NHS Standard Contract 2021/22

Particulars (Full Length)

Contract title / ref: ***NHS Practitioner Health / NHSPH_2022-24***

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Contract Reference	NHSPH_2022-24

DATE OF CONTRACT	**04th November 2021**
SERVICE COMMENCEMENT DATE	**1st April 2022**
CONTRACT TERM	**Two years commencing 1st April 2022 (or as extended in accordance with Schedule 1C)**
COMMISSIONERS	**NHS Commissioning Board (T/A NHS England & NHS Improvement), Quarry House, Quarry Hill, Leeds, LS2 7UE**
CO-ORDINATING COMMISSIONER	**Primary Care Group, Primary Care, Community Services and Strategy Directorate, NHS England & NHS Improvement**
PROVIDER	**Hurley Clinic Partnership T/A The Hurley Group, Hurley Clinic, Ebenezer House, Kennington Lane, London, SE11 4HJ**

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CONTRACT

Contract title: NHS Practitioner Health

Contract ref: NHSPH_2022-24

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

[redacted]

.....
Signature

[redacted] **for and on behalf of NHS England**

[redacted]

.....
Title

8th November 2021

.....
Date

SIGNED by

[redacted]

.....
Signature

[redacted] **for and on behalf of The Hurley Group**

[redacted]

.....
Title

5th November 2021

.....
Date

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date	**1st April 2022**
Expected Service Commencement Date	**1st April 2022**
Longstop Date	**1st April 2022**
Service Commencement Date	**1st April 2022**
Contract Term	**Two years commencing 1st of April 2022 (or as extended in accordance with Schedule 1C)**
Option to extend Contract Term	**Yes**
Commissioner Notice Period (for termination under GC17.2)	**12 months**
Commissioner Earliest Termination Date	**6 months after the service Commencement Date.**
Provider Notice Period (for termination under GC17.3)	**12 months**
Provider Earliest Termination Date	**6 months after the Service Commencement Date**

SERVICES	
Service Categories	**Indicate all that apply**
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	Not Applicable
Acute Services (A)	Not Applicable
Ambulance Services (AM)	Not Applicable
Cancer Services (CR)	Not Applicable
Continuing Healthcare Services (including continuing care for children) (CHC)	Not Applicable
Community Services (CS)	Not Applicable
Diagnostic, Screening and/or Pathology Services (D)	Not Applicable
End of Life Care Services (ELC)	Not Applicable
Mental Health and Learning Disability Services (MH)	Applicable
Mental Health and Learning Disability Secure Services (MHSS)	Not Applicable
NHS 111 Services (111)	Not Applicable
Patient Transport Services (PT)	Not Applicable
Radiotherapy Services (R)	Not Applicable
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	Not Applicable
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	**YES**
Activity Planning Assumptions	**YES**
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	Expected Annual Contract Value Agreed, up to an available: • FY22/23: £11m • FY23/24: £11m And subject to Schedule 1C: • FY24/25: £11m • FY25/26: £11m Total Potential Life Cost of contract: £44m
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	**General Practice Partnership**
GOVERNANCE AND REGULATORY	
Nominated Mediation Body (where required – see GC14.4)	**CEDR**
Provider's Nominated Individual	[redacted]
Provider's Information Governance Lead	
Provider's Data Protection Officer (if required by Data Protection Legislation)	
Provider's Caldicott Guardian	
Provider's Senior Information Risk Owner	
Provider's Accountable Emergency Officer	
Provider's Safeguarding Lead (children) / named professional for safeguarding children	
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults	
Provider's Child Sexual Abuse and Exploitation Lead	

Provider's Mental Capacity and Liberty Protection Safeguards Lead	[redacted]
Provider's Prevent Lead	
Provider's Freedom To Speak Up Guardian(s)	
Provider's UEC DoS Contact	
Commissioners' UEC DoS Leads	
Provider's Infection Prevention Lead	
Provider's Health Inequalities Lead	
Provider's Net Zero Lead	
CONTRACT MANAGEMENT	
Addresses for service of Notices	[redacted]
Frequency of Review Meetings	Monthly
Commissioner Representative(s)	[redacted]
Provider Representative	

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

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

A.	Evidence of appropriate Indemnity Arrangements
B.	Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required)
C.	Evidence the service provider has a fully registered Responsible Officer (RO) as per the Medical Profession (Responsible Officers) Regulations 2010
D.	Evidence of relevant internal standard operating procedures (SOP) and policies, e.g., information governance.
E.	Evidence of all clinicians who have all relevant professional registration in place (GMC, NMC, etc)
F.	Evidence of all clinicians who have been suitably trained to fulfil the requirement of this contract (Health for Health Practitioners).
G.	Evidence of Monitor's Licence in respect of Provider and Material Sub-Contractors (where required)
H.	Copies of all Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner

The Provider must complete the following actions:

Providing all documents and requirements as set out in the above Conditions Precedent prior to service commencement.

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Not APPLICABLE		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

1. As advertised to all prospective providers before the award of this Contract, the Commissioners may opt to extend the Contract Term by 2 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 6 months before the original Expiry Date.

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

   a. As required up to the maximum duration of 2 years;

   b. only by all Commissioners, unless a commissioner withdraws from the contract; and

   c. may be in respect of some or all Services outlined in this contract.

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

SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. Population Needs

1.1 Purpose

NHS Practitioner Health (NHSPH) is a free and confidential national mental health treatment service for health and social care staff in England, funded nationally. NHSPH operates in a unique space where there is a crossover between the professional and regulatory environment in which a clinician or healthcare professional works, and their mental health treatment needs.

NHSPH expertise lies in managing the confidentiality associated with accessing healthcare, taking responsibility for the safety of the service user(s) accessing NHSPH but also the professional and patient responsibilities and risks associated with a healthcare professional's role. NHSPH's understanding and experience are in the mental health presentation of health and social care professionals, especially where this is a high risk of suicide, and the specialist support they may require to return to safe, effective practice. More information about NHSPH can be found here: https://www.practitionerhealth.nhs.uk/

NHSPH complements local staff Mental Health & Wellbeing Hubs (hubs) which have been set up at Integrated Care System level, to support health and social care staff. The hubs offer proactive outreach and engagement with at-risk staff groups, contacting individuals to offer rapid clinical assessment and support should they need it. Care co-ordination and supported onward referral enables staff to receive rapid access to mental health treatment. The hubs are confidential and free of charge for all health and social care staff across England, and is where the majority of >3m health and social care staff will be supported. The hubs are not in scope of this exercise; more information about hubs can be found here: https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/

A small proportion of health and social care staff may require more specialist support whose needs cannot be met by the hubs, and therefore may be referred to (or self-refer) to NHSPH. The majority of patients accessing NHSPH are doctors, who present with complex mental health and/or addiction issues and therefore may self-refer into NHSPH. Other healthcare staff who also have complex regulatory circumstances e.g., dentists, or are operating in senior leadership roles also have the option to self-refer into NHSPH. All other health and social care staff are encouraged to access the local hubs in the first instance which are better placed to meet more common mental health issues but may refer to NHSPH as required.

The strategic objectives of NHSPH are:

1. To retain a healthy workforce and support return to work/clinical practice after a period of sickness
2. To reduce the perception of stigma among health and social care staff who wish to access mental health services
3. Maintain a visible presence proactively engaging different local staff groups who may have unmet needs with a nationally consistent offer across England
4. Work with local Mental health and Wellbeing hubs to enable easy and timely direct access to the NHSPH service for staff who require it

5. To lead on service development and academic exploration through clinical networks and key partnerships, providing clinical leadership for learning and sharing good practice in supporting the mental health of practitioners.

NHSPH supports mental health conditions such as depression, anxiety, obsessive-compulsive disorder, bipolar affective disorder, complex traumatic stress reactions, complex PTSD, personality disorders and psychosis. The service also prescribes medicines where appropriate and treats patients with a range of drug and alcohol addiction issues including detox and inpatient addiction. NHSPH will provide the following services (working with hubs where appropriate):

- Proactive outreach and engagement with staff groups to promote the service as a safe, confidential space for health and social care staff, through workforce wellbeing resources, apps, hosting events, webinars, podcasts, social media etc.
- Central access through website, email, phone and apps to make it easy for health and social care staff to access services
- Initial clinical assessment, and through consultation, identifying what support service users may need.
- Developing a treatment plan in conjunction with multidisciplinary teams (MDTs), providing a variety of NICE recommended treatment options, including but not limited to; talking therapies e.g., CBT, Prescribed medication, Psychiatry, Individual and group interventions, In-patient addition rehabilitation.
- Provide ongoing case management supporting service users through their treatment plan as lead clinician maintaining the important therapeutic relationship with the patient throughout, and coordinating across other support the service user might be accessing
- Provide professional advice and support to service users who are experiencing professional regulatory action and establish good working relationships with health care regulators to ensure confidential treatment can be provided to patients.

NHSPH is confidential with an independent clinical record management system which is not linked to the shared care record and has a variety of different premises for seeing patients e.g., option of non-NHS premises, and both face to face and digital/online consultations.

It is important to note that the NHSPH does not replace the role of Hubs or mainstream NHS mental health services who will also treat health and social care staff, and it is not an occupational health service.

1.2 Background

NHSPH has been the outcome of over 12 years of service development to support clinicians with complex mental health needs. It began as a review of health problems in the context of the professional regulation of medical and dental performers and findings from referrals to NCAS, looking to improve the safety of services for patients. One of the main catalysts to the new service was the suicide of a doctor and their 3-month baby[1]. This led to a number of noticeable papers, research and commissioning activities:

- In 2006, the Chief Medical Officer found that doctors and dentists can face a number of barriers when dealing with personal health difficulties, particularly mental health and addiction problems[2].

- In 2007 the White Paper: *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century*[3], directed the National Clinical Assessment Service (NCAS) to work with stakeholders to define a specification for 'a pilot service for practitioners with mental health or addiction problems'
- In 2008 the NHS Practitioner Health Service was launched providing mental health treatment for all doctors and dentists in London as a pilot.
- In 2010, *Invisible patients: Report of the Working Group on the health of health professionals*[4] was published by the Department of Health, which reviewed the evidence on health professionals' ill health. Based on this evidence and the first years' experience of the pilot of the NHS Practitioner Health Service (NHS PHP[5], the report recommended a national programme for the provision of services.
- In 2011, a literature review[6] found 'that doctors face a large number of risk factors, both occupational and individual; and help-seeking is difficult due to complexities surrounding a doctor becoming a patient.'
- In 2014 the General Medical Council (GMC) published its review of 28 doctors who had died by suicide while under the fitness to practise procedures between 2005 and 2013[7]. The review showed that many of the doctors who died by suicide suffered from a recognised mental health disorder, most commonly depressive illness, bipolar disorder and personality disorder. A number also had drug and/or alcohol addictions. Other factors that may have contributed to their deaths included marriage breakdown, financial hardship, the involvement of the police and the impact of the GMC investigation. The report made nine recommendations, eight to the GMC and one externally to its stakeholders, which was to establish a National Support Service (NSS) for doctors.
- In 2015 NHS England announced a major drive to improve health in the workplace, which included a commitment to support the mental health of general practitioners[8]. NHS England engaged with key stakeholders and learned:
    - A Medical Protection Society survey of more than 600 UK members revealed that 85% had experienced mental health issues, with common issues being stress (75%), anxiety (49%) and low self-esteem (36%). A third of respondents (32%) had depression during their medical career, while one in 10 (13%) stated they had experienced suicidal feelings. Of those who had experienced mental health issues, heavy workload (76%) and long working hours (70%) were cited as factors that had a high or moderate impact on their mental health[9].
    - The Royal Medical Benevolent Fund (RMBF) surveyed 1,351 doctors in primary and secondary care and found more than eight in ten doctors (82%) would not contact mainstream NHS services about mental health issues, such as depression or anxiety, due to fear of discrimination or stigma from colleagues (84%), or would be inhibited by their 'high achieving' personality traits (66%)[10].
    - Cardiff University found that there was a discrepancy between how doctors think they might behave and how they actually behaved when experiencing mental illness, and Doctors continued to have concerns about disclosure and a lack of care pathways was evident[11].
    - Increasing pressures in general practice are cited by the RCGP and GPC as a key reason for GPs leaving the profession, with increasing numbers of GPs allegedly looking towards early retirement. A BMA Tracker survey showed that 74% of GPs described their workload as

"unmanageable"[12]. The BMA have created a 'heat map' to illustrate the scale of the problem across England.[13]

- Over the last 25 years a number of local services have been developed to support doctors' access to health care. These have usually resulted from the work of interested clinicians, Primary Care Trusts or Local Medical Committees (LMCs) e.g. PSUs. The BMA also has a free counselling service for doctors.
- In 2016 NHS GP Health service was commissioned by NHS England as part of the GPFV[14] to support mental health and addiction issues for GPs across England and launched in January 2017[15].
- In 2018, a Report on the First 10 Years of the Practitioner Health Service was published demonstrating the learnings and insights of supporting the mental health of doctors[16].
- In 2018, the NHS Long Term Plan was published including a commitment to prioritising doctors' mental health[17]. This was fulfilled in 2019 with NHS GP Health being transitioned into NHS Practitioner Health and services extended to include all doctors and dentists working in England.
- In 2020, in response to the covid-19 pandemic, NHS Practitioner health was extended to all NHS staff working in England[18], in collaboration with mental health and wellbeing hubs[19]. This was following engagement with key stakeholders and emerging evidence which found:
    - Recent reviews by Harvey et al (2020) suggest that due to the current covid-19 pandemic support services for health care workers will likely need to expand and adapt.
- Greenberg et al[20] (2021) confirmed these findings with real life data from staff working in Intensive Care Units in nine English hospitals during June and July 2020. 709 participants completed the surveys comprising 291 (41%) doctors, 344 (49%) nurses and 74 (10%) other healthcare staff, the findings showed:
- 45% met the threshold for probable clinical significance on at least one of the following measures:
    - severe depression (6%),
    - PTSD (40%),
    - severe anxiety (11%)
    - or problem drinking (7%).
- 13% of respondents reported frequent thoughts of being better off dead, or of hurting themselves in the past 2 weeks.
- Staff well-being impacts patient safety. Psychological morbidity continues to exist on a scale sufficient to functionally impair a significant fraction of the workforce in the performance of life critical tasks (Rona et al. 2008). The Greenberg et al research makes clear the need for additional support for frontline staff in response to the adverse impact of the covid-19 pandemic.
- In 2021 NHS Practitioner Health published a report on their experiences of supporting NHS staff during the pandemic[21]. This reported that nearly as many patients presented in the 12 month pandemic period (April 2020 –March 2021) as in the first ten years of the service (4355 in last 12 months vs 5000 over first 10 years). Month on month, over the course of the pandemic an average of 46% more doctors presented during the pandemic compared to pre-pandemic.

[1] Depressed psychiatrist received "poor care"
[2] Good Doctors, Safer Patients (2006), Department of Health

[3] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century
[4] Invisible patients: Summary of the report of the Working Group on the health of health professionals
[5] Practitioner Health Programme
[6] Review of literature on the mental health of doctors: Are specialist services needed?
[7] Doctors who commit suicide while under GMC fitness to practise investigation
[8] Simon Stevens announces major drive to improve health in NHS workplace
[9] 85% of doctors have experienced mental health issues, reveals Medical Protection survey
[10] Alarming numbers of doctors experiencing mental health issues as a result of work pressures
[11] Understanding doctors' attitudes towards self-disclosure of mental ill health
[12] BMA Tracker survey 2014
[13] BMA Heatmap
[14] General Practice Forward View
[15] NHS to launch world's first free health service for GPs
[16] The Wounded Healer: Report on the First 10 Years of Practitioner Health Service
[17] NHS to prioritise doctors' mental health
[18] Accessing the service for NHS PH Workforce
[19] Staff mental health and wellbeing hubs
[20] Mental health of staff working in intensive care during COVID-19
[21] Practitioner Health COVID Experience: Meeting the mental health needs of doctors during the pandemic

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 Provider will contribute to the delivery of high quality, safe and effective NHS services through providing support to enable a healthy workforce.
- The Provider must improve staff health and wellbeing, provide effective diagnosis and treatment, support early intervention, and relapse prevention
- The Provider must improve coordination of mental health support for staff through case management within each catchment area, supporting integration with other health and care services as appropriate.
- The Provider must continuously monitor service user satisfaction in the NHS Practitioner Health service, promoting its values and building confidence and trust in the service.
- The Provider will support health and social care staff to remain in work, and to safely return to clinical practise following a period of sickness.
- The Provider must support a greater awareness of workforce health issues through effective data collection, audit and data analysis.
- The Provider will reduce the perception of stigma associated with health and social care staff accessing help for their mental health.
- The Provider must maintain a nationally consistent offer across England.
- The Provider must make it easy for health and social care staff to access the service, and ensure confidentiality.

3. Scope

3.1 Aims and objectives of service

The NHS Practitioner Health (NHSPH) service should be a nationally consistent offer across England, delivering to national standards but allowing local flexibility to best support local population needs.

NHSPH service delivery model has been designed with 5 main principles / strategic objectives in mind:

1. To retain a healthy workforce and support return to work/clinical practice after a period of sickness
2. To reduce the perception of stigma among health and social care staff who wish to access mental health services
3. Maintain a visible presence proactively engaging different local staff groups who may have unmet needs with a nationally consistent offer across England
4. Work with local Mental health and Wellbeing hubs to enable easy and timely direct access to the NHSPH service for staff who require it
5. To lead on service development and academic exploration through clinical networks and key partnerships, providing clinical leadership for learning and sharing good practice in supporting the mental health of practitioners.

The Provider must deliver the service to support all these objectives and all aspects of this service specification.

The Provider will work with the Commissioner and its key partners to continue to develop the NHSPH Service throughout the duration of the contract. The Provider is expected to work flexibly with the Commissioner, and where it is deemed appropriate to make changes to the service specification.

There is recognition that the impact of the on-going pandemic will see an increase in the need for more specialist mental health interventions amongst all healthcare staff groups. While we expect the majority of health and social care staff's mental health needs to be met by the local mental health and wellbeing hubs, there is recognition that there is an increased demand for specialist support for healthcare staff with complex addiction or mental health difficulties that cannot be treated by local services.

3.2 Glossary

For clarity, in this service specification the following terms apply:

- **Commissioner** refers to NHS England & NHS Improvement as the Commissioner of this service.
- **Provider** refers to the successful Bidder who has entered into a Contract with the Commissioner to provide NHS Practitioner Health, otherwise known as the Supplier.
- **Mental Health and Wellbeing Hubs (MH&WH)** are local system-based staff support services, emerging across England. They do not form part of this contract but the overall delivery model is required to link into MH&WHs.
- **NHS Practitioner Health (NHSPH) Central Services** refer to the core requirements set out in this service specification led by the coordinating Provider or a central team within the Provider.

- **NHS Practitioner Health (NHSPH) Local Clinical Services** refer to the core requirements set out in this service specification led by the local Providers sub-contracted by the coordinating Provider, or local teams within the Provider, as required to deliver services for each catchment area.
- **Catchment area** refers to the local population of Practitioners which the NHSPH Local Clinical services shall be provided for.
- **Medical Director** refers to the Medical Director for NHS Practitioner Health. The Medical Director will be the accountable officer for the delivery of NHS Practitioner Health service and provides oversight and leadership for England.
- **Clinical Lead** refers to the lead NHSPH Clinician within a catchment area as assigned by the Medical Director, and is responsible for the oversight of care and providing leadership for their catchment area
- **NHSPH Clinician** refers to a member of the NHS Practitioner Health team assessing or treating the service user(s).
- **Service User(s)** refers to the patients of NHSPH i.e. a health and social care staff member as a patient.
- **GP** refers to the Service User(s) own general practitioner
- **OH** refers to Occupational Health services
- **RO** refers to the Responsible Officer for the Service User(s)
- **Other services** refer to any other NHS, private, charity or other support commissioned by other means which may be accessed by the Service User(s). These services do not form part of this contract.

3.3 Service description

The NHS Practitioner Health (NHSPH) service Provider is responsible for the delivery of the service across England as set out in these contract particulars. The development of the delivery model is intended to be continually refined as required to support the needs of Service User(s). The Provider is expected to be flexible and be able to make changes in-contract as appropriate to develop the service in line with best practice and recommendations from key stakeholder groups. The Provider must adapt systems and develop pathways as required to support the development of NHSPH as we learn more about the emerging needs of the health and social care workforce .

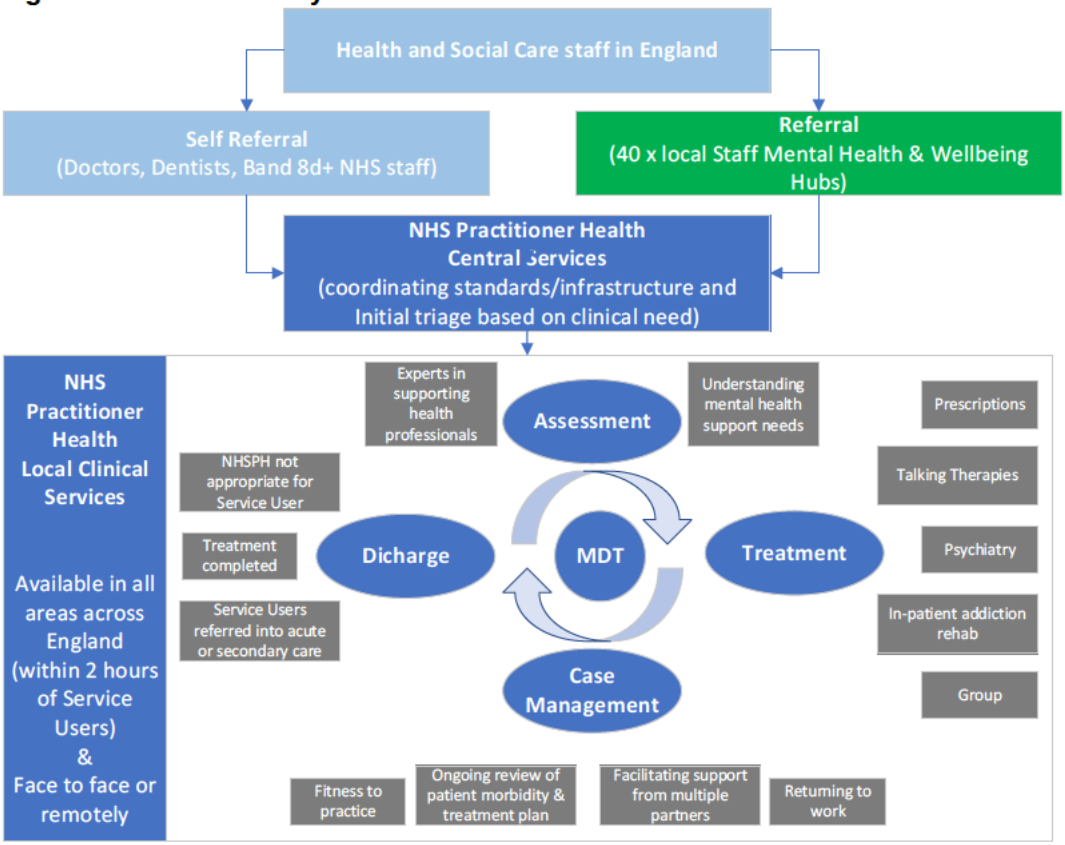
3.3.1 Delivery Model

The delivery model is split into 2 key functions: NHSPH Central services and NHSPH Local Clinical Services.

The Provider:

- is responsible for delivering the NHS Practitioner Health Central Services and NHS Practitioner Health Local Clinical Services functions,
- work in partnership with local system based Mental Health and Wellbeing Hubs, as part of this service.

Figure 1: Outline Delivery Model



3.3.2 NHS Practitioner Health Central Services

This part of the service is the main point of access for Practitioners and will provide strategic leadership to the service.

3.3.2.1 Clinical and strategic leadership

NHSPH must appoint specific roles to fulfil its regulatory duties and leadership functions.

3.3.2.2 Responsible Officer:

NHSPH must have a Responsible Officer as required by The Medical Profession (Responsible Officers) Regulations 2010[1] to enable appointment of medical doctors required for delivering mental health services i.e. psychiatrists. A Responsible Officer doesn't need to be directly involved in the delivery of NHSPH but must be accountable for the doctors employed by the service (unless the Responsible Officer function is achieved through other means.

[1] The Medical Profession (Responsible Officers) Regulations 2010

3.3.2.3 Medical Director:

The Provider must appoint a Medical Director of NHSPH to oversee the delivery and accountability of the service, responsible for ensuring standards and acting as the professional lead for the service.

The Medical Director must act as a 'clinical champion' and lead the delivery of NHSPH service in England. They will uphold the highest standards of care for Service Users, hold all NHSPH clinicians to account (with the support of the Responsible Officer), and be

responsible for overseeing the training and development of the NHSPH service and its staff.

The Medical Director will be the Accountable Officer for NHSPH and is responsible for ensuring NHSPH adheres to all the requirements of these contract particulars, to ensure the safety and wellbeing of Practitioners accessing NHSPH.

The Medical Director will be responsible for professional leadership and medical management of directly employed clinical staff, as well as having oversight of the clinical quality provided by the service and any sub-contracted services. The Medical Director must be an experienced clinician and have a good understanding of supporting health and social care staff experiencing mental ill-health.

The Medical Director must be either an experienced GP with an extended role (GPwER) in mental health and/or physician health, or a psychiatrist experienced in treating other Practitioners. The Medical Director for the NHSPH must be a Medical Practitioner registered with the GMC and licensed to practise.

The Medical Director must be a Partner or employee of the Provider organisation and on a payroll salary.

The Provider must have a nominated deputy or co-medical director complying with the same requirements set out above, who can deputise for the Medical Director in their absence. This role could be based within NHSPH Central or Local Clinical Services function.

3.3.2.4 Clinical Director:

The Provider must appoint a Clinical Director to lead on the day to day clinical management and leadership of NHSPH clinical services, e.g. leading multidisciplinary team meetings, providing training/supervision, supporting non-clinical teams with service user registrations, and supporting the Medical Director with any other appropriate duties to ensure the smooth running of all NHSPH services.

The Clinical Director may be part of the NHSPH central structure or a NHSPH Local Clinical Services Clinical Lead who is either:

- an experienced GP with an extended role (GPwER) in Mental Health and/or Physician Health with expertise in treating other health professionals
- an experienced occupational physician with expertise in mental health and treating other health professionals,
- an experienced psychiatrist with expertise in treating other health professionals,
- an experienced specialist nurse practitioner of mental health with expertise in treating other health professionals,
- an experienced psychologist with expertise in treating other health professionals.

3.3.2.5 Specialist clinical Advisors:

The Provider will appoint specialist clinical advisors as required who are available to support Central and Local Clinical Services clinicians with any additionally complex Service Users that require further advice. Areas which might apply are:

- Complex cases of regulatory involvement
- Complex PTSD or complex traumatic stress reactions
- Complex multi-morbidity cases

- Complex addiction cases
- Forensic Psychiatry assessments
- Education and Training for NHSPH clinicians

3.3.2.6 Multi-disciplinary leadership: The service should ensure that there are multi-disciplinary roles as part of its clinical leadership and service development. This staffing model could include psychology professionals, therapists, psychiatrists, nursing, general practitioners, occupational health physicians, as well as other relevant professionals.

3.3.2.7 Mental health support for NHSPH clinicians

The Provider must ensure support is available to all NHSPH clinicians who themselves may require mental health support as a result of the services they provide to Service Users, recognising the complex cases which NHSPH will experience.

3.3.2.8 Operational Management

The Provider must appoint a Chief Executive (CE) or Chief Operating Officer (COO) to support the Medical Director and Clinical Director with the operational management of NHSPH and is responsible for delivery of all on-clinical functions of NHSPH. The CE/COO will oversee the operational aspects of NHSPH and ensure processes are in place to support the effective delivery of the Services described in these contract particulars.

The CE/COO must ensure all aspects of NHSPH are effective and compliant with set standards and governance requirements.

The CE/COO must ensure IT, premises, website, phone systems, apps/digital consultation services, and patient records systems are in place as set out in this service specification.

The CE/COO must maintain good relationships with the Commissioner and ensure processes are in place for quality and activity reporting as set out in Schedule 4 and 6 of these Particulars.

The CE/COO must be an employee of the Provider organisation and on a payroll salary.

The CE/COO will be responsible for the appointment of all non-clinical staff within NHSPH Central and Local Clinical Services, comprising of operational, financial, data, administrative, skilled call handlers and technology/website management. NHSPH Central services may comprise a number of posts, which the Provider can propose as part of the tender. All staff in the NHSPH Central services should ideally be employed by the Provider organisation but this is not mandatory. In some cases, fixed term employees or temporary contractors may be used, but the Provider must ensure resources are used as effectively as possible so the majority of resources can be directed at the clinical requirements of the NHSPH Local Clinical services, as set out in Schedule 3A: Local Prices.

NHSPH Central services staff skill mix must include:

- clinical and non-clinical case managers, with relevant specialist experience of managing Service Users with mental ill-health;
- experienced operational staff with extensive skills in managing health services, finance and accounting, programme development, and service delivery, and leading the development of communications and engagement strategies;
- skilled operational and administrative staff with effective call handling experience in health care, including triage and management of clinical services;

- administrative staff skilled and experienced in audit and research, secretariat/support of stakeholder/governance boards, maintaining clinical networks and supporting communications and engagement strategies, including use of social media.

The Provider will demonstrate how it will recruit and support suitably experienced and qualified individuals to support delivery of NHSPH.

The Provider will Inform the commissioner who the Medical Director, Responsible Officer, Clinical Director and CE/COO of the service is and notify the commissioner of any amendments to staffing.

3.3.2.9 Online Access

The Provider must have or commission an accessible and informative website for NHSPH on the Commissioner's behalf and be responsible for the content and on-going management of the website. The website must be independent of any existing websites which the Provider may have, to support any transfer of services as set out in Schedule 2I Exit Arrangements.

The website is the front end of NHSPH and will provide the telephone number to access NHSPH on the homepage. The website will also provide an email address which the Service User can use to contact the service where preferred.

A significant role of the website will be to provide Service Users with information about how NHSPH will work. Stigma around disclosure of mental ill-health and addiction is a significant barrier to Service Users' accessing support, therefore the website will clearly describe:

- how to access the service,
- what sort of support is available,
- how the service will use their (the Service User) information, and
- the responsibilities of the service with regard to confidentiality, and its duty to report performer concerns where there may be significant risks to patient safety, as set out in Schedule 2G Section 1: Terms of Performer Escalation.

The website will provide information on other available support, sign-posting service users to other services, and hosting a suite of evidence-based resources and self-help tools developed in conjunction with key partners.

The website will host professional networks relevant to this service to enable a better understanding of the impact of mental health issues affecting Service Users. The Provider will look to establish an accurate database of a network of clinicians e.g., GPs around England with an extended role (GPwER) in Mental Health and/or Physician Health, who could also support Practitioner's in their locality as part of local NHS services alongside NHSPH.

The website will list by locality, the senior Clinicians (e.g., Clinical Leads) working within NHSPH Clinical services so Service Users can identify who provides support in their catchment area. Contact details for NHSPH Local Clinical services should clearly indicate that access to local clinical advice is by appointment only.,.

The Provider must provide email contact details so Service Users can contact NHSPH by email. The email account must be monitored during the working hours of NHSPH Central services - between 8.00 – 20.00 on weekdays (excluding public/bank holidays) and between 8.00 – 14.00 on Saturdays. The Provider should aim to respond to all emails

within one working day of receiving the email from the Service User. The Provider must ensure the email out of office is set up to inform Service Users when emails are viewed and provide additional information signposting Service Users to other services.

The Provider must ensure the email contact details/accounts set up for NHSPH are stand-alone of the Provider to support any transfer of services as set out in Schedule 2I Exit Arrangements.

In addition to website access, other means of online access may be developed as the NHSPH service is mobilised, for example smartphone apps. The Provider may include proposals for additional forms of access as part of the tender, in addition to the core requirements.

The Provider will use an app for booking appointments allowing access and patient choice all over the country across catchment areas.

The Provider must put in place an appropriate web-based patient record system and demonstrate how the system supports the highest standards of Information Governance, as set out in Schedule 5E: Information Governance Toolkit Compliance, and SC23 Service User Health Records. The provider will ensure that records kept in NHSPH can only be accessed by NHSPH Clinicians during their contracted hours with the service. The records system must be accessible remotely across England by NHSPH Clinicians as required to support Service Users within all catchment areas in England.

This patient records system must be stand-alone from any other patient records system in use by the Provider for other services to support any transfer of services as set out in Schedule 2I Exit Arrangements.

3.3.2.10 Telephone access

The Provider must provide a single point of access into the NHSPH Central service by phone. The NHSPH Central services must include skilled call handlers who are experienced in taking calls from vulnerable Service Users who may well be stressed, anxious or scared. Call handling will be managed directly by the Operational Lead. The Provider must provide the call centre function in-house of the NHSPH service and must not commission external or overseas call centre function for this service.

The national phone number (which must be visible on the homepage) will be the main point of access into NHSPH and the Provider must ensure the phone line is answered between 8.00 - 20.00 Monday to Friday (excluding bank/public holidays) and 8.00 – 14.00 on Saturday. The call handler should be competent to answer any queries about the service, take contact details and triage the Service User to the NHSPH Local Clinical services for an initial assessment.

If a Service User requires urgent mental health support, then the call handler must refer the Service User immediately to an available NHSPH Clinician within NHSPH Central services or NHSPH Local Clinical services. If no NHSPH Clinician is immediately available, the call hander must refer the Service User to urgent NHS mental health services. The call handler should be trained to recognise emergency needs of Service Users and be able to provide advice and support referral to emergency NHS services if required.

If a Service User calls out of hours, the Provider will enable an automatic answer message explaining the service opening times and referring to the website for more

information, as well as being made aware of other support available out of hours, including crisis services.

The core role of the call handler and email handler within the NHSPH Central services function is to take information from the Service User, answer any questions about the service, and then facilitate them to NHSPH Local Clinical services for initial assessment and ongoing treatment.

The Provider must ensure that the national phone number set up for NHSPH is distinct from any other services being delivered by the provider, so Service Users are not required to access through a switchboard facility to access NHSPH, and that the national phone number is transferable to other providers as set out in Schedule 2I Exit Arrangements.

3.3.3 NHS Practitioner Health Local Clinical services

The NHS Practitioner Health local clinical services function is the front end of the service and will be the part of the service most visible to service users. It provides the main clinical function of NHS Practitioner Health and a point of access for service users undergoing initial or ongoing assessment and treatment.

3.3.3.1 NHS Practitioner Health Local Clinical services formation

NHSPH Local Clinical services functions must be based within the catchment areas they are supporting as set out in Section 6 of this Schedule 2A: Location of Provider Premises.

The Provider must assign a NHSPH Clinical Lead in each catchment area as the lead representative. They will be accountable for service delivery in that catchment area and will be required to be visible and provide local leadership to the service. The Clinical Lead will be required to support local engagement and communications and oversee the delivery of all aspects of this section of the service specification. The Clinical Lead will be accountable to the Medical Director and Clinical Director. The Clinical Lead must be a NHSPH Clinician and must be either an experienced GP with an extended role (GPwER) in Mental Health and/or Physician Health, or a psychiatrist experienced in treating other health professionals, or an experienced specialist nurse practitioner or psychologist. The Clinical Lead must have a license to practise.

The Provider must establish NHSPH Local Clinical services for each NHSPH catchment area. The clinical skill mix should be multi-disciplinary and able to provide a broad range of evidence-based services, this will likely require input from GPwER in mental health and/or physician health, occupational physicians, psychiatrists, practitioner psychologists, therapists, specialist nurse practitioners, counsellors and specialists in addiction therapy.

Services should have the capacity to meet the reasonable needs of the catchment area.

The Provider must ensure NHSPH Local Clinical services are formed of multi-disciplinary roles. This staffing model could include psychology professionals, psychiatrists, nursing, general practitioners, occupational health physicians, as well as other relevant professionals. They should be staffed to provide contract/performance and administrative support to help monitor data, record-keeping, and diary-management etc. They should also be staffed to meet the agreed service model and functions of the NHSPH Local Clinical Services including proactive outreach, clinical assessment, care coordination, delivery of NICE recommended treatments.

NHSPH Local Clinical Services must include:

- clinicians experienced in assessing and treating other health professionals

- experience clinicians with a good understanding of the health and social care work environment
- experienced clinicians with good understanding of general practice, psychiatry including treatment of addictive disorders, psychotherapy, occupational health, and complex mental health needs e.g., addiction and PTSD or trauma-related symptoms;
- clinical and non-clinical case managers, with relevant specialist experience; and
- skilled administrative staff with audit/research skills.

3.3.3.2 NHS Practitioner Health Local Clinicians role in promoting access

The Provider must ensure the NHSPH Local Clinical services have a pivotal role in promoting the NHSPH service and are able to demonstrate that NHSPH is accessible and widely known to Service Users. The NHSPH will support appropriate dissemination of the availability of the service via local media and NHS briefing routes to make sure all Service Users are both aware of the service, and how to access it.

The NHSPH Local Clinical services will be responsible for local outreach to promote access and tackle the perceived stigma associated with seeking mental health support. This may include liaising with key local stakeholders such as professional networks, charities, colleges/faculties, and commissioners/provider organisations. NHSPH must work in close collaboration with local staff mental health and wellbeing hubs where available and other local organisations/forums to help promote staff mental health and wellbeing. The NHSPH Local Clinical services staff should work with NHS England and Improvement, and local mental health and wellbeing hubs to understand other initiatives which Service Users may have access to alongside NHSPH, for example the national wellbeing offers, Returner schemes, or Whistle-blowers Support Schemes.

All outreach must be done by a Provider with the right skills and expertise who has a good understanding of the healthcare environment, including the regulatory environment in which it operates. The service must understand the patient safety considerations and the consequence for patients and the public in having a health care professional at work, suffering with health problems that may affect their performance. The service must likewise understand how the pressures in healthcare can affect a Service User's health and well-being.

The NHSPH Local Clinical services function must be responsible for providing leadership for their locality and supporting local communications and events. The NHSPH Local Clinical services function must support national strategies and programmes recommended by the commissioner, on behalf of key stakeholder groups e.g., Staff mental health support expert reference group, including preventative and proactive activities, sharing learning through dissemination, presenting at key events and working proactively with local stakeholders.

The Provider will use social media including Twitter and Facebook, as well as their membership of other sites, e.g. Tea & Empathy, to promote access to NHSPH. Furthermore, the Provider will provide:

- specialist workshops for appraisers, trainers, ROs, employers;
- preventative training to medical/nursing students;
- events to address needs of special groups.

3.3.3.3 NHS Practitioner Health Local Clinical services assessment and treatment

The NHSPH Local Clinical services must be responsible for all assessment and treatment requirements of NHSPH as set out in this service specification.

Appointment times for assessments and treatments should be mutually agreed between the NHSPH Local Clinical services and Service User, but the Provider must be flexible to suit where possible, the needs of the Service User. Services should usually be available between 08.00 - 20.00 Monday to Friday (excluding bank/public holidays) and 08.00 – 14.00 on Saturday's.

All assessment and treatment provided must be evidence based and undertaken by Clinicians with the right training, skills and expertise. The Provider will ensure that their staff have the appropriate skill-mix to treat patients and that their treatment is based on well-defined professional competencies that have been defined nationally, such as:

- GUIDANCE AND COMPETENCIES FOR GENERAL PRACTITIONERS WITH AN EXTENDED ROLE Health for Health Professionals Practitioner (Updated October 2018; accredited by RCGP)
- Other relevant training available via the Royal Colleges, Faculties, and Health Education England.

The following organization for inclusion of registered psychological therapies:

- Health and Care Professions Council Registered as a Practitioner Psychologist
- British Association of Behavioural and Cognitive Psychotherapies Accredited
- British Association of Counselling and Psychotherapy Accredited
- British Psychoanalytic Society Registered
- National Counselling Society Accredited Professional Registrant
- United Kingdom Council for Psychotherapy Registered

The Provider must ensure all staff working in NHSPH have the required professional registration and medical indemnity to practice in their clinical area.

More information on scope of assessments and treatments for Service Users can be found in section 3.4 NHSPH Service Pathway.

The Provider will support clinicians through Multi-disciplinary Team meetings (MDT) given the expectation of managing caseload.

The Provider will support the development of expertise for the future - trainees and HHP doctors (GP, psychiatrists, occupational health) - future associates in collaboration with colleges.

3.3.3.4 Provision of NHS Practitioner Health Clinicians

The Provider will manage a number of NHS Practitioner Health Clinicians across catchment areas in England as part of delivering the requirements of this Service. These Clinicians may be employees of the Provider, sub-contracted from the Provider, or associates of the Provider. The Provider will need to have regard to Schedule 2A Section 3.5: Population covered, and Schedule 2B: Indicative Activity Plan when planning the provision of NHS Practitioner Health Clinicians, and demonstrate good value for money on the use of resources for NHS Practitioner Health Clinical services.

The Provider must consider appropriate numbers of NHS Practitioner Health Clinicians required to support the relative demand of Practitioners accessing the service as set out in Schedule 2B: Indicative Activity Plan.

3.4 Service pathway

The Provider must deliver all requirements of the service specification and this NHS Practitioner Health service pathway for all Practitioners accessing NHS Practitioner Health. The NHS Practitioner Health service pathway sets out the roles and responsibilities of the NHS Practitioner Health Central services and NHS Practitioner Health Local Clinical services, which the Provider must provide as part of this service specification.

3.4.1 Scope of NHS Practitioner Health

The NHS Practitioner Health service will help those Practitioners with:

- Common and more complex mental health conditions including traumatic stress reactions and complex PTSD
- Mental health problems relating to a physical health issue
- Community and inpatient based addiction interventions
- Rehabilitation and return to work after a mental health problem

Whilst the service may be required to stay connected to Practitioners experiencing acute exacerbation of their health problems, the NHS Practitioner Health service should not offer to lead the care for Practitioners with:

- A mental health crisis that would require emergency or urgent assessment
- Acute in-patient detoxification treatment
- Complex eating disorders requiring medical stabilisation
- In-patient care (except for in-patient addiction services).
- Long term treatment needs in excess of the recommended guidance's set out below (although NHS Practitioner Health may act as a case manager or help with rehabilitation aligned with other services).

The Provider must only provide initial assessment, case management and signposting to appropriate other services available to Practitioners with the diagnoses outlined below. In these circumstances appropriate NHS care will be funded through normal NHS mechanisms. Service users with:

- a complex or chronic illness that requires the input of local NHS services e.g. patients with suicidal behaviour, psychosis, serious eating disorders, and patients with complex forensic histories
- physical health issues, where these should normally be dealt with by mainstream NHS providers e.g. back pain, migraines, cancer treatment.

The Provider will be expected to accept Service Users suffering the types of mental ill-heath and addiction problem included in Care Clusters 1-8 as set out in the *Mental Health Clustering Booklet 2016/2017* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf) providing treatment in line with appropriate NICE guidance (for example *Mental health and behavioural conditions (https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions)*.

Where a Service User's needs are not within the scope of the service specification i.e. Practitioners accessing the service are represented by Care Clusters 9-21 (as set out in the *Mental Health Clustering Booklet 2016/2017),* the Provider should signpost Practitioners to other services. The NHS Practitioner Health service can still, at the discretion of the service, support the Practitioner through case management and advice, but should not treat conditions not in scope of this service specification.

3.4.2 Availability of NHS Practitioner Health

The NHSPH service must be accessible to Service Users to allow effective and timely assessment and treatment. The service must not be commissioned as an emergency or urgent service but must be accessible to Service Users in a flexible way to accommodate the needs of those who are at work.

Initial contact into NHSPH via the national phone line may be accessed 8.00 – 20.00 Monday to Friday (excluding public/bank holidays) and 8.00 – 14.00 Saturdays. Service Users who attempt to contact the NHSPH service outside of these times will be signposted to other services which are available out of hours.

Appointment times for assessments and treatments should be mutually agreed between the NHSPH Local Clinical services and Service User, but the Provider must be flexible to suit the Service User where possible, between 08.00 - 20.00 Monday to Friday (excluding bank/public holidays) and 08.00 – 14.00 on Saturday's.

The NHSPH local Clinical services are not required to be available out of hours, on Sundays or bank/public holidays.

3.4.3 Practitioner initial contact with NHS Practitioner Health

A Service User may make the decision to access the NHSPH service after a long time of deliberation or following a crisis. The service will need to be responsive, not only in terms of time, but also in terms of ensuring that the Service User engages with and trusts the NHSPH service.

If a Service User contacts the NHSPH Central services phone line, calls must be answered promptly between 8.00 – 20.00 Monday to Friday (excluding bank/public holidays) and 8.00 – 14.00 Saturday. The Provider must enable a system which can inform the call handler if more than one Service User is attempting to contact NHSPH at the same time and redirect that Service User to another call handler to support the second call. Where more than two Service Users attempt to contact NHSPH at the same time and there is not another available call hander, the Provider should ensure a call waiting system is in place to inform the waiting Service User their call will be answered as soon as possible. The Provider must not use a premium rate telephone number and must provide a Free phone number from both landlines and mobiles.

If a Service User contacts the NHSPH service by email, the Provider must respond to the email within one working day. In all circumstances the Provider must ensure an appropriate out of office notification is set up informing the Service User the opening times of NHSPH and that if received during out of hours, the email will be answered the next working day.

The Provider will develop an app for booking appointments allowing access and patient choice all over the country across catchment areas.

The NHSPH service must be able to offer an appointment to the Service User with a NHSPH Clinician for an initial phone assessment within 2 working days of first contact, and/or the first face to face assessment within 10 working days of first contact, taking account of the individual Service Users needs with regard to the potential urgency or severity of their mental Ill-health.

In all circumstances, the call handler must take the appropriate amount of information to pass on to an assessing NHSPH Clinician, be able to advise the Service User calling NHSPH of any relevant terms of access and respond to any queries. The call handler must be appropriately trained and skilled in collecting the necessary information sensitively and confidentially.

The Provider will ensure clinical support for call handlers if a Service User is identified at risk or in severe distress. Clinical staff will be contactable during opening hours.

3.4.4 First (and on-going) clinical assessment by NHS Practitioner Health

The purpose of this assessment is to engage with the Service User and understand their reasons for accessing NHSPH, the nature of their problem, if the service can offer support, what that support may be, and assess the urgency and the risks posed by the Service User's needs.

The initial assessment must be performed by a NHSPH Clinician who is appropriately trained and skilled. This initial assessment may be performed over the telephone or video call. The assessment should be offered at a convenient time for the Service User, i.e. avoiding times of busy clinical activities, and sufficient time should be allowed for an initial assessment to be made. All notes made during the initial clinical assessment must be recorded within the patient record system.

The first face-to-face assessment must be to allow the assessing NHSPH Clinician to gain an in-depth understanding of the Service User's needs. A treatment plan should be formulated, through discussion of what the NHSPH service and / or other services can offer to help the Service User. The assessment should also give an opportunity to discuss the relationship of the NHSPH service with the Service User, how the service must work with the Service User's own GP (with consent), and the limits of confidentiality. The Service User may opt to have the first full assessment by video technology or by telephone if preferred and NHSPH clinicians should be trained and competent to manage remote consultations.

The outcome of the full assessment may require further discussion with other NHSPH Clinicians within the NHSPH service, thus allowing the planning of the following:

- Advice and signposting to supportive self-help, e.g. mindfulness-based interventions and executive coaching
- Extended assessment where required
- Access to a variety of agreed psychological treatments and therapeutic interventions within the NHSPH service
- Initiation of new prescriptions where appropriate
- Referral for specialist assessment and treatment by specialist mental health or addiction services outside NHSPH services, which may require liaison with local NHS services or the Service User's own GP.
- Arranging specialist assessment or treatment for physical health problems as required by liaison with the NHS and the Service User's GP
- Completion of full in-depth assessment (whether in a single or multiple session as required by the Service User) and a treatment/care plan agreed

If the Service User is not happy to continue with NHSPH for any reason, the case may be closed, and the Service User signposted to other services available. The NHSPH Clinician will consider the potential risks to the Service User and the Service User's patients and discuss any such case with the Medical Director and/or Clinical Lead. If required the case may be discussed anonymously with the Local Regional team to consider next steps, including whether concerns require a breach of confidentiality on the grounds of patient risk.

Whilst all NHSPH clinicians need to have expertise in managing Health Professionals as patients and to be cognisant of risk to patients and the public, the NHSPH will not make an assessment of a Service Users' fitness to practise. In all circumstances where the NHSPH Clinician is concerned regarding wider safety issues, the NHSPH clinician must discuss this with the Medical/Clinical Director and/or Clinical Lead, who may discuss informally with the Service Users applicable regulator or Responsible Officer.

3.4.5 Treatment provision in NHS Practitioner Health

The NHSPH Local Clinical services must be able to provide a mental health and addiction service within the scope of NHSPH. This must include treatment packages, including but not limited to:

- GPwER or Psychiatric services with expertise in substance misuse

- Therapeutic interventions involving prescribing medications, psychological therapies, e.g. counselling and CBT, in line with appropriate NICE guidance (for example *Mental health and behavioural conditions: https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions* within the scope of this service)
- One to one sessions and group work

The NHSPH Local Clinical services must have close links with other local NHS specialist mental health and addiction services. This will ensure that the Provider makes best use of resources in that area and provides choice for a Service User enabling optimal care. If the Service User requires more specialist mental health support not covered by NHSPH, then a referral into mainstream NHS services will need to be facilitated via the Service Users own GP or via the local staff mental health and wellbeing hub where appropriate, with an arranged follow up contact to check that Service User has engaged and is satisfied with the suitability of the service to which they were referred to and is meeting their needs.

The NHSPH Local Clinical services must, where appropriate, link to the Service User's workplace, occupational health, the NHS, and health charities. It should also maintain good links with local support services such as mentoring, coaching, Balint groups, peer support, and resilience training which may benefit Service Users.

Where NHSPH services refer on or share information with other agencies, (including the Service User's own GP) the Service User's consent must be clearly documented in NHSPH records. NHSPH clinical records should electronically code consent status to ensure this is an auditable field.

The Provider will support clinicians with direct access to dedicated team of clinical expertise in addiction, complex mental health, complaints, and for general advice.

3.4.6 Case management responsibilities of NHS Practitioner Health

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.[1]

A named case manager must be in place for each Service User who will be responsible for managing and coordinating the Service User's care, including liaising over professional matters and as appropriate with the Service User's workplace.

Case management will include monitoring and follow-up of Service Users who access the service or who are referred to other services, including more specialist services, a local GPwER in mental health and/or Physician Health, and occupational health services.

As part of the case management process, and in conjunction with a multi-disciplinary team, risk assessments will need to be carried out at times during the episode of care of the Service User.

The Provider will need a system for managing risks associated with the Service User's health condition. Risks assessment would need to include risk to self as well as risk to others, including risks to the Service User's patients. The risk assessment should usually be shared with the Service User.

The Provider will need a system for monitoring and managing escalating risks of Service Users.

3.4.7 Continuing care relationship with Service User's own GP

[1] http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx

Subject to consent from the Service User, the NHSPH service will maintain effective communication with the Service User's own GP, recognising the importance of effective communication with primary care. This is particularly important if NHSPH services intend to initiate medication.

On discharge from NHSPH the Provider will be expected (subject to consent by the Service User) to provide to the Service User's own GP, a full summary of care provided and any recommendations about follow up or re-referral arrangements, as set out in Schedule 2J - Transfer of and Discharge from Care Protocols.

If on engagement with the NHSPH service, the Service User does not give consent for communication with their own GP, the risks should be formally assessed and discussed with the Service User and clearly documented.

The NHSPH Clinician should discuss significant risks with the Clinical Director and/or Clinical Lead to seek advice on what (if any) amendments to the treatment plan would reduce risk to an acceptable level (e.g. undertake no prescribing) or whether (rarely) the lack of consent, negates the ability of NHSPH services to effectively engage with the Service User.

In such a case, a discharge letter should detail the reasons for failing to progress treatment, and the Service User should be signposted to other services such as doctors support networks or charities. An exception report as set out in Schedule 6C: Incidents Requiring Reporting Procedure should be completed by the NHSPH Clinician.

3.4.8 Liaison with the Service Users workplace

At the time of engagement with the NHSPH, a Service User may or may not be working. The NHSPH service will actively be focusing on plans to support a Service User's rehabilitation towards safe and effective clinical practice by liaising, as appropriate, with the employer or Service User's practice, and occupational health services. The NHSPH Local Clinical services may not communicate at all with the Service User's workplace without the prior written consent of the Service User.

When a Service User is not working and is ready to return to work, adjustments to the workplace may be required. NHSPH clinicians should work with occupational health services to advise Service Users and their workplace/ employers on appropriate modifications to aid return to work.

Some Service User's may need a period of retraining or restriction of their scope of practice to return to safe clinical practice in a phased way. In such cases the Service User must speak to their Local Regional team, with the support of the NHSPH Local Clinical services.

3.4.9 Principles for long term relationships with the Service User

The course of treatment for different Service Users will depend on their individual requirements and NHSPH Local Clinical services must manage this on a case by case basis. NHSPH is not intended as a long-term treatment service, however NHSPH may in some cases, act as a case manager or help with rehabilitation working closely with mainstream NHS services or other charity and private providers.

The NHSPH Local Clinical services must regularly monitor capacity and will need to balance the benefits of longer-term support for Service Users with the needs to maintain availability for new referrals.

Indicative treatment duration is set out in the *Mental Health Clustering Booklet 2016/2017* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf). The Provider should not exceed the recommended duration of treatment for a condition unless agreed by the Medical Director and Local Regional team.

Where a Service User's treatment is likely to exceed the recommended duration of treatment for a condition as set out in the *Mental Health Clustering Tool 2016/2017,* an exception report as set out in Schedule 6C.Incidents Requiring Reporting Procedure should be completed by the NHSPH Local Clinical services.

When it is deemed appropriate to transfer or discharge a Service User from the NHSPH service, the Provider must follow Schedule 2J - Transfer of and Discharge from Care Protocols.

3.4.10 Development of the NHS Practitioner Health service

The Provider will regularly review internal systems and processes and the effectiveness of NHSPH, as set out in Schedule 4: Quality Requirements, and Schedule 6: Contract Management, Reporting and Information requirements. The Provider must promote service development and develop strategies for improvement to be shared with the Commissioner and its assigned key stakeholder groups.

The Provider must adapt systems and processes as set out by the Commissioner following any recommendations, where appropriate.

3.4.11 NHS Practitioner Health staff training and workforce development

The Provider must put in place a workforce development programme which ensures the following:

- Audit of staff skills, competencies and training
- Identification of staff skills/ training needs
- Access to training programmes to ensure CPD of all staff
- Roles and responsibilities of each member of the multi-disciplinary team will need to be made explicit
- Provider and Commissioner collaboration regarding the number and range of staff.

- The Provider must enable ensure provision of appropriate clinical supervision by qualified clinical supervisors on a regular basis, where for all NHSPH staff require or request it. The supervision will be informed by best practice and should consider the following:
    - Staff emotional well-being
    - Workload
    - Practice/clinical issues and standards
    - Reflective practice
    - Service standards
    - information about legal procedures for staff recruitment, management and HR
    - Identifying training and development needs

3.4.12 Confidentiality

Any Service User accessing the NHSPH service must be assured that, their case within NHSPH will be handled on a strictly confidential basis. Any information about the Service User should not be shared with any other party unless they are a NHSPH Clinician and are directly involved with the Service User's treatment, or where there is a need for escalation to the Medical Director.

The Provider will need to make sure it has secure, confidential record storage, whether paper or electronic. Patient records should be kept on a separate confidential computer record. This record will only be accessible by PHS staff and will **not** be "uploaded" to any shared medical record system. This means that the record will not form part of the NHS shared electronic record. The Provider must have a policy to protect patient confidentiality, underpinned by protocols and procedures that the service will have agreed

and must adhere to. The policy must specifically describe and be clear about confidentiality, when anonymity is appropriate, the issues of and conditions for disclosure, and will detail circumstances in which information may be disclosed without their consent. The policy and procedures will address the provision of fair processing information as required by the Data Protection Act 1998.

The confidentiality policy will set out the procedures for reporting, investigating, and implementing and sharing lessons learned from breaches in confidentiality, and must ensure all staff as part of NHSPH area aware and understand the Policy. The Provider must aim for a 100% staff and system compliance with the Confidentiality Policy.

Any transfer of information from NHSPH to an external party (including other services involved in the care of the Service User) may only occur with the Service User's prior written consent.

Consent should be coded on a Service Users electronic medical record in an auditable fashion.

The Commissioner may use non-identifiable information obtained as required for Schedule 4: Quality Requirements and Schedule 6: Contract Management, Reporting and Information requirements.

The Provider may use non-identifiable information to support the requirements set out in Schedule 6 – Contract Management, Reporting and Information requirements. Any use of data outside of the requirements set out in Schedule 6 – Contract Management, Reporting and Information requirements may not occur without the Commissioners written permission. This is to maintain governance standards around the use and disclosure of information.

Where the NHSPH Clinician has serious concerns that a Service User's health has affected or has the potential to seriously affect their ability to offer safe patient care, the NHSPH Clinician has a duty to disclose the identity of the Service User as set out in Schedule 2G Section 1: Terms of Performer Escalation.

The Provider will ensure Memoranda of Understanding (MoU) are in place between NHSPH and relevant organisations such as GMC,NMC, and NCAS, which offer guidance around the limits of NHSPH confidentiality and requirements for disclosure of information, in addition of the requirements of Schedule 2G Section 1: Terms of Performer Escalation.

3.5 Population covered

NHSPH is designed to support health and wellbeing of staff whose clinical needs cannot be met through local staff mental health and wellbeing hubs, the Service Users own GP, Improving Access to Psychological Therapies (IAPT), secondary mental health service or other local mental health services. This includes the following reasons:

- Confidentiality issues preclude the person from seeking and receiving care and support in local staff mental health and wellbeing hubs or local mental health services.
- Employer, occupational health or professional regulators has specific concerns and feels care would be better provided by a service which specialises in supporting Service Users in these conditions.
- Experiencing elements of complex addiction or other complex needs which cannot be met by local hubs.
- The service will give special consideration to the needs of very senior NHS staff – Board level staff and their deputies (i.e. 8d and above) that may require additional support and face barriers around accessing confidential care locally.

Following available evidence on identifying health and wellbeing staff groups who may present with these barriers to accessing services, or have complex needs that cannot be

met by mainstream NHS services (as set out in the Background section), and following the recommendations of the Staff Mental Health Support Expert Reference Group, the following access criteria's have been established, which are designed to target access for Service Users most likely to fall within these groups, and ensure NHSPH is not overwhelmed by over-attendance of health and wellbeing staff who in the first instance should access local staff health and wellbeing hubs.

Health and social care staff, employed by or registered as delivering NHS commissioned service in England or registered social care organisation including care homes in England, may access NHSPH as follows:

- Referred from local Staff Health and Wellbeing Hubs
- Self-referral by any senior (i.e. 8d or equivalent) staff member delivering NHS services
- Self-referral by any Doctors with GMC registration and a license to practise, Dentists with GDC registration and a license to practise, and trainee doctors/dentists in England, who may access the service irrespective of their residence.

Any health and social care staff living in England, but not working in England i.e. not linked to an NHS or social care service in England, or any regulated profession who are not registered nor seeking registration with the relevant regulator are not eligible and should be signposted to alternate support based in their area of employment or mainstream NHS services. Any staff who are dismissed and barred from practicing in England or have retired should be discharged and transferred to other support services within 12 months.

The Commissioner will keep the above criteria for access under review and may amend through contract variation as required.

The Provider must ensure access to all Service Users as set out above. The Provider must not provide support to staff outside this population but must have regard to any ineligible staff attempting to access NHSPH and assist any such staff to other services available to that patient in a supportive manner.

3.6 Any acceptance and exclusion criteria and thresholds

The NHSPH Local Clinical services may need to verify a Service User's eligibility to access this service. In all cases the NHSPH Local Clinical services should maintain the trust and confidentiality of the Service User accessing the service and be considerate to the Service Users' mental wellbeing on initial assessment.

There may be occasions when a Service User is not working due to long term sickness, and as a result isn't registered to their professional regulator, or are unemployed as a result of other disciplinary-based or whistleblowing related reason NHSPH must manage these circumstances sensitively and consider further the appropriateness of their admittance into NHSPH. But lack of professional registration or employment must not be a barrier to accessing NHSPH. But Service Users should be evidently planning to return to work in a health and social care environment as per the population covered.

Prior consent from the Service User is required before verifying eligibility; the NHSPH Local Clinical services will use their discretion when to continue to assess and/or treat the Service User without verification. The Commissioner is not responsible for compensating the Provider for any Service Users who access the service and receive treatment but are later found not to be eligible.

3.6.1 Equity of Access, Equality and Non-Discrimination

All Service Users matching the population covered as set out above must have equal access to the NHSPH service as set out in SC13: Equity of Access, Equality and Non-Discrimination, and as per Schedule 2N: Health Inequalities Action Plan.

3.7 Interdependence with other services/providers

Improving health and social care staff health and wellbeing depends on good communication and cooperation between many services. NHSPH cannot work in isolation and the Provider must work with partners to address the needs of sick health professionals to attain optimal outcomes. To support effective multidisciplinary working clear care pathways and formal working agreements need to be in place. A very important partner are local staff health and wellbeing hubs who will need close working with, and other key partners includes GPs, community mental health teams, specialist mental health services, specialist addiction services, specialist eating disorder services, occupational health services, as well as the voluntary and charitable sector. Other services and teams available locally may need to be identified on a case-by-case basis.

3.7.1 Links with local services

NHSPH must establish links with services that are local to Service Users to enable it to advise on the use of such services, and to work with these services where this is appropriate. These must include local staff health and wellbeing hubs, and may include local GPs, NHS and specialist services, occupational health, private providers, peer support and self-help, and services provided through Deaneries. This must include the emerging network of clinicians with enhanced competencies in occupational health, general practice and psychiatry.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Mental Health services statutory, regulatory and best practice guidance on national standards applies to NHSPH, including but not limited to:

- Relevant NICE national quality and treatment standards for Mental Health
- Professional clinical registration and licence to practise as required, including General Medical Council (GMC) and Nursing and Midwifery Council (NMC)
- Professional clinical registration as required including British Association for Behavioural and Cognitive Psychotherapies (BABCP), British Association of Counselling and Psychotherapy (BACP), Health and Care Professions Council (HCPC), General Regulatory Council for Complementary Therapies (GRCCT) and any other nationally recognised bodies.

The Provider must be able to demonstrate high professional standards across all disciplines. It is understood that Service Users receiving support will often be in a very difficult situation. The Provider must work supportively and non- judgmentally. They will adopt a sensitive approach to help the Service User and the Provider must maintain strict confidentiality of the Service User.

The following quality assurance standards apply, as appropriate, to the provision of this Service:

- The Provider must have regard to the General Medical Council (2013) Good Medical Practice guidance (http://www.gmc-uk.org/static/documents/content/GMP_.pdf); in particular:

  "25: You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised."

"73: You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality."

- The Provider must have regard to the General Medical Council (2012) Raising and acting on concerns about patient safety guidance (http://www.gmc-uk.org/static/documents/content/Raising_and_acting_on_concerns_about_patient_safety_-_English_1015.pdf); in particular:

  "20: Concerns about patient safety can come from a number of sources, such as patients' complaints, colleagues' concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority."

- The Provider must have regard to the General Medical Council guidance (2009) Confidentiality (http://www.gmc-uk.org/Confidentiality___English_1015.pdf_48902982.pdf); in particular:

  8: Confidentiality is an important duty, but it is not absolute. You can disclose personal information if:
  a) it is required by law (see paragraphs 17 to 23)
  b) the patient consents – either implicitly for the sake of their own care (see paragraphs 25 to 31) or expressly for other purposes (see paragraphs 32 to 35)
  c) it is justified in the public interest (see paragraphs 36 to 56)."

  9: When disclosing information about a patient, you must:
  a) use anonymised or coded information if practicable and if it will serve the purpose
  b) be satisfied that the patient:

  i. has ready access to information that explains that their personal information might be disclosed for the sake of their own care, or for local clinical audit, and that they can object, and
  ii. has not objected

  c) get the patient's express consent if identifiable information is to be disclosed for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in the public interest

  d) keep disclosures to the minimum necessary, and
  e) keep up to date with, and observe, all relevant legal requirements, including the common law and data protection legislation."

The Provider must adhere to the standards as above and must comply with Schedule 2G Section 1: Terms of Performer Escalation, as appropriate.

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

Competent bodies setting standards for mental health apply, which includes but is not limited to:

- GUIDANCE AND COMPETENCIES FOR GENERAL PRACTITIONERS WITH AN EXTENDED ROLE Health for Health Professionals Practitioner (Updated October 2018; accredited by RCGP)
- Other relevant training available via the Royal Colleges (e.g. RCGP, RCPSY), Faculties (e.g., FOM), Professional bodies (e.g., BPS) and Health Education England.

5. Applicable quality requirements and CQUIN goals

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

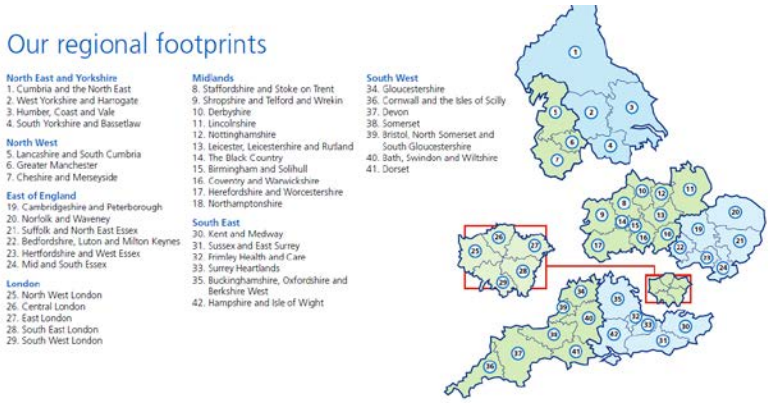
5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

The Provider must put in place NHSPH Local Clinical services across England, within all regional population catchment areas as shown in the map below. These catchment areas match the NHS England commissioning footprint via ICS and regions. Each catchment area will have access to all NHSPH Local Clinical services as set out in this schedule 2A.

Figure 2: NHS (England) commissioning footprints



6.2 Premises location and coverage by the NHS Practitioner Health Local Clinical services

The Provider must configure their NHSPH Local Clinical services to cover the catchment area as above. There could be one or more sites depending on geography and transport links or it may be a hub and spoke arrangement. The Provider will be expected to locate services with the expectation that most Service Users accessing NHSPH would travel up to two hours to attend an appointment. The Provider should also consider how technology could assist consultations in large or remote geographies.

The physical location where Service Users are seen should be selected after consideration of factors relating to access, local travel arrangements, and confidentiality. They should be sensitively located so that a Service User has a choice not to be assessed or treated in a location where they may work, or where the Service Users own patients or peers may be present. The location will need to provide both confidentiality and anonymity. Perceived stigma may for instance, reduce the number of Service Users accessing a service if it is located alongside or within mainstream NHS health services. This does not mean the Provider cannot use premises used for mainstream NHS health services, rather they must offer a choice of premises to the Service User.

Where the premises are shared with other (NHS or private) services, appropriate arrangements should be made for confidential booking of appointments, waiting area and storage of clinical records.

The NHSPH Local Clinical services premises must be comfortable with a welcoming environment. It will need to comply with health and safety standards and be registered with the Care Quality Commission (CQC) where required. Guidance on CQC registration can be found here: https://www.cqc.org.uk/content/hospitals-mental-health-and-community-health-services

The Provider is encouraged to arrange for NHSPH Clinical services to utilise existing NHS premises.

Service Users presenting with mental ill-health and accessing NHSPH should ideally have their assessment and treatment within the catchment area in which they reside. However, the Provider must ensure arrangements are in place to allow Service Users to receive support by NHSPH Local Clinical services in a different catchment area, effectively allowing out of area treatment as an option.

The Provider will ensure that treating clinicians have consulting rooms are accessible locally and that the details of these clinicians and premises will be located within the NHSPH national data base, and will form part of the NHSPH booking App.

The Provider will enable clinicians to undertake home visits where possible and where appropriate for the Service Users' requirements.

6.3 Location of NHSPH Central services Premises

The main sites for NHSPH Central services are based across 2 areas in England:

1 Riverside Medical Centre, St George Wharf, Wandsworth Road, London, SW8 2JB
2 Bevan House, 34-36 Springwell Road, Leeds, LS12 1AW

7. Individual Service User Placement

Not APPLICABLE

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate
As set out in Schedule 2M

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

Aii. Service Specifications – Primary and Community Mental Health Services

Not APPLICABLE

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

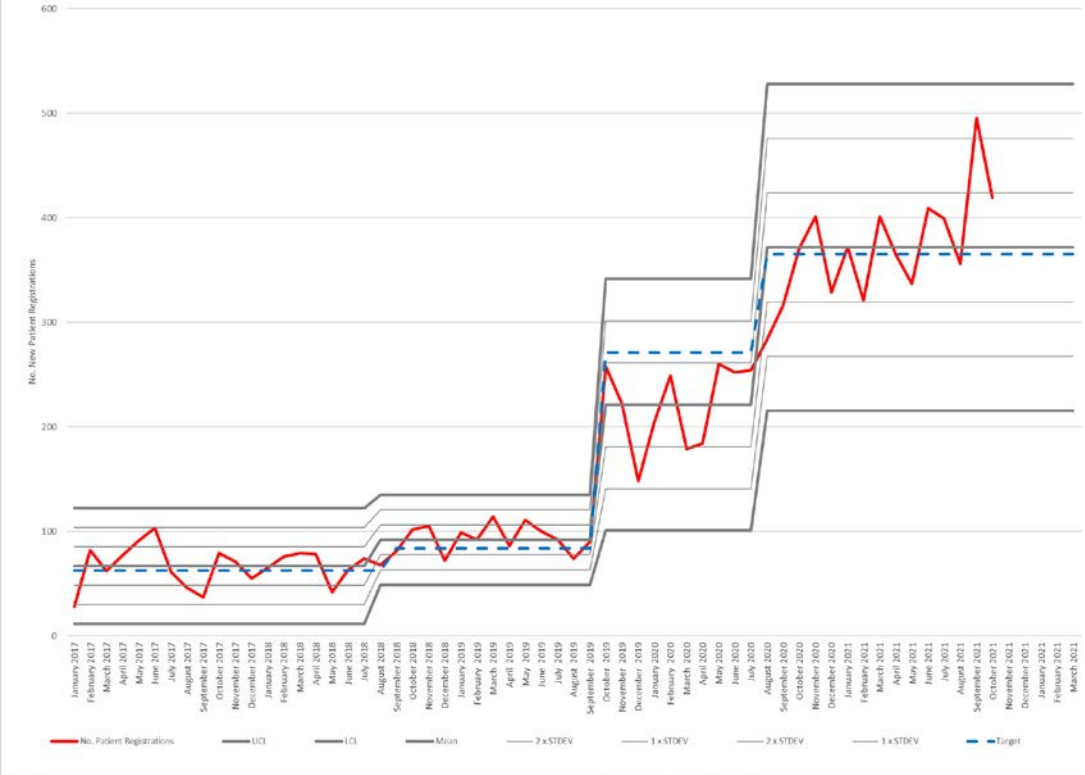
The Provider must provide services for all Service Users as set out in Section 3.5: Population Covered in this Schedule 2A.

The indicative demand for the service is subject to complex changing circumstances as we progress further through the COVID-19 pandemic to meet the unmet needs of health and social care workers in England. The latest NHS Digital workforce statistical publications is available here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

NHSPH currently see c. 350-400 new patients per month and have an ongoing case load of c. 5,300 patients. The significant majority of these patients are doctors.

The indicative Activity planning is based on previous research and experience, which suggests c. 2% of the target population would present to NHSPH. This is demonstrated by the SPC analysis below which sees between 1-2.5% of GPs accessed NHSPH between 2017-2019. This is also observed following expansion of NHSPH to include all doctors and dentists in England Oct 19, to just below expected levels of demand. However, since Apr-June 20 we have observed more than expected levels of demand which is likely a result of the pandemic. We expect activity will continue at this level for the next 12 months, steadily increasing as other staff groups emerge with unmet needs.

Figure 3: SPC analysis of NHSPH New Patient Registrations



Indicative Activity from April 2022 onwards

It is difficult to predict what the level of demand will be on award of a new NHSPH contract, as the ongoing impact of the pandemic is relatively unknown, which may result in a significant demand for PTSD type support, relative awareness of the service, and ongoing development of local staff Health and Wellbeing Hubs.
We have proposed some modelling below based on some assumptions and experience to date. Based on the Population covered criteria in the draft specification:

- Self-referral by any Doctors with GMC registration and a license to practise, Dentists with GDC registration and a license to practise, and trainee doctors/dentists in England, who may access the service irrespective of their residence.
    - This will likely be the majority of Service Users due to good knowledge of the service and how to access it (compared to other staff groups).
    - Based on 12+ years of Practitioner Health related services experience, we anticipate c. 2% of the target population to access NHSPH.
    - There are approx. 180,000 doctors/dentists working in England; 2% = 3,600 will likely access NHSPH per annum, or c. 300 per month.
    - This aligns to previous activity as demonstrated in the SPC analysis, albeit currently inflated as a result of the pandemic.
- Referred from local Staff Health and Wellbeing Hubs, and Self-referral by any senior NHS staff member
    - There is currently limited data on the prevalence of mental health and addiction issues in health and social care staff. Using the level of incidence experienced in doctors at 2%, we could speculate that this level of staff may seek support.
    - There are over 3,000,000 staff working in health and social care. We will use this number as part of this modelling. 2% of 3m = 60,000 health and social care staff members may seek to access mental health support per annum.
    - The majority of these staff will access one of the 40 local staff mental health and wellbeing hubs across England. Based on profiling by NHSEI, we have estimated in the initial term that between 0.05 - 0.1% of health and social care staff may require onward referral or self-refer to NHSPH as their complex needs cannot be met by local staff mental health and wellbeing hubs or local services; this amounts to approx. 1,500 - 3,000 per annum or 125 - 250 per month.

Different type of morbidity

From data on Practitioners accessing existing services, we have also suggested an assessment of potential percentage of different morbidity and acuity in Practitioners presenting with mental ill-health.

Figure 4: Assessment of different type of morbidity

Patients by category	Common Mental Health	Major Mental Health	Multiple Diagnosis (without Addiction)	Addictions (incl. Multiple with Addiction)	Physical	Other-Assessment only	Unassigned
FY 16-17	70.51%	6.58%	11.27%	2.53%	0.63%	0.25%	8.23%
FY 17-18	70.16%	5.88%	10.00%	2.13%	0.35%	0.70%	10.78%
FY 18-19	75.08%	6.55%	6.65%	3.74%	0.42%	0.66%	6.90%
FY 19-20	75.00%	6.64%	4.40%	6.11%	0.26%	0.82%	6.77%
FY 20-21	79.03%	5.40%	2.42%	4.08%	0.48%	1.72%	6.88%
FY 21-22	93.71%	5.05%	1.84%	3.25%	0.62%	3.20%	7.28%
Life average	77.2%	6.0%	6.1%	3.6%	0.5%	1.2%	7.8%

This information has been provided to offer some insight into potential morbidity of Practitioners accessing the NHS Practitioner Health as Practitioners accessing NHS Practitioner Health will have different support requirements

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

The Provider is under a contractual obligation to use all reasonable endeavors to manage activity in accordance with Schedule 2B: Indicative Activity Plan.

The Provider must monitor activity and report to the Commissioner as set out in Schedule 6: Contract Management, Reporting and Information requirements.

Where demand thresholds are exceeded beyond the Activity Planning Assumptions, the Provider must provide proposals to manage demand as appropriate, which may include temporarily suspension of some services or making changes to existing processes to improve efficiencies.

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

The Provider must manage various clinical network to support sharing and learning to promote development of NHSPH and knowledge in supporting health and social care professionals.

The Provider must also support the management of other professional networks and events as recommended by the commissioner, subject to the Commissioner and Provider agreeing that the network is within scope and interest of NHS Practitioner Health.

Clinical / Professional Networks managed by the Provider should include:

- National NHSPH Clinical Leads forum (learning/sharing events)
- Local NHSPH Clinicians forum (Learning/sharing events)
- National Stakeholder events (awareness of service)
- Local Stakeholder events (Awareness of service)
- National Subgroups (Research/development group to support EOG / Education & Training e.g. HHP / Volunteers)
- Focus groups for suspended GPs
- International network of providers of practitioner health (and equivalent).

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

1. Terms of Service User Escalation

1.1. Purpose

The purpose of this Terms of Performer Escalation is to set out a framework between Responsible Officers (ROs) **[the Commissioner]** and NHS Practitioner Health **[the Provider]** for heath care professionals to ensure that effective channels of communication are maintained between the ROs and NHSPH Clinicians. The Provider have been specifically commissioned by NHS England to provide this service.

This Schedule relates to the areas of interface between the ROs and the Provider, clarifies respective roles and responsibilities and outlines mechanisms in place to promote effective liaison.

The agreement does not affect existing statutory functions or amend any other policies or agreements relating to the activities of the ROs and the Provider.
Where the term RO is used in this Schedule this must include a member of the RO's team such as medical/assistant medical directors, appraisal & revalidation teams, and applicable clinical oversight of the employer.

Where the term Provider is used in this Schedule this must include a member of NHSPH who is the Medical Director, Clinical Director or the Clinical Lead within the relevant catchment area. Any requirements as set out in this Schedule must be completed by a Clinician within the Provider.

1.2. Functions of the Responsible Officers [the Commissioner]

ROs are appointed by NHS England and NHS organisations to undertake the following duties as a statutory function under The Medical Profession (Responsible Officers) Regulations 2010 (and amendments 2013):

- To ensure annual appraisals are carried out on health care professionals as applicable.
- To establish and implement procedures to investigate concerns about a service user(s) fitness to practise raised by patients or staff of the designated body or arising from another source
- To refer concerns about the service user to the applicable regulator where appropriate
- To monitor compliance with those conditions or undertakings where a Service User is subject to conditions imposed by or undertakings agreed with the applicable regulator
- To make recommendations to the applicable regulator about service user()s) fitness to practice
- To maintain records of service user(s) fitness to practise evaluations including appraisals and any other investigations or assessments

1.3. Functions of the Provider of NHSPH for health and social care staff [the Provider]

- The Provider provides free, confidential services for service users who have mental health concerns and/or addiction problems.

- Performers approaching the Providers for help need to be assured that they have the same rights to confidentiality as any other patient.

1.4. Potential areas of communication

Communication between the ROs and the Provider is based on an overriding duty to protect patients whilst, as far as possible, being fair to performers and protecting confidential health information. Areas of potential communication between the ROs and the Provider include the following (the list is not intended to be exhaustive):

a) Pre-referral discussion:
   I. 'in principle' about how best to manage concerns about a performer and whether or not the RO would need to be informed on an anonymised basis, or
   II. Discussions about performers who have been referred to either the RO or the Provider, where there are concerns about public protection or the safety of patients under the care of the Provider, on a named performer basis.

b) Post-referral discussion – to coordinate activity where appropriate.

1.5. Pre-referral discussions 'in principle' or about named performers

It may sometimes be appropriate for the RO and the Provider to liaise in order to clarify the issues raised in advance of a referral. In these cases, the RO and the Provider must discuss the matters about the individual anonymously.

Where it is not possible or inappropriate to have an anonymised discussion, consent must be sought before doing so and if not provided there should be an assessment of whether the risk is such that the information should be disclosed without consent. If the nature of the risk is judged to be high, the enquiring organisation or individual should be offered appropriate contact details for both the RO and the Provider so they may conduct their own discussions.

1.6. Post-referral discussions about individual performers

The RO and the Provider must recognise that there may be times where they both have a case open about a named service user. If it is appropriate, and service user consent given, they should work together to ensure that appropriate channels of communication exist.

1.7. Disclosure of concerns

Disclosure should be made to the RO where the service user's health raises concerns that may affect patient safety, particularly where the service user has limited insight and is not complying with assessment, treatment or monitoring, or heeding advice to remain on sick leave.

If disclosure to the Service User's RO is considered inappropriate, for example due to personal relationships between the RO (or a member of their team as delegated) and the Service User, then the Service User concern should be disclosed to the second tier (regional) RO.

If disclosure to the Service User's second tier (regional) RO, is not possible, then the concern regarding the performer should be referred to an alternative second tier RO.

1.8. Cases under investigation/monitoring by the RO

Whenever the RO becomes aware of a possible performance concern regarding a service user an initial assessment is conducted by the Performance Advisory Group (PAG) or

equivalent. The concern may include information which indicates a health element to the concern.

Where a service user is under investigation or being monitored by the RO and is also under the care of NHSPH, with the service user's consent, NHSPH will inform the RO in what capacity they are supporting the service user. If the Provider is actively treating the service user, they will provide a named person with whom the RO can liaise. In these circumstances, NHSPH will only be aware if they are treating a service user under investigation, if the service user informs NHSPH themselves.

The Provider will ensure that any information arising from the monitoring of the health of a service user being investigated or monitored by the RO that indicates they have breached amy conditions imposed on their practice and/or are not complying with advice on managing their health problem, and/or their condition appears to pose a risk to their patients, will be shared with the RO as soon as possible.

1.9. Service User(s) being treated/monitored by the Provider

When the Provider receives a referral (self-referrals or referrals from an organisation or individual with the service user's consent) they will ask the service user or referrer if the service user is currently under investigation or being monitored by the RO or applicable regulator.

If the service user or referring organisation or individual indicates that the RO is currently investigating or monitoring, the Provider will seek the service users consent to contact the RO or applicable regulator to explain that the service user has sought NHSPH intervention. If consent is not forthcoming, the Provider will consider whether or not disclosure to the RO / regulator is required, without consent, using the criteria set out in the paragraphs above.

1.10. Thresholds for referral

The RO and the Provider are subject to a range of legislative duties in relation to information governance, including the Data Protection Act 1998, Human Rights Act 1998, and the Freedom of Information Act 2000. This document sets out the approach to the routine exchange of information between the two organisations within this legal framework.

1.11 Resolution of disagreement

Where any issues arise which cannot be resolved at an operational level, the matter will be referred to the contract leads identified in Schedule 6 – Contract Management, Reporting and Information requirements to ensure a satisfactory resolution.

1.12 Review and Governance arrangements

The Authority will assign a local RO or their delegated representative to be the local identified operational lead for this Schedule.

The Supplier will assign the Medical Director or Clinical Director for England, and the Clinical Lead for each catchment area, to be the operational lead for this Schedule. Both these assigned representatives are required to ensure this Schedule is kept up to date and to identify any emerging issues in the working relationship between the two bodies.

The Authority and the Supplier will conduct a formal review of this Schedule at each annual contract review meeting to assess and review the operational effectiveness of this agreement in enabling both bodies to fulfil their functions.

2. Intellectual Property Rights

The GC22 Intellectual Property applies. In addition to this, all information, data & systems as set up by this service including but not limited to, national telephone numbers, email accounts, website and online tools & resources including patient records systems, as commissioned in this service specification is the Intellectual Property of NHS Practitioner Health, which the Provider is commissioned to deliver. The Commissioner of NHS Practitioner Health service therefore holds the Intellectual Property of these services.

The Commissioner does not make any claim to the Intellectual Property of the technical software or platform which is used for the Providers booking application used by NHS Practitioner Health Clinicians and Service Users as part of managing appointments, or the eConsult tool used for managing new patients accessing the service.

The Provider grants the Commissioner a licence for use of the booking application & eConsult and is expressed to be England-wide, perpetual, irrevocable, non-exclusive and royalty-free for NHS Practitioner Health for the duration of this contract.

3. Information Governance Toolkit Compliance

The GC21: Patient Confidentiality, Data Protection, Freedom of Information and Transparency, requires that:

- The Provider must complete and publish an annual information governance assessment using the NHS Information Governance Toolkit ("the IG Toolkit") and must achieve a minimum level 2 performance against all requirements in the relevant Toolkit ("the Toolkit Requirement").

and

- The Provider must ensure that its NHS Information Governance Toolkit submission is audited in accordance with Information Governance Audit Guidance where applicable. The Provider must inform the Commissioner of the results of each audit and publish the audit report both within the NHS Information Governance Toolkit and on its website ("the Audit Requirement").

Together these are the **"IG Requirements"** for the purposes of this Schedule 5E.
To be eligible for award of contract the Provider must have provided evidence that the Provider, its partner organisations, and any sub-contractors to be engaged by the Provider for the delivery of the Services (whether in the provision of front-line delivery or support functions) meet the **IG Requirements**.

The Toolkit Requirement

Evidence for the Toolkit Requirement will be an IG Toolkit accreditation of at least Level 2 on all requirements achieved by the Provider, its partner organisations and sub-contractors in the relevant Toolkit published in the latest March submission on the IG Toolkit website.

The Provider should note that:

The IG Toolkit contains a number of requirements. These requirements vary according to the type of organisation using the IG Toolkit. NHS England will decide which version of the IG Toolkit is relevant by reference to:

- the role to be played by the organisation in the delivery of the Services; and

- the guidance on Organisation Types available on the IG Toolkit website – see here: https://www.igt.hscic.gov.uk/requirementsorganisation.aspx?tk=423537712574832&cb=f281700b-c33d-4af1-8145-1f85af00e0b2&lnv=2&clnav=YES

The Provider must provide a justification as to why they have selected a particular Organisation Type for their IG Toolkit return and the IG Toolkit returns for its partner organisations and any sub-contractors.

NHS England highlights that under the Guidance:

- *"if an organisation provides direct or indirect patient care, it will **not be appropriate** to allocate the IG Toolkit* [Commercial Third Party] *organisation type to such organisations."*

NHS England will check assessment reports available on the IG Toolkit website to assess whether this requirement has been passed.

The Audit Requirement

Evidence for the Audit Requirement will be reports on independent audits of all IG Toolkit submissions relied upon. The audits must be independent of the Provider, its partner organisations and any of its subcontractors. The evidence must be in the form of full, final and unredacted audit reports. The audit reports must conclude and provide assurance that the Toolkit Requirement is warranted.

A Provider will fail this requirement if it is unable to provide for itself, its partner organisations or for any of its sub-contractors:

- An IG Toolkit accreditation of at least level 2 on all requirements in the relevant Toolkit for the latest complete year, ending 31st March. For the avoidance of doubt the Provider will fail this requirement if they, a partner organisation or sub-contractor have completed an IG Toolkit return for an organisation type that is not appropriate taking into account the role of that organisation in the delivery of Services and the Guidance on Organisation Types referred to above;

and

- A full, final and unredacted report setting out the results of an independent audit of any IG Toolkit submissions relied upon to satisfy the requirement set out above, which concludes and provides assurance that the IG Toolkit accreditation relied upon to fulfil the above requirement is appropriate.

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

Not APPLICABLE

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

Service Continuity & Patient Transition Arrangements
The Provider is required to ensure the orderly transition of the services from the Provider to the Commissioner and/or any Replacement Provider in the event of termination, as set out in GC17 – Termination.

The Provider must be aware of GC18 - Consequence of Expiry or Termination.

In all circumstances the Provider and Commissioner will agree a Succession Plan and must have the highest regards to the needs of service users of NHS Practitioner Health. The Provider and Commissioner must agree whether service users under the care of NHS Practitioner Health at contract termination or expiry, need to be transferred to other services such as Local Staff health and wellbeing hubs and mainstream NHS Mental Health services.

Maintaining confidentiality
With regard to the patent records system, the Commissioner will instruct the Provider to transfer all records to the replacement provider or temporary safekeeping by the Commissioner if a replacement provider is not available. The Commissioner under no circumstances will access the confidential data and will assign an Information Governance Lead and Caldicott Guardian to oversee the patient records system on the Commissioner's behalf.

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

This applies to Practitioners exiting the NHS Practitioner Health, being referred to other services or discharged with no further referral requirements.

Transition arrangements should be framed by the following principles:

1 The mental and physical health of the Service User in transition should not decline during the process of transition.
2 The Service User should be assisted to maximise their health and wellbeing.
3 The Service User should be treated as far as possible within their own community and close to home.
4 Services should work together in integrated and coordinated ways in the best interests of the Service User.

It is essential that Practitioners are involved in commissioning and service design (as well as providing feedback to services). Practitioners presenting with mental ill-health, as well as those who have yet to access services, can help the Commissioner and Provider prioritise and identify any gaps and blocks to access, and assist the Provider in improving services and evaluating change.

The Provider should ensure they understand the diversity of the populations they are responsible for, not only in terms of cultural and ethnic diversity, but all of the factors that may both influence the risk of developing mental health problems, as well as those that need to be taken into account in the design and delivery of services.

Transition is a process undertaken over time. It may include, but is more than, a planned transfer to another provider of support for mental ill-health. Primary care services should be included to achieve streamlined, efficient and effective transition for all Practitioners. This is, particularly true for those Practitioner needing a range of health and social care services during their transition and beyond, which the Practitioner's own GP will need to support to enable transfer into other NHS services. However, the Practitioner must give prior written consent to the NHS Practitioner Health service before NHS Practitioner Health involves anyone else in the care of the Practitioner outside of NHS Practitioner Health.

Transfers from NHS Practitioner Health whether to NHS Mental Health services or to other services including discharge back to primary care, are single point events in the entire transition process. Practitioners may be subject to serial and sequential transfers within and across different health care organisations / specialist teams over time. NHS Practitioner Health should follow Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time, where possible, so that the Practitioner and both NHS Practitioner Health and the receiving service(s) have good time to communicate the needs and provide continuity of care at this vulnerable time.

Transfers require coordinated, documented and integrated support plans for Practitioners from NHS Practitioner Health service and any other support in partnership with other providers (e.g. Charity and NHS services). In order to enable Practitioner's to become and remain active partners in their care, prepare for transfer(s) and engage with adult mental health or other services; the transition process between services needs to be underpinned by individual circumstances on a case by case basis and include appropriate care planning that is:

- Supported by access to wide range of resources with which all Service Users including Practitioners may engage with
- Supported by access to peer support which may be offered individually or in groups, face to face or through social media

- Supported by a NHS Practitioner Health Clinician who can take a co-ordinating support role throughout the transition process. It is recognised that whilst this Clinician may change over time, Practitioners, where appropriate should be able to name the Clinician undertaking this role at any point in the process.
- Delivered by staff that have specific training or experience in working with Practitioners.
- Delivered by processes, systems and environments that promote safety, quality, effectiveness and are suitable for Practitioners, bearing in mind stigmas associated with Practitioners accessing mental health services.
- Documented in the Practitioner's NHS Practitioner Health medical records and reviewed at each key point in the transition pathway. Where the Practitioner gives written consent, details of the transition may be recorded in the NHS patient records as held by the Practitioner's own GP.

The NHS Practitioner Health may not be able to support all needs of the Practitioner as set out in the scope of this service specification, but where appropriate the NHS Practitioner Health service must provide on-going case management of the Practitioner to support transition.

In supporting the transfer or discharge of the Practitioner, the Provider must:

- Co design and review the transition care pathways with the Commissioner, the NHS Practitioner Health protocol and enable suitable referral as needed for a safe and smooth transition
- ensure the NHS Practitioner Health can facilitate the Practitioner effectively during transition and address their individual needs, providing a holistic approach.
- Where the Practitioner provides written consent, include the Practitioner's own GP in the pathway development to ensure the GP have the relevant information to support Practitioner's during and after transition.
- Ensure that Practitioners are treated with compassion, respect and dignity, without stigma or judgment
- Ensure that the Practitioners physical health needs are considered alongside their mental health needs
- Ensure that Practitioners who require services during and post transition are seen in a timely manner
- Ensure that services are identified who can provide support to the Practitioner in an emergency or crisis, including out of hours.
- Provide an agreed care plan that is written and shared with the Practitioner.
- Provide information at all stages of the pathway about interventions or treatment options to enable the Practitioner to make informed decisions about their care appropriate to their competence and capacity.
- Co-produce the care plan and provide that written information to the Practitioner about the care plan, how to access the new services routinely and in a crisis
- Provide written assessments, care plans etc. that are jargon free (where any technical terms are defined)
- Ensure that Practitioners leaving the service have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary.
- Where a Practitioner is moving to another service, whether to NHS mental health services or to a different service, the Provider will ensure that the agreed transition protocol is followed with, as a minimum, a joint meeting between the NHS Practitioner Health Clinician and new service that includes the Practitioner, a written discharge summary, and followed up after six months to check the transition has proceeded smoothly. The NHS Practitioner Health Clinician will agree with the Practitioner what information will be provided to the other service to minimise the need for the Practitioner to repeat information, but maintaining the Practitioners confidentiality.
- Ensure that the other service is accessible and provided in an appropriate setting that creates a safe physical environment

- Ensure that appropriate clinical information, structural governance and audit arrangements are in place, including protocols around information sharing and confidentiality.
- Ensure that care plans (following Care Programme Approach, or CPA, where applicable) are in place for the Practitioner receiving support for mental health problems. These plans may be (where more than one Clinical team is involved in delivering care) and developed in collaboration with the Practitioner. A copy should be given to the Practitioner, and following written consent from the Practitioner, the Practitioner's own GP.
- Ensure that the care plan includes risk management and crisis planning
- Review the care plan with the Service User, including the goals of treatment, and revise the care plan at agreed intervals of no more than one year.
- Select treatment options in consideration of NICE HTAs.
- Ensure that systems are in place to coordinate effectively with other services when Practitioners are in treatment, when they move between other services both for their physical and mental health and that there are processes in place to plan the ending of treatment or services.

The Provider will be required to work with local hubs to identify and agree local referral pathway between the local hub and ensure information on transfer of care and discharge is shared with the local hubs where appropriate.

The Provider should consider with patients whether they should be discharged or referred back to the referring mental health and wellbeing hub (including any relevant patient records).

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

The Provider must have regard to SC32 - Safeguarding, Mental Capacity and Prevent. The Provider must ensure that Practitioners are protected from abuse and improper treatment in accordance with the Law, and must take appropriate action to respond to any allegation of abuse as set out in the service conditions.

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

The Provider should consider and deliver as appropriate to the Service User any Personalised Care Plans as set out below:

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.

The Provider should develop specific actions which NHSPH 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 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 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/.

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.

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).

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.

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

The Provider should consider and deliver as appropriate to their Service User any Action Plan(s) to reduce Health Inequalities, as set out below:

Intelligence and needs assessment

The Provider may set out

2 *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;*

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

4 *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, and what action is being taken to close any gaps which the analysis reveals.*

Community engagement

The Provider may 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

The Provider may 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.*

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.

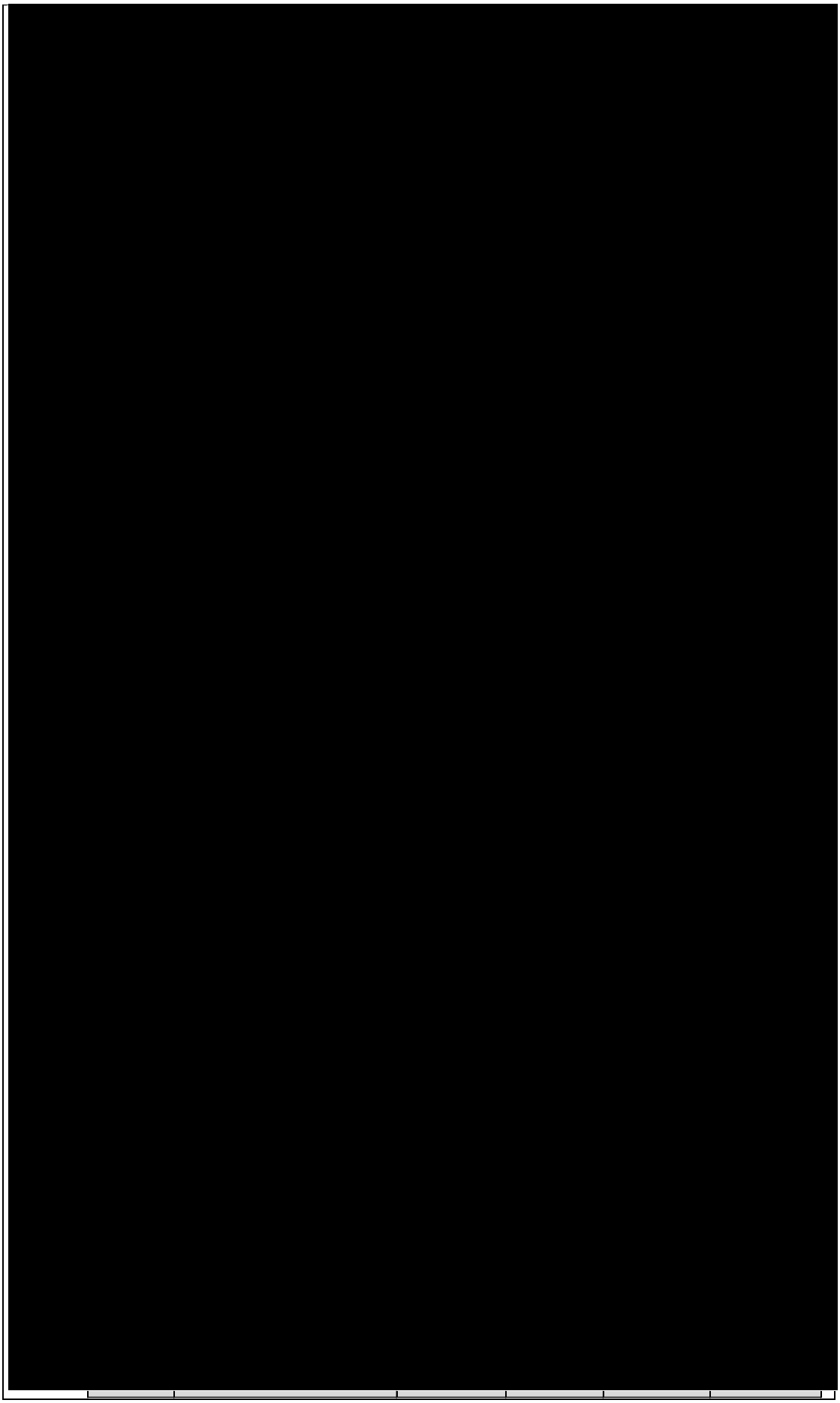
Implementation, monitoring and evaluation

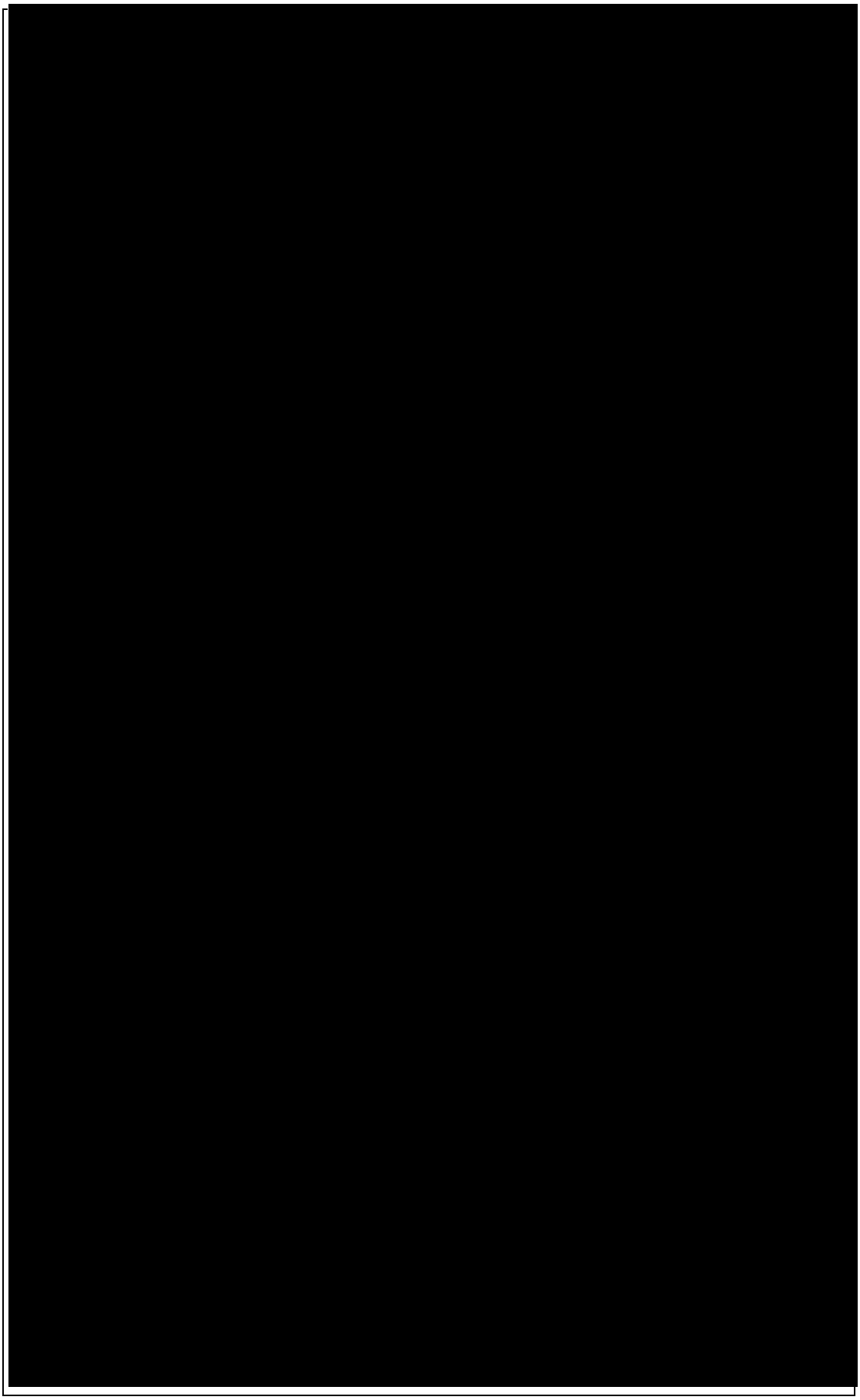
The Provider can set out clear timescales for the agreed actions described above, as well as arrangements through which the Parties will jointly monitor progress and evaluate whether improved outcomes are achieved. This should involve other partners as appropriate, and include engagement with the prioritised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

SCHEDULE 3 – PAYMENT

A. Local Prices

[redacted]





SCHEDULE 3 – PAYMENT

B. Local Variations

Not Applicable

SCHEDULE 3 – PAYMENT

C. Local Modifications

Not Applicable

SCHEDULE 3 – PAYMENT

D. Aligned Payment and Incentive Rules

Not Applicable.

SCHEDULE 3 – PAYMENT

E. CQUIN

Not Applicable

SCHEDULE 3 – PAYMENT

F. Expected Annual Contract Values

Commissioner	**Expected Annual Contract Value (include separate values for each of one or more Contract Years, as required)**
NHSEI (Primary Care Group)	For all doctors and dentists: the annual contract value expected for this contract is up to £7m. • FY22/23: £7m • FY23/24: £7m And subject to Schedule 1C: • FY24/25: £7m • FY25/26: £7m
NHSEI Mental Health Unit & Chief People Officer (Health and wellbeing) Unit.	For all staff types (excluding doctors and dentists): the annual contract value expected for this contract is up to *£4m.* • FY22/23: *£4m* • FY23/24: *£4m* And subject to Schedule 1C: • FY24/25: *£4m* • FY25/26: *£4m*
Total	• FY22/23: *£11m* • FY23/24: *£11m* And subject to Schedule 1C: • FY24/25: *£11m* • FY25/26: *£11m* Total Potential Life Cost of contract: £44m
The annual contract value expected for this contract is up to £11m. However, both the Commissioner and Provider must give regard to the total value available in the contract (up to a maximum of £44m including potential contract extension). The Commissioner reserves the right to put in place restrictions on access to the service to ensure it doesn't overspend on the annual contract value, or as otherwise specified by the Commissioner in writing.	

SCHEDULE 3 – PAYMENT

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

The timings and amounts are set out in Schedule 3A: Local Prices.

SCHEDULE 4 – QUALITY REQUIREMENTS

A. Operational Standards

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
	RTT waiting times for non-urgent consultant-led treatment				
E.B.3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Operating standard of 92% at specialty level (as reported to NHS Digital)	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Month	Services to which 18 Weeks applies NOT APPLICABLE
	Diagnostic test waiting times				
E.B.4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test	Operating standard of no more than 1%	See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/	Month	A CS CR D NOT APPLICABLE
	A+E waits				
E.B.5	Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4 hours of	Operating standard of 95%	See A+E Attendances and Emergency Admissions Monthly Return Definitions at: https://www.england.nhs.uk/statistics/	Month	A+E U

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
	their arrival at an A+E department		statistical-work-areas/ae-waiting-times-and-activity/		NOT APPLICABLE
	Cancer waits - 2 week wait				
E.B.6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
E.B.7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	Operating standard of 93%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
	Cancer waits – 28 / 31 days				
E.B.27	Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer	Operating standard of 75%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
E.B.8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	Operating standard of 96%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
					NOT APPLICABLE
E.B.9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery	Operating standard of 94%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
E.B.10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	Operating standard of 98%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
E.B.11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	Operating standard of 94%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
	Cancer waits – 62 days				
E.B.12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	Operating standard of 85%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
					NOT APPLICABLE
E.B.13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	Operating standard of 90%	See National Cancer Waiting Times Monitoring Dataset Guidance, available at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/	Quarter	A CR R NOT APPLICABLE
	Ambulance Service Response Times				
	Category 1 (life-threatening) incidents – proportion of incidents resulting in a response arriving within 15 minutes	Operating standard that 90th centile is no greater than 15 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	AM NOT APPLICABLE
	Category 1 (life-threatening) incidents – mean time taken for a response to arrive	Mean is no greater than 7 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	AM NOT APPLICABLE
	Category 2 (emergency) incidents – proportion of incidents resulting in an appropriate response arriving within 40 minutes	Operating standard that 90th centile is no greater than 40 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	AM NOT APPLICABLE
	Category 2 (emergency) incidents – mean time taken for an appropriate response to arrive	Mean is no greater than 18 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/	Quarter	AM NOT APPLICABLE

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
			statistical-work-areas/ambulance-quality-indicators/		
	Category 3 (urgent) incidents – proportion of incidents resulting in an appropriate response arriving within 120 minutes	Operating standard that 90th centile is no greater than 120 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	AM NOT APPLICABLE
	Category 4 (less urgent "assess, treat, transport" incidents only) – proportion of incidents resulting in an appropriate response arriving within 180 minutes	Operating standard that 90th centile is no greater than 180 minutes	See AQI System Indicator Specification at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/	Quarter	AM NOT APPLICABLE
	Mixed-sex accommodation breaches				
E.B.S.1	Mixed-sex accommodation breach	>0	See Mixed-Sex Accommodation Guidance, Mixed-Sex Accommodation FAQ and Professional Letter at: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/	Ongoing	A CR MH NOT APPLICABLE
	Cancelled operations				
E.B.S.2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28	Number of Service Users who are not offered another binding date within 28 days >0	See Cancelled Operations Guidance and Cancelled Operations FAQ at: https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/	Ongoing	A CR NOT APPLICABLE

Ref	Operational Standards	Threshold	Guidance on definition	Period over which the Standard is to be achieved	Application
	days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice				
	Mental health				
E.B.S.3	The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	Operating standard of 80%	See Contract Technical Guidance Appendix 2	Quarter	MH Except MH (Specialised Services) NOT APPLICABLE

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

SCHEDULE 4 – QUALITY REQUIREMENTS

B. National Quality Requirements

	National Quality Requirement	Threshold	Guidance on definition	Period over which the requirement is to be achieved	Application
E.A.S.4	Zero tolerance methicillin-resistant *Staphylococcus aureus*	>0	See Contract Technical Guidance Appendix 2	Ongoing	A NOT APPLICABLE
E.A.S.5	Minimise rates of Clostridioides difficile	As published by NHS England and NHS Improvement	See Contract Technical Guidance Appendix 2	Year	A (NHS Trust/FT) NOT APPLICABLE
	Minimise rates of gram-negative bloodstream infections	As published by NHS England and NHS Improvement	See Contract Technical Guidance Appendix 2	Year	A (NHS Trust/FT) NOT APPLICABLE
E.B.S.4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Ongoing	Services to which 18 Weeks applies NOT APPLICABLE
E.B.S.7a	All handovers between ambulance and A+E must take place within 15 minutes with	>0	See Contract Technical Guidance Appendix 2	Ongoing	A+E

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

	National Quality Requirement	Threshold	Guidance on definition	Period over which the requirement is to be achieved	Application
	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95%	See Contract Technical Guidance Appendix 2	Quarter	A NOT APPLICABLE
	Duty of candor	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 APPLICABLE
E.H.4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	Operating standard of 60%	See Guidance for Reporting Against Access and Waiting Time Standards and FAQs Document at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/	Quarter	MH NOT APPLICABLE
E.H.1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait six weeks or less from referral to entering a course of IAPT treatment	Operating standard of 75%	See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: https://www.england.nhs.uk/operational-planning-and-contracting/	Quarter	MH NOT APPLICABLE

	National Quality Requirement	Threshold	Guidance on definition	Period over which the requirement is to be achieved	Application
E.H.2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who wait 18 weeks or less from referral to entering a course of IAPT treatment	Operating standard of 95%	See Annex F1, NHS Operational Planning and Contracting Guidance 2020/21 at: https://www.england.nhs.uk/operational-planning-and-contracting/	Quarter	MH NOT APPLICABLE
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider (other than those dealing with children, teenagers and young adults) across all tumor sites	Failure to achieve full implementation as described under Service Specification B15/S/a Cancer: Chemotherapy (Adult)	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Ongoing	Where both Specialised Services and Cancer apply NOT APPLICABLE
	Full implementation of an effective e-Prescribing system for chemotherapy across all relevant clinical teams within the Provider dealing with children, teenagers and young adults across all tumor sites	Failure to achieve full implementation as described under Service Specification B15/S/b Cancer: Chemotherapy (Children, Teenagers and Young Adults)	Service Specification at: https://www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/	Ongoing	Where both Specialised Services and Cancer apply NOT APPLICABLE
	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	See Contract Technical Guidance Appendix 2	Quarter	A, A+E NOT APPLICABLE

	National Quality Requirement	Threshold	Guidance on definition	Period over which the requirement is to be achieved	Application
	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	Operating standard of 90% (based on a sample of 50 Service Users each Quarter)	See Contract Technical Guidance Appendix 2	Quarter	A NOT APPLICABLE

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

SCHEDULE 4 – QUALITY REQUIREMENTS

C. Local Quality Requirements

Quality Requirement	Threshold	Method of Measurement	Period over which the Requirement is to be achieved	Applicable Service Specification
Access The satisfaction of Service User experience within NHSPH with regard to location of the service, including: a) First contact b) Initial assessment c) Ongoing Treatments d) Ongoing case management	The Provider must achieve a satisfaction rate for each of these criteria's of at least 80% per Practitioner and an England average of 90%.	Annual survey of Service Users in NHSPH, or on discharge from NHSPH	If satisfaction rate is less than 60% Issue of Contract Performance Notice and subsequent process in accordance with GC9	Per GC9 process
Responsiveness The satisfaction of Service User experience within NHSPH with regard to timely support of the service, including: a) First contact b) Initial assessment c) Ongoing Treatments d) Ongoing case management	The Provider must achieve a satisfaction rate for each of these criteria's of at least 80% per practitioner and an England average of 90%.	Annual survey of Service Users in NHSPH, or on discharge from NHSPH	If satisfaction rate is less than 60 % Issue of Contract Performance Notice and subsequent process in accordance with GC9.	Per GC9 process
Reputation The satisfaction of Service User perception of NHSPH with a positive reputation and recognised local leadership a) Trustworthiness b) Recommendation c) Accessible	The Provider must achieve a satisfaction rate for each of these criteria's of at least 80% per Practitioner and an England average of 90%.	Annual survey of Service Users in NHSPH, or on discharge from NHSPH Other appropriate data sources	If satisfaction rate is less than 60 % Issue of Contract Performance Notice and subsequent process in accordance with GC9.	Per GC9 process

Quality Requirement	Threshold	Method of Measurement	Period over which the Requirement is to be achieved	Applicable Service Specification
d) Well known e) Confidential				
Engagement The satisfaction of key stakeholders' perception of NHSPH with high confidence in delivery and effective national leadership a) Stakeholder management b) Lead by example c) Effective delivery of strategy	The Provider must achieve a satisfaction rate for each of these criteria's of at least 80% per stakeholder and an England average of 90%.	Surveys and engagement (by exception) as considered required by the commissioner. This would be undertaken by NHSEI.	If satisfaction rate is less than 60 % Issue of Contract Performance Notice and subsequent process in accordance with GC9.	Per GC9 process
Continuity of Care Any Service User accessing NHSPH must be cased managed effectively and supported through appropriate care pathways whether being treated in NHSPH or other services.	The Provider must achieve a satisfaction rate for each of these criteria's of at least 80% per stakeholder and an England average of 90%.	Annual survey of Service Users in NHSPH, or on discharge from NHSPH Surveys and engagement (by exception) as considered required by the commissioner. E.g. with local Staff MH&W hubs.	If satisfaction rate is less than 60 % Issue of Contract Performance Notice and subsequent process in accordance with GC9.	Per GC9 process

SCHEDULE 4 – QUALITY REQUIREMENTS

D. Local Incentive Scheme

Not APPLICABLE

SCHEDULE 5 – GOVERNANCE

○ Documents Relied On

Documents supplied by Provider

Date	Document
Not Applicable	

Documents supplied by Commissioners

Date	Document
Not Applicable	

SCHEDULE 5 - GOVERNANCE

B. Provider's Material Sub-Contracts

"

Permitted Material Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing data – Yes/No
[redacted]	[redacted]		No
			No
			No
			No
			No
			No
			No
			No
			No

"

SCHEDULE 5 - GOVERNANCE

1. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
Co-ordinating commissioner	To Advise the Provider on day to day commissioning and strategic direction of wider system activity/issues and other stakeholder activity where relevant to the NHS Practitioner Health, to ensure a coordinated and cohesive partnership between the Commissioner and Provider in delivering this service.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

Quality and assurance

The Provider needs to be able to demonstrate the quality, accessibility and value for money of the service. Reports for the Commissioner of the NHS Practitioner Health service must be provided to support contract monitoring and improvement. The Provider must evidence the usage and success of the NHS Practitioner Health service. Reporting may be limited to high level information only when small numbers of patients are involved. No personally identifiable details must ever be shared.

Clear and simple metrics must provide a minimum rather than a maximum standard for assurance, so that assurance processes are not top-heavy or bureaucratic. These would focus mainly on the clinical metrics, particularly user-reported wellbeing measurements and longer-term outcome measures e.g. wellbeing one year on.

Data collection and evaluation

- Evaluation of the Practitioner Health service is a key aspect and the collection of anonymised data will support:
    - understanding of referral patterns
    - assessment of the impact of the service
    - economic impact assessment, and
    - external clinical evaluation

Commissioner and user satisfaction assessments will be undertaken.

Measures of outcomes for the cohort as well as individuals should be recorded, as these may demonstrate value for money of the service. Such measures may include:

- Is the service responsive, using evidence based treatment, and supporting employment and wellbeing, and getting service users back to work?
- Contact times would need to be defined and measured
- Proportion of service users who stay in or return back to work
- Percentage of addiction patients who remain abstinent
- The length of and number of spells of absence (e.g., via MED3s)
- Measures of symptoms and function, e.g. PHQ-9, Gad-7 or CORE10
- Appraisals and training of the team.
- Service user feedback using established 'patient experience questionnaires' or equivalent

The Local Requirements Reported Locally section below will be developed over the course of the contract and is subject to change.

This will apply for all staff types (including trainees or students) employed by an NHS commissioned service or registered social care organisation in England, subject to the entry criteria and number of admissions allowed as defined by the Commissioner.

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
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** **APPLICABLE**
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** **NOT APPLICABLE**
2. *Patient Reported Outcome Measures (PROMS):* a. *PHQ9* b. *CORE10* c. *GAD7* d. *Psychlops* *For all service user(s) at registration, 6 months and discharge*	*Quarterly Report:* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March*	*See annex G*	*Report due 15 operational days after the end of the reporting period*	**All** **APPLICABLE**
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** **NOT APPLICABLE**
1b. Activity and Finance Report	i. *Activity Highlight report – Monthly* ii. *Activity (detailed trends) and Finance report – Quarterly* • *1st April – 31st June*	I. *See Annex A* II. *See Annex B*	i. *Report due 7 operational days after the end of the reporting period* ii. *Report due 15 operational days after the end of the reporting period*	**All except A, MH** **APPLICABLE**

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
	• *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March*			
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: 6 details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; 7 details of all requirements satisfied; 8 details of, and reasons for, any failure to meet requirements.	I. *Urgently following incident* II. *Verbal summary at monthly contract meetings as required* iii. *Quarterly Report:* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March*	I. *See Annex C* II. *See Annex A See Annex B*	I. *Verbal and/or written, depending on severity of incident; see Annex C.* II. *Verbal summary at monthly contract meetings as required* iii. *Report due 15 operational days after the end of the reporting period*	**APPLICABLE** **All** **All** **All**
5. 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]	**NOT APPLICAIBLE** **All**
6. 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** **NOT APPLICABLE**
7. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	*Quarterly Report:* • *1st April – 31st June*	*See Annex B*	*Report due 15 operational days after the end of the reporting period*	**All** **APPLICABL**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
		• *1st July – 30th Sept* • *1st Oct – 31st Dec* *1st Jan – 31st March*			**E**
8.	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** **APPLICABLE**
9.	Summary report of all incidents requiring reporting	I. *Urgently following incident* II. *Verbal summary at monthly contract meetings as required* III. *Quarterly Report:* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March*	I. *See Annex C.* II. *See Annex A* *See Annex B.*	I. *Verbal and/or written, depending on severity of incident* II. *Verbal summary at monthly contract meetings as required* III. *Report due 15 operational days after the end of the reporting period*	**All** **APPLICABLE**
10.	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** **APPLICABLE**
11.	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A+E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	**A** **A+E** **U** **NOT APPLICABLE**
12.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (*Staff*)	*6-Monthly report* • *1st April – 30th Sept*	*See Annex B*	*Report due 15 operational days after the end of the reporting period*	**All** **APPLICABL**

		Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
		• *1st Oct – 31st March*			**E**
13.	Report on compliance with the National Workforce Race Equality Standard.	*Annually* • *1st April – 31st March*	*See Annex D*	*Report due 15 operational days after the end of the reporting period*	**All** **APPLICABLE**
14.	Report on compliance with the National Workforce Disability Equality Standard.	Annually	[For local agreement]	[For local agreement]	**NHS Trust/FT** **NOT APPLICABLE**
15.	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** **NOT APPLICABLE**
16.	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)** **NOT APPLICABLE**
17.	Report on progress against Green Plan in accordance with SC18.2	Annually	To be agreed as part of contract implementation	To be agreed as part of contract implementation	**All** **APPLICABLE**
Local Requirements Reported Locally					
Access		*Trend data* *Monthly report: a, d, i*	*Trend data* *See Annex B*	*Report due 15 operational days after the end of the reporting*	*Applicable*

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Trend data *To understand trends on access to NHS Practitioner Health:* a. *Number of service users accessing the service (caseload)* b. *How service users are accessing the service, via annual survey* c. *When service users are accessing the service, via review of phone and web records* d. *Attendance rates of service users* e. *DNAs* f. *Where service users are accessing the service* g. *What services service users are accessing and frequency* h. *Demographic of service users accessing the service* i. *When service users are re-admitted to the service following discharge* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the accessibility of the service, service users will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health.*	*Quarterly Report: e, f, g, h* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements: b,c* • *1st April – 30th Sept* • *1st Oct – 31st March*	*Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E*	*period*	
Responsiveness *Trend data* *To understand trends on responsiveness of NHS Practitioner Health:* 1. *Number of service users successfully triaged into NHS Practitioner Health Local Clinical services* a. *Within the Practitioner's own catchment area (in area) in set timeframe* b. *Not within the Practitioner's own catchment area (out of area) in set timeframe* 2. *Timeliness of referral into local clinical services following initial contact, between the respective channels* 3. *Frequency of sessions for:* a. *Treatments*	*Trend data* *Quarterly Report:* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March* *Re 3 a,b,c NHS Practitioner Health to confirm the frequency of appointments related to RAG status, frequency of CBT and Groups*	*Trend data* *See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E*	*Report due 15 operational days after the end of the reporting period*	*Applicable*

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
b. *Case management* c. *Group sessions* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the accessibility of the service, Practitioners will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health*	*Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*			
Continuity of Care *Trend data* *To understand trends on responsiveness of NHS Practitioner Health:* 1. *Number of service users on NHS Practitioner Health caseload: (including treatment duration)* 2. *Caseload risk status for Practitioners in NHS Practitioner Health* 3. *Number of service users undergoing each treatment type and duration* 4. *Number of service users in NHS Practitioner Health who are:* a. *Not in Clinical Practice looking to return to clinical practice* b. *Undergoing Interim order panel (IOP) or Fitness to Practice review by a regulatory body* c. *Subject to NHS England Performer List Regulations* d. *Suspended from the Performers list* e. *Presenting with Mental ill-health beyond the treatment scope of NHS Practitioner Health* 5. *Number of Practitioners who have returned to clinical practice following treatment* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the continuity of the service, Practitioners will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health*	*Trend data* *Monthly report: 1,2,3* *Quarterly Report: 4,5* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*	*Trend data* *See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E*	*Report due 15 operational days after the end of the reporting period*	*Applicable*
Reputation	*Trend data*	*Trend data*	*Report due 15 operational days*	*Applicable*

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
Trend data *To understand trends on the reputation of NHSPH from feedback via:* 1. *Stakeholder engagement* 2. *Commissioner Oversight* 3. *Other networks where applicable* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the reputation of the service, Practitioners will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health. Key stakeholders will be invited to respond to a survey on their experience within NHS Practitioner Health*	1. *Stakeholder meetings* 2. *Oversight meetings* 3. *Other feedback via annual stakeholder questionnaire* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*	*See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E & F*	*after the end of the reporting period*	
Engagement *Trend data* *To understand trends on the effective engagement of NHS Practitioner Health, from feedback via:* 1. *Stakeholder engagement* 2. *Commissioner Oversight* 3. *Other networks where applicable* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the engagement requirements of the service, key stakeholders will be invited to respond to a survey on their experience within NHS Practitioner Health*	*Trend data* 1. *Stakeholder meetings* 2. *Oversight meetings* 3. *Other feedback via annual stakeholder questionnaire* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*	*Trend data* *See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex F*	*Report due 15 operational days after the end of the reporting period*	*Applicable*
Confidentiality *Trend data* *To understand trends on the confidentiality of NHS Practitioner Health, from feedback via:* 1. *Stakeholder engagement* 2. *Commissioner Oversight* 3. *Other networks where applicable*	*Trend data* 1. *Stakeholder meetings* 2. *Oversight meetings* 3. *Other feedback via annual stakeholder questionnaire,*	*Trend data* *See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E & F*	*Report due 15 operational days after the end of the reporting period*	*Applicable*

	Reporting Period	Format of Report	Timing and Method for delivery of Report	Application
4. *Practitioner* 5. *Report on breaches* 6. *Audit on access to confidential systems* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the confidentiality of the service, Practitioners will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health. Key stakeholders will be invited to respond to a survey on their experience within NHS Practitioner Health.*	4. *Annual Service user questionnaire* 5. *When it occurs* 6. *When it occurs* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*			
Responsiveness *Trend data* *To understand trends on responsiveness of NHS Practitioner Health:* 2. *Number of service users successfully triaged into NHS Practitioner Health Local Clinical services* b. *Within the Practitioner's own catchment area (in area) in set timeframe* c. *Not within the Practitioner's own catchment area (out of area) in set timeframe* 3. *Timeliness of referral into local clinical services following initial contact, between the respective channels* 4. *Frequency of sessions for:* b. *Treatments* c. *Case management* d. *Group sessions* *Key Performance Indicators (KPIs), with regard to Schedule 4C: Local Quality Requirements* *To measure how the service is performing in regard to the accessibility of the service, Practitioners will be invited to respond to a satisfaction survey on their experience within NHS Practitioner Health*	*Trend data* *Quarterly Report:* • *1st April – 31st June* • *1st July – 30th Sept* • *1st Oct – 31st Dec* • *1st Jan – 31st March* *Re 3 a,b,c NHS Practitioner Health to confirm the frequency of appointments related to RAG status, frequency of CBT and Groups* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* • *1st April – 30th Sept* • *1st Oct – 31st March*	*Trend data* *See Annex B* *Key Performance Indicators (KPIs), as per Schedule 4C: Local Quality Requirements* *See Annex E*	*Report due 15 operational days after the end of the reporting period*	*Applicable*

Annex A – Activity Highlight Report (monthly)

New Patients													
New Patients	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FY
London patients Registered	0	0	0	0	0	0	0	0	0	0	0	0	0
Of Which were re-engaging	0	0	0	0	0	0	0	0	0	0	0	0	0

Risk Rating of Caseload												
London Patients	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Green	0	0	0	0	0	0	0	0	0	0	0	0
Amber	0	0	0	0	0	0	0	0	0	0	0	0
Red	0	0	0	0	0	0	0	0	0	0	0	0
Other assessment only	0	0	0	0	0	0	0	0	0	0	0	0
Unassigned	0	0	0	0	0	0	0	0	0	0	0	0
Total London Caseload	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	0	0	0	0	0	0	0	0	0	0	0	0

Patients by Category												
London Patients	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Minor Mental Health	0	0	0	0	0	0	0	0	0	0	0	0
Major Mental Health	0	0	0	0	0	0	0	0	0	0	0	0
Multiple Diagnosis	0	0	0	0	0	0	0	0	0	0	0	0
Addictions	0	0	0	0	0	0	0	0	0	0	0	0
Physical	0	0	0	0	0	0	0	0	0	0	0	0
Other - Assessment only	0	0	0	0	0	0	0	0	0	0	0	0
Unassigned	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	0	0

PHP referrals	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	All (inc Outstanding liabilities)
PHP total referrals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In-Patient Admissions (referrals)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Daycare (referrals)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Psychotherapy (referrals)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Psychotherapy (authorised sessions)	0	0	0	0	0	0	0	0	0	0	0	0	0
CBT referrals (referrals)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CBT referrals (authorised sessions)	0	0	0	0	0	0	0	0	0	0	0	0	0

PHP2 Costs	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	All (inc Outstanding liabilities)
Funds transferred on account	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	**£0**
In Patient Admissions	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Daycare	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
Psychotherapy	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
CBT (external providers)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0
											Total		**£0**
											Remaining		**£0**

Annex B – Activity (trend data) and Finance Report (Quarterly)

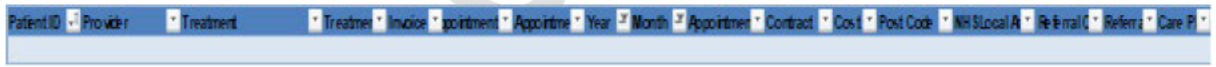
As above plus numbers and graphs showing:

- *Sex*
- *Ethnicity*
- *Specialty (where appropriate)*
- *CCG / area of residence*
- *Equality monitoring including:*
  - *Sexual orientation*
  - *Disability*
  - *Religion*

Performance indicators as below:

Performance Indicator	*Indicator*	*Method of Measurement*
Care / case management	% of cases discussed at MDT	% of total GPH caseload
	% of new patients discussed at MDT	% of Total New patients in Quarter
	MDTs with Medical Director involvement	% of MDTs
	No of patients discharged	No. of patients in quarter
Outcomes	Abstinence rate	Quarterly snapshot based on last known status
	Return to work rate	Quarterly snapshot based on last known status
Quality	Number of complaints	Number of complaints
	Number of critical incidents	Number, seriousness and reporting (see Schedule 11)
Re-admissions / relapse	All patients split by mental health and addiction	Log of re-presentations post discharge
Improving productivity	Did not attend	No of DNAs per quarter
	No of sessions cancelled by PHP 1 clinicians	No. of cancellations per month and cumulatively over year
	No & % of patients exceeding treatment limits	No. patients exceeding 2 years+, how many have regulator involvement
		No. patients exceeding 5 years+, how many have regulator involvement

Finance reconciliations as per the combined patient records and booking app spreadsheet showing:



Proms data template still being developed.

Annex C – Exception Report (Incidents/events requiring escalation)

As appropriate given the circumstances – template example provided below.

Example reporting template: Complaints, Incidents & Compliments Reporting Proforma:

Supplier name: Service: Reporting period:		Report compiled by: Date report compiled:	

Complaints

No./ Date	Informal (I) or Formal (F)	Description:	Consequences to service user	Immediate Action Taken:	Learning for Organisation / Longer Term Action Taken

Untoward Incidents

No./ Date	Description:	Consequences to service user	Immediate Action Taken:	Learning for Organisation / Longer Term Action Taken

Compliments

(Please provide details of positive feedback that you would like to include. This can include positive feedback from individual patients, patient and carer letters and/or patient surveys etc. What went well? What did patients like?)

Annex D – Compliance with National Workforce Race Equality Standard Report (Annual)

Commissioner and Provider to agree

Annex E – Practitioner Health patient Survey (extract)

NHS Practitioner Health Patient Survey

1. INTRODUCTION

NHS Practitioner Health was commissioned in 2019, building on the previous NHS GP Health service to provide mental health services for all doctors and dentists in England. We are asking for feedback on experiences of patients who have accessed the service to support further development and ensure we are meeting the needs of patients. We would be very grateful if you could take the time to complete this survey, which we believe will take between 10-15 minutes. Your responses will be kept strictly anonymous and no feedback will be attributable to you. Disclaimer: The information collected by this survey will primarily be used by the commissioner (NHS England) and provider (NHS Practitioner Health) of this service for quality assurance and service development purposes. This information could also be used for other purposes such as research and communications about the performance of the service. By completing this survey you are consenting for this information to be used in this way. Remember - your responses will be kept strictly anonymous and no feedback will be attributable to you personally.

2. FRIENDS AND FAMILY TEST

1. How likely are you to recommend our service to friends and family (who are eligible) if they need similar care or treatment?

- [ ] Extremely likely
- [ ] Likely
- [ ] Neither likely nor unlikely
- [ ] Unlikely
- [ ] Extremely Unlikely
- [ ] Don't know

GPH Patient Survey.docx

Annex F – Stakeholder Survey

No template developed as yet.

Annex G – Patient Reported Outcome Measures (PROMS) Survey

To be agreed between the Commissioner & Provider.

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.

To be completed as required following contract implementation and via contract management

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date
Indicators of health improvement and improved wellbeing	TBC	Use the info gathered through patient questionnaires (e.g. GAD, Core OM etc.)	TBC

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
Exception Report The Provider is required to complete an exception report (which template will be developed on contract award) and send to the Commissioner to report on all incidents as set out in these contract particulars. This includes (but not limited to) activity as set out in: • Schedule 2A section 3.4.7 Continuing care relationship with Practitioner's own GP • Schedule 2A section 3.4.9 Principles for long term relationships with the Practitioner • Schedule 2G section 1: Terms of Performer Escalation • SC33 Incidents Requiring Reporting • Schedule 2G section 3: Information Governance Toolkit Compliance, and GC21: Patient Confidentiality, Data Protection, Freedom of Information and Transparency

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
Review of service use and requirements by area	Quarterly review	Quarterly review	To enable understanding of need and adjust capacity appropriately To identify areas of low service use and consider appropriate actions
Evaluation of outcomes in terms of patient improvement and wellbeing	Quarterly and Annual review	Quarterly and Annual review	To enable learning re best clinical practice and provide evidence of improved outcomes

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	Ongoing and sent to each patient	Through contract monitoring and annual review	Not published currently	**All**
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	As required nationally	As required nationally	As required nationally	**All**
As set out in Schedule 6A				

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Provider Data Processing Agreement

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	*Patient records, quality and reporting, and financial data.*
Duration of the processing	*As per this contract term*
Nature and purposes of the processing	*As required to support delivery of the NHS Practitioner Health service, and as required by schedule 4 and Schedule 6.*
Type of Personal Data	*Personal data of Service Users and staff, including name, DoB, address, contact details, personal demographic data (sex, religion, etc) and clinical records associated with this service.*
Categories of Data Subject	*Staff (including volunteers, agents, and temporary workers), suppliers, patients, members of the public, users of a particular website.*
Plan for return and destruction of the data once the processing is complete UNLESS requirement under law to preserve that type of data	*Data on current and previous patients are retained by NHS Practitioner Health (in case of re-admission) and secured by the incumbent provider. This data is subject to transfer to an alternate Supplier should this contract or new contract be transferred to a newly appointed Supplier following re-procurement.* *In scope of the above, relevant data protection legislation applies.*

SCHEDULE 7 – PENSIONS

The Provider is responsible for any arrangements to enable staff to access pensions via the relevant Pension Authority. Pension costs are included in Schedule 3A.

SCHEDULE 8 – LOCAL SYSTEM PLAN OBLIGATIONS

Not Applicable

SCHEDULE 9 – SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT AGREEMENT

Not Applicable.

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