



NHS Standard Contract 2019/20 Particulars (Full Length)

Contract title / ref: Complex Cases

NHS Standard Contract 2019/20

Particulars (Full Length)

Version number: 1

First published: March 2019

Prepared by: NHS Standard Contract Team
nhscb.contractshelp@nhs.net

Classification: OFFICIAL

Publication Approval Number: 000248

Contract Reference	Complex Cases ref:008
---------------------------	-----------------------

DATE OF CONTRACT	
SERVICE COMMENCEMENT DATE	01/09/2019
CONTRACT TERM	13 months commencing 01/09/2019 (Subject to extension in accordance with Schedule 1C)
COMMISSIONERS	<p>Stafford and Surrounds Clinical Commissioning Group Staffordshire Place 2 1st Floor Stafford ST16 2LP O5V</p> <p>Cannock Chase Clinical Commissioning Group Staffordshire Place 2 1st Floor Stafford ST16 2LP 04Y</p> <p>East Staffs Clinical Commissioning Group Edwin House, Second Avenue, Burton on Trent DE14 2WF 05D</p> <p>North Staffs Clinical Commissioning Group Smithfield 1 Leonard Coates Way Hanley Stoke-on-Trent Staffordshire ST1 4FA 05G</p> <p>Stoke-on-Trent Clinical Commissioning Group Smithfield 1 Leonard Coates Way Hanley Stoke-on-Trent Staffordshire</p>

CONTENTS

PARTICULARS

CONTENTS.....	5
SCHEDULE 1 – SERVICE COMMENCEMENT	15
A. Conditions Precedent	15
B. Commissioner Documents	16
C. Extension of Contract Term	17
SCHEDULE 2 – THE SERVICES	19
A. Service Specifications	19
B. Indicative Activity Plan	29
C. Activity Planning Assumptions	30
D. Essential Services (NHS Trusts only)	31
E. Essential Services Continuity Plan (NHS Trusts only)	32
F. Clinical Networks	33
G. Other Local Agreements, Policies and Procedures	34
H. Transition Arrangements	35
I. Exit Arrangements	36
J. Transfer of and Discharge from Care Protocols	38
K. Safeguarding Policies and Mental Capacity Act Policies	39
L. Provisions Applicable to Primary Medical Services	40
M. Development Plan for Personalised Care	41
SCHEDULE 3 – PAYMENT	43
A. Local Prices	43
B. Local Variations	44
C. Local Modifications	46
D. Emergency Care Rule: Agreed Blended Payment Arrangements	46
E. Intentionally omitted	47
F. Expected Annual Contract Values	48
G. Timing and Amounts of Payments in First and/or Final Contract Year	49
SCHEDULE 4 – QUALITY REQUIREMENTS	50
A. Operational Standards	50
B. National Quality Requirements	57
C. Local Quality Requirements	63
D. Commissioning for Quality and Innovation (CQUIN)	64
E. Local Incentive Scheme	65

F. Clostridium difficile	66
SCHEDULE 5 – GOVERNANCE.....	67
A. Documents Relied On	67
B. Provider’s Material Sub-Contracts	68
C. Commissioner Roles and Responsibilities.....	69
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS.....	70
A. Reporting Requirements.....	70
B. Data Quality Improvement Plans.....	73
C. Incidents Requiring Reporting Procedure.....	74
D. Service Development and Improvement Plans.....	75
E. Surveys	76
F. Provider Data Processing Agreement	77
SCHEDULE 7 – PENSIONS	82
SCHEDULE 8 – LOCAL SYSTEM OPERATING PLAN OBLIGATIONS	83

SERVICE CONDITIONS

- SC1 Compliance with the Law and the NHS Constitution
- SC2 Regulatory Requirements
- SC3 Service Standards
- SC4 Co-operation
- SC5 Commissioner Requested Services/Essential Services
- SC6 Choice and Referral
- SC7 Withholding and/or Discontinuation of Service
- SC8 Unmet Needs, Making Every Contact Count and Self Care
- SC9 Consent
- SC10 Personalised Care
- SC11 Transfer of and Discharge from Care; Communication with GPs
- SC12 Communicating With and Involving Service Users, Public and Staff
- SC13 Equity of Access, Equality and Non-Discrimination
- SC14 Pastoral, Spiritual and Cultural Care
- SC15 Urgent Access to Mental Health Care
- SC16 Complaints
- SC17 Services Environment and Equipment
- SC18 Sustainable Development
- SC19 Food Standards and Sugar-Sweetened Beverages
- SC20 Service Development and Improvement Plan
- SC21 Antimicrobial Resistance and Healthcare Associated Infections
- SC22 Assessment and Treatment for Acute Illness
- SC23 Service User Health Records
- SC24 NHS Counter-Fraud and Security Management
- SC25 Procedures and Protocols
- SC26 Clinical Networks, National Audit Programmes and Approved Research Studies
- SC27 Formulary
- SC28 Information Requirements
- SC29 Managing Activity and Referrals
- SC30 Emergency Preparedness, Resilience and Response
- SC31 Force Majeure: Service-specific provisions
- SC32 Safeguarding, Mental Capacity and Prevent
- SC33 Incidents Requiring Reporting
- SC34 Care of Dying People and Death of a Service User
- SC35 Duty of Candour
- SC36 Payment Terms
- SC37 Local Quality Requirements and Quality Incentive Scheme
- SC38 Commissioning for Quality and Innovation (CQUIN)
- SC39 Procurement of Goods and Services

GENERAL CONDITIONS

- GC1 Definitions and Interpretation
- GC2 Effective Date and Duration
- GC3 Service Commencement
- GC4 Transition Period
- GC5 Staff
- GC6 Intentionally Omitted
- GC7 Intentionally Omitted
- GC8 Review
- GC9 Contract Management
- GC10 Co-ordinating Commissioner and Representatives
- GC11 Liability and Indemnity
- GC12 Assignment and Sub-Contracting
- GC13 Variations
- GC14 Dispute Resolution
- GC15 Governance, Transaction Records and Audit
- GC16 Suspension
- GC17 Termination
- GC18 Consequence of Expiry or Termination
- GC19 Provisions Surviving Termination
- GC20 Confidential Information of the Parties
- GC21 Service User Confidentiality, Data Protection, Freedom of Information and Transparency
- GC22 Intellectual Property
- GC23 NHS Identity, Marketing and Promotion
- GC24 Change in Control
- GC25 Warranties
- GC26 Prohibited Acts
- GC27 Conflicts of Interest and Transparency on Gifts and Hospitality
- GC28 Force Majeure
- GC29 Third Party Rights
- GC30 Entire Contract
- GC31 Severability
- GC32 Waiver
- GC33 Remedies
- GC34 Exclusion of Partnership
- GC35 Non-Solicitation
- GC36 Notices
- GC37 Costs and Expenses
- GC38 Counterparts
- GC39 Governing Law and Jurisdiction

CONTRACT

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

1. these **Particulars**;
2. the **Service Conditions (Full Length)**;
3. the **General Conditions (Full Length)**,

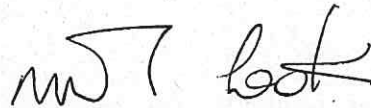
as completed and agreed by the Parties and as varied from time to time in accordance with GC13 (*Variations*).

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

SIGNED by

**for and on behalf of the CLINICAL
COMMISSIONING GROUPs (CCG)**

Stafford and Surrounds CCG
Cannock Chase CCG
Seisdon and Peninsula CCG
North Staffordshire CCG
Stoke-on-Trent CCG
East Staffordshire CCG



.....
Signature

Interim Director of Finance
.....
Title

23/1/20
.....

Date

CONTRACT

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

4. these **Particulars**;
5. the **Service Conditions (Full Length)**;
6. the **General Conditions (Full Length)**,

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

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

SIGNED by

.....
Signature

**for
and on behalf of the Provider**

.....
Title

.....
Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	TBC
Expected Service Commencement Date	1st September 2019
Longstop Date	N/A
Service Commencement Date	1st September 2019
Contract Term	13 months or as extended in accordance with Schedule 1C
Option to extend Contract Term	YES by up to 2 years
Commissioner Notice Period (for termination under GC17.2)	6 months
Commissioner Earliest Termination Date	6 months after the Service Commencement
Provider Notice Period (for termination under GC17.3)	6 months
Provider Earliest Termination Date	6 months after the Service Commencement Date

SERVICES	
Service Categories	Indicate <u>all</u> that apply
Accident and Emergency (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (CHC)	
Community Services (CS)	
Diagnostic, Screening and/or Pathology Services (D)	
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	YES
Mental Health and Learning Disability Secure Services (MHSS)	
NHS 111 Services (111)	
Service User Transport Services (PT)	
Radiotherapy Services (R)	
Urgent Care/Walk-in Centre Services/Minor Injuries Unit (U)	
Services commissioned by NHS England	
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	NO
Service Requirements	
Indicative Activity Plan	NO
Activity Planning Assumptions	NO
Essential Services (NHS Trusts only)	Not applicable
Services to which 18 Weeks applies	NO
Prior Approval Response Time Standard	Not applicable
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract?	NO SCHEDULE 6F DOES NOT APPLY FOR THE PURPOSE OF THIS AGREEMENT

Is the Provider providing CLINICAL COMMISSIONING GROUP-commissioned Services which are to be listed in the UEC DoS?	NO
PAYMENT	
Expected Annual Contract Value Agreed	NO
Must data be submitted to SUS for any of the Services?	NO
QUALITY	
Provider type	Other
Clostridium difficile Baseline Threshold (Acute Services only)	Not applicable
GOVERNANCE AND REGULATORY	
Nominated Mediation Body	CEDR/Other –
Provider's Nominated Individual	Name: Email: Tel:
Provider's Information Governance Lead	Name: Email: Tel:
Provider's Data Protection Officer (if required by Data Protection Legislation)	Name: Email: Tel:
Provider's Caldicott Guardian	Name: Email: Tel:
Provider's Senior Information Risk Owner	Name: Email: Tel:
Provider's Accountable Emergency Officer	Name: Email: Tel:
Provider's Safeguarding Lead	Name: Email: Tel:
Provider's Child Sexual Abuse and Exploitation Lead	Name: Email: Tel:
Provider's Mental Capacity and Deprivation of Liberty Lead	Name: Email: Tel:
Provider's Prevent Lead	Name:

	Email: Tel:
Provider's Freedom To Speak Up Guardian(s)	Name: Email: Tel:
Provider's UEC DoS Contact	N/A
Commissioners' UEC DoS Leads	N/A
CONTRACT MANAGEMENT	
Addresses for service of Notices	<p>MLCSU Contracts Manager Amanda Capewell Heron House 120 Grove Road Fenton Stoke-on-Trent Staffordshire ST4 4LX Email: Amanda.capewell@nhs.net</p> <p>Provider: Address:</p> <p>Email:</p>
Frequency of Review Meetings	Ad hoc
Commissioner Representative(s)	<p>Lead Commissioner NHS Staffordshire and Surrounds Clinical Commissioning Group Staffordshire Place 2 Stafford ST16 2LP</p>
Provider Representative	<p>Address:</p> <p>Email:</p>

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

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

- | |
|--|
| <ol style="list-style-type: none">1. Evidence of appropriate Indemnity Arrangements2. Evidence of CQC registration in respect of Provider |
|--|

The Provider must complete the following actions:

Not applicable

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Not Applicable		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

1. The Commissioners may opt to extend the Contract Term by 2 years.
2. If the Commissioners wish to exercise the option to extend the Contract Term, the Co-ordinating Commissioner must give written notice to that effect to the Provider no later than 1 months before the original Expiry Date.
3. The option to extend the Contract Term may be exercised:
 - 3.1 only once, and only on or before the date referred to in paragraph 2 above;
 - 3.2 only by all Commissioners; and
 - 3.3 only in respect of all Services
4. If the Co-ordinating Commissioner gives notice to extend the Contract Term in accordance with paragraph 2 above, the Contract Term will be extended by the period specified in that notice and the Expiry Date will be deemed to be the date of expiry of that period.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification	Complex Cases
No.	Ref: 008
Service	Locked and Step-down Rehabilitation Services for Adults with Complex Mental Health
Commissioner Lead	
Provider Lead	
Period	1 st September 2019 to 30 th September 2020
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Midlands and Lancashire Commissioning Support Unit (MLCSU) will manage the delivery of a high-quality service for Non-Continuing Healthcare Complex Cases for Mental Health (including EMI Service Users) and those with Acquired Brain injury. This cohort of Service Users will be required to be registered with a GP from either North Staffordshire, Stoke-on-Trent, Cannock, Stafford and Surrounds, East Staffordshire, Seisdon & Peninsula.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

3. Scope

3.1 Aims and objectives of service

In referring a Service User to the Provider, there is an explicit expectation that Service Users will receive appropriate services to treat, care and support the Service User along a continuum of rehabilitation as speedily as their condition and ability can accommodate. The desirable outcome will be for the Service User to move towards a return to living in the community setting.

Objectives

- To assure that all treatment and care will have clearly agreed outcome measures that will be actively monitored.
- Actively involve each Service User and their family/carer/advocate in reviewing their program of support and treatment, ensuring that they are provided with appropriate information and guidance.
- Ensure the care is delivered in the least restrictive setting and least disruptive manner possible.
- Assess, formulate a rehabilitation care package offering treatment and skills development for Mental Health disorder and/or Acquired Brain Injury (with predominant mental health) through therapies.
- Reduce the risk of harm to self and others
- Provide individualised care that meets the needs of each patient and involvement of their family and carers in decision making with consent.
- Provide a time-limited intervention that supports recovery and enable a safe transition through the rehabilitation care pathway.
- Provide the patient with a full multi-disciplinary assessment including assessment of risk and formulation resulting in a care plan developed in collaboration with them and reflective of their wishes and aspiration
- Ensure the care is delivered in the least restrictive setting and least disruptive manner possible.
- To support the development of repatriation pathways where appropriate jointly between health and social care. To achieve a delivery of an efficient seamless transfer of service users between care settings.
- Use the Care Programme Approach to underpin service delivery.
- Proactively manage behaviors such as self-harm, violence and aggression.

3.2 Service description/care pathway

The contracted service will actively support a 'whole systems' approach to care, including the Patient's physical and mental health and fully engage with all relevant organisations, family, carers, advocates and Service users to ensure their needs are effectively supported.

The Service will deliver person centered assessment, care management in line with evidence based best practice and health legislation.

The Provider will:

- Provide on-going case management to service users in receipt of NHS Funding.
- Ensure the provider organisation maintains CQC registration. If a providers CQC rating is Inadequate in any one of the 5 CQC domains this may deter any further placements into the service until assurance is gained that the provider is able to deliver safe care.

The Service will operate within applicable Legislation, National Standards and Guidance, the service must adhere to guidance and requirements set out in:

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- The Care Act 2014
- NAPICU (updated 2014)
- Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards
- The Equality Act 2010
- The Disability Discrimination Act 1995
- Confidentiality, NHS Code of Practice

- Independence, choice and risk: a guide to best practice in supported decision making 2007
- NICE guidance
- Locally agreed pathways
- Who Pays Guidance; responsible commissioner (2013) and any updated guidance.

The above is not a comprehensive list, and the provider will make themselves aware of any changes and updates to the appropriate legislation and guidance for their Service User and facility. Information for Independent Healthcare Services can be found on the CQC website.

The contracted service will actively support a 'whole systems' approach to care, including the Service User's physical and mental health and fully engage with all relevant organisations, family, carers, advocates and Service Users to ensure their needs are effectively supported.

The Service will deliver person centered assessment, care management in line with evidence based best practice and health legislation.

The Provider will:

- Provide on-going case management to Service Users in receipt of NHS Funding
- Endeavour to achieve a CQC standard of overall, Good.
- Ensure all professionals/support workers have the relevant, up to date qualifications for their skills recognised by a professional body and they maintain all core skills by continued professional development, i.e. Medical staff are registered by GMC, Nursing staff are registered and revalidated with NMC, Social workers have the relevant UK practice standards and ensure that all support workers have the relevant competencies, skills training and qualifications to perform their role effectively.
- The provider as an employee, will ensure all their employed care staff receive and engage in the relevant programme of training that supports them in the role of caring for Service Users.
- Assist in the development of clinical governance activities such as audit and identification of training needs.
- If the provider has to sub-contract any services such as Speech and Language Therapy, Occupational Therapy, physiotherapy, Cognitive Behaviour Therapy, Eye Movement Desensitization and Reprocessing, Dialectical Behaviour Therapy they must ensure that the provider has the relevant qualifications to perform a task and they have the relevant public liability, indemnity and insurance, and must seek the consent of MLCSU.
- Designate a named Case Manager for the patient to liaise with the MLCSU Commissioner and Care Co-Ordinator regarding Tribunals, Ministry of Justice Meetings, Care Programme Approach (CPA) and future care provision. The provider will advise the MLCSU Commissioner and Care Co-Ordinator of any changes in need and/or of any serious untoward incidents the same day or the next day.
- Ensure that MLCSU Commissioners are invited (where appropriate) to Tribunal reviews. MDT outcomes to be reported back to the MLCSU Commissioner and Care co-ordinator in a timely manner.
- Establish a level of support and information required by family and carers (as appropriate) to enable effective engagement, taking into account the Service Users

right to confidentiality.

- Provide confidential advice to the Service User. Neither party to this contract will disclose to any third-party information acquired during the period of the Agreement which concerns the identity or personal details of any individual without that person's consent, except where legally required to do so.
- Provide a flexible case management service which will respond rapidly to changes in individual need and assure continuity of care.
- To ensure completed risk assessments reflect any safeguarding issues for vulnerable Service Users and where abuse has/or is likely to occur.
- Improve cross-boundary working, resulting in continuity of care, effective communication and increase of appropriate use of other specialist services where necessary.
- Ensure the care is delivered in the least restrictive setting and least disruptive manner possible.
- For service users with additional restrictions through the Ministry of Justice (MoJ), ensure compliance with the MoJ requirements and directions e.g. care coordinator seeking approval prior to changes in care package.
- The service will be non-discriminatory and anti-oppressive by way of service delivery and Equality Impact Assessments will be completed as appropriate
- Provide a culturally competent service, including ready access to interpreter services for minority languages and British Sign language.

The service must ensure the patient's physical health care needs are assessed, reviewed and met through:

- The effective facilitation of primary and secondary health care including health promotion, health screening e.g. smoking cessation, cholesterol monitoring, blood pressure monitoring and that the information related is integrated into one patient record.

It is the right of all mental health Service Users and/or acquired brain injury Service Users to have their needs met without discrimination based on any circumstances such as;

- age.
- being married or in a civil partnership.
- being pregnant or on maternity leave.
- race including colour, nationality, ethnic or national origin.
- religion, belief or lack of religion/belief.
- sex.
- carer and parental status.
- disability (including physical, sensory and intellectual disability, work related injury, medical conditions, and mental, psychological and learning disabilities)
- employment activity.
- gender identity, lawful sexual activity and sexual orientation, being or becoming a transsexual person.
- marital status.

The commissioned Mental Health service and/or Acquired Brain Injury service should run so as to:

- ensure treatment with dignity and respect at all times for Service Users, for their

- families and staff,
- focus on recovery,
- promote choice; self-determination and independence,
- maximise quality of life by recognition of citizens' rights and the encouragement of independence and social inclusion. ,
- provide as homely an environment as possible with a balance between the need for security and a domestic environment,
- deliver the service in the least restrictive manner as is possible whilst maintaining Service User safety
- improve health efficiently and provide value for money,
- provide a comprehensive yet flexible service to meet assessed need,
- be aware of risks from and to individual Service Users,
- be integral to comprehensive mental health services in the locality,
- be local, reliable, comprehensive and seamless,
- reduce risk for the individual and local community whilst being the least restrictive as possible,
- be equitable, person centred and culturally sensitive,
- be evidence based, high quality and accountable; and
- work in partnership with others services and stakeholders.

3.4 Commissioning process

Authorisation of a care package is sought after assurance from the referrer that there are no local specialised NHS services that can meet the Service User's needs. Signed off by the Head of Clinical/Medical services. The application should identify the presence of a Mental Health disorder and/or Acquired Brain Injury where the responsible MDT have identified the individual will benefit from hospital placement for further rehabilitation and treatment.

The commissioner will request assessments for individuals from at least two different providers on behalf of Clinical Commissioning Group.

- This demonstrates consideration of available care providers and consideration of placements that represent value for money through costing, timely availability of placement and progressive rehabilitation service specific to the individual Service User need with consideration being given to the geographical location of the available placement.
- Following referral the provider is required to confirm bed availability and offer an assessment date within 7 working days of receipt of the referral.
- An offer of placement is required through full assessment of service users current needs (patient history and summary of referral, identify professional reports reviewed as part of the assessment, current presentation, current treatment plan, service users view on how future needs to be met, risk assessment), outlining the proposed care plan (short and long term goals), proposed duration of Fage and a breakdown of costs. Following assessment the care provider is required to submit an outline of the proposed care plan in writing to MLCSU

3.5 Main responsibilities for the provider

- The provider shall make available a bed in a registered Independent Hospital to provide care and treatment in relation to the complex mental health needs of the Service User. The terms of registration of the Independent Hospital will have provision for Service Users detained under the Mental health Act e.g. Section 2, 3, 37/41 45/49
- The needs and wishes of the individual are considered as paramount, through the best interests decision making.

- Discharge plans are clearly documented in the individual's health record.
- The commissioner will pay the provider for the provision of one bed for the Service User under the conditions of this agreement. The cost to the commissioner is as agreed prior to placement for the duration of placement.

Care provider is to coordinate the commissioner for the same Clinical Commissioning Group to be invited to a cyclical predetermined monthly MDT and 3 monthly CPA of individuals on the same date for that Clinical Commissioning Group patient group

- Any additional equipment needed for the Service User will be provided and funded by the provider.
- Any changes to Service User fees will only be in the case of:
 - An agreed % inflationary uplift as agreed for all providers through the responsible Clinical Commissioning Group
 - Clinical Commissioning Group approved increase in care package in response to changing clinical need of Service User. The commissioner on behalf of the Clinical Commissioning Group will be informed of any changes the same day or the next day.
 - Request for any funding changes to care package to be submitted to commissioner on behalf of Clinical Commissioning Group. Sent to complex.caseteam@nhs.net including the required evidence.

Care pathways:

- Commissioner is provided with adequate notice of planned health appointment and shall identify at this time any requirement for escort and costs for prior approval.
- Commissioner is notified by provider of Service User attending general hospital for emergency care and treatment. **If admission to hospital is required from Accident and emergency/an assessment unit or directly to a general hospital in-Service User bed evidence of discussion between hospital manager and provider in relation to presenting needs and responsibilities for management under the mental health act to made available to the Commissioner.** A Risk Assessment to be completed for any additional observations if required. The commissioner will need to be informed of any additional support for a Service User admitted to a general hospital, and any necessary ongoing support from the provider should be maintained.
- When a Service User requires an unplanned hospital visit the Provider shall where possible and where appropriate retain responsibility for appropriate Service User escort and supervision to support the Service User until the hospital admits or discharges the Service User.
- Where a Service User is admitted to an in Service User bed of a NHS Hospital and the bed vacancy is maintained at the care provider, following 72 hours in the NHS Hospital the care provider shall discount the bed fee by 10% for each full day of hospitalisation.
- All additional observation funding will cease on the day of an admission to an acute hospitalisation, unless the Mental Health Act or Minister of Justice necessitates the need to accompany a Service User. Funding will be made available for additional observation support for either the part of/ or for the full duration of the stay
- Granting of leave, escorted or unescorted in accordance with the MHA must be granted by the patient's Responsible Clinician. It must be well planned and follow an effective risk assessment which includes assessment of risk of absconding and risk of harm to self and public and anyone that may be affected by the patient's past actions.
- The Care plan should include how the planned leave supports the patient's recovery.
- Commissioner is notified of primary services required that are not available through responsible GP service.

Additional Observations/ increase in care package

In exceptional circumstances MLCSU will consider additional observation payments to

maintain the safety and well-being of service users funded on behalf of Staffordshire Clinical Commissioning Group and that of other service users.

Where an increased need has been identified, which may require enhanced observation, the provider must ensure alternative strategies/interventions have been considered. For example:-

- The use and deployment of Assistive technology
- Investigations completed for possible physiological cause e.g. infection, constipation, been seen by GP and treated accordingly.
- Within eyesight observations, where the patient is accessible at all times, day and night.
- Appropriate and timely referrals are made to specialist professionals to ensure that the formulation of strategies for the behavioral disorder are deployed
- Therapeutic use of prescribed medication, including effective use of PRNs, (if this is deemed to be the least restrictive option) and rapid specialist review by professionals as appropriate.

The provider must ensure that enhanced observations are carried out in accordance with NICE guidance (Clinical Guidelines 25).

The provider must also demonstrate that staff employed, have appropriate skills to manage the needs of a particular client group and there are adequate base level staffing ratios to meet the needs of the patient group and that these staff are available and managed effectively.

Where an increase in care is required to address short term crisis/escalation in needs the initial 72 hours of increased care package to be provided by the care provider at no additional costs to the Commissioners. Care provider MDT to agree proposed care plan is least restrictive and proportionate to meet Service User's needs. Where the agreed care plan is anticipated to be required beyond 72 hours then an application for Clinical Commissioning Group additional funding approval is to be made by the Provider to the Commissioner. Care provider is required to provide a clinical rationale for the request, incident forms, behavioural charts, safeguarding referrals, professional referrals, proposed care plan. If evidence is not provided this will delay funding agreement or that any funding put in place will be retrospectively clawed back from the provider.

The commissioner will only pay for services that have been delivered.

Additional funding for enhanced observation should be discussed with and agreed by the commissioner on next working day. A written clinical rationale should be submitted within 48 hours of any verbal agreement being made. Delay in notification may impact on ability to agree retrospective requests.

The provider will be able to provide documented evidence at review of the prescribed additional observations and be able to produce the documents.

Where an individual's needs change, and the additional support is no longer required, the provider will inform the commissioner immediately and payments for the additional support will cease. A suitable escort should always be provided as per the National Contract however if the patient is admitted the provider will not receive further funding for the 1:1 support until the patient returns to the accommodation

Any service user requiring additional observation will be required to have a care plan specifically related to this need. The care plan will be prescriptive regarding the hours required and positive engagement with their carer will be given at all times and this will be detailed in the care plan and evidenced in all evaluations. The care plan will include the need to complete behavioral charts, 1:1 observation charts, incident forms and where necessary the use of physical intervention techniques. The Clinical Commissioning Group

expectation is that the carer will be within arms length of the service user and able to intervene immediately as required. Exceptions to this will be discussed with the commissioner and detailed in the care plan. Carers will be delegated to carry out the additional observation and have the necessary skill and experience to manage the needs.

The care plan will be reviewed weekly and justification for continued additional support will be documented within the care notes. This information should be available to the commissioner or their representative on request.

Out of hours.

The provider has a duty to maintain a safe environment for all its residents therefore if a sudden deterioration occurs and the provider is unable to contact the commissioner the safety of residents is the prime objective. The provider should put in place all necessary risk management strategies and this may include additional support. A detailed report should be made and then discussed with the commissioner at the first opportunity for additional funding agreement.

- Enhanced observations should only be considered with a framework of support and engagement with the service users to minimize risks and prevent deterioration through least restrictive care package.
- The need for enhanced observation must be regularly reviewed and reduced to the minimum level necessary at the earliest opportunity while maintaining a safety in line with the Mental Health Act Code of Practice.
- Provider to offer Assurance through a policy on observation and engagement and maintenance of environmental, procedural and relational safety to uphold dignity, respect and care for the patient and reflect their immediate needs and the needs of others.

Travel costs

- Travel costs that are health related are provided through NHS Ambulance services.
- Travels costs and escorts that are related to rehabilitation activity and discharge planning are through the existing agreed care package i.e transport for community access and home leave
- Travels costs that require a specialist service beyond those commissioned through NHS Ambulance services are to be submitted to the commissioner and considered on a case by case basis through the responsible Clinical Commissioning Group prior to care event.

Staff escorts

- Where staff escorts are needed for appearance in Court, the commissioner is to be provided with risk assessments and informed in good time to assess the costs and to secure approval.

Equipment:

- Following initial assessment of need the provider is required to ensure their service is able to provide all equipment required to meet the Service User's needs or to accommodate and support maintenance of Service Users own equipment. Any request for bespoke equipment will need to be discussed and agreed with the commissioner before providing such a service. Consideration will be given on an individual basis.

Discharge planning:

- There is full involvement of the MPFT Care-Coordinator and MLCSU Commissioner, Service User and their family, carers/advocate as appropriate in all aspects of the discharge/transfer process.
- Structured rehabilitation commences as from the point of acceptance of the care package for individual Service User. Rehabilitation is focused towards progressing Service User care to recovery enabling a future placement in least restrictive care.
- Care provider is to coordinate the commissioner for the same Clinical Commissioning Group are invited to a cyclical predetermined monthly MDT and 3 monthly CPA of individuals on the same date for that Clinical Commissioning Group Service User group.
- Service Users receive rehabilitation programme supported by use of legal frameworks of the Mental Health Act 1983(reviewed 2007) and the Mental Capacity Act 2005.
- Ensure if Service User is discharged on a Supervised Community Treatment Order (CTO) under MHA S17A a Responsible Clinician is identified to ensure arrangements for any return to hospital or a timely review of the Section (CTO) is organised before discharge to community.
- Provider liaises with nominated care coordinator to consider continuing to utilise legal frameworks on discharge to provide positive support or recall to hospital in presence of deterioration.
- Community contacts in preparation for discharge are part of the agreed care package e.g transition to the community which is escorted or unsupervised community leave to discharge address inclusive of travel costs.
- That a detailed discharge letter has been sent to the Service User's identified Responsible Consultant Psychiatrist, Community Mental Health Team (CMHT) and Service Users GP.

Termination:

- Notice of termination of care package will be through a minimum 28 day written notification by either parties to the contract. However there is an expectation that the notice period may require extending whilst an alternative placement is sourced and secured, this will ensure the continuity of safe care and will ensure the safe transition of care for the Service User:
 - The Provider serving notice of the termination of the placement to the Commissioners
 - The Commissioners serving notice of the termination of the placement to the Provider
- Termination of placement will be immediate where there are safeguarding concerns requiring an alternative place of safety to meet the Service Users needs. Funding arrangements shall cease on the day of the Service Users transfer to an alternative placement.
- Service User is informal and has mental capacity to make the decision to transfer their care to an alternative placement. Funding arrangements shall cease on the day of the Service Users transfer to an alternative placement.
- In the event that the provider presents an immediate risk to the Service User the commissioner reserves the right to source an alternative provider with immediate effect. Should the provider fail to perform, or defaults the commissioner reserves the right to cancel the contract and source an alternative provider to meet Service User's needs. Funding arrangements shall cease on the day of the Service Users transfer to an alternative placement.

On request the provider will make available periodic reports to the commissioner. These will include :

- Reports from regulators within 14 days of receipt

- Changes to RMO arrangements during the period of Service User placement to be reported within 28 days of their occurrence
- Changes to Mental Health Act management arrangements
- Any changes to the registration of the provider

Changes in individual Service User needs that may impact on appropriateness of placement will be reported to the MPFT care-coordinator and Commissioners.

3.7 Population covered

- People meeting the acceptance criteria aged 18 and over who are registered with in North and South Staffordshire, and Stoke on Trent GP attached to the following Clinical Commissioning Group (and as per the Who Pays Guidance 2013):
 - NHS Stafford and Surrounds.
 - NHS Cannock Chase
 - NHS South Staffs and Seisdon Peninsula
 - NHS East Staffordshire
 - NHS North Staffordshire
 - NHS Stoke on Trent

Exclusion criteria

- S117 funded service users
- Learning Disability service users
- NHSE funded service users
- PICU (direct from NHS ward)
- CAMHS
- IFR treatments

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE, MHA, Care Act)

The Provider shall (i) meet and maintain national quality standards and any other national quality requirements that may from time to time be specified, (ii) agree local quality improvements of health and wellbeing and reduction of health inequalities in line with local priorities and the expressed preferences of local communities.

4.2 National Standards

Robust procedures relating to the responsibilities of services and staff under the Mental Health Act and other relevant legislation must be put in place and regularly reviewed. Any medical treatment provided to the service users must comply with the Mental Health Act Part 4 and, where relevant, the Mental Capacity Act 2005 and the common law.

The Service will operate within applicable Legislation, National Standards and Guidance, the service must adhere to guidance and requirements set out in:

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- The Care Act 2014
- NAPICU (updated 2014)
- Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards 2007
- The Equality Act 2010
- The Disability Discrimination Act 1995

- Confidentiality, NHS Code of Practice
- Independence, choice and risk: a guide to best practice in supported decision making 2007
- Locally agreed pathways
- Who Pays Guidance; responsible commissioner (2013) and any updated guidance.

Services must ensure compliance against the Care Quality Commission's (CQC) "Essential Standards of Quality and Safety" (2010) www.cqc.org.uk with respect to maintaining safety and in the management of emergencies. This must include

- Provision of appropriately trained staff
- Availability of appropriate staffing capacity
- Robust on call arrangements,
- Easy access to emergency medical equipment
- Facilitation of rapid access for emergency services into the unit.

Services should deliver treatment in line with the NICE Guidance as follows:

- CG136 Service User Experience in Adult MH Services
- CG82 Schizophrenia
- CG38 Bipolar disorder
- CG90 Depression in adults
- CG120 Psychosis with coexisting substance misuse
- CG77 Antisocial personality disorder
- CG78 Borderline personality disorder
- CG51 Drug misuse: psychosocial interventions
- CG25 Violence (short-term management)
- CG133 Self-harm (longer term management)

The above is not a comprehensive list, and the provider will make themselves aware of any changes and updates to the appropriate legislation and guidance for their patient and facility. Information for Independent Healthcare Services can be found on the CQC website.

4.3 Other Applicable National Standards to be met by commissioned providers

- Any medical treatment provided to the service users must comply with the Mental Health Act Part 4 and, where relevant, the Mental Capacity Act 2005 and the common law.
- Services must comply with the requirement to liaise with the bodies responsible for providing after-care services to service users under MHA Section 117.
- Providers must promote equality of access, experience and outcomes across ethnic groups, faiths, gender, disabilities, sexual orientation and socio-economic status.
- CPA meetings must be held within the first three months of admission and then every six months.
- All service users must have an estimated date of discharge identified with 4 weeks of admission to the service and this date reviewed as often as required but specifically at CPA.
- Joint working protocol/care pathway with primary healthcare providers with specialist

and emergency health teams must be developed and followed.

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

Not Applicable

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Not Applicable

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Not Applicable

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

Early Termination of Contract

The Commissioner expects to incur no additional cost as a result of early termination of the contract.

In the event that the contract term expires and is not renewed, or the Commissioner or Provider terminates this agreement in accordance with the agreed terms, the following arrangements will apply:

Communication with Service Users

The Provider will agree with the Commissioner, the content, style and format of communications with Service Users which will include at least the following information:

- ☐ Service(s) end date
- ☐ Providers on-going responsibilities with regard to Service User records in accordance with the Data Protection Act
- ☐ Details of arrangements for transfer of care

Other Communications

Commissioners will be responsible for agreeing a communications strategy with the Provider.

This strategy will be delivered by the Commissioner and will include:

- ☐ Communications with other Providers on the care pathway
- ☐ Communications with referrers
- ☐ Communications with media
- ☐ Communications with Service User groups and members of the public

Service User Management and Transfer of Care

The Provider shall ensure that all Service User Management Function remains in place during the notice period..

All equipment (clinical and non-clinical) shall remain in place for the duration of the notice period to ensure continuity of service(s). Post service(s) end date, the Provider will remain responsible for the removal of any of its equipment from NHS sites

Premises

The Provider will continue to operate from agreed premises during the notice period. All signage will remain in place during this time and where applicable, any Commissioner or NHS signage will be removed upon the termination date.

IM&T

The Provider will agree an IM&T exit strategy with the Commissioner. This will include:

- ☐ Milestones for e-Referral System (e-RS) changes
 - ☐ Strategy for Smart Card Roles to be deactivated for relevant staff members
 - ☐ Confirmation of archive and storage arrangements for any relevant electronic data.
 - ☐ Confirmation that relevant procedures and policies such as disaster recovery, will stay in place until the termination date.
 - ☐ Confirmation that the Provider will ensure any licenses purchased for the delivery of service(s) in accordance with this Agreement shall remain in place until the termination date.
- The Provider is responsible for all associated costs post termination.

Sub-Contractors

The Provider will be responsible for managing any sub-contractor relationships impacted by termination of the service(s) within this Agreement.

The Provider is responsible for ensuring the exit strategy agreed with sub-contractors does not impact service delivery prior to the service termination date.

The Provider is responsible for any costs associated with early termination of its sub-contracting arrangements.

Risk Assessment and Management

The Provider and Commissioner will undertake a joint risk assessment of the exit plan and will seek to manage these jointly to minimise any negative impact

Eviction

The Provider shall take all reasonable endeavours to mitigate Service User eviction from the home and will work with the Commissioner to take steps to resolve issues as and when they arise. Eviction shall only occur if all other demonstrable efforts to resolve issues have been unsuccessful. If, despite all reasonable endeavours to resolve issues, the Provider wants to evict a Service User, written notice of one month must be given to both the Service User and the Commissioners

All equipment (clinical and non-clinical) shall remain in place for the duration of the notice period to ensure continuity of service(s). Post service(s) end date, the Provider will remain responsible for the removal of any equipment from the site.

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

Discharge and transfer of Service User's placement to a third party (change of provision). Service Users shall not be transferred to any other Provider without prior approval from the Commissioner.

The Provider shall not discharge a Service User where their discharge would not be in accordance with the good practice within the publication Good Health and Social Care Practice and Good Clinical Practice.

Prior to the transfer of a Service User to the care of a third party provider the Provider will liaise with the third party provider to prepare an appropriately detailed and comprehensive transition care plan relating to the transfer of the Service User's care.

The Provider shall not discharge or transfer a Service User to the care of a third party provider until the care transfer plan relating to the Service User has been prepared, agreed with the care coordinator, Commissioner and third party provider, and is ready for implementation.

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

SAFEGUARDING – ADULTS AT RISK

The following section sets out the commissioner's requirements and standards to which providers must conform.

Compliance with the Care Act 2014

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect. It is an important part of what many public services do, but the key responsibility is with local authorities in partnership with police and the NHS. **The Care Act 2014 puts safeguarding on a legal footing from April 2015.**

Mental Capacity Act (MCA) 2005

The MCA covers England and Wales and provides a statutory framework for people who lack the capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations and how they should go about this.

The Standard NHS Contract specifically identifies Conditions for compliance:

- S. Condition 1 requires -all services will be compliant with the Law (1.1.2)
- S. Condition 9 -Publish, maintain and operate a service user consent policy, which complies with Good Practice and the Law (9.1)
- S. Condition 12 -assurance that experience and views of those lacking capacity and their families are recorded and acted on (12.1 – 12.4)
- S. Condition 13; -equality of access and non-discrimination
- assistance provided to service users (13.2)
- G. Condition 5 ensure appropriate staff to enable the services to be provided in accordance with the contract (5.2.1)
 - appropriately qualified to perform the duties required of them (5.3.2)
 - are aware of and respect equality and human rights (5.3.5)

General Statement

The Care Act updates the scope of adult safeguarding and safeguarding duties which apply to an adult who:

- ☐ Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- ☐ Is experiencing or at risk of abuse or neglect; and
- ☐ As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

Adult Safeguarding Board

There is a single Staffordshire and Stoke on Trent Safeguarding Adults Partnership Board (SSASPB) details regarding this SAB and the 'Inter-agency Adult protection Procedures' can be found at:- www.ssaspb.org.uk

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

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

Local initiatives to support implementation of personalised care

This Schedule 2M can be used to set out specific actions which the Commissioner and/or Provider will take to give Service Users greater choice and control over the way their care is planned and delivered. This could include taking forward any of the six key aspects of the personalised care model:

1. *Shared decision making*
2. *Personalised care and support planning*
3. *Enabling choice, including legal rights to choice*
4. *Social prescribing and community-based support*
5. *Supported self-management*
6. *Personal health budgets and integrated personal budgets.*

Actions set out in this Schedule 2M could focus on making across-the-board improvements applying to all of the Provider's services – or on pathways for specific conditions which have been identified locally as needing particular attention.

Implementation of personal health budgets

More specifically, this Schedule 2M can be used to set out the detailed actions which the Commissioner and/or Provider will take to facilitate the roll-out of personal health budgets to appropriate Service Users.

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

Key statutory obligations

Regulation 32B of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

- *This entitles individuals who receive Continuing Healthcare or Continuing Care for Children to personal health budgets, where appropriate.*
- *The CLINICAL COMMISSIONING GROUP must retain responsibility for, amongst other things:*
 - *deciding whether to grant a request for a personal health budget;*
 - *if a request for a personal health budget is granted, deciding whether the most appropriate way to manage the personal health budget is:*
 - ❖ *by the making of a direct payment;*
 - ❖ *by the application of the personal health budget by the CLINICAL COMMISSIONING GROUP itself; or*

- ❖ *by the transfer of the personal health budget to a third party (for example, the Provider) who will apply the personal health budget.*

- *If the CLINICAL COMMISSIONING GROUP decides that the most appropriate way of managing a personal health budget is by the transfer of the personal health budget to the Provider, the Provider must still obtain the agreement of the CLINICAL COMMISSIONING GROUP in respect of the choices of services / treatment that Service Users/Carers have made.*

Section 12A of the National Health Service Act 2006 and the National Health Service (Direct Payments) Regulations 2013 (the "2013 Regulations")

- *Direct payments by definition can only be made by the Secretary of State, NHS England a CLINICAL COMMISSIONING GROUP or Local Authority, therefore any direct payments would have to be made by the CLINICAL COMMISSIONING GROUP and not the Provider.*
- *The CLINICAL COMMISSIONING GROUP must make the decision as to whether to make a direct payment, and it must be made in accordance with the 2013 Regulations.*

Examples of the matters this Schedule 2M should cover in relation to personal health budgets

- *which identified groups of Service Users are to be supported through a personalised care approach and which particular cohorts are to be offered personal health budgets and/or integrated personal budgets*
- *the funding arrangements, including what is within the Price and what is not;*
- *a roll-out plan, with timescales and target levels of uptake (aimed at delivering the CLINICAL COMMISSIONING GROUP's contribution towards the targets set out in the [NHS Framework for Universal Personalised Care]) for the Provider to implement personalised care and to offer personal health budgets and integrated personal budgets to Service Users/Carers from particular care groups, including, but not limited to, people eligible for NHS Continuing Healthcare and children eligible for Continuing Care for Children; people with multiple long-term conditions; people with mental ill health including those who are under s117 aftercare; people with learning disabilities; and people who use wheelchairs;*
- *how the process of personal health budgets is aligned with delivery of personal budgets in social care and education, to ensure a seamless offer to Service Users/Carers*
- *require the Provider to implement the roll-out plan, supporting Service Users/Carers, through the care and support planning process, to identify, choose between and access services and treatments that are more suitable for them, including services and treatments from non-NHS providers – and to report on progress in implementation;*
- *require the Provider to agree appropriate financial and contractual arrangements to support the choices Service Users/Carers have made;*
- *set out any necessary arrangements for financial audit of personal health budgets, and integrated personal budgets, including for clawback of funding in the event of improper use and clawback in the event of underspends of the person's budget, ensuring this is discussed and agreed with the person beforehand.*

SCHEDULE 3 – PAYMENT

A. Local Prices

Prices shall be agreed at the point of placement and each placement will be underpinned by a Service Agreement. The Parties hereby agree that the terms and conditions of each Individual Service User Placement shall be as set out in the Service Agreement and the conditions within the NHS Standard Contract.

SCHEDULE 3 – PAYMENT

B. Local Variations

Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

Continuing Healthcare make payments for clients on a self-bill system whereby payments are generated and paid either weekly or monthly, without the need for providers to submit invoices.

Service Conditions 36.36 will not apply and will be replaced with the following text:

The Commissioners and the Provider shall use a Self-Billing procedure for all payment related transactions in respect of the Services;

The Commissioners and the Provider shall adhere to the conditions imposed by HM Revenue and Customs in respect of Self-Billing invoices and processes, as may be amended from time to time;

The Provider shall:

- accept electronically delivered Self-Billing invoices raised on its behalf by the appropriate Commissioner(s) in respect of all Relevant Transactions;
- not to issue VAT invoices in respect of the Services provided;
- where for internal compliance reasons The Provider raises dummy invoices, the Provider will reconcile such dummy invoices to the Self-Billing Invoice;
- to reconcile their account with any factoring company as may be applicable from time to time;
- to only submit paper-copy Service where pre-agreed in writing with the Commissioners;
- subject to (v) above, to ensure the Application's Service Receipt submission system is used to capture all hours/deliverables provided in respect of the Services;
- to ensure that rates, hours and expenses are verified prior to submission or on-line entry of Service Receipts;
- to raise any discrepancies between a Self-Billing invoice received from the appropriate Commissioner(s) and invoicing data in its internal records within seven (7) days of receipt of such Self-Billing invoice;
- to notify The Commissioners representative, Midlands and Lancashire Commissioning Support Unit immediately if the Provider changes its VAT registration number, ceases to be VAT registered or sells or otherwise disposes of all or part of its business;
- to respond to any request for confirmation of its VAT registration details within 7 days of request.

Where there is any breach whatsoever of Service Condition 36.45.3, the Commissioner may delay or not process payment of the sums due to the Provider from such Self-Billing invoices that the breach relates to.

The Commissioner shall:

- wherever reasonably possible, to provide a valid Self-Billing VAT invoice to the Provider on a weekly or monthly basis;
- to include on each invoice the Provider's name, address and VAT registration number, invoice total and details of applicable VAT at the prevailing rate;
- to inform the Provider of any relevant changes to the applicable Commissioner's VAT registration status, and enter into a new Self-Billing agreement should this be necessary.

The Commissioner shall not accept any liability for payment of any of the Provider's services where the Provider does not hold a valid signed/approved Service Receipt, as applicable, or where the Service Receipt has not been authorised via the Application's online Service Receipt system, SProc.Net, or such other application as directed by the Commissioner from time to time.

The Provider shall provide the Commissioner with its accurate bank details within the Application and must notify the Commissioner immediately if any of the Provider's bank details set out in the Application are to be changed in any way. The Commissioner reserves the right to withhold any sums due, without penalty, whilst investigating any such change of details.

SCHEDULE 3 – PAYMENT

D. Emergency Care Rule: Agreed Blended Payment Arrangements

Commissioner	Value of Planned Activity (£)	Blended Payment applies (see footnote 1)	Emergency Care Threshold(s) (see footnote 2)	Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)
			Not applicable	Not applicable

SCHEDULE 3 – PAYMENT

E. Intentionally omitted

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Commissioner	For the avoidance of doubt, there is no expected annual contract value.
---------------------	---

SCHEDULE 3 – PAYMENT

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

Not Applicable

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	RTT waiting times for non-urgent consultant-led treatment					
E.B.3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Operating standard of 92% at specialty level (as reported to NHS Digital)	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Where the number of Service Users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each such Service User above that threshold	Monthly	Services to which 18 Weeks applies
	Diagnostic test waiting times					
E.B.4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	Operating standard of no more than 4%	See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/	Where the number of Service Users waiting 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Monthly	A CS CR D

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	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 95%	See A&E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/	Where the number of Service Users in the month not admitted, transferred or discharged within 4 hours exceeds the tolerance permitted by the threshold, £120 in respect of each such Service User above that threshold. To the extent that the number of such Service Users exceeds 15% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month	Monthly	A+E U
	Cancer waits—2 week wait					
E.B.6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first out Service User appointment	Operating standard of 93%	See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Quarterly	A CR R
E.B.7	Percentage of Service Users referred urgently with breast symptoms	Operating standard of 93%	See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Quarterly	A CR R

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	(where cancer was not initially suspected) waiting no more than two weeks for first out Service User appointment		uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold		
	Cancer waits – 31 days					
E.B-8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Operating standard of 96%	See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly	A CR R
E.B-9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	Operating standard of 94%	See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly	A CR R
E.B-10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug	Operating standard of 98%	See Annex F, 2019/20 Planning Guidance at: https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly	A CR R

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	<i>regimen</i>		<u>contracting-annex-f/</u>	<i>respect of each such Service User above that threshold</i>		
E.B.11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	Operating standard of 94%	See Annex F, 2019/20 Planning Guidance at: <u>https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/</u>	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly	A C R
	Cancer waits – 62 days					
E.B.12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%	See Annex F, 2019/20 Planning Guidance at: <u>https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/</u>	Where the number of Service Users who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly	A C R
E.B.13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	Operating standard of 90%	See Annex F, 2019/20 Planning Guidance at: <u>https://www.england.nhs.uk/publication/preparing-for-2019-20-operational-planning-and-contracting-annex-f/</u>	Where the number of Service Users in the Quarter who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above	Quarterly	A C R

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
				that threshold		
	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 AQL System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	For each second by which the Provider's actual 90th centile performance exceeds 15 minutes, £5 per 1,000 Category 1 incidents received in the Quarter	Quarterly	AM
	Category 1 (life-threatening) incidents—mean time taken for a response to arrive	Mean is no greater than 7 minutes	See AQL System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Issue of a Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	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 AQL System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	For each second by which the Provider's actual 90th centile performance exceeds 40 minutes, £3.50 per 1,000 Category 2 incidents received in the Quarter	Quarterly	AM
	Category 2 (emergency) incidents—mean time taken for an appropriate response to arrive	Mean is no greater than 18 minutes	See AQL System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Issue of a Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	AM
	Category 3 (urgent) incidents—proportion of incidents resulting in	Operating standard that 90 th centile is	See AQL System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	For each second by which the Provider's actual 90th centile performance exceeds	Quarterly	AM

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	an appropriate response arriving within 120 minutes	no greater than 120 minutes	<u>uk/statistics/statistical-work-areas/ambulance-quality-indicators/</u>	120 minutes, £2 per 1,000 Category 3 incidents received in the Quarter		
	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/	For each second by which the Provider's actual 90th centile performance exceeds 180 minutes, £1 per 1,000 Category 4 incidents received in the Quarter	Quarterly	AM
	Mixed-sex accommodation breaches					
E.B.S.1	Mixed-sex accommodation breach	>0	See Mixed-Sex Accommodation Guidance, Mixed-Sex Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/	£250 per day per Service User affected	Monthly	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	Number of Service Users who are not offered another	See Cancelled Operations Guidance and Cancelled Operations FAQ at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/	Non-payment of costs associated with cancellation and non-payment of reimbursement (as applicable) of re-scheduled episode of	Monthly	A CR

Ref	Operational Standards	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	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	binding date within 28 days >0	areas/cancelled elective operations/	care		
	Mental health					
E.B.S.3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-Service User care	Operating standard of 95%	See MHPC Guidance at: https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/	Where the number of Service Users in the Quarter not followed up within 7 days exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Quarterly	MH MHSS

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

In respect of those Operational Standards shown in ***bold italics***, the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.A.S.4	Zero tolerance methicillin-resistant <i>Staphylococcus aureus</i>	>0	See Contract Technical Guidance Appendix 3	£10,000 in respect of each incidence in the relevant month	Monthly	A
E.A.S.5	Minimise rates of <i>Clostridium difficile</i>	[Insert baseline threshold identified for Provider-see Schedule 4F]	See Contract Technical Guidance Appendix 3	As set out in Schedule 4F, in accordance with applicable Guidance	Annual	A
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	£2,500 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Monthly	Services to which 18 Weeks applies
E.B.S.7a	All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes	>0	See Contract Technical Guidance Appendix 3	£200 per Service User waiting over 30 minutes in the relevant month	Monthly	A+E

National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.B.S.7b All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 60 minutes	>0	See Contract Technical Guidance Appendix 3	£1,000 per Service User waiting over 60 minutes (in total, not aggregated with E.B.S.7a consequence) in the relevant month	Monthly	A+E
E.B.S.8a Following handover between ambulance and A & E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 30 minutes	>0	See Contract Technical Guidance Appendix 3	£20 per event where > 30 minutes in the relevant month	Monthly	AM
E.B.S.8b Following handover between ambulance and A&E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 60 minutes	>0	See Contract Technical Guidance Appendix 3	£100 per event where > 60 minutes (in total, not aggregated with E.B.S.8a consequence) in the relevant month	Monthly	AM
E.B.S.5 Waits in A&E not longer than 12 hours	>0	See A&E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/	£1,000 per incidence in the relevant month	Monthly	A+E

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.B.S.6	No urgent operation should be cancelled for a second time	>0	See Contract Technical Guidance Appendix 3	£5,000 per incidence in the relevant month	Monthly	A CR
	VTE risk assessment: all in Service User Service Users undergoing risk assessment for VTE	95%	See Contract Technical Guidance Appendix 3	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	A
	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	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	Monthly	All
E.H.4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE recommended package of care	Operating standard of 56%	See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	MH

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
E.H.1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment	Operating standard of 75%	See Contract Technical Guidance Appendix 3	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	MH
E.H.2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment	Operating standard of 95%	See Contract Technical Guidance Appendix 3	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	MH
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with	Failure to achieve full implementation as described under Service Specification B15/S/a Cancer:	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Where both Specialised Services and Cancer apply

National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
children, teenagers and young adults) across all tumour sites	Chemotherapy (Adult)				
Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumour sites	Failure to achieve full implementation as described under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults)	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	Where both Specialised Services and Cancer apply
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	See Contract Technical Guidance Appendix 3	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	A, A&E
Proportion of Service Users in Service Users who undergo sepsis screening and who, where screening is positive, receive IV	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	See Contract Technical Guidance Appendix 3	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Quarterly	A

	National Quality Requirement	Threshold	Guidance on definition	Consequence of breach	Timing of application of consequence	Application
	<i>antibiotic treatment within one hour of diagnosis</i>					

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

In respect of the National Quality Requirements shown in ***bold italics***, the provisions of SC36.38 apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement
Notification of a Serious Incident to be reported to complex.caseteam@nhs.net within 2 operational days of it being identified as an Serious Incident	100%	Via reporting and cross validation with Serious Incident team

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Commissioning for Quality and Innovation (CQUIN)

For the period 19/20 the Commissioners have applied the small-value contract exception as set out in CQUIN Guidance and the provisions of SC38.15 apply to this Contract.

Commissioners may choose to publish a scheme for 20/21. In this case the small-value contract exception shall not apply.

SCHEDULE 4 – QUALITY REQUIREMENTS

E. Local Incentive Scheme

Not Applicable

SCHEDULE 4 – QUALITY REQUIREMENTS

F. Clostridium difficile

Clostridium difficile adjustment: NHS Foundation Trust/NHS Trust (Acute Services only)

The financial adjustment (£) is the sum which is the greater of Y and Z, where:

$$Y = 0$$

$$Z = ((A - B) \times 10,000) \times C$$

where:

A = the actual number of cases of Clostridium difficile in respect of all NHS Service Users treated by the Provider in the Contract Year

B = the baseline threshold (the figure as notified to the Provider and recorded in the Particulars), being the Provider's threshold for the number of cases of Clostridium difficile for the Contract Year, in accordance with Guidance:

<https://www.england.nhs.uk/ServiceUsersafety/associated-infections/clostridium-difficile/>

C = $\frac{\text{no. of inService User bed days in respect of Service Users in the Contract Year}}{\text{no. of inService User bed days in respect of all NHS Service Users treated by the Provider in the Contract Year}}$

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

Clostridium difficile adjustment: Other Providers (Acute Services only)

The financial adjustment (£) is the sum equal to A x 10,000, where:

A = the actual number of cases of Clostridium difficile in respect of Service Users in the Contract Year.

The financial adjustment is calculated on the basis of annual performance. For the purposes of SC36.37 (*Operational Standards, National Quality Requirements and Local Quality Requirements*), any repayment or withholding in respect of Clostridium difficile performance will be made in respect of the final Quarter of the Contract Year.

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
Not Applicable	

Documents supplied by Commissioners

Date	Document
Not Applicable	

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

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

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
NHS Stafford & Surrounds Clinical Commissioning Group	Jointly manage the Contract including all quality, finance, negotiation and performance management of the contract through contract with Midlands and Lancashire Commissioning Support Unit

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	All
2. Service User Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/Service-User-reported-outcome-measures-proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	All
National Requirements Reported Locally				
1. Activity and Finance Report (note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31)	N/A	N/A	By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable	All
2. Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: <ol style="list-style-type: none"> details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; details of all requirements satisfied; details of, and reasons for, any failure to meet requirements; the outcome of all Root Cause Analyses and audits performed pursuant to SC22 (Assessment and Treatment for Acute Illness); report on performance against the HCAI 	N/A	N/A	Within 15 Operational Days of the end of the month to which it relates.	All All All A All except

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	Reduction Plan			111
3.	CQUIN Performance Report and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied	N/A for 19/20 For CCGs consideration for 20/21	[For local agreement]	All
4.	NHS Safety Thermometer Report, detailing and analysing: a. data collected in relation to each relevant NHS Safety Thermometer; b. trends and progress; c. actions to be taken to improve performance.	N/A	[For local agreement], according to published NHS Safety Thermometer reporting routes	All (not AM, CS, D, 111, PT, U)
5.	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	[For local agreement]	[For local agreement]	All
6.	Report against performance of Service Development and Improvement Plan (SDIP)	In accordance with relevant SDIP	In accordance with relevant SDIP	All
7.	SEDRIUS	Monthly	[For local agreement]	All
8.	Data Quality Improvement Plan: report of progress against milestones	In accordance with relevant DQIP	In accordance with relevant DQIP	All
9.	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A&E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594	Monthly	As set out in relevant Guidance	A A+E U
10.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (Staff)	Annually (or more frequently if and as required by the Coordinating Commissioner from time to time)	[For local agreement]	All
11.	Report on compliance with the National Workforce Race Equality Standard.	Annually	[For local agreement]	All
12.	Specific reports required by NHS England in relation to Specialised Services and other	As set out at http://www.england.nhs.uk	As set out at http://www.england.nhs.uk/nhs-	Specialised Services

Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	k/nhs-standard-contract/ss-reporting	uk/nhs-standard-contract/ss-reporting	
13. Report on performance in reducing Antibiotic Usage in accordance with SC21.4 (<i>Antimicrobial Resistance and Healthcare Associated Infections</i>)	Annually	[For local agreement]	A
14. Report on progress against sustainable development management plan in accordance with SC18.2	Annually	[For local agreement]	All
Local Requirements Reported Locally			
1. Notification of a Serious Incident		to be reported to complex.caseteam@nhs.net within 2 operational days of it being identified as an Serious Incident	
2. Safeguarding referral		to be reported to complex.caseteam@nhs.net within 2 operational days of the referral being made	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

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

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
Not Applicable				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Service User Safety Incidents

The Provider must comply with the **Serious incident Framework: Supporting learning to prevent recurrence**, NHS England (March 2015).

<https://www.england.nhs.uk/ServiceUsersafety/serious-incident/>

The Provider must comply with the **Revised Never Events Policy & Framework**, NHS England (March 2015).

<https://www.england.nhs.uk/ServiceUsersafety/never-events/>

The Provider will adhere to North Staffordshire CLINICAL COMMISSIONING GROUP (NS CLINICAL COMMISSIONING GROUP), Stoke-on-Trent CLINICAL COMMISSIONING GROUP (SOT CLINICAL COMMISSIONING GROUP) & Staffordshire & Stoke-on-Trent Partnership NHST Trust (SSOTP) Serious Incident policies.

<http://www.northstaffsClinicalCommissioningGroup.nhs.uk/policiesnorthstaffs>

The commissioner must be informed (via STEIS and/or verbally if required) of a Serious Incident within 2 operational days of it being identified as an SI, where it is not clear whether an incident fulfils the definition of a serious incident, providers and commissioner shall engage in open and honest discussions to agree the appropriate and proportionate response.

The provider must provide a 72 Hour briefing (as set out in SI policy and national / regional guidelines for those SI's where this is appropriate).

The Provider & Commissioner(s) will meet monthly forming a Serious Incident Review Group. The Serious Incident Review Group is an integral part of the Quality Management System within the CLINICAL COMMISSIONING GROUPs to establish a system of good governance across the Local Health Economy to promote a culture of openness and an attitude that facilitates learning from all incidents. This should include prompt reporting, appropriate and robust investigation, identification of corrective actions, learning and effective and timely follow-up.

Closure of an incident marks the completion of the investigation process only.

Commissioners should close incidents on receipt of the final investigation report and action plan if they are satisfied that the requirements outlined within the serious incident framework are fulfilled. Incidents can be closed before all preventative actions have been implemented and reviewed for efficacy, particularly if actions are continuous or long term. Mechanisms must be in place for monitoring implementation of long term/on-going actions.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

D. Service Development and Improvement Plans

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

	Milestones	Timescales	Expected Benefit	Consequence of Achievement/ Breach
[Ambulance services – relevant recommendations in Lord Carter’s report Operational Productivity and Performance in English NHS Ambulance Trusts]				
[Maternity services – Continuity of Carer Standard in accordance with SC3.13.2]				
[Staff Mental Health and Wellbeing Plan]				
Insert text locally				[Subject to GC9 (Contract Management)] or [locally agreed]

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication
Friends and Family Test (where required in accordance with FFT Guidance)	As required by FFT Guidance	As required by FFT Guidance	As required by FFT Guidance
Service User, Carer and Employee	Ad hoc	Detailing the outcomes and action from the Service User and carer surveys	Information to be available to Commissioners on request
Complaints process post complaint response satisfaction survey and Service User association review	Ad hoc	Detailing the outcomes and action from the Complaints survey.	Information to be available to Commissioners on request

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

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

1. SCOPE

- 1.1 The Co-ordinating Commissioner appoints the Provider as a Data Processor to perform the Data Processing Services.
- 1.2 When delivering the Data Processing Services, the Provider must, in addition to its other obligations under this Contract, comply with the provisions of this Schedule 6F.
- 1.3 This Schedule 6F applies for so long as the Provider acts as a Data Processor in connection with this Contract.

2. DATA PROTECTION

- 2.1 The Parties acknowledge that for the purposes of Data Protection Legislation in relation to the Data Processing Services the Co-ordinating Commissioner is the Data Controller and the Provider is the Data Processor. The Provider must process the Processor Data only to the extent necessary to perform the Data Processing Services and only in accordance with written instructions set out in this Schedule, including instructions regarding transfers of Personal Data outside the EU or to an international organisation unless such transfer is required by Law, in which case the Provider must inform the Co-ordinating Commissioner of that requirement before processing takes place, unless this is prohibited by Law on the grounds of public interest.
- 2.2 The Provider must notify the Co-ordinating Commissioner immediately if it considers that carrying out any of the Co-ordinating Commissioner's instructions would infringe Data Protection Legislation.
- 2.3 The Provider must provide all reasonable assistance to the Co-ordinating Commissioner in the preparation of any Data Protection Impact Assessment prior to commencing any processing. Such assistance may, at the discretion of the Co-ordinating Commissioner, include:
 - (a) a systematic description of the envisaged processing operations and the purpose of the processing;
 - (b) an assessment of the necessity and proportionality of the processing operations in relation to the Data Processing Services;
 - (c) an assessment of the risks to the rights and freedoms of Data Subjects; and
 - (d) the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.
- 2.4 The Provider must, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F:
 - (a) process that Personal Data only in accordance with Annex A, unless the Provider is required to do otherwise by Law. If it is so required the Provider must promptly notify the Co-ordinating Commissioner before processing the Personal Data unless prohibited by Law;
 - (b) ensure that it has in place Protective Measures, which have been reviewed and approved by the Co-ordinating Commissioner as appropriate to protect against a Data Loss Event having taken account of the:

- (i) nature, scope, context and purposes of processing the data to be protected;
 - (ii) likelihood and level of harm that might result from a Data Loss Event;
 - (iii) state of technological development; and
 - (iv) cost of implementing any measures;
- (c) ensure that:
- (i) when delivering the Data Processing Services the Provider Staff only process Personal Data in accordance with this Schedule 6F (and in particular Annex A);
 - (ii) it takes all reasonable steps to ensure the reliability and integrity of any Provider Staff who have access to the Personal Data and ensure that they:
 - (A) are aware of and comply with the Provider's duties under this paragraph;
 - (B) are subject to appropriate confidentiality undertakings with the Provider and any Sub-processor;
 - (C) are informed of the confidential nature of the Personal Data and do not publish, disclose or divulge any of the Personal Data to any third party unless directed in writing to do so by the Co-ordinating Commissioner or as otherwise permitted by this Contract;
 - (D) have undergone adequate training in the use, care, protection and handling of Personal Data; and
 - (E) are aware of and trained in the policies and procedures identified in GC21.11 (*Service User Confidentiality, Data Protection, Freedom of Information and Transparency*).
- (d) not transfer Personal Data outside of the EU unless the prior written consent of the Co-ordinating Commissioner has been obtained and the following conditions are fulfilled:
- (i) the Co-ordinating Commissioner or the Provider has provided appropriate safeguards in relation to the transfer as determined by the Co-ordinating Commissioner;
 - (ii) the Data Subject has enforceable rights and effective legal remedies;
 - (iii) the Provider complies with its obligations under Data Protection Legislation by providing an adequate level of protection to any Personal Data that is transferred (or, if it is not so bound, uses its best endeavours to assist the Co-ordinating Commissioner in meeting its obligations); and
 - (iv) the Provider complies with any reasonable instructions notified to it in advance by the Co-ordinating Commissioner with respect to the processing of the Personal Data;
- (e) at the written direction of the Co-ordinating Commissioner, delete or return Personal Data (and any copies of it) to the Co-ordinating Commissioner on termination of the Data Processing Services and certify to the Co-ordinating Commissioner that it has done so within five Operational Days of any such instructions being issued, unless the Provider is required by Law to retain the Personal Data;
- (f) if the Provider is required by any Law or Regulatory or Supervisory Body to retain any Processor Data that it would otherwise be required to destroy under this paragraph 2.4, notify the Co-ordinating Commissioner in writing of that retention giving details of the Processor Data that it must retain and the reasons for its retention; and

- (g) co-operate fully with the Co-ordinating Commissioner during any handover arising from the cessation of any part of the Data Processing Services, and if the Co-ordinating Commissioner directs the Provider to migrate Processor Data to the Co-ordinating Commissioner or to a third party, provide all reasonable assistance with ensuring safe migration including ensuring the integrity of Processor Data and the nomination of a named point of contact for the Co-ordinating Commissioner.
- 2.5 Subject to paragraph 2.6, the Provider must notify the Co-ordinating Commissioner immediately if, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F, it:
- (a) receives a Data Subject Access Request (or purported Data Subject Access Request);
 - (b) receives a request to rectify, block or erase any Personal Data;
 - (c) receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;
 - (d) receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is processed under this Schedule 6F);
 - (e) receives a request from any third party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;
 - (f) becomes aware of or reasonably suspects a Data Loss Event; or
 - (g) becomes aware of or reasonably suspects that it has in any way caused the Co-ordinating Commissioner or other Commissioner to breach Data Protection Legislation.
- 2.6 The Provider's obligation to notify under paragraph 2.5 includes the provision of further information to the Co-ordinating Commissioner in phases, as details become available.
- 2.7 The Provider must provide whatever co-operation the Co-ordinating Commissioner reasonably requires to remedy any issue notified to the Co-ordinating Commissioner under paragraphs 2.5 and 2.6 as soon as reasonably practicable.
- 2.8 Taking into account the nature of the processing, the Provider must provide the Co-ordinating Commissioner with full assistance in relation to either Party's obligations under Data Protection Legislation and any complaint, communication or request made under paragraph 2.5 (and insofar as possible within the timescales reasonably required by the Co-ordinating Commissioner) including by promptly providing:
- (a) the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;
 - (b) such assistance as is reasonably requested by the Co-ordinating Commissioner to enable the Co-ordinating Commissioner to comply with a Data Subject Access Request within the relevant timescales set out in Data Protection Legislation;
 - (c) assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;
 - (d) assistance as requested by the Co-ordinating Commissioner with respect to any request from the Information Commissioner's Office, or any consultation by the Co-ordinating Commissioner with the Information Commissioner's Office.
- 2.9 Without prejudice to the generality of GC15 (*Governance, Transaction Records and Audit*), the Provider must allow for audits of its delivery of the Data Processing Services by the Co-ordinating Commissioner or the Co-ordinating Commissioner's designated auditor.

- 2.10 For the avoidance of doubt the provisions of GC12 (*Assignment and Sub-contracting*) apply to the delivery of any Data Processing Services.
- 2.11 Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:
- (a) notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;
 - (b) obtain the written consent of the Co-ordinating Commissioner;
 - (c) carry out appropriate due diligence of the Sub-processor and ensure this is documented;
 - (d) enter into a binding written agreement with the Sub-processor which as far as practicable includes equivalent terms to those set out in this Schedule 6F and in any event includes the requirements set out at GC21.16.3; and
 - (e) provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.
- 2.12 The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:
- (a) the categories of processing carried out under this Schedule 6F;
 - (b) where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;
 - (c) a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and
 - (d) a log recording the processing of the Processor Data by or on behalf of the Provider comprising, as a minimum, details of the Processor Data concerned, how the Processor Data was processed, when the Processor Data was processed and the identity of any individual carrying out the processing.
- 2.13 The Provider warrants and undertakes that it will deliver the Data Processing Services in accordance with all Data Protection Legislation and this Contract and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Services complies with Data Protection Legislation and ensures that the rights of Data Subjects are protected.
- 2.14 The Provider must comply at all times with those obligations set out at Article 32 of the 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 GDPR and equivalent provisions implemented into Law, taking into account the nature of processing and the information available to the Provider.
- 2.16 The Provider must take prompt and proper remedial action regarding any Data Loss Event.
- 2.17 The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

Annex A

Data Processing Services

Processing, Personal Data and Data Subjects

1. The Provider must comply with any further written instructions with respect to processing by the Co-ordinating Commissioner.
2. Any such further instructions shall be incorporated into this Annex.

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

SCHEDULE 7 – PENSIONS

Not Applicable

SCHEDULE 8 – LOCAL SYSTEM OPERATING PLAN OBLIGATIONS

Not Applicable

© Crown copyright 2019
First published: March 2019
Published in electronic format only

