**Leicester City Council**



Authorisation Scheme

Application Form

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| PH Ref No [ASC0236] Provision of intrauterine devices and systems (IUD/S) & provision of sub-dermal Implants (SDI) for contraception and the provision of IUS for non-contraceptive purposes. |
| **01 April 2019** |

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| **1.0 GENERAL INFORMATION** |
| 1.1 | Full Name of Provider  |  |
| 1.2 | Full Address (including postcode) |  |
| 1.3 | GP Practice Registration Number (CCG Code) |  |
| 1.4 | GP Practice Manager’s Name |  |
| 1.5 | Lead Contact for the Contract |  |
| 1.6 | Telephone Number |  |
| 1.7 | Mobile Phone Number |  |
| 1.8 | Email Address |  |

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| **\* All questions must be answered otherwise your application will be deemed to be incomplete. For any Yes/No questions, a ‘No’ response will result in a failed application and you will NOT be awarded a contract.** |

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| Provision of intrauterine devices and systems (IUD/S) & provision of sub-dermal Implants (SDI) for contraception and the provision of IUS for non-contraceptive purposes Please indicate in the table below the service you are applying for (you can apply for both services) |
| Provision of intrauterine devices and systems (IUD/S) | Yes [ ]  No [ ]  |
| Provision of sub-dermal Implants (SDI) | Yes [ ]  No [ ]  |
| Please state which Health Needs Neighborhood areas you will be providing this service for:

|  |  |  |
| --- | --- | --- |
| **Health Need Neighborhood** | **IUS/D** | **SdI** |
| City Central | [ ]  | [ ]  |
| North and East  | [ ]  | [ ]  |
| North and West  | [ ]  | [ ]  |
| South  | [ ]  | [ ]  |

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| **2.0 APPLICATION QUESTIONS (Ensure you have completed all the questions)** |
| 2.1\* | Is the Provider named in 1.1 above applying to provide the entire service/s itself | Yes [ ]  No [ ]  |
| 2.2\* | Is the Provider named in 1.1 above applying as the lead contact for a number of other GP Practices / provider?*(If ‘Yes’, please provide details in question 2.3 below)**(If ‘No’ please proceed to question 3.4)* | Yes [ ]  No [ ]  |
| We would welcome applications from groups of GP Practices that will work together or with other sexual health clinical providers to deliver this service/s. The lead provider named in 1.1 above will be responsible for signing the contract and distributing the payments to other providers in this arrangement. The Authority will only issue payments to the lead provider named in 1.1 above. |

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| 2.3\* |  | **GP Practice/Provider 1** | **GP Practice/Provider 2** | **GP Practice/Provider 3** | **GP Practice/Provider 4** | **GP Practice/Provider 5** |
| Full Name of GP Practice/provider  |  |  |  |  |  |
| Full Registered GP Practice/ provider Address (including postcode) |  |  |  |  |  |
| GP Practice Registration Number (CCG Code) |  |  |  |  |  |
| GP Practice/ providers Manager’s Name |  |  |  |  |  |
| Telephone Number |  |  |  |  |  |
| Mobile Phone Number |  |  |  |  |  |
| Email Address |  |  |  |  |  |
| Locality  |  |  |  |  |  |
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|  | **GP Practice/Provider 6** | **GP Practice/Provider 7** | **GP Practice/Provider 8** | **GP Practice/Provider 9** | **GP Practice/Provider 10** |
| Full Name of GP Practice/provider  |  |  |  |  |  |
| Full Registered GP Practice /provider Address (including postcode) |  |  |  |  |  |
| GP Practice Registration Number (CCG Code) |  |  |  |  |  |
| GP Practice /provider Manager’s Name |  |  |  |  |  |
| Telephone Number |  |  |  |  |  |
| Mobile Phone Number |  |  |  |  |  |
| Email Address |  |  |  |  |  |
| Locality  |  |  |  |  |  |

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| 2.4\* | Please confirm that your GP Practice and others that may be listed in question 2.3 above is/are registered with the Care Quality Commission (CQC) for the provision of the regulated activity of Family Planning Services. | Yes [ ]  No [ ]  |
| If not, a GP Practice please state under what regulations you can provide this service: |
| 2.5\* | Please confirm that you have read the terms and conditions of the contract and service specification, and please confirm that you will adhere to meet all the requirements contained within these documents during the period of the contract | Yes [ ]  No [ ]  |
| 2.6\* | Please confirm that you have equipment available to provide this service including:* Room fitted with a couch and adequate space and compliant with all clinical guidance regarding premises and equipment
* Equipment for decontamination and basic resuscitation
* Sterile surgical instruments
 | Yes [ ]  No [ ]  |
| 2.7\* | Staffing:* Including a trained assistant present in the building to support and assist the clinician as required
* A clinician trained according to the requirements in Appendix 1 of the service specification is providing the service.
 | Yes [ ]  No [ ]   |
| 2.8\*  | Agreement to receive patients from other practices via an electronic referral system. | Yes [ ]  No [ ]  |
| 2.9\*  | Agree to the safeguarding adults and Children and FGM requirements in the contract. | Yes [ ]  No [ ]  |
| 2.10\* | Agree that clinicians providing this service have and agree to maintain the training requirements detailed in Appendix 1 of the service specification. | Yes [ ]  No [ ]  |
| 2.11\* | Agree to a yearly audit as detailed in Section 11 of Appendix 1 (Service Specification) to be sent to Public Health in May  | Yes [ ]  No [ ]  |
| 2.12\* | Agree that aggregated demographic data of the patients provided with this service will be shared with Leicester City Council once a year  | Yes [ ]  No [ ]  |

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| **3.0 DATA PROTECTION & INFORMATION GOVERNANCE** |
| 3.1\* | Please tell us your organisation’s Information Commissioner’s Office (ICO) Notification Number and Expiry Date. | ICO No: |
| Expiry Date: |
| 3.2\* | Please give the name and contact details for the person who will act as Data Protection Officer for the purposes of the Contract. | Name: |
| Contact Details: |
| 3.3\* | Please confirm that you have previously successfully completed the NHS IG Toolkit Level 2 requirements | Yes [ ]  No [ ]  |
| 3.4\* | Please confirm that you are working towards completing the new Data Security & Protection Toolkit. | Yes [ ]  No [ ]  |

Please submit your application form via email to procurement-asc@leicester.gov.uk.

1. In the subject field, please state: Authorisation Form from (add your GP Practice / provider name)
2. Address the email for the attention of Procurement Team (Adult Social Care and Public Health)