NHS Wide Project On
Introduction Of Bedside Communications And Entertainment.

"PATIENT POWER".

Developing Bedside Communications and Entertainment in NHS Hospitals.

"Patient Power" Project.

Concession and Licence Documents Part 2
Terms and Conditions of the National Licence.

Section 1 to Form of Agreement:-
Terms and Conditions Document.

NHS Estates
An Executive Agency of the Department of Health

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A	22/02/01	Changed Patient Link to Patient Power	Kelly O'Brien
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TERMS AND CONDITIONS OF THE NATIONAL LICENCE.
FOR THE PROVISION OF SERVICES
FOR THE PATIENT POWER PROJECT

1) INTERPRETATION

In these Conditions:

a) "Authority" means the healthcare body placing the Concession for an individual healthcare premises or group of premises, and shall include its legal representatives, successors and assigns;

b) "Authority Property" means anything issued or otherwise furnished in connection with the Concession by or on behalf of the Authority;

c) “Charges” means charges including Value Added Tax at the prevailing rate;

d) “Concession” means the provision of services by the Licensee in accordance with the Concession Agreement;

e) “Concession Agreement" means the Provisional Form of Agreement, [Schedules 1 - 3, Sections 1(Terms and Conditions of National License) and 2 (Concession Agreement)] and the document entitled “Concession and Licence Documents Part 1:Project requirements” thereto between the Authority and the Licensee and incorporates this National Licence and all specifications, plans, drawings and other documents which are relevant to the Concession; **OR** Form of Agreement, [Schedule 1 , Sections 1(Terms and Conditions of National License) and 2 (Concession Agreement)] and the document entitled “Concession and Licence Documents Part 1:Project requirements” thereto between the Authority and the Licensee and incorporates this National Licence and all specifications, plans, drawings and other documents which are relevant to the Concession .

f) "Concession Charging Strategy" means the method or methods by which the Licensee will recover the costs of installing and operating the Concession for the full and proper performance by the Licensee of his part of the Concession as determined under the provisions of the Concession but before taking into account the effect of authorised and agreed amendments and variations;

g) “Condition” means a condition of these conditions;

h) "Control Centre" means any area identified for the main or exclusive use of the Licensee in the delivery of the services as described in Schedule 3 of the Concession Agreement;

i) “Costs” means costs net of any Value Added Tax;

j) “Designated Locations” means locations within the Healthcare Premises at which the Equipment connected to the System is to be installed as described in Schedule 4 of the Concession Agreement; as shown in the Installation Programme and otherwise agreed by the parties prior to or during the Implementation Period or

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as the same may be varied by agreement between the parties from time to time;

k) "Equipment" means all equipment, materials, consumables, plant and cabling, other than Authority Property, to be used by the Licensee in the Concession;

l) "Healthcare Premises" means the healthcare premises under the control of the Authority the details of which are in Schedules 3 (Control Centre – where applicable) and 4 (Healthcare Premises) to the Concession Agreement.

m) "Implementation Date" means the date on which the Licensee confirms and the Authority agrees (such agreement not being unreasonably withheld or delayed) that the Equipment has been installed and the System is operational in accordance with the Concession Agreement;

n) "Implementation Period" means the period commencing on the date of the Concession Agreement during which the System is being installed in the Healthcare Premises and ending on the Implementation Date;

o) "Installation Programme" means the programme for the installation of the System at the Healthcare Premises contained in Schedule 2 of the Concession Agreement (The Installation Programme) as amended from time to time;

p) "Intellectual Property" means any patent, registered or unregistered trademark or service mark, copyright, registered design or unregistered design right, any application for any of the foregoing, any right in respect of technical or commercial information and any other form of protection;

q) "Licensing Body" means the Secretary of State for Health acting through NHS Estates an executive agency of the Department of Health and shall include its legal successors and assigns;

r) "Licensee" means the individual, company or partnership identified in the Concession Agreement and shall include any person to whom the benefit of the Concession Agreement may be assigned by the Licensee with the consent of the Authority;

s) "Minimum Unit Level" means the number of units agreed by the Licensee and the Authority as set out in the Concession Agreement ;

t) "Model Concession Agreement" means the form of concession agreement set out in Schedule 1 hereto;

u) "Month" means calendar month;

v) "National Licence" means the Form of Agreement between the Licensing Body and the Licensee to provide a Bedside Patient Communication and Entertainment System in NHS healthcare premises [Schedule 1 , Sections 1 (Terms and Conditions of National License) and 2 (Model Concession Agreement)] and the document entitled "Concession and Licence Documents Part 1:Project requirements" **OR** the Provisional Form of Agreement [Schedules 1-3 , Sections 1 (Terms and Conditions of National License) and 2 (Model Concession Agreement)] and the document entitled "Concession and Licence Documents

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Part 1:Project requirements" In the event of ambiguity or contradiction, these documents shall be given preference in the order listed

w) "Patient" means a person resident at the Healthcare Premises for clinical treatment and occupying a Designated Location, and, where applicable, shall include a person in respect of whom the parties have agreed that the System should be made available;

x) "Person" includes corporation or an unincorporated association;

y) "Regulations" means the Authority's published regulations, policies and codes of practice of relevance to the Licensee providing services at the Healthcare Premises as amended by the Authority from time to time;

z) "System" means the system for transmission of radio, television programmes and telephone communications and the like; as provided and operated by the Licensee and as described in Schedule 1 to the Concession Agreement (System Overview) and to be installed by Licensee at the Healthcare Premises pursuant to the Concession Agreement, including where appropriate, the Equipment;

aa) "Technology" means methods, techniques, discoveries, inventions (whether patentable or not), formulae, formulations, technical and product specifications, equipment descriptions, plans, layouts, drawings, computer programs, assembly, quality control, installation and operating procedures, operating manuals, technical and marketing information, designs, data, know-how and other information; and

bb) "Work" includes the work to be performed by and the other obligations of the Licensee as specified in the Concession Agreement and all data reports drawings specifications designs inventions plans programmes or other material produced or acquired in the course of the production or performance of the Work.

1.2. Unless the context otherwise requires, each reference in this National Licence to

a) the singular includes the plural and vice versa; he includes she;
b) any enactment order regulation or other similar instrument shall be construed as a reference to any subsequent or amended enactment order regulation or instrument;

1.3 The headings to these Conditions shall not affect the interpretation thereof

2) NOTICES

a) All notices and other communications served upon either party under this National License agreement shall be deemed to have been properly served if sent by recorded delivery to the address of the party in the National Licence or such other address as either party may specify in writing to the other by notice given in accordance with this Condition
b) No notice or other communication from one party to another shall have any validity unless made in writing by or on behalf of the party concerned.

3) AMENDMENTS AND VARIATIONS

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a) No amendments to any of the provisions of this National Licence or the Model Concession Agreement will be valid or can be implemented unless they have been agreed previously in writing by the parties to the National Licence or the Concession Agreement respectively.

b) The Licensee shall not be entitled to carry out any Work which has not been authorised, either by the Concession Agreement or by agreed amendment thereto, except at the discretion of the Authority.

4) TRANSFER AND SUB-LETTING

a) The Licensee shall not give, bargain, sell, assign, or otherwise dispose of the Concession or any part thereof nor sub-licence any Authorities Premises licensed to it for the performance of the Concession without the previous consent in writing of the Licensing Body and the Authority except that the Licensee may without consent assign any monies due or to become due to him under the Concession Agreement. The Authority has a duty to act reasonably in this respect and shall give reasons should consent be withheld.

5) PERFORMANCE

a) The Work shall be carried out in accordance with the Concession Agreement to the satisfaction of the Authority. The Concession Agreement will contain the detailed performance criteria necessary to effectively monitor the provision of the Concession.

b) The Licensee shall provide such evidence of performance as may reasonably be required by the Authority and / or the Licensing Body for independent verification of the performance of the Concession. This will include such information as the Licensing Body from time to time deems necessary for the maintenance of proper monitoring and control of all National Licences and Concession Agreements made and any information which, from time to time, the Licensing Body deems necessary to undertake effective benchmarking. It is the responsibility of the Licensee to provide the necessary information from its sub contractors or participating partners.

c) The Licensee is permitted to install its System in Healthcare Premises subject to entering a Concession Agreement with the relevant Authority on terms of the Model Concession Agreement. The Licensing Body may extend the period of the National License by a further period of 3 years to those Licensees who meet the standards prevailing at the date of the extension provided that the Licensee has satisfactorily provided evidence of good performance to the Licensing Body and provided that the Licensing Body determines that the services provided under the Model Concession Agreement are still required. The Licensing Body has a duty to act reasonably in this respect and shall give reasons should the period not be extended. Any disputes shall be dealt with in accordance with Condition 29 (Arbitration and Disputes Resolution Procedure).

d) If the Work or any part thereof be suspended by the Authority (otherwise than in consequence of some neglect or default on the part of or by the Licensee) or the Licensee is delayed in proceeding with the Work by the Authority, the Authority shall not be held liable for any loss incurred by the Licensee as a result of such suspensions or delay other than in the case of proven negligence on the part of the Authority or its employees. The Licensee and Authority shall agree details in respect of this which shall be included in the Concession Agreement. The Authority will use its reasonable endeavours to avoid causing delay and to assist in measures taken by the Licensee to mitigate the costs incurred.

e) The Schedules to the **"Concession and Licence Documents Part 1 Project Requirements"** form part of the National Licence (including in particular Schedule 4: Guidance on acceptable Concession Charging Strategies within the NHS) and must be taken into account when any Authority assesses the Concession Charging Strategies proposed by potential Licensees. Details of the equipment used on the site should be the subject of a form of asset register and should distinguish amongst other things Equipment provided by the Licensee from Authority Property.

f) If the performance of the Concession by the Licensee be delayed:

i) by reason of any act or default on the part of the Authority;

ii) by industrial disputes; or

iii) by any event of Force Majeure as referred to in Condition 28.

the Licensee shall be allowed a reasonable extension of time for completion. Risks arising out of this Condition will remain the sole responsibility of the Licensee. The risks must be assessed and incorporated as part of the commercial assessment of his Concession Charging Strategy. No claim for recovery of costs by the Licensee due to unforeseen delays will be accepted by the Authority under any circumstances. The Licensee and the Authority shall agree details in respect of this in the Concession Agreement.

g) The Authority may in its absolute discretion make alterations to all or part of or demolish any part of the Healthcare Premises. No compensation will be given to the Licensee for loss of profit or any other losses as a result of such changes. The costs of transferring or installing the System in new or refurbished areas is to be met by the Licensee except that the cost of any relocation or alteration to the Control Centre not specified in the Concession Agreement that may be required by the Authority shall be met by the Authority. The Authority will give the Licensee prior written notice of at least 6 months of such changes.

6) STANDARDS

a) The Work carried out under this National Licence shall be to standards laid down in Standard Guidance issued by the Licensing Body and / or the Authority and applicable at the time. Where these standards have not already been provided or there are no appropriate NHS Standards the standards shall be agreed by the parties before the planned commencement of the phase of Work concerned or, in the absence of such standards, the Licensee shall perform the Work with all due diligence, and in accordance with good industry practice. Advice on standards relating to all bed-head services may be obtained from the Licensing Body technical department.

b) From time to time new entrants to the market will be assessed for competency and if satisfactory they will be licensed to install their system in Healthcare Premises. The selection or otherwise of additional licensees is at the absolute discretion of the Licensing Body.

7) PROGRESS REPORTS

a) Formal progress reports are necessary as part of the Concession requirement. The Licensee shall render such reports as to the progress of the Concession at such time and in such form as may be specified or as otherwise agreed between the Licensee and the Authority. A copy of all reports must be sent immediately upon issue to the Licensing Body.

b) The submission and acceptance of these reports shall not prejudice the rights of the Authority under any other Condition of this National License or under the Concession Agreement.

8) ISSUE AND USE OF PROPERTY

a) All Authority Property used in connection with a Concession shall remain the property of the Authority and shall be used in the execution of the Concession and for no other purpose whatsoever without the prior written approval of the Authority.

b) All such Authority Property shall be deemed to be in good condition when received by the Licensee unless he/she notifies the Authority to the contrary immediately in writing.

c) The Licensee undertakes the due return of all such Authority Property so issued and will be responsible for all loss or damage from whatever cause to the full amount of such loss or damage.

d) The Licensee undertakes to maintain and keep in a good state of repair and serviceable condition all such Authority Property used by it in the execution of the Concession.

e) Deterioration in such property, resulting from its normal and proper use in the execution of the Concession, shall not be deemed to be loss or damage (except where the deterioration is contributed to by want of maintenance or repair as required of the Licensee).

f) Occupation of Healthcare Premises under the terms of a Concession Agreement shall be for the purposes of the Concession Agreement and for no other purpose whatsoever and will terminate at the date of termination of the Concession Agreement with the Authority. The Licensee and Authority shall agree details in respect of this including the mechanism and time limits for the Licensee to remove Equipment from the site which shall be included in the Concession Agreement.

9) EQUIPMENT

a) Apart from Authority Property used in accordance with Condition 8, the Licensee shall provide all other equipment necessary for the provision of the Concession.

b) The Licensee shall maintain all items of Equipment in good and serviceable condition.

c) All Equipment shall be at the risk of the Licensee and the Authority shall have no liability for any loss of, or damage to, any Equipment unless the Licensee is able to demonstrate that such loss or damage was caused or contributed to by the negligence or default of the Authority or its employees.

d) The Licensee shall provide for the haulage or carriage of Equipment to the Healthcare Premises and its off-loading and removal when no longer required.

e) The Authority may at its option purchase the cabling from the Licensee (or require the Licensee to sell the cabling to an incoming Licensee who will operate the Concession in its place either on expiry or termination of the present Concession Agreement with the Licensee). Other items of Equipment may be purchased by the Authority where this is agreed between the Authority and the Licensee . Schedule 1 of this Concession Agreement sets out which items of Equipment are subject to this purchase option and the purchase price for the cabling and item(s) of Equipment.

10) ADVERTISING

a) Neither party to the Concession Agreement shall publish or reproduce or arrange press releases about the Concession or the Work without the prior written consent of the other.

b) Unless by prior written agreement with the Authority the Licensee shall not place any notice on any Work which he has produced for the Authority which advertises his connection with the Work or the Authority.

c) Any such written agreement for the Licensee to advertise on any Work he has produced for the Authority may be subject to payment of a reasonable fee by the Licensee to the Authority, such fee to be agreed by the two parties.

d) In particular Schedule 4 to the Concession and Licence Documents, Part 1, Project Requirements, shall apply in respect of advertising controls.

11) INTELLECTUAL PROPERTY RIGHTS.

a) The Intellectual Property rights in material owned or licensed by the Licensee including material created specially for the implementation of a Concession Agreement shall remain the property of the Licensee or third party as appropriate. If the Authority or the Licensing Body commissions work from the Licensee then this must be subject to a separate agreement which includes provision in respect of intellectual property rights.

b) The Licensee warrants that the use of the Equipment and the System will not infringe any Intellectual Property rights of any third party.

c) Subject to compliance with the provisions of the Data Protection Act 1998 and any other relevant legislation the Authority shall have the right of access to relevant data or information collected or computed as part of the Concession, including drawings, schedules and any other information necessary for the proper maintenance of the Authority's records. The Licensee shall provide this in a suitable format agreeable to the Authority.

12) CONFIDENTIALITY

The Licensing Body, Authority and Licensee will:

a) Treat as confidential all information which is not public knowledge which may be derived from or obtained in the course of the National Licence and / or Concession, or which may come into the possession of the Licensing Body, Authority or Licensee as a result of or in connection with the National Licence and / or Concession Agreement:

b) Take all necessary precautions to ensure that all such information is treated as confidential by the Licensing Body, Authority or Licensee and unless required to do so by law is not disclosed or used without prior approval of the appropriate party otherwise that for the purpose of the National License or the Concession Agreement.

c) The obligations imposed by this Condition shall continue to apply after the expiry or termination of the National License and Concession Agreement.

d) Nothing in this Condition shall prevent the Licensing Body, Authority or Licensee from disclosing information obtained to any other department office or agency of the crown, which is required to be disclosed by law or in response to proper requests for information by Parliament or by Ministers of the Crown.

13) DATA PROTECTION ACT

a) The Licensee shall not disclose or allow access to any personal data provided by the Authority or acquired by the Licensee during the course of tendering for, or execution of, the National License or any Concession Agreement other than to a person employed or engaged by the Licensee or partner for duties in connection with the Concession Agreement.

b) The Licensee shall give a notification to the Data Protection Commissioner of its wish to be included in the register maintained under section 19 of the Data Protection Act 1998 in accordance with section 18 of that Act.

c) Any disclosure of or access to personal data allowed under this Condition shall be made in and shall extend only so far as that which is specifically necessary for the purpose of the National Licence or Concession Agreement.

d) The Licensee shall store or process such personal data only at secure sites, specifically notified in writing 30 days in advance to the Authority. The Authority, acting reasonably and giving a full explanation of the reasons, may require an alternative site to be used by giving written notice within 15 days of receipt of notification from the Licensee.

e) Subject to paragraph (f) of this Condition the Licensee shall take all steps to ensure that in the execution of the Concession Agreement, the Licensee, its employees, and partners at all times comply with all relevant requirements of the Data Protection Act 1998.

f) If the Licensee fails to comply in any way whatsoever with any provision of this Condition then the Authority may summarily terminate the Concession Agreement by written notice to the Licensee, provided

always that:-

i. such termination shall not prejudice or affect any right of action or remedy which shall have accrued or shall accrue thereafter to the Authority;

ii. the Licensee shall first be given an opportunity to remedy the fault to the reasonable satisfaction of the Authority within a period of thirty days from notification by the Authority provided always that the Licensee has in no way acted in bad faith in respect of the breach;

iii. if the Concession ceases or is suspended in order to comply with this Condition the Authority will not be liable under the Concession Agreement but may continue charging the Licensee for any use of Authority Premises during the period of the suspension and prior to the termination of the Concession Agreement;

iv. the Licensing Body or Authority may terminate the National Licence or Concession Agreement respectively if such cessation of the Concession under sub-clause 3 above exceeds thirty days or the Licensee breaches this Condition on more than one occasion.

g) The Licensing Body and Authority have a duty to act reasonably with regard to this Condition and shall give reasons for any termination. Any disputes shall be dealt with in accordance with the Condition 29 (Arbitration and Disputes Resolution).

14) LICENSEE'S PERSONNEL

a) The Licensee and Authority shall each appoint a named authorised representative. The Parties shall take all reasonable steps to ensure that an authorised representative remains in post for the full period of the Concession Agreement. Necessary changes of the person in post shall be subject to a minimum of ten working days written notice by the appointing Party to the other. In the event of sickness or other unavoidable absence the Licensee shall, if so requested by the Authority, provide replacement personnel acceptable to the Authority without additional charge and at the earliest opportunity.

b) The Authority reserves the right to refuse to admit to Healthcare Premises any person employed by the Licensee, or partner , whose admission would be, in the opinion of the Authority's monitoring officer, undesirable. The Licensee may appeal to the Head of the Authority (usually the Chief Executive) in respect of any such refusal of admission. The Authority have a duty to act reasonably in this respect and shall give reasons for their refusal to admit any person to Healthcare Premises.

c) In the event that the Licensee is unable to provide replacement personnel acceptable to the Authority within sufficient time to enable the Licensee to complete the Work on time then the Authority may obtain replacement personnel from other sources

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d) All employees of the Licensee will be required to undertake medical examinations at the expense of the Licensee as deemed necessary by the Authority. The medicals may, by agreement, be undertaken at Authority's Premises, otherwise they must be carried out by a suitably qualified medical practitioner

acceptable to the Authority. Additionally the Licensee must comply with any specific rules made by the Authority as amended from time to time and notified to the Licensee regarding the employment of staff in particular areas or roles.

e) Employees of the Licensee may be required to undertake further checks as required in the individual circumstances of a Concession Agreement. If the Licensee is aware that relevant employees are arrested, charged or convicted of a criminal offence, the Licensee is required to keep the Authority fully informed of the circumstances and the action being taken by the Licensee.

f) The Authority shall provide current copies of its human resources policies including recruitment procedures to the Licensee, as specified in the Concession Agreement.

15) ON-SITE WORKING ARRANGEMENTS

a) Hours of Work shall be in accordance with the Concession Agreement.

b) The installation of any item necessary for the operation of the Concession is to be in accordance with a programme of works agreed at the time of the making of the Concession Agreement between the Authority and the Licensee.

c) The Authority shall be notified as soon as possible of absence which may cause disruption to service of the Concession and if it is likely to be prolonged, and if so requested by the Authority the Licensee shall provide a replacement in accordance with Condition 14 (Licensee's Personnel).

d) The Licensee's personnel including employees or partners shall work under the direction and control of the Licensee who shall be responsible for their conduct and discipline at no cost to the Authority.

e) The Licensee's personnel shall at all times during their engagement in the work of the Concession remain servants of the Licensee and the Licensee shall not be relieved of any of his statutory or other responsibility in relation to the Licensees personnel by virtue of the Concession.

f) The frequency of progress meetings and the manner of presentation of progress reports will normally be specified in the Concession Agreement and in accordance with Schedule 3 to the document entitled " Concession and Licence Documents, Part 1, Progress meetings, progress reports, monitoring and evaluation" or as agreed from time to time between the Licensing Body, the Authority and the Licensee as appropriate.

16) PAYMENT

a) By this National Licence the Licensing Body licences and gives approval to a Licensee to negotiate with and enter into a Concession Agreement based on the Model Concession Agreement with any Authority. It does not establish a contract to purchase services by any Authority or other third party.

b) Payment to the Authority for occupation of Healthcare Premises shall be agreed by the Licensee and the Authority and included in the Concession Agreement.

c) Regular financial and operational reports shall show a unique Concession reference together with details the level of charges, usage, income, and the amount of Value Added Tax which is payable against each income stream. The report shall also include costs actually incurred. These reports will be confidential and should be sent to both the Authority and the Licensing Body on a quarterly basis within 1 month of the last date to which the information refers. The Licensee shall provide further information as the Licensing Body may reasonably require on request.

d) The Licensee will be expected to operate an open book accounting policy in respect of each and every Concession granted.

e) Where the Licensee enters into a sub-contract for any part of the Concession, the Licensee shall ensure that a term is included in the sub-contract which requires the Licensee to pay all sums due to the sub-contractor within a specified period, not exceeding 30 days of the due date as defined by the terms of that sub-contract or sub-licence following receipt of a valid invoice.

17) RECOVERY OF SUMS DUE

a) Whenever under the Concession Agreement any sum of money shall be recoverable from or payable by the Licensee the same may be deducted from any sum then due, or which at any time thereafter may become due to the Licensee under its Concession Agreement with the Authority or any other agreement between the Licensee and the Authority.

18) INDEMNITIES FOR INTELLECTUAL PROPERTY RIGHTS.

a) The Licensee shall indemnify the Authority against all actions, claims, demands, costs, charges and expenses arising from, or incurred by reason of, any infringement or alleged infringement of Copyright, Patent, Registered Design or any other intellectual property right used by or on behalf of the Licensee for the purpose of the Concession provided that such infringement is not knowingly caused by or contributed to by any act of the Authority or its employees.

b) The Authority shall indemnify the Licensee against all actions. claims, demands. costs, charges and expenses arising from or incurred by reason of any infringement or alleged infringement of Copyright, Patent, Registered Design or any other intellectual property right used at the request of the Authority by the Licensee in the course of undertaking the Work.

c) The obligation of indemnity accepted by each party in this Condition is conditional upon the indemnifying party being allowed the exclusive right to conduct all negotiations for settlement of any claim or demand or action brought against the other and any litigation that may arise there from and being given prompt notice of each claim, demand or action brought and the reasonable assistance of the other party.

19) LIABILITY

a) The Licensee shall indemnify the Authority against:

i) any loss or damage caused either to any property of the Authority, its servants or agents, or by any physical injury (including injury resulting in death) sustained by the Authority's employees by reason of any negligent act or omission of the Licensee's personnel including its employees, or partners during the time they are working, for the Licensee under the Concession:

ii) any claim, demand or liability made against or incurred by the Authority in respect of:

(1) any loss or damage to any property of the Licensee's personnel or injury (including injury resulting in death) sustained by the Licensee's personnel during the currency of the Concession unless and to the extent that such loss damage or injury is caused by the negligent act or omission of the Authority or its employees;

(2) any loss or damage or injury (including injury' resulting in death) sustained by any third party during the currency of the Concession in consequence of any negligent act or omission of the Licensee's personnel including its employees, or partners.

(b) Except in respect of liability for death or personal injury the total of the Licensee's liability under this Condition is limited to a maximum of £2 million for each Concession in respect of any one event or series of events in respect of loss or damage to property only.

(c) The Licensee shall not be liable for any loss. damage or delay suffered by the Authority to the extent such that loss, damage or delay is attributable to instructions given by the Authority.

(d) Without prejudice to the provisions of Condition 17 (Recovery Of Sums Due) the Licensee shall be liable to reimburse the Authority for all reasonable payments, or additional payments by the Authority to third parties which become necessary in direct consequence of a delay in the Work due to default of the Licensee which the Licensee has failed to remedy after being given reasonable notice by the Authority.

(e) Without prejudice to the foregoing sub-Conditions and to Condition 18 (Indemnities for Intellectual Property) the Licensee shall only be liable to the Authority for any loss, damage, injury or expense (whether direct or consequential) arising out of or in connection with the Work, including the operation of any computer software contained in or contributing to the Work, where such loss, damage, injury or expense arises out of the negligence of the Licensee, including its employees, partners, agents or sub contractors.

(f) The Licensee shall effect and maintain with a reputable insurance company, a policy or policies of insurance providing an adequate level of cover in respect of all risks which may be incurred by the Licensee, arising out of the Licensee's performance of the Concession, in respect of death or personal injury, or loss of, or damage to, property. Such policies shall include cover in respect of any financial loss arising from any advice given or omitted to be given by the Licensee in the direct pursuance of its obligations under the terms of the Concession.

(g) The Licensee shall hold employers' liability insurance in respect of its personnel in accordance with any legal requirement in force.

(h) The Licensee shall produce to the Authority, on request, copies of all insurance policies referred to in this Condition, or written evidence from the insurance provider confirming the Licensee has sufficient insurance cover to meet all liabilities under the National License and the Concession Agreement, or other evidence acceptable the Authority confirming the existence and extent of cover given by those policies, together with receipts or other evidence of payment of the most recent premiums due under those policies.

20) SECURITY

a) The Licensee shall take all measures necessary to comply with the provisions of any Authority rules relating to security, which may be applicable to the Licensee in the performance of the Concession Agreement.

b) The Licensee shall take all reasonable measures, by the display of notices or other appropriate means, to ensure that its personnel have notice that all such provisions will apply to them.

c) Whilst on Healthcare Premises, the Licensee's personnel, including employees and partners, shall comply with all security measures implemented by the Authority. The Authority shall provide current copies of its relevant written security procedures to the Licensee, as specified in the Concession Agreement.

d) The Authority shall have the right to carry out any search of the Licensee's personnel, including employees, and partners, or of vehicles used by the Licensee's personnel at the Healthcare Premises.

e) The Licensee shall co-operate with any investigation relating to security which is carried out by or on behalf of the Authority and, if required, shall use his reasonable endeavours to make the Licensee's personnel, including employees, and partners available for interview for the purposes of the investigation. Licensee personnel who are interviewed shall have the right to be accompanied by any person whose attendance at the interview is acceptable to both the Authority and the Licensee.

21) BREAK

a) If at any time the Healthcare Premises cease to be under the control of the Authority, then the Authority may terminate the Concession Agreement by giving the Licensee 6 months' written notice subject to the following provisions:

(i) In the event of such notice being given, the Authority will pay to the Licensee the agreed value at the date when the Concession Agreement is to terminate of all cabling and any of other Equipment listed in Schedule 1 to the Concession Agreement installed in the Healthcare Premises and ownership thereof shall then pass to the Authority.

(ii) In addition to sums payable under condition 21 a)(i) above, the Authority will indemnify the Licensee against any commitments, liabilities or expenditure which would represent an unavoidable loss by the Licensee by reason of the termination of the Concession Agreement.

b) If termination under this Condition 21 takes effect on or before a date being [27] months from the date of the Concession Agreement ("the Profit Date") the Authority will in addition pay to the Licensee a sum equal to the loss of profit incurred by the Licensee in the period commencing on [the date of termination] and ending on the Profit Date. Loss of profit shall be calculated pro-rata on actual profit made in the 12 months preceding the date of termination.

c) If the Licensee can demonstrate to the satisfaction of the Authority that the Concession has become unprofitable, the Licensee may terminate the Concession Agreement by giving the Authority 3 months' written notice.

d) If the Licensee terminates the Concession Agreement under Condition 21 c) above, the Authority shall not

be liable to pay to the Licensee any sum in respect of any loss incurred as a result of the termination and ownership of all cabling shall pass to the Authority at no cost to the Authority. The Authority may at its discretion, exercise its option to purchase any other item listed in Schedule 1 (Table A) to the Concession Agreement.

22) DEFAULT, SUSPENSION AND TERMINATION

a) In the event of a total failure to provide the Concession, the Licensee shall within 14 days of notification to the Licensee by the Authority submit to the Authority a recovery plan to provide the Concession in accordance with the National Licence and the Concession Agreement. The Authority may approve the recovery plan, which approval shall not be unreasonably withheld, or the Authority shall give reasons for withholding approval.

b) Notwithstanding paragraph a) above the Authority may withhold approval of any recovery plan which anticipate a total failure to provide the Concession for more than 30 days or does not anticipate provision of the Concession in accordance with this National Licence and the Concession Agreement within 60 days of the notification of failure.

c) Provided that any total failure to provide the Concession is not solely a direct consequence of any act or omission of the Authority, the Authority may terminate the Concession Agreement without compensation for any loss incurred by the Licensee if:

(i) the Authority reasonably withholds approval of the Licensee's recovery plan, or

(ii) the Licensee fails to implement the recovery plan as approved.

d) Except where paragraphs a) – c) inclusive of this Condition 22 apply either party to the Concession Agreement may terminate the Concession Agreement if the other is in material default and such default cannot be remedied to the satisfaction of the other within 60 days of the date of written notification of the default.

e) Notice of termination shall be given to the defaulting party in writing with immediate effect and shall be without prejudice to the rights of the Parties accrued to the date of termination.

f) The National Licence may be suspended at any time by the Licensing Body in all or any of the following circumstances:

(i) Notice is given by any Authority which may result in the termination of a Concession Agreement between that Authority and the Licensee for breach of that Concession Agreement for so long as such notice remains in force.

(ii) A Concession Agreement between the Licensee and any Authority is lawfully and properly terminated by that Authority.

(iii) Occurrence of the events in Condition 24 (Bankruptcy etc)

(iv) The Licensee is in material default of any obligation under the National Licence or the Concession Agreement for so long as that default persists.

g) A National Licence to install into new locations may at the absolute discretion of the Licensing Body be terminated without compensation if any suspension pursuant to this Condition is upheld on review by an authorised representative of the Licensing Body who did not take part in the suspension decision. The Licensing Body shall act reasonably in this respect and shall give reasons for the termination. Any dispute

shall be dealt with in accordance with Condition 29 (Arbitration and Disputes Resolution).

h) If a National Licence is suspended or terminated, the Licensee will not be permitted thereafter to enter into a Concession Agreement with any Authority. Any Concession Agreement in effect between the Licensee and any Authority shall continue in full force and effect subject to compliance by the Licensee with that Concession Agreement.

23) WAIVER

a) The right of either party at any time to enforce any provision of the National Licence or the Concession Agreement shall in no way affect its right thereafter to require complete performance by the other party.

b) Nor shall the waiver of any breach of any provision be taken or held to be a waiver of any subsequent breach of any provision or be a waiver of the provision itself.

c) No waiver shall be effective unless it is communicated to the other party in writing.

24) BANKRUPTCY ETC

a) The Authority may at any time by written notice summarily terminate the Concession without compensation to the Licensee in any of the following events:

i) If the Licensee shall at any time become bankrupt, or shall have a receiving order made against it or shall make any composition or arrangement with or for the benefit of its creditors. or shall purport to do so, or any applications shall be made under any legislation for the time being in force for sequestration of its estate, or a trust deed shall be granted by for behalf of its creditors;

or

ii) If the Licensee, being a company, shall pass a resolution, or the Court shall make an order, that the company shall be wound up otherwise than for the purpose of reconstruction or amalgamation, or if a receiver or manager on behalf of a creditor shall be appointed, or if circumstances shall arise which entitle the Court or a creditor to appoint a receiver or manager or which entitle the Court otherwise than for the purpose of amalgamation or reconstruction to make a winding up order.

b) Such termination shall not prejudice or affect any right of action or remedy which shall have accrued or shall accrue thereafter to the Authority.

25) EQUAL OPPORTUNITY

a) The Licensee shall not discriminate unlawfully against any person in the execution of the Concession within the meaning of any Act or statutory regulation relating discrimination whether in relation to a person's nationality, race, sex, religion or disabilities or otherwise.

b) The Licensee shall take all reasonable steps to secure the observance of the provisions of this Condition by all servants employees or agents of the Licensee partners and the like, employed in the execution of the concession.

26) INDUCEMENTS

a) The Licensee shall not offer to the Licensing Body or Authority any advantage other than lower charges for use of the System.

b) If the Licensee shall have offered or given or agreed to give to any person gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the Concession or any other Concession with any Authority, or for showing or forbearing to show favour or disfavour to any person in relation to the Concession or any other Concession with any Authority, or if the like acts shall have been done by any person employed by him, or acting on his behalf (whether with or without the knowledge of the Licensee) or if in relation to the Concession or any other Concession with any Authority the Licensee or any person employed by him or acting on his behalf shall have committed any offence under the Prevention of Corruption Acts l889 to 1916, or shall have given any fee or reward to any officer of the Authority which shall have been exacted or accepted by such officer in the course of his office or employment and is otherwise than such officer's proper remuneration, the Authority shall be entitled to terminate (or cancel if the Work has not yet commenced) the Concession and to recover from the Licensee the amount of any loss resulting from such termination or cancellations.

27) LAW

a) The National Licence and the Concession Agreement shall be deemed to be agreements made in England and shall be subject to and interpreted in accordance with English Law.

28) FORCE MAJEURE

a) The Licensing Body, Authority or Licensee shall not be liable for any failure to perform its obligations under this National License or any Concession Agreement arising as a result of any cause beyond its control not attributable to any act or failure to take preventive action by the Licensee but shall not include any industrial action taken by any person or persons providing any service to any of the parties.

b) If any event of Force Majeure occurs in relation to Licensing Body, Authority or the Licensee which affects or may affect the performance of any of its obligations under this National License or any Concession Agreement, it shall forthwith notify the other Parties as to the nature and extent of the circumstances in question.

c) The Licensing Body, Authority or Licensee shall not be deemed to be in breach of this National License or Concession Agreement, or shall not otherwise be liable to the Authority, Licensing Body or Licensee by reason of any delay in performance, or the non-performance of any of its obligations hereunder, to the extent that the delay or non-performance is due to any Force Majeure and the relevant time for performance of that

obligation shall be extended accordingly.

d) If the performance by Licensing Body, Authority or the Licensee of any of its obligations under this National License or any Concession Agreement is prevented or delayed by Force Majeure for a continuous period in excess of 6 months, the Licensing Body, or Authority and the Licensee shall enter into bona fide discussions with a view to alleviating its effects, or to agreeing upon such alternative arrangements as may be fair and reasonable and subject thereto if the matter cannot be resolved the Licensing Body, or Authority shall then be entitled to terminate this National License or any Concession Agreement with immediate effect by giving written notice to the Licensee.

29) ARBITRATION AND DISPUTE RESOLUTION.

a) Disputes arising under this National Licence or any Concession Agreement should be resolved as quickly as possible. However, in the event that a dispute cannot be resolved, then subject to the written Agreement of the Parties to the dispute, the matter may be referred to the Secretary of State for resolution.

b) The Secretary of State may –

i) require each side to submit a written case together with any supporting documentation deemed necessary for the presentation of the case;

ii) review both submissions and determine the nature of the issues at hand;

iii) determine how the matter will proceed;

iv) decide that the matter is not a dispute in respect of which he can propose resolution in which case any Party may refer the matter to ACAS, CEDR or to the courts;

v) determine that matter is a dispute in respect of which he may propose resolution in which case he may do so and if agreed by the Parties, that resolution shall be reduced to a written agreement which shall be binding on the Parties.

vi) If the parties do not agree to refer the dispute to the Secretary of State or if they do not agree to accept the resolution proposed by the Secretary of State, the Parties may refer the matter to ACAS, CEDR or the courts, as appropriate.

c) Unless otherwise agreed all negotiations connected with the dispute and any settlement agreement relating to it shall be conducted in confidence and without prejudice to the rights of the Parties in any future proceedings.

d) The performance of the National Licence and any Concession Agreement shall not cease or be delayed by reference of a dispute for resolution to the Secretary of State, any other person or a court under this Condition.

e) Each Party shall bear its own costs incurred in referring this dispute for resolution under this Condition unless the person who or court which finally resolves the dispute directs otherwise.

30) HEALTH AND SAFETY

a) The Licensee shall promptly notify the Authority of any health and safety hazards which may arise in connection with the performance of the Concession.
b) The Authority shall promptly notify the Licensee of any health and safety hazards which may exist or arise at Healthcare Premises and which may affect the Licensee in the performance of the Concession.
c) The Licensee shall inform all personnel engaged in the provision of the Concession at Healthcare Premises, of all known health and safety hazards and shall instruct those personnel in connection with any necessary safety measures.
d) Whilst on Healthcare Premises, the Licensee shall comply with any health and safety measures implemented by the Authority in respect of any persons Working at Healthcare Premises.
e) The Licensee shall notify the Authority immediately of any incident occurring in the performance of the Concession on Healthcare Premises, where that incident causes any personal injury or any damage to property which could give rise to personal injury.
f) The Licensee shall take all measures necessary to comply with the requirements of the Health & Safety at Work etc Act 1974 and any other Acts, Orders, Regulations and Codes of Practice relating to health and safety, which may apply to its personnel in the performance of the Concession.

31) HUMAN RIGHTS

a) If, and in so far as in carrying out the Concession, the Licensee will be exercising a function of a public nature pursuant to the Human rights Act 1998, the Licensee agrees to take reasonable steps to ensure that in so doing its personnel, including its employees, and partners, will comply with all relevant requirements of the Human Rights Act 1998.
b) The Licensee agrees to take such action as the Authority reasonably requires for the purpose of ensuring compliance with the requirements of the Human Rights Act 1998.
c) If, in carrying out the Concession, the Licensee breaches its obligations under the Human Rights Act 1998, or fails to comply with any requirements of the Authority under Condition (b) of this Condition above, the Authority shall be entitled to terminate the Concession.

32) SEVERABILITY

a) If any provision of this National Agreement or any Concession Agreement is held by any court or other competent authority to be invalid or unenforceable in whole or in part, this National Agreement or any Concession Agreement shall continue to be valid as to its other provisions and the remainder of the affected provision.

33) RIGHT OF AUDIT

a) The Licensee shall keep secure and maintain until two years after the termination of the Concession Agreement or such longer period as may be agreed between the Parties, full and accurate records of the Concession, all expenditure reimbursed by the Authority and all payments made by the Authority.

b) Subject to compliance with the provisions of the Data Protection Act 1998 and any other relevant legislation the Licensee shall grant to the Authority, or its authorised agents, such access to those records as they may reasonably require in order to check the Licensee's compliance with the National Licence and the Concession Agreement
c) Pursuant to paragraph b) of this Condition 33 for the purpose of:

    i) the examination and certification of the Authority's accounts; or
    ii) any examination pursuant to section 6(1) of the National Audit Act 1983 of the economy, efficiency and effectiveness with which the Authority has used its resources
d) Subject to compliance with the Data Protection Act the Comptroller and Auditor General may examine such

documents as he may reasonably require which are owned, held or otherwise within the control of the Licensee and may require the Licensee to provide such oral and/or written explanations as he considers necessary. This Condition does not constitute a requirement or agreement for the examination, certification or inspection of the accounts of the Licensee under section 6(3)(d) and (5) of the National Audit Act 1983.

34) CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999.

a) A person who is not a party to this National License or a Concession Agreement shall have no right to enforce any terms of those documents which or which purport to confer a benefit on him.

SCHEDULE 1
MODEL CONCESSION AGREEMENT

Contents

Model Concession Agreement

NHS Patient Power Project.

MODEL CONCESSION
FOR THE INSTALLATION
AND
OPERATION OF A
PATIENT ENTERTAINMENT
AND
COMMUNICATION SYSTEM

BETWEEN _____

_____ **THE AUTHORITY**

AND

_____ **THE LICENSEE**

Section 2 to Form of Agreement:-
Model Concession Document.

REF No

Contents

NHS Wide Project

Introduction of Bedside Communications and Entertainment

"PATIENT POWER"

Model Concession Agreement

Contents

Schedules

1 Introduction

1.1 The Authority occupies and administers the premises and facilities at the Healthcare Premises detailed in Schedule 4 (Schedule of Healthcare Premises) at which it provides residential clinical care to Patients.

1.2 The Licensee will provide equipment, control systems and devices for the provision of an integrated telecommunication system for transmission of radio, television programmes and data and voice communications and the like, for the use of Healthcare Premises Patients and the Authority.

1.3 The Authority has agreed to permit the Licensee to install and operate the Licensee's telecommunication system at the Authority's Healthcare Premises for the period of this Concession Agreement on the terms and conditions hereof.

2 Interpretation

2.1 In this Concession Agreement expressions shall have the meanings given to them in Condition 1 of the National License.

2.2 This Concession Agreement shall be subject to the terms and conditions of the National Licence and in the event of any conflict between the terms of this Concession Agreement and the terms and conditions of the National Licence the terms and conditions of the National Licence shall prevail.

3 The Installation Programme

3.1 The Authority will from time to time assist the Licensee in the preparation and implementation of the Installation Programme by advising the Licensee of any matters which are likely to affect the Installation Programme or any aspect of it. In particular, the Authority will supply to the Licensee:-

3.1.1 detailed plans of the Healthcare Premises showing the layout and configuration of all existing wiring and electronic transmission systems and of all ducting and other existing conduits for cables and wiring within the Healthcare Premises;

3.1.2 the Regulations and all other regulations, rules and instructions applied by the Authority in respect of the installation of electronic systems and other related Works at the Healthcare Premises which will need to be complied with and observed in the conduct of the Installation Programme;

3.1.3 plans of the Healthcare Premises, showing the location of wards, the nature of patients in each of the wards and any proposed changes to the configuration of the wards or of the Healthcare Premises; and

3.1.4 such other information and material as the Licensee may reasonably request for the preparation and implementation of the Installation Programme, or which the Authority may be aware of and which is likely to affect the Installation Programme.

3.2 The Authority will allow the Licensee and its authorised representatives and subcontractors to have access to the Healthcare Premises for the purpose of preparing the Installation Programme in accordance with the timetable for work to be carried out at the Healthcare Premises and otherwise at reasonable times and on reasonable prior notice, subject to their complying with the Regulations.

3.3 The Licensee will make reasonable endeavours to ensure that the Installation Programme is carried out in accordance with the timetable for the Works contained therein, provided that the timetable for the Works shall be extended if and to the extent that the Installation Programme is delayed by any of the following:-

3.3.1 any changes in the requirements of the Authority in relation to the Installation Programme or in the condition of the Healthcare Premises or the wards therein which affect the Installation Programme;

3.3.2 any alteration or modification of the Installation Programme which is requested or approved by the Authority.

3.4 The Authority will take such steps as may be necessary to manage the logistical requirements at the Healthcare Premises to enable the Installation Programme to be carried out in accordance with the schedule of work shown therein, and in particular the Authority will take the measures required to make the wards in which the System is to be installed available at the times and for the periods when the installation work is to be carried out in the wards in accordance with the Installation Programme. If and to the extent that any of the wards or other areas of the Healthcare Premises are not able in the absolute discretion of the Authority to be made available because of clinical or other operational priorities, the Authority will give the Licensee notice thereof at the earliest opportunity and the Licensee and the Authority will use all reasonable endeavours to agree revisions to the Installation Programme to accommodate the need to reschedule the installation work accordingly.

3.5 If the Installation Programme cannot proceed as a result of delays caused by the wards or other areas not being available for the installation work and as a result the Installation Programme is to be delayed by more than a total of [*insert number of days agreed in here*] the Licensee may by written notice to the Authority either:

3.5.1 suspend the Installation Programme for such period as the Authority and the Licensee may agree is reasonable; or

3.5.2 terminate this Concession Agreement with immediate effect.

3.6 If the Implementation Date has not occurred on or before [*Insert Date here*] (other than by reason of delay resulting from matters referred to in Clause 3.5 above) either party may at any time within thirty (30) days after that date give written notice to the other to terminate this Concession Agreement with immediate effect and this Concession Agreement will be terminated accordingly with neither Party having any claim against the other arising from such termination.

3.7 Each of the Licensee and the Authority shall nominate one or more senior managers who shall be responsible for liaison in connection with the operation and use of the System at the Healthcare Premises. The representatives of the Licensee and the Authority will meet at regular intervals for the purpose of reviewing any matter likely to be relevant in relation to the manufacture, development, use or promotion of the Equipment and the System and will assist and cooperate in the assessment and analysis of the System and the use by and response from Patients and others to the operation of the System with a view to the development and improvement of the facility.

3.8 During the period of the Concession Agreement the Authority shall have the power to inspect and examine the Work at any reasonable time.

The Licensee shall give all such assistance as the Authority may reasonably require for such inspection and examination.

3.9 If any part of the Work is found to be defective or in any way not in compliance with the Concession Agreement, other than as a result of default of the Authority, the Licensee shall at his own expense reschedule and perform the Work in accordance with the Concession Agreement within such time as may reasonably be required by the Authority.

4 Grant Of Rights

4.1 The Authority hereby grants the right to the Licensee and the Licensee shall install and operate the System at the Healthcare Premises for the period of this Concession Agreement, including the right and obligation to:-

4.1.1 install the Equipment in the Healthcare Premises so that the System is available to be used by Patients at the Designated Locations;

4.1.2 install and use cables, wiring and other forms of transmission equipment at the Healthcare Premises to connect the bedside terminal which is part of the Equipment to the System;

4.1.3 install the switch, voice mail and television control centres comprised in the Equipment and such other control systems as may from time to time be included in the Equipment and aerials, receivers and dishes at suitable sites at the Healthcare Premises as specified in the Installation Programme and make all necessary connections to external public telecommunications systems and aerials, receivers and other means of radio and television reception and transmission;

4.1.4 install at the Healthcare Premises in locations shown in the Installation Programme or otherwise as determined by the Concession Agreement between the parties from time to time dispensers and other facilities to provide charge cards.

Enter details of what is to agreed to be installed in the way of pay machines etc here.

4.1.5 install and operate within the System [e*nter here the number agreed]* of pay phones in each ward and at such locations within the Healthcare Premises as may be agreed between the

Authority and the Licensee;

(To be the basis of detailed negotiations based upon the Licensees approved Charging Strategy for ward phones. Note phones not on the ward or at the bedside may be subject to alternative negotiated arrangements).

4.1.6 market the use of the System as a facility of the Healthcare Premises and to display advertising material in public corridors, walkways, reception areas, lifts and in the Designated Locations, including television monitors to transmit advertising material, and to promote the use of the System by patients and sell charging facilities in respect of the System in such manner as the Licensee may determine subject to the reasonable regulation of the Authority.

4.2 The Licensee will endeavour to ensure that the maintenance of the Equipment at the Healthcare Premises and any other activities carried on by the Licensee at the Healthcare Premises pursuant to this Concession Agreement shall be carried out with minimum inconvenience or nuisance to the equipment, staff and patients at the Healthcare Premises.

4.3 The Authority will, at the Licensee's request, insert material containing information about the System and its operation in any admissions pack or similar material given to Patients on or prior to admission. The Authority shall where possible include a message on the PABX advising incoming callers of the Licensee phone numbers**.**

[This condition may be changed as required as a result of the local negotiations. *The Authority may wish to adapt the admissions process so that ward staff may with the consent of the Patients register them on the System as part of that process (Optional but may be of value if the Authority requires to use to information collected)].*

4.4 The Authority grants the Licensee and his authorised personnel;

4.4.1 reasonable access to and use of the services and facilities at the Healthcare Premises including electricity supply, power, water and other similar services insofar as required to operate and maintain the System.

4.4.2 reasonable access to those parts of the Healthcare Premises in which the System is installed at reasonable times for the purpose of installation, maintenance and operation of the System and to monitor and make available charging facilities in respect of the

System.

4.4.3 reasonable access to the Control Centre and will ensure that the Licensee is able to occupy and use the Control Centre for the purpose of the administration and maintenance of the System for the period of this Concession Agreement.

5 Consideration

5.1 The Authority grants to the Licensee the rights set out in this Concession Agreement in consideration for the provision by the Licensee of the System at the Healthcare Premises for use by patients on the terms set out in this Concession Agreement. The Licensee is providing the System at no cost to the Authority on the basis that all charges for the use of the System will be paid by the Patients and the Licensee will have no recourse to the Authority in respect of such charges unless otherwise agreed between the parties in any particular circumstances.

5.2 The Authority will not discourage the use of the System by Patients and will not during the period of this Concession Agreement grant rights or permit patients or any person other than the Licensee to install or operate telephone or television transmission systems for use by patients in the wards or at their bedside (other than communal television sets which are provided by the Authority for use by patients in the day rooms). The Authority will prohibit the use of mobile phones within the Healthcare Premises in circumstances where it is lawful and there is proper reason to do so, including but not limited to the risk of interference with the functioning of medical equipment or the care of patients. The Authority undertakes to maintain this prohibition for as long as it is lawful and there are reasonable grounds for so doing.

5.3 The Authority will inform the Licensee of any changes in the configuration or occupancy of the Healthcare Premises which would increase or reduce the numbers of patients for whom the System would be available and the Licensee will use his reasonable endeavours to adjust the System accordingly. If the number of Designated Locations at the Implementation Date is less than the Minimum Unit Level or if changes in the configuration or occupancy of the Healthcare Premises are, in the Licensee's reasonable opinion, likely to reduce the usage of the System to a level at which it is uneconomic, the Licensee will have the right to terminate this Concession Agreement by giving not less than six (6) months notice in writing to the Authority. The Minimum Unit Level pursuant to this Concession Agreement is [Insert the number of Designated Locations here].

6 The Licensee's Obligations

6.1 The Licensee undertakes to the Authority that it will, at its own expense, during the period of this Concession Agreement:-

6.1.1 install the Equipment at the Healthcare Premises in accordance with Clause 3 and the Installation Programme;

6.1.2 operate the System at the Healthcare Premises so that Patients have the use of a terminal at their bedside and have access to the System at the Designated Locations. In the event that the Designated Locations are modified or patient occupancy changes to a material extent during the period of this Concession Agreement, the Licensee will change the System accordingly to ensure as far as reasonably practicable, that each Patient has access to the System; and

6.1.3 maintain the Equipment in a proper efficient and workmanlike manner and correct all material faults in the System within a period of [*insert agreed period(s) of response in here*] after the same have been identified.

6.2 The Licensee shall be responsible for:-

6.2.1 all costs and expenses incurred by it in the design, manufacture or procurement and development of the System;

6.2.2 all costs and expenses incurred by it in the installation removal, servicing, maintenance and repair of the Equipment at the Healthcare Premises;

6.2.3 all claims and liability arising by reason of any defect or fault in the Equipment or caused as a result of the defective workmanship of the Licensee; and

6.3 The Licensee will at its own expense obtain and maintain in force all licenses, permits and authorisations required for the operation of the System at the Healthcare Premises.

6.4 Subject to the consent of the Authority (which shall not be unreasonably withheld or delayed) the Licensee may use any suitable containment (cable trays, trunking and the like) located in the voids, which for the purpose of this Concession Agreement are the areas of space located in the vertical and horizontal plane immediately between the floors of the Healthcare Premises for the purpose of installing and thereafter maintaining any wiring and cables required for the operation of the System.

7 Specification And Improvements

7.1 The Licensee warrants that the Equipment and the System installed at the Premises comply with the Specifications shown in Schedule 1, subject to modifications thereof in respect of subsequent enhancements or alterations to the System, and will be maintained so as to ensure the continued operation of the System for the period of this Concession Agreement.

7.2 The Licensee will provide suitably qualified staff to install, operate and supervise the System at the Healthcare Premises. These staff will be instructed to comply with local Regulations and subject thereto the Licensee shall be responsible for all risk and liability incurred as a result of their activities during the course of their duties. The Authority shall supply to the Licensee up to date copies of the local Regulations and shall notify the Licensee of all amendments and modifications to the Regulations.

7.3 The representatives of the Licensee and the Authority will meet (at regular intervals) [specify here the agreed frequency of those formal meetings] for the purpose of reviewing any matters likely to be relevant in relation to the manufacture, development, use or promotion of the Equipment and the System.

7.4 The Licensee will free of charge, permit the Authority to use at least of one of the television channels available on the System to transmit material of any kind created and provided by or on behalf of the Authority or the NHS including but not limited to clinical information, health promotion, detail concerns the Authority or its staff, the NHS, education or Healthcare Premises. The Licensee will inform the Authority of any improvement by way of development enhancement or derivative of the System which would make the System more effective or economic and the Licensee shall at the request of the Authority incorporate such improvement in the System.

The Licensee shall make additional channels available to the Authority subject to availability and to agreeing the basis for charging (if any). The Authority will provide the Equipment at the Control Centre needed to transmit material provided by the Authority on such channels.(Optional to be the basis of local negotiations).

8 The Licensee's Liability And Insurance

In particular Condition 19 of the National License shall apply.

The Licensee will hold harmless the Authority its officers and employees from and against all liability for injury to or death of any person and for loss of or damage to property and all claims demands proceedings damages costs losses liabilities and expenses whatsoever resulting there from arising out of or in consequence of the operation and use of the Equipment and the System at the Healthcare Premises.

9 Intellectual Property

Condition 11 of the National License shall apply.

10 Period Of Concession Agreement

10.1 This Concession Agreement will come into force on the [*insert the implementation date here, words and numbers 200_*] and shall continue:-

10.1.1 for an initial period of [I*nsert the negotiated Concession Agreement period in years here words and numbers*] from the Implementation Date;

10.1.2 for a further period of [*insert the negotiated Concession Agreement period in years here, words and numbers*] years after the end of the said initial period if either party gives to the other written notice of more than 12 months before the expiry of the initial period that it wishes to extend the period of the Concession Agreement for such further period ("an extension notice") and that other party does not give written notice to the first party within 3 months after the extension notice that it does not wish to extend the period; and

10.1.3 shall continue after the end of the period specified in paragraph 10.1.1 or 10.1.2 above unless and until terminated by either party giving to the other not less than twelve [*insert the negotiated Concession Agreement period in months here, words and numbers*] months notice in writing.

10.2 If at any time the Licensee is required to alter the configuration of the System and/or to relocate Designated Locations as a result of any redevelopment of the Healthcare Premises or any other matters affecting the Healthcare Premises with the effect that at least one tenth of the total number of terminals at Designated Locations are inoperative, then The Licensee may give notice to the Authority that it wishes to extend the period of this Concession Agreement under Clause 10.1 by

the period in which the relevant number of terminals are inoperative but so that the extension of the period of this Concession Agreement shall not be greater, as a proportion of the total period of this Concession Agreement, than the proportionate reduction in the number of operative Designated Locations. [*the detail of this arrangement to be agreed at the start of the Concession Agreement and is for local negotiation*].

11 Effects Of Termination of the Concession Agreement

11.1 Upon the termination of this Concession Agreement Condition 22 of the National Licence shall apply.

11.2 The Authority shall forthwith cease to use, either directly or indirectly, the System and/or the Equipment and shall permit the Licensee to remove all Equipment and other property belonging to it at the Healthcare Premises (subject to making good any damage caused thereby).

11.3 The Authority may at its option purchase the cabling from the Licensee (or require the Licensee to sell the cabling to an incoming Licensee who will operate the Concession in its place either on expiry or termination of the present Concession Agreement with the Licensee). Other items of Equipment may be purchased by the Authority where this is agreed between the Authority and the Licensee . Schedule 1, Table A of this Concession Agreement sets out which items of Equipment are subject to this purchase option and the purchase price for the cabling and item of Equipment.

Include the details of the agreed Equipment and relevant write down values in Schedule 1 to this Concession Agreement.

11.4 Subject as provided in this clause 11 and except in respect of any accrued rights, neither party shall be under any further obligation to the other.

12 Notices And Service

12.1 Any notice or other information required or authorised by this Concession Agreement to be given by either party to the other shall be given by:-

12.1.1 delivering it by hand;

12.1.2 sending it by pre-registered first class post; or

12.1.3 sending it by facsimile transmission or comparable electronic means of communication;

to the other party at the address given in clause 12.4.

12.2 Any notice or information given by post in the manner provided by clause 12.1.2 which is not returned to the sender as undelivered shall be deemed to have been given on the seventh day after the envelope containing it was so posted; and proof that the envelope containing any such notice or information was properly addressed, pre-paid, registered and posted, and that it has not been so returned to the sender shall be sufficient evidence that the notice or information has been duly given.

12.3 Any notice or information sent by facsimile transmission or comparable means of communication shall be deemed to have been duly given on the date of transmission, provided that a confirming copy of it is sent as provided in clause 12.1.2 to the other party at the address given in clause 12.4 within 24 hours after transmission.

12.4 Service of any document for the purposes of any legal proceedings concerning or arising out of this Concession Agreement shall be effected by either party by causing it to be delivered to the other party at its registered or principal office, or to such other address as may be notified to it by the other party in writing from time to time.

13 Miscellaneous

13.1 Nothing in this Concession Agreement shall create, or be deemed to create, a partnership, or the relationship of principal and agent, between the parties.

13.2 This Concession Agreement and the National License contain the entire Concession Agreement between the Parties with respect to its subject matter and may not be modified except by an instrument in writing

signed by the duly authorised representatives of the Parties.

13.3 Each Party acknowledges that, in entering into this Concession Agreement, it does not rely on any representation, warranty or other provision except as expressly provided in this Concession Agreement, and all conditions, warranties or other terms implied by statute or common law are excluded to the fullest extent permitted by law.

13.4 No failure or delay by either Party in exercising any of its rights under this Concession Agreement shall be deemed to be a waiver of that right, and no waiver by either Party of a breach of any provision of this Concession Agreement shall be deemed to be a waiver of any subsequent breach of the same or any other provision.

13.5 Each Party shall from time to time (both during the continuance of this Concession Agreement and after its termination) do all such acts and execute all such documentation as may be reasonably necessary in order to give effect to the provisions of this Concession Agreement.

13.6 The Parties shall bear their own costs of and incidental to the preparation, execution and implementation of this Concession Agreement.

SCHEDULE 1

SPECIFICATION *(to be modified to reflect differences between Licensee's systems)*

The Licensee's System is an information, telecommunication and entertainment system, designed specifically for Healthcare Premises bedsides. The Licensee's service is provided to suitable beds and allows patients/visitors to enjoy both free and paid-for services of the System.

The equipment [I*nsert here details of all equipment which applies or modify this clause to suit the individual Licensees proposed equipment*], including the wall box, is of proprietary design and is manufactured by or on behalf of the Licensee. The remaining System parts, including the network and control room equipment are selected by the Licensee from major leaders in the communications industry. The supporting software listed in the Schedule is largely proprietary to the Licensee, written either by the company or by sub-contractors.

The complete System is provided and maintained by the Licensee.

Bed head Features

Each terminal includes the following facilities: *(these are examples only and the detail of the individual Licensee's system is to be inserted here)*

- Television (LCD or otherwise)
- Push button tone dialling telephone
- Answer phone
- Radio
- Smart card reader
- Directional speaker
- Headphones

The System provides a wide range of television and radio channels and transmissions all of which are compliant with the relevant standards applicable to advertising and other broadcasting regulations concerning content.

This section is also intended to describe the method of operation of the System and also the method and degree of charges.

Technical Compliance – Please seek the necessary Technical advice locally and from NHS Estates.

Compliance with British and international standards, known to be applicable to this type of equipment is as follows *(below are examples of what will be required to be specified, the individual Licensee will include the specification if his own particular equipment)*:-

- Bed head units used are classified as IT equipment and must be made to comply with BS EN 60-950 (1992)
- Bed head units and phone services must have approval from the British Approvals Board for Telecommunication (B.A.B.T.), (The Licensee certificate reference 503482)?
- Bed head units must comply with the Electricity Compatibility (EMC) EN 55022 and EN 50082-1.
- Telecommunication cables comply with cable specific CW1311, writing specification NS.9/23/L/10005.
- Bed head unit must be compliant with all relevant sections of CE legislation.

All electrical equipment is correctly rated and marked for connection to the UK electrical mains supply.

The patient arm mounted terminal contains the following low-voltage supplies, +6.6volts, -10 volts +12 volts DC.

All the electrical equipment is designed and manufactured to Electrical Class 1 Construction standards. None of the System located at any of the designed location required provision of any special clean mains power supply. Documentation relating to installation and BABT approvals is retained on site and available to the public on request.

User Information

The Licensee will provide various means to inform patients and visitors about the use of the System. This will include printed material, which is available in locations throughout the Healthcare Premises, dedicated instruction videos broadcast on the System and on-site information from the Licensee Staff.

Quality Assurance

The Licensee currently contracts with [*insert names of companies here]* companies for the manufacture of the terminal units. The companies are approved contractors under ISO900-2 Quality Assurance Scheme. Manufacturer accreditation details will be made available to the Authority on request.

The Control Room for the System [i*nsert here full details of the control room requirements and specifications*].

The Licensee expects to respond to requests for repair within [x] hours of reported fault**.** [I*nsert here what the number of hours expected is and indicate precisely whether this is response or repair; if only response detail here the guaranteed repair time is; also indicate whether this is working hours or 24 hour 7 day s etc*]

TABLE A.

Equipment Write Down Schedule

The following Equipment is that referred to in clause 11.1.2 of this Concession Agreement and clauses 9f) and 21a) of the Terms and Conditions of the National Licence.

Description of Item		Value at installation	Write down period in years	Write down per part or complete year.
Main distribution cables		£ 50 000	5	£10 000
		£		£
		£		£
[insert details of other Equipment (if any) as appropriate]				

Equipment Asset Register

TABLE B

[Tabulate here details of all Equipment provided by Licensee]

Software Provided by the Licensee

TABLE C

[*Tabulate details here*].

SCHEDULE 2

THE INSTALLATION PROGRAMME

This section is for the Licensee to set out details of the agreed Installation Programme with milestone dates.

SCHEDULE 3

CONTROL CENTRE *(If required by the Licensee).*

An area shall be identified within the Healthcare Premises that during the Installation Period will be converted into a suitable site for the following purposes relating to the concession:

1. Housing and servicing of the telephone switch equipment.
2. Housing and servicing of the television head-end to provide TV, radio and signals to the network.
3. Housing and servicing computer equipment.
4. Equipment testing function.
5. Equipment storage.
6. Administration services including cash handling / security. Including general office equipment.

These functions will be provided in a suite of rooms / single room [insert here approx X m² in area], consisting of the following that *must be / are not necessarily* located together:

1. Equipment area.
2. Test area.
3. Store area.
4. Managers office.
5. Area for Cash office
6. Other functions.

The control centre will be located in [*Insert here details of location and any specific requirements for the site of the control room*].

The control centre will be provided with mains electrical services [*insert here any building or engineering requirements such as heating and ventilation*].

The control centre will be constructed by converting and fitting out the suitable site with plasterboard partitions, suspended ceilings, doors & frames, carpeting & flooring and joinery fixtures. The area will also be provided with all necessary fire barriers, alarm systems and means of escapes required by the building and construction, Health & Safety and any other relevant legislation.

SCHEDULE 4

Schedule of Parts of Healthcare Premises to which this Concession applies.

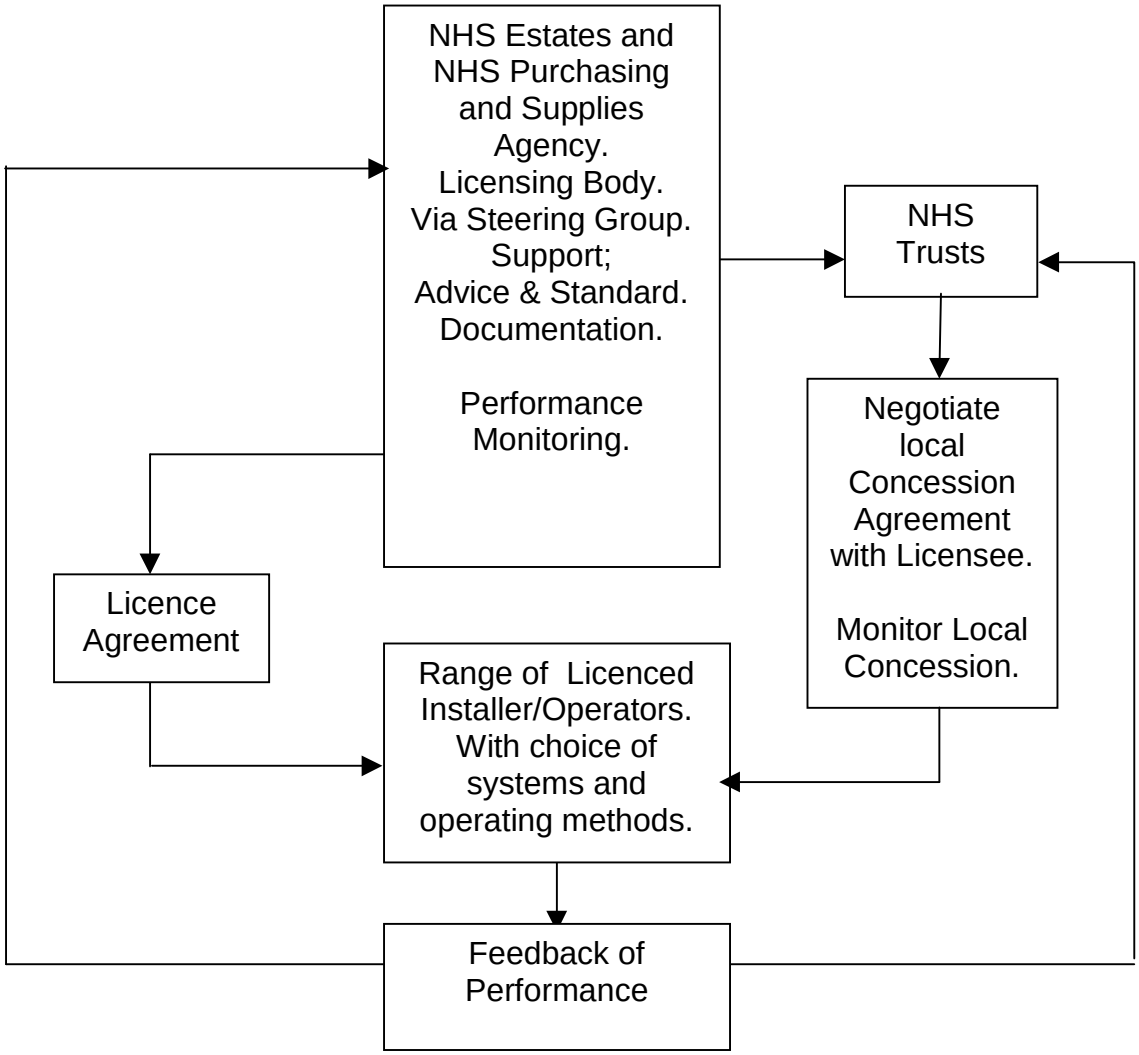
Reference	Name	Address / Location	Comments – Explain

Schedule of Parts of Healthcare Premises which are Specifically Excluded from this Concession.

Reference	Name	Address / Location	Comments

Any part of the Healthcare Premises not listed above may be added to this Schedule by Agreement

Diagram of Process



FREQUENTLY ASKED QUESTIONS

The following FAQs are divided into five sections:
Finance, Patient Focus, Technical, Compliance and Commercial

FINANCE

1. Question:
How will this be funded and by whom?

Answer*:*
The installation is to be funded by the Licensees.
a. There may be minimal exchanges of money for rent, electricity, emergency links to switchboard etc., but apart from that there should be no funding requirement from the Trust.
b. The only time monies should or could be paid to a Licensee from a Trust, is if there is a decision to use the Licensee's kit/wiring etc., for Trust purposes. Caution should be exercised when doing this so as not to change the nature of this as a concession agreement. A Trust purchasing services direct from the Licensee for health related purposes might mean that a formal procurement is required and there is also a possibility that a business case might be needed by the NHS Executive.
c. In the case of new builds (whether PFI or not) It would be expect the Trust to require the constructor to liase with their Patient Power Licensee in order to ensure that cabling etc is installed at build time (thereby saving money all round). Further PFI advice will be posted soon, however it is recommended that the Trust enter the concession agreement with the Licensee rather than the SPV.

2. Question:
Is there provision for extra funding should it be required?

Answer:
It is the Licensee's responsibility to fund the installation in total. If for any reason more funding were needed it would be the responsibility of the Licensee, NOT the Trust.

3. Q*uestion:*
Where a Trust has previously received commissions from the Pay Phone provider, how will this money be found under the new system of bedside TV and Telephony?

Answer
Revenue from all payphones is falling with the rise in mobiles and cell phones, so it is likely that even without Patient Power you may have had to find alternatives to your shortfall.
The remit of Patient Power in the NHS Plan is that TV and Telephones will be provided at the bedside at no cost to the Trust. Clearly the use of payphones will decrease with the installation of bedside equipment, and as a result rebate payments/commissions will be lower. There is no provision for Trusts from any central funding to make up this shortfall. The Trusts might still accept commission from non-patient bedside areas, either general circulation areas or areas such as residencies or private patient accommodation for TV telephone or other services. This should be subject to a separate agreement covering these specifically agreed areas and services. *Please note If Trusts had to make the capital investment themselves then they would have to allocate the capital (between 1500 & 3000 per bed) they would also need to find the capital charges.*

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PATIENT FOCUS

1. Question:
How easy will it be for Patients to use?

Answer:
Every endeavour has been made to ensure ease of use. User group representatives have been fully involved Licensees are continually evaluating and upgrading their products and making them easier to use.

2. Question:
How do we know what patients are interested in?

Answer:
We have done a survey of 4 hospitals, 308 patients and 65 members of staff at mature installations, if you have not seen a copy of this, an electronic copy is available on request from the NHS Estates Website.

3. Question:
How accessible will the systems be?

Answer
a. Ease of accessibility and readability for the patient and hospital staff has been a major consideration in awarding licences.
b. Where accessibility for ongoing repair and maintenance is concerned, this will need to be provided for in the contract specification via the Concession Agreement.

4. Question:
How much disruption is there likely to be to ward routine which could be dangerous to patients and staff?

Answer
The systems are built to be robust and meet all of the pre requisite quality standards. Installation schedules will be agreed by individual Trusts with the chosen Licensee to minimise disruption. Feedback from the installation survey indicates that the disruption is actually minimal. Copies of the installation survey are available on the NHS Web site.

5. Question
How much consideration was given to the Ligature Risk that might be increased by the introduction of Bedside TV and telephones?

Answer.
The steering group paid a great deal of attention to the risks that might be posed in a ward environment by the introduction of Bedside TV and Telephone. Suggestions were made to some of the provisional and full Licensees about the design of their units where risks were identified during the Concession Negotiation process.

However, it is up to each Trust to satisfy them that there is no additional risk to patient, staff and visitor from the installation of bedside TV and telephony.

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6. Question:
Will an agreed pricing model be built into the contract?

Answer.
Yes. Each of the Licensees and provisional Licensees has had to declare their pricing structure over the period of contract so the steering group has visibility of the proposals. This represents the maximum that the Licensees can charge.

There will be opportunities for negotiation on a local basis but this will depend on the individual contract.

7. Question:
Given the increased risk from MRSA and Hospital Acquired Infection, does the installation of equipment that will be used by dozens of patients in quick succession, not pose a bigger threat to patient's health?

Answer:
This has been considered by each of the Licensees. Some of the equipment is in wipe clean membranes which helps prevent germs harbouring in the equipment. Some Licensees are aiming to clean the equipment between each patient, whilst others are going to provide 'clean wipes' so a new patient arriving at a bedside, can clean their own system. This will then be supplemented by 'attended' cleaning as soon as possible afterwards.

7. Question:
How can a Trust 'manage' the resistance demonstrated by patient groups to the charges for using the equipment?

Answer
It is important that Trusts involve patients from the outset. Trusts that have already been through an installation recommend bringing patients onto the working party so that patients have a voice in the whole process.

Ensure that there is plenty if information and communication about the process in newsletters and posters, and possibly hold 'public' meetings in the hospital to inform the wider public about what is being done, and what the benefits will be.

8. *Question*
Will we have to take TVs out of the day rooms when we have 'Patient Power' installed?

Answer
No, there is no requirement to move TVs that are already in place in public areas.

TECHNICAL

1. Question:
Can we use the installed services to run EPR access at bed-head or other Trust activity?

Answer:
Yes, but possibly not immediately. The linking of the Patient Power network with that of the Trusts will cause security issues that must be addressed and resolved before this type of inter-connection is attempted. In addition, it is essential to note that, if a Trust starts to use the installed services to run EPR, it may be required to pay the supplier. This might well amount to a capital investment for which the NHS Executive would require a business case. In any event the NHS Information authority should be involved in the process to ensure that there are no back doors inadvertently created to the NHS Net and that appropriate firewalls and protocols are adopted.

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2. Question:
We have an extensive data network that is large enough and powerful enough to deliver these services. We have agreed a possible partial 'buy-back' from the network supplier who will then deliver the Patient Power services over the existing infrastructure. Presumably we can then deliver EPR directly to the bed-head?

Answer:
No, not automatically. Although the infrastructure is technically yours, the access methodology of the provider may well infringe your Security code of connection to NHSnet. Specific agreement from the NHS Information Authority Security Board must be sought and granted before this type of activity should be attempted. There are a huge number of issues around legality, technical, commercial and financial which make this a very unwise course of action.

3. Question:
Will it combine with current infrastructure?

Answer:
This will need to be established on a Trust by Trust basis and covered in the Concession Agreement which should clearly define all quality standards such as cat 5 cabling requirements.

4. Question:
Will non-technical personnel be able to assess the technical attributes of the options available?

Answer:
No. With the issues of the wiring and compatibility, it is assumed a technical person will need to be part of the commissioning team from Trusts looking to select a Licensee.

5. Question
Does the equipment meet all quality and safety standards?

Answer:
Yes all quality and safety standards will be met. The terms of the Licenses include these clauses.

6. Question
While I am keen to utilise the work being done nationally in this area I am concerned that the national picture seems to be limited or directed only at
TV and Phone, when clearly the future need is for integrated IT, TV and
phone to support EPR at the bedside as well as patient bed-head services.
At X Trust we have already undertaken a considerable amount of research into the provision of all three over an IP service. The technology products are available, the business cases (fully supplier funded) are available,
adequate quality VOIP is now proven for non-critical areas and Cat 5 cabling is the standard network.

Given the trust's commitment to EPR as well as bed-head services, I cannot envisage my Trust, or any trust with similar goals, entering into a
contract that would duplicate network cabling and bed-head devices.

So I am confused as to why when the Information for Health Strategy plans for EPR/IT at the bedside, that the bed-head services programme is apparently adopting a retro strategy?

Answer
The point about integrated "Bedside Communications &
Entertainment" and "EPR" is one that is commonly raised; however this is not the solution many Trusts wish.

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The Patient Power Steering Group readily accept that there are some Trusts for which an integrated solution may well be the best solution. The Steering Group has talked about this issue a number of times. If you think that an integrated solution is the correct one for you then you will need a full business case for your individual development and undertake a formal EU - OJEC procurement. There are also major issues to be resolved about system security and integrity if EPR is linked to Bedside C&E the NHS Information Authority are represented on the Patient Power Steering Group and have a number of concerns which are in the process of being addressed.

There are a number of companies who promise to deliver a fully integrated bedside service via Voice over IP, which not only delivers your EPR needs but also has the potential to deliver (but subject to the necessary bandwidth being available) the requirements of the NHS Plan in respect of Bedside Communication & Entertainment.

However, the companies who have made themselves known to us require a financial investment in infrastructure by the Trust and this takes it out of the terms of reference of the Patient Power project. Whereas all the licensed companies are prepared to provide the necessary capital and take on board the risks themselves for the Patient Entertainment and Communication System.

The main area of concern for NHS Estates is that by 2004 every major hospital should have Bedside C&E, if you can deliver this successfully through an integrated solution and provided that your proposal meet with the NHS Plan objective and time scale, then the approach would seem valid.

You will not be the only Trust who want to have an integrated solution and the Steering Group would be very keen to know a little more about your project so that we may be able to advise other Trusts who indicate that a similar solution is appropriate. If it is successful then I expect many Trusts will be able to benefit from the approach you are taking.

Trusts should be prudent in their approach and recognise that not all business cases receive approval or funding. In these circumstances Trusts should have a fall back position for meeting the requirements of the NHS plan. The most obvious “plan B” would be to agree a concession with a Patient Power Licensee.

Finally all of the Licensees are making plans to have the capability to work with Trusts in delivering an integrated solution and will be happy to discuss this with you if you would like.

7. Question
How much space will the Licensee need within the hospital for their equipment?

Answer
This varies from company to company, and each will specify their requirements depending on the size of your site and the remit of the installation. Typically, there is the need for a switch room, and some type of small office environment.

COMPLIANCE

1. Question
I am the Purchasing Manager at a Trust, and I am concerned about the procurement process needed to implement this system within our Trust. Could you please confirm that there would be no need for us to issue an OJEC advert as NHS Estates has already carried out the full procurement process in line with European guidelines.
My understanding is that, providing we use one of the licensed suppliers, the Trust will merely need to obtain proposals and implement a licensing agreement with the successful bidder. Is this correct?

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Answer:
Provided you go with Licensees for the Patient Power bedside project then you do not need to go to OJEC. Concessions are specifically exempted from the EU / OJEC - Ref CUP Guidance No 51 you could look it up on the Office of Government Commerce web site.

Although this is not subject to OJEC, NHS Estates have followed a formal procurement process for reasons of openness & probity and the DOH Legal department at each step has advised us.

In respect of process, you can invite the Licensees in to give you a talk and submit a proposal specific to your Trust. Then decide who you want to strike a deal with, keeping your options open of course until you have got the best deal you can. There are some standard terms and conditions, which go with this deal, which are with the Department of Health Solicitors at the moment. Part of the documentation is a model Concession Agreement that is designed to be flexible enough for Trusts to shape to suit local circumstances.
Mike Power from NHS PASA at Reading is the NHS Supplies representative on the Steering Group; he may also be of some help.
It is expected that these documents have been available in draft form since the end of January 2001. Copies are also posted on the NHS Estates website.

2. Question:
What is the difference between Full and Provisional Licensees?

Answer:
There will be 2 classes of licence, Full and Provisional. The Full licence allows Licensees to approach any Trust with their full product. The Provisional will allow the development of a Pilot (Or Pilots) at designated sites. Provisional Licensees at pilot sites will then be free to approach the Steering Group when they think they are ready for a full Licence. They will then be invited to submit a full proposal and this will be assessed with a view to upgrading to a full Licence.

3. Question:
I have recently been asked to take the lead for the Regional Office to ensure that the NHS Plan requirements in regard to the installation of Patients Bedside television and telephone systems are implemented in the PFI schemes in our region. I am not yet up to speed on the details of this initiative but my understanding is as follows:
The NHS Plan (Section 4.20) requires Bedside Televisions and telephones to be available in every major hospital by 2004 and that a contract for these services was to be let.
PFI schemes were required to use licensed suppliers and as of 18/12/00 there were three full license holders with another 4 provisional licence holders.
A note from NHS Estates to PFU unit on 16/11/00 states that PFI hospitals must only use licensed operators.

Answer:
Yes the principles are correct, and the note from NHS Estates that you mention has been forwarded by the PFI Unit in Quarry House to NHS Executive Regional Offices, but we are seeking further discussion with the PFI unit so that further advice can be given.

If a Trust feel they are justified in taking another course of action or using an un-licensed supplier then our advice would be to submit a case of need to NHS Estates with a copy to the Regional Office. This process to include bedside entertainment and communications in parallel should be straightforward given the quite lengthy PFI/major project development time scales.

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It should be noted, incidentally, that the Patient Power requirements apply equally to all major hospitals, old or new, PFI-funded or otherwise.

The Licensees are very much aware of the PFI situation and may be happy to install into your existing situation with a view in future to transferring their system to the new buildings at the appropriate time.

4. Question:
Our Trust is looking to ensure that it can meet the NHS Plan target for the introduction of TV and Telephone systems at the bedside before 2004.
We have a framework agreement with IT operator (Not currently a Licensee) and we have been working with them to develop a single multi media infrastructure that is capable of supporting EPR level 6 and the provision of bed-head entertainment services. We expect to start piloting the Bed-head Services in 2001.
I would be grateful if you could confirm that as long as we are able to meet the NHS plan target for the provision of the bed-head services we can continue working with the operator on the implementation of the infrastructure for EPR level 6 and the Bed-head Services.

Answer:
The Patient Power steering group have discussed this issue and the position is as follows. Trusts who wish to provide bedside entertainment and communication as an integrated service are to follow the normal business planning and business case guidance.

The Patient Power project is exempt from EU procurement regarding OJEC because concessions themselves are exempt. However a Trust, which purchases services directly from the operator, may not be exempt.
What your trust is charged with delivering in respect of Patient Power is to deliver patient bedside Communications and entertainment by 2004. However all the Patient Power Licensees will provide the capital and will operate their systems thus reducing the need for Trusts to input capital and minimising or eliminating the operational risk.

The Licensees are very keen to help Trusts in the area of EPR etc and you may find that they are worth contacting in this respect.

NHS Estates still have the duty to inform Ministers on progress against the NHS Plan on this issue and will need you to keep us informed of your plan in respect of the bedside services aspect of your project.

Members of the Patient Power Steering Group have expressed an interest in the progress of this type of project and I am sure that should it be successful other Trusts who are following a similar path may be interested to learn any lessons from your project.

Finally you need to consider the a possibility that the Unlicensed company proposal does not deliver a satisfactory bedside solution and it would be prudent for you have a fallback position for meeting the NHS Plan (presumably this would be to use a Licensee of the Patient Power project).

5. Question:
With reference to the questionnaire, can you please clarify what is regarded as "meeting the requirement"
Is this access to a phone, albeit a cordless phone shared by a ward, or an individual phone at each bedside?
With television, is the requirement for a separate TV for each bed, or for each bed to have ability to watch TV, albeit shared with other beds in a ward / bay.

Answer:
The intention of the NHS Plan is to have bedside TV and Telephone rather than communal facilities so it would be difficult to envisage a situation where shared facilities as you indicate would meet this in a major hospital.

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6. Question:
We are keen to move toward an installation of the above but had been holding on before starting awaiting the outcome of what I believed was to be a tendering of the various providers. However the recent CEO letter from Kate Priestley now only talks about licensed suppliers. Is this how we are now to proceed or is there to be a competitive tender?

Answer:
This service is a concession as defined in Government Procurement Guidance (CUP 51). Concessions are specifically excluded from EU procurement. However as good practice NHS Estates have been through a procurement process and have selected the Licensees on the basis of what they have put forward and previous experience against a clear set of criteria.
In short you have the flexibility to approach any of the Licensees and
strike up a deal with one of them using standard terms and conditions, which are at the moment being finalised.
It might be helpful to invite them all to give you their proposals for
your site and select the company you feel best suits your local circumstances. Provided you have rational reasons for selection then you do not need to undertake any further procurement.
The National License Conditions come with a Model Concession Agreement. This is an agreement between the Trust and the Licensee for the Licensee to deliver services on your site. The Model Concession Agreement is designed to be modified by Local Trusts to cover individual Local circumstances.

7. Question:
In response to the memo received from Kate Priestley at NHS Estates my concerns are as follows:

1. We are not a major hospital.
2. We have a low number of beds (dispersed sites)
3. Care plans for our clientele relies more on social activities e.g. day rooms etc.
4. Installation would be uneconomical (due to 2 above)
5. Having televisions and telephones in bedrooms introduces new Health and Safety Risks for our clientele (current technology does not offer a sufficiently robust system)
6. There would be a high maintenance cost associated with the upkeep of the equipment.

These points suggest that the benefits would be minimal compared to the costs and associated risks. Hence, can you advise on the implementation of this part of the NHS Plan at X Priority Care?
NB. We are Mental Health and Community, approximately 238 beds, across 12 sites.

Answer:

The line of reasoning in respect of your Trust is reasonable. It does not look as if this section of the NHS Plan was set up for your kind of clientele. However some Trusts of this type would quite like to consider various patient groups (often on an acute site) to benefit from this. They will be talking to the acute Trust with a view to participating with them in the project.

The Patient Power project is targeted at Major hospitals. Although these are not defined in the NHS Plan in the vast majority of cases community services and services for mental illness and learning difficulties fall outside this description.
Additionally the feedback from Trusts of this genre is that a policy
of phones and TVs at the side of the bed would run counter to their
therapeutic regime, in that they are in many cases trying to get patients to
socially interact and bedside TV would be negative in this respect. In

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addition because this is a commercial service the number of beds needed for an investment at the hospital is likely to be in excess of the total capacity of smaller Trusts.

The situation is likely to be similar at the special hospitals e.g. Broadmoor, additionally there are also material security issues about having bedside email, telephone etc. Although it may be outside of the formal NHS Plan requirement the hospital management wished to consider an installation but this would be purely a matter for them and they should approach a Licensed provider in the same way as any other hospital.

8. Question:
Can you tell me the status of the Licensee, as they are one of the bidders for our upcoming PFI? Would their licence allow them to work with us, or is it just for previously nominated Trusts?

Answer:
Full or Provisional Licensees can work together with you to do this. For Provisional Licensees your Trust would be a named Trust and when the project is successful for you both then they may be upgraded to a full licensee.
There would need to be a Concession Agreement between you and the Licensee at some stage for the provision of the Patient Power services. ***[NOTE: This makes it clear that the concession agreement referred to here is for Patient Power and is not the entirely separate concession arrangement entered into for a PFI build scheme].*** As long as you are a named Trust on the Form of Agreement for Provisional Licensees between NHS Estates and the Provisional Licensee then we foresee no major impediments to this.

9. Question:
Do all parties understand what a Concessionary Licence agreement means and its legal requirements?

Answer:
The Concessionary Licence has been awarded in recognition that the supplier has met all of the Patient Power advert requirements to install, support and maintain this particular solution in the NHS.

10. Question:
We already have a contract for payphone services that does not end until 2006, will we get anyone to put just the TV side of Patient Power in for us without the payphone revenue?

Answer:
It may be worth asking the incumbent supplier to enter into negotiations with the potential licensed supplier. Failing this, the other services provided under Patient Power may well make it financially viable for another supplier to provide a service within your Trust.

11. Question:
We are exploring the possibility of providing this service 'in-house'. Are we allowed to do this and can we recoup any of the costs from the DoH?

Answer:
The government made it clear that the preferred route for Patient Power services was through the provision of services from other organisations than the NHS. No funding has been agreed so any costs incurred by the Trust would not be met by the DoH. (See Question 2 in the Technical section).

12. Question:
How are Trusts meant to monitor the performance of the Licensee once the contract is up and running?

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Answer.
It will be the responsibility of each Trust to establish regular review meetings between themselves and the Licensees. It is recommended that in addition to Estates, Facilities, Nursing and The Board a representative from the Patient Group is included.

The Licensee will be able to produce a performance report on a daily, weekly or monthly basis that identifies system down time, specific problems with units etc. The survey undertaken by NHS Estates of 308 patients and 65 staff might provide a useful as a benchmark for future monitoring.

13. Question:
If the government requires all 'major' hospitals to comply with the installation of TV and telephones by 2004, will the three Licensees be able to meet the demand?

Answer.
During the evaluation process the steering group looked at the Trusts/Regions that each tenderer is hoping to secure. The pro formas that were sent out to each Trust with the letter from Kate Priestley in December are being used to map out the installation programme in order to deliver against the NHS Plan.

In addition, it is hoped that the Provisional Licensees will be awarded Full Licenses as a result of the work they are doing on the nominated test sites, which will increase the number of Licensees able to carry out this work.

Also a further advertisement seeking interested parties to tender for the second tranche of Licensees has already been issued, and further expressions of interest have already been received. These will be evaluated over the next few months, and successful licensees will be confirmed probably by the end of the summer.

14. Question
What is the difference between a licensee and a provisional licensee?

Answer
Licensees can approach any trust with a view to discussing installation, and enter commercial negotiations. Provisional Licensees have to nominate the trust with whom they have agreed a concession and also agree written criteria for success with the Trust. Once this has been up and running for a period of time, and the Provisional Licensee feels that they can demonstrate security, safety and full compliance with all aspects of the the Patient Power agreement, and have the support of the Trust they can apply to the Steering Group for Full Licence status.

COMMERCIAL

1. Question:
What about smaller Trusts, is it uneconomical at the moment?

Answer:
One Licensee indicates it may get as low as 100 -150 beds to be viable. However bed numbers can be a bit misleading because a lot depends on the capital cost to install at each site and every site is of course different. Trusts are also encouraged to work together towards a joint Concession.

2. Question
Can a Trust get comparison data on all the Licensees and Provisional Licensees call charges?

Answer
This is commercially sensitive information and will not be published, but is available by talking to each individual operator. Each Licensee will provide you with their information as part of their proposal. NHS Estates would be happy (on request) to confirm to the Trust that the proposal is within the parameters of the original charge limits.

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3. Question
How long does it take from signing the contract to installation being completed?

Answer
This varies from Trust to Trust, and what other pressures the Trust may be experiencing. Some installations require ward bays to be decanted, whilst others do not.

To try to get a realistic picture of timing, it would be worth discussing installation with other Trusts who have already completed the process. See also the installation survey available on the NHS Estates Web page.

4. Question:
Will all providers sign the same licence contract with no caveats?

Answer:
There will be a common National Agreement with all providers, and individual concession agreements will be drawn up if necessary to cover any local variations.

5. Question:
How will supplier performance be measured and how will this information be consolidated and reviewed?

Answer:
Performance management will be covered in the concession agreements. The National Licence will set out minimum criteria in key performance areas.

It is recommended that the Trust establish a regular review meeting format where the Trust and Licensee meet to discuss any issues. The Patient Power Steering Group aims to collate feedback from installed Trusts, and make information and performance issues available for other Trusts.

6. Question:
Are the systems fully compliant, interchangeable and portable with other TV and telephony systems providers? And do they need to be?

Answer:
They will not be compliant, and they do not need to be, as they will be stand-alone systems. There is no requirement for the system to work with a system already installed, like the hospital LAN or WAN.

7. Question:
Will there be a service level agreement between the user and the provider setting out the minimum levels of performance to be met?

Answer:
It is unlikely that any provider will enter into a formal service level agreement with an individual user (i.e. patient), but they will be expected to compensate users if they fail to deliver to publicised levels of service.

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Hospital	Role of the respondent	Previous situation	How it was decided to install the system	Contract
A	The respondent is now Facilities Operations and Contracts manager.	Before they had TVs on trolleys, which got in the way of staff.	The respondent felt that having a telephone was very important to patients when they are first in hospital. The TV becomes useful once patients have been in for a couple of days. Therefore, he feels the TV is secondary to the phone – he was impressed that the system provided both services. The respondent persuaded the Chief Executive to go to other hospitals to see the system. The Chief Executive like what he saw – the only complaint was that the screen was too small. From then on, the Chief Executive led the way forward with the project.	The main concern at the contract stage was that there should be no cost incurred to the Trust and that the system operator would be responsible for the upkeep of the system e.g. cleanliness, maintenance. The system operator did not want to install units into geriatric wards, or wards with elderly patients. The Trust paid for a few units to be installed in such wards. The hospital still has TV in day rooms – except there is not many of these left. It was agreed that some communal public TVs would remain in special sections of wards. Some patients would also still be able to bring in their own TVs.
B	The respondent is now Estates Manager at another hospital. At the time of installation, he was Assistant Estates Manager, responsible for overseeing the project and sorting out contractual requirements. Note: the respondent didn't remember much about the installation.	The hospital had an old Thorn-EMI system for rental TV. However Thorn sold the contract on to a company who didn't have the infrastructure to maintain the system. They used terrestrial TV and weren't prepared to invest and spread TV into wards. Some wards had plenty of TVs and videos and didn't want to change to a new system.	The respondent saw the system in other hospitals and decided to look into it.	The hospital was concerned about a company coming in and wanting to do the installation quicker than the hospital did. As freeing up of beds would be a difficult and gradual process, the contractors would need to be flexible about when they worked.

Hospital	Role of the respondent	Previous situation	How it was decided to install the system	Contract
C	The respondent was Director of Estates during the installation. He co-ordinated and chaired meetings.	The hospital had ward TV, which is still present in day rooms	The respondent received a mail shot and then contacted the current Managing Director of the system. He said he'd done some previous sites and was looking for a small site with 500 beds to carry out an installation. He wanted an easy installation –the hospital was a good candidate in terms of layout and location. In Sep 97 the respondent met with the Chief Executive who wasn't sure of the system at first. It was also put to the medical practitioners and the to Community Health Council before it was decided to go ahead to the with the system. The case was presented to the Trust board in public. The Trust decided to go forward - one trust board member said it was a good idea as it would be good for patients, although some were worried about the cost to patients. Key personnel were invited to visit other sites (mostly senior sisters, an estates officer, director of operations and nurse managers).	The respondent did not mention any aspect of the contract.
D	Respondent is now Facilities Manager. He was Commercial Manager at the time of installation. He championed the whole installation process.	League of Friends bought TVs to put into wards but this caused a continuous problem. TV's were problematic to maintain as many of them were old. Also, there was only one telephone per 20-30 beds on wards. Patients could not receive incoming calls.	Respondent had heard of the system when it was still very new. After a visit to another hospital which already had the system installed, he decided he liked it and convinced the trust to go ahead with it. He put a business case to the trust and met with them on a couple of occasions. It took 6 months to get them the trust to approve it. There was resistance from the board as some didn't want to take away ward TV. Prior to going ahead with the system, nursing staff also visited this other hospital to have a look at the system They also thought the system was a good idea.	As not many installations had been done at that time, the system operator was quite keen to get the hospital on board, so the hospital was in a strong negotiating position. The respondent felt the contract that the system operator offered was biased towards them, e.g. inadequate service spec, quality standards and deliverables. In the final contract, it was agreed the system operator was to pay for the units to be tested as the hospital was worried about electrical faults. The system operator was also to pay rent for the control room and pay for the electricity they used. Basically all costs to install and run the system were absorbed by the system operator. Another point of contention was repairs –the system operator agreed to pay for these. The respondent also asked the system operator to put in a bond of £10,000, in case they went into liquidation and couldn't finish the work. Then the hospital could then complete the work without any further penalty.

Commentary of depth interviews

Hospital	Negotiations prior to installation	Communication of the installation	How the installation process took place	Worries / Problems / difficulties
A	The respondent, the Chief Executive, Director of Facilities, and Senior Nursing officer were involved in the pre-installation process. The system operator was very professional and surveyed the hospital in order to plan the installation. They also communicated with the Estates Office about access etc.. The system operator originally wanted to install quicker than the hospital wanted to. It was agreed to close sections, not whole wards. Staff wanted to know what services would be available to patients, how services would be sold to patients and how patients would access the system.	Staff were consulted prior to installation, which included a demonstration of the system by the system operator. Staff were told how wards were going to be shut down. Staff were quite keen – some wanted to 'get in there before the others' and have the units installed in their wards first.	In some wards, installation was just not practical as the ward walls were not strong enough. These wards still have ward TV. 25 wards were done in 5 or 6 months. It would have been very difficult to run the installation smoothly if the business managers had not been keen on the system. Lots of different contractors were used - no problems were experienced. The installation was no more disruptive than expected and worked well. It was "A joy to do it".	Foresaw a problem with the cost of incoming calls – still a source of complaint but there seems to be no solution as the system operator has to pay to use the telephone cables. Also, availability of system operator staff – information does not get to switchboard / Call Centre when numbers change – so relatives don't always get through to the right person.
B	There was Trust committee set-up which had representatives from nursing staff and core hospital personnel.	The committee stayed together throughout the installation. The respondent had regular meetings with Bed Managers. The Trust did Roadshows before and during the installation. The system operator were good at letting wards know about the installation. They bought in a manager from another site to oversee the installation until the hospital had its own system site manager.	The installation was supposed to take 6-7 months from the start of the contract to the completed installation The installation took a bit longer than this. This was all about 2 years ago. The control room was done first and then the main wiring was done. This went smoothly. The contractors were told not to go into the hospitals main electrical boards. They then did the spine corridors before moving onto the wards. Corridors were done separately. The contractors got better as they went along. The hospital was quite particular about how they put the system in. The system operator wanted to free up 6-8 beds per day but the hospital couldn't do this.	The hospital was worried about electrics. All electrical work was to be inspected by an outside regulator, which the system operator paid for. The system operator wanted to be selective about where to install the units. They didn't want to put them in elderly wards whereas the hospital did. The respondent didn't think that the system operator was as good once the units were installed, i.e. system operator staff did not concentrate on advising staff of how the system works. System operator staff should have been present in each new ward every day during the installation process to support ward staff. Contractors were not as flexible as they could have been, but this was to do with the fact that the contractors were not warned that it would be as slow a process and that flexibility was needed. The respondent felt he had to check up on contractors when they were working.

Hospital	Negotiations prior to installation	Communication of the installation	How the installation process took place	Worries / Problems / difficulties
C	The implementation plan was devised by the respondent, the Clinical Directors and Clinical Managers. Estates worked closely with contractors. The hospital thought the telephone was a very valuable asset and would be a comfort to the patient as it gave them the ability to communicate.	The hospital had a video about the system which could be shown to staff. Communicating the installation was carried out via internal hospital systems and Directorate and Nurse Managers. The system operator would just go and see the Sister before moving into wards.	The installation took over one and a half times longer than expected. The installation was a flexible process and the plan kept changing –the hospital couldn't open some wards when planned. No beds were shut beds down when working in corridors. The hospital did other essential maintenance work at the same time as the installation. They therefore needed to co-ordinate with decorating, plastering and building work. Installation was not disruptive to wards but impacted on management time.	Nursing staff were concerned about the ability of some patients to operate the units. There was some opposition from staff in elderly wards. Units were actually taken out of some areas and replaced with ordinary TVs. In 2 wards (out of 48), staff were not keen on the system – they did not think that patients should pay. The hospital was worried that some patients would be embarrassed as they wouldn't be able to afford to use the system – this was overcome by the card donation system. Staff were also worried about how the units would look in the wards and how they would be positioned. Some pieces of trunking had to be done – would this be done neatly? Would they get in the way of them doing their job and be intrusive to their daily work? Problems arise now when the hospital has to move beds – The units tie down the beds to a centralised position. However, the respondent felt that 'Whatever we ask for, the system operator deals with'.
D	The respondent felt that the implementation plan put forward by the system operator would be difficult. The hospital was worried about the safety of the units – especially the electrics. The hospital selected a contractor from their approved contractor list to do all the electrics and bed heads. The hospital thought it was good that they could do away with ward TV, and that patients could have a personal phone. It was decided not to install units in children's or elderly wards.	A report was circulated to Clinical Directors which explained how the installation would work and how they would liaise with the wards. Senior nursing staff were also spoken to. Some nursing staff already knew about the system after visiting other sites which already had the system. System operator personnel were on site during the whole installation – a site manager was there who liaised between the contractors and the wards.	The installation was supposed to take 4-5 months from when the contract started. However, it took one and a half times longer than expected as the hospital couldn't free up the beds. The control room was fitted first. It took 2 months to do the switchboard and the spine corridors. Installing the units in wards was the slow process but this got faster as contractors got used to the process. Problems came with planning how to free up beds. Once they had accepted the process, the staff were OK.	Units dropped down from the walls when they were first installed. However, none have fallen down in the last 3 years. Again, the main problem was freeing up beds so the units could be installed. The hospital staff were worried about the cost of incoming calls. Even now, people call in to patients not realising how much it costs them.

	What went particularly well	**Most difficult part of the process**	**What they would've done differently**	**Tips / Comments**
A	Planning details that the system operator did –They were commended. The respondent felt the telephone system was very good and beneficial to patients.	The initial installation meeting was difficult – in particular, negotiating the rate of ward closures. The system operator wanted to close wards more quickly than the hospital.	Nothing mentioned	Choice of TV payment cards is confusing to patients. 'I'm a great fan of the system' -to be able to phone patients – the respondent was very keen on this.
B	Contractors worked weekends with no extra cost to the Trust. Once they got an area, they worked quickly to install the units.	Most difficult part: freeing up beds. Need to work closely with Bed Managers.	Installation could have been done better by combining installations more frequently with ward refits – combine installation with long term hospital plans.	Be wary as the system operator wanted to install quickly to get their money back on the units. Make sure the installation is completely separate from hospital systems. e.g. use colored cables with the system operators name written on them.
C	One main contractor was used to do the work. Rapport between contractor and hospital staff was good. This helped with the installation process.	Freeing up of beds was the most difficult part of the process. Once contractors got into wards, the work was done quickly.	Ideally, install when the hospital is already doing a new development.	System operator payphones were taking profit away from the hospital, so after installation, it was agreed that the system operator was to pay the hospital a rental based on what the hospital was taking. 'Do a sensible program of installation' 'Once you've decided to go for the system, tread on anyone who is being negative. Be alert to opposition and have a good positive response prepared'.
D	Contractors got faster as they went along and got used to the installation process.	Freeing up beds so that the units could be installed onto wards.	Organise the release of beds on a sequential basis and help the contractors more so they know when they are working.	Organise release of beds on a sequential basis. Help the contractors more so they are not expecting to work when they are not needed.

Patient bedside entertainment and communication system
Report of quantitative research
September 2000
Draft Report Edited for Circulation to Tenderers.

Note
Some small sections of this report have been removed for commercial reasons.

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1 Introduction

NHS Estates has commissioned research to find out about bedside entertainment and communication systems in hospitals. The study focused on finding out what the important issues are which need to be addressed both from the users point of view and that of staff who have to work alongside these systems. This information is intended to aid the smooth installation and running of bedside systems in hospitals. The study offers a clear overview of the issues needed to develop bedside entertainment systems.

Research was conducted amongst staff and patients in a number of hospitals in England. A combined quantitative and qualitative study was commissioned. This report is based on the quantitative findings of the study aimed to define the relevant issues amongst patients who use the system and front line staff, such as doctors and nurses who work alongside the systems. The qualitative aspect of the research was undertaken amongst Senior Management and was used to find out about the negotiation and management of the installation process. This is reported on elsewhere.

2 Management Summary

BMRB, on behalf NHS Estates conducted research to find out about bedside entertainment and communication systems in hospitals. This research focused on finding out what the important issues are which need to be addressed both from the users point of view and that of staff who have to work alongside these systems. This report looks at the quantitative findings of a patient and staff survey conducted in a number of hospitals in England.

2.1 Patient Survey

The majority of patients interviewed were satisfied by the service the system offered them. Many of them found it easy to use and were generally positive about the system.

Patients tended to say they used the system most often for making outgoing phone calls. The fact that they can make phone calls without having to ask a member of staff to help was the most important reason cited for using the system. They also used it a lot for receiving incoming calls, watching TV and listening to the radio. Younger people were likely to have watched the cinema channel. When asked about possible services that could be offered in the future, the most popular were a meal ordering service and films on demand.

Perceptions of the system were generally good. Many thought the system was better than other TVs and phones in hospitals.

Few patients said others using this system had disturbed them, although one in five patients did say that other people watching TV or listening to radio had disturbed them.

Although many patients thought the system was good value for money, there were certain things they felt were expensive.

2.2 Staff survey

As with patients, the majority of staff are satisfied by the service the system offers to patients. However, they were less likely than patients to feel that the system offered good value for money.

Staff felt that the most important benefit of the system was that patients can make and receive phone calls without asking a member of staff to help. The low amount of noise created on wards compared to having ward TV was also an important benefit for them. However, they were more likely than patients to say that the use of the system disturbed other patients.

With regards to future use of the system for staff, some felt that they would not feel comfortable using the system for any of the things suggested to them. However, over half were comfortable with the idea of using the system for scheduling future appointments and accessing general hospital information.

Most staff were aware of the credit donation system and most had not experienced any problems with it.

3 Research Method

The quantitative research was carried out amongst patients and staff in a number of hospitals in England. These hospitals were selected as they had had the system installed for some time and the system was therefore relatively well established. Development visits by BMRB research staff were carried out in each of the hospitals in mid August 2000 and interviews with patients and staff were conducted in late August 2000. Interviews were conducted by BMRB interviewers using a questionnaire programmed onto a laptop computer. This questionnaire is appended. All interviewers were from BMRB's full trained and supervised field-force, and worked in accordance with the Market Research Society's Code of Conduct. Interviews took place causing as little disruption as possible to hospitals.

In total, 308 interviews were conducted with patients and 65 interviews were conducted with staff. Table 1a shows the number of interviews achieved.

Table 3a: Number of interviews achieved

	Patient interviews	Staff interviews
Total	308	65

The interviews took place in a one week period in pre-selected wards in. The patient and staff questionnaires were administered by CAPI (Computer Aided Personal Interviewing), using a laptop computer. Questions appear on the computer screen and answers are keyed directly into the computer. The patient interviews lasted 10-20 minutes, whilst the staff interviews lasted 5-10 minutes.

For patients, interviews took place at their bedsides. Interviewers were conducted in as much privacy as possible with interviewers taking measures such as drawing curtains around patients' beds. Staff interviews were conducted in the same pre-selected wards as patient interviews. When interviewers arrived on wards, they identified member(s) of staff to be interviewed and arranged a time for the interview to take place on that day. If there was a private room available staff interviews took place there, else in as much privacy as possible.

3.1 Development Visits

Prior to conducting the interviews themselves, BMRB research staff conducted development visits at each of the hospitals. The purpose of these visits was to publicise the survey within hospitals, to select wards to take part in the study and to find out about how the system worked in each of the hospitals. The development visits were also a good opportunity for BMRB to meet with the system operator staff and hospital management to discuss the survey and to address any worries or concerns.

3.2 Who we interviewed

The research aimed to interview a sample of patients and staff from the hospitals. With patients, we attempted to interview a sample from each hospital that represented the patients that were in that hospital during the fieldwork period. There were certain types of patients and staff who were not available for interview, for example those who were too unwell, or who were undergoing medical procedures at the time of the survey. BMRB interviewers visited pre-selected wards on appointed days and conducted interviews with patients and staff on the ward.

3.2.1 Ward Selection

In each hospital, a minimum of eight wards were selected to take part in the survey. The wards were selected by BMRB research staff, working in consultation with system operator staff and hospital trust staff. Firstly, from a list of all wards in each hospital, wards in which we would not be able to conduct interviews in were excluded – this included intensive care, isolation, and children's wards. Those wards which only included a small number of system units were also excluded, or two wards combined to make one interviewer assignment. Any wards with patients who would generally be too sick to be interviewed, or very low system take-up (such as Geriatrics) were also excluded.

From the list of remaining wards, a minimum of 8 wards were selected per hospital. Table 3b shows which wards patients and staff were interviewed in.

Table 3b: Ward type
Base: All Patients and staff (373)

	Patients (308) %	**Staff (65) %**
Orthopaedic	17	12
General Medicine	17	29
Maternity	13	12
Surgery	11	11
Gynaecology	8	8
Neurology	6	8
Head Injuries	4	0
Oncology	4	3
Thorasic	3	3
Rheumatology	2	0
Elderly	2	0
Gastro	2	0
Respiratory	1	2
Other	5	6

A spread of wards were selected according to ward type and patient type. Suitable times were selected for interviewers to conduct the interviews in wards, avoiding meal and rest periods. Selected wards were notified prior to the interview visits and were given an information sheet about the study.

3.2.2 How Patients were selected

On arrival on the wards interviewers made a record of all the patients in that ward with the help of a member of staff. They recorded the age and gender of patients as well as making a note of whether they were registered with the bedside system. Interviewers also consulted staff to find out if there were any patients that should not be approached for an interview, usually because they were to sick or distressed.

From this list of patients, the interviewer excluded those who were not eligible to be interviewed - those under 16, too ill to be interviewed or not registered with the system - and picked a random sample of the remaining patients. These patients were then approached for interview.

3.2.3 How staff were selected

In addition to the views of patients, the research aimed to find out about the views of staff who work in hospitals alongside the system. Staff working on the selected wards were approached for interview. On each ward, interviewers attempted to speak to one doctor and one nurse or other member of support staff arranging a suitable time and place to conduct those interviews.

3.3 Profile of respondents

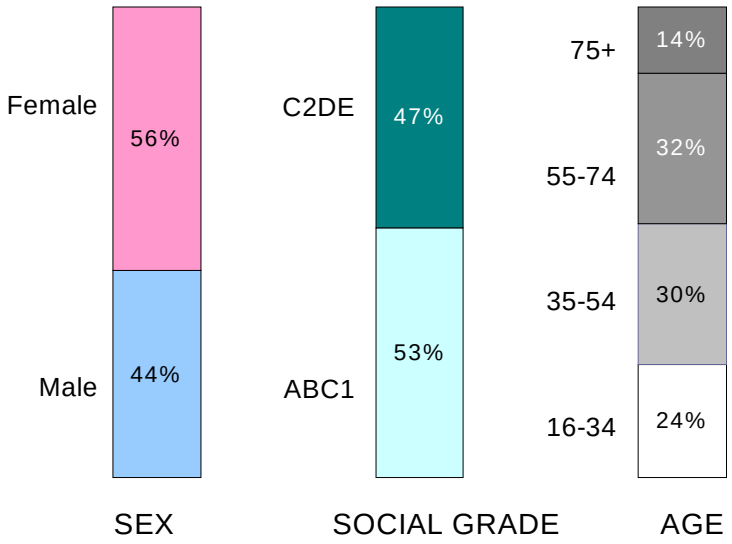
The research aimed to interview a representative sample of system users. This section details the profile of those interviewed.

3.3.1 Patients

Chart 3a shows the sex, age and social grade profile of patients that were interviewed. Of the 308 patients that were interviewed, nearly three fifths (56%) were women and over two fifths (44%) were men. Just under a quarter (24%) of patients were aged 16-34, whilst just under a third (30%) were aged 35-54. Almost half of patients (48%) were aged 55 or over, with just under a third (32%) aged 55-74 and one in seven (14%) aged over 75.

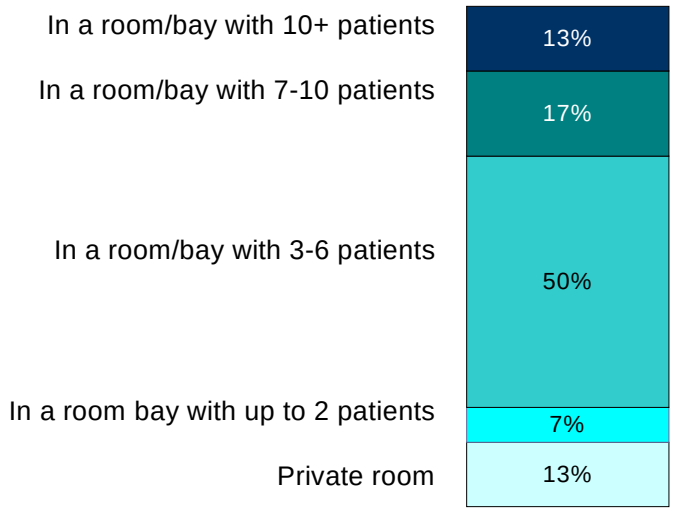
In terms of social grade, just under half (47%) were of social grade ABC1 whilst just over half (53%) were C2DE's.

Chart 3a: Sex, age and Social Grade of patients
Base: All Patients (308)



The set-up of the ward in which patients were in was also recorded. Chart 3b shows what kinds of wards patients were in, in terms of how many other patients were in the same room/bay. One in seven (13%) of patients interviewed were staying in a private room. Over half of patients (57%) were in a room/bay with up to six other patients whilst three out of ten patients were in a room/bay with seven or more other patients.

Chart 3b: Ward Set-up
Base: All Patients (308)



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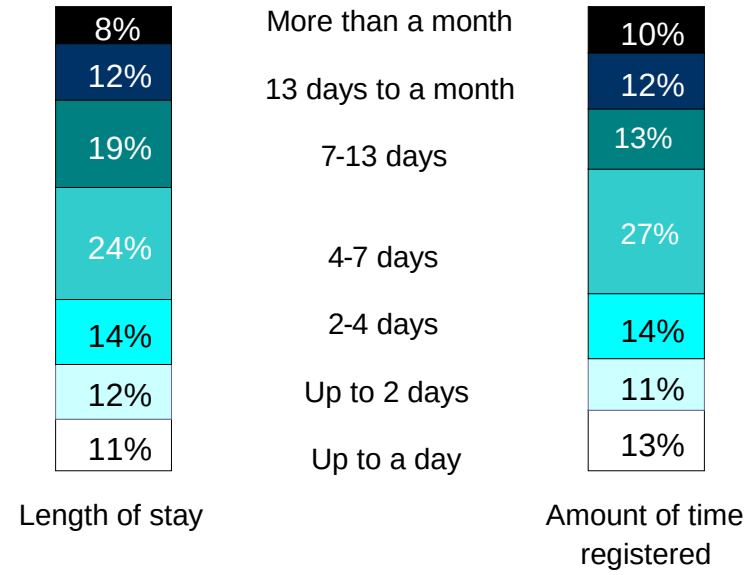
Patients were asked how long they had been in hospital for that stay and how long they had been registered with the bedside system. This was asked in order to find out how familiar patients were with the system. Chart 3c shows this information. Three fifths of patients interviewed (61%) said that they had been in hospital for less than a week, with the remaining two fifths (39%) saying that they been in for a week or more. One in thirteen (8%) had been in for over a month. Almost two thirds (65%) of patients had been registered with the system for less than a week whilst 13% had only been registered for up to a day. One in ten patients (10%) had been registered for more than a month.

Chart 3c: Length of stay and length of time registered
Base: All Patients (308)



3.3.2 Staff

Chart 3d shows the profile of staff interviewed, in terms of sex and age. Sex and age was asked of staff during the interview. Of the 65 staff who were interviewed, three quarters (75%) were women and a quarter (25%) were men. In terms of age, six out of ten (60%) staff interviewed were aged between 16-and 34, three in ten (32%) were aged between 35-54 and one in ten (8%) were aged between 55 and 74.

Chart 3d: Age and sex of staff
Base: All staff (65)

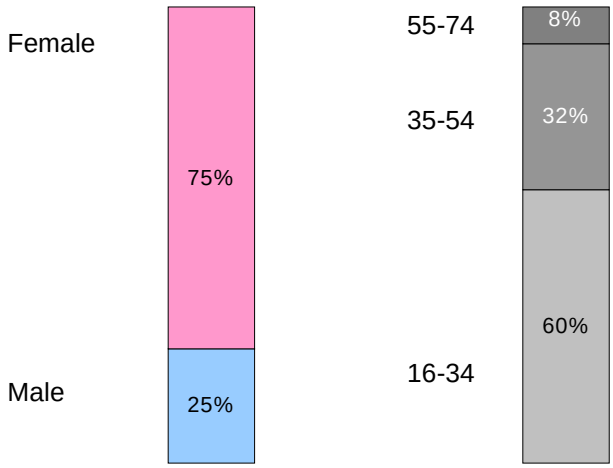
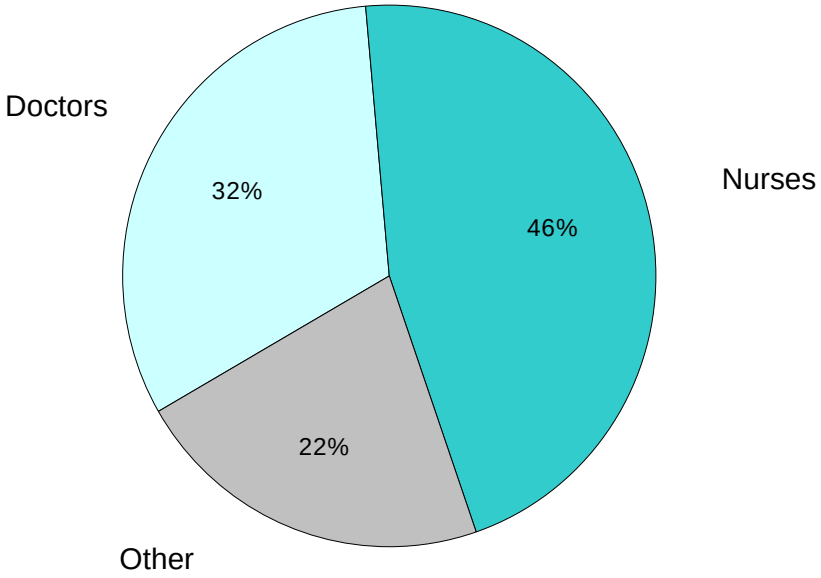


Chart 3e shows the profile of staff interviewed in terms of whether they were a doctor or a nurse. Just under half (46%) of all staff who were interviewed were nurses, whilst just under a third (32%) were doctors. 22% of staff classified themselves as 'other'.

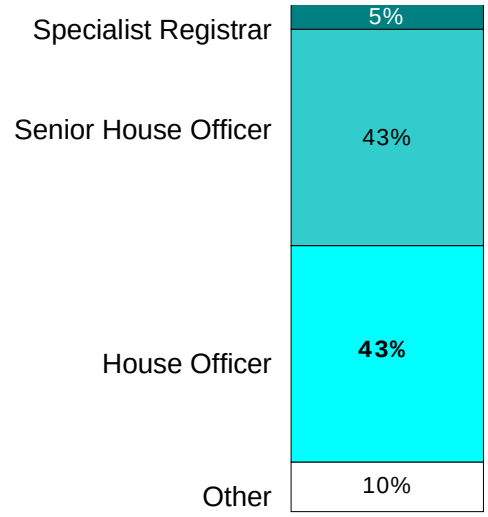
Chart 3f: Staff profile
Base: All staff (65)



Those staff who said they were doctors were then asked if they would best describe themselves as a House Officer, Senior House Officer, Specialist Registrar, Consultant/Professor or Clinical

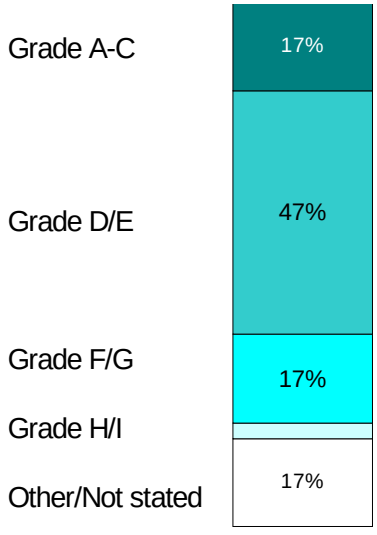
Assistant. Chart 3f shows that the majority of staff interviewed (86%) were House Officers or Senior House Officers.

Chart 3f: Profile of Doctors interviewed
Base: All Doctors (21)



Those staff who said they were nurses were asked what grade of nurse they were. Chart 3g shows that almost half of nurses interviewed (47%) were grade D or E. Almost two fifths (17%) were grade A-C, whilst the same proportion were grade F or G.

Chart 3g: Profile of Nurses interviewed
Base: All Nurses (30)



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4 Starting out with the system

This chapter covers how patients found out about the system, and their reasons for using it.

4.1 Sources of information about the system

At the start of the interview, all patients were asked how they find out about the system. They were presented with a list of possible sources of information, and asked which they had used. Results are shown in table 4a.

Table 4a: Sources of information about the bedside system
Base: All patients (308)

	%
Saw the unit by bed	63
Saw the unit elsewhere in the hospital	11
Friend/relative told about it	10
From another patient	6
From system staff/representatives at hospital	6
From information card on the unit	6
From medical staff at hospital	3
Saw vending machine	2
From TV display	1
Posters	1
From other staff (non-medical) at hospital	1
Found out in some other way	1
Don't know	4

The way in which the majority of patients found out about the system was when they saw the unit by their bedside, this was mentioned by over three fifths (63%) of patients. Just over one in ten (11%) had seen the units elsewhere in the hospital and a similar proportion (10%) had been told about it by a friend or relative. Other sources of information were mentioned by 6% or fewer.

Of those who said they had found out about the system by seeing the units elsewhere in the hospital, many (19 of the 34) had used it on a previous stay at that hospital.

4.2 Reasons for using the system

In order to find out why they chose to use the system, all patients were presented with a number of statements about it and asked to say how important each one was in their decision to use it. Results are shown in table 4b.

Table 4b: Reasons for using the system *Base: All patients (308)*				
	Very important	**Quite important**	**Not very important**	**Not at all important**
The fact that I can make phone calls from the system phone rather than having to go to a payphone	69	16	8	7
Because I can make phone calls without asking a member of staff to help	66	21	6	5
If people want to phone me, they can do so direct without having to go through hospital phones	60	22	12	6
I like being able to watch whatever I want on TV	56	22	10	11
It would be boring in hospital if I didn't have the bedside system	50	26	15	7
There is a variety of things to watch through the bedside system	38	26	19	16
To listen to the radio	36	24	24	15
I do not like watching TV in hospital rooms with other patients	22	22	23	31

The most popular reasons cited for choosing to use the bedside system relate to use of the telephone. Over four fifths (84%) said it was important to them to be able to make phone calls from the system phone, and just under seven in ten (69%) said this was very important. Over four fifths (87%) also said it was important for them to be able to make telephone calls without having to ask a member of staff for help, and a similar proportion (82%) said it was important for them that other people could contact them without going through hospital phones.

Some differences were observed among patients of different ages. Table 4c shows the proportion of patients in each age group who felt that each reason was important (either very or quite important).

Table 4c: Reasons for using the system by patients of different ages					
	All patients (308) %	16-34 (73) %	34-54 (91) %	55-74 (100) %	75 + (44) %
The fact that I can make phone calls from the system phone rather than having to go to a payphone	84	89	85	84	77
Because I can make phone calls without asking a member of staff to help	87	90	87	88	82
If people want to phone me, they can do so direct without having to go through hospital phones	82	92	81	83	66
I like being able to watch whatever I want on TV	78	89	84	73	57
It would be boring in hospital if I didn't have the bedside system	77	82	87	68	66
There is a variety of things to watch through the bedside system	64	81	71	54	41
To listen to the radio	60	53	64	68	48
I do not like watching TV in hospital rooms with other patients	44	51	44	45	32

Patients aged 75 and older were less likely to cite the use of the telephone as important in their decision to use the system. Two thirds (66%) of those aged 75 and older said that it was important that people could call them without having to go through hospital phones, compared with over nine in ten (92%) of those aged under 35 and over four fifths (86%) of those aged under 55. Similarly, those aged 75 and older were less likely to say that it was important for them to be able to make phone calls without having to go to a payphone (77%, compared with 89% of those aged under 35).

The next most important reasons for using the system were to watch TV. Just under four fifths (78%) said it was important for them to be able to watch what they want on TV, and over half (56%) said this was very important. Just under two thirds (64%) said it was important that there is a variety of things to watch through the bedside system TV, and two fifths (44%) said it was important because they do not like watching TV in hospital rooms with other patients (day rooms).

Younger patients were much more likely than their older counterparts to say that watching TV was important in their decision to use the system. Just under nine in ten (89%) of those under 35 said it was important for them to be able to watch what they want on TV, compared with under three fifths (57%) of those aged 75 and older. Similarly, 81% of those aged under 35 said the fact that there is a variety of things to watch through the bedside system was important to them compared with 41% of those aged 75 and older.

Three fifths (60%) of patients said it was important for them to listen to the radio, and over a third (36%) said it was very important. Here, patients from the oldest age group were no less likely to say that it was important (53% of those aged under 35, compared with 48% of those aged 75 and older).

Over three quarters (77%) said it was important to use the bedside system because it would be boring in hospital if they did not have it. Young patients (82% of under 35s) were more likely to say it was important than their older counterparts (66% of over 75s).

4.3 Summary

Over three fifths of patients found out about the system by seeing it by their bed, and one in ten were told about it by a friend or relative. 6% found out about the system from the system staff.

The most important reasons for choosing to use the system related to using the telephone – over four fifths said that it was important for them to make phone calls

without having to ask for help, for them to make phone calls without having to go to a payphone, and to receive phone calls without having to go through hospital phones. The television was the next most important reason for using the system, followed by radio. Over three quarters thought the system was important because it would be boring in hospital without it.

Patients aged under 35 were more likely than their older counterparts to say it was important to use the telephone and watch television. Older patients were as likely to say it was important to them to listen to the radio.

5 Current and future use of the system

5.1 Current use

In order to find out what patients currently used the system for, they were shown a list of features and asked which they had used since they had been in hospital for that particular stay. Results are shown in chart 5a.

Chart 5a: Current use of system
Base: All Patients (308)

Just under four fifths (79%) of patients had used the system to make outgoing phone calls, and 68% had used it to receive incoming phone calls. Just under seven in ten (69%) had used it to watch TV, and 57% had listened to radio (other than hospital radio).

Overall, only 7% of patients had only used the services which the system provides for free (notification phone call to friends and family, incoming phone calls, breakfast TV and radio).

Differences were observed in the way the system was used by patients of different ages, as shown in table 5a.

Table 5a: Current use of system by patients of different ages

	All patients (308) %	16-34 (73) %	35-54 (91) %	55-74 (100) %	75 + (44) %
Make outgoing phone calls	79	81	79	77	82
Watch television	69	82	79	61	43
Receive incoming phone calls	68	71	71	65	61
Listen to radio (non-hospital)	57	51	62	64	43
Watch breakfast TV	33	41	43	28	14
Listen to hospital radio	28	22	37	26	20
Notify friends and family to phone	28	25	33	23	32
Watch cinema channel	14	19	16	13	2
Watch system information video	11	10	18	9	7
Watch hospital information video	8	7	11	7	5
Play games	2	3	3	-	-
Listen to audio books	*	-	1	-	-
Don't know	1	1	-	1	-

The most popular use of the system for patients of all ages was making outgoing phone calls.

Patients aged over 75 were much less likely than their younger counterparts to watch television (43% compared with 69% on average, and 83% of those aged under 35). In addition, older patients were less likely to listen to the radio (43%, compared with 57% on average), and watch the cinema channel (2%, compared with 14% on average).

Patients aged under 35 were more likely than those from other age groups to watch TV and watch the cinema channel.

5.2 Not Used

5.3 Summary

The currently available services most often used by patients relate to the telephone, with just under four fifths using the system to make outgoing calls, and just under seven in ten using the system to receive incoming calls. Seven in ten had watched TV and three fifths had listened to the radio.

Younger patients were more likely to have watched TV or the cinema channel.

Among possible future services, the most popular were a meal ordering service and films on demand. Younger patients were more likely than their older counterparts to say that they would use all of the possible future services.

6 Perception of the system

This chapter will cover perceptions of the system, including ease of use, quality of service, and comparisons with alternative services.

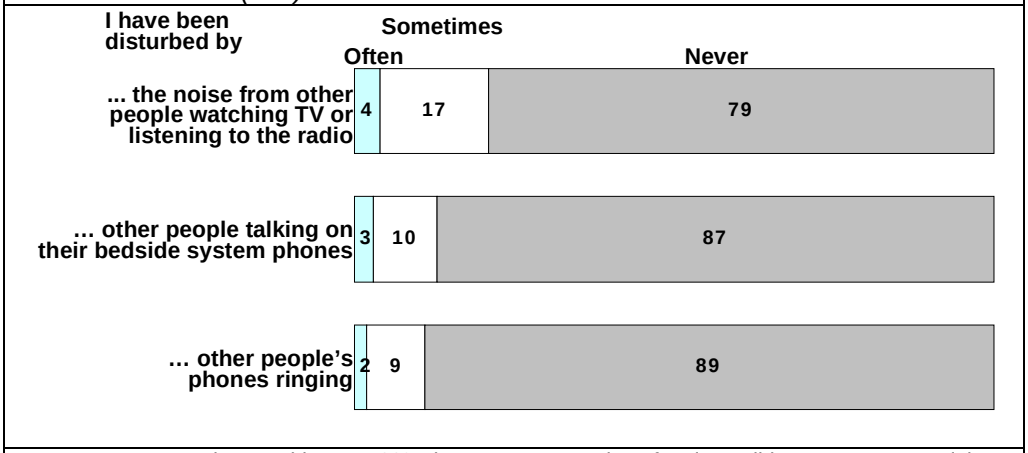
6.1 Ease of use

6.2 Quality of service provided

6.3 Disturbance caused by the system

When researchers visited the hospitals, some staff mentioned that patients could be disturbed by others using the system. In order to quantify this, all patients were asked how frequently they had been disturbed by others using the system in different ways. Responses are shown in chart 6d.

Chart 6d: How frequently have been disturbed by other patients using system
Base: All Patients (308)



Note: percentages do not add up to 100%, because a proportion of patients did not express an opinion

Few patients complained that they had been disturbed by other people using their bedside units. Nine in ten (89%) said that they had never been disturbed by other people's telephones ringing, and a similar proportion (87%) said that they had never been disturbed by other people talking on their telephones. Just under eight in ten (79%) had never been disturbed by the noise from other people watching TV or listening to the radio.

Patients located in a room or bay with many other patients were no more likely to say that they had been disturbed by other people using their units.

6.4 Comparison with alternative services

In those hospitals where the survey took place, the system operator is the only provider of patient entertainment systems. In most cases, all other televisions, and trolley telephones, have been removed.

In order to provide a comparison of the service offered by the system with alternative arrangements, all patients were asked if they had stayed overnight in the hospital before, and if so whether they had used other TVs and telephones. Those who had were asked to rate the service offered by the system operator against the other provisions. Results are shown in table 6a.

Table 6a: Comparison of system with alternative provisions

How system compares with …	A lot better	A little better	About the same	A little worse	A lot worse
TV in ward/dayroom *Base: All who have used TV in ward/dayroom (77)*	57	9	17	6	6
Payphones or trolley phones *Base: All who have used payphone/trolley phone (87)*	66	9	13	3	5

Note: percentages do not add up to 100%, because a proportion of patients did not express an opinion

The majority of patients who had used alternative services felt that the system was better than the old arrangements. Two thirds (66%) thought that the system TV is better than a TV in a ward or dayroom, and just under three fifths (57%) thought it is a lot better. Similarly, three quarters (75%) thought that the system phone is better than a payphone or trolley phone, and two thirds (66%) thought it is a lot better. Only 8% thought that the system phone was worse than the old payphone or trolley phone.

6.5

6.6 System staff

6.7 Summary

Few patients said others using the system had disturbed them, although other people watching TV or listening to the radio had disturbed a fifth of patients.

The system compares well with alternative services. Two thirds thought the system was better than other TVs, and three quarters thought it was better than other telephones.

7 Paying to use the system

This chapter will cover all aspects of the payment system. This includes the ways in which patients chose to pay to use the system, their reasons for doing so and their preferences. The chapter will also look at perceptions of value for money.

7.1 Using paid for services

Almost all (93%) of patients had used system services which have to be paid for – watching TV (other than breakfast TV), watching the cinema channel, playing games, listening to audio books and making outgoing telephone calls.

Those who had not used paid for services were asked whether there was any particular reason why they had not. Because only 21 patients had not used paid for services, raw numbers are shown, rather than percentages.

8 patients had simply not yet got round to using them, and 8 were happy with just using the free services provided by the system. 7 said that they were simply not interested in using any of the paid for services. 5 patients said that they did not want to pay that much to use the system, and 1 patient said that they could not afford to use it. 3 patients said that they did not feel well enough to use the system.

Of those who used paid for services, three fifths paid for the services themselves, and two fifths were paid for by a friend or family member.

7.2 How paid for system services

7.3

7.4 Amount spent using services .

[It should be noted that there is not a system at every bedside in each hospital and the numbers represented in this report relate to only a proportion of patients registered on the system where the bedside system is actually installed].

All patients who had used paid for services were asked how much, in total, they had spent using the system. Responses are shown in table 7b.

Table 7b: Amount spent on using system services
Base: All who had used paid for services (287)

	All (287) %	Length of time registered with system		
		Up to 2 days (66) %	2-7 days (117) %	More than 7 days (103) %
Up to £2.00	11	21	12	5
£2.01 - £4.00	9	20	8	4
£4.01 - £8.00	18	24	16	15
£8.01 - £15.00	24	20	32	17
£15.01 - £20.00	10	6	9	15
More than £20.00	26	6	21	44
Don't know	2	3	2	1

One in ten (11%) patients had spent up to £2 on using the system services, and a similar proportion had spent between £2 and £4. Three fifths (60%) had spent more than £8 on the paid for services, and over a quarter (26%) had spent more than £20.

Patients who had been registered with the system for some time were more likely to have spent more using the services than those who had only been registered for a few days. Over two fifths (44%) of those who had been registered with the system for more than 7 days had spent more than £20 using the system.

Younger people were more likely than their older counterparts to have spent more using the system. Just under a third (32%) of patients aged under 55 who had used paid for services had spent more than £20, compared with only just under a fifth (18%) of their counterparts aged 55 and older.

7.5 Perceptions of cost of using paid-for services

All patients who had used paid-for services were asked what they think about the costs involved. They were asked whether they felt the service was very cheap, quite cheap, quite expensive or very expensive. To minimise bias which may be introduced by an order effect, the answer list was flipped for every other interview. For example, the for the first interview, a patient was asked if they felt the service was very cheap, quite cheap, etc. In the next interview, the answer list would start with very expensive and work to very cheap.

Patients were asked their perceptions of cost for four services, incoming and outgoing phone calls, watching TV and watching the cinema channel. Responses are shown in table 7c.

Table 7b: Perception of the cost of using system services
Base: All who had used paid for services (287)

	Very cheap	Quite cheap	Quite expensive	Very expensive	Don't know
Watching TV	2	20	37	23	18
Watching films on cinema channel	-	10	15	9	66
Outgoing phone calls	7	40	28	10	15
Incoming phone calls	*	2	20	60	18

Just over a fifth (22%) of patients who had used paid for services felt that the cost of watching TV was cheap, although only 2% thought it was very cheap. However, three fifths (60%) thought that watching TV was expensive, and just under a quarter (23%) thought it was very expensive.

Two thirds of those who had used paid for services did not know about the cost of the cinema channel. However, just over a quarter (28%) of those who did express an opinion thought that watching films on the cinema channel was quite cheap.

Just under half (47%) of patients using paid for services felt that the cost of outgoing phone calls was cheap. However, four fifths felt that the cost of incoming calls was expensive, and three fifths felt that incoming calls were very expensive.

Patients aged 75 and older who had used paid for services were more likely not to know about the cost of services. Any differences in perceptions of the cost of services were likely to be driven by the large proportion of older patients answering 'don't know' to questions, rather than any real differences in perceptions.

7.6 Perceptions of value for money

All patients were asked for their perceptions of the value for money offered by the system. They were shown a list of possible answers:

Very good value for money
Quite good value for money
Not very good value for money
Not good value for money at all
Don't know

The answer list was reversed for every second interview, to ensure that there was no order effect introduced in the question. Responses are shown in table 7c.

Table 7c: Perceptions of value for money offered by system
Base: All patients (308)

	%
Very good value for money	12
Quite good value for money	50
Not very good value for money	23
Not at all good value for money	9
Don't know	6

Over three fifths (62%) felt that the system offers good value for money, and one in eight (12%) felt that it offers very good value. However, just under a third (32%) felt that the system does not offer good value for money.

Patients from one Hospital were less likely than average to feel that the system offers good value for money (51%, compared with 62% on average). Those who had only used free services were much less likely to feel that the system offers good value for money – 19% of those who had used free services only felt it is good value, compared with 65% of those who had used paid for services.

7.7 Offering reduced price services for specific groups

All patients were then asked whether they thought certain groups of people should pay full price to watch TV, watch it for free or pay half price. This was asked for children, those aged 60 or older, those in hospital for more than two weeks and those on a low income or benefits. Table 7e shows who patients think should get reduced rate of free TV.

Table 7e: Who patients think should get reduced rate TV
Base: All patients (308)

	Pay full price %	Pay half price %	Watch for free %
Children	6	20	68
People aged 60 or older	5	40	52
Those in hospital for more than 2 weeks	5	55	35
Those on a low income or on benefits like income support	10	54	32

Most patients thought that all groups of people asked about should watch TV for free or for half price. Almost seven out of ten (68%) patients thought that children should

watch for free, whilst half (52%) thought that those aged 60 or older should watch for free. A smaller proportion felt that those in hospital for more than two weeks (35%) or those on a low income or benefits (32%) should watch TV for free.

Some patients when then asked about those on benefits/low income. This was to explore how the system operator would go about identifying this group of people if reduce rate TV were offered to them. Those who felt people on a low income or benefits should receive reduced price/free TV were asked how they thought the system operator should find out which people are eligible. Patients were given two options and asked to choose which one they thought should be used. Table 7f shows that slight majority of people (54%) thought that reduced rates for those on a low income/benefits should be stated in the information sheet and patients should then say if they are eligible.

Table 7f: How patients should find out that those on low income/benefits are eligible for reduced rate TV
Base: All patients who think those on a low income or benefits should get reduced rate TV (266)

	%
It should state that reduced rates are available in the information sheet, and it is up to the patient to say if they are eligible	54
The operator should ask the patient if they are eligible when they register to use the unit	43
Don't know	3

These patients were then asked how those on a low income/benefits should notify the system operator that they are eligible for reduced rate/free TV. Table 7g shows that most patients (70%) who were asked this question favoured telling the system operator direct rather than telling a member of hospital staff (21%).

Table 7g: How those on a low income/benefits should notify this system operator that they are eligible for reduced rate TV
Base: All patients who think those on a low income or benefits should get reduced rate TV (266)

	%
Tell the system operator direct	70
Tell a member of hospital staff who would then tell the system operator on their behalf	21
Don't know/ No preference	9

7.8 Summary

When asked who they thought should be benefiting from this, seven out of ten (68%) felt that children should get free TV whilst over half (52%) feeling that those over 60 should get free TV. Just over half felt that those in hospital over two weeks or on a low income/benefits should get reduced rate TV.

8 Overall satisfaction and improvements

Detail removed from this section as it relates only to the operators system.

8.1 Overall satisfaction

8.2 System improvements

8.3 Summary

STAFF SURVEY

9 Perception of the system

The staff questionnaire asked staff their perceptions of the system. As well as asking staff about how the system affects them, it asks about the system in relation to patients.

9.1 Staff information needs

9.2 The installation process

9.3 Advantages and disadvantages of the system

Staff were read out a number of statements which describe benefits of the system for patients and staff. They were then asked to say how important they felt each one was using the scale very, quite, not very or not at all important. This was to find out which aspects of the system staff felt was most important of benefit to themselves and patients. Table 9c shows the statements that were read out to staff and shows the proportion of staff who rated each statement as 'very important' or important.

Table 9c: How important staff feel certain aspects of the system are
B*ase: All staff (65)*

	Very important %	**Important %**
If someone wants to phone a patient, they can do so direct without having to go through ward staff	68	95
Patients can make phone calls without asking a member of staff to help or going to a payphone	63	92
The bedside system TV is not as noisy as communal ward TV	60	88
Patients can listen to radio	45	94
Patients can watch TV when they want to	43	91
Patients can watch TV without getting out of bed	35	77
Patients do not have to watch TV in hospital rooms with other patients	23	63

All of the statements were rated as being important by over three fifths of staff. The two statements that were most frequently rated as very important were related to the management and handling of patients' phone calls. Most frequently mentioned as being very important was 'If someone wants to phone a patient, they can do so direct without asking a member of staff to help'. Seven in ten (68%) of staff said that they felt this was very important. The second statement most frequently mentioned as very important was 'Patients can make phone calls without asking a member of staff to help or going to a payphone'. Just over three fifths (63%) of patients said they felt this was very important.

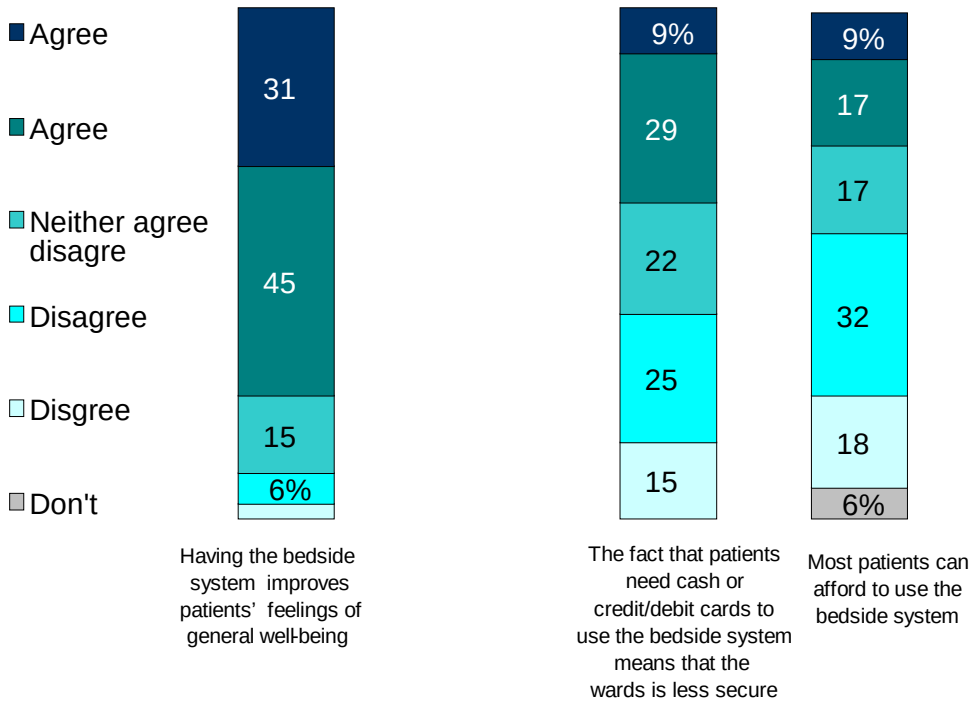
The fact that the system units were not as noisy as ward TV was another aspect of the system that staff felt was important. Three fifths (60%) of staff said that 'The bedside system TV is not as noisy as communal ward TV ' was very important. 45% of staff felt that the fact that patients can listen to radio was very important.

Of those statements read out to staff, the three which were least frequently mentioned as being very important related to the fact that patients can watch TV when they want to, can watch TV without getting out of bed and the fact that they don't have to watch TV with other patients. However, staff still felt these things were important, with nine in ten (91%) of staff saying that 'Patients can watch TV when they want' was important. 77% felt that ' Patients can watch TV without getting out of bed' was important whilst 63% felt that' Patients do not have to watch TV in hospital rooms with other patients' was important.

In order to explore staff perceptions of certain aspects of the system such as security, staff were read out attitude statements and asked whether they agreed with them. The statements read out were chosen because it was felt they touched on issues which staff would have opinions of. Chart 9c shows staff agreement with each of the statements.

There was a positive response amongst staff to the statement 'Having the bedside system improves patients' feelings of general well being.' Three quarters (76%)of staff agreed with this statement with only one in ten (9%) disagreeing with it. There was a more varied response to the other three statements in terms of staff agreement

Chart 9c: Agreement with statements about the system
Base: All Staff (65)



As patients have to pay for services which the system offers, staff were asked if they agreed with the statement 'The fact that patients need cash or credit/debit cards to use the bedside system means that the ward is less secure'. Two fifths (38%) agreed that it did make the wards less secure but a similar proportion of staff (40%) felt that it did not.

When staff were asked if they agreed with the statement 'Most patients can afford to use the bedside system' just over half (51%) of staff did not feel that patients could afford to use the system. However one in four (26%) staff felt that most patients could afford to use the system.

Staff mentioned that any system installed should not unduly interfere with the daily hospital bedside routine.

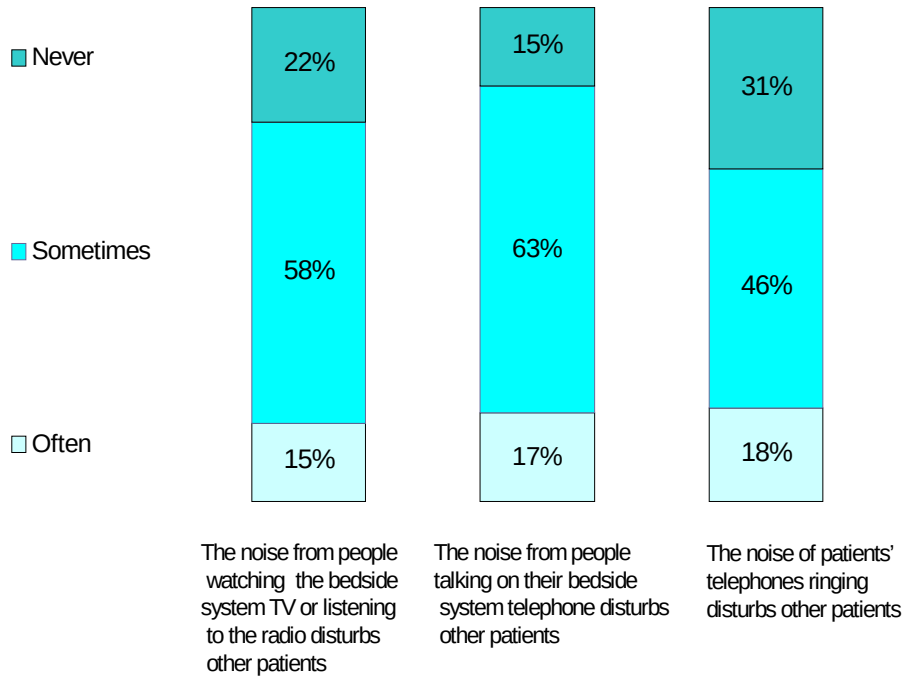
9.4 Noise from system units.

As patients have individual system units by their beds, staff were asked about their perceptions of noise created by the system. Staff were asked how frequently noise from the TV, radio or telephone disturbed patients. Overall, most staff said that noise created by the system sometimes disturbed other patients.

When asked how frequently 'The noise from people watching the bedside system TV or listening to the radio disturbs other patients', one in seven (15%)of staff interviewed said

that this happened often and as many as three fifths (58%) claimed that this sometimes happened.

Chart 9d: Agreement with statements about the system
Base: All Staff (65)



When asked whether 'The noise from people talking on their bedside system telephone disturbs other patients', one in six (17%) claimed that this happened often with a further three fifths (63%) saying that this sometimes happened. Almost two fifths (18%)of staff interviewed said that the noise from patients' telephones ringing disturbing other patients often happened, whilst almost half (46%) of staff said that this sometimes happened.

9.5 Summary

Two thirds of staff are often asked questions about the system by patients or their friends or relatives. Of those who are ever asked questions, over half (56%) feel they don't know enough about the system to address these questions.

The installation process was seen as disruptive by two fifths of staff, however two out of ten staff did not find it disruptive at all. This may be related to the experiences of staff during the installation process. Some may have been more affected by it than others.

Staff felt that the system's handling of patients phone calls was an important benefit to them. Over nine out of ten staff thought it was important the people could phone patients directly and that patients can phone out of hospitals without asking staff to help or going to a pay phone. Similarly high proportions of staff also felt that the fact that the

system created a low amount of noise compared to Ward TV was important. They also felt it was important that patients could listen to radio and that they could watch TV when they wanted to. Over three fifths of staff thought it was important that patient could watch TV without getting out of bed and that they didn't have to watch TV in rooms with other patients.

An issue of some concern is security on wards Two fifths of staff felt that the ward was less secure because patients needed to carry cash and credit/debit cards around with them. It is also quite easy for patient's special system cards (card which patients buy to use system services) to be taken out of their units and used by someone else.

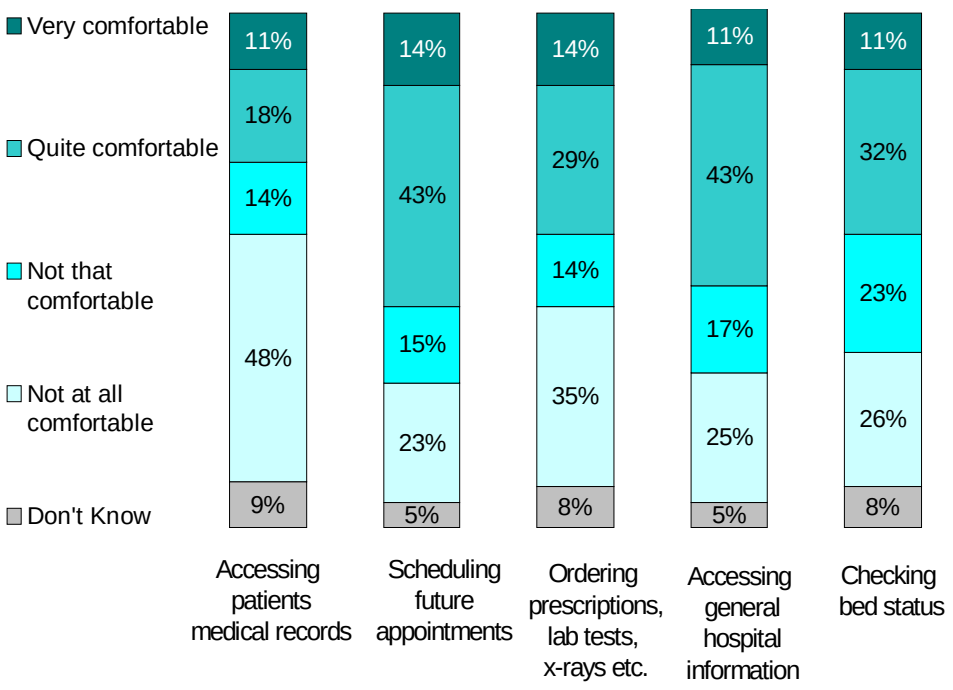
Less than two out of ten staff said that noise created from the patients using the system - either from using their phones or watching TV, often disturbed other patients. Most commonly, staff said that the noise sometimes disturbed other patients. However, noise can be minimised on wards by patients' using headphones – the system operator can easily set units from wards to work on headphones only. Also, the system operator can enforce 'rest periods' whereby the units are switched off.

On a positive note three quarters of staff agreed that having the system improved patients' feelings of general well-being.

10 Staff use of the system

Part of the staff survey was used to find out how comfortable staff would be using the system for things that weren't yet available, such as scheduling appointments and accessing hospital information. As staff were asked about uses of the system which were not yet available, they were asked how comfortable they would feel using each one through the system if it were available to them. Chart 10a shows how staff responded when asked how comfortable they would feel using the system for certain things.

Chart 10a: How comfortable staff feel about using the system for certain things
Base: All Staff (65)



For each future system use staff were asked about, there was a large proportion of staff who would feel not comfortable doing that through the system. The thing that staff most frequently mentioned they would feel comfortable using the system for was 'Scheduling future appointments'. Almost three fifths (57%) of staff said they would feel comfortable using the system for this. However almost a quarter (23%) said that would not be at all comfortable using the system for scheduling future appointments. Another use of the system which staff were relatively positive about was 'Accessing general hospital information'. Over half (54%) of staff said that they would feel comfortable doing this through the system.

With regards to using the system for ordering prescriptions and checking bed status, 43% of staff said they would feel comfortable doing this through the system. However, a similar proportion 49% said that they would not feel comfortable doing these things through the system. The thing that staff tended to be most negative about doing through the system was accessing patient records Over two-fifths (62%) of staff said that they would not be comfortable doing this through the system.

10.1 Staff use of the credit donation system

In each of the hospitals that took part in the study, there was a credit donation system in place, whereby patients could donate their cards with unused credit left on

Contents

them. These cards were collected by the system operator who would then reissue them to other patients. It is up to staff to identify the patients which receive donated credit. The staff survey looked at whether staff were actually aware that of this donation system and if so, if they had experienced any problems using it.

Table 10a shows that almost four out of ten (38%) staff interviewed were not aware of the donation system. However, table 10b shows that of the majority of staff (90%) aware of the system had not experienced any problems with it

Table 10a: Whether staff are aware of the donation system
Base: All staff (65))

	Staff (65) %
Yes – Aware of the donation system	62
No - Not aware of the donation system	38

Table 10b: Whether experienced a problem with the donation of unused credits
Base: All staff who are aware of the donation system(40)

	Staff (52) %
Yes – Have experienced problems	10
No – Have not experienced problems	90

10.2 Summary

For each system use suggested, there was a large proportion of staff who said they would not feel comfortable using the system for that purpose. In particular, three fifths of staff said they would not fell comfortable accessing patients' medical records through the system.

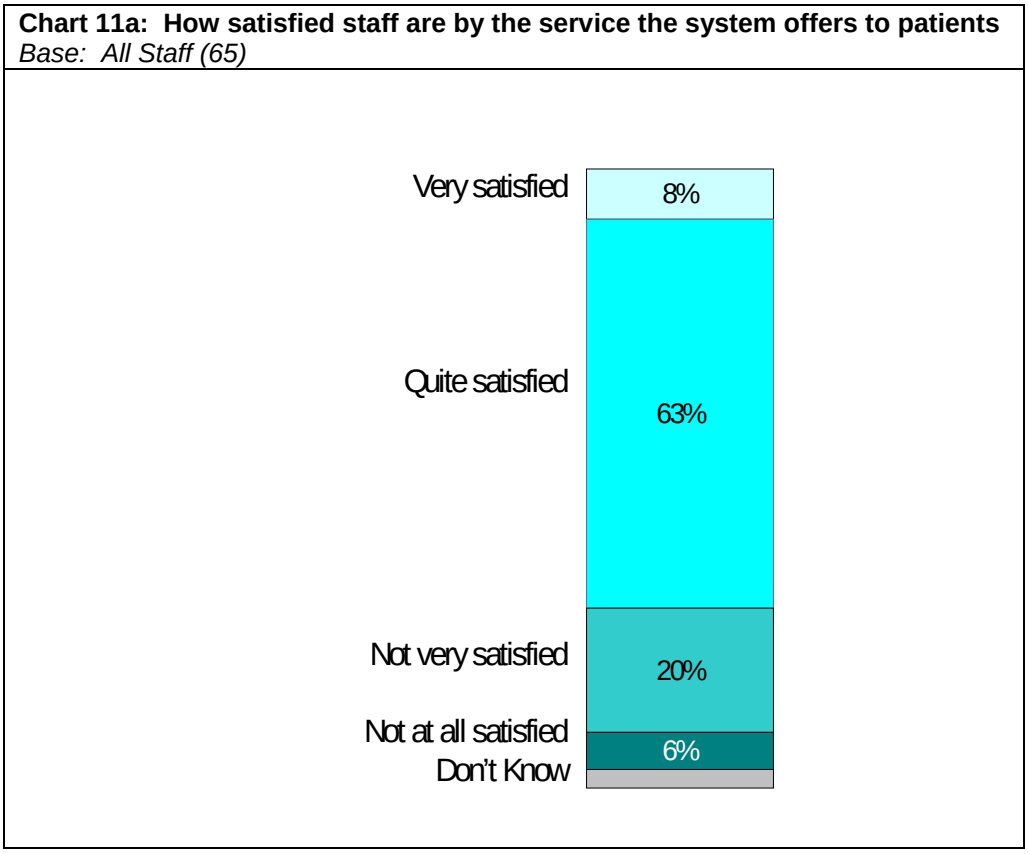
Staff seemed to be most comfortable with the idea of using the system for scheduling future appointments and accessing general hospital information.

Three fifths of staff were aware of the credit donation system, of whom 90% had not experienced any problems.

11 Staff overall satisfaction and perception of value for money

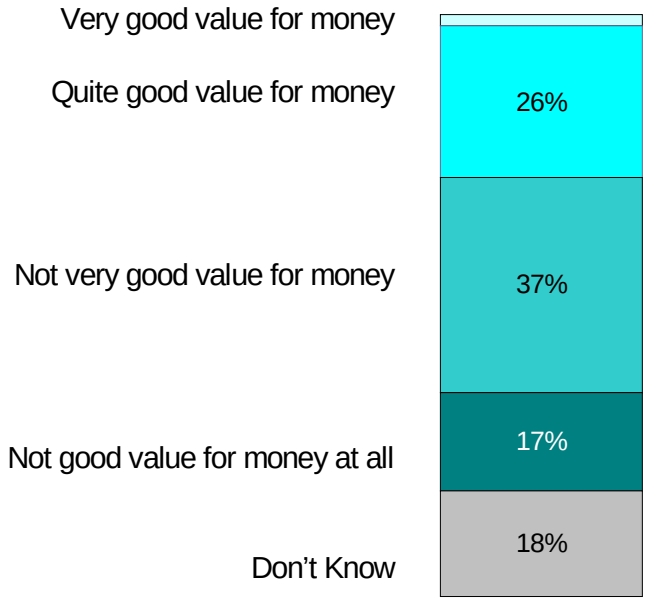
In order to gauge how satisfied staff were overall with the service the system offered to patients, they were asked to say whether they were very, quite, not at all or not very satisfied. This list of possible answers was reversed for alternate interviews to eliminate any order effects. Chart 11a show that seven out of ten staff (71%) are satisfied with the service the system offers to patients, with 8% being very satisfied. However, as many as two out of ten staff (20%) are not very satisfied with the system, with a further 6% saying they are not at all satisfied.

Chart 11a: How satisfied staff are by the service the system offers to patients
Base: All Staff (65)



As with overall satisfaction, when staff were asked whether the system offered good value for money, the list of possible answers was reversed for alternate interviews to eliminate any order effects. When staff were asked whether they felt the system offered good value for money for patients, the most common answer was that it does not offer very good value for money. Chart 11b shows staff response to this question. Just over half of staff interviewed (54%) felt that the system did not offer good value for money whilst just over a quarter (28%) felt that the system did offer good value for money.

Chart 11b: Whether staff feel that the system offers patients good value for money
Base: All Staff (65)



11.1 Summary

Seven out of ten staff are satisfied with the service the system offers to patients. Only 6% are not at all satisfied.

Only a quarter of staff feel the system offers patients good value for money, whereas half of staff interviewed actually felt the system did not offer good value for money.