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2026/27 NHS Standard Contract

Particulars (Shorter Form)

Contract title:	NHS Surrey and Sussex Integrated Care Board Personalised Home Care Any Qualified Provider (AQP)
Contract ref:	*2627-SRRYSSSX-PHC-AQP*

Version 1, January 2026

Prepared by: NHS Standard Contract team, NHS England
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DATE OF CONTRACT	**[DATE]**
EXPECTED SERVICE COMMENCEMENT DATE	**[DATE]**
CONTRACT TERM	**3 years commencing [DATE] (or as extended in accordance with Schedule 1C)**
COMMISSIONERS	**NHS SURREY AND SUSSEX INTEGRATED CARE BOARD (ODS S9B9J)**
CO-ORDINATING Commissioner *See GC10*	**NHS SURREY AND SUSSEX INTEGRATED CARE BOARD (ODS S9B9J)**
PROVIDER	**[ ] (ODS [ ])** **Principal and/or registered office address:** **[ ]** **[Company number: [ ]**

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CONTRACT

Contract title: NHS Surrey and Sussex Integrated Care Board Personalised Home Care Any Qualified Provider (AQP)

Contract ref: 2627-SRRYSSSX-PHC-AQP

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 varied from time to time in accordance with GC13 (*Variations)*;

2. the **Service Conditions (Shorter Form)**, as published by NHS England from time to time at: https://www.england.nhs.uk/nhs-standard-contract/;

3. the **General Conditions (Shorter Form)**, 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	**……** **Signature**
[INSERT AUTHORISED SIGNATORY'S NAME] for and on behalf of NHS SURREY AND SUSSEX ICB	**……** **Title** **……** **Date**

[INSERT AS ABOVE FOR EACH COMMISSIONER]

SIGNED by	**……** **Signature**
[INSERT AUTHORISED SIGNATORY'S NAME] for and on behalf of [INSERT PROVIDER NAME]	**……** **Title** **……** **Date**

SERVICE COMMENCEMENT AND CONTRACT TERM	
Effective Date *See GC2.1*	**[DATE]**
Expected Service Commencement Date *See GC3.1*	**[DATE]**
Longstop Date *See GC4.1*	**3 months from the Service Commencement date**
Contract Term	**3 years/months commencing [DATE] (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**
Notice Period (for termination under GC17.2)	**12 months**
SERVICES	
Service Categories	**Indicate <u>all</u> 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.*
Continuing Healthcare Services (including continuing care for children) (CHC)	YES
Community Services (CS)	
Diagnostic, Screening and/or Pathology Services (D)	
End of Life Care Services (ELC)	
Mental Health and Learning Disability Services (MH)	
Patient Transport Services (non-emergency) (PT)	
Service Requirements	
Prior Approval Response Time Standard *See SC29.11*	**Not applicable**
GOVERNANCE AND REGULATORY	
Provider's Nominated Individual *See SC1.4*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Accountable Emergency Officer *See SC30.1*	**[ ]** **Email: [ ]** **Tel: [ ]**

Provider's Child Sexual Abuse and Exploitation Lead *See SC32.2*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Mental Capacity and Liberty Protection Safeguards Lead *See SC32.2*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Safeguarding Lead (adults) / named professional for safeguarding adults *See SC32.2*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Safeguarding Lead (children) / named professional for safeguarding children *See SC32.2*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Freedom To Speak Up Guardian(s) *See GC5.7*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Caldicott Guardian *See GC21.3*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Data Protection Officer (if required by Data Protection Legislation) *See GC21.3*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Information Governance Lead *See GC21.3*	**[ ]** **Email: [ ]** **Tel: [ ]**
Provider's Senior Information Risk Owner *See GC21.3*	**[ ]** **Email: [ ]** **Tel: [ ]**
CONTRACT MANAGEMENT	
Addresses for service of Notices *See GC36*	**NHS SURREY AND SUSSEX INTEGRATED CARE BOARD (S9B9J)** Sackville House Brooks Close Lewes BN7 2FZ
Commissioner Representative(s) *See GC10.2*	**Evalucom Consulting Limited** **Email:** **sussex.homecareaqp@evalucom.co.uk**
Provider Representative *See GC10.2*	**[ ]** **Address: [ ]** **Email: [ ]** **Tel: [ ]**

GLOSSARY

The definitions below are additional to those found in the General Conditions. The following terms shall have the following meanings:

Advance Care Plan (ACP)

A record of voluntary, person-centred discussions between an individual and their care providers about their preferences and priorities for their future care, while they have the mental capacity for meaningful conversations about these. The record may include one or more of the following:

- advance statement of wishes, preferences and priorities, and may include nomination of a named spokesperson
- Advance Decision to Refuse Treatment (ADRT)
- nomination of a Lasting Power of Attorney (LPA) for health and welfare who is legally empowered to make decisions up to, or including, life sustaining treatment on behalf of the person if they do not have mental capacity at the time, depending on the level of authority granted by the person.
- context-specific treatment recommendations such as emergency care and treatment plans, treatment escalation plans, cardiopulmonary resuscitation decisions, etc.

(Adapted from: NHS England, 2022. *Universal Principles for Advance Care Planning (ACP)*. Available at: https://www.england.nhs.uk/wp-content/uploads/2022/03/universal-principles-for-advance-care-planning.pdf).

Advance Decision to Refuse Treatment (ADRT)

As defined in 2005 Act. Available at: http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf.

Advocate

Advocate can be used in a general sense, as one who speaks on behalf of another, or it can have special meanings derived from the 1983 Act and the 2005 Act. There are formal and informal Advocates and these can be:

- individuals acting informally: carers, relatives, partners, neighbours or friends and staff;
- those prescribed by legislation, such as Independent Mental Health Advocates and Independent Mental Capacity Advocates; and
- those provided by schemes run by Local Authorities, the NHS and charities.

(CQC, 2025. *Glossary of terms used in the guidance for providers and managers*. Available at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/glossary-terms-used-guidance-providers-managers).

Appointed Person

A Legal Guardian, Advocate, or best interest representative appointed by the Commissioner.

Behaviour that Challenges

A person's behaviour can be defined as "challenging" if it puts them or those around them (such as their carer) at risk or leads to a poorer quality of life. It can also impact their ability to join in everyday activities. Challenging behaviour can include:

- aggression
- self-harm
- destructiveness
- disruptiveness

	(NHS, 2024. *How to deal with challenging behaviour in adults*. Available at: https://www.nhs.uk/social-care-and-support/practical-tips-if-you-care-for-someone/how-to-deal-with-challenging-behaviour-in-adults/).
Care Plan	A plan developed and maintained by the Provider setting out how care will be delivered to the Service User, informed by the Personalised Care and Support Plan.
Care Tier	A category of Service User needs and Provider requirements.
Care Worker	A person employed by the Provider to provide the Domiciliary Care services.
Comorbidities	The co-occurrence of two or more long term conditions in a person. (Department of Health, 2014. *Comorbidities: A framework of principles for system-wide action*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/307143/Comorbidities_framework.pdf).
Contact Time	The time Care Workers spend delivering care to the Service User.
Daily Average Agreement	As defined in the National Minimum Wage Regulations 2015. Available at: http://www.legislation.gov.uk/uksi/2015/621/part/5/chapter/5/made).
Decision Support Tool (DST)	The assessment tool used to determine eligibility for NHS CHC under the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. (Department of Health and Social Care, 2022. *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1170290/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care_July-2022-revised_corrected-July-2023.pdf).
Delegated Healthcare Activities (DHAs)	Activities, usually, but not exclusively of a clinical nature, that a regulated healthcare professional delegates to a paid care worker or personal assistant. The regulated healthcare professional as the delegator, remains accountable for the appropriateness of the delegation. (Skills for Care and Department of Health and Social Care, 2024. *Delegated healthcare activities: guiding principles for health and social care in England*. Available at: https://www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities-guiding-principles-November-2024.pdf).
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision	Management plan put in place if cardiac or respiratory arrest is an expected part of the dying process and CPR is unlikely to be successful. Making and recording an advance decision not to attempt CPR means that the patient dies in a dignified and peaceful manner and that the patient's last hours or days are spent in their preferred place of care by, for example, avoiding emergency admission from a community setting to hospital. These management plans are also called Do Not Attempt Resuscitation orders or Allow Natural Death decisions. (Adapted from: General Medical Council, 2024. *Treatment and care towards the end of life: good practice in decision-making*. Available at:

	https://www.gmc-uk.org/-/media/documents/Treatment_and_care_towards_the_end_of_life___English_1015.pdf_48902105.pdf).
Domiciliary Care	Care for people living in their own homes. The needs of people using the services may vary greatly and packages of care are designed to meet individual circumstances. The person is visited at various times of the day or in some cases, care is provided over a full 24-hour period. Where care is provided intermittently throughout the day, the person may live independently of any continuous support or care between the visits. (Adapted from: CQC, 2025. *Service Types*. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/service-types).
Electronic Call Monitoring (ECM)	A method of recording accurate Contact Time. The date, time and duration of care is recorded by the Care Worker logging in and out while at the Service User's home.
End of Life Care (EOLC)	Includes the care and support given in the final weeks and months of life, and the planning and preparation for this. For some conditions, this could be months or years. This includes people with: • advanced, progressive, incurable conditions; • general frailty and coexisting conditions that mean they are at increased risk of dying within the next 12 months; • existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and • life-threatening acute conditions caused by sudden catastrophic events. (Adapted from: NICE, 2019. *End of life care for adults: service delivery*. Available at: https://www.nice.org.uk/guidance/ng142/).
Medication Errors	A Patient Safety Incident (PSI) that involves an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. PSIs are defined in the Patient Safety Incident Response Framework (PSIRF). (Adapted from: NHS Resolution, 2023. *Learning from medication errors*. Available at: https://resolution.nhs.uk/2023/03/30/learning-from-medication-errors/).
Multidisciplinary Team (MDT)	Two or more health and social care professionals who are involved in the assessment of the Service User.
National Minimum Wage (NMW)	The National Minimum Wage is the minimum pay per hour almost all workers are entitled to. The National Living Wage is higher than the National Minimum Wage - workers get it if they're 21 and over. (UK Government, 2026. *The National Minimum Wage and Living Wage*. Available at: https://www.gov.uk/national-minimum-wage).
NHS Continuing Healthcare (CHC)	A package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS

	CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery. (Department of Health and Social Care, 2022. *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1170290/National-Framework-for-NHS-Continuing-Healthcare-and-NHS-funded-Nursing-Care_July-2022-revised_corrected-July-2023.pdf).
Nursing Care	As defined in 2014 Regulations. Available at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf.
Personal Care	As defined in 2014 Regulations. Available at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/pdfs/ukdsi_9780111117613_en.pdf.
Personalised Care and Support Plan	See Personalised Care and Support Plan in the NHS Standard Contract General Conditions (Full Length). Available at: https://www.england.nhs.uk/publication/full-length-nhs-standard-contract-2026-27-particulars-service-conditions-general-conditions/.
Risk Assessment	The process of identifying all the risks to and from an activity and assessing the potential impact of each risk. (CQC, 2025. *Glossary of terms used in the guidance for providers and managers*. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/glossary-terms).
Service User Guide	Provider-produced guide to the Services for the Service User.
Significant Change	An amendment that affects the agreed cost of the care package (e.g. the number of hours of care or the Care Tier). or Any change to the risk profile of care delivery (e.g. turning regime).
Standard Rates	The rates to be paid for the provision of care to the Service User as detailed in this contract.
Treatment of disease, disorder or injury (TDDI)	A regulated activity for which providers must be registered with the Care Quality Commission (CQC). Available at: https://www.cqc.org.uk/guidance-regulation/providers/registration/scope-registration/regulated-activities/treatment-disease-disorder-or-injury.
Unmeasured Work	As defined in the National Minimum Wage Regulations 2015. Available at: https://www.legislation.gov.uk/uksi/2015/621/part/5/chapter/5/made.

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

A. Conditions Precedent

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

1. Evidence of appropriate Indemnity Arrangements.
2. Evidence of CQC registration.
3. Evidence of ICO registration.
4. Evidence of having met the qualification criteria of the NHS Surrey and Sussex Integrated Care Board Personalised Home Care Any Qualified Provider (AQP).
5. Details of sub-contracting arrangements.
6. Evidence that an ECM system is in place.

SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM

C. Extension of Contract Term

1. The Commissioners may opt to extend the Contract Term once by up to 2 years.

2. If the Commissioners wish to exercise the option to extend the Contract Term, the Co-ordinating Commissioner must give written notice to that effect to the Provider no later than 6 months before the Expiry Date as at the date of the written notice.

3. 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*).

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

SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. Scope

1.1 Service Overview

The Contract covers the personalised commissioning of adult All Age Continuing Care (AACC) funded home care for individuals in Sussex assessed as eligible, including end-of-life care via the Fast Track Pathway and specialist and non-specialist NHS Continuing Healthcare (CHC).

The services will be delivered by CQC registered home care providers (CQC service type: domiciliary care service) or by CQC registered hospice providers delivering hospice at home services.

The Services will be provided in the Service User's home or primary place of residence.

A growing number of Service Users wish to remain within their own homes. Supporting Service Users within their own homes promotes community-based, person-centred care and choice. The local provision of the Services is important to supporting timely and responsive care for Service Users in their own homes.

1.2 Service aims

The aims of the Service are to deliver care that:

- puts the health, safety, quality of life and preferences of the Service User at the centre of care provision;
- supports the Service User to make informed choices about their care as per the NHS Constitution and where this is not possible supports actions and decisions taken in the best interests of the Service User;
- supports the Service User to achieve their goals and ambitions, where practical;
- is personalised to the Service User's needs, preferences and aspirations
- provides continuity of care for the Service User;
- strives to continuously improve the quality of care for the Service User;
- reduces hospital admissions and enables safe discharge;
- meets the outcomes outlined in Section 1.3 through effective working partnerships; and
- supports the health, safety and quality of life of Carers as outlined by the Care Act 2014 and in the
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (National Framework for CHC)[1].

1.3 Service outcomes

[1]DHSC, 2023. *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*. Available at: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care.

The key service outcomes are based on the NHS Outcomes Framework domains[2] and Adult Social Care Outcomes Framework domains[3]:

- preventing people from dying prematurely;
- delaying and reducing the need for care and support;
- helping people to recover from episodes of ill-health or following injury;
- enhancing quality of life for people with long-term conditions and/or care and support needs;
- treating and caring for people in a safe environment and protecting them from avoidable harm;
- ensuring people have a positive experience of care and support; and
- safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

Performance indicators for the outcomes are outlined in Schedule 4. The outcomes depend on other services that are complementary to home care services in some cases. The Provider should work co-operatively with the relevant services to meet outcomes.

1.4 Service regulations, legislation and NHS Constitution

The Provider will:

- maintain CQC registration throughout the Contract Term;
- manage and organise care only from CQC-registered locations;
- manage and organise care only from locations added to the CarePulse AQP list;
- comply with all relevant current legislation and regulations as per Service Conditions 1 and 2;
- provide care in line with the Fundamental Standards of Care and Guidance;
- carry out any delegation of healthcare activities to care workers in accordance with *Skills for Care, Delegated healthcare activities: Guiding principles for health and social care in England* (revised November 2024)[4] (and any successor guidance);
- where delegation involves NMC-registered professionals, conduct delegation in accordance with relevant professional codes, including *NMC: Delegation and accountability (supplementary information to the NMC Code)*[5].
- have regard to *NHS England, Personal health budgets: Delegation of healthcare tasks to personal assistants* (March 2023)[6] where the Provider supports individuals in receipt of a Personal Health Budget who employ personal assistants.

[2] NHS Digital, 2025. *About the NHS Outcomes Framework (NHS OF)* . Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework.
[3] DHSC, 2026. *The adult social care outcomes framework: handbook of definitions*. Available at: https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-handbook-of-definitions/the-adult-social-care-outcomes-framework-handbook-of-definitions.
[4] Skills for Care, 2024. *Delegated healthcare activities Guiding principles for health and social care in England (revised November 2024)*. Available at: https://www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Managing-a-service/Delegated-healthcare-activities/Delegated-healthcare-activities-guiding-principles-November-2024.pdf
[5] Nursing and Midwifery Council. Delegation and accountability - Supplementary information to the NMC code. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/delegation-and-accountability-supplementary-information-to-the-nmc-code.pdf
[6] NHS England, 2023. Personal health budgets: Delegation of healthcare tasks to personal assistants – March 2023. Available at: https://www.england.nhs.uk/long-read/personal-health-budgets-delegation-of-healthcare-tasks-to-personal-assistants-march-2023/

2. Care Tiers

Service User needs vary widely for different Service Users. Table 2 categorises the Services into four different Care Tiers of increasing specialism.

Care Tiers 1 and 2 describe non-specialist home care and Care Tier 3 describes specialist home care. The term “specialist” refers to the clinical complexity of the care. Every Service User will receive individual, person-centred care at each Care Tier.

The Provider will agree to deliver a care package that is within the scope of the services that the Provider can deliver. This can be within one or more Care Tiers. The Provider is not required to deliver care at every Care Tier.

Providers are expected to ensure robust clinical governance, oversight and safety for all care packages. Where a care package includes delegated clinical tasks, then care delivery must be supported by appropriate governance, competency assessments and CQC registration for TDDI.

In line with this requirement, CQC-registered TDDI is mandatory for all Care Tier 3 activities, reflecting the level of complexity, clinical risk, and professional judgement involved.

For Care Tier 2, TDDI registration may be required in some cases, and this will be determined by the Commissioner based on the needs of the individual package of care.

The appropriate Care Tier or combination of Care Tiers will be decided by the Commissioner, informed by input from the MDT and the Provider.

Table 2: Care Tiers.

Care Tier 1: Non-specialist care
Overview Care Tier 1: • provides support and enablement for Service Users with significant needs around the personal activities of daily living, potentially including mobility, nutrition, hygiene and personal safety; • includes Personal Care; • excludes Nursing Care or Delegated Nursing Tasks (DHAs) carried out by the Care Worker. Service Users may have Nursing Care needs that are met by other members of the care team; and • provides support and assistance to Service Users in a way that encourages and maximises independence. **Care Workers** In Care Tier 1 Care Workers will: • have or will be working towards The Care Certificate[7] or equivalent qualification standards (e.g. Level 2 Diploma in Health and Social Care[8]) and will comply with the

[7] Skills for Care, 2025. *Care Certificate*. Available at:https://www.skillsforcare.org.uk/Learning-development/inducting-staff/care-certificate/Care-Certificate.aspx
[8] Skills for Care, 2025. *Qualifications*. Available at: https://www.skillsforcare.org.uk/Learning-development/qualifications/qualifications.aspx

Skills for Care statutory and mandatory training requirements[9] and the Skills for Care minimum standards[10].

Activities

Care Tier 1 activities can include but are not limited to:

- supporting Service Users to get up/go to bed and get dressed/undressed;
- supporting Service Users to wash, shower or bathe including washing of hair and oral hygiene;
- supporting Service Users with their toilet/continence requirements;
- helping Service Users to eat their food or take a drink;
- assisting Service Users to make a safe transfer or to mobilise. Service Users will have some ability to weight bear or move independently;
- assisting and facilitating Service Users to take medication. Service Users will not be passive in taking medication and will have the cognitive capacity to manage their medication and to direct the Care Worker. Tier 1 does not include medicine administration; this is included in Tier 2;
- supporting Service Users' social care needs including social interaction and some domestic activities. Domestic activities will be specifically and exclusively for the Service User and may include but are not limited to light housework, preparing meals, washing up after meal preparation, laundry and shopping;
- working towards maintaining a safe environment for Service Users, respecting Service User and family preferences;
- recognising changing mental, physical and emotional needs, and reporting appropriately; and
- EOLC, where appropriate EOLC will be delivered in partnership with specialist palliative care teams, GPs and other healthcare professionals to identify the support and resources required to meet Service Users' needs and to anticipate changes in their condition. The Provider will follow Guidance on End of Life Care.

Care Tier 2: Non-specialist care

Overview

Care Tier 2:

- incorporates all components of Care Tier 1;
- includes anticipating Service Users' needs and responding to dynamic needs that may not be directly communicated by Service Users;
- excludes administration of an intravenous (IV) antibiotic or other drug requiring training in reconstitution, mathematical calculation, or titration; and
- includes greater identification and management of risks compared to Care Tier 1.

Care Workers

In Care Tier 2 Care Workers will:

[9] Skills for Care, 2024. *Statutory and mandatory training*. Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Guide-to-developing-your-staff/Statutory-and-mandatory-training.aspx
[10] Skills for Care. *Minimum Standards*. Available at: https://www.skillsforcare.org.uk/Learning-development/Guide-to-developing-your-staff/Minimum-standards.aspx

- have additional competencies, skills, experience or training (e.g. health and social care qualification[11], continuing professional development or the Level 3 Diploma in Health and Social care[12]); and
- take on further responsibility compared to Care Tier 1. In Care Tier 2 Care Workers can complete DHAs where they are deemed competent, have received the necessary training, and appropriate supervision is agreed[13].

Activities

Care Tier 2 activities include but are not limited to:

- oral suctioning, limited to the oral cavity and upper airway, where the procedure is non-invasive, predictable, and carried out in line with a stable, individualised care plan;
- observation and monitoring of skin including pressure areas;
- continence care, which requires monitoring to minimise risks, for example care associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation;
- supervised feeding where there may be a risk of aspiration. Care will be delivered in line with speech and language therapy (SALT) guidance;
- care for Service Users receiving nutritional support through feeding tubes (such as Percutaneous Endoscopic Gastrostomy (PEG), Radiologically Inserted Gastrostomy (RIG), Nasogastric (NG)) delegated by an appropriate registered health care professional (e.g. a district nurse);
- routine, predictable PEG feeding and maintenance activities that follow a stable care plan with no requirement for clinical assessment, interpretation, or adjustment. The PEG must be mature, stable, and free from complications;
- transferring and mobilising Service Users, where Service Users are unable to weight bear and are unable to assist or cooperate with transfers and/or repositioning;
- careful positioning where Service Users are unable to cooperate and there is loss of muscle tone, pain on movement, or a risk of physical harm;
- care for Service Users with involuntary spasms or contractures placing them or others at risk;
- administration of medication. Care Tier 2 Care Workers have a greater responsibility for delivering medication and have a more active role compared with Care Tier 1 Care Workers. Care Tier 2 Care Workers administer medication as per the Service User's prescription instructions or the Service User's MAR (Medicines Administration Record). Medication is not delivered under the direct instruction of the Service User, as per Care Tier 1. All details of the medication administration will be recorded on appropriate documentation;
- administration of pre-determined, non-variable insulin doses, delivered via an insulin pen, strictly in accordance with a prescribed plan and protocol set by the relevant healthcare professional;
- non-invasive ventilation via a mask interface (e.g. continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP)) when used for routine, stable ventilation, with pre-set parameters prescribed by a registered clinician;
- airway clearance using cough-assist devices (mechanical insufflation–exsufflation) with standard settings prescribed by a registered clinician;

[11] Skills for Care. *Approved Qualifications.* Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Qualifications/Qualifications.aspx
[12] See footnote 5.
[13] Royal College of Nursing, 2024. *Accountability and delegation guide*. Available at: https://www.rcn.org.uk/Professional-Development/Accountability-and-delegation/Guide

- caring for Service Users with Behaviour that Challenges, where the Risk Assessment document indicates a pattern of behaviour that can be managed by appropriately skilled Care Workers and planned interventions;
- care for Service Users who are unable to assess basic risks even with supervision, prompting or assistance, due to cognitive impairment, and who are dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration; and
- care for Service Users who are unable to communicate reliably their needs at any time and in any way, even when all practicable steps to assist them have been taken. Service Users have to have most of their needs anticipated because of their inability to communicate them.

Care Tier 3: Specialist Care

Overview

Care Tier 3:

- incorporates Care Tier 1 and Care Tier 2;
- applies for Service Users with a combination of conditions and disabilities. The conditions or disabilities will be severe or in the advanced stages; and
- may require the Provider to have a greater role in developing the care package. The Provider may be required to share specialist expertise with the Commissioner to enable Service Users' specific specialist needs to be fully understood and met. The Provider's role in developing the care package may include assisting the Commissioner with the assessment of Service Users' needs.

Care Workers

In Care Tier 3 Care Workers will:

- have additional competencies, skills, experience or training (e.g. health and social care qualifications, continuing professional development qualifications, National Occupational Standards, or the Level 3 Diploma in Health and Social care); and
- take on further responsibility than Care Tier1 and Care Tier 2, with a greater emphasis on DHAs;
- have registered nursing / registered professional oversight for particular Care Tier 3 activities.

Activities

Care Tier 3 activities include but are not limited to:

- oral suctioning, including deep suctioning or any suctioning involving insertion of a catheter beyond the oral cavity into the oropharynx or hypopharynx, or suctioning that requires enhanced clinical judgment;
- any insulin administration that requires dose calculation, titration, interpretation of clinical information, or responsiveness to fluctuating health status. Variable-dose scenarios (e.g., newly initiated insulin, titration plans, sliding scales, end-of-life changes, or unstable diabetes) involve higher training and competency requirements;
- care for Service Users with ventilator dependency, including non-invasive ventilation where the Service User requires continuous ventilatory support or advanced modes (e.g. BiPAP with backup rate/volume-targeted modes) that necessitate continuous monitoring or frequent adjustments;

- care for Service Users with a tracheostomy requiring suctioning where the Service User is unable to manage this themselves;
- care for Service Users at risk of autonomic dysreflexia;
- administration of medication through feeding tubes (such as PEG, RIG, NG);
- PEG-related activity requiring clinical reasoning, monitoring, interpretation of symptoms, or adjustment of feeding regimens. These activities present heightened risks and require clinical oversight under the Treatment of Disease, Disorder or Injury (TDDI) regulated activity;
- care for Service Users with altered states of consciousness (ASC) that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm; and
- care for Service Users with Behaviour that Challenges, where the behaviour is of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.

Registered Nursing Care: Specialist Care

- Care that must be delivered by a registered nurse.

3. Care Pathways

3.1 NHS Continuing Healthcare (CHC)

The Services are for the care of adults eligible for CHC, who require personalised care and support in their own homes and chose not to receive an NHS direct payment. For people eligible for NHS Continuing Healthcare (CHC) who receive care in their own home, the default commissioning route is via a notional Personal Health Budget (PHB).

Where an individual has a primary health need and is therefore eligible for CHC, the NHS is responsible for commissioning a care package that meets the individual's assessed health and associated social care needs. Those eligible for CHC continue to be entitled to access the full range of primary, community, secondary and other healthcare services.

ICBs, NHS England, and Local Authorities have legal duties and responsibilities in relation to CHC. The Provider will support the Commissioner to meet those duties and responsibilities. The principles and processes of CHC are detailed in the National Framework for CHC.

3.2 NHS Fast-Track

The Services include the care of adults in receipt of CHC through the Fast-Track Pathway.

Individuals with a rapidly deteriorating condition and the condition may be entering a terminal phase, may require 'fast tracking' for immediate provision of CHC. The intention of the Fast Track Pathway is that it should identify individuals who need to access CHC quickly, with minimum delay, and with no requirement to complete a Decision Support Tool (DST). Instead, the Fast Track Pathway Tool is used.

In order to comply with Standing Rules, an ICB must accept and immediately action a Fast Track Pathway Tool where the Tool has been properly completed. The Provider will support the

Commissioner to meet Fast-Track Pathway responsibilities. This specifically includes supporting the Commissioner to implement a Fast-Track package within 48 hours of the Commissioner receiving the Fast Track Pathway Tool.

4. Care Commissioning

4.1 Referral process

To support an effective referrals process, the Commissioner will endeavour to provide accurate, comprehensive, and up-to-date information to the Provider. The Provider will feedback to the Commissioner where insufficient information has been provided. The Commissioner will endeavour to address and resolve these issues.

Providers are expected to respond to Commissioner communications in a timely manner to support prompt commencement of care for Service Users.

Referrals will generally be made through CarePulse. The initial referral will include key, high-level information about the Service User and the care package requirements. Providers, whose CarePulse profile indicates they can deliver the required care, will receive an email notification, and be invited to respond to the referral by a stated expiry time. The Commissioner will set expiry times appropriate to the urgency of each care package.

By accepting the referral, the Provider is indicating that they can meet the Service User's needs as described in the referral.

Where multiple providers indicate they can accept a referral, the referral responses will be evaluated against defined criteria. The criteria will be set out in a Scoring Framework, which will be available to all providers. The Scoring Framework will outline the scoring methodology, the weighting applied to each criterion, and the process for selecting a provider. The Commissioner may amend the scoring criteria from time to time. Any changes will be communicated to providers in advance.

Once a care package has been awarded, the CarePulse system will update all providers that indicated they could accept the referral. The Commissioner will then share additional information with the awarded provider to support care planning and care commencement as outlined in **Section 4.2: Provider introduction**.

Where a Service User wishes to remain with their incumbent provider and the provider is able to continue supporting the Service User, the ICB's Choice and Equity Policy will apply. In these cases, the care package may not be advertised through CarePulse.

4.2 Provider introduction

After the Commissioner awards the care package to the Provider, the Provider will arrange and undertake a provider introduction.

The purpose of the provider introduction is for the Provider to:

- meet the Service User and their family and Carers, as applicable
- confirm that they can meet the Service User’s needs
- begin planning for care delivery, which may include but is not limited to:

- conducting a risk assessment
- facilitating personalised care conversations (see **Section 6.1: Personalised care conversations**)
- creating the Care Plan (see **Section 6.2: Care Plan**)

The provider introduction should take place in person with the Service User but when this is not possible or practical the provider introduction can take place remotely.

If, after the Provider carries out the provider introduction, it is apparent that the care needs are materially different to the Provider's expectations, the Provider will coordinate with the Commissioner to withdraw from the care package or agree necessary changes to the care package.

In urgent cases where the provider introduction cannot be completed prior to the commencement of care, the Care Worker(s) carrying out the initial care visit must be trained to undertake the provider introduction, including conducting the risk assessment, and must be competent to meet the identified care needs and develop the care plan. The Care Worker(s) will have access to a qualified supervisor to provide support and oversight if required during care delivery.

4.3 Individual Placement Agreement

The final decision on the care package remains with the Commissioner. The decision will be informed by the Provider and the MDT, where necessary.

Once the care package has been agreed, the Commissioner and Provider will complete an Individual Placement Agreement (IPA). The IPA records the cost of the care package. Commissioners can create and share an online IPA through CarePulse.

The care package cost is calculated based on the Standard Rates and the care hours. The care hours will include Care Tier(s), number of Care Workers, timing and duration of care.

A Care Cost Calculator is included on CarePulse to support Providers and Commissioners to calculate the cost of care in accordance with the Standard Rates.

5. Care Commencement

5.1 Transfer to Provider

The Provider will liaise with appropriate partners (e.g. hospital discharge team, CHC team, District Nurse, GP) to make transfer arrangements.

The Provider will assign a named Provider representative to the Service User. The Provider representative's contact details will be provided to relevant partners (e.g. the Commissioner's CHC team, District Nurse, GP).

The Commissioner will be notified by the Provider of any changes to the discharge arrangements and receive written confirmation on the day the Services commence.

5.2 Service User Guide

The Provider will maintain a Service User Guide. The Provider will make the Service User Guide available and accessible to the Service User and Service User's family and Carers at the commencement of care, and will provide instructions on how to use the Service User Guide. The Service User Guide as a minimum includes:

- the Provider's complaints and feedback procedures;
- contact details for the Provider (including out of hours);
- contact details for the CQC;
- Service User rights and Provider obligations;
- Care Worker procedures and policies;
- safeguarding contact details for the relevant Local Authority;
- NHS Commissioner contact details; and
- an explanation of how personal information will be used.

6. Personalised Care Planning

6.1 Personalised care conversations

All Service Users must have a Personalised Care and Support Plan (PCSP) in place. The PCSP should be used to inform the Care Plan outlined in **Section 6.2: Care Plan**. Where a PCSP has not already been completed for a Service User, the Provider must facilitate a person-centred conversation with the Service User and/or their representative to inform the development of the PCSP.

The PCSP should record what matters to the individual, their health and wellbeing outcomes, and how their notional budget will be used to achieve those outcomes.

6.2 Care Plan

The Provider will develop and implement a detailed Care Plan:

- in accordance with Service Condition 10;
- with the involvement of the Service User, the Service User's family and Carers, and any relevant healthcare professionals, as appropriate;
- with Shared Decision-Making;
- that makes all reasonable adjustments to be in a format the Service User or their representative can understand;
- that accurately reflects the Service User's health and wellbeing outcomes;
- that reflects how the Provider will deliver the outcomes and preferences identified from the personalised care conversations (**Section 6.1: Personalised care conversations**) and;
- that is signed by the Service User or their representative.

The Provider will leave a copy of the Care Plan with the Service User unless there are clear and recorded reasons not to do so.

The Care Plan will include, but is not limited to, the following:

- Medical content
- Person-centred content
- Carer related content

- Risk Assessment record
- EOLC content
- Contact details
- GP registration
- DNAR status
- Mental capacity information (including POA, DoLS/LPS as applicable)
- Next of Kin

The Care Plan is a living document and should be reviewed as outlined in **Section 6.3: Care Plan review.** The Provider will continuously evaluate the effectiveness and appropriateness of the Care Plan as part of care delivery.

6.3 Care Plan review

The objective of the Care Plan review is to check that the Provider's care delivery continues to meet the Service User's health and wellbeing needs and outcomes. The review should incorporate input from the Service User, Service User's family, and Carers. The Provider will review care delivery in accordance with Service Condition 10.

The Provider will review the Care Plan:

- every six months;
- at the request of the Service User, Carers, family, Commissioner, or Care Worker;
- as Service User changing needs require it; and
- as prompted by an incident or complaint.

The Provider will maintain a record of Care Plan reviews.

Significant Changes to the Care Plan will be confirmed with the Commissioner before implementation.

The Provider's review may prompt the Commissioner to undertake a review of the care package and care needs.

7. Care Activities

7.1 Care activity log

The care activity log details, in English, the delivery of care during each care visit. This record is standardised and includes as a minimum:

- the date and time care was provided;
- the type and frequency of care provided;
- any relevant observations, including evaluation of Care Plan delivery;
- any actions to be taken and the name of the person responsible; and
- the signatures of the Care Workers providing the care.

The Provider will complete the care activity log each occasion that care is delivered. A Provider supervisor or manager will review the care activity log as required.

7.2 Care Worker training log

The Care Worker training log records of all qualifications, training and induction sessions received by Care Workers, including training for DHAs. Records will show the date training was completed, any relevant evidence, and the signature of the trainer confirming that the training was completed satisfactorily. The Provider will complete the Care Worker training log as necessary and share it with the Commissioner as requested.

7.3 Incident log

The Provider will comply with Service Condition 33 and maintain a record of all Patient Safety Incidents (PSIs). The Provider will notify the Commissioner of all PSIs as soon as is reasonably practicable. This notification will include actions taken by the Provider to mitigate further harm. As required, the Provider will create an action plan and share this with the Commissioner.

7.4 Escalation procedures

The Provider will designate a point of contact for communication regarding the Service User's care. The Commissioner will provide a contact email to providers for communication regarding the Service User's care. Both parties will be responsive, and act promptly as required.

In emergencies, the Provider will instigate relevant escalation procedures based on the Risk Assessment and/or relevant procedures. Emergencies may include Service User absence, no access to the Service User's home, fire, burglary, or a safeguarding alert. Escalation procedures may include calling the police or raising a safeguarding alert. The Provider will inform the Commissioner as soon as is reasonably practicable.

8. Service Integration

8.1 Interdependence with other services/providers

The Services are part of wider integrated adult health and social care services. The Provider and Commissioner will work in partnership with GPs, primary healthcare teams, acute providers, ICBs, Local Authorities, community mental health teams, the voluntary and community sector, hospices, and independent providers (this is not an exhaustive list).

8.2 Cooperating with healthcare professionals and other providers

The Provider has a role in supporting the coordination of services involved in the Service User's care. Where the Provider identifies issues in the delivery of wider services, the Provider will raise these with the Commissioner.

The Provider will comply with Regulation 12.2(i) of the 2014 Regulations and Service Condition 4. The Provider may be expected to:

- enable the Service User to access the full range of primary healthcare services via their GP. The Provider will refer the Service User to their GP in a timely manner;
- enable the Service User to access secondary and tertiary care service appointments, including accompaniment appropriate to the level of risk and care need associated with the activity undertaken by the Service User. This could include engaging with liaison teams; and

- alert the appointment provider of any Service User interpretation and communication requirements prior to the appointment.

Where it becomes evident that a Service User may require an Advocate, the Provider will notify the Commissioner. The Provider will inform any Advocate representing a Service User of major changes in the Service User's life.

8.3 Carers

The Commissioner has a duty of care to the Service User's Carers as per the 2014 Act. As part of the Services the Provider will:

- work cooperatively with Carers to deliver care to the Service User;
- meet the support needs of Carers as agreed in the Care Plan; and
- provide Guidance to Carers, including referring Carers to the Local Authority or local carers' organisation, as required.

8.4 Transition between services

Where a Service User is transitioning into the Services from another provider, service, or care setting, the Provider and Commissioner will cooperate to support a safe and timely transition that maintains continuity of care.

The Provider will engage with transition planning processes in advance of care commencement where reasonably requested by the Commissioner.

Where a care package transfers between Providers, the parties will allow reasonable time to support a safe transition including compliance with Schedule 8.

Where the transition involves a Service User moving from children and young people's services to adult services under this Contract, the Provider and the Commissioner will act in line with relevant guidance, including NHS England's guidance on *Supporting young people to transition into adolescent and adult services*[14].

9. Service Standards

9.1 Service User independence and choice

The Provider will:

- support the Service User to make choices and have as much control over their life and independence as possible;
- engage in Shared Decision-Making;
- give the Service User information about health and safety risks so that the Service User can make informed choices;
- assess risks to the Service User's health and safety as per Regulation 12.2(a) of the 2014 Regulations. Risk Assessments will be proportionate and centred around the needs and preferences of the Service User. Risk Assessments will be regularly reviewed; and

[14] NHS England, 2026. Supporting young people to transition into adolescent and adult services. Available at: https://www.england.nhs.uk/long-read/supporting-young-people-to-transition-into-adolescent-and-adult-services/

- do all that is reasonably practicable to mitigate risks as per Regulation 12.2(b) of the 2014 Regulations.

9.2 Right to social life

As far as is reasonable and practical, the Provider will support the Service User to participate in activities of the Service User's choosing, accompanying the Service User as required.

9.3 Visitors

The Service User's relatives and friends can visit without being unnecessarily restricted. The Service User can refuse to see a visitor, and the Provider will support this decision when on site.

The Provider will not permit any persons to enter the Service User's home without the Service User's knowledge and permission, except in cases of emergency.

The Provider will agree visiting guidelines with the Service User, Carers and family upon commencement of care. If appropriate and with the agreement of the Service User, the Provider may maintain a visitor log, recording all visitors to the Service User's home during the delivery of care.

9.4 Medication

The Provider and the Provider's medicines management policies will comply with all relevant legislation and statutory guidance relating to medicines management, including Regulations 9.3(b), 12.2(g) and 13.7(b) of 2014 Regulations and the 2005 Act. The Provider will work in line with NICE Guideline NG67: Managing medicines for adults receiving social care in the community (2017).

9.5 Electronic Call Monitoring (ECM) system

The Provider will have an implemented ECM system. This will be used for reporting purposes and contract monitoring.

Where the ECM system requires access to the Service User's Wi-Fi the Provider will request permission from the Service User. Where permission is not granted the Provider will inform the Commissioner and will find a suitable alternative to allow use of an ECM system.

10. Care Staff

10.1 Care Worker management

The Provider will:

- act in accordance with Regulations 18 and 19 of the 2014 Regulations, and General Condition 5;
- ensure that Care Workers understand their responsibilities and are aware of Fundamental Standards of Care and Good Practice;
- schedule Care Workers' work to provide continuity and fairness in the timing and duration of tasks;
- enable Care Workers to raise concerns, and action those concerns; and

- have a clear, written description of Care Worker roles and decision-making ability regarding the care of a Service User.

10.2 Care Worker rights

There should be suitable facilities within the Service User's home to enable the Care Worker to adequately carry out their duties. This includes:

- a place to safely store their personal belongings;
- a place to sit and take breaks; and
- access to clean toileting facilities for the purpose of infection prevention and control;
- access to kitchen facilities to make drinks, store perishable food, or prepare simple meals for those on longer shifts where a meal break is required.

10.3 Care Worker health and safety

The Provider is responsible for ensuring a safe working environment for Care Workers. As part of the Risk Assessment, the Provider will minimise and mitigate risks. The Provider will enable Care Workers to make informed choices about risks.

In cases where the Service User's home is not smoke-free, the Provider will take steps to minimise Care Workers' exposure to smoke. Additionally, Care Workers may choose not to work in a smoking environment and the Provider will support this decision without penalty.

Where the Service User's home compromises the ability to deliver safe and appropriate care the Provider will report this to the Commissioner.

10.4 Care Worker role restrictions

Care Workers will not:

- take responsibility for the care of the Service User's animals or pets;
- solicit or accept any gratuity, tip, or any form of money taking or reward, collection or charge for the provision of any part of the Services, other than the payment as agreed under the contract;
- accept any monetary gift, or any gift over the value of £25. All gifts will be reported to the Provider for approval. The Provider will report any concerns regarding the acceptance of gifts to the Commissioner;
- become involved with the making of the Service User's will or with soliciting any form of bequest or legacy;
- agree to act as a witness or executor of the Service User's will;
- become involved with any other legal document, except in circumstances pre-agreed with the Commissioner;
- offer or give advice to the Service User with respect to investments or personal financial matters; and
- accept direct or indirect financial or non-financial gain from the Service User, this includes but is not limited to the use of personal store cards.

10.5 Property

Care Workers will respect the fact that the care environment is the Service User's home. Care Workers will be sensitive to that environment and its contents.

Care Workers will not:

- consume the Service User's food or drink without appropriate permission or invitation;
- use the Service User's possessions for personal use e.g. computer or telephone;
- use furniture or possessions in a way that the Service User would not want; and
- take responsibility for looking after any valuables on behalf of the Service User.

Any loss of or damage to the Service User's property should be immediately reported to the Service User. In the event that Care Workers are responsible for damage or loss the Provider will be responsible for compensating the Service User.

The Service User's possessions will only be disposed of with the permission of the Service User.

10.6 Care Worker Wage

The Provider will:

- pay all of its employees and employees of sub-contractors engaged in the Services an hourly wage (or equivalent of an hourly wage) compliant with National Minimum Wage (NMW) and National Living Wage (NLW) requirements as applicable, and strive to pay the Real Living Wage;
- pay Care Workers for the time spent travelling to Service Users (excluding travel from the Care Worker's place of residence);
- record Care Worker travel time to enable accurate payment of travel time
- pay Care Workers for the cost of travel to Service Users (excluding travel from the Care Worker's place of residence);
- pay Care Workers for training; and
- provide the Commissioner with information concerning employee contracts and payments as the Commissioner may reasonably require from time to time. Requests will extend to the employees of sub-contractors. This is to ensure compliance with the conditions noted above.

The Provider will pay Care Workers at least the Minimum Care Worker Pay Rates as determined by the Commissioner and notified to the Provider. The Commissioner may request information from the Provider to ensure compliance with any Minimum Care Worker Pay Rates that are set out.

11. Equipment

11.1 Provider supplied equipment

The Provider will supply infection prevention and control equipment in line with Regulation 12.2(f) of the 2014 Regulations. The Provider will observe the Code of Practice on the Prevention and Control of Infections.

The equipment will be supplied at no additional cost to the Commissioner. The cost of the equipment will be built into the cost of care. This equipment will include the following (of a type that complies with current national guidance):

- single use disposable gloves;
- single use disposable aprons;

- single use disposable long sleeved gowns;
- alcohol hand rub;
- face masks;
- eye protection; and
- paper towels and liquid soap (when appropriate hand washing facilities are not provided in the Service User's home).

The Provider will safely and appropriately dispose of the above items and clinical waste in the Service User's home.

11.2 Commissioner supplied equipment

All required Equipment, except that specified in **Section 11.1: Provider supplied equipment**, will be supplied by or via the Commissioner.

If the Service User requires further Equipment, the Provider must contact the Commissioner to discuss purchasing arrangements prior to supply.

The Provider will check if Equipment needs to be maintained or serviced and will alert the Commissioner or the equipment supplier appointed by the Commissioner as required.

If the Provider has mistreated or adapted Equipment in any way, the Provider will be liable for the replacement cost, cost of repairs and/or any other incurred costs. Mistreatment includes but is not limited to unauthorised removal or use of Equipment for another person.

12. Service Improvement

12.1 Complaints, compliments and feedback

Complaints, compliments, and feedback should be viewed as a means of improving the Services. The Provider will comply with Regulation 16 of the 2014 Regulations and Service Condition 16.

12.2 Complaints procedure

The Provider will have a complaints procedure for complaints from Service Users, Carers, Care Workers and any other parties involved with the Services.

Serious complaints must be reported to the Commissioner as they occur.

The Provider will maintain a complaints log. The complaints log will be completed as necessary and shared with the Commissioner as required. The complaints log will record:

- all relevant details regarding the complaint;
- the actions taken by the Provider to remedy the complaint; and
- evidence of reporting the complaint to the Commissioner, CQC, or any other relevant body, as necessary.

12.3 Feedback

The Provider will maintain clear procedures for collecting and acting on feedback. The Provider will make available to Service Users, and Service Users' families and Carers, clear information on how to provide feedback and how the Provider will respond.

The Provider will actively seek feedback from Service User's, their families and Carers periodically, in line with Service Condition 12. The Provider will also encourage the Service User, the Service User's family and Carers to submit feedback as they wish.

The Provider will keep a record of all feedback collected and the actions taken to incorporate feedback. The Provider will be able to demonstrate how feedback is used to shape the service.

12.4 Digital Records

In line with local and national ambitions to digitise patient records, the Provider may be required to participate in digital programmes and use digital systems to support the delivery of the Services. This may include access to shared care record platforms, clinical systems, or other digital infrastructure.

Where such access is provided, the Provider must comply with applicable national and local information governance requirements. The Commissioner will support the Provider to meet NHS digital requirements as new systems are introduced.

The Commissioner is working to develop a digital platform to host and update PCSPs. The Provider will be expected to adopt this platform once the system is ready and will be provided onboarding guidance and training to ensure the maintenance of high-quality personalised care documentation.

The Commissioner will engage with the Provider ahead of any rollout to facilitate effective implementation and ensure appropriate support is in place.

13. Changes to Scheduled Care

13.1 Additional Care

The Provider will agree additional care in advance with the Commissioner.

If the Provider assesses that additional care is required, due to an emergency, an exceptional circumstance, or a sudden and significant change in the Service User's condition, and there is insufficient time for advanced agreement, the Commissioner can retrospectively agree the additional care.

The Provider may be asked to provide evidence of the emergency, exceptional circumstance, or change in the Service User's condition to allow the Commissioner to retrospectively agree the additional care.

The Provider will notify the Commissioner about the delivery of additional care that has not been agreed in advance as soon as possible.

13.2 Interruption to care – Provider default

The Provider is responsible for informing the Commissioner when care has not been delivered and will provide an explanation. This may lead to formal action on the part of the Commissioner.

The Commissioner will not be liable for the cost of planned care that was not delivered due to Provider fault. The Provider is responsible for accurate invoicing.

13.3 Interruption to care – no Provider default

The Provider is responsible for informing the Commissioner when care has not been delivered. Where the Provider receives more than 24 hours' notice no payment will be made for interruptions to care for reasons outside the Provider's control. In these instances, the Provider will inform the Commissioner and adjust the care invoice accordingly.

Additionally, no payment will be made if the Provider could reasonably have known that care would not take place (e.g. following Service User hospitalisation or death).

Where an interruption to planned care is beyond the control of the Provider, and the Provider has not received 24 hours' notice, the Commissioner will pay the cost of care for that day, but not for subsequent days. The Provider is responsible for accurate invoicing.

13.4 Refusal of care

The Service User may refuse care or participate in activities that prevent the delivery of care if they have the mental capacity to do so. The Provider will respect the Service User's right to make these decisions. The Provider will act in accordance with the 2005 Act.

Where care is refused by the Service User, **Section 13.3: Interruption to care – no Provider default** will apply.

13.5 Hospital admissions

On admission to hospital, the Service User's care is the responsibility of the hospital, and the Provider will comply with hospital procedures.

The Provider will:

- accompany the Service User up until the point of admission; and
- share any relevant DNACPRs/ADRTs.
- contact the Service User's family or Carers as soon as possible;
- inform the Commissioner by the next working day; and
- inform the Service User's GP as soon as possible.

The Provider will cease to provide the Services to the Service User during the Service User's hospital stay. Unless otherwise agreed with the Commissioner **Section 13.3: Interruption to Care – no Provider default** will apply when a Service User is admitted to hospital.

13.6 Hospital discharge

At the invitation of the Commissioner, the Provider will review the Service User's needs to ensure the Service User's care needs can still be met by the Provider, prior to the Service User's discharge from hospital.

If the Provider can continue to meet the Service User's needs, the Provider will agree any necessary revisions to the Care Plan with the Commissioner. The Provider will, as far as is practical and reasonable, maintain continuity of Care Workers.

In circumstances where the Provider can no longer meet the needs of the Service User, the Provider will notify the Commissioner as soon as possible explaining the rationale for no longer being able to care for the Service User.

If the Provider does not receive adequate and timely information during the discharge process, the Provider should inform the Commissioner who will work to support better information sharing.

14. Care Package Termination

The Service User will be discharged from care in accordance with Regulation 12.2(i) of the 2014 Regulations and Service Condition 11.

The Service User will not be discharged from care without prior approval from the Commissioner, which will not be unreasonably withheld. In most circumstances the Provider will be required to provide a minimum of 28 days written notice before withdrawing from a package of care. The notice period may be extended or reduced if mutually agreed by the Commissioner and the Provider.

All reasonable efforts will be made to prevent termination of the care package. The Provider will work with the Commissioner to take steps to resolve issues as and when they arise. Termination of the care package will only occur if all other demonstrable efforts to resolve issues have been unsuccessful.

If, despite all reasonable endeavours to resolve issues, the Provider cannot meet the Service User's needs, then the Provider and Commissioner will work to discharge the Service User to a service that can meet their needs.

The Commissioner will issue the Provider with 28 days written notice for termination of a standard CHC care package and 14 days written notice for termination of a Fast-Track care package.

Where the Service User is transferred to a new provider, the Provider will produce and share a Care Transfer Plan.

15. Service User Death

15.1 General

The Provider will follow Good Practice and Guidance on End of Life Care as per Service Condition 34.

When the Provider is notified of the death of the Service User, the notification will serve as effective notice of discharge from care.

Where Care Workers attend the Service User's home and the Service User has died or dies during the visit, the Commissioner will pay for the scheduled visit and **Section 15.2: Unexpected death of a Service User, Section 15.3: Expected death of a Service User, and Section 13.3: Interruption to care – no Provider default** will apply.

Live-in care packages will be terminated 24 hours after the death of the Service User. The Commissioner will pay for the 24 hours of care following Service User death for live-in care packages.

15.2 Unexpected death of a Service User

In the event of the unexpected death of the Service User, the Provider will immediately contact the Service User's GP for advice and will follow their reasonable instructions.

Where the Provider considers the circumstances of the death to be suspicious, the Provider will contact the Police and will not disturb the body or its environment.

15.3 Expected death of a Service User

Where the death of the Service User is expected, the Provider will attend to any immediate practical and emotional needs of any family or Carers present. This includes:

- Notification of the Service User's GP for the purposes of verifying the death; and
- Compassionate support of the family or Carers.

15.4 Notification of death

Following the death of the Service User, the Provider will notify the Commissioner by email by the next working day. The notification will record the day of death.

Where the Service User has made a documented request for the Provider to notify a family, Carer or friend who was not present when the Service User died the Provider will comply with this request.

15.5 Support of Care Workers

The Provider will make support services available to Care Workers emotionally affected by the death of the Service User.

SCHEDULE 2 – THE SERVICES

Ai. Service Specifications – Enhanced Health in Care Homes

Not Applicable

SCHEDULE 2 – THE SERVICES

B. Indicative Activity Plan

Not Applicable

G. Other Local Agreements, Policies and Procedures

Documents relied on

The tender Offer Documentation for the procurement of this contract.

Financial standing

As part of on-going contract management, including qualification for contract re-award, the Commissioner may review the Provider's Financial Report through the Supplier Registration Service (SRS), as detailed in Schedule 6A.

The Provider shall co-operate with all reasonable requests for information or confirmation as necessary to complete financial standing reviews.

Registration with the Supplier Registration Service and consent for the Commissioning Authorities to view the Provider's SRS Financial Report are requirements for qualification for the contract.

Any material changes in financial standing identified from financial standing reviews will be raised with the Provider for discussion and agreement on applicable next steps.

Use of VAT grouping

The Provider must comply with HMRC Revenue & Customs Brief 2 (2025): Use of VAT grouping within the care industry[15] (and any successor guidance).

The Commissioners will not enter into or renew contracts, or agree novations, where invoicing for the Services is carried out by an unregulated entity within a VAT group while

[15] HMRC, 2025. *Use of VAT grouping within the care industry*. Available at: https://www.gov.uk/government/publications/revenue-and-customs-brief-2-2025-the-use-of-vat-grouping-within-the-care-industry/use-of-vat-grouping-within-the-care-industry

the regulated provider continues to deliver the care. Any change to invoicing arrangements requires the Commissioners' prior written consent.

The Provider must promptly notify the Commissioners of any proposed or actual changes to its VAT registration status, VAT grouping, or invoicing entity and, on request, provide evidence of relevant HMRC correspondence.

J. Transfer of and Discharge from Care Protocols

Discharge from Care

As per Schedule 2A Section 14: Care Package Termination and local Commissioner agreements.

Transition arrangements

All parties agree that all applicable services delivered after the Service Commencement Date are delivered under the terms of the NHS Surrey and Sussex Integrated Care Board Personalised Home Care AQP contract.

K. Safeguarding Policies and Mental Capacity Act Policies

1. Safeguarding, mental capacity and Prevent

The Provider will comply with:

- Regulation 13 of the 2014 Regulations;
- Service Condition 32;
- 2005 Act Code of Practice[16]; and
- the Local Safeguarding Adults Board as per the 2014 Act[17].

All safeguarding issues will be reported to Commissioners, in addition to the statutory requirement to report all safeguarding issues to CQC and the relevant Local Authority.

Where the Service User lacks mental capacity and has an Appointed Person, the Service User's decisions and choices will involve the Appointed Person. References to Service User decisions and choices in the Contract will be taken to include Appointed Persons as appropriate.

Service Users may not be deprived of their liberty without valid legal authorisation as per Regulation 13.5 of the 2014 Regulations.

[16] *Mental Capacity Act Code of Practice*. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

[17] For Local Safeguarding Adults Board guidance see: Department of Health, 2014. *Care and Support Statutory Guidance: Issued under the Care Act 2014 June*. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2. Safeguarding Policies:

For Local Safeguarding Adults Board guidance see: Department of Health & Social Care, 2025. Care and Support Statutory Guidance. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

See also Social Care Institute for Excellence (SCIE) Prevention in adult safeguarding: Policies and procedures. Available at: https://www.scie.org.uk/safeguarding/adults/

3. MCA Policies:

UK Government, 2020. Mental Capacity Act Code of Practice. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice.

SCHEDULE 3 – PAYMENT

B. Locally Agreed Adjustments to NHS Payment Scheme Unit Prices

Not Applicable

C. Local Prices

1. Standard Rates

The Standard Rates paid by the Commissioner are detailed in Table 1. The Commissioner will pay the Provider the Standard Rates from the Service Commencement Date until the date that Services cease. The Standard Rates include all costs and expenses including travel and training. No additional payments will be made.

The Standard Rates will apply to CHC Service Users that hold a notional personal health budget with the Commissioners.

Table 1: Standard Rates

	Care Tier 1	Care Tier 2	Care Tier 3	Registered Nursing
Daytime (£/hr)	25.59	26.81	30.22	55.94
Waking night (£/hr)	25.09	26.61	29.15	56.83
Sleeping night (£/hr)	23.65	25.22	26.72	46.05
Live-in (£/wk)	1505	1576	1725	3199

Bank holiday enhancements

Bank holiday rates will be paid at 2 times the corresponding hourly weekday rate or for Live-in 2 times 1/7th of the weekly rate. Bank holiday enhancements will be paid on the following days: Christmas Day, Boxing Day, New Year's Day, Good Friday, Easter Monday, Early May bank holiday, Spring bank holiday, and Summer bank holiday. Bank holiday rates will apply from 00:01 to 23:59 on the designated day only and are not payable on adjacent days.

Definitions

- Waking night: A package of at least 6 consecutive hours of care between 8pm and 8am where the Care Worker is awake throughout the night to provide care.

- Sleeping night: A package of at least 6 consecutive hours of care between 8pm and 8am where the Care Worker sleeps at the Service User's home and responds as necessary to care needs. If the Care Worker has to get up three times or more to provide care during the night, then it will be considered a waking night.

- Live-in: A Care Worker lives in the Service User's home to deliver care as required and is undertaking Unmeasured Work. Contract Rates and minimum Care Worker pay rates have been calculated assuming a maximum of 10 hours work each day, which should be reflected in a Daily Average Agreement. The Care Worker is provided with a private bedroom. The Care Worker has a daily 2-hour break during which time they are not required to be present or deliver care. Where another Care Worker is required to cover this break the Commissioner will pay up to 2 hours of break cover per day at the applicable Contract Rate. The requirement for paid break cover will be agreed between the Commissioner and the Provider. The Commissioner may request evidence of the requirement for paid break cover.

- 24-hour care: 24-hour care is comprised of 12 hours of daytime care and 12 hours of waking night care.

2. Minimum care time slot

The minimum time slot for care is 30 minutes. 30-minute time slots are appropriate for a specific single activity e.g. checking if medication has been taken. 30-minute time slots are not suitable where multiple interventions are required or where Service Users need support with intimate care needs.

Visits will be paid at pro-rata the Standard Rate. E.g. for 30-minute visits, Providers will be paid 50% of the relevant hourly rate. Above the minimum time slot, Providers will be paid based on 15-minute increments. For example, a visit of one and a quarter hours will be paid at 125% the hourly rate.

3. Annual Review mechanism

The minimum time slot for care is 30 minutes. The Standard Rates will be reviewed annually. The review will take place in advance of 1 April each year. The Provider will participate in this process and submit information to inform the price review as per Schedule 6A Local Requirements Reported Locally.

SCHEDULE 3 – PAYMENT

D. Expected Annual Contract Values

The Contract does not guarantee any volume of activity or payment to the Provider.

SCHEDULE 4 – LOCAL AND LOCALLY-AGREED QUALITY REQUIREMENTS

A. Local Quality Requirements

1. Context

The Commissioner recognises that the Provider's quality oversight processes are complex with the NHS, Local Authorities and CQC all having quality monitoring and reviewing responsibilities.

Schedule 4 of the Particulars outlines the quality management information required from the Provider by the Commissioner. Commissioners will work with Providers, Local Authorities and CQC to coordinate the review process and reduce duplication.

2. Provider reported Quality Requirements

The Commissioner will request quality management information from the Provider for all Service Users. The quality management information is detailed in Table 1.

Table 1: Provider reported Quality Requirements.

Ref	Reported information	Reporting method	Frequency	Evidence of:
2015-16 NHS Outcome Domain 1	Number of Service Users that died.	CarePulse[18]	Monthly	Reducing premature deaths and mortality.
2015-16 NHS Outcome Domain 2 / 4	Number of formal Provider Care Plan reviews that have taken place.	CarePulse	Monthly	Person-centred care.
2015-16 NHS Outcome Domain 2 / 3	The number of emergency hospital attendances and admissions.	CarePulse	Monthly	Effective management of Service Users' conditions.
2015-16 NHS Outcome Domain 4	Number of complaints made by Service Users, Carers, family or Advocates.	CarePulse	Monthly	Continuous quality improvement.

[18] CarePulse is a web-based reporting system available from CarePulse.co.uk. CarePulse does not support Internet Explorer.

2015-16 NHS Outcome Domain 4	Number of compliments made by Service Users, Carers, family or Advocates.	CarePulse	Monthly	Continuous quality improvement.
2015-16 NHS Outcome Domain 4	Number of Service Users with annual health checks by a healthcare professional, as defined by the CQC.	CarePulse	Monthly	Wider services are working together for Service User.
2015-16 NHS Outcome Domain 4	Number of Service Users with six-monthly medication reviews by a healthcare professional, as defined by the CQC.	CarePulse	Monthly	Wider services are working together for Service User.
2015-16 NHS Outcome Domain 4	Numbers of agency and permanent Care Workers.	CarePulse	Monthly	Continuity of Care Workers.
2015-16 NHS Outcome Domain 4	Number of Service Users with existing care packages that had new Care Workers during the assessment period.	CarePulse	Monthly	Continuity of Care Workers.
2015-16 NHS Outcome Domain 4	Number of Care Workers that ceased employment during the assessment period	CarePulse	Monthly	Continuity of Care Workers.
2015-16 NHS Outcome Domain 4	Total number of missed calls.	CarePulse	Monthly	Minimal disruption to planned care.
2015-16 NHS Outcome Domain 4	Total number of late calls >15mins.	CarePulse	Monthly	Minimal disruption to planned care.
2015-16 NHS Outcome Domain 4	Number of ACPs in place.	CarePulse	Monthly	Good Practice EOL care.
2015-16 NHS Outcome Domain 4	Number of Service Users that died in their place of choice as specified in ACP.	CarePulse	Monthly	Good Practice EOL care.
2015-16 NHS Outcome Domain 4 / 5	Numbers of Care Workers trained by grade and courses attended.	CarePulse	Monthly	Care Worker competency.

2015-16 NHS Outcome Domain 5	Incidence of Venous Thromboembolism (VTEs)	CarePulse	Monthly	Service Users are protected from avoidable harm.
2015-16 NHS Outcome Domain 5	The development or change in status of grade 3 or above pressure ulcers after the Services have commenced.	CarePulse	Monthly	Service Users are protected from avoidable harm.
2015-16 NHS Outcome Domain 5	Incidence of Medication Errors.	CarePulse	Monthly	Service Users are protected from avoidable harm.
2015-16 NHS Outcome Domain 5	Incidence of falls and falls resulting in injury or harm.	CarePulse	Monthly	Service Users are protected from avoidable harm.
2015-16 NHS Outcome Domain 5	Number of safeguarding cases reported to Local Authority.	CarePulse	Monthly	Service Users are protected from avoidable harm.
2015-16 NHS Outcome Domain 5	Patient Safety Incidents (PSIs) reported.	CarePulse	Monthly	Service Users are protected from avoidable harm.

In accordance with Service Condition 28, the Commissioner may also request additional quality management information on a six-monthly basis.

The quality management information does not have associated targets or thresholds since such interpretation of the data would be simplistic. For instance, a low number of ACPs in place could indicate that Service Users in the Provider's care do not wish to be offered ACPs.

The Commissioner will use the quality management information to identify areas for further investigation. The Commissioner will discuss these areas with the Provider.

SCHEDULE 4 – LOCAL AND LOCALLY-AGREED QUALITY REQUIREMENTS

B. National Quality Requirements with Locally-agreed Thresholds

National Quality Requirement	Threshold	Guidance on definition	Period over which the Requirement is to be achieved	Service category
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Operating standard of 92% at specialty level (as reported to NHS England)	See RTT Rules Suite and Recording and Reporting FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/	Month	CS, MH
Percentage of Service Users waiting less than 6 weeks from Referral for a diagnostic test (DM01)		See Diagnostics Definitions and Diagnostics FAQs at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/	Month	CS, D

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

		Reporting Period	Format of Report	Timing and Method for delivery of Report
	National Requirements Reported Centrally			
1	As specified in the Schedule of Approved Collections published at: https://digital.nhs.uk/data-and-information/information-standards/governance/latest-activity/nhs-standard-contract-approved-collections where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance
	National Requirements Reported Locally			
1	Activity and Finance Report *(note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider under SC36.12)*	For local agreement, not less than Quarterly	For local agreement	For local agreement
2	Service Quality Performance Report, detailing performance against National Quality Requirements, Local Quality Requirements and the duty of candour	For local agreement, not less than Quarterly	For local agreement	For local agreement
3	Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	For local agreement, not less than annually	For local agreement	For local agreement
4	Summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from investigations into such Incidents, as agreed with the Co-ordinating Commissioner	For local agreement, not less than annually	For local agreement	For local agreement
	Local Requirements Reported Locally			
1	Service User identifier (unique and not patient identifiable)	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Care commencement date	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Care termination date, if applicable	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Reason for care termination, if applicable	Monthly	CarePulse	Online submission 5

		Reporting Period	Format of Report	Timing and Method for delivery of Report
				working days after the end of the month to which it relates.
	Type of care	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Cost of the care package	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Number of hours at each Care Tier	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Details of double-handed interventions	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Number of Fast Track Pathway Service Users	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Total number of new care packages	Monthly	CarePulse	Online submission 5 working days after the end of the month to which it relates.
	Redacted Care Worker payslips, timesheets and other supporting information for Minimum Care Worker Pay Rates audit as per Schedule 2A, Section 10.6	As requested	Email	As requested by Commissioners.
	SRS Financial Report for financial standing review as per Schedule 2G	As requested	Supplier Registration Service (SRS)	As required by the Commissioner and obtained directly from the SRS.
	Data to support annual price review (e.g. staff and non-staff costs, care hours) as per Schedule 3C Section 3	As requested	CarePulse	As requested by the Commissioner.

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

E. Data Processing Services

Not Applicable

Under the contract the Provider is considered a data controller, not a data processor, and as such this schedule is not applicable.

SCHEDULE 7 – PENSIONS

Not Applicable

SCHEDULE 8 – TUPE

1. The Provider must comply and must ensure that any Sub-Contractor will comply with their respective obligations under TUPE and COSOP in relation to any persons who transfer to the employment of the Provider or that Sub-Contractor by operation of TUPE and/or COSOP as a result of this Contract or any Sub-Contract, and that the Provider or the relevant Sub-Contractor (as appropriate) will ensure a smooth transfer of those persons to its employment. The Provider must indemnify and keep indemnified the Commissioners and any previous provider of services equivalent to the Services or any of them before the Service Commencement Date against any Losses in respect of:

   1.1 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any relevant transfer under TUPE and/or COSOP;

   1.2 any claim by any person that any proposed or actual substantial change by the Provider and/or any Sub-Contractor to that person's working conditions or any proposed measures on the part of the Provider and/or any Sub-Contractor are to that person's detriment, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor; and/or

   1.3 any claim by any person in relation to any breach of contract arising from any proposed measures on the part of the Provider and/or any Sub-Contractor, whether that claim arises before or after the date of any relevant transfer under TUPE and/or COSOP to the Provider and/or Sub-Contractor.

2. If the Co-ordinating Commissioner notifies the Provider that any Commissioner intends to conduct a process to select a provider of any Services, the Provider must within 20 Operational Days following written request (unless otherwise agreed in writing) provide the Co-ordinating Commissioner with anonymised details (as set out in Regulation 11(2) of TUPE but excluding the requirement to provide details of employee identity as set out in Regulation 11(2)(a)) of Staff engaged in the provision of the relevant Services who may be subject to TUPE. The Provider must indemnify and keep indemnified the relevant Commissioner and, at the Co-ordinating Commissioner's request, any new provider who provides any services equivalent to the Services or any of them after expiry or termination of this Contract or termination of a Service, against any Losses in respect any inaccuracy in or omission from the information provided under this Schedule.

3. During the 3 months immediately preceding the expiry of this Contract or at any time following a notice of termination of this Contract or of any Service being given, the Provider must not and must procure that its Sub-Contractors do not, without the prior written consent of the Co-ordinating Commissioner (that consent not to be unreasonably withheld or delayed), in relation to any persons engaged in the provision of the Services or the relevant Service:

   3.1 terminate or give notice to terminate the employment of any person engaged in the provision of the Services or the relevant Service (other than for gross misconduct);

   3.2 increase or reduce the total number of people employed or engaged in the provision of the Services or the relevant Service by the Provider and any Sub-Contractor by more than 5% (except in the ordinary course of business);

   3.3 propose, make or promise to make any material change to the remuneration or other terms and conditions of employment of the individuals engaged in the provision of the Services or the relevant Service;

3.4 replace or relocate any persons engaged in the provision of the Services or the relevant Service or reassign any of them to duties unconnected with the Services or the relevant Service; and/or

3.5 assign or redeploy to the Services or the relevant Service any person who was not previously a member of Staff engaged in the provision of the Services or the relevant Service.

4. On termination or expiry of this Contract or of any Service for any reason, the Provider must indemnify and keep indemnified the relevant Commissioners and any new provider who provides any services equivalent to the Services or any of them after that expiry or termination against any Losses in respect of:

4.1 the employment or termination of employment of any person employed or engaged in the delivery of the relevant Services by the Provider and/or any Sub-Contractor before the expiry or termination of this Contract or of any Service which arise from the acts or omissions of the Provider and/or any Sub-Contractor;

4.2 claims brought by any other person employed or engaged by the Provider and/or any Sub-Contractor who is found to or is alleged to transfer to any Commissioner or new provider under TUPE and/or COSOP; and/or

4.3 any failure by the Provider and/or any Sub-Contractor to comply with its obligations under TUPE and/or COSOP in connection with any transfer to any Commissioner or new provider.

5. In this Schedule:

COSOP means the Cabinet Office Statement of Practice *Staff Transfers in the Public Sector* January 2000, available at https://www.gov.uk/government/publications/staff-transfers-in-the-public-sector

TUPE means the Transfer of Undertakings (Protection of Employment) Regulations 2006

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