NHS Standard Contract 2021/22

Particulars (Full Length)

Contract title / ref:

This comparison document shows the 'tracked changes' between the draft 2021/22 NHS Standard Contract published for consultation in January 2021, and the final version of the 2021/22 NHS Standard Contract published in March 2021.

Prepared by: NHS Standard Contract Team, NHS England
~~england.contractsengagement@nhs.net~~
nhscb.contractshelp@nhs.net
(please do not send contracts to this email address)

Version number: 1

First published: ~~January~~March 2021

Publication Approval Number: ~~PAR272~~PAR478

Contract Reference	

DATE OF CONTRACT	
SERVICE COMMENCEMENT DATE	
CONTRACT TERM	**[ ] years/months commencing [ ]** **[(or as extended in accordance with Schedule 1C)]**
COMMISSIONERS	**[ ] CCG (ODS [ ])** **[ ] CCG (ODS [ ])** **[ ] CCG (ODS [ ])** **[NHS England]** **[Local Authority]**
CO-ORDINATING COMMISSIONER	**[ ]**
PROVIDER	**[ ] (ODS [ ])** **Principal and/or registered office address:** **[ ]** **[Company number: [ ]**

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GENERAL CONDITIONS

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CONTRACT

Contract title: ……

Contract ref: ……..….

This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**;

2. the **Service Conditions (Full Length)**;

3. the **General Conditions (Full Length)**,

as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

IN WITNESS OF WHICH the Parties have signed this Contract on the date(s) shown below

SIGNED by	**…….** **Signature**
[INSERT AUTHORISED SIGNATORY'S NAME] for and on behalf of [INSERT COMMISSIONER NAME]	**…….** **Title** **…….** **Date**

[INSERT AS ABOVE FOR EACH COMMISSIONER]

SIGNED by	**…….** **Signature**
[INSERT AUTHORISED SIGNATORY'S NAME] for and on behalf of [INSERT PROVIDER NAME]	**…….** **Title** **…….** **Date**

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**[The date of this Contract] [*or as specified here*]**
Expected Service Commencement Date	
Longstop Date	
Service Commencement Date	
Contract Term	**[ ] years/months commencing [ ]** **[(or as extended in accordance with Schedule 1C)]**
Option to extend Contract Term	**YES/NO** **By [ ] months/years**
Commissioner Notice Period (for termination under GC17.2)	**[ ] months *[Period(s) as agreed/determined locally in respect of the Contract as a whole and/or specific Services – to be specified here]***
Commissioner Earliest Termination Date	**[ ] months after the Service Commencement Date *[Period(s) as agreed/determined locally in respect of the Contract as a whole and/or specific Services – to be specified here]***
Provider Notice Period (for termination under GC17.3)	**[ ] months *[Period(s) as agreed/determined locally in respect of the Contract as a whole and/or specific Services – to be specified here]***
Provider Earliest Termination Date	**[ ] months after the Service Commencement Date *[Period(s) as agreed/determined locally in respect of the Contract as a whole and/or specific Services – to be specified here]***

SERVICES	
Service Categories	**Indicate <u>all</u> that apply**
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (including continuing care for children) (CHC)	
Community Services (CS)	
Diagnostic, Screening and/or Pathology Services (D)	
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	
Mental Health and Learning Disability Secure Services (MHSS)	
NHS 111 Services (111)	
Patient Transport Services (PT)	
Radiotherapy Services (R)	
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	
Services commissioned by NHS England	
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	**YES/NO**
Co-operation with PCN(s) in service models	
Enhanced Health in Care Homes	**YES/NO**
~~**Anticipatory Care**~~	~~**YES/NO**~~
Primary and Community Mental Health Services	**YES/NO**
Service Requirements	
Indicative Activity Plan	**YES/NO**
Activity Planning Assumptions	**YES/NO**
Essential Services (NHS Trusts only)	**YES/NO**
Services to which 18 Weeks applies	**YES/NO**

Prior Approval Response Time Standard	**Within [ ] Operational Days following the date of request** **Or** **Not applicable**
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract?	**YES/NO**
Is the Provider providing CCG-commissioned Services which are to be listed in the UEC DoS?	**YES/NO**
PAYMENT	
Expected Annual Contract Value Agreed	**YES/NO**
Must data be submitted to SUS for any of the Services?	**YES/NO**
Under the Aligned Payment and Incentive Rules in the National Tariff, does CQUIN apply to payments made by any of the Commissioners under this Contract?	**YES/NO**
QUALITY	
Provider type	**NHS Foundation Trust/NHS Trust** **Other**
GOVERNANCE AND REGULATORY	
Nominated Mediation Body (where required – see GC14.4)	**Not applicable/CEDR/Other – [ ]**
Provider's Nominated Individual	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Information Governance Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Data Protection Officer (if required by Data Protection Legislation)	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Caldicott Guardian	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Senior Information Risk Owner	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Accountable Emergency Officer	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Safeguarding Lead (children) / named professional for safeguarding children	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Child Sexual Abuse and Exploitation Lead	**[ ]** **Email: [ ]** **Tel: [ ]**

Provider's Mental Capacity and Liberty Protection Safeguards Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Prevent Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Freedom To Speak Up Guardian(s)	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's UEC DoS Contact	**[ ]** **Email: [ ]** **Tel: [ ]**
Commissioners' UEC DoS Leads	**[ ] CCG:** **[ ]** **Email: [ ]** **Tel: [ ]** **[INSERT AS ABOVE FOR EACH CCG]**
Provider's Infection Prevention Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Health Inequalities Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Net Zero Lead	**[ ]** **Email: [ ]** **Tel: [ ]**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**Co-ordinating Commissioner: [ ]** **Address: [ ]** **Email: [ ]** **Commissioner: [ ]** **Address: [ ]** **Email: [ ]** **[INSERT AS ABOVE FOR EACH COMMISSIONER]** **Provider: [ ]** **Address: [ ]** **Email: [ ]**
Frequency of Review Meetings	**Ad hoc/Monthly/Quarterly/Six Monthly**
Commissioner Representative(s)	**[ ]** **Address: [ ]** **Email: [ ]** **Tel: [ ]**
Provider Representative	**[ ]** **Address: [ ]** **Email: [ ]** **Tel: [ ]**

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

The Provider must provide the Co-ordinating Commissioner with the following documents:

1.	Evidence of appropriate Indemnity Arrangements
2.	[Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required)]
3.	[Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors (where required)]
4.	[Copies of the following Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner] [*LIST ONLY THOSE REQUIRED FOR SERVICE COMMENCEMENT AND NOT PROVIDED ON OR BEFORE THE DATE OF THIS CONTRACT*]
5.	[Insert text locally as required]

The Provider must complete the following actions:

[**Insert text locally as required**]

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Insert text locally or state Not Applicable		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

To be included only in accordance with the Contract Technical Guidance.

1. As advertised to all prospective providers before the award of this Contract, the Commissioners may opt to extend the Contract Term by [ ] months/year(s).

2. If the Commissioners wish to exercise the option to extend the Contract Term, the Co-ordinating Commissioner must give written notice to that effect to the Provider no later than [ ] months before the original Expiry Date.

3. The option to extend the Contract Term may be exercised:

   3.1 only once, and only on or before the date referred to in paragraph 2 above;

   3.2 only by all Commissioners; and

   3.3 only in respect of all Services

4. If the Co-ordinating Commissioner gives notice to extend the Contract Term in accordance with paragraph 2 above, the Contract Term will be extended by the period specified in that notice and the Expiry Date will be deemed to be the date of expiry of that period.

Or

NOT USED

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

Service Specification No.	
Service	
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

2. Outcomes

2.1 <u>NHS Outcomes Framework Domains & Indicators</u>

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

2.2 Local defined outcomes

3. Scope

3.1 Aims and objectives of service

3.2 Service description/care pathway

3.3 Population covered

3.4 Any acceptance and exclusion criteria and thresholds

3.5	**Interdependence with other services/providers**
4.	**Applicable Service Standards**
4.1	**Applicable national standards (eg NICE)**
4.2	**Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**
4.3	**Applicable local standards**
5.	**Applicable quality requirements and CQUIN goals**
5.1	**Applicable Quality Requirements (See Schedule 4A-C)**
5.2	**Applicable CQUIN goals (See Schedule ~~4D~~3E)**
6.	**Location of Provider Premises**
6.1	**The Provider's Premises are located at:**
7.	**Individual Service User Placement**
8.	**Applicable Personalised Care Requirements**
8.1	**Applicable requirements, by reference to Schedule 2M where appropriate**

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Indicative requirements marked YES are mandatory requirements for any Provider of community physical and mental health services which is to have a role in the delivery of the EHCH care model.

Indicative requirements marked YES/NO will be requirements for the Provider in question if so agreed locally – so delete as appropriate to indicate requirements which do or do not apply to the Provider.

1.0 Enhanced Health in Care Homes Requirements

1.1 Primary Care Networks and other providers with which the Provider must cooperate

[ ] PCN (acting through lead practice [ ]/other)
[ ] PCN (acting through lead practice [ ]/other)
[other providers]

1.2 Indicative requirements

Have in place, by the start of the 2021/22 Contract Year, a list of the care homes for which it is to have responsibility during the 2021/22 Contract Year, agreed with the relevant CCG.	YES
Have in place, by the start of the 2021/22 Contract Year, a plan for how the service will operate, agreed with the relevant CCG(s), PCN(s), care homes and other providers [listed above], and abide on an ongoing basis by its responsibilities under this plan.	YES
Have in place, by the start of the 2021/22 Contract Year, and maintain in operation on an ongoing basis, in agreement with the relevant PCN(s) and other providers [listed above] a multidisciplinary team (MDT) to deliver relevant services to the care homes.	YES
Have in place, by the start of the 2021/22 Contract Year, and maintain in operation on an ongoing basis, protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.	YES
On an ongoing basis from the start of the 2021/22 Contract Year, participate in and support 'home rounds' as agreed with the PCN as part of an MDT.	YES/NO
On an ongoing basis from the start of the 2021/22 Contract Year, operate, as agreed with the relevant PCNs, arrangements for the MDT to develop and refresh as required a ~~personalised care~~Personalised Care and ~~support plan~~Support Plan with people living in care homes, with the expectation that	YES/NO

all ~~personalised care~~Personalised Care and ~~support plans~~Support Plans will be in digital form with effect from no later than 31 March 2022. Through these arrangements, the MDT will: • aim for the plan to be developed and agreed with each new resident within seven ~~working days~~Operational Days of admission to the home and within seven ~~working days~~Operational Days of readmission following a hospital episode (unless there is good reason for a different timescale); • develop plans with the person and/or their carer; • base plans on the principles and domains of a Comprehensive Geriatric Assessment including assessment of the physical, psychological, functional, social and environmental needs of the person including end of life care needs where appropriate • draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and • make all reasonable efforts to support delivery of the plan.	
On an ongoing basis from the start of the 2021/22 Contract Year, work with the PCN to identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows.	YES/NO
On an ongoing basis from the start of the 2021/22 Contract Year, work with the PCN to support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27.	YES/NO

1.3 Specific obligations

[*To include details of care homes to be served*]

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Anticipatory Care

Indicative requirements marked YES are mandatory requirements for any Provider of community physical and mental health services which is to have a role in the delivery of the Anticipatory Care model.

Indicative requirements marked YES/NO will be requirements for the Provider in question if agreed locally – so delete as appropriate to indicate requirements which do or do not apply to the Provider.

1.0 Anticipatory Care Requirements

1.1 Primary Care Networks and other providers with which the Provider must cooperate

[ ] PCN (acting through lead practice [ ]/other)
[ ] PCN (acting through lead practice [ ]/other)
[other providers]

1.2 Indicative requirements

• By no later than 30 September 2021, have agreed with the relevant CCG(s), PCN(s) and other providers listed above a plan for how the Anticipatory Care service will operate.	YES
• From 30 September 2021 assist with the development and improvement of system-level population health management approaches to identify patients with complex needs that would benefit from anticipatory care.	YES
• From 30 September 2021, support the coordination of the care and support of people being treated under the Anticipatory Care model, building links and working across the system to facilitate development of a wider model of integrated care for individuals at risk of unwarranted health outcomes, with a focus on patients with multi-morbidities who are expected to be predominantly, but not exclusively, older people.	YES
• Work with others to develop and sign, as soon as is practicable and by no later than 31 March 2022, data sharing agreements with GP practices, and with other providers delivering acute, community and mental health services, voluntary sector organisations and providers of social care, to support the operation of MDTs and the development of population health data sets.	YES
• From 30 September 2021, support the development of system-level linked data sets to build population health analytics capabilities, including the extraction of anonymised, patient level data.	YES
• From 30 September 2021, support the prioritisation of a target cohort of patients based on professional judgement [and the Anticipatory Care Framework, to be published in February 2021].	YES/NO

• In complying with its continuing obligations under SC4.9, from 30 September 2021, align community nursing staff and allied health professionals to the local PCN and identify other professions that may need to be involved in the MDT discussion.	YES/NO
• From 30 September 2021, attend (virtually or face-to-face as agreed) and participate actively in the MDT discussion – using available information to plan and co-ordinate the care of patients discussed.	YES/NO
• From 30 September 2021, support the PCN in its co-ordination and delivery of constituent parts of comprehensive and targeted needs assessments.	YES/NO
• From 30 September 2021, contribute to the development and delivery of personalised care and support plans (including advance care / end of life care plans) for those individuals whose comprehensive need assessment identifies that they should be supported by community health professionals.	YES/NO
• From 30 September 2021, support the PCN in its co-ordination of support offers if locally agreed.	YES/NO
• From 30 September 2021, deliver relevant support offers as identified in the patient's needs assessment and personalised care and support plan, to include	YES/NO
○ fall risk assessment and intervention including bone health management and strength and balance training	YES/NO
○ long term conditions management	YES/NO
○ rehabilitation services	YES/NO
○ continence services	YES/NO
○ podiatry services	YES/NO
○ tissue viability service	YES/NO
○ care co-ordination	YES/NO
○ mobility assessment	YES/NO
○ continence assessment (urinary and faecal)	YES/NO
○ carer identification and signposting to local support	YES/NO
○ comprehensive or targeted needs assessment for other validated cohorts with complex needs.	YES/NO
○ care coordination review for other validated cohorts with complex needs.	YES/NO
○ relevant outreach services to hard to reach groups	YES/NO
○ mental health assessment and interventions to identify and manage depression and anxiety, including IAPT	YES/NO
○ cognitive assessment (to identify dementia and delirium risk) and post diagnosis dementia support (including cognitive stimulation therapy and cognitive rehabilitation therapy);	YES/NO
○ any other activities as set out in 1.3	YES/NO

1.3 Specific obligations

SCHEDULE 2 – THE SERVICES

Aiii. Service Specifications – Primary and Community Mental Health Services

~~*Negotiations are ongoing between NHS England and GPC England about the national GP Contract for 2021/22. One element under discussion relates to the way in which a Primary Care Network (PCN) will, in future, be supported by at least one WTE (or for larger PCNs at least two WTE) registered mental health practitioners, employed by a secondary care provider but embedded as part of the PCN's core multi-disciplinary team.*~~

~~*Subject to these negotiations, there is likely to be a role for each main local provider of community mental health services, where requested by a PCN, in identifying, supplying and supporting suitable staff to fulfil this role – and this would necessitate the inclusion of detailed requirements in the NHS Standard Contract.*~~

~~*We are not yet in a position to confirm the precise expectations, but the likely approach is described below.*~~

~~*Each identified practitioner would be employed by the secondary care provider (typically a Trust) but would work as a full member of the PCN core multi-disciplinary team and act as a shared resource across both the PCN core team and the secondary care provider's primary care mental health / community mental health team. PCNs would provide match funding for the salary and employer NI/pension costs associated with the role, with reimbursement to the PCN available via the Additional Roles Reimbursement Scheme up to the relevant maximum reimbursable rate.*~~

~~*The contractual requirement would focus on adult mental health practitioners in the first instance, but with scope for similar arrangements to be established, by mutual agreement, in relation to practitioners dealing with children and young people.*~~

~~*Secondary care providers would be expected to work with PCNs and CCGs to agree the new arrangements from 1 April 2021.*~~

~~*Depending on the outcome of the GP Contract negotiations, we will share further details and drafting as soon as possible, so that CCGs and affected providers have the opportunity to review and comment.*~~

This Schedule will be applicable, and should be included in full, where the Provider is the main provider of secondary community-based mental health services in the local area. For other providers, delete the text below and insert Not Used.

NHS England and NHS Improvement will shortly publish specific guidance on implementation of the new arrangements below. In the interim, please note the following.

- *Supporting General Practice in 2021/22 makes clear that the entitlement for PCNs to claim 50% reimbursement for Mental Health Practitioners (up to a maximum reimbursable amount), under the Network Contract DES Additional Roles Reimbursement Scheme, applies from 1 April 2021. Where PCNs wish to take up this entitlement, CCGs, Trust and PCNs should therefore take forward introduction of this new arrangement as soon as possible, based on local discussions and collective agreement between the relevant parties.*
- *A number of sites around the country have received national funding to become 'early implementers' of the NHS Long Term Plan commitment to create new and integrated models of primary and community mental health services programme across England, and have been making good progress. In those circumstances, where a new integrated*

service model has already been put in place and is proving effective, a PCN may not need to use its ARRS funding to take up the mental health practitioner entitlement through the ARRS. Where a PCN does wish to take up the ARRS entitlement, local partners should work together to ensure alignment with these models so that adoption of the scheme builds on and complements the new models and does not destabilise progress made to date.

As part of the arrangements described below, the Provider must put in place a separate written provision of service agreement with the PCN, setting out the detail of the local arrangements. In developing these agreements, providers may find the ARRS employment models materials produced by NHS England helpful.

Primary Care Networks in respect of which the requirements of this Schedule apply to the Provider: PCNs with a registered population of 100,000 patients or fewer: [ ] PCN (acting through lead practice [ ]/other) [ ] PCN (acting through lead practice [ ]/other) PCNs with a registered population of more than 100,000 patients: [ ] PCN (acting through lead practice [ ]/other) [ ] PCN (acting through lead practice [ ]/other)
Specific requirements in respect of any PCN with a registered population of 100,000 patients or fewer Where requested by the PCN and where provided by that PCN with Match Funding, identify in agreement with the PCN at least one Additional whole-time-equivalent adult / older adult Mental Health Practitioner, employed by the Provider, to work from 1 April 2021 (or such later date as shall be agreed between the Provider, the Commissioner and the PCN) onwards as a full member of the PCN core multidisciplinary team (MDT) and act as a shared resource across both the PCN core team and the Provider's primary care mental health / community mental health team. Where agreed with the PCN and where provided by that PCN with Match Funding, identify in agreement with the PCN at least one whole-time-equivalent children / young people's Mental Health Practitioner, employed by the Provider, to work from 1 April 2021 (or such later date as shall be agreed between the Provider, the Commissioner and the PCN) onwards as a full member of the PCN core multidisciplinary team (MDT) and act as a shared resource across both the PCN core team and the Provider's children and young people's primary care mental health / community mental health team.
Specific requirements in respect of any PCN with a registered population of more than 100,000 patients Where requested by the PCN and where provided by that PCN with Match Funding, identify in agreement with the PCN at least two Additional whole-time-equivalent adult / older adult Mental Health Practitioners, employed by the Provider, to work from 1 April 2021 (or such later date as shall be agreed between the Provider, the Commissioner and the PCN) onwards as a full member of the PCN core multidisciplinary team (MDT) and act as a shared resource across both the PCN core team and the Provider's primary care mental health / community mental health team.

Where agreed with the PCN and where provided by that PCN with Match Funding, identify in agreement with the PCN at least two whole-time-equivalent children / young people's Mental Health Practitioners, employed by the Provider, to work from 1 April 2021 (or such later date as shall be agreed between the Provider, the Commissioner and the PCN) onwards as an part of the PCN core multidisciplinary team (MDT) and act as a shared resource across both the PCN core team and the Provider's local children and young people's primary care mental health / community mental health team.

Requirements to support the role of a Mental Health Practitioner in any PCN

Agree with the PCN appropriate triage and appointment booking arrangements so that Mental Health Practitioners have the flexibility to undertake their role without the need for formal referral of patients from GPs and that the PCN continues to have access to the Provider's wider multidisciplinary community mental health team

Work with the PCN to define and implement an effective role for Mental Health Practitioners, so that each Practitioner

i. is able to provide a combined consultation, advice, triage and liaison function, with the aim of:
   a) supporting shared decision-making about self-management
   b) facilitating onward access to evidence-based treatment services;
   c) providing some brief psychological interventions, where qualified to do so and where appropriate; and

ii. works in a multidisciplinary manner with other PCN-based clinical staff, including PCN clinical pharmacists and social prescribing link workers, to help address the potential range of biopsychosocial needs of patients with mental health problems.

Ensure that each Mental Health Practitioner is provided with appropriate support, including in relation to training, professional development and supervision, in accordance with the Provider's general arrangements for supporting Staff as required under General Condition 5.5.

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

Insert text locally in respect of one or more Contract Years, or state Not Applicable

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Insert text locally in respect of one or more Contract Years, or state Not Applicable

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Insert details/web links as required* or state Not Applicable

*** ie details of and/or web links to local agreement, policy or procedure as at date of Contract. Subsequent changes to those agreements, policies or procedures, or the incorporation of new ones, must be agreed between the Parties.**

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

Insert text locally

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

Insert text locally

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Insert text locally or state Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

~~*Consultation note: We have updated Schedule 2M; the changes are not shown in tracked changes, as they affect the guidance notes only.*~~

Universal Personalised Care: Implementing the Comprehensive Model (UPC) outlines key actions required to support the roll out of personalised care in accordance with NHS Long Term Plan commitments. UPC has 6 key components: Patient Choice, Personalised Care and Support Planning, Supported Self-Management, Shared Decision Making, Social Prescribing and Personal Health Budgets.

In this context, Schedule 2M should be used to set out specific actions which the Commissioner and/or Provider will take to give Service Users greater choice and control over the way their care is planned and delivered, applying relevant components as listed above. Actions set out in Schedule 2M could focus on making across-the-board improvements applying to all of the Provider's services – or on pathways for specific conditions which have been identified locally as needing particular attention. Actions set out in Schedule 2M should be the result of co-production with Service Users and their families / carers. Those with lived experience of relevant conditions and services should be involved at every stage in the development of personalised approaches.

Detailed suggestions for potential inclusion are set out below.

Patient choice and Shared decision-making (SDM)

Enabling service users to make choices about the provider and services that will best meet their needs, and facilitating SDM in everyday clinical practice are legal requirements, as well as specific contractual obligations under SC6.1 and SC10.2. In brief, SDM is a process in which Service Users and clinicians work together to discuss the risks, benefits and consequences of different care, treatment, tests and support options, and make a decision based on evidence-based, good quality information and their personal preferences; for a full definition, see the General Conditions and the resources available at https://www.england.nhs.uk/shared-decision-making/.

- *Use Schedule 2M to set out detailed plans to embed use of SDM as standard across all relevant services.*

Personalised care and support plans (PCSPs)

Development, use and review of PCSPs are contractual obligations under SC10.3-10.4. In essence, PCSPs are a record of proactive, personalised conversations about the care a Service User is to receive, focused on what matters to the person; for a full definition, see the General Conditions. PCSPs are recommended for all long-term condition pathways plus other priority areas as set out in the NHS Long Term Plan. These include maternity services, palliative and end of life care, cancer, dementia, and cardio-vascular diseases. The COVID pandemic has also highlighted the need for effective personalised care planning for residents of residential settings and those most at risk of COVID-19. PCSPs must also be in place to underpin any use of personal health budgets.

- *Use Schedule 2M to set out detailed plans to embed the development, review and sharing of PCSPs across all of these priority areas and to expand the ways in which Service Users are offered meaningful choice over how services are delivered.*

Social prescribing

Primary Care Networks are now employing social prescribing link workers, tasked with connecting patients to community groups and statutory services for practical and emotional support (see Social prescribing and community-based support: Summary Guide).

- *Use Schedule 2M to set out a plan for how staff within the Provider will be made aware of the local social prescribing offer and for how referrals to and from social prescribing link workers can be made.*

Supported self-management

As part of SDM and PCSPs, the support Service Users need to help them manage their long-term condition/s should be discussed. Interventions that can help people to develop their knowledge, skills and confidence in living well with their condition include health coaching, structured self-management education programmes, and peer support. Identified priority groups include people with newly diagnosed type 2 diabetes and people with Chronic Obstructive Pulmonary Disease. Measures to assess individuals' levels of knowledge, skills and confidence, such as the Patient Activation Measure, can be used to help tailor discussions and referrals to the most suitable intervention. They can also be used to measure the impact of self-management support.

- *Use Schedule 2M to describe plans to embed the offer of supported self-management across these priority areas and others where appropriate.*

Personal health budgets (PHBs)

In brief, PHBs are an amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. Schedule 2M can be used to set out the detailed actions which the Commissioner and/or Provider will take to facilitate the roll-out of PHBs (including integrated personal budgets) to appropriate Service Users.

Not all of the examples below will be relevant to every type of personal budget and the locally populated Schedule 2M will likely need to distinguish between different types of personal budgets to ensure that it is consistent with the CCG's statutory obligations and NHS legal frameworks.

Legal rights to have PHBs now cover:

- *adults eligible for NHS Continuing Healthcare and children / young people eligible for continuing care;*
- *individuals eligible for NHS wheelchair services; and*
- *individuals who require aftercare services under section 117 of the Mental Health Act.*

The CCG must retain responsibility for, amongst other things:

- *deciding whether to grant a request for a PHB;*
- *if a request for a PHB is granted, deciding whether the most appropriate way to manage the PHB is:*
  - *by the making of a direct payment by the CCG to the individual;*
  - *by the application of the PHB by the CCG itself; or*
  - *by the transfer of the PHB to a third party (for example, the Provider) who will apply the PHB.*

If the CCG decides that the most appropriate way of managing a PHB is by the transfer of the PHB to the Provider, the Provider must still obtain the agreement of the CCG in respect of the choices of services/treatment that Service Users/Carers have made, as set out in PCSPs.

- *Use Schedule 2M, for example, to:*
  - *describe which identified groups of Service Users are to be supported through a personalised care approach and which particular cohorts are to be offered PHBs;*
  - *clarify the funding arrangements, including what is within the Price and what is not;*
  - *set out a roll-out plan, with timescales and target levels of uptake (aimed at delivering the CCG's contribution towards the targets set out in the NHS Long Term Plan PHBs to be offered to Service Users/Carers from particular care groups, including, but not limited to those with legal rights listed above, people with multiple long-term conditions; people with mental ill health; people with learning disabilities~~;~~);*
  - *describe how the process of PHBs is aligned with delivery of personal budgets in social care and education, to ensure a seamless offer to Service Users/Carers;*
  - *require the Provider to implement the roll-out plan, supporting Service Users/Carers, through the personalised care and support planning process, to identify, choose between and access services and treatments that are more suitable for them, including services and treatments from non-NHS providers – and to report on progress in implementation;*
  - *require the Provider to agree appropriate financial and contractual arrangements to support the choices Service Users/Carers have made; and*
  - *set out any necessary arrangements for financial audit of PHBs, including for clawback of funding in the event of improper use and clawback in the event of underspends of the person's budget, ensuring this is discussed and agreed with the person beforehand.*

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

The guidance below sets out some considerations to be taken into account in populating Schedule 2N.

Schedule 2N should be used to set out specific actions which the Commissioner and/or Provider will take, aimed at reducing inequalities in access to, experience of and outcomes from care and treatment, with specific relation to the Services being provided under this Agreement.

Successfully tackling health inequalities will always necessitate close working with other local organisations from the statutory sector and beyond – and the specific actions set out in Schedule 2N should always be rooted in wider systems for partnership working across the local area.

Detailed suggestions for inclusion are set out below.

Intelligence and needs assessment

Schedule 2N can be used to set out

- *how the Parties will work with other partners to bring together accessible sources of data to understand levels of variation in access to and outcomes from the Services and to identify and prioritise cohorts of vulnerable individuals, families, and communities, capitalising on growing understanding of population health management approaches and applications;*

- *how they will use this intelligence base to analyse and prioritise action at neighbourhood, "place" and system level; and*

- *what action the Provider will take to ensure that data which it reports about its Services is accurate and timely, with particular emphasis on attributing disability, ethnicity, sexual orientation, and other protected characteristics.*

Community engagement

Schedule 2N can be used to describe how the Parties will work with partners to map established channels of communication and engagement with locally prioritised vulnerable cohorts, to identify barriers or gaps to meaningful and representative engagement, and to develop action plans to address these.

Engagement activity should consider the variety of cohorts with potential vulnerability and disadvantage, which may overlap:

- *socio-economically deprived communities (identified by the English indices of deprivation 2019 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)*
- *those with protected characteristics e.g. BAME; disabled; LGBTQ+*
- *potentially socially excluded cohorts e.g. inclusion health groups such as the homeless; asylum seekers and Gypsy, Roma and Traveller groups*
- *digitally excluded cohorts*
- *geography – urban, rural and coastal inequalities.*

Through these and other routes shared intelligence, insight and understanding can form the basis for practical goals and actions to be agreed, and set out in this Schedule, to meet established needs.

Access to and provision of the Services

Schedule 2N can be used to describe

- *what actions the Parties will take to ensure that appropriate patients are identified for referral to the Services, by GPs and other referrers, with particular emphasis on vulnerable cohorts;*
- *how the Provider can support those referring into its Services through formal and informal means, ranging from shadowing schemes through educational programmes to advice and guidance services;*
- *how the Provider can develop and improve its services so that they respond more appropriately to the needs of vulnerable groups, ensuring a culturally sensitive approach and a range of appropriate channels and choice for patients (e.g. digital; single point of access/hub; face-to-face direct)*
- *how the Provider can reduce unwarranted variations in experience and outcomes for those using the Services.*

Implementation, monitoring and evaluation

Schedule 2N can set out clear timescales for the agreed actions described above, as well as arrangements through which the Parties will jointly monitor progress and evaluate whether improved outcomes are achieved. This should involve other partners as appropriate, and include engagement with the prioritised vulnerable groups, including those receiving the service but also those who might benefit but are not accessing the services.'

SCHEDULE 3 – PAYMENT

A. Local Prices

Enter text below which, for each separately priced Service:

- *identifies the Service*
- *describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template (available at~~:~~ ~~https://improvement.nhs.uk/resources/locally-determined-prices/)~~:www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices) should be copied or attached)*
- *describes any currencies (including national currencies) to be used to measure activity*
- *describes the basis on which payment is to be made (that is, whether dependent on activity, quality or outcomes (and if so how), a block payment, or made on any other basis)*
- *sets out prices for the first Contract Year*
- *sets out prices and/or any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s)*.

Insert template in respect of any departure from an applicable national currency; insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

B. Local Variations

For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement (available at~~:~~ ~~https://improvement.nhs.uk/resources/locally-determined-prices/) – or state Not Applicable.~~:www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by NHS Improvement (available at: ~~https://improvement.nhs.uk/resources/locally-determined-prices/)~~.www.england.nhs.uk/pay-syst/national-tariff/locally-determined-prices). For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.

Insert template; insert any additional text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 3 – PAYMENT

D. Aligned Payment and Incentive Rules

Insert text and/or attach spreadsheets or documents locally – or state Not Applicable. Include separate values / information for each of one or more Contract Years, as required.

The content of this Schedule should cover the following. See the Aligned Payment and Incentive Rules within the National Tariff for more detailed advice.

Fixed Payment

Include a table setting out the agreed Fixed Payment for each Commissioner to which the Aligned Payment and Incentive Rules apply.

Best Practice Tariffs

Include a table setting out, for each applicable Best Practice Tariff and for each applicable Commissioner, the financial value which has been included within the Fixed Payment in relation to the Provider's expected performance against that Best Practice Tariff. This is the value against which actual performance will be measured in-year, with adjustments to payment being made accordingly.

Value of Elective Activity

Include a table setting out, for each applicable Commissioner, the Value of Elective Activity which has been included within the Fixed Payment. This is the value against which actual activity will be measured in-year, with adjustments to payment being made accordingly at the default 50% variable rate described in rule 2 of section 3 of the National Tariff.

High-cost drugs, devices and listed procedures

Include a table setting out, for each applicable Commissioner, the financial value which has been included within the Fixed Payment for any high-cost drugs, devices and listed procedures which are within scope of the Aligned Payment and Incentive Rules (as described in rule 2b of section 3 of the National Tariff). There will be no in-year adjustment to payment for such drugs, devices and procedures – but it is important that the agreed values are recorded here.

CQUIN

Include a table setting out, for each applicable Commissioner, the financial value which has been included within the Fixed Payment for CQUIN. This should be based on the assumption that the Provider will achieve full compliance with the applicable CQUIN Indicators and will therefore earn the full 1.25% value. But reductions to payment will be made after the year-end, under the CQUIN reconciliation process set out in SC38, if the Provider under-performs against the CQUIN Indicators.

Agreed local adjustments and departures

Include here, for each applicable Commissioner, any local adjustments to, or departures from, the Aligned Payment and Incentive Rules which have been agreed between that Commissioner and the Provider and approved by NHS Improvement. The scope for these is set out in rules 3 and 6 of the Aligned Payment and Incentive Rules; they could be agreed in order to adopt a different variable rate than the default 50% value, for instance, or to set aside any variable element to payment for Best Practice Tariffs or CQUIN.

SCHEDULE 3 – PAYMENT

E. ~~D.~~ CQUIN

Where the Aligned Payment and Incentive Rules apply in respect of payments to be made by any Commissioner, insert details of applicable CQUIN Indicators in respect of the relevant Contract Year – or state Not Applicable

SCHEDULE 3 – PAYMENT

~~D.~~F. Expected Annual Contract Values

Commissioner	**Expected Annual Contract Value (include separate values for each of one or more Contract Years, as required)** ~~*(Exclude any expected CQUIN payments. CQUIN on account payments are set out separately in Table 2 of Schedule 4D, as required under SC38.3.)*~~ *(Specify the proportion of the Expected Annual Contract Value to be invoiced each month, in accordance with SC36.25.)* *(In order to be able to demonstrate compliance with the Mental Health Investment Standard and with national requirements for increased investment in Primary Medical and Community Services, ensure that the indicative values for the relevant services are identified separately below. For guidance on the definitions which apply in relation to the Mental Health Investment Standard, see Categories of Mental Health Expenditure. Guidance in relation to primary medical and community services will be published as part of the NHS Operational Planning Guidance for 2021/22 in due course.)*
Insert text and/or attach spreadsheets or documents locally	
Total	

SCHEDULE 3 – PAYMENT

~~E.~~G. Timing and Amounts of Payments in First and/or Final Contract Year

Insert text and/or attach spreadsheets or documents locally – or state Not Applicable

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
	RTT waiting times for non-urgent consultant-led treatment					
E.B.3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Operating standard of 92% at specialty level (as reported to NHS Digital)	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Month	~~Monthly~~	Services to which 18 Weeks applies
	Diagnostic test waiting times					
E.B.4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	Operating standard of no more than 1%	See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/	Month	~~Monthly~~	A CS CR D
	A+E waits					
E.B.5	Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4	Operating standard of 95%	See A+E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/	Month	~~Monthly~~	A+E U

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
	hours of their arrival at an A+E department					
	Cancer waits - 2 week wait					
E.B.6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
E.B.7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
	Cancer waits – 28 / 31 days					
E.B.27	Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	Operating standard of 75%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
E.B.8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Operating standard of 96%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
E.B.9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	Operating standard of 94%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
E.B.10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	Operating standard of 98%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
E.B.11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	Operating standard of 94%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
	Cancer waits – 62 days					

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
E.B.12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
E.B.13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	Operating standard of 90%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	~~Quarterly~~	A CR R
	Ambulance Service Response Times					
	Category 1 (life-threatening) incidents – proportion of incidents resulting in a response arriving within 15 minutes	Operating standard that 90th centile is no greater than 15 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM
	Category 1 (life-threatening) incidents – mean time taken for a response to arrive	Mean is no greater than 7 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM
	Category 2 (emergency) incidents – proportion of	Operating standard that 90th centile is	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
	incidents resulting in an appropriate response arriving within 40 minutes	no greater than 40 minutes				
	Category 2 (emergency) incidents – mean time taken for an appropriate response to arrive	Mean is no greater than 18 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM
	Category 3 (urgent) incidents – proportion of incidents resulting in an appropriate response arriving within 120 minutes	Operating standard that 90th centile is no greater than 120 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM
	Category 4 (less urgent "assess, treat, transport" incidents only) – proportion of incidents resulting in an appropriate response arriving within 180 minutes	Operating standard that 90th centile is no greater than 180 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	~~Quarterly~~	AM
	Mixed-sex accommodation breaches					
E.B.S.1	Mixed-sex accommodation breach	>0	See Mixed-Sex Accommodation Guidance, Mixed-Sex	Ongoing	~~NA~~	A CR MH

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
			Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/			
	Cancelled operations					
E.B.S. 2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice	Number of Service Users who are not offered another binding date within 28 days >0	See Cancelled Operations Guidance and Cancelled Operations FAQ at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/	Ongoing	~~NA~~	A CR
	Mental health					
E.B.S. 3	The percentage of Service Users under adult mental illness specialties who were followed up within 72	Operating standard of 80%	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Quarter	~~Quarterly~~	MH Except MH (Specialised Services)

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved		Application
	hours of discharge from psychiatric in-patient care					

The Provider must report its performance against each applicable Operational Standard through its Service Quality Performance Report, in accordance with Schedule 6A.

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Period over which the ~~Requirement~~requirement is to be achieved		Application
E.A.S.4	Zero tolerance methicillin-resistant *Staphylococcus aureus*	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	A
E.A.S.5	Minimise rates of Clostridioides difficile	As published by NHS England and NHS Improvement	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Year	~~Annual~~	A (NHS Trust/FT)
	Minimise rates of gram-negative bloodstream infections	As published by NHS England and NHS Improvement	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Year	~~Annual~~	A (NHS Trust/FT)
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Ongoing	~~NA~~	Services to which 18 Weeks applies
E.B.S.7a	All handovers between ambulance and A+E must take place within 15 minutes with none waiting more than 30 minutes	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	A+E

	National Quality Requirement	Threshold	Guidance on definition	Period over which the ~~Requirement~~requirement is to be achieved		Application
E.B.S.7b	All handovers between ambulance and A+E must take place within 15 minutes with none waiting more than 60 minutes	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	A+E
E.B.S.8a	Following handover between ambulance and A+E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 30 minutes	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	AM
E.B.S.8b	Following handover between ambulance and A+E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 60 minutes	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	AM
E.B.S.5	Waits in A+E not longer than 12 hours	>0	See A+E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/	Ongoing	~~NA~~	A+E
E.B.S.6	No urgent operation should be cancelled for a second time	>0	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Ongoing	~~NA~~	A CR
	VTE risk assessment: all inpatient Service Users	95%	~~See Contract Technical Guidance Appendix 3~~See	Quarter	~~Quarterly~~	A

	National Quality Requirement	Threshold	Guidance on definition	Period over which the ~~Requirement~~requirement is to be achieved		Application
	undergoing risk assessment for VTE		Contract Technical Guidance Appendix 2			
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour	Ongoing	~~NA~~	All
E.H.4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	Operating standard of 60%	See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Quarter	~~Quarterly~~	MH
E.H.1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment	Operating standard of 75%	See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: ~~https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21-annex-f-activity-and-performance/~~https://www.england.nhs.uk/operational-planning-and-contracting/	Quarter	~~Quarterly~~	MH

	National Quality Requirement	Threshold	Guidance on definition	Period over which the ~~Requirement~~requirement is to be achieved		Application
E.H.2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment	Operating standard of 95%	See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: ~~https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21-annex-f-activity-and-performance/~~https://www.england.nhs.uk/operational-planning-and-contracting/	Quarter	~~Quarterly~~	MH
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumour sites	Failure to achieve full implementation as described under Service Specification B15/S/a Cancer: Chemotherapy (Adult)	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Ongoing	~~NA~~	Where both Specialised Services and Cancer apply
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumour sites	Failure to achieve full implementation as described under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults)	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Ongoing	~~NA~~	Where both Specialised Services and Cancer apply
	Proportion of Service Users presenting as emergencies	Operating standard of 90%	~~See Contract Technical Guidance Appendix 3~~See	Quarter	~~Quarterly~~	A, A+E

	National Quality Requirement	Threshold	Guidance on definition	Period over which the ~~Requirement~~requirement is to be achieved		Application
	who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	(based on a sample of 50 Service Users each Quarter)	Contract Technical Guidance Appendix 2			
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	~~See Contract Technical Guidance Appendix 3~~See Contract Technical Guidance Appendix 2	Quarter	~~Quarterly~~	A

The Provider must report its performance against each applicable National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Period over which the Requirement is to be achieved	Applicable Service Specification
Insert text and/or attach spreadsheet or documents locally in respect of one or more Contract Years				

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

We are considering changes for 2021/22 to CQUIN, the national scheme to incentivise improvements in quality of care. We are keen to simplify the financial arrangements, whilst not losing our focus on taking forward key clinical initiatives. At this stage, we have not proposed changes to the Contract text relating to CQUIN (Service Condition 38 and Schedule 4D). Revised arrangements will be published in the New Year, and we will then make any necessary amendments when we publish the final version of the Contract.

EITHER:

CQUIN Table 1: CQUIN Indicators

Insert completed CQUIN template spreadsheet(s) in respect of one or more Contract Years

CQUIN Table 2: CQUIN Payments on Account

Commissioner	Payment	Frequency/Timing	Agreed provisions for adjustment of CQUIN Payments on Account based on performance

OR:

The Commissioners have applied the small-value contract exception set out in CQUIN Guidance and the provisions of SC38.15 apply to this Contract.

SCHEDULE 4 – QUALITY REQUIREMENTS

~~E.~~D. Local Incentive Scheme

Insert text locally in respect of one or more Contract Years, or state Not Applicable

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
Insert text locally or state Not Applicable	

Documents supplied by Commissioners

Date	Document
Insert text locally or state Not Applicable	

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

Sub-Contractor **[Name]** **[Registered Office]** **[Company number]**	**Service Description**	**Start date/expiry date**	**Processing Personal Data – Yes/No**	**If the Sub-Contractor is processing Personal Data, state whether the Sub-Contractor is a Data Processor OR a Data Controller OR a joint Data Controller**
Insert text locally or state Not Applicable				

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
Insert text locally	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
1a. Without prejudice to 1 above, daily submissions of timely Emergency Care Data Sets, in accordance with DCB0092-2062 and with detailed requirements ~~to be~~ published by NHS Digital at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds/ecds-latest-update	As set out in relevant Guidance	As set out in relevant Guidance	Daily	**A+E, U**
2. Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
National Requirements Reported Locally				
1a. Activity and Finance Report	Monthly	~~In the~~ If and when mandated by NHS Digital, in the format specified in the relevant Information Standards Notice (DCB2050) ~~published by NHS Digital~~	[For local agreement]	**A, MH**
1b. Activity and Finance Report	Monthly	[For local agreement]	[For local agreement]	**All except A, MH**
2. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of	Monthly	[For local agreement]	Within 15 Operational Days of the end of the month to which it relates.	

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	candour, including, without limitation: a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; c. details of, and reasons for, any failure to meet requirements				**All** **All** **All**
3.	a. CQUIN Performance Report and details of progress towards satisfying any CQUIN Indicators, including details of all CQUIN Indicators satisfied or not satisfied b. Local Incentive Scheme Performance Report and details of progress towards satisfying any Local Incentive Scheme Indicators, including details of all Local Incentive Scheme Indicators satisfied or not satisfied	[For local agreement]	[For local agreement]	[For local agreement]	~~**All**~~**CQUIN applies** **All**
4.	Report on performance in respect of venous thromboembolism, catheter-acquired urinary tract infections, falls and pressure ulcers, in accordance with SC22.1.	Annual	[For local agreement]	[For local agreement]	**A**
5.	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	[For local agreement]	[For local agreement]	[For local agreement]	**All**
6.	Report against performance of Service Development and Improvement Plan (SDIP)	In accordance with relevant SDIP	In accordance with relevant SDIP	In accordance with relevant SDIP	**All**
7.	Summary report of all incidents requiring reporting	Monthly	[For local agreement]	[For local agreement]	**All**
8.	Data Quality Improvement Plan: report of progress against milestones	In accordance with relevant DQIP	In accordance with relevant DQIP	In accordance with relevant DQIP	**All**
9.	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A+E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	**A** **A+E** **U**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	Specification https://digital.nhs.uk/isce/publication/isb1594				
10.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	Annually (or more frequently if and as required by the Co-ordinating Commissioner from time to time)	[For local agreement]	[For local agreement]	**All**
11.	Report on compliance with the National Workforce Race Equality Standard.	Annually	[For local agreement]	[For local agreement]	**All**
12.	Report on compliance with the National Workforce Disability Equality Standard.	Annually	[For local agreement]	[For local agreement]	**NHS Trust/FT**
13.	Specific reports required by NHS England in relation to Specialised Services and other services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	**Specialised Services**
14.	Report on performance in reducing Antibiotic Usage in accordance with SC21.43 (*Infection Prevention and Control and Influenza Vaccination*)	Annually	[For local agreement]	[For local agreement]	**A (NHS Trust/FT only)**
15.	Report on progress against Green Plan in accordance with SC18.2	Annually	[For local agreement]	[For local agreement]	**All**
Local Requirements Reported Locally					
Insert as agreed locally				The Provider must submit any patient-identifiable data required in relation to Local Requirements Reported Locally via the Data Landing Portal in accordance with the Data Landing Portal Acceptable Use Statement. [Otherwise, for local agreement]	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s43 of the Contract Technical Guidance, which requires commissioners and providers to agree DQIPs in the areas below.

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	~~Consequence~~
[Providers of maternity services - improving the accuracy and completeness of Maternity Services Data Set submissions]				
Insert text locally				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Patient Safety Incidents
Insert text locally

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

This is a non-mandatory model template for population locally. Commissioners may retain the structure below, or may determine their own. Refer to s41 of the Contract Technical Guidance, which requires commissioners and providers to agree SDIPs in the areas below.

	Milestones	Timescales	Expected Benefit	~~Consequence of Achievement / Breach~~
[Ambulance services – full implementation of SC23.4 and SC23.6]				
[Maternity services – Continuity of Carer Standard in accordance with SC3.13.2]				
[Mental Health and Mental Health Secure Services – certified training in restrictive practices]				
[Elective ophthalmology services – relevant recommendations in Healthcare Safety Investigation Branch's report on timely monitoring for Service Users with glaucoma]				
[Acute services - patient initiated follow-ups]				
Insert text locally				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication	Application
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance	**All**
Service User Survey **[Insert further description locally]**				**All**
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance) **[Other]** **[Insert further description locally]**				**All**
Carer Survey **[Insert further description locally]**				**All**
[Other insert locally]				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

[NOTE: This Schedule 6F applies only where the Provider is appointed to act as a Data Processor under this Contract]

1. SCOPE

1.1 The Co-ordinating Commissioner appoints the Provider as a Data Processor to perform the Data Processing Services.

1.2 When delivering the Data Processing Services, the Provider must, in addition to its other obligations under this Contract, comply with the provisions of this Schedule 6F.

1.3 This Schedule 6F applies for so long as the Provider acts as a Data Processor in connection with this Contract.

2. DATA PROTECTION

2.1 The Parties acknowledge that for the purposes of Data Protection Legislation in relation to the Data Processing Services the Co-ordinating Commissioner is the Data Controller and the Provider is the Data Processor. The Provider must process the Processor Data only to the extent necessary to perform the Data Processing Services and only in accordance with written instructions set out in this Schedule, including instructions regarding transfers of Personal Data outside the ~~EU~~UK or to an international organisation unless such transfer is required by Law, in which case the Provider must inform the Co-ordinating Commissioner of that requirement before processing takes place, unless this is prohibited by Law on the grounds of public interest.

2.2 The Provider must notify the Co-ordinating Commissioner immediately if it considers that carrying out any of the Co-ordinating Commissioner's instructions would infringe Data Protection Legislation.

2.3 The Provider must provide all reasonable assistance to the Co-ordinating Commissioner in the preparation of any Data Protection Impact Assessment prior to commencing any processing. Such assistance may, at the discretion of the Co-ordinating Commissioner, include:

(a) a systematic description of the envisaged processing operations and the purpose of the processing;

(b) an assessment of the necessity and proportionality of the processing operations in relation to the Data Processing Services;

(c) an assessment of the risks to the rights and freedoms of Data Subjects; and

(d) the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.

2.4 The Provider must, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F:

(a) process that Personal Data only in accordance with Annex A, unless the Provider is required to do otherwise by Law. If it is so required the Provider must promptly notify the Co-ordinating Commissioner before processing the Personal Data unless prohibited by Law;

(b) ensure that it has in place Protective Measures, which have been reviewed and approved by the Co-ordinating Commissioner as appropriate to protect against a Data Loss Event having taken account of the:

(i) nature, scope, context and purposes of processing the data to be protected;

(ii) likelihood and level of harm that might result from a Data Loss Event;

(iii) state of technological development; and

(iv) cost of implementing any measures;

(c) ensure that:

(i) when delivering the Data Processing Services the Provider Staff only process Personal Data in accordance with this Schedule 6F (and in particular Annex A);

(ii) it takes all reasonable steps to ensure the reliability and integrity of any Provider Staff who have access to the Personal Data and ensure that they:

(A) are aware of and comply with the Provider's duties under this paragraph;

(B) are subject to appropriate confidentiality undertakings with the Provider and any Sub-processor;

(C) are informed of the confidential nature of the Personal Data and do not publish, disclose or divulge any of the Personal Data to any third party unless directed in writing to do so by the Co-ordinating Commissioner or as otherwise permitted by this Contract;

(D) have undergone adequate training in the use, care, protection and handling of Personal Data; and

(E) are aware of and trained in the policies and procedures identified in GC21.11 (*Patient Confidentiality, Data Protection, Freedom of Information and Transparency*).

(d) not transfer Personal Data outside of the ~~EU~~UK unless the prior written consent of the Co-ordinating Commissioner has been obtained and the following conditions are fulfilled:

(i) the Co-ordinating Commissioner or the Provider has provided appropriate safeguards in relation to the transfer as determined by the Co-ordinating Commissioner;

(ii) the Data Subject has enforceable rights and effective legal remedies;

(iii) the Provider complies with its obligations under Data Protection Legislation by providing an adequate level of protection to any Personal Data that is transferred (or, if it is not so bound, uses its best endeavours to assist the Co-ordinating Commissioner in meeting its obligations); and

(iv) the Provider complies with any reasonable instructions notified to it in advance by the Co-ordinating Commissioner with respect to the processing of the Personal Data;

(e) at the written direction of the Co-ordinating Commissioner, delete or return Personal Data (and any copies of it) to the Co-ordinating Commissioner on termination of the Data Processing Services and certify to the Co-ordinating Commissioner that it has done so within five Operational Days of any such instructions being issued, unless the Provider is required by Law to retain the Personal Data;

(f) if the Provider is required by any Law or Regulatory or Supervisory Body to retain any Processor Data that it would otherwise be required to destroy under this paragraph 2.4, notify the Co-ordinating Commissioner in writing of that retention giving details of the Processor Data that it must retain and the reasons for its retention; and

(g) co-operate fully with the Co-ordinating Commissioner during any handover arising from the cessation of any part of the Data Processing Services, and if the Co-ordinating Commissioner directs the Provider to migrate Processor Data to the Co-ordinating Commissioner or to a third party, provide all reasonable assistance with ensuring safe migration including ensuring the integrity

of Processor Data and the nomination of a named point of contact for the Co-ordinating Commissioner.

2.5 Subject to paragraph 2.6, the Provider must notify the Co-ordinating Commissioner immediately if, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F, it:

(a) receives a Data Subject Access Request (or purported Data Subject Access Request);

(b) receives a request to rectify, block or erase any Personal Data;

(c) receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;

(d) receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is processed under this Schedule 6F);

(e) receives a request from any third party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;

(f) becomes aware of or reasonably suspects a Data Loss Event; or

(g) becomes aware of or reasonably suspects that it has in any way caused the Co-ordinating Commissioner or other Commissioner to breach Data Protection Legislation.

2.6 The Provider's obligation to notify under paragraph 2.5 includes the provision of further information to the Co-ordinating Commissioner in phases, as details become available.

2.7 The Provider must provide whatever co-operation the Co-ordinating Commissioner reasonably requires to remedy any issue notified to the Co-ordinating Commissioner under paragraphs 2.5 and 2.6 as soon as reasonably practicable.

2.8 Taking into account the nature of the processing, the Provider must provide the Co-ordinating Commissioner with full assistance in relation to either Party's obligations under Data Protection Legislation and any complaint, communication or request made under paragraph 2.5 (and insofar as possible within the timescales reasonably required by the Co-ordinating Commissioner) including by promptly providing:

(a) the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;

(b) such assistance as is reasonably requested by the Co-ordinating Commissioner to enable the Co-ordinating Commissioner to comply with a Data Subject Access Request within the relevant timescales set out in Data Protection Legislation;

(c) assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;

(d) assistance as requested by the Co-ordinating Commissioner with respect to any request from the Information Commissioner's Office, or any consultation by the Co-ordinating Commissioner with the Information Commissioner's Office.

2.9 Without prejudice to the generality of GC15 *(Governance, Transaction Records and Audit),* the Provider must allow for audits of its delivery of the Data Processing Services by the Co-ordinating Commissioner or the Co-ordinating Commissioner's designated auditor.

2.10 For the avoidance of doubt the provisions of GC12 *(Assignment and Sub-contracting)* apply to the delivery of any Data Processing Services.

2.11 Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:

(a) notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;

(b) obtain the written consent of the Co-ordinating Commissioner;

(c) carry out appropriate due diligence of the Sub-processor and ensure this is documented;

(d) enter into a binding written agreement with the Sub-processor which as far as practicable includes equivalent terms to those set out in this Schedule 6F and in any event includes the requirements set out at GC21.16.3; and

(e) provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.

2.12 The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:

(a) the categories of processing carried out under this Schedule 6F;

(b) where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;

(c) a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and

(d) a log recording the processing of the Processor Data by or on behalf of the Provider comprising, as a minimum, details of the Processor Data concerned, how the Processor Data was processed, when the Processor Data was processed and the identity of any individual carrying out the processing.

2.13 The Provider warrants and undertakes that it will deliver the Data Processing Services in accordance with all Data Protection Legislation and this Contract and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Services complies with Data Protection Legislation and ensures that the rights of Data Subjects are protected.

2.14 The Provider must comply at all times with those obligations set out at Article 32 of the UK GDPR and equivalent provisions implemented into Law by DPA 2018.

2.15 The Provider must assist the Commissioners in ensuring compliance with the obligations set out at Article 32 to 36 of the UK GDPR and equivalent provisions implemented into Law, taking into account the nature of processing and the information available to the Provider.

2.16 The Provider must take prompt and proper remedial action regarding any Data Loss Event.

2.17 The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

Annex A

Data Processing Services

Processing, Personal Data and Data Subjects

1. The Provider must comply with any further written instructions with respect to processing by the Co-ordinating Commissioner.

2. Any such further instructions shall be incorporated into this Annex.

Description	Details
Subject matter of the processing	*[This should be a high level, short description of what the processing is about i.e. its subject matter]*
Duration of the processing	*[Clearly set out the duration of the processing including dates]*
Nature and purposes of the processing	*[Please be as specific as possible, but make sure that you cover all intended purposes. The nature of the processing means any operation such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction of data (whether or not by automated means) etc. The purpose might include: employment processing, statutory obligation, recruitment assessment etc]*
Type of Personal Data	*[Examples here include: name, address, date of birth, NI number, telephone number, pay, images, biometric data etc]*
Categories of Data Subject	*[Examples include: Staff (including volunteers, agents, and temporary workers), Co-ordinating Commissioners/clients, suppliers, patients, students/pupils, members of the public, users of a particular website etc]*
Plan for return and destruction of the data once the processing is complete UNLESS requirement under ~~union or member state~~ law to preserve that type of data	*[Describe how long the data will be retained for, how it be returned or destroyed]*

SCHEDULE 7 – PENSIONS

Insert text locally (template drafting available via http://www.england.nhs.uk/nhs-standard-contract/) or state Not Applicable

SCHEDULE 8 – LOCAL SYSTEM PLAN OBLIGATIONS

Insert text locally in respect of one or more Contract Years, or state Not Applicable

The guidance below sets out some considerations to be taken into account in populating this Schedule 8.

NOTE: the Local System Plan obligations set out here should be confined to operational or strategic planning matters to avoid (where relevant) duplication or conflict with the System Collaboration and Financial Management Agreement for the ICS.

Background

Guidance to the NHS emphasises the importance of collaborative working across local health systems – to ensure that services provided by multiple different organisations are integrated and coordinated around patients' needs and maximise quality, outcomes and value for money. For 2021/22, each Integrated Care System (ICS) will produce a Local System Plan, setting out local actions to deliver the long-term plan and local improvements. This Schedule 8 offers a way in which – at whatever level of specificity is felt to be locally appropriate – commitments made as part of a Local System Plan can be given contractual effect.

Principle

The intention of Schedule 8 is to express obligations on the part of both the Commissioner(s) and the Provider.

Application

Completion of Schedule 8 is not mandatory, but should be considered for each contract where the Provider plays a significant role in delivering a Local System Plan.

The general expectation is that the content of Schedule 8 will relate to the main local ICS in which the Provider is a partner. Some Providers (ambulance Trusts, for instance) may be partners in more than one ICS, in which case reference to multiple ICSs and Local System Plans within one contract may be necessary; in such situations, care should be taken to avoid too onerous or detailed requirements. Equally, a local contract may involve multiple CCGs, not all of whom are partners in the ICSs relevant to the Provider. Local completion of this Schedule 8 will therefore need to make clear which ICSs and which commissioners it applies to.

Content

Exactly what to include in this Schedule 8 is a local decision, but there are a number of different options.

- *If the Local System Plan is sufficiently detailed to state specific actions which the Parties have agreed to take, these could be extracted and included in the Schedule.*
- *Alternatively, this Schedule 8 could build on the high-level intentions of the Local System Plan, identifying specific actions*
    - *which the Provider will take to integrate its services with those of other local providers and to support those providers in delivering effective care for patients; and*

- *which the Commissioners will take to ensure that other local providers support this Provider in delivering the Services covered by this Contract effectively.*

- *These specific actions could cover expectations around patient pathways (consistent signposting for patients of the most appropriate pathway; communication and support between providers when patients are transferring from one service to another); practical arrangements for ongoing liaison between different services involved with the same patient, including shared or interoperable IT systems; arrangements for multi-disciplinary working across providers; and so on.*

- *And reference could be included in this Schedule 8 to participation in agreed partnership / governance forums and planning processes.*

Care should be taken when completing this Schedule 8 to avoid duplication or contradiction of issues addressed in other local Schedules (such as Service Specifications). The Schedule should not be used to express financial agreements or arrangements; these should be reflected as appropriate in Schedule 3A (Local Prices) or ~~3D~~3F (Expected Annual Contract Values), or in the System Collaboration and Financial Management Agreement.

Other approaches to integration

More formal approaches to service integration could involve putting in place a lead provider contract or an alliance agreement – see the Contract Technical Guidance for further detail.

This Schedule 8 is aimed at commitments made by the Provider and the Commissioners who are party to the local contract. Arrangements agreed directly between providers (to share back-office functions or facilities, for instance) should be set out elsewhere.

SCHEDULE 9 – SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT AGREEMENT

List here details (date, parties) of any SCFMA to which the Provider and relevant Commissioners are party.

Do not *include, attach or embed the SCFMA itself (either here or at Schedule 2G), as that may have the effect of making the SCFMA legally binding as between some or all parties, which is not the intention.*

Or state Not Applicable.

First published ~~January~~March 2021
Published in electronic format only