NHS Commissioning Board

2013/14 NHS Standard Contract

Technical Contract Guidance

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2013/14 NHS Standard Contract

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on behalf of the NHS Commissioning Board

Technical Guidance to the 2013/14 NHS Standard Contract

Contents

1. Introduction

1.1 The 2013/14 contract is the first NHS standard contract published by the NHS Commissioning Board (NHS CB).

1.2 The NHS standard contract is the key lever for commissioners to secure improvements in the quality and cost effectiveness of the services they commission.

1.3 *Everyone Counts: Planning for Patients 2013/14*
http://www.commissioningboard.nhs.uk/everyonecounts/
sets out the expectation that commissioners should enforce the standard terms of the contract, including financial consequences for under-performance or failure to provide data on which to assess performance.

1.4 The new contract includes some significant changes to reflect the new NHS commissioning arrangements but also retains a level of continuity with previous versions of the contract.

1.5 To support the delivery of more integrated and personalised care, to improve quality and productivity, and to promote innovation and a stronger focus on prevention, commissioners will need to take new and innovative approaches, working across organisational boundaries and focusing more strongly on outcomes and on quality of whole care pathways, particularly for people with long term conditions and people with mental health problems.

1.6 The new contract has been designed so that commissioners can use it to deliver different and innovative approaches to commissioning.

1.7 The 2013/14 contract has been developed with extensive stakeholder input.

1.8 The key changes include:

- simplification of language;
- clarity in processes;
- ensuring the contract can be tailored to different provider and service types.

1.9 The contract will be published as an eContract. This will allow commissioners to produce a contract on-line using only the service-related and provider type clauses that are relevant to the services being commissioned.

1.10 The contract should be used when commissioning any NHS funded healthcare services with the exception of primary care services commissioned by the NHS CB. Care homes and high secure services, which were previously commissioned using separate forms of standard contract, should now be commissioned using the 2013/14 contract.

1.11 Further changes are planned for 2014/15 as the new system beds in, continuing to build on the work undertaken to date. In particular, the NHS CB, working with stakeholders, will during 2013/14 oversee a fundamental review of the incentives, rewards and sanctions within the NHS standard contract to inform the 2014/15 planning round.

1.12 This document 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 contract will prevail. **Appropriate legal advice should be sought as needed.**

2. Using the NHS standard contract

When the contract should be used

2.1 The contract must be used by clinical commissioning groups (CCGs) and the NHS CB when commissioning NHS funded healthcare services (including acute, ambulance, care home, community-based, high secure and mental health and learning disability services). The only exception to this is primary care services commissioned by the NHS CB, where the relevant primary care contract should be used.

2.2 CCGs should use the NHS standard contract for all community-based services with the exception of any primary care improvement schemes commissioned on behalf of the NHS CB, any Local Enhanced Services (LESs) commissioned on behalf of the NHS CB under the transitional arrangements set out in the NHS CB Enhanced Services Commissioning Fact Sheet, http://www.commissioningboard.nhs.uk/files/2012/03/fact-enhanced-serv.pdf and any out of hours services commissioned on behalf of the NHS CB using the APMS contract.

2.3 Local authorities may also be a party to the contract. This may be appropriate when local authorities are commissioning services from a provider whose main business is the supply of services to NHS commissioners, for example public health services provided by an NHS provider. However, it is not mandatory for local authorities to use the NHS standard contract.

Co-ordinated commissioning

2.4 The contract may be used for both bilateral and multilateral commissioning ie for commissioning by a single commissioner or by a group of commissioners collaborating to commission together.

2.5 The NHS CB has published supporting guidance for commissioners considering the different ways of working with other commissioning bodies. *The Framework for collaborative commissioning* can be found at: http://www.commissioningboard.nhs.uk/files/2012/03/collab-commiss-frame.pdf.

2.6 Commissioners should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider in a formal agreement. A model collaborative commissioning agreement has been published to support commissioners developing their collaborative arrangement. This model agreement is available at: http://www.commissioningboard.nhs.uk/files/2013/01/model-comm-agreement.doc

2.7 Where a group of commissioners wishes to enter in to a contract with a provider, each of the commissioners must sign the contract and cannot delegate this responsibility to another commissioning body.

2.8 Commissioners should set out the roles and responsibilities of each commissioner in relation to the contract in Schedule 5 Part D (Commissioner roles and responsibilities). This will be the same as the table set out in the collaborative commissioning agreement.

2.9 Where a single commissioner enters into a contract with a provider the nominated co-ordinating commissioner will be the single commissioner and the roles and responsibilities table will be completed with the commissioner details.

2.10 Where commissioners have a separate agreement with a commissioning support organisation the roles and responsibilities of the CSU should be set out in Schedule 5 Part D.

Legally binding agreements

2.11 The contract creates legally binding agreements between NHS commissioners and FT, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as set out in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract document and should be treated by NHS commissioners with the same degree of rigour and seriousness as if the agreements were legally binding. Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding.

3. Contracting fairly

3.1 The contract is an agreement between two parties: commissioner(s) and provider. Once entered into, the contract is a key lever for commissioners in delivering high quality, safe and cost effective services. However, the contract in isolation will not achieve this. An effective relationship between commissioner(s) and provider is a key element of successful contracting.

3.2 A good relationship will depend on both parties taking a fair and proportionate approach, in particular:

- relationships should be constructive and co-operative;
- the contract should be based on terms that are deliverable;
- providers should be given appropriate notice of any changes the commissioner wishes to make to the services they are commissioning;
- there should be a fair balance of risk between commissioner and provider
- any financial sanctions should be proportionate;
- the contract is not intended as a lever to micro-manage providers;
- commissioners should set clear outcomes and appropriate quality standards, and not over-specify these;
- commissioners should only request information from providers that is reasonable and relevant, with consideration given to the burden of provision of the information. Wherever possible information that is already available should be used.

3.3 Consideration over the use of choice and competition will play an important role in contracting fairly. Beyond upholding patients' statutory rights to choice as set out in the NHS Constitution, it is for commissioners to decide how best to use competition to meet the local needs of patients with a view to improving the quality and efficiency of services. In taking these decisions, commissioners will have to comply with statutory regulations to ensure that their procurement decisions are transparent, non-discriminatory and proportionate, and that they purchase services from the providers best placed to meet patients' needs.

3.4 Good practice case studies on using the contract and innovative commissioning will be published on the eContract portal.
https://commissioning.supply2health.nhs.uk/econtracts

4. Contract duration and variation

Duration

4.1 The default duration for the 2013/14 contract is one year, with an automatic expiry date of 31 March 2014. This is to support the transition to the new commissioning structures and to allow commissioning organisations time to determine their longer term commissioning plans.

4.2 As in previous years, there are a limited number of circumstances where the default one year duration may be varied.

4.3 These circumstances are:

- contracts already awarded following SHA approval which extend beyond March 2013 and where duration is greater than one year (as per the Gateway letter of 15 February 2012) http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132735 ;
- adverts already approved for contracts with a termination date beyond 31 March 2014;
- pending/ planned adverts for competitive procurements with a termination date beyond 31 March 2014;
- new competitive procurements for services where the costs of responding to the tender could discourage new market entrants;
- where a provider under an AQP based procurement has been accredited for a three-year period.

4.4 For all other scenarios, including re-award of existing contracts, a one year duration should be used.

4.5 The one year default duration does not affect contracts entered into in previous years which have an expiry date beyond 31 March 2013.

Transfer of existing contracts

4.6 Existing contracts with an expiry date beyond 31 March 2013 will be included in the transfer schemes which list the assets and liabilities of PCTs and other current organisations. The transfer schemes will be the mechanism by which these assets and liabilities, including clinical contracts, are transferred to the new commissioning bodies.
http://www.dh.gov.uk/health/2012/10/handover-guidance-transition/

4.7 This means that CCGs and the NHS CB will inherit existing contracts which have an expiry date beyond 31 March 2013 on the existing terms and conditions.

Variations

4.8 There are two options for these contracts, to ensure they reflect mandated changes included in *Everyone Counts: Planning for Patients 2013/14* http://www.commissioningboard.nhs.uk/everyonecounts/

- the parties agree to transfer their existing contract into the new contract form in its entirety, maintaining the current duration of the contract;
- the parties use the national variation templates that will be published in early 2013 and which will include changes mandated through *Everyone Counts.*

4.9 Where providers and commissioners are unable to agree either of these options, they should use the mediation and disputes process set out in their existing agreement.

4.10 Where either option is not agreed, commissioners using an NHS standard contract will be able to issue a notice to terminate the existing contract with three months' notice. Any new contract subsequently offered will be the 2013/14 contract but in the interim providers will be paid in arrears for continued activity undertaken outside of any contract on receipt and clearance of invoices.

5. The contract, Payment by Results, patient choice and personal health budgets

Payment by Results (PbR)

5.1 The standard contract reflects requirements in relation to PbR and patient choice. The contract requires the parties to comply with the Payment by Results Code of Conduct and Guidance, where applicable
http://www.dh.gov.uk/health/2012/12/pbr-road-test/

5.2 The contract also supports the use of mental health PbR. The draft mental health PbR Guidance for 2013/14 sets out the minimum requirements in relation to the use of mental health PbR in 2013/14 contracts:
"As a minimum, all contracts for 2013-14 for working age adults and older people that fall within the scope of the mental health currencies should be agreed based on the clusters, and a price should be agreed for each cluster review period based on the current contract value".
https://www.wp.dh.gov.uk/publications/files/2012/12/Draft-Mental-Health-PbR-Guidance-for-2013-14-not-accessible.pdf

5.3 As outlined in the draft guidance, contracts for mental health services should include cluster-based quality and outcome measures.

Patient choice

5.4 The contract requires the provider to comply with the national requirements relating to patient choice and to use Choose and Book, where applicable to the services. Any new guidance relating to choice should be implemented in-year.

5.5 The contract accommodates services commissioned on an Any Qualified Provider (AQP) basis to enable patients to have choice as to which provider they are referred to. Where a provider is commissioned to provide services both on a non-AQP and AQP basis, the commissioner should consider whether a separate standard contract needs to be used for those services commissioned on an AQP basis.

5.6 AQP services can be incorporated in the existing contract through a revised service specification and variations to the quality, activity, pricing and information schedules. FAQs relating to AQP and the contracts are available on the AQP Resource Centre:
https://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx

Personal health budgets

5.7 The Government has made clear that individual choice and control in public services are a priority. Personal health budgets, which were piloted in the NHS from 2009 to 2012, are one of the ways of achieving this, enabling individuals to better manage their physical and mental health.

5.8 On 30 November 2012, the Government announced that, based on the positive evidence in the independent evaluation of the pilot programme, https://www.phbe.org.uk,
the use of personal health budgets would be rolled out more widely across the NHS.

5.9 A practical toolkit is available online to support implementation and will evolve as more is learned about personal health budgets during the early stages of rollout. The toolkit explains the three options for managing a personal health budget – notional budget, third party budget and direct payment. http://www.personalhealthbudgets.dh.gov.uk/

5.10 Where a commissioner commissions services funded by a personal health budget on behalf of an individual (a notional budget), the standard contract should be used. However, where individuals (or their representative) are contracting directly with service providers, or employing personal assistants, there will be no need for a contract between the NHS commissioner and a provider. Where a personal health budget is being managed by a third party, the commissioners will contract with a third party organisation that will organise the care and support. In this case the standard NHS contract may not be appropriate - any contract should be as simple and as flexible as possible.

6. Key changes for 2013/14

6.1 The 2013/14 NHS standard contract looks very different from previous contracts. The contract was made available as an eContract on 1 February 2013. This allows commissioners to generate automatically and use only those contract clauses applicable to the type of service being commissioned and provider type.

6.2 The contract is also be available as a paper version. It will be possible to tailor this to specific types of services/ provider types, but that would need to be done manually.

6.3 The key changes are:

- the contract now consists of three parts: the Particulars, the Service Conditions and the General Conditions (see chapter 7);
- language has been simplified;
- processes have been updated and improved, making them easier to navigate;
- the contract has been updated to reflect the new legislative and regulatory framework;
- there have been changes to a number of schedules and clauses to incorporate the priorities set out in *Everyone Counts: Planning for Patients 2013/14.*

6.4 Changes to schedules and clauses include:

- the service specification template has been updated to reflect a greater focus on outcomes rather than processes;
- quality requirements are now divided into three sections: Operational Standards (which are derived from NHS Constitution rights and pledges); National Quality Requirements (which are requirements set through the NHS CB planning guidance); and Local Quality Requirements;
- mandatory goods and services have been changed to commissioner requested services (CRS): these should be used for Foundation Trusts only. Essential services should continue to be used for all other providers;
- simplification of withholding and/ or discontinuation of service wording;
- significant changes to activity planning and management processes which require either party to alert the other if there have been unusual changes in activity or referrals and for either party to issue an activity query notice, leading to a joint activity review, activity management plan or utilisation review. The responsibilities of each contract party for demand management have also been clarified;
- changes to the emergency preparedness and resilience clause to reflect changes to national processes;
- the service development and improvement plan is now non-mandatory;
- the addition of requirements relating to Prevent (a cross government policy that aims to stop people becoming terrorists or supporting terrorism) in the safeguarding clause;
- addition of requirements relating to the duty of candour;
- simplification of the payments clause;
- simplification of the CQUIN process;

- changes to the disputes resolution process to include new processes for disputes, including a revised mediation and expert determination process;
- new provisions governing the responsibilities of the parties in the expectation or event of TUPE applying on transfer/ decommissioning of services;
- risk share agreements can now be used across all services, subject to the PbR code of conduct and guidance.

7. Structure of the new contract

7.1 The contract is divided into three parts:

the Particulars. These contain all the sections which require local input, including details of the parties to the contract, the service specifications and schedules relating to payment, quality and information. The Particulars also drive the eContract in that commissioners are required to identify in the Particulars which categories of provider type and service are relevant. The selections made here then drive the content of the Service Conditions which will be included in the eContract form.

the Service Conditions. This section contains the generic, system-wide clauses which relate to the delivery of services. Some of these will be applicable only to particular services or types of provider. The eContract will automatically produce a contract with only the relevant clauses or versions of the clauses included, based on the choices made by the commissioner in the Particulars. For commissioners using a paper-based version of the contract, all variants of the clauses are included. The margin clearly identifies which clauses apply to which service types. The content of the provisions applicable to the services commissioned and the provider type cannot be varied.

the General Conditions. This section contains the fixed standard conditions which apply to all services and all types of provider, including mechanisms for contract management, generic legal requirements and defined terms. These are not open to variation.

8. Service specifications

8.1 The service specifications are one of the most important parts of the contract, as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified.

How detailed should a service specification be?

8.2 A service specification should set out a brief summary of the service being commissioned, including:

- any relevant context to the service either at a national or local level;
- the broad outcomes that are required from the service: any applicable measures relating to these should be set out in Schedule 4 (Quality Requirements);
- scope, ie the service being commissioned, who is it for and any key links with other services;
- any generally applicable service standards which the service should adhere to eg NICE standards or any locally agreed standards;
- which quality requirements and CQUIN goals, as set out in Schedule 4, are relevant to each specific service specification;
- location of the service: this will not be relevant to all services but could be used where the location in which services is provided needs to be specified (eg in the case of services commissioned from a national provider with multiple locations where services are required to be delivered from only a limited number of the provider's units).

8.3 The level of detail required in a specification will depend on the services being provided. For example, where a range of services is commissioned from a large provider, detailed service specifications for each service may not be required. However, if just one service is being contracted for from a provider on an AQP basis, then greater detail may be appropriate. However, even in this circumstance a specification should not be a detailed operational policy for a service, and should rarely need to be more than 4-5 pages long as it should focus on the outcomes required from the service rather than the inputs.

8.4 During the procurement process a detailed specification may have been used. This does not need to be replicated in full within the contract but can be included as a document relied on (Schedule 5 Part A), if required.

Can I add additional detail to the service specification template?

8.5 The specification template is intended as a guide to the minimum amount of detail that should be included in a specification. The template is colour coded. Sections 1-4 are all amber which means that content should be included under each one. Sections 5-7 are green which means that they are optional to use. Below that level, it is for local agreement what to include. The sub headings are intended to act as suggestions. It is possible to add additional sections to the specification, if required. The eContract will allow the commissioner to attach additional documents and/ or cut and paste from other documents.

8.6 There is no need to replicate in the service specification wording or clauses which already appear in the main body of the contract. Putting these in the service specification will serve no legal purpose.

8.7 Quality requirements and information requirements should not be included in the service specification as there is no link between the specification and the contract management elements of the contract. This is to ensure that there is no confusion between the contents of the service specifications and the relevant contract schedule. If there are any specific requirements relating to the particular service, these should be included in Schedule 4 (Quality Requirements), together with any associated information requirements in Schedule 6 Part C (Reporting Requirements). However as noted above, it is possible to indicate in the service specification which of the quality and information requirements listed in the relevant contract schedules are relevant to each service specification by allocating a reference number to the requirement and listing the relevant reference numbers in the service specification.

What process should be used for developing service specifications?

8.8 The way in which service specifications are developed will vary according to local circumstances. It is the commissioner's responsibility to develop service specifications. However, the commissioner may wish to involve prospective providers in developing a specification. It is also good practice to consider involving service users in the development of specifications. In considering whom to involve, the commissioner should take into account whether the specification will form part of a competitive procurement process.

8.9 Considerations in completing each section of the service specification template are detailed below.

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement

Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	Numbering the specification may be useful where you wish to identify which services particular quality requirements relate to.
Service	The level at which services are specified will depend on the particular service. For example for acute hospital services, it is unlikely that you would wish to specify at HRG level. On the other hand, a specification which covers 'all elective services' is unlikely to be appropriate. It may also be appropriate to consider whether developing a specification on the basis of a care pathway would be appropriate.
Commissioner Lead	The name of the individual leading on the commissioning of the service should be inserted here.
Provider Lead	The name of the individual leading on this service for the provider should be inserted here (this may be the

	same or different for all services being commissioned).
Period	The period covered by this specification should be inserted here. This may be the same as the duration of the contract but where there is a long contract duration, you may wish to review the specification at an earlier date (subject to any procurement and competition considerations). There may be circumstances where the overall duration of the contract may be longer than a particular service is being commissioned. Where this is the case, it is important that a duration is clearly specified for the service being commissioned.
Date of Review	If you wish to review the specification mid-contract, then a date by which the specification is to be reviewed should be inserted here.

1. Population Needs

1.1 National/local context and evidence base

This section should set the context for the service being commissioned. For example, for a mental health service it may be relevant that one in six people at some stage will experience a mental health issue. Locally, prevalence may be higher or lower than national averages.

2. Outcomes

2.1 NHS Outcomes Framework domains & indicators

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

Any relevant indicators from the NHS Outcomes Framework may be added here. If the provider is to be held accountable for them, they should be included in the locally agreed quality requirements.

2.2 Local defined outcomes

Any broad outcomes to which the service should be working should be inserted here.

3. Scope

3.1 Aims and objectives of service

A brief description of the aims and/ or objectives of the service may be included here. Service specifications should clearly set out requirements for protected groups where there is a need to do so.

3.2 Service description/care pathway

This section should include a brief description of the service being commissioned. For some services, it may be relevant to describe the care pathway.

3.3 Population covered

Where the service is not subject to patient choice and where the service is limited to a defined population, the description of that population should be included in this section.

3.4 Any acceptance and exclusion criteria

This section may be used to identify any clinical criteria used for the service.

3.5 Interdependence with other services/providers

The services commissioned under a contract may be part of a wider care pathway. If this is the case, how the service links into and works with other services or providers can be identified here.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

This section may be used to identify NICE standards, other national standards and any locally agreed standards that are relevant to the service.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2	**Applicable CQUIN goals (See Schedule 4 Part E)** The reference numbers for quality requirements and CQUIN goals which apply to the service can be listed here. This allows clarity about the requirements relating to specific services.
6.	**Location of Provider Premises**
The Provider's Premises are located at: Where it is considered important to specify that a service is provided from a particular location, this may be specified here.	
7.	**Individual Service User Placement**
This section may be used to include details of any individual service user placements (eg for care homes). This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.	

8.10 A national service specification for specialist learning disability services is being developed and will be available in Spring 2013.

9. Quality

Context

9.1 The White Paper, *Equity and Excellence- Liberating the NHS* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf sets out the primary purpose of all NHS funded care as being improvement in quality and health outcomes.

9.2 The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience.

9.3 The *NHS Outcomes Framework 2013/14* https://www.wp.dh.gov.uk/publications/files/2012/11/121109-NHS-Outcomes-Framework-2013-14.pdf is designed to provide a national overview of how well the NHS is performing and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities. The framework is structured around five domains which cover the three dimensions of quality described in the Health and Social Care Act.

9.4 The NHS CB has set out an expectation that commissioners will prioritise and make improvements against all the measures from the NHS Outcomes Framework set out in *Everyone Counts: Planning for Patients 2013/14.* http://www.commissioningboard.nhs.uk/everyonecounts/

9.5 The Clinical Commissioning Group Outcomes Indicator Set, formerly known as the 'Commissioning Outcomes Framework', aims to support and enable CCGs and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs. The indicators have been derived from the NHS Outcomes Framework, from NICE standards or guidelines http://www.nice.org.uk/aboutnice/ccgois/CCGOIS.jsp

Measuring quality

9.6 In contractual terms, quality can be measured at three levels:

- compliance against Care Quality Commission (CQC) regulatory standards which are the legal essential standards to be achieved by registered providers in order to achieve and maintain registration;
- compliance against the requirements set out in the NHS standard contract, which should be focused on achieving a standard of care over and above the essential standards of quality and safety set by CQC;
- quality incentive schemes (including CQUIN) which are used to incentivise continual quality improvement above contractual baselines.

Quality in the NHS Standard Contract

9.7 The NHS standard contract is a key enabler for commissioners to secure improvements in the quality of services for patients.

9.8 The quality requirements are set out in Schedule 4 of the contract. The quality requirements are split into six sections:

- **Operational standards**: these are nationally set standards, derived from the rights and obligations of the NHS Constitution, which all providers are expected to achieve. Where consequences for failure to achieve the requirements are set nationally these must be applied;
- **National quality requirements**: this is a small set of national requirements, derived from the NHS planning guidance, which all providers are expected to achieve. Consequences for failure to achieve are set nationally and must be applied;
- **Local quality requirements**: these are agreed locally. Annex 3 sets out a list of nationally approved quality requirements derived from NICE quality standards, the core set of quality indicators for mandatory reporting in provider quality accounts, and from previous years' NHS standard contracts. Commissioners may wish to select relevant indicators from this list. However, this is not an exhaustive list and there may be more appropriate local indicators;
- **Never events**: Never events are serious patient safety events that are largely preventable. Guidance on the implementation and monitoring of the list is available at: https://www.wp.dh.gov.uk/publications/files/2012/10/never-events-policy-framework-update-to-policy.pdf;
- **CQUIN**: this is the national quality incentive framework. The majority of quality incentive goals will be agreed locally, with a small number of national goals which should be used, when applicable to the services. Guidance on the 2013/14 framework, including the national goals is available at: http://www.commissioningboard.nhs.uk/files/2013/02/cquin-guidance.pdf;
- **Local incentive schemes**: as in previous years, it is possible to agree local quality incentive schemes in addition to CQUIN.

Selecting local quality requirements

9.9 As noted above, the three dimensions of quality are clinical effectiveness, patient experience and patient safety. In considering how quality is reflected in the contracting process, all three dimensions of quality should be taken into account.

9.10 *Everyone Counts: Planning for Patients 2013/14* also emphasises the essential importance of involving patients and carers in decisions about their health and care.

9.11 The 2011 National Quality Board publication *'Quality Governance in the NHS- a guide for provider boards'* is a useful guide to commissioning for quality. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125239.pdf

9.12 The CCG Outcome Indicators Set will help guide local commissioning for outcomes. In addition commissioners can look at NICE's evidence and the indicators in the Outcomes Framework, with the existing data on outcomes for their population, to think carefully about where services might need to improve for the future. Improved services will help lead to improved outcomes.

9.13 In considering the local quality requirements it is important to consider:

- whether you are trying to measure improvement or absolute standards;
- whether your proposed requirements are measurable and achievable;
- how many indicators you should be measuring - generally fewer is better: identifying a smaller number of key indicators may be more effective in providing an early alert system to potential problems, rather than requiring reporting on hundreds of quality requirements;
- using process measures to assess progress on achievement of broad outcomes and building on initial measures over a period of time.

9.14 When commissioning for outcomes, it is not always possible to commission improvements in the high-level outcomes contained in the NHS Outcomes Framework or associated measures in the CCG Outcomes Indicator Set. However, commissioners can use a range of quality requirements and associated indicators. For example, reduced mortality following fragility fractures will cumulatively support the high-level outcome in domain 1 (Preventing premature death).

9.15 In determining how quality requirements are measured the whole time span of the contract should be considered. Where it is not possible to utilise outcome measures initially or to collect the information necessary for demonstrating the outcomes desired, a developmental approach should be employed. This may mean that the quality indicator for a given quality requirement is the development and implementation of a relevant policy or the definition and establishment of collection methodology for new information requirements.

9.16 Where a new contract is subsequently awarded, or in the next contract year, there might be an audit to establish whether specific aspects of service delivery have been achieved. This in turn may lead to more challenging requirements relating to improvements in clinical outcomes or patient experience against the known baseline.

9.17 There are a variety of potential methods for measurement of quality indicators such as patient, service user, carer or staff surveys, audit, service user visits, incidents and complaints monitoring etc. as well as routine data collection.

9.18 In considering the data collection requirements associated with establishing quality indicators, commissioners and providers should discuss how data can most efficiently and effectively be collected, eg whether electronically or through manual collection, and consider the resource implications of data collection. Data quality, such as timeliness, reliability, accuracy, verifiability and comparability, should be considered. In developing measurement processes, it is also important to consider the risk of introducing perverse incentives. Additionally the size of the organisation should be considered, to ensure that information requests are proportionate for the monitoring of the contract.

9.19 Wherever possible existing data collections should be used. The Health and Social Care Information Centre (HSCIC) website is a key source of nationally collected data to support commissioners make better decisions about care. It also publishes information and indicators, including the NHS and Social Care Outcomes Frameworks and the CCG Outcomes Indicator Set:
HSCIC website - http://www.ic.nhs.uk

HSCIC Indicator Portal - http://www.ic.nhs.uk/indicatorportal
Assessed list of Mandated Collections- http://www.ic.nhs.uk/datacollections

9.20 There are a number of other sources of information which can be used. These include:

- CQC data (including quality risk profiles);
- national quality dashboards;
- PROMS;
- clinical audits;
- provider quality accounts.

9.21 The quality requirements should be agreed annually prior to the start of the contract year as set out in SC 37. Only in exceptional circumstances should these requirements be lower than those which they are to supersede. The quality requirements can be used to embed high quality care, achieved through the previous year's CQUIN or local incentive scheme, as a baseline contractual requirement. Review of performance against quality indicators should be included in the regular contract review meetings (GC8).

Monitoring quality

9.22 In monitoring the quality of services, commissioners will wish to use information from a number of different sources, of which quality requirements are only one. This data should be combined with data from the HCAI reduction plan, equality monitoring report, complaints monitoring report, report on incidents requiring reporting and other sources such as feedback from patient and staff surveys, to form an overall view of the quality of service provision.

9.23 A service quality performance report should be produced for each month, as outlined in Schedule 6 Part C of the contract. The frequency of reporting should be agreed locally and set out in Schedule 6 Part C. Schedule 6 Part C outlines the matters which should be included in the report.

9.24 GC8 outlines the contract review process that should cover quality requirements, incentives schemes, the service development and improvement plan (SDIP) and other aspects of quality of service provision such as complaints, patient safety incidents, never events, investigations, HCAIs and care plan review and audit. Action to be taken if there are queries against performance is outlined in GC9.

9.25 Any productivity measures agreed between the parties should be included in an SDIP (SC18).

9.26 Generally, failure to achieve a quality requirement amounts to a contractual failure rather than a systemic quality failure. However, failure of a number of quality requirements could be an indication of a systemic quality failure.

Breaches of quality requirements

9.27 The Operational Standards and National Quality Requirements include nationally set consequences for breaches. In line with the 2013/14 planning guidance, these must be applied by commissioners.

9.28 For locally agreed quality requirements, it is for commissioners to decide whether they wish to set specific consequences. As an alternative, commissioners may use the contract management process set out in GC9. Where this approach is taken the words 'as set out in GC9' should be inserted as the relevant consequence.

9.29 This year a cap has been applied to the overall quantum of financial consequence that can be applied in relation to local quality requirements. This is set at 1 per cent of the actual annual value of the contract. A calculation will need to be made after the end of the contract year to ensure this is not exceeded.

9.30 Commissioners may wish to consider re-investing within the local health economy any financial consequences that are levied.

Clostridium difficile (CB_A16)

9.31 The financial consequences for breaches in the thresholds set for rates of Clostridium difficile (C.diff.) have been updated in the 2013/14 contract. For NHS providers (ie NHS Trusts and NHS FTs), commissioners should insert the nationally set threshold in Schedule 4 Part B. For non-NHS providers, the baseline threshold is zero.

9.32 The consequences for breaches of the threshold are set out on Schedule 4 Part H. There are separate consequences for NHS providers (ie NHS Trusts and FTs) and other providers (ie independent and voluntary sectors). References to letters below refer to the formula set out in Schedule 4 Part H.

9.33.1 For NHS providers, the financial adjustment is based on a sanction of £50,000 per case above the provider's nationally set threshold moderated by a weighting factor based on the provider's rate of C.diff. cases per 100,000 bed days compared to the England objective C.diff. rate per 100,000 bed days.

9.33.2 The appropriate figures relating to the 2013/14 baseline threshold (B) and the ambition rate per 100,000 inpatient bed days (D) are available in the CDI table: http://www.commissioningboard.nhs.uk/files/2012/12/ccg-prov-c-diff-2013-14.xls

9.33.3 The actual number of cases of C.diff. for all NHS patients treated by the provider in 2013/14 (A) and the inpatient bed days in respect of all NHS patients for the provider in 2013/14 (C) will be available only after the end of the 2013/14 contract year.

9.33.4 Performance is based on the provider's performance across all NHS contracts. Any financial consequences will be allocated to each of the provider's contracts, based on the ratio of the contract actual inpatient bed days compared with the overall total of inpatient bed days in respect of all NHS patients treated by the provider (F).

9.33.5 The maximum financial consequence that may be levied per contract has been capped at 1.5% of the actual inpatient revenue for the contract. Therefore, the final financial adjustment will be the lesser of the calculation described above (Z) and 1.5% of the actual inpatient revenue (Y).

9.34 The commissioners who are party to each contract will need to decide how any contractual financial consequences are allocated to each commissioner.

9.35 For non- NHS providers (ie independent and voluntary sector providers), the baseline threshold is set at zero. A financial consequence of £50,000 per case of C.diff will be applied (Z), subject to a financial cap set at 1.5% of the actual inpatient revenue (Y). Financial sanctions can be allocated to the relevant CCG, as it is possible to attribute each case to a specific commissioner.

Ambulance/ A & E handovers (CB_S7 and CB_S8)

9.36 *Everyone counts: planning for patients 2013/14* sets out new national quality requirements relating to ambulance and A & E handover times. For handovers between ambulance and A & E and also for ambulance crew readiness to accept new calls, financial sanctions should be applied where performance does not take place within 30 minutes. There is a separate financial sanction for performance beyond 60 minutes. Where this applies, it should be applied instead of the 30 minute sanction rather than in addition to. The quantum of financial sanctions takes account of the significantly smaller number of emergency ambulance providers compared with A & E providers.

Patient experience

9.37 *Everyone counts: planning for patients 2013* emphasises the importance of treating patients respectfully and putting their interests first and sets out the requirement to know more about what patients think of services.

9.38 For learning disability services, the following principles are widely recognised as being good practice and should be followed by commissioners of learning disability services:

- identifying communication needs when using health services;
- providing written information in a range of accessible formats;
- offering choice of service provider in line with national guidance;
- actively involving service users in the admission process, and providing appropriate and accessible information about the admission process;
- providing information on the experience of staying in hospital;
- actively involving service users in the discharge planning process;
- making sure that hospital appointments take account of any special requirements and needs of service users;
- providing information on what to expect during treatment ;
- ensuring staff are appropriately trained and treat service users with respect as an individual;
- providing an accessible environment;
- ensuring privacy and dignity;
- treating service users with respect at all times;
- explaining medication and ensuring it is regularly reviewed;
- ensuring service users are able to make complaints and give feedback.

9.39 These principles can be audited and may also be used as the basis for service user-led auditing of services.

Friends and family test

9.40 As set out in the *Mandate a mandate from the government to the NHS Commissioning Board: April 2013 to March 2015* https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf

providers of NHS services should implement the national Friends and Family Test in acute inpatient services and accident and emergency (type 1 and 2) departments from 1 April 2013 and in maternity services from 1 October 2013. Providers should implement the test according to the published guidance https://www.wp.dh.gov.uk/publications/files/2012/10/NHS-Friends-and-Family-Test-Implementation-Guidance-v2.pdf

and subsequent reporting guidance http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test-information/ and publication guidance. The Friends and Family Test has been included as a national CQUIN goal for applicable services in 2013/14. Further guidance can be found in *Commissioning for quality and innovation (CQUIN): 2013/14 guidance*: http://www.commissioningboard.nhs.uk/files/2012/12/cquin-guidance.pdf.

Duty of candour

9.41 The contractual requirements relating to the duty of candour are set out in SC 35 and an associated national quality requirement in Schedule 4 Part B. Guidance on how to implement and enforce the contractual requirements is set out in Annex 4.

Formulary

9.42 SC 27 requires the Provider to publish its formulary and ensure that the formulary reflects all positive NICE technology appraisals, making these treatments available to patients. Schedule 4 Part B sets out an associated national quality requirement relating to the provider's failure to publish its formulary.

The Service Development and Improvement Plan (SDIP)

9.43 The SDIP is now non-mandatory, with local discretion on whether to agree one. Any plan agreed at the start of the contract or subsequently should be closely aligned to the commissioner's local commissioning plan and may include the following:

- productivity and efficiency plans agreed as part of the provider's contribution to local QIPP plans;
- any agreed service redesign programmes
- service development plans;
- any priority areas for quality improvement (where this is not covered by a quality incentive scheme).

9.44 Any plan should be appended in Schedule 6 Part F. Progress against the plan should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9). Where the parties agree changes, these should be recorded as a contract variation in Schedule 6 Part A and the plan updated as appropriate.

Health Care Associated Infections (HCAI) reduction plan

9.45 The HCAI reduction plan is a mandatory requirement for all service types. The plan should set out the provider's role in reducing infections. For an acute hospital provider, the HCAI plan may be quite complex. For a small provider, the plan may be limited to ensuring clean equipment or washing of hands.

9.46 Progress against the plan should be monitored through the contract review process.

Provider quality accounts

9.47 Commissioners are statutory consultees of their providers' annual quality accounts, and can make use of this opportunity to assure themselves that there is shared understanding of each other's quality improvement priorities. Provider quality accounts include mandatory reporting on a core set of quality indicators. Some of these indicators form part of the contract quality requirements or are mandated through the contract reporting requirements. Where they are not, they have been included in the pick list of local quality requirements appended to this technical guide.

Mid Staffordshire NHS Foundation Trust public inquiry

9.48 The recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry may lead to changes to the approach to quality in the contract. Any changes required will be introduced through the use of a national variation to the contract.

Other useful references

9.49 The following documents provide further information and guidance on quality issues:

National Quality Board – Review of Early Warning Systems in the NHS, Acute and Community Services (February 2010)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113021.pdf

Quality Governance in the NHS – A Guide for Provider Boards (March 2011)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125239.pdf

Care Quality Commission quality risk profiles
http://www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-grps

10. Information requirements

10.1 Good quality information is essential to enable providers and commissioners to monitor their performance against the contract. The following guiding principles should underpin the provision of information to support contract management:

- the provision of information should be used for the overall aim of high quality service user care;
- it should be for a clear purpose or to answer a clearly articulated question, which may be required on a regular or occasional basis;
- 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;
- requests should not be made for information directly from providers where this information is available through national systems without justifiable reasons;
- information provided should be of good quality.

10.2 *Everyone Counts- Planning for Patients 2013/14* sets out the requirement that all NHS funded providers submit data sets that comply with published information standards.

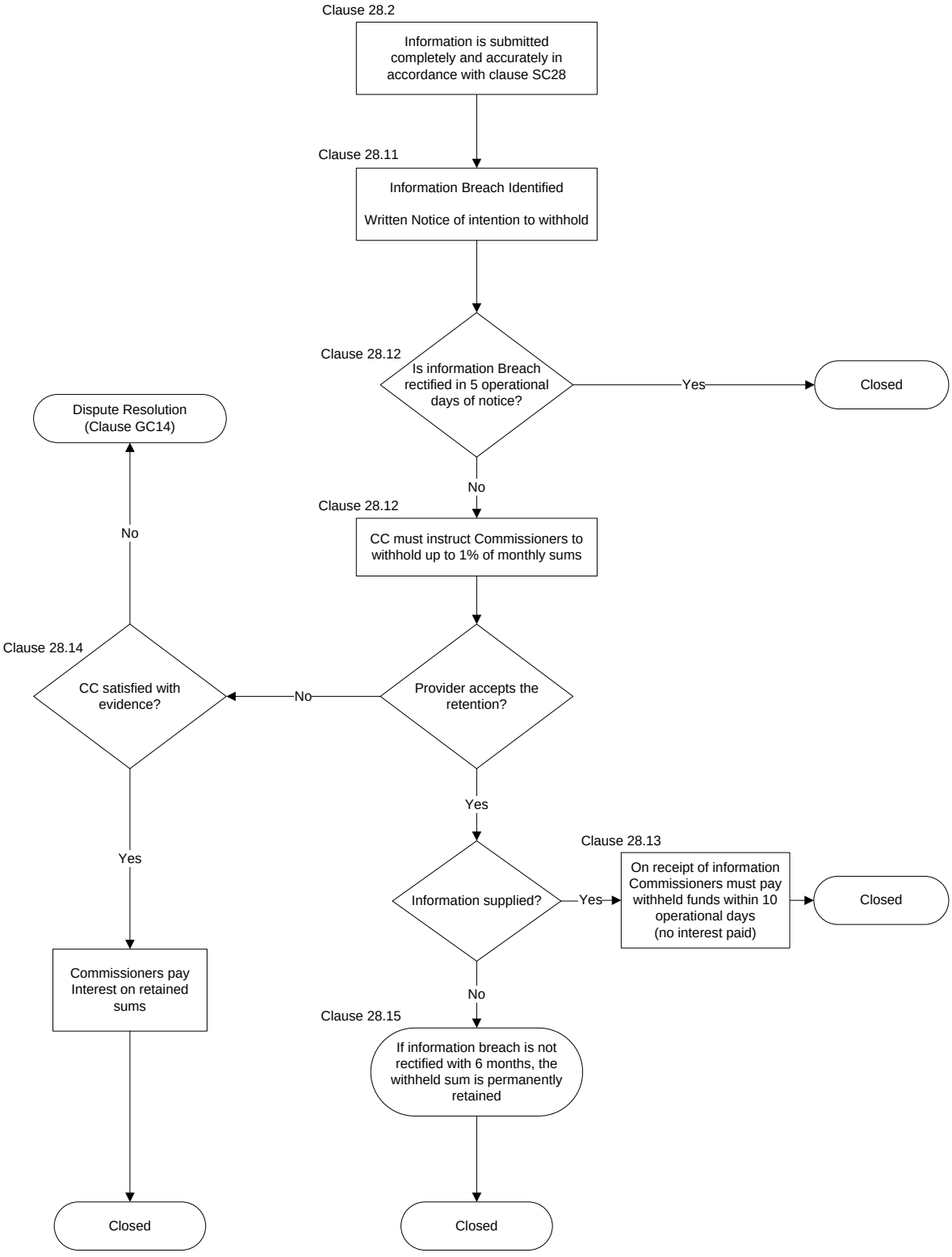
10.3 SC28 sets out the contractual requirements regarding the provision of information and the financial withholdings that can be applied for failure to provide this information. It is expected that the parties will generally resolve information matters in day-to-day dealings, with the contract setting the boundaries and rules where the normal relationship has failed to resolve issues.

10.4 Schedule 6 Part C outlines the reports required under the contract:

- **National requirements reported centrally.** This references the list of assessed mandatory collections published on the HSCIC website www.ic.nhs.uk/datacollections
  formerly the list of the Review of Central Returns (ROCR) approved collections. Providers must submit data returns as appropriate for their organisation type and the services they provide from the list. This also includes the delivery of any data or definition set out in the HSCIC guidance, and any information standard notice (ISN) relevant to the service being provided
  www.isb.nhs.uk/
  Reporting requirements relating to PROMS are also included in this section. For any substance misuse services commissioned using the NHS standard contract, the reporting requirements relating to the national drug treatment monitoring system should be followed.
- **National requirements reported locally.** This lists the national requirements, which are to be reported through local systems. Many of these relate to reports mandated within the contract eg the provision of a regular service quality performance reports.
- **Local requirements reported locally** is where any locally agreed requirements should be inserted. Commissioners should be clear why these

reports are required and whether the information is occasional or routine and set the timeframe, content and method of delivery for these reports accordingly.

Service Condition 28 – information requirements



The data quality improvement plan (DQIP)

10.5 The DQIP allows the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to support both the commissioning and contract management processes. Where a DQIP is agreed, this should be inserted in Schedule 6 Part D of the Particulars.

10.6 The DQIP should not be used to waive or delay financial withholdings against nationally mandated information items. Where there are issues relating to the provision of nationally mandated data items, these should be addressed through the use of SC28.

10.7 The DQIP can be used to secure improvement in accuracy and completeness of data for contract requirements, including the development of outcome based quality measures. For example, the DQIP can support:

- a new provider system upgrade enabling implementation of national datasets;
- any plans that commissioners of acute hospital services may wish to include to increase the percentage coverage of the NHS number during the Service User episode over and above the national requirements;
- the sharing of anonymised information with local community safety partnerships to tackle violent assault;
- continued implementation of mental health PbR.

10.8 Commissioners and providers should also use the DQIP to ensure that providers achieve the expectations relating to high quality relevant data described in *Everyone Counts: Planning for Patients 2013/14*.

10.9 Using the DQIP means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under SC 28 only if the requirements of the DQIP are not achieved.

Information management

10.10 The following section outlines a number of key issues that commissioners and providers need to consider, relating to the provision of information under the contract:

- information governance;
- system compliance;
- reporting requirements;
- information services.

Information governance (IG) – service user data and its protection

10.11 All providers and commissioners should manage service user identifiable data in accordance with the law, good clinical practice and/or good health and social care practice as defined in Definitions and Interpretation (General Conditions). The NHS IG controls are designed to ensure the accuracy and traceability of any information stored on systems and to protect the confidentiality of service user information.

10.12 It is a requirement of all providers wishing to provide NHS funded services that they meet the requirements set out in the information governance toolkit (IGT) and, where there is a requirement, to integrate their IM&T solution to NHS

systems and services, including Choose and Book, PDS, NHS Mail and N3, the provider will need to complete an information governance statement of compliance (IGSoC).

10.13 The IGT applies to all and the requirement is set out in General Condition 21. All parties are required to have met a minimum level 2 performance against the relevant NHS IGT. There are many organisation types listed and online help is available if it is unclear which version of the toolkit to complete: https://www.igt.connectingforhealth.nhs.uk/Help.aspx?tk=413034060997301&lnv=5&cb=971d0d43-fbfc-4ab8-be3c-6b00986466e3

10.14 The IGSoC is the first compliance step towards gaining access to NHS CfH systems and services and is the agreement between a provider, commissioner and NHS national systems management that sets out the information governance policy, terms and conditions to enable integration with the centrally managed systems and services listed below. It is a range of security related requirements, which must be satisfied in order for an organisation to be able to provide assurances in respect of safeguarding the N3 network and any information assets that may be accessed. This process includes the IGT and the nomination of a senior information risk owner (SIRO) and Caldicott guardian. A brief description for these key roles, which are both a requirement of the contract, is outlined below:

- **senior information risk owner (SIRO)**: the nominated person needs to be an executive or senior manager on the board who is familiar with information risks and the organisational response to risks. The SIRO takes ownership of the organisation's information risk policy and ensures, working through senior staff responsible for information assets (information asset owners), that there are regular reviews of information risk across the organisation and that all reasonable steps are taken to manage and mitigate against all key risks;
- **Caldicott guardian**: the role of the Caldicott guardian is advisory, providing a focal point for confidentiality/information sharing issues and the management of service user information at Board level. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114509

10.15 It is suggested that the provider nominate an informatics lead to support the contract. Their role would be to implement Schedule 6 Part C and be responsible for meeting the requirements and any new information requirements that emerge during the life of the contract. It is the responsibility of all commissioners to ensure that appropriate IG assurance is obtained when contracting for the delivery of information services. Further information on the IGSoC and IGT can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/

10.16 The commissioner and provider should ensure that any suppliers and sub-contractor with access to service user information and to any NHS systems or services as part of the contract meet the required IG obligations.

System compliance

NHS number	The NHS number is the national unique service user identifier that supports the sharing of information and is used to help healthcare staff and service providers match the service user to their health records. It is a required field within data returns to commissioners and should be contained in all referrals. Further information on the NHS number can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/nhsnumber/

To help facilitate the use of the NHS number, centrally managed applications for the retrieval of the NHS number are provided as follows:

Patient demographic service (PDS)	PDS is the national electronic database of demographic details for service users and is available via a PDS compliant patient administration system (PAS). Further information on PDS can be found at http://www.connectingforhealth.nhs.uk/resources/systserv/nhs-personal/
Summary Care Record application (SCRa)	The SCRa is a web based portal by which service user information held on the Spine (a national, central database where, for example, summary patient records are stored) can be accessed. As with other centrally managed applications, access is controlled. Further information on SCRa can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/scr/
Demographic Batch Service (DBS)	DBS enables a user to submit a file containing service user demographics for multiple service users, for tracing against the PDS. The correct NHS number and demographics for each service user will be returned where an exact match is found. DBS will also return a deceased status for service users and information where no match has been made. Further information on DBS can be found at http://nww.connectingforhealth.nhs.uk/demographics/dbs/

Reporting requirements

To enable reporting, the provider may during the life of the contract require access to a number of NHS systems and services and, following registration for an IGSoC, the provider will be required to apply for access to some or all of the following:

Organisation data services (ODS)	The provider must acquire a unique ODS code for their organisation and separate site codes, where relevant, to support all central reporting. This code is the provider's unique ID that allows publication of services and activity undertaken for the NHS. Further information on ODS can be found at www.connectingforhealth.nhs.uk/systemsandservices/data/ods/

N3	In order to use NHS IT services the provider must obtain an N3 connection. There are several methods of connecting to the network. Further information on this service and options available can be found at www.connectingforhealth.nhs.uk/systemsandservices/n3
NHS mail	NHS mail is the secure, web based email and directory designed for NHS staff, providing secure email services for the transmission of service user identifiable data. All providers will be required to register for NHS mail and will need to discuss this provision with their commissioner. For further information on this service www.connectingforhealth.nhs.uk/systemsandservices/nhsmail/

To enable information flows and meet the requirements of the HSCIC and Information Standards Board (ISB), the provider may require access to a number of reporting systems. The main collection methods and links to key information websites for further explanation are set out below:

Secondary Uses Service (SUS)	SUS is the single comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS. SUS data is derived from commissioning data sets (CDS), which must be submitted to the system by the provider. The provider must register with SUS to enable submission and details of how to register can be found at www.ic.nhs.uk/susguidance
Unify2	Unify2 is the system for sharing and reporting NHS health care activity and performance information. The provider will be required to register for access to Unify. For further information and access to Unify, please contact unify@dh.gsi.gov.uk
NHS OMNIBUS Survey	Omnibus is an online tool managed by the HSCIC to help NHS and social care organisations submit data. The provider and commissioner where appropriate will need to register with the HSCIC to support data submissions. Further information on OMNIBUS is available at www.ic.nhs.uk
Strategic Executive Information System (STEIS)	STEIS is used by NHS organisations for the collection of Incidents Requiring Reporting SC 33 and Situation Reports (SITREP). For further information and agreement of method, please contact the relevant commissioner.

Information services

Below are useful links for both providers and commissioners to ensure that they are aware of the information requirements and standards set:

Information Standards Board (ISB)	The ISB is the board responsible for setting information standards for the NHS and adult social care in England. Information standard notices (ISNs) are notices issued to commissioners and providers by the ISB giving instructions on information standards to be met. For further information: www.isb.nhs.uk/
Information standard notices (ISNs)	Providers and commissioners are required under the contract to implement all ISNs relevant to the services being provided that are issued during the life of the contract. An information standard describes a common way of managing information, which supports national initiatives. There is a registration system which provides notification of ISNs by email: www.isb.nhs.uk/yoursay/index_html
NHS Data Model and Dictionary Service	A reference point for all information standards that support healthcare activities and data definitions: www.datadictionary.nhs.uk/data_dictionary/data_field_notes/c/cds/cds_type_de.asp?shownav=1
Health and Social Care Information Centre (HSCIC)	The HSCIC is England's central, authoritative source of health and social care information. It manages the national data repository and routine data flows between the health and care system and the centre. It publishes national and official statistics, indicators and measures used for national accountability. It has a key role in information governance and data quality assurance in relation to nationally collected and published data. In 2013/14 the HSCIC is planning to produce more comprehensive, regular and consistent reports on the quality of data submitted nationally by NHS organisations. These reports can be used locally by both providers and commissioners to monitor local data quality and inform declarations and assessments of quality accounts. The HSCIC produces information and reports such as the secondary uses service (SUS) data quality dashboards and mental health minimum data sets (MHMDS) data quality reports, to identify issues with the quality of nationally submitted data. The HSCIC has a national role to reduce the administrative burden of data collections, and as part of this role provides a list of mandated and voluntary national collections for health and social care. www.ic.nhs.uk/datacollections The HSCIC's National Casemix Office designs and refines currencies that are used to describe healthcare activity and which underpin policies from costing through to payment, supporting local and national commissioning and performance management. It also provides analytical services to support specialised commissioning. Further information on the HSCIC is available at: www.ic.nhs.uk From April 2013 the IT delivery aspects and NHS Systems and Services provided by NHS Connecting for Health are moving into the HSCIC.

Workforce minimum data set

10.17 The Health and Social Care Act 2012 places a duty on all organisations that deliver NHS funded care to provide data on their current workforce and to share their anticipated future workforce needs. It does this through the duty placed on:

- the Secretary of State to put in place an effective education and training system;
- providers of NHS funded care to co-operate within the new education and training system; and
- the NHS CB and CCGs to ensure that providers from whom they commission services have regard to education and training when carrying out their functions.

10.18 All providers of NHS funded services are required to co-operate with Health Education England (HEE) and its Local Education and Training Boards (LETBs) to support them to:

- understand the current workforce;
- plan the future workforce and understand education and training needs; and
- manage the provision of education and training to the workforce.

10.19 Early in 2013, the detailed guidance on the workforce information that providers need to supply and the collection timetable for 2013/14 will be signposted from the following web page:
www.ic.nhs.uk/workforce/

10.20 Schedule 6 Part C requires providers to supply information in accordance with all relevant ISNs, and, therefore, to supply information on the workforce minimum data set.

10.21 Workforce planning requires an understanding of the external environment, internal environment, business strategy and plans, current workforce and forecasted impact of turnover, retirements, recruitment and continuing professional development. All areas of the workforce minimum data set will assist planners in understanding workforce demographics and in developing strategies and plans to ensure appropriate education commissioning to provide the future workforce.

Type of data	Use
Absence data	Absence data helps planners to understand one of the elements of the internal environment. It can help provide an understanding of temporary staff costs and the impact of those costs on overall staffing numbers.
Deployment data	The essential elements of this group of data allow planners to ascertain if there are any gaps in workforce provision against their organisational structure, how much the workforce is currently costing the organisation and the potential costs of future requirements.
Education, training	Education, training and development are key elements in

and development data	workforce planning. Analysis of the current workforce's professional registrations, skills and competencies and comparing that data with the current and future requirements provides an indication of any gaps that may need filling. Education, training and development data can also link to the LETB's workforce skills and development strategy.
Organisational data	Indicates the organisation relevant to the employee.
Personal/operational data	This data will help workforce planners by building an understanding of the age profile of the workforce to support understanding of turnover, retention and retirement data and the effect of gender on working patterns.
Staff movement data	This provides essential information on how the shape of the historical and current workforce has ebbed and flowed. Staff movement data provides current vacancies, where staff have come from and where they go to, retirements, churn and natural wastage. It also shows the relationship between those employed and the hours they work, the role they play and whether or not they hold a substantive contract.

11. Managing activity and referrals

Background

11.1 Following stakeholder feedback, SC 29 has been substantially changed to ensure that, whilst it still meets the requirements relating to the primacy of patient choice, it clearly identifies commissioner responsibilities in relation to managing external demand for services and provider responsibilities in relation to internal demand for services.

11.2 As a result some changes have been made to the contractual processes and levers for managing activity and referrals. Key changes include:

- introduction of an early warning system to alert the parties to any unexpected patterns of referrals or activity;
- an activity query process to understand the reasons behind changes in activity and take appropriate action;
- the option to agree a utilisation review;
- the extension of the option of risk share agreements to all service types but only when the risk share agreement is in accordance with the PbR code of conduct and guidance.

Responsibilities of commissioners and providers in relation to managing activity and referrals

11.3 The contract identifies the respective responsibilities of commissioners and providers in managing activity:

- commissioners are responsible for managing external demand for services: this means they are responsible for primary care referrals to providers and for ensuring that referrals comply with any agreed protocols;
- providers are responsible for managing internal demand for services: this means they should work within caseloads, occupancy levels and clinical thresholds that have either been agreed by the parties or been published in their directory of services on Choose and Book, as well as the APAs referred to in paragraph 11.10. Any changes must be agreed with the commissioner.

11.4 Providers must accept any clinically appropriate referrals for any patient who chooses that provider under patient choice. This includes referrals that contravene any primary care based referral and treatment protocols, as once the patient has made their choice of provider, this choice must be honoured.

Processes for managing activity and referrals

11.5 Prior to the start of the contract year, the parties should agree, where relevant, an indicative activity plan (IAP). This plan is an indication of the activity that is estimated by the two parties but it is not a guarantee of activity or a cap on activity.

11.6 A non-mandated IAP template for acute hospital services will be published alongside the contract.

11.7 The IAP should include sufficient detail for both parties to understand the indicative activity that has been agreed and any thresholds for reporting purposes that are required by the commissioner. Any thresholds should act as a

trigger for discussion to understand why activity is over or under the indicative levels and are not intended as a cap on activity.

11.8 For some contracts, an IAP may not be relevant. This may be the case for small contracts commissioned on an AQP basis or for a care home contract. In these cases, the parties may dispense with an IAP or agree an IAP of zero.

11.9 The commissioner may also wish to set activity planning assumptions (APAs), but this is not mandatory. These are assumptions relating to how the provider will manage activity once a referral has been accepted and are monitored as part of the activity management process. They should not be used in such a way as to restrict patient choice. Where APAs are set by the commissioner, they should be notified to the provider before the start of the contract year.

11.10 APAs are likely to be used particularly for acute hospital services. To be effective, they should be measurable and evidence based. Common APAs include:

- first to follow up outpatient ratios;
- consultant to consultant referrals;
- emergency readmissions;
- non-elective admissions.

11.11 Where APAs are used, the commissioner should notify the provider of the APAs prior to the start of the contract year.

11.12 It is a new requirement in the contract that either party must give early warning to the other, as soon as it becomes aware of any unexpected or unusual patterns of activity or referrals. This would be outside the normal process for monitoring activity.

11.13 Either party may issue an activity query notice (AQN), either on receipt of an activity report or where an unexpected or unusual pattern of activity has been notified.

11.14 Where an AQN is received, the parties must meet to review referrals and activity and the exercise of patient choice. There are three possible outcomes of the meeting:

- the AQN is withdrawn;
- a utilisation meeting is held;
- a joint activity review is held.

Utilisation improvement plan (UIP)

11.15 Following an activity management meeting, the parties may agree that they need to understand how resources and capacity are being used. If this is the case, they may agree a UIP. This would identify any agreed actions to be undertaken by both parties to change or improve the way that resources and capacity are used.

Joint activity review

11.16 A joint activity review will be used to identify the reasons for variances in activity and may result in an activity management plan (AMP) being agreed.

11.17 Where it is found that the variation in activity is due wholly or mainly to the exercise of patient choice, no further action should be taken.

Activity management plan (AMP)

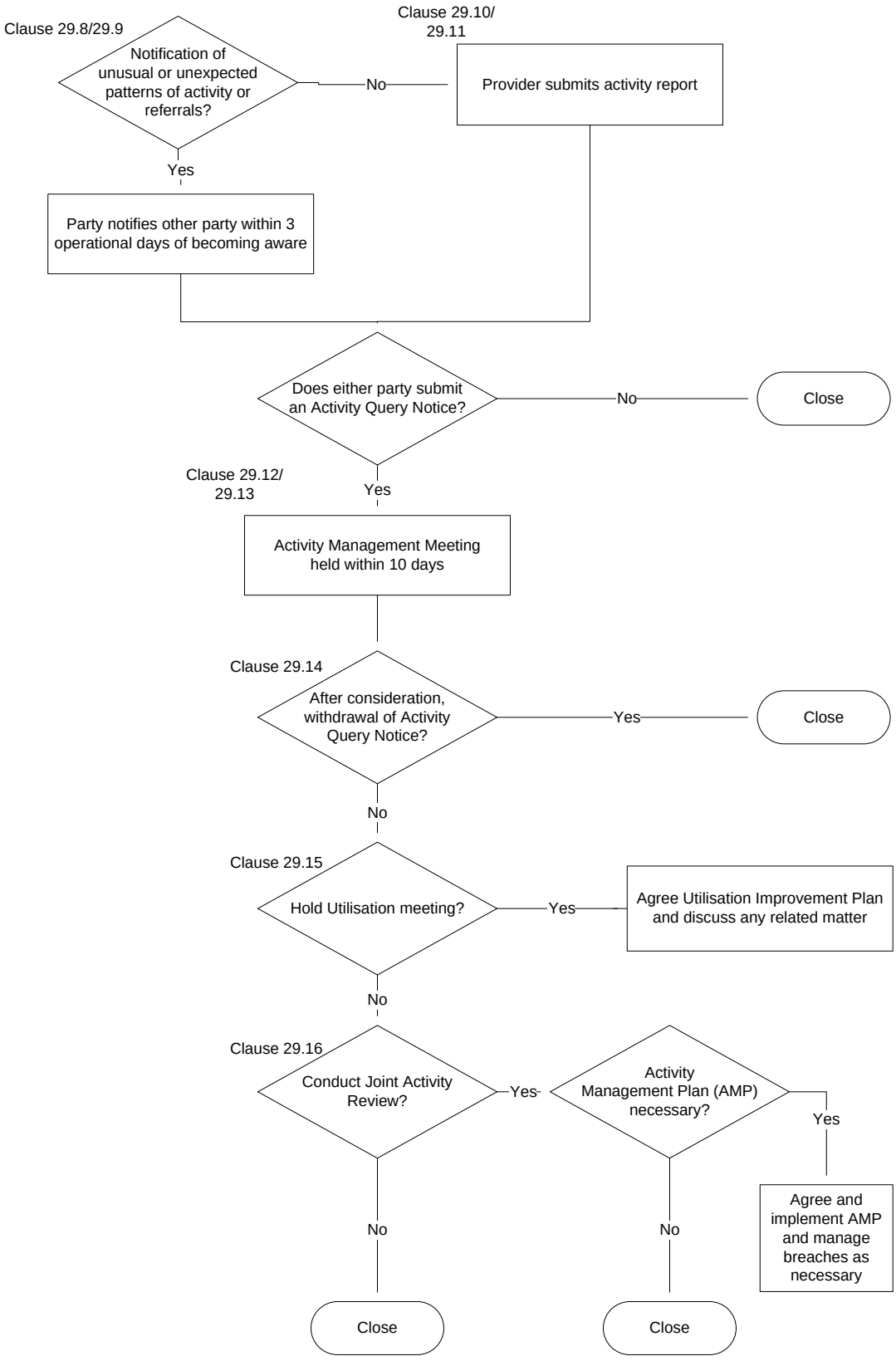
11.18 Otherwise, an AMP may be agreed. Where this cannot be agreed, a joint notice should be sent to the boards of directors, or equivalent, of both organisations and, if a plan still cannot be agreed, the parties should refer the matter to disputes resolution.

11.19 The AMP may include agreements on how activity should be managed for the remainder of the contract period. The plan should not in any way restrict patient choice. Where it is found that the provider has been generating internal demand for services, for example by reducing clinical thresholds or introducing new clinics without the agreement of the commissioner, the plan may include an immediate consequence of non-payment for that activity.

11.20 An AMP could include the following elements:

- details of the APA threshold that has been breached including a breakdown of actual activity, actual cost of activity (where appropriate) and actual variance;
- evidence of review of the activity, including source data (waiting lists, interviews, sample of patient notes, clinical process and patient flow);
- review of the findings that are relevant to the breach by clinical and non-clinical staff;
- analysis of the likely causes of any breach;
- provider specific actions to improve the management of internal demand and timescales for those actions to be completed;
- commissioner specific actions to manage external demand and timescales for those actions to be completed;
- any proportionate financial consequences where actions are not completed on time.

Service Condition 29 - managing activity and referrals



Prior approval schemes

11.21 The commissioner should notify the provider of any prior approval schemes before the start of the contract year.

11.22 Any prior approval scheme which restricts patient choice of provider is void and cannot be used to restrict payment for activity carried out by the provider.

Risk share agreements

11.23 The concept of risk share agreements has been extended from mental health services to cover any services commissioned under the NHS standard contract. A risk share agreement must be in accordance with the PbR code of conduct, which sets out that providers 'are also free to enter into time limited gain or loss sharing agreements with commissioners where significant service redesign is proposed'. This means that there is only a limited set of circumstances where a risk share agreement could be used when commissioning acute hospital services.

12. Contract management

Contract review process

12.1 The contract review process is set out in GC8 (Review).

12.2 The frequency of reviews will depend on the size of the contract and the level of financial or clinical risk involved. The parties may agree a suitable interval between reviews, which should be at least every six months. The review frequency agreed should be set out in the Particulars.

12.3 The matters for review will depend on the type of contract. Potential areas for review will include service quality, finance and activity, information, and general contract management issues.

12.4 Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the quality and Information schedules.

12.5 Either party may call an emergency review meeting at any time.

12.6 Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.

12.7 The review process will be used to agree any amendments for each contract year.

Contract management process

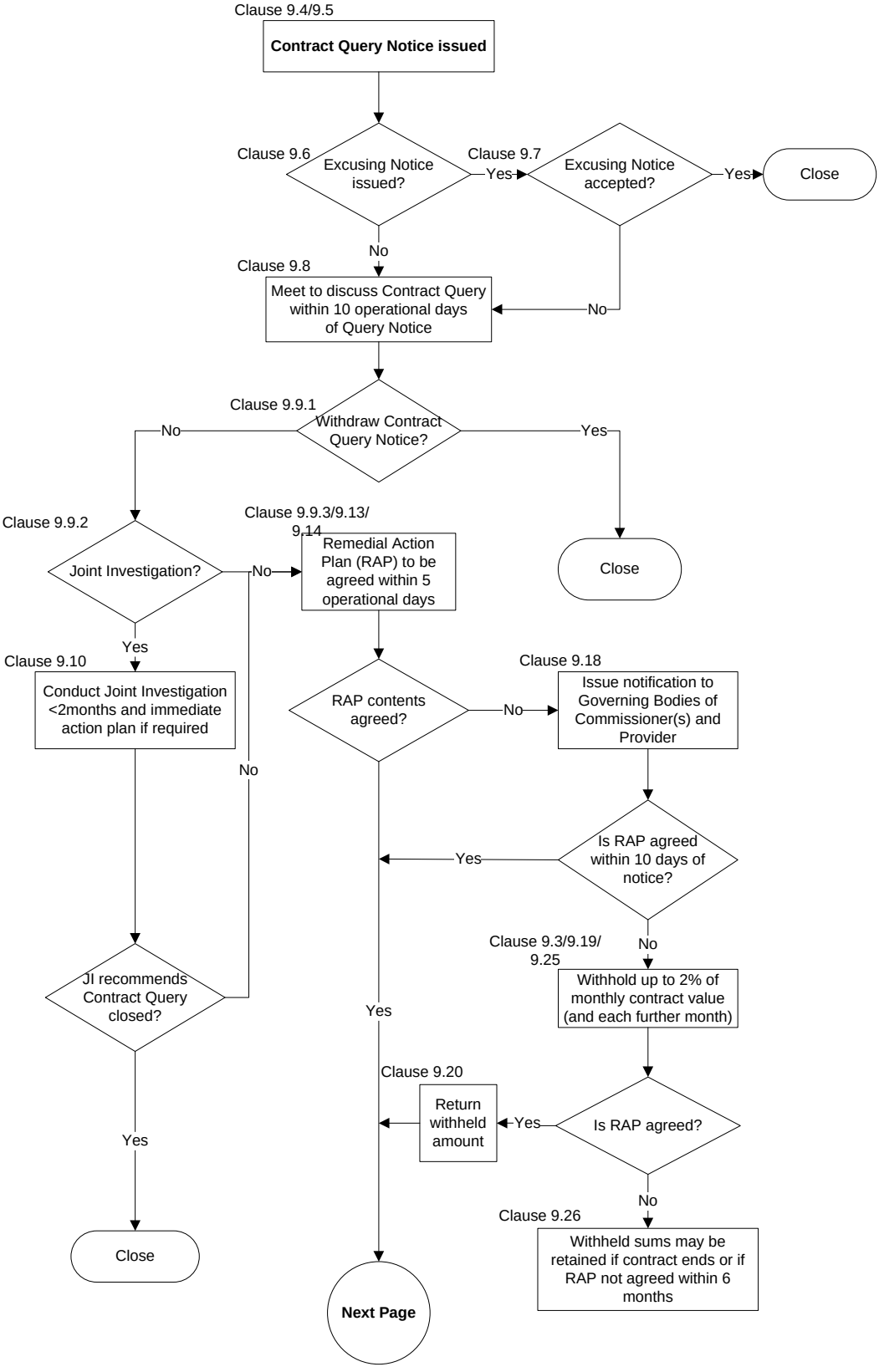
12.8 The contract management process is similar to that of previous NHS standard contracts. However, the clause has been changed to make the process clearer. There are a number of stages to the contract management process. These can be summarised as follows:

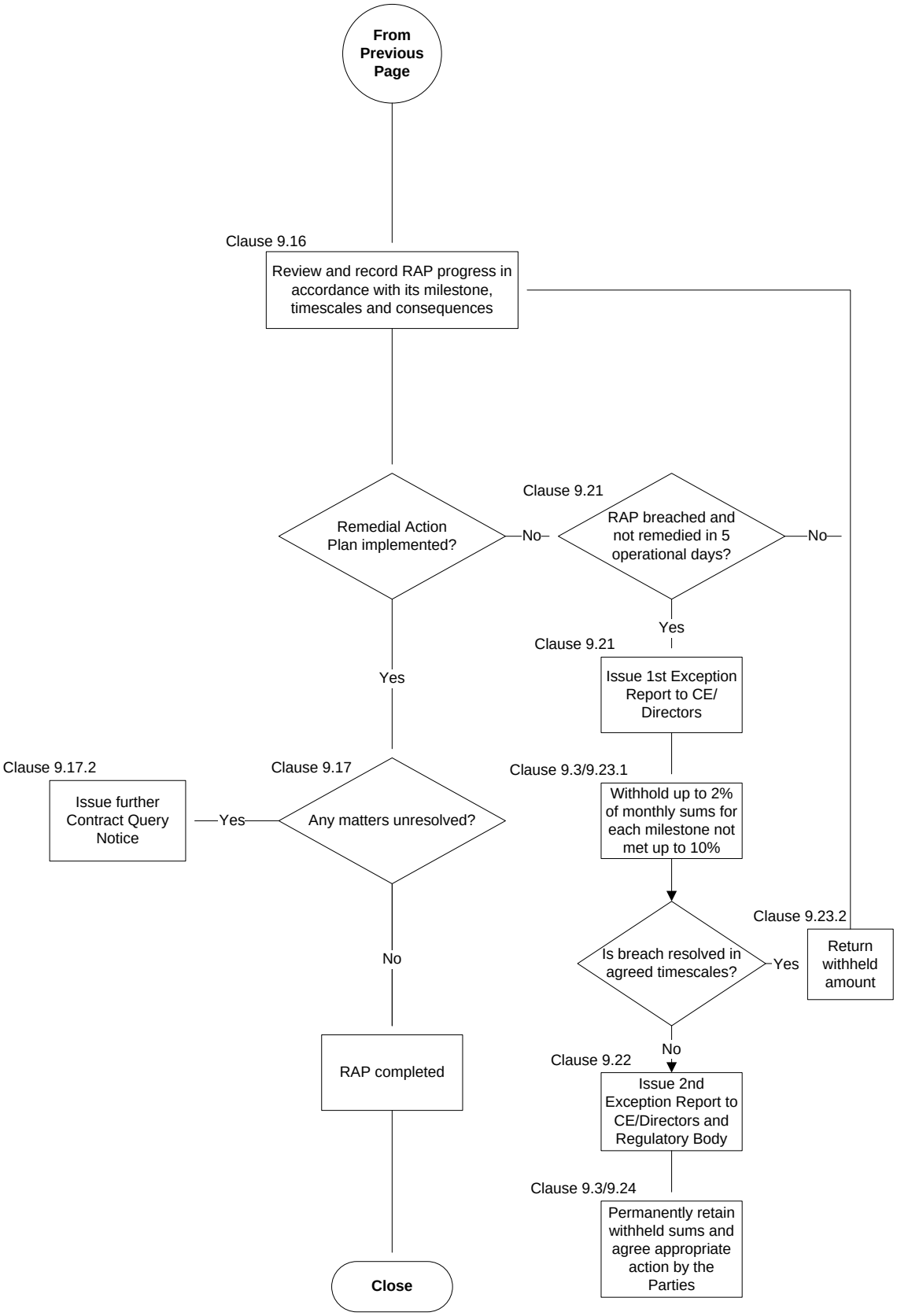
- issue of contract query;
- excusing notice (where relevant);
- meet to discuss the contract query;
- implement a remedial action plan and/ or joint investigation;
- withhold payment in the event of failure to agree a remedial action plan;
- issue an exception report where there is a breach in the remedial action plan which remains un-remedied and withholding of funding;
- issue a second exception report to the boards where there is a breach of timescales for remedy identified in the first exception report and permanently retain withheld funding

Immediate consequences

12.9 Where the parties have agreed an immediate consequence in relation to meeting a quality requirement, that consequence can be exercised without the need to go through the formal contract management processes.

General Condition 9 - contract management




From Previous Page
Clause 9.16
Review and record RAP progress in accordance with its milestone, timescales and consequences
Remedial Action Plan implemented?
No
Clause 9.21
RAP breached and not remedied in 5 operational days?
No
Yes
Clause 9.21
Issue 1st Exception Report to CE/ Directors
Yes
Clause 9.17.2
Issue further Contract Query Notice
Yes
Clause 9.17
Any matters unresolved?
Clause 9.3/9.23.1
Withhold up to 2% of monthly sums for each milestone not met up to 10%
Clause 9.23.2
Return withheld amount
Yes
Is breach resolved in agreed timescales?
No
No
RAP completed
Clause 9.22
Issue 2nd Exception Report to CE/Directors and Regulatory Body
Clause 9.3/9.24
Permanently retain withheld sums and agree appropriate action by the Parties
Close

13. Payment

13.1 The requirements relating to payment under the contract have been updated and simplified. By selecting the appropriate options when completing the eContract the commissioner can ensure that only the relevant payment arrangements relating to each contract are set out in the final eContract documentation.

13.2 The clause covers:

- overarching principles and rules;
- arrangements for small providers relating to payment and reconciliation;
- arrangements for other providers relating to payment and reconciliation;
- general provisions covering other matters.

13.3 The contract specifies two different types of prices:

- those paid under national tariff rules: PbR rules should be used for all services to which PbR applies. There are two options within PbR Rules: full tariff or permitted variations to tariff price. Any permitted variations to tariff prices should be agreed in accordance with PbR guidance.
- Non-tariff prices: these should be used for all services to which the national tariff does not apply.

13.4 As in previous years, the contract allows for quarterly payments on account to small providers where an expected annual contract value (EAV) has been agreed.

13.5 For all other providers where an EAV has been agreed, the provider should issue a monthly invoice, before the first day of the month. The contract sets a default for payment on the 15th day of the month. This can be varied by agreement by the parties in writing.

13.6 Where there is no expected annual contract value, the provider should issue a monthly invoice at the end of each month based on the actual services provided.

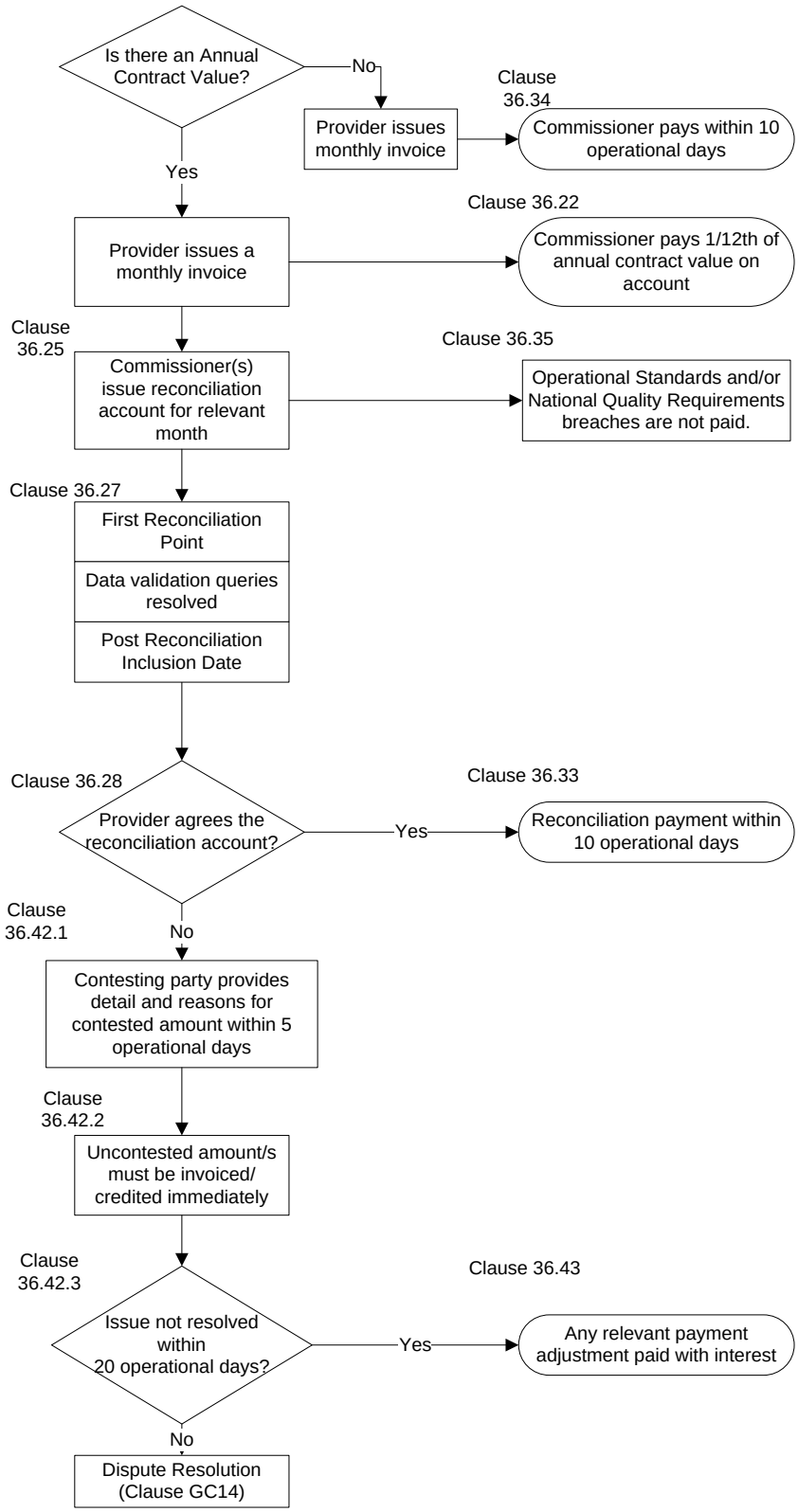
13.7 Reconciliation will be required where payment is made on the basis of a monthly/quarterly proportion of the expected annual contract value. It will not be required for 'block' contracts.

13.8 For services where national tariff applies, reconciliation should be carried out in accordance with PbR rules.

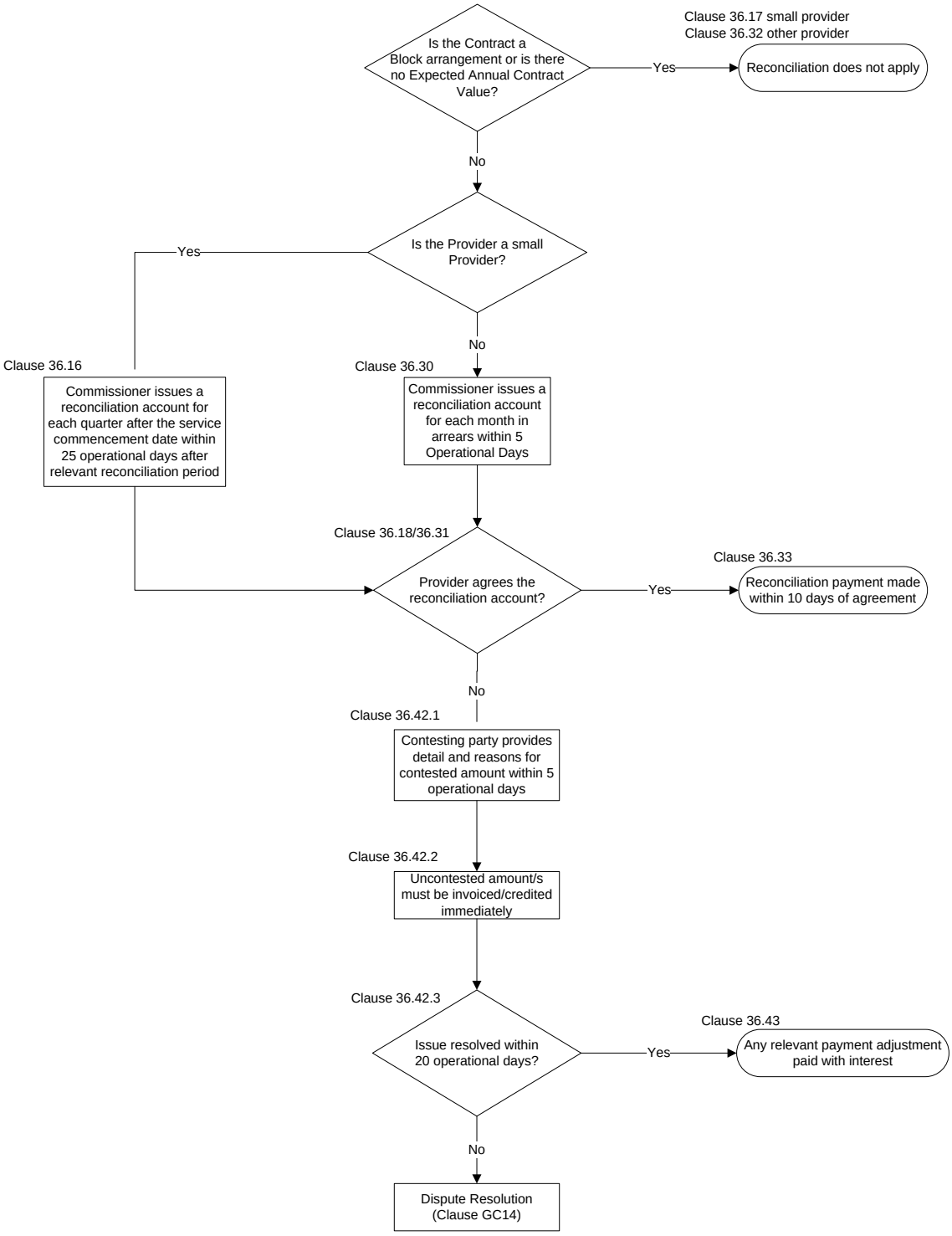
13.9 For reconciliation relating to non- tariff priced services, either the same process as for PbR rules activity can be used, or commissioners may send a reconciliation account using the activity information submitted by the provider.

13.10 Any disputes in relation to the calculation of payments should be addressed by using the process set out in SC36.42.

Service Condition 36 - National Tariff reconciliation



Service Condition 36 Non-Tariff reconciliation



14. Safeguarding

14.1 The Safeguarding provisions in the contract (SC 32) remain broadly unchanged from last year, with the one key exception of added provisions relating to the Prevent strategy.

Prevent

14.2 Providers' responsibilities in complying with the Prevent strategy (2011) are set out in SC32 (Safeguarding).

14.3 Prevent is part of the Government's counter-terrorism strategy CONTEST http://www.homeoffice.gov.uk/counter-terrorism/uk-counter-terrorism-strat/. Its aim is to stop people becoming terrorists or supporting terrorism.

14.4 Healthcare organisations are to maintain an appointed responsible person for Prevent with executive authority for including Prevent within the organisation's policies and procedures. The Prevent lead will work in collaboration with the regional Prevent coordinator based in the appropriate NHS CB area team.

14.5 The name of the Prevent lead should be inserted in the Particulars and updated if this changes.

14.6 The Prevent lead is responsible for the Workshop to Raise Awareness of Prevent (HealthWRAP) delivery programme for frontline workers that is supported by accredited HealthWRAP facilitators. The delivery programme is to raise awareness of Prevent to frontline workers involved in healthcare delivery.

14.7 Guidance on the Prevent strategy is available at: http://www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy/prevent-strategy-review?view=Binary

14.8 Specific guidance to which healthcare organisations should adhere, *Building Partnerships, Staying Safe – guidance and toolkit documents for healthcare organisations and frontline workers*, is available at: http://www.dh.gov.uk/health/2011/12/guidance-vulnerable-adults/

Annex 1

Summary guide to completing the contract

A.1 This annex provides a summary of the key elements that should be completed in the period leading up to the Commissioner and the Provider signing the contract and a guide to some of the key clauses in the contract.

A.2 Initial advice on the general interpretation of the contract term is available through the NHS standard contract help email at: nhscb.contractshelp@nhs.net.

A.3 The parties to the agreement should seek their own legal advice in the event of any uncertainty as to the meaning of any specific terms in the contract and its impact on them.

The scope of the contract

A.4 There are two types of contract that can be entered into using the 2013/14 NHS standard contract:

- a multilateral contract designed to be entered into by a number of commissioners and a single provider;
- a bilateral contract entered into by a single commissioner and a single provider.

A.5 For multilateral contracts, the roles and responsibilities table set out in the collaborative commissioning agreement (CCA) will be used to identify the roles each commissioner will play in relation to the contract ie who will play the role of Co-ordinating Commissioner in respect of specific, or all, provisions in which the Co-ordinating Commissioner is mentioned.

A.6 The CCA is a separate document entered into by a group of commissioners and governs the way the group of commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, the signed contract is still be legally effective and binding on all the parties without a collaborative agreement in place. The CCA should not be included in the contract.

A.7 Although each of the commissioners signs the contract and the roles and responsibilities table/schedule sets out the specific roles that each of the commissioners will play in relation to the contract, the other commissioners are bound by the contract and should play an active part in the contract relationship.

A.8 The contract contains provisions which are either:

- mandatory and non-variable, whether for all NHS services or only for specific types of service;
- mandatory, but for local agreement and definition;
- non-mandatory, and for local agreement and definition.

A.9 For ease these three levels have been colour coded:

	All of the **General Conditions** are mandated and cannot be amended, or deleted. They apply to all services and to all providers of NHS funded clinical services The **Service Conditions** apply automatically to all services or to the relevant service, as indicated, and are mandated for all services or the relevant service, as appropriate. The Service Conditions applicable to the relevant Service cannot be changed, amended or deleted. The Service Conditions that are not applicable to the relevant service are deleted by the operation of the eContract.	
	The **Particulars** contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green' Action is required on all items that are amber coloured and must be completed prior to signing the contract. The parties cannot 'leave' any amber marked element for later completion.	
	Any element indicated as 'green' is optional and may be left blank, although for good practice and clarity any 'green' element that is not used will be marked as 'not applicable'.	

A.10 Where a term in the contract is capitalised this means that the term is defined. Definitions are in the definitions section at the end of the General Conditions.

A.11 Commissioners should be aware that embedding documents within contracts, other than in accordance with the e-contract system guidance, is not good practice and must be avoided, as links to embedded documents can be lost when the documents are moved or copied within IT systems.

Front Page		
Contract reference	The unique contract reference will be automatically added by the e-contract system. The contract reference number is based on the ODS code of the Commissioner creating the contract, the 'route to market' code, the year and a sequential number.	
Particulars		
Date of contract	Enter the date on which the contract has been signed by all parties and is agreed by them as the date of the contract. This is the date the contract is legally executed and is not the date of service commencement.	
Service Commencement Date	Enter the date when the services actually start delivery. This will usually be 1 April 2013 but will be the date agreed between the Commissioner and the Provider (the Expected Service Commencement Date) or the date on which any Conditions Precedent to Service Commencement (see GC2 and Schedule 1 Part A) are satisfied, whichever is later.	
Contract Term	The default duration is set at 12 months. Commissioners should see guidance in chapter 4. Separate variants for 'one-year/multi-year' contract are not provided. The contract term should be recorded in months.	
Commissioners	Enter the full legal name and address of each commissioner organisation (CCGs, NHS CB and, if appropriate, the local authorities) which will be a commissioning party to the contract. Include the relevant ODS code for each as this will aid identification and is linked to the information flows. All Commissioners to this contract will need an ODS code. Information on ODS codes can be found at http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/	
Co-ordinating Commissioner	This is the Commissioner (or Commissioners) identified by the other Commissioners fulfilling the role (or roles) of Co-ordinating Commissioner for this contract. This links to Schedule 5 Part D and the Collaborative Commissioning Agreement . Where the contract is a bilateral contract the sole	

	Commissioner will be the Co-ordinating Commissioner.	
Provider	Enter the full legal name and address of the Provider. Include the Provider ODS code.	

Inside Page		
Table of contents	The table of contents cannot be changed.	
Contract		
Signatures	Each of the Commissioners who are parties to this contract must sign the contract. Insert additional signature blocks as required for the number of Commissioners that are party to the contract. The Provider must sign the contract.	
Contract Term		
Effective Date	Insert the date on which the contract is to take effect. This may be the date of contract or a later date.	
Expiry Date	Insert the date on which the contract will expire. This will be the day before the relevant anniversary of the contract commencement date. The expiry date will either be the date set out in any procurement advert or 31 March 2014 where the contract has been awarded without a procurement exercise being undertaken. See Chapter 4.	
Service Commencement		
Expected Service Commencement Date	Enter the date (or dates) when the services are expected to start to be delivered.	
Longstop Date	Enter the date by which all the Conditions Precedent have to be completed. This should be no later than three months after the Expected Service Commencement Date in most instances. The Co-ordinating Commissioner or the Provider may terminate the contract if another party to the contract has not met the Conditions Precedent relevant to it by the Longstop Date. If there are no Conditions Precedents then enter 'not	

	applicable'.	
Conditions Precedent	Insert details of any documents that must be provided and/or actions, which must be completed by the Provider before it can start providing services. The items/actions on the list should be provided/completed prior to the Expected Service Commencement Date or, at the latest, by the Longstop Date Set out the Conditions Precedents that the Provider has to fulfil in Schedule 1 Part A or state 'not applicable'.	
Commissioner Documents	These are any documents to be delivered by the Commissioner(s) before the Expected Service Commencement Date. Set out the Commissioner Documents that the Commissioner(s) have agreed to provide in Schedule 1 Part A or state 'not applicable'.	
Services		
Service Categories		
Commissioners should select <u>all</u> the services that are to be provided under the contract. This section is particularly important when using the eContract, as the selection made will drive the content of the Service Conditions. For Commissioners not using the eContract the selection of the services relevant to the Provider will give an indication which of the Service Conditions is applicable. The Service Conditions that are not applicable will be 'read over'. Where a service is added to or removed from an existing contract, this section will need to be updated. The process set out in GC13 (Variations) should be used		
Service Requirements		
Service Specification	The Service Specification(s) for each service to be provided under the contract must be included in Schedule 2 Part A. See Chapter 8 on completion of the Service Specification form.	
Indicative Activity Plan (IAP) SC29.5 – SC29.6	Insert the Indicative Activity Plan (if any) at Schedule 2 Part B. It is helpful if Indicative Activity Plan also has the individual commissioner plans, as it will assist the parties to reconcile their own records. The Indicative Activity Plan is not an upper or lower cap or limitation on the activity that that Provider can undertake.	

	A model template to record the Indicative Activity Plan for acute services is available on the 2013/14 standard contracts web page. Where no specific level of activity is agreed or identified, indicate 'not applicable'. The indicative activity will then be zero. The response 'not applicable' will remove the clause(s) in the Service Conditions that are rendered redundant and will mark them as 'not used'.	
Activity Planning Assumptions (APA) SC29.7	The Commissioner may notify the Activity Planning Assumptions before the start of each contract year. A model template is available on the 2013/14 standard contract web page. For multi-lateral contracts, where there is an APA the default position is a single set of APAs for all Commissioners. However, a provider may agree to have more than one set of APA where Commissioners cannot agree a common approach. The APA is to be set out in Schedule 2 Part C. If there is no APA, insert 'Not Applicable'. Chapter 11 paragraph 9 of this guidance refers. The response 'not applicable' will remove the clause(s) in the Service Conditions that are rendered redundant and will mark them as 'not used'.	
Commissioner Requested Services (CRS) SC5	See guidance on CRS on the Monitor web site www.monitor-nhsft.gov.uk/ and SC5. Any CRS are to be set out in Schedule 2 Part D. If there are no CRS, insert 'not applicable' The response 'not applicable' to this and in respect of Essential Services will remove the clause(s) in the Service Conditions that are rendered redundant and will mark them as 'not used'.	
Essential Services SC5	The Commissioner may identify services that are key to the local health economy, which, if absent, would significantly affect the healthcare available to the local population. These Essential Services only apply to those providers not caught by the Monitor licence requirements.	

	Any Essential Services are to be set out in Schedule 2 Part D. If there are no Essential Services, insert 'not applicable'. The response 'not applicable' to this and in respect of CRS will remove the clause(s) in the Service Conditions that are rendered redundant and will mark them as 'not used'.	
Services to which 18-Week applies SC21	Do the services being commissioned include services to which the 18-Weeks Standard applies? Answer 'yes' or 'no'. A positive response will allow the clauses relevant to 18 Weeks set out in the Services Conditions to apply. A negative response will remove the relevant clause in the Service Conditions and will mark the deleted clause(s) as 'not used'.	
Payment		
Tariff Services SC36	List the Services (and, where relevant, the Specification number (set out in Schedule 2 Part A)) that are subject to National Tariff. Enter 'all' where every service commissioned will be Tariff based. A positive response will allow the clauses relevant to tariff services set out in SC36 to apply. Where this does not apply, indicate as 'not applicable'. The response 'not applicable' will remove the clause(s) in the Service Conditions that are rendered redundant and will mark them as 'not used'.	
Permitted Variations to Tariff SC36.5 – SC36.7	List the services (and, where relevant, the specification number (set out in Schedule 2 Part A)) in respect of which there is a Permitted Variation to Tariff (as defined in the Payment by Results Guidance). A full description of the Permitted Variations to Tariff prices must be set out in Schedule 3 Part A Table 2. Where there are, no Permitted Variations to Tariff indicate 'not applicable'.	
Non-Tariff Services SC36.8-SC36.11	List the Services (and, where relevant, the specification number (set out in Schedule 2 Part A)) to which a Non-Tariff price is to apply. Enter 'all' where every service commissioned will have	

	a Non-Tariff Service price. A full description of the locally agreed prices, and how they are calculated, must be set out in Schedule 3 Part A Table 1. Where there are no Services to which a Non-Tariff price will apply indicate 'not applicable'.	
Small Providers SC36.12-SC36.20	A "Small Provider" is defined in this contract as an organisation with fifty or fewer FTE and whose aggregate income for the relevant contract year in respect of services provided to NHS commissioners is not expected to exceed £130,000. Where the Provider falls within the definition answer 'yes' and if not answer 'no'. Certain clauses in the SC 36 Payment Terms (specifically SC36.12 – SC36.20) apply only to Small Providers. A positive response will allow the relevant clauses to apply. A negative response will remove the relevant clause in the Service Conditions and will mark the deleted clause(s) as 'not used'.	
Expected Annual Contract Value Agreed SC36	Indicate whether an Expected Annual Contract Value has been agreed – 'yes' or 'no' Insert (where applicable) at Schedule 3 Part B the total Expected Annual Contract Value in aggregate and for each Commissioner as this will form the basis of the 1/12th monthly payments or quarterly payments, as applicable). A sum entered as Expected Annual Contract Value will not be a cap on a provider's ability to meet patient demand for choice services Where there is no Expected Annual Contract Value, payment through the Contract Year will be based on actual activity undertaken. Where there is no Expected Annual Contract Value, the Provider will be paid against a submitted invoice for any service delivered.	
Any Service not included in Expected Annual contract Value SC36.20, 36.34 (as	A positive response will allow the clauses set out in Service Conditions SC36.20 or 36.34 (as appropriate) to apply. Where there is no Expected Annual Contract Value, the Provider will be paid against a submitted invoice for any	

applicable)	service delivered.	
Other Clinical Arrangements SC36.45	Other Clinical Arrangements are ISTC contracts. Select 'yes' if the Provider is party to an on-going ISTC contract. This will allow the clauses set out in the Service Condition SC36.45 to apply.	
First/last contract Year less than 12 Months SC36.14	Select 'yes' if the contract commences or is due to expire part way through a financial year. The payments due in each month of the first/last year should then be set out in Schedule 3 Part A Table 4.	
Notice given to aggregate payments SC36.2	Select 'yes' if the Commissioners have agreed and are notifying the Provider that payments are to be aggregated into a single payment to be made by the Co-ordinating Commissioner.	
Notice given to disaggregate payments SC36.2	Select 'yes' if or when, during the contract term, the Commissioners agree and are notifying the Provider that payments are to be disaggregated and made separately.	
Risk Share Agreement SC29.28	A positive response will allow Service Condition SC29.28 to apply Where the parties have agreed a risk share arrangement the terms agreed must be set out in Schedule 3 Part C. Where there is no Risk Share Agreement then enter 'not applicable'.	
Quality		
Local Incentive Schemes SC37	Where the Commissioner and Provider agree a local incentive scheme in addition to the CQUIN scheme, select 'yes'. Details of the agreed local scheme should be set out in Schedule 4 Part F. Where there is not a Local Incentive Scheme select 'no'.	
CQUIN Payment SC38	The parties must agree whether the CQUIN Payment for 2013/14 will be paid monthly, annually or at another frequency. Enter the agreed frequency here.	
Clostridium difficile Threshold	Where applicable, indicate whether the Provider is NHS or non-NHS.	

SC22	The threshold for NHS FTs and NHS Trusts is found in the following link: http://www.commissioningboard.nhs.uk/files/2012/12/ccg-prov-c-diff-2013-14.xls For other providers the C. diff. threshold should be set at zero.	
Governance		
Commissioner Authorised Signatories	Insert the name of the person authorised by each of the Commissioners to sign the contract. Each Commissioner will need to identify a person who will sign the contract.	
Provider Authorised Signatory	Insert the name of the person authorised by the Provider to sign the contract.	
Documents Relied On	If there are any documents, consents or certificates that have been relied on by any Party in deciding whether to enter the contract these should be inserted here. The documents should not include letters of intent that relate to commissioning assumptions, nor should this section be used to endeavour to contradict or circumvent the mandated terms and conditions of the contract. Set out details to any documents relied upon in Schedule 5 Part A or state 'not applicable'.	
Mandatory Material Sub-contractors GC12.1	As part of a procurement exercise, a commissioner may have agreed a service offering based on specific, defined contributions by one or more named sub-contractors, the identity and role of whom is essential to the delivery of the contracted services. Where this is the case, the Provider must enter into formal contracts with those agreed Sub-contractors (Mandated Material Sub-contractors). If there are no Mandatory Material Sub-contractors this section will be identified as 'not applicable'. Set out details of any Mandated Material Sub-contractors in Schedule 5 Part B1 or state 'not applicable'.	
Permitted Material Sub-contractors GC12.2	Where the Provider may use a sub-contractor to deliver an element of the Service, but the Commissioners have an interest in the identity and contribution to be made by that sub-contractor, that sub-contractor should be identified as a Permitted Material Sub-contractor. See	

	GC12. If there are no Permitted Material Sub-contractors this section will be identified as 'not applicable'. Set out details of any Permitted Material Sub-contractors in Schedule 5 Part B2 or state 'not applicable'.	
IPR (Intellectual Property Rights) GC22	Any IPR owned or licensed by any Commissioner to be used by the Provider in the delivery of the Services should be agreed and listed in Schedule 5 Part C. Any IPR owned or licensed by the Provider and that is to be used in the delivery of the Services should be agreed and listed in Schedule 5 Part C. If there is no such IPR state 'not applicable'.	
Commissioner Roles and Responsibilities GC10	The Commissioners must set out the roles and responsibilities that each Commissioner has in relation to this contact – in essence, who will be the Co-ordinating Commissioner for all, or for some specific, purposes under the contract. The roles and responsibilities must be set out in the separate Collaborative Commissioning Agreement document entered into by all the Commissioners who are parties to the contract. Set out the Commissioner roles and responsibilities in Schedule 5 Part D.	
Nominated Mediation Body GC14.4	This links to GC14 - Dispute Resolution. Insert the details of the organisation that will act as the external mediator. If the Commissioners are CCGs and/or NHS CB and the Provider is an NHS Trust mediation will be arranged jointly by the NHS TDA and NHS CB.	
Caldicott Guardian SC24	The name of the Provider's Caldicott Guardian must be inserted here.	
Senior Information Risk Owner SC24	The name of the Provider's Senior Information Risk Owner must be inserted here.	
Accountable Emergency Officer SC30	The name and contact details of the Accountable Emergency Officer for <u>each</u> Commissioner must be inserted here. The name and contact details of the Provider's	

	Accountable Emergency Officer must be inserted here.	
Prevent Lead SC32	The name and contact details of the Provider's Prevent Lead should be inserted here.	
Regulatory		
CQC Registration	Commissioners will need to identify whether any or all of the commissioned services fall within the scope of Regulated Activities under the CQC regulatory regime, and indicate whether CQC Registration is required here. Enter 'required' where any Service under this contract is a Regulated Activity under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 No. 781 or 'not required' where none of the Services in the contract is a Regulated Activity	
Monitor Licence	Insert 'yes' or 'not applicable'. For 2013/14 where the Provider is an NHS FTs enter 'yes'; for all other provider types including NHS Trusts enter 'not applicable'. The position in respect of any specific provider may change during the term of its contract. Guidance will be available during 2013/14 on the Monitor website: www.monitor-nhsft.gov.uk/	
Contract Management		
Addresses for service of notices GC36	Insert for each Party the name and address to which notices relating to the contract should be sent.	
Frequency of Review Meetings GC8.1	Insert the frequency of the contract review meetings between the parties. The review meeting will focus on the quality and performance of the Services. The frequency of the review meetings should reflect the nature of the Services and the relationship between the parties. It is expected that the minimum frequency will be every six months.	
Commissioner Representative(s)	Insert for each Commissioner the name and contact details of the person that will be the contact point for the	

GC10.3	Provider. Where the CCG(s) have contracted with a commissioning support service then the name and the contact details of the relevant contact point within the commissioning support service should be entered. This links to Schedule 5 Part D.	
Provider Representative GC10.3	Insert the name and contact details of the person that will be the Provider's contact point for the Commissioners.	
Data Quality Improvement Plan (DQIP) SC28.16	A DQIP allows commissioners and providers to agree a local plan to improve the capture, quality and timeliness of data flows to support the commissioning and contract management processes. The DQIP may provide for financial sanctions relating to specific performance milestones. Where there is a breach, the Commissioner may retain the agreed sum immediately. A DQIP is non-mandatory but may be agreed at any time during the term of the contract. Further guidance on use of a DQIP can be found in Chapter 10. If there is no DQIP enter 'not applicable'.	
Service Development and Improvement Plan (SDIP) SC18	The SDIP is an agreed plan setting out improvements to be made by the Provider to the Services and/or the Services Environment. An SDIP could include the Provider's contribution to: • QIPP Plans; • service quality improvements (not included in CQUIN or Local Incentive Schemes); • service user experience; • productivity and efficiency; • service integration; • priority areas for development. An SDIP is not mandatory and is likely to be put in place at the start of a contract only where there have been issues with the Provider's performance under a previous contract. Further guidance on use of a SDIP can be found in Chapter 9 paragraphs 39 and 40. If there is no SDIP enter 'not applicable'.	
Schedule 1 – Service Commencement		
A - Conditions precedent	These are specific requirements (documents to be produced and/or actions to be completed) that have to	

GC2.1.2	be satisfied by the Provider prior to Service Commencement. Insert any locally agreed Conditions Precedent at Schedule 1 Part A.	
B - Commissioner Documents GC4.1.2	Insert details of any specific documents that have to be provided by the Commissioner(s) to the Provider prior to Service Commencement.	
Schedule 2 – The Services		
A - Service Specification	Commissioners and Providers should agree Service Specifications for all services commissioned under this contract. An example of how the Service Specification template should be completed is set out in this guidance in Chapter 8.	
B – Indicative Activity Plan (IAP) SC29.5	There may be a plan identifying the anticipated indicative activity for each activity (which may be zero) for the following contract Year. This plan is not an upper or lower cap or limitation on activity that a provider can undertake. A model, non-mandated, template for acute hospital services is available on the 2013/14 standard contracts web page.	
C – Activity Planning Assumptions (APA) SC29.7	The Commissioner(s) must notify the Provider of any APA for that contract year, specifying a threshold for each assumption. The Provider will manage its internal activity once a referral has been accepted within the scope of the APA. The APA is not mandated but is likely to be more widely used for contracts covering acute hospital services than in other contexts. APA must not be used in such a way as to restrict patient choice. The APA may relate to specific areas of care (clinical thresholds) or across a number of specialities e.g. consultant-to-consultant referrals. The APA must be based on best practice and be evidence based. Assumptions must be measurable. Examples include: • first to follow up outpatient ratios; • consultant to consultant referral ratios.	

	For multi-lateral contracts, Commissioners should seek to have common APA for all Commissioners. Where this is not possible, the number of different APA in the contract must be kept to a minimum. See Chapter 11 paragraph 9.	
D – Commissioner Requested Services and Essential Services SC5	There are two alternative text boxes to complete. CRS will only apply to Monitor licenced providers. For 2013/14, these will be NHS Foundation Trusts only. In the CRS text box, insert any identified CRS for the FT Provider. For all other providers (or if, for an FT, there are no CRS) this box will be marked 'not applicable'. For further guidance on CRS, refer to the Monitor guidance www.monitor-nhsft.gov.uk/ For 2013/14, Essential Services will apply to all providers that are not NHS Foundation Trusts. Commissioners should enter any essential services that are applicable to the contract. If there are no essential services identified or the Provider is an FT enter 'not applicable'.	
E – CRS Continuity Plan and Essential Services Continuity Plan SC5	If there are CRS or Essential Services, the Provider must have a Continuity Plan in relation to those Services. That plan (or a link or reference to it) must be inserted here. Where there are no CRS or Essential Services identified in Schedule 2 Part D mark this Part E as 'not applicable'.	
F – Clinical Networks, Screening Programmes and National Audit SC26	Set out here any clinical networks and screening programmes in which the Provider is required to participate. If there are no relevant clinical networks or screening programmes applicable to the Services enter 'not applicable'.	
G – Other Locally Agreed Policies and Procedures SC25.3	If there are specific local policies and procedures with which the Provider and/or Commissioner(s) are to comply enter details of them here.	
H – Transition Arrangements	The contract Transition Period is the time between the Effective Date and the Services Commencement Date. There may be certain things that need to be done	

GC4	during that period in order that services commence smoothly. Details of any such arrangements should be inserted here.	
I – Exit arrangements GC18.9	Where the parties agree specific payments to be made by one or more parties, and/or other specific arrangements which are to take effect, on the expiry or termination of the contract or termination or any service, these should be set out in this section. Where there are no exit payments, this section should be marked 'not applicable'.	
J – Social Care Provisions SC8.4	Where a service has been jointly commissioned under a Partnership Agreement under section 75 of the 2006 Act and where the CCG/NHSCB is the lead Commissioner there may be performance monitoring or information requirements required by the local authority to meet their obligations. Where there are specific requirements for the local authority associated with a service, these be inserted here otherwise mark as 'not applicable'.	
K – Transfer of and Discharge from Care Protocols SC11	Any local agreement or protocols relating to Service Users' transfer and discharge from various care settings should be set out here. There is no mandatory format for this. A single protocol will not necessarily satisfy the needs of all types of Service User. Equally, separate local requirements for each Commissioner will need to be balanced against the provider's ability to accommodate different protocols for similar service users. Ideally, a single set of protocols will apply to all Commissioners. Where any individual Commissioner needs different transfer and discharge protocols, the collaborative commissioning group should discuss. Several protocols may be tabled for agreement with the Provider. The exact number will be for negotiation but it is expected that providers and commissioners will agree a sufficient number of different protocols broadly to satisfy local requirements without over-burdening the provider's ability to deliver.	
L – Safeguarding Policies SC32	The Provider's written policies for safeguarding children and adults should be appended in Schedule 2 Part L and may be varied from time to time in accordance with SC 32. The policy should reflect the local multi-agency	

	safeguarding policy	
Schedule 3 – Payment		
A - Permitted variations to tariff, non-tariff prices and other payments SC36	Table 1 – Insert the detail of any Non-Tariff prices in this table. Where there are none, enter 'not applicable' (36.4.2, 36.8). Table 2 – Insert the detail of any Permitted Variations to Tariff prices in this table. Where there are none, enter 'not applicable' (SC36.4.1, 36.5). Table 3 – Insert the detail of any Other Payment Arrangements (for example, payments based on outcomes) in this table. Where there are none, enter 'not applicable'. Table 4 – If the Service Commencement Date is not 1 April and/or the expiry of the contract will not be on 31 March, insert here the schedule of payments to be made in the first and/or final year of the contract (SC36.15). If the Service Commencement Date is 1 April and the expiry date is 31 March, enter 'not applicable'.	
B - Expected Annual Contract Values SC36	Insert the total Expected Annual Contract Value for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). The Expected Annual Contract Value must not be seen as an upper or lower cap on the provider delivering choice services. Where there is no Expected Annual Contract Value, enter 'not applicable'. Payment will then be based on actual activity undertaken by the Provider.	
C - Risk share agreement SC29.28	Enter here the details of any agreement between the Provider and the Commissioner(s) under which the parties share the costs and/or other consequences of over and/or under performance on specified Services to an agreed proportion. (Note that any such agreement must comply with - and not seek to override - relevant PbR and other guidance.) Where there is no Risk Share Agreement, enter 'not applicable'.	
D - Notices to aggregate/disaggregat	The Commissioners may agree to aggregate payments to the Provider into one payment to be made by the Co-ordinating Commissioner. Notices to the Provider	

e payments SC36.2	informing it of the intention to aggregate payments, or to disaggregate payments, must be inserted here.	
Schedule 4 – Quality Requirements		
A - Operational Standards	These Operational Standards cannot be changed or amended. Elements for local insertion are indicated by the amber highlight. These link to the service categories in the Particulars section - only those applicable to the commissioned services will appear in the contract.	
B - National Quality Requirements	Elements of National Quality Requirements that are for local agreement or insertion are indicated by the amber highlight. The remainder of the table cannot be amended. These link to the service categories in the Particulars section - only those applicable to the commissioned services will appear in the contract	
C - Local Quality Requirements	Commissioners may wish to agree additional quality requirements with the Provider. Where these are agreed, they should be recorded here. Any sanction should be proportionate to the breach, be focused and achievable by the Provider. Local quality requirements are subject to the annual financial cap on consequences of breach set out in Schedule 4 Part C. Further guidance can be found in paragraphs 9.8 and 9.29.	
D - Never Events	The Never Events link to the service categories in the Particulars section - only those applicable to the commissioned services will appear in the contract.	
E - Commissioning for Quality and Innovation (CQUIN)	Commissioners should complete this section in accordance with the CQUIN guidance which can be found at http://www.commissioningboard.nhs.uk/everyonecounts	
F - Local Incentive Scheme	If the parties have agreed a Local Incentive Scheme in addition to CQUINs (or do so at any time during the contract term) the details should be inserted here.	
G - 18-Weeks	This table will be required if the Services include any to which the 18-Weeks requirements apply. See Particulars – Services to which 18-Weeks applies.	

H - Clostridium difficile (C. diff)	The relevant formula for calculation of C. diff sanctions will be incorporated into the contract once the provider-type is selected in the Particulars. Where the C. diff. standard does not apply to any of the Services then neither formula will appear in the contract.	
Schedule 5 – Governance		
A - Documents relied on	If there are any documents, consents or certificates that have been relied on by any party in deciding whether to enter the contract, these should be identified and referenced here. However, the documents should not include letters of intent that relate to commissioning assumptions, nor should this Schedule be used to endeavor to contradict or circumvent the mandated terms and conditions of the contract.	
B1 - Provider's Mandatory Material Sub-contractors GC12.1	Details of any Mandatory Material Sub-contractors should be inserted here.	
B2 – Provider's Permitted Material Sub-contractors GC12.2	Details of any Permitted Material Sub-contractors should be inserted here.	
C – IP (Intellectual Property) GC22	Commissioner IP: any IP owned or licensed by any Commissioner to be used by the Provider in the delivery of the Services should be agreed and listed here. Provider IP: any IP owned or licensed by the Provider to be used by Commissioners in the exercise of their functions and to derive full benefit from the Services should be agreed and listed here. This links to the 'Particulars, Governance' section.	
D - Commissioner Roles and Responsibilities GC10	The Roles and Responsibilities table imported from the Commissioners' Collaborative Commissioning Agreement should be inserted here. This links to the 'Particulars, Governance' section.	
E - Partnership Agreements	This table is used to record any partnership arrangements (i.e. s75 agreements) between the Commissioner(s) and a local authority or the Provider	

GC7	and a local authority. If there are no Partnership Agreements enter 'Not Applicable' in the relevant table(s).	
Schedule 6 – Contract Management, Reporting and Information		
A - Recorded Variations GC13	This table is used to record any variations to the contract agreed during the contract term. It should be left blank unless and until any variations are agreed.	
B - Recorded Dispute Resolutions GC14	This table is used to record the outcome of any disputes in relation to the contract during the contract term. It should be left blank unless and until any dispute arises.	
C - Reporting Requirements SC28	This table sets out the information that is required to be reported under the contract. There are • national requirements that are reported nationally to the Health and Social Care Information Centre; • national requirements reported locally; • local requirements reported locally – the local requirements should be agreed with the Provider and should not duplicate nationally reported information.	
D - Data quality improvement plan (DQIP) SC28.16	This table is used to record any agreed DQIP.	
E – Incidents Requiring Reporting Procedure SC33	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.	
F – Service Development and Improvement Plan SC18	This table is used to record any agreed Service Development and Improvement Plan.	
G – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys.	

Annex 2

Contract clause translation tables 2012/13 v 2013/14

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
SECTION A - THE PARTICULARS		
	1: AGREEMENT	Particulars - Front Page and Contract
	2: EFFECTIVE DATE	Particulars - Contract Term and General Conditions GC 3
	3: DURATION	Particulars - Contract Term and General Conditions GC 3
	4: SERVICE COMMENCEMENT	Particulars - Service Commencement and General Conditions GC 2
	5: LONGSTOP DATE	Particulars - Service Commencement
	6. FREQUENCY OF REVIEW MEETINGS	Particulars - Contract Management and General Conditions GC 8.1
	7: ASSOCIATES	Particulars - Front Page and Contract
	8: NOTICES	Particulars - Contract Management and General Conditions GC 36.1
SECTION B - THE SERVICES		Particulars - Schedule 2
	PART 1: SERVICE SPECIFICATIONS	Particulars - Schedule 2 Part A
	PART 2: ESSENTIAL SERVICES	Particulars - Schedule 2 Part D
	Commissioner Requested Services	Particulars - Schedule 2 Part D
	CRS Continuity Plan / Essential Services continuity plan	Particulars - Schedule 2 Part E
	PART 3: INDICATIVE ACTIVITY PLAN	Particulars - Schedule 2 Part B
	PART 4: ACTIVITY PLANNING ASSUMPTIONS	Particulars - Schedule 2 Part C
	PART 5: ACTIVITY MANAGEMENT PLAN	
	PART 6: NON-TARIFF AND VARIATIONS TO TARIFF PRICES	Particulars - Schedule 3 Part A

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	PART 6.1: NON-TARIFF PRICES	Particulars - Schedule 3 Part A Table 1
	PART 6.2: VARIATIONS TO TARIFF PRICES	Particulars - Schedule 3 Part A Table 2
	PART 7: EXPECTED ANNUAL CONTRACT VALUES	Particulars - Schedule 3 Part B
	PART 8: QUALITY	Particulars - Schedule 4
	PART 8.1: QUALITY REQUIREMENTS	
	Operational Standards	Particulars - Schedule 4 Part A
	Local Quality Requirements	Particulars - Schedule 4 Part C
	PART 8.2: NATIONALLY SPECIFIED EVENTS	
	National Quality Requirements	Particulars - Schedule 4 Part B
	PART 8.3: NEVER EVENTS	Particulars - Schedule 4 Part D
	PART 8.4: 18 WEEK REFERRAL-TO-TREATMENT STANDARD FOR CONSULTANT-LED SERVICES FINANCIAL ADJUSTMENTS TABLES	Particulars - Schedule 4 Part G
	PART 8.5: CLOSTRIDIUM DIFFICILE ADJUSTMENTS TABLES	Particulars - Schedule 4 Part H
	PART 9: QUALITY INCENTIVE SCHEMES	
	PART 9.1: NATIONALLY MANDATED INCENTIVE SCHEMES	
	PART 9.2: COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)	Particulars - Schedule 4 Part E
	PART 9.3: LOCALLY AGREED INCENTIVE SCHEMES	Particulars - Schedule 4 Part F
	PART 10: ELIMINATING MIXED SEX ACCOMMODATION PLAN	
	PART 11: SERVICE DEVELOPMENT AND IMPROVEMENT PLAN	Particulars - Schedule 6 Part F
	PART 12: SERVICE USER, CARER AND STAFF SURVEYS	Particulars - Schedule 6 Part G

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	PART 13: CLINICAL NETWORKS AND SCREENING PROGRAMMES	Particulars - Schedule 2 Part F
	PART 14: REPORTING AND INFORMATION MANAGEMENT	Particulars - Schedule 6
	PART 14.1: NATIONAL REQUIREMENTS REPORTED CENTRALLY	Particulars - Schedule 6 Part C
	PART 14.2: NATIONAL REQUIREMENTS REPORTED LOCALLY	Particulars - Schedule 6 Part C
	PART 14.3: LOCAL REQUIREMENTS REPORTED LOCALLY	Particulars - Schedule 6 Part C
	PART 14.4: DATA QUALITY IMPROVEMENT PLAN	Particulars - Schedule 6 Part D
SECTION C - SERVICE MATTERS		
	PART 1: CONDITIONS PRECEDENT	Particulars - Schedule 1 Part A
	PART 2: DOCUMENTS TO BE DELIVERED BY THE CO-ORDINATING COMMISSIONER	Particulars - Schedule 1 Part B
	PART 3: TRANSITION ARRANGEMENTS	Particulars - Schedule 2 Part H
	PART 4: DOCUMENTS RELIED ON	Particulars - Schedule 5 Part A
	PART 5: PROVIDER'S MATERIAL SUB-CONTRACTORS	
	PART 5.1: MATERIAL SUB-CONTRACTS	
	Provider's Mandatory Material Sub-contractors	Particulars - Schedule 5 Part B1
	Provider's Permitted Material Sub-contractors	Particulars - Schedule 5 Part B2
	PART 5.2: MATERIAL SUB-CONTRACTORS	
	Provider's Mandatory Material Sub-contractors	Particulars - Schedule 5 Part B1
	Provider's Permitted Material Sub-	Particulars - Schedule 5 Part B2

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	contractors	
	PART 6: TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS	Service Conditions SC 11
	PART 6A: TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS FOR ACUTE SERVICES	Service Conditions SC 11
	PART 6B: TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS FOR MENTAL HEALTH AND LEARNING DISABILITY SERVICES	Service Conditions SC 11
	PART 6C: TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS FOR COMMUNITY SERVICES	Service Conditions SC 11
	PART 6D: TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS FOR AMBULANCE SERVICES	Service Conditions SC 11
	PART 7: POLICIES	
	PART 7.1: TRANSFER OF AND DISCHARGE FROM CARE PROTOCOLS	Particulars - Schedule 2 Part K
	PART 7.2: SAFEGUARDING POLICIES	Particulars - Schedule 2 Part L
	PART 7.3: INCIDENTS REQUIRING REPORTING PROCEDURE	Particulars - Schedule 6 Part E
	PART 7.4: EMERGENCY AND CRISIS CARE PROCEDURE	
	PART 7.5: MAJOR INCIDENTS FOR ACUTE SERVICES PROVIDER	
	PART 8: INTELLECTUAL PROPERTY	Particulars - Schedule 5 Part C
	PART 8.1: COMMISSIONER IPR	Particulars - Schedule 5 Part C
	PART 8.2: PROVIDER IPR	Particulars - Schedule 5 Part C
	PART 9: CONSORTIUM AGREEMENT	
	Commissioner Roles and Responsibilities	Particulars - Schedule 5 Part D
	Partnership Agreements	Particulars - Schedule 5 Part E

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	PART 10: LOCAL COMMISSIONING PLANS	If required may be included at Particulars - Schedule 1 Part B
	PART 11: EXIT ARRANGEMENTS	Particulars - Schedule 2 Part I
	PART 12: SOCIAL CARE PROVISIONS	Particulars - Schedule 2 Part J
SECTION D - RECORDED VARIATIONS, DISPUTES AND CHANGE IN CONTROL		
	PART 1: RECORDED VARIATIONS	Particulars - Schedule 6 Part A
	PART 2: NOTICES TO AGGREGATE/DISAGGREGATE PAYMENTS	Particulars - Schedule 3 Part D
	PART 3: DISPUTES	
	PART 3.1: RECORDED DISPUTE RESOLUTIONS D3	Particulars - Schedule 6 Part B
	PART 3.2: DETAILS OF MEDIATOR AND INDEPENDENT BINDING PENDULUM ADJUDICATOR	Particulars - Governance
	PART 3.3: PROCEDURE FOR DISPUTES BETWEEN DIVISIONS OF THE SAME NHS BODY	
	PART 4: CHANGE IN CONTROL NOTIFICATION	A template notification will be available on the NHS CB's website
	PART 5: RISK SHARE AGREEMENT	Particulars - Schedule 3 Part C
SECTION E - CORE LEGAL CLAUSES AND DEFINITIONS		
	1. DEFINITIONS AND INTERPRETATION	General Conditions GC 1
	2. CONDITIONS PRECEDENT	Particulars - Schedule 1 Part A and General Conditions GC 4.1.1
	3. DOCUMENTS TO BE DELIVERED BY THE CO-ORDINATING COMMISSIONER	Particulars - Schedule 1 Part B and General Conditions GC 4.1.2

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	4. TRANSITION PERIOD	Particulars - Schedule 2 Part H and General Conditions GC 4
	5. SERVICE PROVISION	Service Conditions SC 1
	6. REGULATORY AND QUALITY IMPROVEMENTS	Service Conditions SC 2
	7. PRICES AND PAYMENT	Service Conditions SC 36
	8. SERVICE USER INVOLVEMENT	Service Conditions SC 12
	9. EVIDENCE OF SERVICE USER INVOLVEMENT	Service Conditions SC 12.2
	10. SERVICE USER BOOKING AND CHOICE AND REFERRALS	Service Conditions SC 6
	11. UNMET NEEDS	Service Conditions SC 8
	12. OTHER SERVICES	Service Conditions SC 8.3
	13. SERVICE USER HEALTH RECORDS	Service Conditions SC 23
	Caldicott Guardian and Senior Information Risk Owner	Service Conditions SC 24
	14. PLACES OF SAFETY	Service Conditions SC 16
	15. CARE PLANNING	Service Conditions SC 10
	16. ESSENTIAL SERVICES CONTINUITY	
	Commissioner Requested Services / Essential Services	Service Conditions SC 5
	17. TRANSFER OF AND DISCHARGE FROM CARE OBLIGATIONS	Service Conditions SC 11
	18. CO-OPERATION	Service Conditions SC 4
	19. EQUITY OF ACCESS, EQUALITY AND NO DISCRIMINATION	Service Conditions SC 13
	20. PASTORAL, SPIRITUAL AND CULTURAL CARE	Service Conditions SC 14
	21. WITHHOLDING AND/OR DISCONTINUATION OF SERVICE	Service Conditions SC 7

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	22. SERVICES ENVIRONMENT AND EQUIPMENT	Service Conditions SC 15
	23. STAFF	General Conditions GC 5
	24. SAFEGUARDING CHILDREN AND VULNERABLE ADULTS	Service Conditions SC 32
	25. INCIDENTS REQUIRING REPORTING	Service Conditions SC 33
	26. CONSENT	Service Conditions SC 9
	27. COMPLAINTS	Service Conditions SC 17
	28. DEATH OF A SERVICE USER	Service Conditions SC 34
	29. SERVICE DEVELOPMENT AND IMPROVEMENT PLAN E19	Service Conditions SC 18
	30. ELIMINATING MIXED SEX ACCOMMODATION E20	
	31. TRANSFERS PURSUANT TO LOCAL COMMISSIONING PLANS	
	32. VENOUS THROMBOEMBOLISM	Service Conditions SC 20
	33. HCAI REDUCTION PLAN	Service Conditions SC 19
	34. PROCEDURES AND PROTOCOLS	Service Conditions SC 25
	35. NETWORKS AND SCREENING PROGRAMMES	Service Conditions SC 26
	36. EMERGENCY PREPAREDNESS AND RESILIENCE INCLUDING MAJOR INCIDENTS	Service Conditions SC 30
	37. NHS COUNTER-FRAUD AND SECURITY MANAGEMENT	General Conditions GC 6
	38. PARTNERSHIP ARRANGEMENTS	General Conditions GC 7
	39. INFORMATION REQUIREMENTS	Service Conditions SC 28
	40. SERVICE STANDARDS	Service Conditions SC 3
	41. MANAGING ACTIVITY AND REFERRALS	Service Conditions SC 29

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	42. WAITING TIMES	
	43. 18 WEEKS REFERRAL-TO-TREATMENT STANDARD FOR CONSULTANT-LED SERVICES AND FINANCIAL ADJUSTMENTS	Service Conditions SC 21
	44. FINANCIAL ADJUSTMENTS FOR PERFORMANCE IN REDUCING CLOSTRIDIUM DIFFICILE	Service Conditions SC 22
	45. SERVICE QUALITY REVIEW	General Conditions GC 8.1.1
	46. REVIEW	General Conditions GC 8
	47. CONTRACT MANAGEMENT	General Conditions GC 9
	48. COMMISSIONER AND REPRESENTATIVES	General Conditions GC 10
	49. BUSINESS CONTINUITY	Service Conditions SC 30.2
	50. LIABILITY AND INDEMNITY	General Conditions GC 11
	51. ASSIGNMENT AND SUB-CONTRACTING	General Conditions GC 12
	52. VARIATIONS	General Conditions GC 13
	53. DISPUTE RESOLUTION	General Conditions GC 14
	54. GOVERNANCE, TRANSACTION RECORDS AND AUDIT	General Conditions GC 15
	55. SUSPENSION	General Conditions GC 16
	56. TERMINATION	General Conditions GC 17
	57. CONSEQUENCE OF EXPIRY OR TERMINATION	General Conditions GC 18
	58. PROVISIONS SURVIVING TERMINATION	General Conditions GC 19
	59. CONFIDENTIAL INFORMATION OF THE PARTIES	General Conditions GC 20
	60. DATA PROTECTION, FREEDOM OF INFORMATION AND TRANSPARENCY	General Conditions GC 21

Position and Headings in 2012/13 contract		Position in 2013/14 NHS Standard contract
	61. NHS BRANDING, MARKETING AND PROMOTION	General Conditions GC 23
	62. INTELLECTUAL PROPERTY	General Conditions GC 22
	63. CHANGE IN CONTROL	General Conditions GC 24
	64. WARRANTIES	General Conditions GC 25
	65. PROHIBITED ACTS	General Conditions GC 26
	66. CONFLICTS OF INTEREST	General Conditions GC 27
	67. FORCE MAJEURE	General Conditions GC 28
	Force Majeure: Service-specific provisions	Service Conditions SC 31
	68. THIRD PARTY RIGHTS	General Conditions GC 29
	69. ENTIRE AGREEMENT	General Conditions GC 30
	70. SEVERABILITY	General Conditions GC 31
	71. WAIVER	General Conditions GC 32
	72. REMEDIES	General Conditions GC 33
	73. EXCLUSION OF PARTNERSHIP	General Conditions GC 34
	74. NON-SOLICITATION	General Conditions GC 35
	75. NOTICES	General Conditions GC 36
	76. COMPLIANCE WITH THE LAW	Services Conditions SC 1
	77. COSTS AND EXPENSES	General Conditions GC 37
	78. COUNTERPARTS	General Conditions GC 38
	79. GOVERNING LAW AND JURISDICTION	General Conditions GC 39
	SCHEDULE 1: DEFINITIONS AND INTERPRETATION	General Conditions Definitions
	Formulary	Service Conditions SC 27
	Duty of Candour	Service Conditions SC 35

Annex 3

Local quality requirements pick list

Quality Requirement	Data Collection	Source	Service type
Domain 1: Preventing people dying prematurely			
Antenatal assessments <13 weeks	National IQI- VSB06 https://mqi.ic.nhs.uk/	COF/OF	Acute/ community
Mortality within 30 days of hospital admission for stroke	National CCG Outcomes Indicator Set 1.34	COF/OF	Acute
Evidence of local arrangements to ensure that patients with suspected stroke are admitted directly to a specialist acute stroke unit and are assessed for thrombolysis, receiving it if clinically indicated.	National (SINAP) http://www.rcplondon.ac.uk/projects/stroke-improvement-national-audit-programme-sinap CCG Outcomes Indicator Set 3.33 & 3.34	NICE QS	Acute
People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support. (evidenced by 4-week quit rates)	Vital Signs VSB05	NICE QS	All
People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated		NICE QS	Acute

setting.			
People with lung cancer stage I–III and good performance status who are offered radiotherapy with curative intent receive planned treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage.	National (Lung Cancer Audit) http://www.ic.nhs.uk/lung	NICE QS	Acute
People with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis.	National (Lung Cancer Audit) http://www.ic.nhs.uk/lung	NICE QS	Acute
Children and young people who have had bacterial meningitis or meningococcal septicaemia have a follow-up appointment with a consultant paediatrician within 6 weeks of discharge.	National	NICE QS	Acute
Summary Hospital-Level Mortality Indicator - SHMI value and banding - Percentage of admitted patients whose treatment included palliative care - Percentage of admitted patients whose deaths were included in the SHMI and whose	National (HSCIC) HSCIC Indicator Portal https://indicators.ic.nhs.uk	Quality Account Standard	All

treatment included palliative care			
Cardiac Rehabilitation	National (NACR) http://www.ic.nhs.uk/rehab		Acute
Ambulance trust clinical outcomes: - Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle - Suspected stroke patients assessed face to face who received the appropriate care bundle - Ambulance outcome from cardiac arrest- return of spontaneous circulation - Ambulance outcome cardiac arrest – survival to discharge (also Domain 3)	National DH Ambulance Quality Indicators http://transparency.dh.gov.uk/2012/06/19/ambqidownloads/ Also HSCIC Indicator Portal Quality Accounts/Domain 1 https://indicators.ic.nhs.uk/webview/	Quality Account Standard	Ambulance
The number of patients who were recruited to participate in research approved by a research ethics committee within the National Research	Local	Quality Account Report	All

Ethics Service (also domains 2.3.4.and 5)			
Domain 2: Enhancing the quality of life of people with long-term conditions			
People with COPD and MRC dyspnoea scale >/= 3 referred to pulmonary rehab	Local	COF/OF	Acute
Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.	National (SINAP) http://www.rcplondon.ac.uk/projects/stroke-improvement-national-audit-programme-sinap	NICE QS	Acute
People using mental health services who may be at risk of crisis are offered a crisis plan.	National (CPA dataset)	NICE QS	Mental health
COPD Discharge bundle - referral of smokers to smoking cessation; referral for pulmonary rehab; provision of management plan; optimisation of inhaler technique	Local		Acute
All patients with long-term conditions will be offered a personalised care plan.	Local	Mandate	All
The number of new cases of psychosis			Mental

served by early intervention teams year to date			health
Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	National HSCIC Indicator Portal Quality Accounts/Domain 2/17 https://indicators.ic.nhs.uk/webview/		
Domain 3: Helping people to recover from episodes of ill-health or following injury			
PROMs for i. Groin hernia surgery ii. Varicose vein surgery iii. Hip replacement surgery iv. Knee replacement surgery	National HSCIC Indicator Portal Quality Accounts/Domain 3/18 https://indicators.ic.nhs.uk/webview/ or http://www.ic.nhs.uk/proms/	Quality Account Standard	Acute
People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.	National- Heart failure audit http://www.ucl.ac.uk/nicor/audits/heartfailure	NICE QS	Acute
Emergency readmissions to hospital with 28 days of discharge	National (HSCIC) HSCIC Indicator Portal Quality Accounts Domain 3 https://indicators.ic.nhs.uk	Quality Account Standard	Acute

Improving Access to Psychological Therapies (IAPT): Of those completing treatment it is expected that at least 50% will recover. - Rate of recovery higher than previous quarter until 50% recovery rate is achieved and when achieved maintained	National (HSCIC) http://www.ic.nhs.uk/catalogue/PUB07281		
Domain 4: Ensuring that people have a positive experience of care			
Percentage of patients seen within 18 weeks for direct access audiology	National		Acute/ community
Friends and Family Test	National	COF/OF Quality Account Standard	Acute/ community
Improving people's experience of outpatient care	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.1 https://indicators.ic.nhs.uk/webview/	COF/OF	All
Responsiveness to inpatients personal needs	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.2 https://indicators.ic.nhs.uk/webview/	COF/OF	Acute

Women's experience of maternity services	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.5 https://indicators.ic.nhs.uk/webview/	COF/OF	Acute
Patient experience of mental health services	National	COF/OF	Mental health
Parents of babies receiving specialist neonatal care are encouraged and supported to be involved in planning and providing care for their baby, and regular communication with clinical staff occurs throughout the care pathway.	National NNAP Q5 http://www.rcpch.ac.uk/child-health/standards-care/clinical-audit-and-quality-improvement/national-neonatal-audit-programme	NICE QS	Acute
Mothers of babies receiving specialist neonatal care are supported to start and continue breastfeeding, including being supported to express milk.	National NNAP (Q4) http://www.rcpch.ac.uk/child-health/standards-care/clinical-audit-and-quality-improvement/national-neonatal-audit-programme	NICE QS	Acute
Babies receiving specialist neonatal care have their health outcomes monitored.	National NNAP (Q8) http://www.rcpch.ac.uk/child-health/standards-care/clinical-audit-and-quality-improvement/national-neonatal-audit-programme	NICE QS	Acute
Percentage of people who are supported to die in their usual place of residence	Local		All

Number of health visitors	http://www.ic.nhs.uk/healthvisitors		Community
Ambulance call abandonment rate	Ambulance Quality Indicators (DH) http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/		Ambulance
Ambulance re-contact rate following discharge from care	Ambulance Quality Indicators (DH) http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/		
Ambulance service experience			
Ambulance time to answer call	Ambulance Quality Indicators (DH) http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/		
Ambulance calls closed with telephone advice or managed without transport to A & E (where clinically appropriate)	Ambulance Quality Indicators (DH) http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/		
A & E unplanned re-admission rate	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		
A & E left department without being seen rate	Search for latest releases under 'A&E Indicators' at www.ic.nhs.uk		
A & E total time spent in A & E department	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		
A & E time to initial assessment (95th percentile)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		
A & E time to treatment in department (median)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		
Percentage of A & E attendances for cellulitis and DVT that	National – HES http://www.ic.nhs.uk/hes		

end in admission			
Number of admissions for cellulitis and DVT per head of weighted population			
A & E service experience	HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.3 https://indicators.ic.nhs.uk/webview/		
Delayed transfers of care to be maintained at a minimal level			
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Patient safety incidents resulting in severe harm or death	NRLS/ local	Quality Account Standard	All
Incidence of newly-acquired category 2, 3 and 4 pressure ulcers	National http://www.ic.nhs.uk/thermometer		All
Rostered continuing consultant presence on both Saturday and Sunday in emergency medicine, emergency surgery or both.	Local		Acute
Reducing the number of suicides and incidents of serious self-harm or harm to others	Local	Mandate	Mental health
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being			

discharged			

Annex 4

Implementing the contractual requirements relating to the Duty of Candour

1. Of primary concern is ensuring that patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences.

2. The contractual duty of candour applies to patient safety incidents that occur during care provided under the NHS Standard Contract and that result in **moderate harm, severe harm or death** (using NPSA definitions[1]) that are reported to local risk management systems. It will not apply to low/no harm incidents to avoid excessive burdens but these incidents should still be reported to the patient if appropriate.

3. There should be an appropriate **investigation** to establish the facts of the incident. This should be consistent with published guidance[2] and the procedures set out in SC35.

4. The contractual requirements are as follows;
   I. The **patient or their family/carer must be informed** that a suspected or actual patient safety incident has occurred **within at most 10 working days of the incident being reported to local systems,** and sooner where possible. Incidents may be identified well after they take place but the clock starts ticking when the incident is reported to local risk management systems.
   II. **The initial notification must be verbal** (face to face where possible) unless the patient cannot be contacted in person or declines notification. Providers must take into account any circumstances that will affect the ease of communication with the patient (language barriers, communication difficulties, relevant disability).The verbal notification must be accompanied by an offer of a written notification. The notification must be recorded for audit purposes.
   III. It may initially be unclear whether a patient safety incident has occurred, or what degree of harm was caused. This is not a reason to avoid disclosure. Patients or their carers/families must be told if there is a suspected patient safety incident that might involve moderate or severe harm or death within 10 working days of the incident being reported. They should be given all the facts that are known at the time, and be kept updated throughout the process of investigation.
   IV. **An apology must be provided** - a sincere expression of sorrow or regret for the harm caused must be provided verbally and in writing. This does not require fault to have been demonstrated. *Being Open*[3] provides more detail on how to apologise. Expressing regret for harm caused is not the same as admitting liability and the risk of litigation should not prevent an apology.
   V. **A step-by-step explanation** of what happened, in plain english, based on the facts, must be **offered** as soon as is practicable. This may constitute an initial view, pending an investigation, but patients and families must be kept informed of progress.

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[1] Definitions for levels of harm are contained in *Seven Steps to Patient Safety*, available at http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[2] Root Cause Analysis report writing and templates, available at http://www.nrls.npsa.nhs.uk/resources/all-settings-specialties/?entryid45=59847&p=3

[3] *Being Open*, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=83726

VI. **Full written documentation of any meetings must be maintained**, according to the principles in the *Being Open* guidance. If the patient or their family/carer explicitly decline any offers of meetings, this must be clearly recorded and open to audit.

VII. Information that emerges during an investigation or subsequent to the initial explanation must be offered to patients and their carers/families as soon as is practical. It is helpful to establish regular updates with affected individuals. Any incident investigation reports must be shared **within 10 working days of being signed off as complete and the incident closed** by the relevant authority (Board, Medical Director, commissioner etc.). This includes action plans and the details of investigations and means the actual written reports and, if necessary, plain English explanations of their contents.

VIII. Providers should inform the patient's commissioner (and lead commissioner if appropriate) when they are communicating with a patient and their family/carers about an incident. To reduce the burden of reporting this could take the form of regular reports on the number of incidents concerned as part of the 6-monthly contract review process or other contractual discussions. Providers must be able to provide copies of the documentation and information given to the patient and their family/carer to their commissioner if necessary, to demonstrate compliance with contractual requirements, ensuring data protection and Caldicott principles are observed.

5. There may be circumstances where a patient safety incident is not reported to local risk management systems, but commissioners become aware that it has occurred through other means. These incidents (if resulting in moderate or severe harm or death) are also subject to the contractual duty of candour and, in addition, may represent further failures in reporting. Incidents that have not been reported are, by their nature, harder to detect and verify. In the first instance, they should be raised with the relevant provider. Where a relevant patient safety incident is found to have occurred and not been reported to either the patient or local systems in breach of existing requirements, this should be treated extremely seriously. Commissioners should consider referral to CQC for breach of registration requirements in the case of serious incidents and deaths.

Identification of a breach

6. A breach is a failure to comply with the steps in the Contract clauses as expanded above. Commissioners should establish and advertise to local clinicians, HealthWatch groups and providers the existence of a contact point within the commissioner for raising potential breaches of the contractual requirement. This may be part of the commissioner's existing complaints handling team or the commissioning function with responsibility for quality of care or patient experience. This should also be the point of referral from providers' complaints handling processes.

7. Providers should notify their commissioners when a complaint they receive includes reference to a failure to disclose a patient safety incident to. Providers should not establish separate complaints processes for failures of disclosure.

8. Clinicians, local Healthwatch organisations and anyone else with concerns about a failure to disclose a patient safety incident to a patient/their family can choose to raise the concern with the relevant provider or commissioner. The provider must notify the commissioner of any concerns/complaints reported to it.

9. Concerns from clinicians, local Healthwatch organisations, the public or via the provider's complaints process, about failures of disclosure, should prompt the commissioner to investigate to determine if the circumstances represent a breach of the above requirements. This will involve determining if a patient safety incident involving the patient concerned is recorded on the local risk management system and whether there are records of any disclosure.

10. Where an incident is alleged to have occurred, but has not been reported to local risk management systems, it will be difficult to confirm whether it has happened. Where it is thought that an incident occurred but has not been reported, commissioners should undertake a review of the case notes and any further investigations required to establish the facts. Commissioners will need to balance the importance of enforcing the contractual duty with other burdens placed on them when deciding how vigorously to investigate an allegation. While they may not pursue an allegation for which there is little evidence, repeated allegations from different sources should prompt greater scrutiny.

11. There are likely to be circumstances where allegations about a lack of openness relate to an organisation's overall perceived behaviour. The contractual duty of candour is not designed to deal with general perceptions about how transparent an organisation is. The contractual duty of candour relates to specific reportable patient safety incidents and their disclosure to the patient or their family. If there is no evidence a patient safety incident has occurred involving moderate harm or worse, to a patient, the contractual duty of candour is not relevant.

12. An explanation of the commissioner's investigation of the potential breach, their findings, details of any action taken, or an explanation for why no action is being taken, should be provided to the source of the notification.

Consequences of a breach of the requirement

13. There are a range of actions available to commissioners where a provider breaches the requirement. These are set out in SC35:
    - requiring a direct written apology and explanation for the breach to the individual(s) affected from the provider's chief executive:
    - publication of the fact of a breach prominently on the provider's website;
    - notification to CQC by the commissioner.

14. Where there is a breach of the national quality requirement to notify patients/ carers of a suspected or actual patient safety incident that resulted in moderate or severe harm or death, then commissioners must apply the nationally set consequence ie recovery of the cost of the episode of care or £10000 if the cost of the episode of care is unknown.

15. It is likely that circumstances will arise which are not covered by this guidance. Where a situation does not fall within the circumstances described above,

commissioners should also refer to the '*Being Open*' guidance for more detailed guidance on what providers should be doing. Concerns raised about a provider may not be covered by the specific details of the contractual requirement, but failure to follow the principles in *Being Open* may indicate wider failures in the provision of care, which are subject to other contractual requirements around quality or safety, or indeed regulatory requirements set by CQC.

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