SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	**Phlebotomy Service**
Commissioner Lead	Shropshire CCG
Provider Lead	GP Practices
Period	1st April 2019 – 31st March 2020
Date of Review	October 2019

1. Population Needs

1.1 National/local context and evidence base

1.1.1 This is a transitional service whilst a comprehensive review of the phlebotomy pathway is undertaken incorporating the Shropshire Care Closer to Home and Primary Care network models which will both influence how community based phlebotomy is provided.

1.1.2 As chronic diseases are increasingly being managed in Primary Care the number of blood tests required by Practices to monitor, diagnose and treat patients has risen.

1.1.3 This service will provide comprehensive and consistent Primary Care based phlebotomy provision in Shropshire, using the skills and expertise of trained practice staff. This will provide a convenient, local service, for patients requiring blood tests and will be a key element in the effective management of patients in Primary Care.

1.2 GP Providers of Service

1.2.1 All GP practices are expected to provide 'essential' and those additional services they are contracted to provide under GMS/PMS/APMS to all their patients. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

1.2.2 Commissioners encourage collaborative provider services to deploy good principles of commissioning by improving access to patients through a joined up delivery model including working together across the emerging

Primary Care Networks to share and make best use of resources. Whilst delivery of this service is offered at an individual practice level; the CCG encourages joint working.

1.2.3 The CCG wish this service to be available to all appropriate patients. If a practice does not agree to deliver the service, they will be required to refer their patients to another Primary Care provider who will undertake this service on their behalf. We would expect there to be an inter-practice agreement to cover this.

1.2.4 This service is offered to practices on a variable rate dependent on the level of support provided by SaTH phlebotomy services.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

This service relates to the following NHS Outcomes Framework Domains and Indicators:

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	**x**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	**x**
Domain 4	**Ensuring people have a positive experience of care**	**x**
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

3. Scope

- **Aims and objectives of service**

  - The aims of this service are to reduce the number of patient visits to hospital by undertaking phlebotomy services in primary care thereby:

- Improving the patient experience;
- Providing equitable local, convenient and accessible services;
- Encouraging closer working between primary and secondary care and across primary care providers
- Providing equity in remuneration to practices for service delivery
- Ensuring the most cost-effective use of NHS resources.

3.2 Service description/care pathway

3.2.1 The provider will be required to deliver the following phlebotomy service to adults:

- Take blood samples as required, based on medical need with patient consent
- Provide the service at an appropriate time, location and environment suitable to meet patients' needs.
- Provide the equipment necessary to deliver the service ensuring that equipment meets the requirements of the local laboratory service.
- Record blood tests on practice clinical systems which must be auditable.
- Offer a phlebotomy appointment as soon as possible. Wherever possible within 3 working days.
- Provide the patient with information regarding what their blood test is for, how to get the results of their test, how long they have to wait for the results and who to contact in case of queries.

3.3 Population covered

3.3.1 Patients registered with or attending a GP practice that is a member of Shropshire Clinical Commissioning Group.

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Inclusions

Patients requiring practice based phlebotomy services.

3.4.2 Exclusions

- Practices that are supported by a full phlebotomy service from SaTH (see list at appendix)
- Patients on a secondary care 2WW/urgent pathway where a blood test is deemed clinically appropriate on the same day
- Patients within a secondary care outpatient clinic where a blood test is deemed clinically appropriate on the same day
- Patients under the care of Accident & Emergency
- Inpatients
- Patients from whom venepuncture is difficult
- Children under 16
- Patients who choose to attend secondary care for blood sampling procedure.

In the event that Primary Care send a patient to Hospital for phlebotomy, the patient will be required to take with them a request from their GP detailing the reason why the phlebotomy was not able to be performed in Primary Care (this can include patient choice), and why the patient requires the blood sampling procedure at the Hospital

3.5 Interdependence with other services/providers

3.5.1 Seamless service delivery is dependent on building and maintaining effective working relationships including the development of robust communication and liaison mechanisms. Staff are therefore required to establish and maintain effective key stakeholder relationships by working closely with the following key services/staff groups:

Shropshire CCG Practices
SaTH (or neighbouring acute trusts)
Shropshire Community Health Trust

3.6 Annual Review

All practices providing this service shall conduct an annual review of the register of a sample of patients receiving the service to include;

- Staff training records in place and up to date
- Length of appointments
- Complications and onward referrals

3.7 Equality & Diversity

3.6.1 The service will adhere to all national and local legislation and practice guidance with reference to equality and diversity.

This includes ensuring the service complies with the Public Sector Equality Duty – more information available at: http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/introduction-to-the-equality-duty/

In particular the provider must ensure they have paid due regard to the Equality Act 2010 and can evidence, that they meet the needs of those covered by the requirements of the protected characteristics.

Further information about the Equality Act 2010 and key supporting documents for reference can be accessed at **www.equalityhumanrights.com**

The provider must ensure that there is an equality impact assessment completed for the service agreed with commissioners prior to contract commencement to ensure equity of access, support and outcomes; and where there are barriers to put in place an action plan to resolve them.

4.1 Applicable national standards (eg NICE)

4.1,1 As stated in paragraphs SC2 (Regulatory Requirements) and SC3 (Service Standards) the Provider is required to adhere to all national standards as issued from time to time by any relevant Regulatory and Statutory bodies

including guidance issued by appropriate competent bodies (eg Royal Colleges).

4.2 Applicable local standards

4.2.1 There are no local quality standards in addition to the requirements pertaining to facilities and staff competencies and as set in the General Conditions.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.1.1 The Provider will develop and follow a standard operating policy for provision of this service.

5.1.2 The Provider will inform the CCG on an annual basis (no later than the 31st January) of their intention to continue delivery of the service for the following financial year.

6. Corporate and Clinical Governance

6.1 Responsibilities of the provider

The Provider will:

- Apply the principles of sound clinical and corporate governance;
- Actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
- Undertake systematic risk assessment and risk management to meet requirements monitored by Care Quality Commission;
- Ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
- Challenge discrimination, promote equality and respect human rights;
- Develop, implement and adhere to quality standards and protocols;

The Provider will ensure that:

- Clinical care and treatment are carried out under supervision and leadership, at appropriately regular intervals, expected to be at least quarterly;
- Clinicians continuously update skills and techniques relevant to their clinical work and maintain relevant professional registration;
- Clinicians participate in regular clinical audit and reviews of clinical services, with relevant partners (this could be GP Practice, Intermediate Tier, Secondary Care).

6.2 Safeguarding Adults

The provider has a duty to work within the Adult Safeguarding Policy and Procedure Framework, until statutory legislation is in place.

6.3 Safeguarding and Promoting Children's and Vulnerable Adult's Welfare

All staff working with children, young people and vulnerable adults will have been recruited in line with Shropshire's Safeguarding Board Standards for Safer Recruitment 2013 and will be subject to an enhanced DBS check, in line with DBS Guidance 2014. Staff will have quarterly (as a minimum) safeguarding supervision.

The provider or any subcontractor will comply with the Shropshire Service Agreements for Safeguarding Children (appended to this specification), and the local inter-agency local safeguarding children's board. In addition, it is expected that their internal procedures comply with section 11 duties and SSCB multi agency guidelines and procedures, and the Safeguarding Adults Procedures and the Practice guidelines. These guidelines relate to the protection of all vulnerable adults residing within Shropshire. The broad definition of a "vulnerable adult", is a person (aged 18+) who is or may be in need of community care services by reason of mental or other disability , age or illness; and who is or may be unable to take care of him/herself, or unable to protect him or herself against significant harm or exploitation.

Organisations will need to have a child protection policy and vulnerable adult protection policy in place that informs staff and/or volunteers about the requirements regarding safeguarding children, young people and vulnerable adults. Included within this is the expectation regarding their behaviour and conduct, which needs to be in line with their professional code of conduct, as well as LSCB and LSAB guidance detailing what to do if they are worried about a child, young person or vulnerable adult. Organisations will operate in line with Managing Allegations against people who work with children procedures, and whistle blowing procedures.

We require that all staff are trained in compliance with the requirements of Working Together guidance (DfE, 2013), to ensure that they understand what safeguarding children and young people is, what the requirements are through statute around safeguarding children and what to do if they were worried about a child or young person.

We also require that all staff are trained to the appropriate level of the ADASS National Training Standards Framework for Safeguarding Vulnerable Adults, with all staff completing at least level one awareness.

The provider must also comply with any requests for safeguarding audits that may be submitted by, or on behalf of the commissioner from time to time. Furthermore, the provider must work with the Safeguarding Team to resolve any safeguarding issues following referrals.

Safeguarding must be a core part of each of the four levels of service right through from universal services education about protective behaviours, to working as part of a team providing high intensity services where required.

The provider has a duty to work within the safeguarding legislation set out in The Children Act (2004) and the accompanying statutory guidance Working Together to Safeguard Children (2013).

6.4 Complaints Policy

The service is expected to operate and promote an effective complaints policy in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 for users of its services or their representatives. Any person wishing to make a complaint has the right to complain either to the provider or the commissioner (in this case Shropshire CCG. All complaints correspondence should be acknowledged within three working days and responded to in writing within a timescale agreed with the complainant. If the complainant is not satisfied after receiving the written response they have the right to refer their complaint to either the Local Government Ombudsman (for Complaints about Adult Social Care) or the Parliamentary Health Service Ombudsman (for complaints about health services). Providers are required to provide a quarterly report to the Commissioner detailing all complaints received, The procedure should aim to meet the following objectives:

- Be well publicised;
- Be consistent;
- Be easy to access, simple to understand and use;
- Be fair and impartial to staff and complainants alike;
- Ensure that the care of patients will not be adversely affected if they or their advocate make a complaint;
- Ensure that rights to confidentiality and privacy are respected;
- Provide a thorough and effective mechanism for resolving complaints and satisfying the concerns of the complainant;
- Provide answers or explanations promptly and within agreed time limits;
- Keep the complainant or their representative informed of progress;
- Enable lessons learnt to be used, and evidenced, to improve the quality of services to patients;
- Regularly review the complaints procedure and amend if found to be lacking in any respect.

6.5 Providers Premises

The provider's premises should be accessible by patients in line with the

requirements of the Disability Discrimination Act.

7. Pricing and payment arrangements

7.1 Patients included and being claimed as part of this service shall be coded appropriately.

Please refer to the Read Codes included in the Supporting Documents Folder for the codes that should be used for recording patient activity for this scheme.

Frequency of data extraction shall be completed on a monthly basis.

Please see Schedule 3 Part A for the Local Prices.

Please also refer to Schedule 6 Part A for the Reporting Requirements.