

Comparison document

NHS Standard Contract 2025/26

Service Conditions (Full Length)

Version 1, September 2025

This comparison document shows the 'tracked changes' between the [2024/25 NHS Standard Contract full length Service Conditions](#) published in February 2024, and the [final version of the 2025/26 NHS Standard Contract full length Service Conditions](#) published in September 2025.

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Some Service Conditions apply only to services within particular service categories, as indicated in the right column using the abbreviations set out below. The Parties have indicated in the Particulars the service categories applicable to their Contract:

All service categories	All
Accident and Emergency Services (Type 1 and Type 2 only)	A+E
Acute Services	A
Ambulance Services	AM
Cancer and/or Radiotherapy 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 (non-emergency)	PT
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units)	U

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PROVISION OF SERVICES	
SC1 Compliance with the Law and the NHS Constitution 1.1 The Provider must provide the Services in accordance with the Fundamental Standards of Care and the Service Specifications. The Provider must perform all of its obligations under this Contract in accordance with: 1.1.1 the terms of this Contract; 1.1.2 the Law; and 1.1.3 Good Practice, and having regard to the CQC Quality Statements. The Provider must, when requested by the Co-ordinating Commissioner, provide evidence of the development and updating of its clinical process and procedures to reflect Good Practice.	All
1.2 The Commissioners must perform all of their obligations under this Contract in accordance with: 1.2.1 the terms of this Contract; 1.2.2 the Law; and 1.2.3 Good Practice, and having regard to the CQC Quality Statements.	All
1.3 The Parties must abide by <u>have regard to</u> and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.	All
1.4 The Provider must: 1.4.1 (if it is an NHS Trust or an NHS Foundation Trust) comply with the Fit and Proper Person Test Framework, <u>adopting and applying the NHS Leadership Competency Framework in its recruitment and appraisal processes</u>; and 1.4.2 comply with the requirements of regulations 4 – 7 of the 2014 Regulations as appropriate to the Provider; and 1.4.3 (whether or not it is required to be CQC registered for the purpose of the Services) identify and give notice to the Co-ordinating Commissioner of the name, address and position in the Provider of the Nominated Individual.	All

1.5	In performing their respective obligations under this Contract, each Party must have due regard to the Armed Forces Covenant and the Armed Forces Duty Statutory Guidance.	All
SC2 Regulatory Requirements		All
2.1	The Provider must:	
2.1.1	comply, where applicable, with the registration and regulatory compliance guidance of any relevant Regulatory or Supervisory Body;	
2.1.2	respond to all applicable requirements and enforcement actions issued from time to time by any relevant Regulatory or Supervisory Body;	
2.1.3	comply, where applicable, with the standards and recommendations issued from time to time by any relevant Regulatory or Supervisory Body;	
2.1.4	consider and respond to the recommendations arising from any audit, clinical outcome review programme, Serious Incident investigation report, Patient Safety Incident investigation report or other patient safety related review process;	
2.1.5	comply with the standards and recommendations issued from time to time by any relevant professional body and agreed in writing between the Co-ordinating Commissioner and the Provider;	
2.1.6	comply, where applicable, with the recommendations contained in NICE Technology Appraisals and have regard to other Guidance issued by NICE from time to time;	
2.1.7	respond to any reports and recommendations made by Local Healthwatch; and	All
2.1.8	meet its obligations under Law in relation to the production and publication of Quality Accounts.	
2.2	The Parties must comply, where applicable, with their respective obligations under, and with recommendations contained in, MedTech Funding Mandate Guidance.	All
SC3 Service Standards		All
3.1	The Provider must:	
3.1.1	not breach the thresholds in respect of the National Quality Requirements; and	

3.1.2	not breach the thresholds in respect of the Local Quality Requirements.	
3.2A	A failure by the Provider to comply with SC3.1 will be excused if it is directly attributable to or caused by an act or omission of a Commissioner, but will not be excused if the failure was caused primarily by an increase in Referrals.	All
3.2B	For the purposes of SC3.2A, 'an increase in Referrals' will include Activity due to an increased use of 999, 111 or any other emergency telephone numbers.	AM, 111
3.3	If the Provider does not comply with SC3.1 the Co-ordinating Commissioner may, in addition and without affecting any other rights that it or any Commissioner may have under this Contract:	All
3.3.1	issue a Contract Performance Notice under GC9.3 (<i>Contract Management</i>) in relation to the breach or failure; and/or	All
3.3.2	take action to remove any Service User affected from the Provider's care; and/or	All except AM, 111
3.3.3	if it reasonably considers that there may be further non-compliance of that nature in relation to other Service Users, take action to remove those Service Users from the Provider's care.	All except AM, 111
3.4	The Provider must continually review and evaluate the Services, must act on insight derived from those reviews and evaluations, from feedback, complaints, audits, clinical outcome review programmes, Patient Safety Incidents, and from the involvement of Service Users, Staff, GPs and the public (including the outcomes of Surveys), and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result and how these improvements have been communicated to Service Users, their Carers, GPs and the public.	All
3.5	The Provider must implement policies and procedures for reviewing deaths of Service Users whilst under the Provider's care and for engaging with bereaved families and Carers.	All
3.6	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must comply with National Guidance on Learning from Deaths where applicable.	All

3.7	The Provider must: 3.7.1 if it is an NHS Trust or an NHS Foundation Trust (and except as otherwise agreed with the National Medical Examiner), establish and operate a Medical Examiner Office; and 3.7.2 comply with Medical Examiner Guidance as applicable.	A All
3.8	The Provider must co-operate fully with the Responsible Commissioner and the original Referrer in any re-referral of the Service User to another provider (including providing Service User Health Records, other information relating to the Service User's care and clinical opinions if reasonably requested). Any failure to do so will constitute a material breach of this Contract.	All
3.9	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must assess its performance using the Board Assurance Framework for Seven Day Hospital Services as required by Guidance and must share a copy of each assessment with the Co-ordinating Commissioner.	A, A+E, CR
3.10	Where the Provider provides vascular surgery Services, hyper-acute stroke Services, major trauma Services, STEMI heart attack Services or children's critical care Services, the Provider must ensure that those Services comply in full with Seven Day Service Hospital Priority Clinical Standards.	A
3.11	If providing maternity and/or neonatal services, the Provider must implement the requirements on providers set out in the Delivery Plan for Maternity and Neonatal Services in accordance with the timescales which it sets out, and then comply with those requirements.	A, CS
3.12	In performing its obligations under this Contract, the Provider (if it is an NHS Trust or an NHS Foundation Trust) must have regard to Learning Disability Improvement Standards.	All
3.13	The Provider must use all reasonable endeavours to ensure that each relevant clinical team achieves level 3 or above compliance with the requirements of the Early Intervention in Psychosis Scoring Matrix effective treatment domain.	MH, MHSS
3.14	The Co-ordinating Commissioner (in consultation with the other Commissioners) and the Provider must jointly assess, by no later than 30 September in each Contract Year, the effectiveness of their arrangements for managing the interface between the Services and local primary medical services, including the Provider's compliance with SC8.2-5, SC11.5-7, SC11.9-10, SC11.12 and SC12.2 of this Contract.	All

3.15	If the assessment undertaken under SC3.14 identifies any deficiencies, the Co-ordinating Commissioner and the Provider must:	All
3.15.1	agree, at the earliest opportunity, an action plan to address those deficiencies, ensuring that this action plan is informed by discussion with and feedback from the relevant Local Medical Committees;	
3.15.2	arrange for the action plan to be approved in public by each of their Governing Bodies and to be shared with the relevant Local Medical Committees; and	
3.15.3	in conjunction with the relevant Commissioners, implement the action plan diligently, keeping the relevant Local Medical Committees informed of progress with its implementation.	
3.16	The Provider (if it is not an NHS Trust or an NHS Foundation Trust) must have regard to the Medical Practitioners Assurance Framework.	All
3.17	The Provider must nominate a 2018 Act Responsible Person and must ensure that the Co-ordinating Commissioner is kept informed at all times of the identity of the person holding that position. The Provider must comply, and must ensure that its 2018 Act Responsible Person complies, with their respective obligations under the 2018 Act and 2018 Act Guidance.	A (where applicable), MH, MHSS
3.18	The Provider must implement and maintain a system of early screening, risk assessment and health optimisation for all adult Service Users waiting for inpatient surgery, in accordance with Perioperative Care Pathways Guidance.	A
3.19	If providing diagnostic imaging Services, the Provider must have regard to Guidance on Diagnostic Imaging Reporting Turnaround Times.	A, D
3.20	<u>The Provider must use all reasonable endeavours to assist the Commissioners in implementing National Medicines Optimisation Priorities.</u>	<u>All except AM, 111, D, PT</u>
SC4 Co-operation		
4.1	The Parties must at all times act in good faith towards each other and in the performance of their respective obligations under this Contract.	All
4.2	The Parties must co-operate in accordance with the Law and Good Practice to facilitate the delivery of the Services in accordance with this	All

	Contract, having regard at all times to the welfare and rights of Service Users.	
4.3	The Provider and each Commissioner must, in accordance with Law, Good Practice and any guidance issued by the Secretary of State under sections 72 and 82 of the 2006 Act regarding the duty to co-operate, co-operate fully and share information with each other and with any other commissioner or provider of health or social care in respect of a Service User in order to: 4.3.1 ensure that a consistently high standard of care for the Service User is maintained at all times; 4.3.2 ensure that high quality, integrated and co-ordinated care for the Service User is delivered across all pathways spanning more than one provider; 4.3.3 achieve continuity of service that avoids inconvenience to, or risk to the health and safety of, the Service User, employees of the Commissioners or members of the public; and 4.3.4 seek to ensure that the Services and other health and social care services delivered to the Service User are delivered in such a way as to maximise value for public money, optimise allocation of resources and minimise unwarranted variations in quality and outcomes.	All
4.4	The Provider must ensure that its provision of any service to any third party does not hinder or adversely affect its delivery of the Services or its performance of this Contract.	All
4.5	The Provider and each Commissioner must co-operate with each other and with any third party provider to ensure that, wherever possible, an individual requiring admission to acute inpatient mental health services can be admitted to an acute bed close to their usual place of residence.	MH
4.6	In performing their respective obligations under this Contract the Parties must have regard to, and support each other to observe and promote, the NHS's stated strategic objectives of improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money, and supporting broader social and economic development, through active involvement in the work of the relevant local Integrated Care Partnerships and/or through constructive mutual support and challenge to and from those Integrated Care Partnerships and the organisations which provide health and social care services within the areas of those Partnerships.	All

4.7	The Parties must at all times use all reasonable endeavours to contribute towards the implementation of and have regard to any relevant Joint System Plan and/or Integrated Care Strategy and must perform any specific obligations on their respective parts agreed as part of or pursuant to that Joint System Plan and/or Integrated Care Strategy from time to time.	All
4.8	Where the Provider provides community-based Services, it must use all reasonable endeavours to agree, with local Primary Care Networks, and implement ongoing arrangements through which delivery of those Services and the delivery of complementary services to the relevant Service Users by members of those Primary Care Networks will be effectively integrated.	CS, MH
4.9	The Provider must, in co-operation with each Primary Care Network and with each other provider of health or social care services listed in Schedule 2Ai (<i>Service Specifications – Enhanced Health in Care Homes</i>), perform any obligations on its part set out or referred to in Schedule 2Ai (<i>Service Specifications – Enhanced Health in Care Homes</i>) and/or Schedule 2G (<i>Other Local Agreements, Policies and Procedures</i>).	A, CS, MH
4.10	The Provider must, in co-operation with each Primary Care Network listed in Schedule 2Aii (<i>Service Specifications – Primary and Community Mental Health Services</i>), perform any obligations on its part set out or referred to in Schedule 2Aii (<i>Service Specifications – Primary Mental Health Services</i>) and/or Schedule 2G (<i>Other Local Agreements, Policies and Procedures</i>).	MH
SC5 Commissioner Requested Services and Hard To Replace Providers		All
5.1	The Provider must comply with its obligations under the Provider Licence:	
5.1.1	in respect of any Services designated as CRS by any Commissioner from time to time; and	
5.1.2	if and while the Provider is designated as a Hard To Replace Provider by NHS England as appropriate to that designation.	

SC6 Choice and Referral 6.1 Each Party must comply with its obligations under and otherwise have regard to Patient Choice Legislation and Guidance, including in relation to patients' rights to choice of provider and/or Consultant or Healthcare Professional.	All except AM, ELC, MHSS, PT
6.2 The Provider must describe and publish all acute GP Referred Services in the NHS e-Referral Service through a Directory of Service, offering choice of any clinically appropriate team led by a named Consultant or Healthcare Professional as applicable. In relation to all such GP Referred Services, the Provider must: 6.2.1 ensure that all such Services are able to receive Referrals through the NHS e-Referral Service; and 6.2.2 in respect of Services which are Directly Bookable: 6.2.2.1 use all reasonable endeavours to make sufficient appointment slots available within the NHS e-Referral Service to enable any Service User to book an appointment for a GP Referred Service within a reasonable period via the NHS e-Referral Service; and 6.2.2.2 ensure that it has arrangements in place to accept Referrals via the NHS e-Referral Service where the Service User or Referrer has not been able to book a suitable appointment, ensuring that it has safe systems in place for offering appointments promptly where this occurs.	A
6.3 The Commissioners must use all reasonable endeavours to ensure that, in respect of all Referrals by GPs and other primary care Referrers, the Provider is given accurate Service User contact details and all pertinent information required by relevant local Referral protocols in accordance with the PRSB Clinical Referral Information Standard.	A
6.4 The Commissioners must use all reasonable endeavours to ensure that all Referrals by GPs for GP Referred Services are made through the NHS e-Referral Service.	A
6.5 Each Commissioner must take the necessary action, as described in NHS e-Referral Guidance, to ensure that all GP Referred Services are available to their local Referrers within the NHS e-Referral Service.	A

6.6	The Provider must offer clinical advice and guidance to GPs and other primary care Referrers: 6.6.1 on potential Referrals, through the NHS e-Referral Service; and/or 6.6.2 on potential Referrals and on the care of Service Users generally, as otherwise set out in the Service Specifications, whether this leads to a Referral being made or not.	A
6.7	The price payable by each Commissioner for advice and guidance offered in accordance with SC6.6 will be either: 6.7.1 deemed to be included in the Fixed Payment set out in Schedule 3A (<i>Aligned Payment and Incentive Rules</i>), or 6.7.2 the Local Price as set out in Schedule 3C (<i>Local Prices</i>), as appropriate.	A
6.8	Subject to the provisions of NHS e-Referral Guidance: 6.8.1 the Provider need not accept Referrals by GPs to Consultant-led acute outpatient Services made other than through the NHS e-Referral Service; 6.8.2 the Provider must implement a process through which the non-acceptance of a Referral under this SC6.8 will, in every case, be communicated without delay to the Service User's GP, so that the GP can take appropriate action; and 6.8.3 each Commissioner must ensure that GPs within its area are made aware of this process.	A
6.9	The Provider must use reasonable endeavours to: 6.9.1 describe and publish all mental health GP Referred Services in the NHS e-Referral Service through a Directory of Service, offering choice of any clinically appropriate team led by a named Consultant or Healthcare Professional, as applicable; and 6.9.2 ensure that all such Services are able to receive Referrals through the NHS e-Referral Service.	MH
6.10	This SC6.10 applies to all acute GP Referred Services and to all other Services which the Provider chooses to list within the NHS e-Referral Service. The Provider must, having consulted all relevant Commissioners, ensure that each Service to which this SC6.10 applies and each site from which that Service will be delivered is listed	A, CS, MH

on the correct menu<u>accurately and appropriately</u> within the NHS e-Referral Service, so that: 6.10.1 each Service to which the legal right to choice applies, as set out in Patient Choice Legislation and Guidance, and each site from which that Service will be delivered, is listed on the Secondary Care Menu<u>so as to be available to all Referrers in England</u>; and 6.10.2 all other Services and the sites from which those Services will be delivered are listed in the Primary Care Menu<u>so as to be available only for referral of individuals whose Responsible Commissioner has specifically commissioned that Service</u>.	
6.11 The Provider must make the specified information available to prospective Service Users through the NHS Website, and must in particular use the NHS Website to promote awareness of the Services among the communities it serves, ensuring the information provided is accurate, up-to-date, and complies with the provider profile policy set out at www.nhs.uk.	A, CS, D, MH
Local Access Policy 6.12 In respect of Consultant-led Services to which the 18 Weeks Referral-to-Treatment Standard applies, the Provider must publish on its website and operate a Local Access Policy complying with the requirements of the Co-ordinating Commissioner.	A, CS, MH
Acceptance and Rejection of Referrals 6.13 Subject to SC6.8 and to SC7 (<i>Withholding and/or Discontinuation of Service</i>), the Provider must: 6.13.1 accept any Referral of a Service User made in accordance with the Referral processes and clinical thresholds set out or referred to in this Contract and/or as otherwise agreed between the Parties and/or as specified in any Prior Approval Scheme, and in any event where necessary for a Service User to exercise their legal right to choice as set out in Patient Choice Legislation and Guidance; and 6.13.2 (subject to SC6.13.1) accept any clinically appropriate referral for any Service of an individual whose Responsible Commissioner (ICB or NHS England) is not a Party to this Contract where necessary for that individual to exercise their legal right to choice as set out in Patient Choice Legislation and Guidance; and 6.13.3 where it can safely do so, accept a referral or presentation for emergency treatment, within the scope of the Services, of or by any individual whose Responsible Commissioner is not a Party to this Contract.	All except CHC

Any referral or presentation as referred to in SC6.13.2 or 6.13.3 will not be a Referral under this Contract and the relevant provisions of the Contract Technical Guidance will apply in respect of it.	
6.14 Any referral or presentation as referred to in SC6.13.2 or 6.13.3 will not be a Referral under this Contract but the terms of this Contract will by implication apply as between the Provider and the Responsible Commissioner in relation to any such referral or presentation.	All
6.15 Where the Provider accepts any referral or presentation as referred to in SC6.13.2 or 6.13.3, it must (if it has not already done so), on request, share the Particulars of this Contract with the Responsible Commissioner in complete, up to date and unredacted form. If the Responsible Commissioner has made such a request, it will be entitled to withhold payment for services delivered in response to such a referral or presentation until the Provider has shared the complete, up to date and unredacted Particulars as requested.	All
6.146.16 The existence of this Contract does not entitle the Provider to accept referrals in respect of, provide services to, nor to be paid for providing services to, individuals whose Responsible Commissioner is not a Party to this Contract, except: 6.14.16.16.1 where such an individual is exercising their legal right to choice as set out in Patient Choice Legislation and Guidance; and then only if: 6.14.1.16.16.1.1 the service provided to that individual is a Service as described in this Contract; and 6.14.1.26.16.1.2 where this Contract otherwise identifies a site or sites at which or a geographical area within which the Service is to be delivered, the service provided to that individual is delivered from such a site or within that geographical area, as appropriate; or 6.14.26.16.2 where necessary for that individual to receive emergency treatment.	All
Care (Education) and Treatment Reviews 6.156.17 The Parties must co-operate with each other, with relevant local authorities, and with other relevant providers of health, social care, education and housing services, to implement and comply with Care (Education) and Treatment Review Guidance.	MH, MHSS
Urgent and Emergency Care Directory of Services 6.166.18 If a Commissioner requires that any Services are to be listed in the UEC DoS:	All

6.16.16.18.1 the Provider must nominate a UEC DoS Contact and must ensure that the Co-ordinating Commissioner and each Commissioner's UEC DoS Lead is kept informed at all times of the person holding that position; 6.16.26.18.2 that Commissioner must nominate a UEC DoS Lead and must ensure that the Provider is kept informed at all times of the person holding that position; and 6.16.36.18.3 the Provider must ensure that its UEC DoS Contact: 6.16.3.16.18.3.1 continually validates UEC DoS entries in relation to the Services to ensure that they are complete, accurate and up to date at all times; and 6.16.3.26.18. notifies each Commissioner's UEC DoS Lead immediately on becoming aware of any amendment or addition which is required to be made to any UEC DoS entry in relation to the Services.	
6.17 Where it provides Accident and Emergency Services or Urgent Treatment Centre Services, the Provider must, when updating, developing or procuring any relevant information technology system or software, ensure that that system or software enables direct electronic booking of attendance slots for Service Users, in those Services, by providers of 111 and IUC Clinical Assessment Services, in accordance with UEC Booking Standard.	A+E, U
6.19 Where it provides any Service to which the UEC Booking and Referral Standard applies, the Provider must: 6.19.1 comply with the UEC Booking and Referral Standard as applicable to the Services; 6.19.2 when updating, developing or procuring any relevant information technology system or software, ensure that that system or software enables direct electronic booking of attendance slots for Service Users, in those Services, by relevant providers in accordance with the UEC Booking and Referral Standard; 6.19.3 once the relevant system or software is in place, use all reasonable endeavours to make sufficient appointment slots available to enable an appointment to be booked for any Service User within a reasonable period; and 6.19.4 use all reasonable endeavours to ensure that, where relevant systems or software are in place, Staff use those systems or software to make electronic bookings for relevant Service Users.	A, A+E, AM, CS, 111, U

SC7 Withholding and/or Discontinuation of Service 7.1 Nothing in this SC7 allows the Provider to refuse to provide or to stop providing a Service if that would be contrary to the Law.	All
7.2 The Provider will not be required to provide or to continue to provide a Service to a Service User: 7.2.1 who in the Provider's reasonable professional opinion is unsuitable to receive the relevant Service, for as long as they remain unsuitable; 7.2.2 in respect of whom no valid consent (where required) has been given in accordance with the Service User consent policy; 7.2.3 who displays abusive, violent or threatening behaviour unacceptable to the Provider, or behaviour which the Provider determines constitutes discrimination or harassment towards any Staff or other Service User (within the meaning of the Equality Act 2010) (the Provider in each case acting reasonably and taking into account that Service User's mental health and clinical presentation and any other health conditions which may influence their behaviour); 7.2.4 in that Service User's domiciliary care setting or circumstances (as applicable) where that environment poses a level of risk to the Staff engaged in the delivery of the relevant Service that the Provider reasonably considers to be unacceptable; or 7.2.5 where expressly instructed not to do so by an emergency service provider who has authority to give that instruction, for as long as that instruction applies.	All All except 111 All All except 111 All
7.3 If the Provider proposes not to provide or to stop providing a Service to any Service User under SC7.2: 7.3.1 where reasonably possible, the Provider must explain to the Service User, Carer or Legal Guardian (as appropriate), taking into account any communication or language needs, the action that it is taking, when that action takes effect, and the reasons for it (confirming that explanation in writing within 2 Operational Days); 7.3.2 the Provider must tell the Service User, Carer or Legal Guardian (as appropriate) that they have the right to challenge the Provider's decision through the Provider's complaints procedure and how to do so;	All

7.3.3 7.3.4	wherever possible, the Provider must inform the relevant Referrer (and if the Service User's GP is not the relevant Referrer, subject to obtaining consent in accordance with Law and Guidance, the Service User's GP) in writing without delay before taking the relevant action; and the Provider must liaise with the Responsible Commissioner and the relevant Referrer to seek to maintain or restore the provision of the relevant care to the Service User in a way that minimises any disruption to the Service User's care and risk to the Service User.	
7.4A 7.4A1 7.4A2	Except in respect of Services to which SC7.4B, SC7.4C or SC7.4D applies: If the Provider, the Responsible Commissioner and the Referrer cannot agree on the continued provision of the relevant Service to a Service User, the Provider must (subject to any requirements under SC11 (<i>Transfer of and Discharge from Care; Communication with GPs</i>)) notify the Responsible Commissioner (and where applicable the Referrer) that it will not provide or will stop providing the Service to that Service User. The Responsible Commissioner must then liaise with the Referrer to procure alternative services for that Service User.	All except AM, MHSS, 111
7.4B 7.4B1 7.4B2	In relation to Ambulance Services: If the Provider, the Responsible Commissioner, and the emergency incident co-ordinator having primacy of the relevant incident, cannot agree on the continued provision of the relevant Service to a Service User, the Provider must (subject to any requirements under SC11 (<i>Transfer of and Discharge from Care; Communication with GPs</i>)) notify the Responsible Commissioner (and where applicable the Referrer) that it will not provide or will stop providing the Service to that Service User. The Responsible Commissioner must then liaise with the Referrer as soon as reasonably practicable to procure alternative services for that Service User.	AM
7.4C 7.4C1	In relation to Mental Health Secure Services: If the Provider, the Responsible Commissioner and the Referrer cannot agree on the continued provision of the relevant Service to a Service User, the Provider must (subject to any requirements under SC11 (<i>Transfer of and Discharge from Care; Communication with GPs</i>)) give the Responsible Commissioner (and where applicable the	MHSS

	Referrer) not less than 20 Operational Days' notice that it will stop providing the Service to that Service User.	
7.4C2	The Responsible Commissioner must then liaise with the Referrer to procure alternative services for that Service User.	
7.4D	In relation to 111 Services:	111
7.4D1	If the Provider, the Responsible Commissioner, the Referrer and the Service User's GP cannot agree on the continued provision of the relevant Service to a Service User, the Provider must notify the Responsible Commissioner and the Service User's GP that it will not provide or will stop providing the Service to that Service User.	
7.4D2	The Responsible Commissioner must then liaise with the Service User's GP to procure alternative services for that Service User.	
7.5	If the Provider stops providing a Service to a Service User under SC7.2, and the Provider has complied with SC7.3, the Responsible Commissioner must pay the Provider in accordance with SC36 (<i>Payment Terms</i>) for the Service provided to that Service User before the discontinuance.	All
SC8	Unmet Needs, Making Every Contact Count and Self Care	
8.1	If the Provider believes that a Service User or a group of Service Users may have an unmet health or social care need, it must notify the Responsible Commissioner accordingly. The Responsible Commissioner will be responsible for making an assessment to determine any steps required to be taken to meet those needs.	All
8.2	If the Provider considers that a Service User has an immediate need for treatment or care which is within the scope of the Services it must notify the Service User, Carer or Legal Guardian (as appropriate) of that need without delay and must provide the required treatment or care in accordance with this Contract, acting at all times in the best interest of the Service User. The Provider must notify the Service User's GP as soon as reasonably practicable of the treatment or care provided.	All except 111
8.3	If the Provider considers that a Service User has an immediate need for care which is outside the scope of the Services, it must notify the Service User, Carer or Legal Guardian (as appropriate) and the Service User's GP of that need without delay and must co-operate with the Referrer to secure the provision to the Service User of the required	All

	treatment or care, acting at all times in the best interests of the Service User. In fulfilling its obligations under this SC8.3, the Provider must ensure that it takes account of all available information relating to the relevant locally-available services (including information held in the UEC DoS).	
8.4	If the Provider considers that a Service User has a non-immediate need for treatment or care which is within the scope of the Services and which is directly related to the condition or complaint which was the subject of the Service User's original Referral or presentation, it must notify the Service User, Carer or Legal Guardian (as appropriate) of that need without delay and must (unless Unless referral back to the Service User's GP is required in order for the Provider to comply with its obligations under SC29.4.1) provide the required treatment or care in accordance with this Contract, and acting at all times in the best interest of the Service User. The the Provider must notify the Service User's GP as soon as reasonably practicable of the treatment or care provided. <u>8.4.1 if that treatment or care is within the scope of the Services, provide the required treatment or care in accordance with this Contract;</u> <u>8.4.2 if that treatment or care is not within the scope of the Services, co-operate with the Commissioner to secure the provision to the Service User of the required treatment or care; and</u> <u>8.4.3 notify the Service User's GP as soon as reasonably practicable of the treatment or care provided or secured.</u>	All except 111
8.5	Except as permitted under an applicable Prior Approval Scheme, the Provider must not carry out, nor refer to another provider to carry out, any non-immediate or routine treatment or care that is not directly related to the condition or complaint which was the subject of the Service User's original Referral or presentation without the agreement of the Service User's GP.	All except 111
8.6	The Provider must develop and maintain an organisational plan to ensure that Staff use every contact that they have with Service Users and the public as an opportunity to maintain or improve health and wellbeing, in accordance with the principles and using the tools comprised in Making Every Contact Count Guidance.	All

8.7 In accordance with the Alcohol and Tobacco Brief Interventions Guidance, the Provider must screen inpatient Service Users for alcohol and tobacco use and, where appropriate: 8.7.1 offer brief advice or interventions to Service Users; and/or 8.7.2 refer the Service User to available alcohol advisory and/or smoking cessation services provided by the relevant Local Authority; and/or 8.7.3 if the Provider is an NHS Trust or an NHS Foundation Trust, refer the Service User to an appropriate NHS Smoking Cessation Advance Service.	A, MH, MHSS A, MH, MHSS A
8.8 Where clinically appropriate, the Provider must support Service Users to develop the knowledge, skills and confidence to take increasing responsibility for managing their own ongoing care.	All
8.9 The Provider must have regard to the Standards for Inpatient Mental Health Services and must monitor the cardiovascular and metabolic health of Service Users with severe mental illness and Service Users with a learning disability, autism or both who are receiving anti-psychotic medication, in accordance with: 8.9.1 NICE clinical guidance CG178 (<i>Psychosis and schizophrenia in adults: prevention and management</i>); and 8.9.2 the Lester Tool, and if a need for further treatment or care is indicated, take appropriate action in accordance with this SC8.	MH, MHSS
SC9 Consent 9.1 The Provider must publish, maintain and operate a Service User consent policy which complies with Good Practice and the Law.	All
SC10 Personalised Care 10.1 In the performance of their respective obligations under this Contract the Parties must (where and as applicable to the Services): 10.1.1 give due regard to Guidance on Personalised Care; and 10.1.2 use all reasonable endeavours to implement any Development Plan for Personalised Care.	All
10.2 The Provider must comply with regulation 9 of the 2014 Regulations. In planning and reviewing the care or treatment which a Service User	All

	receives, the Provider must employ Shared Decision-Making, using supporting tools and techniques approved by the Co-ordinating Commissioner.	
10.3	Where required by Guidance, the Provider must, in association with other relevant providers of health and social care, 10.3.1 develop and agree a Personalised Care and Support Plan with the Service User and/or their Carer or Legal Guardian; and 10.3.2 ensure that the Service User and/or their Carer or Legal Guardian (as appropriate) can access that Personalised Care and Support Plan in a format and through a medium appropriate to their needs.	All except A+E, AM, D, 111, PT, U
10.4	The Provider must prepare, evaluate, review and audit each Personalised Care and Support Plan on an on-going basis. Any review must involve the Service User and/or their Carer or Legal Guardian (as appropriate).	All except A+E, AM, D, 111, PT, U
10.5	The Provider must use all reasonable endeavours to ensure that, when arranging an outpatient or community appointment in relation to any Service (subject to the requirements of the Service Specification and where clinically appropriate), it offers the Service User the option of a telephone or video appointment, or any other available remote consultation option, as an alternative to a face-to-face consultation.	A, CS, MH
10.6	Where the Provider provides outpatient Services, it must have regard to Guidance on Implementing Patient Initiated Follow-up.	A, CS, MH
10.7	Where a Local Authority requests the cooperation of the Provider in securing an Education, Health and Care Needs Assessment, the Provider must use all reasonable endeavours to comply with that request within six weeks of the date on which it receives it.	A, CS, MH
SC11 Transfer of and Discharge from Care; Communication with GPs		
11.1	The Provider must comply with: 11.1.1 the Transfer of and Discharge from Care Protocols; 11.1.2 the 1983 Act; 11.1.3 the 1983 Act Code (including following all procedures specified by or established as a consequence of the 1983 Act Code);	All MH, MHSS MH, MHSS

11.1.4	Care (Education) and Treatment Review Guidance insofar as it relates to transfer of and discharge from care;	MH, MHSS
11.1.5	the 2014 Act; and	All
11.1.6	Transfer and Discharge Guidance and Standards.	All
11.2	The Provider and each Commissioner must use its best efforts to support safe, prompt discharge from hospital and to avoid circumstances and transfers and/or discharges likely to lead to emergency readmissions or recommencement of care.	All
11.3	Before the transfer of a Service User to another Service under this Contract and/or before a Transfer of Care or discharge of a Service User, the Provider must liaise as appropriate with any relevant third party health or social care provider, and with the Service User and any Legal Guardian and/or Carer, to prepare and agree a Care Transfer Plan. The Provider must implement the Care Transfer Plan when delivering the further Service, or transferring and/or discharging the Service User, unless (in exceptional circumstances) to do so would not be in accordance with Good Practice.	All except 111, PT
11.4	A Commissioner may agree a Shared Care Protocol in respect of any clinical pathway with the Provider and representatives of local primary care and other providers. Where there is a proposed Transfer of Care and a Shared Care Protocol is applicable, the Provider must, where the Service User's GP has confirmed willingness to accept the Transfer of Care, initiate and comply with the Shared Care Protocol.	All except 111, PT
11.5	When transferring or discharging a Service User from an inpatient or day case or accident and emergency Service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or other Referrer and to any relevant third party provider of health or social care, using the applicable Delivery Method. The Provider must ensure that it is at all times able to send and receive Discharge Summaries via all applicable Delivery Methods.	A, A+E, CR, MH, MHSS
11.6	When transferring or discharging a Service User from a Service which is not an inpatient or day case or accident and emergency Service, the Provider must, if required by the relevant Transfer of and Discharge from Care Protocol, issue the Discharge Summary to the Service User's GP and/or other Referrer and to any relevant third party provider of health or social care within the timescale, and in accordance with any other requirements, set out in that protocol.	All except A+E, 111, PT
11.6A	By 8.00am on the next Operational Day after the transfer and/or discharge of the Service User from the Provider's care, the Provider must send a Post Event Message to the Service User's GP (where appropriate, and not inconsistent with relevant Guidance) and to any	111

	relevant third party provider of health or social care to whom the Service User is referred, using the applicable Delivery Method. The Provider must ensure that it is at all times able to send Post Event Messages via all applicable Delivery Methods.	
11.7	Where, in the course of delivering an outpatient Service to a Service User, the Provider becomes aware of any matter or requirement pertinent to that Service User's ongoing care and treatment which would necessitate the Service User's GP <u>and/or other Referrer</u> taking prompt action, the Provider must communicate this by issue of a Clinic Letter to the Service User's GP <u>and/or other Referrer</u> . The Provider must send the Clinic Letter as soon as reasonably practicable and in any event within 7 days following the Service User's outpatient attendance. The Provider must issue such Clinic Letters using the applicable Delivery Method.	A, CR, MH
11.8	The Commissioners must use all reasonable endeavours to assist the Provider to access the necessary national information technology systems to support electronic submission of Discharge Summaries and Clinic Letters and to ensure that GPs are in a position to receive Discharge Summaries and Clinic Letters via the Delivery Method applicable to communication with GPs.	All except AM, PT
11.9	Where a Service User has a clinical need for medication to be supplied on discharge from inpatient or day case care, the Provider must ensure that the Service User will have on discharge an adequate quantity of that medication to last: 11.9.1 for the period required by local practice, in accordance with any requirements set out in the Transfer of and Discharge from Care Protocols (but at least 7 days); or 11.9.2 (if shorter) for a period which is clinically appropriate. The Provider must supply that quantity of medication to the Service User itself, except to the extent that the Service User already has an adequate quantity and/or will receive an adequate supply via an existing repeat prescription from the Service User's GP or other primary care provider.	A, CR, MH
11.10	Where a Service User has an immediate clinical need for medication to be supplied following outpatient clinic attendance, the Provider must itself supply to the Service User an adequate quantity of that medication to last for the period required by local practice, in accordance with any requirements set out in the Transfer of and Discharge from Care Protocols (but at least sufficient to meet the Service User's immediate clinical needs until the Service User's GP receives the relevant Clinic Letter and can prescribe accordingly).	A, CR, MH
11.11	The Parties must at all times have regard to NHS Guidance on Prescribing Responsibilities, including, in the case of the Provider, in	A, CR, MH

fulfilling its obligations under SC11.4, 11.9 and/or 11.10 (as appropriate). When supplying medication to a Service User under SC11.9 or SC11.10 and/or when recommending to a Service User's GP any item to be prescribed for that Service User by that GP following discharge from inpatient care or clinic attendance, the Provider must have regard to Guidance on Prescribing in Primary Care.	
11.12 Where a Service User either: 11.12.1 is admitted to or discharged from hospital; or 11.12.2 attends an outpatient clinic or accident and emergency department, the Provider must, where appropriate under and in accordance with Fit Note Guidance, issue free of charge to the Service User or their Carer or Legal Guardian any necessary medical certificate to prove the Service User's fitness or otherwise to work, covering the period until the date by which it is anticipated that the Service User will have recovered or by which it will be appropriate for a further clinical review to be carried out.	A, A+E, CR, MH
11.13 The Provider must use all reasonable endeavours to refer Service Users, on discharge from inpatient care and where clinically appropriate, into the NHS Discharge Medicines Service, in accordance with the NHS Discharge Medicine Service Toolkit as applicable to the Provider.	A, MH, MHSS
11.14 The Parties must comply with their respective obligations under the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and must co-operate with each other, with the relevant Local Authority and with other providers of health and social care as appropriate, to minimise the number of NHS Continuing Healthcare assessments which take place in an acute hospital setting.	A, CHC, CS, ELC, MH, MHSS
SC12 Communicating with and Involving Service Users, Public and Staff 12.1 The Provider must: 12.1.1 arrange and carry out all necessary steps in a Service User's care and treatment promptly and in a manner consistent with the relevant Service Specifications and Quality Requirements until such point as the Service User can appropriately be discharged in accordance with the Transfer of and Discharge from Care Protocols; 12.1.2 ensure that Staff work effectively and efficiently together, across professional and Service boundaries, to manage their interactions with Service Users so as to ensure that	All

	they experience co-ordinated, high quality care without unnecessary duplication of process; 12.1.3 notify the Service User (and, where appropriate, their Carer and/or Legal Guardian) of the results of all investigations and treatments promptly and in a readily understandable, functional, clinically appropriate and cost effective manner; and 12.1.4 communicate in a readily understandable, functional and timely manner with the Service User (and, where appropriate, their Carer and/or Legal Guardian), their GP and other providers about all relevant aspects of the Service User's care and treatment.	
12.2	The Provider must: 12.2.1 provide Service Users (in relation to their own care) and Referrers (in relation to the care of an individual Service User) with clear information in respect of each Service about who to contact if they have questions about their care and how to do so; 12.2.2 ensure that there are efficient arrangements in place in respect of each Service for responding promptly and effectively to such questions and that these are publicised to Service Users and Referrers using all appropriate means, including appointment and admission letters and on the Provider's website; and 12.2.3 wherever possible, deal with such questions from Service Users itself, and not by advising the Service User to speak to their Referrer.	All
12.3	The Provider must comply with the Accessible Information Standard.	All
12.4	The Provider must, <u>having regard to Statutory Guidance on Working In Partnership With People And Communities where applicable:</u> <u>12.4.1</u> actively engage, liaise and communicate with Service Users (and, where appropriate, their Carers and Legal Guardians), Staff, GPs and the public in an open, clear and accessible manner in accordance with the Law and Good Practice, seeking their feedback whenever practicable. In communicating with a Service User (and, where appropriate, their Carer and/or Legal Guardian), the Provider must have regard to their health literacy in order to support them to make informed decisions about the Service User's health, care and wellbeing; and <u>12.4.2</u> involve Service Users (and, where required by Law or as otherwise appropriate, their Carers and Legal Guardians), Staff, Service Users' GPs and the public when considering	All

	<u>and implementing (within the scope permitted by the Service Specifications) developments to and redesign of Services.</u> <u>As soon as reasonably practicable following any reasonable request by the Co-ordinating Commissioner, the Provider must provide evidence of that involvement and of how the views of those involved have been taken account of in the relevant developments to and redesign of Services.</u>	
	<u>12.5 In communicating with a Service User (and, where appropriate, their Carer and/or Legal Guardian), the Provider must have regard to their health literacy in order to support them to make informed decisions about the Service User's health, care and wellbeing.</u>	All
	As soon as reasonably practicable following any reasonable request by the Co-ordinating Commissioner, the Provider must provide evidence of that involvement and of how the views of those involved have been taken account of in the relevant developments to and redesign of Services.	All
12.6	The Provider must: 12.6.1 carry out the Friends and Family Test Surveys as required in accordance with FFT Guidance, using all reasonable endeavours to maximise the number of responses from Service Users; 12.6.2 (if it is an NHS Trust or an NHS Foundation Trust) carry out the National Quarterly Pulse Survey as required in accordance with National Quarterly Pulse Survey Guidance; 12.6.3 carry out Staff Surveys which must, where required by Staff Survey Guidance, include the appropriate NHS staff surveys; 12.6.4 carry out all other Surveys; and 12.6.5 co-operate with any surveys that the Commissioners (acting reasonably) carry out. The form, frequency and reporting of the Surveys will be as set out in Schedule 6D (Surveys) or as otherwise agreed between the Co-ordinating Commissioner and the Provider in writing and/or required by Law or Guidance from time to time.	All
12.7	The Provider must review and provide a written report to the Co-ordinating Commissioner on the results of each Survey. The report must identify any actions reasonably required to be taken by the Provider in response to the Survey. The Provider must implement	All

those actions as soon as practicable. The Provider must publish the outcomes of and actions taken in relation to all Surveys.	
SC13 Equity of Access, Equality and Non-Discrimination 13.1 The Parties must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law.	All
13.2 The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.	All
13.3 In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010 and section 6 of the HRA. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.	All
13.4 In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan setting out how it will comply with its obligations under SC13.3. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner in order to comply with this SC13.4.	All
13.5 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must implement EDS.	All
13.6 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must implement the high impact actions set out in the NHS Equality, Diversity and Inclusion Improvement Plan and measure its progress against the success metrics set out in the Plan, as well as the wider metrics under the National Workforce Race Equality Standard and the National Workforce Disability Equality Standard. The Provider must be prepared, if requested to do so by the Co-ordinating Commissioner, to provide a written report on its implementation and progress to its public board meeting and/or to the Co-ordinating Commissioner.	All

13.7	In performing its obligations under this Contract, the Provider must use all reasonable endeavours to: 13.7.1 support the Commissioners in carrying out their duties under the 2006 Act in respect of the reduction of inequalities in access to health services and in the outcomes achieved from the delivery of health services; and 13.7.2 implement any Health Inequalities Action Plan.	All
13.8	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must nominate a Health Inequalities Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position.	All
13.9	The Provider must implement the Patient and Carer Race Equality Framework by 31 March 2025 .	MH, MHSS
SC14 Pastoral, Spiritual and Cultural Care		
14.1	The Provider must take account of the spiritual, religious, pastoral and cultural needs of Service Users.	All
14.2	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must have regard to NHS Chaplaincy Guidelines.	All
SC15 Urgent Access to Mental Health Care		
15.1	The Parties must have regard to the Mental Health Crisis Care Concordat and must reach agreement on the identification of, and standards for operation of, Places of Safety in accordance with the Law, the 1983 Act Code and the Royal College of Psychiatrists Standards.	A, A+E, MH, MHSS, U
15.2	The Parties must co-operate to ensure that individuals under the age of 18 with potential mental health conditions are referred for, and receive, age-appropriate assessment, care and treatment in accordance with the 1983 Act.	A, A+E, MH, MHSS, U
15.3	The Parties must use all reasonable endeavours to ensure that, where an individual under the age of 18 requires urgent mental health assessment, care or treatment, that individual is not : 15.3.1 <u>is not</u> held in police custody in a cell or station; or	A, A+E, MH, MHSS, U

15.3.2 is not admitted to an adult inpatient service (unless this is clinically appropriate in line with the requirements of the 1983 Act); or and 15.3.3 if admitted to an acute paediatric ward, (unless this is required in accordance with NICE guideline CG16 (Self harm in over 8s) or if the individual has an associated physical health or safeguarding need).is treated in accordance with NICE Guideline 225 (Self-harm: assessment, management and preventing recurrence).	
15.4 The Parties must use all reasonable endeavours to ensure that, where an individual under the age of 18 requiring urgent mental health assessment, care or treatment attends or is taken to an accident and emergency department: 15.4.1 a full biopsychosocial assessment is undertaken and an appropriate care plan is put in place; and 15.4.2 the individual is not held within the accident and emergency department beyond the point where the actions in SC15.4.1 have been completed.	A, A+E, MH, MHSS, U
SC16 Complaints 16.1 The Commissioners and the Provider must each publish, maintain and operate a complaints procedure in compliance with the Fundamental Standards of Care, the NHS Complaint Standards and other Law and Guidance.	All
16.2 The Provider must: 16.2.1 provide clear information to Service Users, their Carers and representatives, and to the public, displayed prominently in the Services Environment as appropriate, on how to make a complaint or to provide other feedback and on how to contact Local Healthwatch; and 16.2.2 ensure that this information informs Service Users, their Carers and representatives, of their legal rights under the NHS Constitution, how they can access independent support to help make a complaint, and how they can take their complaint to the Health Service Ombudsman should they remain unsatisfied with the handling of their complaint by the Provider.	All

<u>SC17 Services Environment and Equipment</u> <u>17.1</u> The Provider (if it is an NHS Trust or an NHS Foundation Trust) must have due regard to, and where and as applicable comply with, NHS Estates Guidance.	<u>All</u>
<u>17.2</u> The Provider must: 47.1.1<u>17.2.1</u> ensure that the Services Environment and the Equipment comply with the Fundamental Standards of Care; and 47.1.2<u>17.2.2</u> comply with National Standards of Healthcare Cleanliness- <u>2025</u>.	All All-except AM and PT
17.2<u>17.3</u> Unless stated otherwise in this Contract, the Provider must at its own cost provide all Equipment necessary to provide the Services in accordance with the Law and any necessary Consents.	All
17.3<u>17.4</u> The Provider must ensure that all Staff using Equipment, and all Service Users and Carers using Equipment independently as part of the Service User's care or treatment, have received appropriate and adequate training and have been assessed as competent in the use of that Equipment.	All
17.4 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must comply with the requirements of Health Building Note 00-08 in relation to advertising of legal services.	All
17.5 Without prejudice to SC17.4, theThe Provider (if it is an NHS Trust or an NHS Foundation Trust) must not enter into, extend or renew any contractual arrangement under which a Legal Services Provider is permitted to provide, promote, arrange or advertise any legal service to Service Users, their relatives, Carers or Legal Guardians, whether: 17.5.1 at the Provider's Premises; or 17.5.2 on the Provider's website; or 17.5.3 through written material sent by the Provider to Service Users, their relatives, Carers or Legal Guardians, if and to the extent that that legal service would or might relate to or lead to the pursuit of a claim against the Provider, any other provider or any commissioner of NHS services.	All
17.6 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must use all reasonable endeavours to ensure that no Legal Services	All

	Provider makes any unsolicited approach to any Service User or their relatives, Carer or Legal Guardian while at the Provider's Premises.	
17.7	The Provider must ensure that supplies of appropriate sanitary products are available and are, on request, provided promptly to inpatient Service Users free of charge.	A, MH, MHSS
17.8	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must use reasonable endeavours to ensure that the Provider's Premises are Smoke-free at all times.	All
	17.9 The Provider (if it is an NHS Trust or an NHS Foundation Trust) must complete the NHS Premises Assurance Model and submit a report to its Governing Body in accordance with the requirements and timescales set out in the NHS Premises Assurance Model, and make a copy available to the Co-ordinating Commissioner on request.	All
17.9	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must comply, where applicable, with NHS Car Parking Guidance, and in particular must ensure that any car parking facilities at the Provider's Premises for Service Users, visitors and Staff are available free of charge to those groups and at those times identified in, and otherwise in accordance with, that guidance.	All
17.11 17.10	The Provider must operate a clinically appropriate policy for visits to and by, and accompaniment of, Service Users which complies with the 2014 Regulations and relevant Guidance.	All except AM and PT
SC18 Green NHS and Sustainability		
18.1	In performing its obligations under this Contract the Provider must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in Delivering a 'Net Zero' National Health Service.	All
18.2	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must: 18.2.1 nominate a Net Zero Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position; 18.2.2 maintain and deliver a Green Plan, approved by its Governing Body, in accordance with Green Plan Guidance; and 18.2.3 provide an annual summary of progress on delivery of that plan, covering actions taken and planned, with quantitative progress data, to the Co-ordinating Commissioner and publish that summary in its annual report.	All

18.3 The Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' with regard to Delivering a 'Net Zero' National Health Service commitments in relation to: 18.3.1 air pollution, and specifically how it will take action: 18.3.1.1 to reduce air pollution from fleet vehicles, to offer and promote more sustainable travel options for Service Users, Staff and visitors and to increase use of such options, in accordance with the NHS Net Zero Travel and Transport Strategy; and 18.3.1.2 to phase out fossil fuels for primary heating and replace them with less polluting alternatives. 18.3.2 climate change, and specifically how it will take action: 18.3.2.1 to reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service; 18.3.2.2 in accordance with Good Practice, to reduce the carbon impacts of environmentally damaging gases used as anaesthetic agents and as propellants in inhalers, by reducing piped nitrous oxide waste, by eliminating the use of desflurane in line with Guidance, by prescribing of lower greenhouse gas emitting inhalers where clinically appropriate, and by encouraging Service Users to return their inhalers to pharmacies for appropriate disposal; and analgesic agents and as propellants in inhalers; 18.3.2.3 18.3.2.3 to reduce piped nitrous oxide and nitrous oxide and oxygen mixture waste; 18.3.2.4 18.3.2.4 to eliminate the use of desflurane in line with Desflurane Decommissioning and Clinical Use Guidance; 18.3.2.5 18.3.2.5 to prescribe inhalers with the lowest environmental impact among suitable devices in line with NICE Guidance 245; 18.3.2.6 18.3.2.6 to encourage Service Users to return their inhalers to pharmacies for appropriate disposal; and 18.3.2.7 18.3.2.7 to adapt the Provider's Premises and the manner in which Services are delivered to reduce risks associated with climate change and severe weather.	All
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18.4	TheSubject to SC18.4A, whilst adopting a strategic approach to buying energy that protects against price volatility and ensures value for money, the Provider (if it is an NHS Trust or an NHS Foundation Trust) must <u>either</u>: <u>18.4.1 make all of its energy purchases through the Central Energy Purchasing Agreement; or</u> <u>18.4.2 ensure that, as far as reasonably feasible, energy is purchased at a lower cost than that available through the Central Energy Purchasing Agreement and that all electricity it purchases is purchased from a supplier with a fuel mix containing at least 55% of electricity generated from Renewable and Low Carbon Sources.</u>	All
18.4A	<u>The obligation in SC18.4 does not apply if the Provider is under a binding contractual obligation to purchase energy through an arrangement entered into before 1 April 2025 and it cannot exit that arrangement without paying a financial penalty which would exceed any savings that it could make by purchasing energy through either the Central Energy Purchasing Agreement or from an alternative provider as permitted by SC18.4.2.</u>	All
18.5	The Provider must, in performing its obligations under this Contract: 18.5.1 give due regard to the potential to secure wider social, economic and environmental benefits for the local community and population in its purchase and specification of products and services, and must discuss and seek to agree with the Co-ordinating Commissioner, and review on an annual basis, which impacts it will prioritise for action; and 18.5.2 (if it is an NHS Trust or an NHS Foundation Trust), when procuring goods, services and/or works, comply with the requirements set out in the NHS Net Zero Supplier Roadmap.	All
SC19 National Standards for Healthcare Food and Drink		
19.1	The Provider must comply with the National Standards for Healthcare Food and Drink, as applicable.	All
RECORDS AND REPORTING		
SC20 Service Development and Improvement Plan		
20.1	The Co-ordinating Commissioner and the Provider must agree an SDIP where required by and in accordance with Guidance.	All

20.2	The Co-ordinating Commissioner and the Provider may at any time agree an SDIP.	All
20.3	Any SDIP must be appended to this Contract at Schedule 6C (<i>Service Development and Improvement Plans</i>). The Commissioners and Provider must comply with their respective obligations under any SDIP. The Provider must report performance against any SDIP in accordance with Schedule 6A (<i>Reporting Requirements</i>).	All
SC21 Infection Prevention and Control and StaffSeasonal Vaccination <u>Infection Prevention and Control</u>		
21.1	The Provider must:	
21.1.1	comply with the Code of Practice on the Prevention and Control of Infections and put in place and implement an infection prevention programme in accordance with it;	All except 111
21.1.2	if it is an NHS Trust or an NHS Foundation Trust, comply with, the National Infection Prevention and Control Manual;	All except 111
21.1.3	if it is not an NHS Trust or an NHS Foundation Trust, have regard to the National Infection Prevention and Control Manual;	All except 111
21.1.4	nominate an Infection Prevention Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position;	All except 111
21.1.5	have regard to NICE guideline NG15 (<i>Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use</i>); and	All except 111
21.1.6	have regard to the Antimicrobial Stewardship Toolkit for English Hospitals.	A

21.2	The Provider must ensure that all laboratory services (whether provided directly or under a Sub-Contract) comply with the UK Standards for Microbiology Investigations.	All except 111
21.3	The Provider (if it is an NHS Trust or an NHS Foundation Trust) must use all reasonable endeavours, consistent with good practice, to minimise its Broad-Spectrum Antibiotic Usage in accordance with the requirements of the National Action Plan for Antimicrobial Resistance	A
21.4	<u>Seasonal Vaccination</u> The Provider must use all reasonable endeavours to ensure that all eligible frontline Staff in contact with Service Users are vaccinated, in accordance with JCVI and Green Book Guidance, promptly against influenza and/or Covid-19 in accordance with either: <u>21.4.1 the National Guidance on Seasonal Vaccination Programmes for Staff, where this has been published for the relevant vaccination programme; or</u> <u>21.4.2 where such guidance is not available for the relevant vaccination programme, the JCVI and Green Book Guidance.</u>	All
21.5	The Provider must use all reasonable endeavours to ensure that, where Staff have any contact with a Service User who is either immunosuppressed and/or pregnant (other than while that Service User is an inpatient), they provide that Service User with brief advice on Covid-19 vaccination, in accordance with JCVI and Green Book Guidance, including on available routes for accessing a vaccination service.	A, CS, MH
SC22 Assessment and Treatment for Acute Illness		
22.1	The Provider must implement the methodology described in NEWS 2 Guidance for assessment of acute illness severity for adult Service Users, ensuring that each adult Service User is monitored at the intervals set out in that guidance and that in respect of each adult Service User an appropriate clinical response to their NEWS Score, as defined in that guidance, is always effected.	A, AM
	22.2 The Provider must comply with Sepsis Implementation Guidance.	A

SC23 Service User Health Records 23.1 The Provider must accept transfer of, create and maintain Service User Health Records as appropriate for all Service Users. The Provider must securely store, retain and destroy those records in accordance with Data Guidance, Records Management Code of Practice for Health and Social Care and in any event in accordance with Data Protection Legislation.	All
23.2 The Provider must: 23.2.1 if and as so reasonably requested by a Commissioner, whether during or after the Contract Term, promptly deliver to any third party provider of healthcare or social care services nominated by that Commissioner a copy of the Service User Health Record held by the Provider for any Service User for whom that Commissioner is responsible; and 23.2.2 notwithstanding SC23.1, if and as so reasonably requested by a Commissioner at any time following the expiry or termination of this Contract, promptly deliver to any third party provider of healthcare or social care services nominated by that Commissioner, or to the Commissioner itself, the Service User Health Record held by the Provider for any Service User for whom that Commissioner is responsible.	All
23.3 The Provider must give each Service User full and accurate information regarding their treatment and must evidence that in writing in the relevant Service User Health Record.	All except 111, PT
NHS Number 23.4 Subject to and in accordance with Law and Guidance the Provider must: 23.4.1 ensure that the Service User Health Record includes the Service User's verified NHS Number; 23.4.2 use the NHS Number as the consistent identifier in all clinical correspondence (paper or electronic) and in all information it processes in relation to the Service User; and 23.4.3 be able to use the NHS Number to identify all Activity relating to a Service User; and 23.4.4 use all reasonable endeavours to ensure that the Service User's verified NHS Number is available to all clinical Staff when engaged in the provision of any Service to that Service User.	All

23.5	The Commissioners must ensure that each Referrer (except a Service User presenting directly to the Provider for assessment and/or treatment) uses the NHS Number as the consistent identifier in all correspondence in relation to a Referral.	All
Information Technology Systems		All
23.6	Subject to GC21 (<i>Patient Confidentiality, Data Protection, Freedom of Information and Transparency</i>) the Provider must ensure that all Staff involved in the provision of urgent, emergency and unplanned care are able to view key Service User clinical information from GP records, whether via the Summary Care Records Service or a locally integrated electronic record system supplemented by the Summary Care Records Service.	
23.7	The Provider must ensure that (subject to GC21 (<i>Patient Confidentiality, Data Protection, Freedom of Information and Transparency</i>)) all of its major clinical information technology systems enable clinical data to be accessible to other providers of services to Service Users as structured information through open interfaces in accordance with Open API Policy and Guidance and Care Connect APIs.	All
Internet First and Code of Conduct NHS Digital Architecture Principles		All
23.87	When updating, developing or procuring any information technology system or software, the Provider must have regard to the NHS Internet First Policy and the Code of Conduct for Data-Driven Health and Care Technology<u>Digital Architecture Principles</u>.	
SC24 NHS Counter-Fraud Requirements		All
24.1	The Provider must put in place and maintain appropriate measures to prevent, detect and investigate fraud, bribery and corruption, having regard to NHSCFA Requirements.	
24.2	If the Provider: 24.2.1 is an NHS Trust; and/or 24.2.2 holds a Provider Licence (unless required to do so solely because it provides CRS as designated by the Commissioners or any other commissioner),	All

	it must take the necessary action to meet NHSCFA Requirements, including in respect of reporting via the NHS fraud case management system.	
24.3	If requested by the Co-ordinating Commissioner, or NHSCFA or any Regulatory or Supervisory Body, the Provider must allow a person duly authorised to act on behalf of NHSCFA, on behalf of any Regulatory or Supervisory Body or on behalf of any Commissioner to review, in line with the NHSCFA Requirements, the counter-fraud measures put in place by the Provider.	All
24.4	The Provider must implement any reasonable modifications to its counter-fraud arrangements required by a person referred to in SC24.3 in order to meet the NHSCFA Requirements within whatever time periods as that person may reasonably require.	All
24.5	On becoming aware of any suspected or actual bribery, corruption or fraud involving NHS-funded services, the Provider must promptly report the matter to its nominated Local Counter Fraud Specialist and to NHSCFA.	All
24.6	On the request of the Department of Health and Social Care, NHS England, NHSCFA, any Regulatory or Supervisory Body or the Co-ordinating Commissioner, the Provider must allow NHSCFA or any Local Counter Fraud Specialist nominated by a Commissioner, as soon as it is reasonably practicable and in any event not later than 5 Operational Days following the date of the request, access to: 24.6.1 all property, premises, information (including records and data) owned or controlled by the Provider; and 24.6.2 all Staff who may have information to provide, relevant to the detection and investigation of cases of bribery, fraud or corruption, directly or indirectly in connection with this Contract.	All
SC25 Other Local Agreements, Policies and Procedures		
25.1	If requested by the Co-ordinating Commissioner or the Provider, the Co-ordinating Commissioner or the Provider (as the case may be) must within 5 Operational Days following receipt of the request send or make available to the other copies of any Services guide or other written agreement, policy, procedure or protocol implemented by any Commissioner or the Provider (as applicable).	All
25.2	The Co-ordinating Commissioner must notify the Provider and the Provider must notify the Co-ordinating Commissioner of any material changes to any items it has disclosed under SC25.1.	All

25.3 The Parties must comply with their respective obligations under the documents contained or referred to in Schedule 2G (<i>Other Local Agreements, Policies and Procedures</i>).	All
SC26 Clinical Networks, National Audit Programmes and Approved Research Studies 26.1 The Provider must: 26.1.1 participate in the Clinical Networks, programmes and studies listed in Schedule 2F (<i>Clinical Networks</i>); 26.1.2 participate in: 26.1.2.1 any national programme within the National Clinical Audit and Patient Outcomes Programme; 26.1.2.2 any other national clinical audit or clinical outcome review programme managed or commissioned by HQIP; and 26.1.2.3 any national programme included within the NHS England Quality Accounts List for the relevant Contract Year, relevant to the Services.; and 26.1.3 make national clinical audit data available to support national publication of Consultant-level activity and outcome statistics in accordance with HQIP Guidance.	All except PT
26.2 The Provider must adhere to all protocols and procedures operated or recommended under the programmes and arrangements referred to in SC26.1, unless in conflict with existing protocols and procedures agreed between the Parties, in which case the Parties must review all relevant protocols and procedures and try to resolve that conflict.	All except PT
26.3 The Provider must put arrangements in place to facilitate recruitment of Service Users and Staff as appropriate into Approved Research Studies.	All
26.4 If the Provider chooses to participate in any Commercial Contract Research Study which is submitted to the Health Research Authority for approval, the Provider must ensure that that participation will be in accordance with the National Directive on Commercial Contract Research Studies, at a price determined by NIHR for each Provider in accordance with the methodology prescribed in the directive and under such other contractual terms and conditions as are set out in the directive.	All

26.5	The Provider must comply with HRA/NIHR Research Reporting Guidance, as applicable.	All
26.6	The Parties must comply with NHS Treatment Costs Guidance, as applicable.	All
SC27 Formulary		A, CR, MH, MHSS
27.1	Where any Service involves or may involve the prescribing of drugs, the Provider must:	
27.1.1	ensure that its current Formulary is published and readily available on the Provider's website;	
27.1.2	ensure that its Formulary reflects all relevant positive NICE Technology Appraisals; and	
27.1.3	make available to Service Users all relevant treatments recommended in positive NICE Technology Appraisals.	
SC28 Information Requirements		All
28.1	The Parties acknowledge that the submission of complete and accurate data in accordance with this SC28 is necessary to support the commissioning of all health and social care services in England.	
28.2	The Provider must:	All
28.2.1	provide the information specified in this SC28 and in Schedule 6A (<i>Reporting Requirements</i>):	
28.2.1.1	with the frequency, in the format, by the method and within the time period set out or referred to in Schedule 6A (<i>Reporting Requirements</i>); and	
28.2.1.2	as detailed in relevant Guidance; and	
28.2.1.3	if there is no applicable time period identified, in a timely manner;	
28.2.2	where and to the extent applicable, conform to all NHS information standards notices, data provision notices and information and data standards approved or published by the Secretary of State, NHS England or NHS Digital;	
28.2.3	implement any other datasets and information requirements agreed from time to time between it and the Co-ordinating Commissioner;	

28.2.4	comply with Data Guidance issued by NHS England and NHS Digital and with Data Protection Legislation in relation to protection of patient identifiable data;	
28.2.5	subject to and in accordance with Law and Guidance and any relevant standards issued by the Secretary of State, NHS England or NHS Digital, use the Service User's verified NHS Number as the consistent identifier of each record on all patient datasets;	
28.2.6	comply with the Data Guidance and Data Protection Legislation on the use and disclosure of personal confidential data for other than direct care purposes; and	
28.2.7	use all reasonable endeavours to optimise its performance under the Data Quality Maturity Index (where applicable) and must demonstrate its progress to the Co-ordinating Commissioner on an ongoing basis, through agreement and implementation of a Data Quality Improvement Plan or through other appropriate means.	
28.3	The Co-ordinating Commissioner may request from the Provider any information in addition to that to be provided under SC28.2 which any Commissioner reasonably and lawfully requires in relation to this Contract. The Provider must supply that information in a timely manner.	All
28.4	The Co-ordinating Commissioner must act reasonably in requesting the Provider to provide any information under this Contract, having regard to the burden which that request places on the Provider, and may not, without good reason, require the Provider:	All
28.4.1	to supply any information to any Commissioner locally where that information is required to be submitted centrally under SC28.2; or	
28.4.2	where information is required to be submitted in a particular format under SC28.2, to supply that information in a different or additional format (but this will not prevent the Co-ordinating Commissioner from requesting disaggregation of data previously submitted in aggregated form); or	
28.4.3	to supply any information to any Commissioner locally for which that Commissioner cannot demonstrate purpose and value in connection with the discharge of that Commissioner's statutory duties and functions.	
28.5	The Provider and each Commissioner must ensure that any information provided to any other Party in relation to this Contract is accurate and complete.	All

Counting and coding of Activity		
28.6	The Provider must ensure that each dataset that it provides under this Contract contains the ODS code and/or other appropriate identifier for the relevant Commissioner. When determining the correct Commissioner code in activity datasets, the Parties must comply with Who Pays? Rules and must have regard to Commissioner Assignment Methodology Guidance.	All
28.7	The Parties must at all times comply with Guidance relating to clinical coding published by NHS Digital or NHS England and with the definitions of Activity maintained under the NHS Data Model and Dictionary.	All
28.8	Where NHS England issues new or updated Guidance on the counting and coding of Activity and that Guidance requires the Provider to change its counting and coding practice, the Provider must: 28.8.1 as soon as reasonably practicable inform the Co-ordinating Commissioner in writing of the change it is making to effect the Guidance; and 28.8.2 implement the change on the date (or in the phased sequence of dates) mandated in the Guidance.	All
28.9	Where any change in counting and coding practice required under SC28.8 is projected, once implemented, to have, or is found following implementation to have had, an impact on the Actual Annual Value of Services, the Parties must adjust the relevant Prices payable, 28.9.1 where the change is to be, or was, implemented within the Contract Year in which the relevant Guidance was issued by NHS Digital or NHS England, in respect of the remainder of that Contract Year; and 28.9.2 in any event, in respect of the whole of the Contract Year following the Contract Year in which the relevant Guidance was issued by NHS Digital or NHS England, in accordance with the NHS Payment Scheme to ensure that that impact is rendered neutral for that Contract Year or those Contract Years, as applicable.	All
28.10	Except as provided for in SC28.8, the Provider must not implement a change of practice in the counting and coding of Activity without the agreement of the Co-ordinating Commissioner.	All

28.11 Either the Co-ordinating Commissioner (on behalf of the Commissioners) or the Provider may at any time propose a change of practice in the counting and coding of Activity to render it compliant with Guidance issued by NHS Digital or NHS England already in effect. The Party proposing such a change must give the other Party written notice of the proposed change at least 6 months before the date on which that change is proposed to be implemented.	All
28.12 The Party receiving notice of the proposed change of practice under SC28.11 must not unreasonably withhold or delay its agreement to the change.	All
28.13 Any change of practice proposed under SC28.11 and agreed under SC28.12 must be implemented on 1 April of the following Contract Year, unless the Parties agree a different date (or phased sequence) for its implementation.	All
28.14 Where any change in counting and coding practice proposed under SC28.11 and agreed under SC28.12 is projected, once implemented, to have, or is found following implementation to have had, an impact on the Actual Annual Value, the Parties must adjust the relevant Prices payable: 28.14.1 where the change is to be, or was, implemented within the Contract Year in which the change was proposed, in respect of the remainder of that Contract Year; and 28.14.2 in any event, in respect of the whole of the Contract Year following the Contract Year in which the change was proposed, in accordance with the NHS Payment Scheme to ensure that that impact is rendered neutral for that Contract Year or those Contract Years, as applicable.	All
28.15 Where any change of practice in the counting and coding of Activity is implemented, the Provider and the Co-ordinating Commissioner must, working jointly and in good faith, use all reasonable endeavours to monitor its impact and to agree the extent of any adjustments to Prices which may be necessary under SC28.9 or SC28.14.	All
Aggregation and disaggregation of information 28.16 Information to be provided by the Provider under this SC28 and Schedule 6A (<i>Reporting Requirements</i>) and which is necessary for the purposes of SC36 (<i>Payment Terms</i>) must be provided: 28.16.1 to the Co-ordinating Commissioner in aggregate form; and/or	All

28.16.2	directly to each Commissioner in disaggregated form relating to its own use of the Services, as the Co-ordinating Commissioner may direct.	
SUS		All
28.17	The Provider must submit commissioning data sets to SUS in accordance with SUS Guidance, where applicable. Where SUS is applicable, if:	
28.17.1	there is a failure of SUS; or	
28.17.2	there is an interruption in the availability of SUS to the Provider or to any Commissioner,	
	the Provider must comply with Guidance issued by NHS England and/or NHS Digital in relation to the submission of the national datasets collected in accordance with this SC28 pending resumption of service, and must submit those national datasets to SUS as soon as reasonably practicable after resumption of service.	
Data Quality Improvement Plan		All
28.18	The Co-ordinating Commissioner and the Provider may at any time agree a Data Quality Improvement Plan (which must be appended to this Contract at Schedule 6B (<i>Data Quality Improvement Plans</i>)). Any Data Quality Improvement Plan must set out milestones to be met.	
MANAGING ACTIVITY AND REFERRALS		
SC29 Managing Activity and Referrals		All
29.1	The Commissioners and the Provider must each monitor and manage Activity and Referrals for the Services in accordance with this SC29 and the NHS Payment Scheme.	
29.2	The Parties must not agree or implement any action that would operate contrary to Patient Choice Legislation and Guidance or so as to restrict or impede the exercise by Service Users or others of their legal rights to choice.	All
29.3	The Commissioners must use all reasonable endeavours to:	All except 111
29.3.1	procure that all Referrers adhere to Referral processes and clinical thresholds set out or referred to in this Contract and/or as otherwise agreed between the Parties and/or as specified in any Prior Approval Scheme;	

29.3.2 29.3.3	manage Referral levels in accordance with any Activity Planning Assumptions; and notify the Provider promptly of any anticipated changes in Referral numbers.	
29.3A	The Commissioners must notify the Provider promptly of any anticipated changes in Referral numbers.	111
29.4 29.4.1 29.4.2	The Provider must: comply with and use all reasonable endeavours to manage Activity in accordance with Referral processes and clinical thresholds set out or referred to in this Contract and/or as otherwise agreed between the Parties and/or as specified in any Prior Approval Scheme, and in accordance with any Activity Planning Assumptions; and comply with the reasonable requests of the Commissioners to assist the Commissioners in understanding and managing patterns of Referrals.	All
	Indicative Activity Plan 29.5 The Parties may agree (and must agree for any Services Paid for on an Activity Basis) an Indicative Activity Plan for each Contract Year⁷. Where possible that plan should be agreed either before the date of this Contract or (failing that) before the start of the relevant Contract Year, specifying the threshold for each activity (and those agreed thresholds may be zero). If the Parties have not agreed an Indicative Activity Plan before the start of any Contract Year an Indicative Activity Plan with an indicative activity of zero will be deemed to apply for that Contract Year.	All
	The29.5A If the Parties have not been able to agree an Indicative Activity Plan will comprise the aggregated: <u>29.5A.1 within three months of the Service Commencement Date; or</u> <u>29.5A.2 by 30 June, where the Provider has been providing the Services under a previous contract before the Service Commencement Date,</u> <u>each Commissioner may set an Indicative Activity Plans of all of Plan for the Commissioners Contract Year.</u>	All

<u>29.5B</u> If an Indicative Activity Plan is not agreed, or a Commissioner does not set an Indicative Activity Plan, an Indicative Activity Plan with an indicative activity of zero will be deemed to apply for that Contract Year.	All
<u>29.6</u> The Indicative Activity Plan will comprise the aggregated Indicative Activity Plans of all of the Commissioners.	All
Activity Planning Assumptions <u>29.629.7</u> The Co-ordinating Commissioner must notify the Provider of any Activity Planning Assumptions for each Contract Year, specifying a threshold for each assumption, either before the date of this Contract or (failing that) before the start of the relevant Contract Year.	All
<u>Reporting and Monitoring Activity</u> <u>29.8</u> The Provider must submit an Activity and Finance Report to the Co-ordinating Commissioner and, where requested, any other Commissioner, in accordance with Schedule 6A (<i>Reporting Requirements</i>).	All
<u>29.9</u> Each Commissioner and the Provider will monitor actual Activity reported in each Activity and Finance Report in respect of each Commissioner against: <u>29.9.1</u> thresholds set out in any Indicative Activity Plan; and <u>29.9.2</u> thresholds set out in any Activity Planning Assumptions; and <u>29.9.3</u> any previous Activity and Finance Reports, as appropriate.	All
Activity <u>Management Meeting</u> <u>29.10</u> The Following the submission of any Activity and Finance Report in accordance with SC29.8, which indicates: <u>29.10.1</u> variances against the thresholds set out in any Indicative Activity Plan; and/or <u>29.10.2</u> any breaches of the thresholds set out in any Activity Planning Assumptions; and/or <u>29.10.3</u> any unexpected or unusual patterns of Referrals and/or Activity,	All

<u>in relation to any Commissioner, either the Commissioner or the Provider must submit may issue to the other an Activity and Finance Report to Query Notice. The relevant Commissioner must notify the Co-ordinating Commissioner in accordance with Schedule 6A (Reporting Requirements) that an Activity Query Notice has been issued.</u>	
<u>29.11 The Commissioner and the Provider must meet to discuss any Activity Query Notice within 10 Operational Days following its issue.</u>	<u>All</u>
<u>29.12 At that meeting the Commissioner and the Provider must:</u> <u>29.12.1 consider patterns of Referrals, of Activity and of the exercise by Service Users of their legal rights to choice; and</u> <u>29.12.2 agree either:</u> <u>29.12.2.1 that the Activity Query Notice is withdrawn; or</u> <u>29.12.2.2 to conduct a Joint Activity Review, in which case the provisions of SC29.13 to 29.16 will apply.</u>	<u>All</u>
<u>Joint Activity Review</u> <u>29.13 Within 10 Operational Days following agreement to conduct a Joint Activity Review under SC29.12, the Commissioner and the Provider must meet:</u> <u>29.13.1 to consider in further detail the matters referred to in SC29.12.1 and the causes of the unexpected or unusual pattern of Referrals and/or Activity; and</u> <u>29.13.2 (if the Commissioner considers it necessary or appropriate) to agree an Activity Management Plan.</u>	<u>All</u>
<u>29.14 If the Commissioner and the Provider fail to agree an Activity Management Plan at or within 10 Operational Days following the Joint Activity Review, the Commissioner may set an Activity Management Plan. The Commissioner must notify the Co-ordinating Commissioner that an Activity Management Plan has been agreed or set.</u>	<u>All</u>

29.7 The Co-ordinating Commissioner and the Provider will monitor actual Activity reported in each Activity and Finance Report in respect of each Commissioner against: 29.9.1 thresholds set out in any Indicative Activity Plan; and 29.9.2 thresholds set out in any Activity Planning Assumptions; and 29.9.3 any previous Activity and Finance Reports, as appropriate.	All
Activity Management Meeting 29.8 Following the submission of any Activity and Finance Report in accordance with SC29.8, which indicates: 29.10.1 variances against the thresholds set out in any Indicative Activity Plan; and/or 29.10.2 any breaches of the thresholds set out in any Activity Planning Assumptions; and/or 29.10.3 any unexpected or unusual patterns of Referrals and/or Activity, in relation to any Commissioner, either the Co-ordinating Commissioner or the Provider may issue to the other an Activity Query Notice.	All
29.9 The Co-ordinating Commissioner and the Provider must meet to discuss any Activity Query Notice within 10 Operational Days following its issue.	All
29.10 At that meeting the Co-ordinating Commissioner and the Provider must: 29.12.1 consider patterns of Referrals, of Activity and of the exercise by Service Users of their legal rights to choice; and 29.12.2 agree either: 29.12.2.1 that the Activity Query Notice is withdrawn; or 29.12.2.2 to conduct a Joint Activity Review, in which case the provisions of SC29.13 to 29.16 will apply.	All

<u>Joint Activity Review</u> 29.11 Within 10 Operational Days following agreement to conduct a Joint Activity Review under SC29.12, the Co-ordinating Commissioner and the Provider must meet: 29.13.1 to consider in further detail the matters referred to in SC29.12.1 and the causes of the unexpected or unusual pattern of Referrals and/or Activity; and 29.13.2 (if they consider it necessary or appropriate) to agree an Activity Management Plan.	All
29.12 If the Co-ordinating Commissioner and the Provider fail to agree an Activity Management Plan at or within 10 Operational Days following the Joint Activity Review they must issue a joint notice to that effect to the Governing Body of the Provider and of each Commissioner. If the Co-ordinating Commissioner and the Provider have still not agreed an Activity Management Plan within 10 Operational Days following the date of the joint notice, either may refer the matter to Dispute Resolution.	All
29.13<u>29.15</u> The Parties must implement any Activity Management Plan agreed or determined in accordance with SC29.13 or 29.14 inclusive in accordance with its terms.	All
29.14<u>29.16</u> If any Party breaches the terms of an Activity Management Plan, the Commissioners or the Provider (as appropriate) may exercise any consequences set out in it.	All
<u>Escalation procedure</u> 29.16A If a Commissioner has set an Indicative Activity Plan under SC29.5A and/or an Activity Management Plan under SC29.14, and the Provider considers that the Commissioner has not complied with the relevant provisions of the Contract Technical Guidance, the Provider may refer this as a Dispute to the Escalation Procedure instead of to Dispute Resolution. Until resolution of the Dispute, the Provider must comply with the disputed Indicative Activity Plan and/or Activity Management Plan.	All
29.16B The relevant Commissioner and the Provider must comply with the Escalation Procedure and, if the Escalation Panel determines that the Commissioner is in breach of the Contract Technical Guidance, the Commissioner is required to comply with any recommendations or actions required by the Escalation Panel in the relevant timescales.	All

<u>29.16C If:</u> <u>29.16C.1 the Escalation Panel does not accept the Provider's referral; or</u> <u>29.16C.2 the Escalation Panel concludes that the Commissioner has complied with the Contract Technical Guidance; or</u> <u>29.16C.3 the Provider is not satisfied with the Commissioner's actions and/or any revised Indicative Activity Plan and/or Activity Management Plan after the Escalation Panel has concluded the Escalation Procedure.</u> <u>the Provider may refer the Dispute to Dispute Resolution and the Escalation Panel will have no further involvement.</u>	<u>All</u>
Prior Approval Scheme <u>29.15</u><u>29.17</u> Before the start of each Contract Year, the Co-ordinating Commissioner must notify the Provider of the terms of any Prior Approval Scheme for that Contract Year. In determining whether to implement any new or replacement Prior Approval Scheme or (on an ongoing basis) whether to continue, amend or disapply any existing Prior Approval Scheme, the relevant Commissioners must have regard for<u>to</u> the objectives of that Prior Approval Scheme, <u>and</u> to the administrative and financial burdens which that Prior Approval Scheme may place on the Provider. The Commissioners must use reasonable endeavours to minimise the number of separate Commissioner-specific Prior Approval Schemes in relation to any individual condition or treatment. The terms of any Prior Approval Scheme may specify the information which the Provider must submit to the Commissioner about individual Service Users requiring or receiving treatment under that Prior Approval Scheme, including details of the scope of the information to be submitted and the format, timescale and process for submission (which may be paper-based or via specified electronic systems).	All except AM, ELC, 111
<u>29.16</u><u>29.18</u> The Provider must manage <u>the Services and Referrals into them</u> in accordance with the terms of any Prior Approval Scheme. If the Provider does not comply with the terms of any Prior Approval Scheme in providing a Service to a Service User, the Commissioners will not be liable to pay for the Service provided to that Service User.	All except AM, ELC, 111
<u>29.17</u><u>29.19</u> If a Prior Approval Scheme imposes any obligation on a Provider that would operate contrary to Patient Choice Legislation and Guidance: 29.19.1 that obligation will have no contractual force or effect; and 29.19.2 the Prior Approval Scheme must be amended accordingly; and	All except AM, ELC, 111

29.19.3	if the Provider provides any Service in accordance with the Prior Approval Scheme as amended in accordance with SC29.19.2 the relevant Commissioner will be liable to pay for that Service in accordance with SC36 (<i>Payment Terms</i>).	
29.18 29.20	The Co-ordinating Commissioner may at any time during a Contract Year give the Provider not less than one month's notice in writing of any new or replacement Prior Approval Scheme, or of any amendment to an existing Prior Approval Scheme. That new, replacement or amended Prior Approval Scheme must be implemented by the Provider on the date set out in the notice, and will only be applicable to decisions to offer treatment made after that date.	All except AM, ELC, 111
29.19 29.21	Subject to the timely provision by the Provider of all of the information specified within a Prior Approval Scheme, the relevant Commissioner must respond within the Prior Approval Response Time Standard to any request for approval for treatment for an individual Service User. If the Commissioner fails to do so, it will be deemed to have given Prior Approval.	All except AM, ELC, 111
29.20 29.22	Each Commissioner and the Provider must use all reasonable endeavours to ensure that the design and operation of Prior Approval Schemes does not cause undue delay in Service Users accessing clinically appropriate treatment and does not place at risk achievement by the Provider of any Quality Requirement.	All except AM, ELC, 111
29.24 29.23	At the Provider's request in case of urgent clinical need or a risk to patient safety, and if approved by the Commissioner's medical director or clinical chair the medical director's nominated deputy (that approval not <u>to</u> be unreasonably withheld or delayed), the relevant Commissioner must grant retrospective Prior Approval for a Service provided to a Service User.	All except AM, ELC, 111
Evidence-Based Interventions Guidance		
29.22 29.24	The Commissioners must use all reasonable endeavours to procure that, when making Referrals, Referrers comply with the Evidence-Based Interventions Guidance.	A
29.23 29.25	The Provider must manage Referrals and provide the Services in accordance with the Evidence-Based Interventions Guidance.	A

EMERGENCIES AND INCIDENTS	
SC30 Emergency Preparedness, Resilience and Response	
30.1 The Provider must comply with EPRR Guidance if and when applicable. The Provider must identify and have in place an Accountable Emergency Officer.	All
30.2 The Provider must have and at all times maintain an up-to-date Incident Response Plan and must provide the Co-ordinating Commissioner with a copy of it.	All
30.3 The Provider must have and at all times maintain an up-to date Business Continuity Plan, an Exercising Plan and a Commander Training Plan and must provide the Co-ordinating Commissioner with a copy of each on request.	All
30.4 The Provider must notify the Co-ordinating Commissioner immediately following the activation of its Incident Response Plan, or if there is any disruption to any CRS.	All
30.5 The Provider must notify the Co-ordinating Commissioner as soon as reasonably practicable and in any event within five Operational Days following: 30.5.1 the activation of its Business Continuity Plan; 30.5.2 the Provider becoming aware of a material risk of imminent disruption to any CRS; or 30.5.3 the occurrence of any actual disruption to any Service which is not CRS.	All
30.6 The Commissioners must have in place arrangements that enable the receipt at all times of a notification made under SC30.4 or SC30.5.	All
30.7 The obligations of the Parties under SC30.1 - 30.6 above apply in addition to those under GC28 (<i>Force Majeure</i>) and neither qualify the other in any way.	All
30.8 The Provider must provide whatever support and assistance may reasonably be required by the Commissioners and/or NHS England and/or the UK Health Security Agency in response to any national, regional or local public health emergency or incident.	All

30.9 The right of any Commissioner to: 30.9.1 withhold or retain sums under GC9 (<i>Contract Management</i>); and/or 30.9.2 suspend Services under GC16 (<i>Suspension</i>), will not apply if the relevant right to withhold, retain or suspend has arisen only as a result of the Provider complying with its obligations under this SC30.	All
30.10 The Provider must use reasonable endeavours to minimise the effect of an Incident or Emergency on the Services and to continue the provision of Elective Care and Non-elective Care notwithstanding the Incident or Emergency. If a Service User is already receiving treatment when the Incident or Emergency occurs, or is admitted after the date it occurs, the Provider must not: 30.10.1 discharge the Service User, unless clinically appropriate to do so in accordance with Good Practice; or 30.10.2 transfer the Service User, unless it is clinically appropriate to do so in accordance with Good Practice.	A
30.11 Subject to SC30.10, if the impact of an Incident or Emergency is that the demand for Non-elective Care increases, and the Provider establishes to the satisfaction of the Co-ordinating Commissioner that its ability to provide Elective Care is reduced as a result, Elective Care will be suspended or scaled back as necessary for as long as the Provider's ability to provide it is reduced. The Provider must give the Co-ordinating Commissioner written confirmation every 2 calendar days of the continuing impact of the Incident or Emergency on its ability to provide Elective Care.	A
30.12 During or in relation to any suspension or scaling back of Elective Care in accordance with SC30.11: 30.12.1 GC16 (<i>Suspension</i>) will not apply to that suspension; 30.12.2 if requested by the Provider, the Commissioners must use their reasonable efforts to avoid any new referrals for Elective Care and the Provider may if necessary change its waiting lists for Elective Care; and 30.12.3 the Provider must continue to provide Non-elective Care (and any related Elective Care), subject to the Provider's discretion to transfer or divert a Service User if the Provider considers that to be in the best interests of all Service Users to whom the Provider is providing Non-elective Care whether or not as a result of the Incident or Emergency (using that discretion in accordance with Good Practice).	A

30.13 If, despite the Provider complying fully with its obligations under this SC30, there are transfers, postponements and cancellations the Provider must give the Commissioners notice of: 30.13.1 the identity of each Service User who has been transferred and the alternative provider; 30.13.2 the identity of each Service User who has not been but is likely to be transferred, the probable date of transfer and the identity of the intended alternative provider; 30.13.3 cancellations and postponements of admission dates; 30.13.4 cancellations and postponements of out-patient appointments; and 30.13.5 other changes in the Provider's list.	A
30.14 As soon as reasonably practicable after the Provider gives written notice to the Co-ordinating Commissioner that the effects of the Incident or Emergency have ceased, the Provider must fully restore the availability of Elective Care.	A
SC31 Force Majeure: Service-Specific Provisions 31.1 Nothing in this Contract will relieve the Provider from its obligations to provide the Services in accordance with this Contract and the Law (including the Civil Contingencies Act 2004) if the Services required relate to an unforeseen event or circumstance including war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake.	AM, 111
31.2 This will not however prevent the Provider from relying upon GC28 (<i>Force Majeure</i>) if such event described in SC31.1 is itself an Event of Force Majeure or if the subsequent occurrence of a separate Event of Force Majeure prevents the Provider from delivering those Services.	AM, 111
31.3 Notwithstanding any other provision in this Contract, if the Provider is the Affected Party, it must ensure that all Service Users that it detains securely in accordance with the Law will remain in a state of secure detention as required by the Law.	MHSS
31.4 For the avoidance of doubt any failure or interruption of the National Telephony Service will be considered an event or circumstance beyond the Provider's reasonable control for the purpose of GC28 (<i>Force Majeure</i>).	111

SAFETY AND SAFEGUARDING	
SC32 Safeguarding Children and Adults	
32.1 The Provider must ensure that Service Users are protected from abuse, exploitation, radicalisation, serious violence, grooming, neglect and improper or degrading treatment, and must take appropriate action to respond to any allegation or disclosure of any such behaviours in accordance with the Law.	All
32.2 The Provider must nominate: 32.2.1 Safeguarding Leads and/or named professionals for safeguarding children (including looked after children) and for safeguarding adults, in accordance with Safeguarding Guidance; 32.2.2 a Child Sexual Abuse and Exploitation Lead; 32.2.3 a Mental Capacity and Liberty Protection Safeguards Lead; and 32.2.4 a Prevent Lead, and must ensure that the Co-ordinating Commissioner is kept informed at all times of the identity of the persons holding those positions.	All
32.3 The Provider must comply with the requirements and principles in relation to the safeguarding of children, young people and adults, including in relation to deprivation of liberty safeguards, child sexual abuse and exploitation, domestic abuse, radicalisation and female genital mutilation (as relevant to the Services) set out or referred to in: 32.3.1 the 2014 Act and associated Guidance; 32.3.2 the 2014 Regulations; 32.3.3 the Children Act 1989 and the Children Act 2004 and associated Guidance; 32.3.4 the 2005 Act and associated Guidance; 32.3.5 the Modern Slavery Act 2015 and associated Guidance; 32.3.6 Safeguarding Guidance; 32.3.7 Child Sexual Abuse and Exploitation Guidance; 32.3.8 Prevent Guidance; and	All

32.3.9	the Domestic Abuse Act 2021 and associated Guidance.	
32.4	The Provider has adopted and must comply with the Safeguarding Policies and MCA Policies. The Provider has ensured and must at all times ensure that the Safeguarding Policies and MCA Policies reflect and comply with: 32.4.1 the Law and Guidance referred to in SC32.3; and 32.4.2 the local multi-agency policies and any Commissioner safeguarding and MCA requirements.	All
32.5	The Provider must implement comprehensive programmes for safeguarding (including in relation to child sexual abuse and exploitation) and MCA training for all relevant Staff and must have regard to Intercollegiate Guidance in Relation to Safeguarding Training. The Provider must undertake an annual audit of its conduct and completion of those training programmes and of its compliance with the requirements of SC32.1 to 32.4.	All
32.6	At the reasonable written request of the Co-ordinating Commissioner, and by no later than 10 Operational Days following receipt of that request, the Provider must provide evidence to the Co-ordinating Commissioner that it is addressing any safeguarding concerns raised through the relevant multi-agency reporting systems.	All
32.7	If requested by the Co-ordinating Commissioner, the Provider must participate in the development of any local multi-agency safeguarding quality indicators and/or plan.	All
32.8	<u>The In respect of any Service within the scope of Child Protection Information Sharing Guidance, the Provider must:-</u> <u>32.8.1 comply with Child Protection Information Sharing Guidance and Data Protection Legislation;</u> <u>32.8.2 ensure that all Staff involved in the delivery or administration of that Service have access to the Child Protection Information Sharing Service and make full use of it as and when appropriate in accordance with Child Protection Information Sharing Guidance; and</u> <u>32.8.3 co-operate fully and liaise appropriately with third-party all local providers of social-care relevant healthcare and other public services as necessary for the effective operation of the Child Protection Information Sharing Project Service.</u>	A+E, A, AM, CS, MH, U

32.8<u>32.9</u> The Provider must: 32.8<u>32.9.1</u> include in its policies and procedures, and comply with, the principles contained in the Government Prevent Strategy and the Prevent Guidance; and 32.8<u>32.9.2</u> include in relevant policies and procedures a comprehensive programme to raise awareness of the Government Prevent Strategy among Staff and volunteers in line with the NHS England Prevent Training and Competencies Framework and Intercollegiate Guidance in Relation to Safeguarding Training.	All
SC33 Patient Safety 33.1 The Provider must comply with the arrangements for notification of deaths and other incidents: 33.1.1 to CQC, in accordance with CQC Regulations and Guidance (where applicable); and 33.1.2 to any other relevant Regulatory or Supervisory Body, any NHS Body, any office or agency of the Crown, or to any other appropriate regulatory or official body, in accordance with Good Practice and the Law; and 33.1.3 in the case of any Service User with a learning disability and/or autism whose death occurs while an inpatient in any Service or of whose death the Provider otherwise becomes aware, report that death via the Learning from Lives and Deaths Platform.	All
33.2 The Provider must comply with the Patient Safety Incident Response Framework and the Never Events Policy Framework. The Provider must have a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan which are agreed with the Co-ordinating Commissioner.	All
33.3 The Provider must: 33.3.1 publish on its website the agreed Patient Safety Incident Response Policy and Patient Safety Incident Response Plan; 33.3.2 engage compassionately with affected Service Users, Carers and Staff following any Patient Safety Incident; 33.3.3 respond in a proportionate way to Patient Safety Incidents, undertaking Patient Safety Incident Investigations where appropriate; and	All

33.3.4	ensure that, where indicated and as part of the overall process set out in SC3.4, improvements to the Services are implemented following responses to Patient Safety Incidents, in accordance with the Patient Safety Incident Response Framework.	
33.4	The Provider must ensure that it is able to report Patient Safety Incidents to the Learn From Patient Safety Events Service.	All
33.5	The Parties must comply with their respective obligations in relation to deaths and other incidents in connection with the Services under Schedule 6A (<i>Reporting Requirements</i>).	All
33.6	If a notification the Provider gives to any relevant Regulatory or Supervisory Body directly or indirectly concerns any Service User, the Provider must send a copy of it to the relevant Commissioner.	All
33.7	The Commissioners will have complete discretion (subject only to the Law) to use the information provided by the Provider under this SC33 and Schedule 6A (<i>Reporting Requirements</i>) in any report which they make to any relevant Regulatory or Supervisory Body, any NHS Body, any office or agency of the Crown, provided that in each case they notify the Provider of the information disclosed and the body to which they have disclosed it.	All
33.8	The Provider must have in place arrangements to ensure that it can: 33.8.1 receive National Patient Safety Alerts; and 33.8.2 in relation to each National Patient Safety Alert it receives, identify appropriate Staff: 33.8.2.1 to coordinate and implement any actions required by the alert within the timescale prescribed; and 33.8.2.2 to confirm and record when those actions have been completed.	All
33.9	The Provider must 33.9.1 designate one or more Patient Safety Specialists; and 33.9.2 ensure that the Co-ordinating Commissioner is kept informed at all times of the person or persons holding this position.	All
33.10	<u>The Provider, if it is an NHS Trust or an NHS Foundation Trust, must identify two or more Patient Safety Partners to fulfil the role described in the Framework for Involving Patients in Patient Safety.</u>	<u>All</u>

<u>33.11 The Provider must:</u> <u>33.11.1 appoint a Medical Devices Safety Officer and a Medication Safety Officer; and</u> <u>33.11.2 ensure that the Co-ordinating Commissioner and the MHRA Central Alerting System are kept informed at all times of the person or persons holding these positions.</u>	All
33.10<u>33.12</u> The Provider (if it is an NHS Trust, an NHS Foundation Trust or an English Independent Hospital) must: 33.10<u>33.12.1</u> appoint <u>and support</u> a Medical—Devices Safety<u>Controlled Drugs Accountable</u> Officer and—a Medication Safety Officer; in accordance with, and otherwise comply with its duties as a responsible body under, the 2013 Regulations; and 33.10<u>33.12.2</u> ensure that the <u>Controlled Drugs Accountable Officer</u> complies with their duties under the 2013 Regulations; and <u>33.12.3</u> ensure that the Co-ordinating Commissioner and the MHRA Central Alerting System<u>CQC</u> are kept informed at all times of the person or persons holding these positions<u>the position of Controlled Drugs Accountable Officer.</u>	All
SC34 End of Life Care 34.1 The Provider must have regard to Guidance on End of Life Care and must, where applicable and for as long as it remains operative, comply with SCCI 1580 (Palliative Care Co-ordination: Core Content).	All
34.2 The Provider must maintain and operate a Death of a Service User Policy.	All
SC35 Duty of Candour 35.1 The Provider must act in an open and transparent way with Relevant Persons in relation to Services provided to Service Users.	All
35.2 The Provider must, where applicable, comply with its obligations under regulation 20 of the 2014 Regulations in respect of any Notifiable Safety Incident.	All
35.3 If the Provider fails to comply with any of its obligations under SC35.2 the Co-ordinating Commissioner may: 35.3.1 notify the CQC of that failure; and/or	All

35.3.2 require the Provider to provide the Relevant Person with a formal, written apology and explanation for that failure, signed by the Provider's chief executive and copied to the relevant Commissioner; and/or 35.3.3 require the Provider to publish details of that failure prominently on the Provider's website.	
PAYMENT TERMS	
SC36 Payment Terms Payment Principles 36.1 Subject to any express provision of this Contract to the contrary, <u>including any financial consequences set out in an Activity Management Plan and/or any right to withhold payment in accordance with GC9.20 to GC9.24</u>, each Commissioner must pay the Provider in accordance with the NHS Payment Scheme, to the extent applicable, for all Services that the Provider delivers to it in accordance with this Contract.	All
36.2 To avoid any doubt, the Provider will be entitled to be paid for Services delivered during the continuation of: 36.2.1 any Incident or Emergency, except as otherwise provided or agreed under SC30 (<i>Emergency Preparedness, Resilience and Response</i>); and 36.2.2 any Event of Force Majeure, except as otherwise provided or agreed under GC28 (<i>Force Majeure</i>).	All
Prices 36.3 If the Provider is an NHS Trust or an NHS Foundation Trust, the Prices payable by each Commissioner for services delivered under this Contract for the relevant Contract Year will be: 36.3.1 the price(s) payable in accordance with rule 2 of the Aligned Payment and Incentive Rules; or 36.3.2 the price(s) payable in accordance with rule 2 of the Aligned Payment and Incentive Rules, adjusted for the relevant Contract Year as agreed, approved by NHS England and published in accordance with rule 3 of the Aligned Payment and Incentive Rules, in either case recorded in Schedule 3A (<i>Aligned Payment and Incentive Rules</i>) and, where applicable, Schedule 3C (<i>Local Prices</i>); and/or	All

36.3.3 where rule 4 or rule 5a)ii of the Aligned Payment and Incentive Rules applies, the price(s) agreed or determined in accordance with that rule and recorded in Schedule 3C (<i>Local Prices</i>), for the relevant Contract Year.	
36.4 If the Provider is not an NHS Trust or an NHS Foundation Trust, the Prices payable by each Commissioner for Services delivered under this Contract for the relevant Contract Year will be: 36.4.1 for any Service for which the NHS Payment Scheme mandates an NHSPS Unit Price: 36.4.1.1 the NHSPS Unit Price; or 36.4.1.2 the NHSPS Unit Price as adjusted by a Locally Agreed Adjustment for the relevant Contract Year, submitted to NHS England, published and recorded in Schedule 3B (<i>Locally Agreed Adjustments to NHS Payment Scheme Unit Prices</i>), in accordance with rule 3 of section 6 of the NHS Payment Scheme; or 36.4.2 for any Service for which the NHS Payment Scheme does not mandate an NHSPS Unit Price, the Local Price agreed or determined for the relevant Contract Year in accordance with the rules set out in section 7 of the NHS Payment Scheme and recorded in Schedule 3C (<i>Local Prices</i>).	All
36.5 Where the rule set out in section 3.4 of the NHS Payment Scheme applies, the price payable by each Commissioner for any high cost drug, device, listed product or listed innovative product listed in Annex A to the NHS Payment Scheme to which that rule applies will be the price as agreed or determined (and subject to any adjustment which must be made) in accordance with that rule, and where necessary recorded in Schedule 3C (<i>Local Prices</i>).	All
Local Prices 36.6 For any Service in respect of which none of the payment mechanisms set out in sections 4 – 6 of the NHS Payment Scheme determines a price, the Co-ordinating Commissioner and the Provider must agree and record in Schedule 3C (<i>Local Prices</i>) a Local Price. The Co-ordinating Commissioner and the Provider may agree that a Local Price is to apply for one or more Contract Years or for the duration of the Contract. In respect of a Local Price agreed for more than one Contract Year the Co-ordinating Commissioner and the Provider may agree and document in Schedule 3C (<i>Local Prices</i>) the mechanism by which that Local Price is to be adjusted with effect from the start of each Contract Year. Any adjustment mechanism must require the Co-ordinating Commissioner and the Provider to have regard to the	All

	efficiency factor and cost uplift factor set out in the NHS Payment Scheme where applicable.	
36.7	The Co-ordinating Commissioner and the Provider must apply annually any adjustment mechanism agreed and documented in Schedule 3C (<i>Local Prices</i>). Where no adjustment mechanism has been agreed, the Co-ordinating Commissioner and the Provider must review and agree before the start of each Contract Year the Local Price to apply to the following Contract Year, having regard to the efficiency factor and the cost uplift factor set out in the NHS Payment Scheme where applicable. In either case the Local Price as adjusted or agreed will apply to the following Contract Year.	All
36.8	If the Co-ordinating Commissioner and the Provider fail to review or agree any Local Price for the following Contract Year by the date 2 months before the start of that Contract Year, or there is a dispute as to the application of any agreed adjustment mechanism, either may refer the matter to Dispute Resolution for escalated negotiation and then (failing agreement) mediation.	All
36.9	If on or following completion of the mediation process the Co-ordinating Commissioner and the Provider still cannot agree any Local Price for the following Contract Year, within 10 Operational Days of completion of the mediation process either the Co-ordinating Commissioner or the Provider may terminate the affected Services by giving the other not less than 6 months' written notice.	All
36.10	If any Local Price has not been agreed or determined in accordance with SC36.7 and 36.8 before the start of a Contract Year, then the Local Price will be that which applied for the previous Contract Year increased or decreased in accordance with the efficiency factor and the cost uplift factor set out in the NHS Payment Scheme where applicable. The application of these prices will not affect the right to terminate this Contract as a result of non-agreement of a Local Prices under SC36.9.	All
Aggregation and Disaggregation of Payments		
36.11	The Co-ordinating Commissioner may make or receive all (but not only some) of the payments due under SC36 in <u>respect of some or all Commissioners and/or some or all Services in</u> aggregate amounts for itself and on behalf of each of the <u>relevant</u> Commissioners provided that it gives the Provider 20 Operational Days' written notice of its intention to do so: <u>and full details of the Commissioners and/or Services involved</u> . These aggregated payments will not prejudice any immunity from liability of the Co-ordinating Commissioner, or any rights of the Provider to recover any overdue payment <u>in respect of the relevant Services</u> from the relevant Commissioners individually. However, they will discharge the separate liability or entitlement of the <u>relevant</u> Commissioners in respect of their separate Services. To	All

	avoid doubt, notices to aggregate and reinstate separate <u>relevant</u> payments may be repeated or withdrawn from time to time. Where notice has been given to aggregate payments, references in SC36 to “a Commissioner”, “the Commissioner” or “each Commissioner” are where appropriate to be read as referring to the Co-ordinating Commissioner, <u>and references to ‘Services’ are where appropriate to be read as referring to the relevant Services.</u>	
	Payment where the Parties have agreed an Expected Annual Contract Value 36.12 If the Provider is an NHS Trust or an NHS Foundation Trust, each Commissioner must agree an Expected Annual Contract Value with the Provider to be specified in Schedule 3D (<i>Expected Annual Contract Values</i>). If the Provider is not an NHS Trust or an NHS Foundation Trust, each Commissioner may agree an Expected Annual Contract Value with the Provider to be specified in Schedule 3D (<i>Expected Annual Contract Values</i>). Each Commissioner which has agreed an Expected Annual Contract Value with the Provider must make payments on account to the Provider in accordance with the following provisions of SC36.4413, or if applicable SC36.15 and 336.16.	All
	36.13 If the Provider is an NHS Trust or an NHS Foundation Trust, on the fifteenth day of each month (or other day agreed by the Provider and the Co-ordinating Commissioner in writing) after the Service Commencement Date each Commissioner must pay the Provider, using the Invoice Payment File Approach, the amount which is one twelfth (or other such proportion as may be specified in Schedule 3D (<i>Expected Annual Contract Values</i>)) of the individual Expected Annual Contract Value for that Commissioner.	All
	36.14 If the Provider is not an NHS Trust or an NHS Foundation Trust, it must supply to each Commissioner a monthly invoice on the first day of each month setting out the amount to be paid by that Commissioner for that month. The amount to be paid will be one twelfth (or other such proportion as may be specified in Schedule 3D (<i>Expected Annual Contract Values</i>)) of the individual Expected Annual Contract Value for that Commissioner. Subject to receipt of the invoice, on the fifteenth day of each month (or other day agreed by the Provider and the Co-ordinating Commissioner in writing) after the Service Commencement Date each Commissioner must pay such amount to the Provider.	All
	36.15 If the Service Commencement Date is not 1 April the timing and amounts of the payments for the period starting on the Service Commencement Date and ending on the following 31 March will be as set out in Schedule 3E (<i>Timing and Amounts of Payments in First and/or Final Contract Year</i>).	All

36.16 If the Expiry Date is not 31 March the timing and amounts of the payments for the period starting on the 1 April prior to the Expiry Date and ending on the Expiry Date will be as set out in Schedule 3E (<i>Timing and Amounts of Payments in First and/or Final Contract Year</i>).	All
Reconciliation where the Parties have agreed an Expected Annual Contract Value and SUS applies to some or all of the Services 36.17 Where the Parties have agreed an Expected Annual Contract Value and SUS applies to some or all of the Services, in order to confirm the actual sums payable for the Services delivered the Provider must provide a separate reconciliation account for each Commissioner for each Quarter showing the sum equal to the Prices for all relevant Services delivered and completed in that Quarter. That reconciliation account must be based on the information submitted by the Provider to the Co-ordinating Commissioner under SC28 (<i>Information Requirements</i>) and must be sent by the Provider to the relevant Commissioner by the First Quarterly Reconciliation Date for the Quarter to which it relates.	All
36.18 The Provider must send to each Commissioner a final reconciliation account for each Quarter within 5 Operational Days after the Final Quarterly Reconciliation Date for that Quarter. The final reconciliation account must either be agreed by the relevant Commissioner, or be wholly or partially contested by the relevant Commissioner in accordance with SC36.30. No Commissioner may unreasonably withhold or delay its agreement to a final reconciliation account.	All
Reconciliation for Services where the Parties have agreed an Expected Annual Contract Value and SUS does not apply to any of the Services 36.19 Where the Parties have agreed an Expected Annual Contract Value and SUS does not apply to any of the Services, in order to confirm the actual sums payable for delivered Services the Provider must provide a separate reconciliation account for each Commissioner for each Quarter showing the sum equal to the Prices for all relevant Services delivered and completed in that Quarter. That reconciliation account must be based on the information submitted by the Provider to the Co-ordinating Commissioner under SC28 (<i>Information Requirements</i>) and sent by the Provider to the relevant Commissioner within 20 Operational Days after the end of the Quarter to which it relates.	All
36.20 Each Commissioner and Provider must either agree the reconciliation account produced in accordance with SC36.19 or wholly or partially contest the reconciliation account in accordance with SC36.30. No Commissioner may unreasonably withhold or delay its agreement to a reconciliation account.	All

Other aspects of reconciliation for all Prices where the Parties have agreed an Expected Annual Contract Value		
36.21	For the avoidance of doubt, there will be no reconciliation in relation to Block Arrangements.	All
36.22	Each Commissioner's agreement of a reconciliation account or agreement of a final reconciliation account as the case may be (or where agreed in part in relation to that part) will trigger a reconciliation payment by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate. 36.22.1 If the Provider is an NHS Trust or an NHS Foundation Trust, the Commissioner must process the appropriate payment adjustment using the Invoice Payment File Approach within 15 Operational Days of that agreement (or if SUS applies, and if later, within 10 Operational Days after the relevant First Monthly Reconciliation Date or First Quarterly Reconciliation Date). 36.22.2 If the Provider is not an NHS Trust or an NHS Foundation Trust, it must supply to the Commissioner an invoice or credit note (as appropriate) within 5 Operational Days of that agreement and payment must be made within 10 Operational Days following the receipt of the invoice or issue of the credit note (or if SUS applies, and if later, within 10 Operational Days after the relevant First Monthly Reconciliation Date or First Quarterly Reconciliation Date).	All
Payment where the Parties have not agreed an Expected Annual Contract Value for any Services and SUS applies to some or all of the Services		
36.23	Where the Parties have not agreed an Expected Annual Contract Value and SUS applies to some or all of the Services, the Provider (if it is not an NHS Trust or a Foundation Trust) must issue a monthly invoice within 5 Operational Days after the Final Monthly Reconciliation Date for that month to each Commissioner in respect of those Services provided for that Commissioner in that month. Subject to SC36.30, the Commissioner must settle the invoice within 10 Operational Days of its receipt (or, if later, within 10 Operational Days after the relevant First Monthly Reconciliation Date).	All
Payment where the Parties have not agreed an Expected Annual Contract Value for any Services and SUS does not apply to any of the Services		
36.24	Where SUS does not apply to any of the Provider's Services and where the Parties have not agreed an Expected Annual Contract Value, the Provider (if it is not an NHS Trust or a Foundation Trust) must issue a monthly invoice within 20 Operational Days after the end	All

of each month to each Commissioner in respect of all Services provided for that Commissioner in that month. Subject to SC36.30, the Commissioner must settle the invoice within 10 Operational Days of its receipt.	
Statutory Charges 36.25 The Provider must administer and collect all statutory charges which the Service User is liable to pay and which may lawfully be made in relation to the provision of the Services, and must account to whoever the Co-ordinating Commissioner reasonably directs in respect of those charges.	All except 111
36.26 The Parties acknowledge the requirements and intent of the Overseas Visitor Charging Regulations and Overseas Visitor Charging Guidance, and accordingly: 36.26.1 the Provider must comply with all applicable Law and Guidance (including the Overseas Visitor Charging Regulations and the Overseas Visitor Charging Guidance) in relation to the identification of and collection of charges from Chargeable Overseas Visitors, including the reporting of unpaid NHS debts in respect of Services provided to Chargeable Overseas Visitors to the Department of Health and Social Care; 36.26.2 the Provider must take all reasonable steps to: 36.26.2.1 identify each Chargeable Overseas Visitor; and 36.26.2.2 recover charges from each Chargeable Overseas Visitor or other person liable to pay charges in respect of that Chargeable Overseas Visitor under the Overseas Visitor Charging Regulations, 36.26.3 the Provider must make full use of existing mechanisms designed to increase the rates of recovery of the cost of Services provided to overseas visitors insured by another state, including the overseas visitors treatment portal; and 36.26.4 each Commissioner must pay the Provider, in accordance with all applicable Law and Guidance (including Overseas Visitor Charging Regulations and Overseas Visitor Charging Guidance) and the NHS Payment Scheme, the appropriate sum for all Services delivered by the Provider to any overseas visitor in respect of whom that Commissioner is the Responsible Commissioner and which have been reported through the overseas visitors treatment portal.	All
36.27 In its performance of this Contract the Provider must not provide or offer to a Service User any clinical or medical services for which any	All

charges would be payable by the Service User except in accordance with this Contract, the Law and/or Guidance.	
VAT 36.28 Payment is exclusive of any applicable VAT for which the Commissioners will be additionally liable to pay the Provider upon receipt of a valid tax invoice at the prevailing rate in force from time to time.	All
Validation Queries 36.29 Once the Provider has submitted Activity data to SUS in respect of a given month, each Commissioner may raise with the Provider any validation queries it has in relation to that data, and the Provider must answer those queries promptly and fully. The Parties must use all reasonable endeavours to resolve any queries by the Post Reconciliation Monthly Inclusion Date.	All
Contested Payments 36.30 If a Commissioner contests all or any part of any payment calculated in accordance with this SC36: 36.30.1 the Commissioner must: 36.30.1.1 within 5 Operational Days after receiving the reconciliation account in accordance with SC36.17 or an invoice in accordance with SC36.24; or 36.30.1.2 within 5 Operational Days after receiving the final reconciliation account in accordance with SC36.18 (or, if later, within 5 Operational Days after the relevant First Quarterly Reconciliation Date); or 36.30.1.3 within 5 Operational Days after receiving an invoice in accordance with SC36.23 (or, if later, within 5 Operational Days after the relevant First Monthly Reconciliation Date), as appropriate, notify the Provider, setting out in reasonable detail the reasons for contesting that account or invoice (as applicable), and in particular identifying which elements are contested and which are not contested; and 36.30.2 any uncontested amount must be paid in accordance with this Contract by the Commissioner from whom it is due; and	All

36.30.3	if the matter has not been resolved within 20 Operational Days of the date of notification under SC36.30.1, the contesting Commissioner must refer the matter to Dispute Resolution.	
36.31	Following the resolution of any Dispute referred to Dispute Resolution in accordance with this SC36.30.3, 36.31.1 if the Provider is an NHS Trust or an NHS Foundation Trust, insofar as any payment adjustment is agreed or determined to be necessary, the Commissioner must at the next opportunity process that payment adjustment using the Invoice Payment File Approach, including any interest calculated in accordance with SC36.32; 36.31.2 if the Provider is not an NHS Trust or an NHS Foundation Trust, insofar as any amount is agreed or determined to be payable, the Provider must immediately issue an invoice or credit note (as appropriate) for such amount. Any sum due must be paid immediately together with interest calculated in accordance with SC36.32. For the purposes of SC36.32 the date the amount was due will be the date it would have been due had the amount not been disputed.	All
	Interest on Late Payments 36.32 Subject to any express provision of this Contract to the contrary, each Party will be entitled, in addition to any other right or remedy, to receive interest at the applicable rate under the Late Payment of Commercial Debts (Interest) Act 1998 on any payment not made from the date after the date on which payment was due up to and including the date of payment.	All
	Set Off 36.33 Whenever any sum is due from one Party to another as a consequence of reconciliation under this SC36 or Dispute Resolution or otherwise, the Party due to be paid that sum may deduct it from any amount that it is due to pay the other, provided that it has given 5 Operational Days' notice of its intention to do so.	All
	Invoice Validation 36.34 The Parties must comply with Law and Guidance (including Who Pays? Rules and Invoice Validation Guidance) in respect of the use of data in the preparation and validation of invoices.	All

Submission of Invoices 36.35 The Provider must submit all invoices via the e-Invoicing Platform in accordance with e-Invoicing Guidance or via an alternative PEPPOL-compliant e-invoicing system.	All
QUALITY REQUIREMENTS	
SC37 Local Quality Requirements 37.1 The Parties must comply with their duties under the Law to improve the quality of clinical and/or care services for Service Users, having regard to Guidance.	All
37.2 Nothing in this Contract is intended to prevent this Contract from setting higher quality requirements than those laid down under the Provider Licence (if any) or required by any relevant Regulatory or Supervisory Body.	All
37.3 Before the start of each Contract Year, the Co-ordinating Commissioner and the Provider will agree the Local Quality Requirements that are to apply in respect of that Contract Year. In order to secure continual improvement in the quality of the Services, those Local Quality Requirements must not, except in exceptional circumstances, be lower or less onerous than those for the previous Contract Year. The Co-ordinating Commissioner and the Provider must give effect to those revised Local Quality Requirements by means of a Variation (and, where revised Local Quality Requirements are in respect of a Service to which an NHSPS Unit Price applies and if appropriate, a Locally Agreed Adjustment in accordance with SC36.4.1.2).	All
37.4 If revised Local Quality Requirements cannot be agreed between the Parties, the Parties must refer the matter to Dispute Resolution for escalated negotiation and then (failing agreement) mediation.	All
SC38 CQUIN 38.1 Where and as required by the Aligned Payment and Incentive Rules and by CQUIN Guidance: 38.1.1 the Parties must implement a performance incentive scheme in accordance with the Aligned Payment and Incentive Rules and with CQUIN Guidance for each Contract Year or the appropriate part of it; and	All

38.1.2	if the Provider has satisfied a CQUIN Indicator, a CQUIN Payment calculated in accordance with CQUIN Guidance will be payable by the relevant Commissioners to the Provider in accordance with Schedule 3F (<i>CQUIN</i>).	
CQUIN Performance Report		
38.2	The Provider must submit to the Co-ordinating Commissioner a CQUIN Performance Report at the frequency and otherwise in accordance with the National Requirements Reported Locally.	All
38.3	The Co-ordinating Commissioner must review and discuss with each Commissioner the contents of each CQUIN Performance Report.	All
38.4	If any Commissioner wishes to challenge the content of any CQUIN Performance Report (including the clinical or other supporting evidence included in it) the Co-ordinating Commissioner must serve a CQUIN Query Notice on the Provider within 10 Operational Days of receipt of the CQUIN Performance Report.	All
38.5	In response to any CQUIN Query Notice the Provider must, within 10 Operational Days of receipt, either: 38.5.1 submit a revised CQUIN Performance Report (including, where appropriate, further supporting evidence); or 38.5.2 refer the matter to Dispute Resolution.	All
38.6	If the Provider submits a revised CQUIN Performance Report in accordance with SC38.5, the Co-ordinating Commissioner must, within 10 Operational Days of receipt, either: 38.6.1 accept the revised CQUIN Performance Report; or 38.6.2 refer the matter to Dispute Resolution.	All
Reconciliation		
38.7	Within 20 Operational Days following the later of: 38.7.1 the end of the Contract Year; and 38.7.2 the agreement or resolution of all CQUIN Performance Reports in respect of that Contract Year, the Provider must submit a CQUIN Reconciliation Account to the Co-ordinating Commissioner.	All

38.8 Within 5 Operational Days of receipt of either the CQUIN Reconciliation Account under SC38.7, the Co-ordinating Commissioner must either agree it or wholly or partially contest it in accordance with SC38.10. The Co-ordinating Commissioner's agreement of the CQUIN Reconciliation Account under SC38.7 must not be unreasonably withheld or delayed.	All
38.9 The Co-ordinating Commissioner's agreement of the CQUIN Reconciliation Account under SC38.7 will trigger a reconciliation payment by each relevant Commissioner to the Provider or by the Provider to each relevant Commissioner (as appropriate). The Provider must supply to each Commissioner a credit note within 5 Operational Days of the agreement and payment must be made within 10 Operational Days following issue of the credit note.	All
38.10 If the Co-ordinating Commissioner contests the CQUIN Reconciliation Account: 38.10.1 the Co-ordinating Commissioner must within 5 Operational Days notify the Provider accordingly, setting out in reasonable detail the reasons for contesting the account, and in particular identifying which elements are contested and which are not contested; 38.10.2 any uncontested amount identified in the CQUIN Reconciliation Account under SC38.7 must be paid in accordance with this SC38.10 by the Provider; and 38.10.3 if the matter has not been resolved within 20 Operational Days following the date of notification under SC38.10.1, either the Provider or the Co-ordinating Commissioner may refer the matter to Dispute Resolution, and within 20 Operational Days following the resolution of any Dispute referred to Dispute Resolution in accordance with this SC38.10, if any amount is agreed or determined to be payable the Provider must immediately issue a credit note for that amount. The Provider must immediately pay the amount due to together with interest calculated in accordance with SC36.32. For the purposes of SC36.32 the date the amount was due will be the date it would have been due had the amount not been disputed.	All

PROCUREMENT OF PRODUCTS AND SERVICES	
SC39 Procurement of Products and Services 39.1 The provisions of SC39.2 – 39.9 below apply to NHS Trusts and to NHS Foundation Trusts only. The obligations of the Provider under SC39.3 – 39.6 below apply in addition to the obligation of the Provider under SC39.2 and do not qualify it in any way.	All
All Products and Services 39.2 If the Provider intends to purchase via a framework any product or service required for use in the provision of the Services and/or in any activity of the Provider in connection with the Services, Service Users, Staff, the Provider's Premises or its business, and that product or service (or one similarly clinically or otherwise appropriate for that use) is at the time of purchase available for timely supply via an Accredited Framework, the Provider must purchase the required product or service via an Accredited Framework. This obligation does not apply if the Provider: 39.2.1 has existing stock of the same or a similar product purchased through other means before 1 April 2024; 39.2.2 is under a binding contractual obligation to buy that product or service entered into before 1 April 2024; or 39.2.3 can demonstrate that it had already commenced, before 1 April 2024, an internally approved process for the purchase of that new product or service via a framework which is not an Accredited Framework.	All
Medicines and High Cost Devices 39.3 If an NHSEa Medicines <u>Procurement and Supply Chain</u> Framework Product is clinically appropriate for use in the provision of the Services and is at the time of purchase available for timely supply via an NHSEa Medicines <u>Procurement and Supply Chain</u> Framework Agreement, the Provider must purchase that product via the relevant NHSE Medicines <u>Procurement and Supply Chain</u> Framework Agreement. This does not preclude the use of the Provider's existing stock of the same or a similar product purchased through other means before the date on which the relevant NHSE Medicines <u>Procurement and Supply Chain</u> Framework Agreement came into effect.	All

39.4	The Provider will not be entitled to payment for any medicine purchased in breach of SC39.3 where that medicine is listed in the High Cost Drugs tab at Annex A to the NHS Payment Scheme.	All
39.5	If any device which is listed in the High Cost Devices and Listed Procedures tab at Annex A to the NHS Payment Scheme is required in the delivery of any Service which is a Specialised Service and is available for purchase via NHS Supply Chain, the Provider must purchase that device via NHS Supply Chain. The Provider will not be entitled to payment for any such item purchased in breach of this SC39.5.	All
NHS Core List		All
39.6	Where the Provider requires a product for use in, or in support of, the provision of the Services and where that product, or a product which is a suitable equivalent alternative, is listed on the NHS Core List and is available for timely supply via NHS Supply Chain, the Provider must purchase that product (or the suitable equivalent alternative, as appropriate) via NHS Supply Chain.	
National Ambulance Vehicle Specification		AM
39.7	If the Provider wishes to place any order for a new standard double-crewed emergency ambulance base vehicle and/or conversion for use in provision of the Services, it must (unless it has submitted a request in writing, counter-signed by the Co-ordinating Commissioner, to NHS England for confirmation that the National Ambulance Vehicle Specification need not apply to that order and the requested confirmation has been given in writing by NHS England):	
39.7.1	ensure that its order specifies that the vehicle and/or conversion must comply with the National Ambulance Vehicle Specification; and	
39.7.2	place its order via and in accordance with a Compliant Ambulance Vehicle Supply Contract.	
Agency Rules		All
39.8	The Provider must:	
39.8.1	if within the scope of the Agency Rules, comply with the Agency Rules;	
39.8.2	if not within the scope of the Agency Rules, have regard to the Agency Rules; and	
39.8.3	use all reasonable endeavours to achieve any financial objective in relation to agency expenditure set by NHS	

England, under section 223L of the 2006 Act, for the Provider, the Integrated Care Board(s) of which it is a partner <u>ICB(s)</u> and that Board's other partner NHS Trusts and NHS Foundation Trusts.	
<u>Modern Slavery</u> <u>39.9 The Provider must, in its procurement of products and services:</u> <u>39.9.1 comply with any regulations made by the Secretary of State under section 12ZC of the 2006 Act;</u> <u>39.9.2 have regard to any Guidance in relation to those regulations; and</u> <u>39.9.3 apply any process of modern slavery risk assessment specified in such Guidance.</u>	<u>All</u>
Duty to Explain Purchasing Decisions 39.9<u>10</u> The Provider must be prepared, if requested to do so by the Co-ordinating Commissioner and/or NHS England, to provide a written statement to its public board meeting, to the Co-ordinating Commissioner and/or to NHS England, explaining any purchasing decision in contravention of SC39.2-39.89 and what it will do to ensure that SC39.2-39.89 are complied with in future.	All
<u>Biosimilar Medicines</u> <u>39.11 The Provider must use all reasonable endeavours to ensure that, where clinically appropriate and in accordance with Guidance on Biosimilar Medicines, Service Users are prescribed the best-value biosimilar biological medicines where these are required.</u>	<u>All</u>
National Genomic Test Directory 39.40<u>12</u> Where, in the course of providing the Services, the Provider or any Sub-Contractor requires a sample taken from a Service User to be subject to a genomic laboratory test listed in the National Genomic Test Directory, that sample must be submitted to the appropriate Genomic Laboratory Hub commissioned by NHS England to arrange and/or perform the relevant test. Each submission of a sample must be made in accordance with the criteria for ordering tests set out in the National Genomic Test Directory.	A+E, A, CR, CS, D, MH, MHSS

ANNEX A National Quality Requirements

Ref	National Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Service category
	RTT waiting times for non-urgent Consultant-led Services				
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 England)	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	A, CS, MH
E.B.S.4	Zero tolerance RTT waits over 7852 weeks for incomplete pathways	From 1 April 2024 >0 *By March 2026 < 1% *	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	A, CS, MH
E.B.S.4	Zero tolerance RTT waits over 65 weeks for incomplete pathways	By 30 September 2024 >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	A, CS, MH
* subject to any tolerances confirmed in national guidance for Service Users who choose to wait longer or for specific specialties					
	Diagnostic test waiting times				
E.B.4	Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test	Operating standard of at least 95% —by March 2025	See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-	Month	A, CS, CR, D

Ref	National Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Service category
			diagnostics-waiting-times-and-activity/		
	A+E waits				
E.B.5	Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A+E department	Operating standard of at least 78% by March 2025	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	A+E, U
E.B.S.5	Waits in A+E from arrival to discharge, admission or transfer	Operating standard of no more than 2% waiting more than 12 hours	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Month	A+E
	Cancer waits				
E.B.27	Percentage of Service Users waiting no more than 28 days to communication of definitive cancer / not cancer diagnosis from - urgent referral where referred urgently (including with breast symptoms); and - referral from NHS cancer screening, as appropriate	Operating standard of at least 77% <u>80%</u> by March 2025 <u>2026</u>	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Month	A, CR
E.B.8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis <u>decision to treat/earliest clinically</u>	Operating standard of 96%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at:	Month	A, CR

Ref	National Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Service category
	<u>appropriate date</u> to any cancer treatment		https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/		
E.B.12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral (including for breast symptoms), NHS cancer screening or consultant upgrade (as appropriate) to first cancer treatment	Operating standard of at least 70% 75% by March 2025 2026	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Month	A, CR
	Ambulance Service Response Times				
	Category 1 (life-threatening) incidents – proportion of incidents resulting in a response arriving within 15 minutes	Operating standard that 90 th 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/	Year	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/	Year	AM
	Category 2 (emergency) incidents – proportion of incidents resulting in an appropriate response arriving within 40 minutes	Operating standard that 90 th centile is no greater than 40 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Year	AM
	Category 2 (emergency) incidents – mean time taken for an appropriate response to arrive	Mean is no greater than 30 minutes	See AQI System Indicator Specification at:	Year	AM

Ref	National Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Service category
			https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/		
	Category 3 (urgent) incidents – proportion of incidents resulting in an appropriate response arriving within 120 minutes	Operating standard that 90 th 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/	Year	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 90 th 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/	Year	AM
	Ambulance handover and “crew clear” times				
E.B.S.7	Handovers between ambulance and hospitals, A+E departments or Urgent Treatment Centres	Operating standard of • 100% within 60 minutes • 95% within 30 minutes • 65% within 15 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Year	A, A+E, U
E.B.S.8	Following handover between ambulance and hospitals, A+E departments or Urgent Treatment Centres, ambulance crew should be ready to accept new calls within 15 minutes	>0	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Ongoing	AM

	Mixed-sex accommodation breaches				
E.B.S.1	Mixed-sex accommodation breach	>0	See Delivering Same-Sex Accommodation and Mixed-Sex Accommodation Guidance at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/	Ongoing	A, CR, MH
	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	A, CR
E.B.S.6	No urgent operation should be cancelled for a second time	>0	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Ongoing	A, CR
	Mental health				
E.B.S.3	The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care (note – this standard does not apply to specialised mental health services commissioned by NHS England, including where NHS England has delegated the	Operating standard of 80%	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Quarter	MH

	function of commissioning those services to an ICB)				
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%	Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQs at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Quarter	MH
E.H.1	NHS Talking Therapies for Anxiety and Depression programmes: the percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	Operating standard of 75%	See Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQs at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Month	MH
E.H.2	NHS Talking Therapies for Anxiety and Depression programmes: the percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	Operating standard of 95%	See Improving Access to Psychological Therapies (IAPT) Waiting Times Guidance and FAQs at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Month	MH
E.H.11	Where the Provider provides Services for children and young people with an eating disorder, the percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week.	Operating standard of 95%	See Access and Waiting Time Standard for Children and Young People with an Eating Disorder at: https://www.england.nhs.uk/mental-health/cyp/eating-disorders/	Quarter	MH, MHSS

E.H.10	Where the Provider provides Services for children and young people with an eating disorder, the percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks.	Operating standard of 95%	See Access and Waiting Time Standard for Children and Young People with an Eating Disorder at: https://www.england.nhs.uk/mental-health/cyp/eating-disorders/	Quarter	MH, MHSS
	Patient safety				
E.A.S.4	Zero tolerance methicillin-resistant <i>Staphylococcus aureus</i>	>0	See https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/	Ongoing	A
E.A.S.5	Minimise rates of Clostridium difficile (NHS Trusts / FTs only)	As published by NHS England at: https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/	See https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/	Year	A
	Minimise rates of gram-negative bloodstream infections (NHS Trusts / FTs only)	As published by NHS England at: https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/	See https://www.england.nhs.uk/patient-safety/healthcare-associated-infections/	Year	A
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	Operating standard of 95%	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Quarter	A
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive,	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	See Contract Technical Guidance Appendix 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Quarter	A, A+E

	receive IV antibiotic treatment within one hour of diagnosis				
	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 2 at: https://www.england.nhs.uk/nhs-standard-contract/	Quarter	A
	Duty of candour				
	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	All
	Community				
	Community health services two-hour urgent response standard	Operating standard of 70% from 1 January 2023	See: <i>Community health services two-hour urgent response standard guidance</i> , available at: https://www.england.nhs.uk/publication/community-health-services-two-hour-urgent-community-response-standard-guidance/ ; and <i>Community services data set technical guidance for the two-hour urgent community response standard</i> , available at https://www.england.nhs.uk/publication/community-services-data-set-technical-guidance-for-the-two-hour-	Quarterly	CS

			urgent-community-response-standard/		
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The Provider must report its performance against each applicable National Quality Requirement through its Service Quality Performance Report, in accordance with Schedule 6A (*Reporting Requirements*).

ANNEX B Provider Data Processing Agreement

*This **Provider Data Processing Agreement** 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 **Provider Data Processing Agreement, which incorporates Schedule 6E to the Particulars**.
- 1.3 This **Provider Data Processing Agreement** 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 **Provider Data Processing Agreement**, including instructions regarding transfers of Personal Data outside the 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 **Provider Data Processing Agreement**:

- (a) process that Personal Data only in accordance with this **Provider Data Processing Agreement** (and in particular **Schedule 6E**), 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 **Provider Data Processing Agreement** (and in particular **Schedule 6E**);
 - (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 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 **Provider Data Processing Agreement**, 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 **Provider Data Processing Agreement**);
 - (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 (*Assignment and Sub-Contracting*), before allowing any Sub-processor to process any Personal Data related to this **Provider Data Processing Agreement**, 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 **Provider Data Processing Agreement** 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 **Provider Data Processing Agreement**, containing:
 - (a) the categories of processing carried out under this **Provider Data Processing Agreement**;
 - (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 **Provider Data Processing Agreement**; 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.

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