

## GUIDANCE

# Modernising Information Management and Technology in General Practice

Support Services  
[Version 1.0]

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## Glossary of Terms

<b>Term</b>	<b>Definition</b>
CD	Compact Disc
Component System	The set of applications used by the Contractor to provide the Services
GMS	General Medical Services may also be marked as nGMS; n standing for new
GMS Contractual Agreement	The publication “New GMS Contract 2003 – Investing in General Practice” [the Blue Book].
IM&T	Information Management & Technology
Incident	Means any defect in or failure of any service (whether or not a component system is available) which results in a failure to provide that service, or any part of that service.
IT	Information Technology
ITIL	Information Technology Information Library
LMC	Local Medical Committee
LSP	Local Service Provider
Local	Where the term local is used this refers to PCT level. There is however no reason that the SLA should not be implemented at SHA level where economies of scale are able to be achieved.
PCT	Primary Care Trust
RCGP	Royal College of General Practitioners
Third party	An organisation or its agent contracted by the PCT to provide support services under this SLA e.g. a clinical system supplier or support organisation.

# Modernising Information Management and Technology in General Practice

## 1. Background

- 1.1 The “*New GMS Contract 2003: Investing in General Practice*” (the Blue Book) was published in February 2003. This set out the agreement reached between the NHS Confederation and the General Practitioners Committee of the BMA on a new practice based contract in GMS. Chapter 4 of the Blue Book makes provision for the modernisation of practice infrastructure, including (at paragraphs 4.24 – 4.48) detailed provisions relating to the modernisation of Information Management and Technology in General Practice.
- 1.2 In terms of Information Management & Technology (IM&T) a principal change is the transfer of ownership and responsibility for support from practices to the Primary Care Trust (PCT).
- 1.3 The intention is that future information systems in primary care will be based on integration at a community level and on the concept of GPs receiving an information technology service rather than simply being provided with hardware and software. The objective is to provide clinicians and others with access to information wherever and whenever it is needed to support patient care.
- 1.4 New arrangements will be needed to provide these integrated services and applications. To facilitate the use of IM&T within primary care, Primary Care Trusts (rather than practices) are now responsible for funding the purchase, maintenance, future upgrades and running costs of integrated IT systems. This means that as new money is spent on providing new systems and upgrading existing systems, ownership of the IT assets will transfer from practices to PCTs.
- 1.5 With ownership of the IT systems also comes responsibility to provide maintenance, future upgrades, education and training and a full support service. It is expected that PCTs will enter into agreements with each of their practices for the provision of support services. Any such agreements are for local determination, to be negotiated between the PCT and its GMS practices, usually by way of the local Information and Management Technology Group.
- 1.6 The content of this guidance has been agreed between the Department of Health and the General Practitioners Committee and is intended to provide further advice and guidance to PCTs that they are recommended to take into account when making any arrangements for the provision of IM&T support services. It sets out good practice and proposes a number of sensible service standards and procedures that the PCT and the practice can utilise as a basis for their agreement. However, this document does not purport to represent a

model contract between the PCT and the GMS practice. The content of any contract is for local agreement and should reflect local factors such as the provision of local (including via LSPs) IM&T arrangements and any existing contractual standards that underpin current support arrangements.

- 1.7 PCTs are reminded that they now have a one to one contractual relationship with their GMS practices and that any agreement entered into to support practice IM&T is also contractual and should be appropriately set out in a contract document. As part of the process of developing the contract either side may wish to consider accessing, at its own cost, appropriate professional advice.
- 1.8 In this document the term “practice” or “GP Practice” should be read as relating to a GMS contractor. PCTs may, if they wish, use this document to inform any similar agreements in PMS.

## **2 Arrangements for the provision of Support and Maintenance Services for Information Management and Technology Systems**

### **2.1 General**

- 2.1.1 The new GMS Contractual agreement introduces the concept of managed IT service for GMS practices. In order for this to happen, PCTs need to provide a support and maintenance service to practices. Such a service needs to be comprehensive and to apply across all those IT software and hardware items that a PCT has agreed to fund. The additional funding for general practice IT identified core items that PCTs should fund and those additional items that PCTs may fund dependant on funding availability. These items are set out at Appendix 1 to this document. These core and additional items should be borne in mind when the support and maintenance services arrangements between the PCT and the GP practice are drawn up.
- 2.1.2 This guidance sets out advice and suggestions to PCTs, which it is recommended they take into account when making arrangements with GP practices for the provision of support and maintenance services for IM&T systems. PCTs are advised that they should always take their own legal advice in concluding any agreement with a GP practice as to the level of service that will be provided.
- 2.1.3 This guidance does not cover IT hardware or software that continues to be owned by GMS practices. PCTs may agree to include practice owned equipment but this is at the discretion of the PCT and may include a reasonable charge.

### **2.2 Objectives**

- 2.2.1 The principal objectives of the IM&T Support Service are to:

- appropriately support patient care and help support practices in meeting their obligations under the contract;
- help practices support the IT needs of their businesses;
- be easily understood and facilitate engagement with practices;
- have reliable systems for measuring and monitoring;
- clarify appropriate obligations for all the parties to the contract e.g. the practice, the PCT and supplier(s);
- support practice's integration with local and national IM&T initiatives;
- provide best value for money.

### **2.3 Service description**

- 2.3.1 Any agreement drawn up between a PCT and a GP practice should set out the details of the service to be provided, always bearing in mind the suggested principle objectives of such a service as set out above. An outline service description/example is provided at Appendix 2 to this document. It is intended as a guide to both PCTs and practices to inform negotiations on an appropriate level of service provision.
- 2.3.2 In the case of any new IM&T systems, the PCT will want to ensure that any service and maintenance agreement negotiated with the service suppliers reflects the required level of service they have agreed to provide to the GP practice. PCTs are advised to take their own legal advice when concluding any agreement with a service supplier, in particular with regard to whether such agreements will enable them to meet any standard of service they agree to provide to a GP practice.
- 2.3.3 PCTs are advised to bear in mind particular factors applicable where the IT services is an existing one they have taken over from the practice (see comments under "Transition" below) or where the service is to be provided under LSP agreements (see comments under "Local Service Providers" below).

### **2.4 Transition**

- 2.4.1 The current, but evolving position in relation to general practice IM&T infrastructure is a mixture of practice and PCT owned facilities, and there will inevitably be a period of transition as ownership of IT transfers from practices to PCTs.
- 2.4.2 Where existing support service agreements are still between the practice and the GP system supplier, any such support agreements may need to be amended to meet any revised service levels agreed between the PCT and the practice at the time that the ownership of the asset transfers from the practice to the PCT. It is at this point of transfer that the PCT assumes responsibility for the level of service provision. This may require negotiation of a revised level of

support and maintenance service. PCTs may need to take into account the potential financial implications of improved support and factor this into the business case for the selection of any new clinical systems.

- 2.4.3 PCTs will want to ensure that all their practices receive a consistent and high standard of support. Where, exceptionally, the new IM&T support agreement may lead to a level of service below that required by the practice, the PCT and the practice will wish to discuss the operational implications of the new arrangements and, subject to justification through a business case, may adjust the level of service where necessary.

## **2.5 Local Service Providers**

- 2.5.1 NHS Connecting for Health have made arrangements with a number of Local Service Providers to supply and maintain IT services. Where any IT system to be provided to a practice is provided under such an LSP arrangement, the maintenance service will be as agreed under the overarching arrangement between NHS Connecting for Health and the LSP provider. PCTs should bear this in mind in reaching any agreements with practices for the provision of IMT support and maintenance for such systems.

## **2.6 Liability**

- 2.6.1 Any agreement between the practice and the PCT on the level of support and maintenance services to be provided may also include provision for the reimbursement to practices for costs incurred due to service failures. Examples and suggestions of what might be included in such liability provisions of an agreement is provided at Appendix 3, and is intended to inform discussions between practices and PCTs.

## **2.7 Good Practice Principles**

- 2.7.1 It should be noted that the transfer of ownership and therefore support of Information Management and Technology under the GMS Contract will be a phased approach due to the roll through of new and replacement systems. The policies stated below are therefore for guidance once the transfer has taken place.
- 2.7.2 It is suggested that the transfer takes effect from the point a practice system is replaced or where the hardware and software is depreciated to a zero book value in financial accounting terms.

### **IT equipment**

- 2.7.3 PCTs are expected to procure equipment that meets the current EC electrical and ergonomic standards. Practices are expected to use this equipment in conformance with the manufacturers' recommended instructions and operating environment.

## **Insurance**

- 2.7.4 Practices are not be expected to insure PCT owned equipment; however practices should remember insurance companies will need to be informed that IT equipment will be in the premises. Practices are advised to insure practice owned IT equipment and cover for consequences of loss e.g. the need to re-populate their database.

## **Premises Security**

- 2.7.5 PCTs are responsible for the supply and maintenance of new IT equipment. Practices are expected to take reasonable precautions to ensure that PCT owned equipment is protected from theft. Practices may need to discuss premises' physical security with the owners of the premises. The contractual "Liability Agreement" to include the position with respect to additional security costs.

## **Electrical Infrastructure**

- 2.7.6 PCTs need to be assured that all electrical infrastructures meet current electrical regulations. Practices should discuss electrical infrastructure issues with the owner of the premises.

## **Health and Safety**

- 2.7.7 Practices are to be expected to comply with all current Health and Safety legislation as it applies to the use of IT equipment.

## Core and Additional Items to be funded by PCTs

1. The BMA General Practitioners Committee, the NHS Confederation and the Department of Health have agreed that claims for funding for general practice IT systems may be categorised as core and additional.

### Core Items

2. The nGMS contractual agreement is very clearly predicated on an expectation that PCTs will be expected to meet purchase, maintenance and appropriate upgrade costs for core components in full (Blue Book – paragraph 4.29-4.30). Expenditure on core components should be prioritised against other calls on the IM&T allocation. Further details are as set out in the document “New GMS Contract – Additional Funding for General Practice IT (England)” issued in November 2003 (Gateway Reference 2159).
3. As such, the following should be regarded as core components for which PCTs will be expected to meet purchase, maintenance and appropriate upgrade costs in full:

<b>Heading</b>	<b>Note</b>
Clinical system server (and administrative/network servers where appropriate)	This equipment should be fit for purpose to support appropriate, efficient and effective access to clinical information and supporting applications. Memory and storage capacity should be sufficient to meet the immediate and foreseeable requirements of the practice.
Workstations	Normally to be available in consulting rooms and appropriate administrative areas. Memory and storage capacity should be sufficient to meet the immediate and foreseeable requirements of the practice.
Printers	Normally to be available in consulting rooms and appropriate administrative areas. Dual bin cut sheet feeder to enable printing of prescriptions and other documents.
System Management	Backup devices and backup, restore and verification software. Virus protection software for servers and workstations.

	Auto power down software. Network support software Network backup facility
Clinical applications	Core clinical software (RFA 99 compliant) and associated applications and licences e.g. Read codes, drug database. Dispensing system and stock control system (dispensing practices only). Messaging including patient registration and pathology. Knowledge bases such as eBNF, Mentor and Oxford Textbook of Medicine. Appointment system.
NHSnet and the Internet	Connection and usage including firewall and email services
Network infrastructure	Including agreed branch surgery connections and UPS devices, routers, network equipment, cabling and storage
Core office applications	Office tools under NHS-wide licence arrangements.

4. This list is not exhaustive and PCTs and practices are expected to apply common sense and make all reasonable endeavours to reach an agreed position when considering items that have not been included.
5. The clinical system and the data that it contains needs to be secured and managed in accordance with national guidelines including “Good Practice Guidelines for General Practice Electronic Patient Records” Version 3.1 published in July 2005.

### **Additional Items**

6. It is recommended that priority ought to be given to practices with funding requirements for core items although this will depend on any special local circumstances and priorities. Funding of additional items need to be contingent on a clear business case and the adoption of safe, evaluated and supported solutions that are in widespread use.
7. National standards do not yet exist for many items that might be included in this “additional items” category and therefore local discretion may need to be applied. The following items are regarded as examples of “additional” items

and ought, therefore, to receive a lower priority.

- Out of Hours,/A&E/MIU/NHSD links
- Discharge and referrals messaging
- Chronic disease management software
- Drug monitoring software
- Scanning software and document management systems
- Remote access / dial up software.
- Out of surgery records and transfer, taking individual record(s) on visits and synchronisation on return, mobile computing and handheld devices.

## Outline Service Description (including recommended standards)

1. This Appendix sets out, by way of example, a description of matters that might be included in an agreement for the provision of IM&T support and maintenance. It is intended as a guide to PCTs and practices to inform negotiations on the appropriate level of service provision.

### **Service Hours and Standard Service Availability**

2. Standard hours of service
  - Between the hours 07.30 – 19.00 Monday<sup>1</sup> – Friday excluding bank holidays;
  - Between the hours 0900 to 1300 on Saturdays where a practice in negotiation with a PCT has agreed to provide a Saturday Surgery.

Extended support hours may be provided, however this is at the discretion of the PCT and may be subject to a reasonable charge.

### **Support Desk**

3. It is expected that the first point of contact for practices in notifying Incidents will be with the agreed Help Desk facility. The core functions of a Support Desk service include:
  - receive user reports against the service;
  - agree with the reporter what the Incident Priority Level is;
  - allocate a unique incident identification number;
  - initiate and manage the support process;
  - agree incident closure.
4. Whilst in some cases the Support Desk operator may assist in the solution of incident reports it should not be assumed that provision of detailed technical support is a core function of the Support Desk. Where the Support Desk cannot offer detailed technical support its role is to facilitate access to such support under the terms of the relevant agreement.
5. The Service needs to be available 100% of the time within the Service Hours and a recommended standard would be for the Help Desk to answer 90% of initial Incident calls within 30 seconds.

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<sup>1</sup> This is in line with new contract (core hours plus a short start-up/close down window) – provision for Saturday am, bank holidays and Out of hours Services will be locally arranged

6. Outside the standard hours of service an automated facility should exist to log and record incident reports. The method in place will vary depending upon local service infrastructure, for example:-
  - answer machine;
  - e-mail; or
  - online via intranet
7. Whatever method is in place any user needs to be provided with details of the hours the support service is operational, how to log an incident and be provided with a likely elapsed time by which the user will be contacted to confirm the details and agree a priority for the incident once the service is open, for example, “within 2 hours of the start of the next service day”.

### **Incident Priority Levels and Standard Response Times**

8. The Support Desk needs to be able to agree with the caller a Priority Level for every Incident based on the information received from the caller and by having appropriate regard to the Priority Level guidelines.
9. Each Incident needs to be assessed individually and its Priority Level assigned based on the service impact on the practice. The Incident can then be managed and reported against its Priority Level. The Priority Level of an Incident may be altered as events proceed. Where a contractual service level is missed, and a practice can demonstrate that there has been a material financial impact, the parties need to reach an agreement (often a level of financial reimbursement) which is based on the “liability agreement” set out in the contract (unless both parties agree an extra contractual voluntary settlement).
10. Since Priority One Incidents are likely to require close coordination of resources between the practice and the Service, the practice and the Support Desk Agent need to agree these details and closely monitor their progress to maximise efforts to successfully resolve the incident and restore the service in accordance within any agreed response times so as to minimise the impact on patient care.
11. We have included below a set of illustrative Priority Levels and associated examples that are intended to inform PCT/practice agreements. As there are many dependencies and it is not possible to list all types of incidents here, it should be regarded merely as a guide. However, it is intended to provide sufficient information to form a basis from which a reasonably consistent approach to the setting of Priority Levels by PCTs and practices can evolve.

**An example of an “Incident Priority Level Matrix**

<b>Severity Level</b>	<b>Standard Fix Time</b>	<b>Typical Examples</b>
1*	<p>&lt;=3 working hours                      [Where it is not possible to meet the agreed standard, apply an agreed temporary solution with an agreed timescale for a permanent solution to be implemented.]</p>	<p>A Service Failure which, in the reasonable opinion of the allocating party has the potential to:</p> <ul style="list-style-type: none"> <li>• have a significant adverse impact on the provision of the Service to a large number of practice users;</li> <li>• have a significant adverse impact on the delivery of patient care to a large number of patients within a practice;</li> <li>• cause significant financial loss and/or disruption to the practice;</li> <li>• result in any material loss or corruption of Patient Data, or in the provision of incorrect Patient Data;</li> <li>• result in a compromise in the security of Patient Data.</li> </ul> <p>e.g. Total loss of service to all staff, security incident involving patient records.                      The failure of a clinical server.                      Total lack of access to the appointment system.                      Complete failure of the repeat prescription printing service.                      The failure of a number of desktops commensurate with the size of the practice</p>

Severity Level	Standard Fix Time	Typical Examples
2	<=8 working hours [Where it is not possible to meet the agreed standard, apply an agreed temporary solution with an agreed timescale for a permanent solution to be implemented].	A Service Failure which, in the reasonable opinion of the allocating party has the potential to: <ul style="list-style-type: none"> <li>• have a significant adverse impact on the provision of the Service to a small number of practice users;</li> <li>• have a significant adverse impact on the provision of patient care to a small number of patients within a practice;</li> <li>• have a moderate adverse impact on the delivery of patient care to a significant number of patients;</li> <li>• cause a financial loss and/or disruption to the practice, which is more than trivial but less severe than the significant financial loss described in the definition of a Severity 1 Service Failure.</li> </ul> e.g. data entry, referrals (unless no alternative for urgent referrals), appointments
3	<=2 working days [Where it is not possible to meet the agreed standard, apply an agreed temporary solution with an agreed timescale for a permanent solution to be implemented].	A Service Failure which, in the reasonable opinion of the allocating party has the potential to: <ul style="list-style-type: none"> <li>• have a moderate adverse impact on the provision of the Service to a small number of practice users to;</li> <li>• have a moderate adverse impact on the delivery of patient care to a small number of patients;</li> <li>• cause a minor financial loss and/or disruption to the practice.</li> </ul> E.g. loss of access to some support system printing facilities PC and / or printer faults resulting in impaired usage.

Severity Level	Standard Fix Time	Typical Examples
4	<= 3 working days [Where it is not possible to meet the agreed standard, apply an agreed temporary solution with an agreed timescale for a permanent solution to be implemented].	A Service Failure which, in the reasonable opinion of the allocating party has the potential to: <ul style="list-style-type: none"> <li>• have a minor adverse impact on the provision of the Service to a small number of practice users;</li> <li>• have a minor adverse impact on the delivery of patient care to a small number of patients.</li> </ul> E.g. slow system operation, minor application errors.
5	To be agreed with practice	A Service Failure affecting only the presentation of the Service that does not undermine the End User's confidence in the information being displayed, and which does not impact on the delivery of patient care to any patient.  e.g. spelling error, misalignment of data on screen display

**Notes:**

- a) Severity 1 is the highest (i.e. most serious) Severity Level and Severity 5 is the lowest (i.e. least serious) Severity Level.
- b) A Service Failure which results in the Non-Availability of any Component System should always be classified as either a Severity Level 1 or 2 Service Failure
- c) Standard Fix Time: is the elapsed period between the user reporting the incident and restoration of the service.
- d) All Response Times and Fix Times exclude delays due to the practice preventing site access.
- e) Where an activity is required to be completed by the User in order to rectify the fault, the time taken to complete this task is excluded from the measurement of the Service Level.
- f) Services provided outside of the PCT responsibility e.g. NHSnet/N3 should be explicitly excluded in the PCT tailored contract.

## Referral to Third Party Suppliers

This section provides recommended times for the referral of Service Failures received by the Help Desk to the help desk of another Service Provider e.g. LSP, where the responsibility for resolution (in the PCTs reasonable opinion) lies with the other Service Provider.

<b>Severity</b>	<b>Recommended Standard</b> <i>(percentage of calls that are referred within the specified limits)</i>
1	- 90% within 15 minutes - 95% within 20 minutes - 100% within the standard fix time for the severity level
2	- 90% within 15 minutes - 95% within 30 minutes - 100% within the standard fix time for the severity level
3	- 90% within 45 minutes - 100% within the standard fix time for the severity level
4	- 90% within 4 hours - 100% within the standard fix time for the severity level
5	- 90% within 4 hours - 100% within the standard fix time for the severity level

### **Service Provision method**

12. The support service may be provided to practices by a number of methods, dependent upon the type of Incident identified, local agreements and existing infrastructures.

Methods that may be employed are as follows:

<b>Types of support</b>	<b>Example Instances</b>
Telephone support	Upon notification of Incident or a call back from the support organization
Remote Software Support (where available)	By remote connection, agreed with the practice. This may be at notification of Incident stage or after a call back from the support organisation. This method may also be used by third party suppliers to connect to practices systems to support Incidents or where suppliers are required to check if practices have activated patches or system upgrades.
Practice Site Visit (PCT or relevant contractor)	Where an Incident requires onsite support by PCT staff (or contractors).
Practice Site Visit (GP Clinical system supplier)	Where an Incident requires onsite support from the Clinical System Supplier.
Repair /Replacement	Where hardware or network equipment requires repair or replacement. Where equipment needs to be repaired off site, loan equipment should normally be provided and the installation signed off by the practice to ensure business continuity.

### **Incident Closure**

13. Ownership and management of all Incidents should be the responsibility of the Help Desk. If an Incident requires a Third Party to be involved this need not normally lead to the registering of a new Incident. In such cases the original Incident number (and obligations in respect of Priority Levels and Standard Response Times) will apply.
14. Priority Levels may be varied (upon agreement with the Help Desk and the practice) during the period of an Incident, dependent on user impact.
15. Where it is agreed (between the practice and the Help Desk) that an Incident has been resolved (by whatever Service Provision method) the incident needs to be closed in the Help Desk system. This may be by direct contact between the Help Desk and the practice, or by “signing off” an Incident by the practice to a support person, using prevailing local custom and practice.

16. Closure of an incident should not generally take place without agreement from the user affected. The protocol for obtaining/confirming user agreement needs to be agreed and documented locally. The protocol needs to cover instances where the user has been unable to be contacted, for example if the Support Desk has failed to receive a response from the user after a minimum of three separate contact attempts, over more than one working day, the incident may be closed if in the reasonable opinion of the PCT the Incident has been resolved.

### **Service Areas Covered**

17. It is recommended that any contractual agreements set out the services that are to be covered by the agreements.

For example, core products may be categorised as follows:

- accredited General Practice clinical system hardware, software and networking equipment required to operate the system at existing versions and/ or to prevailing manufacturers standards in current use within the practice and any branches, including document management systems or handheld computers;
- supporting business software and/or hardware (e.g. Microsoft Office, Antivirus utilities) at existing versions in current use within the practice and any branches, including electronic mail systems;
- software and/ or hardware at existing versions in current use within the practice and any branches for connection to services provided by the PCT (i.e. NHSnet or internet services) or to national systems (i.e. electronic access to referrals, discharges, diagnostic tests etc);
- the implementation and operation of current security and access policies e.g. role based access control;
- other software and/or hardware at existing versions in current use within the practice and any branches for clinical/administrative support purposes. It is likely that this category will encompass “non standard” software and/ or hardware discovered as part of any baseline audit/ due diligence exercise undertaken by the PCT as part of the transfer of assets/responsibilities from the practice;
  - such software and/ or hardware will be supported on a reasonable endeavours only basis by the PCT;
  - where the practice requires a defined service level the PCT may consider this to be an additional service and make a reasonable charge for the support service;
  - where this software/hardware requires to be upgraded, a case for the investment to be made will need to be made by the

practice to the PCT, with the PCT not being obliged to meet these costs.

- PCTs to agree an approved list of software that may be loaded onto PCT equipment.
18. PCTs may also have agreed to fund additional items (see Appendix [1]). Where this is the case any support service agreements should include support for the additional items under the same terms and conditions as apply to core items, this will maintain a standard level of service to the practice.

### **Third party suppliers**

19. It is likely that elements of the Service may be provided by third party organisations. These may be for example clinical system suppliers or other suppliers engaged by the PCT to deliver the Service, or elements of the Service.
20. Where the PCT contracts with third party suppliers to provide the Service, or elements of the Service, it is recommended to ensure that such services are consistent with the processes and timescales set out in the service support agreement made with the practice. Third party contracts that reflect lower standards etc. might expose the PCT under any “liability agreement” in the contract.

### **Preventative maintenance**

21. In order to minimise the number of Incidents, PCTs need to put in place arrangements with their local IM&T groups for preventative maintenance and routine housekeeping tasks.
22. This ought to include arrangements with Third Party suppliers for routine tasks such as drug dictionary and other reference file updates.
23. It will also be good practice for PCTs to develop over time an analysis of reported Incidents. This may be used to identify specific trends and allow the PCT to put in place strategies designed to minimise future Incidents.

### **Asset Management**

24. An example of an outline asset management procedure is set out at Annex 1 to this Appendix 2. This has been developed to assist practices and PCTs manage proposed changes to the supported equipment and /or software.

### **Security and Confidentiality**

25. It is the responsibility of all parties to adhere to prevailing Security and Confidentiality policies at all times. Further details of current Security and Confidentiality policies can be found on the following web site:

<http://www.dh.gov.uk/pricare/computing/#gpg>

### **Data Protection and Related Legislation**

26. It is the individual responsibility of all parties to ensure that they conform to current legislation relating to the use of IT systems within general practice, including the Data Protection Act 1998, Computer Misuse Act 1990, Freedom of Information Act 2000 and the Regulation of Investigatory Powers Act 2000.
27. The GMS contract includes a clause that obliges practices to adhere to all relevant legislation and to have regard to relevant guidance (Schedule 6, paragraph 125), a similar clause (applying to both parties) in this part of support contract would be good practice.

Relevant documents can be accessed via the Data Protection website:

<http://www.dataprotection.gov.uk/>

### **Recommended Processes and Procedures**

28. To operate successfully the support service in a manner that is efficient and fair to all parties there needs to be a set of procedures and processes that everyone agrees to adhere to. Some basic ground rules are suggested below.

#### **Preparing to Call the Help Desk**

29. In order that a call can be dealt with quickly and efficiently it is good practice for the caller, as far as possible, gather the following information prior to making the call:
  - the practice name and location of the equipment;
  - the support tag number, where it exists, being provided for all Incidents;
  - the GP clinical system and version of the software used e.g. EMIS LV, EMIS PCS;
  - Consider the impact of the Incident in relation to the Priority Levels described in their support agreement;
  - Check if anyone else in the practice is experiencing similar Incidents. This is important as it may be symptomatic of a larger Incident (i.e. access to an application) and provision of this information will aid a speedy resolution.
30. It is always good practice for the calls to be made by the person experiencing the fault in order that full details are available to the Help Desk. The practice may find it useful for one or two individuals to act as the owner of the practice

fault log monitoring that each of the faults recorded are resolved to the practice's satisfaction.

### **Logging the Incident**

31. When the call is answered the Help Desk operator needs to lead the caller through a series of questions. The first set of questions should aim to establish caller identity and verify the caller location and contact telephone number are correct.
32. Having established caller identity the operator needs then take details of the Incident. The operator may ask the caller to carry out some diagnostic checks but this will only happen if the caller is comfortable with the checks they are being asked to carry out.
33. Finally, the operator needs to agree the Priority Level of the Incident and issue the caller with a unique call reference number, which should be noted, by the caller together with the time that the call was logged. The call reference number should be quoted in any further contact with the Help Desk relating to the Incident.

### **Service Management**

#### **Service Standards**

34. The following industry standards are applicable and it is recommended that they are, where relevant, carefully incorporated when developing the support service:
  - BSI PD0005, - code of practice for IT service management
  - BS15000
  - ISO 9000 series, EN29000 and BS5750 - Quality Management and Quality Assurance Standard
  - British Standard 7799 for Information Security Management

Information to aid in the development of services is also available through IT Infrastructure Library (ITIL).

#### **Service Reviews**

35. In order to review the effectiveness of the Service it is recommended that the PCT/Service Provider and the LMC undertake an annual Service Review. A basic review would cover Service Reports, discuss serious service outages and preventative actions that may be implemented and any requests for enhancements to the Service.

## **Service Reporting**

36. It is recommended that the PCT / Service Provider provide periodic Service Reports to the practice detailing the level of service provided to practices for that period. The level and detail of these reports will be agreed locally dependent upon systems in use and available resources.
37. It is suggested that these reports conform to the information set described below but where systems do not currently exist to support this, the best available data may be substituted until such time as more detailed data sets can be compiled.
38. Information to be provided to the practice should include the following:
  - period of Report (quarterly);
  - the total number of Incidents raised;
  - the number of incidents in each Priority Level;
  - the percentage of incidents resolved within the standard response time by Priority Level;
  - for Priority Level 1 incidents not resolved within the standard response time;
    - details of the incident and remedial action taken;
    - reason for the failure to meet the standard response time and corrective actions taken.

## **Escalation and Dispute Resolution Procedures**

### **Escalation**

39. Escalation is the process whereby any unresolved Incident is referred up the management chain. This process is repeated at each level of the organisation until the Incident is satisfactorily resolved.
40. Escalation usually occurs when an Incident is not, or it appears likely not to be, resolved within the agreed contractual Response Times.
41. Where an existing escalation process is already in place and functions to the satisfaction of all parties this may be incorporated into the service support agreement. Where no escalation process exists, the following model is recommended.
42. Escalation of an Incident will be initiated by the practice point of contact to the PCT Support Desk Manager (or equivalent), with the next logical level being a GP partner and the PCT IM&T Manager, although this will vary dependent upon local circumstances. A third stage might involve the Senior Partner and the PCT Chief Executive.

## Resolving Disputes

43. As with any agreement between two parties involving the delivery of services there will be times where there is a dispute between the parties. It is important that any contract describing services and responsibilities should also set out how any resulting disputes are to be resolved (dispute resolution procedure).
44. It is recommended that any dispute resolution procedure that is agreed between the parties should give active consideration to avoiding litigation as a final stage to the process.
45. In setting up a dispute resolution procedure the following areas should be considered:-
  - the process by which a dispute is instigated;
  - a requirement that both parties continue to meet their obligations under the contract during the dispute resolution process;
  - that the first stage of the procedure should involve reasonable attempts by the parties to resolve the dispute between themselves (it would be good practice if this part of the procedure set out who had authority to represent each party in such discussions);
  - a second stage to the process that documents an agreed mediation process;
  - a third stage that documents an agreed binding arbitration process (or alternatively “Expert Determination”);
  - each stage should have clear time limits;
  - the apportionment of costs;
  - the terms of the dispute resolution procedure surviving the expiry or termination of the contract.
46. PCTs may also wish to consider the role of sub-contractors in the dispute resolution process. For example, agreements with sub-contractors might require them to provide such assistance as is reasonably required in order to resolve or assist in the resolution of any dispute (including personal attendance and the provision of relevant information, documentation or information). It would be unusual for a sub-contractor to be able to instigate a dispute under the dispute resolution procedure.
47. PCTs should have experience in contracting for services and should have access to internal advice (or from within their local health community) on the drafting of appropriate contractual terms. Various sources of advice can also

be accessed over the internet. However, if they have any doubts PCTs should seek independent legal advice.

48. The model APMS contract, available through the NHS PASA APMS toolkit, contains a section dealing with dispute resolution. This guidance should not be seen as advocating the use of this clause but it provides an example of how these issues might be structured. The APMS Toolkit is available at:-

[http://www.nhsconfed.org/docs/apms\\_contract\\_template.pdf](http://www.nhsconfed.org/docs/apms_contract_template.pdf)

## **Responsibilities of the parties**

### **Local administration and environment**

49. To minimize incidents and down time agreements there is a need to require all parties to recognise and respond to their individual responsibilities.
50. In order to ensure the appropriate operation of the Service, it is recommended that the support service agreement needs to set out what is expected of the parties. It is recommended that as a minimum this includes:
- practices having robust and documented business continuity arrangements (see below);
  - regular system and data back ups being taken and tapes are stored securely (ideally offsite), in accordance with PCT guidelines.
  - practices working to IM&T policies, which have been agreed between the PCT and LMC;
  - practices not installing unauthorised software or making unauthorised changes to the hardware configuration;
  - practices ensuring that equipment is sited safely and treated in accordance with manufacturers instructions and guidelines;
  - practices and PCTs normally providing a minimum of 3 months notification regarding any significant proposed moves and / or changes;
  - the latest software patch levels, when supplied, being applied to systems covered by the Service e.g. where a GP clinical system supplier has provided the practice with a CD for installation of software this being done as soon as is reasonable. This will be undertaken on the advice of GP clinical system suppliers and in conjunction with the PCT, as a minimum this needs to include a notification to the PCT;
  - all Help Desk calls being initiated by the practice in accordance with the contract or agreed protocols and the practice providing a contact number which the support service can then use to inform the practice of progress (this would ideally be a number not used for general practice business);

- appropriate mains power supplies being maintained to all equipment, for example, a normal mains supply conforming to workplace health and safety standards and manufacturers guidelines;
- where remote support is used by the PCT to deliver the Service, the practice allowing appropriate access to the PCT (and nominated third parties) to allow the service to be delivered effectively. The practice point of contact(s) having an understanding of how this software works. Training may be provided by the PCT. However, any training, or lack of such training, by the PCT should not be relied upon by the practice in any claim relating to the failure of operation of the service, unless such training is manifestly inappropriate.
- practices ensuring that no staff use the practice IM&T equipment until they have been adequately trained to do so, with the records of staff training being maintained by the practice. Where a member of practice staff uses any part of the system for which they have not completed an appropriate and recognised training module it is recommended that any agreement should provide that the PCT have no liability under the “liability agreement” in such circumstances. Training may be provided by the PCT. However, any training, or lack of such training, by the PCT should not be relied upon by the practice in any claim relating to the failure of operation of the service, unless such training is manifestly inappropriate.
- when faults are reported, practices ensuring that staff and communication facilities are made available where reasonable to enable the Service Provider to meet the standard response time;
- practices ensuring that they notify any change of contact details (including email addresses) to the Service Provider;
- practices complying with the latest version of the Royal College of General Practitioner’s Good Practice Guidelines for the use of IT in General Practice.

## **Health and Safety**

51. In order to ensure safe usage of the systems, equipment and delivery of the Service, practices need to ensure that all practice staff using systems are adequately trained in Health and Safety issues and that systems and equipment are sited and used by practice and support staff in accordance with appropriate Health and Safety legislation.

## **Access to premises and systems**

52. Practices need to ensure that support persons have reasonable access (including via agreed remote support) to premises and equipment during Service hours. Where access is not made available, it is recommended that the consequent delays should not be taken account of in calculating response times.

53. Where equipment is sited in clinical areas and as a consequence this affects the delivery of the Service, it is recommended that consequent delays should not be taken account of in calculating service provision.

### **Disposal of equipment**

54. When equipment has been replaced, it is important that when it is taken off the practice premises that any patient based or business confidential data has been removed. Additionally if any software is to be reinstalled onto new equipment (to comply with end user license agreements) then that software must be removed, or if to be retained by the practice, appropriately licensed by the practice taking into account the need to preserve initial licenses for any version upgrades.
55. When practice-owned equipment is replaced then the responsibility for disposal lies with the practice. Responsibility for the disposal of PCT-owned equipment lies with the PCT. PCT disposal ought to be completed within an agreed timeframe.
56. The PCT should have in place arrangements/contracts for secure disposal of equipment, which can also be accessed by practices, at their own cost, for equipment that they are responsible for.

### **Business Continuity (Contingency) Arrangements**

57. It is good practice for practices to be required to develop “Business Continuity Arrangements” (BCAs) to cover situations where the service or elements of the service are not available. Practices need to develop these arrangements against their need to maintain appropriate standards of support for patient care during periods where access to their GP Clinical system is denied to them.
58. These arrangements need to be tested periodically in conjunction with the PCT. They may be discussed at service reviews, where any adjustments to the frequency of the tests can be agreed. An example of an outline BCA is provided as a guide at Annex 2 to this Appendix 2.

### **Software Not Supplied by NHS**

59. It is recommended that the support service agreement require practices to seek permission from the PCT prior to loading any software not supplied by the NHS. It would not be desirable for the PCT to withhold permission for software that a practice reasonably needs to perform NHS and non-NHS services unless it has reasonable grounds for suspecting that installation will materially affect system performance/availability. It is good practice for the PCT to advise the practice of their decision within a reasonable time, for example within one month. Such software may include payroll, accountancy, or reference software etc.
60. It would be sensible for the PCT in conjunction with its LMC (if any) to reach local agreements regarding which software is normally acceptable.

61. Practices would normally be required to load the non-NHS supplied software, and to rectify any problems caused by the software. It is not reasonable to expect the PCT to accept financial or other responsibility for such software and all costs of maintenance, upgrades and support are to be considered as falling to the practice unless, exceptionally the PCT agrees otherwise.

### Example of an Asset Management Procedure

1. This example has been developed to assist practices and PCTs manage changes to the practices IT Asset (e.g. hardware, software and equipment in use within the practice) and is recommended for use by PCTs/practices.
2. An asset register is necessary so that PCTs have an up to date list of what systems practices are using and therefore what they have to support. Any changes to the practice asset records need to be managed by the PCT.

#### **Hardware Assets**

3. When hardware or other equipment (e.g. networking equipment) is to be changed the following process is suggested
  - the PCT to coordinate with the practice point of contact regarding a suitable time
  - the PCT to manage the installation, and testing of the hardware/ equipment to ensure that it works in the intended manner.
  - a new system ID tag to be assigned to the replacement hardware/ equipment
  - any residual problems that interfere with full installation to be reported to the Help Desk
  - the practice point of contact to “accept” the new hardware/ equipment – in writing

[The first time that hardware/ equipment is replaced, the “old” equipment normally belongs to the practice. If this is to be recycled for use out with the practice or disposed of the practice is to be responsible for disposal or any other obligations under its agreement with the PCT. For all subsequent replacements or upgrades any old hardware/ equipment normally belongs to the PCT and disposal is to be their responsibility.]

#### **Software**

4. When new software is being installed (or upgraded), the following process is suggested:
  - the PCT to record what software and version number is to be installed and ensure that the License agreement covers the intended use;
  - the PCT to coordinate with the practice point of contact regarding a suitable time;

- the PCT to manage the installation of the software and test that it works in the intended manner. N.B. this is NOT a full acceptance test for shrink-wrap (i.e. off the shelf) software. A practice may install an upgrade if agreed with the PCT;
- any residual problems that interfere with full installation to be reported to the Help Desk;
- the practice point of contact to “accept” the installation of the new software as being complete and operational – in writing;

[The first time that software is upgraded/ or replaced, rights to the “old” licence normally belongs to the practice. If the software is being upgraded, then often rights to the “old” software are lost as this is built into the new software’s licence. However, if the software is to be recycled for use out with the practice it must (to comply with the terms of the end user licence) be appropriately licensed by the practice. For all subsequent installations and / or upgrades, all rights to the software licences normally belong to the PCT.]

- Software should be set to auto update wherever applicable.
5. When an upgrade/ replacement is being made that includes software and hardware/ equipment, a combination of the two above processes needs to be followed.
  6. Periodically clinical system suppliers will (and others suppliers may) provide scheduled (and sometimes unscheduled) software releases or “patches” as part of their software support arrangements with the PCT for the practice.
  7. This may be undertaken by direct contact from the supplier with the practice (without the PCTs intervention); either remotely or by issue of a CD, however the supplier must have agreement from the PCT that the system upgrades may take place. This may be a general approval to cover regular issues e.g. Read Code upgrades. At other times when major upgrades are needed (which may require hardware/ equipment upgrades/ replacement) it is suggested that the PCT be involved in the planning of the upgrade.
  8. In any event, practices are to inform the PCT (usually via the Help Desk) of any changes and/ or upgrades to their IT Assets.

## An example of an Outline Business Continuity Arrangement (BCA)

### Introduction

1. This outline is provided as a basic guide to assist practices to develop arrangements to cope with the unavailability of practices' GP clinical systems in the event of unscheduled downtime. These events may not solely relate to clinical system outage but may involve the non-availability of operational supplies such as electricity.
  
2. The outline BCA suggests a matrix under which different degrees of unavailability might be dealt with, either manually or by alternative arrangements. It also identifies the role of System Custodian who, in this context, is the nominated person in the practice responsible for the initiation and operation of the arrangements. It would be good practice for BCA to be properly documented. Example headings and subject areas could be as follows.

**SYSTEM NAME AND VERSION [insert a system name and version(s)]**  
**SYSTEM CUSTODIAN [insert a name]**

3. It should be noted that the System Custodian role is not necessarily the same as the "point of contact" role for contacting the Help Desk but it may be that in a large practice, or one with a branch surgery, that there may be more than one point of contact, but there should only be one System Custodian per practice.

### Standard Routine Information and Tasks

4. This is any information, data or operational reports that are required to maintain manual operation in the event of unscheduled system downtime. System users are responsible for the generation of specific information for use in the event of downtime and should routinely produce these, to minimise the impact of any unscheduled downtime.
  
5. Additional information concerning alternative locations where system access may be available, the location of off site backup tapes and spare equipment could be included in this section and updated on a regular basis.

Information/ Tasks Required	System User
<i>Print out surgery lists</i>	<i>Receptionist #1</i>
<i>Get back up from safe</i>	<i>Practice Manager</i>

Some possible examples are given in italics

6. Upon identification of a priority 1 incident that is not able to be resolved there ought to be a process to reach a joint decision between the practice and the PCT Head of IM&T (or equivalent) to agree to the implementation of the appropriate parts of the practice BCA and any related remedial action:
  - the PCT Head of IM&T being responsible for ensuring that PCT IM&T resources are co-ordinated to resolve technical issues.
  - the practice being responsible for ensuring that local co-ordination of activities and information dissemination occurs.

**Implementation of Continuity Arrangements**

7. This section of our example illustrates a suggested manual operating procedure to be followed in the event of unscheduled downtime. A minimum objective would be to update information on an ongoing basis, and to ensure the maintenance of the core practice functions as much as possible.
8. It is anticipated that not all unscheduled disruptions to system access will result in major operational difficulties. For this reason a traffic signal coding system may be used to indicate those remedial activities that would be needed to be invoked to support minor (green), intermediate (amber) and major (red) disruptions to system access. For example,

<b>Minor disruption (green)</b>	<b>&gt; 1 hour and less than 4 hours</b>
<b>Intermediate (amber)</b>	<b>&gt; 4 hours and less than 24 hours</b>
<b>Major (red)</b>	<b>&gt; Greater than 24 hours</b>

9. The timescales are for illustrative purposes only and are aimed at focusing attention on those activities that “typically” follow from the different levels of disruption to system access.
10. It should be noted that a decision to implement remedial actions based upon the three levels of disruption indicated above need not always be bound to the time scales indicated, there needs to be scope for flexibility. Rather, the decision to implement the different stages of remedial action associated with each of these levels needs to be initiated on the basis of joint agreement between the System Custodian and the PCT.

### Minor Disruption Status – Green

11. The table below can be used to indicate what remedial activities follow from minor disruptions to system access.

Tasks	Method (i.e. phone call)	System User	Timescales

### Intermediate Disruption Status – Amber

12. The table below can be used to indicate what remedial activities follow from intermediate disruptions to system access.

Tasks	Method (i.e. phone call)	System User	Timescales

### Major Disruption Status - Red

13. This section can be used to identify those key tasks and processes that have to be continued in the event of a major disruption to system access. This is assumed to be as a result of an Incident that may require that the practice relocate to another location.

Tasks	Method (i.e. phone call)	System User	Timescales

### Testing Restoration of Systems

14. In many cases unscheduled downtime can be minimised by the availability of fully working system back ups. Therefore in order to ensure that the back up procedures on the system are working the practice and the PCT needs to establish an arrangement whereby the practice can either restore the back up in conjunction with the PCT or have this verified by a third party (usually the GP

clinical system supplier). The PCT and practice(s) should agree a procedure for the periodic testing of the restore functionality.

### **Restoring to Normal Working**

15. When a normal working environment is ready to be restored (i.e. the unscheduled downtime has finished) the practice and the PCT normally need to agree that the BCA should cease, and also agree what tests and or activities need to be made or undertaken to ensure that any residual problems that may exist are be dealt with.

### **Frequency of BCA Tests**

16. In order to find out if the practice BCA are effective, they need to be regularly tested, and if necessary, amended as a result of a test. This may be to add new activities (or take some obsolete one out) or to amend the status of particular tasks. The tests may be conducted from documentation walkthrough and process review and simulation rather than full-scale physical tests.
17. It is recommended that the BCA be tested, as a minimum, on an annual basis. This may be as part of a larger BCA test, or maybe in conjunction with other practices in a Health Centre where unscheduled downtime could affect all practices.
18. Tests need to be conducted in conjunction with the PCT, but it is good practice that they are managed by the System Custodian.

### **Review of BCA**

19. BCA should be discussed with the PCT as part of the annual PCT visit to the practice

### Example of matters relating to liability to be included in an agreement

1. This appendix is provided as a guide to enable any agreement entered into between the PCT and the practice to set out appropriately each party's liabilities to the other. It is recommended that to ensure completeness terms covering the following points be included. These are offered as suggestions and in some cases examples of the kind of things PCTs and practices may want to consider in drawing up their agreements.

#### **Definitions**

2. Some terms may need a clear agreed definition to be set out within the agreement. For example:-

“For the purposes of these liability clauses "Approval" shall be defined as follows:

"written confirmation from the PCT stating it agrees that for the purposes of this agreement the software/hardware upon which approval is sought is acceptable by the PCT to be utilised by the practice".”

#### **Claims**

3. All Hardware/Software requiring replacement/maintenance, due to usual wear and tear, theft, fire or accidental damage, (save and except where the accidental damage is directly or indirectly caused by a third party independent contractor engaged by the practice) including where equipment is removed from the practice for purposes connected with the practice (e.g. visits), shall be replaced or maintained by the PCT provided always that the said Hardware/Software is 100% funded by the PCT.
4. Once software/hardware has been replaced by the PCT, as set out above, ownership will transfer from the practice to the PCT, despite any previous funding contributions by the practice.

#### **Premises Security**

5. The practice shall at all times ensure that adequate security arrangements are in place in the practice premises in accordance with the terms of the IM&T support contract.
6. If as a result of a claim made by a practice, the PCT, its agents, employees or contractors, discover inadequate security arrangements within that practice, it shall inform the practice of such and require the practice at its own cost to upgrade the security arrangements in accordance with the contract. Should the

practice subsequently incur loss and/or damage, theft, or malicious damage due solely to a lapse in reasonable security arrangements which should have been in place, the PCT has the right to decline any claim or payment in relation to such claim and/or decline to replace the lost/damaged equipment until such time as the security arrangements are rectified.

7. However, if failure by a practice to comply with adequate security as agreed with a PCT is directly attributable to the PCT's failure or delay in providing funding that it is obliged to provide under any relevant SoS Directions then the PCT shall not be entitled to decline or refuse any claim by a practice.
8. In any event, the PCT shall not be liable to replace Hardware and or Software as a result of malicious damage caused by a member of the practice or any member of that practice's staff.

### **Additional Costs**

9. If from the time the practice makes a request that the PCT meets its obligations in respect of the practice IM&T system, or where a practice makes a claim or logs a complaint in accordance with the conditions set out in their contract, the PCT fails to meet the response times as set out in their contract, and as a result the practice incurs reasonable and demonstrable additional costs, then the PCT shall reimburse the practice in full for those costs. Reimbursement should be made within 3 months from the date the claim(s) is made or from the date that such additional information as the PCT might reasonably require is forthcoming. By way of example, these are costs that would be incurred should the practice be unable to access or enter clinical data or print repeat prescriptions, or unable to access appointment systems. Such costs may cover the costs of employing or engaging additional staff or paying current staff overtime in order to perform functions which otherwise would have been performed by the Hardware and or/ Software either during or after the actual event.
10. Such reasonable and demonstrable additional costs are only recoverable in respect of a fault that has been appropriately and timeously reported to the PCT in accordance with the agreed procedures. Liability only extends to costs incurred in relation to faults not cleared within the agreed response/fix time and then only in relation to costs incurred after that period has expired. The PCT is not liable to make any reimbursements that relate to costs incurred before the expiry of the agreed response/fix time. This is always subject to the practice taking all reasonable steps to mitigating its losses.
11. For the avoidance of doubt, the PCT shall not be entitled or required to reimburse any costs to the practice should the practice have previously received reimbursement from any third party, although the practice shall not be under a duty to recover those costs from such third party. However, if the practice subsequently receives reimbursement from a third party the PCT shall take reasonable steps to recover its own costs (up to the limit of the amount reimbursed by the third party).

12. Prior to incurring any additional expenditure the practice shall wherever practicable agree an upper expenditure limit with the PCT. This limit should be reviewed if subsequently found to be inadequate. In any event, the PCT shall not unreasonably withhold or delay approval.

#### **Approved and or Funded Hardware/Software**

13. Any third party Software/Hardware that is utilised by the practice and is approved and supported but not necessarily funded by the PCT shall be subject to the same conditions including liability contained within the contract.
14. The PCT may indicate that it will approve third party Software/Hardware but not support it. In the event, a practice suffers a failure caused by approved but unsupported Hardware/Software, then the practice agrees to bear the cost of remedying the failure and any losses howsoever incurred as a result of the failure. The PCT shall use all reasonable endeavours to assist the practice in rectifying the failure but shall only bear the cost of reconfiguring and/or rebooting the practice system.
15. Any Software/Hardware utilised by the practice without the knowledge and/approval of the PCT shall be the entire responsibility of the practice and the loss/damage incurred by any party as a result of its use shall be borne by the practice.

#### **Data Migrations**

16. It shall be the responsibility of the PCT, its agents, employees or contractors to extract data to a specification agreed with the practice. If it subsequently becomes apparent that the migration did not meet the specification, the practice can claim for any reasonable and demonstrable additional costs incurred by the practice. The PCT shall not be liable if the said failure can be substantially attributed to any action, or any failure to take action on the part of the practice.

#### **Administration**

17. The mechanism for the pursuit of any claims as set out in the proceeding paragraphs shall be dealt locally through procedures agreed between the practice and the PCT in consultation with the LMC.

#### **Arbitration**

18. The parties agree before instigating the arbitration procedures set out in the agreement contract they shall use all reasonable endeavours to attempt to resolve the dispute amicably between them. (See Appendix 2 paragraphs 43-48.)

## **Force Majeure**

19. Neither party shall be responsible to the other for any failure or delay in performance of its obligations and duties under the contract due to a force majeure.
20. In this agreement, “force majeure” shall mean any cause preventing either party from performing any or all of its obligations which arises from or is attributable to EITHER acts, events, omissions or accidents beyond the reasonable control of the party so prevented including without limitation strikes, lock-outs or other industrial disputes (whether involving the workforce of the party so prevented or of any other party act of God, war, riot, civil commotion, malicious damage, compliance with any law or governmental order, rule, regulation or direction, accident, fire, flood or war, civil war, armed conflict or terrorist attack, nuclear, chemical or biological contamination.
21. If either party is prevented or delayed in the performance of any of its obligations under this agreement by force majeure, that party shall forthwith serve notice in writing on the other party specifying the nature and extent of the circumstances giving rise to force majeure, and shall, subject to service of such notice and having taken all reasonable steps to avoid such prevention or delay, have no liability in respect of the performance of such of its obligations as are prevented by the force majeure events during the continuation of such events, and for such time after they cease as is necessary for that party, using all reasonable endeavours, to recommence its affected operations in order for it to perform its obligations