Invitation to tender

Adult social care model

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Deadline date: 30 April 2021

Attached documents include

- Sample application form
- Sample contract
- PowerPoint annex

1.0 About the Health Foundation

1.1 The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

1.2 Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

1.3 We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

1.4 We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

2.0 The REAL Centre

2.1 The REAL Centre (Research and Economic Analysis for the Long-term) is a new specialist unit within the Health Foundation that will work with a network of external academic partners. It will produce independent projections, research and analysis, strongly rooted in robust quantitative modelling, to help ensure the long-term sustainability of health and social care in the UK. Its aim is to help health and social care leaders and policymakers look beyond the short term to understand the implications of their funding and resourcing decisions over the next 10-15 years. This tender is for a key project to develop the Centre's quantitative modelling of adult social care.

2.2 The REAL Centre will provide rigorous evidence and analysis that looks beyond the short-term, preparing decision-makers to address future challenges. It will seek to understand the future demand for health and social care, the resulting workforce and funding requirements, the potential for productivity improvements, and the impact of innovations in service delivery. It will draw on wider Health Foundation work on service innovations, as well as insights and analysis on the future impact of population risk factors and the wider determinants of health.

2.3 As a key element in achieving this, the REAL Centre will seek to build on previous work conducted by the Health Foundation to develop a sophisticated suite of health and social care demand and supply projection models. These models will seek to incorporate evidence on need, costs, and workforce supply. The work described here is one phase of a multi-phase, multi-disciplinary approach to developing a suite of health and social care supply and demand projection models. This suite of models aims to answer questions about health and social care that cannot be answered by other approaches.

2.4 This tender is to work in partnership with the REAL Centre to develop a model (or models) to project future adult social care demand, workforce supply and output (eg the number of care packages or hours of client facing care a person delivers). Ideally this model (or models) should be able to:

- quantify adult social care demand into the future, over a 10-20 year timeframe, both in terms of the number of people accessing care and the number of care packages required; and
- quantify workforce supply over a similar time frame (in terms of headcount and full-time equivalent staff numbers as well as the number of hours of care available), both under alternative policy scenarios and accounting for changes in the drivers of care demand and workforce supply (eg changes in pay, changes in disease and disability prevalence and so on).
- translate workforce inputs (eg number of care workers) into projected outputs (eg number of care packages).

2.5 We welcome bids from both individual supplier organisations and consortia. Alongside this social care modelling work, we have commissioned work to model the future supply of nurses and future demand for health care.

3.0 Context

Social care services

3.1 Social care services provide care and support to increase independence and promote wellbeing. In practice much of this involves face-to-face care by individuals. For older people this may include help with everyday activities, like washing and dressing. When living independently and safely at home is no longer possible, residential care may be needed. More complex needs require nursing support in a residential setting and at the extremes round-the-clock care. For younger people this can involve help with everyday tasks and also support to live independent lives, eg finding a job and learning to live independently.

Demand for care

3.2 Population ageing means that there could be more older people with complex needs requiring support, while the life expectancy of younger adults needing support, such as those with severe learning difficulties, is increasing. While the broader trend of increasing life expectancy is to be celebrated, this gives rise to questions about how this potential increase in demand for care should be met.

3.3 These trends mean the demand for adult social care services is projected to rise over the next three decades, however the level of increase is uncertain. Currently, CPEC publish the most widely used modelling of social care demand and expenditure. While the resulting projections are useful, they make assumptions about a set of policies being fixed and they model demand drivers following

specific trends. The REAL Centre is commissioning demand modelling as we wish to:

- use the model to explore the impacts of future policy changes or variations in the factors which influence the demand for care and care workforce supply.
- have control over any microdata and the update process and timing for demand modelling, which is not possible when relying on externally funded and produced research.
- publish underlying code and assumptions for the model, so this can be used and varied by any interested stakeholders.

COVID-19 has had a disproportionate impact on the people who work in and rely on social care services. The workforce has suffered higher rates of COVID-19 illness, higher workloads and increased stress. Some social care workers have also been affected financially (for example, if required to self-isolate after having tested positive for COVID-19). Councils have reported sharp increases in demand due to hospital discharges, domestic violence and the loss of support from unpaid carers. People in residential care and those receiving care in their homes have suffered from high mortality rates. This is likely to have implications for both the demand and supply of care, which are currently unclear.

Funding and provision of services

3.4 The funding and provision of social care is different from the NHS. Publicly funded social care currently only covers those with the highest needs and lowest means. The availability of private social care insurance is limited to a very narrow range of products, such as immediate needs annuities. This means that, for older people:

a) Those who would not qualify for means-tested support face uncertainty about their future care costs, with the possibility that these costs may run into several hundreds of thousands of pounds. Households therefore have little ability to plan and face being left uninsured against substantial risks.

b) Uninsured households may receive less care than they need (or the wrong type), or rely more on unpaid care, putting excessive strain on carers.

c) There is an incentive to use free-at-the-point-of-use NHS care and not paid-for social care. As an example, an individual who is medically fit to be discharged from hospital may avoid moving to a more suitable setting and receiving social care support.

3.5 Currently care needs are met in three main ways: through state support, private “self-funded” provision and unpaid care. It is likely that this mix will continue in the future. There are complex interactions between the privatised market, self-funders and local authority purchasers, which we believe are not fully understood.

3.6 Given there are market failures in both care insurance and provision in England, there is a case for reform in the role of the state in social care. Further research is

required to understand the likely challenge growing demand presents to society as a whole, to the public sector finances and public policy.

Importance of the workforce

3.7 Capital investment in terms of care homes and supported housing are vital to the future of providing care. There is also an important place for technology (eg to help keep people safe and enable self-directed care). However, social care relies on people and is relatively labour-intensive. The paid workforce accounts for up to two-thirds of public spending on adult social care[1], The role of unpaid or informal care by families, looking after other family members, is also vital in meeting current and future demand for care. Understanding the future workforce is therefore central to understanding how future care needs will be met.

3.8 In addition, there is widespread acceptance of challenges in the social care workforce, for example, around vacancy and turnover rates, and pay. However, there is limited evidence of the impact of these challenges on service users or the effectiveness, costs, benefits and trade-offs of the policy options to meet additional demand and improve quality of care. Our engagement with policy stakeholders has identified future social care workforce sustainability as a top policy priority.

3.9 Previous modelling shows that close to 140,000 additional full-time equivalent social care staff and an estimated 70,000 additional care home places are needed over the next five years. To reverse these trends and meet these challenges likely solutions may include addressing low pay and zero hours contracts, additional funding and system reform, alongside a national strategy for the workforce. However, the evidence base on what interventions are needed, and what effect they may have, is disparate and relatively weak. While a model of social care will be agnostic about what interventions government should pursue, it will be able to provide insights into the potential impacts of specific policies on care demand and the care workforce.

3.10 The broader policy context provides impetus for coherent and systematic analysis of the social care workforce. This is a fragmented provider market, there is variable integration with the NHS and the workforce has been significantly affected by COVID-19. There are clearly significant overlaps with the NHS; there are roles with similar skill sets (eg health care assistants and care workers) and professions that work across the NHS and adult social care (eg nursing). However, there is no joined up health and social care workforce strategy and terms and conditions vary significantly across sectors. The NHS has clear pay

[1] REAL Centre calculations based on NHS Digital Adult Social Care Activity and Finance Report, eg https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2019-20

and progression set out in the Agenda for Change, which enables the government to act if it wishes to increase pay or change relative pay levels. There is no such pay structure in adult social care.

3.11 Given the range of social care policy challenges that remain unaddressed, the uncertainty and limited evidence in this area, this is a priority project for the REAL Centre.

4.0 Priority questions for modelling

4.1 Based on the contextual information and aims of this work, set out above, the four priority questions the work should address, ideally through quantified modelling, are listed in the table below. Alongside each question are additional points that merit consideration. The extent to which these additional points can be addressed will depend on data availability, resource and time constraints. Bids should clearly identify how the priority questions will be addressed and the extent to which additional points can be addressed (see below for more information on expectations around low, medium and high specification bids).

Priority Question	**Additional Points to consider**
Over the next 10 to 20 years what is the likely total demand for care under a range of different scenarios, levels of need and different groups in society (eg older people and younger adults)?	Examples of alternative scenarios include needs eligibility for state funded care remaining as it is, and access to state funded care being widened. There may also be different demographic assumptions or assumptions about future morbidity. Ideally the modelling would also be able to offer insights into patterns of service delivery that might help meet demand under alternative scenarios (for instance, changes in the mix between residential/ nursing care and home care, and 'live-in care')
What configurations of the care workforce (formal and unpaid/informal, residential/ nursing care and home care) could meet the projected demand for care?	This raises additional questions that it might be interesting to consider, subject to data availability. For instance, how might the productivity and quality of care vary? What are the structural and workforce implications of COVID-19 for the social care provider market, particularly in residential care?
What is the likely gap between current or projected levels of a formal workforce and different scenarios for demand?	Eventually, the model should be able to provide insights into future gaps between care demand and workforce supply under different scenarios. This should be underpinned by a good understanding of the drivers of both care demand and workforce supply. As social care is largely a private market, the demand-supply interactions in care provision are likely to differ from those in the NHS.

Priority Question	Additional Points to consider
How much unpaid or informal care would be needed to fill this gap?	Having projected the extent to which the formal workforce can meet care demand levels in the future, the model should ideally be able to provide estimates of the implied residual of unpaid or informal care (from family and friends or volunteers) that is likely to be needed to meet shortfalls under different scenarios.

4.2 Outputs of any quantitative modelling and assessment of policy options should account for the different segments of the formal and informal social care workforce including:

a) The workforce in residential and nursing homes and domiciliary or home care, ideally for both publicly and privately funded care.

b) The registered and unregistered subsectors of the formal workforce.

c) The workforce catering for younger adults (for instance, those aged 18 to 64) and older people.

d) Regional and local variation in social care labour markets and provider markets.

e) Informal care providers (primarily friends and family) – estimates suggest that as many as 4.5 million people in the UK provided informal care in 2018/19, which makes it important to account for policies which might affect this group.

4.3 The model will also need to include costs, in order to be able to understand the financial impacts of alternative policy options. For example, the model should be able to show the cost and impact on supply of policy options such as increasing care worker pay by a given factor (eg 10%).

4.4 The REAL Centre wishes to use this modelling to analyse what policy levers government could use to meet estimated demand through either the formal or informal workforce (or both), and what their quantitative impact would be. The policy questions of interest are as follows in priority order:

a) What impact would a change in social care pay rates have on labour supply, vacancy and staff turnover rates? Does this vary by sub-sector (eg home care and residential care)? What would the total cost of this policy be for government and private payers?

b) What impact on supply or quality would other workforce policies have, for example professional registration?

c) What would the impact be of policies to grow the size of the unpaid/informal workforce, for example tax breaks or carers allowance?

d) What impact might changes in the post-Brexit migration policy have on the formal workforce supply? For example, reducing the salary threshold for work permits.

e) What would be the impact of different service models (eg residential care, home care) on the costs of meeting demand and workforce required?

4.5 Where possible the development of evidence-based assumptions is preferable, but the modelling work does not need to include definitive answers or a review of evidence in all of these areas. Rather the model needs to include functionality so that these questions can be addressed.

4.6 For example, this would allow the user to vary assumptions about pay growth (possibly by sub-sector) with the model providing outputs on the size and shape of the workforce relative to demand. Alternatively the model could allow the user to vary assumptions about the number of workers being recruited from overseas, providing different estimates of the size and shape of the workforce relative to demand.

4.7 The model will need to be consistent with any relevant assumptions or outputs from our health care demand model and our nursing workforce supply model, being developed separately. The relevant information will be made available to the successful bidder.

5.0 Methods

5.1 There are a range of different approaches to modelling that may be appropriate to model social care workforce supply. This could focus on individuals, rather than cohorts, eg microsimulation modelling, agent-based modelling (which allows interactions between individuals), and types of systems dynamics models. Alternatively, a more aggregated approach may be suitable for social care demand.

5.2 The REAL Centre is agnostic about the techniques used to answer these questions. We recognise the work is very likely to highlight gaps in the data and evidence. A key output of the work will be an assessment of areas for further research and evidence collection. We will be led by the expertise of the supplier as to how to best deliver the objectives of the model and answer the priority questions, however we believe that this work could include:

a) Quantitative modelling of demand for care and the workforce supply (both formal and informal) that may be needed to meet that demand.

b) Analysis of existing survey and administrative data, reviews of the existing literature, primary data collection (eg through surveys) or work with other organisations who hold unpublished data (eg Skills for Care or local authorities).

c) Collection and analysis of qualitative data.

d) Stakeholder engagement to identify key policy questions and develop assumptions to support modelling, in the absence of evidence.

5.3 Key inputs to the work include:

a) Data on labour supply: Skills for Care microdata, the ONS Labour Force Survey (LFS) and the ONS Annual Survey of Hours and Earnings (ASHE).

b) Data on social care needs: Care Policy and Evaluation Centre (CPEC)/ Personal Social Services Research Unit (PSSRU) care demand modelling, the English Longitudinal Study of Ageing (ELSA), the Health Survey for England (HSE), Understanding Society (US), National Child Development Study (NCDS)

c) Rapid Evidence Review on workforce drivers undertaken by School of Health and Related Research (ScHARR) for the REAL Centre (a summary of this is included in the evidence pack which accompanies this document).

d) Findings from research undertaken or being undertaken by the REAL Centre, including: analysis of publicly available Skills for Care data, a review of selected literature, research around low paid staff in the NHS and social care, and research around the social care provider market.

5.4 This is a challenging area, and our expectation is that there will need to be trade-offs in the development of the model and what is deliverable. Applicants should state the types of trade-offs and assumptions that may need to be made in developing the model.

5.5 The social care systems, policies and data sources vary across the UK devolved administrations. It is unlikely that a single set of policies would be appropriate, or have a similar impact, across the whole of the UK. As such, building a single UK model may not make sense. We think the most practical approach is to commission an England only model. Depending on relative priorities this could then be used as a basis to develop in-house (or externally contracted) models for the devolved administrations.

5.6 The supplier will be responsible for designing, developing and testing the model, working in partnership with the REAL Centre. They will also need to transfer the model in-house to the REAL Centre at the end of the contract. We wish to encourage open sourcing of the model in the future to promote openness and transparency. While we are flexible about the software used by the supplier to develop the model, the model would need to be transferred to R when the supplier transfers it to the REAL Centre. The aim is for the model to continue to develop iteratively in future years.

5.7 We will expect the supplier to work closely with key sector and government stakeholders in developing the modelling. The REAL Centre and the Health Foundation will make available its network of stakeholders to enable this. We are happy to discuss this in more detail prior to submission of bids.

5.8 We would also expect the supplier to consider service user, public and staff involvement and engagement within their work. Considering and collaborating with those impacted by the social care system is an important principle for the REAL Centre and we believe makes for more comprehensive and impactful work. Involvement of service users, the public and the care workforce should be considered within the bid.

6.0 Data access

6.1 The nature of this type of modelling is that it is data-intensive. For example, in order to model the social care supply and demand at an individual level, in a way that is consistent with the aims in section 5.0, would require a basis in microdata. Being able to model this successfully will require data on the demand for care across different demographic groups (by age, gender, ethnicity, the level of support required and other variables) and the existing workforce. These will need to be complemented by evidence-based assumptions of how people move through their careers, potentially translated into cohort modelling probabilities of retiring, changing roles, returning to practice, leaving training etc. These assumptions would need to come from data analysis and existing evidence.

6.2 There are existing data sources such as Skills for Care and ONS data, although both the level of detail and accessibility varies. We are looking for the supplier to include details on what data they intend to use that would be appropriate for their chosen approach.

6.3 This is likely to involve storing of sensitive data. We would be looking for any application to make clear any data access requirements as well as their approach to information governance and that they have the correct systems and processes in place to safely store and use the proposed datasets.

7.0 Deliverables and milestones

7.1 We anticipate that the contract will last for up to two years. The exact deliverables will be agreed with the successful provider once appointed. Below we have given an illustrative timeline of how this work could progress over a two year time frame. These dates are open to negotiation depending on the exact method and length of project the successful supplier proposes.

Date	Deliverable
August 2021	Inception meeting with supplier.
November 2021	Initial model protocol/specification delivered to the Health Foundation.
November 2021 - January 2022	Period of peer review and negotiation, including data access.
January 2022	Final protocol agreed.
January 2022 – January 2023	Model development. We will work with the successful supplier to agree appropriate deliverables during this period, dependent on the proposed method and what is appropriate.
January 2023	Working model ready for testing and processing.
January 2023 – May 2023	Period of testing and final development. Work to transfer the model in-house/open source. As above, we will work with the successful supplier to agree specific deliverables and testing criteria.
June 2023	Model transferred to the Health Foundation.

8.0 Outputs

8.1 The following are expected interim outputs of the work:

a) An interim working paper including proposed methods, data sources, key assumptions and evidence to be used in the final model.

b) A stakeholder engagement plan and conceptual framework developed with the support of the REAL Centre who have established links in local and central government, other think-tanks and research organisations.

8.2 The following are expected final outputs of the work:

a) A quality-assured and documented model, as described above, transferred in-house to the REAL Centre by the end of the contract period. We expect any outputs, including code, developed as part of this process, to be made available as open access.

b) A final report including methods, a full list of data sources, key assumptions and evidence used.

8.3 We expect that the final model will be able to answer some of our questions clearly, whilst others may be answered with broad uncertainties remaining and others may not be answerable given current knowledge and data. We expect reports to include discussion of this, including a list of research needs to narrow uncertainties or answer questions which cannot be addressed.

8.4 Depending on the bid there may be need for additional outputs. For example, if the bid includes a sub-project to look at a specific question, such as how the workforce supply responds to pay increases, we would expect a separate output for this work. Details of these proposed outputs should be included in the bid.

8.5 We would welcome bids for any other interim or final outputs which could help communicate the work effectively, for example data visualisation tools.

8.6 We would expect the supplier to be involved in a number of events to present and disseminate the work to key stakeholders (virtually or in person, TBC). The REAL Centre and the Health Foundation would organise these events, the supplier would be expected to present the modelling to relevant audiences. Bids should include provision for three events.

9.0 Working with us

9.1 The Health Foundation takes a partnership approach to its work. The work will be managed by the Programme Officer for the REAL Centre with significant content input from a Senior Economist, Economist and Research Manager. REAL Centre and wider Health Foundation staff will provide strategic and content input.

9.2 Given that the model will eventually be transferred in-house, or open sourced, we will expect the supplier to take a highly collaborative approach with the REAL Centre and Health Foundation, working closely to develop the model. We have outlined in as much detail as we are able to, the specification for the model but anticipate that there may be changes over time. We are interested in hearing how suppliers propose working closely with us to ensure the model meets our requirements and the process for any changes over time. We expect the supplier

to enable effective hand over and knowledge transfer at the end of the contract. The REAL Centre expect to be able to use and update the model on an ongoing basis after the contract is over.

9.3 The REAL Centre has its own governance structure, including an oversight board chaired by Sir Andrew Dilnot. The REAL Centre will look to draw on the expertise from a range of individuals who specialise in this kind of modelling work. Alongside their own quality assurance processes, we expect that the successful supplier will engage with our external advisory boards to ensure sufficient assurance of robustness and quality.

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9.4 We expect the supplier to work effectively with other teams in the Health Foundation, notably the policy team, who will have significant interest and input for policy options, and the communications team, who will help to promote and disseminate outputs.

9.5 We anticipate sending some aspects of this work for peer review, in particular the model protocol/specification. We will work with the successful supplier to agree a process for this and will manage the peer review process on their behalf.

10.0 Preferred supplier

10.1 The bid should demonstrate that the project team has:

a) Good knowledge and understanding of the social care sector.

b) Experience in quantitative modelling and policy analysis.

c) Experience engaging key stakeholders in the ongoing development of complex policy-relevant work.

10.2 It is not vital that the successful supplier has built a social care model similar to this previously. The bid may involve providing evidence of transferable skills and experience from work in related research areas. This could include health care demand, the NHS workforce or the labour market in sectors such as hospitality and retail, which are often posited as competing with social care for labour supply.

11.0 Costs

11.1 Responses to this invitation should include accurate pricing, inclusive of expenses and VAT. It is emphasised that assessment of responses to this tender invitation will be on perceived quality of service and demonstrable ability to meet the brief, rather than lowest cost, but value for money is a selection criterion.

11.2 We anticipate bids of approximately **£250,000** inclusive of VAT and expenses. We will consider bids that set out what might be achievable with different budget constraints (up to a maximum of £300,000).

12.0 Instructions for tender responses

Please note that the application form provided on AIMs is a standard Health Foundation form and is not specific to this ITT. Please ensure you refer to the points below when structuring your bid.

At a minimum the bid should include:

a) a short overview of your approach (section 1.3 of the application form)
b) a description of your methodology (section 1.4)
c) outputs and deliverables (section 1.4)
d) project management approach and how you propose to work collaboratively with the REAL Centre and the Health Foundation (section 2.1 and section 2.2)
e) your approach to engagement with key stakeholders (section 2.1 and section 2.2)
f) your approach to data governance (section 2.2)
g) project plan/timeline (section 2.2)
h) full budget (section 4)
i) key risks (section 2.3)
j) relevant skills and experience of project team members (section 3.1).

12.1 The Foundation reserves the right to adjust or change the selection criteria at its discretion. The Foundation also reserves the right to accept or reject any and all responses at its discretion, and to negotiate the terms of any subsequent agreement.

12.2 This work specification/invitation to tender (ITT) is not an offer to enter into an agreement with the Foundation, it is a request to receive bids from third parties interested in providing the deliverables outlined. Such bids will be considered and treated by the Foundation as offers to enter into an agreement. The Foundation may reject all bids, in whole or in part, and/or enter into negotiations with any other party to provide such services whether it responds to this ITT or not.

12.3 The Foundation will not be responsible for any costs incurred by you in responding to this ITT and will not be under any obligation to you with regard to the subject matter of this ITT.

12.4 The Foundation is not obliged to disclose anything about the successful bidders, but will endeavour to provide feedback, if possible, to unsuccessful bidders.

12.5 Your bid is to remain open for a minimum of 180 days from the bid response date.

12.6 You may, without prejudice to yourself, modify your bid by written request, provided the request is received by the Foundation prior to the bid response date. Following withdrawal of your bid, you may submit a new bid, provided delivery is affected prior to the established bid response date.

12.7 Please note that any bids received which fail to meet the specified criteria contained in it will not be considered for this project.

13.0 Selection criteria

13.1 Responses will be evaluated using the following criteria:

- Quality and clarity of the bid.
- Ability to deliver on all required services, including a realistic project plan.
- Ability to work collaboratively with the REAL Centre throughout the project, through effective governance structures and project management.
- Ability to engage effectively with stakeholders.
- Experience and knowledge of your team/organisation.
- Value for money.

13.2 It is important to the Foundation that the chosen supplier is able to demonstrate that the right calibre of staff will be assigned to the project; therefore, the project leader who will be responsible for the project should be present during the panel interviews if you are selected for interview. In addition, due diligence will be undertaken on all shortlisted organisations.

14.0 Selection process

14.1 Please complete the online tender response form on the AIMS system by **30 April**

14.2 Ahead of this please submit any questions by **12 March**

14.3 A response to your application will be made by **25 June**

14.4 Interviews will be held on **5, 6 or 7 July**

14.5 Final decision will be communicated by **23 July**

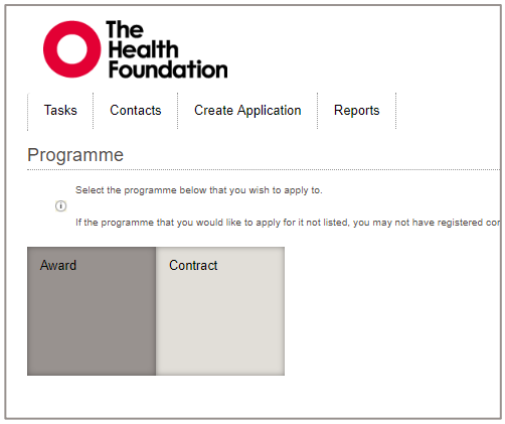
AIMS quick start

Once you have registered with AIMS and activated your profile via the verification email, you can start a tender response. If you are applying on behalf of a team or organisation, register with the organisation via the 'Contacts' tab before doing so.

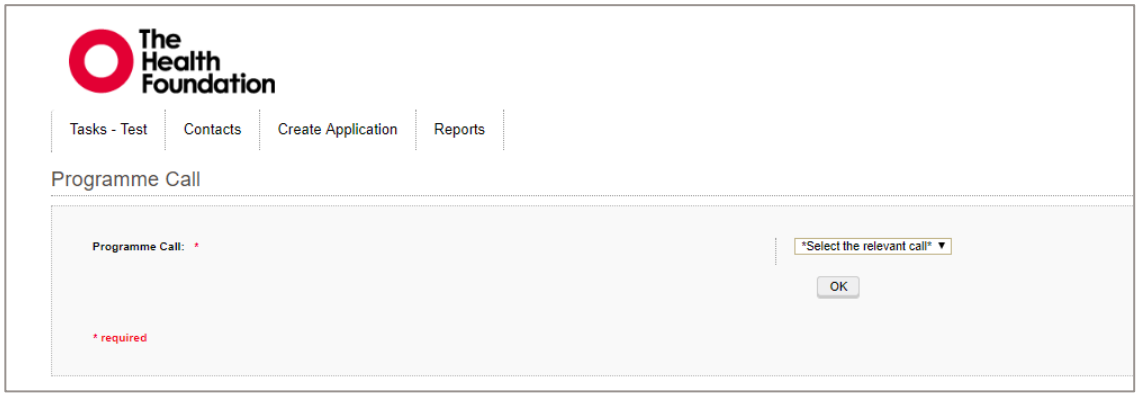
Then click on '*Create Application'* and select to apply on behalf of the organisation you have just registered with.

Open tender instructions

Select the '*Contract*' programme, as shown below.



On the next screen, click into the drop-down menu and select the 'Adult Social Care Model' call, as shown below.



15.0 Confidentiality

15.1 By reading/responding to this document you accept that your organisation and staff will treat the information contained as confidential and will not disclose to any third party without prior written permission being obtained from the Foundation.

15.2 Providers may be requested to complete a non-disclosure agreement.

16.0 Conflicts of interest

16.1 The Foundation's conflicts of interest policy describes how it will deal with any conflicts which arise as a result of the work which the charity undertakes. All external applicants intending to submit bids to the Foundation should familiarise themselves with the contents of the conflicts of interest policy as part of the tendering process and declare any interests that are relevant to the nature of the work they are bidding for. The policy can be found and downloaded from the Foundation's website at the following location: https://www.health.org.uk/sites/default/files/2019-02/Health-Foundation-policy-on-conflicts-of-interest.pdf

17.0 Contract arrangements

The Health Foundation's standard contract for delivery of services is attached. Any queries about the contract terms should be detailed in your application.