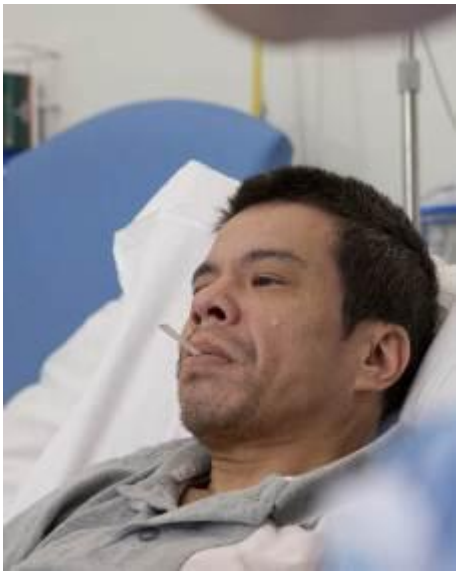
NHS Standard Contract 2014/15

Updated Technical Guidance



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Description	The NHS Standard Contract is the key lever for Commissioners to secure improvements in quality and cost-effectiveness in their secondary care contracts. The Technical Guidance outlines the changes made to the 2014/15 Contract, provides general guidance on contracting, and outlines the key topics in the Contract. It also includes a summary guide to completing the Contract.
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NHS Standard Contract 2014/15

Updated Technical Guidance

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NHS England

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Part 4 Appendices

Executive Summary

1 Introduction

1.1 The NHS Standard Contract is a key lever for commissioners to secure improvements in the quality and cost-effectiveness of the clinical services they commission. The NHS Standard Contract must be used by CCGs and NHS England for all their clinical services contracts, with the exception of those for primary care services.

1.2 The joint letter of 4 November 2013 from NHS England, Monitor, the NHS Trust Development Authority and the Local Government Association (*Strategic and operational planning in the NHS, Gateway 00658)* sets out a clear expectation that commissioners and providers will sign contracts for 2014/15 by 28 February 2014, and this has now been reinforced in *Everyone Counts: Planning for Patients 2014/15 to 2018/19.*

2 More flexible business rules for 2014/15

2.1 The 2014/15 Contract retains the same three-part structure and much of the same detailed content as the 2013/14 version, allowing commissioners and providers to benefit from the familiarity they are gaining from using it in practice. However, there are also some significant changes.

2.2 The development of the NHS Standard Contract for 2014/15 was underpinned by a stakeholder engagement exercise which took place during the summer of 2013. We issued discussion documents on the future development of the Contract and on the regime of incentives, rewards and sanctions within the NHS business rules, and we ran a number of joint workshops with Monitor on the latter topic. The feedback we received from this engagement process is summarised at http://www.england.nhs.uk/wp-content/uploads/2013/11/rev-incent.pdf.

2.3 The fundamental aim of our changes to the NHS business rules for 2014/15 has been to create greater flexibility for commissioners to vary, by local agreement, national rules which were sometimes seen as obstacles to major service redesign and improvement. So, for 2014/15, commissioners will have greater flexibility to:

- determine the duration of the contract they wish to offer, within the framework of national guidelines and regulations on procurement, choice and competition, with the option of longer contract terms than previously (see paragraph 16);
- move away, by agreement with providers, from rigid national prices, using the Local Variation flexibility set out in the National Tariff guidance, potentially developing different payment models based more on quality and outcomes and less on activity; and
- utilise innovative contracting models such as the prime provider approach (see paragraph 20).

2.4 Taken together, these new flexibilities should mean that commissioners will be equipped with the tools to employ longer-term, transformational, outcomes-based commissioning approaches.

3 Key changes to the NHS Standard Contract for 2014/15

3.1 The key changes to the Contract for 2014/15, in addition to the changed approach on contract duration, are summarised below, with links as applicable to further detail described later in this document. A clause-by-clause summary of where changes have been made is available at Appendix 1.

Francis Report

3.2 The 2014/15 Contract includes a range of new and revised requirements relating to implementation of recommendations in the Francis report, including:

- more explicit wording on the requirement for all parties, including any sub-contractors, to abide by the NHS Constitution (SC1 Compliance with the Law and the NHS Constitution);
- a new requirement for providers to use an evidence-based approach, reflecting National Quality Board guidance, to setting staffing levels, to review intended and actual staffing levels regularly at ward or service level, linking this to indicators of service quality, and to share the outcome of these reviews in public and with commissioners (GC5 Staff) (see paragraph 27.7);
- a new requirement for providers to have in place effective procedures to ensure that staff have a means to raise concerns about service quality and prevent the use of “gagging” or non-disparagement clauses (GC5 Staff);
- extended powers for commissioners to intervene where they are concerned about the quality or outcomes of care being provided (GC16 Suspension) (see paragraph 27.6);
- clearer requirements for sub-contractors to meet (and for the provider to ensure that they meet) all of the service standards required of the main provider (GC12 Assignment and Sub-Contracting);
- a new requirement for providers to comply with the NHS England Serious Incident Framework (SC 33 Incidents Requiring Reporting) (see paragraph 29);
- a broader requirement for providers to demonstrate “lessons learned” from complaints, incidents, Never Events, surveys and other forms of service user and staff involvement (SC3 Service Standards) (see paragraph 27.5); and
- a more detailed reporting requirement on complaints (Particulars, Schedule 6B).

Implementing the review of incentives, rewards and sanctions

3.3 The revised Contract sets out updated Quality Requirements and associated financial consequences ("sanctions") at Schedule 4. The aim has been to ensure that the Contract includes workable and proportionate sanctions, with a greater focus on mental health services than has previously been the case.

- A small number of additional National Quality Requirements have been included.
- Sanctions levied under Schedule 4 in respect of Operational Standards, National Quality Requirements and Local Quality Requirements are limited to a maximum of 2.5 per cent of Actual Quarterly Value in any quarter.
- There is a new flexibility for the application of sanctions under Schedule 4 to be varied by local agreement.

3.4 Paragraphs 27-28 set out full detail on these issues.

Payment Terms

3.5 The payment terms (SC36) have been revised for 2014/15, along with the associated Schedules, to

- reflect the new arrangements for the National Tariff, rather than the Payment by Results;
- make allowance for the new pricing flexibilities (Local Modifications and Local Variations)
- reverse the onus for the production of reconciliation accounts, so that this now falls on the provider (in line with common practice across the country), not on the co-ordinating commissioner.

3.6 Paragraph 34 sets out full detail on these issues.

Service categories and applicability of clauses

3.7 In response to feedback particularly from smaller providers, we have reviewed the applicability of a range of clauses within the Service Conditions to particular service types, making changes where we felt that the applicability was stated too broadly in the 2013/14 Contract, placing an unrealistic and excessive burden on providers of certain services.

3.8 These changes affect, for instance, carbon reduction (SC15), formulary (SC27), emergency preparedness (SC30), Prevent and WRAP (SC32) and counter-fraud arrangements (SC24).

3.9 We have introduced a number of new service categories for 2014/15 – community pharmacy services, Urgent Care Centre and Walk-In Centre services, hospice services, and diagnostic, screening and pathology services. We have removed the separate categories for termination of pregnancy services (which should be categorised in the contract as acute services) and primary care services. Where primary care providers such as GPs or optometrists are also providing services under the NHS Standard Contract, these should generally be categorised as community services. Further detail is set out in paragraph 24.

3.10 Use of the electronic Contract (see paragraph 4 below) is the most effective way to ensure that a contract is generated which contains only the clauses which have been agreed to be relevant to the services being offered by that specific provider.

Other changes

3.11 Other key changes to the Contract for 2014/15 are summarised below.

- **Commissioner Requested Services (CRS) and Essential Services.** We have updated the Contract in the light of Monitor's guidance on CRS. Contract provisions for Essential Services remain in place for NHS Trusts. See paragraph 26.

- **Information requirements and governance.** We have updated the provisions of GC21 in relation to data protection and information governance and SC28 in relation to data sets, reporting requirements and the NHS Number. We have reduced the number of national requirements mandated under Schedule 6B (Reporting Requirements). See paragraph 31.

- **Staff pensions.** The Contract has been updated to reflect the provisions of the revised Fair Deal for staff pensions; further materials on this will be made available in early 2014. The revised provisions will affect primarily those new contracts where procurement exercises are concluded which result in staff transferring under TUPE from NHS employers to independent sector employers. See paragraph 35.

- **Service Development and Improvement Plan (SDIP).** Agreement and implementation of an SDIP (SC18 and Schedule 6E) is mandated in two situations for 2014/15, as set out in paragraph 30.

    - Each provider of acute services must agree, within an SDIP, action that it will take during 2014/15 to commence implementation of the recommendations of the review into 7-day services.

    - Each provider which has not yet completed implementation of the high-impact innovations set out in *Innovation, Health and Wealth* must agree within an SDIP action that it will take during 2014/15 to complete full implementation of all the innovations relevant to its services.

- **Audit.** We have made significant amendments to the provisions for appointment of independent third-party auditors (GC15). See paragraph 35.

4 The e-Contract system

4.1 A very strong feature of stakeholder feedback was a plea for greater scope to tailor the contract content to suit the type of services being commissioned. The 'one-size-fits-all' Standard Contract can seem overwhelming in particular for small providers with limited resources for contract management. With the Standard Contract covering providers of former 'enhanced services' from April 2014, the number of Standard Contracts held by small provider organisations will increase significantly.

4.2 The key advantage of the online electronic contract system (the eContract), launched for 2013/14, is that it offers the ability to adjust the content of the Service Conditions and Particulars – so that text which is not relevant to the provider or the services to be delivered is excluded. The result is a slimmer, clearer contract. For a small provider – a care home, a small voluntary provider, a general practice, a community pharmacy – this is a really important benefit.

4.3 For 2014/15, our aim has been to encourage much greater use of the eContract approach. The eContract team has been in active discussion with system users and has listened to feedback on how to develop and refine the current eContract. Significant improvements have been developed for 2014/15, including

- moving to an updated SharePoint platform, so that the system will be more versatile in its operation, faster and more responsive;
- 'de-bugging' the system, eradicating some of the common problems which users have experienced, such as copy and paste and PDF errors; and
- enhancing the system with new features, including template approaches allowing multiple similar contracts to be produced easily and enabling auto-population of some fields, and auto population of some areas of the contract.

4.4 We are aware, however, that the release of some of this new functionality has been delayed, and this may jeopardise commissioners' ability to use the system whilst also meeting national deadlines for contract signature. Where commissioners do still complete paper contracts, however, we would nonetheless encourage them to consider entering their contracts, once complete, onto the eContract system at a later stage.

4.5 The eContract portal now has a new web address: www.econtract.england.nhs.uk. Please note that the revised eContract system operates on Sharepoint 2013 technology and requires users to have Internet Explorer 8, Mozilla Firefox or Google Chrome as their web browser.

5 Status of this guidance

5.1 This Contract Technical Guidance is intended to support commissioners in using the NHS Standard Contract and sets out clear expectations for how certain aspects should be addressed.

5.2 This guidance should not, however, be viewed as an interpretation of the NHS Standard Contract. In the event of conflict between this guidance document and the Contract, the terms of the Contract will prevail. Commissioners should seek their own legal advice as necessary.

5.3 This guidance was initially issued in draft form. It has now been updated, providing clarification on issues raised at the workshops we ran for commissioners and providers during January. A summary of the changes made between the draft and final versions of this guidance is included at Appendix 10.

6 Advice and support

6.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact nhscb.contractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general.

7 Links to other resources

Everyone Counts: Planning for Patients 2014/15 to 2018/19
NHS England
http://www.england.nhs.uk/ourwork/sop/

National Tariff for 2014/15
Monitor and NHS England
http://www.monitor.gov.uk/NT
Queries relating to the National Tariff can be sent to pricing@monitor.gov.uk

Who Pays? Determining the responsible commissioner
NHS England
http://www.england.nhs.uk/wp-content/uploads/2013/08/who-pays-aug13.pdf

Who Pays? Information Governance Advice for Invoice Validation
NHS England
http://www.england.nhs.uk/ourwork/tsd/data-info/ig/in-val/

Commissioning for quality and innovation (CQUIN) guidance for 2014/15
NHS England
http://www.england.nhs.uk/nhs-standard-contract/

How to ensure the right people, with the right skills are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability
National Quality Board
http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Framework of Excellence in Clinical Commissioning
NHS England
http://www.england.nhs.uk/resources/resources-for-ccgs/dev-insight/

Commissioning for Value data packs
NHS England
http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

Primary medical care functions delegated to clinical commissioning groups
NHS England
http://www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf

Section A General guidance on contracting

8 Use of the NHS Standard Contract

When should the NHS Standard Contract be used?

8.1 The NHS Standard Contract exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of provider and allowing economies in the drafting and production of contracts, for example in respect of legal advice.

8.2 The draft version of the Technical Guidance published in December 2013 set out that the NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, care home, community-based, high-secure, mental health and learning disability services). The only exceptions to this identified in the December guidance were:

- primary care services commissioned by NHS England, where the relevant primary care contract should be used;
- any primary care improvement schemes commissioned by CCGs on behalf of NHS England (which would be effected through the primary care contracts held by NHS England); and
- any out-of-hours primary medical services commissioned by CCGs on behalf of NHS England, for which an APMS contract must be used.

8.3 The draft Guidance also made clear that, from 1 April 2014 onwards, CCGs must use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that have been previously commissioned as Local Enhanced Services as set out in the 2013/14 guidance on primary medical care functions delegated to CCGs available at: http://www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf.

8.4 NHS England is reviewing aspects of this guidance and will provide further clarification, in the form of a final version of the Contract Technical Guidance document, as soon as possible.

What elements of the Standard Contract can be agreed locally

8.5 The elements of the Contract for local agreement fall within the Particulars. The Service Conditions may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The General Conditions must not be varied at all.

8.6 Commissioners must not

- put in place locally-designed contracts for healthcare services, instead of the NHS Standard Contract; or
- vary any provision of the NHS Standard Contract except as permitted by GC13 (Variation); or
- seek to override any aspect of the NHS Standard Contract.

8.7 Where commissioners and providers wish to record agreements they have reached on additional matters, they may use Schedule 2G (Other Local Agreements, Policies and Procedures) or Schedule 5A (Documents Relied On) for this purpose. Commissioners are reminded that any such local agreements must not conflict with the provisions of the Contract. In the event of any such conflict or inconsistency, the provisions of the Contract will apply, as set out in GC1.

9 Use of grant agreements

9.1 Where voluntary sector organisations provide healthcare services, commissioners remain able to provide funding support for those services through grant agreements, rather than using the NHS Standard Contract in all circumstances.

9.2 Use of the Standard Contract is necessary

- where the relevant services are being commissioned through a competitive procurement process; or
- where the commissioner is meeting the full costs of a specific service provided by a voluntary sector provider.

9.3 However, where the commissioner is making only a partial contribution, or subsidy, to the costs a voluntary sector provider faces in running a service, rather than commissioning the whole service at full cost, commissioners may use a grant agreement rather than the Standard Contract. This may apply to some hospice services, for example. In these circumstances, it will be for commissioners to choose which approach they feel will give the most appropriate and proportionate outcome for their local circumstances.

9.4 Any grant agreement should of course be very clear as to the purpose for which the grant is being made, suitably robust (particularly in terms of clinical governance requirements) and properly managed. Grant agreements should not be seen simply as an easy alternative to the Standard Contract. They have a very specific, limited purpose. They raise their own legal, governance and financial issues. We strongly recommend that commissioners take their own legal advice before entering into any grant agreements.

10 Funded Nursing Care

10.1 We recognise that there is varied practice across the country in respect of the use of the NHS Standard Contract with residential care homes and nursing homes, particularly in respect of NHS Funded Nursing Care (where, following assessment, the NHS makes a nationally-set contribution to the costs of a nursing home resident's nursing care).

- We expect the NHS Standard Contract to be used where a commissioner is fully funding a resident's NHS Continuing Healthcare placement in a care home.
- Where commissioners are already successfully using the NHS Standard Contract for NHS Funded Nursing Care, we recommend that they continue to do so.
- CCGs should consider the benefits of collaborative contracting for NHS Continuing Health Care and to pay for NHS Funded Nursing Care, both with other CCGs and with local authorities; this approach will help to limit the number of separate contracts a care home holds.
- Where commissioners have not yet started to use the NHS Standard Contract for NHS Funded Nursing Care, it is not mandatory for them to do so. However, any local agreements must be sufficiently robust to provide full ongoing assurance in relation to the quality of the nursing care the home will provide.

11 Collaborative contracting

11.1 The NHS Standard 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, with one acting as the co-ordinating commissioner.

11.2 NHS England strongly encourages commissioners to collaborate closely in negotiating and agreeing contracts with providers. Using the co-ordinating commissioner model enables a consistent approach to contracting and is more efficient for both commissioners and providers, avoiding a proliferation of small, separate contracts. However, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model. NHS England 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.

11.3 Where commissioners choose to contract collaboratively, they should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider in a formal collaborative commissioning agreement (CCA). The CCA is a separate document entered into by a group of commissioners and governs the way the commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, a contract which has been signed by all the parties (as outlined in paragraph 14 below) is still legally effective and binding on all the parties without a collaborative agreement in place. The CCA should not be included in the contract.

11.4 A revised model CCA has now been published and is available at http://www.england.nhs.uk/nhs-standard-contract/. The revised model agreement has been adapted to allow for the situation where a local authority is party to the collaborative arrangements and to make appropriate provision for the revised arrangements for agreement of Variations (see paragraph 14), and for agreement of other key actions to be taken by the co-ordinating commissioner on behalf of all commissioners.

12 Which commissioners can be party to the Standard Contract

12.1 The Standard Contract may be used by CCGs, by NHS England and by local authorities. Any combination of these commissioners may agree to work together to hold a single contract with a given provider, identifying a co-ordinating commissioner and putting in place a collaborative agreement as set out above.

12.2 Even where they are placing separate contracts from NHS commissioners, local authorities may wish to use the NHS Standard Contract, for example to commission services from a provider whose main business is the supply of services to NHS commissioners. In this situation, it is not mandatory for local authorities to use the NHS Standard Contract. In a situation where NHS commissioners and a local authority are intending to sign the same single contract with a provider, however, and where the service being commissioned involves a healthcare service, then the NHS Standard Contract must be used.

12.3 By contrast, where an NHS commissioner has devolved commissioning responsibility to a local authority under a formal lead commissioning arrangement, the local authority would be able to contract on its own chosen basis. As the NHS commissioner would not be a party to the contract, there would be no requirement for the NHS Standard Contract to be used. The NHS commissioner should, however, satisfy itself that the arrangements being put in place are such that it can meet its statutory obligations.

13 Non-contract activity

13.1 NHS England has set out revised guidance on non-contract activity (NCA) as part of *Who Pays? Establishing the Responsible Commissioner*, available at http://www.england.nhs.uk/wp-content/uploads/2013/08/who-pays-aug13.pdf

13.2 Commissioners and providers should refer to this guidance for full detail, but it may be helpful to re-state certain key points here.

13.3 The guidance makes clear that *"Written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider where there are established flows of patient activity with a material financial value. Non-contract activity billing arrangements are not intended as a routine alternative to formal contracting, but are likely to be required in some circumstances, usually for small, unpredictable volumes of patient activity delivered by a provider which is geographically distant from the commissioner."*

13.4 The concept of NCA is most relevant to acute hospital services, most of which are covered by mandatory national tariffs and where patients have choice of provider. As a guideline, we would strongly recommend that any CCG with activity of over £200,000 per annum with an acute provider should put in place a written contract, rather than relying on the NCA approach. For non-acute services, the NCA approach is generally less relevant.

13.5 The guidance also explains that, where there is no written contract in place, there is nonetheless an implied contract on the terms of the NHS Standard Contract. In particular, the guidance is clear that 'NCA' commissioners have the same rights to challenge payment as commissioners covered by written contracts, stating that *"Arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance (Payment by Results guidance in 2013/14) and the terms and conditions set out in the NHS Standard Contract. Commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements."*

14 Signature of contracts and variations

14.1 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.

14.2 Contracts must be signed physically, in hard copy form, by each party. As set out in GC38, this can be done in counterpart form where necessary. Such hard copy signatures can be physically returned to the co-ordinating commissioner by post, but can alternatively be scanned and either uploaded onto the eContract system or returned to the co-ordinating commissioner by email. The co-ordinating commissioner should maintain a record of all contract signatures and should provide copies to other commissioners for audit purposes.

14.3 For 2014/15, we have removed the requirement for authorised signatories to be listed in contract documentation, prior to actual contract signature. We are aware that this requirement could become a bureaucratic burden. However, each party must ensure that the contract is signed by an officer with the appropriate delegated authority. The use of cut-and-paste electronic signatures, applied by more junior staff on behalf of authorised signatories, is not permitted.

14.4 We recognise that the collection of signatures from commissioners is a time-consuming process. In response to feedback on the Variation process (General Condition 13), therefore, we have made a change for 2014/15, so that it is possible, under the terms of the Contract, for Variations to be signed by the provider and the co-ordinating commissioner only, rather than by all commissioners.

14.5 Commissioners must therefore ensure that their collaborative agreements set out very clear arrangements through which Variations are agreed amongst commissioners, prior to signature by the co-ordinating commissioner. The co-ordinating commissioner must maintain a record of evidence that variations have been properly approved and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed. We will update our separate guidance on the process for making National Variations to reflect this change early in 2014; the guidance will be available at http://www.england.nhs.uk/nhs-standard-contract/.

15 Legally binding agreements

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

16 Contract duration

16.1 In recent years, the NHS Standard Contract has had a default duration of one year only, though with potential for this to be varied in specific circumstances. For 2014/15 onwards, a more flexible approach has been adopted.

16.2 Longer-term contracts can be a key tool for commissioners in transforming services and delivering significant, lasting improvements in service quality and outcomes. A longer-term contract allows time for providers to plan and deliver substantial service reconfiguration, for example. Where significant up-front capital investment is needed, a longer-term contract allows the provider to recoup this over the full duration of the contract. In both cases, offering contracts with a longer term has the potential to attract a wider range of providers, thus strengthening the pool of bidders from which the commissioner can select its preferred provider.

16.3 Equally, there will, of course, be situations where contracts with a shorter term may be appropriate, for example where the commissioning requirement is for a short-term or pilot service or where the service or supplier landscape is changing rapidly.

16.4 For 2014/15 onwards, therefore, we do not propose to set an arbitrary limit to contract duration, nor to establish a central approval process for contracts beyond a certain term. It is for commissioners to determine locally, having regard to the guidelines below, the duration of the contract they wish to offer.

- Commissioners will need to consider carefully what benefits they can expect from offering providers the increased certainty of a longer-term contract, setting this against the need to ensure that they are able to use a competitive procurement approach when this will be in patients' best interests, in line with regulations and guidance.

- Where commissioners are seeking, through competitive procurement, transformative solutions requiring major investment and service reconfiguration, contracts with a duration of up to five to seven years may often be appropriate. We would advise commissioners not to offer contracts with a duration longer than seven years, other than in exceptional circumstances. Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.

- Where no competitive procurement is undertaken, increased flexibility in contract duration will also apply, but we would advise commissioners not to place contracts with a duration longer than three years.

16.5 Alongside greater flexibility of contract duration, the Contract continues to include provisions for early termination on a no-fault basis. In this situation, exit arrangements may be agreed, which may include payment of compensation to cover unrecovered capital investment or a proportion of it; these can be set out in Schedule 2 Part I of the contract.

16.6 The Contract also continues to allow for National Variations to be mandated by NHS England, in particular to reflect annual updates to the NHS Standard Contract. Both commissioner and provider are able to propose other variations (for example to effect annual reviews of local prices, service specifications and local quality requirements).

17 Extension of contracts

17.1 The 2013/14 NHS Standard Contract made no provision for the contract terms to be extended. We are aware, however, that commissioners may wish, when procuring services on a competitive basis, to offer a contract with the possibility of extension – for example, a five year contract term with the potential for an extension, at the commissioner's discretion, by a further two years.

17.2 We have added an optional provision to the 2014/15 Standard Contract (*Schedule 1C Extension of Contract Term*) so that details of any potential extensions can be recorded at the start of the contract.

17.3 It is essential that this provision is not misused.

- The provision may be used only where a competitive procurement is undertaken for the contract and where the commissioner has made clear, from the very outset of the procurement process, the period and other details of any possible extension to the initial contract term.

- Commissioners should have regard to procurement guidance in determining whether it is appropriate to offer provision for contract extension. We would advise commissioners not to provide for extensions of more than two years.

- Any provision for extension must be made clear in the contract at the point the contract is agreed and signed and must not be varied subsequently.

- Any extension provision must apply to all the Services within the contract and to all the commissioners who are party to it.

- The option may be exercised once and once only (ie it may be an option to extend for, for example, one year or two years, but not for one year then for another year).

- This provision does not allow commissioners to extend contracts which would otherwise expire on 31 March 2014. It applies solely to new contracts agreed to take effect from 1 April 2014 onwards.

17.4 The provision for extension must not be incorporated into existing contracts expiring after 31 March 2014 when effecting the 2014/15 National Variation, nor by means of any other contract variation. However, where a contract expiring after 31 March 2014 already includes a provision for the extension of its term, and the 2014/15 National Variation is being effected via the eContract system, Schedule 1C may be used to restate that existing provision for extension.

18 Contracts not expiring at 31 March 2014

18.1 There will be contracts already in place which do not expire at 31 March 2014. To ensure that, for 2014/15, these contracts reflect the changes mandated in national planning guidance, three options are available. Either

- where the existing contract is an eContract, the parties may update that eContract to the 2014/15 Standard Contract form in its entirety (preserving and/or varying their locally agree content at the same time), maintaining the current duration of the contract, via the eContract variations mechanism; or

- where the existing contract is in paper form, the parties may agree to transfer their existing contract into the 2014/15 Standard Contract form in its entirety, maintaining the current duration of the contract, via eContract system; or

- again, where the existing contract is in paper form, the parties may use the National Variation Agreement templates which have now been published at http://www.england.nhs.uk/nhs-standard-contract/ to adopt changes mandated through national planning guidance.

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

18.3 Where neither option is agreed, commissioners will be able to issue a notice to terminate the existing contract on three months' notice, as set out in GC13.13 (or the equivalent provision of the relevant contract).

18.4 Further guidance on the process for National Variations will be made available at http://www.england.nhs.uk/nhs-standard-contract/ .

19 Letting of contracts following procurement (including AQP)

19.1 Our draft Technical Guidance advised commissioners that a provider which is qualified under an AQP procurement should be awarded a contract in the form of the NHS Standard Contract in respect of the relevant AQP services; those services should not be added to or combined with another contract held by or awarded to that provider under a separate procurement or commissioning exercise.

19.2 This topic was debated at several of our workshops in January 2014, and in response we have clarified and expanded our guidance below, so that it now deals with contracts let following competitive procurements, as well as contracts for AQP services.

19.3 Where a contract is being let following a competitive procurement process, the commissioner must let the contract to the chosen provider exactly on the advertised basis. This will mean that there is a separate, specific contract for the procured service, rather than – if the tender has been won by a provider which already has a contract with the commissioner – the new service being 'added in' to that existing contract. To do otherwise raises a risk of challenge from other potential providers on the grounds of a breach of procurement rules and should be avoided.

19.4 Contracts for AQP services are slightly different. AQP procurements are not competitive processes, in terms of price or quality; rather, all providers which can demonstrate an ability to meet the service specification and quality standards for the agreed price are admitted to the market. We also recognise that, in response to the perceived risk of a proliferation of separate AQP contracts, there has been previous guidance suggesting that commissioners could consider incorporating AQP services into existing contracts.

19.5 Adding AQP specifications into existing contracts is problematic from a procurement point of view, as the contract awarded is not the one advertised. There is a risk that different terms and conditions apply in the existing contract (duration, for instance, or CQUIN) than were used for the AQP procurement. To minimise the risk of challenge, our recommendation is that commissioners should let separate contracts for AQP services, but this is an issue where commissioners should determine their own approach in the light of local circumstances, seeking legal advice as appropriate. Where commissioners have already incorporated AQP services into existing contracts, we are not mandating that this must be undone; commissioners should, however, ensure that a consistent and even-handed approach is taken to AQP providers over time, in terms of pricing, incentive schemes, contract duration and any re-accreditation process.

20 Innovative contracting models

20.1 Commissioners looking at major service redesign projects have wanted the flexibility for longer-term contracts, and the 2014/15 Standard Contract allows for this. Equally, the National Tariff for 2014/15 creates increased flexibility for commissioners and providers to agree Local Variations to national prices.

20.2 We are aware that commissioners are also looking increasingly at innovative contracting models, particularly to facilitate closer integration of services. Some of the innovative models which we know are being explored are described briefly below.

Prime contractor / lead provider model

20.3 Under this model, the commissioners enter into a contract with a provider (the prime contractor or lead provider). That contract allocates risk and reward as between the commissioner and the prime contractor. The prime contractor then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The prime contractor remains responsible to the commissioners for the delivery of the entire service, and for the co-ordination of its 'supply chain' (ie its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime contractor is likely to be a provider of clinical services itself, but it could sub-contract all but the co-ordination role.

Integrated pathway hub (IPH)

20.4 In this case, the commissioners enter into separate contracts with a number of providers, all of whom contribute towards the delivery of an integrated service. Risks and rewards are allocated as between the commissioner and the provider under each contract. One of the providers (the IPH provider) assumes responsibility for the co-ordination and management of the integrated service and risks and rewards are allocated as between the commissioner and the IPH provider in relation to that integration and management function. The IPH provider may be a provider of clinical services itself, but may just take on the non-clinical co-ordination and management role. No one provider is responsible for the delivery of the entire integrated pathway.

Alliance contracting

20.5 The concept of alliance contracting derives from the construction and engineering sectors and can cover a number of different contracting models (including prime contractor and IPH structures). In other sectors, an alliance contract will typically bring together a number of separate providers under a single contract, but the term is often used in a broader sense, where multiple parallel contracts are put in place. In either case, key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability; contracting for outcomes; and an expectation of innovation.

How these models fit with the NHS Standard Contract

20.6 Both the prime provider and the IPH models can be used with the NHS Standard Contract, and we have specifically strengthened the provisions in the Contract around sub-contracting for 2014/15, so that they better support these models.

20.7 Some forms of alliance contracting are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to a single commissioning contract – but the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts. Any commissioners who are keen to discuss an alliance contracting approach are encouraged to contact the NHS Standard Contract Team via nhscb.contractshelp@nhs.net.

Summary

20.8 Innovative contracting that supports collaboration can support patient-centred care. Here, the commissioner is able to ensure the whole system is aligned to patients' needs, rather than fitting patient pathways across individual providers. It also allows more scope for support services, such as peer support, to be incorporated into a pathway as providers in the pathway realise the benefits of these services and share the success as providers' goals are aligned.

20.9 Non-traditional contracting models have potential advantages, and we encourage commissioners to consider them carefully when assessing their procurement options. They may offer a way of delivering, as set out in the revised Mandate, "new models of contracting and pricing which reward value-based, integrated care that keeps people as healthy and independent as possible." Such models may not offer panaceas, of course; as a first step, therefore, commissioners may wish to explore the scope to achieve their objectives by use of the individual flexibilities on National Tariff, incentives and sanctions and contract duration.

20.10 Commissioners are reminded that, in their procurement processes, they should have regard to *The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013*. NHS England will shortly publish good practice guidance on procurement.

21 Contracting approaches to support personal health budgets

21.1 The Mandate to NHS England states that, by 2015, “patients who could benefit will have the option to hold their own personal health budget as a way to have even more control over their care”. The roll-out of personal health budgets for those eligible for NHS fully-funded continuing health care is already under way, with a “right to ask” for a personal health budget from April 2014 and then a “right to have“ from October 2014.

21.2 There is a national delivery support programme in place to support CCGs in implementing personal health budgets. The support available includes regional networks, an accelerated development programme, an online progress check and a practical online toolkit. The toolkit explains the three options for managing a personal health budget – notional budget, third party budget and direct payment and is available at: http://www.personalhealthbudgets.england.nhs.uk/Topics/Toolkit/HowPHBswork/Options/. Further information about personal health budgets can be found on the website at http://www.personalhealthbudgets.dh.gov.uk.

21.3 The guidelines below are intended to help commissioners determine the appropriate contracting model for each of the three options, but commissioners will need to exercise local discretion and common sense to ensure that a proportionate approach is adopted.

- **Notional budget.** Where a commissioner itself commissions healthcare services funded by a personal health budget on behalf of an individual (a notional budget), use of the NHS Standard Contract is likely to be appropriate. A commissioner may, for instance, hold a single NHS Standard Contract with a provider which provides part of a package of care for a number of patients, funded from a personal budget in each case. The individual care packages could be expressed in the contract as separate brief specifications, for instance.

- **Third party.** Where a personal health budget is being managed by a third party, (for example where the third party is administering a trust fund set up on behalf of the individual), the commissioner will contract with the third party organisation that will organise, and be responsible for, the patient’s care and support. It may be appropriate to use the NHS Standard Contract in this situation, but CCGs could also consider using their grant-making powers.

- **Direct payment.** Where an individual (or their representative) holds the personal health budget and makes direct payments from it to service providers (for example, where he or she employs personal assistants directly), there will be no need for a contract between the NHS commissioner and a provider. Here, the personalised care plan will set out all the details of the needs to be met and the outcomes to be achieved from the services being provided.

21.4 Personal health budgets may in some cases be spent on other services or items, rather than traditional healthcare. Where this is the case, under the notional budget or third party options, use of the NHS Standard Contract is not appropriate; rather, the commissioner will wish to use the NHS terms and conditions for the supply of goods and the provision of services, available at https://www.gov.uk/government/publications/nhs-standard-terms-and-conditions-of-contract-for-the-purchase-of-goods-and-supply-of-services.

22 Contracting fairly

22.1 The contract is an agreement between the commissioner(s) and the 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.

22.2 A good relationship will depend on the 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 reasonable notice of any changes the commissioners wish to make to the services they are commissioning;
- there should be a fair balance of risk between commissioner and provider
- any local 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, via central collections or otherwise, should be used.

22.3 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 legal requirements 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. As sector regulator, Monitor has a responsibility for enforcing the procurement, patient choice and competition regulations and will shortly be producing substantive and enforcement guidance. NHS England will also be publishing procurement guidance for commissioners which will complement Monitor's guidance. NHS England's guidance is intended to support commissioners when procuring services and also provides advice on compliance with other rules, including the Public Contracts Regulations 2006 and EU law. It is expected that this will be available shortly on NHS England's website.

Section B Key topics in the NHS Standard Contract

23 Structure of the Standard Contract

23.1 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 Schedules to the Particulars and 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 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 which are 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.

24 Service categories

24.1 The service specifications (set out in Schedule 2A) describe the full detail of the services the provider is required to offer. The service categories, listed in the Particulars, are broad descriptions of different types of services; as set out above, their sole purpose in the contract is to determine whether or not certain provisions within the Particulars and Service Conditions apply to a specific contract.

24.2 For this reason, the service categories are not an exhaustive list of all the possible types of service. Rather, the list reflects the way in which the content of contracts can be tailored to reflect the nature of the service being provided.

24.3 We have made changes to the list of service categories for 2014/15.

- We have removed the separate category of Termination of Pregnancy Services, as there are no longer any specific requirements within the contract for this service. Depending on the specific nature and setting of the services being offered, TOP services should normally now be described as either Acute Services, Community Services or Surgical Services in a Community Setting.

- We have removed the separate category of Primary Care Services. Where primary care providers such as GPs or optometrists are also providing services under the NHS Standard Contract, these should generally be categorised as Community Services.

- We have clarified the description of Surgical Services, so that this now refers to Surgical Services in a Community Setting. Surgical services undertaken within hospitals should be classified as Acute Services.

- We have introduced new service categories for Community Pharmaceutical Services, Urgent Care Centre / Walk-In Centre / Minor Injuries Unit Services, Hospice Services, and Diagnostic, Screening and/or Pathology Services.

24.4 There is inevitably some imprecision with these categories. For instance, the applicability of the Community Services category is aimed at out-of-hospital services. If a provider of community services also runs community hospitals with inpatient beds, and the provisions on VTE or C difficile are relevant, then the commissioner should also tick the Acute Services category. If in doubt, commissioners should tick all of the services categories that could potentially apply to the specific contract.

25 Service specifications

25.1 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.

Specifications for maternity services

25.2 Both the National Audit Office and the Public Accounts Committee have recently published reports on maternity services in England. One key finding of these reports was that, for over a quarter of providers of maternity services, there was no written service specification in place. In this context, the Public Accounts Committee commented that it was unclear how commissioners were ensuring maternity services meet Department of Health policy objectives and how they were holding providers to account. In response to these reports, NHS England has confirmed that all commissioners should put in place robust service specifications for maternity services with relevant providers. If this cannot be achieved in all cases at the point at which 2014/15 contracts are signed, commissioners should ensure that a specification is subsequently included in contracts at the earliest possible stage, through the contract variation process.

25.3 NHS England has published a resource pack to support CCGs in commissioning maternity care, and this is available at: http://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf. Commissioners will also wish to refer to guidance and standards for maternity services published by NICE, available at: http://www.nice.org.uk/usingguidance/implementationtools/thematicguidancesupport/supportantenatalcare.jsp.

25.4 A wide range of specifications for community-based services have been produced as part of Any Qualified Provider procurement processes. CCGs may wish to use or adapt these specifications; they are available at: https://www.supply2health.nhs.uk/AQPResourceCentre/AQPServices/PTP/Pages/SampleServiceSpecs.aspx

How detailed should a service specification be?

25.5 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).

25.6 The level of detail required in a specification will depend on the services being provided. A specification should not be a detailed operational policy for a service; specifications that are no longer than 4-5 pages may be sufficient, especially if they focus on the outcomes required from the service rather than the inputs.

Can I add additional detail to the service specification template?

25.7 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.

25.8 Commissioners should avoid replicating 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 and may cause confusion. However, commissioners should ensure that they use correct contract terminology listed in the Definitions in the General Conditions (for example, 'Service User' rather than 'patient').

25.9 Quality requirements and information requirements in relation to a specific service should not be included in the service specification, as there is no link between the specification and the contract management elements of the contract. 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 B (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?

25.10 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, subject to procurement guidance, wish to involve prospective providers in developing a specification. A high level of clinical engagement is essential, and it is good practice to involve service users in the development of specifications wherever possible.

25.11 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 and/or payment regimes 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.

26 Commissioner Requested Services and Essential Services

26.1 We have made changes for 2014/15 to the arrangements set out in the Contract in relation to Commissioner Requested Services and Essential Services.

26.2 Monitor has published guidance on Commissioner Requested Services (CRS) (http://www.monitor.gov.uk/sites/default/files/publications/ToPublishFinalCRSGuidance28March13.pdf). During 2013/14, this CRS guidance has applied only to Foundation Trusts, but from April 2014 it will apply to all providers of NHS-funded services under the NHS Standard Contract, with the exception of NHS Trusts.

26.3 For NHS Trusts, the existing contractual arrangements for Essential Services will continue to apply in 2014/15, although we have now adopted a definition of Essential Services which is consistent with that for CRS used by Monitor. It is important to note that, whereas CRS designation is for each individual commissioner to determine in respect of each service, as set out in Monitor's guidance, the concept of Essential Services applies at contract level, not at commissioner level.

26.4 Under Monitor's CRS guidance,

- individual commissioners (CCGs and NHS England) have until 31 March 2016 to complete the process of determining whether individual services at specific providers should be designated as CRS or not;

- for services provided by Foundation Trusts, the starting point is that all services will be considered as CRS, until such point as the commissioner may determine otherwise, in line with Monitor's guidance;

- in contrast, services to be provided by other providers from 1 April 2014 will not be designated as CRS unless otherwise determined and specified by commissioners in line with Monitor's guidance. Although there is no requirement on commissioners to complete their designations by 1 April 2014, Monitor's clear expectation is that, wherever practical, CRS designations should be determined and agreed with providers during the 2014/15 contracting round.

26.5 Under the 2014/15 NHS Standard Contract,

- commissioners and providers must comply with their respective obligations under CRS Guidance in respect of any Services designated as CRS from time to time (SC5);

- any party proposing a Variation must have regard to the impact of the proposed Variation on other Services, and in particular any CRS or Essential Services (GC13); and

- the provider must ensure that, when Services are suspended or terminated, there is no interruption in the availability of CRS or Essential Services (GC16 and 18).

26.6 We do not propose that there should be a requirement to list CRS within contracts.

- The intention in Monitor's guidance is that any disputed CRS determinations are referred to Monitor for a final decision. Listing CRS within contracts would create doubt as to whether the contractual dispute resolution process could be used instead.

- Decisions on CRS are made individually by each commissioner for each service at each provider, rather than for the contract as a whole. Other than for the simplest contracts, a schedule recording all such decisions would be extremely complex, and would quickly be outdated as commissioners go through the designation process – so a labour-intensive process of varying the contract would be required, each time a commissioner reached a new decision on CRS designation in relation to a particular service.

26.7 However, Monitor and NHS England emphasise the following points to commissioners in relation to CRS.

- Individual commissioners should ensure that they have a clear process for reaching decisions on CRS designation within the timescale set out in Monitor's guidance.

- The annual contracting round offers a good opportunity for commissioners to take stock of progress on CRS with their providers.

- It is particularly important that commissioners consider, at an early opportunity, the CRS status of services provided by other providers than Foundation Trusts. These providers fall within the scope of the CRS guidance from 1 April 2014. It is important for two reasons that commissioners and such providers discuss potential CRS designation.

    - From the commissioner's perspective, the default position is that no services at such providers will be designated as CRS from 1 April 2014. This means that, unless commissioners address CRS designation in the coming months, they will not enjoy the protection afforded by CRS status for their services where this would be appropriate.

    - Equally, CRS designation is an important issue for providers. CRS have to be extremely resilient (which may in turn lead to cost pressures for the provider); and, for a small provider which currently falls below the de minimis threshold for Monitor's licensing regime, designation as a provider of CRS would mean that the full licensing regime then applied.

26.8 We strongly recommend, therefore, that commissioners take the opportunity of the 2014/15 contracting round to reach decisions about CRS designation of services provided by providers other than NHS Foundation Trusts and NHS Trusts. Although these decisions are for commissioners to make individually, there will often be benefit, as Monitor's guidance sets out, in commissioners coming together to consider CRS designation across a wider health economy, and the contracting round offers a good opportunity for that to happen.

26.9 Commissioners should

- submit their CRS designations (and any subsequent changes to their designations) to Monitor via crs@monitor.gov.uk, completing the spreadsheet available at http://www.monitor-nhsft.gov.uk/regulating-health-care-providers-commissioners/supporting-the-continuity-services/crs-data-collection/crs-data-collection-commis

- maintain an up-to-date record, accessible to the public via their website, of the services which they have designated as CRS at each provider.

26.10 Further information can be found in Monitor's *Briefing for commissioners on the NHS provider licence*, available at http://www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-commissioners/supporting-the-c.

27 Quality

27.1 The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience. Where we refer to quality below, we are referring to all three elements. In considering how quality is reflected in the contracting process, commissioners should take all three dimensions of quality into account.

Strengthening the Standard Contract in relation to service quality

27.2 The Government's detailed response to the Francis Report has now been published (http://francisresponse.dh.gov.uk/), as has National Quality Board guidance on nursing, midwifery and care staffing (http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf).

27.3 As set out in paragraph 3.2 above, a key focus for our development of the NHS Standard Contract for 2014/15 has been to put in place new contractual mechanisms to enable implementation of certain recommendations within the Francis Report, as well as addressing the requirements set out in the National Quality Board guidance.

27.4 For the most part, the changes listed in paragraph 3.2 are self-explanatory, but specific elements are worth describing in greater detail – Lessons Learned (SC3), Suspension (GC16), and Staff (GC5).

27.5 We have strengthened the arrangements for Lessons Learned for 2014/15. These are defined in the 2013/14 Contract as "experience derived from provision of the Services or otherwise, the sharing and implementation of which would be reasonably likely to lead to an improvement in the quality of the Provider's provision of the Services". The 2013/14 Contract includes a requirement under SC17 (Complaints) for providers to implement Lessons Learned from complains and demonstrate at Review meetings the extent to which Service Improvements have been made as a result. For 2014/15, we have converted this into a broader requirement for providers to demonstrate Lessons Learned from complaints, incidents, Never Events, surveys and other forms of service user and staff involvement; this new provision is now included in SC3 (Service Standards).

27.6 The 2014/15 Contract providers extended powers for commissioners to intervene where they are concerned about the quality or outcomes of care being provided. Arrangements for suspension of services are set out in GC16 (Suspension). The change we have made for 2014/15 is to the definition of a Suspension Event, which now includes the situation of "any Commissioner and/or any Regulatory or Supervisory Body having reasonable and material concerns as to the continuity, quality or outcomes of any Service, or for the health and safety of any Service User".

27.7 We have significantly extended the detailed provisions in GC5 (Staff) for 2014/15, specifically in the light of the National Quality Board report referenced at paragraph 27.1 above. The changes we have made apply generically to all staff groups. The key new requirements are for providers to

- continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis;

- link this data on staff numbers to data on patient experience and outcomes, using the full range of available information on this – so that the impact of staffing levels on patient experience can be clearly understood;

- undertake a detailed review of staffing requirements at service level every six months; and

- report to the co-ordinating commissioner, and make available in public, at least once every six months, the outcome of these reviews and evaluations, including demonstrating Lessons Learned as a result.

27.8 The National Quality Board guide contains a clear statement of the responsibilities of commissioners in relation to service quality, specifically as affected by staffing issues in providers. The wording of the guide provides a helpful overview of the role commissioners should be playing in assuring service quality more generally, and we have re-stated it for ease of reference in Appendix 4.

Quality Requirements in the NHS Standard Contract

27.9 The NHS Standard Contract is a key enabler for commissioners to provide assurance on, and secure improvements in, the quality of services for patients.

27.10 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 (in so far as they relate to the commissioned services). Consequences for failure to achieve these standards are set nationally.

- **National Quality Requirements**. This is a small set of national requirements, derived chiefly from the NHS planning guidance, which all providers are expected to achieve (again, in so far as they relate to the commissioned services). Consequences for failure to achieve these requirements are again set nationally.

- **Local Quality Requirements.** Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. It is reasonable for financial consequences to be agreed for non-achievement, so long as these are proportionate. 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.

Appendix 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 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 is available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213046/never-events-policy-framework-update-to-policy.pdf
  For 2014/15, we have clarified the financial consequence which applies when a Never Event occurs. The guidance above makes clear that commissioners may exercise discretion over the application of financial consequences for Never Events.

- **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 2014/15 framework, including the national goals is available at: http://www.england.nhs.uk/nhs-standard-contract/

- **Local incentive schemes**. It is possible to agree local quality incentive schemes in addition to CQUIN. For 2014/15, it is also possible to agree local incentive schemes as an alternative to the national CQUIN scheme, in line with the new flexibility set out in CQUIN guidance:

  http://www.england.nhs.uk/wp-content/uploads/2013/12/cquin-guid-1415.pdf

Revisions to nationally-mandated Quality Requirements

27.11 Following completion of the review of incentives, rewards and sanctions set out in *Everyone Counts: Planning for Patients 2013/14*, changes have been made to the nationally-mandated Quality Requirements set out in Schedule 4A and B. Some new indicators have been included, and many of the financial consequences have been revised.

27.12 New nationally-mandated Quality Requirements, with associated financial consequences, have been introduced in relation to VTE assessment (previously a national CQUIN indicator) and for several data quality indicators (completeness of NHS Number, completeness of ethnicity data in the Mental Health Minimum Data Set, and completeness of outcome data in the IAPT Minimum Data Set).

27.13 We have set out definitions of the new indicators are Appendix 6 and provided some worked examples of how to calculate the revised financial consequences at Appendix 7.

27.14 Definitions for other Operational Standards and National Quality Requirements (in Schedules 4A and 4B of the Contract) are set out in *Everyone Counts: Planning for Patients 2014/15 - 2018/19: Technical Definitions for Clinical Commissioning Groups and Area Teams* (available at http://www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf). We are aware the Technical Definitions document introduces a new referencing system for the standards, replacing the references starting with 'CB' with new references beginning with 'E'. The Contract continues to use the old CB references, but the read-across from the Contract to the Technical Definitions is straightforward on the basis of the description in the Contract of each standard, and we have therefore decided not to re-issue the Contract with the revised references.

Selecting local quality requirements

27.15 The CCG Outcomes Indicator 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.

27.16 Commissioners should be cautious in setting quality requirements, especially with financial consequences, for indicators in Domain 5 of the Outcomes Framework, particularly those relating to patient safety incidents (5a and 5b), medication errors (5.4) and monitoring of children (5.6). The national ambition here is for increased reporting; these parts of the Outcomes Framework should not be used as a measure of actual harm, and there should not be contractual consequences that could discourage the open and honest reporting of all patient safety incidents.

27.17 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 than requiring reporting on hundreds of less targeted quality requirements;
- using process measures to assess progress on achievement of broad outcomes and building on initial measures over a period of time.

27.18 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).

27.19 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 from the outset 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 a collection methodology for new information requirements.

27.20 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.

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

27.22 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.

27.23 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.hscic.gov.uk/
- HSCIC Indicator Portal - http://www.hscic.gov.uk/indicatorportal
- Assessed list of Mandated Collections http://www.hscic.gov.uk/datacollections

27.24 There are a number of other sources of information which can be used to monitor quality. These include:

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

27.25 Commissioners should work closely with local Healthwatch representatives in the design and monitoring of local Quality Requirements and in assessing the extent to which providers are implementing service improvements as a result of analysis of complaints, incidents, Never Events, surveys and other forms of service user and staff involvement.

27.26 The quality requirements should be agreed annually prior to the start of the contract year as set out in SC37. 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

27.27 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.

27.28 A Service Quality Performance Report should be produced for each month, as outlined in Schedule 6B of the contract. Schedule 6B outlines the matters which should be included in the report.

27.29 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. The course of action which may be taken if there are queries against performance is outlined in GC9.

27.30 Generally, failure to achieve a single 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.

Duty of candour

27.31 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 Appendix 5.

Health Care Associated Infections (HCAI) reduction plan

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

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

Provider quality accounts

27.34 Commissioners are statutory consultees for 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.

28 Financial consequences in relation to Quality Requirements

28.1 We are aware that there can be confusion about the basis on which performance against the Quality Requirements in Schedule 4 is measured and about the attribution of financial consequences across commissioners. The guidelines below are intended to provide some clarification; where doubt remains, commissioners and providers should use common sense and good faith to arrive at reasonable solutions.

28.2 The simplest sanctions apply to each single breach of an agreed standard; Never Events, 52-week breaches, MRSA cases and sleeping accommodation breaches are all examples. In these instances, the Responsible Commissioner can be identified for each patient breaching the standard, and any financial adjustment should be made in favour of the specific commissioner affected.

28.3 The situation is more complicated where there is a national target with a performance threshold (18-weeks, cancer waiting times, Care Programme Approach, for example) or a provider-specific target (Clostridium difficile). In these cases, a certain number of breaches may be permitted, and the sanction only applies to breaches beyond the permitted tolerance. It is therefore not usually possible to identify the specific cases which are responsible for causing the sanction and attribute these to individual commissioners. It can also be difficult to distinguish between CCG-commissioned activity and NHS England-commissioned activity – and these are of course usually covered by separate contracts.

28.4 The following principles therefore apply for nationally-mandated Quality Requirements with a performance threshold.

- For any nationally-mandated Quality Requirement, the contractual requirement on the provider is to achieve the performance threshold for the specific contract as a whole. Providers should of course strive to achieve the threshold separately for each commissioner within the contract, but this is not a contractual requirement.

- Measurement of performance against nationally-mandated Quality Requirements should therefore take place at the level of the contract as a whole.

- The exception to this is Clostridium difficile, which operates on the basis of a threshold which is for the provider as a whole. Specific arrangements for the calculation of any relevant sanction in relation to Clostridium difficile performance are set out in Schedule 4G of the Contract and described in detail in paragraph 27.14 onwards below.

- Where a provider has multiple contracts in place, it should only ever face a sanction under one contract for a breach of a Quality Requirement relating to a specific Service User. “Double jeopardy”, whereby the provider faces multiple sanctions for the same patient-level breach under separate contracts, must be avoided.

- In some situations, where it is agreed that local performance information cannot support analysis of provider performance at contract level, the provider and its co-ordinating commissioners may need to agree a pragmatic approach to attribution of financial sanctions, using reasonable proxies where an exact split is not possible. In the absence of agreed alternatives, the default position is that the value of any sanction across the provider as a whole should be split across contracts in proportion to total actual contract value for the period in question.

- Commissioners may wish to set out their agreed approach to this as part of a collaborative agreement (in relation to attribution and allocation of sanctions as between commissioners who are party to a specific contract) and/or in a separate memorandum of understanding (as between one contract and another).

Caps on value of sanctions

28.5 The 2013/14 Contract included a provision to cap the impact of any locally agreed sanctions to 1 per cent of Actual Annual Value across the Contract Year as a whole.

28.6 To minimise unintended consequences from the new package of sanctions for 2014/15, the capping provision has been revised and is now set out in SC36.47. For 2014/15, the cap will apply to the value of sanctions in respect of Operational Standards, National Quality Requirements and Local Quality Requirements (Schedules 4A, B and C), taken together, on a quarterly basis and will be set at 2.5 per cent of Actual Quarterly Value. The cap does not apply to funding which commissioners may withhold under other sections of the contract, for example Contract Management (GC9) or Information Requirements (SC28). The cap does not apply to sanctions for Never Events.

28.7 For consistency with the approach to CQUIN, the calculation of Actual Quarterly Value should exclude payments for high-cost drugs, devices and listed procedures which are identified within the National Tariff as having been excluded from National Prices.

28.8 In addition, there is a specific cap on the monthly impact of the sanction relating to four-hour waits in A&E. Effectively, the sanction ceases to increase if the provider's performance in the month falls below 92 per cent. A worked example is given in Appendix 7.

28.9 The 2.5 per cent cap is not in any sense intended as a norm for the level of sanctions that commissioners should expect to impose; rather, it is a maximum which must not be exceeded.

28.10 Equally, the 2.5 per cent cap on sanctions is not intended to prevent commissioners from setting payment structures within contracts which reward quality or outcomes, rather than simply levels of activity – so long as any such arrangements are in line with National Tariff guidance. To ensure that they do not fall within the scope of the 2.5 per cent cap, such outcome- or quality-based payment arrangements should be structured very clearly as comprising elements of payment for achievement of specified goals, and not as deductions from payments for failure to achieve specified goals, and should be set out in Schedule 3A (Local Prices) or, if appropriate, Schedule 3B (Local Variations).

Agreement to vary the application of nationally-mandated sanctions

28.11 Where commissioners and providers are seeking to radically change or improve services, through innovative contracting and payment models, it may become inappropriate to apply rigidly the mandatory national sanctions for non-achievement of the Operational Standards and National Quality Requirements set out in Schedule 4 of the Contract.

28.12 The default position set out in the Contract remains that, where financial consequence are triggered under Schedule 4, commissioners must apply them. However, for 2014/15 onwards, it is now permissible for commissioners and providers to agree, in advance (that is, before the contract is entered into and/or before the start of a new contract year), to vary this approach locally, so as to disapply or vary the consequence of a particular breach, provided the parties apply the following principles.

- The variation is in the best interests of patients. It will support the development of new and innovative service delivery models which are in the best interests of patients today and in the future. The variation will create a more effective incentive for the provider(s) to achieve the desired outcomes for patients. It is part of an innovative payment model.

- The variation promotes transparency to improve accountability and encourage sharing of best practice. It must be documented in the relevant contract and submitted to NHS England; submissions will be published. Providers remain under a contractual duty to achieve nationally-mandated Quality Requirements in full and at all times and to report on performance both to the commissioners and through national returns as applicable.

- Commissioners and providers must engage constructively with each other when seeking to agree variations to nationally-mandated sanctions. This process should involve clinicians, patient groups and other relevant stakeholders where possible. Providers and commissioners should agree short and long-term objectives for service improvement and a framework for agreeing variations, including the sharing of information and whether other stakeholders will be involved in making decisions on the variation.

28.13 Commissioners should note the following.

- Any sanction variation should be agreed for the contract as a whole, not for individual commissioners within it.

- A sanction variation can be agreed for more than one year, although the duration must not be longer than the duration of the relevant contract.

- Agreements to vary the application of sanctions should be recorded in contracts at Schedule 4H, using the template at Appendix 8. Once agreed, the completed Schedule 4H should be submitted to NHS England via england.sanctionvariation@nhs.net

- Sanction variations should be agreed in advance, as part of a deliberate set of measures to create more effective local incentives to improve services. They must not be agreed simply to avoid the application of sanctions in reaction to actual provider breaches.

- When considering making sanction variations, commissioners should ensure that they treat different providers of similar services in an even-handed manner. Proposals to vary sanctions should be highlighted to all potential providers where the contract is to be let under a competitive tender.

- Commissioners and providers may agree to utilise the new flexibility to vary from mandated national prices in combination with the flexibility to vary the amount and/or application of sanctions (and potentially also the flexibility to vary the national CQUIN scheme). Where this is the case, the variation templates for sanctions (and if relevant CQUIN) may be completed in briefer form, with the full detail only recorded on the Local Variation submission relating to variation from national tariffs.

Clostridium difficile

28.14 In response to stakeholder feedback through NHS England's review of incentives, rewards and sanctions, we have revised and simplified the national approach to setting financial consequences for breaches in the thresholds for rates of Clostridium difficile for 2014/15.

28.15 For NHS providers (NHS Trusts and NHS Foundation Trusts), commissioners should insert the nationally set threshold in Schedule 4 Part B. NHS England will publish provider targets for 2014/15 shortly, alongside further guidance. For non-NHS providers, the baseline threshold is zero. The consequences for breaches of the threshold are set out in Schedule 4G.

28.16 For NHS providers, the financial adjustment is based on a sanction of £10,000 per case above the provider's nationally set threshold. The appropriate figures relating to the 2014/15 baseline threshold will be made available on the NHS website early in the New Year. Performance is assessed on the provider's performance across all NHS contracts for the full year as a whole. 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.

28.17 For non-NHS providers, the baseline threshold is set at zero. A financial consequence of £10,000 per case of Clostridium difficile will be applied. Financial sanctions can be allocated to the relevant commissioner, as it is possible to attribute each case to a specific commissioner.

28.18 For the purposes of the quarterly cap on the value of local and national sanctions (see paragraph 28.5 onwards above), for both NHS and non-NHS providers, the full annual value of any financial consequence in respect of Clostridium difficile should be considered as part of the assessment for the final quarter of the Contract Year. This will provide for consistent treatment of NHS and non-NHS providers.

29 Serious Incidents and Patient Safety Incidents

29.1 In finalising and agreeing Schedule 6B (*Reporting Requirements*) and Schedule 6D (*Incidents Requiring Reporting Procedure)*, commissioners should ensure that the following requirements are clear.

- The provider must report any Serious Incidents (SIs) via the Strategic Executive Information System (STEIS) (http://nww.steis.doh.nhs.uk/steis/steis.nsf/steismain?readform) in line with the timeframes set out in the *NHS Serious Incident Framework* (http://www.england.nhs.uk/ourwork/patientsafety/) and ensure such incidents are also reported to the National Reporting and Learning System (http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/).

- The provider must investigate any SI using appropriate Root Cause Analysis methodology as set out in the NHS Serious Incident Framework and relevant guidance or, where reasonably required by the commissioner in accordance with the NHS Serious Incident Framework, commission a fully independent investigation.

- The outcomes of any investigation, including the investigation report and relevant action plan should be reported to the commissioner within the timescales set out in the NHS Serious Incident Framework.

- The provider and commissioner must ensure that the processes and principles set out in the Serious Incident Framework are incorporated into their organisational policies and standard operating procedures.

- The provider must operate an internal system to record, collate and implement learning from all patient safety incidents and will agree to share such information with the commissioner as the commissioner reasonably requires. (This is a requirement under the revised, more general provisions for Lessons Learned under SC3.4.)

- The commissioner should address any failure by the provider to comply with the requirements specified in Schedule 6B or 6D by using the provisions for Review (GC8) and Contract Management (GC9). However, commissioners and providers should recognise the primary importance of encouraging and supporting the reporting of incidents in order to promote learning and the improvement of patient safety. Incident reports must be welcomed and appreciated as opportunities to improve, not automatic triggers for sanction. Only where the provider fails to report, or does not comply with the specific requirements of Schedule 6B or 6D, or where the reporting of patient safety incidents or SIs identifies a specific breach of contractual terms leading to the incident in question occurring, should the commissioner address these using the formal processes of Review and Contract Management.

30 The Service Development and Improvement Plan (SDIP)

30.1 As set out in paragraph 3.11 above, an SDIP must be agreed in two situations for 2014/15.

- Each provider of acute services must agree with local commissioners, and detail within an SDIP, action that it will take during 2014/15 to implement the clinical standards set out in the *NHS Services, Seven Days a Week Forum* review into seven-day services (http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf).

- Each provider which has not yet completed implementation of the high-impact innovations set out in *Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS* must agree within an SDIP action that it will take during 2014/15 to complete full implementation of all the innovations relevant to its services (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf)

30.2 The specific high-impact innovations which, where applicable, should be fully implemented by March 2015 are as follows:

- set a trajectory for 2013/14 for increasing planned use of telehealth / telecare technologies;
- demonstrate to commissioners that trajectories for the intra-operative fluid management (IOFM) technologies are in place which are consistent with National Technology Adoption Centre (NTAC - now the Health Technology Adoption Programme) guidance;
- review the provision of wheelchair services to ensure outcomes similar to those achieved by the best-performing providers of mobility services for children;
- demonstrate that clear plans are in place to exploit the value of commercial intellectual property – either standalone or in collaboration with Academic Health Science Network;
- establish a 2012/13 baseline and a trajectory for improvement to reduce inappropriate face-to-face contact; and
- demonstrate that plans have been put in place to ensure that for every person who is admitted to hospital where there is a diagnosis of dementia, their carer is signposted to relevant advice and receives relevant information to help and support them.

30.3 Where these innovations are not relevant to a specific provider, or where the provider has already completed implementation, the SDIP offers an opportunity to record a broader action plan to take forward innovation in service provision. Further supporting information on innovations will shortly be available at www.innovation.england.nhs.uk.

30.4 In other respects, the inclusion of an SDIP is for local agreement. An SDIP need not be a single document, it can contain different elements. 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 or service development plans;

- any priority areas for quality improvement (where this is not covered by a quality incentive scheme).

30.5 Any plan should be included in the contract at Schedule 6E. 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.

31 Information requirements and information governance

Changes for 2014/15

31.1 We have made changes for 2014/15 to the main sections of the Contract dealing with information issues. These are SC23 (*Service User Health Records*), SC28 (*Information Requirements*), GC21 (*Data Protection, Freedom of Information and Transparency*) and Schedule 6B (*Reporting Requirements*).

31.2 The changes

- strengthen the requirements around use of the NHS Number as the primary identifier in both datasets and clinical correspondence (SC23.5);
- update the information governance requirements set out in the Contract, particularly in the light of the most recent Caldicott Review (GC21.4 onwards);
- clarify how the financial impact of recording changes should be dealt with, an issue previously dealt with in the Code of Conduct for Payment by Results (which is no longer being published for 2014/15) (SC28.10-11);
- revise and reduce the *National Requirements Reported Locally* elements of Schedule 6B (Reporting Requirements); and
- update terminology and references in various respects.

31.3 Commissioners have told us that they need stronger contractual levers to ensure that providers supply reports and datasets as required under the contract. We have therefore included a new provision for a modest financial consequence in relation to such Information Breaches, where these are sustained or recurrent, to be withheld and retained by commissioners, as set out in SC28.14 onwards. This will operate in addition to the existing provision for commissioners to withhold up to 1 per cent of Actual Monthly Value where Information Breaches occur.

31.4 Further information on information about information reporting and information governance is contained in Appendix 9.

31.5 NHS England has now issued draft advice on access to personal confidential data for the purposes of invoice validation, *Who Pays? Information Governance Advice for Invoice Validation*. This is available at http://www.england.nhs.uk/ourwork/tsd/data-info/ig/in-val/.

Reporting Requirements

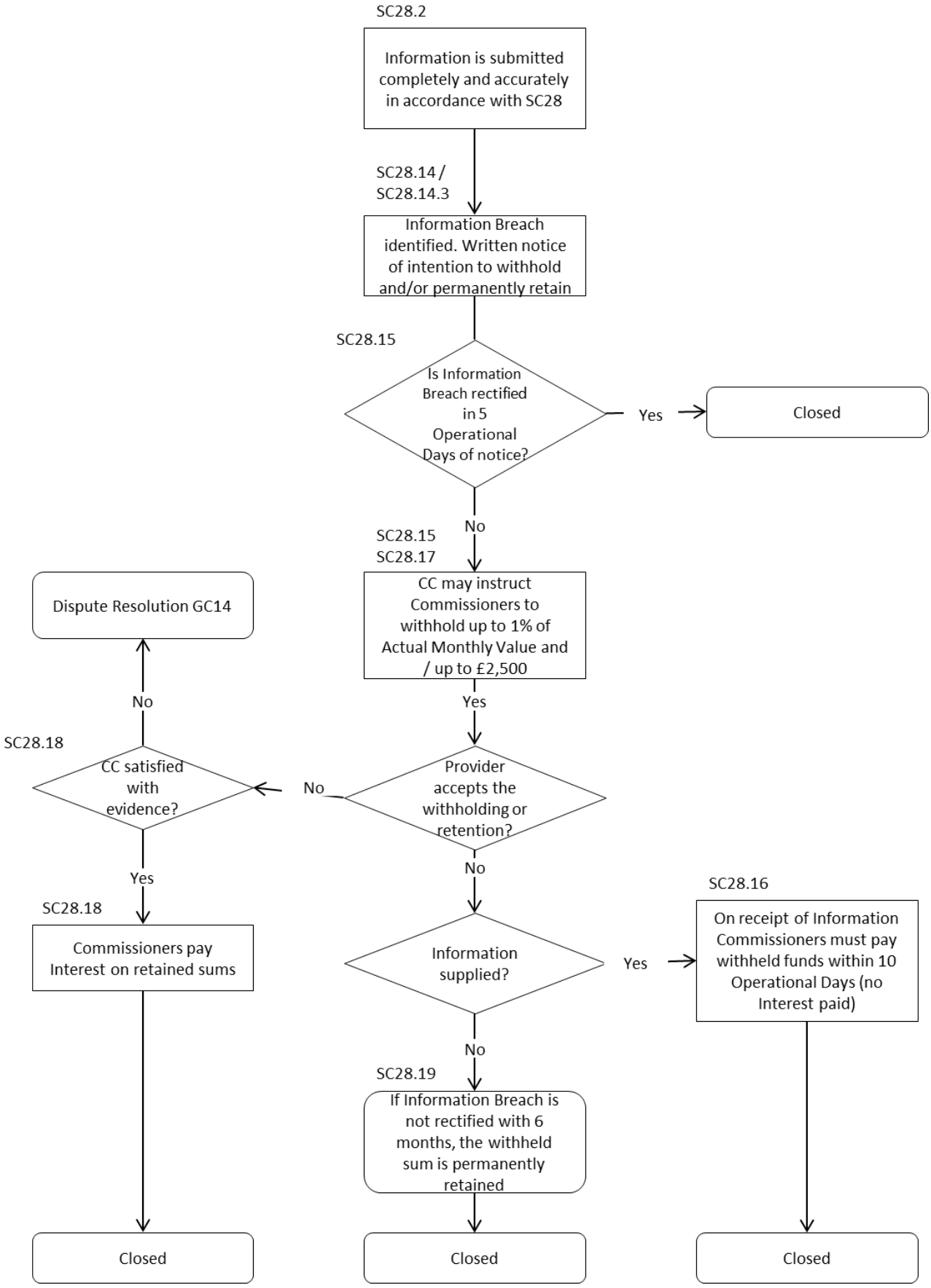
31.6 Good quality information is essential to enable providers and commissioners to monitor their performance under the contract. The following guiding principles should underpin the provision of information to support contract management:

- 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;
- unless there are justifiable reasons for doing so, commissioners should not request information directly from providers where this information is available through national systems; and
- information provided should be of good quality.

31.7 Schedule 6B outlines the reports required under the Contract:

- **National requirements reported centrally.** This references the list of assessed mandatory collections and extractions published on the HSCIC website. 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. Reporting requirements relating to PROMS and substance misuse services are also included in this section.
- **National requirements reported locally.** This lists the national requirements which are to be reported through local systems.
- **Local requirements reported locally.** This is where any locally agreed requirements should be inserted. Commissioners should be clear why these reports are required and whether the information requirement is occasional or routine and should set the timeframe, content and method of delivery for these reports accordingly.

Service Condition 28 – Information requirements



The Data Quality Improvement Plan (DQIP)

31.8 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 6C of the Particulars.

31.9 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.

31.10 Using the DQIP means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under SC28 only if the requirements of the DQIP are not achieved.

Sharing data about violent assaults

31.11 The revised Mandate for 2014/15 re-states the importance of "improving the way the NHS shares information about violent assaults with partners".

31.12 Schedule 6B of the Contract sets out a specific duty for providers of A&E, Urgent Care and Walk-In Centres and ambulance services to report monthly data on violence-related injuries to the local Community Safety Partnership and the local police force, where it can be used to target a range of different interventions at specific locations. Evidence shows that this approach can have a significant impact in helping to reduce violent crime at local level.

31.13 This requirement to share data has been in place for a number of years, but progress has been slow. The latest audit by the Department of Health (2013) has shown that only around one third of A&E departments are providing full data in line with contractual requirements. A new Information Standard in this area is expected to be introduced early in 2014 to assist in increasing compliance.

31.14 To ensure that there is progress against this important Mandate commitment in 2014/15, commissioners should

- take steps to understand whether providers are collecting information appropriately;
- take steps to understand whether their local Community Safety Partnership and police force are receiving the necessary data from providers; and
- take prompt contractual action against providers which are not providing comprehensive and timely data, including use of the financial sanctions set out in SC28.14 onwards.

32 Managing activity and referrals

32.1 In line with the feedback from our engagement process with stakeholders, we have not made changes for 2014/15 to the clauses of the Contract which deal with managing activity and referrals (SC29). We have clarified a number of points in the guidance notes below.

Responsibilities of commissioners and providers

32.2 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 Activity Planning Assumptions referred to below. Any changes must be agreed with the commissioner.

Indicative Activity Plan and Activity Planning Assumptions

32.3 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.

32.4 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.

32.5 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.

32.6 The commissioner may also wish to set Activity Planning Assumptions (APAs). These may include assumptions about the expected level of external demand for the Services and / or assumptions relating to how the provider will manage activity once a referral has been accepted. APAs are monitored as part of the activity management process.

32.7 APAs are for inclusion at the discretion of the commissioner. Where the commissioner wishes to use them, they should be notified to the provider before the start of the contract year. APAs should not be set in such a way that, as a result, a provider cannot provide the Services in line with Good Clinical Practice or that patient choice of provider (where this applies under Choice guidance) is restricted. For multi-lateral contracts, commissioners should seek to have common APAs for all commissioners. Where this is not possible, the number of different APAs in the contract must be kept to a minimum.

32.8 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 as a proportion of AE attendances.

Early Warning and Activity Query Notices

32.9 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.

32.10 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.

32.11 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) and joint activity review

32.12 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.

32.13 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.

32.14 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)

32.15 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 dispute resolution.

32.16 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 of provider. Where it is found that the provider's actions have been causing increased internal demand for services, for example by reducing clinical thresholds or introducing new services without the agreement of the commissioner, the plan may include an immediate consequence of non-payment for that activity.

32.17 An AMP could include the following elements:

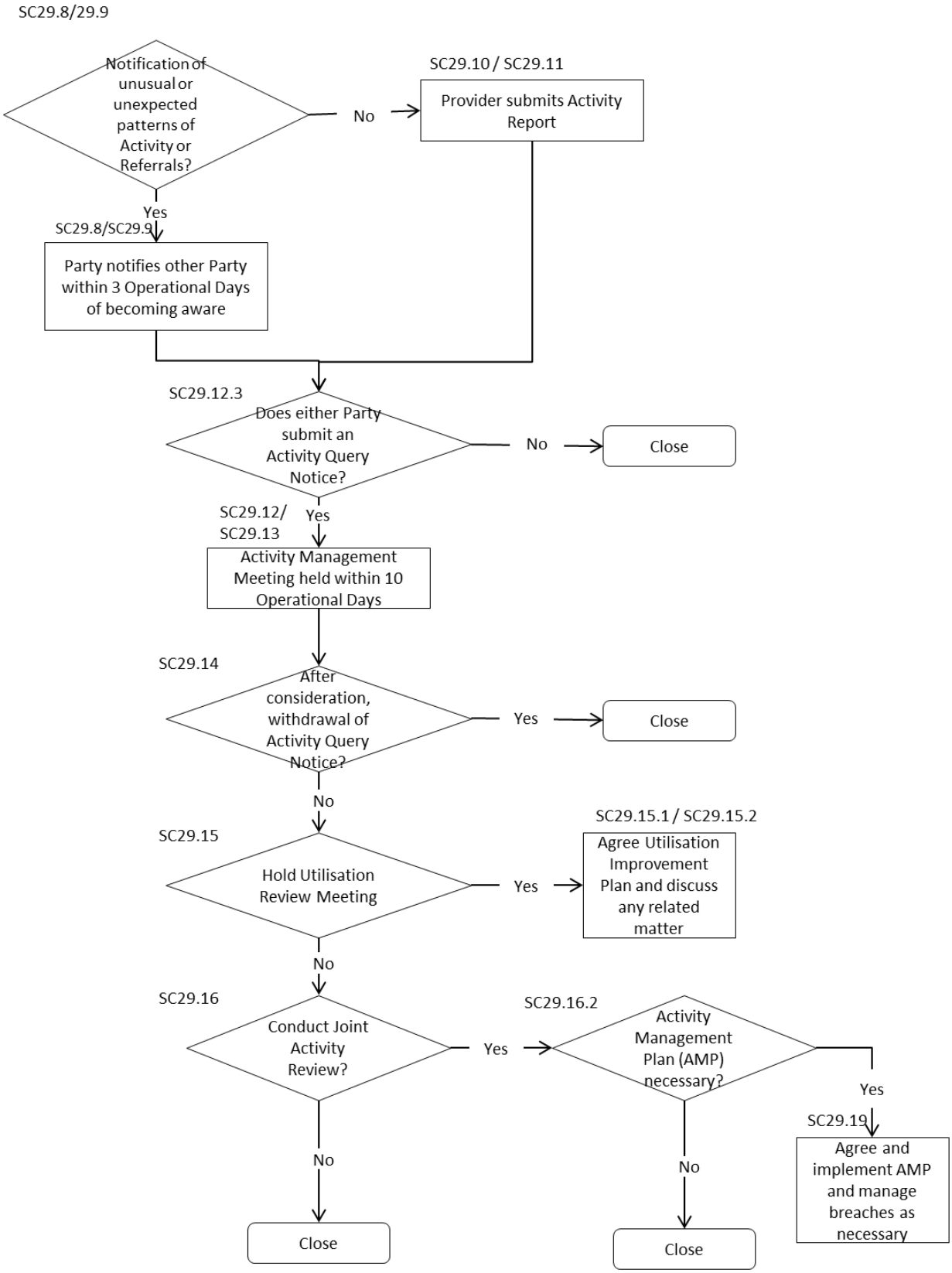
- details of the APA threshold that has been breached including a breakdown of actual activity, actual cost of activity (where appropriate) and actual variance;
- evidence of review of the activity, including source data (waiting lists, interviews, sample of patient notes, clinical process and patient 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.

Prior approval schemes

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

32.19 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.

Service Condition 29 – managing activity and referrals



33 Contract management

Contract review process

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

33.2 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.

33.3 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.

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

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

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

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

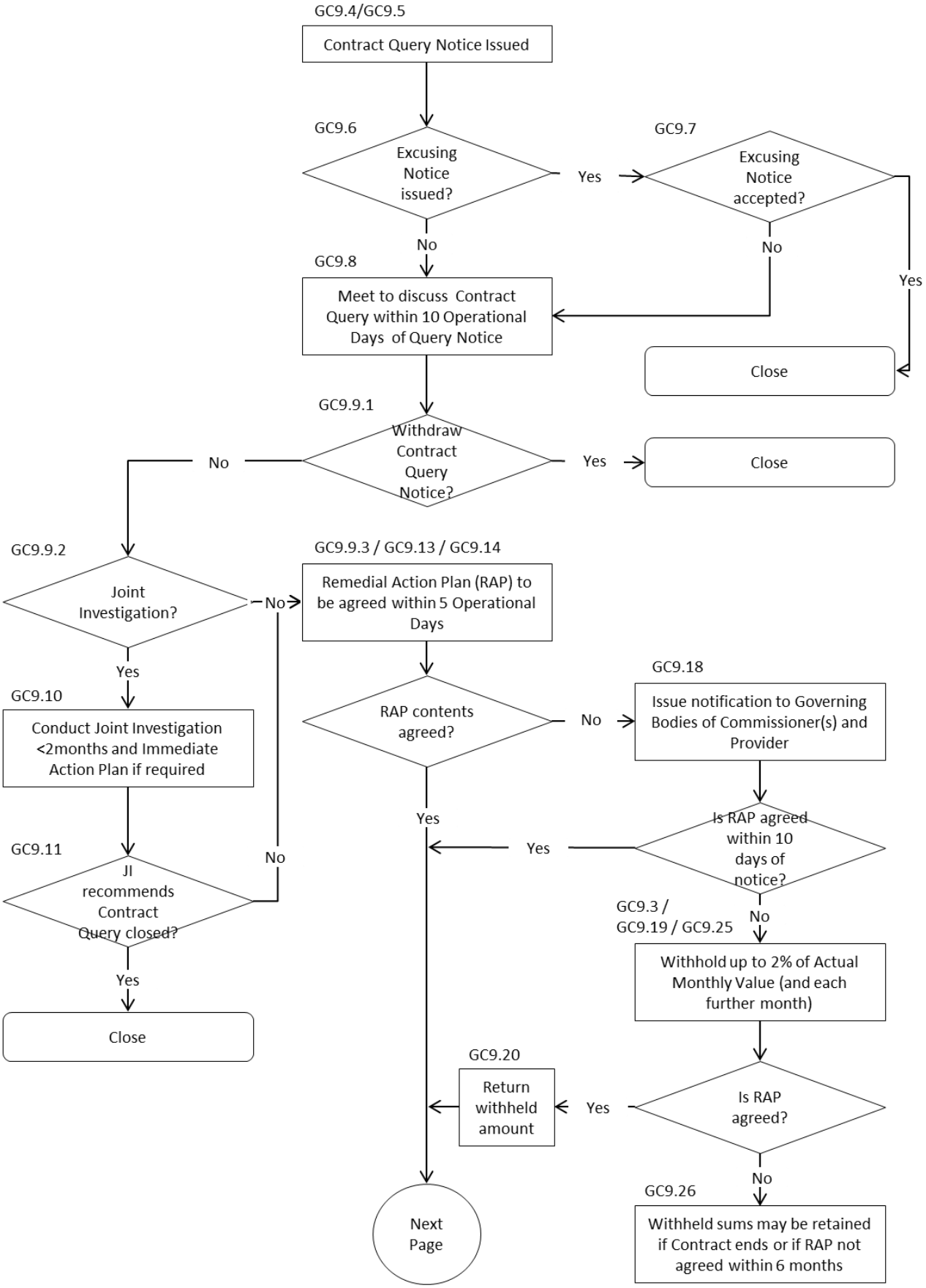
Contract management process

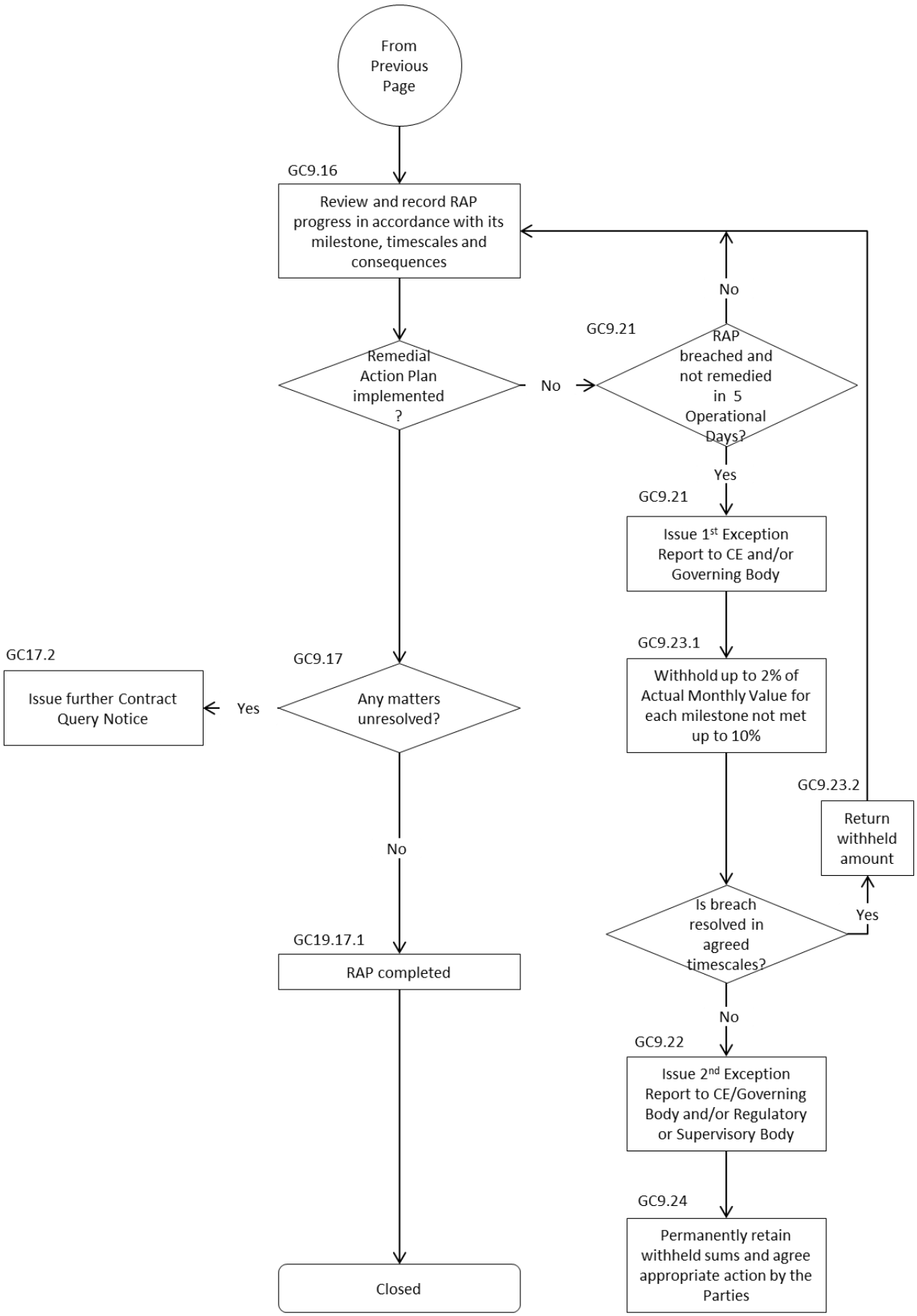
33.8 There are a number of stages to the contract management process. These can be summarised as follows:

- 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.

33.9 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
GC9.16
Review and record RAP progress in accordance with its milestone, timescales and consequences
Remedial Action Plan implemented ?
No
GC9.21
RAP breached and not remedied in 5 Operational Days?
No
Yes
GC9.21
Issue 1st Exception Report to CE and/or Governing Body
GC9.23.1
Withhold up to 2% of Actual Monthly Value for each milestone not met up to 10%
GC9.23.2
Return withheld amount
Is breach resolved in agreed timescales?
Yes
No
GC9.22
Issue 2nd Exception Report to CE/Governing Body and/or Regulatory or Supervisory Body
GC9.24
Permanently retain withheld sums and agree appropriate action by the Parties
GC17.2
Issue further Contract Query Notice
Yes
GC9.17
Any matters unresolved?
No
GC19.17.1
RAP completed
Closed

34 Payment

Main changes for 2014/15

34.1 We have made a number of changes for 2014/15 to the main clause of the Contract dealing with payment terms (SC36) and the associated Schedule (Schedule 3).

34.2 Our revised wording uses updated terminology, reflecting the new arrangements for the National Tariff, rather than Payment by Results. In line with the National Tariff, the Contract continues to specify two different types of prices – National Prices and Local Prices.

34.3 SC36 now makes allowance for the new pricing flexibilities (Local Modifications and Local Variations). Specific schedules (Schedules 3B and 3C) have been included where any Local Modifications and Local Variations can be recorded. In order to avoid duplication, the format of these has been designed to mirror the templates which must be submitted to Monitor.

34.4 For acute providers, to reflect the arrangements set out in the National Tariff, Schedule 3D now allows for the Agreed Baseline Value to be recorded for the Marginal Rate Emergency Rule, while the Agreed Threshold for Emergency Re-admissions within 30 Days can be recorded in Schedule 3E.

34.5 In the case of a contract covering more than one Contract Year, there is now a specific provision for the parties to record any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years. Any agreement on this issue can be set out in Schedule 3A (Local Prices).

34.6 Responding to clear feedback from our engagement process, we have re-drafted SC36 to reverse the onus for the production of reconciliation accounts, so that this now falls on the provider (in line with common practice across the country), not the co-ordinating commissioner. The responsibility in respect of CQUIN reconciliation has been similarly adjusted in SC38. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due. Commissioners will continue to need to review and validate the reconciliation accounts produced by providers, raising any contested issues in line with the arrangements set out in SC36.54.

Charging overseas visitors and migrants

34.7 We have added new wording into SC36.50 to refer specifically to the existing requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants.

34.8 The following references may be helpful as a reminder of current legislation and guidance:

- the statutory provisions which enable overseas visitors to be charged for NHS treatment, set out in section 175 of the National Health Service Act 2006 http://www.legislation.gov.uk/ukpga/2006/41/contents

- the National Health Service (Charges to Overseas Visitors) Regulations 2011 http://www.legislation.gov.uk/uksi/2011/1556/introduction/made

  as amended by regulations made consequent upon the Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

- the National Health Service (Charges to Overseas Visitors) Amendment Regulations 2012 (www.legislation.gov.uk/uksi/2012/1586/pdfs/uksi_20121586_en.pdf)

- guidance on implementing the overseas visitors hospital charging regulations, Department of Health, first published 2004, updated in 2011 and again on 31 October 2013 (www.gov.uk/government/uploads/system/uploads/attachment_data/file/254530/ovs_visitors_guidance_oct13a.pdf)

34.9 The 2014/15 Mandate makes clear the importance of this issue to the Government, and changes are likely to the legislation in this area during 2014/15, which may place new requirements on providers.

Risk-sharing

34.10 For 2014/15, we have removed the separate Schedule for risk-sharing agreements to be recorded (Schedule 3C in the 2013/14 Contract), as there was potential for confusion between this and the new provisions for Local Variations (see above).

34.11 Any agreements to share financial risk in relation to services covered by National Prices in 2014/15 should be recorded as Local Variations.

34.12 Any agreements on risk-sharing in relation to services covered by Local Prices can be recorded either in Schedule 3A (*Local Prices*) or in Schedule 2G (*Other Local Agreements, Policies and Procedures*).

Other

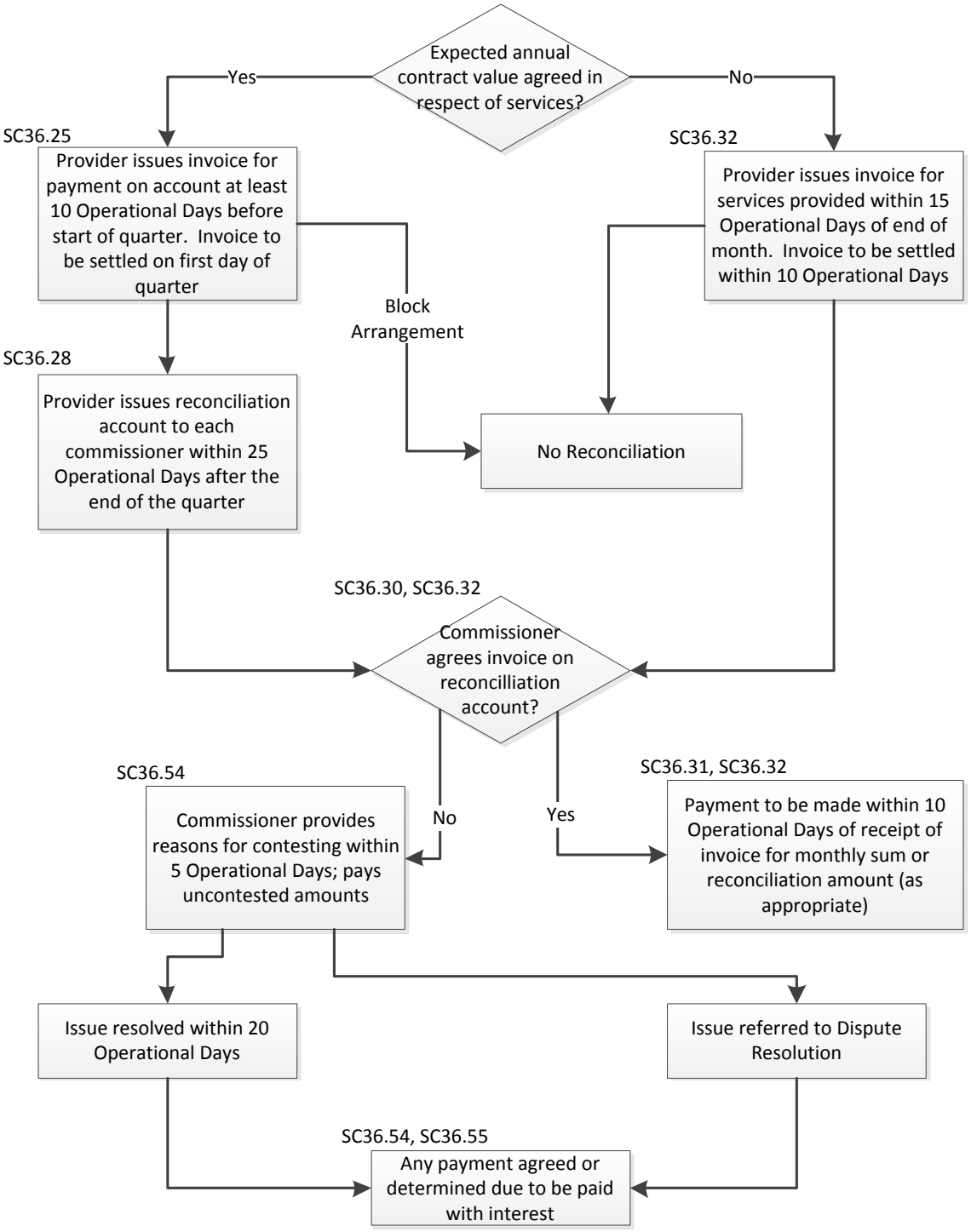
34.13 By selecting the appropriate options when completing the eContract, the commissioner can ensure that only the relevant payment arrangements relating to each contract are set out in the final eContract documentation.

34.14 As in previous years, the contract allows for quarterly payments on account to small providers where an expected annual contract value (EACV) has been agreed. Please note that the definition of 'Small Provider' has been revised (see paragraph 35.7).

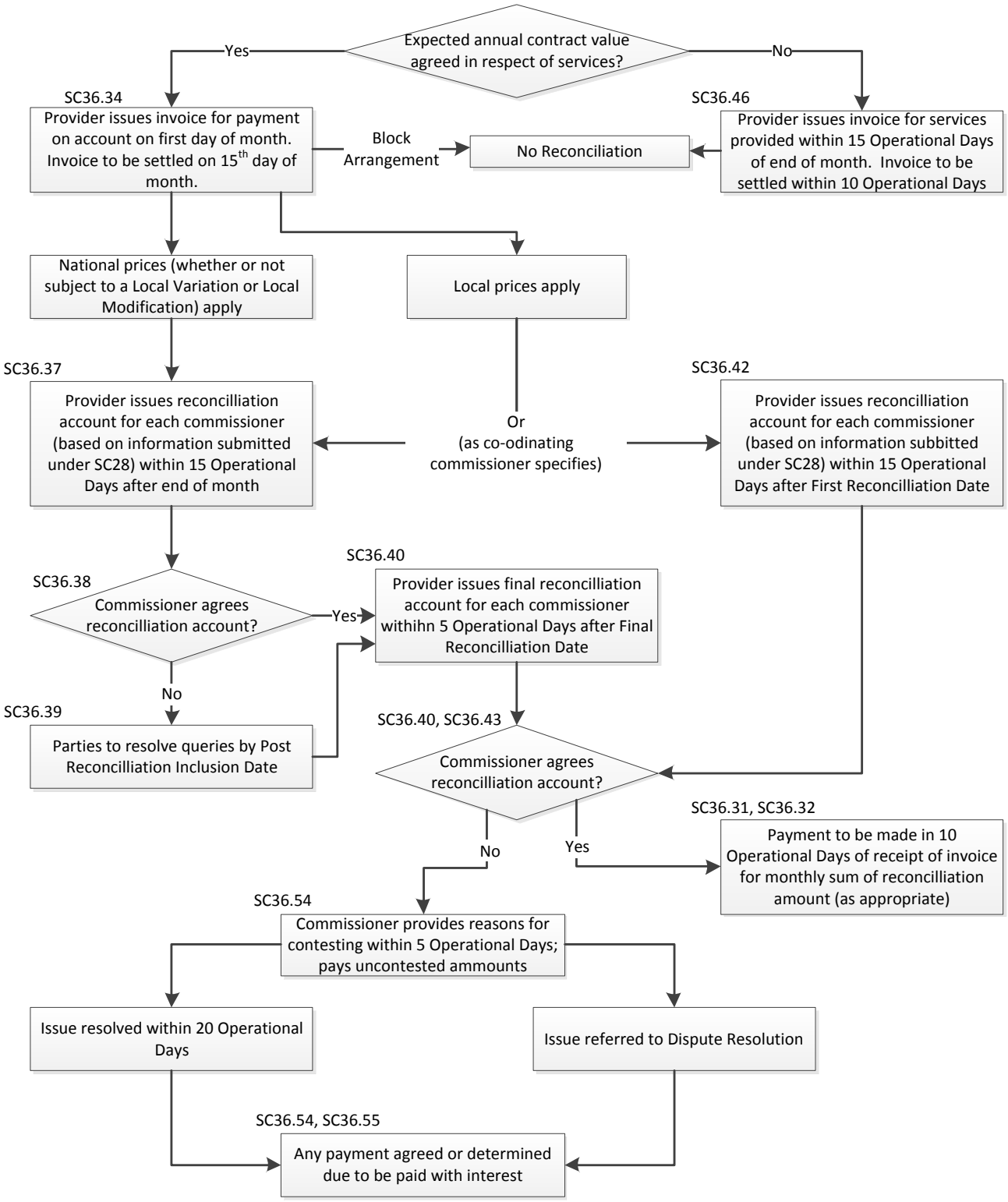
34.15 For all other providers where an EACV has been agreed, the provider should issue a monthly invoice, before the first day of the month. The contract sets a default for payment on the 15th day of the month. This can be varied by agreement by the parties in writing.

34.16 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.

Service Condition 36: Payment and Reconciliation – Small Providers



Service Condition 36: Payment and Reconciliation – Other Providers



34.17 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.

34.18 A single, mandated reconciliation process is set out in relation to services covered by National Prices (including any Local Modifications or Local Variations). For reconciliation relating to services covered by Local Prices, either the same process can be used as for services covered by National Prices activity, or the alternative process set out in SC36.41 and 36.42 (Reconciliation for Services to which Local Prices apply where the Parties have agreed an Expected Annual Contract Value).

34.19 Any disputes in relation to the calculation of payments should be addressed by using the process set out in SC36.54 (Contested Payments).

35 Other issues

Sub-contracting

35.1 GC12 sets out arrangements for Sub-Contracting. Material Sub-Contractors are recorded in Schedules 5B1 (Mandatory Material Sub-Contractors) and 5B2 (Permitted Material Sub-Contractors). It may be helpful to explain the intentions behind these distinctions.

- Whether or not Sub-Contractors are classified as "Material" is for local agreement, based on the importance of the sub-contracted element of the service to the delivery of the Provider's obligations. It may be useful to think of Material Sub-Contractors primarily as those involved in the direct provision of the Services, rather than those involved in the provision of non-clinical support functions or equipment (although sub-contracts for the provision, operation and maintenance of, for example, scanning equipment may be very material).

- Where the use of a specific Material Sub-Contractor is only one of several options available, all acceptable to the commissioners, that Sub-Contractor is likely to be a Permitted Material Sub-Contractor – ie a Sub-Contractor which the Provider may engage.

- Where contracts are agreed through a competitive procurement process, the commissioner may sometimes appoint the chosen provider in reliance on that provider engaging to use the services of a specific Sub-Contractor named in that provider's bid submission. This Sub-Contractor would be a Mandatory Material Sub-Contractor – ie a Sub-Contractor which the Provider must engage.

- Where the use of a specific Material Sub-Contractor is integral and vital to the delivery by the Provider of some or all of the Services, that Sub-Contractor is likely to be a Mandatory Material – ie a Sub-Contractor which the Provider must engage.

- The Contract makes provision for the terms of Material Sub-Contracts to be made available to the Commissioner as a Condition Precedent, at the Commissioner's discretion.

35.2 There is no requirement that a provider must use the NHS Standard Contract as the form for its sub-contracts and the NHS Standard Contract is not designed to be used as a sub-contract – but, in most cases, it would be appropriate for sub-contracts to be based on the relevant elements of the NHS Standard Contract.

Conditions Precedent

35.3 For 2014/15, we have added requirements for the provider to provide evidence to the commissioner, as a Condition Precedent, that it has put in place appropriate Indemnity Arrangements and that it has CQC registration and a Monitor licence where applicable. Other optional Conditions Precedent have also been included relating to sub-contracts and pensions.

Contractual processes carried forward from previous contracts

35.4 Where an existing contract is about to expire and the commissioner is intending to enter a new contract with the same provider, contractual processes unfinished during the previous contract (a Remedial Action Plan or an Activity Management Plan, for instance) may need to be referenced in the new contract This issue can be addressed by the inclusion of the agreed Plan within a Service Development and Improvement Plan under the new contract. In this situation, a commissioner may wish to treat the agreement of Service Development and Improvement Plan as a Condition Precedent for the purposes of the new contract. Where, under an expiring contract, a commissioner has reached the stage of withholding or retaining funding in respect of a provider failure (under GC9 or SC28, for example), the commissioner may also seek to specify in the Service Development and Improvement Plan to be included in the new contract that withholding or retention of funding will continue under the new contract, until such point as the original failure is rectified.

Audit

35.5 The provisions for audit set out in GC15 (Governance, Transaction Records and Audit) have been re-drafted for 2014/15. The new provisions make clear

- the Provider's responsibilities for carrying out a programme of audit at its own expense (GC15.6);

- the right of the Commissioner to appoint independent auditors (who must be appropriately qualified) to review clinical service provision, activity and performance recording, financial reconciliation and local prices (GC15.7); and

- what should happen as a result of the reports of independent audits and who should pay for them (GC15.8-15.12).

Formulary

35.6 SC27 requires the Provider to publish its formulary, and Schedule 4B sets out an associated national quality requirement relating to the provider's failure to publish its formulary. For 2014/15, we have clarified that this requirement applies only to providers of acute and mental health services.

Small Provider

35.7 We have reviewed the definition of Small Provider for 2014/15. The Small Provider category now includes those providers whose aggregate annual income for the relevant Contract Year, in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000.

35.8 To date, the key function of the Small Provider category has been that it triggers slightly different payment arrangements under SC36. In particular, under SC36.31 and SC36.32, the commissioner is under a duty to pay provider reconciliation accounts and/or invoices within ten Operational Days. This is an important provision to help small provider organisations to avoid cashflow difficulties, and commissioners should take steps to ensure that their local providers are being paid in accordance with this timescale.

35.9 For 2014/15, the Small Provider category is also being used as a filter to ensure that some specific provisions within the Service Conditions do not apply to provider organisations doing only a small volume of business with NHS commissioners. This is to avoid placing an inappropriate and unrealistic burden on such small providers.

TUPE

35.10 We have added a new provision at GC5.13 requiring the provider and any sub-contractor to comply with their respective obligations under TUPE if staff are to transfer to either as a result of the contract or a sub-contract being entered into.

New Fair Deal for staff pensions

35.11 In October 2013, the Treasury published guidance on the treatment of staff pensions on the transfer of staff from public bodies to the independent sector. https://www.gov.uk/government/publications/fair-deal-guidance. We have been liaising with the Department of Health to agree how that guidance is to be reflected in NHS commissioning and other contracts where transfers of staff originating with NHS employers arise. The Department's guidance is likely to be published in early 2014.

35.12 We have included new provisions in the Standard Contract for 2014/15 anticipating that guidance:

- an optional Condition Precedent (Schedule 1A), requiring production of a Direction Letter (which is the document which will set out the terms on which the provider is to be admitted as an employer to the NHS Pension Scheme;

- a new Provider Default Event (GC17.7.14), entitling the co-ordinating commissioner to terminate the contract if the NHS Business Services Authority notifies the commissioners that the provider or any sub-contractor is materially failing to comply with its obligations under the NHS Pension Scheme;

- a new Schedule 7 at which commissioners may (in the appropriate circumstances – ie where TUPE applies to transfer NHS staff to an independent sector provider or sub-contractor) include further provisions dealing with

    - the provider's obligations to ensure that transferring staff are able to stay, or remain eligible to become, members of the NHS Pension Scheme

    - allowing commissioners to set off any arrears of contributions to the NHS Pension Scheme where requested to do so by the Business Services Authority

    - the offer of broadly comparable benefits, where appropriate

    - the treatment of pension benefits on expiry or termination of the contract or Services.

35.13 A template for these provisions will be made available shortly, with further guidance. Both the template and our guidance may need to be updated subsequently in order to conform with the Department of Health's Fair Deal guidance when finalised.

35.14 In the meantime, commissioners are advised to consult the Treasury's guidance (see above) and take legal advice if engaged in or contemplating a procurement which may result in the transfer of staff from an NHS provider to an independent sector provider.

CQUIN

35.15 The 2014/15 CQUIN guidance makes clear that "it may not always be a good use of time for commissioners and providers to develop and agree detailed CQUIN schemes for very low-value contracts. At their sole discretion, therefore, commissioners may choose simply to pay the CQUIN value to providers where the 2.5 per cent CQUIN value would be non-material, rather than develop a specific CQUIN scheme."

35.16 Where commissioners do choose to adopt this approach, they should

- select 'No' against the CQUIN scheme item in the box on page 12 of the Particulars, reflecting that the provider does not have the opportunity, for this contract, to earn 2.5 per cent CQUIN funding on top of the actual contract value;

- record the disapplication of all national CQUINs in Schedule 4 Part I using the template available with the CQUIN guidance and submit the completed template to NHS England via england.cquinvariation@nhs.net in accordance with CQUIN Guidance; and

- ensure that the Local Prices set out in Schedule 3A are expressed at full value (that is, including any value which would otherwise have been paid as CQUIN).

35.17 The CQUIN guidance also sets out a new flexibility for commissioners and providers, by agreement, to vary the nationally set terms of the CQUIN scheme. Where this approach is used, commissioners should

- select 'Yes' against the CQUIN scheme item in the box on page 12 of the Particulars;

- record the variation to or disapplication of any national CQUINs in Schedule 4 Part I using the template available with the CQUIN guidance and submit the completed template to NHS England via england.cquinvariation@nhs.net in accordance with CQUIN Guidance;

- include the details of the locally-varied CQUIN scheme in Schedule 4E; and

- ensure that the Local Prices set out in Schedule 3A are expressed in the normal way, excluding any value to be paid under the locally-varied CQUIN scheme).

Appendix 1

Clause-by-clause guide to changes to the 2014/15 Standard Contract

This Appendix is intended to give users of the Standard Contract a simple clause-by-clause guide identifying what has changed, what has moved and what has stayed the same for 2014/15.

Delta View comparison documents showing changes made to the Service Conditions and the General Conditions for 14/15 will also be made available on the NHS Standard Contract webpage during January 2014 http://www.england.nhs.uk/nhs-standard-contract/.

Particulars

Section or Schedule	**Extent of changes**
Contract	No change
Service Commencement and Contract Term	Changed
Services	Changed
Payment	Changed
Quality	Changed
Governance and Regulatory	Changed
Contract Management	No change
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM	
A. Conditions Precedent	Changed
B. Commissioner Documents	No change
C. Extension of Contract Term	New
SCHEDULE 2 – THE SERVICES	
A. Service Specifications	No change
B. Indicative Activity Plan	No change
C. Activity Planning Assumptions	No change
D. Essential Services	Changed
E. Essential Services Continuity Plan	Changed
F. Clinical Networks, National Clinical Audit and Patient Outcomes Programme	Changed
G. Other Local Agreements, Policies and Procedures	Changed
H. Transition Arrangements	No change
I. Exit Arrangements	No change
J. Social Care Provisions	No change
K. Transfer of and Discharge from Care Protocols	No change
L. Safeguarding Policies	No change
SCHEDULE 3 – PAYMENT	
A. Local Prices	**Significant changes**
B. Local Variations	New
C Local Modifications	New
D. Marginal Rate Emergency Rule: Agreed Baseline Value	New

E. Emergency Re-admissions Within 30 Days: Agreed Threshold	New
F. Expected Annual Contract Values	Changed
G Notices to Aggregate/Disaggregate Payments	No change
H. Timing and Amounts of Payments in First and/or Final Contract Year	No change
Risk Share Agreements	Deleted
SCHEDULE 4 – QUALITY REQUIREMENTS	
A. Operational Standards	**Significant changes**
B. National Quality Requirements	**Significant changes**
C. Local Quality Requirements	Changed
D. Never Events	Changed
E. Commissioning for Quality and Innovation (CQUIN)	Changed
F. Local Incentive Scheme	No change
G. Clostridium difficile	**Significant changes**
H. Sanctions Variations	New
I. CQUIN Variations	New
SCHEDULE 5 – GOVERNANCE	
A. Documents Relied On	No change
B1. Provider's Mandatory Material Sub-Contractors	Changed
B2. Provider's Permitted Material Sub-Contractors	Changed
C. IPR	No change
D. Commissioner Roles and Responsibilities	No change
E. Partnership Agreements	No change
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS	
A. Recorded Variations	No change
B. Reporting Requirements	**Significant changes**
C. Data Quality Improvement Plan	No change
D. Incidents Requiring Reporting Procedure	No change
E. Service Development and Improvement Plan	No change
F. Surveys	No change
Recorded Dispute Resolutions	Deleted
SCHEDULE 7 – TUPE AND PENSIONS	New

Service Conditions

Clause	Title	Extent of changes
SC1	Compliance with the Law	Changed
SC2	Regulatory Requirements	Changed
SC3	Service Standards	Changed
SC4	Co-operation	Changed
SC5	Commissioner Requested Services/Essential Services	Changed
SC6	Service User Booking and Choice and Referrals	Changed
SC6.3	18 Weeks Information	New
SC7	Withholding and/or Discontinuation of Service	Changed
SC8	Unmet Needs	Changed
SC9	Consent	No change
SC10	Personalised Care Planning and Shared Decision Making	Changed
SC11	Transfer of and Discharge from Care Obligations	Changed
SC12	Service User Involvement	Changed
SC13	Equity of Access, Equality and Non-Discrimination	Changed
SC14	Pastoral, Spiritual and Cultural Care	Changed
SC15	Services Environment and Equipment	Changed
SC16	Places of Safety	No change
SC17	Complaints	Changed
SC18	Service Development and Improvement Plan	Changed
SC19	HCAI Reduction Plan	No change
SC20	Venous Thromboembolism	Changed
SC21	Not used	(Previously 18 weeks)
SC22	Not used	(Previously C difficile)
SC23	Service User Health Records	**Significant changes**
SC24	NHS Counter Fraud and Security Management	Moved from GC6
SC25	Procedures and Protocols	Changed
SC26	Clinical Networks, National Programmes and Approved Research Studies	Changed
SC27	Formulary	Changed
SC28	Information Requirements	**Significant changes**
SC29	Managing Activity and Referrals	Changed
SC30	Emergency Preparedness and Resilience Including Major Incidents	Changed
SC31	Force Majeure: Service-specific provisions	No change
SC32	Safeguarding	Changed
SC33	Incidents Requiring Reporting	Changed
SC34	Death of a Service User	No change
SC35	Duty of Candour	No change
SC36	Payment Terms	**Significant changes**
SC38	Commissioning for Quality and Innovation	Changed

General Conditions

Clause	Title	Extent of changes
GC1	Definitions and Interpretation	No change
GC2	Service Commencement	Changed
GC3	Effective Date and Duration	Changed
GC4	Transition Period	Changed
GC5	Staff	**Significant changes**
GC6	NHS Counter-Fraud and Security Management	Moved to SC24
GC7	Partnership Arrangements	No change
GC8	Review	No change
GC9	Contract Management	Changed
GC10	Co-ordinating Commissioner and Representatives	No change
GC11	Liability and Indemnity	Changed
GC12	Assignment and Sub-Contracting	Changed
GC13	Variations	Changed
GC14	Dispute Resolution	Changed
GC15	Governance, Transaction Records and Audit	**Significant changes**
GC16	Suspension	Changed
GC17	Termination	Changed
GC18	Consequence of Expiry or Termination	Changed
GC19	Provisions Surviving Termination	No change
GC20	Confidential Information of the Parties	No change
GC21	Data Protection, Freedom of Information and Transparency	**Significant changes**
GC22	Intellectual Property	No change
GC23	NHS Branding, Marketing and Promotion	No change
GC24	Change in Control	Changed
GC25	Warranties	No change
GC26	Prohibited Acts	No change
GC27	Conflicts of Interest	No change
GC28	Force Majeure	Changed
GC29	Third Party Rights	Changed
GC30	Entire Contract	No change
GC31	Severability	No change
GC32	Waiver	No change
GC33	Remedies	No change
GC34	Exclusion of Partnership	No change
GC35	Non-Solicitation	No change
GC36	Notices	No change
GC37	Costs and Expenses	No change
GC38	Counterparts	No change
GC39	Governing Law and Jurisdiction	No change

Appendix 2

Summary guide to completing the contract

This Appendix 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.

Initial advice on the general interpretation of NHS Standard Contract terms and use of the NHS Standard Contract is available through the NHS Standard Contract help email at: nhscb.contractshelp@nhs.net. The parties to the contract 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.

Use of the eContract system is recommended although not mandated. The Service Conditions and national Quality Requirements that are not applicable to the relevant service are automatically deleted by the operation of the eContract depending on which service categories are selected by the commissioner, resulting in a shorter, more tailored contract which is easier for commissioners and providers to use. Assistance in using the eContract system is available at england.econtracthelp@nhs.net (please note that this will change to exeter.helpdesk@hscic.gov.uk around 1 April 2014). The 2014 release of the eContract system also includes additional functionality to make the system easier and quicker to use. The eContract system can be accessed at www.econtract.england.nhs.uk.

The scope of the contract

There are two types of contract that can be entered into using the 2014/15 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.

For multilateral contracts, the roles and responsibilities table set out in the collaborative commissioning agreement 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.

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.

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 **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 must be marked as 'not applicable'.	

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.

Commissioners should be aware that embedding documents within contracts, other than in accordance with the eContract 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 eContract system. Where the eContract system is not used, the Commissioner should allocate their own reference 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 2014 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 GC3 and Schedule 1 Part A) are satisfied, whichever is later.	
Contract Term	Enter the initial contract term, excluding any potential extension period (which are stated in Schedule 1 Part C). Commissioners should refer to paragraphs 16-17 above regarding contract duration and any provisions to extend the contract.	
Commissioners	Enter the full legal name and address of each commissioner organisation (CCGs, NHS England 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://systems.hscic.gov.uk/data/ods/guidance.	
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 Commissioner who is a party to the 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. When using the eContract, the signature from the hard copy of the contract may be scanned in and uploaded. Refer to paragraph 14 above.	

Completion of the tables listed on pages 9 to 15 of the Particulars (from Service Commencement and Contract Term to Pensions) will determine whether certain of the Service Conditions or Schedules apply for a specific contract. Where the eContract is used, the Service Conditions affected will then either appear in full or show as 'not used'; the Schedules affected will either appear as open fields, so that they can be completed or marked as not used..

Service Commencement and 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.	
Expected Service Commencement Date	Enter the date (or dates) when the services are expected to start to be delivered. The Provider must satisfy all Conditions Precedent by this date. Services may not start until it has done so.	
Longstop Date	This is the longstop date for satisfying Conditions Precedent. This should be no later than three months after the Expected Service Commencement Date in most instances. If the Longstop Date is reached and the Conditions Precedent have still not been met, the Co-ordinating Commissioner can then terminate the contract under GC17.7.1.	
Commissioner Documents	Completing this will determine whether Schedule 1B (Commissioner Documents) applies and appears for completion in the eContract. See also below.	
Service Commencement Date	Enter the date when the services actually start delivery. This will usually be 1 April 2014 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 GC3 and Schedule 1 Part A) are satisfied, whichever is later.	
Contract Term	Enter the initial contract term excluding any extension period.	
Option to extend Contract Term	Indicate here whether the Commissioners are to have an option to extend the term of the contract, and the length of the permitted extension	
Expiry Date	Insert the date on which the initial period contract will expire.	
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. See paragraph 24 above for further detail on service categories.		
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 paragraph 25 on completion of the Service	

	Specification template.	
Indicative Activity Plan SC29.5 – SC29.6	Completing this will determine whether Schedule 2B (Indicative Activity Plan) applies and appears for completion in the eContract. See also below.	
Activity Planning Assumptions SC29.7	Completing this will determine whether Schedule 2C (Activity Planning Assumptions) applies and appears for completion in the eContract. See also below.	
Essential Services SC5	Completing this will determine whether Schedule 2D (Essential Services) applies and appears for completion in the eContract. See also below. The concept of Essential Services will apply only to NHS Trusts for 2014/15.	
Services to which 18-Week applies	Completing this will determine whether the Service Conditions and Quality requirements relating to 18 Weeks apply and appears in the eContract. Answer 'yes' or 'no'.	
Payment		
National Prices	Where National Prices apply to all or some of the Services, state Yes. The specific Services to which National Prices apply may be listed here, by specification number, if desired. Where no National Prices apply, state 'not applicable'.	
Local Prices SC36.4 – SC36.10	Where Local Prices apply to some or all of the Services, state "Set out in Schedule 3 Part A." Otherwise state 'not applicable'.	
Local Variations SC36.11 – SC.36.15	Where Local Variations have been agreed in line with National Tariff Guidance, state "Set out in Schedule 3 Part B." Otherwise state 'not applicable'.	
Local Modifications SC36.16 – SC 36.20	Where Local Modifications have been agreed in line with National Tariff Guidance, state "Set out in Schedule 3 Part C." Otherwise state 'not applicable'.	
Small Providers	A "Small Provider" is defined in this contract as an organisation whose aggregate income for the relevant contract year in respect of services provided to NHS commissioners under an NHS Standard Contract is not expected to exceed £200,000. Where the Provider falls within the definition, answer 'yes' and if not answer 'no'. Certain Service Conditions, especially but not only in the Payment Terms (SC36.24 - SC36.32) apply only to Small Providers.	
Expected Annual Contract Value Agreed SC36	Indicate whether an Expected Annual Contract Value has been agreed – 'yes' or 'no'.	
Any Service not included in Expected Annual Contract Value SC36.32, 36.46 (as applicable)	A positive response will allow the clauses set out in Service Conditions SC36.32 or 36.46 (as appropriate) to apply. Where there is no Expected Annual Contract Value, the Provider will be paid against a submitted invoice for any service delivered.	
First / last contract	Select 'yes' if the services commence or the contract is due	

Year less than 12 Months SC36.36	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 H.	
Notice given to aggregate / disaggregate payments SC36.23	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 or are to be disaggregated and made separately. Details are then set out in Schedule 3 Part G.	
Quality		
CQUIN Scheme SC38	Where the Commissioner and Provider agree a CQUIN Scheme, select 'yes'. Details of the agreed local scheme should be set out in Schedule 4 Part E. Where there is not a CQUIN Scheme, select 'no'. See paragraph 35.10-12 above.	
CQUIN Payments on Account Made SC38	The parties must agree whether the CQUIN Payment for the term of the contract will be paid monthly, annually or at another frequency. Enter the agreed frequency in Schedule 4 Part E.	
Local Incentive Schemes SC37	Where the Commissioner and Provider agree a Local Incentive 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'.	
Provider type	Indicate whether the Provider is an NHS Trust / NHS Foundation Trust or another type of provider. This will determine which arrangement applies for the application of financial consequences in relation to C difficile performance.	
Clostridium Difficile Baseline Threshold	The threshold for each NHS Trust and NHS Foundation Trust will be available on the NHS England website in the New Year. For other providers the C. diff. threshold should be set at zero.	
Governance		
Documents Relied On	Set out details to any documents relied upon in Schedule 5 Part A or state 'not applicable'.	
Mandatory Material Sub-contractors GC12.3	Set out details of any Mandated Material Sub-contractors in Schedule 5 Part B1 or state 'not applicable'. See below and also paragraph 35.1 above.	
Permitted Material Sub-contractors GC12.4	Set out details of any Permitted Material Sub-contractors in Schedule 5 Part B2 or state 'not applicable'. See below and also paragraph 35.1 above.	
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	Set out the Commissioner roles and responsibilities in	

and Responsibilities GC10	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 England and the Provider is an NHS Trust mediation will be arranged jointly by the NHS TDA and NHS England.	
Provider 's Information Governance Lead GC 21.4.2	The name and contact details of the Provider's Information Governance Lead must be inserted here.	
Provider's Caldicott Guardian SC24	The name and contact details of the Provider's Caldicott Guardian must be inserted here.	
Provider's Senior Information Risk Owner SC24	The name and contact details of the Provider's Senior Information Risk Owner must be inserted here.	
Provider's Accountable Emergency Officer SC30	The name and contact details of the Provider's Accountable Emergency Officer must be inserted here.	
Provider's Prevent Lead SC32	The name and contact details of the Provider's Prevent Lead must be inserted here.	
Provider's Safeguarding Lead SC32	The name and contact details of the Provider's Safeguarding Lead must be inserted here.	
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) GC10.3	Insert for each Commissioner the name and contact details of the person that will be the contact point for the 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.	
TUPE and Pensions		
New Fair Deal	Enter yes where TUPE applies to transfer NHS staff to an	

applies	independent sector provider or sub-contractor. Otherwise enter no. Please refer to paragraphs 35.11 – 35.14 above.	

Schedule 1 – Service Commencement		
A - Conditions precedent GC2.1.2	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. Where this is not done by the Longstop Date, the Co-ordinating Commissioner is able to terminate the contract under GC17.7.1. Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to Direction Letters, see paragraph 35.12 above.	
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.	
C – Extension of Contract Term	To be used only as described in paragraph 17 above. Where applicable, insert the extension period of the contract, as advertised to potential providers during the procurement process.	
Schedule 2 – The Services		
A - Service Specification	Commissioners and Providers should agree Service Specifications for all services commissioned under this contract. See paragraph 25 above for further details.	
B – Indicative Activity Plan (IAP) SC29.5	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 32.3ff above. The overall Indicative Activity Plan should include a breakdown of individual commissioner plans.	
C – Activity Planning Assumptions (APA) SC29.7	Insert any APA for the relevant Contract Year, specifying a threshold for each assumption. See paragraph 32.6ff above for further details.	
D –Essential Services SC5	Commissioners should list here any Essential Services that are applicable to the contract. The concept of Essential Services will apply only to NHS Trusts for 2014/15. See paragraph 26 above for further information on Essential Services and Commissioner Requested Services.	
E –Essential Services Continuity Plan SC5	If there are 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 Essential Services identified in Schedule 2 Part D, mark this Part E as 'not applicable'.	
F – Clinical Networks SC26	Set out here any Clinical Networks in which the Provider is required to participate. If there are no relevant clinical networks applicable to the	

	Services, enter 'not applicable'.	
G – Other Local Agreements, Policies and Procedures SC25.3	If there are specific local agreements, policies and procedures with which the Provider and/or Commissioner(s) are to comply, enter details of them here. See paragraph 34.10-12 above.	
H – Transition Arrangements GC4	The contract Transition Period is the time between the Effective Date and the Service Commencement Date. There may be certain things that need to be done 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 or other arrangements, this section should be marked 'not applicable'. See paragraph 16.5 above.	
J – Social Care Provisions SC8.5	Where a service has been jointly commissioned under a Partnership Agreement under section 75 of the 2006 Act and where the CCG/NHS England 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 should 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 SC32. The policy should reflect the local multi-agency safeguarding policy.	
Schedule 3 – Payment		
A - Local Prices	Insert the detail of any Local Prices into Schedule 3A,	

SC36.4 -36.10	entering text (or attaching documents or spreadsheets) which, for each separately priced Service: • identifies the Service; • describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template available at http://www.monitor.gov.uk/locallydeterminedprices should be copied or attached) • describes any currencies (including national currencies) to be used to measure activity; • describes the basis on which payment is to be made (that is, whether (and if so how) dependent on activity, quality or outcomes, or a block payment) • sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s).	
B – Local Variations SC36.11 – SC36.15	For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by Monitor (available at http://www.monitor.gov.uk/locallydeterminedprices) – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.	
C – Local Modifications SC36.16 – SC36.20	For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by Monitor (available at http://www.monitor.gov.uk/locallydeterminedprices) - or state Not Applicable. For each Local Modification application granted by Monitor, copy or attach the decision notice published by Monitor. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.	
D - Marginal Rate Emergency Rule: Agreed Baseline Value SC36.21	Enter the baseline value for emergency admissions as agreed between the Parties in line with National Tariff Guidance – or enter 'not applicable'. (This Schedule only applies to acute services providers.)	
E – Emergency Readmission Within 30 Days: Agreed Threshold SC36.22	Enter the threshold for emergency readmissions within 30 days, as agreed between the Parties in line with National Tariff Guidance – or enter 'not applicable'. (This Schedule only applies to acute services providers.)	
F - Expected Annual Contract Values SC36	Insert the total Expected Annual Contract Value (EACV) for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). The EACV must not be seen as an upper or lower cap on the provider delivering choice services. Where there is no EACV, enter 'not applicable'. Where applicable, specify EACV including and excluding anticipated values of any high cost drugs, devices and procedures (as listed in the National Tariff) expected to be	

	used in connection with the relevant Services. (CQUIN calculations will be based on contract values excluding costs of these drugs, devices and procedures.)	
G - Notices to aggregate/disaggregate payments SC36.23	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 informing it of the intention to aggregate payments, or to disaggregate payments, must be inserted here.	
H – Timing and Amounts of Payments in First and/or Final Contract Year SC36	If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here. Where the first and final Contract Year is 1 April – 31 March, enter 'not applicable'.	
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 Standards link to the service categories in the Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraphs 27-28 above.	
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 Requirements link to the service categories in the Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraphs 27-28 above.	
C - Local Quality Requirements	Commissioners may wish to agree additional quality requirements with the Provider. Where these are agreed, they should be recorded here. See also paragraphs 27-28 above.	
D - Never Events	The Never Events link to the service categories in the Particulars section. Where the eContract is used, only those applicable to the commissioned services will appear in the contract.	
E - Commissioning for Quality and Innovation (CQUIN)	CQUIN guidance has been updated for 2014/15. Commissioners should complete this section in accordance with the updated CQUIN guidance. The Contract layout has been simplified for 2014/15, allowing commissioners simply to attach or upload a document setting out their CQUIN scheme.	
F - Local Incentive Scheme	If the parties have agreed a Local Incentive Scheme (or do so at any time during the contract term), the details should be inserted here.	
G - Clostridium difficile (C. diff)	Where the eContract is used, 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.	
H - Sanctions Variations	Where the Parties have agreed to utilise the new flexibility to vary the application of national sanctions, they must complete the template available at Appendix 8. The completed template should be inserted here as Schedule 4H and returned to NHS England via england.sanctionvariation@nhs.net	
I - CQUIN Variations	Where the Parties have agreed to utilise the new flexibility to vary the application of the national CQUIN scheme (as set out in CQUIN guidance), they must complete the template available in the CQUIN guidance. The completed template should be inserted here as Schedule 4I and returned to NHS England via england.cquinvariation@nhs.net	
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 endeavour to contradict or circumvent the mandated terms and conditions of the contract.	
B1 - Provider's Mandatory Material Sub-contractors GC12	Details of any Mandatory Material Sub-contractors should be inserted here. If there are no Mandatory Material Sub-contractors, this section will be identified as 'not applicable'. Further guidance is set out in paragraph 35.1 above.	
B2 – Provider's Permitted Material Sub-contractors GC12	Details of any Permitted Material Sub-contractors should be inserted here. If there are no Permitted Material Sub-contractors this section will be identified as 'not applicable'. Further guidance is set out in paragraph 35.1 above.	
C – IPR (Intellectual Property Rights) GC22	Commissioner IPR: 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 here. Provider IPR: any IPR 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.	
D - Commissioner Roles and Responsibilities GC10	The Commissioners must set out in this Schedule 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.	

E - Partnership Agreements GC7	This table is used to record any partnership arrangements (i.e. s75 agreements) between the Commissioner(s) and a local authority or the Provider 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 - Reporting Requirements SC28	This table sets out the information that is required to be reported under the contract. See also paragraph 31.6ff above.	
C - Data quality improvement plan (DQIP) SC28.19ff	This table is used to record any agreed DQIP.	
D – 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.	
E – Service Development and Improvement Plan SC18	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 30 above, which sets out certain situations in which an SDIP must be included.	
F – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys.	
Schedule 7 – Pensions		
Pensions	Please refer to paragraphs 35.11 – 35.14 above.	

Appendix 3

Local quality requirements pick list

Note that, in line with the recommendations of the Independent Review of the Liverpool Care Pathway, commissioners must not put in place financial incentives relating to the use of the Liverpool Care Pathway. Further detail is available at: https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients

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 setting.		NICE QS	Acute
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 treatment included palliative care	National (HSCIC) HSCIC Indicator Portal https://indicators.ic.nhs.uk/webview/	Quality Account Standard	All
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 Ethics Service (also domains 2.3.4.and 5)	Local	Quality Account Report	All
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,	National (SINAP) http://www.rcplondon.ac.uk/projects/stroke-improvement-national-audit-programme-sinap	NICE QS	Acute

and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.			
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 served by early intervention teams year to date			Mental 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/		Mental health
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/webview/	Quality Account Standard	Acute
Improving Access to Psychological	National (HSCIC)		Mental

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	http://www.ic.nhs.uk/catalogue/PUB07281		health
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	National NNAP (Q4) http://www.rcpch.ac.uk/c	NICE QS	Acute

and continue breastfeeding, including being supported to express milk.	hild-health/standards-care/clinical-audit-and-quality-improvement/national-neonatal-audit-programme		
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
Ambulance service experience			Ambulance
Ambulance time to answer call	Ambulance Quality Indicators (DH) http://transparency.dh.gov.uk/category/statistics/amb-quality-indicators/		Ambulance
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/		Ambulance
A & E unplanned re-admission rate	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute

A & E left department without being seen rate	Search for latest releases under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E total time spent in A & E department	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E time to initial assessment (95th percentile)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E time to treatment in department (median)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
Percentage of A & E attendances for cellulitis and DVT that end in admission	National – HES http://www.ic.nhs.uk/hes		Acute
Number of admissions for cellulitis and DVT per head of weighted population			Acute
A & E service experience	HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.3 https://indicators.ic.nhs.uk/webview/		Acute
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			Acute

Appendix 4

National Quality Board "How to" guide – expectations on commissioners

Below is an extract from the recent National Quality Board guide on staffing capacity and capability, summarising the key responsibilities of commissioners in relation to ensuring the quality of the services they commission. The full report (*How to ensure the right people, with the right skills are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability)* is available at: http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Expectation 10

Commissioners take an active interest in ensuring that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality of care, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

Why is this important?

Commissioners are responsible for ensuring that they commission high-quality services. The impact that nursing, midwifery and care staffing capacity and capability can have on patient safety has been well documented and should therefore be a key focus for commissioners. Commissioners should continually hold providers to account for ensuring that they deliver safe, high-quality services, ensuring that they maintain sufficient staffing capacity and capability to do this at all times.

Commissioners must commission high-quality care whilst also delivering value for public money. Where prices for the services the commission are set through local negotiations, rather than by national tariffs, commissioners have a responsibility to ensure that the local prices agreed mean that provision of safe, effective services remains viable.

What does this mean in practice?

Commissioners set clear standards for safety, quality and outcomes in their contracts, through services specifications and incorporating quality standards.

As outlined in *Everyone Counts: Planning For Patients 2013/14*, commissioners actively review and discuss the cost improvement programmes proposed by their major providers, ensuring that these have clinical ownership within the provider and do not threaten service quality.

- Commissioners have mature discussions with providers about local prices, efficiency requirements so that commissioner financial constraints do not inadvertently encourage providers to operate unsafe staffing levels.

- Commissioners monitor service safety, quality and outcomes, alongside expenditure and activity levels, using the monitoring information which providers are required to supply under the NHS Standard Contract; this covers quality standards, complaints, serious incidents and Never Events, infections rates, clinical audit reports and patient and staff surveys. Commissioners maintain a constant and close dialogue with providers about any issues relating to service safety and staffing levels.

- Commissioners triangulate this data on service quality with provider reports on actual staff available on a shift-to-shift basis versus planned staffing levels. The NHS Standard Contract for 2014/15 is expected to set out new requirements on providers to report on this to commissioners.

- In liaison with regulators and Area Teams through Quality Surveillance Groups, commissioners use the levers set out in the NHS Standard Contract to address any provider issues with service quality and safe staffing. These levers include the ability to:

    require remedial action plans to be agreed and implemented

    report formally to the provider's Board and levy financial sanctions where such actions plans are not implemented

    suspend services temporarily or terminate them permanently.

- In deciding whether to suspend or terminate services, commissioners balance risks and benefits carefully and work closely with providers to ensure that sufficient service provision can be maintained and that delivery of the normal service can be re-established as soon as possible, if necessary through a new provider.

- Commissioners share information and intelligence with their local commissioning and regulatory partners through their Quality Surveillance Group.

Appendix 5

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,

[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

pending an investigation, but patients and families must be kept informed of progress.

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, local Healthwatch organisations 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 indeed regulatory requirements set by CQC.

Appendix 6

Definitions of new nationally-mandated Quality Requirements

Venous thromboembolism

National Quality Requirement	Risk assessment of inpatients for venous thromboembolism (VTE)
Rationale	Improved outcomes for patients. Previous national CQUIN indicator, included as a National Quality Requirement in the NHS Standard Contract for 2014/15
Definition	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with the published guidance http://www.vteprevention-nhsengland.org.uk **Denominator:** Number of adults who were admitted as inpatients (includes day cases, maternity and transfers, both elective and non-elective admissions)
Threshold	95% rate of inpatients undergoing risk assessment each month
Reporting	Nationally through Unify2 (monthly) and to commissioners through the Service Quality Performance Report (monthly)
Application of any sanctions	Monthly
Further information	A range of resources are available to local health economies to tackle VTE: National VTE Risk Assessment Tool: http://www.vteprevention-nhsengland.org.uk/images/downloads/National%20Risk%20Assessment%20Tool.pdf Hospital Associated Thrombosis and Root Cause Analysis guidance and tools (housed on national VTE prevention website) http://www.vteprevention-nhsengland.org.uk/images/vte-prev-guide-may2013.pdfNICE clinical guideline CG92, and NICE Quality Standard for VTE Prevention (QS3) http://guidance.nice.org.uk/CG92 Other resources and information are available on the VTE Prevention website: http://www.vteprevention-nhsengland.org.uk

NHS Number – mental health and acute services excluding A&E

National Quality Requirement	Completion of a valid NHS Number field in mental health and acute Commissioning Data Set records submitted to SUS (excluding A&E services)
Rationale	This is a required Information Standard and has been set out as a priority in national planning guidance. National Patient Safety Agency guidance has identified risks to patient safety of not using the NHS Number as the national identifier for all patients.
Definition	% of all mental health and acute Commissioning Data Set records submitted to SUS in which a valid NHS Number for the Service User was included A "valid NHS Number" means the correct number for the specific Service User. The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Commissioning Data Set records submitted to SUS for mental health services and for acute outpatient, daycase and inpatient services and in which a valid NHS Number for the Service User was included **Denominator:** Total number of Commissioning Data Set records submitted to SUS for mental health services and for acute outpatient, daycase and inpatient services
Threshold	99% rate of completion of NHS Number
Reporting	To commissioners through the monthly Service Quality Performance Report It may be possible to rely on HSCIC monthly Data Quality Dashboard reports – see below Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	HSCIC produces monthly Data Quality Dashboard reports, which commissioners and providers may be able to use as an effective method of monitoring this indicator, and we encourage this wherever possible. These reports operate at the level of the provider as a whole and include data for the most recent month – so, in some situations, they may not provide sufficiently accurate information to enable performance to be

	measured for the purposes of the calculation of any contractual sanction. The Co-ordinating Commissioner may therefore determine, at its discretion, that the provider will need to generate separate specific performance data for commissioners as part of the monthly Service Quality Performance Report. For a number of sensitive diagnoses and procedures (e.g. IVF, Genitourinary Medicine), where SUS removes all patient identifiable data including the NHS Number, a blank NHS Number should be classed as valid. Data on overseas and private patients should be excluded from the numerator and denominator, together with data on any cross-border activity with providers outside England (for example in Scotland) where NHS Number requirements are not mandated.

NHS Number – A&E services only

National Quality Requirement	Completion of a valid NHS Number field in A&E Commissioning Data Set records submitted to SUS
Rationale	This is a required Information Standard and has been set out as a priority for providers in national planning guidance. National Patient Safety Agency guidance has identified risks to patient safety of not using the NHS Number as the national identifier for all patients.
Definition	% of all A&E Commissioning Data Set records submitted to SUS in which a valid NHS Number for the Service User was included A "valid NHS Number" means the correct number for the specific Service User. The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Commissioning Data Set records submitted to SUS for A&E services in which a valid NHS Number for the Service User was included **Denominator:** Total number of Commissioning Data Set records submitted to SUS for A&E services
Threshold	95% rate of completion of NHS Number
Reporting	To commissioners through the monthly Service Quality Performance Report It may be possible to rely on HSCIC monthly Data Quality Dashboard reports – see below Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	HSCIC produces monthly Data Quality Dashboard reports, which commissioners and providers may be able to use as an effective method of monitoring this indicator, and we encourage this wherever possible. These reports operate at the level of the provider as a whole and include data for the most recent month – so, in some situations, they may not provide sufficiently accurate information to enable performance to be measured for the purposes of the calculation of any contractual sanction. The Co-ordinating Commissioner may therefore determine, at its discretion, that the provider will need to generate separate specific performance data for commissioners as part of the monthly Service

	Quality Performance Report. For a number of sensitive diagnoses and procedures (e.g. IVF, Genitourinary Medicine), where SUS removes all patient identifiable data including the NHS Number, a blank NHS Number should be classed as valid. Data on overseas and private patients should be excluded from the numerator and denominator, together with data on any cross-border activity with providers outside England (for example in Scotland) where NHS Number requirements are not mandated.

Mental Health Minimum Data Sets – completion of ethnicity field

National Quality Requirement	Completion of the ethnicity field in Mental Health Minimum Data Set records
Rationale	Improvement in the standard of completion of Mental Health Minimum Data Set records has been defined as an important priority by clinical stakeholders.
Definition	% of all Mental Health Minimum Data Set records in which the ethnicity code for the Service User was properly completed (HSCIC Data Quality Measure 6.) The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Mental Health Minimum Data Set records in which the ethnicity code for the Service User was properly completed **Denominator:** Total number of Mental Health Minimum Data Set records 'Proper completion' is defined as meaning: • inclusion of a code showing the Service User's ethnicity (defined as 'Valid' in the HSCIC summary data at http://www.hscic.gov.uk/mhmdsmonthly); or • inclusion of a code showing that the Service User had been asked about their ethnicity but had declined to answer (defined as 'Other' in the HSCIC summary data at http://www.hscic.gov.uk/mhmdsmonthly).
Threshold	90% rate of proper completion of the ethnicity field
Reporting	To commissioners through the monthly Service Quality Performance Report It may be possible to rely on HSCIC monthly summary analysis of MHMDS data quality and consistency – see below Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	HSCIC publishes monthly summary analysis of MHMDS data quality and consistency at http://www.hscic.gov.uk/mhmdsmonthly. Commissioners and providers may be able to use these as an effective method of monitoring this indicator, and we encourage this wherever possible.

	These reports operate at the level of the provider as a whole and include data for the most recent month – so, in some situations, they may not provide sufficiently accurate information to enable performance to be measured for the purposes of the calculation of any contractual sanction. The Co-ordinating Commissioner may therefore determine, at its discretion, that the provider will need to generate separate specific performance data for commissioners as part of the monthly Service Quality Performance Report.

IAPT Minimum Data Sets – completion of IAPT outcome data

National Quality Requirement	Completion of the outcome field in IAPT Minimum Data Set records
Rationale	Improvement in the standard of completion of IAPT Minimum Data Set records has been defined as an important priority by clinical stakeholders.
Definition	% of all IAPT Service Users for whom at least two outcome scores were recorded in IAPT Minimum Data Set records, using each of the PHQ9 and GAD7/ ADSM assessment tools The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Service Users who completed IAPT treatment* during the period and for whom at least two outcome scores using each of the PHQ9 and GAD7/ ADSM assessment tools** were completed in those IAPT Minimum Data Set records submitted covering that course of treatment **Denominator:** Total number of Services Users completing IAPT treatment during the period * Treatment is defined as at least two treatment contacts with services. The rationale for this approach is that those patients attending only one therapeutic session will be unable to provide end of care pathway clinical outcome data. This calculation excludes people who had an initial assessment but did not enter treatment AND those who receives only one treatment session. ** The measure of success is that at least two scores are recorded for each assessment tool, making four scores for the Service User in total.
Threshold	90% rate of completion
Reporting	To commissioners through the monthly Service Quality Performance Report Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	http://www.isb.nhs.uk/documents/isb-1520/index_html/?searchterm=iapt HSCIC currently publish quarterly reports that include these measures: http://www.hscic.gov.uk/article/2021/Website-Search?q=Routine+Quarterly+Improving+Access&sort=Relevance&size=10&page=1&area=both#top

Appendix 7

Worked examples of calculation of financial consequences

CB_B1 Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral

Number of Service Users who started treatment on an admitted RTT pathway in the specialty in the month (under this Contract)	=	1,500
Operating Standard for the proportion treated within 18 weeks (threshold)	=	90%
Permitted number of breaches of the standard in the specialty in the month (under this Contract)	=	150
Actual performance against the Operating Standard in the specialty in the month	=	86%
Actual number of breaches of the standard in the specialty in the month (under this Contract)	=	210
Excess number of breaches in the specialty beyond the tolerance permitted by the threshold (under this Contract)	=	60
Financial sanction per breach	=	£400
Total value of financial sanctions in the specialty in the month (under this Contract)	=	£24,000

CB_B6 Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment

Number of Service Users referred urgently with suspected cancer who attended outpatient clinic in the quarter (under this Contract)	=	3,000
Operating Standard for the proportion seen within two weeks (threshold)	=	93%
Permitted number of breaches of the standard in the quarter (under this Contract)	=	210
Actual performance against the Operating Standard across the quarter as a whole	=	90%
Actual number of breaches of the standard in the quarter (under this Contract)	=	300
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	90
Financial sanction per breach	=	£200
Total value of financial sanctions in the quarter (under this Contract)	=	£18,000

CB_A16 Minimise rates of Clostridium difficile

Schedule 4G of the Particulars sets out the formula used to calculate the sanction generated when a provider exceeds its target for cases of C difficile and to apportion this across the different contracts a provider may hold. The formula is as follows:

The financial adjustment (£) is the sum which is the greater of Y and Z, where:

Y = 0

Z = ((A – B) x 10,000) x C

where:

A = the actual number of cases of Clostridium difficile in respect of all NHS patients treated by the Provider in the Contract Year

B = the Baseline Threshold (the figure as notified to the Provider and recorded in the Particulars, being the Provider's threshold for the number of cases of Clostridium difficile for the Contract Year, in accordance with Guidance)

C = no. of inpatient bed days in respect of Service Users in the Contract Year / no. of inpatient bed days in respect of all NHS patients treated by the Provider in the Contract Year

The distinction between Y and Z above is included simply to ensure that, where the provider does better than its C difficile target (ie has fewer cases), the formula does not generate a financial adjustment in the provider's favour.

i) Calculation of overall sanction for the provider as a whole

The actual number of cases of Clostridium difficile in respect of all NHS patients treated by the provider in the Contract Year (A)	=	150
Provider Baseline threshold (B)	=	130
Excess number of Clostridium difficile cases above baseline threshold (A-B)	=	20
Financial sanction per breach	=	£10,000
Total value of financial sanctions for the year (whole provider)	=	£200,000

ii) Attribution of sanction value to a specific contract

The sole purpose of C in the formula is to allow the provider-wide sanction to be attributed across the different contracts the provider may hold. This is done on the basis of total inpatient beddays.

Both the numerator and denominator for the bedday element of the formula refer to total inpatient beddays, not just those beddays relating to patients with C difficile. For the numerator, “Beddays in respect of Service Users in the Contract Year” means all of the beddays for all patients treated under a given contract in the contract year.

So, assuming a notional split of contracts and beddays as set out below, the calculation would work as follows:

Contracts held by the provider	Actual number of inpatient beddays in the Contract Year	% of provider total inpatient beddays in the Contract Year
Main contract with local CCGs	240,000	60%
Contract with NHS England for specialised and other services	100,000	25%
Other small CCG contracts	60,000	15%
Total	400,000	100%

Local CCGs’ contract inpatient beddays as a percentage of total NHS inpatient beddays for the provider = 60% (C)

Total financial sanction for the year (main contract with local CCGs) = £200,000 x 60% = £120,000

Note that NHS England will shortly publish further guidance on provider targets and application of sanctions for Clostridium difficile.

CB_B5 A&E four hour waiting times

Number of Service Users who attended A&E in the month (under this Contract)	=	6,000
Operating Standard for the proportion admitted, transferred or discharged within four hours (threshold)	=	95%
Permitted number of breaches of the standard in the month (under this Contract)	=	300
Actual performance against the Operating Standard in the month	=	91%
Actual number of breaches of the standard in the month(under this Contract)	=	540
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	240
Level of performance at which sanction is capped	=	92%
Excess number of breaches at level of cap	=	480
Breaches to which sanction applies	=	180
Financial sanction per breach	=	£200
Total value of financial sanctions in the quarter (under this Contract)	=	£36,000

Appendix 8

Publication template for sanction variations

Whenever the Commissioners and the Provider agree to vary or disapply the sanction applicable to any Operating Standard or National Quality Requirement in respect of any Contract this template should be completed by the Co-ordinating Commissioner and submitted to:

england.sanctionvariation@nhs.net

A Word version of this template is available on the NHS England website at http://www.england.nhs.uk/nhs-standard-contract/

BACKGROUND	
Overview	*Summary of and rationale for the service change that will be supported by varying or disapplying the national sanctions. Justify the new approach and explain how it is in patients' best interests.*
Link to Local Variation to National Price	*Is this related to a Local Variation to a National Price?* *If Yes, attach completed Monitor submission template in respect of that Local Variation* *If full details of the variation to or disapplication of national sanctions have been included in the attached Monitor submission template no further details need be provided in this template*
Operational Standards and/or National Quality Requirements affected	*List all affected*
Commissioner(s)	*Commissioner(s) party to the agreement (this must be all Commissioners who are parties to the relevant Contract)*
Provider	*Provider party to the agreement*
Proposed duration	*[ ] years [ ] months.* *Commencing [ ]* *Frequency of any planned reviews [ ]* *Note: The duration of any sanction variation or disapplication should not exceed (but may be less than) the remaining duration of the Contract in respect of which it is agreed.*
Impact	*How will the new approach impact the quality of care patients receive?* *What quality metrics are being monitored?* *Are there associated operational risks? How are these being*

	managed? *How will the new approach be evaluated?* *How will the variation or disapplication create more effective incentives for the Provider to achieve the desired outcome for patients?*
Contact	*Email address in case of follow up enquiries*

Appendix 9

Information management and information governance

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; and
- workforce minimum data set.

Please note that the sections of the contract dealing with information management and information governance have been substantially redrafted for 2014/15 in conjunction with NHS England's Information Governance Lead and with specialist legal input to reflect current law and guidance. Contracting parties should not seek to override or supplement the contractual position. Any queries should be directed to NHS England's Information Governance Lead via nhscb.contractshelp@nhs.net.

Information governance – service user data and its protection

GC21 – Data Protection, Freedom of Information and Transparency (GC21.1)	All providers and commissioners must manage service user identifiable data in accordance with the law and established good practice in health and social care settings. Key laws include the Freedom of Information Act 2000 (FOIA), the common law duty of confidence, Data Protection Act 1998 (DPA), and Human Rights Act 2000 (HRA). The parties acknowledge that they must assist each other in complying with the law, agree to general responsibilities and specific requirements relating to DPA and FOIA.
The Information Governance Toolkit and IGSoC (GC21.2, GC21.6)	It is a requirement of all providers wishing to provide NHS funded services that they meet the full range of information governance requirements and specifically the requirements set out in the relevant Information Governance Toolkit (IGT), at a minimum level 2. 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).The IGSoC process is agreed once for each organisation i.e. per legal entity. Continuing compliance is reconfirmed through the annual submission of the Information Governance Toolkit and acceptance of the IG Assurance Statement.

	The IGT and IGSoC require the nomination of a Caldicott Guardian and Senior Information Risk Owner. It is suggested that the provider additionally 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/
Senior Information Governance Roles (GC21.3, Particulars – Governance and Regulatory)	Information Governance Lead A representative from the senior level of management should be appointed to act as the overall Information Governance lead to co-ordinate the IG work programme. Senior Information Risk Owner (SIRO) The Senior Information Risk Owner (SIRO) should be an Executive Director or other senior member of the Board (or equivalent senior management group/committee). The SIRO may also be the Chief Information Officer (CIO) if the latter is on the Board, but should not be the Caldicott Guardian as the SIRO should be part of the organisation's management hierarchy rather than being in an advisory role. The *Information Security Management: NHS Code of Practice* can be found at: http://systems.hscic.gov.uk/infogov/codes/securitycode.pdf Caldicott Guardian The role of the Caldicott Guardian is to oversee the arrangements for the use and sharing of patient information. Acting as the 'conscience' of an organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information. The Caldicott Guardian also has a strategic role, which involves representing and championing confidentiality and information sharing requirements and issues at senior management level and, where appropriate, at a range of levels within the organisation's overall governance framework. The Caldicott Guardian should be, in order of priority: • an existing member of the senior management team; • a senior health or social care professional; • the person with responsibility for promoting clinical

	governance or equivalent functions. The nominated Information Governance Lead, Caldicott Guardian and Senior Information Risk Owner must be identified in the Governance and Regulatory section of the Contract Particulars. GC21.3.3 additionally requires that the Commissioner is kept informed of any changes to the individuals holding these roles. The *Caldicott Guardian Manual 2010* can be found at: http://systems.hscic.gov.uk/infogov/links/2010cgmanual.pdf The *Confidentiality: NHS Code of Practice* can be found at: https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice *A guide to confidentiality in health and social care* published by the HSCIC, with supporting references can be found at: http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf There is a requirement within the Caldicott Review to ensure that these individuals (Information Governance Lead, Senior Information Risk Owner and Caldicott Guardian) are given appropriate education and training to support them in being clear about the respective roles and supporting them in performing their functions well.
The Response to the Caldicott Review (GC21.4, SC23)	The Caldicott Information Governance Review, published in March 2013 has the overarching aim of ensuring that there is an appropriate balance between the protection of the patient or user's information and the use and sharing of such information to improve care. It refers to an imperative to meet the needs of an ageing population, particularly at the boundary between health and social care. There is a particular focus on the duty to share information for care purposes, now established in a new 7th Principle. The Government Response to the Review, published in September 2013 includes expectations and commitments for all health and social care organisations. These are summarised in a table of commitments. The Provider must implement the recommendations of the review as given in the Government Response, and in particular the commitments listed in the table of commitments under the headings: • All staff and workers within the health and care system expectation; • All health and care organisations expectations; • Local NHS providers expectation.

	In GC21 and the SC23 we have drawn attention to aspects that would benefit from strengthening in order to address the requirements of the Caldicott Review, specifically proactive fair processing, consent for the use of data, where applicable, anticipating data management requirements for contract termination and assurance through information governance audit. Whilst attention has been drawn to these it does not mean other requirements are unimportant. *Information: To share or not to share? The Information Governance Review* is available at: https://www.gov.uk/government/publications/the-information-governance-review *Information: To share or not to share? The Government Response to the Caldicott Review* is available at: https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response
NICE Clinical Guideline 138 (GC21.5)	The provider must audit its practices against quality statements regarding data sharing set out in *NICE Clinical Guideline 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services* (CG138). It is expected that by conducting this audit, and revising practice accordingly, the provider will be able to demonstrate assurance that whilst information is shared lawfully by their employees, there are no obstacles to meeting the requirements of the Guideline arising from a failure to share. The Caldicott Review includes 7 quality statements or recommendations taken from CG138 that emphasise the importance of appropriate sharing. *CG138 Patient experience in adult NHS services*, and the full guidance document including methods evidence and recommendations can be found at: http://guidance.nice.org.uk/CG138. *QS15 Quality standard for Patient experience in adult NHS services* can be found at: http://publications.nice.org.uk/quality-standard-for-patient-experience-in-adult-nhs-services-qs15 *CG138 Patient experience in adult NHS services: baseline assessment tool* can be found at: http://guidance.nice.org.uk/CG138/BaselineAssessment/xls/English
Data Breaches and Information	The Caldicott Review broadened the definition of data breaches and how they should be handled [see below]. Organisations need

Governance Breaches (GC21.7)	to have regard to these recommendations alongside following the HSCIC's *Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation.* This can be found at: https://www.igt.hscic.gov.uk/KnowledgeBaseNew/HSCIC%20IG%20SIRI%20%20Checklist%20Guidance%20V2%200%201st%20June%202013.pdf Data breach reporting should be included in Schedule 6 to the contract.
Data Controller responsibilities (GC21.8 – GC21.13)	The Provider is a Data Controller under the Data Protection Act, and as such takes sole responsibility for its obligations under the Act for Personal Data it processes in the delivery of the Services. Where data are required by the Commissioner for the purposes of quality assurance, performance management and contract management, the parties acknowledge that they are acting as joint Data Controllers. As such they hold shared responsibility for ensuring that the requirements of the Data Protection Act and other information law requirements are met in respect of this data, including shared responsibility for incidents relating to this data. Commissioners must engage with their commissioned providers to ensure that their joint responsibilities are met, in particular provision of fair processing information, responding to subject access requests and respecting subjects' other rights under the Data Protection Act. Providers should be aware that commissioners cannot require providers to process data unlawfully. This is particularly important to consider where there are contract variations. Even though providers are data controllers they will still need to demonstrate to commissioners that they have appropriate organisational and technical measures in place to protect personal and confidential data in line with Data Protection principle 7 requirements.
Responsibilities when engaging sub-contractors (GC21.14, Particulars – Schedule 5)	When engaging a sub-contractor to process data on its behalf, the Provider takes full responsibility for ensuring that the requirements of the DPA and other legal requirements are met by the sub-contractor, who is acting as a Data Processor. The specified written agreement commits the sub-contractor to measures that ensure that the Provider can meet its responsibilities under the DPA and FOIA. Contract Particulars, Schedule 5 must be completed in B1 with the identities of any Mandatory Materials Sub-contractors, and in B2 with those of any Permitted Materials Sub-contractors. Against each of these there must be an indication of whether the sub-

	contract includes data processing on behalf of the provider, and therefore a need for contractual commitments as stated above.
Responsibilities as a Data Processor (GC21.15)	Where the Provider organisation is commissioned specifically to deliver an information service that involves the processing of personal data on behalf of the Commissioner, the Provider is acting as a Data Processor under the DPA. In this situation the Commissioner takes full responsibility for data protection compliance, and the Provider must only process the data in accordance with the Commissioners instructions. Guidance on identifying Data Controllers and Data Processors can be found at: http://ico.org.uk/for_organisations/guidance_index/data_protection_and_privacy_and_electronic_communications
Commissioning Datasets (Particulars – Schedule 6)	Datasets in support of this contract must be submitted to bodies that have a legal power to receive Personal Confidential Data for this purpose. Guidance on this can be found at: http://www.england.nhs.uk/ourwork/tsd/ig/in-val/ All local datasets must be listed in the Contract Particulars, Schedule 6 under Local Requirements Reported Locally, or with reference to guidance on Prescribed Specialised Services where this applies. The *Manual for prescribed specialised services* and *Identification rules for prescribed specialised services* published by NHS England can be found at: http://www.england.nhs.uk/resources/spec-comm-resources/
Ensuring that proper IG controls are in place when introducing new technologies and applications.	The Provider must ensure that where new systems and technologies are introduced that they are implemented using an appropriate project management methodology, are assured as clinically safe, and meet Information Governance Standards, in line with national standards and processes. Business change processes must be accompanied by clinical safety and privacy impact assessments.

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://systems.hscic.gov.uk/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://systems.hscic.gov.uk/demographics/index_html
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://systems.hscic.gov.uk/scr/index_html
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://systems.hscic.gov.uk/data/dataquality/macs

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 http://systems.hscic.gov.uk/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 http://systems.hscic.gov.uk/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 http://systems.hscic.gov.uk/nhsmail

To enable information flows and meet the requirements of the HSCIC, 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 http://www.hscic.gov.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 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. http://www.hscic.gov.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: http://www.hscic.gov.uk/

Workforce minimum data set

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

- NHS England and CCGs to ensure that providers from whom they commission services have regard to education and training when carrying out their functions.

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.

The detailed guidance on the workforce information that providers need to supply are signposted from the following web page: http://www.hscic.gov.uk/workforce/

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

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 and development data	Education, training and development are key elements in 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.

Appendix 10

Summary of changes made between the draft and updated versions of this Guidance

This Appendix lists the sections of the Technical Guidance which have been materially amended in the updated version, published in February 2014, from the draft version published in December 2013.

Paragraph / section	Change
4.5	Additional note regarding internet browser requirements for the eContract system.
7	Additional link to NHS England planning guidance and email address for National Tariff queries
8.3	Note that final guidance is awaited on the use of the NHS Standard Contract in relation to services commissioned from providers which already hold a primary care contract
11.3	Clarification relating to Collaborative Commissioning Agreement and contract signature
11.4	Reminder that the updated Model Collaborative Commissioning Agreement has now been published
14.5	Clarification relating to the need for the co-ordinating commissioner to confirm to the provider the agreement of all commissioners to any proposed Variation
17.3	Clarification relating to the new provision for extension of contract duration
18.1	Clarification on variations to contracts not expiring at 31 March 2013
19	Clarification on the creation of separate contracts where competitive or AQP procurements are undertaken
24.3	Clarification on potential service categories to use for TOP services
25.2	New requirements relating to service specifications for maternity services
26.9	Details of how to submit designation decisions on Commissioner Requested Services to Monitor
27.14	Clarification relating to Technical Definitions for Operational Standards and National Quality Requirements
28.4	Additional guidance on the default approach to attributing financial sanctions across contracts
28.6	Clarification of the coverage of the quarterly cap on the value of sanctions applied under the contract
28.12 / 28.13	Clarification on provisions to vary the national approach to

	contract sanctions
28.15	Reminder that provider targets and further guidance will be published shortly on Clostridium difficile.
30.2 / 30.3	Additional information on high-impact innovations
34	New flowcharts describing the processes for Service Condition 36 (Payment)
35.1	Clarification relating to Mandatory Material Sub-Contractors
35.4	Amended guidance relating to carrying forward actions not completed in previous contracts
35.11	Clarifications relating to New Fair Deal for staff pensions
Appendix 2, Longstop Date / Conditions Precedent	Clarification on Conditions Precedent, service commencement and Longstop Date
Appendix 6, NHS Number	Clarification of the definition of a ‘valid NHS Number’
Appendix 7	Additional detail relating to the worked example for the C difficile sanction
Appendix 9, Information Governance	Updated section added on information governance issues

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