

Inform the patient to be ready 90 minutes prior to their scheduled pick-up. Standard information will be contained in the patient PTS information sheet and hospital letter.

The Provider will operate an agreed system for: confirming more accurate transport pick-up times with patients; notifying the patients of any changes and how patients can contact the Provider.

The Provider will set up a 'call back' service to patients to confirm whether they still require the transport as requested. This should be done the working day prior to travel at the latest.

Operational Planning and Booking

The Provider will be able to proactively plan on a 'live' basis to allow capacity to be flexed according to need. In effect this will allow a floating fleet of vehicles to be able to respond to patient demand in an efficient manner maximising resources e.g. less down time for crews but also response times to patients.

The Provider will have data migration support from the existing booking/record systems to ensure a seamless transfer of journey scheduling to the new provider system. The new system will be designed to allow for migration of data to future systems, should this become necessary. This should include the ability to prove the data migration process via test or trial loads.

The Provider's system must have the ability to handle electronic transfer and the import of an electronic data file of transport bookings, for example from a Commissioning Agent's PAS system.

The Provider will predominately receive bookings by electronic transfer of data or telephone from the Commissioning Agents or the Help Centre via an agreed data system approved by the Commissioner. The Provider will electronically confirm bookings to the booker of the transport request.

The electronic booking system will have all the details necessary to schedule the patient journey and any additional information to provide to the relevant crew. Where a journey falls outside the core contract the pricing for the journey will be determined at the time of booking, based on the postcodes of the pick-up and drop-off points, tier of service and mobility. If further adaptations are needed, these will be agreed between the Provider and the Commissioner.

Cancelled and Abortive Journeys

Journeys which are cancelled will not form part of the chargeable contract activity if cancelled before the day the journey was required or "on the day" if the vehicle has not commenced the journey.

Journeys may be aborted for reasons outside the control of the Provider. This will form part of the chargeable contract activity if the journey could not be or is not required to be reallocated. Escorts booked to travel with the aborted patient will not count as chargeable activity.

The Provider will proactively work with the Commissioner on ways to reduce aborted journeys.

It is expected that only in exceptional circumstances shall the Provider cancel journeys for reasons within their control. The Provider must notify the affected Commissioning Agents in advance if there is a need to cancel any journey and must undertake to inform any patients concerned of the cancellation.

Activity Levels and Demand Management

The levels of expected activity for the patients are attached – Section B Part 3. These figures are mainly based on 2011/2012 levels carried out by the current main provider and various other suppliers. As the activity data was not collected in the same format from all suppliers, the levels are indicative and for guidance only.

The majority of the workload will be planned, but the workload for short-notice/ same-day requests will fluctuate from day to day.

The Provider should be aware that there will be significant daily and seasonal peaks and troughs in demand.

The Provider will assist the Commissioner and Commissioning Agents in actively managing demand. This will include providing systematic feedback on patients who, it is thought, may not be eligible to NHS funded transport, discussing modifications to existing procedures, and piloting new or innovative schemes.

Activity levels for this contract cannot be guaranteed.

Incidents & Complaints Processes

Please refer to Clause 25 of Section E, core legal clauses and definitions, "Incidents Requiring Reporting" and 27 "Complaints" and Section C, Service Matters part 7.3.

2.3 Population Covered

The service is primarily for patients registered with a GP in Bournemouth and Poole and Dorset and who meet the eligibility criteria.

The journeys will mainly be in or around Dorset, Hampshire, Wiltshire, Somerset and Devon areas but there will be a requirement for transport to anywhere within England, Scotland or Wales.

There may also be a requirement to transport some patients who are not GP registered in geographical area covered – this will primarily be for returning patients who are being discharged from an inpatient stay. It will not generally be for outpatient or day hospital appointments. The Provider must engage with the Commissioner in developing a process to manage the repatriation of patients where they are registered with a non Bournemouth and Poole and Dorset GP. A charge will need to be made to the responsible commissioner organisation. The Provider will be responsible for raising invoices with the relevant commissioner and mechanisms will need to be developed to support this process.

2.4 Any acceptance or exclusion criteria

Please refer to section 2.2 Service Description.

2.5 Interdependencies with other Services

The Provider will work proactively and jointly with Commissioning Agents to ensure the adherence to Eligibility Criteria. To underpin this, the Provider will give regular information on potential misuse of the service so that issues can be quickly resolved. Where there is thought to be blatant disregard for the criteria the Provider is empowered to refer the request to the authorised transport co-ordinator within the Commissioning Agency, or if necessary escalate to the relevant Commissioner.

On-site Facilities and Parking

NHS organisations will allow the Provider's staff to use their hand-washing facilities and public refreshment areas.

NHS organisations will provide administrative facilities if it is agreed to a Provider's member of staff being temporarily or permanently based within a hospital of which any costs will be reimbursed by the Provider.

Parking will be provided for the dropping off and collection of patients at the main Hospital sites within the area. On-site facilities are not available for overnight or long term parking.

All parking is solely at the Providers own risk.

The Commissioner, Commissioning Agents and other NHS organisations will not be providing linen unless in an emergency sanctioned by the NHS Organisation's nominated person and disposal of Waste (domestic and clinical) is the responsibility of the Provider.

Communication with Commissioner, Commissioning Agents, Health Staff and Patients

The Authorised Officer of the Commissioner is named in the contract.

The Commissioner expects the Provider's staff to have a proactive, friendly, solution-focussed style of communication. A key objective is to have high-quality communication processes to discuss flexible and innovative approaches.

The Provider shall establish a proactive communications/customer relations policy with the

Commissioner. The aim shall be to:

- Ensure public awareness of the access to the service, e.g. via an effective website and information sheets.
- Encourage proper use of the criteria by service users within the Commissioner and Commissioning Agents, e.g. via an effective website, information sheets and face-to-face meetings with key departments.
- Encourage understanding of the system and co-operation from all Healthcare professionals/patients who are requesting transport.
- Ensure the highest standards of communication with Healthcare professionals/patients so there can be a proactive improvement programme.
- Eliminate abuse of the service and minimise abortive journeys and cancellations.

3. Applicable Service Standards and Service Delivery

3.1 National Standards

The Provider must comply with all relevant current and future legislation, national standards and evidence base set out within this Service Specification and required in the provision of this Service.

In developing this specification the following documents have been drawn upon:

Department of Health – Finance Arrangements for ambulance services
Department of Health – Guidance for the commissioning of Ambulance Services
Department of Health – Eligibility Criteria for non-emergency patient transport

I3.2 Local Standards

Local Standards are throughout the specification but are shown in full in Section B part 8, part 12 and part 14.

Change of Destination

Patients must not be taken to a destination other than that specified on the booking request or as subsequently amended unless it is authorised by Commissioners/ Commissioning Agents designated point of contact.

Delivery Points

It is a principle within this contract that every reasonable attempt is made to collect/deliver patients to and from the agreed points at the agreed time. Within NHS Facilities, patients shall be delivered to the designated Ward/Department and collected from the same unless a discharge lounge system is in place or alternative destination is specified.

Location of Office Base and Vehicles

The Provider is required to have an office base within the boundaries of the geographical area covered from which it will manage the service. The Commissioner will not be providing the office

base.

The Provider will provide garaging, maintenance, cleaning and consumables for all vehicles.

The Provider will provide as many office bases, garages, shower, rest and changing areas and facilities for their staff as are required to service the contract. These are expected to be Disability Discrimination Act compliant and to be of a good standard in line with being a good employer.

4. Key Service Outcomes

The outcomes of this specification are to deliver an efficient, responsive, equitable and accessible service to all eligible patients measured through the key quality standards as set out in Section B part 8.

5. Location of Provider Premises

The Provider's Premises are located at:

[Name and address of the Provider's Premises **OR** details of the Provider's Premises **OR** state "Not Applicable"]

6. Individual Service User Placement

Not applicable

Appendix 1

Definitions

"Activity"	The movement of patients within the scope of this contract.
"Abort"	When a vehicle has been allocated and has started moving on the journey. If the first leg of the journey is aborted, then the return is cancelled. Aborts are chargeable. Escorts booked to travel with the aborted patient will not count as chargeable activity.
"Bariatric"	A bariatric patient will be defined as anyone regardless of age, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environmental access with one or more of the following area' - Has a Body Mass Index (BMI) > 40 kg/m² and or are 40kg above ideal weight for height (NICE 2004) - Exceeds the Working load limit (WLL) and dimensions of the support surface such as a bed, chair, wheelchair, couch, Trolley, toilet, mattress
"Cancellation"	Journeys cancelled before the live day, or "on the day" where a vehicle has not started moving on the journey. Cancellations are not chargeable.
"Commissioner"	The organisations responsible for, and seeking to, secure the provision of patient transport services for their populations, by a provider under this contract. For the purposes of this contract this refers to the local Primary Care Trusts.
"Commissioning Agent"	Organisations with delegated responsibility for the day to day management of patient transport contracts on behalf of the Commissioner. For the purposes of this contract Commissioning Agent refers to the local Acute and Partnership trusts.
"Confirmed"	A journey undertaken to be delivered by the Provider. An agreed number of patient movements available to each PCT and Commissioning Agent, profiles of which should be agreed in advance of the contract.

"Contracted Activity"	
"Declined/Refused"	At initial request, the Provider is unable to accommodate the journey. The Provider will notify the Commissioner of this in good time.
"Escorts"	An accompanying person who is escorting a patient, where a medical need has been identified in line with DH Eligibility Criteria. Escorts must be approved by the Commissioner and notified at the time of booking.
"Eligibility Criteria"	A set of decision making principles, following release of DH guidance, collaboratively agreed across the counties of Cornwall, Devon, Dorset & Somerset (see Enc 29).
"Loading Times"	The time taken to load a patient from collection point to vehicle (and vice-versa) Consideration must be given at time of booking if the length of time required to load is likely to be extensive – i.e. due to medical conditions or type of equipment required.
"Out of Area"	Operationally agreed as being outside of the 4 south west counties but with the explicit inclusion of those treatment centres identified which are not within the 4 south west counties.
"Patient Ready"	A patient will be deemed ready when they are able to move immediately to a vehicle. Wards must ensure patients have relevant equipment, medicines and luggage – ready to go.
	The Provider of patient transport services under this contract.
	Operationally agreed as being within the 4 south west counties but

with the explicit inclusion of those treatment centres identified which are not within the 4 south west counties.

"Provider"

.

"Within Area"

Appendix 2

Eligibility Criteria for

Non-Emergency Patient Transport Services (PTS)

Purpose of Document

This document sets out the general principles of eligibility for patients requiring non-emergency, planned transportation to/from premises providing NHS healthcare and between NHS healthcare providers.

What is PTS?

Non-Emergency Patient Transport Services (PTS) is the non-urgent, planned transportation of patients whose medical condition is such that they require the skills or support of clinically trained PTS staff and/or their equipment on/after their journey.

The forms of transport provided should include a range of vehicle types and levels of care consistent with the patients' *medical needs*. This could be an ambulance or another type of suitably equipped vehicle.

PTS is not provided for patients with a medical condition that does not require the skills or support of clinically trained PTS staff/equipment on/after their journey unless their health would be detrimentally impacted if travelling by other means.

Eligible patients are not charged for PTS transport provided by the NHS.

Who is eligible for PTS?

Eligible patients are those:

- Where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.

- Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
- Recognised as a parent or guardian where children are being conveyed.

PTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

Affordability is not a qualifying factor for PTS. Only patients whose health would be adversely affected if travelling by other means are eligible. Financial assistance with transport is provided for through the Hospital Travel Costs Scheme.

What is 'medical need'?

Medical need is defined as the definite or likely requirement for the skills or support of clinically trained PTS staff and/or their equipment on/after the patient's journey.

There are three main categories of medical need based on a patient's mobility, protection and treatment:

Mobility:

- Patient will need substantial assistance/support to move from their bed/chair at pick-up point to vehicle and from vehicle to destination
- Unable to weight-bear, transfer or self-mobilise.
- Substantial assistance/support due to poor building access.

Protection:

- Journey by other means would be detrimental to health
- Patient needs protection to prevent harm to themselves and/or existing wound or condition
- Passengers or vehicle crew will need to be protected due to the patient's condition

Treatment:

- Patient needs to be monitored and/or treated on or after the journey.

PTS eligibility and journey distance, frequency and duration

DH guidance (November 2007) states that patients should be able to access healthcare without detriment to their medical condition. The **distance**, **frequency** and **duration** of the journey should be taken into consideration in *conjunction with the patient's medical condition at that time* when determining their need for PTS.

Distance, frequency and journey duration are not qualifying criteria for PTS transport without taking the patient's medical condition and requirement for clinical support into account. Frequency, distance or time travelling will not affect a patient's eligibility for PTS unless it detrimentally impacts on the health of the patient.

NHS Dorset Clinical Commissioning Group Governing Body

Contract for the provision of a Non-Emergency Patient Transport Service in Dorset

Date of the meeting	15th May 2013
Author	David Way – Deputy Head of Procurement Sarah Turner - Principal Programme Lead (Mid)
Sponsoring DCCGGB member	Jane Pike, NHS Dorset Clinical Commissioning Group, Director of Review Design and Delivery
Purpose of report	To inform the Trust Board of the tendering process undertaken and the associated recommendations following evaluation
Recommendation	The Governing Body is asked to **Approve** the report.
Resource implications	£3,893,973.70 approx per annum
Link to strategic objectives	Designing Services around patients Preventing ill health and reducing inequalities Ensuring sustainable healthcare services
Risk assurance Impact on high level risks	Risk that Activity Data does not reflect true activity at the Trusts Risk of the outgoing providers not meeting service levels Risk of mobilisation failures due to size and scope of the project.
Privacy impact assessment	The Commissioner is to work with the new provider and Information Governance Team to sign off that all points will be addressed before launch date 1st October 2013
Outcome of equality impact assessment process	An Equality Impact Assessment has been completed and the need to ensure that leaflets in other languages are available and that access to translators to arranged where required
Actions to address impact	In coming provider and Commissioner to work on any leaflets and ensure translators can be accessed.

Legal implications	
Freedom of information	Restricted – any request would have to be considered in relation to commercial confidentiality.
Public and patient involvement	• 2 patient representatives evaluated were involved in assessing the submissions on the presentation day of the shortlisted tenders, to give their opinions. • Various patient groups and the local authorities were briefed and views sort throughout the process
Current status	**GREEN**
Trend	⟺

Contract for the provision of a Non-Emergency Patient Transport Service in Dorset

Recommendation Report for the Award of Contract

1. Purpose of Report

1.1 The purpose of this report is to seek approval for the award of a NHS Standard Contract for the supply of Non-emergency Patient Transport Services (PTS) in Dorset.

1.2 The report will outline the tender process undertaken and the basis upon which recommendations are made, providing proof of compliance with corporate governance requirements and demonstrating where best value has been achieved.

2. Reason for the Contract

2.1 The current service has been on-going for in excess of 10 years with South Western Ambulance Service Foundation Trust (SWASFT) and its predecessor Dorset Ambulance Service as the main provider and with a number of other smaller private providers under what is known as the 5 Lots contract. The 5 Lots contract covered PTS requirements such as out of hours, out of area and specialist transport for bariatric patients etc. where SWASFT could not provide a service.

2.2 The current contract was managed across the South West region by Torbay Care Trust and the decision was made by all the PCTs party to the contract that a full market testing should be carried out, as it was felt the current provision had not moved with the changes in the NHS such as longer clinic times and weekend working. The Commissioners decided a fresh approach was needed to give more flexibility.

2.3 Following engagement with key stakeholders through a project group and review of the market it was decided that each county would tender for their own service. So Dorset CCG has tendered the opportunity for a pan Dorset approach to be led and contract managed by the CCG.

2.4 As part of the service re-design it is the intention to change the current funding structure of PTS by removing the funding from the Acute and Community Trust contracts and the CCG holding the funding. The intention being that the CCG will have overall control of how PTS funding is spent.

3. Project scope and specification

3.1 The key objectives of the procurement were set as:-

- To procure for innovative approaches to delivering the specifications
- Contract with a compliant provider meeting the agreed specifications
- The introduction of a new Help/call centre to ensure patients meet eligibility criteria is able to sign post non eligible patients to other means of transport and provide better levels of data than currently available.
- To offer the opportunity to smaller and local businesses and the voluntary sector by giving the opportunity of providing smaller lots as part of a bigger service.
- If there are multiple organisations submitting a tender, to have an identified lead organisation and for it to add value to the service
- Deliver clinical effectiveness and patient safety
- Ensure that the patient and public needs are listened to and met
- Secure the full range of services within the agreed budget
- Meet project timelines
- Engage, communicate and consult effectively with all key stakeholders and ensure issues are considered in the selection process
- System and corporate governance is applied.

3.2 The decision was made to include the use of standard NHS patient eligibility criteria for Patient Transport services for the new contract and to that end it was decided that a Patient Help / Call centre would be part of the service specification. The Help / Call centre staff would be accessible to both health professionals and patients and would be responsible to checking eligibility, allocating resources, managing data and ensuring full utilisation of the service. The centre would also act as a resource for signposting non-eligible patients to other providers of transport such as the voluntary sector, social transport schemes and public transport.

3.3 The decision was made that due to the current mix of providers of PTS, NHS, private PTS and Taxis that we would offer the opportunity for bidders to bid for individual lots, a mix of lots or all lots. The Lots consisted of:

- Lot 1 The Help / Call Centre
- Lot 2 PTS (core PTS ambulances, mini buses etc)
- Lot 3 Other modes of transport Cars MPV etc (taxi type service)
- Lot 4 Qualified crew (for the non-urgent transfer of complex patients requiring constant monitoring of their condition)
- Lot 5 Bariatric and Infectious patients
- Lot 6 Mental Health (specialist)
- Lot 7 Out of Area (repatriation and any out of area specialist care appointments)

3.4 The project team overseeing the procurement is:

Sarah Turner	Project Lead
Jane Pike	Commissioning Lead
Vanessa Reed	Quality Lead
Hayley Goddard	Workforce Lead
Chris Hickson	Finance Lead
Michael Richardson	The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Mevalyn Cross	The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Tony James	Dorset County Hospital NHS Foundation Trust
Angie Forsey	Dorset County Hospital NHS Foundation Trust
David Bennett	Poole Hospital NHS Foundation Trust
Beckie Leighs	Poole Hospital NHS Foundation Trust
Sally O'Donnell	Dorset Healthcare University NHS Foundation Trust
David Way	Sustainability Lead
David Way	Procurement

4. Selection of Suppliers

4.1 The procurement falls under the 'Part A' regulations of the European Union Procurement Law, so it requires the full vigor of the regulations of a European Procurement there is an obligation to adhere to the core principles of transparency, openness and non discrimination.

4.2 Accordingly an advert was placed on the national Supply2Health website and in the Official Journal of the European Union on 11th May 2012 seeking expressions of interest in provision of the services before the deadline of 7th June 2012.

4.3 All suppliers were directed to express an interest on the online procurement portal 'Tactica'

4.4 46 suppliers expressed an interest in the service opportunity; a full list is available upon request.

4.5 A bidder event was undertaken as part of the procurement process. The event held during the expressions of interest period, was a market stimulation/briefing event that was scheduled for 18th January 2013. The event was an information briefing session giving the levels of data available and the outline of the specifications for the service

5. Tender Process

5.1 Pre-qualification Questionnaire (PQQ) documents were distributed via Tactica on 27th June 2013 with a submission date of 7th July 2013. As part of the tender questionnaire, a separate section was included to test provider compliance against governance requirements and financial probity/viability.

5.2 There were 27 completed PQQ received and all 27 passed successfully the full list of suppliers is available upon request.

5.3 All suppliers were invited to submit a tender bid and tender documents were distributed on 30th August 2012, with an initial submission deadline for completed tenders to be uploaded on Tactica by midday 12th October 2012.

5.4 Tender submissions were received from the following 15 organisations:

- 1st Response Medical Services Ltd
- Ability Transport Services
- Arriva Passenger Services
- Clearanswer Call Centres
- Coperforma Ltd
- E-Zec Medical Transport Services Ltd
- F.A.S.T Ambulance Service Ltd
- Integrated Transport Management Solutions
- Medical Services Ltd
- Mobilecare Ltd with Salisbury Hospital NHS Foundation Trust
- NSL Ltd
- Poole Radio Cabs (Ambutrax ltd)
- Radio Cabs (Yeovil)
- South Western Ambulance Service Foundation Trust
- Salisbury Patient Transport Services LTD

6. Evaluation and Adjudication

6.1 An evaluation plan detailing how tenders would be evaluated was prepared and agreed by the project team prior to the receipt of tenders. The evaluation panel comprised:

Sarah Turner	Project Lead
Matt Wain	Quality Lead
Hayley Goddard	Workforce Lead
Chris Hickson	Finance Lead
Michael Richardson	Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Mevalyn Cross	Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Tony James	Dorset County Hospital NHS Foundation Trust
Angie Forsey	Dorset County Hospital NHS Foundation Trust
David Bennett	Poole Hospital NHS Foundation Trust
Beckie Leighs	Poole Hospital NHS Foundation Trust
Sally O'Donnell	Dorset Healthcare University Foundation Trust
David Way	Sustainability Lead
Heather Teasdale	Patient representative (presentation phase only)
Sarah Horniman	Patient representative (presentation phase only)
David Way	Procurement

6.2 Following receipt of the tender submissions the proposals were dispatched to all evaluators for scoring. The evaluators' scores and comments were consolidated onto a summary spreadsheet.

6.3 The following an analysis of the scores of the bidders submitting for individual lots or a mix of lots it was clear that only those bidders offering to provide all the lots were able to demonstrate the quality and ability required to meet the specifications. None of the single or mixed lot bidders which were evaluated and scored were found to be within the top 5 of any of the individual lots

6.4 The decision was made to short list to the following bidders:

- Arriva Passenger Services
- Coperforma Ltd
- E-zec Medical Transport Service Ltd
- Medical Services Ltd
- Mobilecare Ltd with Salisbury Hospital NHS Foundation Trust
- NSL Ltd
- South Western Ambulance Service NHS Foundation Trust

6.5 All 7 bidders were invited to attend one of two Provider Presentation days held on 27th March and 4th April 2013 at the Hamworthy Club to explain why they consider their organisation best placed to provide the service and to answer clarification questions.

6.6 At this event, the evaluation team were present as well as additional patient representatives. The patients and the team had an opportunity to ask various questions to the bidders..

6.7 Following the presentations further clarifications were sort from providers and the evaluators were given the opportunity to further moderate their scores based on the answers given at both the presentations and the answers to the further clarifications sort.

6.8 An adjudication meeting was held on 15th April 2013 to review the short listed bidders evaluation scores. A summary of these scores can be found at Appendix A. Full evaluation documents are available on request.

6.9 The evaluation team having reviewed the scores agreed on a preferred provider.

6.10 It was accepted that there will be a level of risk in changing provider however the team has confidence in the preferred provider being able to deliver the specification requirements and improving the level of service to both patients, Trusts and the CCG. During the life of the contract we would expect improvements in the quality of the service and be able to deliver potential savings through the correct use of the eligibility criteria and optimisation of routes and vehicles.

Provider	Quality Score	Finance Score	Total Score	Annual cost
E-Zec Medical Transport Services Ltd	95.46	10.34	105.80	£3,893,973.70
Medical Service Ltd	96.04	8.05	104.10	[redacted]
NSL Ltd	92.23	11.69	103.92	[redacted]
South Western Ambulance Service	90.59	12.20	102.79	[redacted]

Foundation Trust				
Arriva	91.06	8.96	100.02	[redacted]
Mobilecare with Salisbury Hospital NHS foundation Trust	85.02	13.00	98.02	[redacted]
Coperforma	78.95	10.60	89.55	[redacted]

7. Recommendation

7.1 Approval is requested for an award of preferred provider status to E-Zec Medical Transport Services Ltd

7.2 Approval of E-Zec Medical Transport Services Ltd as preferred provider meets the objectives agreed at the start of the project and there was the universal agreement of the evaluation panel. E-Zec currently run patient transport services for Portsmouth Hospitals NHS Foundation Trust, Royal United Hospital Bath NHS Trust and The Hillingdon Hospitals NHS Foundation Trust and provided excellent references

7.3 It is recommended that a contingency fund of £100k be made available on an open book accounting basis to ensure the smooth implementation of the service. This is required as there is a level of uncertainty on the activity levels and the rigid implementation of eligibility criteria. This contingency fund will be monitored on a monthly basis and minimal use of the fund will be incentivised

8. Next Steps

8.1 Following Board approval of the recommendation, bidders will be informed of the decision followed by the requisite "stand-still" (Alcatel) period of 10 calendar days. Following the stand-still period there would be a period of contract due diligence before final award of contract. The intention is to reach agreement as early as practicable in order to permit mobilisation and establishment of operational arrangements in time for the contract to commence on the 1st October 2013

David Way

Deputy Head of Procurement

3rd May 2013

Appendices

Appendix 1 **Summary of Evaluators Scores**

Summary removed as commercially sensitive with bidders prices

NHS DORSET CLINICAL COMMISSIONING GROUP

CONTRACT PERFORMANCE MEETING

E-ZEC MEDICAL

A monthly contract performance meeting with E-Zec Medical will be held on **Wednesday 14 May 2014** at **10.00** in **Room 2, Canford House**

Chair: Margaret Allen, Deputy Director, RDD (Mid), NHS Dorset CCG

AGENDA

		LEAD	ENC
1.	**APOLOGIES**		
2.	**NOTES OF MEETING 9 APRIL AND ACTION TRACKER**		**Enc A/B**
3.	**CONTRACT MONITORING EXCEPTIONS** • Sch 6 S1 Monthly Activity Reports • Sch 6 S2 Service Quality Performance Reports • Sch 6 S17 Local Requirements • Monthly Operational Reports and KPIs	**ST/** **E-zec**	
4.	**OTHER UPDATES** • 4.1 Service Improvement Plan – Update from CEO meeting • 5.1 bp7 Complaints procedure – Update from quality on visit in relation to complaints and reporting • 8 May E-Zec visit summary from Matt Wain and Jaydee Swarbrick – document to be tabled	**MA/AW** **JS** **MW**	
5.	**OUTSTANDING ISSUES** • 4.8 Repatriation process • 4.13 Notify patient of reimbursement for transport cost	**RB**	

		LEAD	ENC
	•	**E-Zec**	
6.	**ANY OTHER BUSINESS**		
	DATE AND TIME OF NEXT MEETING: 19 June 2014, 10 am, Canford House, Room 2		

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NHS DORSET CLINICAL COMMISSIONING GROUP

FINANCE AND INFROMATION GROUP MEETING

E-ZEC MEDICAL LTD

A monthly Finance and Information Group meeting with E-Zec Medical will be held on **Wednesday 14 May 2014** at **14.00** in **Room 2, Canford House**

Chair: Phil Dove, Head of Performance Intelligence, NHS Dorset CCG

AGENDA

		LEAD	ENC
1.	**APOLOGIES AND INTRODUCTIONS**	**CHAIR**	
2.	**TERMS OF REFERENCE**	**ALL**	**A**
3.	**PTS (INFORMATION/FINANCE DEVELOPMENT)**	**PD**	
4.	**PATIENT EXAMPLES/QUERIES**	**AA**	**B**
5.	**MAP POINT**	**ALL**	
6.	**ACTION ISSUE LOG**	**AA**	**C**
7.	**CALL HANDLING**	**CHAIR**	
8.	**ANY OTHER BUSINESS**		
	DATE AND TIME OF NEXT MEETING: 19 June 2014, 14:00, Canford House, Room 2		

NHS DORSET CLINICAL COMMISSIONING GROUP

ASSURANCE GROUP MEETING

DORSET NON-EMERGENCY PATIENT TRANSPORT SERVICES

A meeting will be held on Wednesday 30 April at 10am at Canford House Room 1.

If you are unable to participate please inform Sarah Turner on email:
sarah.turner@dorsetccg.nhs.uk

Chair: Margaret Allen, Deputy Director, RDD (Mid) NHS Dorset CCG

1.	**Welcome, Introductions and Apologies**	
2.	**Minutes of Meeting on 10 March 2014** • **Matters Arising**	**Enc A**
3.	**Feedback from providers**	
4.	**AOB**	
5.	**Date of Next Meeting:** Thursday 12 June at 2pm at Canford House, Room 1	

E-ZEC SERVICE DEVELOPMENT IMPROVEMENT PLAN MAY 2014 - D R A F T V 3

ITEM	STRATEGIC RELEVANCE	DESCRIPTION OF ISSUE	ACTION	MEASURES	TIMESCALE	RAG
1	Business Relationship Management	To improve and develop communication structures and processes externally with commissioners, providers, patients and internally to the organisation.	To provide monthly operational meetings with all providers	TBA	Ongoing	
			PTLOs to lead meetings and be proactive in the development both internal and external processes	TBA	Ongoing	
			Identification of key staff to liaise with, within the Trusts	TBA	31-May-14	
			Implement patient service user groups, particular focus with renal, oncology and mental health including carers	TBA	30-Jun-14	
			Send out regular newsletters	TBA	Ongoing	
			Provide regular training with providers on booking of appropriate use of PTS	TBA	Ongoing	
			Provide regular updates and feedback on non-medically eligible bookings – internally/externally	TBA	Ongoing	
			Distribute and communicate Customer Care Charter	TBA	31-May-14	
			Provide staff awareness workshops dealing with procedures and processes particularly in relation to positive communication, vulnerable adults, infection control, complaints	TBA	30-Jun-14	
2	Service Improvement	Complaint Management	To provide a pro-active complaint management process	TBA	31-May-14	
			To take forward the actions from the Quality review visit	TBA	31-May-14	
			To provide appropriate, formal responses to complaints within policy timeframe	TBA	31-May-14	
			To localise the complaint process	TBA	31-May-14	
			To identify themes and trends from all complaints and develop a learning structure organisation wide	TBA	Ongoing	
			Proactive development of feedback questionnaires to service users	TBA	Ongoing	

3	Whole System Efficiencies	Capacity v contracted activity: Vehicles; Staff; Out of Hours; Paramedic Crews	Stratify vehicles according to mobility and crew need against patient dependency. Agree process and mechanism with Trusts.	TBA TBA	31-May-14	
			Recruit and train PTS staff to support stratification of vehicles, strengthening HDU service with PSoS education	TBA	14-May-14	
			Monitor patient movement across Dorset, vehicle productivity and plan to appropriate shift patterns, increase flexibility in rotas, leading to responsive working flows	TBA	30-Jun-14	
			Provide a 24/7 service which reflects the needs of the service, with bank crew, where appropriate to support extra resource and timely intervention	TBA	30-Jun-14	
4	Whole System Efficiencies	Planning and Control	Move to a full make ready system and dynamic planning system – live planning system	TBA	30-Jun-14	
			Provide alternative processes for clinics which cannot support make ready system	TBA	Ongoing	
			Provide training plan for call handlers/control centre staff in assessment of calls, data collection/verification, customer care and general call handling. Regular updates.	TBA	Ongoing	
			Increase CLERIC visibility to clinic staff and journey allocation – real time information	TBA	31-May-14	
			Provide performance feedback to staff to improve waiting times and call handling	TBA	30-Jun-14	
			Define and communicate Repatriation process to providers and commissioner	TBA	14-May-14	
			Define, plan and communicate the process by which Out of Area transportation is to be booked and delivered.	TBA	31-May-14	
5	Whole System Efficiencies	Partnership working between SWAST and E-zec to resolve Specification issues	Review current specification of SWAST and E-zec to resolve patient flows which do not "fit" with either commissioned service with DCCG and SWAST, (including inter hospital transfers)	TBA	31-May-14	

6	Patient Experience	Planned transport	Implement a service for renal patients who have regular planned appointments to receive a timely, efficient and appropriate service and which has been developed and supported via the patient service user group	TBA	31-May-14	
7	Patient and Clinical Experience	Booking processes	Monitor the telephone lines to ensure patients receive timely response and telephone system within new premises does not "drop" people out of the queue	TBA	30-Jun-14	
			Ensure all interactions with patients are timely, accurate, supportive, informative and polite	TBA	14-May-14	
			Streamline booking processes for clinical staff, supporting and delivering training to Trusts and departments using the online system	TBA	Ongoing	
			PTLOs to work closely with Trusts to develop and assist with training in the use of the NHS Booking line	TBA	Ongoing	

	On plan and achieved
	In progress
	Not started

APPENDIX J

NHS Dorset Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Policy for Non-Emergency Patient Transport Service (NEPTS) Eligibility Criteria

3 September 2013



Supporting people in Dorset to lead healthier lives

DOCUMENT TRAIL AND VERSION CONTROL SHEET	
Heading	Policy for Non-Emergency Patient Transport Service (NEPTS) Eligibility Criteria
Project Sponsor	Cancer and End of Life Care CCP
Purpose of document	
Date of document	3 September 2013
Review Date	
Author	Sarah Turner
Approved by	
Date approved	
Effective from	
Status	Draft
Version	V2

NHS DORSET CLINICAL COMMISSIONING GROUP

POLICY FOR NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS) ELIGIBILITY CRITERIA

CONTENTS

NHS DORSET CLINICAL COMMISSIONING GROUP

POLICY FOR NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS) ELIGIBILITY CRITERIA

1. WHAT IS NON EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)?

1.1 Non-emergency Patient Transport Services (NEPTS) are provided for patients who are being transported to an NHS funded service for NHS treatment and who are deemed **medically eligible** based on the Department of Health (DH) eligibility criteria, which Dorset Clinical Commissioning Group (DCCG) has localised.

1.2 This service is for non-urgent, planned transportation of patients whose medical condition is such that they require the skills or support of clinically trained NEPTS staff and/or their equipment on/after their journey. Eligible patients are not charged for NEPTS transport provided by the NHS.

1.3 NEPTS should be seen as part of an integrated programme of care. A non-emergency patient is one who whilst requiring treatment, which may or may not be of a specialist nature, does not require an immediate or urgent response.

1.4 Some patients may be eligible to have their transport provided for them so that they are able to access non urgent planned healthcare i.e. procedures which were traditionally provided in hospital, but are now available in a hospital or community setting, in secondary and primary care settings, in a reasonable time and in reasonable comfort, without detriment to their medical condition.

1.5 Patients will be able to book their transport direct with the Dorset Patient Transport Bureau (DPTB). The eligibility assessment for NEPTS will be undertaken by the DPTB in consultation with the patient using the DH eligibility criteria.

1.6 The forms of transport provided include a range of vehicle types and levels of care consistent with the patient's medical needs. This may be an ambulance, a car with the facilities to take a wheelchair or another type of suitably equipped vehicle.

2. WHO IS ELIGIBLE FOR NEPTS?

2.1 Patients are deemed eligible for NEPTS where they meet the following Department of Health (DH) criteria.

Eligible journeys are those:

- made for non-primary healthcare services, for which the patient has been referred by a doctor or dentist;
- made for treatment paid for by the NHS, regardless of whether it is carried out by an NHS care professional or an independent one.

Eligible patients are those:

- where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means;

- where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means;

- recognised as a parent or guardian where children are being conveyed.

2.2 NEPTS could also be provided to a patient's escort or carer where their particular skills and/or support are needed e.g. this might be appropriate for those accompanying a person with a physical or mental incapacity, vulnerable adults or to act as a translator. Discretionary provision such as this would need to be agreed in advance, when transport is booked.

2.3 Affordability is not a qualifying factor for PTS. Only patients whose health would be adversely affected if travelling by other means are eligible. Financial assistance with transport is provided for through the Hospital Travel Costs Scheme **(Appendix 1).**

3. WHAT IS 'MEDICAL NEED'?

3.1 Medical need is defined as the definite or likely requirement for the skills or support of clinically trained PTS staff and/or their equipment on/after the patient's journey.

3.2 There are three main categories of medical need based on a patient's mobility, protection and treatment:

Mobility

- patient will need substantial assistance/support to move from their bed/chair at pick-up point to vehicle and from vehicle to destination;

- unable to weight-bear, transfer or self-mobilise.

Protection

- journey by other means would be detrimental to health;

- patient needs protection to prevent harm to themselves and/or existing wound or condition;

- passengers or vehicle crew will need to be protected due to the patient's condition.

Treatment

- patient needs to be monitored and/or treated on or after the journey.

4. PTS ELIGIBILITY AND JOURNEY DISTANCE, FREQUENCY AND DURATION

4.1 DH guidance (November 2007) states that patients should be able to access healthcare without detriment to their medical condition. The **distance**, **frequency** and **duration** of the journey should be taken into consideration in *conjunction with the patient's medical condition at that time* when determining their need for PTS.

4.2 Distance, frequency and journey duration are not qualifying criteria for PTS transport without taking the patient's medical condition and requirement for clinical support into account. Frequency, distance or time travelling will not affect a patient's eligibility for PTS unless it detrimentally impacts on the health of the patient. **(Appendix 2 – Eligibility Criteria)**

5. GUIDANCE FOR ASSESSING ELIGIBILITY

5.1 The guidance for booking NEPTS is the DH national eligibility criteria which Dorset CCG has localised for the needs for patients registered with a Dorset General Practitioner.

5.2 The criteria will be used for all patients requesting transport to and from and NHS facility, whether booked directly by the patient themselves or by a clinician.

5.3 The guidance for assessing eligibility is attached at **Appendix 3.**

6. HOW IS NEPTS BOOKED?

6.1 E-Zec Patient Transport Services will be providing NEPTS for NHS Dorset CCG from the 1 October 2013.

6.2 Patients are expected to make their own way to and from their NHS appointment. This can be with the assistance of friends, relative or community transport schemes. Transport may be provided for a patient only if they meet the medical eligibility criteria.

6.3 Patients will be able to book the transport for their appointments directly by contacting the Dorset Patient Transport Bureau whereby they will be assessed for their medical eligibility. All requests for transport will be against the medical eligibility criteria and patients will be assessed for each request as medical conditions change over time. For the majority of requests, at least 48hours notice is required to book transport.

6.4 Patients may book transport by ringing the DPTB on 0300 777 5555. The bureau is open Monday to Friday 8am through to 6pm for patients. An additional telephone line and on line booking facility is available for clinical staff. (**Appendix 4 – Booking process**)

7. WHO FUNDS NEPTS?

7.1 Essentially it is the responsibility of NHS Dorset CCG to fund NEPTS for patients who are medically eligible for transport, registered with an NHS Dorset CCG GP and receiving NHS funded care within:

- Dorset NHS Acute Trusts;
- Dorset Community Hospitals, clinics and services;
- Independent sector providers who are contracted to provide NHS care;
- Out of county providers;
- Respite and care homes where the patient is receiving NHS funded nursing care.

NHS Dorset CCG is not responsible for funding NEPTS for:

- Transport to primary care services such as a GP surgery or dentist;
- Patients travelling for private treatment paid for by themselves;
- Transport relating to care homes or respite care or patients that are being moved within their place of residence that are arranged by social services or self-funded with no NHS funded nursing care. (Table 1 - Social Care and NHS Transport Crib Sheet)

SOCIAL CARE TRANSPORT REQUESTS TO THE NHS

8. WHAT THE NHS FUNDS

8.1 The NHS will fund patient transport services (NEPTS) where the patient is assessed as medically eligible by a healthcare professional. Medically eligibility is determined as per the local Dorset policy (reviewed August 2013).

8.2 NEPTS is defined as “Non-emergency patient transport services, known as NEPTS, are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from a premises providing NHS health care and between NHS health care providers. This can and should encompass a wide range of vehicle types and levels of care consistent with the patients’ medical needs.” (DH, 2007)

8.3 The above statement states that NEPTS funded by the NHS is for patients receiving NHS care.

8.4 NEPTS does not include transport to GP surgeries for primary care treatment, dentists or optometrists.

8.5 Patients can seek NEPTS (defined by medical eligibility) for non-primary care services provided at a GP surgery or dental premises. Non-primary care services are those services not covered by GP or GDP contract and could include community services hosted by a practice e.g. access to ultrasound scans or a community interface service for orthopaedics.

8.6 The NHS and Local Authority are committed to working together to ensure that patients receive transport as appropriate to the criteria in place. Where there are disputes between organisations then both organisations agree that patients / clients will not be left vulnerable and in need. If a dispute cannot be resolved in a timely manner prior to the journey, the organisation that first raised the transport issue will arrange transport whilst funding issues are resolved at a later date.

Social Needs Transport

8.7 CCGs do not have to provide transport for social reasons. However, the NHS can use income generation powers to charge patients for the provision of transport for 'social' rather than 'medical' needs. (DH, 2007)

8.8 This guidance is not relevant to transport related to social needs which are not currently funded within Dorset by the NHS.

8.9 Using the DH guidance above on what NEPTS provision the NHS will fund has highlighted gaps in transport funding between health and social care. In these examples the NHS is not liable to pay as the patient is not being transported to premises providing NHS healthcare.

- Transfer from residential home to residential home;
- Transport into residential respite care from a patient's home.

9. CRITERIA

9.1 Where patients are travelling from a social care premises to NHS funded treatment and meet the medical eligibility criteria then the NHS would fund NEPTS as per the guidance quoted from DH as per section 1.

9.2 Where patients are travelling from a social care premises to NHS funded treatment, do not meet the medical eligibility criteria but are on low income and qualify for HTCS then the patient would be able to claim back transport costs as per the HTCS scheme.

9.3 The above criteria would mean that where an NHS service was being provided eg rehabilitation or re-ablement then if the NHS is providing the service patients would be eligible for transport depending on medical eligibility or qualification against the HTCS scheme.

9.4 Patients who pay privately for their own social care or for private healthcare treatment would need to make their own transport arrangements.

9.5 For those individuals who require conveyance having been detained under 1983 Mental Health Act, they would meet the eligibility criteria.

10. REFERENCES

- Eligibility Criteria for Patient Transport Services, Department of Health, August 2007 (Updated January 2008);
- Guidance on Non-Emergency Patient Transport Services: Post-Consultation Report, Department of Health, September 2007;
- Hospital Travel Cost Scheme: Guidance for NHS Organisations, Department of Health, November 2007;
- Chapter 20 Finance Manual: Finance Arrangement for Ambulance Services, Department of Health, September 2007.

SOCIAL CARE AND NHS TRANSPORT CRIB SHEET

Table 1

Based on the criteria contained within the document **Social Care Transport Requests to the NHS,** the following table sets out examples of organisational responsibility for patient transport.

Journey type		**Who is responsible?**	**Comments**
From	**To**		
Hospital	Residential Care	NHS	Assuming residential care as 'home' for the patient and patient meets medical eligibility.
Hospital	Intermediate care beds (part or all NHS funded)	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.
Hospital	Nursing Home	NHS	Patient going to NHS funded treatment and meets medical eligibility criteria.
Hospital	Home	NHS	If patients meet medical eligibility criteria.
Residential Care	Hospital (outpatient or for treatment)	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.
Residential Care	Residential Care	Local Authority	No health involvement (generally). Patient may have to pay.
Residential Care	Respite	Local Authority	No health involvement (generally). Patient may have to pay.
Residential Care	Intermediate care beds (part or all NHS funded)	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.
Residential Care	Nursing Home	NHS	Patient going to NHS funded treatment but NEPTS only if medical

Journey type		**Who is responsible?**	**Comments**
			eligibility met.
Residential Care	Home	Local Authority	No health involvement (generally). Patient may have to pay.
Nursing Home	Residential Care	NHS	Assume residential care as 'home' for patient and patient meets medical eligibility.
Nursing Home	Intermediate care beds (part or all NHS funded)	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.
Nursing Home	Nursing Home	NHS	Assuming health involvement in funding of nursing care and patient meets medical eligibility.
Nursing Home	Home	NHS	If patient has received funding for nursing care and still meets eligibility criteria.
Home	Residential Care	Local Authority	No health involvement (generally). Patient may have to pay.
Home	Respite	Local Authority	No health involvement (generally). Patient may have to pay.
Home	Intermediate care beds (part or all NHS funded)	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.
Home	Nursing Home	NHS	Patient going to NHS funded treatment but NEPTS only if medical eligibility met.

APPENDIX 1

HOSPITAL TRAVEL COSTS SCHEME

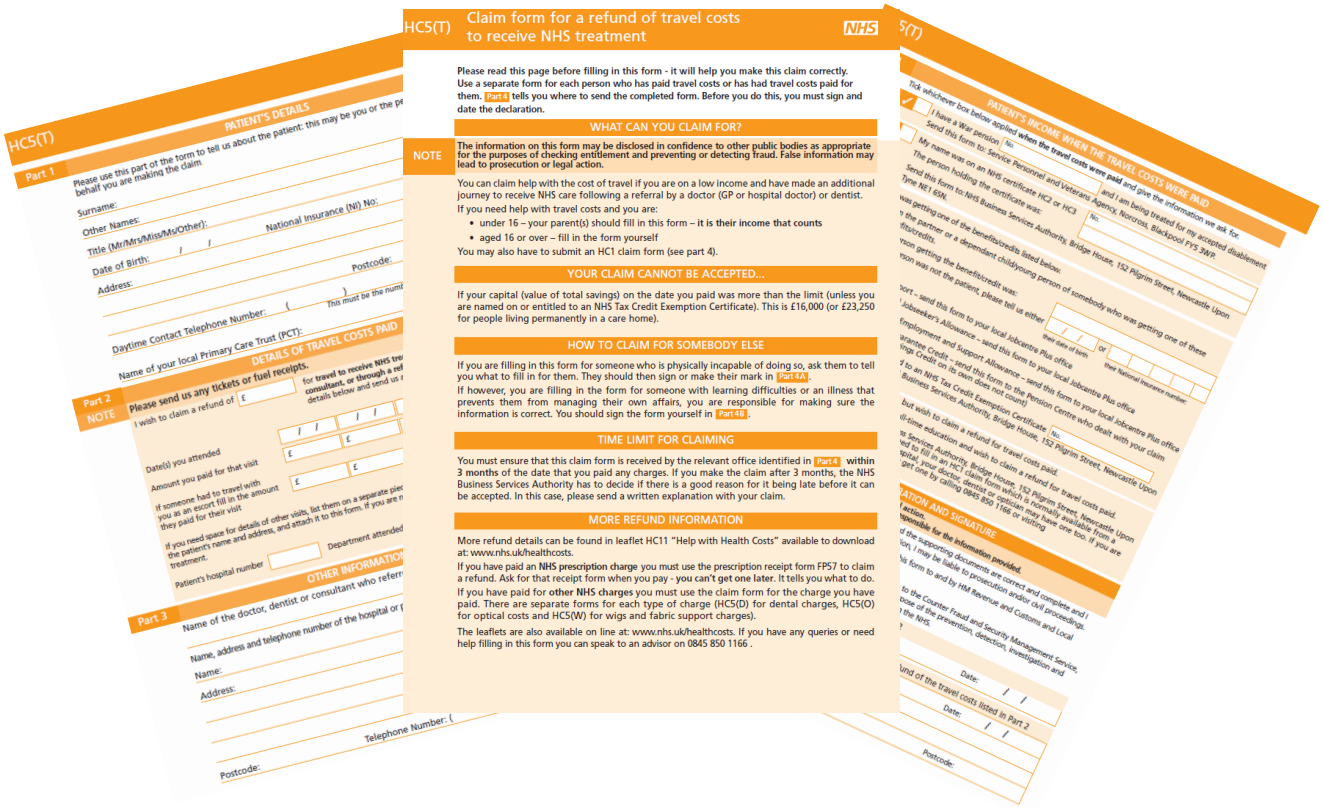
This scheme is for patients who are on any of the following:

- Income Support
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance
- Guarantee Pension Credit

The patient also qualifies if their income is at the current level as stated in the document or less and in receipt of one of the following:

- Child Tax Credit (with or without Working Tax Credit)
- Working Tax Credit with the disability element or severe disability element

In order to claim under the HTC scheme the patient must complete an HTC(5) form which they then send to the relevant agency stated on the form (depending on which section they complete). Once this has been approved it will be sent to the relevant CCG and then authorised for payment via SBS. NHS Dorset CCG's current mileage rate is 12p per mile (May 2013).


HC5(T) Claim form for a refund of travel costs to receive NHS treatment

NHS

Please read this page before filling in this form - it will help you make this claim correctly. Use a separate form for each person who has paid travel costs or has had travel costs paid for them. Part 4 tells you where to send the completed form. Before you do this, you must sign and date the declaration.

WHAT CAN YOU CLAIM FOR?

NOTE The information on this form may be disclosed in confidence to other public bodies as appropriate for the purposes of checking entitlement and preventing or detecting fraud. False information may lead to prosecution or legal action.

You can claim help with the cost of travel if you are on a low income and have made an additional journey to receive NHS care following a referral by a doctor (GP or hospital doctor) or dentist.

If you need help with travel costs and you are:

- under 16 – your parent(s) should fill in this form – it is their income that counts
- aged 16 or over – fill in the form yourself

You may also have to submit an HC1 claim form (see part 4).

YOUR CLAIM CANNOT BE ACCEPTED...

If your capital (value of total savings) on the date you paid was more than the limit (unless you are named on or entitled to an NHS Tax Credit Exemption Certificate). This is £16,000 (or £23,250 for people living permanently in a care home).

HOW TO CLAIM FOR SOMEBODY ELSE

If you are filling in this form for someone who is physically incapable of doing so, ask them to tell you what to fill in for them. They should then sign or make their mark in Part 4A.

If however, you are filling in the form for someone with learning difficulties or an illness that prevents them from managing their own affairs, you are responsible for making sure the information is correct. You should sign the form yourself in Part 4B.

TIME LIMIT FOR CLAIMING

You must ensure that this claim form is received by the relevant office identified in Part 4 within 3 months of the date that you paid any charges. If you make the claim after 3 months, the NHS Business Services Authority has to decide if there is a good reason for it being late before it can be accepted. In this case, please send a written explanation with your claim.

MORE REFUND INFORMATION

More refund details can be found in leaflet HC11 "Help with Health Costs" available to download at: www.nhs.uk/healthcosts.

If you have paid an **NHS prescription charge** you must use the prescription receipt form FP57 to claim a refund. Ask for that receipt form when you pay - **you can't get one later**. It tells you what to do.

If you have paid for **other NHS charges** you must use the claim form for the charge you have paid. There are separate forms for each type of charge (HC5(D) for dental charges, HC5(O) for optical costs and HC5(W) for wigs and fabric support charges).

The leaflets are also available on line at: www.nhs.uk/healthcosts. If you have any queries or need help filling in this form you can speak to an advisor on 0845 850 1166 .

http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Travelcosts.aspx

APPENDIX 2

NON EMERGENCY PATIENT TRANSPORT SERVICES (PTS) ELIGIBILITY CRITERIA

NHS funded transport includes ambulance, cars, voluntary or taxi provision for non-emergency journeys to NHS treatment facilities for planned healthcare.

ELIGIBLE	NOT ELIGIBLE
A patient is eligible for PTS where one or more of the following applies:	*A patient is not eligible for PTS where one or more of the following applies:*
✓ Travelling by any other means would have a serious detrimental effect on the patient's condition or recovery.	➢ The patient is able to travel by their own means. They do not require support from a qualified PTS ambulance crew and it would not have a serious or detrimental effect on their condition or recovery to do so.
✓ The patient has restricted mobility and is unable to self-mobilise (ie is unable to stand or walk more than a few steps), including from a pre-existing condition, where it would be detrimental to their condition or recovery to travel by any other means.	➢ The patient has a member of family, friend or carer who could help with travel to and from the patient's appointment.
✓ The patient requires support from a qualified PTS crew during the journey and is required to lie down for at least part of the journey or they are a stretcher patient.	➢ The patient is registered as disabled but has their own means of transport which is suitable for transporting them back and forth to their appointment.
✓ The patient is being transferred to another NHS facility and requires medical assistance during the journey.	➢ The patient is able to, but is not willing to pay for transport and is not medically eligible
✓ The patient requires continuous oxygen or other medical gases or intravenous support.	➢ The patient is unable to afford to pay for transport but is not medically eligible for PTS. In this instance, they may be eligible for support through the Hospital Travel Cost Scheme (HTCS) HC11 NHS – Help With Travel Costs Leaflet may assist patients. Eligible patients will need to complete an HC5 – Claim Form For Travel Costs.). The national HTCS advice line is 0845 850 11 66 for help and assistance.
✓ Patients with clearly recognised disabilities who are genuinely unable to travel by private or public transport to and from their appointments.	

PATIENT ESCORTS

Only professional escorts will normally be allowed to travel with patients. A family, friend, carer escort may travel only if the patient falls into one of the following categories:

- The patient is under 16 years of age;
- The patient has significant communication difficulties, including learning difficulties, impaired sight or is hard of hearing;
- The patient has mental health problems that prevents them travelling alone;
- The patient's clinical condition is such that they require constant supervision for safety;
- The patient requires a carer to assist them at their destination.
- The patient lacks the mental capacity to either make/translate the booking and/or be able to travel to their destination and be mentally fit.
- *NB: Mobility needs alone do not necessitate an escort as the patient's mobility needs will be met by ambulance transport crew or hospital staff.*

APPENDIX 3

GUIDANCE FOR ASSESSING A PATIENT'S ELIGIBILITY FOR NHS PATIENT TRANSPORT SERVICE (PTS)

Is There A Medical Reason Why The Patient Is Unable To Use Public Or Private Transport?

YES

PTS must only be provided if a medical need has been established

Patient to be reminded at all times that PTS is only available for those with a genuine medical need.

Is the patient able to walk short distances with driver assistance?

Book PTS but MUST provide reason why.

NO

Does the patient require lifting and/or carrying from a vehicle?

YES

Book PTS. Request wheelchair if necessary. Identify stairs or obstacles to manage.

NO

Is the patient in a wheelchair and requires a single or double crew eg to assist with lifting?

YES

Book PTS. State if there are any stairs or obstacles to overcome.

NO

Does the patient need a stretcher?

YES

Book PTS. Request stretcher.

NO

Is the patient high dependency, going to a same level or lower care facility?

YES

Book PTS. Request necessary clinical crew/vehicle.

NO

Does the patient have a mental health problem, illness or a learning disability/condition or mental capacity issues, which makes it difficult or impossible to travel by other means?

YES

Book PTS.

NO

If patient answers YES to any questions PTS must NOT be booked

Is patient fully mobile?

YES

Patient is not eligible for PTS.

NO

Does the patient have a relative, carer, friend who would transport them to and from their appointment?

YES

Patient is not eligible for PTS. Patient to arrange transport accordingly.

NO

OPA or Discharge
If the appointment time was changed could a relative, friend, assist them with transport?

YES

Patient is not eligible for PTS. Patient to arrange transport accordingly.

NO

Could the patient use public transport, taxi or a voluntary car scheme?

YES

Patient is not eligible for PTS. Patient to arrange transport accordingly.

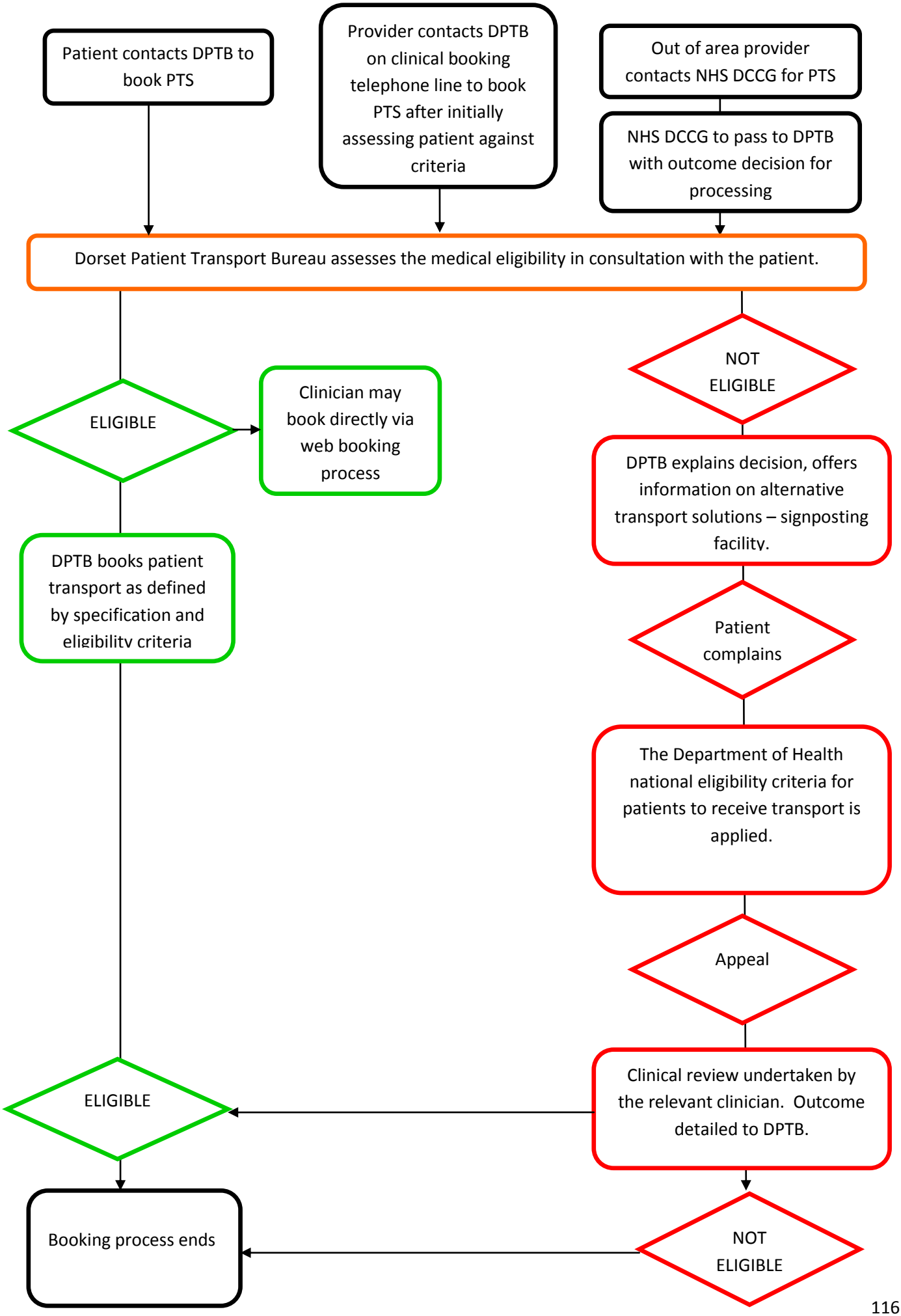
NO

Patient states transport is too expensive.
If patient is on low income, they may be able to reclaim fees. (HTCS)

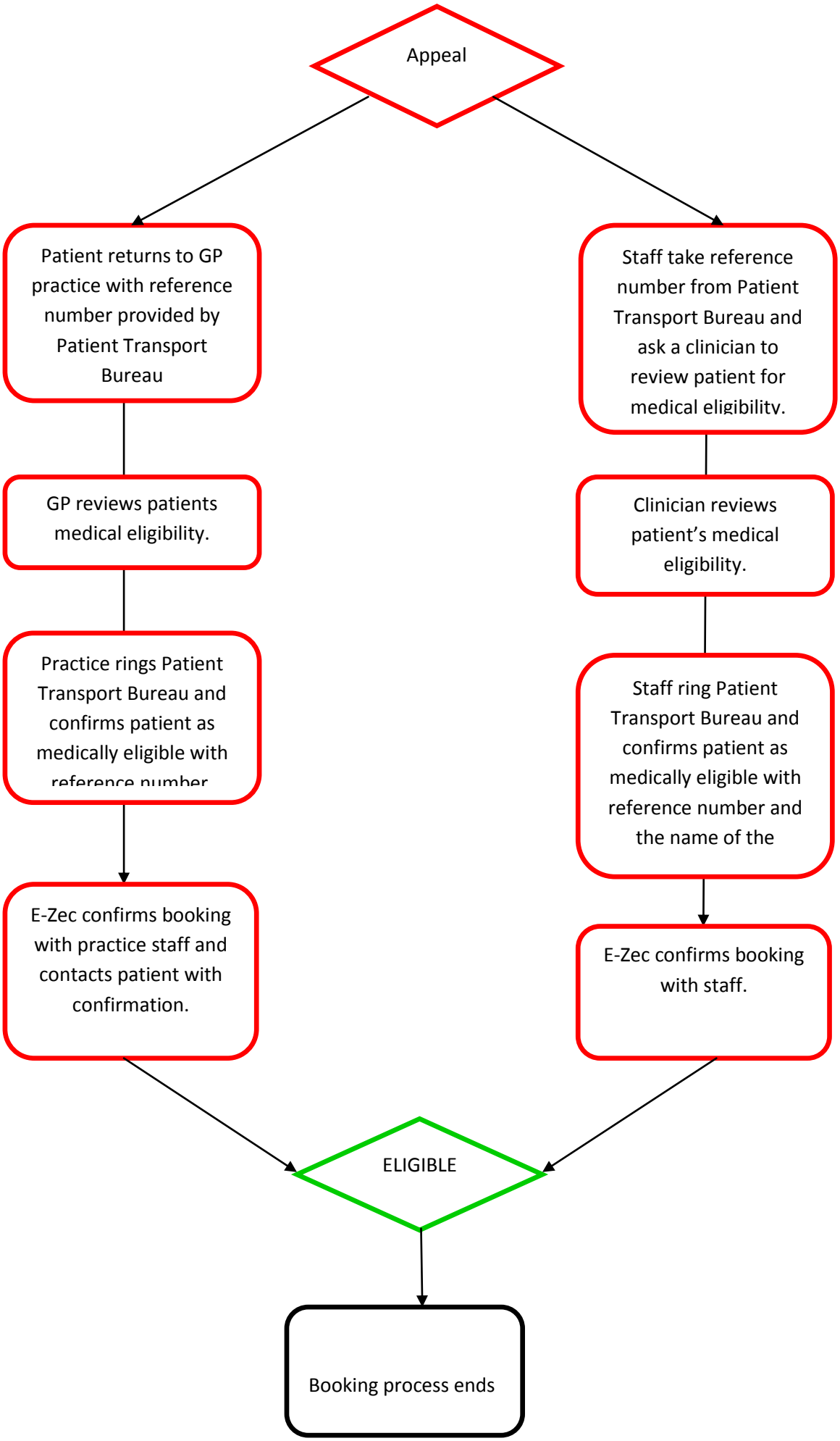
Patient is not eligible for PTS. Patient to arrange transport accordingly.

APPENDIX 4

DORSET PATIENT TRANSPORT BUREAU (DPTB) – BOOKING PROCESS FOR PATIENT TRANSPORT SERVICES (PTS)



APPEALS PROCESS



NHS
Dorset
Clinical Commissioning Group

APPENDIX K

Announced site visit to E-zec medical transport services Dorset hub, Basepoint Centre, Christchurch. 8/5/14

The visit was conducted by Jaydee Swarbrick, Professional Practice Lead (JS) and Judy Franek, Customer Care officer (JF) from NHS Dorset Clinical Commissioning Group. The purpose of the visit was to provide support and gain a better understanding of processes within E-zec in the following areas;

- Infection Control
- Serious Incident reporting
- Incident investigation and management
- Complaints procedures

Information was provided by Joanna Little, Governance Manager (JL) and Charlotte Palmer, Incidents and complaints lead (CP). We also met Becky Lees, interim manager who explained how the hub worked. It was good to hear how telephone lines are re- allocated at different points in the day to meet demand. The example given was around lunchtime when there is a decrease in NHS staff calls more call handlers are allocated to patient enquiry lines. The office was calm and quiet with all staff engaged in call handling work.

Our initial discussion was about the lack of access to an NHS net email address. The Cisco encryption system is currently successfully used by the safeguarding teams to email causes for concerns for investigation. JF agreed to email CP a test encrypted email to enable complaints and feedback emails to be sent securely in this way.

Infection control.

The report at appendix A was compiled following an unannounced inspection by CCG infection control team was shared. JL agreed to email Jacqueline Campbell, Infection prevention and control Nurse Specialist for the CCG an up to date copy of the Infection Control Policy. Overall the findings were good and JL will pick up on the points raised in the report. We were shown the daily, weekly and monthly cleaning schedules and recording sheets that are carried on vehicles. E-zec supervisors and own management team also carry out spot inspections of vehicles and any shortfall is fed back to drivers either directly, via staff meetings or through annual training updates.

Serious Incident reporting.

JS shared the following documents with regard to the contractual requirements for reporting incidents resulting in death or serious harm to a service user; the National Framework for Reporting and Learning from serious incidents requiring investigation (NPSA 2010), NHS England Serious Incident Framework (March 2013) and the Department of

Health Never events list 2013/14. JL described the internal reporting and investigation processes referring to the risk and safety policies of the organisation. There is a comprehensive set of incident reporting forms to cover patient incidents, vehicle accidents, staff accidents and general safety concerns which are available in all vehicles and locations. The templates for investigating officers were sufficiently detailed and enabled full analysis of the potential causes for adverse incidents. We discussed Root Couse Analysis (RCA) and JL explained this method was used when required. There are also systems for capturing the learning from incidents which is shared across the organisation and is used to inform staff training.

JL asked for confirmation of the process of reporting a SIRI to the CCG. JS explained that as a non NHS organisation E-zec would not have access to the National reporting system (STEIS). Our expectation is that E-zec will inform the CCG within 48 hours of an incident occurring in order that our risk management team can report on behalf of E-zec. The CCG would then expect to receive a full RCA within 45 working days with an action plan to mitigate/prevent future similar incidents. JF shared direct line contact details of the risk management team and JS encouraged CP to use this contact to gain advice regarding the management of any incident where there were concerns.

Incident management

JS asked for confirmation of the process for investigating incidents reported by other providers as it had been raised as concern to the CCG that Amber graded incidents in particular were not being investigated and responded to appropriately. CP explained that the process has been changed within the last month. The Patient Transport Liaison Officers (PTLOs) are now investigating these incidents locally and it is intended in a more timely way. JS agreed to feed this back to risk leads in other providers. Incidents will still need to be copied centrally for recording purposes but it is intended the PTLO will be able to respond to the risk management departments. The incidents and learning is recorded in a spreadsheet and enables the management team to identify themes and trends. Incidents will also be reported to the CCG through the contract monitoring process.

Complaints procedures

JF described how the NHS Constitution sets out a number of rights and expectations of patients with regard to NHS services including a number in relation to making complaints. The following documents were shared which form the basis of current expectations for the Standard NHS Complaints procedures: the Clinical Commissioning Group Customer Care and Complaints Policy; the NHS Constitution Handbook (2013) and a parliamentary briefing note relating to NHS Complaints Procedures. The standard letter templates for acknowledgement of a formal complaint and formal responses were discussed and JF agreed to share the CCG

'e' versions if required. CP described how recent improvements have been made and the intention of E-zec supervisors to call each complainant individually to discuss the issues raised, to resolve over the phone if possible and to agree how the issue will be investigated and the response provided. The form used to record all verbal and telephone complaints was shared by JL. All informal and formal complaints are recorded and will be reported to the CCG through the contract monitoring process. Themes and trends are also reported to head office and learning shared organisation wide.

Patient feedback questionnaires are also available on vehicles along with copies of the Customer Care leaflet. This leaflet sets out the values of the organisation, the service that patients can expect and contact details should they wish to complain which includes details of the Parliamentary and Health Ombudsman and the national ICAS service. JF recommended that it would be preferable for Dorset Advocacy details to be included or confirmation that the national contact would signpost Dorset patients to this service.

Conclusion

Overall there was sufficient evidence to provide significant reassurance regarding processes within E-zec in regard to patient safety and patient experience. The process for sharing and using learning from incidents and complaints to inform staff training was particularly good. JL shared the staff training presentation and explained this is used on induction and at annual updates. It included all aspects of mandatory training as well as elements of customer care. In particular the inclusion of the Chief Nursing officer's 6 C's – Compassion in Practice in the values for staff demonstrates a patient focus and commitment to 'getting it right'. There were some areas for suggested further improvement (see recommendations) and the recent improvements described during the visit will be monitored by the CCG.

Recommendations

1. Use of CISCO encryption emails to share sensitive information with the CCG.
2. Ensure adequate provision of Personal protective Equipment on all vehicles as per company policy.
3. Infection Control Policy to be shared with CCG Infection Prevention and Control Specialist Nurse.
4. Develop relationship with CCG Risk management team to enable open and honest reporting of Serious Incidents requiring Investigation and reporting.
5. Confirm role of PTLOs in other provider settings to enable timely responses and communications in regards to incident and complaints investigations.

6. Reports for CCG contract monitoring meetings to include information on numbers of complaints and serious incidents.
7. Themes and trends from incidents and complaints to be shared quarterly to CCG, or as per internal reporting to board.
8. Ensure requirements of the NHS Constitution and NHS Complaints procedures are included within the complaints policy and standards met.
9. Check link to national patient advocacy service in customer care leaflet signposts Dorset residents to the Dorset Advocacy Service.
10. Consideration of a patient focus group with renal patients and the Renal Service Manager.

Jaydee Swarbrick, Professional Practice Lead, NHS Dorset Clinical Commissioning Group

Judy Franek, Customer Care officer, NHS Dorset Clinical Commissioning Group

APPENDIX K

Appendix A

E Zec vehicle unannounced inspection carried out at

Dorset County Hospital Foundation Trust on 1st May 2014.

An unannounced inspection of E- zec patient transport vehicles was carried out on the 1st May 2014 at DCHFT by Dorset Clinical Commissioning Group, Infection Prevention Control. This action took place following a meeting between E-zec and Dorset Clinical Commissioning Group when issues regarding cleanliness and standards of service provided by E-zec were raised.

Three vehicles were inspected. The general cleanliness of the vehicles was seen to be of a good standard, and staff were polite and helpful.

Outcomes:

- The interior of the vehicle was generally clean and tidy.
- E-zec Infection Control Policy HS02 Version: 01**:** **'**A supply of three Spillage Kits should be maintained on each vehicle at all times'. On all three vehicles inspected there was only 1 spillage kit supplied to each vehicle.
- Two members of staff were aware of the process for decontamination following a body fluid spillage. They were able to demonstrate knowledge of the procedure and policy.
- One member of staff was unsure of the policy when spillage of bodily fluids in the vehicle.
- There were disposable gloves for use
- No disposable aprons were kept on any of the vehicles inspected other than those with the spillage kits.
- No eye protection was available for use as in policy.
- No clinical waste containers were seen on two of the vehicles – Staff advised that they dispose of waste by putting it into the correct bags and taking it to the ward to dispose of.
- Hand hygiene wipes were available, with one member of staff having their own alcohol gel for use in addition.

- There were no biohazard signs available for display in the vehicle when transporting specimens but it was not determined if the crews visited would be carrying out specimen carriage.

Infection Prevention and control team

May 8th 2014

Complaints	**Site**	
2013		
October	Independent Organisation	
	E-zec Medical Ltd	8
November	Independent Organisation	
	E-zec Medical Ltd	6
December	Independent Organisation	
	E-zec Medical Ltd	5
2014		
January	Independent Organisation	
	E-zec Medical Ltd	8
Feb	Independent Organisation	
	E-zec Medical Ltd	3
March	Independent Organisation	
	E-zec Medical Ltd	3
April	Independent Organisation	
	E-zec Medical Ltd	5

LOCAL QUALITY REQUIREMENTS – KPI'S

Patient Transport Bureau – Help Centre

Quality Requirement	Threshold	Method of Measurement	Consequence of Breach
Full booking details to be placed onto CLERIC at time of receiving the booking	100%	Monthly Operational Report	As per Contract Management Clause GC9
Cancelled journeys to be recorded within 15 minutes of receiving request	95%	Monthly Operational Report	As per Contract Management Clause GC9
All requests will be given a unique reference number to provide full traceability	100%	Monthly Operational Report	As per Contract Management Clause GC9
No booking request which has passed the eligibility screening to be declined once accepted by PTS provider	Zero tolerance	Monthly Operational Report	As per Contract Management Clause GC9
Calls to be answered within 30 seconds	80%	Monthly Operational Report	As per Contract Management Clause GC9
No more than 1% of all calls should receive the engaged tone	Max 1% of total calls engaged	Monthly Operational Report	As per Contract Management Clause GC9
Calls to be answered effectively and efficiently achieving a 95% answer service	No more than 5% of calls abandoned	Monthly Operational Report	As per Contract Management Clause GC9
Service Users unable to communicate effectively in English will be provided with an interpretation service within 15 mins of initial contact.	100%	Monthly Operational Report	As per Contract Management Clause GC9
All same day requests to be confirmed within 60 minutes of receipt	95%	Monthly Operational Report	As per Contract Management Clause GC9

Service User to receive confirmation of approximate pick up time	95%	Monthly Operational Report	As per Contract Management Clause GC9
Service users to be contacted one working day prior to booked journey to confirm transport arrangements	100%	Monthly Operational Report	As per Contract Management Clause GC9

Patient Transport

Quality Requirement	**Threshold**	**Method of Measurement**	**Consequence of Breach**
Service users to arrive at ultimate destination within defined thresholds	50% up to 30 minutes prior to appointment time; 90% up to 45 minutes prior to appointment, 95% by appointment time.	Monthly Operational Report	As per Contract Management Clause GC9
Service users to be collected at their agreed discharge/ready time within defined thresholds	90% up to 45 minutes after their identified ready time; 95% up to 60 minutes after their identified ready time; 30 minutes for renal patients after their identified ready time;	Monthly Operational Report	As per Contract Management Clause GC9
Service users to be delivered home or to their agreed destination within 10 minutes of "Time to Specific Home Visit"	95%	Monthly Operational Report	As per Contract Management Clause GC9
Heath provider to receive at least 30 minutes notice of any change to Service User drop	95%	Monthly Operational Report	As per Contract Management Clause GC9

off time or collection time			
Service user living up to 10 miles away from the treatment centre should not spend more than 60 minutes on the vehicle on either an outward or return journey	90%	Monthly Operational Report	As per Contract Management Clause GC9
Service users living over 10 and under 35 miles away from the treatment centre should not spend more than 90 minutes on the vehicle on either an outward or return journey	90%	Monthly Operational Report	As per Contract Management Clause GC9
Service users living over 35 and less than 50 miles away from the treatment centre should not spend more than 120 minutes on the vehicle on either an outward or return journey	90%	Monthly Operational Report	As per Contract Management Clause GC9
Identification of service users transported who do not meet the medical eligibility criteria as a % of the total number of service users transported	To be reviewed on a regular basis	Monthly Operational Report	As per Contract Management Clause GC9