

NHS Standard Contract 2022/23

Particulars (Full Length)

Contract title / ref: Sussex

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Contract Reference	C63366
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DATE OF CONTRACT	As per signature
SERVICE COMMENCEMENT DATE	1st August 2022
CONTRACT TERM	As set out in paragraph 3.11 of Schedule 2A (Service Specification) subject to early termination
COMMISSIONERS <i>Note: contracts signed before the formal establishment of the relevant successor ICB(s) must list and be signed on behalf of the relevant CCGs</i>	NHS Commissioning Board ("NHS England")
CO-ORDINATING COMMISSIONER <i>See GC10 and Schedule 5C</i>	NHS Commissioning Board ("NHS England")
PROVIDER	PULSE HEALTHCARE LIMITED TRADING AS XYLA HEALTH & WELLBEING ODS ([AQML]) Principal and/or registered office address: Turnford Place, Great Cambridge Road, Turnford, Broxbourne Company number: 03156103

CONTENTS

PARTICULARS

CONTENTS.....	
SCHEDULE 1 – SERVICE COMMENCEMENT	
A. Conditions Precedent	
B. Commissioner Documents.....	
C. Extension of Contract Term	
SCHEDULE 2 – THE SERVICES	
A. Service Specifications	
Ai. Service Specifications – Enhanced Health in Care Homes	
Aii. Service Specifications – Primary and Community Mental Health Services	
B. Indicative Activity Plan	
C. Activity Planning Assumptions.....	
D. Essential Services (NHS Trusts only)	
E. Essential Services Continuity Plan (NHS Trusts only)	
F. Clinical Networks	
G. Other Local Agreements, Policies and Procedures	
H. Transition Arrangements.....	
I. Exit Arrangements	
J. Transfer of and Discharge from Care Protocols	
K. Safeguarding Policies and Mental Capacity Act Policies	
L. Provisions Applicable to Primary Medical Services	
M. Development Plan for Personalised Care	
N. Health Inequalities Action Plan	
SCHEDULE 3 – PAYMENT.....	
A. Local Prices	
B. Local Variations	
C. Local Modifications.....	
D. Aligned Payment and Incentive Rules	
E. CQUIN.....	
F. Expected Annual Contract Values.....	
G. Timing and Amounts of Payments in First and/or Final Contract Year ..	
SCHEDULE 4 – LOCAL QUALITY REQUIREMENTS.....	
SCHEDULE 5 – GOVERNANCE.....	
A. Documents Relied On	
B. Provider’s Material Sub-Contracts.....	
C. Commissioner Roles and Responsibilities.....	
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS.....	
A. Reporting Requirements	
B. Data Quality Improvement Plans.....	
C. Incidents Requiring Reporting Procedure	

D.	Service Development and Improvement Plans
E.	Surveys
F.	Data Processing Services.....
SCHEDULE 7 – PENSIONS	
SCHEDULE 8 – JOINT SYSTEM PLAN OBLIGATIONS	

SERVICE CONDITIONS

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

Annex A National Quality Requirements

Annex B Provider Data Processing Agreement

GENERAL CONDITIONS

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

Definitions and Interpretation

CONTRACT

Contract title: NDPP FRAMEWORK 3 – LOT 11 SUSSEX

Contract ref: C63366

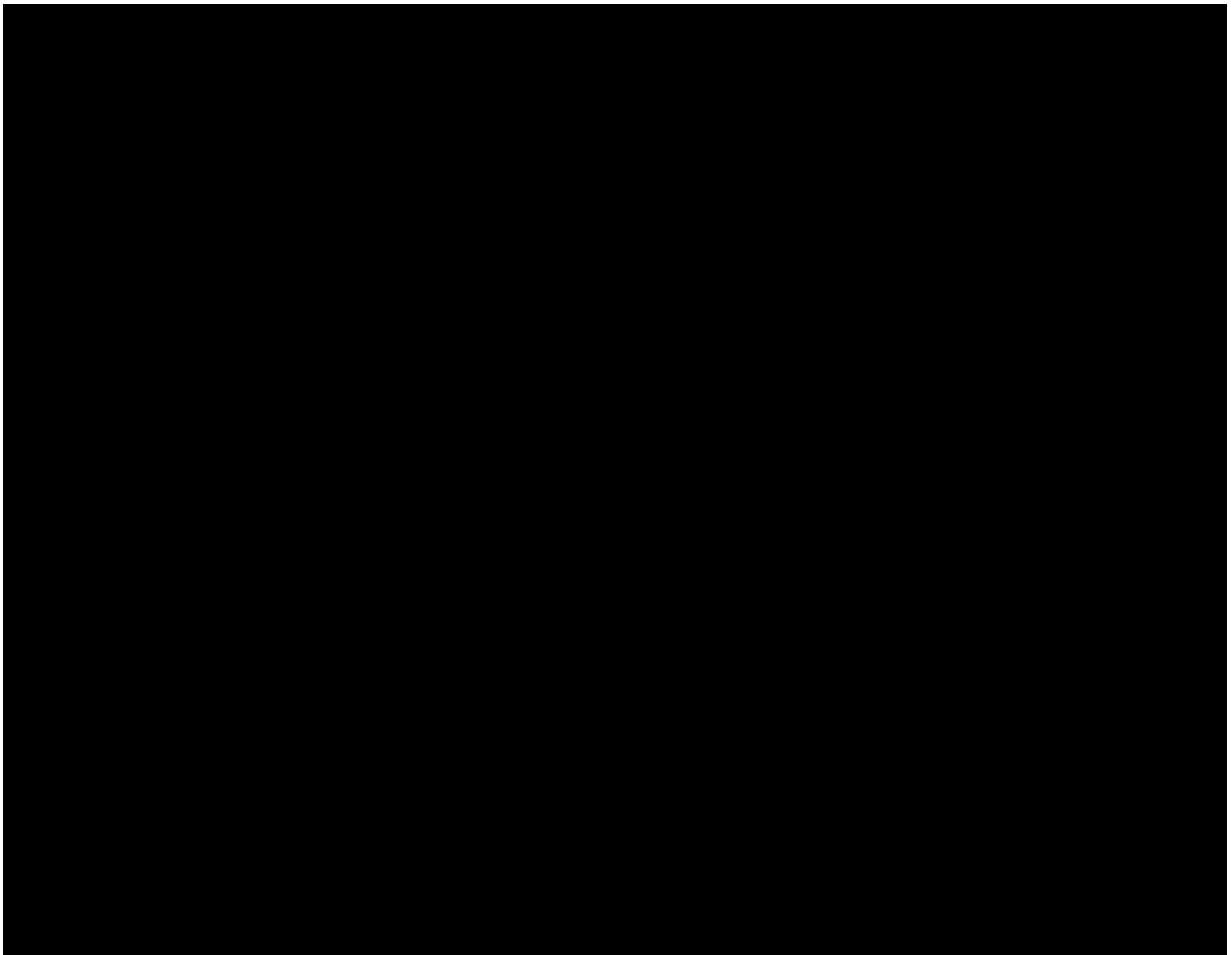
This Contract records the agreement between the Commissioners and the Provider and comprises

1. these **Particulars**, as completed and agreed by the Parties and as may be varied from time to time in accordance with GC13 (*Variations*);
2. the **Service Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>;
3. the **General Conditions (Full Length)**, as published by NHS England from time to time at: <https://www.england.nhs.uk/nhs-standard-contract/>.

Each Party acknowledges and agrees

- (i) that it accepts and will be bound by the Service Conditions and General Conditions as published by NHS England at the date of this Contract, and
- (ii) that it will accept and will be bound by the Service Conditions and General Conditions as from time to time updated, amended or replaced and published by, NHS England pursuant to its powers under Regulation 17 of the National Health Service Commissioning Board and Clinical Commissioning Groups (*Responsibilities and Standing Rules*) Regulations 2012, with effect from the date of such publication.

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



SERVICE COMMENCEMENT AND CONTRACT TERM

Effective Date <i>See GC2.1</i>	Date of Contract
Expected Service Commencement Date <i>See GC3.1</i>	1st August 2022
Longstop Date <i>See GC4.1 and 17.10.1</i>	31st August 2022
Contract Term	As set out in paragraph 3.11 of Schedule 2A (Service Specification) subject to early termination
Commissioner option to extend Contract Term <i>See Schedule 1C, which applies only if YES is indicated here</i>	Yes By up to 12 months x 2 (24 months total)
Commissioner Notice Period (for termination under GC17.2)	6 months
Commissioner Earliest Termination Date (for termination under GC17.2)	6 months from Commencement Date
Provider Notice Period (for termination under GC17.3)	6 months
Provider Earliest Termination Date (for termination under GC17.3)	6 months after the Service Commencement Date

SERVICES	
Service Categories	Indicate <u>all</u> categories of service which the Provider is commissioned to provide under this Contract. <i>Note that certain provisions of the Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others.</i>
Accident and Emergency Services (Type 1 and Type 2 only) (A+E)	
Acute Services (A)	
Ambulance Services (AM)	
Cancer Services (CR)	
Continuing Healthcare Services (including continuing care for children) (CHC)	
Community Services (CS)	
Diagnostic, Screening and/or Pathology Services (D)	
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	
Mental Health and Learning Disability Secure Services (MHSS)	
NHS 111 Services (111)	
Patient Transport Services (PT)	
Radiotherapy Services (R)	
Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)	
Service Requirements	
Prior Approval Response Time Standard See SC29.25	Not applicable
GOVERNANCE AND REGULATORY	
Nominated Mediation Body (where required – see GC14.4)	
Provider's Nominated Individual	
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	██████████████████ ██████████████████████████████████████ ██████████
Provider's Prevent Lead	██████████████████ ██████████████████████████████████████ ██████████
Provider's Freedom To Speak Up Guardian(s)	██████████████████ ██████████████████████████████████████ ██████████
Provider's UEC DoS Contact	Not applicable
Commissioners' UEC DoS Leads	Not applicable
Provider's Infection Prevention Lead	██████████████████ ██████████████████████████████████████ ██████████
Provider's Health Inequalities Lead	██████████████████ ██████████████████████████████████████ ██████████
Provider's Net Zero Lead	██████████████████

Provider's 2018 Act Responsible Person	
CONTRACT MANAGEMENT	
Addresses for service of Notices <i>See GC36</i>	
Frequency of Review Meetings <i>See GC8.1</i>	Monthly
Commissioner Representative(s) <i>See GC10.3</i>	
Provider Representative <i>See GC10.3</i>	

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

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

1. Evidence of appropriate Indemnity Arrangements
2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required)
3. In relation to the Data Security and Protection Toolkit ("DSPT") - the published results confirming the Provider has met the standards of the DSPT and met the audit requirements in relation to the DSPT set out in the Contract
4. In relation to the Digital Technology Assessment Criteria ("DTAC"), evidence that the Provider has met the assessment criteria of the DTAC
5. Evidence that the Provider has carried out Enhanced DBS & Barred List Checks in respect of all members of Staff engaged in the Services who are eligible for such checks
6. If the Provider's Digital Service is by its nature a service to which NHS Digital's "Identity Verification and Authentication Standard for Digital Health and Care Services" applies, then evidence that the Provider adheres to this standard

The Provider must complete the following actions:

Not Applicable

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

B. Commissioner Documents

Date	Document	Description
Not Applicable		

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

1. As advertised to all prospective providers before the award of this Contract, the Commissioners may opt to extend the Contract Term by up to 24 months from service commencement date.
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:
 - 3.1. only on or before the date referred to in paragraph 2 above;
 - 3.2. only by the Commissioner; and
 - 3.3. only in respect of all Services
4. If the Co-ordinating Commissioner gives notice to extend the Contract Term in accordance with paragraph 2 above, the Contract Term will be extended by the period specified in that notice and the Expiry Date will be deemed to be the date of expiry of that period.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification

All defined terms set out in this document reflect the definitions contained within the Call-off Contract unless defined in this document

Service Specification No.	1
Service	Provision of behavioural interventions for people with non-diabetic hyperglycaemia or people with normoglycaemia with a previous history of gestational diabetes
Commissioner Lead	NHS England
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National / local context and evidence base

1.1.1 Introduction to the NHS Diabetes Prevention Programme

The Healthier You NHS Diabetes Prevention Programme (NDPP) is a joint initiative between NHS England & Improvement (NHSE&I), Public Health England and Diabetes UK. It delivers services across the whole of England for people with non-diabetic hyperglycaemia or women with a previous history of gestational diabetes and normoglycaemia, who are at high risk of developing Type 2 diabetes. Eligible individuals are offered a behavioural intervention which will continue for a period of 9 months ('the "Service"') to support and motivate them to reduce their risk of developing Type 2 diabetes through weight loss and/or a reduction in their blood glucose parameters, as a result of improved diet and increased levels of physical activity.

Diabetes constitutes a major burden on public health and preventative action is necessary to prevent the onset of the condition for those at high risk. A recent report published by Diabetes UK (2021)¹ estimates that the number of individuals at increased risk of type 2 diabetes could now be as high as 13.6 million people across the whole of the UK; a report published by the National Cardiovascular Intelligence Network (NCVIN)² suggests that the average prevalence of non-diabetic hyperglycaemia in England is 10.7%, which equates to approximately five million people. The report describes how prevalence is higher among Black, Asian and Minority Ethnic groups (and onset is often at a younger age in these groups), and that prevalence increases with age and obesity.

The NDPP is modelled on proven UK and international models. The first NDPP Framework Agreement was implemented in 2016 becoming the first national evidence-based diabetes prevention programme. By 2018 in-person group-based services were being offered across the whole of England and in 2019 the second NDPP Framework Agreement, comprising of improved in-person services and new digital services, was implemented and rolled out across

¹ Diabetes UK. 2021. Diabetes Can't Wait.

² National Cardiovascular Intelligence Network. 2015. NHS Diabetes Prevention Programme (NDPP) Non-diabetic hyperglycaemia. Public Health England.

England by 2020. The NHS Long Term Plan, published in 2019, made a commitment to double the size of the NDPP to support 200,000 people every year by 2023/24.

In January 2020 early outcomes from the NDPP were [published](#) in Diabetes Care (American Diabetes Association)³. Reductions in weight and HbA1c compare favourably to those reported in recent meta-analyses of pragmatic studies and suggest likely future reductions in participant type 2 diabetes incidence.

NDPP services are procured under the NDPP Framework Agreement by the Commissioner for local health economies, and the geographical scope of the Services under individual call-off contracts are based on Integrated Care System (“ICS”) areas. ICS partnerships and primary care are responsible for identifying and referring eligible participants and until March 2020 successfully generated sufficient referrals to meet Long Term Plan targets. In 2019/20 this resulted in 170,000 referrals and circa.120,000 people supported on the NDPP.

In March 2020 in response to the COVID-19 pandemic, all in-person delivery was paused and the NDPP converted to remote video and teleconference delivery to continue to support those already participating in the NDPP, as well as continuing to accept new referrals for those at risk of developing Type 2 diabetes.

The Commissioner has expanded the scale of the NDPP following the first two NDPP Framework Agreements and is building on learning in order to offer improved in-person group-based services (the “**Face to Face Service**”) and online and app based digital services (the “**Digital Service**”) as the primary intervention offer, along with tailored remote group-based sessions for those cohorts of Service Users that are more likely to experience health inequalities (the “**Tailored Remote Service**”). Remote sessions will also be available for participants in the Face to Face Service who require a remote catch-up in place of a missed in-person session.

For the avoidance of doubt, in this Service Specification references to the delivery of “remote” sessions means with Service Users and the Staff delivering the sessions not being physically present at the same location but having face to face contact through a suitable videoconferencing and teleconferencing platform such as MS Teams, Zoom or Skype or other similar platform.

Analysis undertaken on the NDPP minimum dataset has concluded that where an element of choice had been offered to participants with regards to delivery channels, uptake rates for the NDPP were evidently higher for both younger and older age groups. Similarly, the analysis also detailed good completion rates and outcomes across digital, remote and face to face delivery channels with regards to the mean weight change, with an average of 3.2kg weight loss amongst participants who went on to complete the NDPP.

Evidence from diabetes structured education management shows that people learn in different ways and offering more flexible ways to learn has been shown to increase engagement in self-management and to deliver increased knowledge and confidence (Kings Fund level 2 review, Diabetes UK 2016).

In line with NICE guidance (NG183, October 2020) and based on analysis of previous delivery of the NDPP, and in order to support Service User choice and widened access, the overriding principle of the Service will be that all Service Users must be given unconstrained choice between the Face to Face Service and Digital Service, with a remote service offered to Service Users in the Face to Face Service who miss a session and require a catch-up on content prior to their next scheduled in-person group meeting.

The Tailored Remote Service must also be offered to Service Users upfront as an alternative to the Face to Face Service and the Digital Service but only to particular cohorts or groups who are at higher risk of experiencing health inequalities as set out in this Service Specification, paragraph 3.2.6.

Where the Provider is not providing the Digital Service, the term “Service” relates only to the Face to Face Service and Tailored Remote Service.

³ Diabetes Care. 2019. Early Outcomes From the English National Health Service Diabetes Prevention Program. <https://care.diabetesjournals.org/content/early/2019/11/11/dc19-1425>

2. Outcomes

2.1 Expected outcomes of the NDPP

- | Reduction in incidence of Type 2 diabetes among Service Users as a result of the intervention;
- | Reduction in weight of Service Users where they are overweight or obese, and the maintenance of a healthy weight; and
- | To reduce blood glucose parameters (HbA1c or Fasting Plasma Glucose (FPG)) in Service Users at 12 months from referral and beyond.

3. Scope

3.1 Aims of the Service

The primary aim of the Service is to prevent Type 2 diabetes. All aspects of the Service must be delivered by the Provider in accordance with the NDPP outcomes and with the aim of achieving three core aims:

- Support people to achieve or maintain a healthy body weight, having appropriate regard to achievement of UK dietary recommendations related to fibre, fruit and vegetables, oily fish, saturated fat, salt and free sugars;⁴
- Support people to increase their physical activity and reduce sedentary behavior, and wherever appropriate achieve the England Chief Medical Officer's (CMO) physical activity recommendations;
- To maximise completion rates of Service Users, including across groups that share a protected characteristic.

The above goals are for the Service as a whole, and at an individual Service User level goals must be tailored to suit individual Service User requirements.

A secondary aim of the Service is to establish sound data collection mechanisms to ensure that the effectiveness of the Service in reducing the long term microvascular and cardiovascular complications of Type 2 diabetes, as well as to reduce the associated higher mortality risk, can be assessed over time. It is also to establish the evidence base for the effectiveness of the Service in delivering outcomes.

The tertiary aims of the Service are to continue to build the evidence base around the effectiveness of remote or digital approaches to diabetes prevention and to develop and build an evidence base around the effectiveness of tailored approaches for harder to reach cohorts and other specific groups.

3.2 Service description / care pathway

3.2.1 Principles

The Provider will deliver the Services in accordance with the following principles:

- The Provider must provide the Services in accordance with this Schedule 2A and the Annexes and Appendices to this Schedule 2A;
- The content of the sessions must aim to empower people at risk of Type 2 diabetes to take a leading role in establishing and maintaining long-term behaviour changes;
- Delivery of the Services will be tailored to the individual circumstances of all Service Users, including age, physical wellbeing or frailty, weight, personal goals, cultural considerations and culinary traditions;

⁴ Full references for government dietary guidelines are provided in Annex 1

- The Service must aim to ensure equal access by all Service User groups, reduce health inequalities and promote inclusion, tailoring the Services to support and target those with greatest need through a proportionate universalism approach and equality of access for people with protected characteristics under the Equality Act 2010;
- Access to Services will accommodate the diverse needs of the target population in terms of availability (including any out of hours provision), accessibility, customs and location (where relevant), as far as possible;
- The Provider must build effective working relationships with relevant local stakeholders (including local health economies and community sector organisations) to plan and support referral generation and deliver an inclusive programme;
- The Provider must maximise the flexibility of their offering in order to increase reach for all, including communities who face the most barriers to access;
- The Provider must ensure Service User involvement in the co-production/co-design of the Service;
- The Provider must ensure Service User involvement and engagement in the evaluation and improvement of Services;
- The Service interventions must be developed in consultation with behaviour change specialists;
- The Provider must engage proactively with primary care services whilst ensuring that the impact on workload for existing providers of primary care services is minimised;
- All individuals must be treated with courtesy, respect and an understanding of their needs;
- All individuals invited to participate in the Service must be offered the Face to Face Service in line with NICE Guideline NG183 (October 2020);
- All individuals invited to participate in Services must be provided with adequate information and full transparency on the delivery channels available and their associated benefits and risks, in a format which is accessible to them. This information must allow an informed decision to be made by the individual on which delivery intervention is most appropriate to their personal circumstances and preference, in order to maximise NDPP uptake.
- Ongoing improvements and adjustments will be made to the delivery of the Services as new evidence, standards and/or guidance emerges. The Provider acknowledges and agrees that the Services may be adjusted to respond to best available evidence, including (by way of example only) as a result of planned innovation-testing evaluation (e.g. a research project or time-limited pilot of an innovation to improve the Services). Any such adjustments would be effected as a variation to this Contract in accordance with the variation procedure set out in General Condition 13 (Variations).

Subject to the bullet point immediately below, in the event and to the extent only of a conflict between any of the provisions of this Service Specification and Appendix 1 (Tender Response Document) and/or Appendix 2 (Local Service Requirements) of this Schedule 2A, the conflict shall be resolved in accordance with the following descending order of precedence:

- this Service Specification;
- Appendix 1 of Schedule 2A (Tender Response Document);
- Appendix 2 of Schedule 2A (Local Service Requirements).

Where Appendix 1 of Schedule 2A (Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) contains provisions which are more favourable to the Commissioner in relation to the Service Specification and/or Appendix 1 of Schedule 2A (Tender Response Document) as relevant, such provisions of Appendix 1 of Schedule 2A

(Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) shall prevail.

The Commissioner shall in its absolute and sole discretion determine whether any provision in Appendix 1 of Schedule 2A (Tender Response Document) or Appendix 2 of Schedule 2A (Local Service Requirements) is more favourable to it in relation to the Service Specifications and/or Appendix 1 of Schedule 2A (Tender Response Document) as relevant.

3.2.2 Eligibility

The Services are available to the following:

- individuals aged 18 years or over, up to and including eighty years old. Individuals who are over eighty years old are eligible to access the Service if their GP provides written confirmation to the Provider that the GP perceives the benefits of the NDPP to outweigh any potential risks of participating in a weight loss programme for that individual;
- individuals who have 'non-diabetic hyperglycaemia', defined as having an HbA1c of 42 – 47 mmol/mol (6.0 – 6.4%) or an FPG of 5.5 – 6.9 mmol/l within the 12 months prior to the date of referral into the Service. This excludes individuals with a previous diagnosis of Type 2 diabetes from any time in the past, regardless of whether their latest blood reading is within the non-diabetic hyperglycaemic range;
- individuals who have a previous history of Gestational Diabetes Mellitus (GDM) and 'normoglycaemia', defined as having an HbA1c lower than 42 mmol/mol or an FPG of less than 5.5 mmol/l within the 12 months prior to date of referral into the Service.
- where an additional self-referral pathway is required in accordance with paragraph 3.2.5, individuals who achieve a qualifying risk score [to be defined by the Commissioner] when completing the Know Your Risk assessment tool will be eligible for the NDPP.

Where both HbA1c and FPG blood readings are provided on referral, if all readings are NDH (or normal for women with previous GDM) the individual is eligible for the NDPP. Where any reading is in the diabetic range (HbA1c ≥ 48 mmol/mol or FPG ≥ 7 mmol/l) the individual is not eligible for the NDPP and must be referred back to their GP for further diagnostic clarification. Where one reading is normal and the other is in the non-diabetic hyperglycaemic range the individual is eligible for the Service.

Oral Glucose Tolerance Testing (OGTT) is rarely used now clinically for diagnosis of hyperglycaemia outside pregnancy; in pregnancy it is used to assess for gestational diabetes. However, it is acknowledged that there may be circumstances where impaired glucose tolerance has been identified in an individual through OGTT (2 hour post 75 gram glucose load glucose value ≥ 7.8 and < 11.1 mmol/l), and such individuals are eligible for the Service.

3.2.3 Exclusion criteria

The following individuals must be excluded from the Service:

- Individuals with an existing or previous diagnosis of Type 2 diabetes at any time in the past;
- Individuals with an active eating disorder;
- Individuals on referral who do not meet the eligibility criteria as defined in paragraph 3.2.2 above;
- Individuals with severe/moderate frailty as recorded on a frailty register;
- Individuals who have undergone bariatric surgery in the last two years;
- Individuals aged under 18 years; and/or
- Pregnant women.

If a Service User becomes pregnant whilst participating in the Service, the Provider must tailor the Service accordingly, following the specification set out in NICE Guideline PH27, for example adjusting any weight loss goals. This guidance stipulates recommendations for diet, physical activity and weight management during pregnancy.

3.2.4 Referral pathway

The principal referral routes into the Service will be through General Practice and Health Checks. For General Practice these include identification of eligible Service Users and referral via opportunistic direct referrals of patients, centralised searches of GP systems or through annual glycaemic reviews for eligible cohorts.

The Provider must be able to receive and accept eligible referrals from all agreed pathways and will collaborate with local health economies to develop and agree additional referral routes into the NDPP and associated protocols.

3.2.5 Self-referral pathway

The Commissioner may require the Provider to implement a self-referral pathway as part of the Service to widen access to the NDPP, improve equity of access and increase referral volumes. If the Commissioner so requires, it shall notify the Provider and will indicate from when, for how long, and for whom self-referrals must be accepted alongside any additional financial arrangements.

This referral route into the Service will be additional to, and will not replace the principal referral routes through GP Practices and Health Checks listed in paragraph 3.2.4.

Eligibility for self-referral will be based upon a threshold score generated through completion of an online 'Know Your Risk' tool by potential Service Users. The Commissioner may require the Provider to embed a version of this tool upon their website or to accept self-referrals directed to the Provider via an NHS operated or NHS commissioned online 'Know Your Risk' tool host.

The 'Know Your Risk' tool, which is currently available at <https://riskscore.diabetes.org.uk/start>, asks a series of basic questions including: age, weight, Body Mass Index (BMI), family history of diabetes and ethnicity to generate a risk score. The Commissioner may require the Provider to accept referrals based on any risk score and will notify the Provider what risk score to use as the basis for eligibility to the NDPP.

Self-referrals will not require a blood test eligibility as described in paragraph 3.2.2, but all Service Users must be informed of the importance of seeking a blood test from their GP. All other eligibility criteria described in paragraph 3.2.2 and exclusion criteria described in paragraph 3.2.3 will apply to self-referrals.

The Commissioner may market the self-referral pathway nationally through online and other means to promote uptake of the service (subject always to the Intervention Cap, as defined in paragraph 3.11). The Commissioner reserves the right to require the Provider to undertake additional marketing of the self-referral pathway and this must be delivered as described in paragraph 3.3.

Where the Commissioner requires the Provider to implement a self-referral pathway, the Provider must put in place arrangements to invite eligible participants that are self-referred via the self-referral pathway to participate in the Service as described in paragraph 3.2.6.

3.2.6 Invitation to participate

Subject to the Intervention Cap and Intervention Period (referred to in paragraph 3.11 of this Service Specification), the Provider will invite all referred individuals to participate in the Face to Face or Digital Service. The Provider will initiate contact with all individuals referred to them in accordance with paragraphs 3.2.4 or 3.2.5, within 5 Operational Days of receipt of the referral, inviting them to participate in either the Face to Face Service or the Digital Service and the individual will be entitled to choose whether to participate in the Face to Face Service or the Digital Service.

The Tailored Remote Service can be delivered on a cross-contract basis and will only be offered alongside the Face to Face Service and the Digital Service to individuals whom the Provider has identified as requiring tailored or specific support. These groups include, but are not limited to, the following:

- Those with a hearing impairment requiring British Sign Language;
- Those with a visual impairment;
- Women with a previous diagnosis of Gestational Diabetes;
- Service Users from Bangladeshi or Pakistani backgrounds who require a specific cultural and language tailored Service.

The Provider can request from the Commissioner agreement to deliver the provision of a Tailored Remote Service to support additional cohorts alongside those listed above, in line with local needs as identified across particular contract areas.

The Provider will work with local health economies to manage the trajectory of referrals in line with the volume of contracted interventions and work together with the local health economy and with the Commissioner to match supply and demand across the duration of the Contract.

The invitation and all follow-up contact will contain basic, accessible information about Type 2 diabetes and information about how to reduce the risk of developing Type 2. All contact made with potential Service Users must be grounded in theory and evidence from behavioural insights and the Provider must make use of templates provided by the Commissioner.

Where there is no response from the initial invitation to the potential Service User, the Provider must make additional attempts to contact the potential Service User via at least two of the following methods: letter, phone call, text message or email; within a period of one calendar month from the date of referral into the Service.

Where contact has not been established after one month

If it has not been possible to make contact after a minimum of three attempts and through different channels after one calendar month, the individual must be discharged back to their GP. A discharge notice to the individual must also be communicated, signposting them to NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Where contact has been established

Where contact has been established with referred individuals, the Provider must explain the differences between the Face to Face Service and the Digital Service and offer the individual a choice between the Face to Face Service and the Digital Service as part of the same conversation. The Provider must support individuals to make appropriate choices, but should not influence choice for commercial or operational reasons. Where an individual is identified as requiring tailored support as listed in paragraph 3.2.6, the Provider must offer the option to partake in the Tailored Remote Service intervention as an alternative to the Face to Face Service or Digital Service.

The Commissioner may require the Provider to use an approved script and set of criteria for this purpose in which case the Commissioner will notify the Provider of the script and criteria and the Provider shall use that script and criteria. This also applies to all further references in this Service Specification to the Provider offering individuals a choice between the Face to Face Service and the Digital Service (and where applicable the Tailored Remote Service).

Where contact has been established and an individual accepts an invitation to participate in the Service, the Provider must offer a choice of appropriate dates and times for the Service User's Individual Assessment (as set out in paragraph 3.2.7 below).

If the individual declines the invitation to participate in the Service on three separate occasions, they must be discharged back to their GP.

If the individual accepts the invitation to participate in the Service, the individual will become a Service User and the Provider must notify the Service User's GP that the Service User has

agreed to participate in the Service once Milestone 1 has been Achieved (as those terms are defined in Schedule 3A (Local Prices) of the Contract) in relation to that Service User. The Provider must comply with any template letters or discharge communication content that the Commissioner notifies the Provider must be used.

The Provider must comply with relevant clinical codes associated with data items and include clinical codes in all notifications as specified by the Commissioner under the Contract.

The Provider will work closely with local health economies to identify and implement a feasible and locally appropriate mechanism for ensuring data is fed back to the GP in read coded format and can be integrated within GP clinical systems; ideally by electronic transfer. The Provider will also work with the local health economies to ensure that there is a monthly update on referral and uptake rates, waiting list size and outcomes at CCG level.

Additionally the Commissioner may require the Provider to notify GPs about progression of Service Users through the Service. The Commissioner will notify the Provider if this is required and the Provider shall comply with such notification.

Where contact has been established but an individual indicates that they do not accept the Service then the individual must be discharged back to their GP. A discharge notice to the individual must also be communicated, signposting them to NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

3.2.7 Individual assessments

Individual assessments of Service Users ("Individual Assessments") form the first stage of the Service. The Provider will conduct Individual Assessments with all Service Users who accept the invitation to participate in the Service. The Provider will use Individual Assessments to confirm whether Service Users are eligible for the Service and to gather baseline data as specified in Schedule 6A. Data must be gathered at all points of Service delivery in accordance with the requirements of this Service Specification and Schedule 6A.

The Provider will also use the Individual Assessment to deliver a brief intervention in line with NICE guidelines (see NICE PH38 and PH49). The Individual Assessment may also be used as an opportunity to assess an individual's motivation for behaviour change. Motivational interviewing must be used to support Service Users in setting appropriate goals and if a desire to set unhealthy goals is identified during this process, the Service User may require additional advice on the risks of some elements of the Service (see paragraph 3.2.9).

Elements of the Individual Assessment might be conducted through remote or digital channels. Weight measurements need to be taken through calibrated and objective mechanisms for the Face to Face Service. For the Digital Service, the Tailored Remote Service and any remote catch-up sessions delivered as part of the Face to Face Service, weight measurements may be self-reported by Service Users.

If an individual has previously accepted the Service but fails to attend a scheduled and agreed Individual Assessment, the Provider must make at least two further attempts to offer an Individual Assessment at times and, where delivered in-person, venues appropriate to the individual. If the individual does not attend any of the offered Individual Assessments, the Provider must discharge the individual back to their GP, signposting the individual to the NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Attendance at Face to Face Service or Tailored Remote Service

If, following the Individual Assessment as part of the Face to Face Service or Tailored Remote Service, a Service User:

- does not attend the first group session after the Provider has offered the first group session on 3 separate occasions at times and, for the Face to Face Service, venues appropriate to the Service User;
- defers attendance at the first group session after the Provider has offered the first group session on 3 separate occasions at times and, for the Face to Face Service, venues appropriate to the Service User; or

- declines the Face to Face Service or Tailored Remote Service,

the Provider must discharge the Service User back to their GP, signposting the Service User to the NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

Where a Service User misses an in-person group session as part of the Face to Face Service, the Provider must offer a choice of either a remote catch-up session or alternative Face to Face group session to support the Service User in catching up on missed course content.

Attendance at Digital Service

If, following the Individual Assessment as part of the Digital Service, the Service User:

- has not registered for the Digital Service within the first calendar month post Individual Assessment; or
- does not have any recorded activity for the first calendar month post Individual Assessment,

the Provider must make a minimum of three attempts to contact the Service User, using at least two of the following means of communication: letter, phone call, text message or email.

Where the Service User cannot be contacted or declines the Digital Service, the provider must discharge the Service User back to their GP, signposting the Service User to the NHS Better Health website, the NHS Live Well website, the Diabetes UK website and to any other locally available resources for supporting weight loss, healthy eating and physical activity.

The Provider must record details about the number of contact attempts made to offer the Face to Face Service, including date and method of contact as set out in this section. The Provider is not required to record all of this information under Schedule 6A but must share this information with the Commissioner if requested.

The Commissioner may, from time to time, require the Provider to offer a person the Services under other circumstances alongside those listed in paragraph 3.2.6, for example tailored remote and digital Services for specific characteristics, demographics, languages or population needs. Where the Commissioner so requires, it shall notify the Provider in writing.

Service Users who smoke

The Provider must conduct a very brief intervention (offering very brief advice) with Service Users who are smokers, as detailed in training provided by the National Centre for Smoking Cessation and Training and recommended in NICE guidance NG92. This will involve the following steps: i) Ask – if the Service User smokes (yes/no); If yes, ii) Advice – the best way to quit is with a combination of medication and support. Would you be interested in this? If yes: Act – refer to stop smoking service. The Provider will establish an appropriate referral mechanism with local health economies and systems. The Provider must maintain a record about Service Users who were screened for smoking, offered advice and referred to stop smoking services.

3.2.8 Intensity and duration of the Face to Face Service and Tailored Remote Service

The Provider must deliver the Face to Face Service and Tailored Remote Service in accordance with the following requirements:

- The Service must consist of a series of 'sessions' as opposed to minimal ('one-off') contact;
- The Service must be spread across a 9 month duration;
- 13 sessions must be provided to each Service User; each session must last between 1 and 2 hours;
- The minimum total contact time must be 16 hours;

- Additional contact outside of the 13 sessions and minimum of 16 hours, to further engage and support Service Users, to encourage retention and, where a Service User has missed sessions, to re-engage them to attend face to face is encouraged, and for the Face to Face Service, remote catch-up sessions must be offered to support session catch-up where appropriate. The Provider must consider how it ensures that Service Users are given appropriate individual support, including dedicated 1:1 time as required;
- The Provider will ensure that sessions are delivered in a format and at times that are appropriate to a range of diverse groups in the community and must include evening and weekend sessions to facilitate access for working people. Sessions must be offered at a range of times, days and, for the Face to Face Service, venues and accessible locations in order to maximise access to (and therefore uptake of) the Service, particularly for those of working age, BAME groups and more socially deprived communities;
- The design of the Service must allow Service Users to make behavioural changes gradually and throughout the 9 month duration of the Service;
- The Individual Assessment does not count towards intervention hours but the final session does. The Individual Assessment is counted outside of the minimum 13 sessions. Weigh-ins do not count towards session time in isolation although they could be part of a session.

3.2.9 Underpinning theory and approach for the Service

- The Provider must ensure that the Service is grounded in and delivered in accordance with behavioural theory. The Provider must be explicit regarding the behavioural change theory and techniques that are being used, and the expected mechanism of action of their intervention. The Provider must use a systematic method to identify links between the components of the intervention, the mechanism of action and the intended behavioural outcomes, to ensure that interventions are adapted for the target behaviours, population and context. This must be reflected in a logic model or theory of change, to clearly specify which techniques they are using and how they expect their interventions to produce the desired behavioural changes.
- Interventions must be developed in consultation with behaviour change specialists and Service Users, to increase engagement. Methods for developing and implementing behaviour change interventions are set out in Public Health England guidance "Achieving behaviour change: a guide for local government and partners".
- The Provider must utilise a behavior change framework which is evidence based, such as the COM-B model- see Michie et al (2011a)⁵.
- The Provider must demonstrate which behavior change techniques from the Behaviour Change Technique Taxonomy Michie et al (2011b)⁶ are met by their intervention. As a minimum the intervention must include all the behaviour change techniques set out in NICE PH38 recommendations 1.9.2, 1.9.3 and 1.9.4⁷.
- The Provider must ensure that all sessions and communications incorporate clear, targeted, and high quality communication of risk, which optimise understanding of the

⁵ Michie, S., et al. (2011a). "The behaviour change wheel: A new method for characterising and designing behaviour change interventions." *Implementation Science* : IS 6: 42-42.

⁶ Michie S, Ashford S, Snihotta FS, et al. (2011b). A refined taxonomy of behaviour change techniques to help people change their physical activity and healthy eating behaviours: The CALORE taxonomy. *Psychology and Health*, 26 (11), 1479 – 1498.

⁷ NICE Guidelines. 2017. Public Health Guideline [PH38]. Information provision; exploration of reasons and confidence for change; motivational interviewing; goal-setting; action planning; coping plans and relapse prevention; social support; self-monitoring; reviewing progress; problem-solving.

risk of developing Type 2 diabetes and how this can be prevented. Application of behavioural science approaches to behaviour change must be demonstrated; particularly in relation to promoting recruitment and retention/reengagement of Service Users, and session attendance. The Provider must comply with any materials and templates provided by the Commissioner.

- The Service must not be designed in a way which increases health anxiety, discourages face to face consulting, encourages inappropriate self-management and/or encourages the adoption of unhealthy behaviours, such as excessive exercise or disordered eating.
- The Provider must be explicit about the intended action expected of Service Users in response to non-face to face contact (marketing, invitation letters, leaflets, referral forms, text messages etc.) and the mechanism of action by which that is expected to occur (with reference to behavioural change frameworks as described above). Evidence and best practice must be considered and described by the Provider when producing these materials and communication channels.
- The Provider must ensure that family or peer support is accommodated where this would be helpful to a Service User.

3.2.10 Content of the Service

- The Provider must develop detailed content for the Service.
- The content must cover information about Type 2 diabetes, including long-term effects, risk factors and benefits of behaviour change. The intervention must provide information and practical tools on nutrition, physical activity and weight management based on national guidance set out below and detailed more fully in Annex 1 of this Service Specification.
- Providers must ensure that interventions do not rely solely on information-giving and encourage interactive engagement with Service Users.
- The Provider must consider the extent to which the intervention is delivered in a logical progression in line with behavioural change techniques as described in paragraph 3.2.9 above. The intervention must aim for steady progress on Service Users' goals.
- The distribution of content across the intervention must seek to maximise continued engagement by the Service User across the duration of the Service.
- The content of interventions must be tailored to individual Service Users where possible and must consider the social and psychological support needed to implement behaviour changes in environments which promote unhealthy behaviours.
- The Provider must advise Service Users that some individuals may be at risk of setting unhealthy goals and must avoid aspects of an intervention that could encourage this. For example, Service Users with a history of disordered eating may decide to avoid aspects of an intervention that they feel might worsen this tendency.
- The risks and benefits of remote or digital interventions that involve the use of adverts and social media must be considered by the Provider when designing the Service. The Provider must ensure that no unregulated content or adverts via social media or other platforms encourages the use of goals, methods or content which fall outside of the evidence and this Service Specification.
- The Provider must be aware of the risks of digital exclusion in the use of the Digital Service or digital components of a Face to Face Service or Tailored Remote Service and take steps to mitigate it.
- Across all Services, use of the Provider's own platform or a moderated platform is preferred for online interactions such as chat rooms, and in instances where third party forums are being used, Service Users must be made aware of risks and the need to only rely on recommendations from the Provider.

3.2.11 Delivery of sessions for the Face to Face Service (including remote catch-up sessions)

The Provider must deliver the Face to Face Service (including remote catch-up sessions) in accordance with the following minimum requirements:

- The Provider must ensure that the Face to Face Service is delivered using predominantly group sessions designed to be delivered to up to 20 Service Users in each group. Individual contact, in addition to the 13 sessions (either in person or remotely) may also be included to enhance delivery and retention. Larger group sizes may be used by exception (for example, a group exceeds 20 people where a Service User is bringing a family member or carer or where a Service User from another group has missed a session and attends to catch up either in-person or remotely). Sessions must be held within a reasonable timeframe and the Provider must ensure that these are not unduly delayed due to lower than anticipated group sizes. A record of group numbers must be kept and made available on request by the Commissioner.
- Group sessions, within the required 13 sessions, will be delivered face to face (in person) unless the Service User does not attend their planned in-person session and accepts a remote catch-up session.
- Service Users must be offered a choice of dates and times for each and any session to encourage attendance and also to offer the opportunity to catch up (either face to face or via remote means) where they have missed a session. This choice must be available throughout the duration of the intervention. The Provider must consider the extent to which the intervention is delivered in a logical progression.
- Service Users will not be able to formally transition from the Face to Face Service to the Tailored Remote Service once they have commenced on the Face to Face Service (but for the avoidance of doubt this will not prevent the Provider from offering remote catch-up sessions to Service Users on the Face to Face Service but only in instances where a session is missed and a remote session to catch-up on content is required and the Provider must ensure these Service Users are booked on to the next appropriate face to face session).
- The Provider must consider how it ensures that Service Users are given appropriate individual support, in particular with self-regulatory and cognitively demanding behaviour change techniques. This must include dedicated 1:1 time as required.
- If a group size diminishes as the Service progresses due to non-attendance, there is no minimum group size; a Service User who wishes to continue on the Service (if they haven't already attended the final session) must be allowed to do so regardless of group size. However, the Provider may introduce mechanisms for joining together groups if numbers of attendees in a group are small.

3.2.12 Delivery of Sessions for the Digital Service

The Provider must deliver the Digital Service in accordance with the following minimum requirements:

- Engagement with the Digital Service by the Service User shall be monitored and reported to the Commissioner. Effective engagement should be defined by the Provider "in relation to the purpose of a particular intervention" (Yardley et al 2016)⁸ and engagement data collected accordingly.
- Engagement shall be characterised by the interest and subjective experience of using the intervention, combined with objective measures of the amount, frequency, duration and depth of usage. Examples of engagement might include: viewing materials, completing any active elements, engaging directly with human coaches, inputting self-monitoring data, or participating in moderated group sessions. Engagement would not include passive receipt of emails and other communications

⁸ Yardley L, Spring BJ, Riper H, Morrison LG, Crane DH, Curtis K, Merchant GC, Naughton F, Blandford A. Understanding and Promoting Effective Engagement With Digital Behavior Change Interventions. *Am J Prev Med*;51(5):833-842. 2016

unless it could be demonstrated that these have been actively read through Service User feedback mechanisms embedded into the communication. Schedule 3A sets out the specific types of engagement methods that the Provider must ensure are used for payments to be claimed and this may include engagement methods proposed by the Provider where this is agreed with the Commissioner.

- The Provider must be able to demonstrate that their curricula/modules are designed to deliver engagement of Service Users for a minimum of nine months and must aim to deliver the same objectives and the same course content as the Face to Face Service and the Tailored Remote Service.
- To ensure engagement is spread over nine months, the Provider must promote and ensure that there is active engagement activity each month. Payment for the Digital Service is dependent on monthly engagement. Schedule 3A (Local Prices) sets out the specific requirements that need to be met for payment.
- The programme material for the Digital Service must be designed to allow Service Users with different levels of knowledge and different approaches to learning to progress at different paces. This must include promoting self-directed learning.
- The Service must comply with NHS guidance on push notifications to Service Users (if used) (see “Notifications and messaging guidance and restrictions”, NHS Digital 2021).
- Access to the Digital Service must be flexible to accommodate Service User preferences about accessing the Digital Service at a time of their choosing and to work through content flexibly at their own pace.
- The Provider must consider how it ensures that Service Users are given appropriate individual support, in particular with self-regulatory and cognitively demanding behaviour change techniques. This must include dedicated 1:1 time as required.
- The Provider must ensure that Service Users are able to adjust their level of interaction with digital systems, for example adjust the frequency of prompts, to their preferred settings.
- The Provider will inform Service Users how to check and set preferences for how their personal information and Personal Data may be used. The Provider will inform Service Users about when digital interventions are likely to use mobile data, and provide an indication of how much data may be used (for example an average, or information on the size of an app). The Provider will inform Service Users that they may therefore incur costs related to data usage depending on how they access the internet and their internet service provider's charges.

3.2.13 Delivery of Sessions for the Tailored Remote Service

The Provider must deliver the Tailored Remote Service in accordance with the following minimum requirements:

- The Provider must ensure that the Tailored Remote Service is offered as an intervention option to specific identified cohorts as set out in paragraph 3.2.6 alongside the Face to Face Service and the Digital Service.
- The Provider must offer a platform for the Tailored Remote Service which can support both videoconferencing and teleconferencing which is free at the point of access for Service Users.
- Service Users must be offered a choice of dates and times for each and any session to encourage attendance. This choice must be available throughout the duration of the intervention. The Provider must consider the extent to which the intervention is delivered in a logical progression.
- Where a Service User misses a session, the Provider must ensure that they are given the opportunity to catch-up before booking the Service User onto the next appropriate Tailored Remote Service session.

- Where the Tailored Remote Service is being delivered to a cohort of Service Users which requires specific tailoring, the Provider must ensure that the necessary requirements are fulfilled to ensure that Service User needs are met e.g. BSL interpreters, visually aided workbooks.
- The Provider must deliver the Tailored Remote Service using predominantly group sessions designed to be delivered to up to 20 Service Users in each group; these Service Users may span across multiple areas in which the Provider provides the Service under Contracts pursuant to the NDPP Framework Agreement.
- Individual contact, in addition to the 13 remote group sessions may also be included to enhance delivery and retention.
- Group sessions, within the required 13 sessions, should not exceed the recommended time limit for each session in order to maintain the effectiveness of the intervention.
- As per paragraph 3.2.7 and paragraph 3.2.9, Providers must ensure that sessions delivered as part of the Tailored Remote Service appropriately mirror the intensity, theory and content as delivered across the Face to Face Service.

3.2.14 Delivery of Services in extraordinary circumstances

The Provider must ensure that they have comprehensive business continuity plans in place in order to support continued access to and delivery of the Service during periods of disruption.

It is recognised that, due to unforeseen circumstances, there may be situations in which the delivery of the Face to Face Service cannot be facilitated in-person and the Commissioner requires the Provider to suspend the provision of the Face to Face Service. At any time during the Contract Term, on one or more occasions the Commissioner may at its absolute discretion require the Provider to suspend the provision of the Face to Face Service. If the Commissioner requires the Provider to suspend the provision of the Face to Face Service, the Commissioner will notify the Provider in writing. Upon receipt of such notification, the Provider will suspend the provision of the Face to Face Service and the Commissioner will work with the Provider to support with Service User management and continued the delivery of the Service in line with the principles set out in this paragraph 3.2.14 below.

Transition between in-person and remotely delivered Face to Face Service

- In circumstances where the Commissioner notifies the Provider that the in-person Face to Face Service is to be suspended in accordance with this paragraph 3.2.14, the Provider must offer affected Service Users the choice to transition to a remote mode of delivery. For the avoidance of doubt, this is not the Tailored Remote Service.
- Where Service Users accept this offer, the Provider must ensure that the Service User is given the appropriate information and guidance to support a smooth transition to remote delivery of the Face to Face Service.
- The Service must be delivered at all times in line with paragraph 3.2.10 and the Provider is responsible for ensuring the appropriate and successful integration of the Service User into the alternative provision.
- The Provider is responsible for ensuring that affected Service Users are appropriately recorded as having transitioned to a remote alternative of the Face to Face Service, and must ensure that affected Service Users are given the option to transfer back to in-person delivery once the Commissioner notifies the Provider that it may resume the Face to Face Service.

Pausing existing Service Users on the Service

- Only in instances where the Commissioner notifies the Provider that the delivery of the Face to Face Service is to be suspended in accordance with this paragraph 3.2.14 should existing Service Users be given the option to pause their participation in the

Service until the Commissioner notifies the Provider that in-person delivery of the Service is to resume.

- The Provider must ensure that they have contacted all affected Service Users to discuss the alternative delivery of the Service and transition to the remote delivery of the Services in accordance with this paragraph 3.2.14 prior to Service Users confirming they wish to pause their participation in the Service and that Service Users are offered appropriate support in the interim prior to the resumption of the Face to Face Service.
- The Provider must ensure that Service Users who have chosen to pause their participation in the Service continue to receive reminders regarding the importance of annual glycaemic reviews.
- The Provider must ensure that Service Users who have chosen to pause their participation in the Service are accurately reflected in reporting requirements as outlined in Schedule 6A.
- Where a Service User chooses to pause their participation in the Face to Face Service, the timescales used for the purposes of calculating the relevant Milestone periods (as defined in Schedule 3A) will also temporarily pause until the Service User resumes their participation in the Face to Face Service. Once a Service User formally resumes their participation in the Face to Face Service, the relevant Milestone period will recommence.

Deferring new Service Users on the Service

- Where the Commissioner notifies the Provider that the delivery of the Face to Face Service is to be suspended in accordance with this paragraph 3.2.14 and new potential Service Users are being referred into the Service during suspension of the in-person Face to Face Service, the Provider must ensure that the individuals are offered the remote alternative of the Face to Face Service, the Digital Service and, for applicable cohorts as outlined in paragraph 3.2.6, the Tailored Remote Service before giving them the option to defer their place on the Service. The Provider must consider how it ensures that Service Users are given appropriate support during their period of deferral from the Service.
- The Provider must ensure that Service Users who have deferred their place on the Service continue to receive reminders regarding the importance of annual glycaemic reviews.
- Where Service Users are deferred on the Service, the Provider must notify their GP via a format as agreed with the Commissioner.
- The Provider must ensure that Service Users who have deferred their place on the Service are accurately reflected in reporting requirements as outlined in Schedule 6A.

Resuming the Face to Face Service following suspension

The Commissioner will notify the Provider in writing when the Face to Face Service is to resume. Following such notification, the Commissioner will work in collaboration with ICS's and the Provider to provide appropriate guidance and support in relation to the resumption of the Face to Face Service following the period of suspension.

3.2.15 Training and Competencies for the design and delivery of the Services

- The Provider acknowledges and agrees that the Services involve training, teaching, instruction, assistance, advice and guidance provided wholly or mainly for adults receiving healthcare. The Commissioner therefore considers the Services to be regulated activity for the purposes of regulations governing the use of Enhanced DBS & Barred List Checks and the Provider must carry out Enhanced DBS & Barred List Checks in respect of all members of Staff engaged in the Services who are eligible for such checks and must not engage any such person in the Services who is barred from working with vulnerable adults or is otherwise unsuitable for working

with vulnerable adults. The Provider must ensure that any Sub-contractor is subject to similar obligations.

- The Provider will ensure that the Services are delivered or, where there is no human coaching element, developed, by suitably trained and competent individuals who are trained in delivery of behaviour change. The Provider will specify the type and level of qualification, training and / or competence to be required aligning with, for example, the Association for Nutrition 'wider workforce' training, Chartered Institute for the Management of Sport and Physical Activity accreditation, City & Guilds qualifications, and the Royal Society of Public Health qualifications. The Provider needs to demonstrate that these qualifications will ensure that front-line staff are appropriately selected and trained to deliver interventions in line with NICE PH49 for both overall behaviour change and for group based delivery. Providers may use the Health Education England Behaviour Change Development Framework (<https://behaviourchange.hee.nhs.uk>) to guide workforce development.
- The Provider must ensure that training focuses on behaviour change technique delivery, group management, communication and rapport. Training must demonstrate delivery of behaviour change techniques and allow front-line staff the opportunity to practice using them. Processes must be in place for assessing Staff competence and for ongoing monitoring of behaviour change technique delivery by a behaviour change specialist, including giving feedback to Staff.
- The Provider must ensure that all individuals involved in the delivery of the Services have sufficient and appropriate training and competencies required to deliver the actions and content of the Services and to manage confidential and sensitive personal identifiable data. This must include training in delivery of the Services. The Provider must also consider the creation of apprenticeships as a means of developing and maintaining skills. Training must be routinely monitored and updated as necessary, and suitable continued professional development strategies must be in place.
- The Provider will ensure that all Staff adopt a person-centred, empathy-building approach in delivering the Services. This includes finding ways to help Service Users make gradual changes by understanding their beliefs, needs and preferences and building their confidence over time. The health coaching approach may be suitable, as detailed in NHS guidance: <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>.
- The Provider must ensure that a multi-disciplinary team of health professionals or specialists relevant to the core components of the Services (i.e. diabetes, behaviour change, weight loss, diet, physical activity and mental wellbeing) is involved in development of the Services and the training of Staff. These must include, for example, a registered dietitian or a registered nutritionist (registered with the Association for Nutrition), a registered health psychologist trained in the application of the COM-B model or other suitable tools and a qualified physical activity instructor.
- There is not a requirement for health professionals to deliver content of group sessions, nor be involved in every session. In discussions about physical activity it would be beneficial to involve a qualified physical activity instructor who has been trained in understanding and communicating the considerations involved with being more active.
- Access to the Service will accommodate the diverse needs of the target population in terms of availability, accessibility and customs as far as possible. The Service must be flexible and tailored to individual Service Users' needs, ability and cultural requirements. The Service must also provide culturally sensitive services and ensure access for people who have a physical or mental impairment. The Service must have access to appropriate interpreter services. The Provider must ensure that the Service complies with the Equality Act 2010 and would be accessible to wheelchair users and others with a physical disability. It must be available for people with low literacy levels, sensory impairment and learning disability and must welcome carers where needed.
- Staff delivering the Services will reflect the diversity of the population accessing the Services.

- In addition to in-depth behaviour change training, Providers where relevant, can draw on resources provided or recommended by Public Health England, for example:
 - Physical activity: applying All Our Health. PHE 2015.
 - Changing Behaviour: Techniques for Tier 2 Adult Weight Management Services. PHE 2017.
 - Health matters: physical activity - prevention and management of long term conditions. PHE 2020.
 - Helping older people stay active at home, Chartered Society of Physiotherapists (<https://www.csp.org.uk/public-patient/keeping-active-and-healthy/staying-healthy-you-age/staying-strong-you-age/strength>).

3.2.16 Weight Loss and Measurement

In relation to weight loss:

- The Service must involve collecting weight data for all Service Users. For the Face to Face Service and Tailored Remote Service, this must include a weigh-in or recording of a self-reported weight at every session. Where a Service User attends a remote catch-up session as part of the Face to Face Service in place of a missed in-person session, they will be required to self-report their weight as part of the session.
- Data collection of weight measurements for the Face to Face Service must be objective and must not be self-reported (except where it is being taken at a remote catch-up session) and taken using appropriately calibrated scales. Scales must meet Class III criteria for levels of accuracy as per UK Weighing Federation guidance (<http://www.ukwf.org.uk/res/medicalguidancenotes.pdf>) and "Weight Management Interventions: Standard Evaluation Framework" (PHE 2018).
- For the Digital Service: the Provider must request that Service Users undertake baseline, 3 month, 6 month and 9 month weigh-ins to monitor progress.
- Where weight is self-reported by Service Users as part of the Digital Service and the Tailored Remote Service, steps to ensure consistency of measurement must be encouraged, for example, using the same scales for each measurement taken. The Provider must also encourage Service Users to use regular weigh-ins as part of self-monitoring.
- The Commissioner will work with the Provider to ensure that people are given advice on options for weighing themselves where they do not have access to scales. There are likely to be a number of options for how people can access scales, including through their GP practice, pharmacy, or through other local services and retail outlets. The Provider must ensure that any Service User that this may affect is made aware of any options that the Commissioner deems appropriate.
- Body mass index (BMI) and waist circumference thresholds must be used as specified in NICE guideline PH46 (see Annex 2). See "Weight Management Interventions: Standard Evaluation Framework" (PHE 2018) for details of measurement of height and weight.
- Motivational interviewing must be used to support Service Users in setting appropriate goals. The Provider must ensure that achievable goals for weight loss (for people who are overweight or obese) are agreed for different stages of the Service for example, within the first few weeks, at three months and at completion of the Service. Service Users must be encouraged to work towards their behaviour change goals as well as weight loss goals, for example, increased physical activity or eating more fruit and vegetables.
- The Provider must ensure that Service Users who are not overweight or obese are not encouraged to lose weight but are supported to maintain a healthy weight, and that weight loss advice for older participants manages any risk of Sarcopenia.

- The Provider must, wherever possible, work with Service Users to assess their dietary intake and support Service Users to plan sustainable dietary changes, aligned with the balance of food groups in the Eatwell Guide (refer to paragraph 3.2.14 below for further information), to achieve weight loss and help with weight maintenance.
- The Provider must design approaches to support individuals who are overweight or obese at baseline (as defined in Annex 2) to reduce their calorie intake. A calorie limit of no more than 1,900kcal for men and 1,400kcal for women should support weight loss at a rate of 0.5kg-1kg each week but calorie limits must take into account individual Service Users' circumstances, such as physical activity level. Weight loss of 5-10% of baseline weight should be used to support individuals who are overweight or obese to understand how much weight loss is required to achieve health benefits and to set achievable targets. Approaches need to support longer term sustainable behaviour change in order to maintain target weight.
- The Provider must design approaches to support individuals who are a healthy weight at baseline to maintain a healthy weight in line with NICE Guideline NG7.
- The Provider must consider making reasonable adjustments for Service Users with a learning disability. Public Health England guidance (Obesity and weight management for people with learning disabilities. PHE, 2020) states that people with learning disabilities may require alternative methods of weight measurement due to chronic constipation and/or atypical body shape. The Provider must work with the local health system to determine the best process for measuring weight where the mainstream method is not appropriate.

3.2.17 Dietary content

The design and delivery of the syllabus must be underpinned by the UK Government dietary recommendations as detailed in the Eatwell Guide⁹ and support weight loss for Service Users who are overweight or obese, or the maintenance of a healthy weight in Service Users of healthy weight. The Eatwell Guide shows the proportions on the main food groups that form a healthy balanced diet. This involves increased intake of fibre, fruit and vegetables and oily fish, and decreased intake of saturated fat, sugar, salt and energy:

- Eat at least 5 portions of a variety of fruit and vegetables every day;
- Base meals on potatoes, bread, rice, pasta or other starchy carbohydrates; choosing wholegrain versions where possible;
- Have some dairy or dairy alternatives (such as soya drinks); choosing lower fat and lower sugar options;
- Eat some beans, pulses, fish, eggs, meat and other proteins (including 2 portions of fish every week, one of which should be oily);
- Choose unsaturated oils and spreads and eat in small amounts;
- Drink 6-8 cups/glasses of fluid a day;
- If consuming foods and drinks high in fat, salt or sugar have these less often and in small amounts.

The Provider must support Service Users towards achieving the Government's dietary recommendations:

- Use dietary approaches that are evidence based and sustainable in the longer term;
- Use motivational interviewing to support Service Users in setting appropriate goals.
- Service Users must be encouraged to set tailored and achievable short, medium and long term goals which help them to achieve their aims.

⁹ Information about the Eatwell Plate can be accessed at www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx.

- The Service must encourage self-monitoring to help Service Users review their progress.
- The Service must inform Service Users about how to effectively utilise self-monitoring to ensure healthy goals are set. This is applicable for the Face to Face Service and the Tailored Remote Service, but particularly for the Digital Service.
- Service Users must be supported to consume wholegrain and higher fibre starchy carbohydrates in line with the Eatwell Guide (about a third of food eaten).
- For Service Users who are overweight or obese and therefore need to lose weight through calorie reduction, the Provider must ensure that this is achieved through the promotion of the balance of food groups as set out in the Eatwell Guide.
- Dietary advice must reflect the culinary traditions of the communities in which the Service is being provided, without making assumptions about what Service Users eat.

3.2.18 Physical activity content

- The Provider will support those Service Users who are not physically active, to aim to become active daily and minimise time spent being sedentary, with an aim of meeting or exceeding the England CMO recommendations for adults, older adults, disabled adults and pregnant and postpartum women (see Annex 1).¹⁰ The Provider will tailor the support provided as part of the Service to meet the needs, goals and capabilities of individual Service Users. Care must be taken to set achievable goals bearing in mind the principle set out by the CMO recommendations that any physical activity is better than none: even light activity and activity in short bursts is better than being sedentary.
- The Provider will promote strength, balance and flexibility activities as set out in the CMO recommendations, particularly for older adults.
- The Provider will take a graded and structured approach to setting, monitoring and reviewing goals to ensure that those who have a very low baseline level of physical activity are supported to aim for the CMO recommendations within a personalised timeframe. Motivational interviewing must be used to support Service Users in setting appropriate goals.
- The Provider will support Service Users to reduce the amount of sedentary activity in their leisure and working time, by promoting and demonstrating the use of breaks after a prolonged period of sitting or other sedentary activity.
- The Provider will support Service Users to incorporate active travel into their daily routine either through walking or cycling skills and group activities; the Provider can use tools which encourage the incorporation of walking into daily routines such as those applied through the Public Health England Active 10 app. Active 10 promotes graded increases and encourages brisk walking. Providers may also use the NHS Better Health and NHS Live Well websites, which include interventions such as Couch to 5k.
- The Provider is required to measure physical activity for the Face to Face, Tailored Remote and the Digital Service using a standard self-reporting tool as determined by the Commissioner and when required by the Commissioner. Self-monitoring and reliable data capture to understand individual-level change in weight, diet, and physical activity are key behavior change techniques. Services must include methods to allow Service Users to accurately and regularly self-monitor their diet and physical activity behaviours.
- The Provider must encourage self-monitoring of physical activity by regularly liaising with Service Users about the number of steps undertaken in the previous week using objective measurement such as use of pedometers, activity trackers, or smart phone step counters. The Provider must promote self-monitoring in a way which ensures that

¹⁰ UK Chief Medical Officers' physical activity guidelines. Department of Health and Social Care. September 2019.

healthy goals and patterns of exercise are embedded. Data on absolute step counts will be required over a measurement period of the previous seven days.

- The Provider must also encourage self-monitoring of activities that do not provide 'steps' (for example, cycling), strength, balance and flexibility activities and activities to reduce sedentary time. The Provider will be required to provide data on physical activity including calculation and reporting of step counts, e.g. by calculating percentage change, to allow comparison of Service User and Provider physical activity changes relating to the Service as determined by the Commissioner and as notified by the Commissioner to the Provider. The Recent Physical Activity Questionnaire (RPAQ) is the tool currently in use for this purpose.
- The Service may include supervised exercise and when used must build gradually to increase exercise capacity of the Service User. It is the Provider's responsibility to ensure that Staff providing supervised exercise are suitably qualified.
- The Provider must provide a choice of physical activities to accommodate as wide a range of Service Users as possible and must measure health inequalities in access and outcomes.

The Provider must ensure that content of the Service is regularly reviewed and adjusted to stay up to date with government standards, recommendations, guidance and new evidence.

3.2.19 Final Session

The "Final Session" is defined as the last session delivered by the Provider as part of the planned Service (for those Service Users still attending).

As part of the Final Session, the Provider must conduct a post intervention assessment of weight, wellbeing and achievement of individual goals for all Service Users who attend. For the Face to Face Service, the weight must be taken via objective means (unless the Final Session is delivered remotely). BMI must also be calculated and arrangements for collection of Service User feedback / customer satisfaction survey must be agreed. Details of the data to be reported are provided in Schedule 6A.

The Provider must again ensure that links are made with local or national activities and services, in order to provide support for Service Users to continue with improvements made to dietary and physical activity behaviours and weight loss.

The Provider must ensure that Service Users are reminded about key sources of information and advice, such as NHS Choices.

The Provider must make available support and advice post intervention to Service Users to encourage the maintenance of improved lifestyles.

3.2.20 Discharge from the Service

The Service User is "Discharged" from the Service in the following circumstances:

- If after the Provider contacts an individual following referral, the individual does not respond to the Provider after one calendar month from referral provided that the Provider has made a minimum of three attempts to contact the individual, and used various different communications channels as set out in paragraph 3.2.5 above;
- If, after the Provider contacts an individual following referral, the individual indicates that they do not accept the Face to Face Service;
- If, after the Provider contacts an individual following referral, the individual indicates that they accept the Face to Face Service, and have either declined, deferred or did not attend an Individual Assessment and/or a first intervention session for the Face to Face Service or the Tailored Remote Service where the Provider has offered the session on 3 separate occasions (including a remote catch-up option for participants on Face to Face Service) at times and, for the Face to Face Service, venues suitable to the individual;

- When a Service User misses three consecutive Face to Face Service or Tailored Remote Service sessions for no known reason, and for the Face to Face Service the Provider has offered appropriate remote catch-up sessions, and the Provider has made a minimum of three attempts to contact the Service User since the last attended session, using at least two of the following means of communication: letter, phone call, text message or email;
- For the Digital Service, where there is no recorded activity for three consecutive calendar months;
- When a Service User informs the Provider that they no longer wish to participate in the Service; and/or
- On completion of the Final Session (or once the Final Session has been delivered). Once the Final Session is completed then the Service User is discharged automatically regardless of the number (or percentage) of sessions attended.

Discharge Requirements

The Provider must provide each Service User's GP and the Service User themselves, with notification of Discharge via template letters or discharge communication content as notified by the Commissioner and as included within Schedule 6A.

The letter of discharge must encourage the Service User to contact their GP to confirm a date for their annual review, including a blood test to confirm whether HbA1c or FPG levels have reduced.

The letter of discharge to the GP must advise that clinical guidelines recommend follow up of people with non-diabetic hyper-glycaemia and/or women with a previous history of gestational diabetes every 12 months, where follow up includes measurement of weight and HbA1c, as well as assessing and addressing cardiovascular risk consistent with standard clinical practice.

The Provider must comply with relevant clinical codes associated with data items and include clinical codes in all notifications as specified by the Commissioner under the Contract.

The Provider will work closely with local health economies to identify and implement a feasible and locally appropriate mechanism for ensuring data is fed back to the GP in read coded format and can be integrated within GP clinical systems; ideally by electronic transfer. The Provider will also work with the local health economies to ensure that there is a monthly update on referral and uptake rates, waiting list size and outcomes at ICS level.

3.2.21 Links to Tier 2 Weight Management and other services

The Provider must ensure that links are made with existing local networks and partnerships (for example, physical activity providers) throughout the development and delivery of the Service. This could include, for example, leisure and public health services, departments within Local Authorities, NHS Choices, and local physical activity schemes.

Alongside this, the Provider must ensure that they are aware of Tier 2 weight management services operating across the relevant geographical area applicable to the Service. These Tier 2 weight management services form part of the obesity pathway and they are commissioned either locally, mainly by local authorities, or on a national basis for the NHS 12-week Digital Weight Management Programme ("NHSDWMP").

Typically, Tier 2 weight management services are multi-component lifestyle interventions that include diet, physical activity and behaviour change components. These services are typically delivered in group settings over 12 weeks and target overweight individuals, defined as having a BMI >25 , although variation does exist across local authority delivered services.

The NHS DWMP is limited to individuals who have a BMI of $\geq 30\text{kg/m}^2$ (adjusted to ≥ 27.5 for people from Black, Asian and ethnic minority backgrounds) and a current diagnosis of either diabetes and/or hypertension.

The NDPP is more intensive than most existing weight management services. Where an individual has been identified as having non-diabetic hyperglycaemia but is also eligible for a

Tier 2 weight management service, they will be referred into the Service if they meet all other eligibility criteria as set out within this Service Specification.

3.3 Marketing of the Service

The Provider must undertake marketing and promotional activity in conjunction with the local health economy to advertise the existence of the Service, with a view to raising awareness about the availability and benefits of the Service amongst local primary care and to people in the geographical area covered by the Contract who may benefit from participating in a diabetes prevention programme. Any marketing or promotional activity must be designed to target groups in the community which are currently less likely to access services, or which are at a disproportionately higher risk of developing diabetes encouraging them to find out more about the Service.

In marketing the Service, the Provider must conform to any guidelines on social marketing of the Service under the Contract, for example to ensure alignment of messaging with any wider social marketing campaigns being undertaken in relation to diabetes, or health promotion more generally. This includes using any branding guidelines developed by the Commissioner specifically for the NDPP.

Where it is required that the self-referral pathway is stood up in accordance with paragraph 3.2.5, the Provider must ensure any marketing requirements that are required by the Commissioner are complied with. Additional support for marketing activity related to the self-referral pathway will be discussed with the Provider should it be required that this pathway be made available across the Service.

3.4 Intellectual Property

For the avoidance of doubt, notwithstanding General Condition 1.2, the Parties expressly agree that this paragraph 3.4 shall take precedence over General Condition 22 in respect of Intellectual Property.

Except as set out expressly in this Contract, no Party will acquire the IPR of the other Party.

The Provider grants the Commissioner a fully paid-up non-exclusive licence to use Provider IPR for the purposes of the exercise of its functions and obtaining the full benefit of the Services under this Contract, which will include the dissemination of best practice to commissioners and providers of health and social care services.

The Commissioner grants the Provider a fully paid-up non-exclusive licence to use Commissioner IPR under this Contract for the sole purpose of providing the Services.

In the event that the Provider or the Commissioner at any time devise, discover or acquire rights in any Improvement it or they must promptly notify the owner of the IPR to which that Improvement relates giving full details of the Improvement and whatever information and explanations as that Party may reasonably require to be able to use the Improvement effectively and must assign to that Party all rights and title in any such Improvement without charge.

Any IPR created by the Commissioner in the exercise of its licence rights under this Contract will be owned by the Commissioner.

The Provider must disclose all documents and information concerning the development of Best Practice IPR to the Commissioner at Review Meetings and must grant the Commissioner a fully paid-up, non-exclusive perpetual licence to use Best Practice IPR for the purpose of the exercise of its functions together with the right to grant sub-licences to Public Health England and any Participating Commissioner for the purpose of the exercise of their respective functions.

“Best Practice IPR” in this paragraph 3.4 means any IPR developed by the Provider including Improvements to such IPR in connection with or as a result of the Services.

“Improvement” in this paragraph 3.4 means any improvement, enhancement or modification to Commissioner IPR, Provider IPR or Best Practice IPR (as the case may be) which cannot be used independently of such IPR.

"IPR" in this paragraph 3.4 means inventions, copyright, patents, database right, domain names, trade marks, module names, rights in computer software, database rights, rights in get-up, goodwill and the right to sue for passing off, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights.

"Participating Commissioner" in this paragraph 3.4 means a clinical commissioning group (including any successor or replacement body), an Integrated Care Board or local authority in relation to whose geographical area the Services are delivered.

"Provider IPR" in this paragraph 3.4 means any IPR owned by or licensed to the Provider (other than by the Commissioner) that will be used by the Provider in the delivery of the Services (as set out in Appendix 3 of this Schedule 2A), including Improvements to such IPR.

The Provider shall ensure and procure that the availability, provision and use of the Service and the performance of the Provider's responsibilities and obligations hereunder shall not infringe any Intellectual Property Rights of any third party.

The Provider shall during and after the Contract Term indemnify the Commissioner against all Losses incurred by, awarded against or agreed to be paid by the Commissioner (whether before or after the making of the demand pursuant to the indemnity hereunder) arising from an IPR Claim. An IPR Claim is defined as any claim of infringement or alleged or threatened infringement by a third party (including the defence of such infringement or alleged or threatened infringement) of any IPR, used to provide the Services or as otherwise provided and/or licensed by the Provider (or to which the Provider has provided access) to the Commissioner in the fulfilment of its obligations under this Contract.

If an IPR Claim is made, or the Provider anticipates that an IPR Claim might be made, the Provider may, at its own expense and sole option, either:

- procure for the Commissioner the right to continue using the relevant IPR which is subject to the IPR Claim; or
- replace or modify the relevant deliverable with non-infringing substitutes provided that:
 - the performance and functionality of the replaced or modified deliverable is at least equivalent to the performance and functionality of the original deliverable; and
 - there is no additional cost to the Commissioner.

If the Provider elects to procure a licence or to modify or replace a deliverable pursuant to the provision above but this has not avoided or resolved the IPR Claim, then:

- the Commissioner may terminate this Contract by written notice with immediate effect; and
- without prejudice to the indemnity set out above, the Provider shall be liable for all reasonable and unavoidable costs of the substitute deliverables and/or services including the additional costs of procuring, implementing and maintaining the substitute deliverables.

3.5 Cyber Essentials

The Provider has and will maintain certification under the HM Government Cyber Essentials Scheme (basic level) until such time as the Provider obtains Cyber Essentials Plus certification in accordance with the provision below.

The Provider shall, as soon as is reasonably practicable after the Services Commencement Date, obtain certification under the HM Government Cyber Essentials Scheme to the level of Cyber Essentials Plus and maintain such certification for the Contract Term.

3.6 Digital Technology Assessment Criteria

The Provider must ensure that the Digital Service is compliant with the requirements of the Digital Technology Assessment Criteria ("DTAC") and ensure that the Digital Service is updated if requirements of the DTAC are updated.

Where a Provider is intending to use an existing product as part of the Digital Service and has completed a Digital Assessment Questionnaire ("DAQ") previously in relation to that product, they must still undertake and complete a DTAC review in relation to that product.

The DTAC should be used alongside the latest version of the NICE Evidence standards framework (ESF) for digital health technologies, to assess clinical safety, data protection, technical assurance, interoperability, usability and accessibility. The Service fits within Tier C of the ESF and evidence must be provided that the intended technology for the Digital Service:

- Has involved user groups within the design, development and/or testing phases;
- Demonstrates effectiveness for preventative behaviour change or self-management functions;
- Uses appropriate behaviour change techniques (as outlined within this Service Specification);
- Can support and monitor reliable information content;
- Supports ongoing data collection to validate usage and value;
- Has appropriate quality and safeguarding measures in place; and
- Promotes equality and can be utilised to support hard-to-reach populations.

Please refer to the ESF for further information on the required evidence and how to apply the framework, which is currently available at:

<https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies>

3.7 Government Digital Service Technology Code of Practice

The Provider must ensure that the Service adheres to the requirements of the Government Digital Service Technology Code of Practice, which is currently available at:

<https://www.gov.uk/government/publications/technology-code-of-practice/technology-code-of-practice>

3.8 Identity Verification and Authentication Standard for Digital Health and Care Services

If the Provider's Digital Service is by its nature a service to which NHS Digital's "Identity Verification and Authentication Standard for Digital Health and Care Services" applies, then the Provider is required to ensure it adheres to this standard. Please refer to the Standard for applicability:

<https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb3051-identity-verification-and-authentication-standard-for-digital-health-and-care-services>.

The Provider agrees to provide evidence of adherence to the standard to the Commissioner on request.

3.9 Cyber Requirements for Remote Service Delivery

The Provider must ensure that any videoconferencing and teleconferencing platform that it intends to use to deliver the Tailored Remote Service or remote catch-up sessions for the Face to Face Service has undergone the appropriate risk assessment and adheres to all other security and information governance requirements as set out in this Service Specification.

A Data Protection Impact Assessment must be completed and be in place before any videoconferencing and teleconferencing platform is used to deliver any sessions remotely to comply with the Data Protection Legislation.

Further information on the use of video conferencing tools in relation to Service User engagement can be found here: <https://www.nhs.uk/nhsx/infomation-governance/guidance/using-video-conferencing-and-consultation-tools/>

3.10 Information Governance

The Provider will submit the "Data Output Specification" document in Schedule 6A to the commissioning support service specified by the Commissioner and in the manner specified by the Commissioner.

The Provider will invite all individuals they have contacted following referral and all Service Users to agree be contacted for the purpose of service evaluation and record their consent where given. The Commissioner will specify this proportion of Service Users and also the timing and manner of the invitation.

The Provider will respect any request by a Service User not to disclose information that identifies them in the documents indicated above.

For the avoidance of doubt, the requirements above are in addition to the information governance requirements set out elsewhere in this Contract.

3.11 Additional Service Delivery Requirements

The Provider must:

- provide the Service in the following geographical area– **Sussex**
- ensure that the number of Service Users who achieve Milestone 1 (as defined in Schedule 3A) for the Service does not exceed 18306 during the Contract Term. This number is the "Intervention Cap" for the purposes of Schedule 3A;
- work with the Local Health Economy to agree and implement a strategy for managing demand within the Intervention Cap;
- ensure that no Service User is invited to participate in the Service after a period of 3 years has elapsed since the Service Commencement Date. This period is the "Intervention Period" for the purposes of Schedule 3A;
- actively monitor and report to the Commissioner and Local Health Economies, the number of Service Users who achieve Milestone 1 across the Service throughout the Contract Term; and
- notify the Commissioner as soon as reasonably practicable where the number of Service Users achieving Milestone 1 (as defined in Schedule 3A) is predicted to exceed the Intervention Cap.

The Commissioner may at its discretion either:

- vary the Intervention Cap and/or the Intervention Period; and/or
- introduce a specific "Digital Service Cap" and/or "Tailored Remote Service Cap" (which it may subsequently vary), to require the Provider to ensure that the number of Service Users who have achieved Milestone 1 (as defined in Schedule 3A) and are participating in the Digital Service and/or the Tailored Remote Service does not exceed a figure that is equal or more than the specified cap; and/or
- notify the Provider that it will not vary the Intervention Cap and/or the Intervention Period.

Where the Commissioner varies the Intervention Cap, introduces (or subsequently varies) a specific Digital Service Cap and/or Tailored Remote Service Cap, and/or varies Intervention Period it will notify the Provider and the Provider shall comply with the variation.

For the avoidance of doubt:

- the Provider's consent is not required for any variations referred to in this paragraph 3.11 and General Condition 13 does not apply to such variations; and
- varying the figures for the purpose of this paragraph 3.10 includes increasing or decreasing the relevant figure.

The Provider will not be paid for the Service provided to any additional Service Users:

- invited to participate in the Service once the Intervention Cap has been reached in accordance with paragraph 2 of Part 1 of Schedule 3A;
- invited to participate in the Service once the Intervention Period has expired in accordance with paragraph 2 of Part 1 of Schedule 3A; and/or
- invited to participate in the Tailored Remote Service or the Digital Service once any specific Digital Service Cap and/or Tailored Remote Service Cap introduced by the Commissioner has been reached in accordance with paragraph 2 of Part 1 of Schedule 3A.

The Contract Term will be the period from the Effective Date to the day after which the Provider submits the data submission for the last Service User on the NDPP who completed the Final Session or other such day as agreed in writing between the Parties.

3.12 Transition

This Contract may require the Provider to provide the Service in an area where, at commencement of this Contract, there is an existing provider providing services under a contract that the Commissioner has previously called off. In such a situation, there will be a period during which the Provider is commencing delivery of the Service and the existing provider is winding down its delivery of services (i.e. it will not be accepting any new referrals to its service).

Prior to expiry or termination of this Contract, the Provider may be required to provide the Service in an area where there is a new provider preparing to deliver services under a contract that the Commissioner has newly called off. In such a situation, there will be a period during which the Provider is winding down its delivery of services (i.e. it will not be accepting any new referrals to its service) and a new provider is commencing delivery of their service.

These periods are referred to as "Transition Periods". This paragraph 3.12 sets out obligations on the existing provider and/or the incoming provider. During a Transition Period, the Provider may be the existing provider or the incoming provider depending on the nature of the Transition Period. Where the Provider is the existing provider or the incoming provider, the Provider will comply with the relevant obligations set out below.

The aim during the Transition Period is that:

- Primary care engagement is maintained and a steady flow of referrals into NDPP service continues;
- A high quality of service is provided to Service Users regardless of which provider's service they are referred to, or enrolled on; and
- There is an orderly wind down by the existing provider and mobilisation and commencement of delivery of the service by the incoming provider.

The existing provider is responsible for delivering the full intervention to all Service Users who have reached milestone one as defined in that contract, within the intervention cap and the Intervention Period specified in that contract. The existing provider needs to maintain high levels of engagement of Service Users throughout the Transition Period, and ensure that there is a sustainable workforce and delivery model to manage the Transition Period.

During the Transition Period, there will likely be individuals who have been referred to the existing provider but who have not yet progressed to milestone one as defined in that contract prior to the Intervention Period expiring. Such individuals will be transferred, in compliance with the Data Protection Legislation, by the existing provider to the incoming provider.

The incoming provider must ensure that the approach adopted to enable such transfers between programmes is agreed with the local health economy and the existing provider. The incoming provider and the existing provider are responsible for complying with relevant data protection legislation and the duty of confidentiality throughout this process.

The existing provider shall provide to the incoming provider details on waiting lists of individuals and current session delivery locations to support sustainability of service delivery and the incoming provider is required to attend joint planning meetings through the Transition Period to support operational delivery. The existing provider will continue to provide data to the local health economy and will provide an operational point of contact until all Service Users being provided with the service by the existing provider have either completed the NDPP or have been discharged.

The incoming provider must support the local health economy and the existing provider in the delivery of a communications and engagement approach across local stakeholders to support a smooth transition of patient flow and service delivery.

The incoming provider must ensure it is able to provide the service to persons referred by the existing provider as if such persons were referred to the service by their GP and in accordance with all requirements in this Schedule 2A.

3.13 Review meetings

Review meetings between the Provider and the Commissioner in accordance with General Condition 8 of this Contract shall be conducted on behalf of the Commissioner by any person nominated by the Commissioner to act on its behalf. References to the "Commissioner" in the context of Review Meetings shall be construed accordingly.

The Provider shall attend monthly meetings (whether in person, by telephone or via videoconference) with the Commissioner Representative to discuss progress of the delivery of the Services and any key issues arising. Such meetings shall be held in addition to Quarterly Review Meetings. The Commissioner will provide a written record of the key outputs from such meetings to the Provider who will review and agree these within one month of the relevant meeting.

Unless agreed otherwise by the Parties, at least one week in advance of the monthly and quarterly Contract Review Meeting the Provider will deliver to the Commissioner the performance reports detailed in Schedule 6A in the format described as well as any additional reports notified to the provider in advance of the meeting.

The Provider shall attend meetings (whether in person, by telephone or via videoconference) as determined by local lead partner organisations, in whose areas the Service is being delivered, to review any specific local issues relating to the delivery of the Service including the level of referrals to the Services and any other matters as either the Provider or the relevant local partner organisations considers relevant to the Service. Local lead partner organisations may require a written record from such meetings with the Provider, and these should be agreed within one month of the relevant meeting. Such meeting records will be reviewed at Review Meetings between the Provider and the local lead partner organisations.

At least one week in advance of these meetings, the Provider will deliver to the local lead partner, the data and performance reports detailed in Schedule 6A, in the format described

3.14 Evaluation and Quality Assurance

The Provider will participate fully in any Quality Assurance processes as defined by the Commissioner and co-operate in undertaking ad-hoc audits and reviews as requested by commissioners in a timely manner. This will include the submission to commissioners of:

- Agreed data and reports from external quality assurance schemes
- Self-assessment questionnaires / tools and associated evidence.

The Provider will also participate in evaluations of the Service commissioned by or approved by the Commissioner.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Provider will deliver the Service in accordance with all relevant clinical guidelines and other guidance and publications published nationally, in particular:

- NICE PH38 Preventing Type 2 Diabetes: risk identification and interventions for individuals at high risk (2012 and updated 2017)
- NICE PH42 Obesity: working with local communities (2012)
- NICE PH6 Behaviour change: the principles for effective interventions (2007)
- NICE PH49 Behaviour change: individual approaches (2014 and updated 2019)
- NICE NG90 Physical activity and the environment NICE CG 43 Obesity: Guidance on the prevention of overweight and obesity in adults and children (2006 and updated 2015)
- NICE CG 189 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults (2014)
- NICE PH 53 Managing overweight and obesity in adults – lifestyle weight management services (2014)
- NICE PH46 BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups (2013)
- NICE NG 92 Stop smoking interventions and services (2018)
- NICE NG183 Behaviour change: digital and mobile health interventions (2020)
- A guide to good practice for digital and data-driven health technologies. DHSC, 2021
- Changing Behaviour: Techniques for Tier 2 Adult Weight Management Services. PHE, 2017
- Evaluating digital health products. PHE, 2020
- Evidence standards framework for digital health technologies. NICE, 2018
- Health matters: physical activity - prevention and management of long term conditions. PHE, 2020
- Healthy Lives, Healthy People: A call to action on obesity in England. Department of Health, 2011
- Physical activity: applying All Our Health. PHE, 2015
- UK Chief Medical Officers' physical activity guidelines. Department of Health and Social Care, 2019

5. Applicable quality requirements

5.1 Applicable Quality Requirements

The Quality Requirements applicable to the Service are set out in Schedule 4 .

5.2 Equity and access

- In the delivery of the Service the Provider must comply with the obligations placed on the Commissioner by section 13G of the NHS Act 2006 (due regard to the need to

reduce health inequalities) and section 149 of the Equality Act 2010 as if those obligations applied directly to the Provider;

- The Provider must promptly provide such co-operation to the Commissioner as the Commissioner reasonably requests regarding the Commissioner's discharge of its duties under section 13G of the NHS Act 2006 and section 149 of the Equality Act 2010; and
- The Provider will complete an annual Equality and Health Inequalities Impact Assessment (E&HIIA) and action plan to challenge discrimination, promote equality, respect Service Users' human rights and to reduce health inequalities in access to services and outcomes. The E&HIIA and action plan shall be provided to the Commissioner on the Effective Date and each anniversary of the Effective Date. Progress against the action plan will be reported by the Provider to the Commissioner on a Quarterly basis at the relevant Review Meeting.

The Provider must at all times adhere to all relevant health and safety and security Law in providing the Services.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Annex 1

Government recommendations for diet and physical activity

Topic	Recommendation
<u>Diet</u>	
Carbohydrates ^{11, 12}	Approximately 50% of total dietary energy ¹⁵ Carbohydrates are found in many different foods, but this recommendation means that starchy carbohydrates (for example, potatoes, bread, pasta and rice) should make up just over a third of the food we eat.
Free sugars ¹³	No more than 5% of total dietary energy. This is equivalent to no more than 30g a day for adults.
Sugar-sweetened drinks ¹⁴	Consumption should be minimised.
Fat ¹⁶	No more than 35% of food energy ¹⁷ (33% total dietary energy).
Of which saturated fat	<i>No more than 11% of food energy (10% total dietary energy). This is approximately no more than 30g per day for men and no more than 20g per day for women.</i>
Salt ¹⁸	No more than 6g for adults.
Fibre ¹⁹ (AOAC)	30g per day for adults.
Fruit & vegetables ²⁰	At least 5 portions of a variety per day. A portion is: 80g fresh, frozen or canned fruit and vegetables; 30g dried; or 150ml of juice or smoothie (maximum, which can only count as one of your 5 A Day).
Fish ²¹	At least 2 portions (2 x 140g) a week, one of which should be oily.

¹¹ Carbohydrates, free sugars, sugar-sweetened drinks and fibre – SACN (2015) Carbohydrates and Health. www.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf

¹² SACN's recommendations for carbohydrates were set as a percentage of 'total dietary energy' only

¹³ As for footnote 10 above

¹⁴ As for footnote 10 above

¹⁵ Total dietary energy includes energy from food and alcohol

¹⁶ Total fat, saturated fat – COMA (1991) Dietary Reference Values for Food Energy and Nutrients for the United Kingdom. London: HMSO.

¹⁷ Food energy excludes energy from alcohol

¹⁸ Salt – SACN (2003) Salt and Health

www.gov.uk/government/uploads/system/uploads/attachment_data/file/338782/SACN_Salt_and_Health_report.pdf

¹⁹ As for footnote 10 above

²⁰ World Health Organisation (1990) Diet, nutrition and the prevention of chronic diseases.

http://www.who.int/nutrition/publications/obesity/WHO_TRS_797/en/index.html

World Health Organisation (2003) Diet, nutrition and the prevention of chronic diseases.

<http://www.who.int/dietphysicalactivity/publications/trs916/download/en/>

²¹ SACN (2004) Advice on Fish Consumption: benefits and risks.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/338801/SACN_Advice_on_Fish_Consumption.pdf

Red and processed meat ²²	For adults with relatively high intakes of red and processed meat (i.e. over 90g/day) to consider reducing their intake to the population average (about 70g/day).
Topic	Recommendation
<u>Physical activity</u>	Adults (19 to 64 years) - For good physical and mental health, adults should aim to be physically active every day. Any activity is better than none, and more is better still. - Adults should do activities to develop or maintain strength in the major muscle groups. These could include heavy gardening, carrying heavy shopping, or resistance exercise. Muscle strengthening activities should be done on at least two days a week, but any strengthening activity is better than none. - Each week, adults should accumulate at least 150 minutes (2 1/2 hours) of moderate intensity activity (such as brisk walking or cycling); or 75 minutes of vigorous intensity activity (such as running); or even shorter durations of very vigorous intensity activity (such as sprinting or stair climbing); or a combination of moderate, vigorous and very vigorous intensity activity. - Adults should aim to minimise the amount of time spent being sedentary, and when physically possible should break up long periods of inactivity with at least light physical activity. Older Adults (65 years and over) - Older adults should participate in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing, and social functioning. Some physical activity is better than none: even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits. - Older adults should maintain or improve their physical function by undertaking activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week. These could be combined with sessions involving moderate aerobic activity or could be additional sessions aimed specifically at these components of fitness. - Each week older adults should aim to accumulate 150 minutes (two and a half hours) of moderate intensity aerobic activity, building up gradually from current levels. Those who are already regularly active can achieve these benefits through 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits. Weight-bearing activities which create an impact through the body help to maintain bone health. Older adults should break up prolonged periods of being sedentary with light activity when physically possible, or at least with standing, as this has distinct health benefits for older people.

²² Red and processed meat – SACN (2011) Iron and Health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/339309/SACN_Iron_and_Health_Report.pdf

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Annex 2

BMI classifications for overweight and obesity

Providers must refer to NICE Guidance PH46. The guidance provides detailed advice, including definitions and BMI and waist circumference thresholds. The key recommendations are listed here.

Recommendation 1 Preventing Type 2 Diabetes

Follow NICE recommendations 1–18 in Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (public health guidance 38). This includes:

- using lower thresholds (23 kg/m² to indicate increased risk and 27.5 kg/m² to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among Asian (South Asian and Chinese) populations
- identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach
- providing those at high risk with a quality-assured, evidence-based, intensive lifestyle-change programme to prevent or delay the onset of type 2 diabetes.

Box 1: International guidance on BMI/waist circumference thresholds

WHO advice on BMI public health action points for Asian populations (World Health Organization 2004)

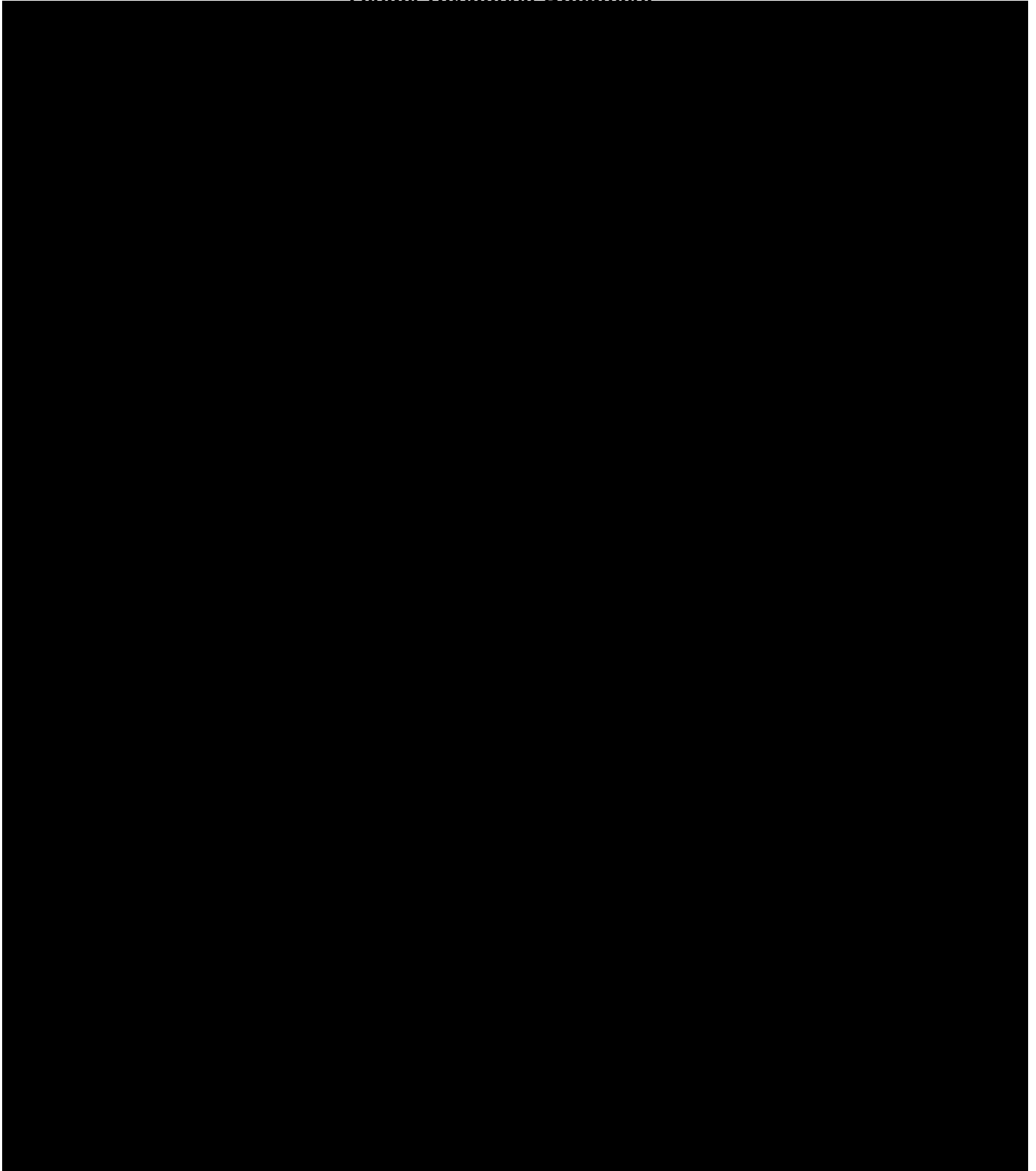
Classification	White European populations	Asian populations
Underweight	<18.5 kg/m ²	<18.5 kg/m ²
Healthy weight	18.5–24.9 kg/m ²	18.5–23 kg/m ²
Overweight	25–29.9 kg/m ²	23.1–27.4 kg/m ²
Obese	30 or more kg/m ²	27.5 kg/m ² or more

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Appendix 1

Tender Response Document



the 1990s, the number of people in the world who are under 15 years of age has increased by 1.2 billion, from 1.1 billion in 1980 to 2.3 billion in 1999. The number of children under 15 years of age in the world is projected to increase to 2.8 billion by 2015 (United Nations 1999).

There is a growing awareness of the need to address the needs of children in the world. The United Nations Convention on the Rights of the Child (1989) is the most widely ratified human rights treaty in the world. It sets out the rights of children and the responsibilities of governments to protect and promote these rights. The Convention has been ratified by 112 countries, including all of the member states of the United Nations.

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the 1990s, the number of people in the UK who are aged 65 and over has increased by 1.5 million (1990–1999) and is projected to increase by a further 1.5 million by 2010 (Office of National Statistics 2000).

There is a growing awareness of the need to develop strategies to meet the needs of the ageing population. The Department of Health (2000) has identified the need to develop a new paradigm of care for the ageing population, one that is based on the concept of 'active ageing'. This paradigm is based on the idea that ageing is a process, not a state, and that the goal of care should be to promote the health and well-being of older people, rather than to simply manage their decline. This paradigm is based on the idea that older people should be able to live independently, actively, and with dignity, and that the health and social care system should be designed to support this goal.

The Department of Health (2000) has identified a number of key areas for action in order to achieve this goal. These include: (1) promoting the health and well-being of older people; (2) supporting older people to live independently; (3) promoting the social inclusion of older people; and (4) ensuring that the health and social care system is designed to support the needs of older people. These areas are interrelated and need to be addressed in a holistic way.

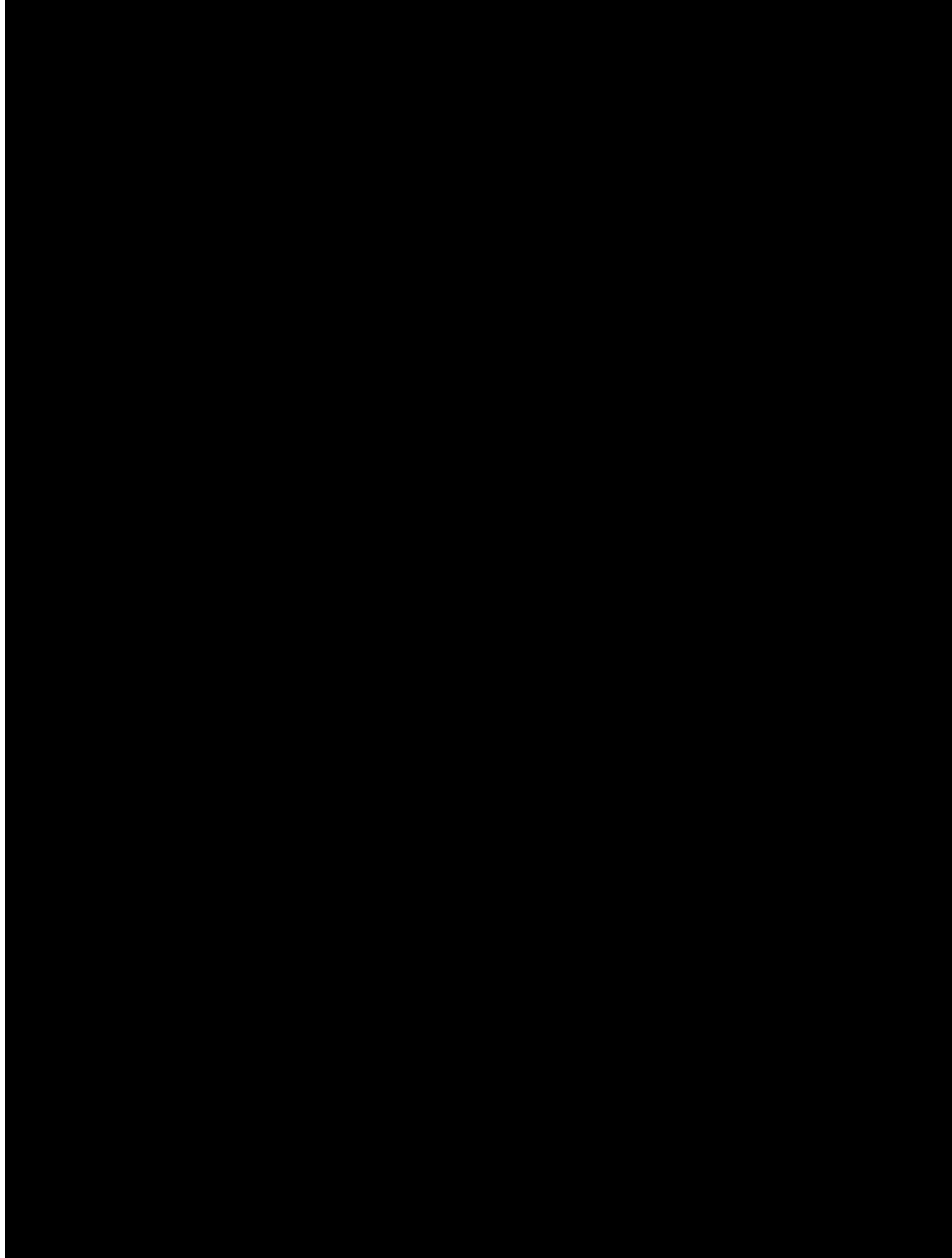
The Department of Health (2000) has also identified a number of key challenges that need to be addressed in order to achieve this goal. These include: (1) the need to develop a new paradigm of care for the ageing population; (2) the need to develop a new workforce for the ageing population; (3) the need to develop a new infrastructure for the ageing population; and (4) the need to develop a new funding model for the ageing population. These challenges are interrelated and need to be addressed in a holistic way.

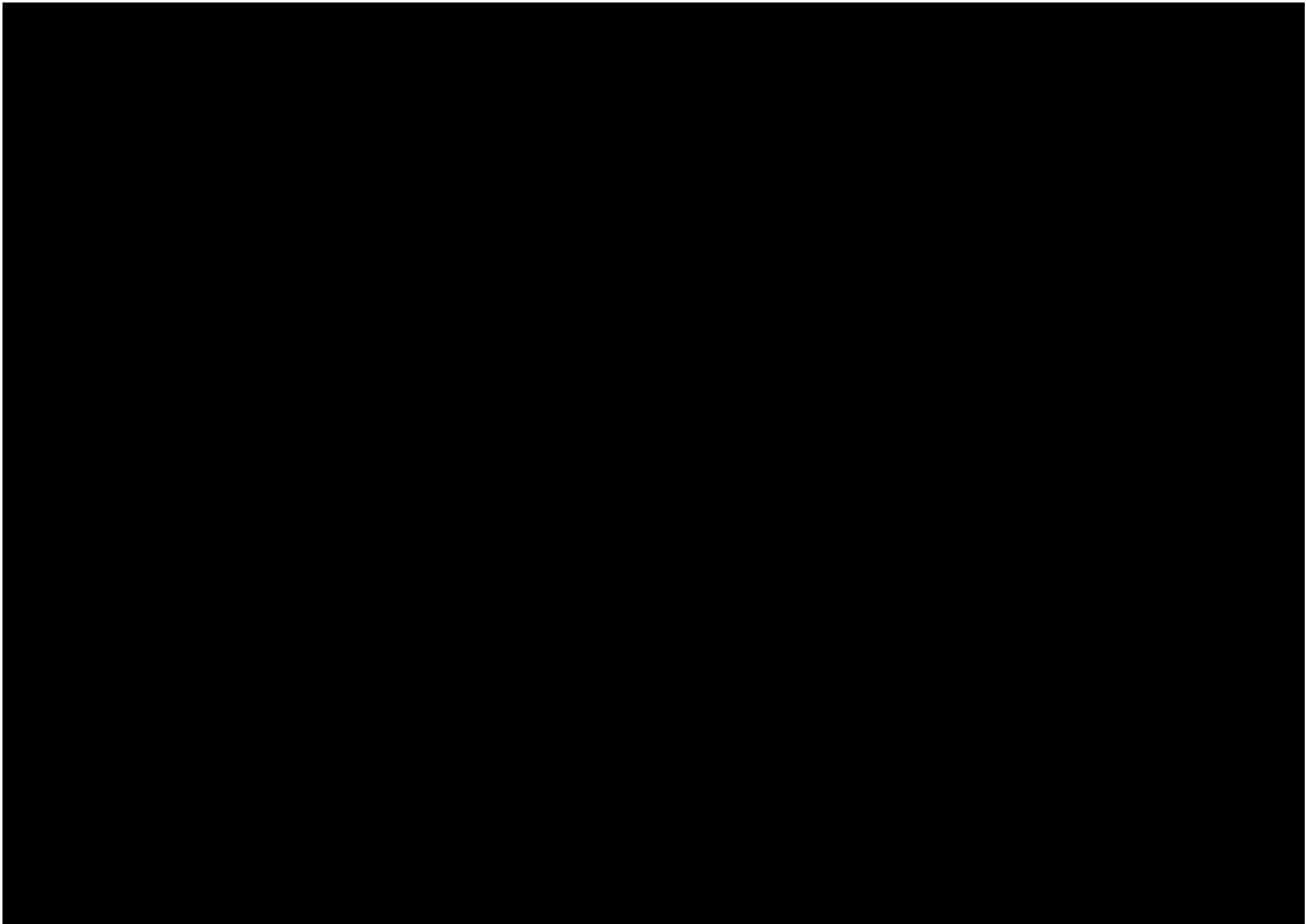
The Department of Health (2000) has also identified a number of key opportunities that need to be seized in order to achieve this goal. These include: (1) the need to develop a new paradigm of care for the ageing population; (2) the need to develop a new workforce for the ageing population; (3) the need to develop a new infrastructure for the ageing population; and (4) the need to develop a new funding model for the ageing population. These opportunities are interrelated and need to be addressed in a holistic way.

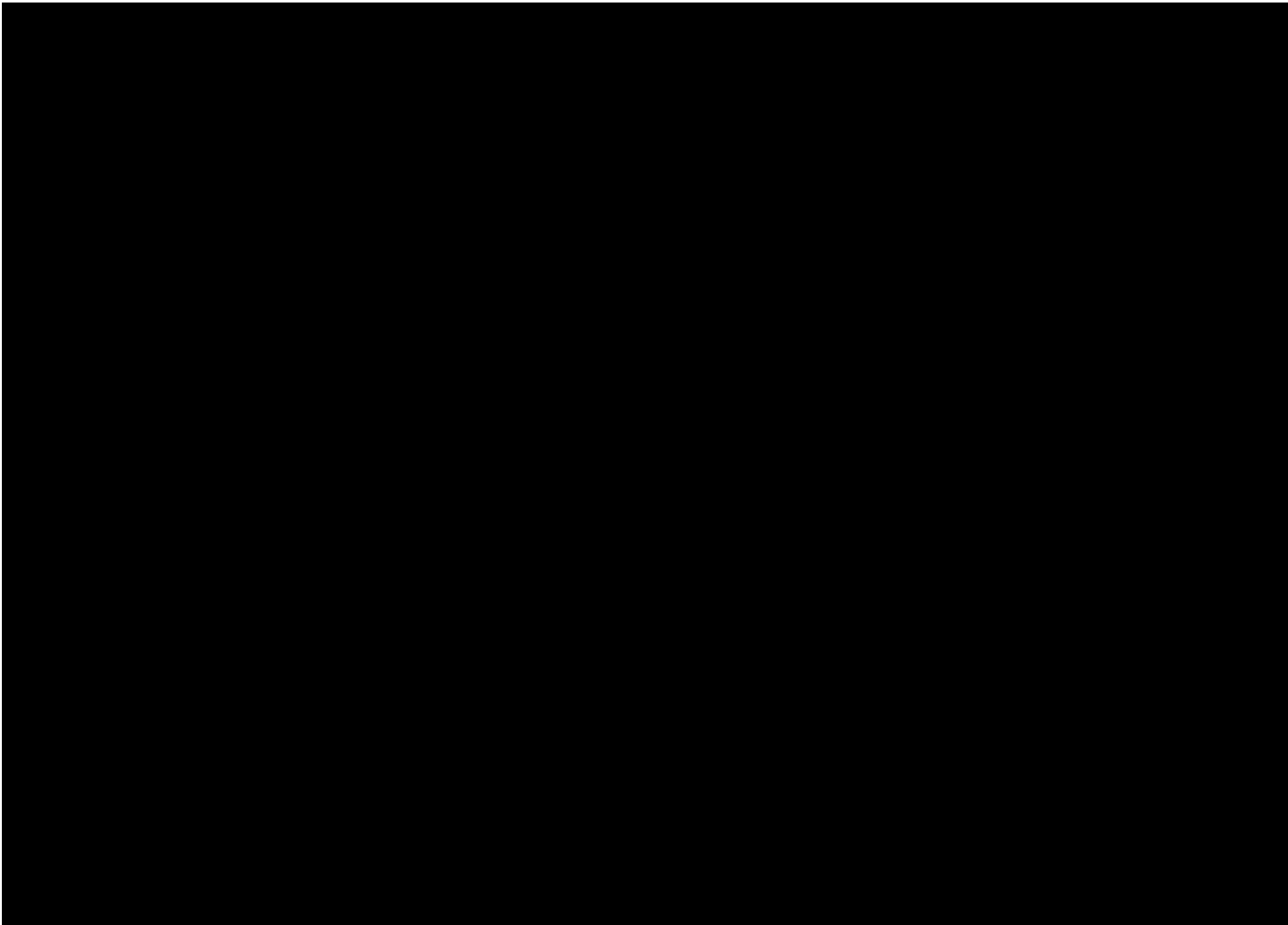
The Department of Health (2000) has also identified a number of key priorities that need to be addressed in order to achieve this goal. These include: (1) the need to develop a new paradigm of care for the ageing population; (2) the need to develop a new workforce for the ageing population; (3) the need to develop a new infrastructure for the ageing population; and (4) the need to develop a new funding model for the ageing population. These priorities are interrelated and need to be addressed in a holistic way.

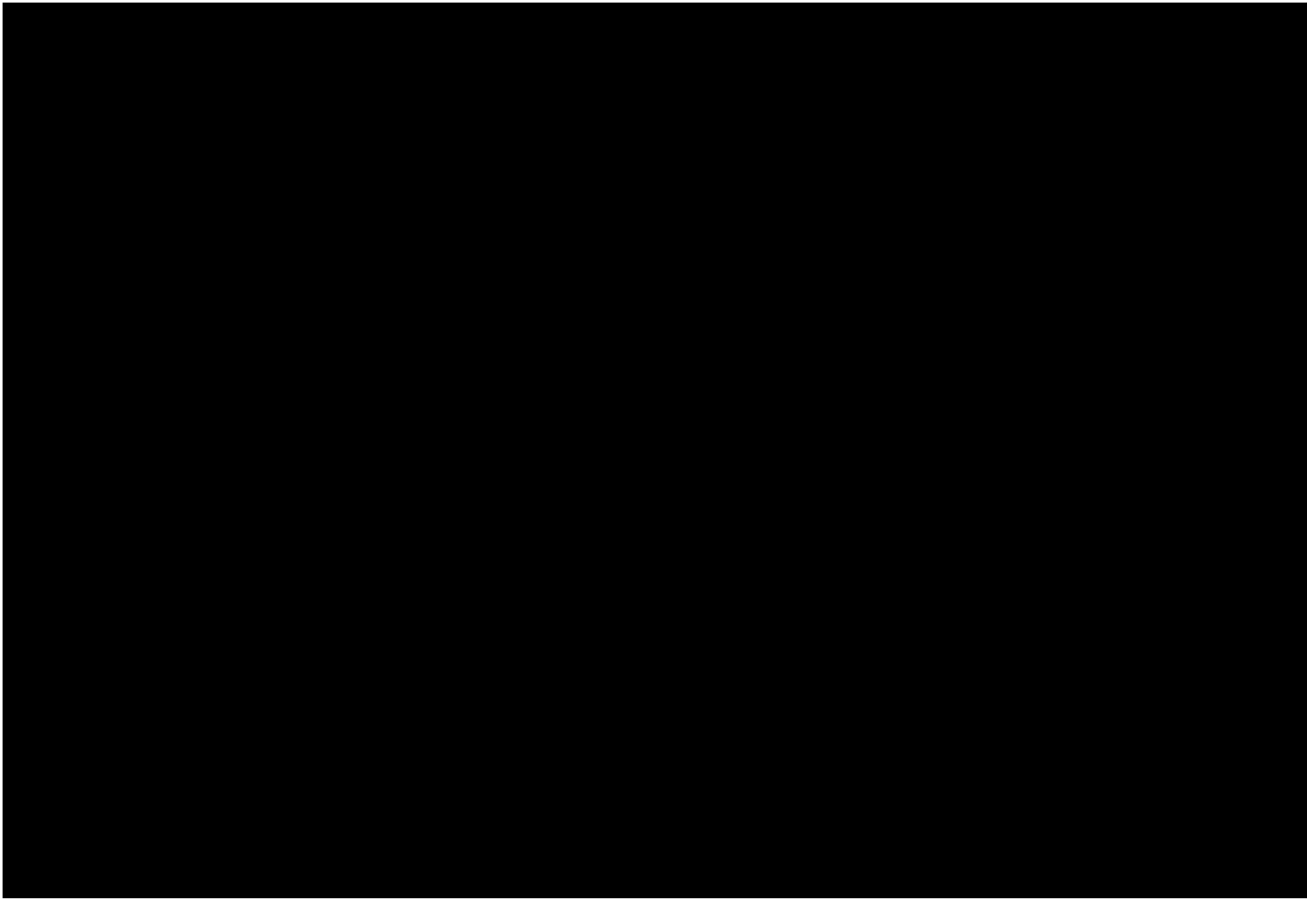
The Department of Health (2000) has also identified a number of key actions that need to be taken in order to achieve this goal. These include: (1) the need to develop a new paradigm of care for the ageing population; (2) the need to develop a new workforce for the ageing population; (3) the need to develop a new infrastructure for the ageing population; and (4) the need to develop a new funding model for the ageing population. These actions are interrelated and need to be addressed in a holistic way.

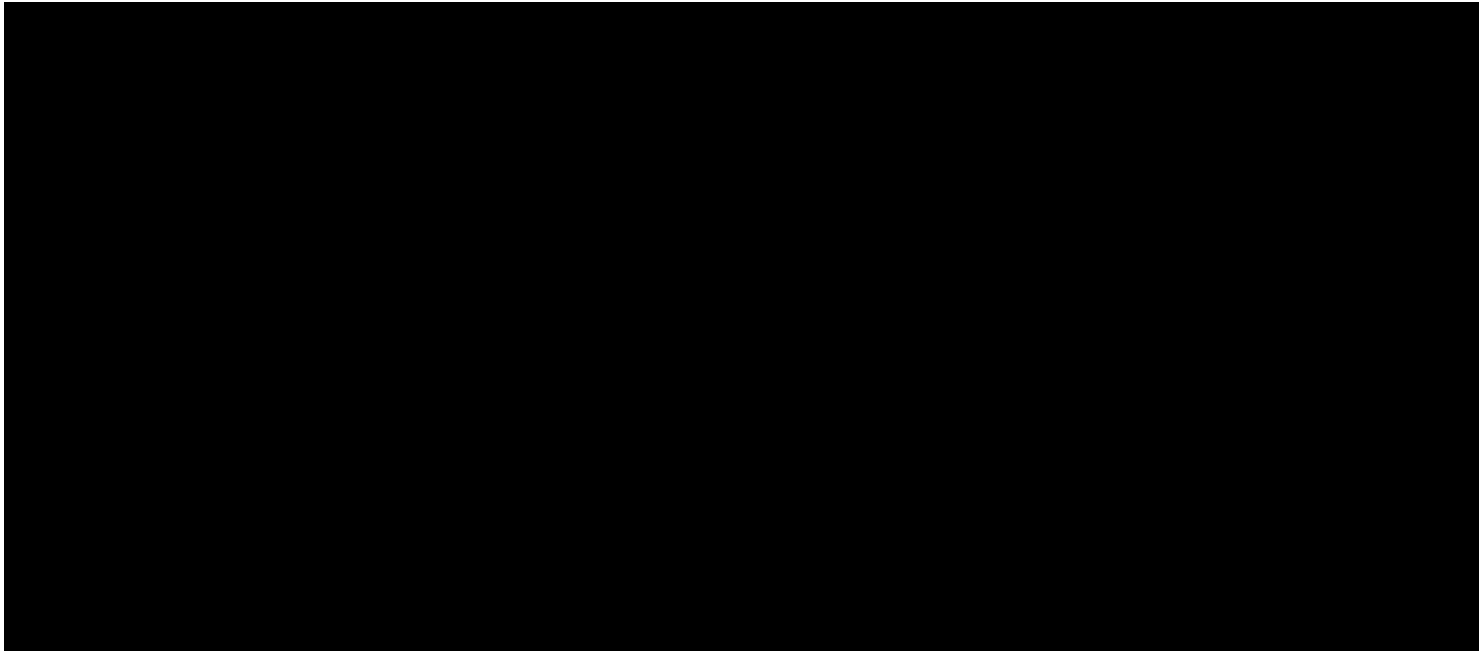
The Department of Health (2000) has also identified a number of key outcomes that need to be achieved in order to achieve this goal. These include: (1) the need to develop a new paradigm of care for the ageing population; (2) the need to develop a new workforce for the ageing population; (3) the need to develop a new infrastructure for the ageing population; and (4) the need to develop a new funding model for the ageing population. These outcomes are interrelated and need to be addressed in a holistic way.

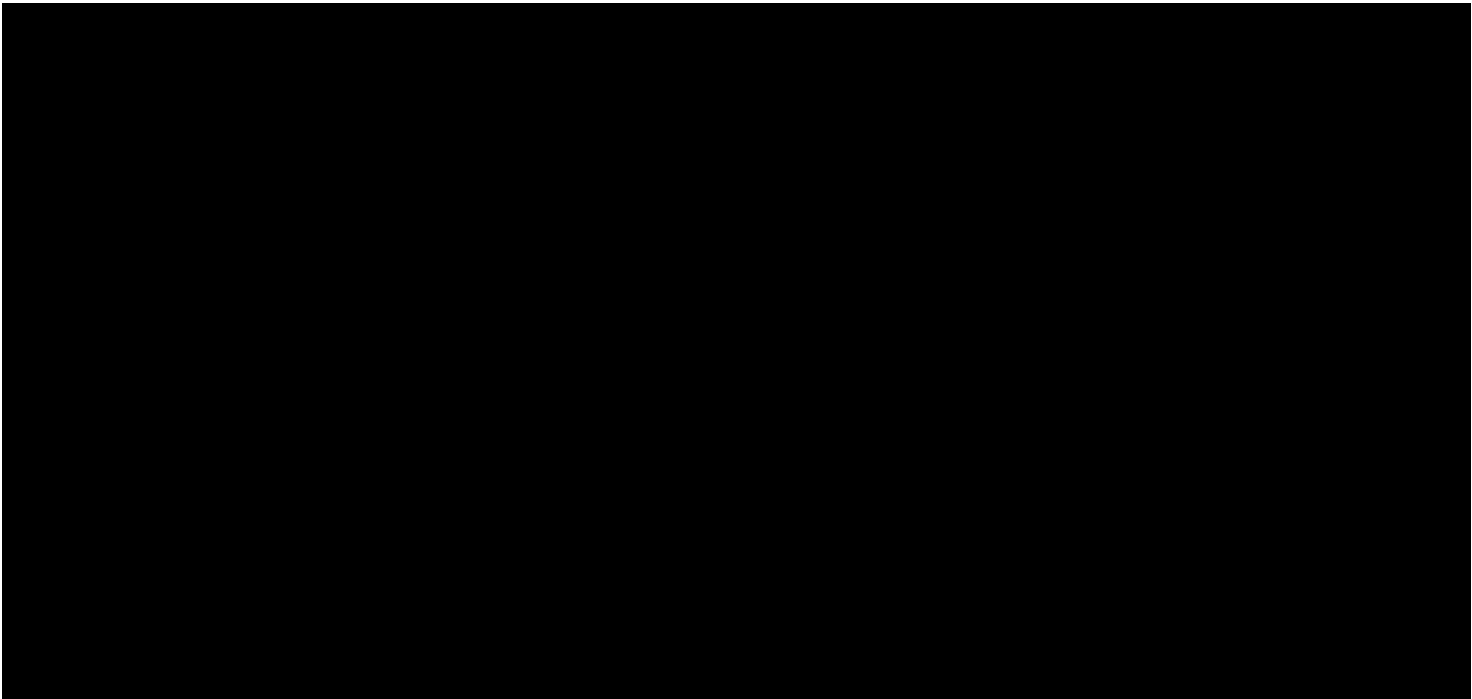












the 1990s, the number of people in the United States who are obese has increased by 100% (Flegal et al. 2002). In the United Kingdom, the prevalence of obesity has increased from 10% in 1980 to 15% in 1997 (Health Survey for England 1997). In the United States, the prevalence of obesity has increased from 15% in 1980 to 23% in 1994 (Flegal et al. 2002).

Obesity is a complex condition, and its aetiology is multifactorial. It is a result of an imbalance between energy intake and energy expenditure. The energy intake is determined by the amount of food and drink consumed, and the energy expenditure is determined by the amount of physical activity. The imbalance between energy intake and energy expenditure is the result of a combination of genetic, environmental, and behavioural factors.

Obesity is a major public health problem because it is a risk factor for a number of chronic diseases, including heart disease, stroke, diabetes, and certain types of cancer. It is also a leading cause of disability and premature death. In the United States, obesity is the leading cause of death among children and adolescents (Flegal et al. 2002).

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the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million, from 2.5 million in 1980 to 4 million in 1995. The public sector has also become an important employer of women, with 5.5 million women employed in the public sector in 1995, compared with 4.5 million in 1980. The public sector has also become an important employer of people with disabilities, with 1.5 million people with disabilities employed in the public sector in 1995, compared with 1 million in 1980.

The public sector has also become an important employer of people who are over 50 years of age. In 1995, 1.5 million people over 50 years of age were employed in the public sector, compared with 1 million in 1980. The public sector has also become an important employer of people who are under 25 years of age. In 1995, 1.5 million people under 25 years of age were employed in the public sector, compared with 1 million in 1980.

The public sector has also become an important employer of people who are from ethnic minorities. In 1995, 1.5 million people from ethnic minorities were employed in the public sector, compared with 1 million in 1980. The public sector has also become an important employer of people who are from the Caribbean. In 1995, 1.5 million people from the Caribbean were employed in the public sector, compared with 1 million in 1980.

The public sector has also become an important employer of people who are from the Indian subcontinent. In 1995, 1.5 million people from the Indian subcontinent were employed in the public sector, compared with 1 million in 1980. The public sector has also become an important employer of people who are from Pakistan. In 1995, 1.5 million people from Pakistan were employed in the public sector, compared with 1 million in 1980.

The public sector has also become an important employer of people who are from Bangladesh. In 1995, 1.5 million people from Bangladesh were employed in the public sector, compared with 1 million in 1980. The public sector has also become an important employer of people who are from Africa. In 1995, 1.5 million people from Africa were employed in the public sector, compared with 1 million in 1980.

The public sector has also become an important employer of people who are from Asia. In 1995, 1.5 million people from Asia were employed in the public sector, compared with 1 million in 1980. The public sector has also become an important employer of people who are from the Middle East. In 1995, 1.5 million people from the Middle East were employed in the public sector, compared with 1 million in 1980.

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the 1990s, the number of people in the UK who are aged 65 and over has increased by 1.5 million (1990–1999) and is projected to increase by a further 1.5 million by 2010 (Office for National Statistics, 2000). The number of people aged 65 and over is projected to increase by 2.5 million by 2020 (Office for National Statistics, 2000).

There is a growing awareness of the need to develop strategies to meet the needs of the ageing population. The Department of Health (1999) has published a strategy for the ageing population, which sets out the government's commitment to improve the health and well-being of older people. The strategy is based on the following principles: (1) to improve the health and well-being of older people; (2) to ensure that older people are able to live independently; (3) to ensure that older people are able to participate in society; and (4) to ensure that older people are able to live in their own homes.

The strategy is based on the following principles: (1) to improve the health and well-being of older people; (2) to ensure that older people are able to live independently; (3) to ensure that older people are able to participate in society; and (4) to ensure that older people are able to live in their own homes. The strategy is based on the following principles: (1) to improve the health and well-being of older people; (2) to ensure that older people are able to live independently; (3) to ensure that older people are able to participate in society; and (4) to ensure that older people are able to live in their own homes.

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the first of these is the fact that the majority of the population is now living in urban areas. This has led to a concentration of people in a few large cities, which has in turn led to a number of problems. One of the most serious is the lack of adequate housing. In many of these cities, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these cities, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these cities, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

The second of these problems is the fact that the majority of the population is now living in rural areas. This has led to a number of problems. One of the most serious is the lack of adequate housing. In many of these areas, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these areas, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these areas, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

The third of these problems is the fact that the majority of the population is now living in coastal areas. This has led to a number of problems. One of the most serious is the lack of adequate housing. In many of these areas, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these areas, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these areas, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

The fourth of these problems is the fact that the majority of the population is now living in mountainous areas. This has led to a number of problems. One of the most serious is the lack of adequate housing. In many of these areas, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these areas, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these areas, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

The fifth of these problems is the fact that the majority of the population is now living in hilly areas. This has led to a number of problems. One of the most serious is the lack of adequate housing. In many of these areas, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these areas, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these areas, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

The sixth of these problems is the fact that the majority of the population is now living in valley areas. This has led to a number of problems. One of the most serious is the lack of adequate housing. In many of these areas, the housing is of very poor quality and is often overcrowded. This leads to a number of health problems, including the spread of disease. Another problem is the lack of adequate sanitation. In many of these areas, there is no proper sewage system, and the waste is often dumped in the streets. This leads to a number of health problems, including the spread of disease. A third problem is the lack of adequate employment opportunities. In many of these areas, the majority of the population is engaged in low-paying, unskilled work. This leads to a number of social problems, including poverty and crime.

the first of these is the fact that the majority of the population is now living in urban areas. This has led to a concentration of people in a few large cities, which has in turn led to a number of problems. One of the most serious is the problem of housing. In many of the large cities, there is a severe shortage of housing, and this has led to a number of people living in slums. Another problem is the problem of pollution. The large cities are now producing a great deal of pollution, and this is having a serious effect on the environment. A third problem is the problem of unemployment. In many of the large cities, there is a high level of unemployment, and this is leading to a number of social problems.

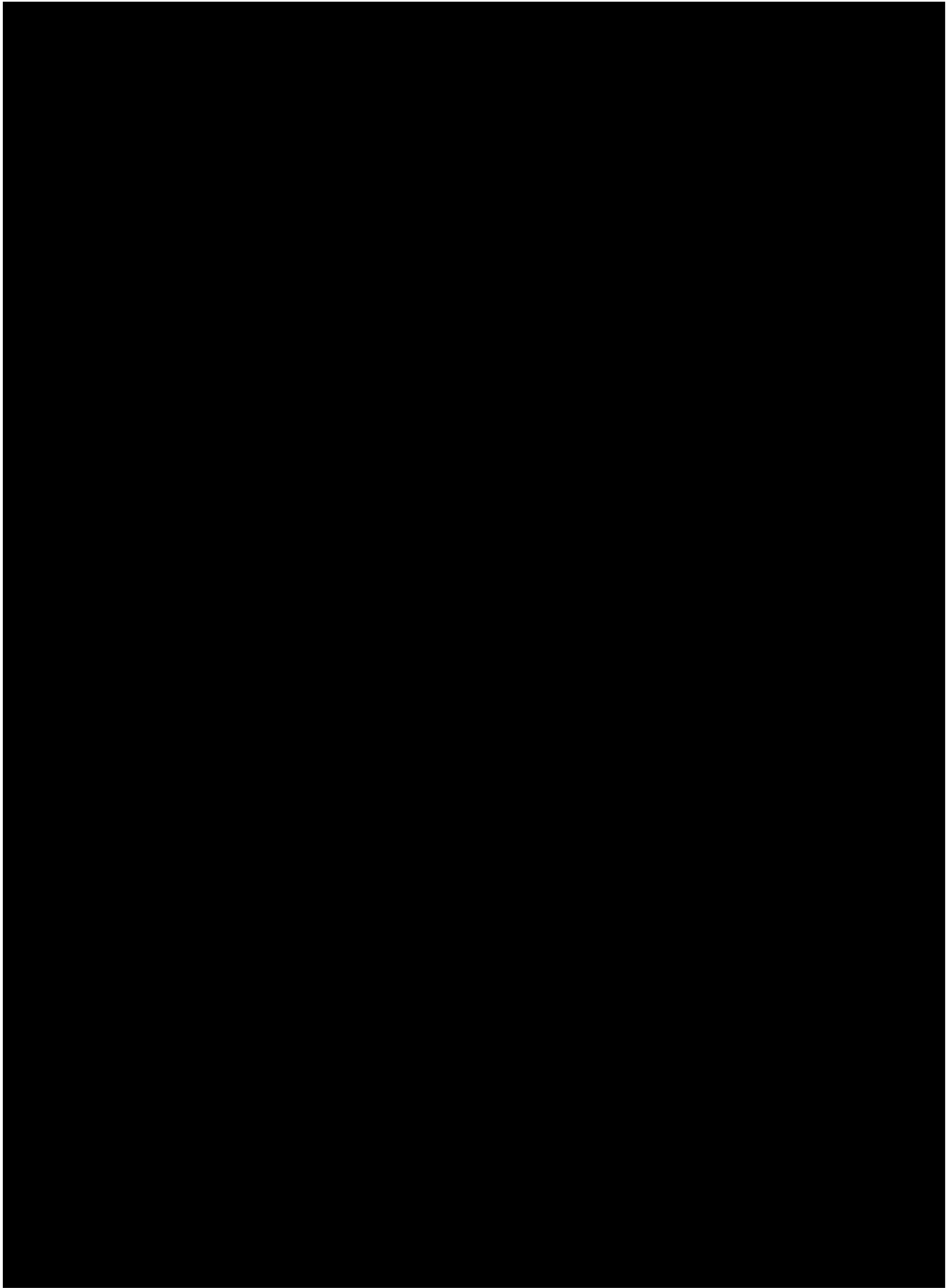
The second of the main trends is the trend towards a more diversified economy. In the past, many of the countries in the world have been dependent on a few primary products, such as cotton or sugar. However, in recent years, many of these countries have been diversifying their economies. This has led to a number of new industries, such as manufacturing and services. This diversification has helped to reduce the risk of economic crisis, and it has also helped to create new jobs.

The third of the main trends is the trend towards a more integrated world. In the past, many of the countries in the world have been isolated from each other. However, in recent years, there has been a great deal of international trade and investment. This has led to a more integrated world, and it has also helped to create new jobs. The trend towards a more integrated world is one of the most important trends in the world today, and it is likely to continue for many years to come.

The fourth of the main trends is the trend towards a more democratic world. In the past, many of the countries in the world have been ruled by authoritarian governments. However, in recent years, there has been a great deal of democratic reform. This has led to a more democratic world, and it has also helped to create new jobs. The trend towards a more democratic world is one of the most important trends in the world today, and it is likely to continue for many years to come.

The fifth of the main trends is the trend towards a more peaceful world. In the past, many of the countries in the world have been at war with each other. However, in recent years, there has been a great deal of peace. This has led to a more peaceful world, and it has also helped to create new jobs. The trend towards a more peaceful world is one of the most important trends in the world today, and it is likely to continue for many years to come.

The sixth of the main trends is the trend towards a more sustainable world. In the past, many of the countries in the world have been exploiting their natural resources. However, in recent years, there has been a great deal of concern about the environment. This has led to a more sustainable world, and it has also helped to create new jobs. The trend towards a more sustainable world is one of the most important trends in the world today, and it is likely to continue for many years to come.



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The second of the main trends is the process of industrialization. This has led to a number of changes in the way that people live and work. One of the most important changes is the fact that people now work in factories and other large-scale enterprises. This has led to a number of changes in the way that people live. For example, people now live in a more organized and planned way than they did in the past. They have access to a number of services that were not available to them in the past, and they are able to live in a more comfortable and convenient way. However, there are also a number of problems associated with industrialization. One of the most serious is the problem of pollution. The concentration of factories and other sources of pollution in a few large cities has led to a number of health problems. Another problem is the problem of unemployment. In many of the large cities, there is a high level of unemployment, and this has led to a number of social problems.

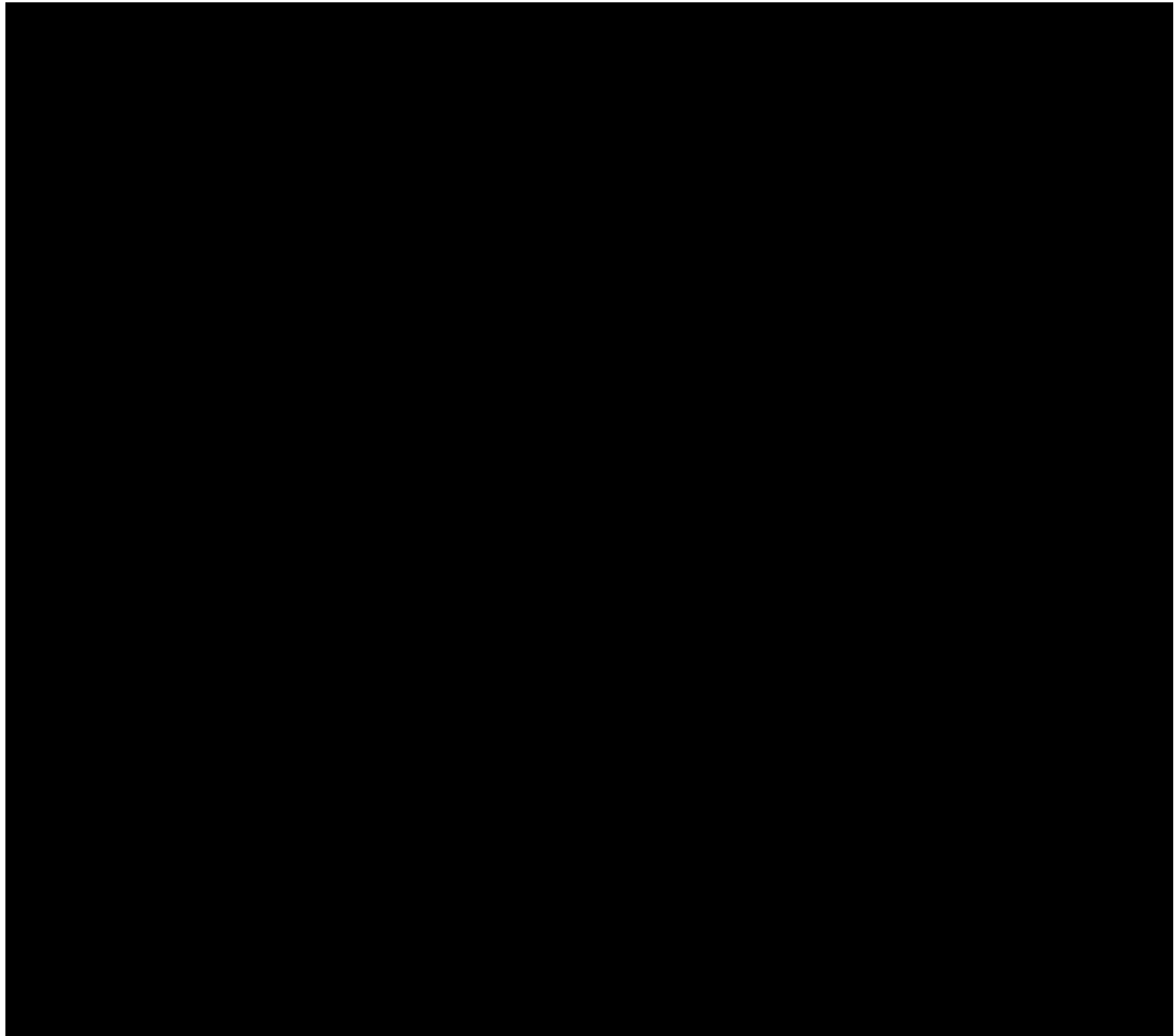
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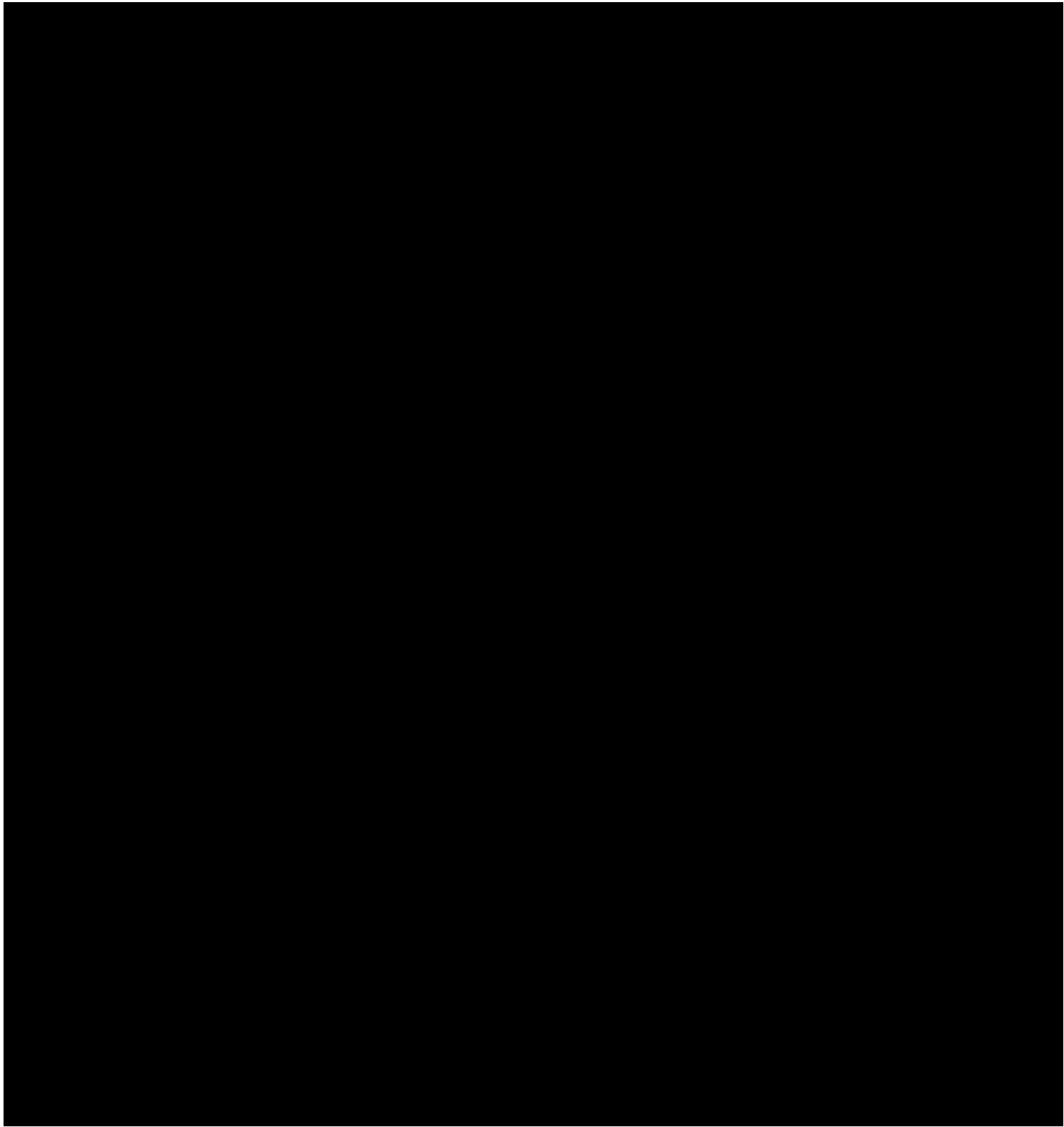
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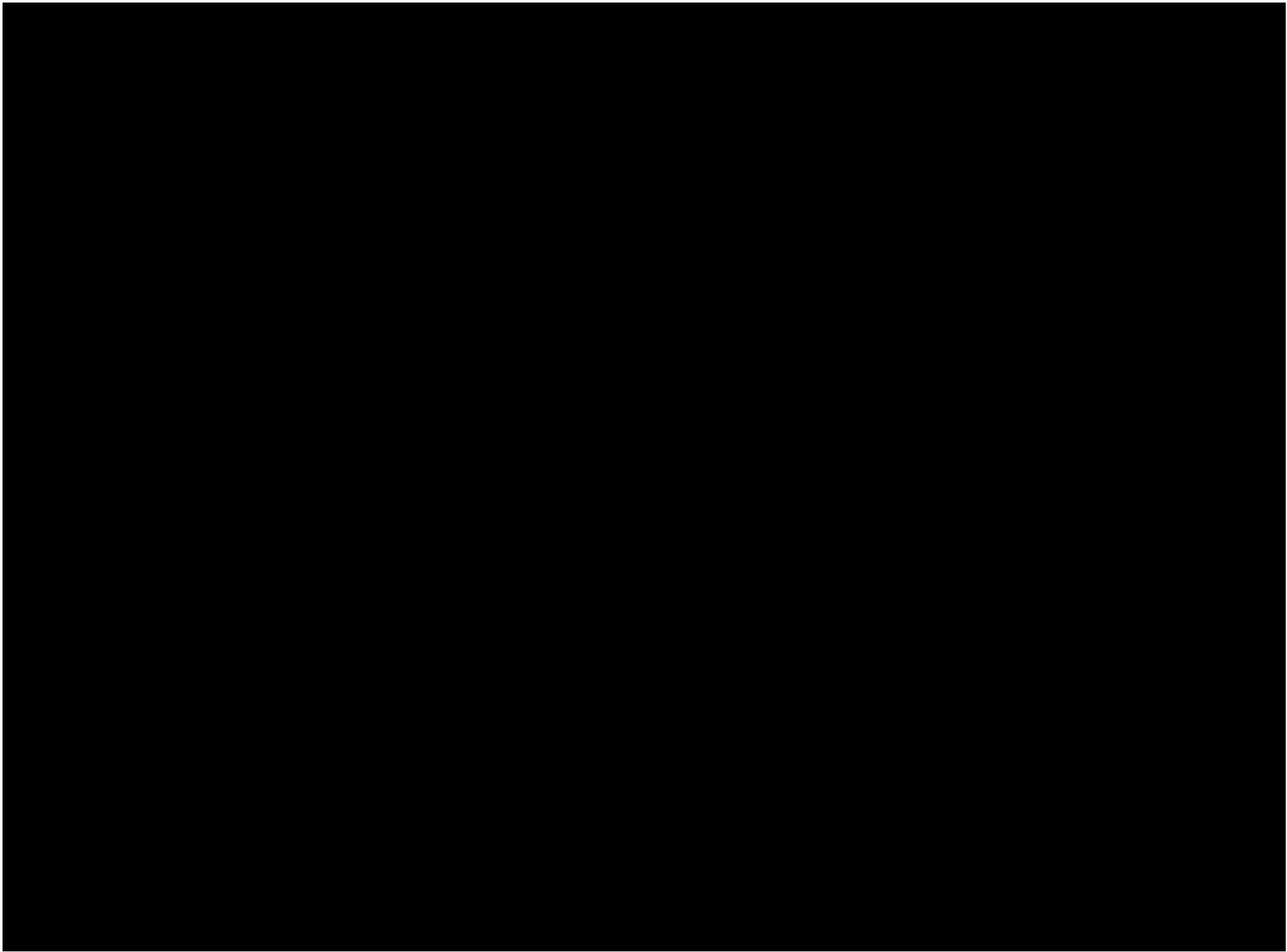
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The sixth of the main trends is the process of ruralization. This has led to a number of changes in the way that people live and work. One of the most important changes is the fact that people now live in a more organized and planned way than they did in the past. They have access to a number of services that were not available to them in the past, and they are able to live in a more comfortable and convenient way. However, there are also a number of problems associated with ruralization. One of the most serious is the problem of pollution. The concentration of factories and other sources of pollution in a few large cities has led to a number of health problems. Another problem is the problem of unemployment. In many of the large cities, there is a high level of unemployment, and this has led to a number of social problems.

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the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million (from 2.5 million in 1980 to 4 million in 1995). The number of people in the public sector who are employed in the health sector has increased by 1.2 million (from 1.2 million in 1980 to 2.4 million in 1995).

There are a number of reasons why the public sector has grown so rapidly. One of the main reasons is that the government has increased its spending on the public sector. Another reason is that the private sector has not been able to provide enough services to meet the needs of the population.

The growth of the public sector has led to a number of problems. One of the main problems is that the public sector is becoming increasingly inefficient. Another problem is that the public sector is becoming increasingly expensive.

There are a number of ways in which the public sector can be made more efficient. One way is to reduce the number of people employed in the public sector. Another way is to reduce the cost of the services provided by the public sector.

The government has a number of policies in place to reduce the size of the public sector. One of the main policies is to reduce the number of people employed in the public sector. Another policy is to reduce the cost of the services provided by the public sector.

There are a number of challenges facing the government in its efforts to reduce the size of the public sector. One of the main challenges is that the public sector is becoming increasingly important to the economy. Another challenge is that the public sector is becoming increasingly popular with the public.

The government has a number of policies in place to address these challenges. One of the main policies is to reduce the number of people employed in the public sector. Another policy is to reduce the cost of the services provided by the public sector.

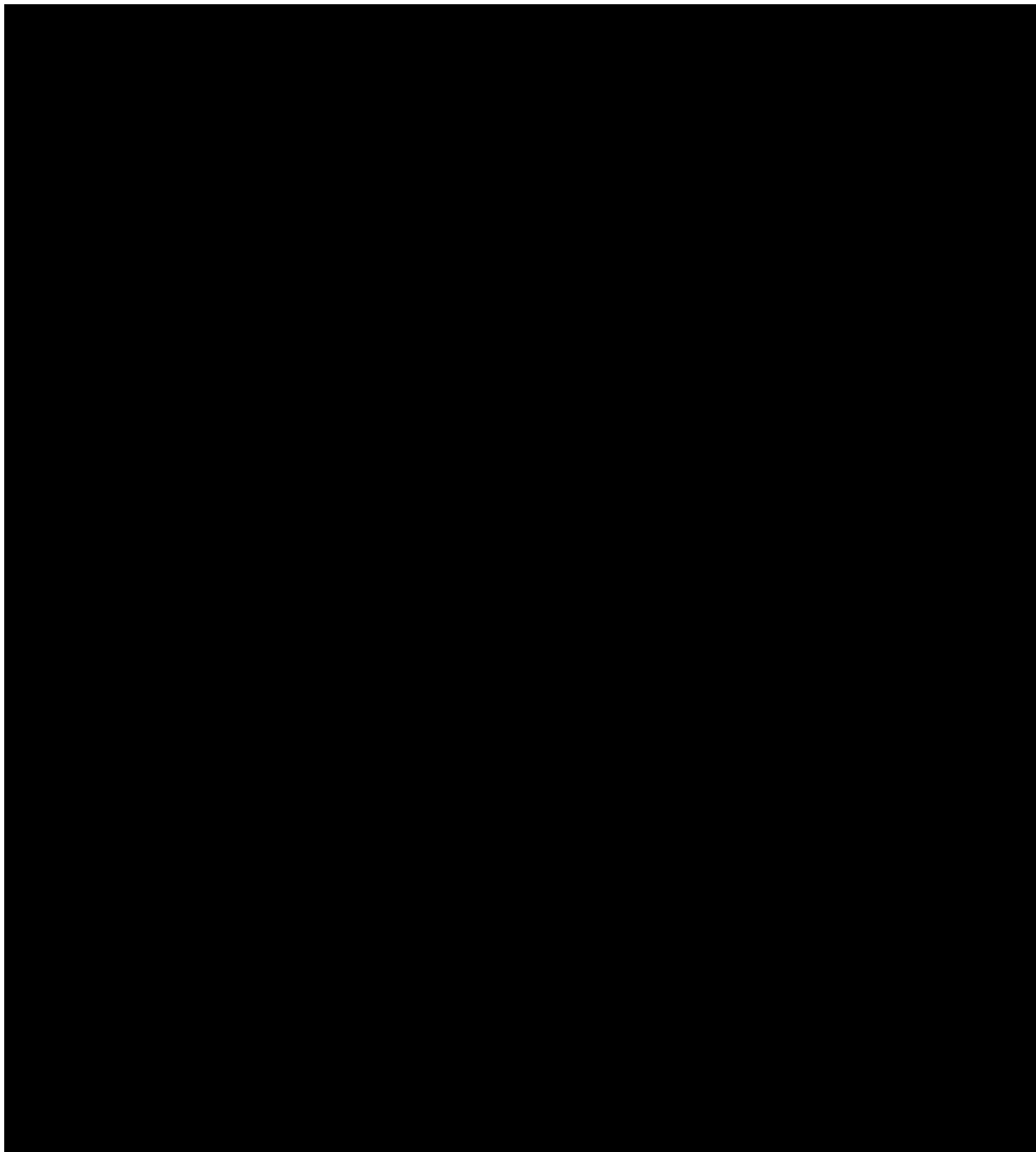
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the 1990s, the number of people in the world who are under 15 years of age has increased from 1.1 billion to 1.5 billion, and the number of people aged 65 and over has increased from 0.2 billion to 0.4 billion (United Nations, 1999).

There are a number of reasons why the world population is ageing. One of the main reasons is that the number of people who are living longer is increasing. This is due to a number of factors, including improvements in medical care, better nutrition, and a decline in the number of people who are dying from infectious diseases. Another reason is that the number of people who are having children is decreasing. This is due to a number of factors, including a decline in the number of people who are having children at a young age, and a decline in the number of people who are having children at all.

The ageing of the world population has a number of implications. One of the main implications is that it will lead to a decline in the number of people who are working. This is because the number of people who are working is declining, while the number of people who are retired is increasing. This will lead to a decline in the number of people who are contributing to the economy, and a decline in the number of people who are paying taxes.

Another implication is that it will lead to a decline in the number of people who are able to support themselves. This is because the number of people who are able to support themselves is declining, while the number of people who are unable to support themselves is increasing. This will lead to a decline in the number of people who are able to pay for their own care, and a decline in the number of people who are able to pay for the care of others.

There are a number of ways in which the world population can be managed to deal with the ageing of the world population. One way is to increase the number of people who are working. This can be done by increasing the number of people who are having children, and by increasing the number of people who are working at a young age. Another way is to increase the number of people who are able to support themselves. This can be done by increasing the number of people who are able to pay for their own care, and by increasing the number of people who are able to pay for the care of others.

There are a number of challenges that the world population will face in the future. One of the main challenges is that the number of people who are working will decline, while the number of people who are retired will increase. This will lead to a decline in the number of people who are contributing to the economy, and a decline in the number of people who are paying taxes. Another challenge is that the number of people who are able to support themselves will decline, while the number of people who are unable to support themselves will increase. This will lead to a decline in the number of people who are able to pay for their own care, and a decline in the number of people who are able to pay for the care of others.

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the 1990s, the number of people in the world who are under 15 years of age has increased by 1.2 billion, from 1.1 billion in 1980 to 2.3 billion in 1999. The number of people aged 15 years and over has increased by 1.5 billion, from 2.5 billion in 1980 to 4.0 billion in 1999.

There are a number of reasons why the world population is growing so rapidly. One of the main reasons is that the number of children born to each woman has increased. This is due to a number of factors, including improved medical care, increased access to contraception, and a shift in cultural values.

Another reason why the world population is growing so rapidly is that the number of people who are surviving into old age has increased. This is due to a number of factors, including improved medical care, increased access to health care, and a shift in cultural values.

There are a number of challenges that the world population growth poses. One of the main challenges is that it is putting a strain on the world's resources. This is because there are a limited number of resources, such as food, water, and energy, and the growing population is increasing the demand for these resources.

Another challenge that the world population growth poses is that it is increasing the risk of environmental degradation. This is because the growing population is increasing the demand for land, which is being converted into agricultural land and urban areas. This is leading to deforestation, loss of biodiversity, and increased pollution.

There are a number of ways that the world population growth can be managed. One way is to improve the world's resources. This can be done by increasing the efficiency of resource use, by developing new technologies, and by improving the distribution of resources.

Another way that the world population growth can be managed is by reducing the number of people who are surviving into old age. This can be done by improving medical care, by increasing access to health care, and by shifting cultural values.

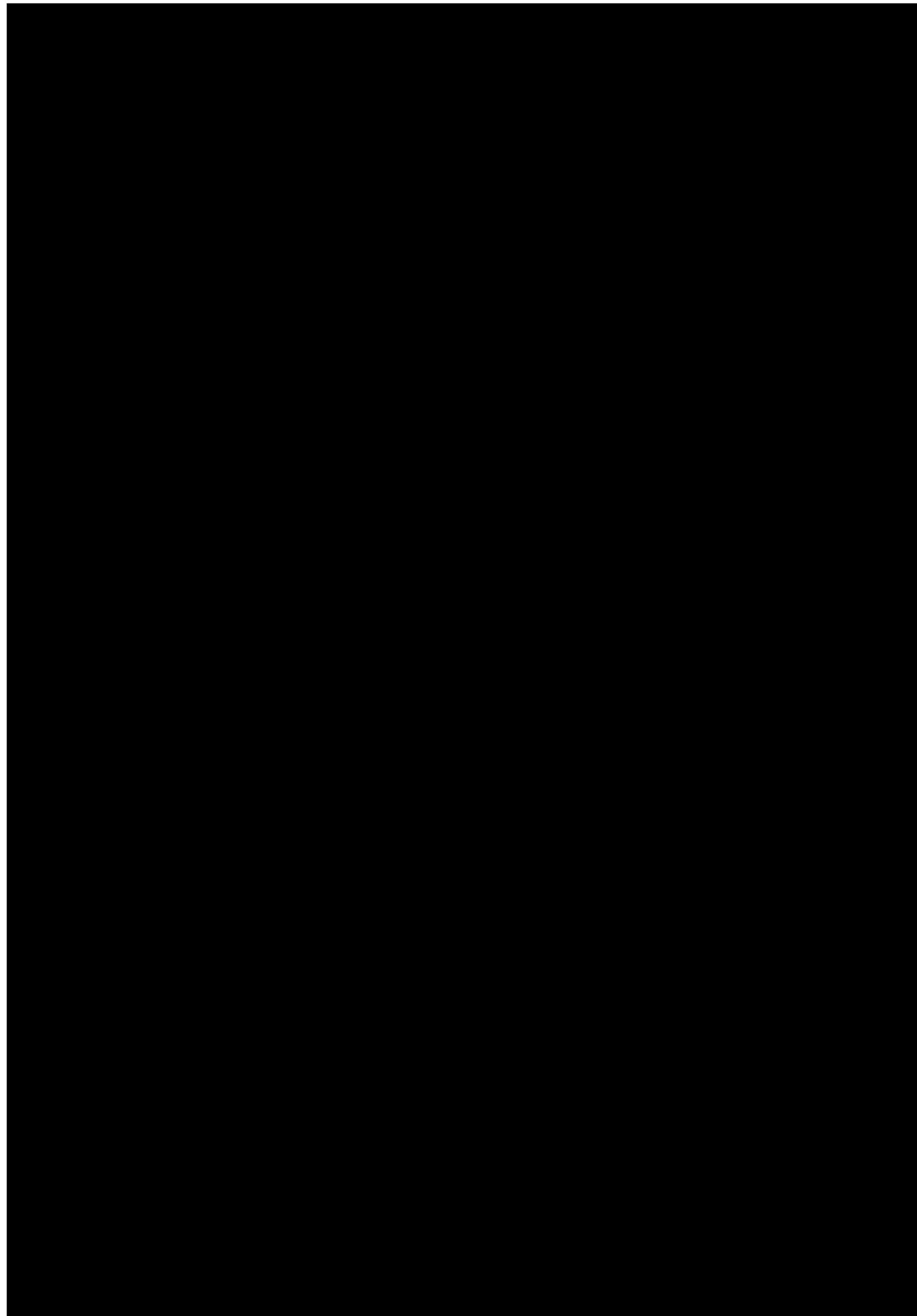
There are a number of other ways that the world population growth can be managed. These include increasing the number of people who are working, by improving the quality of education, and by increasing the number of people who are employed.

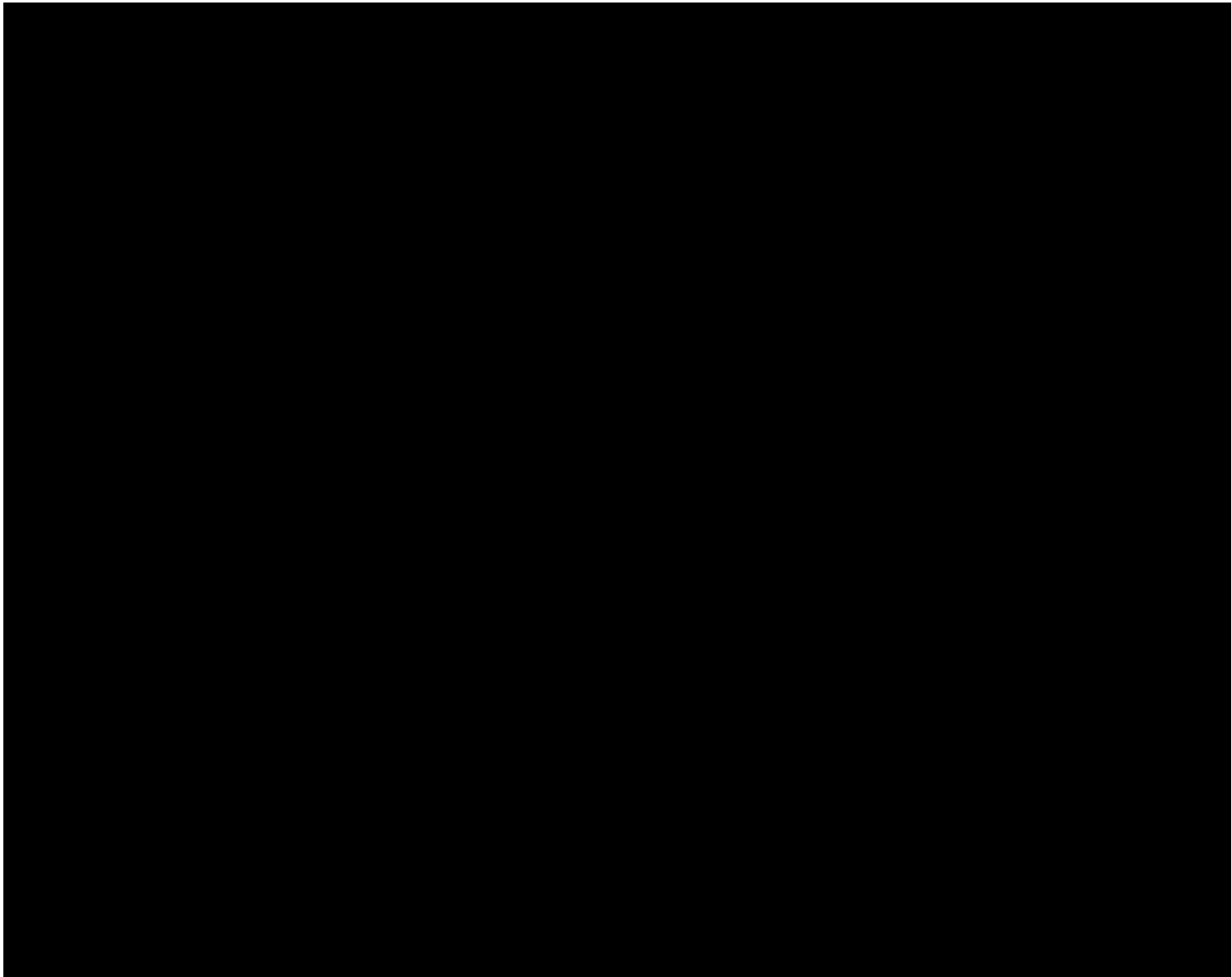
The world population growth is a complex issue that requires a number of different approaches to manage it. It is important that we work together to find solutions that will ensure a sustainable future for all of us.

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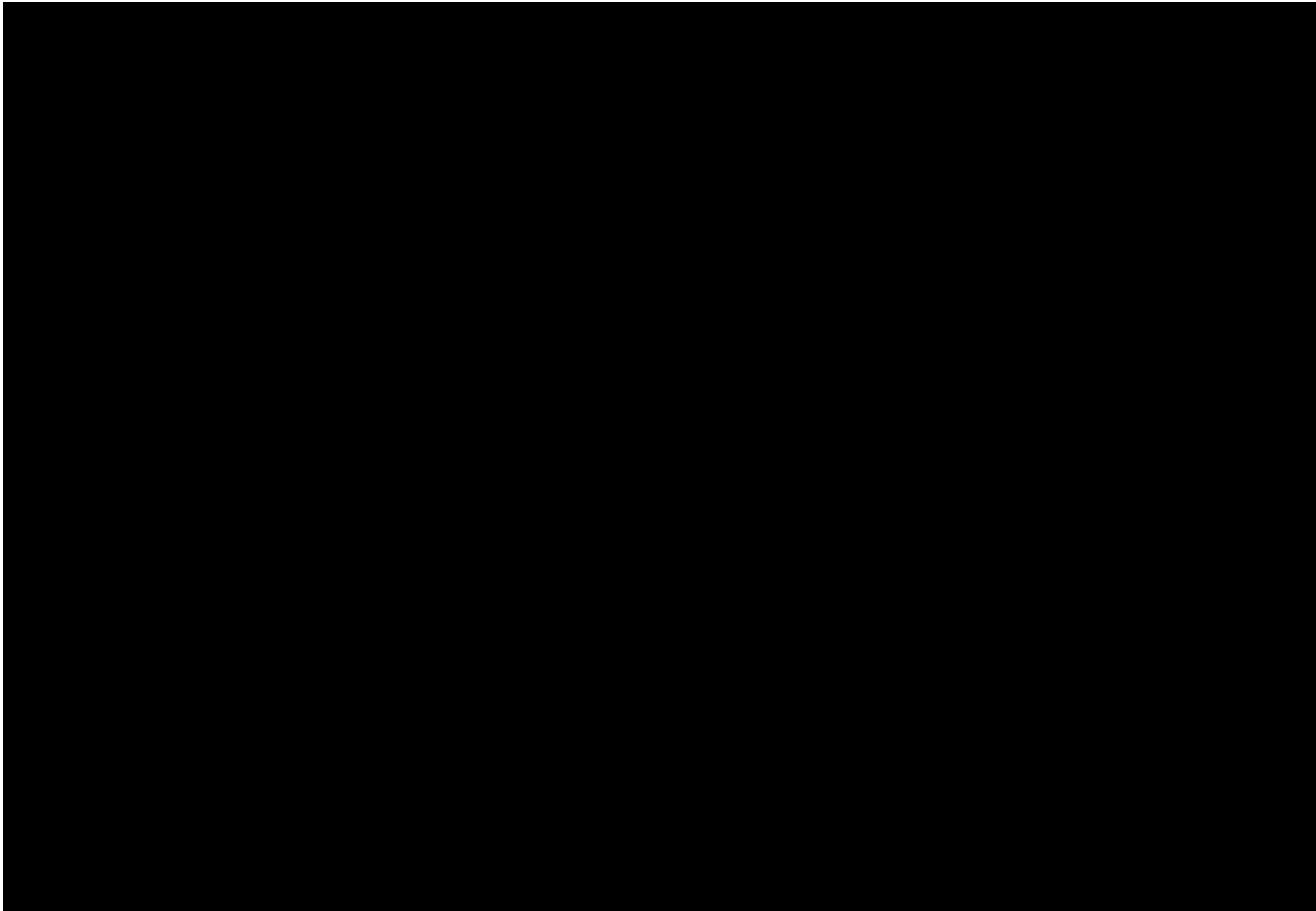
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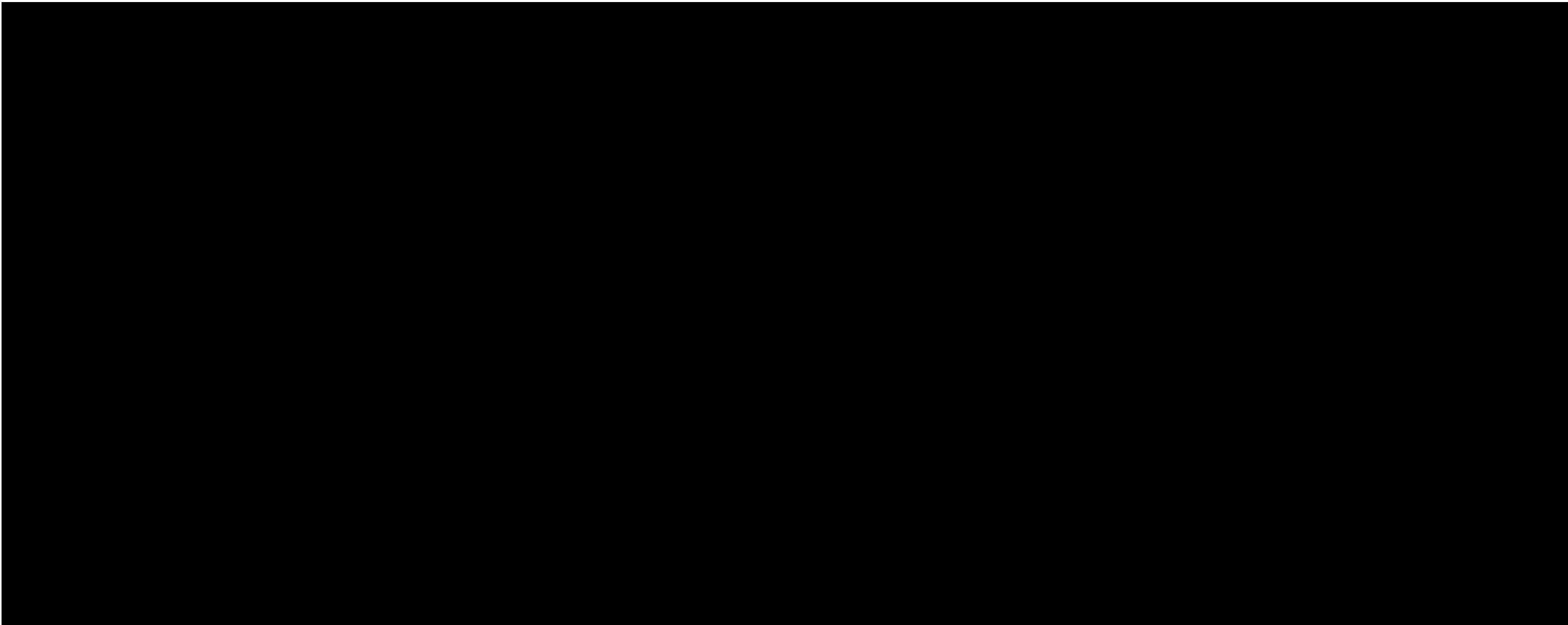
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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Appendix 2

Local Service Requirements

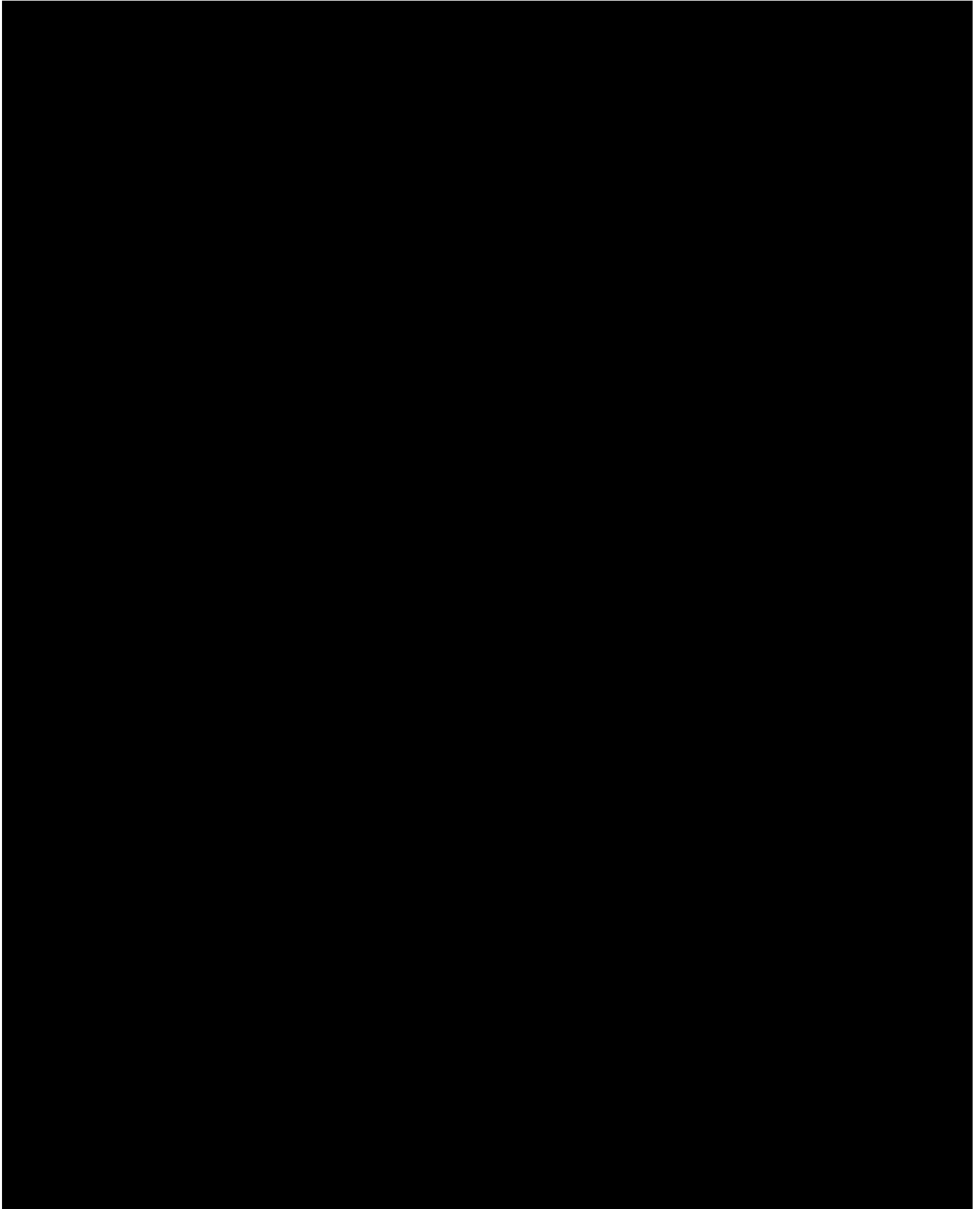


NDPP FW3
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SCHEDULE 2 – THE SERVICES

A. Service Specifications

Appendix 3



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

Not Applicable

SCHEDULE 2 – THE SERVICES

C. Activity Planning Assumptions

Not Applicable

SCHEDULE 2 – THE SERVICES

D. Essential Services (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

E. Essential Services Continuity Plan (NHS Trusts only)

Not Applicable

SCHEDULE 2 – THE SERVICES

F. Clinical Networks

Not Applicable

SCHEDULE 2 – THE SERVICES

G. Other Local Agreements, Policies and Procedures

Not Applicable

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

SCHEDULE 2 – THE SERVICES

H. Transition Arrangements

The Parties acknowledge that the referral profile contained in the Local Service Requirements at Appendix 2 of Schedule 2A is indicative only and not binding on the Parties. The Provider will put into effects its mobilisation plan provided in the Tender Response at Appendix 1 of Schedule 2A and agrees that, from 1st August 2022, it is able to receive referrals and provide the Services in accordance with the Service Specification.

SCHEDULE 2 – THE SERVICES

I. Exit Arrangements

Not Applicable

SCHEDULE 2 – THE SERVICES

J. Transfer of and Discharge from Care Protocols

The Provider must comply with relevant provisions of the Service Specifications that refer to discharge of Service Users.

The Provider must comply with any local protocols agreed with the lead partner organisations set out in the Local Service Requirements set out in Appendix 2 of Schedule 2A.

SCHEDULE 2 – THE SERVICES

K. Safeguarding Policies and Mental Capacity Act Policies

- | |
|--|
| <ul style="list-style-type: none">- Mental Capacity Act Policy- Safeguarding Policy |
|--|

SCHEDULE 2 – THE SERVICES

L. Provisions Applicable to Primary Medical Services

Not Applicable

SCHEDULE 2 – THE SERVICES

M. Development Plan for Personalised Care

Not Applicable

SCHEDULE 2 – THE SERVICES

N. Health Inequalities Action Plan

Not Applicable

SCHEDULE 3 – PAYMENT

A. Local Prices

1. The Commissioner will pay the Provider for the Services in accordance with this Schedule 3A.
2. Notwithstanding General Condition 1.2, the Parties expressly agree that Service Condition 36 shall only apply to and be incorporated into this Contract as follows:

Sub-Conditions of Service Condition 36 which are incorporated into this Contract	Sub-Conditions of Service Condition 36 which are excluded from this Contract
36.2	36.1
36.3	36.5
36.4	36.6 – 36.9 (inclusive)
36.10	36.11 – 36.38 (inclusive)
36.39 – 36.42 (inclusive)	36.43
36.44	36.45A – 36.45 (inclusive)
36.47	36.46
36.48	36.49

Definitions

3. In this Schedule 3A the following definitions are used:

“Achieved” means a Milestone and/or the Outcomes (as relevant) that have been achieved by the Provider in accordance with the Achievement Criteria and **“Achieve”** and **“Achievement”** shall be construed accordingly;

“Achievement Criteria” means the Face to Face Service Achievement Criteria, the Tailored Remote Service Achievement Criteria, the Digital Service Achievement Criteria and the Outcomes Achievement Criteria;

“Course” means the planned complete set of 13 sessions to be delivered by the Provider to each Service User who is invited to participate in the Face to Face Service or Tailored Remote Service following Individual Assessment;

“Data Output Specification” means the data output specification to be submitted by the Provider to the Commissioner in accordance with Schedule 6A;

“Date of Discharge” has the meaning set out in the Data Format Specifications at Annex 2 of Schedule 6A;

"Digital Service"	has the meaning given in paragraph 1.1.1 of Schedule 2A (Service Specification);
"Digital Service Achievement Criteria"	means the criteria which must be met by the Provider in relation to a Service User being provided with the Digital Service in order to Achieve a Milestone as set out in column 3 of Table 2, Part 1 of this Schedule 3A;
"Digital Service First Engagement Date"	means the date of the first episode of engagement for the Digital Service which uses one of the Digital Service Milestone 1 Engagement Methods;
"Digital Service Milestone 1 Engagement Methods"	means the following engagement methods: • conversation with a health coach or mentor comprising a 30 minute coaching appointment over the phone, or four messages sent by the service user, which have been responded to by the coach; • accessing two education modules or educational materials via a digital application or digital platform; • four tracking events of food, weight and/or activity against active goals. Up to two of these could be to amend or set a goal; • participation in a peer support forum or online group conversation, with a minimum of 4 messages sent, posts made, or interactions (comment/like); • 1 interaction with an interactive tool such as a quiz, game, risk calculator etc.
"Digital Service Milestones 2 to 4 Primary Engagement Methods"	means the below engagement methods: • conversation with a health coach or mentor comprising a 30 minute coaching appointment over the phone, or four messages sent by the service user, which have been responded to by the coach; • accessing two education modules or educational materials via a digital application or digital platform.
"Digital Service Milestones 2 to 4 Secondary Engagement Methods"	means the below engagement methods: • four tracking events of food, weight and/or activity against active goals. Up to two of these could be to amend or set a goal; • participation in a peer support forum or online group conversation, with a minimum of 4 messages sent, posts made, or interactions (comment/like); • 1 interaction with an interactive tool such as a quiz, game, risk calculator etc; • Eight occurrences on different days of more than 30 seconds spent in the app on a specific day or more than 20 minutes spent in any given 30 day period.

"Digital Service Milestone 2 Period"	means the period starting on the Digital Service First Engagement Date and ending on the 90 th day after the Digital Service First Engagement Date;
"Digital Service Milestone 3 Period"	means the period starting on the 91 st day after the Digital Service First Engagement Date and ending on the 180 th day after the Digital Service First Engagement Date;
"Digital Service Milestone 4 Period"	means the period starting on the 181 st day after the Digital Service First Engagement Date and ending on the 270 th day after the Digital Service First Engagement Date;
"Digital Service Price"	means the maximum price for the provision of the Digital Service per Service User payable to the Provider when all Milestones have been Achieved;
"Face to Face Service"	has the meaning given in paragraph 1.1.1 of Schedule 2A (Service Specification) and includes remote catch-up sessions as part of the Face to Face Service;
"Face to Face Service Achievement Criteria"	means the criteria which must be met by the Provider in relation to a Service User being provided with the Face to Face Service in order to Achieve a Milestone as set out in column 2 of Table 2, Part 1 of this Schedule 3A;
"Face to Face Service Milestone 2 Period"	means the period starting the day after attendance at the first planned session and ending on the 100 th day after attendance at the first planned session;
"Face to Face Service Milestone 3 Period"	means the period starting on the 101 st day after attendance at the first planned session and ending on the 200 th day after attendance at the first planned session;
"Face to Face Service Milestone 4 Period"	means the period starting on the 201 st day after attendance at the first planned session and ending on the 300 th day after attendance at the first planned session;
"Face to Face Service Price"	means the maximum price for the provision of the Face to Face Service per Service User payable to the Provider when all Milestones have been Achieved;
"Individual Assessment"	means the initial session following acceptance by a Service User of an invitation to participate in the Service at which a Service User is assessed in accordance with paragraph 3.2.7 of Schedule 2A (Service Specification);
"Intervention Cap"	has the meaning set out in paragraph 3.11 of Schedule 2A (Service Specification);
"Milestone"	means a milestone in the provision of the Face to Face Service (including Face to Face Service catch-up sessions delivered remotely), the Tailored Remote Service or the Digital Service (as relevant) for which payment is made as set out in Table 2 of Part 1 of this Schedule 3A and which is more particularly detailed in Table 2 of Part 1 of this Schedule 3A;

"Outcomes"	means the Outcomes Achievement Criteria;
"Outcomes Achievement Criteria"	means the criteria which must be met by the Provider in relation to a Service User as set out in Table 3, Part 1 of this Schedule 3A;
"Required Data Fields"	means the required data fields as specified within Annex 2 of Schedule 6A;
"Tailored Remote service"	has the meaning set out in paragraph 1.1.1 and 3.2.6 of Schedule 2A (Service Specification);
"Tailored Remote Service Achievement Criteria"	means the criteria which must be met by the Provider in relation to a Service User being provided with the Tailored Remote Service in order to Achieve a Milestone as set out in column 2 of Table 2, Part 1 of this Schedule 3A;
"Tailored Remote Service Milestone 2 Period"	means the period starting the day after attendance at the first planned session and ending on the 100 th day after attendance at the first planned session;
"Tailored Remote Service Milestone 3 Period"	means the period starting on the 101 st day after attendance at the first planned session and ending on the 200 th day after attendance at the first planned session;
"Tailored Remote Service Milestone 4 Period"	means the period starting on the 201 st day after attendance at the first planned session and ending on the 300 th day after attendance at the first planned session;
"Tailored Remote Service Price"	means the maximum price for the provision of the Tailored Remote Service per Service User payable to the Provider when all Milestones have been Achieved; and
"Services Prices"	means the maximum Face to Face Service Price, the maximum Tailored Remote Service Price, or the maximum Digital Service Price (as appropriate) per Service User payable to the Provider when all Milestones have been Achieved.

General Principles of Payment

4. The Provider will be paid for the Service it provides under Schedule 2A (Service Specification) subject to the Milestones and Outcomes being Achieved in accordance with Part 1 of this Schedule 3A.
5. Payments payable to the Provider under Parts 1 and 1A of this Schedule 3A will be paid in accordance with Part 2 of this Schedule 3A.

Part 1 – Payment Calculation – Services Prices

1. Subject to paragraphs 2 and 3 of this Part 1:
 - 1.1 the Face to Face Service Price will be paid by the Commissioner for each Service User being provided with the Face to Face Service; and
 - 1.2 the Tailored Remote Service Price will be paid by the Commissioner for each Service User being provided with the Tailored Remote Service; and

- 1.3 the Digital Service Price will be paid by the Commissioner for each Service User being provided with the Digital Service,

in staged payments depending upon Milestones Achieved by the Provider for each Service User and the Outcomes Payment will be paid by the Commissioner for each Service User which satisfies the Outcomes. The Provider will be paid monthly in arrears in respect of the staged payments for Milestones Achieved and the Outcomes Payment in accordance with Part 2 of this Schedule 3A.

2. The Provider will not be paid for any Service provided to additional Service Users who are invited to participate in the Service after the Intervention Cap has been reached. For the avoidance of doubt, once the Intervention Cap is reached, the Commissioner will continue to pay the Provider for the Service provided to existing Service Users subject to the Milestones being Achieved.
3. The Provider will provide the Data Output Specification in accordance with Schedule 6A (Reporting Requirements) to enable the Commissioner to verify invoices submitted by the Provider to the Commissioner in accordance with Part 2 of this Schedule 3A.
4. Table 1 below shows:
- 4.1 the Services Prices;
- 4.2 the percentage of the relevant Services Price payable on Achievement of each Milestone for each Service User; and
- 4.3 the percentage of the relevant Services Price payable on Achievement of the Outcomes for each Service User;

Table 1

Face to Face Service Price	[REDACTED]			
Digital Service Price	[REDACTED]			
Tailored Remote Service Price	[REDACTED]			
Milestone	1	2	3	4
% of relevant Services Price payable on Achievement of Milestone	30%	25%	20%	20%
Outcomes Payment - % of relevant Services Price payable on Achievement of Outcomes	5%			

5. Table 2 below shows the Achievement Criteria at each Milestone for the Face to Face Service, the Tailored Remote Service and the Digital Service to be Achieved by the Provider for each Service User (as applicable) .

Table 2 – Milestones

Milestone	Face to Face Service Achievement Criteria (including remote catch-up sessions) and Tailored Remote Service Achievement Criteria	Digital Service Achievement Criteria
Milestone 1	All of the following criteria have been fulfilled: (1) the Individual Assessment has been provided to the Service User by the Provider and the Provider has recorded and reported to the Commissioner the required details in accordance with Schedule 6A with valid date; (2) the first session has been provided to the Service User by the Provider and the Provider has recorded and reported to the Commissioner the required details (in accordance with Schedule 6A with valid date); (3) the first Session must have lasted a minimum of 60 minutes; (4) a valid referral blood test result for the Service User has been recorded and reported in accordance with Schedule 6A; (5) a valid weight measurement for the Service User has been recorded and reported in accordance with Schedule 6A; (6) a valid height measurement for the Service User has been recorded and reported in accordance with Schedule 6A; (7) the Required Data Fields have been recorded and reported in accordance with Schedule 6A.	All of the following criteria have been fulfilled: (1) the Service User has registered for the Digital Service or created a digital account (as relevant); (2) there has been at least one episode of engagement using one of the Digital Service Milestone 1 Engagement Methods; (3) the Service User has undergone the Individual Assessment and the Provider has recorded and reported to the Commissioner the required details in accordance with Schedule 6A either before or within 30 days after the Digital Service First Engagement Date; (4) a valid weight measurement for the Service User has been recorded and reported in accordance with Schedule 6A either before or within 30 days after the Digital Service First Engagement Date;¹ (5) a valid referral blood test result for the Service User has been recorded and reported in accordance with Schedule 6A either before or within 30 days after the Digital Service First Engagement Date.
Milestone 2	All of the following criteria have been fulfilled: (1) the Face to Face Service Milestone 2 Period or Tailored Remote Service Milestone 2 Period has elapsed;	All of the following criteria have been fulfilled: (1) the Digital Service Milestone 2 Period has elapsed;

¹ In this table 2 and in Schedule 6A, a valid weight measurement will be considered to have been recorded if a Service User self-reports his/her weight:

- By uploading a photograph of his/her weight measurement from a scale onto the Digital Platform; or
- Via an automated reading from an electronic scale which the Service User has connected to the Digital Platform.

In all cases, the Provider must inform Service Users on the Tailored Remote Service and the Digital Service to use the same scale whilst they remain on the programme.

	(2) the Service User has attended at least three of the four planned sessions within the Face to Face Service Milestone 2 Period or Tailored Remote Service Milestone 2 Period and such attendance has been recorded and reported in accordance with Schedule 6A; (3) the sessions attended must have each lasted a minimum of 60 minutes; (4) a valid weight measurement for the Service User at each attended session has been recorded and reported in accordance with Schedule 6A; and (5) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.	(2) there is a time stamped record that the Service User has logged into the Digital Service within the Digital Service Milestone 2 Period; (3) within the Digital Service Milestone 2 Period there has been at least one episode of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods; (4) in each 30 day period within the Digital Service Milestone 2 Period there has been at least two episodes of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods and / or Digital Service Milestones 2 to 4 Secondary Engagement Methods, provided that if both episodes of engagement are the latter these must be two different engagement methods; and (5) in the final 30 days of the Digital Service Milestone 2 Period a valid weight measurement for the Service User has been recorded and reported in accordance with Schedule 6A; and (6) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.
Milestone 3	All of the following criteria shall have been fulfilled: (1) the Face to Face Service Milestone 3 Period or Tailored Remote Service Milestone 3 Period has elapsed; and (2) the Service User has attended at least two of the four planned sessions within the Face to Face Service Milestone 3 Period or Tailored Remote Service Milestone 3 Period and such attendance has been recorded and reported in accordance with Schedule 6A; and (3) the sessions attended must have each lasted a minimum of 60 minutes; (4) a valid weight measurement for the Service User at each attended session	All of the following criteria have been fulfilled: (1) the Digital Service Milestone 3 Period has elapsed; (2) there is a time stamped record that the Service User has logged into the Digital Service within the Digital Service Milestone 3 Period; (3) within the Digital Service Milestone 3 Period there has been at least one episode of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods; (4) in each 30 day period within the Digital Service Milestone 3 Period

	has been recorded and reported in accordance with Schedule 6A; and (5) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.	there has been at least two episodes of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods and / or Digital Service Milestones 2 to 4 Secondary Engagement Methods, provided that if both episodes of engagement are the latter these must be two different engagement methods; and (5) in the final 30 days of the Digital Service Milestone 3 Period a valid weight measurement for the Service User has been recorded and reported in accordance with Schedule 6A; and (6) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.
Milestone 4	All of the following criteria have been fulfilled: (1) the Face to Face Service Milestone 4 Period or Tailored Remote Service Milestone 4 Period has elapsed; (2) the Service User has attended at least two of the four planned sessions within the Face to Face Service Milestone 4 Period or Tailored Remote Service Milestone 4 Period and such attendance has been recorded and reported in accordance with Schedule 6A; (3) the sessions attended must have each lasted a minimum of 60 minutes; and (4) a valid weight measurement for the Service User at each attended session has been recorded and reported in accordance with Schedule 6A; (5) where the Service User has attended the Final Session, attendance must be recorded and reported in accordance with Schedule 6A; (6) a valid Date of Discharge must be recorded and reported in accordance with Schedule 6A; and (7) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.	All of the following criteria have been fulfilled: (1) the Digital Service Milestone 4 Period has elapsed; (2) there is a time stamped record that the Service User has logged into the Digital Service within the Digital Service Milestone 4 Period; (3) within the Digital Service Milestone 4 period there has been at least one episode of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods; (4) in each 30 day period within the Digital Service Milestone 4 Period there has been at least two episodes of engagement using Digital Service Milestones 2 to 4 Primary Engagement Methods and / or Digital Service Milestones 2 to 4 Secondary Engagement Methods, provided that if both episodes of engagement are the latter these must be two different engagement methods; and (5) in the final 30 days of the Digital Service Milestone 4 Period a valid weight measurement for the Service User has been recorded

		and reported in accordance with Schedule 6A; and (6) a valid Date of Discharge must be recorded and reported in accordance with Schedule 6A; and (7) the Required Data Fields have been recorded and reported in accordance with Schedule 6A if not already done.
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6. Table 3 below shows the Outcomes Achievement Criteria to be Achieved by the Provider for each Service User.

Table 3 – Outcomes

Outcomes Achievement Criteria
The following three criteria must be satisfied: (a) a minimum of: a. for the Face to Face Service or Tailored Remote Service, at least 8 (eight) sessions have been attended; and b. for the Digital Service, at least 60% of the engagement required for achievement of the Milestones. The Provider should note that the maximum number of engagement episodes for each month that can be taken into account for the purpose of the Outcomes Achievement Criteria is two regardless of the actual number of engagements that may have occurred; (b) a valid Date of Discharge has been recorded and reported; and (c) either: a. the Service User is a member of a BME group; or b. the Service User is on the LD or SMI register; or c. the Service User is a member of highest deprivation IMD Quintile; or d. if identified as overweight or obese at the weight measurement at Milestone 1, the recorded weight of the Service User at Milestone 4 indicates a weight loss of at least 5% of the weight recorded at Milestone 1.

7. The Commissioner shall determine whether or not the Provider has Achieved a Milestone or the Outcomes in accordance with the reports submitted by the Provider in accordance with Schedule 6A (Reporting Requirements) (including the Data Output Specifications submitted).
8. For the avoidance of doubt, the Provider will not be entitled to any increase to the Services Prices during the Contract Term to account for inflation, indexation or any other factor which may increase the Provider's costs of delivering the Service.
9. The Commissioner may deduct from any payments due to the Provider under this Part 1 of Schedule 3A any sums that the Commissioner is entitled to withhold or retain in accordance with Part 2 of Schedule 4 (Local Quality Requirements). If the Commissioner exercises its right to make such deductions, the Commissioner may deduct such sum from the amount payable under the applicable invoice issued by the Provider. If the amount due

under the applicable invoice has been paid before the applicable deduction has been applied, the Commissioner may require the Provider to repay such amount that it would have been entitled to deduct or the Commissioner may deduct such amount from any subsequent invoice. Any sums that are withheld by the Commissioner that are subsequently to be paid to the Provider in accordance with Part 2 of Schedule 4 (Local Quality Requirements) shall be included in the next invoice issued by the Provider in accordance with Part 2 of this Schedule 3A.

Part 2 – Invoicing Process

1. The Commissioner uses an online service provided by Tradeshift Network Ltd of 55 Baker Street London W1U 7EU found online at www.tradeshift.com (“Tradeshift”) as its online platform for receiving invoices. The Provider will create an online account with Tradeshift from the Effective Date for the purpose of submitting electronic invoices to the Commissioner in accordance with this Part 2, Schedule 3A.
2. The Provider will utilise one of the integration options provided by Tradeshift in order to deliver electronic invoices to the Commissioner.
3. The Provider shall:
 - 3.1 comply with the technical requirements of Tradeshift including any changes to such requirements that may be required by Tradeshift from time to time; and
 - 3.2 ensure that all electronic invoices are received by the Commissioner in accordance with the timescales set out in this Part 2 of Schedule 3A.
4. The Provider shall be responsible for its relationship with Tradeshift at all times.
5. Prior to uploading invoices to Tradeshift, the Provider will submit an electronic invoice to the Commissioner in accordance with paragraphs 1-4 of this Part 2 within 20 Operational Days after the end of the month in which a Milestone and/or the Outcomes have been Achieved.
6. Following submission of an invoice in accordance with paragraphs 1-5 of this Part 2, the Commissioner will consider and verify the invoice as against the Data Output Specifications provided by the Provider in accordance with Schedule 6A for the relevant month within 20 days of receipt of the invoice.
7. If the Commissioner is unable to verify an invoice in accordance with paragraph 6, the Commissioner will request that the Provider submits a revised electronic invoice in accordance with paragraph 1 above. Paragraph 6 above shall then apply in respect of the Commissioner’s verification of the revised invoice.
8. The final invoice will be verified by agreement between the Commissioner (including any representative acting on behalf of the Commissioner) and the Provider, and if the parties do not verify the invoice paragraph 6 above shall apply.
9. Subject to paragraph 10 of Part 2 of this Schedule 3A, the Commissioner will pay the Provider any sums due under an invoice no later than 30 days from the date on which the Commissioner determines that the invoice is valid and undisputed in accordance with paragraph 6.
10. The Parties agree that paragraph 9 of Part 1 of this Schedule 3A shall apply in relation to breaches of thresholds of the Local Quality Requirements as set out in Schedule 4 (Local Quality Requirements).
11. Where any Party disputes any sum to be paid by it then a payment equal to the sum not in dispute shall be paid and the dispute as to the sum that remains unpaid shall be determined in accordance with General Condition 14. Provided that the sum has been disputed in good faith, Interest due on any sums in dispute shall not accrue until the date falling 5 days after resolution of the dispute between the Parties.
12. For the avoidance of doubt, Service Condition 36.47 (Set Off) shall apply.
13. The Provider will maintain complete and accurate records of, and supporting documentation for, all amounts which may be chargeable to the Commissioner pursuant to this Contract. Such records shall be retained for inspection by the Commissioner for 6 years from the end of the Contract Year to which the records relate.

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

Not Applicable

SCHEDULE 3 – PAYMENT

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

Not Applicable

SCHEDULE 4 – LOCAL QUALITY REQUIREMENTS

Part 1 (see overleaf)

Quality Requirement	Method of Measurement and Thresholds	Consequence of Breach	Period over which the Requirement is to be achieved
KPI 1 Component: Data Quality The Provider shall comply with the reporting requirements set out in the Data Output Specification detailed in Annex 2 of Schedule 6A. This includes the monthly reporting of particulars related to Service Users' attendance on the programme to the detail, format and quality prescribed in the "Data Output Specifications" document and the "Data Format Specification" document set out in Annexes 2 and 3 respectively of Schedule 6A and together referred to in this Schedule 4 as the "Data Specifications"	KPI 1a: The proportion of Service User data records at referral that are recorded in line with the Data Specifications. • 100% - "Target" • Between 95% - 99% - "Mid Threshold" • <95% - "Lower Threshold"	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
	KPI 1b: The proportion of Service Users' data records at Individual Assessment that are recorded in line with the 'Outcome' fields in the Data Specifications. • 100% - "Target" • Between 95% - 99% - "Mid Threshold" • <95% - "Lower Threshold"	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
	KPI 1c: The proportion of Service Users' data records at Individual Assessment that are recorded in line with the 'Demographic' fields in the Data Specifications. • 100% - "Target" • Between 95% - 99% - "Mid Threshold" • <95% - "Lower Threshold"	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
	KPI 1d: The proportion of Service Users' data records at Individual Assessment that are recorded in line with the 'Administration' fields in the Data Specifications. • 100% - "Target" • Between 95% - 99% - "Mid Threshold" • <95% - "Lower Threshold"	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly

	KPI 1e: The proportion of Service Users' weight fields that are recorded in line with the Data Specifications. • 100% - “Target” • Between 95% - 99% - “Mid Threshold” • <95% - “Lower Threshold” For Service Users on the Face to Face Service or Tailored Remote Service, weight measurements are recorded for each session. For Service Users on the Digital Service, weight measurement requirements are set out in Schedule 3A.	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
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Quality Requirement	Method of Measurement and Thresholds	Consequence of Breach	Period over which the Requirement is to be achieved
KPI 2 Component: Eligibility	KPI 2a: The proportion of Service Users starting programme interventions who meet the eligibility criteria at referral as defined in Schedule 2A (Service Specification). • 100% - “Target” • Between 97% - 99% - “Mid Threshold” • <97% - “Lower Threshold”	As set out in Part 2 of this Schedule 4 (<i>Local Quality Requirements</i>)	Monthly
	KPI 2b: The proportion of self-referrals with eligible risk scores captured and recorded. • 100% - “Target” • Between 97% - 99% - “Mid Threshold” • <97% - “Lower Threshold”	As set out in Part 2 of this Schedule 4 (<i>Local Quality Requirements</i>)	Monthly
KPI 3 Component: Uptake	KPI 3a: 50% of all referrals to achieve programme start.	As set out in Part 2 of this Schedule 4 (<i>Local Quality Requirements</i>)	Quarterly
	KPI 3b: The proportion of Service Users who have accepted the Face to Face Service or Tailored Remote Service and who have achieved IV01 or beyond. • ≥45% - “Target” • Between 30% - 44% - “Mid Threshold” • <30% - “Lower Threshold”	As set out in Part 2 of this Schedule 4 (<i>Local Quality Requirements</i>)	Quarterly

	KPI 3c: The proportion of Service Users who have accepted the Digital Service and have achieved Milestone 1. • ≥45% - “Target” • Between 30% - 44% - “Mid Threshold” • <30% - “Lower Threshold”	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Quarterly
KPI 4 Component: Efficacy The Provider will be required to report on the KPIs requirements listed under this component allowing sufficient time for a Service Users to have attended the specified number of sessions. Provider performance against KPI 3 and KPI 4 will be reviewed as part of the Quarterly Contract Review Meetings.	KPI 4a: 75% of Service Users on the Face to Face Service or Tailored Remote Service, excluding those aged 80 years or over, who: • are overweight or obese at the first attended session; and • in relation to whom sufficient time has elapsed for 3 months on the programme to have elapsed, to have lost weight by the time the Service User passes the 3-month mark on the programme. 75% of Service Users on the Digital Service, who: • are overweight or obese as recorded as part of the weight measurement required for Milestone 1; and • sufficient time has elapsed since the Digital Service First Engagement Date (as defined in Schedule 3A) for 3 months on the programme to have elapsed, to have lost weight by the time the Service User passes the 3-month mark on the programme.	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Quarterly

KPI 4 Component: Efficacy The Provider will be required to report on the KPIs requirements listed under this component allowing sufficient time for a Service Users to have attended the specified number of sessions. Provider performance against KPI 3 and KPI 4 will be reviewed as part of the Quarterly Contract Review Meetings.	KPI 4b: 80% of Service Users on the Face to Face Service or Tailored Remote Service, excluding those aged 80 years or over, who: • are overweight or obese at the first attended session; and • have attended at least 8 sessions; and • in relation to whom sufficient time has elapsed for the Final Session (as defined in Schedule 2A) to have taken place, to have lost weight by the time the Service User ends their involvement in the Service. 80% of Service Users on the Digital Service, who: • are overweight or obese as recorded as part of the weight measurement required for Milestone 1; and • have achieved 60% of the engagement criteria – the calculation of which is the same as set out in criteria (a) in Table 3 of Part 1 of Schedule 3A; and • sufficient time has elapsed since the Digital Service First Engagement Date (as defined in Schedule 3A) for 9 months on the programme to have elapsed, to have lost weight by the time the Service User ends their involvement in the Service.	As set out in Part 2 of this Schedule 4 (<i>Local Quality Requirements</i>)	Quarterly
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	KPI 4c: 40% of Service Users on the Face to Face Service or Tailored Remote Service, excluding those aged 80 years or over, who: • are overweight or obese at the first attended session; and • have attended at least 8 sessions; and • in relation to whom sufficient time has elapsed for the Final Session (as defined in Schedule 2A) to have taken place, to have lost a minimum of 5% of their body weight by the time the Service User ends their involvement in the Service. 40% of Service Users on the Digital Service, who: • are overweight or obese as recorded as part of the weight measurement required for Milestone 1; and • have achieved 60% of the engagement criteria – the calculation of which is the same as set out in criteria (a) in Table 3 of Part 1 of Schedule 3A; and • sufficient time has elapsed since the Digital Service First Engagement Date (as defined in Schedule 3A) for 9 months on the programme to have elapsed, to have lost a minimum of 5% of their body weight by the time the Service User ends their involvement in the Service.	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Quarterly
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KPI 5 Component: MS2 Retention	KPI 5: For Service Users: • who have fulfilled the Face to Face Service Achievement Criteria, the Tailored Remote Service Achievement Criteria or the Digital Service Achievement Criteria (as relevant) that relate to Milestone 1; and • for whom sufficient time has elapsed for the Face to Face Service Achievement Criteria, Tailored Remote Service Achievement Criteria or the Digital Service Achievement Criteria (as relevant) that relate to Milestone 2 to have been fulfilled, to have fulfilled the Face to Face Service Achievement Criteria, Tailored Remote Service or the Digital Service Achievement Criteria (as relevant) that relate to Milestone 2. • $\geq 75\%$ - “Target” • Between 60% - 74% - “Mid Threshold” • $< 60\%$ - “Lower Threshold”	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Quarterly
KPI 6 Component: Completion	KPI 6a: 40% of Service Users on the Face to Face Service or Tailored Remote Service, for whom sufficient time has elapsed for the Final Session to have taken place, to have attended at least 8 sessions. 40% of Service Users on the Digital Service: • to have achieved 60% of the engagement criteria – the calculation of which is the same as set out in criteria (a) in Table 3 of Part 1 of Schedule 3A; and • for whom 9 months has elapsed since the Digital Service First Engagement Date (as defined in Schedule 3A).	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Quarterly

KPI 7 Component: Demographic Data	KPI 7: No more than 5% of any individual data field to be recorded as “not stated” (i.e. [999]): • Gender • Ethnicity • Weight • Height	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
KPI 8 Component: Discharge	KPI 8: That notification of discharge is communicated to the Service User’s GP and the Service User within 10 working days once the discharge criteria has been met.	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
KPI 9 Component: Group Size	KPI 9: 100% of group sessions to not exceed the numbers as outlined within Schedule 2A Service Specification unless this includes individuals attending to support the Service User (i.e. carers, interpreters, family members).	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly
KPI 10 Component: Remote Catch-Up	KPI 10: 100% of Service Users did not attend a planned Face to Face Service session ahead of being offered a remote catch-up session.	As set out in Part 2 of this Schedule 4 <i>(Local Quality Requirements)</i>	Monthly

Part 2

1. In Part 2 of this Schedule 4 (*Local Quality Requirements*) the following definitions are used:
 - “Core KPIs”** means the following KPIs: KPI 1a to KPI 1e (inclusive), KPI 2a, KPI 2b, KPI 3b, KPI 3c, and KPI 5, as set out in the table in Part 1 of this Schedule 4 (*Local Quality Requirements*);
 - “KPIs”** means the KPIs set out in the table in Part 1 of this Schedule 4 (*Local Quality Requirements*), which are also known as the Local Quality Requirements;
 - “KPI Periods”** means the periods within which the Provider’s performance against each KPI is to be measured, as set out in the column headed “Period over which the Requirement is to be achieved” in the table in Part 1 of this Schedule 4 (*Local Quality Requirements*);
 - “Lower Threshold”** means the Lower Threshold applicable to each of the Core KPIs, as set out in Part 1 of this Schedule 4 (*Local Quality Requirements*);
 - “Mid Threshold”** means the Mid Threshold applicable to each of the Core KPIs, as set out in Part 1 of this Schedule 4 (*Local Quality Requirements*);
 - “Target”** means the Target applicable to each of the Core KPIs, as set out in Part 1 of this Schedule 4 (*Local Quality Requirements*); and
 - “Threshold”** means the threshold(s) applicable to each of the KPIs that are not Core KPIs, as set out in Part 1 of this Schedule 4 (*Local Quality Requirements*).
2. Subject to paragraph 7 of Part 2 of this Schedule 4 (*Local Quality Requirements*), if the Provider fails to meet or exceed the Mid Threshold applicable to any of the Core KPIs for the relevant KPI Period, the Commissioner may, by notice to the Provider, immediately and permanently retain a reasonable and proportionate sum of:
 - 2.1. up to 1% of the Actual Monthly Value applicable to the relevant KPI Period, where the relevant KPI Period is monthly; or
 - 2.2. up to 1% of the Actual Quarterly Value applicable to the relevant KPI Period, where the relevant KPI Period is Quarterly.
3. Subject to paragraph 7 of Part 2 of this Schedule 4 (*Local Quality Requirements*), if the Provider exceeds the Lower Threshold applicable to any of the Core KPIs but fails to meet or exceed the Target applicable to that Core KPI for the relevant KPI Period, the Commissioner may, by notice to the Provider:
 - 3.1. withhold a reasonable and proportionate sum of:

- 3.1.1. up to 1% of the Actual Monthly Value applicable to the relevant KPI Period, where the relevant KPI Period is monthly; or
- 3.1.2. up to 1% of the Actual Quarterly Value applicable to the relevant KPI Period, where the relevant KPI Period is Quarterly; and
- 3.2. require that the Provider submits, within 10 Operational Days of the notice, a remedial action plan to the Commissioner that sets out the actions that the Provider will take prior to the end of the next KPI Period applicable to the relevant Core KPI to remedy the failure to meet or exceed the Target in relation to that Core KPI.
- 4. Where the Provider does not provide a remedial action plan to the Commissioner within the relevant timescale in accordance with paragraph 3.2 of Part 2 of this Schedule 4 (*Local Quality Requirements*), the Commissioner may, by notice to the Provider, immediately and permanently retain the sum withheld in accordance with paragraph 3.1 of Part 2 of this Schedule 4 (*Local Quality Requirements*), subject to paragraph 7 of Part 2 of this Schedule 4 (*Local Quality Requirements*).
- 5. Where the Provider has provided a remedial action plan to the Commissioner within the relevant timescale in accordance with paragraph 3.2 of Part 2 of this Schedule 4 (*Local Quality Requirements*), then if the Provider:
 - 5.1. fails to meet or exceed the Target applicable to that Core KPI for the next KPI Period applicable to that Core KPI, the Commissioner may, by notice to the Provider, permanently retain the sum withheld in accordance with paragraph 3.1 of Part 2 of this Schedule 4 (*Local Quality Requirements*), subject to paragraph 7 of Part 2 of this Schedule 4 (*Local Quality Requirements*); or
 - 5.2. meets or exceeds the Target applicable to that Core KPI for the next KPI Period applicable to that Core KPI, the Commissioner will pay the Provider the sum withheld in accordance with paragraph 3.1 of Part 2 of this Schedule 4 (*Local Quality Requirements*) and no interest will be payable on that sum.
- 6. For the avoidance of doubt, nothing in paragraphs 4 or 5 of Part 2 of this Schedule 4 (*Local Quality Requirements*) will prevent the Commissioner from retaining or withholding any further sums in relation to the next (or any subsequent) KPI Period for the relevant Core KPI in accordance with paragraphs 2 or 3 of Part 2 of this Schedule 4 (*Local Quality Requirements*), subject to paragraph 7 of Part 2 of this Schedule 4 (*Local Quality Requirements*).
- 7. The Commissioner will not withhold or retain more than 10% of the Actual Monthly Value applicable to any individual month pursuant to Part 2 of this Schedule 4 (*Local Quality Requirements*).
- 8. Without prejudice to any other rights or remedies that may be available to the Commissioner under Part 2 of this Schedule 4 (*Local Quality Requirements*), if for any KPI Period the Provider fails to meet or exceed any Target (in relation to any Core KPI) or any Threshold (in relation to any KPI that is not a

Core KPI), the Commissioner will be entitled to issue a Contract Performance Notice to the Provider in accordance with GC9.4 (*Contract Management*). For the avoidance of doubt:

- 8.1. the Commissioner's exercise of any rights or remedies available to it under Part 2 of this Schedule 4 (*Local Quality Requirements*) will not prevent the Commissioner from also exercising its right to issue a Contract Performance Notice to the Provider in accordance with GC9.4 (*Contract Management*) in relation to the same failure to meet the relevant requirement; and
 - 8.2. the Commissioner's exercise of its right to issue a Contract Performance Notice to the Provider in accordance with GC9.4 (*Contract Management*) will not prevent the Commissioner from also exercising any rights or remedies that may be available to it under Part 2 of this Schedule 4 (*Local Quality Requirements*) in relation to the same failure to meet the relevant requirement.
9. The parties acknowledge and agree that for the purposes of GC17.10.4 the Provider will be deemed to be in persistent or repetitive breach of the Quality Requirements if, in the Commissioner's reasonable opinion, the Provider has repeatedly failed to meet or exceed:
- 9.1. the Targets applicable to any of the Core KPIs; and/or
 - 9.2. the Thresholds applicable to any of the KPIs that are not Core KPIs,
- in such a manner as to reasonably justify the Commissioner's opinion that the Provider's conduct is inconsistent with it having the intention or ability to meet or exceed the relevant requirements over a reasonable period of the remaining Contract Term.

SCHEDULE 5 – GOVERNANCE

A. Documents Relied On

Documents supplied by Provider

Date	Document
Not Applicable	

Documents supplied by Commissioners

Date	Document
Not Applicable	

SCHEDULE 5 - GOVERNANCE**B. Provider's Material Sub-Contracts**

Sub-Contractor [Name] [Registered Office] [Company number]	Service Description	Start date/expiry date	Processing Personal Data – Yes/No	If the Sub-Contractor is processing Personal Data, state whether the Sub- Contractor is a Data Processor OR a Data Controller OR a joint Data Controller
Company Name : Oviva UK Limited Registered Office: Runway East, 20 St Thomas Street, London, SE1 9RS Company Number: 9667784	Digital DPP Service	1st August 2022 – The contract term will be the period from the Effective Date to the day after which the Provider submits the data submission for the last Service User on the programme who completed the Final Session, or other such day as agreed in writing between the Parties.	Yes	Joint Data Controller

SCHEDULE 5 - GOVERNANCE

C. Commissioner Roles and Responsibilities

Co-ordinating Commissioner/Commissioner	Role/Responsibility
Not Applicable	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
National Requirements Reported Centrally				
1. 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: a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; c. details of, and reasons for, any failure to meet requirements.	Monthly	As set out in the Service Quality Performance Report template at Annex 1 of this Schedule 6A.	To be submitted to the Contract management provider as appointed and advised by the Commissioner by email using the templates provided within 10 Operational Days of the end of the month to which it relates. Report to be submitted to the Contract management provider's email address for data flows that do not include Patient Identifiable Data (PID).	All All All
2. Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	Quarterly	Included within Service Quality Performance Report	As per Service Quality Performance Report (see above)	All
3. Summary report of all incidents requiring reporting	Monthly	Included within Service Quality Performance Report	As per Service Quality Performance Report (see above)	All
4. Report on compliance with the National Workforce Race Equality Standard.	Annually	Included within Service Quality Performance Report	End of Q1 annually	All
5. Report on compliance with the National Workforce Disability Equality Standard.	Annually	Included within Service Quality Performance Report	End of Q1 annually	All
6. Report on progress against Green Plan in accordance with SC18.2	Annually	Included within Service Quality Performance Report	End of Q1 annually	All
7. Equality and Health Inequalities Impact Assessment (E&HIIA) and related action plan to	Annually	Included within Service Quality Performance	The first E&HIIA and action plan shall be provided electronically	All

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
challenge discrimination, promote equality, respect Service Users' human rights and to reduce health inequalities in access to services and outcomes		Report	to the Contract management provider as appointed and advised by the Commissioner using the templates provided on the Effective Date and each anniversary of the Effective Date. Progress against the action plan will be reported by the Provider to the Commissioner on a Quarterly basis at the relevant Review Meeting.	
8. Data Output Specification	Data to be collected on an ongoing basis in line with the timing set out in the "Data Format Specification" document in Annex 2 of this Schedule 6A. Monthly	The format of the report is as set out in the "Data Output Specifications" document in Annex 3 of this Schedule 6A. The data must be inputted into the report format above in accordance with the codes set out in the "Data Format Specification" document in Annex 2 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided within 10 Operational Days of the end of the month to which it relates. The Provider must submit any patient-identifiable data required in relation to Local Requirements Reported Locally via the Data Landing Portal in accordance with the Data Landing Portal Acceptable Use Statement.	All
9. Finance report	Monthly	The format of the report is as set out in the "Invoice Template" in Annex 4 of this Schedule 6A and "Data Landing Portal Invoice Validation Template" in Annex 5 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided within 10 Operational Days of the end of the month to which it relates.	All
10. Waiting Times Report	Monthly	The format of the report	To be submitted electronically	All

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
		is as set out in the "Waiting Times Report Template" in Annex 6 of this Schedule 6A. This will include as a minimum: - Numbers waiting for course starts (by month of receipt of referral) - Reasons for wait and and/or non-attendance to date	to the Contract management provider as appointed and advised by the Commissioner using the templates provided within 10 Operational Days of the end of the month to which it relates.	
11. Capacity Planning Report	Monthly	The format of the report is as set out in the "Capacity Planning Reporting Template" in Annex 7 of this Schedule 6A – this will include as a minimum: - Expected referrals per month - Number of participants waiting for course starts - Planned number of courses	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided within 10 Operational Days of the end of the month to which it relates.	All
12. Group size report	As required by the commissioner	The format of the report is as set out in the "Group Size Report Template" in Annex 8 of this Schedule 6A detailing the numbers	To be submitted to the Contract management provider as appointed and advised by the Commissioner when requested.	All

NHS STANDARD CONTRACT 2022/23 PARTICULARS (Full Length)

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
		of people attending groups.		
13. Service User Survey reports	Quarterly	The format of the reports are as set out in the various "Service User Survey Reports Templates" in Annex 9-16 (inclusive) of this Schedule 6A	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided in advance of the Quarterly Review Meetings and within 10 Operational Days of the beginning of the month in which that Review Meeting falls Report to be submitted to the Contract management provider's email address for data flows that do not include Patient Identifiable Data (PID).	All
14. Physical Activity Report (RPAQ)	Quarterly	Providers to run Python code on the RPAQ raw data and submit the raw data and output file created. Python code and associated guidance will be provided by the Commissioner or the Commissioner Representative.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the python code provided in advance of the Quarterly Review Meetings and within 10 Operational Days of the beginning of the month in which that Review Meeting falls. A report to be submitted to Contract management providers email address for data flows that do not include Patient Identifiable Data (PID).	All
15. Digital Engagement report	Quarterly	The format of the report is as set out in the "Digital Engagement Report Template" in Annex 17 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided in advance of the Quarterly	All

NHS STANDARD CONTRACT 2022/23 PARTICULARS (Full Length)

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
			Review Meetings and within 10 Operational Days of the beginning of the month in which that Review Meeting falls. Report to be submitted to the Contract management provider's email address for data flows that do not include Patient Identifiable Data (PID).	
16. Step Count report	Quarterly	The format of the report is as set out in the "Step Count Report Template" in Annex 18 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided in advance of the Quarterly Review Meetings and within 10 Operational Days of the beginning of the month in which that Review Meeting falls. Report to be submitted to Contract management providers email address for data flows that do not include Patient Identifiable Data (PID).	All
17. Monthly High Level Service User and Physical Activity (RPAQ) Summary report	Monthly	The format of the report is as set out in the "Monthly High Level Monthly Service User and Physical Activity (RPAQ) Summary Report Template" in Annex 19 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided in advance of the Quarterly Review Meetings and within 10 Operational Days of the beginning of the month in which that Review Meeting falls.	All
18. Weekly Direct to Consumer (DTC) report	Weekly (as required)	The format of the report is as set out in the "Weekly Direct to Consumer (DTC)	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner	All

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
		Report Template" in Annex 20 of this Schedule 6A.	using the templates provided by close of play every Monday (if required).	
19. Weekly Diabetes Prevention Programme (DPP) report	Weekly (as required)	The format of the report is as set out in the "Weekly Diabetes Prevention Programme (DPP) Report Template" in Annex 21 of this Schedule 6A.	To be submitted electronically to the Contract management provider as appointed and advised by the Commissioner using the templates provided by close of play every Monday (if required).	All
Local Requirements Reported Locally				
Operational & Service Delivery Reports – for local contract areas	As a minimum monthly	This will include, as a minimum: • Number of referrals received with details of GP practices (accepted & rejected) • Number of attendees at first session • Number of courses booked in next 3 months • Number of patients declining the service • Waiting list information including times	To be submitted electronically to the lead local health economy representative as detailed in a notification by the Commissioner to the Provider.	All

NHS STANDARD CONTRACT 2022/23 PARTICULARS (Full Length)

	Reporting Period	Format of Report*	Timing and Method for delivery of Report	Application
		for course starts in line with waiting times report (above). Ensure information provided to local health economy provides sufficient information to allow for service delivery planning.		
Letters informing of participants progress/discharge	As and when required	The format of the letters are as set out in the "NHS DPP Letter Template" in Annex 22 or "NHS DPP Letter Template DTC" in Annex 23 of this Schedule 6A.	Timings and method of delivery of letters to primary care to be agreed with the lead local health economy representative.	All

Schedule 6A

Annex 1

Service Quality Performance Report



NDPP FW3 Schedule
6a Annex 1 Service Q

Schedule 6A

Annex 2

Data Format Specification



NDPP Framework 3
MDS Format Specifica

Schedule 6A

Annex 3

Data Output Specification

This Annex 3 (Data Output Specification) will be issued prior to award of the Contract.

Schedule 6A

Annex 4

Invoice Template



NDPP FW3 Schedule
6a Annex 4 NDPP Invc

Schedule 6A

Annex 5

Data Landing Portal Invoice Validation Template



NDPP FW3 Schedule
6a Annex 5 Data Land

Schedule 6A

Annex 6

Waiting Times Report Template



NDPP FW3 Schedule
6a Annex 6 Waiting Ti

Schedule 6A

Annex 7

Capacity Planning Reporting Template



NDPP FW3 Schedule
6a Annex 7 Capacity F

Schedule 6A

Annex 8

Group Size Report Template



NDPP FW3 Schedule
6a Annex 8 Group Siz

Schedule 6A

Annex 9

Service User Surveys Report Template: Digital Survey 1

To be confirmed

Schedule 6A

Annex 10

Service User Surveys Report Template: Digital Survey 2

To be confirmed

Schedule 6A

Annex 11

Service User Surveys Report Template: Digital Survey 3a

To be confirmed

Schedule 6A

Annex 12

Service User Surveys Report Template: Digital Survey 3b

To be confirmed

Schedule 6A

Annex 13

Service User Surveys Report Template: F2F Survey 1

To be confirmed

Schedule 6A

Annex 14

Service User Surveys Report Template: F2F Survey 2

To be confirmed

Schedule 6A

Annex 15

Service User Surveys Report Template: F2F Survey 3a

To be confirmed

Schedule 6A

Annex 16

Service User Surveys Report Template: F2F Survey 3b

To be confirmed

Schedule 6A

Annex 17

Digital Engagement Report Template



NDPP FW3 Schedule
6a Annex 17 Digital_E

Schedule 6A

Annex 18

Step Count Report Template



NDPP FW3 Schedule
6a Annex 18 Step Cou

Schedule 6A

Annex 19

Monthly High Level Monthly Service User and Physical Activity (RPAQ) Summary Report Template



NDPP FW3 Schedule
6a Annex 18 Monthly

Schedule 6A

Annex 20

Weekly Direct to Consumer (DTC) Report Template



NDPP FW3 Schedule
6a Annex 20 Weekly D

Schedule 6A

Annex 21

Weekly Diabetes Prevention Programme (DPP) Report Template



NDPP FW3 Schedule
6a Annex 21 Weekly C

Schedule 6A

Annex 22

NHS DPP Letter Template

To be updated

Schedule 6A

Annex 23

NHS DPP Letter Template DTC

To be updated

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

B. Data Quality Improvement Plans

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

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

C. Incidents Requiring Reporting Procedure

Procedure(s) for reporting, investigating, and implementing and acting on insight derived from: (1) Serious Incidents (where applicable) (2) Notifiable Safety Incidents (3) other Patient Safety Incidents

The Provider must investigate potential Serious Incidents, potential Reportable Patient Safety Incidents and other potential Patient Safety Incidents or serious near misses with the same level of priority as actual incidents.

Whether a Serious Incident, Reportable Patient Safety Incident or other Patient Safety Incident should be declared is a matter of professional judgement on a case by case basis. It should be a joint decision by the key stakeholders informed by protocol and advice from experts.

In distinguishing between a safety concern, safety incident or a serious screening incident, consideration should be given to whether individuals, the public or Staff would suffer avoidable severe (i.e. permanent) harm or death if the problem is unresolved.

The Provider will:

- Report the Serious Incident, Reportable Patient Safety Incident or other Patient Safety Incident to the Commissioner within two (2) Operational Days being identified using the "Incident Example Reporting Form" document as set out in Annex 1 of this Schedule 6C.
 - Use this form to inform the Commissioner of any Never Event and any breach of the Duty of Candour in accordance with the Contract; and
- Provide all reasonable assistance to the Commissioner in investigating and handling an incident.

Schedule 6C

Annex 1

Incident Example Reporting Form²



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Schedule 6C Annex 1

² The document will be inserted here prior to each Contract award. An example document is included for information. The structure and contents of this document may change prior to Contract award.

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

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Surveys

Type of Survey	Frequency	Method of Reporting	Method of Publication
Service User Survey	Reported quarterly	Reporting template as provided by Commissioner or the Commissioner Representative	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

F. Data Processing Services

These are the Data Processing Services to be performed by the Provider, as referred to in the Provider Data Processing Agreement set out in Annex B to the Service Conditions.

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

1. SCOPE

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

2. DATA PROTECTION

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

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

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

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

- (a) receives a Data Subject Access Request (or purported Data Subject Access Request);
- (b) receives a request to rectify, block or erase any Personal Data;
- (c) receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;
- (d) receives any communication from the Information Commissioner or any other Regulatory or Supervisory Body (including any communication concerned with the systems on which Personal Data is processed under this Schedule 6F);
- (e) receives a request from any third party for disclosure of Personal Data where compliance with such request is required or purported to be required by Law;
- (f) becomes aware of or reasonably suspects a Data Loss Event; or
- (g) becomes aware of or reasonably suspects that it has in any way caused the Co-ordinating Commissioner or other Commissioner to breach Data Protection Legislation.

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

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

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

- (a) the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;
- (b) such assistance as is reasonably requested by the Co-ordinating Commissioner to enable the Co-ordinating Commissioner to comply with a Data Subject Access Request within the relevant timescales set out in Data Protection Legislation;
- (c) assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;
- (d) assistance as requested by the Co-ordinating Commissioner with respect to any request from the Information Commissioner's Office, or any consultation by the Co-ordinating Commissioner with the Information Commissioner's Office.

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

- 2.10 For the avoidance of doubt the provisions of GC12 (*Assignment and Sub-contracting*) apply to the delivery of any Data Processing Services.
- 2.11 Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:
- (a) notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;
 - (b) obtain the written consent of the Co-ordinating Commissioner;
 - (c) carry out appropriate due diligence of the Sub-processor and ensure this is documented;
 - (d) enter into a binding written agreement with the Sub-processor which as far as practicable includes equivalent terms to those set out in this Schedule 6F and in any event includes the requirements set out at GC21.16.3; and
 - (e) provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.
- 2.12 The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:
- (a) the categories of processing carried out under this Schedule 6F;
 - (b) where applicable, transfers of Personal Data to a third country or an international organisation, including the identification of that third country or international organisation and, where relevant, the documentation of suitable safeguards;
 - (c) a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and
 - (d) a log recording the processing of the Processor Data by or on behalf of the Provider comprising, as a minimum, details of the Processor Data concerned, how the Processor Data was processed, when the Processor Data was processed and the identity of any individual carrying out the processing.
- 2.13 The Provider warrants and undertakes that it will deliver the Data Processing Services in accordance with all Data Protection Legislation and this Contract and in particular that it has in place Protective Measures that are sufficient to ensure that the delivery of the Data Processing Services complies with Data Protection Legislation and ensures that the rights of Data Subjects are protected.
- 2.14 The Provider must comply at all times with those obligations set out at Article 32 of the UK GDPR and equivalent provisions implemented into Law by DPA 2018.
- 2.15 The Provider must assist the Commissioners in ensuring compliance with the obligations set out at Article 32 to 36 of the UK GDPR and equivalent provisions implemented into Law, taking into account the nature of processing and the information available to the Provider.
- 2.16 The Provider must take prompt and proper remedial action regarding any Data Loss Event.
- 2.17 The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners' obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

Schedule 6F**Annex A****Data Processing Services****Processing, Personal Data and Data Subjects**

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

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

SCHEDULE 7 – PENSIONS

[Note to Bidders: The provisions of this Schedule 7 will be refined and/or confirmed prior to each Call-off Contract award, as appropriate.]

1. Definitions

- 1.1 Terms not defined in the annex to this Schedule shall have the meaning set out in Schedule 1 (Definitions).

2. Introduction

- 2.1 The Parties shall comply with the terms of this Schedule in respect of future pension provision for each Eligible Employee, including each Original Transferring NHS Employee and Original Transferring LGPS Employee who remains wholly or mainly employed in providing the Services, and the provision for transfer of the Original Transferring NHS Employee's or Original Transferring LGPS Employee's pension rights (if applicable) which have accrued in any scheme which is Broadly Comparable to the NHS Scheme or the LGPS, or any other defined benefit occupational pension scheme provided by the Existing Provider to such Original Transferring NHS Employee or Original Transferring LGPS Employee immediately before the Transfer Date.
- 2.2 The Parties shall also comply with the terms of this Schedule in respect of pension provision in respect of the Transferring Employees generally.
- 2.3 It is the understanding of the Commissioner that the majority (if not all) of the Transferring Employees are not currently members of, or are eligible to be members of, the NHS Scheme or the LGPS, although the treatment of any Transferring Employee who is an Eligible Employee is as set out in this Schedule.

3. Fair Deal and Public Providers and Private Providers

- 3.1 The Provider will, and will procure that each of its sub-contractors, will comply with Paragraph 3.2 or Paragraph 3.3 dependent on whether the Provider (and where applicable the sub-contractor) is a Public Provider or a Private Provider.
- 3.2 If the Services or any part of the Services pertaining to this Contract are undertaken by a Public Provider then Paragraph 4 of this Schedule will apply in respect of the Public Provider and Paragraph 5 will not be applicable to the Public Provider.
- 3.3 If the Services or any part of the Services pertaining to this Contract are undertaken by a Private Provider then Paragraph 5 of this Schedule will apply in respect of the Private Provider and Paragraph 4 will not be applicable to the Private Provider.

4. Transfer of employees to a Public Provider under Fair Deal

- 4.1 The Provider will comply with this Paragraph 4 if it is a Public Provider and/or will procure that any sub-contractors which are a Public Provider(s) undertaking any Services under this Contract will comply with this Paragraph 4. In the event that any of the Public Provider's sub-contractors are a Private Provider, the Provider will procure that any such sub-contractors undertaking any Services under this Contract will comply with Paragraph 5.
- 4.2 A Public Provider who is an NHS employer or an LGPS Employer will procure that each Eligible Employee that Transfers to it will be offered continuing membership

or membership (as applicable) of the NHS Scheme or the LGPS with effect from the Transfer Date.

- 4.3 If the Eligible Employee was a member of or eligible to be a member of the NHS Scheme or the LGPS, or is otherwise an Original Transferring NHS Employee or an Original Transferring LGPS Employee, and participation in the NHS Scheme or the LGPS is not permitted to the Public Provider, the Public Provider will procure that Broadly Comparable pension benefits are provided to such Eligible Employee as advised by GAD.

5. **Transfer of employees to a Private Provider under Fair Deal**

- 5.1 The Provider will comply directly with this Paragraph 5 if it is a Private Provider, and/or will procure that any sub-contractors which are Private Provider(s) undertaking any Services under this Contract will comply with this Paragraph 5.
- 5.2 Each Private Provider (and/or applicable sub-contractors) undertakes that with effect from the Transfer Date it will either:
 - 5.2.1 become a participating employer in the NHS Scheme in respect of all Eligible Employees who were members of or eligible to be members of the NHS Scheme and Original Transferring NHS Employees that Transfer to it and accordingly the Private Provider will comply with this Paragraph 5; or
 - 5.2.2 become a participating employer in the LGPS in respect of all Eligible Employees who were members of or eligible to be members of the LGPS and Original Transferring LGPS Employees that Transfer to it and accordingly the Private Provider will comply with this Paragraph 5.

If any Eligible Employee was a member of or eligible to be a member of the NHS Scheme or the LGPS, or is otherwise an Original Transferring NHS Employee or an Original Transferring LGPS Employee, and participation in the NHS Scheme or the LGPS is not permitted to the Private Provider, the Private Provider will procure that Broadly Comparable pension benefits are provided to such Eligible Employee as advised by GAD.

Direction Employer status

- 5.3 In accordance with Fair Deal the Commissioner expects that the Provider will participate in the NHS Scheme in respect of the Eligible Employees and Original Transferring NHS Employees referred to in Paragraph 5.2 above with effect from the Transfer Date.
- 5.4 Also in accordance with Fair Deal, at least sixty (60) days prior to the Transfer Date the Provider shall apply for a Direction, in order to become a Direction Employer. The Provider shall notify the Commissioner immediately of such application and the Provider shall confirm the result of the application to the Commissioner immediately upon receipt. The Commissioner shall use all reasonable endeavours to assist the Provider in its application for a Direction, by ensuring it provides to the Provider and/or the Pensions Division (as applicable and if directed to do so by the Provider) after receiving a written request by the Provider, such information held by the Commissioner and which the Provider must provide as part of its application.
- 5.5 In the event of the Provider being issued with a Direction (and the Provider immediately notifying the Commissioner of the same) to the satisfaction of the Commissioner, the Provider will procure that the Eligible Employees referred to in

Paragraph 5.2 above have membership or continued membership without any break, and the Original Transferring NHS Employees membership, of the NHS Scheme subject to the Direction and with effect from the Transfer Date.

- 5.6 The Provider undertakes that should it cease to participate in the NHS Scheme for whatever reason at a time when it has Eligible Employees, that it will, at no extra cost to the Commissioner, provide to any such Eligible Employee access to an occupational pension scheme certified by GAD (or any other Actuary nominated by the Authority in accordance with relevant guidance produced by GAD) as providing benefits which are Broadly Comparable to those provided by the NHS Scheme at the relevant date.

Breach of Direction

- 5.7 The Commissioner will be entitled to terminate this Contract if the Provider is held to be in material breach of the Direction, in accordance with the respective terms of the Direction, and does not remedy the breach within a reasonable period after receiving written notice from the Commissioner requiring it to remedy the breach.

Admitted Body status

- 5.8 The Commissioner expects that the Provider will participate in the LGPS in respect of the Eligible Employees and Original Transferring LGPS Employees referred to in Paragraph 5.2 above with effect from the Transfer Date.
- 5.9 At least thirty (30) days prior to the Transfer Date the Provider shall agree and execute an admission agreement with the appropriate LGPS Administering Authority in order to become an Admitted Body. The Provider shall notify the Commissioner immediately of such an application to become an admitted body and the Provider shall confirm the result of the application to the Commissioner immediately upon receiving confirmation of its application. The Commissioner shall use all reasonable endeavours to assist the Provider in its application for admitted body status, by ensuring it provides to the Provider and/or the relevant Administering Authority (as applicable and if directed to do so by the Provider) after receiving any written request by the Provider, such information held by the Commissioner which the Provider must provide as part of its application.
- 5.10 In the event of the Provider being granted Admitted Body status (and the Provider immediately notifying the Commissioner of the same) to the satisfaction of the Commissioner, the Provider will procure that the Eligible Employees referred to in Paragraph 5.2 above have membership or continued membership without any break, and the Original Transferring LGPS Employees membership, of the LGPS subject to the terms of the Admission Agreement and with effect from the Transfer Date.
- 5.11 The Provider undertakes that should it cease to participate in the LGPS for whatever reason at a time when it has Eligible Employees, that it will, at no extra cost to the Commissioner, provide to any such Eligible Employee access to an occupational pension scheme certified by GAD (or any other Actuary nominated by the Authority in accordance with relevant guidance produced by GAD) as providing benefits which are Broadly Comparable to those provided by the LGPS at the relevant date.

Breach of Admission Agreement

- 5.12 The Commissioner will be entitled to terminate this Contract if the Provider is held to be in material breach of the Admission Agreement, in accordance with the

respective terms of the Admission Agreement, and does not remedy the breach within a reasonable period after receiving written notice from the Commissioner requiring it to remedy the breach.

Potential additional payments to the NHS Scheme or the LGPS

- 5.13 If the Provider breaches any terms of a Direction, an Admission Agreement or Fair Deal in a way which leads to an increase in NHS Scheme or LGPS liabilities, an additional payment from the Provider may be required. The Provider will comply with the terms of the Direction/the Admission Agreement.

6. Indemnity Regarding Pension Benefits and Premature Retirement Rights

- 6.1 The Provider agrees to indemnify the Commissioner on demand against all liabilities, damages, losses, costs and expenses arising out of any claim by any Transferring Employee relating to the provision of (or failure to provide) pension benefits and premature retirement rights after the Transfer Date, including but not limited to, any claim that the level of any such benefit provided is not in accordance with the Provider's and/or any sub-contractor's obligations under this Schedule.

7. Pensions on termination of the Contract, cessation of the performance of the Services or any part of the Services

- 7.1 The Provider will comply with the requirements of Fair Deal and the terms of the Direction and/or any Admission Agreement (as applicable), in the event of any termination or expiry of this Contract or otherwise cessation of the performance or the Services or any part of the Services, and shall do all acts and things, as may in the reasonable opinion of the Commissioner be necessary or desirable, to enable the Commissioner and/or the New Provider to comply with Fair Deal, in the event of any termination or expiry of this Contract or otherwise cessation of the performance or the Services or any part of the Services.
- 7.2 The Provider shall do all such acts and things, provide all such information and access to the Eligible Employees, Original Transferring NHS Employees and Original Transferring LPS Employees as may in the reasonable opinion of the Commissioner be necessary or desirable to enable the Commissioner, and/or the New Provider to achieve the objectives set out as follows:
- (a) to maintain ongoing pension accrual for the Eligible Employees, Original Transferring NHS Employees and Original Transferring LGPS Employees in the NHS Scheme or the LGPS (as applicable) for so long as they remain wholly or mainly employed in providing the Services;
 - (b) not to adversely affect pension rights accrued by the Eligible Employees, Original Transferring NHS Employees or Original Transferring LGPS Employees in the period ending on the earlier of their ceasing to participate in the NHS Scheme or LGPS (as applicable) as a result of no longer being wholly or mainly employed in providing the Services or any termination or expiry of the Contract or otherwise cessation of the performance of the Services or any part of the Services; and
 - (c) to comply with all applicable legislation, binding codes of practice and non-binding codes of practice issued by any statutory authority which may be admissible as evidence of legislative compliance at the termination or expiry of the Contract or otherwise cessation of the performance of the Services or any part of the Services.

8. Sub-Contractors

- 8.1 In the event that the Provider enters into a sub-contract in connection with the Contract it shall impose obligations on its sub-contractors in the same terms as those imposed on the Provider in relation to pension benefits in this Schedule.

9. Indemnity

- 9.1 The Provider shall indemnify, and keep indemnified, the Commissioner and any New Provider in full against all costs and losses incurred by the Commissioner or any New Provider as a result of, or in connection with, any failure by the Provider or its sub-contractors to comply with this Schedule.

10. Employment Regulations and the Pensions Act 2004

- 10.1 The Provider shall comply with Sections 257 and 258 of the Pensions Act 2004 and the applicable provisions of the Transfer of Employment (Pension Protection) Regulations 2005 (as amended) (if applicable) in relation to the Transferring Employees who are not Eligible Employees or Original Transferring NHS Employees or Original Transferring LGPS Employees with effect on and from the Transfer Date.

11. Auto-enrolment compliance

- 11.1 Where the Provider is a Private Provider, it agrees to indemnify the Commissioner on demand against all liabilities, damages, losses, costs and expenses arising out of any claim by any Transferring Employee in relation to the Private Provider's and/or sub-contractor's auto-enrolment obligations under the Pensions Act 2008 and related legislation.

Schedule 7**Annex 1****Definitions**

The following words and phrases shall have the following meanings when used in this Schedule:

Actuary	means a Fellow of either the Institute of Actuaries or Faculty of Actuaries;
Administering Authority	means a body listed in Part 1 of Schedule 3 of the Local Government Pension Scheme Regulations 2013 (as amended) who maintains a fund within the LGPS;
Admission Agreement	means an agreement between an Admitted Body and an Administering Authority under applicable LGPS Regulations;
Broadly Comparable	means certified by GAD as satisfying the condition that there are not identifiable employees who will suffer material detriment overall in terms of future accrual of pension benefits;
Direction	means a direction made under section 7 of the Superannuation (Miscellaneous Provisions) Act 1967 or a determination made under section 25(5) of the Public Service Pensions Act 2013 (as applicable);
Direction Employer	means a person who is subject to a Direction;
Eligible Employee	means those Transferring Employees who are on the Transfer Date entitled to the protection of Fair Deal and any Original Transferring NHS Employee or Original Transferring LGPS Employee;
Fair Deal	means HM Treasury's "Fair Deal for staff pensions: staff transfer from central government" guidance dated October 2013 (as subsequently amended and updated);
GAD	means the Government Actuary's Department;
LGPS	means the Local Government Pension Scheme;
LGPS Employer	means an employer entitled to participate in the LGPS;
New Provider	means any third party engaged by the Commissioner to supply any services which are the same as or substantially similar to any or all of the Services and which are purchased by or provided to the Commissioner following the termination or expiry of all or a part of this Contract to replace Services formerly provided by the Provider under this Contract;

NHS Scheme	means the NHS Pension Scheme for England and Wales (as amended from time to time);
Original Fair Deal	means the annex to the Code titled "A Fair Deal for Staff Pensions" (dated 1999 and as subsequently amended in 2004);
Original Transferring LGPS Employee	means a Transferring Original Employee who originally was a member of or eligible to be a member of the LGPS and to whom the Original Fair Deal applied at the point of the first transfer between a public sector body or local authority entitled to offer membership of the LGPS and the Existing Provider and who at the Transfer Date became entitled to the protection of Fair Deal, or a Transferring Original Employee who originally was a member of or eligible to be a member of the LGPS and to whom the Best Value Authorities Staff Transfers (Pensions) Direction 2007 ("Best Value Direction") applied at the point of the first transfer between a local authority entitled to offer membership of the LGPS and the Existing Provider and who at the Transfer Date still remained entitled to the protection of the Best Value Direction;
Original Transferring NHS Employee	means a Transferring Original Employee who originally was a member of or eligible to be a member of the NHS Scheme and to whom the Original Fair Deal applied at the point of the first transfer between an NHS employer and the Existing Provider and who at the Transfer Date became entitled to the protection of Fair Deal;
Pensions Division	means the Pensions Division of the NHS Business Services Authority in relation to the NHS Scheme;
Private Provider	means any person or body, including any sub-contractor, who undertakes the Services or part of the Services and who is not a Public Provider;
Public Provider	means any person or body, including any sub-contractor who undertake the Services or part of the Services and who is deemed by the Commissioner to be a public sector body;
Transfer	means the transfer of an organised grouping of employees providing the Services or part of the Services pursuant to the Employment Regulations;
Transferring Original Employee	means an employee of a public sector body (it is the Commissioner's understanding that such a public sector body could but may not necessarily be an NHS body) or a local authority: (a) who became, by the application of the Employment Regulations in relation to what was done for the purposes of carrying out a contract between the Commissioner and the Existing Provider, an employee of someone other than the public sector body or local authority; (b) whose contract of employment on each occasion when an intervening contract was carried out became, by virtue of the application of the Employment Regulations in relation to what

	was done for the purposes of carrying out the intervening contract, a contract of employment with someone other than the existing employer; and (c) whose contract of employment becomes, by virtue of the application of the Employment Regulations in relation to what is done for the purposes of carrying out this Contract between the Commissioner and the Provider, a contract of employment with someone other than the Existing Provider.
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SCHEDULE 8 – JOINT SYSTEM PLAN OBLIGATIONS

Not Applicable

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