Department of Health

Public Health Services Contract 2015/16

Guidance on the non-mandatory contract for public health services

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Public Health Services Contract

Guidance on the non-mandatory contract for public health services

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Executive summary

This document provides guidance to support implementation of the public health services contract which can be used by local authorities when commissioning services to deliver their new public health functions from April 2013. It provides an explanation of key contract clauses and offers guidance on completion of the contract.

The public health services contract is non-mandatory – local authorities can choose to use it if they wish to do so. If the contract is used it should be legally binding between the parties.

The contract was first developed in 2013/14 and was last updated by the Department of Health, working closely with local government and public health professionals.

Introduction

We face significant challenges to the public's health. Rising levels of obesity, misuse of drugs and alcohol, high levels of sexually transmitted disease and continuing threats from infectious disease have a heavy cost in health, life expectancy and a large economic burden through costs to the NHS and lost productivity. Improving public health and developing sustainable services will be a key contribution to meeting the challenges to the public finances.

Under section 2B of the NHS Act 2006, inserted by the Health and Social Care Act 2012, upper tier and unitary local authorities have a duty to take appropriate steps to improve the health of their populations. Local authorities are also required to provide specific services or take particular steps set out in the Local Authorities (Public Health Functions and Entry to Premise by Local Healthwatch Representatives) Regulations 2013.

Local authorities ("LAs") are responsible for commissioning services locally, informed by Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) developed by health and wellbeing boards, on which they are represented. They also need to have regard to the Public Health Outcomes Framework which sets out key indicators of public health from the wider determinants of health through to effectiveness in reducing avoidable mortality. In discharging their functions, they are supported by a ring-fenced budget for public health.

From October 2015, LAs will be responsible for commissioning children aged 0-5 public health services. The NHS England has published guidance on public health services for 0-5 year-olds, commissioning responsibilities transferring to local authorities and additional contracting guidance for NHS commissioners. The document can be found at: http://www.england.nhs.uk/wp-content/uploads/2014/12/0-5-trans-guid-temp-let-stg2.pdf

All other guidance on 0-5 transfer commissioning responsibilities is at webpage:
http://www.england.nhs.uk/nhs-standard-contract/14-15/

*Scroll down the page until you come to the heading "***Public health services for 0-5 year-olds – transfer of commissioning responsibilities to local authorities"**

In addition, for existing contracts proposed to be transferred to LAs from October, the NHS England has produced non-mandatory model deeds of novation, a three-way contract that extinguishes one contract and replaces it with another. NHS England will need to execute the deeds by attaching the NHS England seal, for this reason copies are not available publicly; contact your NHS England Area Team. These must be used carefully as situations will vary locally.

To continue to support local authorities with their public health functions, the Department has worked closely with local government and public health professionals to provide a public health services contract

The public health services contract ("the contract") is for local authority commissioners to use if they choose to do so – it is not a requirement.

However, the contract provides a robust framework to hold providers to account for the delivery of high quality public health funded services to achieve improved health outcomes**.** Use of the public health services contract, which reflects safe clinical practice and processes, offers local authorities (and providers) considerable cost savings as they will not need to develop bespoke contracts or adopt various contract management mechanisms.

This guidance document is not legally binding but is intended to support commissioners in implementing the contract and should not be viewed as an interpretation of the contract. In the event of conflict between this guidance document and the contract, the terms of the contact will prevail.

Appropriate legal advice should be sought as needed.

Public Health Services Contract

This public health services contract is a non-mandatory contract that local authorities, as commissioners, can use for commissioning public health services.

Background to the Public Health Services Contract

The decision to develop a public health services contract arose from responses to the consultation *Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health*[1]. In the Consultation, the Department set out its expectation that local authorities will wish to commission, rather than directly provide, the majority of services by using a plurality of providers for health and wellbeing services. This will present opportunities to engage local communities and sectors such as Voluntary, Community and Social Enterprise (VCSE) sector, more widely in the provision of public health, and deliver best value and best outcomes. The consultation sought views on how greater engagement of the VCSE sector could be achieved.

Respondents were generally positive about widening the range of providers and recognised the benefits it would bring to public health services. Concerns were raised, however, that a barrier to providers, particularly the VCSE sector, might be as a result of the great range of different approaches and processes to commissioning.

Common commissioning tools such as commissioning templates and contracts could help mitigate high administrative costs, not only to commissioners but also providers, and reduce

[1] *Health Lives Healthy People: a consultation on the funding on the and commissioning routes for public health*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123114.pdf

barriers to providers seeking to work across local authorities. Respondents recommended that tools such as a template form of contract for use by local authorities, should be developed.

How the Public Health Services Contract was developed

In order to develop the contract the Department established an Advisory Group comprising local government representatives, public health professionals, commissioners and providers from different sectors and of different sizes and representatives from the VCSE sector. The purpose of the Advisory Group was to help inform the development of a public health contract by providing procurement, contractual and clinical expertise and by providing comment on draft contract clauses, as necessary.

The members of the Department's Public Health Contract Advisory Group have been instrumental in developing the contract.

Scope

The contract has been developed for local authorities to use when commissioning services to satisfy their public health functions, whether under section 2B or not. These can include, but are not limited to

- National Child Measurement Programme
- Health Check assessments
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)

- Interventions to tackle obesity such as community lifestyle and weight management services
- initiatives on nutrition
- Initiatives to Increase levels of physical activity in the local population
- initiatives on workplace health

The contract can be used when commissioning services from a wide range of providers including providers from the independent sector, VCSEs, general practitioners and community pharmacies.

Annual Review

To ensure the contract is beneficial to commissioners and up to date, an annual review and refresh takes place.

This year due to the transfer of children aged 0-5 PH services to LAs from October 2015, we have rolled over the standard contract. The focus has been on getting the 0-5 contracting right for LAs. We will discuss with our partners whether a new contract template will be needed in 2016/17 to support commissioning of all ages public health services.

Procurement Regulations

Each Local Authority shall ensure that they comply with current procurement regulations.

How to use the Contract

The public health services contract has three sections, Sections A, B and C

Section A contains the Particulars and sets out the Parties to the contract and key dates.

Section B contains the General Terms and Conditions, including the Appendices:

A	Service Specifications
B	Conditions Precedent
C	Quality Outcomes Indicators
D	Service User, Carer and Staff Surveys
E	Charges
F	Safeguarding Policies
G	Incidents Requiring Reporting Procedure
H	Information Provision
I	Transfer of and Discharge from Care Protocols
J	Service Quality Performance Report
K	Details of Review Meetings
L	Agreed Variations
M	Dispute Resolution
N	Succession Plan
O	Definitions and Interpretation

Section B therefore identifies the standard commercial position of the parties to the contract. Unless Section B is varied by Section C, then this standard commercial position shall apply to the provision of the commissioned services.

Section C should set out any Special Terms and Conditions required locally. The content of Section C will be for local determination. We have included example additional clauses in the Annex to this Guidance. Where appropriate, any or all of these clauses can be copied and pasted into section C of the contract. Any locally agreed clauses may also be inserted into Section C of the contract.

The public health services contract is not mandatory. It has been developed to provide a consistent, standard commercial position across services and local authorities. However, it can reflect local agreements and allows for great flexibility through the use of Section C.

Section C can be used to record additional clauses, to disapply or vary the standard commercial position in section B or to incorporate other matters that have been locally agreed and therefore not dealt with in Section B. Clauses in section C will where used prevail over any other clauses in the contract.

For this reason we would recommend that parties use the public health services contract as a single document rather than attempt to pick and choose clauses from the contract. Any locally preferred processes or clauses can be included in section C. Also, by using the contract as a single document, confusion as to where clauses should be inserted or deleting the wrong clauses, which may undermine the legal enforceability of the contract, are reduced.

The duration of the contract is for local determination. However, for reasons of service delivery, cost effectiveness and efficiency, we would expect the majority of contracts to be around three years in duration. We have included a suggested clause for extending the duration of the contract which can be used as an additional clause in Section C.

In using the contract, commissioners are expected to maintain a mature and regular dialogue with providers and act in an open and transparent manner. The contract requires that the parties act in good faith towards each other.

There are parts of the contract that may not be relevant or which are not applicable to the provider or commissioner. Where this is the case, “legal convention” is that these sections are “read over” (do not apply where they cannot apply).

The updated versions of the precedent contract contain drafting notes and alternative/optional clauses in blue. Therefore before the contract is prepared for signature the notes and any unwanted clauses should be removed.

Colour coding

We have highlighted some sections in the contract as follows

Red – need to be completed

Amber - these are default time periods and may be replaced with alternative locally agreed periods

Green – optional

Red – need to be completed

Section A

Date of Contract

Parties

A3.2, A3.3

A4.1, A4.2

A5.3

Execution

Section B

B18.1

Appendix D

Appendix E

Amber – default time periods and may be replaced with alternative locally agreed periods

Section A

A5.2

Section B

B2.2

B7.2, B7.9

B8.6, B8.7

B10.2

B11.2

B19.2

B22.3

B24.3

B29.6, B29.7, B29.8, B29.13, B29.19, B29.20, B29.21, B29.23, B29.25

B32.1, B32.3, B32.4

B34.2

B38.2

B40.3

Appendix M 1.1, 2.1, 3.1, 3.4, 3.5, 3.6, 3.9

Green – optional

Section A

Background (C) Execution

Section B

Appendix A, B, F, G, H, I, J, K, L, M, N

Section C

Services

Service Specification

Commissioners and providers should agree the service specifications for all services commissioned through the contract.

Appendix A contains a template which can be used to populate the service specifications. The level of detail should be agreed locally and be proportionate to the value of the contract and the size of the service being commissioned.

The template for the service specification follows the template in the NHS Standard Contract although none of the headings are mandatory and commissioners do not have to follow the format or headings. However, the template can act as a useful prompt for commissioners and providers with the aim of providing clarity on the overall expectations.

Box 1 on Population Needs can be used to articulate the national and local needs and evidence base for commissioning the services. It can be based on

- Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)
- the relevant outcomes and indicators in the Public Health Outcomes Framework

Box 2 on Key Service Outcomes is intended to provide an overview of the headline outcomes relating to the service. Any indicators that relate to performance of the contract should be set out in Appendix C, Quality Outcome Indicators. It is not always possible to commission change in the high level outcomes set out in the Public Health Outcomes Framework. However, commissioning can aim for multiple outputs which cumulatively will support the high level outcomes in the Public Health Outcomes Framework.

Box 3 on Scope will set out the key information relating to the services including: Objectives for the service

- What the service is
- How it links to other services

The population base to be covered should also be included under this heading. The duty to improve the health of people in their area is not restricted to the resident population. In designing services, local authorities will need to consider the extent of their duty and whether any eligibility criteria can be objectively justified.

Local authorities should also consider all prescribing costs associated with the commissioned service. All prescribing costs for public health services are included in the public health grant allocations given to local authorities. Local authorities are liable for any associated public health prescribing costs for services they have commissioned from GP's, for example the supply of public health medicine or devices for treatment of STI or smoking cessation.

Box 4 on Applicable Service Standards can be used to list any national and local standards such as guidance from the National Institute for Health and Clinical Excellence (NICE) or the Royal Colleges.

Providing the Service

In general, Providers must provide the Services to Service Users in line with the agreed Service Specification. However, Clause B2 sets out circumstances in which a Provider can withhold or discontinue providing a service to a Service User. These include, but are not limited to, circumstances where the Service User displays abusive, violent or threatening behaviour. Where the Provider withholds or discontinues a service, Clause B2.2 sets out the actions they must take in relation to informing the Service User and the Authority.

In accordance with clause B16, the parties should use Appendix I to set out any necessary protocols relating to the Transfer and Discharge of Care of Service Users. Appendix I is entirely optional and may not be relevant for the majority of public health services. However, clause 16 and Appendix I act as a prompt for parties to consider whether any protocol is necessary or desirable for the service being provided.

Quality

The need for services users to access appropriate high quality and safe services should be paramount when commissioning public health services.

Local authorities should assure themselves that the services they commission meet appropriate levels of safety, quality and effectiveness and should take relevant action if they do not. Commissioners should also promote innovate practice that leads to improved quality and safety.

Developing and measuring quality

The NHS definition of quality set out in the report by Lord Darzi *"High Quality Care for all"*[2] determined that the domains of quality are clinical effectiveness, patient experience and patient safety. These concepts translate to public health services when commissioned by local authorities as clinical effectiveness, user experience and user safety. The contract has provisions covering these domains.

In accordance with clause B3, providers are required to comply with any registration and any requirements of regulatory bodies such as the Care Quality Commission (CQC). Only providers of regulated activities, set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009[3], are required to register with CQC. The contract also includes the requirement to comply with the recommendations in NICE guidance. Apart from the obligation to comply with funding recommendations set out in NICE Technical Appraisals, local authorities are not under a statutory duty to have regard to NICE guidance. However, this requirement has been included in the contract as a matter of good clinical practice. There is also scope to set out any other appropriate guidance in the Service Specification in Appendix A.

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[3] http://www.legislation.gov.uk/ukdsi/2009/9780111487006/contents

Under clause B3.1(g), providers are also required to comply with the Quality Outcomes Indicators which should be agreed in Appendix C. For the public health services contract there are no nationally mandated requirements, Nationally Specified Events or Never Events which need to be recorded in Appendix C. The quality outcomes indicators therefore need to be agreed locally. The quality outcomes should be an understanding of what is expected to be achieved and the quality outcomes indicators are the means of ascertaining whether these quality outcomes are being met. The rationale for choosing the quality outcomes indicators should be explicit. Parties will also need to consider the data collections requirements in establishing the quality outcomes indicators. They should also agree consequences for the breach of each quality outcome indicator and set this out in Appendix C.

The service specifications may also be used to set out clinical governance processes and requirements relating to clinical effectiveness, user experience and user safety of that particular service. Although the Authorities should not place themselves in a position whereby they will be signing off those policies as this should be the responsibility of the provider.

Monitoring performance against quality

Under clause B18, a Service Quality Performance Report must be delivered for each time period set out in the contract, e.g. monthly, quarterly or each 6 month period. The report should be completed based on performance being monitored against any factors in Appendix J. These factors should, at a minimum, include a review of performance against the Quality Outcome Indicators but can include other factors, such as reports on the number of complaints, or whether any service user experienced an injury. Appendix J of the contract should also be used to set out the form and manner of the report.

The contract provides that the Service Quality Performance Reports should be reviewed, discussed and monitored at Review Meetings to be held at intervals set out in Appendix K. However, either party can require a Review Meeting to be held in emergencies or where a circumstance requires immediate resolution or where, as part of contract management, a Joint Investigation Report requires consideration sooner than the next scheduled Review Meeting.

Incidents requiring reporting

For providers of regulated activities that need to be registered with CQC, the Care Quality Commission (Registration) Regulations 2009[4] sets out requirements that the details of certain incidents, events and changes must be notified to CQC. These are

- incidents which affect a service user e.g. serious injuries, or
- events involving the service in a way that could affect all service users, e.g. events that may stop the service from operating safely and properly.

CQC registered providers should comply with any guidance published by CQC for reporting incidents. Where the provider is not required to be registered with CQC, it is expected that commissioners will develop local procedures for reporting incidents which may be set out in Appendix G.

The parties should agree the arrangements for reporting, investigating, implementing and sharing the Lessons Learned and these arrangements should be set out in Appendix G to the contract.

Service User Experience

One important aspect of measuring quality is by the experience of the service user. Service user involvement is about making sure the views of the people using the services have the opportunity to be heard in order to make real, sustainable changes.

Service User Involvement arrangements are set out under clause B4. The basic principle is that providers should communicate with their service users in a clear and open manner. The contract requires the provider to carry out Service User surveys. Appendix D can be used to set out the form, frequency and method of reporting these surveys. In order for the user experience to have an impact on the quality of the service provided, the contract requires the Provider to identify actions to be taken as a result of the surveys and implement those actions. The

[4] http://www.legislation.gov.uk/uksi/2009/3112/contents/made

commissioner can also require the Provider to publish the outcomes and actions from the surveys.

Complaints

The Provider must comply with the relevant complaints regulations. The relevant regulations for public health services are set out in the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012[5]. Under Part 5 of these regulations, a provider will need to appoint a responsible person who is responsible for ensuring compliance with the arrangements under the regulations and a complaints manager to manage the procedures for handling and considering complaints. The complaints manager and responsible person can be the same person.

The provider and commissioner must make information on their complaints procedure available to the public and will be expected to make an annual report on the number and subject matter of the complaints it receives.

[5] http://www.legislation.gov.uk/uksi/2012/3094/contents/made

Payment and Price

Clause B8 sets out the payment arrangements and parties should set out the Charges payable in Appendix E.

The payment arrangement should take into consideration factors such as the size of a provider, or agreements such as the Compact between government and VCSEs, that may require or favour a particular approach to payment.

The payment clauses give flexibility to commissioners to determine locally how they wish to pay for the services they commission and recognises the different types of pricing arrangements that may be used. These include payment methods such as fixed price block contract arrangements or developing local tariffs which could be used to commission on a Payment by Results or payment by activity basis.

Local authorities are not required to use Payment by Results or national tariff for the public health services they commission. However, experience has shown that using tariff mechanisms lead to fair payments, stabilisation of services, and promotion of innovation.

The Department is currently considering how work can continue on the development of a non-mandatory tariff system for all sexual health services (both genitourinary medicine and contraception), which local authorities can use based on work already undertaken by the London Specialised Commissioning Group.

Clause B8.3 sets out an invoicing mechanism for payment. Rather than attempt to incorporate a clause which would be flexible enough to be adapted to the different payment methods used by councils, the contract has taken a basic payment mechanism of paying on invoice since this should be a necessary process in the majority of cases for accounting purposes. Where a council uses a different method for payment they should use Section C to insert their standard payment mechanism clauses.

Clause B8.3 sets out that payments can be made in advance where the provider is a voluntary organisation. The parties should consider whether this mechanism could be extended to other small organisations to encourage competition and diversity of providers. If this mechanism is extended, it can be recorded in Section C. A drafting note has been added to check that these mechanisms accord with all parties financial requirements.

Under clause B8.5, the provider must not charge the service user for the services it provides. This reflects the statutory position under section 1(3) of the NHS Act 2006[6]. For public health, the relevant charging regulations are the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013[7], which came into force on 1 April 2013[8]. Where the service being commissioned is one where the provider is permitted to charge the service user, the contract should specifically cover this in Section C.

Clause B9 covers the Authority's Best Value duty under section 3 of the Local Government Act 1999, as amended[9]. Although the provider is required to participate in Best Value reviews or benchmarking exercises, the parties should ensure that any requirements placed on the provider are reasonable given the size and resources of the provider. This clause does not preclude the commissioner from being involved in securing improvements from its perspective.

Managing Activity

The local authority and the provider should have a shared responsibility for managing the demand on public health services. Activity planning is often influenced by factors such as the type of service, geographical settings (i.e. urban or rural) and the size of contract. These factors contribute to determining the volume and price of the contract and activity planning will therefore vary accordingly. Local authorities should have an awareness of the likely volumes and flows of activity based on the evidence and priorities in the JSNA and JHWS. Clause B6 of

[6] http://www.legislation.gov.uk/ukpga/2006/41

[7] http://www.legislation.gov.uk/ukdsi/2012/9780111531679/data.pdf

[8] Part 3 of the Regulations which deals with charging for local authority functions came into force on 1 April 2013

[9] http://www.legislation.gov.uk/ukpga/1999/27/contents

the contract provides that any activity planning assumptions should be set out in the Service Specifications.

Contract Controls

Default and Contract management

The Contract should enable commissioners and providers to agree the rules and expectations of their agreements and set out the methods of dealing with the consequences of failure.

We would expect that parties would seek to resolve any issues arising on a day to day basis without resorting to the terms of the contract. Commissioners should continue to maintain a mature and regular dialogue with providers in order to resolve any issues. However parties need certainty about the consequences of failure to comply with the terms of the contract.

Clause B28 gives the commissioner a fast route to manage the contract, without going through the contract management procedure set out in clause B29, where there has been a breach of the provisions of the contract, which the commissioner reasonably considers to be a material breach. The commissioner can

- require the provider to prepare a service improvement plan outlining how the breach will be remedied
- suspend the affected service
- terminate the affected service, but without terminating the whole contract.

It is not possible to define what would constitute a material breach in the contract because this would be determined on a case by case basis.

Clause B29 on Contract Management sets out a clear process for identifying and remedying performance problems or breaches of contractual requirements.

Where the parties have agreed a consequence in relation to a Provider failing to meet a Quality Outcomes Indicator set out in Appendix C, then the Authority can exercise that consequence immediately without undergoing the contract management process outlined below.

The contract provides a number of stages to the contract management process which are

- Issue of a contract query notice - where a party has a query about the performance, or non-performance of the other party's obligations under the contract
- Issue of an Excusing Notice – where the party receiving the notice believes the contract query is unfounded. If this party issuing the contract query accepts the explanation they must withdraw the contract query notice
- Meeting to discuss the contract query – where the contract query notice has not been withdrawn.

At the Contract Management Meeting the parties must agree either:

- that the contract query notice is withdrawn, or
- to implement a Remedial Action Plan, or
- to conduct a Joint Investigation

Where the parties agree to conduct a Joint Investigation, they must agree a joint investigation report which should include a recommendation either to:

- close the contract query, or
- agree and implement a Remedial Action Plan

The contract also sets out the consequences for failing to agree or breaching the Remedial Action Plan. Where the Provider breaches a Remedial Action Plan, the Authority may withhold a percentage of the monthly charges for each milestone that is not met but must pay any withheld payment once the breach has been rectified. The Authority may permanently retain withheld sums where the breach is not rectified within the timescales set out in clauses B29.26 or B29.27 as appropriate. Both of these consequences are options that are available to the Authority under the terms of the contract, they are not required to withhold or retain payment.

Suspension and Termination

Clause B31 sets out circumstances for Suspension Events which allow the Authority to suspend any affected Service.

Clause B32 sets out the rights of the parties to terminate the contract.

Either party may voluntarily terminate the contract on service of notice and the contract suggests that 12 months written notice should be given. However, this notice period can be decided locally.

Clause B32 also sets out the circumstances in which the commissioner can terminate the contract with immediate effect by written notice to the provider.

Dispute Resolution

Clause B30 and Appendix M set out a process for dispute resolution. However, the parties can agree an alternative process for dispute resolution where locally required which must be set out in Section C Special Conditions.

The dispute resolution process set out in Appendix M has three stages: negotiation, mediation and then Expert Determination if the Dispute still remains unresolved. The decision of the Expert is final and binding. Appendix M sets out suggested time periods for each stage of the process but these can be amended locally.

Variation

Under clause B22, either party can request a variation to the contract. The contract suggests an initial time period of 30 business days to negotiate the variation, but commissioners can change this if they wish. If the parties fail to agree a proposed variation within the agreed timescales,

the contract will continue as if the variation was not sought. Where a variation is agreed by the parties, it will not be effective unless it is agreed in writing by both parties. The agreed variation should also be recorded in Appendix L.

Information requirements

Good quality information is essential to enable providers and commissioners to monitor their performance against the contract. It is important for the Authority to identify what is really needed as data requirements will impact directly on the provider and reduce the available spend on services. The Authority will therefore have an interest to ensure that data requirements are kept to a reasonable level. The following principles may guide the provision of information and are a useful mechanism to support contract management:

- the provision of information should be used for the overall aim of high quality service user care
- the parties should recognise that some requests for information may require system improvements over a period of time
- requests for information should be proportionate to the balance of resources allocated between clinical care and meeting commissioner requirements
- information provided should be of good quality

Under Clause B14, the information requirements that need to be provided by the Provider should be set out in Appendix H. Appendix H should include the:

- manner, frequency and timescales for provision of information, and
- consequences of failure to comply with Appendix H and clause B14.

However, even where an information requirement is not set out in Appendix H, the Authority may still be able to obtain it, as under the contract it may request any other information it reasonably requires in relation to the contract.

Information requirements should be determined by what is necessary for providing an overview of the key outcomes relating to the service and associated quality outcomes indicators. However, the level of detail contained in the service specifications and the data requirements requested should be proportionate to the service(s) being commissioned.

Service User Health Records

Under clause B13 the provider must create, maintain, store and retain service user health records for all service users. Providers should manage and retain and destroy service user data in accordance with the law and comply with any applicable guidance. Clause B13.2(a) provides that the provider must use health records solely for the purposes of its obligation under the contract and under clause 13.2(b) the provider must give the service user full and accurate information about their treatment. Where appropriate and required by guidance, service user's NHS number should be identified in their service user health records.

All organisations which could have access to patient identifiable data should have a Caldicott Guardian and this is required by clause B13.3 of the contract. The role of the Caldicott Guardian is advisory, providing a focal point for confidentiality and information sharing issues and the management of service user information at Cabinet level.

A drafting note has been added to ensure that dependent on the nature of the contract, any additional information governance and data ownership requirements should be included.

Data Protection

Under the Data Protection Act 1998 (DPA) all providers and commissioners should manage service user identifiable data in accordance with the law and put in place appropriate controls to ensure the accuracy and traceability of any information stored on systems are designed to protect the confidentiality of service user information. This is reflected in clause B37 and the parties to the contract should help each other, as appropriate, to comply with the provisions of the DPA.

Where the provider is acting as a Data Processor on behalf of the Authority, under clause B37.2 the provider shall only process personal data necessary to perform its contractual obligations and in accordance with any instruction given by the Authority, and ensure it has put in place the appropriate technical and organisational measures against unauthorised or unlawful processing

of the data. The provider must also supply the Authority with the information required in respect of harm that may be suffered by a service user whose information has been affected by a breach of the DPA and, under clause B37.2(f), promptly notify the Authority of any breach of the security measures to protect personal information. The provider is obliged under clause B37.2(g) to ensure it is not omitting to do anything knowingly or negligently which places the Authority in breach of the provisions of the DPA.

The provider must supply the Authority under clause B37.2(d) with any information it reasonably requests to satisfy the Authority that it is complying with the DPA.

Under clause B37.3(c) the provider must take steps to ensure its staff are competent to handle personal data and are properly trained in data protection and clause B37.2(e) requires the provider to promptly notify the Authority of any requests to disclose or gain access to personal data.

Standard legal clauses

The public health services contract also covers the standard legal clauses. A brief overview of some of those clauses is included in this chapter.

Entire Contract

We have included the entire contract clause in Section A. It is likely that some of the existing public health contracts, previously operated by Primary Care Trusts, would have transferred to the relevant local authority under a Transfer Scheme. Clause A6 makes it clear that the public health contract constitutes the entire agreement between the parties in relation to the services being commissioned. It however recognises that similar services may have transferred to a local authority by virtue of a Transfer Scheme and therefore accepts that the public health contract will not be the definitive contract in relation to the commissioned services until the services are provided under the public health contract.

Insurance

Clause B27 requires providers to effect and maintain insurance covering the matters set out in the Service Specifications and requires that a copy of the insurance be provided to the Authority, if requested.

In the Annex to this guidance we have provided an alternative clause for insurance which allows the commissioner to set out the levels of cover for the different types of insurance. However commissioners should consider proportionality and the impact on the VCSE sector when deciding what level to set cover.

Limitation of Liability

Clause B26 sets out a standard limitation of liability provision. In the Annex to this Guidance we have set out an alternative clause which allows the parties to set a limit on the provider's total liability to the Authority.

Audit and Inspection

Under clause B24, the provider must allow the Authority and organisations such as CQC and local Healthwatch reasonably to enter its premises for inspecting and observing the facilities and/or the provision of services. The provider must also provide reasonable information relating to the provision of the services. However, the provider can refuse a request for entry where the service or dignity of the service user may be affected.

These provisions also extend to any sub-contractor so the onus would be on the to ensure that any sub-contract contains clauses to this effect.

Assignment and Sub-contracting

Sub-contracting is often a useful mechanism for enabling smaller organisations and VCSEs to deliver public health services.

Clauses 23 allows the provider to assign, transfer or subcontract its rights or obligations under the contract, provided it has the written consent of the commissioner to the appointment of the sub-contractor and the commissioner approves the sub-contracting arrangements.

Where sub-contracts are put in place, the provider remains accountable to the commissioner for the performance of the contract and for the performance of its sub-contractors. The sub-contract should therefore impose obligations on the sub-contractor on the same terms as those imposed on the provider.

The commissioner may assign, novate or otherwise dispose of its rights and obligations under the contract without the consent of the provider.

Staff

Clause B7 sets out the staffing arrangements and contractual obligations on the provider. It requires that the provider's staff are appropriately qualified, trained and experienced and capable of providing the services. It also requires that where applicable staff are registered with appropriate regulatory bodies and receive continuous professional and personal development.

Clause B7.4 sets out the obligations on providers of public health services to co-operate with the Secretary of State for Health's duty to secure an effective system for the planning and delivery of education and training of the health and public health workforce. This duty has been delegated to Health Education England and its local committees Local Education and Training Boards (LETBs) who co-ordinate workforce planning and education and training activity. It is not the intention to place new burdens on providers and HEE will ensure that any requirements placed on providers are proportionate and fair. It is important that all providers of public funded services are represented by LETBs and where required, they are able to participate in the education and training system. Being part of LETB will mean different things for different providers depending on the nature of service they deliver and the level of involvement they are expected to have in education and training activity. As a minimum, it is expected that all providers will support their LETB in understanding the make-up of the existing workforce and in planning the future workforce.

Equalities Duties

Clause B5 sets out the obligations on commissioners and providers in respect of the Equality Act 2010. The obligations apply regardless of whether the provider is a public authority for the purposes of section 149 of the Equality Act 2010.

Safeguarding Children and Vulnerable Adults

Clause B10 asks that providers must adopt safeguarding policies that comply with the Authority's safeguarding policy, and if necessary participate in the development of any local multi-agency plans. The safeguarding policy should be appended at Annex F.

Freedom of Information and Transparency

The Freedom of Information Act 2000[10] (FOIA) created a public right of access to information held by public authorities. Clause B38 reflects the provisions of the FOIA on the contracting parties. The Contract should be published along with any other provisions which are subject to the FOIA. Clause B38.7 asks that information about the monthly expenditure under the contract should be disclosed on the Authority's website, together with the name of the provider.

Publicity

Clause 45 requires that neither the Provider nor its staff make any press announcements in relation to the Contract without the prior written consent of the Authority.

Consent

Service users should be given sufficient information by providers, in a way that they are able to understand, to enable them to make informed decisions about their care. Clause B12 requires Providers to publish, maintain and operate a service user consent policy.

Counter-Fraud and Security Management

[10] http://www.legislation.gov.uk/ukpga/2000/36/contents

Under clause B35 the provider must put in place and maintain appropriate counter fraud and security management arrangements. The provider must notify the commissioner if they suspect fraud has occurred, is occurring or is likely to occur. If the provider, or its staff, commits fraud the commissioner, under clause B35.4 has the right to terminate the contract by written notice with immediate effect.

Business Continuity

Under clause B34 the Provider is required to maintain a business continuity plan and to inform the commissioner as early as possible when that plan is activated.

Co-operation

As well as the requirement for the parties to act in good faith towards each other, clause B20 sets out the provider's obligations to co-operate and liaise appropriately with other parties including third party providers, primary, secondary and social care services. This should ensure a high standard of care and continuity of service for the Service User.

Confidentiality

Clause B36 sets out the rights of the parties in relation to confidential information that they disclose or receive but does not limit the Public Interest Disclosure Act 1998[11] which protects individuals who disclose certain types of information in the public interest (whistle blowing).

Prohibited Acts

[11] http://www.legislation.gov.uk/ukpga/1998/23/contents

Clause B39 sets out which acts make up Prohibited Acts for the purpose of the Contract. Where prohibited acts or offences under the Bribery Act 2010 have been committed, the clause sets out the rights of the non-defaulting party.

Force Majeure

The applicable provisions where a party is, or claims to be affected by an event of Force Majeure are set out in Clause B40. The definition of Force Majeure, in Appendix O, gives some examples of what could, and what would not, constitute an event of Force Majeure.

Equipment

Under clause B15, the Provider needs to ensure it has the appropriate equipment to supply the services.

Further optional standard legal clauses are provided in the Annex. These could be used in Section C of the contract and include provisions on

- Extending the Duration of the Contract
- Limitation of Liability (alternative clause)
- Insurance (alternative clause)
- Contract Binding on Successors
- Data Protection (alternative clause)
- Agency
- Human Rights
- Scrutiny Board
- Health and Safety
- Disclosure and Barring Service
- Branding Policy
- Conflicts of Interest
- Intellectual Property
- Change In Control

- TUPE

We expect local authorities will have their own clauses covering these matters and these clauses are therefore offered in the Annex to this guidance as suggested clauses which could be copied and pasted into Section C if desired.