NHS Standard Contract 2021/22

Particulars (Full Length)

Contract title / ref:

Healthcare Services at Gatwick Immigration Removal Centre (Brook House and Tinsley House)

PR003251-GAT-21/22-IRC-STD

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

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Contract Reference	**PR003251-GAT-21/22-IRC-STD**

DATE OF CONTRACT	**26th Aug 2021**
SERVICE COMMENCEMENT DATE	**1st September 2021**
CONTRACT TERM	**7 years commencing 1st September 2021**
COMMISSIONERS	**NHS England and NHS Improvement** York House 18-22 Massetts Road Horley Surrey RH6 7DE
CO-ORDINATING COMMISSIONER	**NHS England and NHS Improvement** York House 18-22 Massetts Road Horley Surrey RH6 7DE
PROVIDER	**Practice Plus Group Health and Rehabilitation Services Limited** Principal and/or registered office address: **Hawker House** **5-6 Napier Court** **Napier Road** **Reading** **Berkshire** **RG1 8BW** **Company number: 10498997**

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CONTRACT

Contract title: Healthcare Services at Gatwick Immigration Removal Centre (Brook House and Tinsley House)

Contract ref: PR003251-GAT-21/22-IRC-STD

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

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

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

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

SIGNED by	**Signature**
	.....
	Signature
DAVID BARRON for and on behalf of NHS ENGLAND AND NHS IMPROVEMENT	**Director of Specialised Commissioning and Health and Justice**
	.....
	Title
	9th September 2021
	.....
	Date
SIGNED by	**Signature**
	.....
	Signature
DAVID STICKLAND for and on behalf of PRACTICE PLUS GROUP HEALTH AND REHABILITATION SERVICES LIMITED	**CHIEF FINANCIAL OFFICER**
	.....
	Title
	26 August 2021
	.....
	Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**26th August 2021**
Expected Service Commencement Date	**1st September 2021**
Longstop Date	**3 months after Effective Date**
Service Commencement Date	**1st September 2021**
Contract Term	**7 years commencing 1st September 2021**
Option to extend Contract Term	**NO**
Commissioner Notice Period (for termination under GC17.2)	**A minimum of 12 months in respect of the Contract as a whole**
Commissioner Earliest Termination Date	**12 months after the Service Commencement Date**
Provider Notice Period (for termination under GC17.3)	**12 months in respect of the Contract as a whole**
Provider Earliest Termination Date	**12 months in respect of the Contract as a whole**

SERVICES	
Service Categories	**Indicate all that apply**
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (including continuing care for children) (CHC)	✔
Community Services (CS)	✔
Diagnostic, Screening and/or Pathology Services (D)	✔
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	✔
Mental Health and Learning Disability Secure Services (MHSS)	
NHS 111 Services (111)	
Patient Transport Services (PT)	
Radiotherapy Services (R)	
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	✔
Services commissioned by NHS England	
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	YES
Co-operation with PCN(s) in service models	
Enhanced Health in Care Homes	NO
Primary and Community Mental Health Services	NO
Service Requirements	
Indicative Activity Plan	NO
Activity Planning Assumptions	NO
Essential Services (NHS Trusts only)	NO
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?	**YES**
Is the Provider providing CCG-commissioned Services which are to be listed in the UEC DoS?	**NO**
PAYMENT	
Expected Annual Contract Value Agreed	**YES**
Must data be submitted to SUS for any of the Services?	**NO**
Under the Aligned Payment and Incentive Rules in the National Tariff, does CQUIN apply to payments made by any of the Commissioners under this Contract?	**NO**
QUALITY	
Provider type	**Other**
GOVERNANCE AND REGULATORY	
Nominated Mediation Body (where required – see GC14.4)	**CEDR**
Provider's Nominated Individual	**Dawn Jessop** **Email:** DPA **Tel:**
Provider's Information Governance Lead	**Eilidh Campbell** **Email:** DPA **Tel:**
Provider's Data Protection Officer (if required by Data Protection Legislation)	**Shepherd Makusha** **Email:** DPA **Tel:**
Provider's Caldicott Guardian	**Dr Marjorie Gillespie** **Email:** DPA **Tel:**
Provider's Senior Information Risk Owner	**Barry Nee** **Email:** DPA **Tel:**
Provider's Accountable Emergency Officer	**Jim Easton** **Email:** DPA **Tel:**
Provider's Safeguarding Lead (children) / named professional for safeguarding children	**Kate Carter** **Email:** DPA **Tel:**
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults	**Kate Carter** **Email:** DPA **Tel:**
Provider's Child Sexual Abuse and Exploitation Lead	**Kate Carter** **Email:** DPA **Tel:**
Provider's Mental Capacity and Liberty Protection Safeguards Lead	**Kate Carter** **Email:** DPA **Tel:**
Provider's Prevent Lead	**Kate Carter** **Email:** DPA

	Tel: DPA
Provider's Freedom To Speak Up Guardian(s)	**Louise Batchelor** **Email:** DPA **Tel:**
Provider's UEC DoS Contact	**NOT APPLICABLE**
Commissioners' UEC DoS Leads	**NOT APPLICABLE**
Provider's Infection Prevention Lead	**Dr Marcelle Michail** **Email:** DPA **Tel:**
Provider's Health Inequalities Lead	**Dr Marjorie Gillespie** **Email** DPA **Tel:**
Provider's Net Zero Lead	**Barry Nee** **Email:** DPA **Tel:**
CONTRACT MANAGEMENT	
Addresses for service of Notices	**Commissioning Contracts and Performance Management Team** **Address:** NHS England and NHS Improvement (South East) Oakley Road Southampton Hampshire SO16 4GX **Email** DPA **Commissioner Address:** Jubilee House 5510 John Smith Drive Oxford Business Park John Smith Drive OX4 2LH **Email:** DPA **Provider: Practice Plus Group Health and Rehabilitation Services Limited** **Address:** Hawker House 5-6 Napier Court Napier Road Reading Berkshire RG1 8BW **Email:** DPA **Tel:** DPA With a copy to be sent to: **Lee Gage** **Group General Counsel and Company Secretary** **Practice Plus Group Health and Rehabilitation Services Limited** Hawker House

	5-6 Napier Court Napier Road Reading Berkshire RG1 8BW **Email:** DPA
Frequency of Review Meetings	**Quarterly**
Commissioner Representative(s)	**Commissioner:** Oneal Thomas **Address:** Jubilee House 5510 John Smith Drive Oxford Business Park John Smith Drive OX4 2LH DPA
Provider Representative	**Dawn Jessop** **Practice Plus Group Health and Rehabilitation Services Limited** **Address:** Hawker House 5-6 Napier Court Napier Road Reading Berkshire RG1 8BW DPA

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

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

1. Evidence of appropriate Indemnity Arrangements
   a. Certificate of Employers Liability Insurance(a)

   b. Employers Liability, Public / Product Liability & Excess Medical Malpractice

(Embedded Doc from Lockton LLP details both Employers & Public / Product Liability for PPG)

2. [Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required)]

3. [Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors (where required)]

https://licensing-gateway.monitor.gov.uk/sites/monitor/Documents/Licence_200142_3.0.pdf

4. [Copies of the following Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner] [*LIST ONLY THOSE REQUIRED FOR SERVICE COMMENCEMENT AND NOT PROVIDED ON OR BEFORE THE DATE OF THIS CONTRACT*]

5. Additional conditions precedent will be added as required

The Provider must complete the following actions:

Insert conditions post-award as required by the Commissioner]

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
2018-21 *to be updated thereafter	**Partnership Agreement between: Home Office Immigration Enforcement, NHS England and Public Health England** (to which the latest version can be found on england.nhs.uk) https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf	This is an update of the agreement first published in October 2013. It sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities of NHS England, the Home Office Immigration Enforcement (HOIE) and Public Health England (PHE). Whilst the Department of Health and Social Care, CCG's and Local Authorities are not party to this agreement we recognise that there is a need to support joint working with them to secure the best health outcomes for individuals who are moved from an Immigration Removal Centre (IRC) but still detained under immigration powers to support continuity of services and continued good health, as far as appropriate. It is a tripartite agreement between PHE, Immigration Enforcement and NHS England to commission and deliver healthcare services and improve the health of people to the extent possible in Immigration Removal Centres (IRCs), Pre-Departure Accommodation (PDA) and Residential Short Term Holding Facilities (STHF) across England.
	Shared Occupancy Agreement	The purpose of the Shared Occupancy Agreement is to enable the Immigration Removal Centre (IRC) and Pre-Departure Accommodation (PDA) operational provider (Serco) and the Healthcare provider to flourish and maximise their partnership in the delivery of their respective functions and objectives within the IRC at Gatwick.

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

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

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

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

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

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

~~3.2 only by all Commissioners; and~~

~~3.3 only in respect of all Services~~

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

~~**Or**~~

NOT USED

SCHEDULE 2 – THE SERVICES

A. Service Specifications

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

Service	Healthcare Services at Gatwick Immigration Removal Centre (Brook House and Tinsley House)
Commissioner Lead	Alison Fowler
Provider Lead	Dawn Jessop
Period	1st September 2021 – 31st August 2028
Date of Review	Annually
Specification Documents Forming this Service	Primary Care Service – Medical and Nursing Gatwick IRC - Service Spec PC.doc Mental Health and Learning Disability Service Gatwick IRC - Service Spec MH LD. Integrated Substance Misuse Treatment Service Gatwick IRC - Service Spec SMS.do Dental Service Gatwick IRC - Service Spec Dental.

1. Population Needs

1.1 National/local context and evidence base

The 2012 Health and Social Care Act mandates NHS England and NHS Improvement (NHSE/I) to commission 'health services across IRCs and other places of prescribed detention'. The immigration removal estate constitutes places of prescribed detention, as such, this specification describes the required degree of primary care services that need to be delivered in these environments, ensuring that the principle of 'equivalence' is adhered to, enabling patients access to physical and mental health care as required in line with services offered in the community.

This service specification outlines what should be included in a primary care service being offered to patient populations in IRCs and Short-Term Holding Facilities. It also includes guidance for the support that should be offered to individuals with learning disabilities and other vulnerabilities (such as identifying people with a history of trauma, mental health

presentations, physical impairments including sight and hearing loss and broader cognitive impairments - learning disabilities, autism, neuro disability or acquired brain injury).

It is an integral part of the primary care of a person in detention that such vulnerabilities are brought to attention of the detaining authorities. Delivery of the healthcare services should support the mechanisms in train for identifying individuals who, because of their physical or mental health needs may not be suitable for remaining in detention and need to be considered in relation to the Adults At Risk Policy[1].

Compassionate care needs to be delivered to patients at all times mindful of the previous trauma a person may have received at the hands of others.

The purpose of health care in detention facilities is to provide an excellent, safe and effective service to all detainees ensuring access to and the quality of services delivered is equivalent to that of the community[2]. Services should meet the objectives and outcomes of national frameworks and priorities and are expected to develop and implement measures to monitor these outcomes.

Services should operate from a position of 'Making Every Contact Count'. Wherever a patient presents to any health service, or via some other intervention, it is incumbent upon providers to meet immediate needs and bring appropriate provision to the patient and not 'send' them to another intervention.

Clinicians should be able to adapt evidence-based treatments from the wider community to the IRC estate and regime and be able to work with security staff and systems to reduce harm and to manage risk, particularly the risk of fatalities and self-inflicted harm as well as other risks to consider such as abuse and exploitation. They should also have established links with other providers serving the detention facilities and engagement with the third sector providers supporting individuals, where appropriate, to ensure a holistic package of care and support.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

The NHS Outcomes Framework cuts across a number of specific elements of patient care, not all of which apply to the patient population in an IRC.
It is therefore important to consider the outcomes described in embedded Service Specification(s) to ensure that relevant focused outcomes for this patient population are considered.

[1] HO AAR Policy see p 85 for link to policy document.
[2] For NHSE/I the principle of equivalence across the detained estate does not mean 'the same as' but supports an approach where access to services is not compromised by a persons physical circumstances. There is a full definition of this PoE on page 16 of this document.

3. Scope

3.1 Aims and objectives of service

Brook House
Brook House opened in March 2009 and is a purpose-built immigration removal centre with a prison design on the perimeter road of Gatwick Airport. It holds a mix of detainees, including a number who are regarded as too challenging or difficult to manage in less secure centres and those waiting to be removed from the UK on organised charter flights. Operational capacity is 448 and the profile of the population is diverse, both from an ethnic and a nationality perspective. It has a churn of up to 1000 per month. The centre has four main wings. The ground floor of the induction wing is a discrete unit (E wing) used to manage detainees with complex needs and for removal from association/temporary confinement. Levels of violence are low. This site does not currently have a dental suite but it is anticipated there will be one in place for the new contract.

Tinsley House
Tinsley House is a small immigration removal centre (IRC) close to Gatwick airport and Brook House. It holds predominantly young men although children and women are also detained in its family unit. Operational capacity is 162. There are bedrooms for holding between two and six men plus communal shower and toilet facilities on each residential corridor. It also has a stand-alone family unit of up to 9 units and a capacity of 16 used for families and young women (some pregnant) for up to 3 days and only longer by authority from the Minister. This unit will need to be resourced from healthcare with consideration for key roles to support pregnancy and children's needs where required. Like Brook House, there is no on-site dental suite.

Both Brook House and Tinsley House have a high turnover of arrivals and departures each month.

The service is to be made available to all detainees within the establishment. The provider must meet the unique needs of the establishment and take into account the needs of the population within that establishment.

The service model and how the needs and diverse cultures of the detainees are met must be designed for the Gatwick IRC setting in collaboration with other services provided in the establishment. The service model needs to include the appropriateness of the Gatwick IRC estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, calm, safe and appropriate dispensing facilities, confidential and secure delivery of treatment and care.

It is understood that the detained population is not a stable population. Detainees should have urgent healthcare needs identified and managed appropriately. Where there are other more complex or chronic health problems diagnosed, again where possible these should be responded to by an active management plan which takes account of care pathways and which recognises limitations of continuity of care in those who may be removed or deported from the UK.

Our vision at Gatwick IRC is that:

- Detainees receive high quality healthcare services, to the equivalent standards of community services, appropriate to their needs and reflecting the circumstances of detention. These services are to be made available based on clinical need and in line with the Detention Centre rules and Short-Term Holding Facility rules.
- Health and wellbeing services seek to improve health and wellbeing (including parity of esteem between services which address mental and physical health), tackle health inequalities and the wider determinants of health.
- An new on-site emergency and urgent dental service is provided.

This is a "Prime Provider" model, where service providers must work collaboratively and flexibly with the lead provider to deliver an integrated service.

The lead provider will serve to improve the health and wellbeing of people during their stay in immigration detention, ensuring safe and effective care supporting earlier diagnosis and treatment of illnesses which will protect the wider population and contribute towards our respective statutory responsibilities to reduce health inequalities. The provider will work in a secure environment but with a relaxed regime giving as much free movement as possible to detainees.

The lead provider will support the Home Office's objectives of:

- Ensuring those in detention are held securely and safely, treated humanely and encouraged to depart the UK voluntarily and/or compliantly.
- Ensuring that where removals are enforced, they happen as quickly as possible and are successful first time around.
- Maintaining a safe and secure environment.
- Detainees make the most productive use of their time.
- Having an awareness of the anxieties a detained person may be subject to.

The service provider will strive to continuously improve service delivery, embrace innovation and provide a flexible service which can readily respond to the changing health needs of the population.

To deliver the vision, Commissioners expect the lead Provider to:

- Collaborate with NHS England and NHS Improvement (NHSE/I), Immigration Enforcement (HOIE) Public Health England (PHE), HMPPS and DHSC to deliver the joint priorities of the National Partnership Agreement.
- Form robust working relationships and effective communication processes with the Home Office and Gatwick IRC removal centre leadership team
- Form robust working relationships and communication processes with other providers of services to detainees operating at Gatwick IRC

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

a. **Brook House**: Perimeter Rd S, London, Lowfield Heath, Gatwick RH6 0PQ
b. **Tinsley House**: Gatwick Airport, Lowfield Heath, Gatwick RH6 0PQ

7. Individual Service User Placement

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

NOT APPLICABLE

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

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

~~1.0 Enhanced Health in Care Homes Requirements~~

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

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

~~1.2 Indicative requirements~~

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

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

~~1.3 Specific obligations~~

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

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Primary and Community Mental Health Services

NOT APPLICABLE

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

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

- ~~*Supporting General Practice in 2021/22 makes clear that the entitlement for PCNs to claim 50% reimbursement for Mental Health Practitioners (up to a maximum reimbursable amount), under the Network Contract DES Additional Roles Reimbursement Scheme, applies from 1 April 2021. Where PCNs wish to take up this entitlement, CCGs, Trust and PCNs should therefore take forward introduction of this new arrangement as soon as possible, based on local discussions and collective agreement between the relevant parties.*~~
- ~~*A number of sites around the country have received national funding to become 'early implementers' of the NHS Long Term Plan commitment to create new and integrated models of primary and community mental health services programme across England, and have been making good progress. In those circumstances, where a new integrated service model has already been put in place and is proving effective, a PCN may not need to use its ARRS funding to take up the mental health practitioner entitlement through the ARRS. Where a PCN does wish to take up the ARRS entitlement, local partners should work together to ensure alignment with these models so that adoption of the scheme builds on and complements the new models and does not destabilise progress made to date.*~~

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

~~Primary Care Networks in respect of which the requirements of this Schedule apply to the Provider:~~ ~~PCNs with a registered population of 100,000 patients or fewer:~~ ~~[ ] PCN (acting through lead practice [ ]/other)~~ ~~[ ] PCN (acting through lead practice [ ]/other)~~ ~~PCNs with a registered population of more than 100,000 patients:~~ ~~[ ] PCN (acting through lead practice [ ]/other)~~ ~~[ ] PCN (acting through lead practice [ ]/other)~~
~~Specific requirements in respect of any PCN with a registered population of 100,000 patients or fewer~~ ~~Where requested by the PCN and where provided by that PCN with Match Funding, identify in agreement with the PCN at least one Additional whole time equivalent adult / older adult Mental Health Practitioner, employed by the Provider, to work from 1 April 2021 (or such later~~

~~date as shall be agreed between the Provider, the Commissioner and the PCN) onwards as a full member of the PCN core multidisciplinary team (MDT) and act as a shared resource across both the PCN core team and the Provider's primary care mental health / community mental health team.~~

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

~~Specific requirements in respect of any PCN with a registered population of more than 100,000 patients~~

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

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

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

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

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

- ~~i. is able to provide a combined consultation, advice, triage and liaison function, with the aim of:~~
  - ~~a) supporting shared decision-making about self-management~~
  - ~~b) facilitating onward access to evidence-based treatment services;~~
  - ~~c) providing some brief psychological interventions, where qualified to do so and where appropriate; and~~
- ~~ii. works in a multidisciplinary manner with other PCN-based clinical staff, including PCN clinical pharmacists and social prescribing link workers, to help address the potential range of biopsychosocial needs of patients with mental health problems.~~

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

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

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

- Clinical Quality Board
- Health Partnership Board
- Immigrational Removal Centre National Forum
- Plus attendance at other local and national networks as considered relevant by the Commissioner

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Shared Occupancy Agreement	The purpose of the Shared Occupancy Agreement is to enable the Immigration Removal Centre (IRC) and Pre-Departure Accommodation (PDA) operational provider (Serco) and the Healthcare provider to flourish and maximise their partnership in the delivery of their respective functions and objectives within the IRC at Gatwick. *Under review for agreement and finalization with Partners*
COVID Vaccination Specifications	As applicable and mandated by the National Team and relevant Governmental Bodies

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

The incoming Provider will work cooperatively and collaboratively with the outgoing provider (if the contract has been re-tendered and a new provider has won the contract) in line with the exit plans described by the outgoing provider in their original bid.

This covers arrangements in relation to the transfer of staff (linking to GC5.14 TUPE), the transfer of premises and equipment, transfer of care of Service Users, transfer / archiving of service records generated and used pertaining to the same and so on.

The incoming Provider will ensure:

- Receipt of detailed and complete TUPE information from the outgoing provider at least 30 days prior to the Service Commencement Date.
- Scheduling / completion of the transfer / archiving of records, information (in document & / or electronic form) as required under the guidelines of the NHSE Records Retention Schedule and (for clinical records) the IGA Records Retention Schedule.
- Engagement with the outgoing provider, Commissioner and partner organisations to facilitate the transfer of knowledge / documentation, as applicable, for lessons learned during the tenure of the outgoing incumbent provider as agreed with the Commissioner.
- Full cooperation with the Commissioner and outgoing provider to identify and log all assets, non-clinical maintenance contracts, and any changed material sub-contracts.
- Full adherence to the mobilisation plan in cooperation with the Coordinating Commissioner.

Information on staffing supplied to the incoming Provider will be subject to confidentiality agreements governing use of the TUPE / workforce data between the outgoing provider and the Commissioner.

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

The outgoing incumbent provider will work cooperatively and collaboratively with the Commissioner and the new incoming provider (if the contract has been re-tendered and a new provider has won the contract).

This covers arrangements in relation to the transfer of staff (linking to GC5.15 TUPE), the transfer of premises and equipment, transfer of care of Service Users, and so on.

The outgoing Provider will ensure:

Provision of detailed and complete workforce information to the Commissioner at least 12 months in advance of the Contract expiry date as requested by the Commissioner, or as required under General Condition 5.15, to include but not limited to:

- The anonymised details meeting the standards set out in the ACAS guidance on TUPE relating to the employees who will transfer;
- Information contained in the employees' written particulars of employment;
- any collective agreements;
- any disciplinary or grievance proceedings taken by, or against, the transferring employees;
- any claims brought by the employees against the transferor- in the last two years or in the foreseeable future; and
- details about temporary workers – where they are working and how many.

Full cooperation with the Commissioner to identify and log all assets, non-clinical maintenance contracts, and any changed material sub-contracts and to share this information at an early stage of the new provider's contract mobilisation.

The Provider agrees to the supply of detailed anonymised workforce information as required by the Commissioner in relation to any re-tendering or re-procurement of the Services.

Information on staffing supplied by the Provider will be subject to confidentiality agreements governing use of the TUPE / workforce data between the Commissioner and bidders during any re-tendering process.

The Healthcare Provider will be required to provide a full plan based on the outline which the Healthcare Provider and Commissioner will agree within a timescale specified in the formal agreement.

The Provider will ensure engagement with the incoming provider, Commissioner and partner organisations to facilitate the transfer of knowledge / documentation, as applicable, for lessons learned during the tenure of the Provider as agreed with the Commissioner.

This also provides a right for commissioners, under General Condition GC18.2, if the contract or a service is terminated for provider default, to recover from the provider additional costs they incur (over and above what they would have paid the provider) to secure provision of the relevant services for six months following termination.

It may also be appropriate for the commissioner, on behalf of NHS England:

- To recover from the provider the payment of additional compensation in the event of termination for provider default, or of voluntary termination by the provider;

  And / or

- To recompense the provider in the event of termination for commissioner default, or of voluntary termination by the commissioners (for example, to compensate the provider for otherwise irrecoverable capital expenditure incurred in the expectation of the contract running its full term).

This also covers arrangements as defined under Schedule 2 H – Transition Arrangements.

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

NOT APPLICABLE

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

As per the Provider's own safeguarding policies and Mental Capacity Act policies


hc-governance-safe guarding-adults-po


HC SG 01 assessing-capacity-a

PLUS

Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents *

NHS England Safeguarding Vulnerable People in the NHS Accountability& Assurance Frame work (revised 2015) *
https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding

Department of Health Mental Capacity Act: deprivation of liberty safeguards
https://www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards *

*Or as replaced or updated

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Insert text locally or state Not Applicable

Schedule 2L
Gatwick IRC_v1.docx

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

NOT APPLICABLE

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

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

Detailed suggestions for potential inclusion are set out below.

Patient choice and Shared decision-making (SDM)

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

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

Personalised care and support plans (PCSPs)

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

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

Social prescribing

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

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

Supported self-management

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

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

~~***Personal health budgets (PHBs)***~~

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

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

~~*Legal rights to have PHBs now cover:*~~

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

~~*The CCG must retain responsibility for, amongst other things:*~~

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

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

- ~~*Use Schedule 2M, for example, to:*~~

  - ~~*describe which identified groups of Service Users are to be supported through a personalised care approach and which particular cohorts are to be offered PHBs;*~~

  - ~~*clarify the funding arrangements, including what is within the Price and what is not;*~~

  - ~~*set out a roll out plan, with timescales and target levels of uptake (aimed at delivering the CCG's contribution towards the targets set out in the NHS Long Term Plan PHBs to be offered to Service Users/Carers from particular care groups, including, but not limited to those with legal rights listed above, people with multiple long-term conditions; people with mental ill health; people with learning disabilities);*~~

  - ~~*describe how the process of PHBs is aligned with delivery of personal budgets in social care and education, to ensure a seamless offer to Service Users/Carers;*~~

  - ~~*require the Provider to implement the roll-out plan, supporting Service Users/Carers, through the personalised care and support planning process, to identify, choose between and access services and treatments that are more suitable for them, including services and treatments from non-NHS providers – and to report on progress in implementation;*~~

  - ~~*require the Provider to agree appropriate financial and contractual arrangements to support the choices Service Users/Carers have made; and*~~

- ~~*set out any necessary arrangements for financial audit of PHBs, including for clawback of funding in the event of improper use and clawback in the event of underspends of the person's budget, ensuring this is discussed and agreed with the person beforehand.*~~

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

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

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

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

Detailed suggestions for inclusion are set out below.

Intelligence and needs assessment

Schedule 2N can be used to set out

- *how the Parties will work with other partners to bring together accessible sources of data to understand levels of variation in access to and outcomes from the Services and to identify and prioritise cohorts of vulnerable individuals, families, and communities, capitalising on growing understanding of population health management approaches and applications;*
- *how they will use this intelligence base to analyse and prioritise action at neighbourhood, "place" and system level; and*
- *what action the Provider will take to ensure that data which it reports about its Services is accurate and timely, with particular emphasis on attributing disability, ethnicity, sexual orientation, and other protected characteristics.*

Community engagement

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

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

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

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

Access to and provision of the Services

Schedule 2N can be used to describe

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

Implementation, monitoring and evaluation

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

Recognising Gatwick's short-stay population, our Public Health (PH) Strategy follows the 'Making Every Contact Count' ethos; maximising every opportunity to screen, vaccinate and deliver Health Promotion (HP).

Key principles:

- Understanding needs through screening-programmes, HNAs, SystmOne/QOF coding.
- Promoting positive behaviour and self-management, whilst reducing exposure and risk.
- Empowering engagement via comprehensive HP activities. We have ring-fenced £5k annually for developing multi-lingual, simplistic literature; reducing barriers/health-inequalities.
- Dedicated resource delivering our strategy; improving consistency of screening/vaccinations.

Recognising sporadic Section 7a uptake (10-50%, HNA), our priority will be supporting/training teams to understand the importance of PH, and ways to manage challenges, e.g. assertive outreach for decliners. Training will be supported by our regional and national clinical leadership.

This is important for Gatwick's population; recognising the potential for limited healthcare engagement where detainees have arrived directly from the community and those being deported may have limited access to healthcare following removal.

During mobilisation, we will meet Serco to share/discuss our strategy and proposed HP activities. We recently developed a bespoke HP calendar and will tailor this to Gatwick's mixed cohorts/PH needs.

Delivering PH Programmes:

Our strategy will be overseen by a HP Lead and delivered by an HCA dedicated to Section 7a screening, immunisations/vaccinations. This will be supported by targeted and opportunistic HP activities and simple educational materials.

Peer mentors will support our approach, completing a short-course in Health Improvement, delivered by our dedicated Patient Engagement Lead (PEL). This course raises awareness of common health conditions and can be delivered in two 4-hour sessions on a rolling monthly basis.

We will also pilot a Royal Society for Public Health-accredited Level-1 Award in Health Improvement course, completed in 2.5 days to enhance the skill-sets of mentors. A 6-month pilot will investigate whether this is feasible given average lengths of stay.

Peers will help reduce barriers to engagement, recognising detainees can be suspicious of healthcare services.

We will work with Serco to pilot extended secondary screenings following reception as a one-stop-shop, including public health and wider screenings (e.g. dementia, cancer) and immunisations and vaccinations. This will reduce needs for follow-up attendances, streamlining services and improving uptake.

Families at Tinsley House will be screened urgently upon arrival, recognising they often only stay overnight.

Monthly reporting will identify detainees who declined at reception and still require screening/immunisations; reducing risks of discharging with unmet needs and onward transmission of communicable diseases.

Aligned to NHSE's national schedule, detainees will be offered key screening/immunisations, including:

- Wellman/Wellwoman clinics for over-50s, including Dementia, Testicular, Bowel, Breast, Cervical and Prostate screening.
- Pneumococcal, Shingles and flu vaccination to over-65s and at-risk groups.
- Chlamydia (under-25s).
- AAA.

- Retinal.
- NHS Health Checks.
- Relevant vaccines required for detainees being deported e.g. Tetanus and TB.

We will provide Point-of-Care Testing for Hepatitis-B/C and HIV, providing results within 20-minutes: Ideal for the short-stay population and addressing low uptake (HNA).

We are partnered with NHSE, Gilead and the Hepatitis-C Trust to drive elimination of Hepatitis-C across our secure-services, and in 2019/20 PPG initiated 1 in every 12 Hepatitis-C treatments in England, counting both the community and secure settings. During mobilisation, we will agree pathways with Sussex Hepatology Network for continuity of care on release.
We have adopted NHSE PGDs supporting vaccination/immunisation, ensuring up-to-date practice and will develop women and children-specific HP policies/procedures for Tinsley House's family units.
Targeted delivery will be supported by opportunistic methods to proactively maximise uptake, including:

- Drop-in immunisations/vaccinations clinics at both sites, no appointment needed.
- Pop-up health fairs, promoted via easy-read posters.
- Wing-based harm reduction clinics delivered with our Psychosocial Team, addressing risky-behaviours among drug-users.
- Waiting-room conversations.
- Utilising peer-groups.

Integrating PH within Healthcare:

PH will underpin our provision; maximising every opportunity to educate and support wellness.

With Serco agreement, this includes:

- Joint awareness-sessions with the gym, supporting physical and mental wellness.
- Engaging with the Learning and Skills Provider to co-deliver educational sessions.
- Facilitating healthy meal choices with the kitchen. Our HMP Huntercombe (Foreign Nationals Prison) Dietitian conducted pioneering work supporting weight/Diabetes management in secure settings (highlighted Good Practice by HMIP/CQC), which will be shared with Gatwick.
- Ensuring representation at forums/consultations, co-creating HP materials, and using peers to encourage engagement and healthy behaviours.
- Inviting community/NHS providers and third-sector organisations to run health-fair stalls.
- Utilising internet-access/text messaging to deliver key health-messages relevant to detainees' onward-destinations.

Healthcare staff will complete immunisation/vaccination training and annual refreshers. Our competency packs, frameworks and PGDs ensure staff have the knowledge and skills to deliver this.

We will also provide PH training to detention officers, supporting a whole-systems approach.

SCHEDULE 3 – PAYMENT

A. Local Prices

~~*Enter text below which, for each separately priced Service:*~~

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

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

B. Local Variations

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

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

C. Local Modifications

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

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

D. Aligned Payment and Incentive Rules

NOT APPLICABLE.

~~**Include separate values / information for each of one or more Contract Years, as required.**~~

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

~~***Fixed Payment***~~

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

~~***Best Practice Tariffs***~~

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

~~***Value of Elective Activity***~~

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

~~***High-cost drugs, devices and listed procedures***~~

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

~~***CQUIN***~~

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

~~***Agreed local adjustments and departures***~~

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

SCHEDULE 3 – PAYMENT

E. CQUIN

NOT APPLICABLE

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Contract Term	Yr 21-22 (7 mnths)	Yr 22-23	Yr 23-24	Yr 24-25	Yr 25-26	Yr 26-27	Yr 27-28	Yr 28-29 (5 mnths)	Total
Pay Costs	Commercially sensitive								
Non-Pay Costs									
Gatwick IRC									

- Invoices are to be received on a monthly basis, calculated as a 1/12th of the Annual Contract Value.
- The price at the beginning of each financial year will be subject to the finance and business rules in the NHS Operating Framework; for clarity, this means that the Contract Value may be adjusted on 1st April 2022 and on this day in future years.

SCHEDULE 3 – PAYMENT

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

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

Contract Period	Yr 21-22 (7 mnths)	Yr 28-29 (5 mnths)
Pay Costs	Commercially sensitive	
Non-Pay Costs		
Gatwick IRC		

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

NOT APPLICABLE

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Period over which the requirement is to be achieved	Application
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	See CQC guidance on Regulation 20 at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour	Ongoing	All

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

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
All detainees must receive initial screening at first reception within 2 hours of arrival undertaken by a qualified healthcare professional, to identify any immediate health needs or risk - particularly in relation to issues such as suicide or self-harm, mental health, learning disability, substance misuse (drugs and alcohol), infectious diseases and the needs of the older or younger adult	100%	Percentage of initial screens at first night reception completed within 2 hours of arrival	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	Primary Care
Rule 34 Assessment should be offered within two hours and delivered within 24 hours of arrival at a centre (this offer should be part of the screening assessment) and all outcomes recorded	100%	Percentage of Rule 34 Assessment offered within 2 hours and delivered within 24 hours of arrival	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	Primary Care
General Health Assessment completed within seven days of arrival to include BBV and other appropriate screening.	100%	Percentage of General Health Assessments completed within 7 days of arrival	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	Primary Care
For Primary Mental Health Assessment, the waiting time between initial application/referral and 'nurse triage' should not exceed 24 hours	98%	Number of Primary Mental Health Assessment wait times completed within 24 hours	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	Mental Health
Patients that are identified as having a current mental health or learning disability need will have an initial mental health assessment within 5 business days of reception.	95%	Number of patients with current mental health or learning disability need who had an initial mental health assessment within 5 business days of reception	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	Mental Health

Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Timing of application of consequence	Applicable Service Specification
All staff (including sub-contracted providers) to receive management supervision monthly	100%	Number of staff to have received monthly management supervision	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	All
All clinical staff members (including sub-contracted providers) to receive individual clinical supervision at least quarterly	100%	Number of clinical staff to have received clinical supervision at least quarterly	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	All
Mandatory Training The Provider will ensure that a high standard of Adult and Children Safeguarding training is provided to all staff, at a level relevant to their role. This training will take into account Local Standards set by the Local Safeguarding Adults and Children Boards.	90% of staff have received the identified level of Adult and Children Safeguarding training 80% of all staff have received the identified level of Prevent training 90% of all staff have received the identified level of MCA training	Percentage of staff to have received outlined Mandatory Training	In accordance with GC 9 Contract Management.	Quarterly reporting.	All
Provider to investigate all Serious Incidents as per the Incidents Requiring Reporting Procedure	100%	Serious Incidents reported in line with the Incidents Requiring Reporting Procedure	In accordance with GC 9 Contract Management.	Monthly reporting with a quarterly monitoring process	All

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Local Incentive Scheme

NOT APPLICABLE

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
10th February 2021	Bid as submitted by Practice Plus Group Health and Rehabilitation Services Limited in accordance with ITT and as recorded on the In-Tend system maintained by SWC CSU on behalf of NHS England South
	 Gatwick IRC - Declarations - PPG.p

Documents supplied by Commissioners

Date	Document
18th December 2020	INVITATION TO TENDER DOCUMENT  Gatwick_ITT_v3_Final.docx

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**
THE PRISONS OPTICIANS COMPANY LIMITED Registered Office: 35 Earl Street, 2nd Floor County House, Midstone, KENT ME14 1PF Company Number: 06828145	Optometry	1 September 2021 – 31 August 2028	Yes	Joint Controller
PRACTICE PLUS GROUP HOSPITALS LIMITED Registered Office: Hawker House 5-6 Napier Court Napier Road Reading Berkshire RG1 8BW Company Number: 03462881	Therapies	1 September 2021 – 31 August 2028	Yes	Joint Controller
DOCTOR PA Registered Office: 42 Kew Court Richmond Road Kingston Upon Thames Surrey KT2 5BF Company Number: 09356355	GP services	1 September 2021 – 31 August 2028	Yes	Joint Controller

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**
SPECSAVERS HEARCARE GROUP LIMITED Registered Office: La Villiaze, St Andrews, Guernsey, GY6 8YP Company Number: 35965	Audiology	1 September 2021 – 31 August 2028	Yes	Joint Controller
ELYSIUM HEALTHCARE LIMITED Registered Office: 2 Imperial Place, Maxwell Road, Borehamwood, Hertfordshire. WD6 1JN Company Number 4063391	Psychiatry	1 September 2021 – 31 August 2028	Yes	Joint Controller
Boots UK Limited Registered Office: Nottingham NG2 3AA Company Number 00928555	Pharmacy Services	1 September 2021 – 31 August 2028	Yes	Joint Controller
PRACTICE PLUS GROUP PRIMARY CARE LIMITED Registered Office: Hawker House 5-6 Napier Court Napier Road Reading Berkshire RG1 8BW Company Number: 11078321	Online GP consultations and advice	1 September 2021-31 August 2028	Yes	Joint Controller

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**
PRACTICE PLUS GROUP URGENT CARE LIMITED Registered Office: Hawker House 5-6 Napier Court Napier Road Reading Berkshire RG1 8BW Company Number: 05232967	Out Of Hours GP advice	1 September 2021 – 31 August 2028	Yes	Joint Controller

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
Commissioner: Oneal Thomas **Address:** Jubilee House 5510 John Smith Drive Oxford Business Park John Smith Drive OX4 2LH **Email:** DPA **Tel:**	To carry out all actions required in relation to its rights and obligations under this Contract in relation to its population, including (without limitation): • Modelling demand for the services; • Specifying indicative activity levels for inclusion in this Contract; • Monitoring actual Activity against indicative levels; • Reviewing and where appropriate, contesting reconciliation accounts received from the Provider and making payments to the Provider in respect of Activity allocated to the NHS England Team Commissioner, to the Provider (where payments are disaggregated); • Applying any financial adjustments, deductions or withholdings in accordance with the Contract; • Assessing, and approving or rejecting, individual funding requests; • Managing Service User complaints, and dealing with Serious Incidents; • Specifying and implementing as applicable any Prior Approval Schemes and, in respect of any Service Specification, applicable exclusion or acceptance criteria; • Managing referrals and activity, including notifying the provider of Activity Planning Assumptions, monitoring Activity and reviewing Activity Reports, dealing with Activity Queries and Activity Management Meetings, and agreeing Activity Management Plans; • Agreeing and monitoring Service Development and Improvement Plans and/or Data Quality Improvement Plans with the provider; • Initiating Dispute Resolution; • Agreeing Service Variations; • Agreeing information and reporting requirements, and managing Information Breaches; • Agreeing Local Prices, managing agreements or proposals for Local Variations and Local Modifications, making and receiving payments, including CQUIN payments; • Agreeing and contract management of Local Quality Requirements, CQUIN, Quality Incentive Scheme Indicators and variations to National Sanctions and National CQUINs as applicable; • Implementing financial adjustments or sanctions resulting from breaches of any provider obligations including those relating to Activity Management Plans, Operational Standards, Data Quality Improvement Plans and Service Quality Improvement Plans; • Managing service specific complaints; • Any financial adjustments or sanctions in respect of the Services under GC9 Contract Management; • proposed Variations; • conducting quarterly Contract Review Meetings, and undertaking contract management, including the issuing of and receipt of Contract Queries and Contract Performance Notices and agreeing any Remedial Action Plan or related contract management processes under general contract management under clause GC 9; • serving notice to terminate the Contract, or any Service, in accordance with the terms of the Commissioning Contract; • initiating and conducting Dispute Resolution; The appointment of an auditor.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. As specified in the DCB Schedule of Approved Collections published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
1a. Without prejudice to 1 above, daily submissions of timely Emergency Care Data Sets, in accordance with DCB0092-2062 and with detailed requirements published by NHS Digital at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds/ecds-latest-update	As set out in relevant Guidance	As set out in relevant Guidance	Daily	**A+E, U**
2. Patient Reported Outcome Measures (PROMS) https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	**All**
National Requirements Reported Locally				
1a. Activity and Finance Report	Monthly	If and when mandated by NHS Digital, in the format specified in the relevant Information Standards Notice (DCB2050)	[For local agreement]	**A, MH**
1b. Activity and Finance Report	Monthly	[For local agreement]  Contract_Finance_template_HJOG.xlsx	[For local agreement]	**All except A, MH**
2. Service Quality Performance Report, detailing performance against Operational Standards,	Monthly	[For local agreement]	Within 15 Operational Days of the end of the month to which it	

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

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	(ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594				
10.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	Annually (or more frequently if and as required by the Co-ordinating Commissioner from time to time)	[For local agreement]	[For local agreement]	**All**
11.	Report on compliance with the National Workforce Race Equality Standard.	Annually	[For local agreement]	[For local agreement]	**All**
12.	Report on compliance with the National Workforce Disability Equality Standard.	Annually	[For local agreement]	[For local agreement]	**NHS Trust/FT**
13.	Specific reports required by NHS England in relation to Specialised Services and other services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	As set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting	**Specialised Services**
~~14.~~	~~Report on performance in reducing Antibiotic Usage in accordance with SC21.3 (*Infection Prevention and Control and Influenza Vaccination*)~~	~~Annually~~	~~[For local agreement]~~	~~[For local agreement]~~	~~**A (NHS Trust/FT only)**~~
15.	Report on progress against Green Plan in accordance with SC18.2	Annually	[For local agreement]	[For local agreement]	**All**
16.	National Quality Schedule *Please note, this will be updated with the latest IRC National Quality Schedule during mobilisation*	Quarterly	[For local agreement] IRC Quality Report 2021_22_v1.xlsx	Accurate and timely reporting prior to quarterly Contract Review, and as requested by the Commissioner	**All**
Local Requirements Reported Locally					
1.	Contract Review Meeting Provider Report	Quarterly	[For local agreement]	Accurate and timely reporting prior to quarterly Contract Review, and as requested by the Commissioner	
2.	Local Key Performance Indicators *Please refer to Schedule 4C – Local Quality Requirements*	Quarterly	[As detailed in the Contract Review Meeting Provider Report]	Accurate and timely reporting prior to quarterly Contract Review, and as requested by the Commissioner	

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
3. Financial Returns *For Contract Review Purposes the Provider is expected to provide quarterly financial returns to enable NHS England to monitor and review spend of the service area*	Quarterly	As embedded within National Requirements Reported Locally Section 1b above	Accurate and timely reporting prior to quarterly Contract Review, and as requested by the Commissioner	
4. Safeguarding Children and Adult Reporting Schedule	Quarterly	[For local agreement]  Safeguarding Reporting Schedule  SG Schedule_part b_v2.docx	Accurate and timely reporting prior to quarterly Contract Review, and as requested by the Commissioner	

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
[Providers of maternity services - improving the accuracy and completeness of Maternity Services Data Set submissions]			
Insert text locally			

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

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

Never Events are described in Schedule 4D and other incidents requiring reporting are described in Service Condition SC33. This section refers to guidance on the CQC website.

The healthcare provider must report any Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) in line with the process and timeframes set out in the NHS England Serious Incident Framework (2015).

Specifically, the provider should report Serious Incidents within 48 hours of the date of the incident. The provider should then undertake an initial review of the circumstances. This is often termed the 72 hour report and should be completed and sent to the Nursing and Quality Team DPA 2 hours of the date of the incident.

All Deaths in Custody (DiC), should be reported by the provider to their local Nursing and Quality Team within 48 hours via the locally agreed process (SI Inbox email address: DPA). For all deaths in custody, the provider should also complete and send the 72 hour report to the Health & Justice Nursing and Quality Team within 72 hours of the date of the incident. This review should consider the available information including relevant medical records and should:

- Assess the death in more detail to determine if an incident(s) has occurred which requires reporting and investigating in line with the Serious Incident Framework (SIF).
  Incidents require investigation under the SIF where there is evidence that problems in care (acts and/or omissions) occurring as part of NHS-funded healthcare may have contributed to the death occurring.

- Identify any actions required to ensure, or provide assurance that, the safety of staff, patients and the public is protected.

Following receipt of the 72 hour report by the Health & Justice Nursing and Quality Team, a joint decision will be made regarding whether a SI needs reporting and full investigation. This is not to pass judgement about avoidability or causality but to support the effective use of investigation and help prioritise the investigation of deaths where there is the most significant potential for learning and improvement. The 72 hour report should also be shared with the commissioned Clinical Reviewer to support their contribution to the Investigation.

In addition, providers must inform Commissioners of any never event, any incident mentioned in SC33 and any SI or other safeguarding issues that are reported to the local authority / Regional Office via STEIS. Never Events are described in the NHS England Serious Incident Framework (2015) and the NHS Improvement Never Events List (2018). Incident reports must be sent to and from an nhs.net email account and should be emailed to the Nursing and Quality Generic nhs.net email: DPA

The healthcare provider should ensure that other types of incidents are also reported to the National Reporting and Learning System (NRLS). Typically, these will be lower risk incidents, but where opportunities for learning and improvement remain. These are described in Service Condition SC33 and refers to guidance on the CQC website.

The provider must investigate any Serious Incident using appropriate Root Cause Analysis methodology as set out in the NHS England Serious Incident Framework (2015) and relevant guidance or, where required by the Nursing and Quality team in accordance with the NHS England Serious Incident Framework (2015), commission a fully independent investigation.

The outcomes of any investigation, including the investigation report and relevant action plan should be reported to the Nursing and Quality team within the timescales set out in the NHS England Serious Incident Framework (2015). Specifically, the Root Cause Analysis and comprehensive action plan should be completed within 60

days from the date of the incident. The action plan should form the basis of discussion in subsequent Quality meetings, Contract Review and Performance Management meetings.

Healthcare providers should report this information to the nursing and quality team on a monthly basis as described in the National Requirements.

The provider and commissioner must ensure that the processes and principles set out in the NHS England Serious Incident Framework (2015) are incorporated into their organisational policies and standard operating procedures.

The provider must operate an internal system to record, collate and implement learning from all patient safety incidents and will agree to share such information with the nursing and quality team and commissioner . This is a requirement under the more general provisions for Lessons Learned under SC3.4.

The provider should promptly inform their local Health & Justice Nursing and Quality team and commissioner of relevant correspondence received relating to patient safety incidents. For example, receipt of Regulation 28 reports from Coroners and CQC improvement notices.

The commissioner should address any failure by the provider to comply with the requirements specified in Schedule 6B or 6D by using the provisions for Review (GC8) and Contract Management (GC9). However, commissioners and providers should recognise the primary importance of encouraging and supporting the reporting of incidents in order to promote learning and the improvement of patient safety.

Incident reports must be welcomed and appreciated as opportunities to improve, not automatic triggers for sanction. Only where the provider fails to report, or does not comply with the specific requirements of Schedule 6B or 6D, or where the reporting of patient safety incidents or SIs identifies a specific breach of contractual terms leading to the incident in question occurring, should the commissioner address these.

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

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

1. SCOPE

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

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

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

2. DATA PROTECTION

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

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

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

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

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

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

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

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

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

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

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

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

(iii) state of technological development; and

(iv) cost of implementing any measures;

(c) ensure that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annex A

Data Processing Services

Processing, Personal Data and Data Subjects

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

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

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

SCHEDULE 7 – PENSIONS

Insert text locally (template drafting available via http://www.england.nhs.uk/nhs-standard-contract/)

22-NHSE-revised-schedule-7-pensions-l

SCHEDULE 8 – LOCAL SYSTEM PLAN OBLIGATIONS

NOT APPLICABLE

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

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

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

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

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

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

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

- *If the Local System Plan is sufficiently detailed to state specific actions which the Parties have agreed to take, these could be extracted and included in the Schedule.*
- *Alternatively, this Schedule 8 could build on the high-level intentions of the Local System Plan, identifying specific actions*
  - *which the Provider will take to integrate its services with those of other local providers and to support those providers in delivering effective care for patients; and*
  - *which the Commissioners will take to ensure that other local providers support this Provider in delivering the Services covered by this Contract effectively.*
- *These specific actions could cover expectations around patient pathways (consistent signposting for patients of the most appropriate pathway; communication and support between providers when patients are transferring from one service to another); practical arrangements for ongoing liaison between different services involved with the same patient, including shared or interoperable IT systems; arrangements for multi-disciplinary working across providers; and so on.*
- *And reference could be included in this Schedule 8 to participation in agreed partnership / governance forums and planning processes.*

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

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

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

SCHEDULE 9 – SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT AGREEMENT

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

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

NOT APPLICABLE.

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