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| Classification: Official |
| Publication reference: PRN01624 |



NHS Standard Contract 2025/26

Particulars (Full Length)

|  |  |
| --- | --- |
| Contract title: | National Staff Mental Health Support Service |
| Atamis Project ref: | C346803 |
| Atamis Contract ref: | TBC |

Version 1, April 2025

Text highlighted in yellow to be left and completed after for Contract Award with selected provider

Prepared by: NHS Standard Contract team, NHS England

[england.contractshelp@nhs.net](mailto:ngland.contractshelp@nhs.net)

| **DATE OF CONTRACT** |  |
| --- | --- |

|  |  |
| --- | --- |
| **EXPECTED SERVICE COMMENCEMENT DATE** | **1 April 2026** |
| **CONTRACT TERM** | **12 months commencing**  **1 April 2026 (or as extended in accordance with Schedule 1C)** |
| **COMMISSIONERS** | **NHS England**  Wellington House,  133-155 Waterloo Rd,  London  SE1 8UG |
| **CO-ORDINATING COMMISSIONER**  *See GC10 and Schedule 5C* | **Health and Wellbeing, Staff Experience and Leadership Development, Workforce, Training and Education Directorate** |

|  |  |
| --- | --- |
| **PROVIDER** | TBC with the winning Provider  **[ ] (ODS [ ])**  **Principal and/or registered office address:**  **[ ]**  **[Company number: [ ]** |

|  |  |
| --- | --- |
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**Definitions and Interpretation**

**CONTRACT**

**Contract title:** National Staff Mental Health Support Service

**Atamis Project Ref:** C346803

**Contract ref:** TBC

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**

**Signed by the authorised representative of THE PROVIDER**

**Signed by the authorised representative of THE COMMISSIONER**

|  |  |
| --- | --- |
| **SERVICE COMMENCEMENT AND CONTRACT TERM** | |
| **Effective Date**  *See GC2.1* |  |
| **Expected Service Commencement Date**  *See GC3.1* | **1 April 2026** |
| **Longstop Date**  *See GC4.1 and 17.10.1* | **1 April 2026** |
| **Contract Term** | **12 months commencing**  **1 April 2026 (or as extended in accordance with Schedule 1C)** |
| **Commissioner option to extend Contract Term**  *See Schedule 1C, which applies only if YES is indicated here* | **YES**  **By 2 x 12 months, subject to annual budgetary approval,** **up to a maximum term of 36 Months in total** |
| **Commissioner Notice Period** (for termination under GC17.2) | **6 months** |
| **Commissioner Earliest Termination Date** (for termination under GC17.2) | **6 months after the Service 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** |

|  |  |
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| **SERVICES** | |
| **Service Categories** | **Indicate all categories of service which the Provider is commissioned to provide under this Contract.**  *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.* |
| **Accident and Emergency Services (Type 1 and Type 2 only) (A+E)** | Not Applicable |
| **Acute Services (A)** | Not Applicable |
| **Ambulance Services (AM)** | Not Applicable |
| **Cancer Services and/or Radiotherapy Services (CR)** | Not Applicable |
| **Continuing Healthcare Services (including continuing care for children) (CHC)** | Not Applicable |
| **Community Services (CS)** | Not Applicable |
| **Diagnostic, Screening and/or Pathology Services (D)** | Not Applicable |
| **End of Life Care Services (ELC)** | Not Applicable |
| **Mental Health and Learning Disability Services (MH)** | **Applicable** |
| **Mental Health and Learning Disability Secure Services (MHSS)** | Not Applicable |
| **NHS 111 Services (111)** | Not Applicable |
| **Patient Transport Services (non-emergency) (PT)** | Not Applicable |
| **Urgent Treatment Centre Services (including Walk-in Centre Services/Minor Injuries Units) (U)** | Not Applicable |
| **Service Requirements** | |
| **Prior Approval Response Time Standard**  *See SC29.21* | **Not applicable** |
| **GOVERNANCE AND REGULATORY** | |
| **Provider’s Nominated Individual**  *See SC1.4* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s 2018 Act Responsible Person**  *See SC3.17* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Commissioners’ UEC DoS Leads**  *See SC6.18* | **Not Applicable** |

|  |  |
| --- | --- |
| **Provider’s UEC DoS Contact**  *See SC6.18* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Health Inequalities Lead (NHS Trusts and NHS Foundation Trusts only)**  *See SC13.8* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Net Zero Lead (NHS Trusts and NHS Foundation Trusts only)**  *See SC18.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Infection Prevention Lead**  *See SC21.1* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Accountable Emergency Officer**  *See SC30.1* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Child Sexual Abuse and Exploitation Lead**  *See SC32.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Mental Capacity and Liberty Protection Safeguards Lead**  *See SC32.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Prevent Lead**  *See SC32.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Safeguarding Lead (adults) / named professional for safeguarding adults**  *See SC32.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Safeguarding Lead (children) / named professional for safeguarding children**  *See SC32.2* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Controlled Drugs Accountable Officer (NHS Trusts, NHS Foundation Trusts and English Independent Hospitals only)**  *See SC33.12* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Wellbeing Guardian (NHS Trusts and NHS Foundation Trusts only)**  *See GC5.9* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Freedom To Speak Up Guardian(s)**  *See GC5.10* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Caldicott Guardian**  *See GC21.3* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Data Protection Officer (if required by Data Protection Legislation)**  *See GC21.3* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Information Governance Lead**  *See GC21.3* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Provider’s Senior Information Risk Owner**  *See GC21.3* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **CONTRACT MANAGEMENT** | |
| **Addresses for service of Notices**  *See GC36* | **Co-ordinating Commissioner**:  Health and Wellbeing, Staff Experience and Leadership Development, Workforce, Training and Education directorate  **Contact:** Adam Turner  **Email:** Adam.turner8@nhs.net |
| **Frequency of Review Meetings**  *See GC8.1* | **Monthly** |
| **Commissioner Representative(s)**  *See GC10.3* | **Name:** Aminur Choudhury  **Email:**  Aminur.Choudhury@nhs.net  **Tel:** 07702 404 030 |
| **Provider Representative**  *See GC10.3* | TBC with the winning Provider  **Name:**  **[ ]**  **Email:** **[ ]**  **Tel:** **[ ]** |
| **Nominated Mediation Body (where required – see GC14.4)** | **CEDR** |

# SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

1. **Conditions Precedent**

The Provider must provide the Co-ordinating Commissioner with the following documents in accordance with GC4.1:

| 1. Evidence of appropriate Indemnity Arrangements 2. Evidence of CQC registration in respect of Provider and Material Sub-Contractors (where required) 3. Evidence the service provider has a fully registered Responsible Officer (RO) as per the Medical Profession (Responsible Officers) Regulations 2010 4. Evidence of relevant internal standard operating procedures (SOP) and policies, e.g., information governance. 5. Evidence of all clinicians who have all relevant professional registration in place (GMC, NMC, etc) 6. Evidence of all clinicians who have been suitably trained to fulfil the requirement of this contract. 7. Evidence of Monitor’s Licence in respect of Provider and Material Sub-Contractors (where required) 8. Copies of all Material Sub-Contracts, signed and dated and in a form approved by the Co-ordinating Commissioner |
| --- |

The Provider must complete the following actions in accordance with GC4.1:

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

# SCHEDULE 1 – SERVICE COMMENCEMENT

# AND CONTRACT TERM

1. **Commissioner Documents**

| **Date** | **Document** | **Description** |
| --- | --- | --- |
| **Not Applicable** |  |  |

# SCHEDULE 1 – SERVICE COMMENCEMENT

# AND CONTRACT TERM

1. **Extension of Contract Term**
2. The Commissioners may opt to extend the Contract Term twice by 12 months each up to a maximum term of 36 months in total.
3. 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 (six) months before the Expiry Date as at the date of the written notice.
4. The option to extend the Contract Term may be exercised in conjunction with any variation to the Contract permitted by and in accordance with GC13 (*Variations*).
5. 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

1. **Service Specifications**

Definitions

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

* + **Commissioner** refers to NHS England (NHSE) as the Commissioner of this service.
  + **Provider** refers to the successful Bidder who has entered into a Contract with the Commissioner to provide the service, otherwise known as the Supplier.
  + **Local Clinical Services** refer to the core requirements set out in this service specification led by the local Providers sub-contracted by the lead Provider, or local teams within the Provider, as required to deliver services for each catchment area.
  + **Catchment area** refers to the local population of the NHS workforce as Service Users, which the services Local Clinical services shall be provided for.
  + **Medical Director** refers to the Provider Medical Director for the service. The Medical Director will be the accountable officer for the delivery of the service
  + **Clinical Lead** refers to the Provider lead service Clinician within a catchment area as assigned by the Medical Director, and is responsible for the oversight of care and providing leadership for their catchment area
  + **Service Clinician** refers to a member of the Provider’s service team assessing or treating the Service User(s).
  + **Service User(s)** refers to the patients of the service i.e. an NHS staff member as a patient.
  + **GP** refers to the Service User(s) own general practitioner
  + **OH** refers to Occupational Health services
  + **RO** refers to the Responsible Officer for the Service User(s)
  + **Other services** refer to any other NHS, private, charity or other support commissioned by other means which may be accessed by the Service User(s). These services do not form part of this contract.

1. Background to the specification
   1. Need for this national service in support of NHS staff mental health

Mental Health is the main cause of sickness absence for the NHS workforce. The NHS Staff Survey (2024) identified that 42% of respondents report being affected by work related stress, and national statistics around sickness absence identified that mental health reasons accounted for 27% of all sickness absence in November 2024.

It is acknowledged that the mental health needs of NHS staff are likely higher than the general population, which is exacerbated from the nature of working in the healthcare profession. It is also acknowledged that it is difficult for healthcare professionals to seek support for their mental health needs, as they could be seeking support from potential colleagues that they may work with/know, which may be perceived as a barrier.

* 1. Background to the service

The current service has been running for over 12 years, based on ongoing development of the service to better support clinicians with complex mental health needs. It began as a review of health problems in the context of the professional regulation of medical and dental performers and findings from referrals to National Clinical Assessment Service (NCAS) looking to improve the safety of services for patients.

Since then, the evidence base has continued to demonstrate the need for sustaining this national mental health service for NHS staff. This includes for example:

Over the last 25 years a number of local services have been developed to support doctors’ access to health care. These have usually resulted from the work of interested clinicians, Primary Care Trusts or Local Medical Committees (LMCs) e.g. PSUs. The BMA also has a free counselling service for doctors.

In 2016 NHS GP Health service was commissioned by NHS England as part of the General Practice Forward View[[1]](#footnote-2) to support mental health and addiction issues for GPs across England and launched in January 2017[[2]](#footnote-3).

In 2018, a Report on the First 10 Years of the Practitioner Health Service was published demonstrating the learnings and insights of supporting the mental health of doctors[[3]](#footnote-4).

In 2018, the NHS Long Term Plan was published including a commitment to prioritising doctors’ mental health[[4]](#footnote-5). This was fulfilled in 2019 with NHS GP Health being transitioned into NHS Practitioner Health and services extended to include all doctors and dentists working in England.

In 2020, in response to the covid-19 pandemic, NHS Practitioner Health was extended to all NHS staff working in England[[5]](#footnote-6), in collaboration with mental health and wellbeing hubs[[6]](#footnote-7). This was following engagement with key stakeholders and emerging evidence which found:

Staff well-being impacts patient safety. Psychological morbidity continues to exist on a scale sufficient to functionally impair a significant fraction of the workforce in the performance of life critical tasks. The Greenberg et al research makes clear the need for additional support for frontline staff in response to the adverse impact of the covid-19 pandemic.

In 2021 NHS Practitioner Health published a report on their experiences of supporting NHS staff during the pandemic[[7]](#footnote-8). This reported that nearly as many patients presented in the 12-month pandemic period (April 2020 –March 2021) as in the first ten years of the service (4355 in last 12 months vs 5000 over first 10 years). Month on month, over the course of the pandemic an average of 46% more doctors presented during the pandemic compared to pre-pandemic.

1. Scope of the contract opportunity
   1. Aims and Overview of the Service

This national mental health treatment service for NHS staff seeks to address the need set out above, to help keep our NHS staff well, productive, and therefore maximise their capacity to be able to contribute to safe patient care.

The strategic objectives of the service are:

* **Retain a healthy NHS workforce**: enabling healthcare staff who experience mental health conditions and demonstrate the need for confidential support to safely continue working, and/or support bringing them back into the workplace following a period of sickness.
* **Integrated and equitable access**: a multidisciplinary offer of confidential mental health and addiction support to NHS staff to ensure equitable and consistent access across England. Adding value by signposting to other appropriate treatment/support offers, including local occupational health services to support staff to stay in work or return to work.
* **Demonstrate impact and return on investment of the service**: by evidencing how NHS staff accessing the service increase their mental health, wellbeing, productivity, and capacity to contribute to patient care, ultimately demonstrating how the service adds value to the taxpayer.

The service will be funded nationally and be free to access for healthcare staff in England. The service will operate in a unique space where there is a crossover between the professional and regulatory environment in which a clinician or healthcare professional works, and their mental health treatment needs need to be met in a confidential and supportive way outside normal treatment routes.

The focus of the service will be to support staff with mental health conditions. If this becomes a chronic condition, the service will then support them to gain appropriate long term NHS mental health services (or other appropriate treatment support) to maximise this contract value.

The service expertise lies in supporting the mental health of healthcare staff accessing mental health services, taking responsibility for the safety of the service users accessing the service, but also the professional and patient responsibilities and risks associated with these healthcare professionals’ roles including confidentiality. Whilst patient confidentiality is maintained whilst accessing any form of healthcare service, NHS staff as service users require an enhanced form of confidentiality due to the nature of the potential to be treated by peers, which could compromise them professionally. This service seeks to mitigate and address this.

The service experience and expertise will cover all main aspects of mental health support needs for healthcare staff. Therefore, it will range from anxiety and depression, through to complex mental health care support, so that they may return to safe, effective practice. As part of this, the service will support mental health conditions such as depression, anxiety, obsessive- compulsive disorder, bipolar affective disorder, complex traumatic stress reactions, complex PTSD, personality disorders, psychosis and eating disorders, and this may include treating staff where there is a higher risk of suicide. The service will also prescribe medicines where appropriate and treat patients with a range of drug and alcohol addiction issues including detox and inpatient addiction.

To achieve this, the service should draw on the benefits of a multi-disciplinary team, ensuring the most effective and value-added professional supports/treatments for the service users, to maximise contract value.

All healthcare staff are encouraged to access local mental health treatment and support services in the first instance, which are better placed to meet more common mental health issues. Many healthcare staff can do this through their local occupational health or GP services for common mental health conditions or NHS Talking Therapies for anxiety and depression (which accepts self-referrals). In most cases, staff can be served best by their own occupational health service or local primary care or mental health services, which can protect confidentiality, and in some instances offer reciprocal arrangements with neighbouring services to allow staff to be seen outside of their own service if required. However, a small proportion of healthcare staff may require bespoke intervention which cannot be provided by other services offered by their organisation, and/or who can demonstrate that they cannot gain specialist intervention through local primary care or mental health services because of specific connections with a service that would risk compromising their professional relationship with that service. This contract will focus on supporting this smaller group of staff, through self-referral, and/or being referred into the service (e.g. by their organisational occupational health, or HR support).

This service will focus on supporting healthcare staff in senior leadership positions, including senior clinical positions, which may compromise their ability to benefit from a local service that they have a direct professional relationship with or where sensitive handling of regulatory issues is required. e.g. doctors, dentists, nurses, pharmacists, AHPs psychological professionals, social workers, healthcare scientists and senior managers. Staff can self-refer into the service, should they demonstrate the need for a bespoke service outside of their local primary care or mental health services.

To achieve this, the service will provide the following:

**Proactive outreach and engagement (working in partnership with the commissioner)** with all eligible staff groups to promote the service as a safe, confidential space for health and social care staff, through workforce wellbeing resources, apps, hosting events, webinars, podcasts, social media etc. This includes ensuring that the service is accessible to staff with protected characteristics.

**Central/national access** through website, email, phone and apps to make it easy for health and social care staff to access services.

**Initial clinical assessment and through consultation**, identifying what support service users may need.

**Developing and delivering a treatment plan** in conjunction with multidisciplinary teams (MDTs), providing a variety of NICE recommended treatment options, including but not limited to, talking therapies e.g., CBT, Prescribed medication, Individual and group interventions, In-patient addiction rehabilitation.

**Provide ongoing case management** supporting service users through their treatment plan as lead clinician maintaining the important therapeutic relationship with the patient throughout, and coordinating across other support the service user might be accessing

**Provide professional advice and support** to service users who are experiencing professional regulatory action and establish good working relationships with health care regulators to ensure confidential treatment can be provided to patients.

**Appropriate onward referral** where the service user is not able to be effectively treated by the service, or is best served by alternative sources of treatment, requires further / diverse support, or any other reason as appropriate to support the service user, and also maximise contract value.

The service will be confidential with an independent clinical record management system which is not linked to the shared care record and has a variety of different premises for seeing patients e.g., option of non-NHS premises, and both face-to-face and digital/online consultations. Patient engagement confirms this preferred approach.

It is important to note that the service does not replace the role of mainstream NHS mental health services who will also treat health care staff, and it is not an occupational health service. However, the service will need to interface with these wider services, as appropriate, with the interests of the service user in mind (e.g. liaison with organisation OH, their GP, onward referral to wider NHS mental health services etc).

There is work underway linked to the development of the NHS 10-year plan (due for publication Summer 2025) and aligned to national policy drivers including [Get Britain Working](https://www.gov.uk/government/publications/get-britain-working-white-paper) white paper to explore how the NHS can provide a more consistent and sustainable offer to improve the health and wellbeing of their workforce. This is based on the understanding that the NHS workforce needs to be healthy, productive, and have capacity to support wider population health.

This service will form part of this offer, focusing on the complex mental health needs of NHS staff. As the NHS seeks to enhance its offer to the workforce, it is also expected that the successful provider will work with the Commissioner to flexibly adapt this national service, to maximise impact, contract value, and ultimately respond to the evolving mental health needs of the NHS workforce as appropriate/through negotiation as part of the contract duration.

* 1. Information about current service provision

The current service has been running for over 12 years, and the current contract is coming to an end on 31st March 2026. More information on the current service can be found here: <https://www.practitionerhealth.nhs.uk/>

The Commissioner is looking to compete this invitation to tender in the open market by following a competitive process under the Health Care Services (Provider Selection Regime) Regulations 2023 (Provider Selection Regime) to re-commission services as set out in this specification to provide a National NHS Staff Mental Health Treatment Service, covering an initial period of 12 months with the option to extend in 2 x 12 monthly periods up to a maximum of 3 yrs in total. Options to extend the contract term is subject to further budgetary approval and shall be agreed by formal contract variation procedure with NHSEs Contract Management Team. It is essential to maintain service provision, safety and quality of care between current and future contracts. This will be a key deliverable as part of this new contract.

To provide an idea of scale and scope of the service, the following provides an indication of service usage during 2024 – 2025 NHS financial year.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr 24** | **May 24** | **June 24** | **July 24** | **Aug 24** | **Sept 24** | **Oct 24** | **Nov 24** | **Dec 24** | **Jan 25** | **Feb 25** | **Mar 25** | **Total** |
| **New Registrations** | 561 | 475 | 398 | 413 | 408 | 454 | 509 | 515 | 485 | 466 | 444 | 457 | 5565 |
| **Re-engaging within 1 year** | 8 | 10 | 7 | 12 | 7 | 10 | 6 | 5 | 7 | 7 | 4 | 3 | 86 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr 24** | **May 24** | **June 24** | **July 24** | **Aug 24** | **Sept 24** | **Oct 24** | **Nov 24** | **Dec 24** | **Jan 25** | **Feb 25** | **Mar 25** | **Total** |
| **Common Mental Health** | 456 | 401 | 327 | 329 | 337 | 381 | 413 | 433 | 351 | 331 | 306 | 185 | 4250 |
| **Complex Mental Health** | 22 | 19 | 10 | 19 | 16 | 22 | 32 | 25 | 23 | 22 | 19 | 4 | 233 |
| **Multiple Issues** | 3 | 3 | 4 | 5 | 3 | 5 | 3 | 4 | 1 | 5 | 1 | 0 | 37 |
| **Addiction** | 13 | 8 | 9 | 10 | 10 | 15 | 13 | 8 | 24 | 9 | 11 | 6 | 136 |
| **Physical Issues** | 8 | 3 | 5 | 5 | 1 | 2 | 2 | 3 | 5 | 4 | 0 | 4 | 42 |
| **Assessment only** | 67 | 51 | 50 | 57 | 48 | 39 | 52 | 43 | 55 | 56 | 27 | 13 | 558 |
| **Awaiting coding** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 13 | 46 | 84 | 248 | 395 |
| **Total** | 569 | 485 | 405 | 425 | 415 | 464 | 515 | 520 | 472 | 473 | 448 | 460 | 5651 |

1. Requirements of the Specification
   1. Aims and objectives of service

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

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

The Provider is responsible for the delivery of the service across England as set out in these contract particulars. As this is a national service, it is likely that the Provider will separate the delivery of these services through a national service (e.g. common operating elements, such as central point of access) and local clinical services (e.g. where appropriate, to support local delivery/catchment areas of treatment services) to maximise contract value and service quality. However, this model is at the discretion of the successful Provider.

The development of the delivery model is intended to be continually refined as required to support the needs of Service User(s). The Provider is expected to be flexible and be able to make changes as appropriate to develop the service in line with best practice and recommendations from key stakeholder groups. The Provider must adapt systems and develop pathways as required to support the development of the service as we learn more about the emerging needs of the health care workforce.

* 1. Service access requirements

**Access - Online and digital:**

The Provider must provide an accessible and informative website for the service on the Commissioner’s behalf and be responsible for the content and on-going management of the website. The website must confirm all digital accessibility requirements, to ensure that all potential service users accessibility needs are met, promoting equity of access.

The Provider must adhere to NHS Identity guidelines [NHS Identity Guidelines | Identity guidelines](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fnhsidentity%2Fidentity-guidelines%2F&data=05%7C02%7Chelen.houghton5%40nhs.net%7C5a4f322f36f24b933e2508dd921c4285%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638827372240592396%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=XJ1vn9kKtGAsUw8jUXgtacvd2MGj5AEVKWP8zsRDekk%3D&reserved=0) in promoting and in all communication regarding all aspects of the Service and its delivery.

The website must be independent of any existing websites which the Provider may have, to support any transfer of services as set out in Schedule 2I Exit Arrangements.

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

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

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

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

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

The Provider must provide email contact details so Service Users can contact the service by email. The email account must be monitored during the working hours of the service.

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

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

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

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

The Provider must put in place an appropriate web-based patient record system and demonstrate how the system supports the highest standards of Information Governance, as set out in Schedule 2G section 3: Information Governance Toolkit Compliance, and SC23 Service User Health Records. The provider will ensure that records kept in the service can only be accessed by the appropriately trained staff during their contracted hours with the service. Services must achieve WCAG 2.2 level AA as part of meeting [government accessibility requirements](https://www.gov.uk/service-manual/helping-people-to-use-your-service/making-your-service-accessible-an-introduction#meeting-government-accessibility-requirements).

The records system must be accessible remotely across England by the provider Clinicians as required to support Service Users within all catchment areas in England.

This patient records system must be stand-alone from any other patient records system in use by the Provider for other services to support any transfer of services as set out in Schedule 2I Exit Arrangements. Where data is required to be returned to the Commissioner, this must be at no additional cost to the Commissioner.

**Access - Telephone:**

The Provider must provide a single point of access into their service by phone.

The Provider must ensure the phone line is answered as a minimum between 8.00 - 20.00 Monday to Friday (excluding bank/public holidays) and 8.00 - 14.00 on Saturday.

The Provider services must include skilled call handlers who are experienced in taking calls from vulnerable Service Users who may well be stressed, anxious or scared. Call handling will be managed directly by the Operational Lead.

The Provider must provide the call centre function in-house of the provider service and must not commission external or overseas call centre function for this service.

The national phone number (which must be visible on the homepage) will be the main point of access into the service. The Provider must not use a premium rate telephone number and must provide a Free phone number from both landlines and mobiles

The call handler/s must be competent to answer any queries about the service, take contact details and triage the Service User to the service Local Clinical services for an initial assessment.

If a Service User requires urgent mental health support, then the call handler/s must refer the Service User immediately to an available service Clinician within services or Local Clinical services. If no Clinician is immediately available, the call handler must refer the Service User to urgent NHS mental health services. This information will be shared with the successful Provider. The call handler/s must be trained to recognise emergency needs of Service Users and be able to provide advice and support referral to emergency NHS services if required.

If a Service User calls out of hours, the Provider will enable an automatic answer message explaining the service opening times and referring to the website for more information, as well as being made aware of other support available out of hours, including crisis services.

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

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

The Provider must ensure that Service User accessibility considerations are considered and suitable alternative ways to liaise with the Provider are available, if needed (e.g. to support those with disabilities).

**Role in promoting access:**

The Provider must ensure the Local Clinical services have a pivotal role in promoting the service and are able to demonstrate that the service is accessible and widely known to Service Users. The Provider will support appropriate dissemination of the availability of the service via local media and NHS briefing routes to make sure all Service Users are both aware of the service, and how to access it. This should be as balanced through engagement with the Commissioner, to ensure capacity/demand are maintained.

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

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

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

The Provider may use social media to promote access to the service. However, this must be done in accordance with the Commissioners comms and engagement guidelines. Furthermore, the Provider will provide:

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

The Provider must adhere to NHS Identity guidelines [NHS Identity Guidelines | Identity guidelines](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fnhsidentity%2Fidentity-guidelines%2F&data=05%7C02%7Chelen.houghton5%40nhs.net%7C5a4f322f36f24b933e2508dd921c4285%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638827372240592396%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=XJ1vn9kKtGAsUw8jUXgtacvd2MGj5AEVKWP8zsRDekk%3D&reserved=0) in promoting and in all communication regarding all aspects of the Service and its delivery.

* 1. Delivery of clinical services

The Provider clinical services function (i.e. the clinical arm of the service that is providing assessment/Service User care) is the front end of the service and will be the part of the service most visible to Service Users. It provides the main clinical function of the service and a point of access for Service Users undergoing initial or ongoing assessment and treatment.

Local Clinical services

The Provider Local Clinical services functions must be based within the catchment areas they are supporting as set out in Section 3.6 of this Schedule 2A: Location of Provider Premises.

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

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

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

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

The Provider Local Clinical Services must include:

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

Local Clinical Services assessment and treatment:

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

Appointment times for assessments and treatments should be mutually agreed between the Providers Local Clinical services and Service User, but the Provider must be flexible to suit where possible the needs of the Service User. Services should as a minimum be available between 08.00 - 20.00 Monday to Friday (excluding bank/public holidays in line with Gov.uk website) and 08.00 - 14.00 on Saturday’s.

The Provider will work with the Commissioner to adapt any of these service availability timescales, based on any changes in need and/or to maximise the contract value.

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

* + guidance and competencies for general practitioners with an extended role including the UK Public Health Practitioner Standards [NHS England » Public health practitioner’s education and training directory](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Flong-read%2Fpublic-health-practitioners-education-and-training-directory%2F&data=05%7C02%7Chelen.houghton5%40nhs.net%7C6477c4e64e0b45ded8ee08dd991a21f8%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638835059980531253%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=hSK%2BWXWmLZ3lYeZ0nrjAy0cs9uaD0dbn36CPHsICONQ%3D&reserved=0)
  + Other relevant training available via the Royal Colleges, Faculties, and NHS England.

The following organisation for inclusion of registered psychological professionals:

* + Health and Care Professions Council Registered as a Practitioner Psychologist
  + British Association of Behavioural and Cognitive Psychotherapies Accredited as a cognitive behavioural psychotherapist
  + British Association of Counselling and Psychotherapy Accredited
  + British Psychoanalytic Council Registered
  + National Counselling Society Accredited Professional Registrant
  + United Kingdom Council for Psychotherapy Registered
  + Social Work England
  + Registered Nurses- NMC
  + Registered Doctors-GMC
  + Registered Allied Health Professionals- HCPC (in an AHP category)

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

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

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

Provision of Clinicians:

The Provider will manage a number of appropriate clinical professionals across catchment areas in England as part of delivering the requirements of this Service. These Clinicians may be employees of the Provider, or sub-contracted from the Provider.

The Provider will need to have regard to Schedule 2A Section3.4: Population covered, and Schedule 2B: Indicative Activity Plan when planning the provision of the service’s Clinicians and demonstrate good value for money on the use of resources for the providers Clinical services.

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

* 1. Service pathway

The Provider must deliver all requirements of the service specification and this service pathway for all Service Users accessing the service. This service pathway sets out the roles and responsibilities of the Providers Central services and Local Clinical services, which the Provider must provide as part of this service specification.

**Scope of the service pathway:**

The Service experience and expertise will cover all main aspects of mental health support needs for healthcare staff. Therefore, it will range from anxiety and depression, through to complex mental health care support, so that they may return to safe, effective practice.

As part of this, the Service will support mental health conditions such as depression, anxiety, obsessive- compulsive disorder, bipolar affective disorder, complex traumatic stress reactions, complex PTSD, personality disorders, and psychosis and eating disorders, and this may include treating staff where there is a higher risk of suicide.

The Service will also prescribe medicines where appropriate and treat patients with a range of drug and alcohol addiction issues including detox and inpatient addiction.

The Service will help those Service Users with:

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

Whilst the Service may be required to stay connected to Service Users experiencing acute exacerbation of their health problems, the Service should not offer to lead the care for users with:

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

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

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

The Provider will be expected to accept Service Users suffering the types of mental ill-heath and addiction problems in line with appropriate NICE guidance (for example Mental health and behavioural and neurological conditions <https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-behavioural-and-neurodevelopmental-conditions>

Where a Service User’s needs are not within the scope of the service specification, the Provider should signpost these Service Users to other services. The Service can still, at the discretion of the Provider with agreement of the Commissioner, support the Service User through case management and advice, but should not treat conditions not in scope of this service specification.

Population covered:

Service Users may be accepted into the service; after evidencing they meet an inclusion criteria.

The Service is designed to support Mental health of healthcare staff in England whose clinical needs cannot be met through local services, the Service Users own GP, NHS Talking Therapies for anxiety and depression secondary mental health service or other local mental health services. This includes:

* + Where a direct professional relationship with a service precludes the person from seeking and receiving care and support in local staff mental health and wellbeing support or local NHS mental health services.
  + Employer, occupational health or professional regulators have specific concerns which suggest care would be better provided by a service which specialises in supporting Service Users in these conditions.
  + Experiencing elements of complex addiction or other complex needs which cannot be met by other existing services.
  + The Service will give special consideration to the needs of very senior NHS staff – Board level staff and their deputies or other senior operational, professional or clinical leaders, as directed by the Commissioner, that may require additional support and face barriers around accessing confidential care locally, due to the exposure they receive as part of being a very senior leader in the NHS.

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

* + Self-referral by any senior staff member as directed by the Commissioner delivering NHS services
  + Self-referral by any Doctors with GMC registration and a license to practise, Dentists with GDC registration and a license to practise, and trainee doctors/dentists in England, who may access the service irrespective of their residence.

Any health care staff living in England but not working in England i.e. not linked to an NHS service in England, or any regulated profession who are not registered nor seeking registration with the relevant regulator or professional body are not eligible and should be signposted to alternate support based in their area of employment or mainstream NHS services.

Any Staff who have left working within the NHS, yet who are already engaged in support from this service may be supported for up to a further 6 months. During this time, the Provider should ensure the development of a safe onward care plan / referral to wider support services, as appropriate. The Commissioner will keep the above inclusion criteria for access under review and may amend through contract variation as required.

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

Acceptance and exclusion criteria and thresholds:

The Local Clinical services will need to verify a Service User’s eligibility to access this service to ensure that the Service User meets the eligibility criteria. In all cases the Local Clinical services should maintain the trust and confidentiality of the Service User accessing the service and be considerate to the Service Users’ mental wellbeing on initial assessment.

There may be occasions when a Service User is not working due to long term sickness, and as a result isn’t registered to their professional regulator.The service must manage these circumstances sensitively and consider further the appropriateness of their admittance into the service. Lack of professional registration must not be a barrier to accessing the service. Service Users should be evidently planning to return to work in a health and social care environment as per the population covered.

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

Equity of Access, Equality and Non-Discrimination:

The Equality Act 2010 protects individuals from discrimination and inequality in accessing health and social care resources. The [Care Quality Commission](https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/responsive/equity-access) emphasises the importance of ensuring equitable access to healthcare for all. [NHS England](https://www.england.nhs.uk/long-read/health-equalities-and-digital-inclusion/) focuses on addressing health inequalities, ensuring support for minority groups, and digital inclusion to ensure everyone can access healthcare services. The Provider must therefore be compliant with The Equality Act 2010 and meet the Accessible Information Standards (AIS).

Therefore, this service must demonstrate equity in access by ensuring everyone, regardless of their background or circumstances, has a fair opportunity to access the care they need. This principle aims to eliminate avoidable disparities in health outcomes, ensuring that everyone has the same chance to achieve their full health potential.

The service must evidence how it demonstrates key aspects of equity of access to healthcare, including:

* + Fairness and Opportunity: Everyone should have the same opportunity to access healthcare services, regardless of factors like social, economic, demographic, minority groups, or geographic location.
  + Addressing Inequalities: Equity in healthcare aims to identify and eliminate avoidable differences in health outcomes among different population groups.
  + Horizontal and Vertical Equity: Horizontal equity focuses on equal access for those with equal needs, while vertical equity addresses the need for unequal access for those with unequal needs.
  + Beyond Equality: While equality means treating everyone the same, equity recognises that individuals may have different needs and require tailored approaches to ensure fair access.
  + Importance of Context: Health equity is influenced by various social and economic factors, including where people are born, live, work, and age.

The Service must ensure that it can demonstrate equity of access in practice:

* + Making adjustments for people with disabilities: Ensuring healthcare facilities and services are accessible to people with disabilities.
  + Addressing communication barriers: Providing language interpretation services for those Service Users where English is not their first language.
  + Targeting vulnerable populations: Implementing programs to ensure access to healthcare for marginalized groups, such as those with low incomes or living in remote areas.
  + Using data to identify disparities: Monitoring and analysing healthcare data to identify patterns of inequitable access and address them accordingly.

With respect to the above, the Provider should create and deliver as appropriate a Service User any Action Plan(s) to Reduce Health Inequalities, as set out in Schedule 2.

Initial contact with the service:

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

If a Service User contacts the services Central services phone line, calls must be answered promptly between 8.00 – 20.00 Monday to Friday (excluding bank/public holidays) and 8.00 – 14.00 Saturday.

The Provider must enable a system which can inform the call handler/s if more than one Service User is attempting to contact the service at the same time and redirect that Service User to another call handler to support the second call. Where more than two Service Users attempt to contact the service at the same time and there is not another available call hander, the Provider should ensure a call waiting system is in place to inform the waiting Service User their call will be answered as soon as possible. The Provider must not use a premium rate telephone number and must provide a Free phone number from both landlines and mobiles.

If a Service User contacts the service by email, the Provider must respond to the email within one working day. The Provider should also ensure that there is an auto reply stating contact hours and diverting Service User to emergency support services if their support needs are critical/immediate. In all circumstances the Provider must ensure an appropriate out of office notification is set up informing the Service User the opening times of the service and that if received during out of hours, the email will be answered the next working day.

The Provider will utilise an app (or similar service) for booking appointments allowing access and patient choice all over the country across catchment areas.

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

Accessibility requirements, for example those with disabilities, must be catered for to ensure equity of access to support and treatment.

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

The Provider will ensure clinical support for call handlers if a Service User is identified at risk or in severe distress. Clinical staff will be contactable during opening hours, including appropriate support arrangements (should these be required) out of hours.

First (and on-going) clinical assessment by the provider:

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

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

The first face-to-face assessment must be provided to allow the assessing Clinician to gain an in-depth understanding of the Service User’s needs and risk assessment. A treatment plan and safety plan should be formulated, through discussion of what the service and / or other services can offer to help the Service User.

The Service User may opt to have the first full assessment by video technology or by telephone if preferred and clinicians should be trained and competent to manage remote consultations.

The assessment should also give an opportunity to discuss the relationship of the service with the Service User, how the service must work with the Service User’s own GP or organisational support such as Occupational Health (with consent), and the limits of confidentiality.

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

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

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

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

Treatment provision in the Service:

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

* + GPwER or Psychiatric services with expertise in substance misuse
  + Therapeutic interventions involving prescribing medications, psychological therapies, e.g. counselling and CBT, in line with appropriate NICE guidance (for example Mental health, behavioural and neurodevelopmental conditions: <https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-behavioural-and-neurodevelopmental-conditions> within the scope of this Service)
  + One-to-one sessions and group work

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

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

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

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

Case management:

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

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

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

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

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

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

Continuing care relationship with Service User’s own GP:

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

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

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

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

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

Liaison with the Service User’s workplace:

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

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

Some Service Users may need a period of retraining or restriction of their scope of practice to return to safe clinical practice in a phased way. In such cases the Service User must speak to their Local Regional team, with the support of the Local Clinical Services and where possible, engage with the local Occupational Health provider

Principles for long-term relationships with the Service User:

The course of treatment for different Service Users will depend on their individual requirements and Local Clinical Services must manage this on a case-by-case basis.

The Service is not intended as a long-term treatment service, however the Service may in some cases act as a case manager or help with rehabilitation working closely with mainstream NHS services or other charity and private providers.

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

Indicative treatment duration is set out in relevant NICE guidance. The Provider should not exceed the recommended duration of treatment for a condition unless agreed by the Medical Director and Local Regional team and in agreement with the Commissioner.

Where a Service User’s treatment is likely to exceed the recommended duration of treatment for a condition as set out in relevant appropriate clinical guidance (e.g. NICE guidance), an exception report as set out in Schedule 6C. Incidents Requiring Reporting Procedure should be completed by the Local Clinical services.

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

Development and quality improvement of the service:

Engagement in service quality improvement and development is essential to demonstrate contract value and ensure the Service is meeting need.

The Service should collect and report treatment outcome metrics and patient satisfaction measures for all staff treated.

The Provider will regularly review quality, including internal systems and processes and the effectiveness of the Service, as set out in Schedule 4: Quality Requirements, and Schedule 6: Contract Management, Reporting and Information requirements.

There must be a clear process for how Service Users raise complaints about the service they experience, and this should be available on the website and/or when requested. Details about all complaints must be shared with the Commissioner as part of contract review procedures.

The Provider must promote service development and quality improvement and develop strategies for improvement to be shared with the Commissioner and its assigned key stakeholder groups. The Provider must adapt systems and processes as set out by the Commissioner following any recommendations, where appropriate.

Working with the Commissioner and through negotiation, the Service may require enhancements to ensure alignment with the wider evolving landscape of supporting healthcare staff health and wellbeing, as aligned to national policy and strategy. This will ensure the service remains current, meets service user need, and maximises contract value.

* 1. Confidentiality and data governance:

**Data Security**

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

The Provider will need to make sure it has secure, confidential record storage, whether paper or electronic. Patient records should be kept on a separate confidential computer record. This record will only be accessible by service staff and will not be “uploaded” to any shared medical record system. This means that the record will not form part of the NHS shared electronic record. The Provider must have a policy to protect patient confidentiality, underpinned by protocols and procedures that the service will have agreed and must adhere to. The policy must specifically describe and be clear about confidentiality, when anonymity is appropriate, the issues of and conditions for disclosure, and will detail circumstances in which information may be disclosed without their consent. The policy and procedures will address the provision of fair processing information as required by the Data Protection Act 2018 and UK GDPR <https://www.legislation.gov.uk/eur/2016/679/contents>

The confidentiality policy will set out the procedures for reporting, investigating, and implementing and sharing lessons learned from breaches in confidentiality, and must ensure all staff as part of the service is aware and understand the Policy. The Provider must aim for a 100% staff and system compliance with the Confidentiality Policy. With regard to the patent records system, the Commissioner will instruct the Provider to transfer records of Service Users under the care of the Provider at contract termination or expiry to the replacement provider or temporary safekeeping by the Commissioner if a replacement provider is not available.

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

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

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

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

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

In addition of the requirements of Schedule 2G Section 1: Terms of Performer Escalation. The Provider will ensure Memoranda of Understanding (MoU) are in place before the contract start date, 1st April 2026 between the Provider and relevant organisations such as GMC, NMC, and NCAS, which offer guidance around the limits of the Provider confidentiality and requirements for disclosure of information.

Interdependence with other services/providers:

Improving staff health and wellbeing depends on good communication and cooperation between many services. The Provider cannot work in isolation and the Provider must work with partners to address the needs of sick health professionals to attain optimal outcomes.

To support effective multidisciplinary working clear care pathways and formal working agreements need to be in place. Very important partners who will need close working with a range of stakeholders, and key partners include GPs, community mental health teams, specialist mental health services, specialist addiction services, specialist eating disorder services, Occupational Health services, as well as the voluntary and charitable sector. Other services and teams available locally may need to be identified on a case-by-case basis.

Links with local services:

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

* 1. Location of Provider premises and equitable national coverage

The Provider must put in place Local Clinical services across England, within all regional population catchment areas as shown in the map below. These catchment areas should match the NHS England commissioning footprint via ICS and regions. Note that these catchment areas are correct at the time of publication of this specification. However, these may change over time, in line with wider changes to the NHS system. Therefore, the Provider will work to ensure that Local Clinical Services adapt (as appropriate) to changes in NHS system architecture. Each catchment area will have access to all Local Clinical Services as set out in this schedule 2A.

A map of england with different colored areas

AI-generated content may be incorrect.

*Map Source:* [*NHS England » Integrated care in your area*](https://www.england.nhs.uk/integratedcare/integrated-care-in-your-area/)

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

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

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

The Local Clinical Services premises must be comfortable with a welcoming environment. It will need to comply with health and safety standards and be registered with the Care Quality Commission (CQC).

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

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

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

* 1. Workforce requirements

The workforce forms the main basis of successful service delivery and is therefore a core element of enabling a successful service. The Service operates like an NHS service, and therefore to be successful will follow a similar model. The Service must appoint specific roles to fulfil its regulatory duties and leadership functions. The following describes core workforce elements.

Responsible Officer:

The Service must have a Responsible Officer as required by The Medical Profession (Amendment) Responsible Officers Regulations (2013)[[8]](#footnote-9) to enable appointment of medical doctors required for delivering mental health services i.e. psychiatrists.

A Responsible Officer doesn’t need to be directly involved in the delivery of the Service but must be accountable for the doctors employed by the Service (unless the Responsible Officer function is achieved through other means).

Medical Director:

The Provider must appoint a Medical Director of the Service to oversee the delivery and accountability of the Service, responsible for ensuring standards and acting as clinical leader of the Service.

The Medical Director must act as a ‘clinical champion’ and lead the delivery of the Service in England at a strategic level. They will uphold the highest standards of care for Service Users, hold all clinicians to account (with the support of the Responsible Officer), and be responsible for overseeing the training and development of the Service and its staff.

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

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

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

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

Clinical Lead:

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

Specialist Clinical Advisors:

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

* + Complex cases of regulatory involvement
  + Complex PTSD or complex traumatic stress reactions
  + Complex multi-morbidity cases
  + Complex addiction cases
  + Forensic Psychiatry assessments
  + Education and Training for the Provider clinicians

Multi-disciplinary team:

The Service should ensure that there are multi-disciplinary roles as part of its clinical leadership and service provision.

This staffing model could include psychological professionals, allied health professionals, psychiatrists, nurses, general practitioners, occupational health physicians, as well as other relevant professionals.

Mental health support for clinicians providing the Service:

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

Operational Management:

The Provider must be able to demonstrate that they have an adequate operational leadership/management function to lead and manage the day-to-day running of the Service, both strategically and operationally.

This is at the discretion of the Provider to manage, however they will likely have the equivalent of a Managing Director (MD) and/or Chief Executive (CE) and/or Chief Operating Officer (COO) and wider supportive management architecture, to support the Medical Director and/or Clinical Director with the operational management of the Service and is responsible for delivery of all on-clinical functions of the Service.

The Provider management/leadership function will:

* Oversee the operational aspects of the Service and ensure processes are in place to support the effective delivery of the Services described in these contract particulars.
* They Ensure all aspects of the Service are effective and compliant with set standards and governance requirements.
* Ensure IT, premises, website, phone systems, apps/digital consultation services, and patient records systems are in place as set out in this Service specification.
* Maintain good relationships with the Commissioner and ensure processes are in place for quality and activity reporting as set out in Schedule 4: Quality Requirements, and Schedule 6: Contract Management, Reporting and Information requirements
* Be an employee of the Provider organisation and on a payroll salary.

Central and Local Clinical Services employee skill mix:

The Provider leadership/management function will be responsible for the appointment of all non-clinical staff within the service Central and Local Clinical Services, comprising of operational, financial, data, administrative, skilled call handlers and technology/website management.

The Service Central services may comprise several posts, which the Provider can propose as part of the tender. All staff in the Central services should ideally be employed by the Provider organisation but this is not mandatory.

In some cases, fixed term employees or temporary contractors may be used, but the Provider must ensure resources are used as effectively as possible so the majority of resources can be directed at the clinical requirements of the Service Local Clinical Services, as set out in Schedule 3C: Local Prices.

The Central Service staff skill mix must include:

* + clinical and non-clinical case managers, with relevant specialist experience of managing Service Users with mental ill-health.
  + experienced operational staff with extensive skills in managing health services, finance and accounting, programme development, and service delivery, and leading the development of communications and engagement strategies.
  + skilled operational and administrative staff with effective call handling experience in health care, including triage and management of clinical services;
  + administrative staff skilled and experienced in audit and research, secretariat/support of stakeholder/governance boards, maintaining clinical networks and supporting communications and engagement strategies, including use of social media.

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

The Provider will inform the commissioner who the Medical Director, Responsible Officer, Clinical Director and MD/CE/COO of the Service is and notify the commissioner of any amendments to staffing as part of key roles / senior leadership and management function.

Staff training, development and supervision:

The Provider must ensure that all staff as part of the Service are skilled, trained, and competent as appropriate to meet quality and safe Service provision. To achieve this, the Provider must demonstrate that a workforce development programme is in place, which ensures the following:

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

The Provider must ensure provision of appropriate clinical supervision by qualified clinical supervisors on a regular basis, where for all staff require or request it. The supervision will be informed by best practice and should consider the following:

* + Staff emotional well-being
  + Workload
  + Practice/clinical issues and standards
  + Reflective practice
  + Service standards
  + information about legal procedures for staff recruitment, management and HR
  + Identifying training and development needs
  1. Applicable national standards

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

* + Relevant NICE national quality and treatment standards for Mental Health
  + Professional clinical registration and licence to practise as required, including General Medical Council (GMC) and Nursing and Midwifery Council (NMC)
  + Professional clinical registration as required including British Association for Behavioural and Cognitive Psychotherapies (BABCP), British Association of Counselling and Psychotherapy (BACP), Health and Care Professions Council (HCPC), General Regulatory Council for Complementary Therapies (GRCCT) and any other nationally recognised bodies. <https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality>

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

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

* + The Provider must have regard to the General Medical Council (2013) Good Medical Practice guidance (<http://www.gmc-uk.org/static/documents/content/GMP_.pdf>); in particular:
    - *“25: You must give priority to patients based on their clinical need if these decisions are within your power. If inadequate resources, policies, or systems prevent you from doing this – and patient safety or dignity may be seriously compromised as a result – you must follow the guidance in paragraph 75.*
    - *“73*: *To help keep patients safe you must:*

*A. contribute to confidential inquiries*

*B. contribute to adverse event recognition*

*C. report adverse incidents involving medical devices (including software, diagnostic tests, and digital tools) that put the safety of a patient or another person at risk, or have the potential to do so*

*D. contribute to incident reviews and/or investigations*

*E. report suspected adverse drug reactions*

*F. respond to requests from organisations monitoring public health.*

*When providing information for these purposes you must follow our guidance on Confidentiality: good practice in handling patient information*.

* + The Provider must have regard to the General Medical Council (2012) Raising and acting on concerns about patient safety guidance (<http://www.gmc-uk.org/static/documents/content/Raising_and_acting_on_concerns_about_patient_safety_-_English_1015.pdf> ); in particular:
    - *“20: Concerns about patient safety can come from a number of sources, such as patients’ complaints, colleagues’ concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority.”*
  + The Provider must have regard to the General Medical Council guidance (2017) Confidentiality ([Confidentiality: good practice in handling patient information - professional standards - GMC](https://www.gmc-uk.org/professional-standards/the-professional-standards/confidentiality))

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

* + Guidance and competencies for general practitioners with an extended role Health for Health Professionals Practitioner (Updated October 2018; accredited by RCGP)
  + Other relevant training available via the Royal Colleges (e.g. RCGP, RCPSY), Faculties (e.g., FOM), Professional bodies (e.g., BPS) and Health Education England.

Applicable Quality Requirements (See Schedule 6)

# 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

1. **Indicative Activity Plan**

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

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

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

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|  | **Apr 24** | **May 24** | **June 24** | **July 24** | **Aug 24** | **Sept 24** | **Oct 24** | **Nov 24** | **Dec 24** | **Jan 25** | **Feb 25** | **Mar 25** | **Total** |
| **New Registrations** | 561 | 475 | 398 | 413 | 408 | 454 | 509 | 515 | 485 | 466 | 444 | 457 | 5565 |
| **Re-engaging within 1 year** | 8 | 10 | 7 | 12 | 7 | 10 | 6 | 5 | 7 | 7 | 4 | 3 | 86 |

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|  | **Apr 24** | **May 24** | **June 24** | **July 24** | **Aug 24** | **Sept 24** | **Oct 24** | **Nov 24** | **Dec 24** | **Jan 25** | **Feb 25** | **Mar 25** | **Total** |
| **Common Mental Health** | 456 | 401 | 327 | 329 | 337 | 381 | 413 | 433 | 351 | 331 | 306 | 185 | 4250 |
| **Complex Mental Health** | 22 | 19 | 10 | 19 | 16 | 22 | 32 | 25 | 23 | 22 | 19 | 4 | 233 |
| **Multiple Issues** | 3 | 3 | 4 | 5 | 3 | 5 | 3 | 4 | 1 | 5 | 1 | 0 | 37 |
| **Addiction** | 13 | 8 | 9 | 10 | 10 | 15 | 13 | 8 | 24 | 9 | 11 | 6 | 136 |
| **Physical Issues** | 8 | 3 | 5 | 5 | 1 | 2 | 2 | 3 | 5 | 4 | 0 | 4 | 42 |
| **Assessment only** | 67 | 51 | 50 | 57 | 48 | 39 | 52 | 43 | 55 | 56 | 27 | 13 | 558 |
| **Awaiting coding** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 13 | 46 | 84 | 248 | 395 |
| **Total** | 569 | 485 | 405 | 425 | 415 | 464 | 515 | 520 | 472 | 473 | 448 | 460 | 5651 |

# SCHEDULE 2 – THE SERVICES

1. **Activity Planning Assumptions**

| The Provider is under a contractual obligation to use all reasonable endeavors to manage activity in accordance with Schedule 2B: Indicative Activity Plan.  The Provider must monitor activity and report to the Commissioner as set out in Schedule 6: Contract Management, Reporting and Information requirements.  Where demand thresholds are exceeded beyond the Activity Planning Assumptions, the Provider must provide proposals to manage demand appropriately, which may include temporary suspension of some services or making changes to existing processes to improve efficiencies – these must be agreed with the Commissioner before being actioned. |
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# SCHEDULE 2 – THE SERVICES

1. **Not used**

# SCHEDULE 2 – THE SERVICES

1. **Not used**

# SCHEDULE 2 – THE SERVICES

1. **Clinical Networks**

| The Provider must manage various clinical networks to support sharing and learning to promote development of the Service and knowledge in supporting health professionals.  The Provider must also support the management of other professional networks and events as recommended by the Commissioner, subject to the Commissioner and Provider agreeing that the network is within scope and interest of the Provider.  Clinical / Professional Networks managed by the Provider should include:   * National Provider Clinical Leads forum (learning/sharing events) * Local Provider Clinicians forum (Learning/sharing events) * National Stakeholder events (awareness of service) * Local Stakeholder events (Awareness of service) * National Subgroups (Research/development group to support EOG / Education & Training e.g. HHP / Volunteers) * Focus groups for suspended GPs |
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# SCHEDULE 2 – THE SERVICES

**G.** **Other Local Agreements, Policies and Procedures**

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| 1. **Terms of Service User Escalation**    1. **Purpose**   The purpose of this Terms of Performer Escalation is to set out a framework between Responsible Officers (ROs) **the Commissioner** and **the Provider** to ensure that effective channels of communication are maintained between the ROs and the Provider Clinicians. The Provider have been specifically commissioned by NHS England to provide this service.  This Schedule relates to the areas of interface between the ROs and the Provider, clarifies respective roles and responsibilities and outlines mechanisms in place to promote effective liaison.  The agreement does not affect existing statutory functions or amend any other policies or agreements relating to the activities of the ROs and the Provider.  Where the term RO is used in this Schedule this must include a member of the RO’s team such as medical/assistant medical directors, appraisal & revalidation teams, and applicable clinical oversight of the employer.  Where the term Provider is used in this Schedule this must include a member of the Provider who is the Medical Director, or the Clinical Lead within the relevant catchment area. Any requirements as set out in this Schedule must be completed by a Clinician within the Provider.   * 1. **Functions of the Responsible Officers**   ROs are appointed to undertake the following duties as a statutory function under The Medical Profession (Responsible Officers) Regulations 2010 (and amendments 2013):   * + - To ensure annual appraisals are carried out on health care professionals as applicable.     - To establish and implement procedures to investigate concerns about a Service User(s) fitness to practice raised by patients or staff of the designated body or arising from another source     - To refer concerns about the service user to the applicable regulator where appropriate     - To monitor compliance with those conditions or undertakings where a Service User is subject to conditions imposed by or undertakings agreed with the applicable regulator     - To make recommendations to the applicable regulator about service user(s) fitness to practice     - To maintain records of Service User(s) fitness to practice evaluations including appraisals and any other investigations or assessments   1. **Functions of the Provider for health care staff**       + The Provider provides free, confidential services for Service Users who have mental health concerns and/or addiction problems.      + Performers approaching the Providers for help need to be assured that they have the same rights to confidentiality as any other patient.   2. **Potential areas of communication**   Communication between the ROs and the Provider is based on an overriding duty to protect patients whilst, as far as possible, being fair to performers and protecting confidential health information. Areas of potential communication between the ROs and the Provider include the following (the list is not intended to be exhaustive):   * + - Pre-referral discussion:       * ‘in principle’ about how best to manage concerns about a performer and whether or not the RO would need to be informed on an anonymised basis, or       * Discussions about performers who have been referred to either the RO or the Provider, where there are concerns about public protection or the safety of patients under the care of the Provider, on a named performer basis.     - Post-referral discussion – to coordinate activity where appropriate.   1. **Pre-referral discussions ‘in principle’ or about named performers**   It may sometimes be appropriate for the RO and the Provider to liaise in order to clarify the issues raised in advance of a referral. In these cases, the RO and the Provider must discuss the matters about the individual anonymously.  Where it is not possible or inappropriate to have an anonymised discussion, consent must be sought before doing so and if not provided there should be an assessment of whether the risk is such that the information should be disclosed without consent. If the nature of the risk is judged to be high, the enquiring organisation or individual should be offered appropriate contact details for both the RO and the Provider so they may conduct their own discussions.   * 1. **Post-referral discussions about individual performers**   The RO and the Provider must recognise that there may be times when they both have a case open about a named service user. If it is appropriate, and service user consent given, they should work together to ensure that appropriate channels of communication exist.   * 1. **Disclosure of concerns**   Disclosure should be made to the RO where the service user’s health raises concerns that may affect patient safety, particularly where the service user has limited insight and is not complying with assessment, treatment or monitoring, or heeding advice to remain on sick leave.  If disclosure to the Service User’s RO is considered inappropriate, for example due to personal relationships between the RO (or a member of their team as delegated) and the Service User, then the Service User concern should be disclosed to the second tier (regional) RO.  If disclosure to the Service User’s second tier (regional) RO, is not possible, then the concern regarding the performer should be referred to an alternative second tier RO.   * 1. **Cases under investigation/monitoring by the RO**   Whenever the RO becomes aware of a possible performance concern regarding a service user an initial assessment is conducted by the Performance Advisory Group (PAG) or equivalent. The concern may include information which indicates a health element to the concern.  Where a service user is under investigation or being monitored by the RO and is also under the care of the Provider, with the service user’s consent, The Provider will inform the RO in what capacity they are supporting the service user. If the Provider is actively treating the service user, they will provide a named person with whom the RO can liaise. In these circumstances, the Provider, will only be aware if they are treating a service user under investigation, if the service user informs the Provider, themselves.  The Provider will ensure that any information arising from the monitoring of the health of a service user being investigated or monitored by the RO that indicates they have breached any conditions imposed on their practice and/or are not complying with advice on managing their health problem, and/or their condition appears to pose a risk to their patients, will be shared with the RO as soon as possible. |

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| * 1. **Service User(s) being treated/monitored by the Provider**   When the Provider receives a referral (self-referrals or referrals from an organisation or individual with the Service User’s consent) they will ask the Service User or referrer if the Service User is currently under investigation or being monitored by the RO or applicable regulator.  If the Service User or referring organisation or individual indicates that the RO is currently investigating or monitoring, the Provider will seek the Service User’s consent to contact the RO or applicable regulator to explain that the service user has sought the Provider, intervention. If consent is not forthcoming, the Provider will consider whether or not disclosure to the RO / regulator is required, without consent, using the criteria set out in the paragraphs above.   * 1. **Thresholds for referral**   The RO and the Provider are subject to a range of legislative duties in relation to information governance, including the Data Protection Act 2018 and UK GDPR <https://www.legislation.gov.uk/eur/2016/679/contents>, Human Rights Act 1998￼framework.   * 1. **Resolution of disagreement**   Where any issues arise which cannot be resolved at an operational level, the matter will be referred to the contract leads identified in Schedule 6 – Contract Management, Reporting and Information requirements to ensure a satisfactory resolution.   * 1. **Review and Governance arrangements**   The Commissioner will assign a local RO or their delegated representative to be the local identified operational lead for this Schedule.  The provider will assign the Medical Director for England, and the Clinical Lead for each catchment area, to be the operational lead for this Schedule. Both these assigned representatives are required to ensure this Schedule is kept up to date and to identify any emerging issues in the working relationship between the two bodies.  The Commissioner and the provider will conduct a formal review of this Schedule at each annual contract review meeting to assess and review the operational effectiveness of this agreement in enabling both bodies to fulfil their functions. |

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| 1. **Intellectual Property Rights**   The GC22: Intellectual Property applies. GC22 Intellectual Property states:  22.1 Except as set out expressly in this Contract no Party will acquire the IPR of any other Party.  22.2 The Provider grants the Commissioners a fully paid-up, non-exclusive, perpetual licence to use the Provider Deliverables for the purposes of the exercise of their statutory and contractual functions and obtaining the full benefit of the Services under this Contract.  22.3 The Commissioners grant the Provider a fully paid-up, non-exclusive licence:  22.3.1 to use the Commissioner Deliverables; and  22.3.2 to use the NHS Identity, in each case for the sole purpose of providing the Services. The Provider may not grant any sub-licence of the NHS Identity without the express permission of NHS England’s NHS Identity team.  22.4 The Provider must co-operate with the Commissioners to enable the Commissioners to understand and adopt Best Practice (including the dissemination of Best Practice to other commissioners or providers of NHS services), and must supply such materials and information in relation to Best Practice as the Commissioners may reasonably request, and (to the extent that any IPR attaches to Best Practice), grants the Commissioners a fully paid-up, non-exclusive, perpetual licence for the Commissioners to use Best Practice IPR for the commissioning of NHS services and to share any Best Practice IPR with other commissioners of NHS services (and other providers of NHS services) to enable those parties to adopt such Best Practice  **Provider Deliverables** - all documents, products and materials developed by the Provider or its agents, subcontractors, consultants and employees in relation to the Services in any form and required to be submitted to any Commissioner under this Contract, including data, reports, policies, plans and specifications  **Commissioner Deliverables** - all documents, products and materials developed by any Commissioner in relation to the Services in any form and submitted by any Commissioner to the Provider under this Contract, including data, reports, policies, plans and specifications  **Best Practice** - any methodologies, pathway designs and processes relating to the Services developed by the Provider or any Sub-Contractor (whether singly or jointly with any Commissioner or other provider) for the purposes of delivering the Services and which are capable of wider use in the delivery of healthcare services for the purposes of the NHS, but not including inventions that are capable of patent protection and for which patent protection is being sought or has been obtained, registered designs, or copyright in software.  The GC21: Patient Confidentiality, Data Protection, Freedom of Information and Transparency, requires that:   * + The Provider must complete and publish an annual information governance assessment using the NHS Information Governance Toolkit ("the IG Toolkit") and must achieve a minimum level 2 performance against all requirements in the relevant Toolkit ("the Toolkit Requirement").   and   * + The Provider must ensure that its NHS Information Governance Toolkit submission is audited in accordance with Information Governance Audit Guidance where applicable. The Provider must inform the Commissioner of the results of each audit and publish the audit report both within the NHS Information Governance Toolkit and on its website ("the Audit Requirement").   Together these are the **"IG Requirements"** for the purposes of this Schedule.  To be eligible for award of contract the Provider must have provided evidence that the Provider, its partner organisations, and any sub-contractors to be engaged by the Provider for the delivery of the Services (whether in the provision of front-line delivery or support functions) meet the **IG Requirements**.  **The Toolkit Requirement**  Evidence for the Toolkit Requirement will be an IG Toolkit accreditation of at least Level 2 on all requirements achieved by the Provider, its partner organisations and sub- contractors in the relevant Toolkit published in the latest March submission on the IG Toolkit website.  **The Provider should note that:**  The IG Toolkit contains a number of requirements. These requirements vary according to the type of organisation using the IG Toolkit. NHS England will decide which version of the IG Toolkit is relevant by reference to:   * the role to be played by the organisation in the delivery of the Services; and * the guidance on Organisation Types available on the IG Toolkit website – see here: [https://www.igt.hscic.gov.uk/requirementsorganisation.aspx?tk=42353771257483](https://www.igt.hscic.gov.uk/requirementsorganisation.aspx?tk=423537712574832&cb=f281700b-c33d-4af1-8145-1f85af00e0b2&lnv=2&clnav=YES) [2&cb=f281700b-c33d-4af1-8145-1f85af00e0b2&lnv=2&clnav=YES](https://www.igt.hscic.gov.uk/requirementsorganisation.aspx?tk=423537712574832&cb=f281700b-c33d-4af1-8145-1f85af00e0b2&lnv=2&clnav=YES)   The Provider must provide a justification as to why they have selected a particular Organisation Type for their IG Toolkit return and the IG Toolkit returns for its partner organisations and any sub-contractors.  NHS England highlights that under the Guidance:   * *"if an organisation provides direct or indirect patient care, it will* ***not be appropriate*** *to allocate the IG Toolkit* [Commercial Third Party] *organisation type to such organisations."*   NHS England will check assessment reports available on the IG Toolkit website to assess whether this requirement has been passed. |

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| **The Audit Requirement**  Evidence for the Audit Requirement will be reports on independent audits of all IG Toolkit submissions relied upon. The audits must be independent of the Provider, its partner organisations and any of its subcontractors. The evidence must be in the form of full, final and unredacted audit reports. The audit reports must conclude and provide assurance that the Toolkit Requirement is warranted.  A Provider will fail this requirement if it is unable to provide for itself, its partner organisations or for any of its sub-contractors:  An IG Toolkit accreditation of at least level 2 on all requirements in the relevant Toolkit for the latest complete year, ending 31st March. For the avoidance of doubt the Provider will fail this requirement if they, a partner organisation or sub-contractor have completed an IG Toolkit return for an organisation type that is not appropriate taking into account the role of that organisation in the delivery of Services and the Guidance on Organisation Types referred to above;  And  A full, final and unredacted report setting out the results of an independent audit of any IG Toolkit submissions relied upon to satisfy the requirement set out above, which concludes and provides assurance that the IG Toolkit accreditation relied upon to fulfil the above requirement is appropriate. |

# SCHEDULE 2 – THE SERVICES

**H.** **Transition Arrangements**

| It is expected that the Provider will work with the previous provider of the Services to transfer Service Users safely between services. The previous provider of the Services will supply a Succession Plan to the Commissioner. The Provider will supply a mobilisation and implementation plan, and this will be added to the Transition Arrangements. By working collaboratively and with guidance and support from the Commissioner, it is expected that transition will happen seamlessly for Service Users.    Following transition and upon beginning to deliver the Service as part of this Contract, the Provider must create and maintain a Succession Plan which will be reviewed in the contract Review Meetings with the commissioner, within the first 6 months of the contract start date. The succession Plan must be accessible to the Commissioner at any time, upon reasonable request.  In addition, towards the end of this Contract, there is a requirement on the Provider to ensure that safe transition of Service Users from the Service to any newly commissioned service, or that appropriate arrangements are made should the service be decommissioned. |
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# SCHEDULE 2 – THE SERVICES

**I. Exit / Succession Arrangements**

| **Service Continuity & Patient Transition Arrangements**  The Provider is required to ensure the orderly transition of the services from the Provider to the Commissioner and/or any Replacement Provider in the event of termination, as set out in GC18 - Consequence of Expiry or Termination  The Provider must be aware of GC17 – Termination and GC18 - Consequence of Expiry or Termination.  In all circumstances the Provider and Commissioner will agree a Succession Plan and must have the highest regards to the needs of service users of the Service. The Provider and Commissioner must agree whether service users under the care of the Provider at contract termination or expiry, need to be transferred to other services such as NHS Mental Health services.  **Maintaining confidentiality**  With regard to the patient records system, the Commissioner will instruct the Provider to transfer all records to the replacement provider or temporary safekeeping by the Commissioner if a replacement provider is not available. The Commissioner under no circumstances will access the confidential data and will assign an Information Governance Lead and Caldicott Guardian to oversee the patient records system on the Commissioner’s behalf. |
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# SCHEDULE 2 – THE SERVICES

**J. Transfer of and Discharge from Care Protocols**

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| This applies to Service Users exiting the Service, being referred to other services or discharged with no further referral requirements.  Transition arrangements should be framed by the following principles:   1. The mental and physical health of the Service User in transition should not decline during the process of transition. 2. The Service User should be assisted to maximise their health and wellbeing. 3. The Service User should be treated as far as possible within their own community and close to home. 4. Services should work together in integrated and coordinated ways in the best interests of the Service User.   It is essential that Service Users are involved in commissioning and service design (as well as providing feedback to services). Service Users presenting with mental ill-health, as well as those who have yet to access services, can help the Commissioner and Provider prioritise and identify any gaps and blocks to access, and assist the Provider in improving services and evaluating change.  The Provider should ensure they understand the diversity of the populations they are responsible for, not only in terms of cultural and ethnic diversity, but all of the factors that may both influence the risk of developing mental health problems, as well as those that need to be taken into account in the design and delivery of services.  Transition is a process undertaken over time. It may include, but is more than, a planned transfer to another provider of support for mental ill-health. Primary care services should be included to achieve streamlined, efficient and effective transition for all Service Users . This is, particularly true for those Service Users needing a range of health and social care services during their transition and beyond, which the Service Users own GP will need to support to enable transfer into other NHS services. However, the Service Users must give prior written consent to the Provider, before the Provider, involves anyone else in the care of the Service Users outside of the Service.  Transfers from the Provider, whether to NHS Mental Health services or to other services including discharge back to primary care, are single point events in the entire transition process. Service Users may be subject to serial and sequential transfers within and across different health care organisations / specialist teams over time. the Provider, should follow Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time, where possible, so that the Service Users and both the Provider, and the receiving service(s) have good time to communicate the needs and provide continuity of care at this vulnerable time.  Transfers require coordinated, documented and integrated support plans for Service Users from the Provider, service and any other support in partnership with other providers (e.g. Charity and NHS services). In order to enable Service Users to become and remain active partners in their care, prepare for transfer(s) and engage with adult mental health or other services; the transition process between services needs to be underpinned by individual circumstances on a case by case basis and include appropriate care planning that is:   * + Supported by access to wide range of resources with which all Service Users including Service Users may engage with   + Supported by access to peer support which may be offered individually or in groups, face to face or through social media   + Supported by a Provider Clinician who can take a co-ordinating support role throughout the transition process. It is recognised that whilst this Clinician may change over time, Service Users , where appropriate should be able to name the Clinician undertaking this role at any point in the process.   + Delivered by staff that have specific training or experience in working with Service Users .   + Delivered by processes, systems and environments that promote safety, quality, effectiveness and are suitable for Service Users , bearing in mind stigmas associated with Service Users accessing mental health services.   + Documented in the Service Users medical records and reviewed at each key point in the transition pathway. Where the Service Users gives written consent, details of the transition may be recorded in the NHS patient records as held by the Service Users own GP.   The Provider may not be able to support all needs of the Service Users as set out in the scope of this service specification, but where appropriate the Provider must provide on-going case management of the Service Users to support transition.  In supporting the transfer or discharge of the Service Users , the Provider must:   * + Co design and review the transition care pathways with the Commissioner, and enable suitable referral as needed for a safe and smooth transition   + ensure the Provider, can facilitate the Service Users effectively during transition and address their individual needs, providing a holistic approach.   + Where the Service Users provides written consent, include the Service Users own GP in the pathway development to ensure the GP have the relevant information to support Service Users during and after transition.   + Ensure that Service Users are treated with compassion, respect and dignity, without stigma or judgment   + Ensure that the Service Users physical health needs are considered alongside their mental health needs   + Ensure that Service Users who require services during and post transition are seen in a timely manner   + Ensure that services are identified who can provide support to the Service Users in an emergency or crisis, including out of hours.   + Provide an agreed care plan that is written and shared with the Service Users .   + Provide information at all stages of the pathway about interventions or treatment options to enable the Service Users to make informed decisions about their care appropriate to their competence and capacity.   + Co-produce the care plan and provide that written information to the Service Users about the care plan, how to access the new services routinely and in a crisis   + Provide written assessments, care plans etc. that are jargon free (where any technical terms are defined)   + Ensure that Service Users leaving the service have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary.   + Where a Service Users is moving to another service, whether to NHS mental health services or to a different service, the Provider will ensure that the agreed transition protocol is followed with, as a minimum, a joint meeting between the Provider, Clinician and new service that includes the Service Users , a written discharge summary, and followed up after six months to check the transition has proceeded smoothly. The Provider, Clinician will agree with the Service Users what information will be provided to the other service to minimise the need for the Service Users to repeat information, but maintaining the Service Users confidentiality.   + Ensure that the other service is accessible and provided in an appropriate setting that creates a safe physical environment   + Ensure that appropriate clinical information, structural governance and audit arrangements are in place, including protocols around information sharing and confidentiality.   + Ensure that care plans (following Care Programme Approach, or CPA, where applicable) are in place for the Service Users receiving support for mental health problems. These plans may be (where more than one Clinical team is involved in delivering care) and developed in collaboration with the Service Users . A copy should be given to the Service Users , and following written consent from the Service Users , the Service Users own GP.   + Ensure that the care plan includes risk management and crisis planning.   + Review the care plan with the Service User, including the goals of treatment, and revise the care plan at agreed intervals of no more than one year.   + Select treatment options in consideration of NICE HTAs.   + Ensure that systems are in place to coordinate effectively with other services when Service Users are in treatment, when they move between other services both for their physical and mental health and that there are processes in place to plan the ending of treatment or services.   The Provider will be required to work with Local Services to identify and agree local referral pathway between the local service and ensure information on transfer of care and discharge is shared with the local services where appropriate.  The Provider should consider with patients whether they should be discharged or referred back to the referring local service (including any relevant patient records). |

# SCHEDULE 2 – THE SERVICES

**K. Transfer of and Discharge from Care Protocols**

| This applies to Service Users exiting the Service, being referred to other services or discharged with no further referral requirements.  Transition arrangements should be framed by the following principles:   1. The mental and physical health of the Service User in transition should not decline during the process of transition. 2. The Service User should be assisted to maximise their health and wellbeing. 3. The Service User should be treated as far as possible within their own community and close to home. 4. Services should work together in integrated and coordinated ways in the best interests of the Service User.   It is essential that Service Users are involved in commissioning and service design (as well as providing feedback to services). Service Users presenting with mental ill-health, as well as those who have yet to access services, can help the Commissioner and Provider prioritise and identify any gaps and blocks to access, and assist the Provider in improving services and evaluating change.  The Provider should ensure they understand the diversity of the populations they are responsible for, not only in terms of cultural and ethnic diversity, but all of the factors that may both influence the risk of developing mental health problems, as well as those that need to be taken into account in the design and delivery of services.  Transition is a process undertaken over time. It may include, but is more than, a planned transfer to another provider of support for mental ill-health. Primary care services should be included to achieve streamlined, efficient and effective transition for all Service Users. This is, particularly true for those Service Users needing a range of health and social care services during their transition and beyond, which the Service Users own GP will need to support to enable transfer into other NHS services. However, the Service Users must give prior written consent to the Provider, before the Provider, involves anyone else in the care of the Service Users outside of the Service.  Transfers from the Provider, whether to NHS Mental Health services or to other services including discharge back to primary care, are single point events in the entire transition process. Service Users may be subject to serial and sequential transfers within and across different health care organisations / specialist teams over time. the Provider, should follow Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time, where possible, so that the Service Users and both the Provider, and the receiving service(s) have good time to communicate the needs and provide continuity of care at this vulnerable time.  Transfers require coordinated, documented and integrated support plans for Service Users from the Provider, service and any other support in partnership with other providers (e.g. Charity and NHS services). In order to enable Service Users to become and remain active partners in their care, prepare for transfer(s) and engage with adult mental health or other services; the transition process between services needs to be underpinned by individual circumstances on a case by case basis and include appropriate care planning that is:   * + Supported by access to wide range of resources with which all Service Users including Service Users may engage with   + Supported by access to peer support which may be offered individually or in groups, face to face or through social media   + Supported by a Provider Clinician who can take a co-ordinating support role throughout the transition process. It is recognised that whilst this Clinician may change over time, Service Users, where appropriate should be able to name the Clinician undertaking this role at any point in the process.   + Delivered by staff that have specific training or experience in working with Service Users.   + Delivered by processes, systems and environments that promote safety, quality, effectiveness and are suitable for Service Users, bearing in mind stigmas associated with Service Users accessing mental health services.   + Documented in the Service Users medical records and reviewed at each key point in the transition pathway. Where the Service Users gives written consent, details of the transition may be recorded in the NHS patient records as held by the Service Users own GP.   The Provider, may not be able to support all needs of the Service Users as set out in the scope of this service specification, but where appropriate the Provider, must provide on-going case management of the Service Users to support transition.  In supporting the transfer or discharge of the Service Users, the Provider must:   * + Co design and review the transition care pathways with the Commissioner, and enable suitable referral as needed for a safe and smooth transition   + ensure the Provider, can facilitate the Service Users effectively during transition and address their individual needs, providing a holistic approach.   + Where the Service Users provides written consent, include the Service Users own GP in the pathway development to ensure the GP have the relevant information to support Service Users during and after transition.   + Ensure that Service Users are treated with compassion, respect and dignity, without stigma or judgment   + Ensure that the Service Users physical health needs are considered alongside their mental health needs   + Ensure that Service Users who require services during and post transition are seen in a timely manner   + Ensure that services are identified who can provide support to the Service Users in an emergency or crisis, including out of hours.   + Provide an agreed care plan that is written and shared with the Service Users.   + Provide information at all stages of the pathway about interventions or treatment options to enable the Service Users to make informed decisions about their care appropriate to their competence and capacity.   + Co-produce the care plan and provide that written information to the Service Users about the care plan, how to access the new services routinely and in a crisis   + Provide written assessments, care plans etc. that are jargon free (where any technical terms are defined)   + Ensure that Service Users leaving the  1. Ensure that appropriate clinical information, structural governance and audit arrangements are in place, including protocols around information sharing and confidentiality. 2. Ensure that care plans (following Care Programme Approach, or CPA, where applicable) are in place for the Service Users receiving support for mental health problems. These plans may be (where more than one Clinical team is involved in delivering care) and developed in collaboration with the Service Users. A copy should be given to the Service Users, and following written consent from the Practitioner, the Service Users own GP. 3. Ensure that the care plan includes risk management and crisis planning 4. Review the care plan with the Service User, including the goals of treatment, and revise the care plan at agreed intervals of no more than one year. 5. Select treatment options in consideration of NICE HTAs. 6. Ensure that systems are in place to coordinate effectively with other services when Service Users are in treatment, when they move between other services both for their physical and mental health and that there are processes in place to plan the ending of treatment or services.   The Provider will be required to work with local services to identify and agree local referral pathway between the local service and ensure information on transfer of care and discharge is shared with the local services where appropriate.  The Provider should consider with patients whether they should be discharged or referred back to the referring local service (including any relevant patient records). |
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**L. Provisions Applicable to Primary Medical Services**

| **Not Applicable** |
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**SCHEDULE 2 – THE SERVICES**

**M. Development Plan for Personalised Care**

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| The Provider should consider and deliver as appropriate to the Service User any Personalised Care Plans as set out below:  [*Universal Personalised Care: Implementing the Comprehensive Model*](https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/) *(UPC) outlines key actions required to support the roll out of personalised care in accordance with NHS Long Term Plan commitments. UPC has 6 key components: Patient Choice, Personalised Care and Support Planning, Supported Self-Management, Shared Decision Making, Social Prescribing and Personal Health Budgets.*  *The Provider should develop specific actions which the Provider will take to give Service Users greater choice and control over the way their care is planned and delivered, applying relevant components as listed above. Actions could focus on making across-the-board improvements applying to all of the Provider’s services – or on pathways for specific conditions which have been identified locally as needing particular attention. Actions should be the result of co-production with Service Users and their families / carers. Those with lived experience of relevant conditions and services should be involved at every stage in the development of personalised approaches.*  *Detailed suggestions for potential inclusion are set out below.*  ***Patient choice and Shared decision-making (SDM)***  *Enabling service users to make choices about the provider and services that will best meet their needs and facilitating SDM in everyday clinical practice are legal requirements, as well as specific contractual obligations under SC6.1 and SC10.2. In brief, SDM is a process in which Service Users and clinicians work together to discuss the risks, benefits and consequences of different care, treatment, tests and support options, and make a decision based on evidence-based, good quality information and their personal preferences; for a full definition, see the General Conditions and the resources available at* [*https://www.england.nhs.uk/shared-decision-making/.*](https://www.england.nhs.uk/shared-decision-making/)  ***Personalised care and support plans (PCSPs)***  *Development, use and review of PCSPs are contractual obligations under SC10.3-10.4. In essence, PCSPs are a record of proactive, personalised conversations about the care a Service User is to receive, focused on what matters to the person; for a full definition, see the General Conditions. PCSPs are recommended for all long-term condition pathways plus other priority areas as set out in the NHS Long Term Plan. These include maternity services, palliative and end of life care, cancer, dementia, and cardio-vascular diseases. The COVID pandemic has also highlighted the need for effective personalised care planning for residents of residential settings and those most at risk of COVID-19. PCSPs must also be in place to underpin any use of personal health budgets.*  ***Social prescribing***  *Primary Care Networks are now employing social prescribing link workers, tasked with connecting patients to community groups and statutory services for practical and emotional support (see* [*Social prescribing and community-based support: Summary Guide*](https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/)*).*  ***Supported self-management***  *As part of SDM and PCSPs, the support Service Users need to help them manage their long-term condition/s should be discussed. Interventions that can help people to develop* *their knowledge, skills and confidence in living well with their condition include health coaching, structured self-management education programmes, and peer support. Identified priority groups include people with newly diagnosed type 2 diabetes and people with Chronic Obstructive Pulmonary Disease. Measures to assess individuals’ levels of knowledge, skills and confidence, such as the Patient Activation Measure, can be used to help tailor discussions and referrals to the most suitable intervention. They can also be used to measure the impact of self-management support.* |

# SCHEDULE 2 – THE SERVICES

**N. Health Inequalities Action Plan**

|  |
| --- |
| The Provider should consider and deliver as appropriate to their Service User any Action Plan(s) to reduce Health Inequalities, as set out below:  ***Intelligence and needs assessment***  *The Provider may set out*   1. *how the Parties will work with other partners to bring together accessible sources of data to understand levels of variation in access to and outcomes from the Services and to identify and prioritise cohorts of vulnerable individuals, families, and communities, capitalising on growing understanding of population health management approaches and applications;* 2. *how they will use this intelligence base to analyse and prioritise action at neighbourhood, “place” and system level; and* 3. *what action the Provider will take to ensure that data which it reports about its Services is accurate and timely, with particular emphasis on attributing disability, ethnicity, sexual orientation, and other protected characteristics, and what action is being taken to close any gaps which the analysis reveals.*   ***Community engagement***  *The Provider may describe how the Parties will work with partners to map established channels of communication and engagement with locally prioritised vulnerable cohorts, to identify barriers or gaps to meaningful and representative engagement, and to develop action plans to address these.*  *Engagement activity should consider the variety of cohorts with potential vulnerability and disadva**ntage, which may overlap:*   * + *socio-economically deprived communities (identified by the English indices of deprivation 2019* [*https://www.gov.uk/government/statistics/english-indices-of-*](https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)[*deprivation-2019*](https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019)*)*   + *those with protected characteristics e.g. BAME; disabled; LGBTQ+*   + *potentially socially excluded cohorts e.g. inclusion health groups such as the homeless; asylum seekers and Gypsy, Roma and Traveller groups*   + *digitally excluded cohorts*   + *geography – urban, rural and coastal inequalities.*   *Through these and other routes shared intelligence, insight and understanding can form the basis for practical goals and actions to be agreed, and set out in this Schedule, to meet established needs.*  ***Access to and provision of the Services***  *The Provider may describe*   * + *what actions the Parties will take to ensure that appropriate patients are identified for referral to the Services, by GPs and other referrers, with particular emphasis on vulnerable cohorts;* |

# SCHEDULE 3 – PAYMENT

1. **Aligned Payment and Incentive Rules**

|  |
| --- |
| **Not Applicable** |

# SCHEDULE 3 – PAYMENT

1. **Locally Agreed Adjustments to NHS Payment Scheme Unit Prices**

| **To be agreed with successful Provider and included as part of contract finalisation** |
| --- |

# SCHEDULE 3 – PAYMENT

1. **Local Prices**

**To be agreed with successful Provider**

# SCHEDULE 3 – PAYMENT

1. **Expected Annual Contract Values**

|  |
| --- |
| **Expected Annual Contract Value (include separate values for each of one or more Contract Years, as required)** |
| The annual contract value expected for this contract is up to £11m.   * FY26/27: £11m * FY27/28: £11m * FY 28/29: £11m   And subject to Schedule 1C:  Total Potential Life Cost of contract: £33m |
| The available budget for the initial contract term is £11 million. Should the extension options be exercised, the subsequent terms are anticipated to have a comparable value.  Both the Commissioner and Provider must give regard to the total value available in the contract (up to a maximum of £33m).  The Commissioner reserves the right to put in place restrictions on access to the service to ensure it doesn’t overspend on the annual contract value, or as otherwise specified by the Commissioner in writing. |

# SCHEDULE 3 – PAYMENT

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

| The timings and amounts are set out in Schedule 3C: Local Prices. |
| --- |

# SCHEDULE 3 – PAYMENT

1. **CQUIN**

| **Not Applicable** |
| --- |

# SCHEDULE 4 – LOCAL QUALITY REQUIREMENTS

|  | **Quality Requirement** | **Threshold** | **Method of measurement** | **Period over which the requirement is to be achieved** | **Applicable Service Specification** |
| --- | --- | --- | --- | --- | --- |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |

# SCHEDULE 5 – GOVERNANCE

1. **Documents Relied On**

**Documents supplied by Provider**

| **Date** | **Document** |
| --- | --- |
| **Insert text locally or state Not Applicable** |  |
|  |  |
|  |  |
|  |  |

**Documents supplied by Commissioners**

| **Date** | **Document** |
| --- | --- |
| **Not Applicable** |  |
|  |  |
|  |  |
|  |  |

# SCHEDULE 5 - GOVERNANCE

**B. Provider’s Material Sub-Contracts**

TBC with the winning Provider

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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** |
| **Insert text locally or state Not Applicable** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# SCHEDULE 5 - GOVERNANCE

1. **Commissioner Roles and Responsibilities**

| **Co-ordinating Commissioner/Commissioner** | **Role/Responsibility** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
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# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **Reporting Requirements**

Outcomes, KPIs and contract management

**NHS Outcomes Framework Domains and Indicators**

The Service should align to the [NHS Outcomes Framework (NHS OF)](https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework) high-level national outcomes that the NHS should be aiming to improve, which include:

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

**Service specific outcomes**

To be successful, this national staff mental health treatment service should be able to demonstrate the following outcomes:

* + The Provider will **contribute to the delivery of high quality, safe and effective NHS services** through providing support to enable a healthy workforce.
  + The Provider must **improve staff health and wellbeing**, provide effective diagnosis and treatment, support early intervention, and relapse prevention
  + The Provider must **improve coordination of mental health support for staff** through case management within each catchment area, supporting integration with other health and care services as appropriate.
  + The Provider must continuously monitor and report treatment outcomes and **Service User satisfaction** in the Service, demonstrating continuous improvement.
  + The Provider will support Service User health to **remain in work**, and/or to **safely return to professional practice** following a period of sickness.
  + The Provider must support a greater **awareness of workforce health issues** through effective data collection, audit and data analysis.
  + The Provider will **reduce the perception of stigma** associated with health and social care staff accessing help for their mental health.
  + The Provider must maintain a **nationally consistent offer across England**.
  + The Provider must make it easy to **access the Service and ensure confidentiality** for Service Users.

**Specific Key Performance Indicators**

The following table is a list of Key Performance Indicators (KPI) that we expect for the first 12 months of delivery, after which these may evolve and develop in line with changes to the service. Any changes will follow a period of consultation and change approval process with the Provider and the Commissioner.

In addition to the below, the Provider may be asked to provide further specific evidence or data.

|  |  |  |
| --- | --- | --- |
| **Quality Requirement** | **Threshold** | **Measurement** |
| **1.Service User perception of quality and satisfaction**  Satisfaction of Service User experience, including:**​**   1. Access to service**​** 2. Responsiveness/time to treatment**​** 3. Quality of care received | The provider must demonstrate at **least 90% achievement** | Mid-contract annual service user satisfaction survey |
| **2. Actual time to treatment​**  The time it takes for a Service User to receive care, including:​   1. Time between first contact and being seen/assessed​ 2. Time to first treatment | The provider must achieve **at least 90% achievement of first contact within 2 days of referral and being seen/assessed within 5 days** | Monthly reporting demonstrating agreed minimum timescales/days |
| **3. Management and contract Quality Assurance (QA) reporting​**  **​**  Enhancing the current list of management reporting including data on:**​**   1. Access 2. Current Caseload, reasons and duration in the Service 3. Activity summary 4. Clinical and Service User quality outcomes 5. Operational standards 6. Annual Report | The provider must provide **100% of the required information at agreed intervals** to support contract QA meetings​ | Monthly (See table below for additional detail) |
| **4. Complaints​**  If there are complaints, standards / timescales around dealing with complaints | The provider should receive no more than 3 complaints per month | Monthly reporting demonstrating agreed minimum complaints |

**Contract Management and Quality Assurance Data**

As part of contract quality management, the following outlines the core management data that the Provider must be able to demonstrate, to inform monthly and annual contract quality management.

These form a minimum level of management data required, however it is expected that the Provider can work with the Commissioner to enhance these to demonstrate maximum contract value, impact, and care quality.

**Management and contract Quality Assurance (QA) reporting**

|  |  |  |
| --- | --- | --- |
| **Quality Requirement** | **Threshold** | **Measurement** |
| **a. Access** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Access**:   * Number of new contacts (e.g. website hits, no. contacts via phone/online/ referral etc) * Number of new referrals:   + Routes to entry (e.g. self-referral, organisational/OH/manager referral etc)   + Repeat referrals   + How many referrals accepted / what pathway or condition   + How many referrals rejected     - Reason for rejection     - Assurance of onward referral/support, including where Service Users have been signposted/off boarded to.   Time between:   * + first contact and being seen/assessed   + to receiving first treatment |
| **b. Current caseload, reasons, and duration in service** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Current caseload, reasons, and duration in the Service:**   * Number on caseload, split by demographics / coding agreed with Commissioner, and by duration in Service:   + Months up to one year   + If breach 1 year, a summary justification for this is required by agreed category/coding   + If breach 2 years, a case-by-case review is required to justify with Commissioner * Number on caseload - by treatment pathway / type, in work / out of work (long term sick) etc * Number on caseload - % who have received treatments this month * Risk status of Service Users on caseload by agreed categories with Commissioner |
| **c. Activity summary** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Activity summary**   * Monthly number of activities, split by treatment/intervention type * Utilisation, including attended/DNA and reasons * Service Availability Target 99.999%-. Including number of calls, broken down by core hours and out of hours? * Reply to emails within one (1) days of receipt * Engagement activity, number hosted, theme and attendees- webinars, podcasts, events |
| **d. Clinical and Service User quality outcomes** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Clinical and Service User quality outcomes**   * Annual Service User survey results (once per year – questions negotiated with the Commissioner) * Monthly updates on Service User clinical outcome measures (pre and post intervention, including PHQ9/ GAD7 / Psychlops / CORE10 / successful return to work (of appropriate) - or appropriate as negotiated with the Commissioner) * Monthly updates on Service User experience outcomes (end of treatment survey including a brief sample of questions relating to experience, including perceived outcome, quality of service, responsiveness – or as appropriate as negotiated with the Commissioner) * All Service Users must have a Treatment Plan within 5 days of initial assessment |
| **e. Operational standards** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Operational standards**   * Monthly Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, and complaints * Annual summary of Provider workforce * Bi yearly report on Provider staffing * Services must achieve WCAG 2.2 level AA as part of meeting government accessibility requirements (Include WCAG 2.2 Level AA requirements in specification) |
| **f. Annual report** | The Provider must provide **100% of the required information at agreed intervals** to support contract QA meetings | **Annual report**   * An annual report, summarising overall activity, outcomes, trend data, Provider staff survey and evidence of return on investment to demonstrate service quality and value |

**Contract Management**

The Contract shall follow the Commissioners Contract Management Framework.

The Provider shall ensure must attend Contract Review meetings to ensure compliance with the agreed Key Performance Indicators as per the principles within the Commissioners NHS England Contract Management Framework.

**Reporting**

Communicating planned activities versus actual achievements, critical risks and issues, and statistical summary information on tasks, budget and plan.

Achievements, successes and benefits.

Providing control to monitor and measure change and performance.

Early discussion and communication of problems, issues, or need for help.

Potential changes to time, cost or scope of deliverables

Current resource position with recommendations for decision / approval

Reports should look forwards as well as reporting what has happened.

**Contract Review Meetings**

For the duration of the contract, the Provider shall produce for the formal monthly review meetings as a minimum the following information:

A Highlight Report (executive summary) that tracks performance against Key Performance Indicators;

1.Monthly returns on a template as agreed by the Commissioner;

* + - Key Performance Indicators Exception Report to include details where Service Levels have not met required standards as per the Specification to include:
    - Identification of anomalies or issues
    - Cause
    - Measures/rectification to get Key Performance Indicators back on track
    - Backing Data (anonymised to ensure compliance with Data Protection Act DPA) in format as agreed by the Commissioner;

2.A risk register; and

3.A finance report to include forecasted, actual and variance etc.

The Provider shall ensure relevant Key Stakeholders from their organisation attend monthly and annual review meetings.

The Provider shall note meetings can take via face-to-face, Teams/Zoom, and telephone conferencing. Date and times to be agreed with the Provider following contract award and ‘Contract Kick Off Meeting. The Provider shall note subject to satisfactory performance frequency of meetings may change; for example bi-monthly or quarterly. The Provider will be required to submit Contract Management reports on a monthly basis irrespective of the frequency of meetings.

Annual review meetings will also take place every May after 12-month delivery period (between April through to March) in the same format as monthly meetings. Annual report to be provided by twenty (20) working days after the end of each year.

Reports from Year Two onwards shall include year on year comparisons for each respective month and include trend information.

Insurance certificates to be provided to the Commissioner annually as and when the Provider’s insurance are renewed.

1. Employers Liability (EL); £10m
2. Public Liability (PL); £10m and
3. Professional Indemnity (PI) / Medical Malpractice (MM); £10m

**Contract Management Data Return Dates**

Monthly returns to be submitted ten (10) working days after each preceding month as detailed below:

**Government Transparency Agenda**

The Provider shall note requirement to submit and publish up to four (4) selected Key Performance Indicators for the purposes of the Governments Transparency Agenda.

Key Performance Indicator returns to be completed and submitted on a quarterly basis on template as provided by the Commissioner.

Further information and guidance for Santiago reporting can be accessed via this link [Key Performance Indicators (KPIs) for government’s most important contracts - GOV.UK (www.gov.uk)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.gov.uk%2Fgovernment%2Fpublications%2Fkey-performance-indicators-kpis-for-governments-most-important-contracts&data=05%7C02%7Chelen.houghton5%40nhs.net%7Ccfaf016e78524d868bf508dd93a48a8f%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638829057080084140%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=1R6RLYb7UZDc%2Fm%2BHjlQqVSFIanteTIna2W0ZnUG48Uc%3D&reserved=0))

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **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.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Data Quality Indicator** | **Data Quality Threshold** | **Method of Measurement** | **Milestone Date** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **Incidents Requiring Reporting Procedure**

|  |
| --- |
| **Procedure(s) for reporting, investigating, and implementing and sharing Lessons Learned from: (1) Serious Incidents (2) Notifiable Safety Incidents (3) other Patient Safety Incidents** |
| **Exception Report**  The Provider is required to complete an exception report (which template will be developed on contract award) and send to the Commissioner to report on all incidents as set out in these contract particulars. This includes (but not limited to) activity as set out in:   * Schedule 2A section 3.4 Continuing care relationship with Service Users own GP * Schedule 2A section 3.4 Principles for long term relationships with the Service User * Schedule 2G section 1: Terms of Performer Escalation * SC33 Incidents Requiring Reporting * Schedule 2G section 2: Information Governance Toolkit Compliance, and GC21: Patient Confidentiality, Data Protection, Freedom of Information and Transparency |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **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 for recommended topics for SDIPs.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Milestones** | **Timescales** | **Expected Benefit** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **Surveys**

| **Type of Survey** | **Frequency** | **Method of Reporting** | **Method of Publication** | **Application** |
| --- | --- | --- | --- | --- |
| Friends and Family Test (where required in accordance with FFT Guidance) | As required by FFT Guidance | As required by FFT Guidance | As required by FFT Guidance | **All** |
| As set out in Schedule 6A |  |  |  |  |

# SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

1. **Data Processing Services**

##### SCOPE

* 1. The Co-ordinating Commissioner appoints the Provider as a Data Processor to perform the Data Processing Services.
  2. A close up of a black background

     AI-generated content may be incorrect.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.
  3. This Schedule 6F applies for so long as the Provider acts as a Data Processor in connection with this Contract.

##### DATA PROTECTION

* 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. 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.
  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:
     1. a systematic description of the envisaged processing operations and the purpose of the processing;
     2. an assessment of the necessity and proportionality of the processing operations in relation to the Data Processing Services;
     3. an assessment of the risks to the rights and freedoms of Data Subjects; and
     4. the measures envisaged to address the risks, including safeguards, security measures and mechanisms to ensure the protection of Personal Data.
  4. The Provider must, in relation to any Personal Data processed in connection with its obligations under this Schedule 6F:
     1. 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;
     2. 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:
        1. nature, scope, context and purposes of processing the data to be protected;
        2. likelihood and level of harm that might result from a Data Loss Event;
        3. state of technological development; and
        4. cost of implementing any measures;
     3. ensure that:
        1. when delivering the Data Processing Services the Provider Staff only process Personal Data in accordance with this Schedule 6F (and in particular Annex A);
        2. 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:
           1. A close up of a black background

              AI-generated content may be incorrect.are aware of and comply with the Provider’s duties under this paragraph;
           2. are subject to appropriate confidentiality undertakings with the Provider and any Sub- processor;
           3. 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;
           4. have undergone adequate training in the use, care, protection and handling of Personal Data; and
           5. are aware of and trained in the policies and procedures identified in GC21.11 (*Patient Confidentiality, Data Protection, Freedom of Information and Transparency*).
     4. 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:
        1. the Co-ordinating Commissioner or the Provider has provided appropriate safeguards in relation to the transfer as determined by the Co-ordinating Commissioner;
        2. the Data Subject has enforceable rights and effective legal remedies;
        3. 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
        4. 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;
     5. 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;
     6. 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,](#_bookmark56) 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
     7. 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.
  5. Subject to paragraph [2.6,](#_bookmark58) 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:
     1. receives a Data Subject Access Request (or purported Data Subject Access Request);
     2. receives a request to rectify, block or erase any Personal Data;
     3. receives any other request, complaint or communication relating to obligations under Data Protection Legislation owed by the Provider or any Commissioner;
     4. A close up of a black background

        AI-generated content may be incorrect.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);
     5. 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;
     6. becomes aware of or reasonably suspects a Data Loss Event; or
     7. 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.
  6. The Provider’s obligation to notify under paragraph [2.5](#_bookmark57) includes the provision of further information to the Co-ordinating Commissioner in phases, as details become available.
  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](#_bookmark57) and [2.6](#_bookmark58) as soon as reasonably practicable.
  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](#_bookmark57) (and insofar as possible within the timescales reasonably required by the Co-ordinating Commissioner) including by promptly providing:
     1. the Co-ordinating Commissioner with full details and copies of the complaint, communication or request;
     2. 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;
     3. assistance as requested by the Co-ordinating Commissioner following any Data Loss Event;
     4. 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.
  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.
  10. For the avoidance of doubt the provisions of GC12 *(Assignment and Sub-contracting)* apply to the delivery of any Data Processing Services.
  11. Without prejudice to GC12, before allowing any Sub-processor to process any Personal Data related to this Schedule 6F, the Provider must:
      1. notify the Co-ordinating Commissioner in writing of the intended Sub-processor and processing;
      2. obtain the written consent of the Co-ordinating Commissioner;
      3. carry out appropriate due diligence of the Sub-processor and ensure this is documented;
      4. 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
      5. provide the Co-ordinating Commissioner with such information regarding the Sub-processor as the Co-ordinating Commissioner may reasonably require.
  12. The Provider must create and maintain a record of all categories of data processing activities carried out under this Schedule 6F, containing:
      1. A close up of a black background

         AI-generated content may be incorrect.the categories of processing carried out under this Schedule 6F;
      2. 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;
      3. a general description of the Protective Measures taken to ensure the security and integrity of the Personal Data processed under this Schedule 6F; and
      4. 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.
  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.
  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.
  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.
  16. The Provider must take prompt and proper remedial action regarding any Data Loss Event.
  17. The Provider must assist the Co-ordinating Commissioner by taking appropriate technical and organisational measures, insofar as this is possible, for the fulfilment of the Commissioners’ obligation to respond to requests for exercising rights granted to individuals by Data Protection Legislation.

### Annex A

**Data Processing Services**

##### **Processing, Personal Data and Data Subjects**

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

# SCHEDULE 7 – PENSIONS

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

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1. <https://www.england.nhs.uk/gp/gpfv/> [↑](#footnote-ref-2)
2. <https://www.gponline.com/nhs-launch-worlds-first-free-health-service-gps/article/1411523> [↑](#footnote-ref-3)
3. <https://www.practitionerhealth.nhs.uk/media/content/files/PHP-report-web%20version%20final%20copy.pdf> [↑](#footnote-ref-4)
4. <https://www.longtermplan.nhs.uk/nhs-to-prioritise-doctors-mental-health/> [↑](#footnote-ref-5)
5. <https://www.practitionerhealth.nhs.uk/nhs-ph-workforce> [↑](#footnote-ref-6)
6. <https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/> [↑](#footnote-ref-7)
7. <https://www.practitionerhealth.nhs.uk/research-publications> [↑](#footnote-ref-8)
8. <https://www.england.nhs.uk/professional-standards/medical-revalidation/ro/> [↑](#footnote-ref-9)