Diagnostic Tests
Direct Access Non-Obstetric Ultrasound Service

Ref: Refreshed implementation NOUS 2013

DH INFORMATION READER BOX		
Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	**Provider Development**	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

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Gateway Reference	18658
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Circulation List	
Description	The implementation packs are designed to support commisisoners through the AQP process. These are not DH guidance nor are they mandatory. They are designed to be a toolkit and can be amended to suit local need. This is a refresh of the original implmentation packs published in December 2011.
Cross Ref	N/A
Superseded Docs	Diagnostics (NOUS) Implementation Pack 2011
Action Required	N/A
Timing	**N/A**
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For Recipient's Use	

Preface

Introduction

This implementation pack has been designed to support commissioners to deliver Any Qualified Provider in Diagnostic tests locally. It has been developed by NHS commissioners, clinical experts and DH officials, working in partnership. The use of this pack is not mandatory. Commissioners can refine it to meet local needs and, over time, help to improve it. The pack is simply a place to start, avoiding duplicating effort.

This pack should be used for services that are commissioned using the Any Qualified Provider (AQP) model – where commissioners are aiming to secure innovation or deliver more choice for patients whist maintaining high standards, Other forms of procurement are also available, which might suit other circumstances, more details of these can be found in DH procurement guidance.

The AQP impact assessment shows that the cost of procuring comparable services per project under AQP is lower than existing arrangements. Whilst maintaining and creating opportunities to improve clinical care.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457

This pack has been prepared by working with a range of professionals, from both clinical and commissioning backgrounds and we recommend that commissioners using these packs continue to engage with clinicians, professionals and a wide range of providers wherever possible.

Generally we expect there to be consistency across service specifications to sustain quality and help to spread best practice, but where necessary specifications should be amended to reflect local variations in need .

More information and further resources for commissioners can be found here:

http://nww.supply2health.nhs.uk/AQPRESOURCECENTRE/Pages/AQPHome.aspx. including a pricing principles document that should be read alongside this implementation pack. If commissioners do come up with innovative new ways to drive up the quality of care by offering choice of provider - please use the AQP resource forum to share your hard work.

Workforce, education and training implications

When commissioning a service under patient choice of AQP, there are some important workforce, education and training considerations, which commissioners must take into consideration. Annex 2 provides some additional details on these issues.

Public Sector Equality Duty

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. Please refer to Annex 3: Public Sector Equality Duty and visit the Department of Health website for more information on 'Equality and Diversity'.

Glossary

A glossary of terms used within this implementation pack is included in Annex 4.

Next Steps

These packs should be used by commissioners undertaking AQP in Diagnostic tests for direct access Non-Obstetric Ultrasound through 2012/13. An evaluation of the pack and the AQP process will be undertaken during this period. In the meantime if you have any questions or comments on this pack, please contact **AQP.Queries@dh.gsi.gov.uk**

Document Management

Document Control

Issue Date	Version	Distribution List	Contact Details

Document Approvals

This Document requires the following approvals.

Name	Signature	Title	Version	Date of Issue

Track Changes

Version No	Date	Details of Changes included in Update	Author(s)
1	7-1-13	Minor additions to scope of service	Liz Bailey DH
1	7-1-13	Changes to applicable service standards by updating references, additional information on quality assurance.	Liz Bailey DH
1	7-1-13	Minor changes to key service outcomes.	Liz Bailey DH
2	23-01-13	Minor changes to prices and payments, local requirements.	Liz Bailey DH
2	23-01-13	Total re-write of currency and pricing section and removal of 09/10 reference cost tables	Liz Bailey DH

CONTENTS OF THIS PACK

Section 1

Section B –Service Specification

Section 1 INDEX

SECTION B PART 1 - SERVICE SPECIFICATION

Service: Diagnostic Services – Direct Access Non-Obstetric Ultrasound Service

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	
Service	Diagnostic Services – Direct Access Non-Obstetric Ultrasound Service
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

B1_1.0 Population Needs

The NHS supports the need to develop improved access to diagnostic tests as part of the drive to reduce waiting times and improve choice options for Patients. The need to develop community based diagnostic services is supported by the Royal College of Radiologists and Royal College of General Practitioners as part of a service strategy to improve access to tests and ensure these tests are delivered at the right stage of the Patient care pathway. The overarching aims of the service are:

- To ensure Patients receive the right test at the right time and in the most clinically appropriate local setting;
- To ensure diagnostic testing is integrated across pathways of care, that the report and images follows the Patient and that there is no unnecessary duplication of investigation;
- To enable Patients and referring clinicians to access a choice of provision according to Patient choice, clinical need and relevant care pathway; and
- To ensure diagnostic tests are appropriate, necessary, clinically correct, of high quality, with timely access and reporting.

To develop local service provision as part of a diagnostic commissioning plan which aims to improve access and choice for Patients.

B1_2.0 Scope

B1_2.1 Aims and objectives of service

A local, direct access non-obstetric ultrasound service with staff qualified to appropriate levels of skill and experience, using ultrasound equipment which complies with the guidance set by the Royal College of Radiologists, connection to NHS image transfer solutions, the ability to integrate with the Choose and Book system, robust performance management systems and stringent levels of clinical governance.

The care pathway being commissioned is pre-appointment communication with Patients, the diagnostic investigation and a report being sent to the referrer, which covers not only the description of the investigation and the findings, but also where appropriate covers any recommendations for further imaging or investigation and advice on management. Structured reporting will be encouraged to support local referrers in their options for further clinical management. The service will need to be fully quality assured, validated and supported by the local Commissioners.

The Provider must aim to provide an excellent Patient experience during all parts of the process – to include the examination and the administrative services. In order to measure this, Providers should have in place robust mechanisms for collecting Patient feedback using approaches that reflect the diverse nature of their Patient population. This should include as a minimum, a Patient satisfaction survey, and one real time feedback mechanism. There must be a sound process for receiving and dealing with suggestions, compliments and complaints.

The aim of the service is to aid early diagnostics and avoid the need for unnecessary referral to secondary care clinicians for conditions that can be appropriately managed with a Primary Care setting or to support the shift of activity in to a primary care setting, where this will improve access. Where there are clear secondary care clinical pathways with ultrasound as a core component, it is more appropriate for this diagnostic to be undertaken as an integral part of the clinical pathway.

B1_2.2 Service description/ care pathway

B1_2.2.1 Referral

- Referral should ideally be via the Choose and Book system. As a minimum referrals should be sent by secure email. Providers would be expected to aim to be connected to the Choose and Book system (directly or indirectly bookable) at the earliest opportunity.
- Before conducting the examination, the practitioners must have access to any previous imaging and reports.

- It is anticipated that the majority of referrals will be direct from General Practitioners or a Clinical Assessment Service. Some referrals may be received from secondary care following specific agreement with local Commissioners.
- Providers must provide literature for GPs and referrers to assist them in the decision making processes associated with the most suitable type of diagnostic test for the Patient and presentation that will achieve the best and quickest diagnostic outcome;
- Patients should be contacted within a maximum of [5] working days of acceptance of the referral;
- The Patient should be offered a choice on day and time of appointment that is convenient to them;
- The Provider should ensure Patients have an adequate understanding of the proposed ultrasound scan before the appointment and any particular preparations that they will need to make, by providing written information in advance that explains the purpose of the ultrasound scan, what it involves and when and how they can expect to receive the results. This information should be reinforced on arrival at the appointment, consistent with the written information already received;
- The Provider shall not discriminate between or against Patients or Carers on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristics. The Provider shall provide appropriate assistance and make reasonable adjustments for Patients and Carers who do not speak, read or write English or who have communication difficulties; and
- Providers will provide to Commissioners detailed referral statistical information on referrers, referring organisation, service utilisation, referral rejection rate and clinical outcome to allow refinement of the clinical pathway.

B1_2.2.2 Assessment

- The Provider will provide triage of referrals to meet referral criteria and provide information within 1 working day where a referral does not meet the established criteria for examination;
- Scanning should be undertaken within [10] working days of acceptance of referral and at an absolute maximum of [20] working days ([4] weeks);
- A minimum of verbal consent should be obtained for all Patients and should be recorded in the ultrasound report;
- Patients must be offered the option of chaperone provision for the examination. The definition of intimate or invasive ultrasound may differ between individual Patients for ethnic, religious or cultural reasons and should be considered by the clinician;
- The Provider should be aware of the weight limit for various examination couches and ensure that the appropriate equipment is available or make suitable alternative arrangements when necessary; and

- The Provider will not usually provide the result of the diagnostic test at the time of the investigation, but will explain that a report will be sent without delay to the referrer. However, where the patient requests further information the operator will use their knowledge and discretion to determine the appropriateness of imparting the result within their scope of practice.

B1_2.2.3 Report

- A written clinical report should be sent to the referrer (and GP if this is not the same individual) within [2] working days following the examination and maximum of [5] working days. The information should be communicated electronically via a secure network.
- The Provider shall ensure that the Diagnostic Report is produced according to the guidance set out within the document 'Standards for the Reporting and Interpretation of Imaging Investigations' as published by the Royal College of Radiologists and as updated from time to time in the form agreed with the Authority, as a minimum;
- The report will provide the referrer with a differential diagnosis wherever possible – this will be based upon the presenting complaint described in the referral and the objective findings of the scan;
- If the sonographer requires input from a Consultant Radiologist, this should be available within 24 hours of the investigation; This should be provided by a Radiologist with expertise and current involvement in Ultrasound.
- Patients with a suspected cancer are specifically excluded from this service. However, there will be occasions when a diagnostic study identifies a serious and/or unexpected pathology. The Provider will need to have a clear Patient pathway for this group of Patients, which will ensure that the referrer is made aware of the potential diagnosis and the report is expedited for onward communication and that the diagnostic images are immediately available for review within the secondary care institution. This would include an immediate telephone conversation with the referrer, in line with guidance set out within the document 'Standards for the communication of critical, urgent and unexpected significant radiological findings', RCR;
- GPs or other clinical staff wishing to discuss individual cases will be provided access to the reporting individual through a central contact number; This will be to offer the opportunity to identify the most the appropriate examination and discuss the clinical findings if required.

- The Provider shall submit detailed protocols governing sonographer performance of ultrasound procedures;
- Evidence should be provided that these have been developed in concert with a radiologist expert in ultrasound and that there is a programme of constant review of the examination protocols;
- Sonographers will be expected to undertake regular audit and revalidation in keeping with the policy of the SCoR

- There must be a clearly defined pathway for images to be reviewed promptly by an expert radiologist in concert with the sonographer where there is uncertainty about the findings or for example when further imaging investigations are required;
- The image and report is stored in electronic format, in accordance with The Royal college of Radiologist 'Retention and Storage of Images and Radiological Patient Data' publication ideally via a Picture Archiving and Communications System (PACS) system; and
- The image and report is forwarded, at no charge, to other Providers of NHS funded treatment applicable to the Patient care pathway, within a maximum of a 5 working days of the request and sooner if necessary to correspond with patient care needs. This should include availability for local Multi-Disciplinary Team Meetings in line with the receiving provider image transfer and distribution protocols This may require connection to the National Image Exchange Portal (IEP).

B1_2.3 Population Covered

[For local completion]

B1_2.4 Any acceptance and exclusion criteria

B1_2.4.1 Acceptance Criteria

Referrals for inclusion:

- General abdominal – includes assessment of the aorta, biliary tract, gallbladder, inferior vena cava, kidneys, liver, pancreas, retroperitoneum and spleen;
- Gynaecology – including transabdominal and transvaginal;
- Renal / bladder / prostate;
- Scrotal / testicular;
- Musculoskeletal; and
- Vascular

The referring clinicians should consider the appropriateness of the referral based upon the integral nature of the diagnostic and the clinical pathway, in their deliberations with the Patient, in their choice of Provider.

The Provider must offer assurance that the Professional performing the examination has sufficient module based training to undertake the particular scan. It is acknowledged that much of the practical and academic training of sonographers is module based. It is critical that the training and experience of the sonographer is relevant to the nature of the examination being performed.

B1_2.4.2 Exclusion Criteria

Clinical exclusions

Cancer – any Patient with suspected cancer should be referred through the two week wait referral pathway;

Ultrasound guided procedures;

Obstetric care;

Scans for:

- Breast;
- Cardiac Imaging;
- Chest;
- Ophthalmology;
- Superficial masses or lumps in the neck, axilla or groin; and
- Thyroid.

Other exclusions

- Children under the age of 18; and
- Non-NHS Patients;
- Investigation of any potential clinically urgent condition or pathology (not cancer related)

B1_2.5 Interdependencies with other services

The Provider needs to develop their relationships with other Providers to become an integral member of the Health and Social Care Community. This includes third sector organisations providing help and support for Patients. The development of local clinical networks will be encouraged with the aim of providing parallel services which provide complementary services allowing for further clinical services to be offered closer to home and within the community. The role of service users as key stakeholders will be an important component of this development and Providers should ensure effective mechanisms for their involvement and develop a positive relationship with the local involvement network (Healthwatch).

The Provider may need to develop relationships within the Health Community to enable fulfilment of the Quality Assurance requirements.

The Provider will be required to be involved in local care pathway work and discussions, ensuring the best and most efficient means of treating patients are adopted, including the movement of the relevant clinical information (i.e. images and clinical output report).

B1_3.0 Applicable Service Standards

B1_3.1 Applicable National Standards

- Ultrasound Equipment Evaluation Project (UEEP) recommendations as published from time to time – MHRA.
- Right Test, Right Time, Right Place - Royal College of Radiologists and Royal College of General Practitioners (2006).
- I Refer Making the Best Use of a Clinical Radiology - Royal College of Radiologists (2012).
- Standards for Ultrasound Equipment - Royal College of Radiologists (2005).
- Ultrasound Training, Employment and Registration – Society and College of Radiographers (2010).
- Guidelines for Professional Working Standards: Ultrasound Practice – United Kingdom Association of Sonographers (2008). UKAS merged with the SCoR on 01/01/2009.
- Standards for the communication of critical, urgent and unexpected significant radiological findings - Royal College of Radiologists (2008).
- Society and College of Radiographers suggested documents:
- **http://doc-lib.sor.org/scope-practice-medical-ultrasound**
- **http://doc-lib.sor.org/ultrasound-training-employment-and-registration**
- **http://doc-lib.sor.org/profession-standards-independent-practitioners**
- **http://doc-lib.sor.org/guidelines-profession-working-standards-ultrasound-practice**
- Industry Standards for the Prevention of Work Related Musculoskeletal Disorders in Sonography – Society of Radiographers (2006).
- Prevention of Work Related Musculoskeletal Disorders in Sonography - Society of Radiographers (2007).

This is intended as a non-exhaustive list. Clause [16] takes precedence.

B1_3.2 Applicable Local Standards

B1_3.2.1 Staffing

The Provider shall ensure that this includes a sufficient number of examinations to maintain competence in every area(s) of ultrasound the practitioner is to undertake.

- UK Registered Radiologists on the GMC Specialist Register undertaking sufficient current clinical practice within that modality. For example, a consultant radiologist must have undertaken planned regular clinical ultrasound sessions within their current job plan.

- Sonographers who are either:

currently registered with the Health and Care Professions Council (HCPC) or the Nursing and Midwifery Council (NMC) and have performed regular sessions of relevant ultrasound examinations within the last 12 months

- or hold one or more of the following and have performed regular sessions of relevant ultrasound examinations in the last 12 months:
    - a postgraduate certificate or diploma in medical ultrasound, approved and validated by a UK Higher Education Institution and accredited by the Consortium for the Accreditation of Sonographic Education (CASE);
    - the Certificate / Diploma of the College of Radiographers in Medical Ultrasound,
    - an equivalent level of qualification in medical ultrasound (for example if trained overseas) or individual accreditation from the Society for Vascular Technology
- It is recommended that all sonographers who are not otherwise statutorily registered are registered on the Public Voluntary Register of Sonographers (PVRS), administered by the College of Radiographers. (Information on the PVRS can be **http://www.sor.org/practice/ultrasound/register-sonographers**.

- All staff maintain their Continuing Professional Development in accordance with professional body guidelines

    - All Staff must meet the relevant specification set out in the 'National Occupational Standards for Imaging' for the anatomical area to be scanned (**https://tools.skillsforhealth.org.uk/competence/show/html/id/1208/** particularly CI.C: 'Acquire, interpret and report ultrasound examinations');
    - Staff will have English as a first language or have passed a suitable English language examination to the level of requirement set out on the Health Professions Council website
    - (**http://www.hcpc-uk.org/apply/international/requirements**).

B1_3.2.2 Equipment

The Provider shall provide equipment that meets or exceeds the following:

- Complies with the latest guidance from the National Imaging Clinical Advisory Group and Professional Bodies;
- Transducers that ensure good visualisation at sufficient depth of image without significant loss of accurate spatial resolution; and
- Be capable of flow imaging and measurement.
- Electrical Safety Testing is required annually with regular maintenance and quality assurance testing;
- Details of maintenance contracts to include regular and emergency service cover must be provided; and
- Replacement schedule must be available with the maximum age of equipment of 7 years.

B1_3.2.3 IM&T

Where data is transferred from the Ultrasound Scanner to the provider, PACS or image store the removable media device must have encryption software. Standard operating procedures for handing the data will be implemented as required by the commissioner.

Provision of Digital Data between the Provider PACS systems should be through the Image Exchange Portal or other data sharing systems to other providers as specified by the commissioner, or in clinical circumstances that require the transfer of the image to support the safe treatment of the patient.

In the event of cancellation of the contract (for whatever reasons), the Provider will be required to maintain systems to allow continued access, in a timely manner, to all of the patient information, images and associated patient records.

B1_3.2.4 Facilities

Whilst it is anticipated that the service will be provided from a number of locations. Each site must meet the minimum requirements of:

- A room, which is at least 12 sqm and supports wheelchair access;
- Includes a hand washbasin and adjustable lighting;
- Have adequate provision for patient privacy – sound-proofing, lockable doors etc.
- Is supported by a staffed reception area and waiting area; and
- Has access to toilet facilities, which include disabled access.

It is desirable that the room has an air conditioning system.

Musculoskeletal disorders are the most common work-related illness in Britain and represent a significant potential risk. There are guidance documents, which focus upon preventing, and controlling musculoskeletal disorders for radiographers, other health care professionals engaged in Sonography, and Providers must be aware of and abide by this advice.

B1_3.2.5 Quality Assurance

Ultrasound services are very operator dependent. It is therefore necessary for a clear and stringent quality assurance process to be an integral requirement of the service, at individual operator level. Whilst independent practice is appropriate, working in isolation is not and this must be addressed by Providers. This is an important governance issue and is addressed in the document “Team Working in Clinical Imaging” jointly produced by the Royal College of Radiologists and the Society and College of Radiographers 2012. (http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=373)

The proposed Quality Assurance process should include, as a minimum:

Ongoing 5% audit of ultrasound examinations to include the technical quality of the examination, the quality of static images captured, and the structure and content of clinical reports; with trigger values set for detailed review of service/performance mechanisms to be agreed with Commissioner;

Annual assurance of competency and up to date continuous professional development

Participation by all clinical staff in 'local errors meetings' or similar clinical governance process.

The recall rates for patients (annual report) and reasons.

The Provider must follow The British Medical Ultrasound Society (BMUS) safety guidelines and demonstrate understanding of the 'As Low As Reasonably Achievable' (ALARA)1 principle, and have an effective system in place to ensure awareness of recent safety publications by national and international bodies.

B1_4.0 Key Service Outcomes

Table 1: Key service outcomes

Key Service Outcome	Method of Measurement
Patients reporting a good level of satisfaction of the service.	Patient Satisfaction Survey to be sent out to a minimum of 95% of Patients using the service, with a minimum response rate target of 30%. Target of 95% of Patients reporting good level of overall satisfaction.
Reduced referral to secondary care clinicians when considered in conjunction with specialist services such as Specialist Practitioner assessment and treatment. Improved conversion rate – as proxy for increased appropriateness of referrals.	Secondary Users Service (SUS) system – using previous year as baseline.
Image and Report to follow Patient pathway – no repeat scanning without clinical rationale.	Commissioner to audit random sample – results to be extrapolated.
Improved targeting of referrals to right secondary care clinic first time – less Consultant to Consultant referrals	SUS system – using previous year as baseline.

B1_5.0 Location of Provider Premises

The Provider's Premises are located at:
[Name and address of Provider's Premises OR state "Not Applicable"]

B1_6.0 Individual Service User Placement

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

SECTION B PART 2 - ESSENTIAL SERVICES

[For local agreement]

SECTION B PART 3 - INDICATIVE ACTIVITY PLAN

B3_1.0 Indicative Activity Plan

SECTION B PART 4 - ACTIVITY PLANNING ASSUMPTIONS

B4_1.0 Commissioning Ambitions based on Activity Plan

[State “Not Applicable” where appropriate OR where inserted, the Commissioning Ambitions must not conflict with information in Service Specifications. The standard template published alongside this contract is recommended]

B4_2.0 Capacity Review

[Where relevant to the Service, relevant parts of the Activity Plan and Capacity Review should be inserted here.]

B4_3.0 Prices and Payment

Table 2: Prices and payment

HRG Code	Description	Price
RA23Z	Ultrasound, scan 0 – 20 mins	[local completion]
RA24Z	Ultrasound, scan 20 – 40 mins	[local completion]

This table should be completed according to the National Tariff for the relevant financial year, including the Market Forces Factor for the provider.

SECTION B PART 5 - ACTIVITY MANAGEMENT PLAN

[Insert/append Activity Management Plan]

SECTION B PART 6 - NON-TARIFF AND VARIATIONS TO TARIFF PRICES

B6_1.0 Non-Tariff Prices

[For local agreement]

B6_2.0 Variations to Tariff Prices

[For local agreement]

SECTION B PART 7 - EXPECTED ANNUAL CONTRACT VALUES

[To be inserted for each Commissioner where relevant to the Services **OR** state "Not Applicable"]

SECTION B PART 8 - QUALITY

B8_1.0 Part 1 - Quality Requirements

Table 3: Quality Requirements

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	Patient Reported Satisfaction of an overall good experience of the service.	[95%] report overall satisfaction with the service.	Patient satisfaction survey to be sent out to a minimum of 95% of Patients, with a minimum target response rate of 30%.	Remedial Action Plan.
	Reduced referral to secondary care and improved conversion rate as a proxy for increased appropriateness of referrals.	Previous year as baseline.	SUS.	Remedial Action Plan.
	Improved targeting of referrals to right secondary care clinic first time – less consultant to consultant referrals.	Previous year as baseline.	SUS.	Remedial Action Plan.
	Provider failure to ensure that 'sufficient appointment slots' are made available on the Choose and Book system.	No more than [5%] slot unavailable bookings.	TALs List.	Remedial Action Plan.
	Percentage of referrals received via the Choose and Book system.	[40%]	Monthly Performance Report.	Remedial Action Plan.
	Rejections – total number of referrals	[15%]	Monthly Performance	Remedial Action Plan – to work

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	rejected by Provider.		Report.	with Primary Care to improve the quality, appropriateness & completeness of referrals.
	Number of Patients who have a repeat activity as a result of any incorrectly or inadequately performed activity (expressed as a percentage of the total number of activities).	Greater than [1%]	Monthly Performance Report.	Repeat activity to be provided at no cost to the NHS.
	Provider will provide triage of referrals to meet referral criteria and accept or reject a referral within [1] working day.	[98%]	Monthly Performance Report	Remedial Action Plan
	Once the referral is accepted, initial contact to be made with patient within [5] working days.	[95%]	Monthly Performance Report.	Activity to be provided at no cost to the NHS.
	Patient offered choice on day and time of appointment that is convenient to them.	[95 %]	Patient Satisfaction Survey.	Remedial Action Plan.
	Investigation undertaken within [10] working days of acceptance of referral.	80%	Monthly Performance Report.	Remedial Action Plan.
	Investigation undertaken within	100%	Monthly Performance	Remedial Action Plan; or Activity

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	[20] working days of acceptance of referral.		Report.	to be provided at no cost to the NHS.
	Report of investigation to be sent to referrer within [2] working days of investigation.	80%	Monthly Performance Report.	Remedial Action Plan.
	Report of investigation to be sent to referrer within [5] working days of investigation.	100%	Monthly Performance Report.	Remedial Action Plan; or Activity to be provided at no cost to the NHS.
	Non-attendance: Percentage of referrals not completed due to patient DNA or late cancellation.	No more than [2.5%]	Monthly Performance Report.	Remedial Action Plan.
	Provider cancellation of appointment for non-clinical reasons either before or after Patient arrives for investigation.	No more than [0.8%]	Monthly Performance Report.	Non payment for non investigation.
	Patient waiting more than [30] minutes after appointment time before start of investigation activity (measured as a percentage of all Patients scanned).	No more than [5%]	Monthly Performance Report.	Remedial Action Plan.
	Complaints register to be provided every month.	No more than [5%] of complaints substantiated.	Monthly Complaints Register.	Remedial Action Plan.
	A minimum of one	[85%] overall	Annual Referrer	Remedial Action

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	GP satisfaction survey will be designed and sent to all referring GPs per annum. [85%] of GPs sampled should report overall satisfaction with the service and a response rate of 30% achieved.	satisfaction.	Satisfaction Survey Report.	Plan.

B8_2.0 Nationally Specified Events

Table 4: Nationally Specified events

Technical Guidance Reference	Nationally Specified Event	Threshold	Method of Measurement	Consequence per breach

B8_3.0 Never Events

Table 5: National Definition (part of standard contract)

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)

SECTION B PART 9 - QUALITY INCENTIVE SCHEMES

B9_1.0 Part 1 - Nationally Mandated Incentive Schemes

[For national determination]

B9_2.0 Commissioning for Quality and Innovation (CQUIN) Table 1: CQUIN Scheme

[The Parties are recommended to use the on-line standard template for CQUIN schemes 2011/12 available on the website of the NHS Institute for Innovation and Improvement: **http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html**) to facilitate the completion and recording of their CQUIN scheme.

Where the Parties use the on-line standard template, a copy of the completed scheme must still be printed and appended to this Schedule 18 Part 2 in place of the tables below.]

Quality Incentive Payments can be agreed to be paid monthly or by single annual payments.

PLEASE DELETE AS APPROPRIATE "The Parties agree that Quality Incentive Payments shall be paid monthly and therefore the provisions set out in paragraphs 5 to 13 below shall apply." **OR "**The Parties agree that Quality Incentive Payments shall be paid annually and therefore the provisions set out in paragraphs 14 to 19 below shall apply.

Table 6: Summary of goals[1]

Goal Number	Goal Name	Description of Goal	Goal weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain (Safety, Effectiveness, Patient Experience or Innovation)
1		[insert locally agreed goals]			
2		[insert locally agreed goals]			
3		[insert locally agreed goals]			
4		[insert locally agreed goals]			
etc		[insert locally			

1 The on-line standard template on the website of the NHS Institute for Innovation and Improvement contains some additional fields to assist its automated functions. Parties may include these additional fields in the completed version of the scheme included in the contract

Goal Number	Goal Name	Description of Goal	Goal weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain (Safety, Effectiveness, Patient Experience or Innovation)
		agreed goals]			
		Totals:			

Table 7: Summary of indicators

Goal Number	Indicator Number[1]	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
1		[insert the indicator or indicators that are agreed in respect of each goal]		
2				
3				
Etc				
		Totals:		

Table 8: Detail of Indicator (to be completed for each indicator)

Indicator number	
Indicator name	
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	
Numerator	
Denominator	
Rationale for inclusion	
Data source	

1 There may be several indicators for each goal

Frequency of data collection	
Organisation responsible for data collection	
Frequency of reporting to commissioner	
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Table 9: Milestones (only to be completed for indicators that contain in-year milestones)

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
		Total:	

Table 10: Rules for partial achievement at final indicator period/date

Final indicator value for the part achievement threshold	% of CQUIN scheme available for meeting final indicator value

Final indicator value for the part achievement threshold	% of CQUIN scheme available for meeting final indicator value

1. Subject to paragraph 2, if the Provider satisfies a Quality Incentive Scheme Indicator set out in Schedule 18 Part 2 Table 1, a Quality Incentive Payment shall be payable by the Commissioners to the Provider in accordance with this Schedule 18 Part 2.

2. The Commissioners shall not be liable to make Quality Incentive Payments under this Schedule 18 Part 2 to the Provider in respect of any Contract Year which in aggregate exceed the applicable Actual Outturn Value percentage for the relevant Contract Year set out below:

Table 11: Outturn Value percentage for the relevant Contract Year

Contract Year	Maximum aggregate Quality Incentive Payment
1st Contract Year	[For national determination and local insertion]

In addition, for the avoidance of doubt this paragraph shall limit only those Quality Incentive Payments made under this Schedule 18 Part 2, and shall not limit any Quality Incentive Payments made under any Quality Incentive Scheme set out in Schedule 18 Part 1 or Schedule 18 Part 3.

3. The Provider shall in accordance with clause [33] of this Agreement submit to the Co-ordinating Commissioner a Service Quality Performance Report which shall include details of the Provider's performance against and progress towards the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in the month to which the Service Quality Performance Report relates.

4. The provisions set out in paragraphs 5 to 13 below apply in respect of Quality Incentive Payments made by monthly instalments. The provisions set out in paragraphs 14 to 19 apply in respect of Quality Incentive Payments made by a single annual payment.

Monthly Quality Incentive Payments

5. Where the Co-ordinating Commissioner and the Provider have agreed that Quality Incentive Payments should be made on a monthly basis by any Commissioners, then in each month after the Service Commencement Date during the term of this Agreement each relevant Commissioner shall make the default Quality Incentive Payment set out below to the Provider:

Table 12: Quality Incentive Payment

Commissioners	Monthly Quality Incentive Payment – 1st Contract Year
[insert name of each Commissioner making CQUIN payments]	

In addition, the Provider and the Co-ordinating Commissioner may from time to time, whether as a result of a review performed under paragraph 6 below or otherwise, agree to vary the default monthly Quality Incentive Payment for any Commissioner set out above.

6. The Co-ordinating Commissioner shall review the Quality Incentive Payments made by the Commissioners under paragraph 5 on the basis of the information submitted by the Provider under this Agreement on the Provider's performance against the Quality Incentive Scheme Indicators. Such reviews shall be carried out as part of each Review under clause [8].

7. In performing the review under paragraph 6 the Co-ordinating Commissioner shall reconcile the Quality Incentive Payments made by the relevant Commissioners under paragraph 5 against the Quality Incentive Payments that those Commissioners are liable to pay under paragraph 1 on the basis of the Provider's performance against the Quality Incentive Scheme Indicators, as evidenced by the information submitted by the Provider under this Agreement.

8. Following such reconciliation, where applicable, the Provider shall invoice the relevant Commissioners separately for any reconciliation Quality Incentive Payments.

9. Within [10] Operational Days of completion of the review under paragraph 6, the Co-ordinating Commissioner shall submit a Quality Incentive Payment reconciliation account to the Provider.

10. In each reconciliation account prepared under paragraph 9 the Co-ordinating Commissioner:

10.1 shall identify the Quality Incentive Payments to which the Provider is entitled, on the basis of the Provider's performance against the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in those months of the relevant Contract Year that have elapsed at the time of the review;

10.2 shall ensure that the Quality Incentive Payments made to the Provider in respect of completed Contract Years comply with the requirements of paragraph 2;

10.3 may correct the conclusions of any previous reconciliation account, whether relating to the Contract Year under review or to any previous Contract Year; and

10.4 shall identify any reconciliation payments due from the Provider to any Commissioner, or from any Commissioner to the Provider.

11. Within [5] Operational Days of receipt of the Quality Incentive Payment reconciliation account from the Co-ordinating Commissioner, the Provider shall either agree, or, acting in good faith, contest such reconciliation account.

12. The Provider's agreement of the Quality Incentive Payment reconciliation account (such agreement not to be unreasonably withheld) shall trigger a reconciliation payment by the relevant Commissioner(s) to the Provider, or by the Provider to the relevant Commissioner(s), as appropriate, and such payment shall be made within [10] Operational Days of the Provider's agreement of the reconciliation account and the Provider's invoice.

13. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment reconciliation account:

13.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting such account, and in particular identifying which elements are contested and which are not contested;

13.2 any uncontested payment identified in the Quality Incentive Payment reconciliation account shall be paid in accordance with paragraph 12 by the Party from whom it is due; and

13.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 13.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 13 the relevant Party shall pay any amount agreed or determined to be payable.

Single annual payment of Quality Incentive Payments

14. Where the Provider and Co-ordinating Commissioner have agreed that one single Quality Incentive Payment should be made to the Provider by any Commissioner at the end of each Contract Year, then at the end of each Contract Year during the term of this Agreement each Commissioner set out in the table in this paragraph 14 shall, subject to the Provider's performance against the Quality Incentive Scheme Indicators, make a single Quality Incentive Payment to the Provider in accordance with the procedure set out in paragraphs 15 to 19 below.

Commissioners making single annual Quality Incentive Payment at the end of the Contract Year
[insert name of any Commissioner making CQUIN payments] [Insert amount of the CQUIN payment for each relevant Commissioner]

15. The Co-ordinating Commissioner shall, within [10] Operational Days of the end of the Contract Year to which the Quality Incentive Payments relate or its receipt of final information from the Provider on its performance against the Quality Incentive Scheme Indicators during that Contract Year (whichever is the later), submit to the Provider a statement of the Quality Incentive Payments to which the Provider is entitled on the basis of the Provider's performance against the Quality Incentive Scheme Indicators during the relevant Contract Year, as evidenced by the information submitted by the Provider under this Agreement.

16. Within [5] Operational Days of receipt of the Quality Incentive Payment statement from the Co-ordinating Commissioner under paragraph 15, the Provider shall either agree, or, acting in good faith, contest such statement.

17. The Provider's agreement of the Quality Incentive Payment statement (such agreement not to be unreasonably withheld) shall trigger a payment by the relevant Commissioner(s) to the Provider, and such payment shall be made within [10] Operational Days of the Provider's agreement of the statement and the Provider's invoice.

18. In the event that the Quality Incentive Payment under paragraph 17 is paid before the final reconciliation account for the relevant Contract Year is agreed under clause [7] (*Prices and Payment*) of this Agreement, then if the Actual Outturn Value for the relevant Contract Year is not the same as the expected Annual Contract Value against which the Quality Incentive Payment was calculated, the Co-ordinating Commissioner shall within [10] Operational Days of the agreement of the final reconciliation account under clause [7] send the Provider a reconciliation statement reconciling the Quality Incentive Payment against what it would have been had it been calculated against the Actual Outturn Value, and a reconciliation payment in accordance with that reconciliation statement shall be made by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate, within [10] Operational Days of the submission to the Provider of the reconciliation statement under this paragraph 18.

19. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment statement under paragraph 15 or reconciliation statement under paragraph 18:

    19.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting the relevant statement, and in particular identifying which elements are contested and which are not contested;

    19.2 any uncontested payment identified in the relevant statement shall be paid in accordance with paragraph 17 by the relevant Commissioner or the Provider, as the case may be; and

    19.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 19.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

    and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 19 the relevant Party shall pay any amount agreed or determined to be payable.

The AQP impact assessment shows that the cost of procuring services per project under AQP is lower than existing arrangements:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457

B9_3.0 Locally Agreed Incentive Schemes

[For local agreement]

SECTION B PART 10 - ELIMINATING MIXED SEX ACCOMMODATION PLAN

SECTION B PART 11 - SERVICE DEVELOPMENT AND IMPROVEMENT PLAN

Table 13: Service Development and Improvement Plan

Description of Scheme	Milestones	Timescales	Expected Benefit	Consequence of Achievement/ Breach
[insert as defined locally]	[insert as defined locally]	[insert as defined locally]	[insert as defined locally]	Subject to clause [32] (Contract Management)

SECTION B PART 12 - SERVICE USER, CARER AND STAFF SURVEYS

B12_1.0 Service User, Carer and Staff Surveys

[Mandatory but for local agreement – set out survey type, frequency, how it is to be reported and publication method where relevant]

Cross reference with detail within the Specification and the information within Section 4 – Additional notes from the Implementation Pack Team.

SECTION B PART 13 - CLINICAL NETWORKS AND SCREENING PROGRAMMES

[For local agreement and not to conflict with any information in Service Specifications]

SECTION B PART 14 - REPORTING AND INFORMATION MANAGEMENT

All information gathered for the purposes of reporting is subject to the requirements set out in clause [27], (*Data Protection, Freedom of Information and Transparency*) and clause [56] (*Compliance with the Law*).

B14_1.0 National Requirements Reported Centrally

1. The Provider and Commissioner shall comply with the reporting requirements of SUS and UNIFY2. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs), where applicable to the service being provided.

2. The Provider shall ensure that each dataset that it provides under this Agreement contains the Organisation Data Service (ODS) code for the relevant Commissioner, and where the Commissioner to which a dataset relates is a Specialised Commissioning Group, or for the purposes of this Agreement hosts, represents or acts on behalf of a Specialised Commissioning Group, the Provider shall ensure that the dataset contains the ODS code for such Specialised Commissioning Group.

3. The Provider shall collect and report to the Commissioner on the patient-reported outcomes measures (PROMS) in accordance with applicable Guidance.

4. The Provider shall comply with the national reporting requirements in relation to Sleeping Accommodation Breaches as set out in the Professional Letter.

B14_2.0 National Requirements Reported Locally

DM01

B14_3.0 Local Requirements Reported Locally

Direct access and outpatient diagnostic data is not mandated in a Commissioning Data Set (CDS) and therefore not mandated to flow into SUS. However, CDS 6.2 contains an optional field to identify services that have been accessed directly. SUS PbR does not currently use this field, so if providers do use the outpatient CDS to report direct access diagnostic imaging, they need to ensure that it is reported against Treatment Function Code 812 Diagnostic Imaging so that an attendance tariff is not paid in addition.

Alternatively, a local dataset will need to be specified that will enable linkage to other mandated CDS' and aid contract monitoring.

Commissioners should consider data that will identify patient demographics, referral information, diagnostic test data and outcome results.

Table 14: Data Quality

A data quality improvement plan is set out at Schedule 5 Part 4 which outlines the data quality targets for 2011/12. The table below outlines the expectation for current delivery in 2011/12:

Table 15: Data Quality Thresholds : Expected levels of completeness/validity

Data Item	Expected level of coverage Non SUS data (diagnostics)	Expected level of coverage (SUS submissions)
DOB complete/valid	99%	99%
First attendance	100%	100%
Attended/DNA	98%	98%
NHS Number**	97%	97%
Referral source	97%	97%
Organisation code of referrer	98%	98%
Type of diagnostic test	99%	n/a

*= complete and valid codes
Default codes (V81997/V81998/V81999) not be counted as valid codes.
** if NHS number not given then patient name must be provided

The table below suggests some information that might be useful in monitoring a diagnostic contract, but local knowledge and experience should prevail

Table 16: Information to aid in monitoring a diagnostic contract

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
Demographic	NHS Number	E	To enable linkage to other providers on pathway	*10 digit NHS Number*
Demographic	Patient Date of Birth	D	To validate NHS Number on Summary Care Record	*Date format DD/MM/YYYY*
Referral	Unique referral identifier	E	To monitor repeat activity, if another attendance offered then same referral identifier should be used in second and subsequent attendances	*Format to be confirmed by diagnostic provider, but suggest numerical /integer*
Referral	Organisation code of referrer	E	Practice Code	*6 digit national GP practice code*
Referral	Organisation code of commissioner	D	PCT Code	*3 or 5 digit national code*
Referral	Organisation code of provider	D	Provider Code	*As per NHS Data Dictionary Coding Frames*
Referral	Date sent by referrer	E	To monitor time on pathway	*Date format DD/MM/YYYY*
Referral	Date received by provider	E	To monitor time on pathway, system delays	*Date format DD/MM/YYYY* *Date of referral is date the referral was received*

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
				by the service
Referral	Date referral accepted by provider	E	To monitor time on pathway, system delays	*Date format DD/MM/YYYY*
Referral	Referral source	E	Taken from NHS Data Dictionary definition	*Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *01 following an emergency admission* *02 following a Domiciliary Consultation* *10 following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)* *11 other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode* *03 referral from a GENERAL MEDICAL PRACTITIONER* *92 referral from a GENERAL DENTAL PRACTITIONER* *12 referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)*

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
				04 referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres) *05 referral from a CONSULTANT, other than in an Accident and Emergency Department* *06 self-referral* *07 referral from a Prosthetist* *13 referral from a Specialist NURSE (Secondary Care)* *14 referral from an Allied Health Professional* *15 referral from an OPTOMETRIST* *16 referral from an Orthoptist* *17 referral from a National Screening Programme* *93 referral from a Community Dental Service* *97 other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode*
Referral	Test requested	D	Reason for referral, to check referral compliance	*Text field*
Attendance	Unique activity identifier	E	To separate multiple tests on same day. This is not	*Format to be confirmed by diagnostic provider, but suggest numerical /integer*

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
			the same as the unique referral identifier	
Attendance	Date and time of diagnostic test	E	To monitor time on pathway, contract activity reconciliation	*Date format DD/MM/YYYY hh:mm*
Attendance	Duration of attendance	E	To monitor contract activity	*Numerical/integer* *Number of minutes*
Attendance	First Attendance	E	To monitor contract delivery	*1 First attendance face to face (First Diagnostic)* *2 Follow-up attendance face to face (Repeat Diagnostic)* *3 First telephone or telemedicine consultation (N/A)* *4 Follow-up telephone or telemedicine consultation (N/A)*
Attendance	Type of diagnostic test	E	What diagnostic test / procedure did the provider perform? To monitor contract delivery	*OPCS4 codes or locally defined list?*
Attendance	Anatomical site	D	To monitor contract delivery	*Add the area of the body requiring diagnostic*
Attendance	Staff type seeing patient	E	To monitor contract delivery	*Lead Care Professional* *Member of Care Professional team*

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
Attendance	Attend / DNA	E	To monitor contract delivery	*5 Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT* *6 Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen* *7 PATIENT arrived late and could not be seen* *2 APPOINTMENT cancelled by, or on behalf of, the PATIENT* *3 Did not attend - no advance warning given* *4 APPOINTMENT cancelled or postponed by the Health Care Provider* *0 Not applicable - APPOINTMENT occurs in the future **
Attendance	Seen By	E	To monitor contract delivery	*Name of person completing*
Outcome	Patient Outcome	E		*1 Discharged from CONSULTANT's care (last attendance)* *2 Another APPOINTMENT given* *3 APPOINTMENT to be made at a later date*
Outcome	Date result reported	D	To monitor time on pathway, system delays	*Date format DD/MM/YYYY*

Type of collection	Data Type	Essential / Desirable	Comments Need to reference contract paragraph	Format/definition
Outcome	Date result communicated to referrer	E	To monitor time on pathway	*Date format DD/MM/YYYY*
Contract	Currency type	E	Contract monitoring and reconciliation	*PBR/nonPBR?*
Contract	HRG	E	Contract monitoring and reconciliation	*Refer to list of HRGs*
Contract	Base HRG cost	D	Contract monitoring and reconciliation	*Numerical/Decimal*
Contract	MFF cost	D	Contract monitoring and reconciliation	*Numerical/Decimal*
Contract	Total cost of diagnostic test provided	E	Contract monitoring and reconciliation	*Numerical/Decimal* *Zero cost for DNAs/Cancellations or repeat test for non-clinical reason*

B14_4.0 Data Quality Improvement Plan

Table 17: Data Quality Improvement Plan

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
[for local definition]	[for local definition]	[for local definition]	[for local definition]	[for local definition]

Section 2

Currency and Price

Section 2 INDEX

Section 2 – Currency and Price

S2.1 Pricing Assessment

S2.1.1 Introduction

The tariffs for direct access diagnostic imaging, including MRIs and Ultrasound , were mandated from 2012/13. These tariffs are published as part of the Payment by Results package on the Department of Health's website[1].

The letter from David Flory, NHS Deputy Chief Executive, published on the Department of Health website on 19 December 2012 sets out the intention to "unbundle" the costs of diagnostic imaging from outpatient attendance tariffs and set separate prices for this activity. The letter states: "There are a number of good reasons for doing this, such as promoting greater clinical integration across the patient pathway, more appropriately reimbursing providers with a different from the average casemix in outpatients and addressing concerns that the existing approach can hinder the delivery of appropriate imaging activity." This means that if a scan has already been carried out via direct access and is not repeated in outpatients, there will be no "double payment" for the scan.

S2.2 Potential Contracting Issues

S2.2.1 Coding, Recording and Reporting

Whilst the currencies for this activity have been established for a number of years, some concerns remain generally about provider ability to record, code and group this activity due to the capacity of clinical coders to code the activity and the capability of existing IT systems to capture/hold this information. If the grouping of the activity is not captured systematically, manual intervention increases room for error and makes accurate cost allocation more difficult.

For example: recently resolved local issues caused by manual intervention resulted in 2 or 3 RA01Z (MRI Scan, one area, no contrast agent) charges for single attendances for patients receiving MRI scans on more than one area when the appropriate charge was an RA04Z (MRI Scan, two – three areas, no contrast agent).

Other commissioners have confirmed that block contracts for this activity are still in existence with some providers, due to the difficulties in the coding and recording. This raises a degree of concern about the accuracy of the cost allocation across the casemix (depending on the number of providers in this situation nationally.)

[1] http://www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/

S2.2.2 Performance management considerations

It would be of use to commissioners to understand the volume of repeat diagnostic tests in secondary care following referral to ensure that only clinically indicated repeat tests are carried out. Repeat tests for operational reasons such as images/reports not attached to referrals may go against clinical guidelines, delay patient pathways and be an inefficient use of NHS resources.

Error! Reference source not found. **– 0910 NATIONAL AVERAGE REFERENCE COST ASSESSMENT, DIAGNOSTIC IMAGING (MRI AND NON-OBS ULTRASOUND)**

Table 18: 0910 Reference Cost Activity: DIAGIM (All Org Type and Supplier Type)

Section 3

Any Qualified provider – Diagnostics

Patient and public engagement implementation pack

Section 3 INDEX

TABLES

Section 3 – Any Qualified provider – Diagnostics

S3.1 Introductory notes

This section sets out the activity undertaken to engage with and collect the views of patients in relation to the implementation of any qualified provider process for diagnostics closer to home. It includes a summary of findings along with the recommendations arising from the involvement and a range of support materials used in the process of involvement.

The Department of Health brief for this engagement was to discover what information people would need to make their choice. However we expanded this to ask a further three questions and we asked people:

- What information would you need in order to make a decision about which provider to go to?
- When would you need that information?
- What form should that information take?
- If you needed support to make your decision who would you prefer to get that support from?

This pack contains the information required in Part B of the Department of Health's guidance and content requirements checklist

S3.2 Summary of Findings

Patients and the public were asked about the kind of information that they would need in order to make an informed decision about which of two or more providers they would want to provide their diagnostic tests.

Below is a summary of what people told us in response to the engagement.

S3.3 What information

Thirteen different types of information were identified as being of importance to patients and the public and these are listed below in order of their importance where 1 is of greatest importance and 13 least.

Table 19: Information important to patients and the public

Rating	Type of Information
1	Independent reviews of the services provided
2	Choice of appointment time
3	Recommendation from a health professional

Rating	Type of Information
4	What other users say about the service
5	Waiting times
6	Ease of access
7	Provider reputation
8	Choice about practitioner gender
9	Disability awareness and provision
10	Location
11	Patient satisfaction survey results
12	Quality of clinical care
13	Patient complaints

This sets out very blandly the outcome of engagement however, much rich information was also collected as part of the process and therefore, we are able to say that the relative unimportance regarding quality is an expression of patient expectation. People expect that NHS services will be provided to a high standard.

In addition, the results of satisfaction surveys were viewed as being of questionable value because the questions are devised by the providers and therefore people preferred to refer to what patients have said via more independent means (for example through sites like Patient Opinion).

Finally, the relatively low position of location does not truly reflect its importance in the first instance. It position reflects instead the public's preparedness to go further afield if it means a quicker and/or better service.

S3.4 When information is provided

People were overwhelmingly telling us that the information they need to make a choice should be made available to them at the point when they are told that a test is needed. This allows them to take time to absorb the information, seek advice from others and consider the practical aspects of their attendance (for example arranging childcare, tying it into hours of work). This was particularly important for those people who had a disability whether that disability was physical, cognitive or sensory and those whose first language wasn't English also felt there was a need for that extra time.

There was a small group of respondents who were worried that if the information was provided too far in advance of the point at which they were asked to make a choice they would have forgotten it.

S3.5 Form of information

Our engagement included a diverse range of people with diverse needs and consequently and as we had expected, people identified a range of forms of information that would be needed. The various formats or media identified included:

- Online
  - Virtual tours
  - Basic information
  - Comparison tools
- DVDs
- Pre-visits
- Leaflets
- Face to face

There was also a strong requirement for information to be presented in plain English and Easy read where needed.

S3.6 Support required

Everyone asked said that they would need time to discuss the options with family as going for the test would impact in some way on them. However, in addition people said that if they needed help then they would expect to have that support from their GP or a specialist advisor. Those with learning disabilities were particularly concerned that the person supporting them was someone they knew and trusted.

S3.7 General comments

Those we engaged with also provided some general comments about choice and the information they would need and one theme was prevalent. People said that while it was important that we asked about the information they needed to make a choice, even more important was what we did in terms of putting in place a delivery mechanism that ensured that information for patients was:

- Easy to find
- Easy to use
- Given at the right time
- Given by the right people
- In an effective manner
- Equitable

S3.8 Recommendations

This engagement has suggested a number of recommendations about implementing extended choice of provider in a way that supports the patient.

Table 20: Recommendations about implementing extended choice of provider in a way that supports the patient

Aim	Recommendations
Easy to find	• Establish and agree the most appropriate people to signpost • Ensure that information is held in a variety of places • Develop a communication plan to include giving information about: • Any qualified provider • Where to find the information to support the decision-making • How to find people able to support the process can be found
Easy to use	• Ensure that information is provided in a range of formats • Ensure that it is easy for people to find the format that is appropriate to them • Ensure that there are effective support mechanisms in place
At the right time	• Information should be made available at the point where people are told they need to have a test • Information should be provided in a format that people can take away with them
By the right people	• It is vitally important that the right people are identified to provide support. • These people do not need to be clinicians but do need to have a good understanding of the comparative strengths and weaknesses of a service • These people should be able to support a wide variety of people with a range of communication and decision-making needs • These people should be accessible at the point when people are told they need a test
Effective	• Use existing information delivery mechanisms that are known to users • Recognise that Diagnostics is part of other healthcare pathways and information needs extend beyond the test itself so information on choice should be integrated with the care pathway information generally. • Consider a single point of access for all relevant information

S3.9 NHS Plymouth Engagement plan and report

S3.9.1 Introduction and background

S3.9.1.1 Context

This engagement has been subject to a nationally imposed timetable and, certainly from the point of view of engagement best practice this has required the use of timescales

and methodologies that we might well have supplemented or not used had more time been available. In our evaluation, we set out some alternative methodologies that might be considered if more time is available. Example 1 sets out our engagement plan and timeline.

S3.9.1.2 Key stakeholders

Clearly determining the key stakeholder groups that need to be involved will vary with each commissioning team and is something that will be specific to a particular locale. However, we were asked to devise an implementation pack for national use and consequently, we have taken advantage of our local cluster arrangements to seek the support of colleagues working with more rural populations to determine differences of need between the two population types.

It is important to recognise that the nature of the services at the centre of this work have very few return patients and therefore, it is not usual to have one user group or population that can be targeted for information, feedback and advice.

Whilst the project is focussed on Plymouth the implementation pack should be applicable across the country and so we will be approaching patients and public from urban communities (Plymouth and North Tyne) and from a rural community (Devon). We will be working with engagement colleagues in Devon to correctly target populations who can provide a rural perspective to the engagement.

We are aiming to involve individuals, specialised representative groups, groups representing the whole population. (For a list of Plymouth and Devon centric stakeholders see Example 2).

It is important that we also engage with the stakeholders proportionate to their degree of influence, the impact any decision would have on them and their interest. To determine this we used the tool described in Example 3.

S3.9.1.3 Equality issues

In planning engagement on this AQP implementation we wanted and needed to take account of populations who, for one reason or another might have different needs around choice or look for different information. In Plymouth we have specifically targeted some of these groups to include

- Carers
- People with a disability
- People from the local Pride Forum
- People from local ethnic minority communities
- Children and young people

In addition and as mentioned above, we also worked to include people from both urban and rural communities.

S3.9.1.4 What do we want to engage on?

The Department of Health brief for this pack was to engage with patients and public on the information they would need to make a choice between two or more providers and consequently four questions were identified.

- What information would people need to be able to choose between two or more providers?
- How would people like to get that information?
- Who do people think is the best person to give them that information?
- When would people need the information?

However, advice on engagement best practice constantly reminds us that engagement is not a one off activity and that we should also consider and plan for continued and ongoing engagement. Plymouth's plan for this is described in section S3.9.1.7.

S3.9.1.5 Existing knowledge base

The first step in our engagement was to collect existing information provided by patients and the public that suggest how they might answer these questions and from this to develop a list of characteristics and influencing factors that will serve as the main support tool for our more direct engagement (see Example 4).

S3.9.1.6 Engagement methodology

In recognition of the varying engagement preferences and needs amongst the target population, we used five approaches to engage with patients and the public including the collection of existing information provided by patients and the public discussed above.

We also asked some of our partners to support this process and wherever possible used existing forma for our focus groups. The table below describes the other four approaches and the stakeholders they aim to engage.

Table 21: Additional approaches to engage with patients and the public

Method of engagement	Target stakeholder group	Partnership Activity	Key partners
Online survey	Individual members of the general public.	Partners to share link to the survey	LINks Plymouth 3rd Sector Consortium Individual special interest organisations e.g. Age UK or Carers Champions Devon and Cornwall

Method of engagement	Target stakeholder group	Partnership Activity	Key partners
			PCTs
Information about the project and how people can be involved	Key patient and public stakeholder organisations (Local Groups)	Partner organisations to share with their membership Devon Communication and engagement to support	LINks Plymouth 3rd Sector Consortium Devon Joint Engagement Board GPs
Focus groups	General public and patients		Linking in with community groups in existence through collaboration with Council colleagues e.g. tenants' groups
Targeted focus groups	Specific patient and public groups who may have specific choice and informational needs	Organisations supporting specific patient and public groups	Specific voluntary and third sector organisations supporting and/or working with the identified groups. E.g. Highbury Trust for people with Learning disabilities.

S3.9.1.7 Ongoing engagement

Whilst it is important to meet the requirements to engage on the information needs of patients and the public laid upon us by the Department of Health, best practice tells us that there are other aspects of implementation where engagement should be scoped and planned for. For example, how do we ensure that people have an opportunity to help with the selection of potential providers and the subsequent monitoring and evaluation of those selected? In Plymouth, we proposed the establishment of a Patient and Public advisory group whose members would represent the interests of the wider stakeholder groups and be involved in:

- The development of the service specification
- Involvement in the selection panel
- Involvement in emerging performance monitoring groups

S3.9.1.8 Interdependencies

This engagement plan relies heavily on the willing collaboration of a three key partners:

- The third sector
- The local Authority
- Statutory agencies (OSC/LINks)

S3.9.1.9 Resources

Resources were made available to fund this work. However, we did have to work with one significant constraint, that of time. Engagement work requires that people are involved early and given time to acclimatise to the work and engage with it. People also have their own lives and own commitments which do not always fit in with NHS timelines. The methodology chosen for this engagement reflects this constraint.

The work has required the focused input of the Patient Information Lead and capacity has also represented a constraint and affected our ability to meet all of our deadlines with regards to the timeline.

S3.9.2 Identifying existing patient experience data

Every NHS organisation collects a wide range of patient and public feedback on a regular basis and much of this reflects on the issue of choice and the information patients and the public want about their services and what is important to them. As such it represents a valuable source of information. In Plymouth such information is, for the most part, collected together into an evidence bank which enabled us to draw on this for themes of interest and concern that might help to inform the implementation process. The data used included:

- Feedback provided by LINk members
- Feedback provided by organisations supporting specific groups of patients and the public
- Compliments, suggestions and complaints
- Comments and feedback provided through our web function and NHS Choices
- Data collected by Plymouths referral hub (Sentinel)

The issues and areas of interest that this data revealed has provided us with a basic list of information that patients and the public feel they would need to make an informed choice between two or more providers (See Example 4).

S3.9.3 Communicating with patients and the public

In order to ensure that patients and the public are engaged with, it was important to see that they had accurate information that clearly stated the degree of influence they could have over the decisions being made how those decisions would affect them and what was required of them. All stakeholders required some level of information and we have

developed briefings for the LINks, the general public and an easy read version for use with people who would struggle to read English. These are shown in Example 5 & Example 6. A letter was sent out to all our network inviting people to take part in the survey and log their interest in being part of a focus group or for having more information (See Example 7). To support this we also developed a frequently asked questions document (See Example 8).

S3.9.4 Gathering and analysing feedback

We have chosen to gather feedback through an online survey, through general focus groups and through targeted focus groups. To support this we have developed a questionnaire based on the questions defined in section S3.9.1.4 (See Example 9). We have also offered to meet with groups to talk about AQP in Diagnostics if they wish and have developed a presentation for use here and, in the focus groups (See Example 10 separate document).

S3.9.4.1 The survey

The survey was sent out widely both as a link to an online version and as a hard copy. Despite this responses were limited with a total 77 individuals answering it. 26 were male and 51 female. They ranged in age from 18-36 to 70+ with the bulk being aged between 26-65. Of those answering only 7 responded from rural areas, 4 chose not to answer that question and the rest lived in an urban setting.

S3.9.4.2 Focus groups

We held five separate groups utilising existing fora at which we spoke to a total of 33 people representing specific groups of people. The groups included:

- Carers
- People with learning disabilities
- People with physical and sensory disabilities

S3.9.4.3 Sentinel CIC

Sentinel CIC is Plymouth's central referral hub and its phone operators are responsible for speaking to patients to arrange their appointments. They currently give the choices available in other areas of healthcare and are therefore well placed to understand what patients need and want.

The key questions Sentinel staff took from patients were:

- How far away from the patient's home the service was
- Which provider could offer the quickest appointment
- Which provider could offer them an appointment on a day convenient to them

Sentinel staff are currently able to answer all these questions on the information they have on the system but they are also asked:

- What particular consultants are like
- Whether someone can specify a particular consultant
- Where to find more information about the provider or practitioner

Some providers have websites and where this is the case, Sentinel staff are able to refer patients to these for additional information.

Staff also said that although not a large number, some patients do ask if they can think about the options they have been offered and in this instance Staff ask the patient to call back to arrange their appointment once they have had time to consider. In Sentinel staff experience, patients generally say that they need this time to:

- Check on the practical arrangements needed to get them to an appointment
- Discuss the options with family and or their GP
- Look at the information on a web site they have been directed to

S3.9.4.4 Events

We were able to make use of one prescheduled event to canvass the public view and this was the Hearing and Sight centre exhibition. We spoke to a total of 23 people and registered their views using the tool given in example 12 (separate document). Of these 17 were women and 6 were men and those responding were predominantly over fifty.

S3.9.5 Giving feedback

It is planned to provide feedback to those we have involved and the general public by revisiting the groups who took part, placing a feedback report on our web pages. Sending out the paper report to our original mailing list and offering to meet and discuss the outcomes of this engagement with patients. We will also be using this as an opportunity to involve specific representatives in shaping an information delivery system, assessing the specification being developed and in assessing potential providers.

S3.9.6 Areas for improvement

In terms of how the engagement could have been improved, the approach we took suited our resources and the time we had available to carry out the engagement. However there were a number of learning points:

- We gained more from face to face engagement than through the questionnaire and therefore would need to question the validity of the questionnaire as an effective engagement tool.
- The questionnaire may well have been more effective if we had been able to go out and speak to groups before linking them into the questionnaire.

- More time was needed to link into existing groups to seek people's views.
- Engaging with our ethnic minority population relied on the ability of our volunteer health champions having the capacity to support this process which they did not so there is a significant lack of input from this population.

S3.9.7 Recommendations

Findings from the engagement suggested that, above all, implementing choice and ensuring people have the information they need to make that choice relies not on getting the right information because in fact that already exists but on how we make that information available to them.

Therefore the overriding recommendation from this work must be that NHS Plymouth concentrates on developing an effective and easy to use system of information delivery that can accommodate a wide range of needs for information and a wide range of communication needs.

Once this has been devised in partnership with patients, clinicians and other key stakeholders then patients will need to be told about the fact that they do have a choice and how to go about making sure that the choice they make is right for them.

To bring this about, it is recommended that the project group work closely with those staff working on information delivery systems or currently providing information and this should as a minimum include:

- Sentinel Central Referral Team
- Plymouth City Council (Plymouth Online Directory/MyPod)
- Devon County Council (Devon Online Directory)
- The information prescription's project lead
- The Map of Medicine's project lead
- Members of the public with an interest
- Specialist public advisors around special information needs

In addition there are the general recommendations that were listed at the head of this document and that are given again below.

Table 22: Recommendations about implementing extended choice of provider in a way that supports the patient

Aim	Recommendations
Easy to find	• Establish and agree the most appropriate people to • signpost • Ensure that information is held in a variety of places • Develop a communication plan to include giving information about: • Any qualified provider

Aim	Recommendations
	• Where to find the information to support the decision-making • How to find people able to support the process can be found
Easy to use	• Ensure that information is provided in a range of formats • Ensure that it is easy for people to find the format that is appropriate to them • Ensure that there are effective support mechanisms in place
At the right time	• Information should be made available at the point where people are told they need to have a test. • Information should be provided in a format that people can take away with them
By the right people	• It is vitally important that the right people are identified to provide support. • These people do not need to be clinicians but do need to have a good understanding of the comparative strengths and weaknesses of a service • These people should be able to support a wide variety of people with a range of communication and decision-making needs. • These people should be accessible at the point when people are told they need a test
Effective	• Use existing information delivery mechanisms that are known to users • Recognise that Diagnostics is part of other healthcare pathways and information needs extend beyond the test itself so information on choice should be integrated with the care pathway information generally. • Consider a single point of access for all relevant information

SECTION 3 APPENDIX 1 – EXAMPLES PACK

Example 1 Engagement project plan

Table 23: Engagement project plan

Activity	Weeks																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Confirm local demographics																				
Interrogate existing PPE data around choice																				
Determine range of stakeholder groups																				
Identify groups with specific and particular needs																				
Briefing out to OSC																				
Briefing out to community groups for inclusion in newsletters and websites																				
Online survey uploaded																				
Notifications and links to online survey uploaded to social media sites																				
Invitation to participate in survey out to stakeholders																				
Invitation to focus groups out																				
Online survey closed																				
Analysis of results																				
Focus groups held																				
Virtual Patient and Public advisory group established																				
Feedback out to participating groups																				
Update for OSC																				
Update for project group																				

Example 2 Stakeholder list

Table 24: Stakeholder list

Facilitating partner organisations

Local groups (Plymouth)

Group	Population represented	Survey sent out	Met with
Plymouth Third Sector Consortium	All third sector organisations that are registered members	✓	
Social Inclusion Unit	Diverse communities	✓	
Plymouth Community Homes	Resident groups By locality	✓	
Devon Joint Engagement Board	All (with an emphasis on those who experience inequalities)	✓	
Sentinel CIC	Central referral hub staff		✓
Physical Sensory Disability Board	People with physical and sensory disabilities	✓	✓
Plymouth Disability Action Network	People with disabilities	✓	
Hearing and Sight Centre	People with hearing and vision impairments		✓
Plymouth deaf Association		✓	
RC Diocese Advisor on Learning Disability involvement	Sue King	✓	
Ridleys	People with learning disability	✓	✓
Plymouth People First	People with learning disabilities	✓	✓
Plymouth Involvement and Participation Service	People with mental health issues	✓	
Michael Batt advocacy group	People with learning	✓	✓

Group	Population represented	Survey sent out	Met with
	disabilities		
IAPT	People with mental health issues	-	-
Connexions	Young people	✓	
The Zone	Young people	✓	
Age Concern	Older people	✓	
Carers UK	Carers	✓	
Carers Champions	Carers		
Parent Partnership Forum	Parents	✓	
Devon and Cornwall Refugees council	Non English speakers new residents	✓	
Plymouth Pride Forum	Gay and Lesbian adults	✓	
Physical Sensory Disability Board	People with a range of disabilities	✓	✓

Example 3 Assessing proportionality

Table 25: Assessing proportionality

High	**Keep Satisfied (Consult)**	**Manage Closely (Partner)**
	Example groups Community groups, Service User Groups, media	***Example groups*** Overview and scrutiny panel, MPs, Local strategic partners, providers, opinion formers, LINks Specialist interest groups, complainants,
	Monitor (Inform)	**Keep Informed (Involve)**
Power/ influence	***Example groups*** General public	***Example groups*** PALs enquirers, general patient/public groups
Low	**Low** ← **Interest** → **High**	

Example 4 List of patient and public views on required information

From existing information from patients and the public we have a range of factors that patients and the public say influence what choices they make.

These are:

- Qualification of the provider
- The reputation of the organisation offering the services
- The outcomes achieved by the provider
  - PROMs
- Gender of staff providing care/treatment/procedure
- Recommendation from other users, families and friends.
  - Independent reviews of services (e.g. Patient Opinion, Website)
  - Patient satisfaction survey results
  - 'Down the Pub or in the Supermarket' (Word of mouth)
  - PALs and Complaints
- Recommendation from health professionals
  - Urgency of the medical need
  - Most appropriate provider
  - Experience of various providers
  - Ease of access
  - Convenient location
  - Easy to get to (parking/public transport)
  - Easy to use (Communication/straightforward pathway)
  - Convenient appointment times
  - Short waiting times
  - Provide for specific needs (interpreters, hearing loops disability access)
- Patient perception of specific staff qualification (Specialist Nurse v Consultant)

This list formed the basis of discussions with the patients and the public. This helped to ensure that this is the information they would need and identify any additional information requirements.

Example 5 Briefing note for public release

More Choice for patients

The Department of Health is asking commissioners of health services to give the public more choice about who provides some of their healthcare services. Plymouth has been asked to lead the work to give more choice of provider around the diagnostic tests of ultra sound (but not ultrasound for obstetrics) and Magnetic Resonance Imaging (MRI). We are expected to have identified alternate providers and give people this choice from September 2012.

The Department of Health identified Diagnostics as being appropriate for inclusion in the 'More Choice' programme after extensive consultation with patients, the public and healthcare professionals.

Giving people more choice of provider has a number of benefits and means that patients can choose a provider who meets their specific needs. This might be that the service is based in a more convenient location; that it can offer more convenient appointment times or shorter waiting times or that it is able to meet a specialist need.

The providers of diagnostic services will need to meet some very stringent qualification requirements before they can be named as one of the alternate providers and be able to demonstrate that they are in a position to provide a high standard of care.

Making a choice that is right for you is not always straightforward and people need to have the right information to make the right choice. Plymouth commissioners are currently consulting with patients and the public about what information people think they would need to make that choice, when they would need, how they would like to receive the information and from whom. If you would like to take part in this consultation then go to:

http://www.plymouthpct.nhs.uk/haveyoursay/consultations/Pages/currentconsultations.aspx

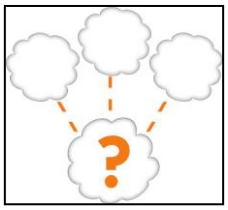
Or if you want to get involved of have more information you can contact:

Sally Parker

Patient and Public Involvement lead on:

01752 431231 or **sally.parker5@nhs.net**

Example 6 Easy read briefing
Information about something new in healthcare in Plymouth



What is new?

- NHS Plymouth wants to give you more choice about who you get some of your health care from.

What services is this about?

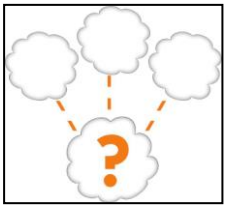
- When you go to the doctor, your doctor might want you to have some tests.
- There are lots of different tests doctors can ask to have done.

- Sometimes they will ask a hospital to do an **ultrasound** to see inside you.

- Sometimes they will ask a hospital to see inside you using a machine called an **MRI** scanner.

- Going into hospital to have these tests can be difficult. It might be a long way from where you live or hard to get to.

- For some people, hospitals are scary places



- We want to make it even easier for people to have an ultrasound test or MRI scan by giving them a choice about who does the tests, and where they can have them.

Why are we doing this?

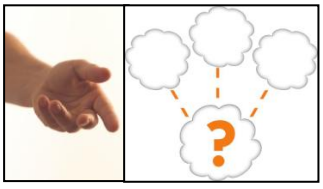
- Because we think it will help people who need these tests.

- People said they wanted more choice about where to get these tests.

- Because the Government says people have told them they want more choice

When will this happen?

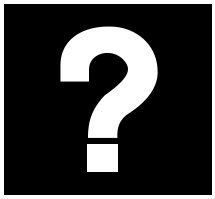
- The Government says we have to do this by September 2012



We want to do everything we can to help people make the right choice for them and are working on ways to do this.

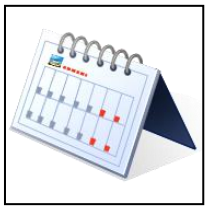
Helping you to make your choice

- Making the right choice is hard and people need to understand why one thing might be better than another.



Help us to give you the help you need by telling us:

- What information you need to help make a choice like this



- When you would like to be given the information

- How you want the information (by email, in a leaflet, get it from the computer yourself, someone to tell you face to face)

- If you want someone to help you you're your choice (a family member or advocate, or doctor)

Help us get this right

If you want to help us get this right and tell us what you think**,** please get in touch or ask someone to do this with you:

Sally Parker
Patient and Public Involvement Lead
NHS Plymouth
Building 1
Derriford Business Park
Brest Road
Plymouth
PL6 5QZ

01752 431231

sally.parker5@nhs.net

With Thanks to staff and members of Plymouth People First
For their comments and advice on how to write this briefing document

Example 7

Email: **sally.parker5@nhs.net**

Get involved, have your say

More Choice about who provides your diagnostic services

During 2010 and 2011, the Department of Health asked patients, the public, healthcare professionals and the NHS how people could influence who provides health services in the future. This took into account which services should offer greater choice, how we could continue to ensure quality and how patient choice can influence decision making. The expected benefits for patients are a greater range of quality services available to them.

Following this national engagement with patients and the public, the Department of Health has told commissioners that this is something that they must do and therefore we have not been asking you whether this should happen we asked you to tell us how we can make this work well for you and make sure that you get all the benefits that a wider choice of provider can give.

As part of a wider team looking to gather the views of the patients and public in our **'More Choice' Consultation**, we asked you to tell us which services we should do this for here in Plymouth.

What you told us in the 'More Choice' consultation, we asked you to tell us which services we should do this for here in Plymouth.

What you told us in the 'More Choice' consultation

One of the clear messages from the consultation was that people who took part in Plymouth shared the view of patients nationally and said that they'd like more choice of provider for diagnostic services.

What we are doing as a result

We are now looking into how we might make this happen here in Plymouth. To do this, we need your help and the help of those people you support and who may use this service. So, we would like your help answering four questions:

- What information would you need to be able to choose between two or more providers?
- How you would like to get that information?
- Who do you think is the best person to give you that information?
- 4when would you like the information

How you can share your views

To help you to give us your answers to these questions, we have put together an online questionnaire and the link to this can be found at:

http://www.plymouthpct.nhs.uk/haveyoursay/consultations/Pages/currentconsultations.aspx

We realise that this way of giving feedback does not suit everyone so, if you want, you can contact us directly at the address above or you can complete the paper questionnaire attached. If you are part of a group and would like to meet with us to share your views directly please get in touch to arrange this (even if this would have to be after the 31st October). We do ask that, whichever way people choose to have their say, that they give their feedback by 15th November 2011.

More information

If you would like more information about this consultation please feel free to contact Sally Parker at the address above. Further information including what the More Choice programme means for patients and providers can be found at:
http://healthandcare.dh.gov.uk/any-qualified-provider-2

We hope that you will want to take part in this work to create more choice in diagnostic services and look forward to hearing your views.

Example 8 Frequently Asked Questions (FAQ)

What is more choice about?

We are looking to offer patients more choice about who provides their services so that patients are able to have their tests with the provider best able to meet their needs and preferences.

How will you make sure that all the alternate providers give a high quality service?

All alternate providers will be required to meet specific standards of care that are set nationally even before they are selected locally and the Care Quality Commission, local commissioners and local service users will be monitoring the services to ensure that they do provide a high quality service.

How will you ensure that we have the information we need to make this choice?

We are able to draw on the example of other PCTs around the country whose earlier work has suggested some approaches. However, no decision on exactly how we will do this will be made until we have talked with users and potential users of diagnostic services to see what information they feel they would need, how they would like to get that information, at what point they want it and who if anyone they would want to support their decision making. Making sure the right information is available and how we get that to patients will be determined by what this engagement work tell us patients and the public want.

Will there be any help for us when making this choice?

Earlier national work has suggested that some people will need help making this decision and various approaches have been explored. However, again, we are waiting to see what patients and the public tell us about the help they want and will develop support on the basis of what they tell us. Early indications would suggest that the level of help needed varies so any support we put in place is likely to be tailored to the individual needs of the patient concerned.

How will it work?

In Plymouth, we are fortunate in having an established referral service (Sentinel). This service arranges appointments for people who have been referred by their GP. Generally what happens is that your GP will refer you for a test and that referral will go into Sentinel. Your GP should give you a leaflet about Sentinel that explains what they do and that they will call you to discuss when, where and with which service provider you want to have your tests.

Sentinel staff will be able to tell you what choices you have but they are not currently in a position to recommend one provider over another. We recognise that this makes it

very important that you have the information about those providers before you are called and we are currently working with patients to determine how best to make this information available to you.

Is this a step towards the privatisation of the NHS?

Giving people a choice of provider is about making sure that we can meet the needs and preferences of as diverse a population as possible. Whilst all service providers will give a high quality service; patients may find that some suit them better and this might be because they are nearer their homes, offer appointment times that suit them, are able to meet the minority needs for instance have a wealth of experience in providing care for people with learning disabilities or are able to offer practitioners of a particular gender. More choice is also about driving up the overall quality of all the services provided.

What about people who don't want to have to decide for themselves or don't feel able to?

Not everyone welcomes choice and the need to make a decision and they prefer to rely on the advice and direction of those professionals they feel better placed to make the decision on their behalf. Choosing not to have to decide is a valid choice and any systems we put in place will ensure that this remains an option for those who wish it.

When will this start?

The department of health has specified that for diagnostics, commissioners have to have identified a range of qualifying providers and have the services in place by September 2012.

Is this only happening for diagnostics?

No, the Department of Health in consultation with clinicians and patients identified seven other services where giving people a choice of provider was feasible and desirable and these are:

- Musculo-skeletal services for neck and back pain
- Adult hearing services in the community
- Continence services (adults and Children)
- Wheelchair services (children)
- Podiatry services
- Venous leg ulcer and wound healing
- Primary Care Psychological Therapies (adults)

The department of health has asked commissioners to look at selecting three services from this list and to implement more choice of provider for those services in their area. In its advice to commissioners, the department has stressed that the list is not exclusive and that it is important that the services for which they offer more choice of provider are

relevant to the local health needs and preferences and that this should be determined in consultation with patients, the public and clinicians.

Will we always get our first choice of provider?

Yes, however, in some instances this may mean waiting longer for your appointment and consequently you may choose to opt for another service provider because you want to be seen more quickly.

If we choose a provider a long way from my home is there help for me to get there?

Existing arrangements regarding the payment of healthcare travel costs will apply. Patients who are eligible will still be able to claim this support. Patients not eligible will be responsible for meeting the cost attached to travelling to their choice of provider.

What support is in place to help those with a hearing impairment, for those whose first language isn't English or who have low literacy, comprehension skills?

We have taken into account the diversity of people's communication needs in determining how to support patients and the public to make the decisions needed when a wider choice is offered. Whatever the system looks like once we have finalised it, it will include provision to meet the specific needs of the people using it.

Example 9 Questionnaire

More choice about who provides your diagnostic services

The questionnaire

Thank you for taking the time to complete this questionnaire and give us your views.

It should not take you more than five minutes. We do not ask you to share personal details that would mean you can be identified.

About you (answering the following questions is optional)

1. Your gender

- ☐ Male
- ☐ Female

2. Where you live

- ☐ A city area
- ☐ A rural area

3. Your age

- ☐ 18 - 25
- ☐ 26 - 35
- ☐ 36 - 45
- ☐ 46 - 55
- ☐ 56 - 65
- ☐ 66 – 75
- ☐ 75+

About your information needs

4. Please tell us what information you would need to be able to choose between providers of a service (For example, their track record, where they are, whether they offer a choice of male or female practitioner)

1. How would you like to get this information?

☐ In writing
☐ Face to face
☐ Online
☐ Other

2. If you clicked other please tell us how you would prefer to get this information

3. Who of the following do you feel is the best person to give you this information?

☐ Your GP
☐ A specialist advisor
☐ Find it for myself
☐ Other

4. If you clicked other please tell us who you think the best person is.

9. This is a very short questionnaire so please use this space to tell us anything else you may want us to know about the information you would need to make a choice between two or more providers.

Thank you for completing this questionnaire

Giving you more choice – Diagnostic services

Any Qualified Provider (AQP)

What is AQP about

AQP is about giving you more choice about who provides your care

Why give people more choice?

Because they have told us they want it

Because they have told the Department of Health they want it

Because more choice makes services work hard to get better at what they do

When will it happen?

September 2012

Who will the providers be?

- Existing NHS providers
- National organisations
- Local organisation

Help us choose the right ones for you

How to get involved

Patient and Public Involvement Lead
NHS Plymouth
Building 1
Derriford Business Park
Brest Road
Plymouth
PL6 5QZ

01752 431231

sally.parker5@nhs.net

What is diagnostics?

Diagnostics is the name given to any process that helps to find out what is making someone ill. It includes lots of tests but for this work we are focussing on two aids to diagnosis:

Non-obstetric Ultrasound

Magnetic Resonance Imaging (MRI)

Will all providers offer the same quality service?

All the organisations providing these services will have to meet the standards the Department of Health has set.

How it will help you

People will be able to choose a service that:

Is where they want it to be

Has appointments when they want them

Can meet specialist needs

Knows them

How will it work

You tell us!

What information you need to help make a choice like this

When you would like to be given the information

How you want the information (by email, in a leaflet, get it from the computer yourself, someone to tell you face to face)

How can you be involved?

Tell us what you need to make a choice

Help us to decide what we say providers must offer

Help us to choose the range of providers

Help us check that the providers we choose are doing what we asked them to

Giving you more choice about who provides your Diagnostic services

Any Qualified Provider (AQP)

NHS

Why give people more choice?

Because they have told us they want it

Because they have told the Department of Health they want it

Because more choice makes services work hard to get better at what they do

NHS

How you can be involved today
Tell us about

- What kind of information you need to choose between two or more providers
- When you think you need this information
- How you would like to get this information
- Who you would like to help you if you need help

NHS

Provision for particular needs (hearing loops disability awareness)

Waiting times

Patient satisfaction survey results

Patient complaints

Recommendation from health professionals

Location

How easy it is to get to (public transport links)

Choice of appointment time

NHS

How would you like to get your information?

Written

Spoken

Online

From a person face to face

Email

From a person over the phone

From the web www.

SMS text

Post

NHS

Have we missed anything?

Stick your post it here…..

Information about the procedure

Can we have an App for this?

Need to know what to ask

Will you use social workers to help signpost people and support them in making their choices?

Other people can help, don't forget the special needs teachers

When you're ill and anxious you don't want to have to think about this kind of thing you want someone to tell you what to do..

I want information about the risks, the benefits and alternatives relating to my choice

Need a professional to discuss the pros and cons of different providers with.

More choice is confusing…!

Information on how to reduce risk

NHS

Diagnostics is the name given to any process that helps to find out what is making someone ill. In providing more choice of provider, we are focussing on two aids to diagnosis:

Non-obstetric Ultrasound

Magnetic Resonance Imaging (MRI)

NHS

You can be involved

Tell us what you need to make a choice

Help us to decide what we say providers must offer

Help us to choose the range of providers

Help us check that the providers we choose are doing what we asked them to

NHS

What is the most important information you need to make your choice?

The provider's reputation

How well different providers perform the procedures

Whether you are offered a choice of male or female practitioner

What other users of the service say about it

Independent reviews of the services

NHS

When do you want your information?

When you are told you need a test

When you are being asked to make your choice

NHS

If you needed help to choose who would you want that help from?

Your GP

Friends or Family

Libraries

Specialist advisors

Nurse

NHS

Section 4

Recommendations on Qualification Requirements for the Service (Based on NHS Plymouth Guidelines)

Section 4 INDEX

TABLES

Section 4 – Recommendations on Qualification Requirements for the Service

Diagnostic and Screening Procedures are included within the scope of regulated activity – all providers must therefore be CQC registered before service commencement.

The Scope of Registration, CQC (March 2010).

The Service Specification sets out a range of Competency Assessments. Additional detail is set out below.

S4.1 Annual Quality Assurance Review

S4.1.1 Audit

- Formal audit of a percentage of ultrasound examinations performed is essential for confirming quality.
- The service specification states that a random 5% of the examinations shall be subject to audit.
- A Consultant radiologist with a particular interest and expertise in ultrasound or a Consultant Sonographer shall undertake this. The CV should be available to the commissioners for review.
- The audit process shall consider the following:

S4.1.1.1 Image quality

The audit scores allocated to image quality are as follows:

Table 26: Image quality scoring allocation

5	High quality examination
4	Reasonable image optimisation but with a few poorer quality images (inappropriate focus, etc.) absent measurements or annotation
3	Suboptimal images but with evidence that this was due to patient factors and attempts made to address the difficulties
2	Poor image quality with inadequate attempts to optimise. Clinical question answered correctly
1	Poor image quality – unacceptable standard

S4.1.1.2 Report quality

The audit scores allocated to report quality are as follows:

Table 27: Report quality scoring allocation

5	Content and structure optimal
4	Essence of report satisfactory – slight modification of emphasis or advice
3	Report satisfactory but additional differential diagnosis or advice could have been provided. Unlikely to lead to patient harm
2	Discrepancy of measurement or interpretation. No immediate harm to patient but requires amended report
1	Unnecessary advice leading to inappropriate further investigation. For example: "can't exclude malignancy" in clearly defined condition leading to invasive test or one involving ionising radiation when unnecessary. Inappropriate follow up recommended leading to downstream costs and patient anxiety.
0	Poor report with risk of inappropriate management pathway

S4.1.1.3 Quality of advice/conclusion

The audit scores allocated to the advice and conclusion in the report are as follows:

Table 28: Quality of advice/conclusion scoring allocation

5	High quality advice – appropriate further management
3	Indeterminate advice – "further imaging/investigation recommended"
1	Poor advice – incorrect further management or investigation e.g. CT when MRI should be advised, CT if no further investigation indicated

S4.1.1.4 Appropriateness of seeking second opinion

An assessment should be made of the need for radiologist comment/ opinion. Failure to seek and obtain additional opinion when the auditor believes this to be necessary should score 1.

S4.1.1.5 Action

Individual sonographer's scores should achieve a mean of 3.8 or above across all categories.

Scores lower than this should be subject to review of performance.

Any score of 2 or lower should be referred to the discrepancy meeting.

Any score of 1 or less should generate an incident procedure and be referred to the commissioner.

More than one score of 2 or less (two separate ultrasound examinations within the same audit cycle) should lead to a period of supervised practice and remedial training for the sonographer.

A trend of high referral rate to the errors/discrepancy meeting should lead to a period of supervised practice and remedial training.

If poor performance is persistent, even after retraining, the auditor must make a recommendation to the provider to withdraw the sonographer from (some selected areas?) practice. This must be copied to the commissioner.

- **http://www.rcr.ac.uk/docs/radiology/pdf/Teamworking.pdf**
- Strategy for Continuing Professional Development SCOR
- Education and Professional Development Strategy: New Directions SCOR
- Continuing Professional Development: Professional and Regulatory
- Requirements – SCOR
- **https://www.rcr.ac.uk/docs/about/pdf/RCR(10)13_CPD_Second.pdf**
- **http://www.rcr.ac.uk/docs/radiology/pdf/Stand_self_assess.pdf**
- **http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)3_Medical_interpretation.pdf**
- **http://www.rcr.ac.uk/docs/radiology/pdf/StandardsforReportingandInetrpwebvers.pdf**
- **http://www.rcr.ac.uk/docs/radiology/pdf/Stand_urgent_reports.pdf**
- **https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)6_Stand_second.pdf**
- **http://www.rcr.ac.uk/docs/radiology/pdf/Stand_radiol_discrepancy.pdf**

S4.1.2 Guidance on Ultrasound Equipment Selection

Generic standards for selection of ultrasound equipment are difficult to develop. Although it is possible to define, for example optimum transducer frequency ranges for certain diagnostic applications, it is much more difficult to specify quality standards for image quality, for Doppler sensitivity and for data processing algorithms that influence such things as image to noise ratio. Indeed, advice from the RCR suggests that decisions on choice of equipment are influenced by personal preference (1).

Some performance characteristics are critical for certain applications, such as measurement of NT for Down's screening. In this situation the accuracy of measurement software is defined as being sufficient to measure 0.1 mm differences (2). Similar accuracy is not required for the measurement of the abdominal aorta in for example the National Aortic Aneurysm Screening Programme. Advances in computer technology and as a consequence equipment performance may mean that manufacturers will offer performance enhancements based on different principles of signal and data generation and data and image processing. Examples include image

smoothing and speckle reduction techniques, algorithms for tissue harmonic imaging and more recently elastography. Advances in the development of transducers promise to deliver similar difficulties in defining quality specifications.

In the process of commissioning ultrasound services therefore the provider should be advised that they should present evidence that they have complied with evidence published from time to time by professional bodies (1,3)

In addition they should be required to report the process used to guide equipment selection for the purpose as defined by the service specification. In particular they should:

- Provide the name and qualifications of the individual leading the selection process;
- Provide evidence of experience of equipment selection in the field of ultrasound;
- Describe the shortlisting process and the criteria used;
- Describe the equipment review process – for example side by side evaluation in the clinical environment;
- Describe the clinical scenarios used to assess image quality;
- Describe how they have made allowances for “difficult to image” patients ;
- List the machines that were shortlisted for clinical review;
- Describe the process of review of output power;
- Describe the involvement (if any) of medical physicists in equipment selection;
- List the reasons for selection – for example:
  - Image quality;
  - Measurement accuracy;
  - Ergonomics;
  - Ease of use ;
  - Range of transducers;
  - Doppler sensitivity;
  - Portability – for certain applications and circumstances;
  - Service support;
  - Advanced features;
  - Cost;
- Describe the equipment replacement policy; and
- Describe the process for evaluation of integrity of probes and cables.

http://www.rcr.ac.uk/docs/radiology/pdf/StandardsforUltrasoundEquipmentJan2005.pdf

http://fetalanomaly.screening.nhs.uk/getdata.php?id=10849

S4.1.3 Quality Assurance for Ultrasound equipment

The maintenance of the quality of ultrasound performance depends on the performance characteristics of the equipment. Robust systems must be in place to ensure regular

testing and maintenance of ultrasound equipment and replacement of components or of the entire machine if performance falls below standards appropriate for accurate diagnosis. This will be informed by a number of factors that will include regular assessment of image quality by experienced supervisors, feedback from those using the equipment and by regular formal maintenance.

S4.1.3.1 Regular equipment maintenance will include:

- Physical and mechanical inspection;
- Image uniformity and artifact survey;
- Geometric accuracy;
- Contrast resolution;
- Fidelity of the ultrasound scanner electronic image display(s);
- System sensitivity; and
- Integrity of transducer elements and cables.

They may also include, but not be limited to, the following tests (as applicable)

- Spatial resolution;
- Fidelity of the display device(s) used for primary interpretation; and
- Qualitative evaluations of Doppler functionality.

Regular maintenance will be informed by national and international recommendations (1, 2). Providers shall describe how they will undertake equipment evaluation and maintenance, who will provide this service, the frequency of equipment review and how they comply with national guidance.

Quality Assurance of Ultrasound Imaging Systems IPEM 2010

ACR technical standard for diagnostic medical physics performance monitoring of real time ultrasound equipment ACR 2011

S4.1.3.2 Quality Assurance for ultrasound imaging and reporting

Ultrasound imaging services are provided within the UK by professional teams. This differs from many European countries where the role is delivered solely by medically qualified practitioners. A debate continues as to whether this is a delegated task or whether sonographers function as independent practitioners. For the purposes of commissioning it is recommended that evidence of team-working is present in any bid to deliver ultrasound services (1)ref RCR/SCoR team Working doc.

- All those performing ultrasound shall have appropriate, nationally recognised qualifications and shall operate under strict governance arrangements;
- There shall be a supervising Consultant radiologist or Consultant sonographer with a demonstrable interest and expertise in ultrasound;

- All practitioners should have a clearly defined record and plan of CPD according to advice from the appropriate professional body (2-6);
- The CPD record shall be reviewed annually at appraisal usually by the supervising consultant;
- All those reporting ultrasound examinations shall follow guidance issued by professional bodies and/or that appropriately modified by the provider (7-10);
- All those providing and reporting ultrasound examinations shall attend regular (monthly) errors/discrepancy meetings. A record of attendance will be maintained and 80% attendance will be the expected standard. The discrepancy meeting shall follow guidance of relevant professional bodies occasionally published and updated (11) ;
- A policy will be developed and published in respect of those whose performance either as a consequence of audit or an unusual number of discrepancies is called into question. Control charts are a useful way of comparing performance.

Section 5

Diagnostics Closer to Home: Guidance to Commissioners

Section 5 INDEX

TABLES

Section 5 – Diagnostics Closer to Home: Guidance to Commissioners

S5.1 Service Specification

S5.1.1 Generic Issues

S5.1.1.1 Key times along the patient pathway

Commissioners will need to stipulate their required timeframes along the patient pathway. The current response times for investigation and report availability vary significantly across the country. The project team have included a suggested maximum waiting time within the specification, but locally commissioners may wish to set much tighter waiting times, dependent upon local circumstances. Whatever timeframes commissioners decide to include within the specification will then need to be replicated in Section B8_1.0 Part 1 - Quality Requirements, to ensure consistency.

S5.1.1.2 Patient Experience

The Patient Survey will need to be aligned to the existing National patient surveys in order to provide benchmarking opportunities, as a minimum. The survey must ask questions that clearly expose a patient's true experience of a service. For example, rather than asking whether patients received information prior to their appointment, it would be preferable to ask whether the information received was helpful, relevant and in a useful format. Surveys should also include an opportunity for patient to write free text. The best providers will use surveys developed by specialist, professional companies.

Patient Experience information can only be gained through a multitude of means which includes complaints, compliments, third sector feedback, online real-time feedback, clinical incidents, etc.

The specification stipulates that Providers 'should include as a minimum, a Patient satisfaction survey, and one real time feedback mechanism'. Examples of the latter would include signing up for Patient Opinion (**www.patientopinion.org.uk**), the use of hand held data collection equipment, and traditional methods such as suggestion boxes and comments books. The best providers may consider an annual 'diary entry' record for patients attending that day, or Critical Incident Interview techniques, linked in with local patient user groups to support patient involvement and service improvement activities.

S5.1.2 Service Specification: Issues Specific to Non-Obstetric Ultrasound

S5.1.2.1 Acceptance and Exclusion Criteria

The exact nature of the acceptance and exclusion criteria will be down to determination by local commissioners. Inclusion of thyroid for example would be appropriate if the Provider offered a holistic thyroid service that included the appropriate us of 'fine needle aspiration'. This could either be done by one Provider, or two Providers working in concert.

- Haematuria – only as part of a co-ordinated pathway access to cystoscopy and possibly other investigations – e.g. CT/MR urography;
- Carotid Doppler – best provided with access to multi-modality investigations, usually as part of a rapid access TIA clinic;
- Vascular:
  - visceral vascular duplex ultrasound. This will be dependent on availability of other investigations and appropriate management strategies. For example, in patients with chronic liver disease – the availability of other non-invasive methods of assessment and the pattern of onward referral for biopsy where appropriate. For renal transplant assessment similar strictures would apply.
  - the inclusion of peripheral arterial duplex ultrasound, peripheral veins, venous duplex ultrasound would be likely to be dependent upon robust methods of communication and sharing of findings with vascular services and other imaging modalities in secondary care.

S5.1.2.2 BMI

Ultrasound examinations may be impeded by patients with increased BMI. Where inadequate visualisation is due to clinical obesity of the patient, one repeat examination only should be offered.

S5.1.2.3 Reporting

Sonographers undertake and report their own ultrasound examinations and will seek advice when uncertain, as should any professional. There are circumstances where sonographers, if they are competent to do so, can and do provide a differential diagnosis and patient management advice. It will depend on the type of examination, ultrasound findings and also the experience of the sonographer. It is within the broad scope of practice and some are doing so at consultant and advanced practitioner level. A sonographer should act within their education, training and competence (personal Scope of Practice) and within the protocols and authorisation of an employer. If they have not undergone the necessary development to support the wider differential diagnosis and further clinical management role they cannot be expected to take that on and would need to have access to other members of the clinical team to be able to offer that support, to enable the outcome specified within the pack to be achieved.

S5.1.2.4 Sonographer competency assessment

The Commissioners should ask for sight of the Providers competency assessment framework to demonstrate the skills and expertise of the staff employed in the service and mechanisms for audit and revalidation. This will also demonstrate there is a clinical structure in place and also that, in the event of lower audit results, there is a process in place to support the sonographer to improve their skills or undergo re-training. This was also the reason for suggesting there is some time spent in the department of the local Acute Trust.

The local data set (see section 'local requirements reported locally in specification) will allow commissioners to cross reference the number of scans undertaken by body part by individual – and thereby check adherence to the staffing standards stipulated within the specification.

S5.1.3 Service Specification: Issues Specific to Ultrasound Imaging and Reporting

A number of radiology information systems (e.g. CRIS) currently do not code at the procedure level. Commissioners should check that they are not being charged twice – for example not being charged (2 x RA01Z) when (1 x RA04Z) should have been charged.

S5.1.3.1 Ultrasound Scanning Protocols

The PCTs should either require the Providers to define and agree them locally, or work up some locally adopted protocols. This would deal with any issues associated with the acceptance of images from all Providers and reduce the need for repeat scanning.

S5.1.3.2 Direct Access Referral Guidelines

To govern appropriateness of referrals, these should be developed locally and based upon the I refer document. This will help to control the local requirements which will become out of control without any referral criteria that has been locally developed and accepted. Commissioner may wish to consider 'unbundling' of certain tests such as MRI from the outpatient price for some specialties and it would be helpful if commissioners could share progress on this to allow learning across the NHS.

S5.1.4 Information Management & Technology Service Requirements

S5.1.4.1 Information Governance

A joint letter from the NHS Chief Executive, Sir David Nicholson, and the Information Commissioner, Christopher Graham, sent to the Chief Executives of all NHS organisations in September 2011 stated that all organisations with access to NHS patient information should, "be using the NHS Information Governance Toolkit to assess and publish details of performance". Commissioners must therefore ensure that all

service providers pursuing a diagnostic contract are required as part of that contract to become registered users of the IG Toolkit (**https://www.igt.connectingforhealth.nhs.uk**) for their Organisation Type. This should include compliance with:

Table 29: IGT Toolkit compliance

Information Governance Management	
9-114	Responsibility for Information Governance has been assigned to an appropriate member, or members, of staff
9-115	There is an information governance policy that addresses the overall requirements of information governance
9-116	All contracts (staff, contractor and third party) contain clauses that clearly identify information governance responsibilities
9-117	All staff members are provided with appropriate training on information governance requirements
Confidentiality and Data Protection Assurance	
9-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines
9-212	Consent is appropriately sought before personal information is used in ways that do not directly contribute to the delivery of care services and objections to the disclosure of confidential personal information are appropriately respected
9-213	There is a publicly available and easy to understand information leaflet that informs patients/service users how their information is used, who may have access to that information, and their own rights to see and obtain copies of their records
9-214	There is a confidentiality code of conduct that provides staff with clear guidance on the disclosure of personal information
Information Security Assurance	
9-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use
9-316	There is an information asset register that includes all key information, software, hardware and services
9-317	Unauthorised access to the premises, equipment, records and other assets is prevented
9-318	The use of mobile computing systems is controlled, monitored and audited to ensure their correct operation and to prevent unauthorised access

9-319	There are documented plans and procedures to support business continuity in the event of power failures, system failures, natural disasters and other disruptions
9-320	There are documented incident management and reporting procedures
9-321	There are appropriate procedures in place to manage access to computer-based information systems
9-322	All transfers of hardcopy and digital personal and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers

S5.1.4.2 IM&T Implementation

Where data is transferred from the Ultrasound Scanner to the provider PACS or image store the removable media device must have encryption software. Standard operating procedures for handing the data will be implemented as required by the commissioner.

Provision of Digital Data between the Provider PACS systems should be through the Image Exchange Portal or other data sharing systems to other providers as specified by the commissioner, or in clinical circumstances that require the transfer of the image to support the safe treatment of the patient. This should be the provision of Digital Medical Image transfer to the PACS Cluster or local Data stores using DICOM V3.0, HL7 v2.3/3.0 integration profiles including the provision for images to be marked for teaching purposes as defined in IHE (UK) IP6.

The Provider should aim to work towards the ability to support the booking of appointments and receipt of referrals from local commissioners by either indirectly or directly bookable Choose and Book Services

S5.1.4.3 IM&T Disposal

In the event of cancellation of the contract (for whatever reasons), the Provider should be required to maintain systems to allow continued access, in a timely manner, to all of the patient information, images and associated patient records. In the event that the Provider goes in to liquidation or ceases trading, the default is that this information will need to be returned to the commissioner. The format and process for this will need to be defined and agreed as many commissioners will not have the means or store capable of holding large amounts of data that could be generated by community diagnostic providers.

S5.1.5 Mobilisation / Conditions Precedent

S5.1.5.1 IM&T

- Need to sign off the Directory of Services.

- Ensure nhs.net account available.
- Image storage and transfer issues resolved to the satisfaction of the commissioner.

S5.1.5.2 Other

CQC registration.

Patient Leaflets – to include purpose of the investigation, what is involved, how and when results will be available.

Central contact number for GPs to discuss with reporting individual.

- Pathway for images to be reviewed by a radiologist in concert with the relevant practitioner.
- Pathway for suspected cancer / urgent findings.

S5.1.5.3 Items for Clarity

One of the key outcomes of the diagnostic services closer to home initiative is that the image and report should follow the patient pathway – and that there should be no repeat scanning without a clinical rationale. Ultrasound is very operator dependent and also there is a lot to be gained clinically from viewing the moving image. Therefore it would be more likely for a clinical rationale for repeating ultrasound scanning in some clinical circumstances. Clearly this would not be the case if the ultrasound picked up the existence of gall stones for example – there would be very little to be gained from repeating this diagnostic. It is proposed that a KPI should be added to contracts with main acute Trusts which states that:

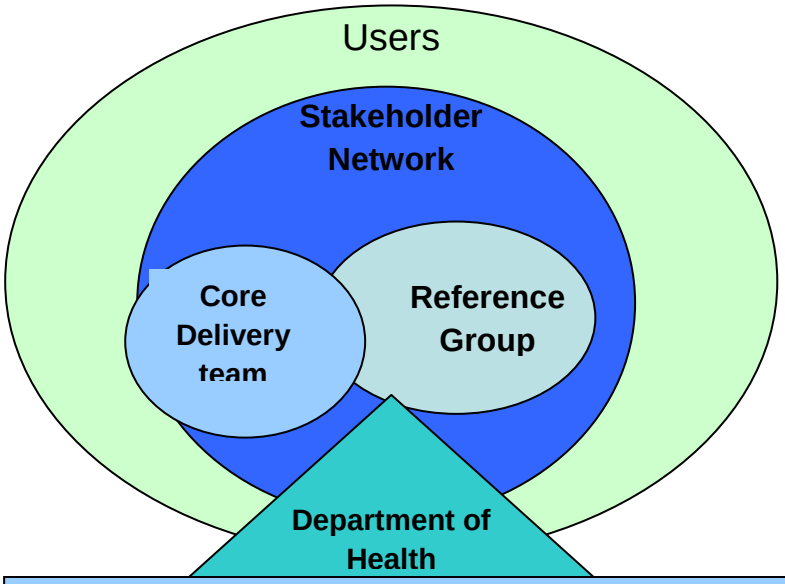
Table 30: KPI technical guidance

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of Breach
	Image and report should follow the patient pathway –there should be no repeat scanning without a clinical rationale.	No more than [1.5%]	Monthly Performance Report; or Commissioner to audit sample for compliance and extrapolate.	None payment for repeat activity without a clinical rationale.

Annex 1

Acknowledgements

Annex 1: Acknowledgments



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BMI Healthcare
Gateshead Health
InHealth
Royal College of Nursing
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Sonarcare
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Annex 2

Considerations

Annex 2: Considerations (to be completed)

Please note Annex 2 is being updated - the following link will take you to the latest version of this document.

http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/Annex2.aspx

Annex 3

Public Sector Equality Duty

Annex 3: Public Sector Equality Duty

The Equality Act 2010 replaces the previous anti-discrimination laws with a single Act making it easier for people to understand. It also strengthens the law in important ways, to help tackle discrimination and inequality. The Public Sector Equality Duty, which came into effect on 5 April 2011, sets out the responsibilities a public authority must undertake in order to ensure an environment that fosters good relations between persons of differing protected characteristics. Protected characteristics under the Equalities Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Duty has three aims. it requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. For more information please visit the Department of Health website and search for 'Equality and Diversity'.

Annex 4

Glossary

Annex 4 – Glossary

Any Qualified Provider	Means that when patients are referred (usually by their GP) for a particular service, they should be able to choose from a list of *qualified* providers who meet NHS service quality requirements, prices and normal contractual obligations[1].
Audit	Clinical audit is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change". The key component of clinical audit is that performance is reviewed (or audited) to ensure that what should be done is being done, and if not it provides a framework to enable improvements to be made.
Caldicott Guardian	A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing[2].
Care Pathway	Means an evidence based plan of goals and key elements of care for a service user that facilitates the communication, coordination of roles and sequencing of the activities across their components of care. The aim of which is to enhance the quality of care by improving service user outcomes, promoting service user safety, increasing service user satisfaction and optimising the use of resources.
Care Quality Commission	Means the Care Quality Commission established under the 2008 Act (**CQC Website**)
Choose and Book	Means the national electronic booking service that gives patients a choice of place, date and time for first hospital or clinical appointments.
Clinical Leadership	Means the Consultant Radiologist with experience of Ultrasound or Lead Sonographer responsible for Clinical oversight, Governance and leadership of the service.
Commissioner	Commissioners have a responsibility to purchase a range of healthcare and/or social care services from Providers to meet the needs of the populations for which they are responsible. These are subject to formal agreements and relate to a specified range of services.

[1] Department of Health; 2011; Operational Guidance to the NHS**:** *Extending Patient Choice of Provider*.
[2] Department of Health; accessed November 2011; **www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/DH_4100563**

Community Based	Services provided from a community setting (as supposed to a secondary care or primary care setting).
CQUIN	Commissioning for Quality & Innovation. A mechanism for incentivising quality improvement within NHS contracts.[1]
CRB	Criminal Records Bureau
Currency	Means the unit for which payment is made and can take a variety of forms including episodic, block and package of care. The NHS costing manual sets out the principles for arriving at a total cost for each currency
DDA	Disability Discrimination Act
Did Not Attend	Means where the appointment did not take place where the patient failed to attend.
Direct Access	Referral straight from GP to the service without the need for secondary care triage (e.g. ENT).
Discharge Summary	Means a document issued to the service user by the lead Healthcare Professional or Care Professional of the service responsible for the service user's care or treatment for the service user to use in the event of any query or concern immediately following discharge, containing information about the service user's treatment, including without limitation: • The dates of the service user's referral or assessment; • The dates of the service user's discharge; • Details of any care plan or treatment delivered; • Name of the service user's responsible lead healthcare professional or care professional at the time of the service user's discharge; • Any relevant or necessary information or instructions; • Contact details for the provider; • Any immediate post-discharge requirement for the GP or Referrer or other healthcare provider; • Any planned follow-up arrangements; and • The name and the position of the person to whom questions about the contents of the discharge letter are to be addressed; and complete and accurate contact details (including telephone number) for that person.
HPC	Health Professionals Council (**HPC Website**)
IM&T	Information Management and Technology

1 Department of Health, 2008; accessed December 2011.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

In-scope, Out of scope	In scope refers to the services that are to be commissioned as part of this service, and as defined within the service specification. If anything is considered out of scope, it will need to be commissioned separately.
Interface Service	Any service (excluding Consultant Led Services) that incorporates any intermediate levels of triage, assessment and treatment between traditional Primary Care and Secondary Care. Interface Services include assessment services and referral management centres. It does not include: • Arrangements established to deliver primary, community or Direct Access Services, outside of their traditional setting • Non-Consultant Led Services for mental health run by Mental Health Trusts • Referrals to Practitioners with Specialist Interests for triage, assessment and possible treatment, except where they are working as part of a wider Interface Service arrangement. Referral To Treatment (RTT) Periods to Interface Services are included in the 18 weeks targets. These are no longer central NHS targets, but are part of local contracting targets[1].
LA	Local Anaesthesia
Local Authority	Means a county council in England, a district council in England or a London Borough Council.
Monitor	Means the public office established under the Health and Social Care (Community Health and Standards) Act 2003 with responsibility for authorising NHS Foundation Trusts and accountable to Parliament, and continuing under section 31 of the 2006 Act and any successor body or bodies from time to time, as appropriate.(**Monitor Website**)
NHS	Means the National Health Service in England.
NHS Branding Guidelines	Refers to the **'Code of Practice for the Promotion of NHS Funded Services.'**
NHS Constitution	Means the constitution for the NHS in England set out in Law and/or Guidance from time to time which establishes the principles and values of the NHS in England and sets out the rights, pledges and responsibilities for patients and public and staff. **NHS Constitution**
NHS Foundation Trust	Means an NHS Foundation Trust as defined in Section 30 of

[1] Source: **http://www.datadictionary.nhs.uk** accessed 09.10.2010

	the 2006 Act.
NHS Trust	Means a body established under the Section 25 of the 2006 Act.
National Institute for Health and Clinical Excellence or 'NICE'	Means the special health authority responsible for providing national guidance on the promotion of good health and the prevention of ill health (or any successor body). (**Nice Website**)
National Standards	Means those standards applicable to the provider under the Law and/or Guidance as amended from time to time.
National Tariff	Means the list of prices published from time to time by the Department of Health and applied in line with the Department of Health guidance relating to National Tariff construction and coding, charging and recording methodologies.
Package of Care	Means any assessment, treatment, nutrition, support, accommodation or other elements of care to be provided under the service and relating to a referral or an emergency presentation.
Patient Booking	Means the procedures for patient booking set out in Module E of the contract.
Patient Choice	Means the commitment to free choice in elective care, which requires that all patients who require a referral for elective care from their GP or primary care professional for a first appointment shall be able: • To choose to be treated by any provider that meets relevant eligibility criteria and registered as a Qualified Provider. • To choose the time and date for their booked appointment, at the time they are referred.
Patient Management Plan	Means a plan to deliver services that are appropriate to the needs of the service user and that pays proper attention to the service user's culture, ethnicity, gender, age and sexuality and takes account of the needs of any children and carers.
Price/Tariff	Price/tariff = Set price for a given currency unit. Has the meaning given to it in Clause 7.2 of the Contract Terms and Conditions.
Provider	Providers supply services to the Commissioners to meet the specification and against the terms of an agreement.
Principles and Rules of Cooperation and Competition	Means **the rules of procedure** published from time to time by the Department of Health, relating to the commissioning and provision of NHS services, to support cooperation and

	competition in the interests of patients and taxpayers in relation to: • Commissioning and procurement. • Cooperation and collusion. • Conduct of individual organisations. • Mergers and vertical integration.
Qualification Process	Means the process of registering providers to be eligible to deliver services to ensure that all providers offer safe, good quality care, taking account of the relevant professional standards in clinical services areas. The governing principles of qualification[1] is that a provider should be qualified if they: are registered with CQC , where a regulated activity is being provided[2] and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements[3] will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law accept NHS prices can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols
Quality Incentive Payment	Means a payment due to the Provider for having met the goals set out in the Quality Incentive Scheme.
Quality Incentive Scheme	Means any performance incentive scheme set out in Section 4 of Module B of the Contract.
Referral Management Service	Many PCTs have set up referral management services to act as a collection point for referrals before they are forwarded to secondary care. Different models have been developed: some act purely as information gathering centres, others clinically assess and triage referrals eg clinical assessment centres. The key is that these services concentrate on working with primary and secondary care clinicians so they have the information necessary to make high quality, consistent referrals[3].

[1] Department of Health; 2011; **Operational Guidance to the NHS:** *Extending Patient Choice of Provider.*
2 **http://www.cqc.org.uk/sites/default/files/media/documents/8798-cqc-the_scope_of_registration_revised.pdf**
[3] Adapted from, NHS institute for innovation
http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/demand_and_capacity_-_demand_management.html

Referral	This is the process for entry to an appropriate service. It usually requires information to be provided in a format that gives sufficient information to triage the individual. Referrals can be made by the individual (self-referral) or by a referrer on behalf of the individual
Referrer	Means: • The NHS Body that refers a service user to the provider for assessment and /or treatment. • The service user's GP • Any organisation, legal person or other entity which is permitted or appropriately authorised in accordance with the Law to refer the service user for assessment and/or treatment by the Provider. • Any individual service user who presents directly to the Provider for assessment and/or treatment if self-referral is included within the service specifications.
Service manager	Responsible for overall service delivery including, but not limited to: • Ensuring a high quality of clinical practice by all practitioners within the service, including necessary supervision of more inexperienced or junior staff • That all staff, including subcontractors, meet the requirements as set out in the service specification and the NHS Terms & Conditions
Service User	Means a patient, service user, client or customer of a Commissioner or any patient, service user, client or customer who is referred or presented to the Provider or otherwise receives services under this Agreement.
Specifications	Means the service requirements set out in the service specifications.
Staff	Means all persons (whether clinical or non-clinical) employed or engaged by the Provider (including volunteers, agency, locums, casual or seconded personnel) in the provision of the Services or any activity related to, or connected with the provision of the Services.
Triage	This is the process of prioritising people for assessment and/or treatment according to the seriousness of their condition or injury. Using the information provided in the referral form, or via additional contact with the individual or the person who referred them.