



NHS Standard Contract 2017/18 and 2018/19 Technical Guidance

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NHS Standard Contract 2017/18 and 2018/19

Technical Guidance

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This is the final version of the NHS Standard Contract Technical Guidance 2017-19.

Yellow highlighting indicates that text has been significantly updated from the [2016/17 Guidance](#).

Green highlighting indicates that text has been significantly updated from the draft version to the final version of the 2017-19 Guidance.

Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- reduce health inequalities in access and outcomes of healthcare services integrate services where this might reduce health inequalities
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

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Executive Summary

1 Introduction

- 1.1 The NHS Standard Contract is published by NHS England and is mandated for use by CCGs and NHS England for all their clinical services contracts, with the exception of those for primary care services. (A separate model contract for use when commissioning services from a Multi-Specialty Community Provider is in preparation and will be published in due course).
- 1.2 The Contract continues to be published in both full-length and shorter-form versions. This Guidance document is relevant to both forms of the Contract, but a separate [User Guide](#) for the shorter-form version is also available. Guidance on when the shorter-form version should be used is set out in paragraph 9 below.

2 Two-year contracts at national and local level

- 2.1 National planning guidance to the NHS sets the expectation that commissioners will offer contracts with a term of at least two years. The intention behind this is to support organisations as they work on service quality and transformation. (Clearly, a new two-year contract will not be appropriate in every instance; flexibility will obviously be needed where, for example, there are existing multi-year contracts in place or where commissioner procurements are planned.)
- 2.2 As with other national business rules such as CQUIN and the National Tariff, therefore, the NHS Standard Contract has been designed, as far as possible, to set out national requirements and contractual process for the whole two-year period, from 1 April 2017 to 31 March 2019. For this reason, more than in previous iterations, the draft Contract features new requirements which will come into effect at a specific stage within the two-year timeframe – rather than all the requirements necessarily applying from 1 April 2017.
- 2.3 The Contract has been designed to include all the requirements which we can currently foresee for both 2017/18 and 2018/19. In the event of significant legislative or policy changes, there may be a need for some further updating of the national terms of the Contract for 2018/19. If this is the case, NHS England will consult on a National Variation to the two-year Contract, which commissioners and providers would then implement locally.
- 2.4 Even where two-year (or longer) contracts are agreed, there may be a need in some cases for a limited local process of contract updating and variation from 2017/18 to 2018/19. This can be managed by use of the Variation provisions in the Contract, and our detailed Contract Guidance on the Variations Process (to be published **later in November**) will provide further advice on this.

3 Key changes to the full-length Contract for 2017-19

- 3.1 The 2017-19 Contract retains the same three-part structure and much of the same detailed content as the [2016/17 version](#). The key changes to the Contract for

2017-19 are summarised in the tables below. A detailed clause-by-clause summary of where changes have been made is available at Appendix 1.

Changes to give effect to new legislation, policy and guidance

3.2 These changes below have been made in order to ensure that the Contract is consistent with changes to legislation and that references to national policy guidance remain up-to-date – or where new guidance has been issued, and we are seeking to give prominence to it by specific inclusion in the Contract.

Topic	Change	Contract Reference
Seven day services	This service condition confirms that acute providers should report on their progress in implementing the four clinical priority standards for seven day services (standards 2, 5, 6 and 8), as well confirming that providers of vascular surgery, hyper-acute stroke, major trauma, STEMI heart attack and children’s critical care services should meet the four standards in respect of those services from November 2017.	Service Condition 3
Right Care	To support implementation of the national Right Care programme, we have clarified that the duty to co-operate within the Contract includes working to optimise efficient allocation of resources and minimise unwarranted variations in quality and outcomes.	Service Condition 4
Electronic Referral System (ERS)	A national CQUIN indicator will incentivise providers to maximise slot availability on ERS during 2017/18. Where non-ERS referrals continue to be made by GPs from October 2018, acute providers will be able to return these to GPs. Equally, providers will only be paid for the resulting first outpatient attendance where the GP referral was made through ERS. The Contract wording makes clear that the provisions on referral return and non-payment will operate in the context of further guidance to be published in due course, as described further in section 42 below.	Service Condition 6
Self-care	We have included a high-level goal of supporting patients to develop the knowledge, skills and confidence they need to take increasing responsibility for managing their own ongoing care.	Service Condition 8
Education, Health and Care needs assessments.	Consistent with existing legislation, we have introduced a new requirement to respond to requests for input into Education, Health and Care Needs Assessments for children and young people with special educational needs and disabilities within six weeks.	Service Condition 10

Topic	Change	Contract Reference
Discharge arrangements	We have strengthened the provisions of the Contract relating to discharge from care by <ul style="list-style-type: none"> introducing a new contractual obligation on commissioners to use their best efforts to support safe, prompt discharge from hospital; and by updating the Contract wording to reference relevant national guidance and information standards, NICE guidelines and national policy on patient choice of care home placement. 	Service Condition 11 and Definitions
Co-ordinated care	We have included a new requirement around coordinated care, aimed at ensuring that a provider's staff work effectively and efficiently together, across professional boundaries, so that patients experience co-ordinated, high quality care without unnecessary duplication of process.	Service Condition 12
Workforce Disability Equality Standard	As recommended by the Equality and Diversity Council, we have included a requirement on providers to comply, from April 2018, with the new national Workforce Disability Equality Standard (WDES).	Service Condition 13
Health eating and drinking options	We have included new provisions relating to the promotion of healthy eating and drinking options and the adoption of the full range of mandatory requirements in Government Buying Standards.	Service Condition 19
Data sharing in urgent and emergency care services	We have included a new requirement on providers of urgent and emergency care services to sign up to data sharing agreements with commissioners and other relevant providers, allowing commissioners to analyse service utilisation and effectiveness across the whole system.	Service Condition 23
Interoperable IT systems	We have included a new requirement on providers to use all reasonable endeavours to ensure that, from January 2019, key clinical data can be shared appropriately with healthcare professionals in other providers via interoperable IT systems.	Service Condition 23
Health and Social Care Network	We have included a new provision requiring providers to collaborate with NHS Digital in the procurement and implementation of the Health and Social Care Network, the replacement for the existing N3 network.	Service Condition 23
Safeguarding	We have updated the Contract provisions on safeguarding to include references to domestic abuse and female genital mutilation.	Service Condition 32
End of life care	We have included a requirement for acute service providers to have regard to the NHSIQ guide, <i>Transforming end of life care in acute hospitals</i> .	Service Condition 34 and Definitions
CQUIN	Reflecting the updated national CQUIN guidance for 2017-19, we have now removed references to either variation or disapplication of national CQUIN indicators or the overall CQUIN scheme.	Service Condition 38

Topic	Change	Contract Reference
Electronic prescribing for chemotherapy	As recommended by the National Cancer Taskforce, we have updated the national quality standards relating to e-prescribing for chemotherapy, so that these now relate to the completion of implementation, rather than simply to the production of an implementation plan.	Particulars Schedule 4B
Data security	We have revised the information governance provisions to require compliance, over time , with the new national data security standards recommended by the Caldicott review and to allow for the expected publication of a successor framework to the Information Governance Toolkit.	General Condition 21
Conflicts of interest and transparency on gifts and hospitality	We have updated the provisions of the Contract relating to the management of conflicts of interest and to transparency on the receipt of gifts and hospitality to require compliance with the new system-wide guidance for commissioners and providers (to be published shortly following the recent consultation).	General Condition 27

Changes affecting the interface between primary and secondary care

- 3.3 Building on the changes made in the 2016/17 Contract, we have introduced a number of changes which will clarify the expectations across the primary care / secondary care interface, improve experiences for patients, support better integration, and reduce avoidable extra workload for GPs.

Topic	Change	Contract Reference
Fit notes	We have included a new requirement on providers to issue 'fit notes' (previously sick notes) to patients under their care, where required under existing guidance from the Department for Work and Pensions. (The expectation is that this is done where patients are seen as part of their normal pathway, not that specific clinic appointments are booked specifically for the purpose of fit note review.)	Service Condition 11
Outpatient clinic letters	To support care integration, as we signalled when we published the 2016/17 Contract, we have tightened the requirements for the production and transmission to GPs of letters (where clinically required) following clinic attendance. The current timescale for production (within 14 days of attendance) will reduce progressively to 10 days (from 1 April 2017) and 7 days (from 1 April 2018). A new requirement for electronic transmission of clinic letters, as structured messages using standardised clinical headings, will take effect from 1 October 2018.	Service Condition 11

Topic	Change	Contract Reference
Patient queries	<p>We have further strengthened the requirements on providers to communicate properly with patients about their care, adding new obligations to</p> <ul style="list-style-type: none"> put in place efficient arrangements for handling patient and GP queries promptly and publicise these arrangements to patients and GPs, on websites and appointment / admission letters; and ensure that they respond properly to patient queries themselves, rather than passing them to practices to deal with. 	Service Condition 12
Discharge summaries	<p>Discharge summaries following inpatient or daycase admission must already be sent electronically as structured messages using standardised clinical headings. From 1 October 2018, this requirement also applies to discharge summaries after A&E attendance.</p> <p>From 1 October 2018, transmission of both clinic letters and discharge summaries to general practices must be via direct electronic transmission, not via email.</p>	Definitions
Outpatient prescribing	<p>We have included a new requirement that providers must supply medication following a patient's attendance at clinic, where clinically indicated, for the period required in local protocols, but at least sufficient to meet the patient's immediate needs up to the point at which the clinic letter reaches the GP.</p>	Service Condition 11
Shared care protocols	<p>We have amended the Contract wording on shared care protocols, making clear that hospitals must only initiate shared care arrangements where the patient's GP is content to accept the transfer of responsibility.</p>	Service Condition 11

Technical improvements to the Contract

3.4 We have made a number of technical changes, primarily as a result of external feedback, which we believe will make the Contract more effective in practice.

Topic	Detailed change	Contract Reference
Referral information	<p>We have set out a new responsibility for commissioners to ensure that referrals from primary care contain accurate patient contact details as well as the information required under local referral protocols.</p>	Service Condition 6

Topic	Detailed change	Contract Reference
Prior Approval Schemes	We have introduced new requirements on commissioners to have regard to the burden which Prior Approval Schemes may place on providers and, as far as possible, to minimise the number of separate commissioner-specific Prior Approval Schemes which operate under one local contract in relation to any individual condition or treatment. We have also introduced a requirement to set a response time standard for prior approval requests in the contract locally and that prior approval arrangements must not place at risk achievement of quality or waiting times standards.	Service Condition 29
Interest on late payments	The Contract contains provisions under which interest is payable on late payments. We have now updated these provisions to reflect current Department for Business, Innovation and Skills guidance. This means that a higher rate of interest is payable and makes it even more important that all payments are made promptly in line with the timescales in the Contract.	Service Condition 36
Audit	We have clarified the provisions on independent audit, making clear that any audit undertaken must be objective and impartial.	General Condition 15

Financial sanctions and the Sustainability and Transformation Fund

3.5 Arrangements in respect of financial sanctions under the Contract will continue broadly as in 2016/17. Where, in respect of both 2017/18 and 2018/19, a provider:

- is granted funding from the general element of the Sustainability and Transformation Fund (STF) and agrees an annual financial control total with NHS Improvement; and
- with regard to its performance against key national quality standards either agrees performance improvement trajectories with NHS Improvement and NHS England, and/or provides those bodies with assurance statements,

then the operation of certain contractual sanctions will continue to be suspended for both 2017/18 and 2018/19 (but where a financial control total and performance trajectories are agreed, or assurance statements are provided, for only one of those years, for that year only). The suspension is described in Service Condition 36.37A of the full-length Contract (Service Condition 36.27A of the shorter-form version).

3.6 This temporary measure covers the financial sanctions which would otherwise apply where providers fail to deliver certain of the national standards set out in Schedules 4A and 4B of the Particulars of the Contract. The standards and sanctions affected are:

- those covering four-hour A&E waits, RTT 18-week incomplete pathways and 62-day cancer waits (for which, under the arrangements to be published by NHS Improvement, providers will either have to submit an assurance statement to NHS Improvement, confirming their commitment to deliver the national standard in full on an ongoing basis or will have to agree with NHS Improvement a monthly performance improvement trajectory, setting out their commitment to improving their performance, over time, towards the level required by the national standard); and
- those covering twelve-hour trolley waits, RTT 52-week waits, six-week diagnostic waits, ambulance response times (Red1, Red 2, other Category A) and ambulance handover standards (affecting both A&E and ambulance providers), for which providers will have to submit an assurance statement to NHS Improvement, confirming their commitment to deliver the national standard in full on an ongoing basis.

- 3.7 If, during the two-year period of this Contract, revised national standards are introduced for ambulance response times (following completion of the ongoing pilots), NHS Improvement and NHS England may then decide to require specific performance improvement trajectories on the new standards from the relevant providers.
- 3.8 The suspension of these sanctions applies only as set out in paragraphs 3.5 to 3.6 above; in all other situations, commissioners must continue to apply the national sanctions set out in Schedules 4A and 4B.
- 3.9 [Arrangements for the management of the STF](#) are set out separately by NHS Improvement. Under these arrangements, providers for whom sanctions under the Contract are suspended will instead face the withdrawal by NHS Improvement of STF funding if their performance is not in line with their improvement trajectories or assurance statements in relation to four-hour A&E waits, RTT 18-week incomplete pathways and 62-day cancer waits. For the other standards (twelve-hour trolley waits, RTT 52-week waits, six-week diagnostic waits, ambulance response times and ambulance handover standards), there will be no financial jeopardy under the STF for providers for whom sanctions under the Contract are suspended.
- 3.10 NHS Improvement will confirm and publish the details of the performance improvement trajectories it has agreed with providers and the assurance statements it has received by 31 March 2017. At this point, details of both should be added to local contracts as Service Development and Improvement Plans (SDIPs) at Schedule 6D of the Particulars, using the separate template [we have made available for this purpose at https://www.england.nhs.uk/nhs-standard-contract/17-18/](#). Where, as a result of a successful appeal by a provider to NHSI, trajectories are subsequently amended, the amendments should be reflected in a revised local SDIP.
- 3.11 Note that:
- the trajectories and assurance statements described above will operate on a whole-provider basis – so if a provider holds multiple contracts, the same SDIP will be included in each; and

- NHS Improvement and NHS England will operate an appeals mechanism (details to be published later in 2016) through which a provider can seek to have a trajectory reviewed and amended; where appeals result in amended trajectories, NHS Improvement will publish the revised versions, which should then be incorporated at local level into updated SDIPs.

3.12 The suspension of sanctions in specific circumstances does not affect the ability of commissioners to use other levers available within the Contract to manage the general performance of providers (including, for instance, the provisions of General Condition 9 on Remedial Action Plans (RAPs) and Service Condition 28 on Information Breaches).

3.13 However, specifically in relation to the agreed performance improvement trajectories and assurance statements described above,

- although commissioners should monitor and manage providers' performance and support them in delivering their trajectories and assurance statements, they must not withhold or retain funding under GC9 if providers fail to achieve the trajectories in full; and
- where a RAP has been agreed in a previous contract year and would normally be carried forward into 2017/18 as an SDIP (under the arrangement described in paragraph 35.12 below), it must be superseded by the SDIP described at paragraph 3.10 above; again, no financial sanctions must be applied in relation to this SDIP.

We have included a provision at GC9.26 (GC9.9 in the shorter form) to make clear that – in order to avoid “double jeopardy” – financial sanctions must not be applied in the above circumstances.

Service Development and Improvement Plans

3.14 As in previous years, we have identified that certain issues can most effectively be taken forward by requiring CCGs to agree Service Development and Improvement Plans (SDIPs) at Schedule 6D in their local contracts with relevant providers. For 2017/18, the following issues should be addressed through local SDIPs (further detail is set out in section 41 below).

- Commissioners will be required to agree SDIPs with each major local provider, setting out the actions they will take jointly to improve working across the secondary / primary care interface, tackling some of the issues described in [Making Time in General Practice](#). The aim of these SDIPs must be to ensure full implementation of the specific new requirements already included within the Contract for 2016/17 (see the [joint letter](#) sent by NHS England and NHS Improvement on 28 July 2016) and now being added for 2017/18 – 2018/19 (outlined in section 3.3 above).
- Commissioners must also agree SDIPs with those providers (particularly of mental health services) who are not yet compliant with the recommendations in [NICE Guideline PH48, Smoking: acute, maternity and mental health services](#)

setting out the action those providers will take to ensure that their premises (including grounds and vehicles) are smoke-free by no later than 31 December 2018. This will support delivery of the commitment in the [Five Year Forward View for Mental Health for the NHS in England](#).

eContract

- 3.15 The eContract system will continue to be available in 2017/18. The basic approach will be unchanged, focussing on the production of tailored contract documentation, rather than the storage of contracts. The 2017/18 eContract will allow users to create tailored contracts in either the full-length or shorter-form versions.
- 3.16 Further details about the eContract system are available in paragraph 33 below and via <https://www.econtract.england.nhs.uk/Home/>.

Model grant agreement and model sub-contract

- 3.17 NHS England has also developed a model grant agreement as a funding vehicle for voluntary bodies, for commissioners to use where a commissioning contract may not be appropriate. The model agreement and associated guidance are available at <http://www.england.nhs.uk/nhs-standard-contract/grant-agreement/> - see also paragraph 11 below.
- 3.18 In 2016, NHS England produced a [model sub-contract](#) for use with the NHS Standard Contract 2016/17. [Model sub-contracts](#) suitable for use with the full-length Contract 2017/18 and with the shorter-form Contract 2017/18 will be published shortly.

4 Advice and support

- 4.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact nhscontractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general.
- 4.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net

Section A General guidance on contracting

5 Terminology

- 5.1 Throughout this guidance, we continue to use the generic term “the NHS Standard Contract” or “the Contract” to refer collectively to both the full-length and shorter-form versions. Where there are material differences in approach between the two versions of the Contract, we identify these below.

6 Content of this section

- 6.1 This section of the Technical Guidance offers broad advice about general contracting issues – including when the NHS Standard Contract should be used, contract signature, collaborative contracting, contract duration and extension, dispute resolution, and non-contract activity.

7 When should the NHS Standard Contract be used?

- 7.1 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.
- 7.2 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, continuing healthcare services, community-based, high-secure, mental health and learning disability services). The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.
- 7.3 The only exceptions are:
- primary care services commissioned by NHS England, where the relevant primary care contract should be used; and
 - any primary care improvement schemes agreed by CCGs with GP practices (with contractual arrangements, involving a variation or supplement to existing general practice contract, agreed between local NHS England teams and CCGs). Such Local Improvement Schemes (LIS) involve payments for improving the quality of services provided under an existing GP contract, not the commissioning of additional services.
- 7.4 CCGs must use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that were previously commissioned as Local Enhanced Services. This will apply where the CCG is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements.

- 7.5 The NHS Standard Contract is neither mandated nor intended for use by provider organisations when contracting with other provider organisations for the provision of clinical services. In most circumstances such arrangements will be correctly categorised as a sub-contracting of services commissioned under an NHS Standard Contract – on which see paragraph 38 below.

8 Contracting for integrated services

Contracting for integrated primary and secondary care

- 8.1 To support the integrated provision of services, commissioners may increasingly wish to commission both secondary and primary medical care services from the same provider under a single contract. This is the case, for instance, with the Multi-specialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) models being developed under the New Models of Care programme. A variant of the NHS Standard Contract for use when commissioning services from a Multi-Specialty Community Provider is in preparation and will be published in due course, and a variant for the PACS model will follow.
- 8.2 However, if a commissioner is already in a position to place a contract for integrated secondary and primary medical care services, it can do so using the 2017-19 NHS Standard Contract with the addition of Schedule 2L (Provisions Applicable to Primary Care Services). This Schedule introduces the further provisions required in order to make the Contract compliant with the Alternative Provider Medical Services (APMS) directions. With this addition, the Contract will be both an NHS Standard Contract and an APMS contract. An updated template form of those further provisions, for inclusion in Schedule 2L where appropriate, will be published shortly on the NHS Standard Contract [2017/18 web page](#) along with guidance about their use.
- 8.3 The APMS-compliant version of the NHS Standard Contract (i.e. one including our template APMS provisions) is likely to be useful where, for instance, a commissioner wishes to commission an integrated NHS 111 and out-of-hours primary medical service from the same provider through a single procurement process.

Lead provider and alliancing models

- 8.4 The NHS Standard Contract can readily be used as a “lead” or “prime” contract. Under this model, the commissioners enter into a contract with a single lead provider / prime contractor. 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’ (i.e. 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. The optional schedule of primary care provisions (see paragraph 8.2 above) enables the Contract to be used as a prime or lead contract under which a package of

primary and secondary care services may be commissioned.

- 8.5 The 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. 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 (and, where appropriate, other forms of commissioning contract). We have produced a model Alliance Agreement, which commissioners may use as a starting point for development of their own alliancing arrangements with providers. If you would like to see a copy or discuss an alliancing approach, please contact us via england.contractsengagement@nhs.net.

9 When to use the shorter-form Contract

- 9.1 The shorter-form Contract must not be used for contracts under which acute, cancer, A&E, minor injuries, 111 or emergency ambulance services, or any other hospital inpatient services, including for mental health and learning disabilities, are being commissioned.
- 9.2 Restricting use of the shorter-form Contract in this way significantly reduces the number of detailed requirements which it has to include, and these providers (that is, providers of those services for which the shorter-form Contract must not be used) tend to be larger organisations.
- 9.3 Subject to the restriction around national prices above, commissioners may use the shorter-form Contract for all other services for which the NHS Standard Contract is mandated – for non-inpatient mental health and learning disability services, for any community services, including those provided by general practices, pharmacies, optometrists and voluntary sector bodies, for hospice care / end of life care services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.
- 9.4 In response to feedback, however, we are amending the shorter-form Contract so that it can now be used for diagnostic, screening and pathology services, including where the National Tariff guidance sets a mandatory national price. We recognise that this will allow the shorter-form Contract to be used in a wider range of appropriate situations. Including the provisions relation to mandatory national prices adds to the length of the Contract, so we strongly recommend that commissioners use the e-Contract functionality, to ensure that this additional wording only appears in those contracts where it is required.
- 9.5 Within the parameters set out in this Guidance, it is for commissioners to determine when they wish to use the shorter-form version of the Contract, as opposed to the longer form.

- 9.6 We have not set a specific financial threshold for use of the shorter-form contract, but we strongly encourage commissioners to use it for appropriate services (as described in 9.3 above) with lower annual values, which will tend to include the great majority of contracts held by the smaller provider organisations which this new contract form is particularly intended to assist. The end result of this approach should be that the shorter-form Contract is used for most contracts with smaller providers, including voluntary organisations, hospices (where grant agreements are not being used – see paragraph 11 below), care home operators and providers of enhanced services such as general practices, pharmacies and optometrists.
- 9.7 However, in deciding whether to use the shorter-form Contract to commission services for which it may be used, commissioners should consider carefully the differences in the management process and other provisions between the shorter-form and full-length Contracts. If the “lighter touch” approach of the shorter-form is not thought appropriate to the services, the relationship or the circumstances, the full-length Contract may be used. Also, if the provider is providing other services under the full-length Contract, it may be more appropriate to keep all services on this form.
- 9.8 Note that when services are being tendered (whether competitively or under AQP) the same form of contract must be offered to all potential providers of those services. The form of contract offered (whether shorter-form or full-length) should be made clear in the Prior Information Notice, advertisements and other communications with potential providers.

10 What elements of the Contract can be agreed locally

- 10.1 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.
- 10.2 Commissioners must not:
- put in place locally-designed contracts or service level agreements for healthcare services, instead of the NHS Standard Contract; or
 - vary any provision of the NHS Standard Contract except as permitted by GC13 (Variations); or
 - seek to override any aspect of the NHS Standard Contract.
- 10.3 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 (in the full-length Contract) 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.

11 Use of grant agreements

- 11.1 Where voluntary sector organisations provide healthcare services, or other services in support of the healthcare needs of the local community, commissioners may choose to provide funding support for those services through grant agreements, rather than using the NHS Standard Contract.
- 11.2 Use of the Standard Contract is, however, necessary where it is clear that the commissioner is commissioning (as distinct from providing funding support for) a specific clinical service (as distinct from non-clinical or clinical support services) from a voluntary sector organisation. (Note also that, whatever the nature of the services being provided, if those services are being competitively tendered and potential providers include both voluntary sector and other types of provider, the same form of contract must be offered to all potential providers of the relevant service – which precludes the use of a grant agreement.)
- 11.3 However, where the commissioner is providing funding support towards the costs a voluntary sector provider faces in running a service (and especially where some of the providers' costs are being met by donations and/or payments by service users), it will generally be more appropriate for commissioners to use a grant agreement rather than the Standard Contract, and we would strongly urge them to do so. This will apply to some hospice services, for example.
- 11.4 NHS England has published a non-mandatory model grant agreement for use by CCGs with voluntary sector organisations which provide clinical services (available on the NHS [Grant Agreement web page](#)). This has been designed to provide an appropriate level of assurance for commissioners about the quality of care to be provided by the voluntary organisation – but without replicating the more onerous requirements of a full contract. Additional NHS England guidance on grant funding is available on the NHS Grant Agreement web page.
- 11.5 Where commissioners choose not to use the national model grant agreement, they should ensure that any locally-drafted grant agreements are 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.

12 NHS Continuing Health Care and Funded Nursing Care

- 12.1 We expect the NHS Standard Contract to be used where an NHS commissioner is fully funding an individual's NHS Continuing Health Care (NHS CHC) placement in a care home or package of home care.
- 12.2 It is clear that there will often be benefits from collaborative commissioning of, and contracting for, NHS CHC services – producing economies of scale for commissioners and reducing the number of separate contracts a care home needs to hold, for instance. Collaborative contracting will also enable commissioners to work jointly in respect of quality oversight of NHS CHC services, ensuring that their limited resource is used effectively and without placing multiple burdens on providers.

- 12.3 When contracting for NHS CHC, commissioners may put in place standardised care packages with fixed prices for different levels of complexity of need, and these should be set out in Schedule 3A (Local Prices). Where individually priced packages of care for new patients are likely to be agreed in-year based on differing inputs from different staff types, Schedule 3A can also record the agreed unit prices for such inputs. It should be possible to avoid having to vary the contract formally in-year to record each new or revised individual care package.
- 12.4 We do not mandate use of the NHS Standard Contract in respect of NHS Funded Nursing Care (NHS FNC) (where, following assessment, the NHS makes a nationally-set contribution to the costs of a nursing home resident's nursing care). If commissioners and providers agree locally that use of the Contract offers an effective route through which NHS FNC payments can be administered, they may do so.
- 12.5 The Department of Health guidance on NHS CHC and NHS FNC is available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf. The NHS England CHC Operating Model is available at: <http://www.england.nhs.uk/ourwork/pe/healthcare/>
- 12.6 We are sometimes asked about the issue of 'top up' fees in respect of NHS CHC. Guidance on this area is provided in s99 of the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care](#).

13 Collaborative contracting

- 13.1 The NHS Standard Contract may be used for both bilateral and multilateral commissioning i.e. for commissioning by a single commissioner or by a group of commissioners collaborating to commission together, with one acting as the co-ordinating commissioner.
- 13.2 Clearly, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model – but it is an approach which NHS England strongly encourages. There can be great benefits for commissioners from working closely together to negotiate and manage 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.
- 13.3 In particular, we would encourage commissioners to work together to use, where they can, consistent contract metrics for the same provider – local quality and reporting requirements, local agreements, policies and procedures, Activity Planning Assumptions or Prior Approval Schemes. This will help to reduce the administrative burden which providers face.
- 13.4 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, and how they are to make decisions in relation to the contract and instruct the co-ordinating commissioner to act on their behalf, 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 15 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 (though the allocation of roles and responsibilities between commissioners which are party to a contract can, where necessary, be set out in Schedule 5C (Commissioner Roles and Responsibilities) to that contract).

- 13.5 Model CCAs are available on the NHS Standard Contract [2017/18 web page](#).
- 13.6 Where NHS England is the sole party to a contract, but the lead for commissioning of particular services from the provider is being taken by different NHS England teams, use of a formal CCA is not appropriate – NHS England is one legal entity. However, it is important to ensure that the different teams understand what role each will play in managing the contract and communicate this clearly to the provider.

14 Which commissioners can be party to the Contract

- 14.1 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.
- 14.2 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, but they may choose to do so. 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.
- 14.3 By contrast, where an NHS commissioner has devolved commissioning responsibility to a local authority under a formal lead commissioning (section 75) 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 – although, again, the local authority may choose to do so. The NHS commissioner should, however, satisfy itself that the arrangements being put in place are such that it can meet its statutory obligations.

15 Signature of contracts and variations

- 15.1 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.

- 15.2 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 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.
- 15.3 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.
- 15.4 We recognise that the collection of signatures from commissioners is a time-consuming process. Variations may therefore be signed by the provider and the co-ordinating commissioner (on behalf of all commissioners) only, rather than by all commissioners (see GC13.3). 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 each variation has been properly approved by all commissioners (whether or not they are directly affected by the variation – because all are parties to the contract being varied) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.

16 Legally binding agreements

- 16.1 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 between those parties.

17 Contract duration

- 17.1 The NHS Standard Contract allows the commissioner to select the contract term it wishes. There is no default duration. **Note however paragraphs 2.1 to 2.4 above.**
- 17.2 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.

- 17.3 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.
- 17.4 There is no nationally-mandated limit to contract duration, nor is there a central approval process for contract terms beyond a certain duration. 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. Commissioners should consider patient choice, competition, the likelihood of technological and other developments affecting service delivery models, all relevant commercial and market considerations, in determining the appropriate length of contract. Contract length should be considered in conjunction with consideration of including any right to extend the contract (see paragraph 18) and/or the consequences of early termination (see paragraph 47).
 - Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.
 - Commissioners must ensure that the duration of any contract (and any proposed right to extend that period) is in compliance with their own standing financial instructions (SFIs) and other governance requirements, and that any approvals are obtained in line with those requirements. NHS England commissioners should note that, under NHS England SFIs, any proposal to let a contract with a potential duration of over five years (including any optional extensions) requires approval through the Efficiency Controls Committee prior to advertisement.
- 17.5 Alongside flexibility of contract duration, the Contract:
- includes an explicit acknowledgement of the parties' rights to terminate the Contract or any Service by mutual agreement (GC17.1); and
 - continues to include provisions for early termination of the Contract or a Service on a no-fault basis, with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).
- 17.6 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).

18 Extension of contracts

- 18.1 Commissioners may wish 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.
- 18.2 The NHS Standard Contract therefore includes an optional provision (Schedule 1C Extension of Contract Term) so that details of any potential extensions can be recorded at the start of the contract.
- 18.3 It is essential that this provision is not misused. The guidance below is designed to reduce the risk of challenges for breach of procurement rules, and so should be complied with in all cases.
- The provision may be used only where the commissioner has made clear to ALL potential providers of the service, from the very outset of the procurement process, the period and other details of any possible extension to the initial contract term.
 - We strongly advise against including the provision in contracts awarded without a Prior Information Notice being issued, or the contract being advertised, in accordance with the Public Contract Regulations.
 - Commissioners should have regard to procurement guidance in determining whether it is appropriate to offer provision for contract extension. We would generally advise commissioners not to provide for extensions of more than two years – and certainly not for extensions longer than the original contract term.
 - Any provision for extension must be made clear in the Prior Information Notice, in any advertisement, in communications with potential providers and 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 (i.e. it may be an option to extend for, for example, one year or two years, but not for one year then for another year).
- 18.4 Where provision for extension is made in a contract, the actual extension can then be effected by the co-ordinating commissioner giving notice to the provider that it wishes to implement the extension. Where such notice is given, the contract term is then automatically extended; no Variation is necessary, and the provider may not refuse an extension (though it may of course give notice to terminate the contract under the provisions of GC17).

19 Contracts not expiring at 31 March 2017

- 19.1 There will be contracts already in place which do not expire at 31 March 2017. To ensure that, for 2017/18, these contracts reflect the current legislative and policy framework, the parties should use the National Variation Agreement template which will be published on the NHS Standard Contract [2017/18 web page](#) shortly, to adopt a specific set of changes. As an alternative, they can choose to use the eContract system to transfer their existing contract into the 2017-19 NHS Standard Contract form in its entirety, maintaining the current duration of the contract. (An existing contract should not be transferred onto the shorter-form version, as that will almost certainly constitute a material change to the terms of the contract, in contravention of procurement rules.)
- 19.2 Where providers and commissioners are unable to agree either of these options, they should use the mediation and disputes process set out in their existing contract.
- 19.3 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 (GC13.4 of the shorter form) (or the equivalent provision of the relevant contract).

20 Negotiation of new contracts for 2017/18

- 20.1 The majority of contracts are still on a one-year basis and will therefore expire automatically on 31 March 2017. In this situation, the issue of commissioners and providers needing to give each other formal notice – either to terminate the contract or specific services or to make changes to services for the following year – does not arise.
- 20.2 But we are often asked about how commissioners and providers should communicate with each other about their future intentions and what timescales apply, and some general guidelines on this are set out below.
- Where a contract is expiring, there is no contractual requirement on either party to give notice to terminate the contract or a specific service at the point at which the contract expires.
 - Equally, there is no contractual requirement for commissioners to publish generic 'commissioning intentions' by a given date. Issuing of generic commissioning intentions documents, often aimed at a commissioner's providers collectively, rather than setting out specific information for individual providers, is at the discretion of the relevant commissioner.
 - However, early communication of both commissioner and provider intentions is always good practice. In terms of a possible new contract for a new financial year, it is in both parties' interests to set out their intentions clearly in time for necessary negotiations, or other processes, to be completed before any new contract is intended to take effect.

- In advance of the expiry of a contract, the commissioner may, for instance, notify the provider that it no longer wishes to commission any services (or a specific service) from that provider in the following year, perhaps because it intends to undertake a competitive procurement process. In such a case, the requirements for the procurement process to be transparent and for the incumbent provider to share information about the services and the potential impact of handover to a new provider (for example, workforce information in expectation of TUPE applying), will mean that early communication of commissioner intentions is always required.
- Similarly, a provider may notify the commissioner that it no longer wishes to provide a particular service in the following year. If the service has been designated as a Commissioner Requested Service (CRS) (see paragraph 37 below), then restrictions on the provider's ability to withdraw provision of the service will apply, in line with NHS Improvement's CRS guidance.
- There will be other instances where either party is seeking changes, in a new contract for the following year, to services commissioned or to detailed contractual provisions (local quality and reporting requirements, say). As with in-year variations to agreed contracts, there is no specific period of notice which must be given for such changes; rather, the complexity of the issues involved and the time realistically needed to implement the specific changes proposed should drive the timescale for discussions. Both parties should remember that agreeing a contract is a process of negotiation; it makes sense for all major changes which either party wishes to propose to be 'on the table' before detailed negotiations get under way, but it will often be possible to accommodate smaller changes after that point.

21 Heads of Agreement

- 21.1 We are sometimes asked about Heads of Agreement and whether these have a place in the negotiation of new contracts.
- 21.2 Heads of Agreement are different to contracts. They are pre-contract agreements and are not intended to create a binding arrangement between the parties. In complex procurement and contract negotiation scenarios, Heads of Agreement (sometimes also referred to as Heads of Terms) may be useful as a way of documenting progress towards intended signature of a binding contract – but in most NHS commissioning situations, both parties will be better advised to focus on agreeing and signing the actual contract itself.

22 Changes in counting and coding practice

- 22.1 One instance where formal notification is required in advance of a new financial year, even where a contract is expiring, is in relation to changes in counting and coding practice, as set out in SC28. This requires that each party gives the other at least six months' notice of proposed counting and coding changes, with the change normally taking effect from the start of the following Contract Year. Further detail, covering how the financial impact of counting and coding changes should be managed, is set out in paragraph 44 below.

23 Resolution of disputes in relation to new contracts

- 23.1 NHS England and NHS Improvement **has published joint guidance** on the resolution of disputes relating to the agreement of new contracts for 2017/18 between NHS commissioners and providers. The guidance describes the steps and timetable for the process, the final stage of which involves formal arbitration.

24 What happens when there is no signed contract in place?

- 24.1 In line with national guidance, commissioners and providers should make every effort to have signed contracts in place by 23 December 2016.
- 24.2 However, there may be instances where commissioners and providers have not signed a new contract by the time at which the current contract expires – but, because the services being provided are crucial for the local community they, must continue to be delivered.
- 24.3 In this situation (assuming services continue to be provided and paid for), a contract will be implied between the parties. The local terms of that implied contract will reflect what can be inferred as having been agreed between them – based on correspondence between them, notes of meetings, drafts exchanged and so on. It would be reasonable to assume that the implied contract would incorporate the nationally drafted terms of the NHS Standard Contract for 2017-19 (since those are the only terms on which NHS commissioners are permitted to commission the services in question).
- 24.4 However, in the absence of clear evidence of terms agreed, aspects of the implied “deal” between the parties may be uncertain. For this reason, it is very important that the parties continue to make every effort to reach agreement and sign a contract as soon as possible.

25 Acceptance of referrals and non-contract activity

- 25.1 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.
- 25.2 The Contract (full-length) includes a specific requirement on providers (SC6.6.2) to accept every referral, regardless of the identity of the Responsible Commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the Responsible Commissioner for the patient affected is a party to a written contract with the provider. **(Note, however, the new restrictions which will apply in respect of GP referrals not made via ERS from October 2018 – see paragraph 3.2 above.)**
- 25.3 There is also an equivalent provision in relation to the acceptance of emergency referrals and presentations which are within the scope of the services it provides (SC6.6.3 of the full-length Contract). Again, this requirement applies whether or not the Responsible Commissioner for the affected patient is a party to a written

contract with the provider. There will be instances where a provider cannot safely accept an emergency referral, and the Contract wording makes provision for this.

- 25.4 These provisions can be enforced by the Responsible Commissioner of any affected patient, either through the co-ordinating commissioner for the provider's main contract or via GC29.1 (Third Party Rights).
- 25.5 Conversely, we also set out clearly (SC6.8 in the full-length Contract, SC6.3 in the shorter form) that the existence of a contract with one commissioner does not automatically entitle a provider to accept referrals in respect of, provide services to, nor to be paid for providing services to, individuals whose Responsible Commissioner is not a party to the contract, except (where appropriate) where such an individual is exercising their legal right to choice as set out in the NHS Choice Framework or where necessary for the individual to receive emergency treatment.
- 25.6 Guidance on non-contract activity (NCA) (including what form of referral constitutes authority to treat) is set out in [Who Pays? Establishing the Responsible Commissioner](#). Commissioners and providers should refer to this guidance for full detail, but it may be helpful to re-state certain key points here.
- 25.7 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.”*
- 25.8 The concept of NCA is most relevant to acute hospital services, most of which are covered by national currencies and prices 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.
- 25.9 The guidance also explains that, where there is no written contract in place, there is nonetheless an implied contract (assumed to be on the terms of the NHS Standard Contract in place between the provider and its local commissioners). 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.”*
- 25.10 We have heard of both commissioners and providers refusing to enter into written contract with their counterparts even where regular activity flows are substantially above the level referred to in paragraph 25.8 above, seemingly believing that it is in their interests to operate under NCA principles instead. We advise strongly against this sort of approach.

- 25.11 In practice, acute NCA will need to be reported via SUS, with invoices raised by providers in line with the timescale set out in SC36.35. It is essential that providers and commissioners comply with the requirements NHS England has published advice on access to personal confidential data for the purposes of invoice validation, [Who Pays? Information Governance Advice for Invoice Validation](#), including the requirement for providers to submit detailed backing datasets to the same timescales as NCA invoices.

26 Letting of contracts following advertisement

- 26.1 All commissioners should ensure that they are fully aware of the requirements and implications of the Public Contracts Regulations 2015, which came into force on 18 April 2016, in respect of the advertisement, procurement, award, variation and assignment of contracts for healthcare services and which now apply alongside the Procurement, Patient Choice and Competition Regulations 2013.
- 26.2 The commissioner must let a contract to the chosen provider exactly on the basis notified to potential providers in the Prior Information Notice and/or otherwise advertised. This means that there must be a separate, specific contract put in place 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. Contracts for Any Qualified Provider (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.
- 26.3 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.

27 Use of the Contract for call-off arrangements

- 27.1 We know that many commissioners have successfully used the Contract in the context of a framework for, for example, care home placements. An NHS

Standard Contract is entered into with each provider appointed to the framework, with processes for “call-off” of activity set out in Schedule 2A and prices/day rates for activity (perhaps based on a needs assessment) set out in Schedule 3A. Either the full-length or the shorter-form version would be fit for purpose in this context – but, as noted above, the same form of contract must be used with each provider appointed under a framework procurement.

- 27.2 We strongly recommend that commissioners take legal advice if considering a framework procurement.

28 Contracting approaches to support personalisation

Integrated Personal Commissioning

- 28.1 The Integrated Personal Commissioning programme is a demonstrator programme involving nine areas wanting to lead the way in implementing a new integrated and personalised commissioning approach for people with complex needs. For the first time, sites will blend comprehensive health and social care funding for individuals, and give them more control over how this is used through person-centred care and support planning and personal budgets. The programme builds on and brings together work that has already started to explore new funding models and places that have taken the lead in implementing personal budgets in health and social care. A new offer of an integrated personal budget will be developed for individuals with both health and social care needs. The programme started in April 2015. NHS England will consider the use of the Standard Contract within the emerging personalised commissioning approaches and share learning and good practice from the programme where appropriate.

Personal health budgets

- 28.2 The new NHS Mandate sets an objective that 50-100,000 people should have a personal health budget or integrated personal budget (PHB) by 2020. General information regarding PHBs is available at: <http://www.england.nhs.uk/healthbudgets/>
- 28.3 The guidelines below are intended to help commissioners determine the appropriate contracting model for each of the three options of managing a PHB, but commissioners will need to exercise local discretion and common sense to ensure that a proportionate approach is adopted.
- **Notional budget.** Where a NHS commissioning organisation itself commissions healthcare services funded by a PHB on behalf of an individual (a notional budget), use of the NHS Standard Contract is likely to be appropriate. Individuals’ needs will be established through the care planning process, and the commissioner may need to contract with a provider to provide part or all of a package of care for one individual patient or for a number of patients, funded from a personal budget in each case. The contract should reflect how the needs of each individual patient will be met from his/her PHB. Individual care packages can be handled within the contract as set out at paragraph 12.3 above.

- **Third party.** Where a PHB is being managed by a third party, (for example where the third party is a trust fund set up on behalf of the individual), the commissioner will contract with the third party organisation to organise, purchase and be responsible for, the patient's care and support. In these instances it may be appropriate to use the NHS Standard Contract to govern the relationship between the commissioner and the third party organisation managing the health budget, but the commissioner should consider on a case by case basis what approach to take. When the third party purchases the services and products on behalf of the individual as agreed in their care plan, the NHS Standard Contract should not be used.
- **Direct payment.** Where a commissioner makes a direct payment to an individual (or their representative or nominee) who then holds the PHB and contracts directly with a provider, the individual (or their representative or nominee) will not need to use the NHS Standard Contract, nor is there a need for a contract between the commissioner and the provider. The care plan, which is an agreement between the CCG and the individual, will set out the details of the needs to be met and the outcomes to be achieved by the services to be provided.

28.4 PHBs may in some cases be spent on non-clinical services or items not routinely commissioned by the NHS. 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.

28.5 Funding for PHBs should not be about new money but money that would have been spent on that person's care using already commissioned NHS services. However, the funding that could be offered as a PHB may often be included in existing contracts, with many of these operating on a block basis. It is therefore important to ensure that both a clear strategic direction and relevant processes are in place to enable the freeing-up of funding for PHBs. From a contracting perspective, this can be addressed through annual negotiations or through in-year variations, but this is likely to be a gradual process. Therefore, alongside the technical steps to establish PHBs, commissioners also need to work closely with providers to influence change and improve services in key areas so that they are more responsive to the needs of individual users. This should be set out clearly in the local offer for PHBs.

29 Contracting fairly

29.1 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 working relationship between commissioner(s) and provider is a key element of successful contracting.

29.2 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues for fear of upsetting each other – but nor will it be one where each party focusses, aggressively and continuously, on protecting

what is perceived to be its own narrow, individual interests.

29.3 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioner and provider:

- have a shared vision for services, with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;
- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;
- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and
- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other.

30 Links to other resources

30.1 A number of useful links are set out below.

[NHS Operational Planning and Contracting Guidance 2017 – 2019](#)
NHS England and national partner organisations

[Joint Contract Dispute Resolution Process](#)
NHS England and NHS Improvement

[CQUIN Guidance and Indicators](#)
NHS England
Queries relating to CQUIN can be sent to e.cquin@nhs.net

[Who Pays? Determining the responsible commissioner](#)
NHS England
Queries relating to *Who Pays?* can be sent to england.responsiblecommissioner@nhs.net

[NHS National Tariff Payment System for 2017-19](#)
Proposals for consultation from NHS Improvement and NHS England
Queries about the National Tariff Payment System can be sent to pricing@improvement.nhs.uk.

[The Sustainability and Transformation Fund and financial control totals for 2017/18 and 2018/19: guidance \(indicative\)](#)
NHS Improvement

[Technical Definitions](#)
NHS England
Describes the indicators in [NHS Operational Planning and Contracting Guidance 2017 – 2019](#)

Section B Completing and using the Contract

31 Content of this section

- 31.1 The aim of this part of the Technical Guidance is to offer advice about both how key sections of the Contract should be completed and how the main contract management processes should be used in practice.
- 31.2 For each topic within this section, we highlight where specific changes have been made to the Contract for 2017-19. Please refer also to:
- Appendix 1, which lists each heading within the Particulars, Service Conditions and General Conditions and identifies whether each has changed at all for 2017-19;
 - Appendix 2, which goes through the different elements of the Particulars on a line-by-line basis, describing what each is for and how each should be completed.
- 31.3 The Technical Guidance is written primarily with the more complex, full-length version of the Contract in mind. Where appropriate, at the start of each section, we highlight briefly any key considerations in relation to the shorter-form Contract. A separate brief [User Guide](#) to the shorter-form Contract is also available.

32 Structure of the NHS Standard Contract

*The **shorter-form Contract** uses the same three-part structure as the full-length version.*

- 32.1 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.

33 The e-Contract system

*The e-Contract system can be used to generate tailored copies of the **shorter-form Contract** documentation, as well as for the full-length version.*

- 33.1 The eContract system hosts both the full-length and the shorter-form versions of the Contract.
- 33.2 The eContract system:
- is simple, quick to use, and reliable
 - focuses on the key benefit of the eContract approach – the production of tailored, shorter contract documentation which strips out content that is not relevant to the services being commissioned.
- 33.3 The eContract system is essentially a contract generation system, rather than a contract storage system. A system user selects basic contract options (for example, service categories and payment options) which both assist the user to select the right form of Contract to use (full-length or shorter-form) and drives changes to the Particulars or Service Conditions of the chosen form.
- 33.4 The system will then produce a tailored and shorter pdf version of the relevant version of the Service Conditions, including only those which are relevant to the specific services being commissioned. The system will also produce a tailored and partially populated Word version of the Particulars (full-length or shorter-form as appropriate). A system user can also create a contract proforma for use when the user intends to use the same tailored Service Conditions multiple times.
- 33.5 The user will then complete population of the Particulars locally (not within the eContract system) and will then issue the draft contract to the other party directly. The system will not store the final contract.
- 33.6 A user guide to the system will be available on the [eContract portal](#), and an email helpdesk is available via england.econtract@nhs.net. The eContract system is designed to run on several internet browsers, including IE7, IE8, Mozilla Firefox or Google Chrome.

34 Tailoring contract content

*The **shorter-form Contract** includes only limited scope for tailoring of the national terms within the Service Conditions and Particulars. Tailoring for the shorter-form Contract can be done using the eContract system.*

Service categories

- 34.1 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. The most convenient way to apply this “tailoring” of the Contract content is through the [eContract system](#).
- 34.2 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.
- 34.3 When completing the contract documentation, to ensure that all of the relevant contractual provisions are included, commissioners should tick as many of the service categories as are relevant to the specific contract. There is inevitably some imprecision with the categories; if in doubt, tick all of those that could potentially apply.
- 34.4 Note that the Community Services category is aimed at out-of-hospital services. These could be provided by NHS Trusts, independent and voluntary providers, GPs or optometrists. If a provider of community services also runs community hospitals with inpatient beds, and acute contractual provisions are relevant, then the commissioner may also wish to tick the Acute Services category. Where primary care services (for example, primary medical care out-of-hours services) are being commissioned under an NHS Standard Contract as part of a package of services, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 8.2 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).

35 Contracts for new services or with new providers

*The **shorter-form Contract** allows for Conditions Precedent to be recorded, but does not make specific provision for Transitional Arrangements. These may be included in Schedule 2G (Other Local Agreements, Policies and Procedures) if required.*

35.1 Completion of the relevant Schedules of the Particulars is obviously a requirement for all contracts – but agreement of a contract with either a new provider or for a new service is likely to mean a focus on certain aspects of the contract which are sometimes less critical where the contract is a ‘roll-over’ contract with an existing provider for an existing service.

Conditions Precedent (Schedule 1A and GC4.1)

35.2 Conditions Precedent are things which the provider must do, and documents which it must provide, to establish to the satisfaction of the co-ordinating commissioner that it is ready and able to start providing the Services as required by the Contract. So they are necessary pre-conditions to the start of Services (and not, as is unfortunately sometimes assumed, a to-do list for later, once Services are already up and running). Those listed in Schedule 1A of the Standard Contract without square brackets will apply in all cases. Those in square brackets will apply in many, if not most, cases. Additional Conditions Precedent required by commissioners may relate to, for example, works to premises being completed, equipment being safely installed and operational, and/or appropriate staff being in post and fully inducted. These additional requirements will need to be agreed locally, and will differ according to local circumstances.

35.3 While the commissioner will wish to have sight of documents referenced in Conditions Precedent (e.g. CQC registrations, NHs Improvement’s licence etc.), the documents do not need to be included in the contract itself.

35.4 The general rule is that each Condition Precedent must be satisfied by the Expected Service Commencement Date. If any Conditions Precedent have not been satisfied by the stated Longstop Date (a date after the Expected Service Commencement Date, which allows for an acceptable amount of “slippage”), the co-ordinating commissioner may terminate the Contract.

35.5 There may be circumstances in which it is appropriate to fix a Longstop Date for satisfaction of certain Conditions Precedent as a date before the Expected Service Commencement Date – for example, if there are staged tests or gateways which the provider must pass in order to establish its readiness to deliver the Services (as is the case for NHS 111). By fixing such an early Longstop Date, the co-ordinating commissioner is given the ability to terminate the Contract before the Expected Service Commencement Date has passed, once it becomes apparent that the Provider has not passed early tests and so is incapable of getting itself into a position to provide the Services. But this type of arrangement will be the exception, not the rule.

35.6 It is important to note that the Longstop Date is not a contractual means of allowing a contract to be signed with various contentious issues parked for resolution by a later date. Commissioners and the provider must make their own individual judgements about whether a contract contains an acceptable package which they are prepared to sign and be bound by. They may each be prepared to note that some non-material issues are not yet agreed at the point of signature (lesser schedules, for instance), with the expectation that these will be incorporated into the contract at a later stage, once agreed, through a variation.

But it is usually very unwise to sign a contract with material issues unresolved. Indeed, unless key elements, such as service specifications and financial terms, are agreed, there will be uncertainty as to whether a contract has been created at all.

- 35.7 Note that Schedule 1B may be used to set out details of any documents which the commissioners are to provide to the Provider before the Expected Service Commencement Date. These may include, for example, records and other documents which are to be obtained from a previous provider of the services.

Transition Arrangements (Schedule 2H and GC4.4 – full-length Contract only)

- 35.8 The parties may set out in Schedule 2H actions which each must take (and/or, in the case of the commissioners, which they must ensure that the outgoing provider of the Services must take) in order to ensure continuity of service and to effect an orderly transition of provision from the outgoing provider to the new provider, and/or from the old service model to the new. These might cover arrangements in relation to the transfer of staff (linking to GC5.11 (TUPE) (Schedule 8 in the shorter-form Contract)), the transfer of premises and equipment, transfer of care of Service Users, and so on. Clearly, there may be overlap between Schedule 1A and Schedule 2H, and it may be appropriate to specify completion of actions on the part of the provider under Transition Arrangements as a Condition Precedent, in order to ensure that the right to terminate the Contract applies if the provider fails to complete those actions. (If using the shorter-form Contract, transition arrangements may be set out in Schedule 2G (Other Local Agreements, Policies and Procedures) if required).

Contractual processes carried forward from previous contracts

- 35.9 Where an existing contract is about to expire and the commissioner is intending to enter a new contract with the same provider, questions arise about what happens to contractual processes unfinished during the previous contract (a Remedial Action Plan or an Activity Management Plan, for instance).
- 35.10 Commissioners can, of course, minimise the impact of this issue by entering into multi-year contracts, so that the contractual process automatically carries forward from one Contract Year to the next, until the contract expires.
- 35.11 However, at the end of a contract of any length, unless commissioners take appropriate action, the default position will be that contractual processes begun under that contract will not automatically be carried forward to a new contract. Rather, the contractual process will have to re-start from the beginning.
- 35.12 This issue can be addressed by the inclusion of the Plan agreed under the expiring contract within a Service Development and Improvement Plan under the new contract. In this situation, a commissioner may wish to treat the agreement of that Service Development and Improvement Plan as a Condition Precedent for the purposes of the new contract (in other words, that agreement of the continuing application of the Plan is a pre-requisite 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.

36 Service specifications

*A specification for the services to be provided should always be included within the **shorter-form Contract** at Schedule 2A. There is no mandated format for a specification in the shorter-form version, but commissioners should ensure that each specification clearly sets out at minimum the service to be provided, the population and geography to be covered, acceptance/exclusion criteria, where the service is to be provided and other key requirements.*

- 36.1 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.
- 36.2 Generally, specifications are for commissioners to develop locally, but in some instances national specifications are mandated and in others national models are available.
- Where services are being commissioned by NHS England, there will often be one national service specification for the particular service, which has been designed with clinical input and signed off at national level. For specialised services, for instance, the Contract now mandates that national specifications must be used, subject to any agreed Derogations (see paragraph 36.3 below).
 - A number of model specifications were previously available on the NHS Commissioning Assembly website; these covered diabetes, self-harm and end of life care. If you would like to see a copy, please contact nhscontractshelp@nhs.net.
- 36.3 The Contract continues to include the concept of Derogations from mandatory national service specifications in relation to services commissioned by NHS England. A Derogation is defined as “agreement by NHS England that specified provisions within a National Service Specification do not apply to the Provider on a time-limited basis, pending action being taken by that Provider to ensure that, from an agreed date, it can meet all of the requirements of the National Service Specification on an ongoing basis”. Any Derogations should be recorded in Schedule 2A1.

Developing service specifications

- 36.4 Service specifications should be recorded in Schedule 2A of the Particulars. A non-mandatory model template for local determination and population is provided at Schedule 2A, and Commissioners may retain this structure, or may determine their own. Where a Commissioner chooses to determine their own structure, the

guidance in paragraphs 36.5 – 36.11 below is still relevant.

- 36.5 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.
- 36.6 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, i.e. 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 e.g. 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 (e.g. 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).
- 36.7 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?

- 36.8 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 local 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.
- 36.9 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').

36.10 Quality requirements and information requirements in relation to a specific service should not be included in the service specification. If there are any specific quality requirements relating to the particular service, these should be included in Schedule 4 (Quality Requirements), with any associated information requirements included in Schedule 6 Part A (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.

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

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 (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. 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-C)

5.2 Applicable CQUIN goals (See Schedule 4 Part D)

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 long-term individual service user placements. 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.

37 Commissioner Requested Services / Essential Services

*The arrangements for CRS and Essential Services in the **shorter-form Contract** are similar to those in the full-length version, but slightly abbreviated.*

- 37.1 The NHS Standard Contract refers to two sets of arrangements under which the provision of services can be protected where the continued availability of those services is regarded as essential. These are covered in SC5 and are:
- the regime of Commissioner Requested Services (CRS) which is the responsibility of NHS Improvement and which applies to all providers other than NHS Trusts
 - the regime of Essential Services which applies to NHS Trusts only.
- 37.2 [Detailed guidance on CRS](#) is available from NHS Improvement. Services can potentially be designated as commissioner requested services where there is no alternative provider close enough, where removing them would increase health inequalities, or where removing them would make other related services unviable.
- 37.3 Under NHS Improvement's CRS guidance, individual commissioners (CCGs and NHS England) had until 31 March 2016 to complete the process of determining whether individual services at specific providers should be designated as CRS or not. The guidance sets out a detailed process for this, including a right of providers to appeal against the commissioner's assessment. Commissioners should submit their designation decisions to NHS Improvement via CRS@monitor.gov.uk.
- 37.4 The Contract requires both parties to comply with the respective obligations under CRS Guidance, but any potential interventions by NHS Improvement under the guidance would not come within the remit of the contractual arrangements between the parties. There is no requirement for decisions on CRS designation to be listed in a schedule to their local contracts, because commissioners report these decisions to NHS Improvement and are expected to publish them on their websites.

37.5 By contrast, the Essential Services arrangements for NHS Trusts are set out within the Contract itself, not within separate guidance (although the definition of Essential Services is consistent with that for CRS used by NHS Improvement). The key contractual requirements are:

- for any agreed Essential Services to be listed at Schedule 2D; and
- for the provider to maintain its ability to provide the Essential Services; and
- for the provider's Essential Services Continuity Plan to be included at Schedule 2E.

37.6 Under the Contract,

- 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).

37.7 Whereas CRS designation is for each individual commissioner to determine in respect of each service at a particular provider, as set out in NHS Improvement's guidance, Essential Services are defined at contract level, not at commissioner level, in agreement between the co-ordinating commissioner and the provider.

37.8 Commissioners should ensure that they make very clear their requirements in respect of designation of Commissioner Requested Services / Essential Services in procurement documentation and in pre-contract discussions with providers.

38 Sub-contracting

The provisions relating to sub-contracting in the shorter-form Contract are very much shorter than those in the full-length version, and there is no expectation that sub-contractors will be recorded within a Schedule to the Particulars. Our expectation is that sub-contracting of material elements of the services will typically not be a feature of the type of commissioning arrangements which are to be governed by the shorter-form Contract, and so more detailed provisions are not necessary. (If there is expected to be extensive reliance on sub-contracting, the full-length Contract should be used). But the basic position remains that the Provider may not sub-contract without the Co-ordinating Commissioner's prior written approval and that the Provider remains liable to the Commissioners for any Sub-contractor's acts and omissions.

38.1 GC12 governs sub-contracting. We are aware that there can be confusion about the extent to which commissioners should be involved in decisions around sub-contracting, and expanded guidance on this is therefore set out below.

- 38.2 The provider is wholly responsible to the commissioners for the delivery of the services and for the performance of all of the obligations on its part under the contract. The default assumption is that the provider will actually provide the services, and everything required in order to deliver those services in accordance with the contract, itself. However, in practice, most providers will wish to or need to sub-contract elements of the services, or contributions towards their delivery, to others.
- 38.3 What do we mean by a sub-contract? For the purposes of the Contract, a sub-contract is defined very broadly: it is any contract entered into by the provider or by any sub-contractor for the purpose of the performance of any of the provider's obligations under the contract. So that would include contracts entered into by the provider or by its sub-contractors with providers of clinical services (often known as "provider-to-provider" contracts), clinical support services, goods and equipment on which the provider or the sub-contract relies in order to be able to deliver the services in accordance with the contract entered into with the commissioners.
- 38.4 It is important for both commissioners and providers to recognise that sub-contracting in no way relieves the provider from responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract: failure on the part of a sub-contractor does not excuse the provider from its obligations to the commissioners.
- 38.5 Nevertheless, commissioners will have an interest in sub-contracting arrangements. Depending on the scope and nature of the service or contribution being sub-contracted, they will need a greater or lesser degree of assurance as to the identity, level of competence and experience of the sub-contractor and the terms on which it is being appointed. Overall, the level of scrutiny which any sub-contract requires from the commissioner should be in proportion to its materiality, in terms of its potential impact on patient care. Commissioners will need to strike a careful balance, aiming for an appropriate and manageable level of oversight and not for micro-management of operational detail.
- 38.6 GC12.1 states that the provider is not to sub-contract any of its obligations under the contract without the written approval of the co-ordinating commissioner. So the co-ordinating commissioner is able to exercise control over what, how and to whom the provider sub-contracts the performance of those obligations. The extent to which it does or should exercise that control in practice will, as suggested above, depend on the scope and nature of what is to be sub-contracted. It is important that commissioners and providers reach an understanding, in the context of their contract, as to when and how this control will be exercised. It may, for example, be readily agreed between the parties that the provider will be free to contract with suppliers of consumables and providers of support services such as catering and cleaning without seeking consent to each individual sub-contract: in effect a blanket consent is granted at the outset. On the other hand, who supplies particular consumables may, in the context of a particular commissioning contract, be very important to the commissioners, and they may therefore wish to exercise the right of approval over sub-contracts for those consumables.
- 38.7 GC12.2 allows the co-ordinating commissioner to designate a sub-contract as a

Mandatory Material Sub-Contract or a Permitted Material Sub-Contract. “Material” in this context means that it relates to all or a significant and necessary element, or contribution towards, the delivery of a service. Materiality is not about the value of the sub-contract, or necessarily about whether or not the subject matter of the sub-contract is itself a clinical service; the key is the importance of the sub-contract and the sub-contractor to the delivery of the provider’s services.

- 38.8 If a sub-contract is designated as a Mandatory Material Sub-Contract or a Permitted Material Sub-Contract, specific controls will apply, governing its termination, variation or replacement (see GC12.5).
- 38.9 A sub-contract will be a Mandatory Material Sub-Contract (and the sub-contractor in question will be a Mandatory Material Sub-Contractor) if it is one without which the provider would simply not be able to provide, or would be seriously hampered in providing, its services: it simply does not have the capability or the capacity to comply with its obligations under the commissioning contract without the input of that particular sub-contractor under that Mandatory Material Sub-Contract. So a Mandatory Material Sub-Contract is, by definition, one which the provider must have in place (see GC12.3 and Schedule 1A), and if it does not it cannot be allowed to start (or continue) providing the services.
- 38.10 A sub-contract will be a Permitted Material Sub-Contract (and the sub-contractor a Permitted Material Sub-Contractor) if, without it, the provider would nevertheless be able to provide the services in accordance with the commissioning contract, either because it can do everything necessary itself or because there are alternative sub-contractors available who can do so to the satisfaction of the provider and the commissioners. The provider may choose to sub-contract a material element of or contribution towards the delivery of the services, but it does not have to be that specific sub-contractor. The commissioners may therefore be happy to confirm that they permit the provider to enter into a sub-contract with any one of a number of identified Permitted Material Sub-Contractors who they are confident will be able to provide the necessary support to the provider.

Form of sub-contract

- 38.11 It is for the provider to put in place the actual sub-contract, but the commissioner has the right to approve the terms of this if it wishes. There is no prescribed form of sub-contract (but see paragraph 38.14 below), but the NHS Standard Contract places a number of specific requirements on the main provider in relation to the conditions of any sub-contracts (see, for example, GC21.14 of the full-length Contract).
- 38.12 The NHS Standard Contract itself is not designed for use, and should not be used, as a sub-contract. One simple, practical example of why this is the case relates to the National Tariff. The Standard Contract requires the commissioner to pay the provider in accordance with the National Tariff (meaning the principles and rules set out in the current National Tariff document) – but no such requirement applies where a provider is paying a sub-contractor.
- 38.13 Where NHS providers are placing sub-contracts for non-clinical goods and services, they may appropriately use the [standard NHS terms and conditions for](#)

[procuring goods and services](#), published by the Department of Health. Where the sub-contract is of a clinical service, the goods and services contract will not be suitable.

- 38.14 The Department of Health and NHS England have worked together to develop a model sub-contract for use by providers for clinical service sub-contracting. This model sub-contract gives a systematic way of flowing down the relevant provisions from the main contract to the sub-contractor. Model sub-contracts suitable for use with the full-length Contract and with the shorter-form Contract will be published shortly on the NHS Standard Contract [2017/18 web page](#).
- 38.15 Use of the model sub-contract is not mandatory, but we hope that its use will save providers time and offer greater assurance to commissioners that robust sub-contracting arrangements are in place.
- 38.16 Where a provider does not use the national model sub-contract, it should ensure that the sub-contract it does put in place reflects the relevant elements and requirements of the NHS Standard Contract.

Management of sub-contracts

- 38.17 Management of the sub-contractor is the responsibility of the provider. The provider is responsible to the commissioner for all of the services, including any provided by sub-contractors. However, the co-ordinating commissioner does have powers to require the replacement of sub-contractors in specific situations, as set out in GC12.13 (full-length Contract).

39 Quality of care

*The core requirements on providers in relation to the provision of safe and effective care are the same under the **shorter-form Contract** as in the full-length version – but there is far fewer applicable national standards, less detail about specific national policy requirements and a greater reliance on the concept of “Good Practice” (as defined in the Contract). Contract management processes are generally abbreviated in the shorter form, but the provisions for service suspension or contract termination provide protection of commissioners in the event that a provider is providing unsafe or consistently low-quality services.*

- 39.1 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.

Using the Contract to manage quality – an overview

- 39.2 Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust

framework through which a commissioner can set clear standards for a provider and hold it to account for the quality of care it (and any sub-contractors) delivers. The key elements of the Contract dealing with quality are summarised below.

- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).
- The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must 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; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every six months.
- The Contract requires providers to adhere to national guidance on specific service areas, such as hospital food standards (SC19), infection control (SC21), safeguarding (SC32), the care of dying people (SC34) and the duty of candour (SC35).
- The Contract sets specific national quality standards which the provider must achieve (Schedules 4A and 4B), with scope for additional local quality requirements (Schedule 4C).
- In addition to these nationally-mandated requirements, commissioners can describe detailed service requirements – whether in terms of outcomes, quality measures or inputs and processes – through locally-designed service specifications (Schedule 2A).
- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and incidents and Never Events (SC33).
- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys, Patient Safety Incidents and Never Events, learning lessons and implementing improvements (SC3).
- Finally, the Contract provides processes through which commissioners can intervene to ensure that high-quality care is delivered – by requiring regular submission of monitoring information (SC28), agreeing Service Development and Improvement Plans (SC20), offering incentive schemes to improve quality (SC37 and SC38), requiring Remedial Action Plans to address service deficiencies (GC9), applying financial sanctions for failure to achieve national standards (SC36), and ultimately by suspending services temporarily (GC16) or terminating them permanently (GC17).

- 39.3 It is essential that commissioners use the tools within the Contract to set high standards for providers and to monitor service quality continually, alongside expenditure and activity levels – and that they maintain a constant and close dialogue with providers about any issues relating to service quality. Local Quality Surveillance Groups offer an important forum through which commissioners can share information and intelligence about service quality with their local commissioning and regulatory partners.
- 39.4 Detailed guidance on reporting requirements, on financial sanctions for breaches of quality requirements and on the use of contract management processes is set out slightly later in this document. The remainder of this section focuses on specific quality aspects.

Operational Standards and National Quality Requirements

- 39.5 These are set out in Schedules 4A and 4B. Both are sets of nationally-mandated standards, with the Operational Standards derived specifically from the NHS Constitution. All providers are expected to achieve all of the Operational Standards and National Quality Requirements which relate to the commissioned services. Consequences for failure to achieve these standards are set nationally, but note the specific Sustainability and Transformation Fund arrangements set out in paragraphs 3.5 to 3.13 above.
- 39.6 Definitions for Operational Standards and National Quality Requirements (in Schedules 4A and 4B) are generally set out on the NHS England website. However, definitions for a number of the newer indicators are included at Appendix 3.
- 39.7 Commissioners and providers should have regard to [Managing long waiting cancer patients – policy on “backstop” measures](#). This sets out a process for providers to manage cancer patients experiencing waits over 62 days and requires root cause analyses and clinical harm reviews to be carried out in certain situations, with the potential for cases to be reported as Serious Incidents where appropriate.

Local Quality Requirements

- 39.8 Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. As a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value. Provisions are set out in SC28 to address this (see paragraph 43.6 below).
- 39.9 It is reasonable for specific financial consequences to be agreed for non-achievement, so long as these are reasonable and proportionate. Regardless of whether specific financial consequences have been agreed in relation to Local Quality Requirements, commissioners may of course use the contract

management process set out in GC9 to address any breaches – see paragraph 45 below. Where no specific financial consequences are agreed for a Local Quality Requirement, the words ‘as set out in GC9’ should be inserted as the relevant consequence in Schedule 4C.

- 39.10 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 Lessons Learned.
- 39.11 We have previously provided a separate appendix with a pick-list of possible local quality requirements. We discontinued this in 2016/17, although the list remains available for reference in the [2015/16 Contract Technical Guidance](#).

CQUIN and local incentive schemes

Note that, while under the full-length Contract it may be agreed that payments are made on account of CQUIN by instalments through the year, with a reconciliation based on actual performance at year end, the shorter-form Contract provides only for a single, end of year payment. This approach is taken in the interests of more streamlined contract management.

- 39.12 CQUIN (*Commissioning for Quality and Innovation*) is the national quality incentive scheme. Guidance on CQUIN is now available at <https://www.england.nhs.uk/nhs-standard-contract/cquin/>
- 39.13 It is possible to agree local quality incentive schemes in addition to CQUIN; these should be documented at Schedule 4E of the Particulars.

Former national CQUIN indicators

- 39.14 Where national CQUIN indicators have been in place for a number of years, with most providers having embedded the good practice described in the indicator within their local working arrangements, it is normal for the indicator to be retired from the national CQUIN scheme, with its place taken by new, more challenging national indicators. In such cases, additional requirements in relation to the ‘retired’ indicators will typically be included in the NHS Standard Contract.
- 39.15 This is already the case for three such indicators.
- **Venous Thromboembolism (VTE).** The national quality requirement (set out in Schedule 4B) remains that acute providers must undertake risk assessments for at least 95% of Service Users each month, with financial sanctions applying where this is not achieved. Requirements to undertake root cause analyses and audits of provision of prophylaxis are set out in SC22, and the provider must report on these under the Reporting Requirements (Schedule 6A).

- **NHS Safety Thermometer.** Schedule 6A sets out a requirement to report the results of NHS Safety Thermometer data collection, together with analysis of trends and action taken.
- **Friends and Family Test (FFT).** SC12 sets out specific requirements in relation to implementation of FFT, including an expectation on maximising response levels.

39.16 The national CQUIN indicator on **dementia and delirium** has also been ‘retired’. The indicator contained three elements:

- two relating to staff training and surveying carers’ needs, which are covered at a generic level by the existing provisions within GC5 and SC12; and
- one relating to the FAIRI (Find, Assess, Investigate, Refer and Inform) data return.

39.17 As part of the CQUIN process, this data return was expanded for 2015/16 to cover community services providers and commissioners. These additional requirements no longer apply, but the original FAIR return remains a mandatory, BAAS-approved data submission for all acute providers.

39.18 In all of these areas previously covered by national CQUIN indicators, commissioners should use the levers in the Contract, including the processes and sanctions set out in GC9 and SC28, to ensure that providers maintain high standards of care and submit the required data and reports. Commissioners may wish to consider agreeing local CQUIN indicators or quality requirements to sustain and continue performance improvements.

Never Events, Serious Incidents and Patient Safety Incidents

39.19 Never Events are serious patient safety events which are largely preventable. The current Never Events Policy Framework, including the detailed list of Never Events, is available at <http://www.england.nhs.uk/ourwork/patientsafety/>. NHS Improvement has recently undertaken a [consultation](#) on possible improvements to the Framework and will announce next steps in due course.

39.20 In finalising and agreeing Schedule 6A (Reporting Requirements) and Schedule 6C (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 \(STEIS\)](#) in line with the timeframes set out in the [NHS Serious Incident Framework](#) and ensure such incidents are also reported to the [National Reporting and Learning System](#).
- 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 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 6A or 6C 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 6A or 6C, 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.

Discharge summaries, clinic letters and other communications to GPs

39.21 In updating the Contract, we have continued to strengthen the arrangements set out in SC11 on discharge summaries following inpatient, daycase or A&E care and clinic letters, with new requirements coming into force at different stages during the two-year Contract period, in line with the national timescale for delivery of a digital NHS by 2020.

39.22 The Contract requirements have three aspects.

- **Timing.** Discharge summaries following inpatient/ daycase care and A&E attendance must already be issued within 24 hours. For clinic letters, the current standard of 14 days reduces to 10 days from 1 April 2017 and 7 days from 1 April 2018. (Note that this standard is not expressed in Operational Days, just 'normal' days.)
- **Transmission.** Discharge summaries must already be sent by either secure email or direct electronic transmission. The latter is the more efficient and secure method, and so only direct electronic transmission will be permitted from 1 October 2018 onwards. This is also the point from which clinic letters must be sent electronically rather than in paper form, again only by direct electronic transmission.

- **Structure.** To gain the full benefit from electronic transmission, it is essential that discharge summaries and clinic letters are constructed using coded data and standardised clinical headings, so that data can be automatically extracted into GP records. A first set of such clinical headings, endorsed by the Academy of Medical Royal Colleges, has already been published for discharge summaries from inpatient / daycase care, and it is already a Contract requirement that providers use these headings. Further headings will be published for A&E discharge summaries and clinic letters in due course, with the contractual obligation to use these new headings taking effect from 1 October 2018.

39.23 NHS Digital has provided [guidance](#) to support providers in implementing electronic 24-hour discharge summaries using standardised headings. Further details on the structured approach to sharing clinical information are set out in the [Transfer of Care Domain Message Specification](#), also published by NHS Digital.

39.24 Commissioners must support providers in resolving any issues about GP preparedness (in terms of IT systems) to receive electronic transmissions (see SC11.7. Commissioners should also take a reasonable and proportionate approach in managing performance against the electronic transmission requirements. The policy direction is clearly to ensure electronic transmission to all GPs, but commissioners may wish to focus first on ensuring that providers can transmit electronically to GPs within their local catchment area.

39.25 Note the following points.

- A provider is not necessarily required to send a clinic letter to the GP after each individual clinic attendance – this will depend on the individual clinical circumstances, as set out in SC11.8.
- For discharges from care where the Service User has not been admitted to hospital or treated in A&E, there is no nationally-mandated requirement for a discharge summary to be sent in all cases. Instead, SC11.6 allows an appropriate locally-specified requirement, including content, format, method of delivery and timescale, to be agreed and set out in Schedule 2J (Transfer of and Discharge from Care Protocols).
- We do not envisage that discharge summaries would ever be required from Patient Transport Services, and the wording of SC11.6 (SC11.3 in the shorter-form Contract) reflects this.
- 111 Services are subject to a separate requirement to send electronic Post Event Messages, rather than discharge summaries (SC11.6A).

39.26 Apart from these provisions for transfer of or discharge from care and clinic attendance, the Contract does not set out other nationally-mandated requirements for communication from the provider to the GP whilst a Service User is receiving ongoing care at that provider. But where a commissioner wishes to set out other local requirements for communication to GPs during a pathway of care (as opposed to at discharge), this can be done by using Schedule 2G (Other Local

Agreements, Policies and Procedures).

Medication on discharge and following clinic attendance

39.27 We included new provisions relating to provision of medication on discharge from inpatient or daycase care in the 2016/17 Contract, and we have expanded these for 2017-19 to cover prescribing by hospitals following outpatient clinic attendances.

39.28 We are aware that there is different practice around the country in respect of both issues. To be clear, the purpose of the measures in the Contract is, in summary, to set minimum requirements which all providers must meet. These are

- for discharge from inpatient or daycase care, a minimum of 7 days' supply; and
- following clinic attendance, sufficient supply for a patient's immediate needs, at least up to the point where the clinic letter has reached the GP and the GP can then prescribe on an ongoing basis.

In each case, the Contract wording deliberately sets these as minimum requirements; if local practice and protocols require supply for a longer period, this must be honoured unless alternative local arrangements are agreed.

39.29 These national-mandated requirements only cover medication. Clearly, hospitals may also supply dressings or appliances, and requirements in relation to these may be specified locally within Schedule 2J (Transfer of and Discharge from Care Protocols).

40 Financial consequences in relation to Quality Requirements

Application of financial consequences ('sanctions')

40.1 Under the STF arrangements described in paragraph 3.5 onwards, the application of financial sanctions in respect of breaches of certain of the national standards in Schedules 4A and 4B has been suspended in some situations for 2017-19. All of the detailed national sanctions remain within the Contract at Schedules 4A and 4B, but Service Condition 36.37A sets out the circumstances under which some of these sanctions are suspended.

Public reporting of sanctions applied by commissioners

40.2 For the last two years, we have required commissioners to publish on their websites details of the sanctions applied to each of their major providers for failure to achieve national standards. Given that application of the majority of these sanctions has been suspended for 2017-19 under the STF arrangements, we have decided to remove the publication requirement, in the interests of reducing reporting burden.

Use by the commissioner of funding retained through sanctions

- 40.3 The guidance below sets out how commissioners may use funding they retain as a result of the application of contractual sanctions, whether for failure to achieve national quality standards or for other contractual breaches.
- 40.4 Essentially, it is for each commissioner to determine the use of funding retained, within the ambit of the purposes for which it uses its overall financial allocation. Where there has been a breach of a national standard, however, we strongly recommend that the commissioner considers whether it is possible to invest the withheld funding in a way which will help to rectify the performance problem. This could mean, for instance:
- where 18 weeks standards have been breached, commissioning additional activity (either from the provider where the breach occurred or from other providers) and paying for this under the normal National Tariff rules; or
 - where the A&E waiting times standard has been breached, commissioning additional community-based alternative services to reduce the pressure on A&E; or
 - where an acute provider has breached its element of the ambulance handover standard, providing additional resource to the ambulance services provider to address the consequences.
- 40.5 As can be seen from the examples above, reinvestment of this nature need by no means necessarily be with the provider where the original breaches occurred. We are aware, however, that commissioners may sometimes consider reinvesting sanctions funding with the same provider, without commissioning any additional services, but with conditions attached relating to the implementation of a Remedial Action Plan and the subsequent ongoing achievement of the relevant national standard. Commissioners should be mindful that this approach may in some circumstances amount to a top-up to National Prices – and will therefore only be legitimate if it is agreed as a Local Variation under National Tariff guidance. This means it must meet the criteria for a Local Variation and that the commissioner must submit a written statement of the Local Variation to NHS Improvement in the required format.

Calculation and apportionment of sanctions

- 40.6 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. Worked examples are provided in Appendix 4.
- 40.7 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.

40.8 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.

40.9 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 4F of the Contract and described in detail in paragraph 40.17 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).

40.10 Note that while the sanction in relation to RTT incomplete pathway performance is measured at specialty level (as reported on Unify), the sanction in relation to six-week diagnostic waits is measured not at the level of each individual type of test, but on an aggregated basis across all the test types recorded by the provider.

Caps on value of sanctions

40.11 The Contract includes a provision, set out at SC36.37, to cap 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. The cap is set at 2.5% 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.

40.12 For consistency with the approach to CQUIN, the calculation of the Actual Quarterly Value should exclude payments for items on which CQUIN is not payable, as outlined in CQUIN guidance.

40.13 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 85%. A worked example is given in Appendix 4.

40.14 **The 2.5% cap is a cap on the actual value of sanctions imposed.** It is not in any sense intended as a norm for the level of sanctions that commissioners should expect to impose in practice; rather, it is a maximum which must not be exceeded. **However, the cap does not mean that a contract can only include sanctions which, if all were triggered to their maximum extent, would total less than the 2.5% value; the point is to cap the actual, not theoretical, value.**

40.15 Equally, the 2.5% 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% 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).

40.16 **We have been asked why we do not place an overall cap on the value of funds which can be withheld from a provider. To clarify:**

- **The 2.5% cap deliberately only applies to sanctions applied in relation to Operational Standards, National Quality Requirements and Local Quality Requirements, as described above.**
- **There are separate arrangements which limit the amounts that can be withheld under the contract management arrangements at GC9 (see paragraph 45.6 onwards) and under the Information Breach provisions at SC28 (see paragraph**

43.14 onwards); in both cases, Contract wording emphasise that sums withheld must be reasonable and proportionate.

We believe that maintaining separate arrangements and caps ensures that the provider is appropriately incentivised across the board. And, of course, there is no overall limit or cap on one party's liability to the other under the Contract: see GC11 (Liability and Indemnity).

Sanctions for *Clostridium difficile* performance

- 40.17 The Contract sets out a national quality requirement for acute providers in relation to *Clostridium difficile*. For each acute NHS provider (NHS Trusts and NHS Foundation Trusts), a national target is set for the number of *C difficile* cases for the year as a whole; this is what the Contract calls the Baseline Threshold, and commissioners should insert this into Schedule 4B. The financial consequences for breaches of the threshold are set out in Schedule 4F. Provider targets for 2017/18 will be published in due course.
- 40.18 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.
- 40.19 For other organisations providing acute services, the Baseline Threshold is set at zero; again, the financial consequences for breaches are as set out in Schedule 4F. These can be allocated to the relevant commissioner, as it is possible to attribute each case to a specific commissioner.
- 40.20 Provider-level *C difficile* targets are set for all major NHS acute providers. Community Trusts may also provide inpatient services (for example, through small community hospitals), but the national *C difficile* quality requirement and associated financial sanctions only apply to such providers if they have been set a specific Baseline Threshold. Commissioners may of course seek to agree local quality requirements with community providers in relation to *C difficile*, if appropriate, or wider infection control issues.
- 40.21 For the purposes of the quarterly cap on the value of local and national sanctions (see paragraph 40.11 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.

41 The Service Development and Improvement Plan (SDIP)

*The concept of a Service Development and Improvement Plan is not generally part of the **shorter-form Contract**. Under the shorter form, if the parties wish to record their agreement of a plan to address a specific service issue, they can include this in their local contract at Schedule 2G (Other Local Agreements, Policies and Procedures). (Note also SC36.17A in relation to SDIPs linked to the Sustainability and Transformation Fund.)*

- 41.1 The Service Development and Improvement Plan (SDIP, Schedule 6D) allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.
- 41.2 SDIPs differ from Remedial Action Plans (RAPs) under GC9 (Contract Management). RAPs are put in place to rectify contractual breaches or performance failures, whereas an SDIP is generally about developing an aspect of the services beyond the currently agreed standard. (Note however that, where specific actions and consequences are set out in a RAP under a contract which is soon to expire, commissioners may opt to roll those requirements into an SDIP under the provider's new contract, to ensure that the matters agreed are not lost in the switch from one contract to the next). Once included in the Contract, commitments set out in SDIPs are contractually binding.
- 41.3 Unless specifically mandated in the guidance below, SDIPs are for local agreement between the parties. SDIPs may for instance include:
- productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or
 - any agreed service redesign programmes; or
 - any priority areas for quality improvement (where this is not covered by a quality incentive scheme).
- SDIPs offer an excellent route through which commissioners and providers can agree a programme of work to implement innovation projects – from medical technologies to service and pathway re-design. NHS England has published a set of [Innovation Case Studies](#), showcasing real life examples of innovative practice which has already been implemented at local level in the NHS. Commissioners and providers are encouraged to review these case studies and to take forward relevant initiatives locally, through agreement of SDIPs where appropriate.
- 41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6D at the point where the contract is signed or incorporated into the contract subsequently by Variation. Progress against the plan should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9).

41.5 In 2016/17, we required commissioners to agree SDIPs in their local contracts with major providers, covering the following topics:

- for acute services, making progress against the four priority standards for **seven-day services** set out in the [NHS Services, Seven Days a Week Forum review](#) and increasing use of the **NHS e-Referral System**, in terms of service publication and slot availability from the hospital/provider perspective and use of the system for booking by referrers;
- for mental health services, taking forward staff training and accreditation to deliver the **new access standards** for Early Intervention in Psychosis programmes (EIP) and Improving Access to Psychological Therapies (IAPT) programmes and contributing to **Local Transformation Plans** for children and young people's mental health services; and
- for all services, making progress in **implementing new digital technologies** (adopting SNOMED-CT, digitising medicines management, utilising positive patient identification and asset tracking technologies, and protecting IT systems from cyber threat).

41.6 Some of these priorities have now been addressed in the 2017-19 Contract or elsewhere in the NHS business rules (seven-day service requirements at SC3, e-Referral through CQUIN and at SC6, new data security standards at GC21). But, to the extent that there is other 'unfinished business' at local level relating to the SDIPs agreed in 2016/17, commissioners should ensure that SDIPs are rolled forward, updated as necessary, for 2017/18.

41.7 For 2017-19, commissioners are required to agree SDIPs with relevant providers in two new areas.

- Commissioners must agree SDIPs with each major local provider, setting out the actions they will take jointly to improve working across the secondary / primary care interface. These plans should aim to tackle the issues described in [Making Time in General Practice](#), ensuring that secondary care providers do not inadvertently create avoidable extra work for general practices. At the same time, plans should identify ways in which processes and behaviours within primary care can be improved to allow secondary care to function more efficiently. One aim of these SDIPs must be to ensure full implementation of the specific new requirements in this area already included within the Contract for 2016/17 (see the [joint letter](#) sent by NHS England and NHS Improvement on 28 July 2016) and now added for 2017-19 (outlined in section 3.3 above).
- Commissioners must also agree SDIPs with those providers (particularly of mental health services) who are not yet compliant with the recommendations in [NICE Guideline PH48, Smoking: acute, maternity and mental health services](#)), setting out the action those providers will take to ensure that their premises (including grounds and vehicles) are smoke-free by no later than 31 December 2018. This will support delivery of the commitment in the [Five Year Forward View for Mental Health for the NHS in England](#).

- 41.8 As in previous years, the intention of these mandatory SDIPs is not to require significant additional investment from commissioners or providers; rather, it is to encourage joint management action to tackle these important priorities to the extent possible within available resources.

42 Managing activity and referrals

*The provisions in the **shorter-form Contract** for managing activity and referrals are very significantly simplified. There is the potential to include an Indicative Activity Plan if needed, but no reference to Activity Planning Assumptions or Prior Approval Schemes, as these would not generally be expected in relation to the types of service for which the shorter-form may be used.*

- 42.1 The key aims of the provisions in SC29 (Managing Activity and Referrals) are to ensure that:
- where patients have a legal right to choose their provider, this is always enabled;
 - activity carried out under a contract is clinically appropriate;
 - activity is managed within the levels the parties have agreed at the start of the year or – where there are variances – these happen for good clinical or patient care reasons (including as a result of the exercise by patients of their legal right to choice) that are understood and accepted by the commissioner and provider.
- 42.2 There will be situations where it is appropriate for commissioners to use the provisions within SC29 to put downward pressure on activity levels within a contract – but SC29 should not be used by commissioners as a blunt instrument simply to control costs. For further guidance on appropriate use of the contractual provisions on activity management, reporting requirements and payment arrangements, please refer to the hypothetical case studies set out in Appendix 6.

Access to services

- 42.3 The Contract must function as a robust tool through which commissioners can secure access to the services which their population needs. At the same time, commissioners need to be able to use the Contract to prevent access to care or treatment which they deem to be unnecessary, ineffective or inefficient. This will enable commissioners to commission services in line with the NHS Right Care approach.
- 42.4 Reflecting on this, we made some important amendments for 2016/17 to the arrangements in the Contract governing access to services. It is worth re-capping on these.
- 42.5 Firstly, we expanded the provisions of SC6. These already required the provider to accept any clinically appropriate referral where a patient is exercising his / her

legal right to choice of provider – even where the patient’s Responsible Commissioner is not a party to the local contract. For 2016/17, we introduced an additional provision requiring acceptance of any emergency referral or presentation for treatment within the scope of the services a provider runs, again even where the patient’s Responsible Commissioner is not a party to the local contract. There is an important caveat here that the provider must be able to provide such emergency treatment safely – we recognise that, for instance, an intensive care unit with fixed bed capacity may not be able to accept transfers from outside its local network if all of its beds are full of very sick ‘local’ patients. But the general principle is that a provider of NHS-funded emergency services must be open to any emergency presentation, regardless of the identity of the patient’s responsible commissioner.

42.6 Secondly, we made small (but significant) changes to the Contract wording around referral protocols and clinical thresholds for treatment (SC29.3-4). These make clear that such documents may be included within service specifications or other aspects of the contract which are agreed between commissioner and provider – but that, in other circumstances, they may instead be notified by the commissioner to the provider as a Prior Approval Scheme (described more fully below).

42.7 It is worth explaining how these provisions are intended to operate.

- Where a service operates on a block contract basis or with marginal prices for under- or over-performance, then the basis on which patients are to access that service (that is, the clinical threshold for patients to be referred and receive care or treatment) is, effectively, a critical determinant of the price. So, for example, it is probably not realistic to expect an intermediate care service which is funded to deal with referrals for patients over 85 to start accepting referrals from over-75s and operate within the same block contract price. In such a situation, it is appropriate for the ‘referral and treatment criteria’ under which the service is to operate to be included within the service specification (or separately within Schedule 2G, Other Local Agreements, Policies and Procedures). If either party wishes to change them, this can only be done by agreement using the Variation provisions at GC13. And discussion on a Variation may, of course, also involve varying the price for the service.
- But what about the situation where a service operates on an “activity x price” basis (such as the majority of consultant-led acute services)? In this instance, the price is not dependent on a fixed or guaranteed level of activity. So, for instance, if the commissioner identifies that it wishes to restrict access to certain treatments when specific clinical criteria are met, it is perfectly reasonable for it to do so – so long as what it is requiring the provider to do remains consistent with Good Practice as defined in the Contract. In this situation, therefore, referral and treatment protocols are best kept separate from service specifications and treated instead as Prior Approval Schemes, which the commissioner can introduce or change through notification to the provider (SC29.21 onwards), but which do not require provider consent.

42.8 What happens if a provider starts to offer and charge for new services which the commissioner has not deliberately chosen to commission? The answer will depend in part on what is documented in the local contract and whether the legal

right of choice of provider applies. In summary:

- Where the local contract contains precise service specifications, the commissioner will in principle be able to argue that, by introducing a new service or treatment beyond the scope of what is described in the specifications, the provider has breached its duties under SC3. The commissioner may therefore be on strong ground in refusing to pay for the new service.
- By contrast, where the specifications in the contract are much looser, the provider will have a stronger argument that it is reasonable for its services to evolve gradually in line with good clinical practice.

We explore this issue in more detail in scenario 4 of Appendix 6.

Prior Approval Schemes

- 42.9 A Prior Approval Scheme will typically set out a commissioner policy for access to a certain service or treatment – a high-cost drug, for instance, or a treatment of perceived low clinical value. By setting out the clinical criteria or access thresholds in advance, the commissioner enables the provider to offer treatment to patients without needing to seek specific approval from the commissioner on an individual patient basis. In determining potential Prior Approval Schemes, commissioners will wish to review the evidence base and consider the need for appropriate consultation.
- 42.10 The commissioner should notify the provider of any Prior Approval Schemes before the start of the contract year. Schemes can be amended and new Schemes introduced in-year with one month's notice. Where this happens, commissioners must ensure that they set reasonable expectations about the applicability of the Scheme in relation to patients who have been referred or have already commenced assessment or treatment.
- 42.11 Where patients have a legal right of choice of provider, any Prior Approval Scheme which simply restricts that choice is void and cannot be used to restrict payment for activity carried out by the provider.
- 42.12 Where the commissioner determines, prior approval may also operate on an individual patient basis, with the provider seeking approval for each individual case. For the 2017/18-2018/19 Contract, we have introduced a requirement to include a response time standard for prior approval requests in the Particulars. The commissioner must respond to a request for approval for treatment within this Prior Approval Scheme Response Time Standard, or will be deemed to have given approval under SC29.25. SC29.26 also makes it clear that prior approval arrangements must not place at risk achievement of quality or waiting times standards.
- 42.13 We have amended the Contract for 2017-19 to make clear that commissioners must have regard to the burden which Prior Approval Schemes can create for providers (SC29.21). It is important, for instance, that commissioners

- ensure that they place the onus on the right part of the system – if a CCG does not wish to commission a particular procedure, it can appropriately inform its GPs of this and advise them not to refer patients for that procedure; in other cases, where the decision to offer a specific treatment would be made only by the hospital clinician after diagnosis, a Prior Approval Scheme operated by the hospital provider is likely to be necessary;
- reserve the more onerous individual prior approval arrangements for a small number of high-cost treatments and complex scenarios (where the decision as to who should access treatment will require detailed information about patients' individual circumstances); and
- review the cost-effectiveness of their prior approval arrangements – if a labour-intensive Scheme requiring individual prior approval in advance is consistently resulting in every patient receiving approval for treatment, it should probably be converted into a commissioning policy of the kind described in paragraph 42.9 above.

42.14 Providers, particularly those which deal with many different commissioners, often raise with us the burden which is caused by having to operate multiple different Prior Approval Schemes, covering the same conditions or treatments, but featuring slightly different requirements for different individual CCGs. Clearly, it is ultimately for each CCG to determine its own commissioning policies, and the Contract must allow these policies to be given effect. However, we have also introduced a new requirement for those commissioners operating under a single contract with a provider to use reasonable endeavours to minimise the number of separate Schemes they operate. CCGs must therefore seek to collaborate across local patches to adopt consistent clinical thresholds and administrative processes in their Prior Approval Schemes as far as possible, thus lessening the number and variability of different Schemes which any individual provider has to deal with.

Overall responsibilities for managing referrals and activity

- 42.15 The Contract identifies that both the commissioner and the provider have responsibilities for managing referrals and activity.
- Commissioners (SC29.3) (SC29.1 in the shorter-form Contract) must seek to ensure that referrals comply with any agreed protocols and any relevant Activity Planning Assumptions. In practice, the reasonable expectation will be that commissioners should be making vigorous efforts to ensure that GPs and other primary care referrers are following agreed protocols.
 - Providers (SC29.4) (SC29.2 in the shorter-form Contract) must also seek to ensure that referrals comply with agreed protocols. They will bear a particular responsibility for managing referrals which are internally generated (consultant-to-consultant referrals, say), but may also reasonably be expected to assist commissioners in ensuring that primary care referrals are in line with agreed protocols.
 - Providers will also bear particular responsibility for ensuring that the decisions made by their clinical staff to provide treatment to patients are made in line with

clinical thresholds set out the Contract or notified through Prior Approval Schemes. They must also seek to work within the Activity Planning Assumptions relating to referrals and other metrics.

NHS e-Referral Service

42.16 A new national CQUIN indicator will provide a financial incentive in 2017/18 for providers to do their part to promote the systematic adoption of the NHS e-Referral Service (ERS) for GP referrals. From 1 October 2018, however, new arrangements are mandated through the NHS Standard Contract.

- From that date, providers need not accept any GP referral into a consultant-led outpatient service unless it is made through ERS.
- As currently, providers must use all reasonable endeavours to ensure that sufficient slots are available to enable direct booking of appointments via ERS.
- Providers must also ensure that they accept all referrals made through ERS via the “appointment slot issues” route (that is, where a GP or patient is unable to book an appropriate slot, but still wishes to make the referral).
- The provider is able to return any non-ERS referral to the GP and will not be paid for any first outpatient attendance which results from a non-ERS GP referral.

42.17 NHS Digital and NHS England will continue to work together to increase the technical capability and robustness of ERS and to promote its functionality to users, improving and publicising the ‘slot issues’ process (through which ERS referrals can be made where there is no bookable appointment available) and ensuring that any remaining technical barriers to GP use and uptake are minimised (by improving integration with GP systems, for example).

42.18 Further guidance on the detailed operation of the arrangements will be issued in due course, covering for instance, whether there should be specific exceptions to the ‘referral return and non-payment’ approach, how the return of referrals should be managed to ensure patient safety, and whether there should be specific services or scenarios where use of ERS for all GP referrals would not be mandated.

Indicative Activity Plan

42.19 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 volume of activity that is estimated by the two parties but it is not a guarantee of a given volume of activity nor a cap on the volume of activity of any particular type which will be paid for by the commissioners.

42.20 The IAP should include sufficient detail for all 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.

- 42.21 An IAP should reflect the expected impact of demographic changes and any firm trends in demand; it may also need to factor in requirements for additional non-recurrent activity to reduce waiting times so that national standards can be achieved. Equally, an IAP can reflect planned service expansions – or expected reductions in activity within a given service, because of commissioner development of other services elsewhere or plans to improve referral practice. The net effect should be a realistic plan, shared between commissioner and provider, giving the provider sufficient confidence to put in place an agreed level of capacity which should be sufficient to cope with the expected demand and achieve national access standards. This shared confidence is particularly important where providers are being expected to shrink their capacity as a result of commissioner plans to manage demand or shift care between hospital and community settings.
- 42.22 The IAP, as the name suggests, is indicative. For a provider to provide more or less activity than is included within the IAP is not a breach of a contractual requirement, and the commissioner cannot withhold payment simply on this basis. For most acute services, payment under the National Tariff rules will fluctuate to reflect the actual level of activity provided, rather than being a fixed block for a planned level of capacity.
- 42.23 Where activity planning discussions identify genuine limitations in capacity in a particular service at a provider, commissioners may need to seek to commission additional providers for patients to choose from – or look at whether, within the confines of Good Practice, more appropriate referral criteria for that service should be introduced. However, the underlying requirement within the Contract remains that providers will need to be able to flex their capacity up and down as demand fluctuates, accepting referrals and treating patients rather than turning them away.
- 42.24 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.

Activity Planning Assumptions

- 42.25 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 to be provided under the specific contract and / or assumptions relating to how the particular provider will manage activity once a referral has been accepted. APAs are monitored as part of the activity management process.
- 42.26 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 be consistent with the IAP and 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 the NHS Choice Framework) 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.

- 42.27 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 A&E attendances;
 - measures of average waiting time.

42.28 By contrast with an IAP, the provider is under a contractual obligation to use all reasonable endeavours to manage activity in accordance with APAs, and the commissioner can use the processes set out in SC29 (Activity Management Plans, for instance) to ensure that this happens.

Early Warning and Activity Query Notices

42.29 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.

42.30 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.

42.31 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

42.32 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.

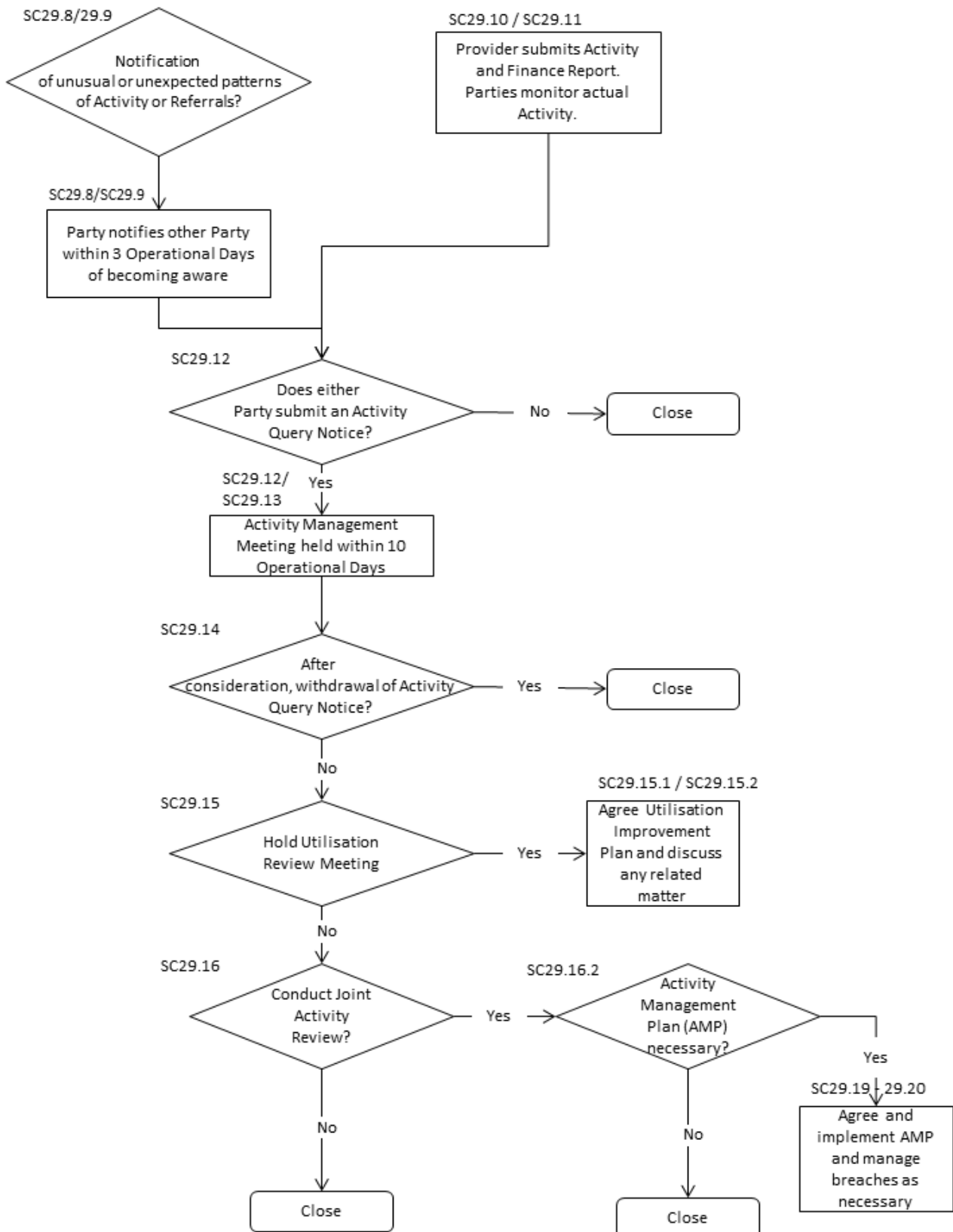
42.33 A joint activity review will be used to identify the reasons for variances in activity and may result in an activity management plan (AMP) being agreed.

42.34 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)

- 42.35 Otherwise, an AMP may be agreed. Where this cannot be agreed, the parties should refer the matter to dispute resolution.
- 42.36 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, changing clinical pathways or introducing new services without the agreement of the commissioner, the plan may include an immediate consequence of non-payment for that activity.
- 42.37 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) and 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.

SC29 (full-length Contract) – managing activity and referrals



43 Information, audit and reporting requirements

*The **shorter-form Contract** does not include the specific processes and sanctions relating to Information Breaches. Failure to comply with reporting and information requirements under the shorter form should be dealt with via the GC9 provisions.*

- 43.1 The Contract sets out a range of provisions relating to records and data, whether used for clinical or management purposes. Some of these are contained, for instance in SC23 (Service User Health Records), GC20 (Confidential Information of the Parties) and GC21 (Data Protection, Freedom of Information and Transparency).
- 43.2 Further background details on information requirements and governance are contained in Appendix 7. The focus of this section of our guidance, however, is on processes through which commissioners can access information about how the provider is providing services – under Schedule 6A (Reporting Requirements), SC28 (Information Requirements), and GC15 (Governance, Transaction Records and Audit).

Reporting Requirements

- 43.3 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 **clearly-communicated** 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, **which they can explain to providers**, commissioners should not request information directly from providers where this information is available through national systems; and
 - information provided should be of good quality.
- 43.4 Schedule 6A outlines the reports required under the Contract:
- **National requirements reported centrally.** This references the list of assessed collections and extractions published on the NHS Digital 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 NHS Digital guidance, and any Information Standard Notice (ISN) relevant to the service being provided.

- **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.

43.5 Despite the established principles above and the existing Contract wording which supports them in SC28, we receive consistent feedback about the high level of burden for providers which is generated by Local Reporting Requirements under the Contract.

43.6 As with Local Quality Requirements (see paragraph 39.8 above), commissioners are likely to find that a targeted approach with a limited number of well-chosen Local Reporting Requirements is the most effective approach. SC28.4 requires that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields. In the current context where NHS finances are under considerable stress, it is essential that commissioners are rigorous in reviewing the information burden they place on providers, ensuring that they only require information which they will actually use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route.

43.7 NHS Digital has developed a [Burden Impact Assessment Tool](#) to encourage providers and commissioners to work together consider the potential burden of any data request at a local level. NHS Digital also offers a [Collection Referral Service](#) which providers may contact confidentially if they believe that a proposed new local data requirement would benefit from objective, independent scrutiny.

Data Services for Commissioners Programme

43.8 The proliferation of local patient-level commissioning data sets – setting similar requirements for similar services, but in a non-standardised way – is a particular concern. The [Data Services for Commissioners Programme](#) (DSfCP) will deliver a new national technical solution (the ‘Data Services Platform’) for the submission, processing and dissemination of patient-level commissioning data sets from April 2017.

43.9 As part of the DSfCP, NHS England and NHS Digital have been working together to review existing local flows of patient-level commissioning data, and to identify areas where such flows could be improved, particularly in key service areas where local data appears to be supplementing or duplicating nationally-mandated flows.

43.10 In addition, the deployment of the Data Services Platform will also require providers to make a number of changes to existing local patient-level commissioning data flows to ensure that submitted data flows can be successfully landed, validated, processed and distributed by the Data Services Platform.

43.11 The specific change requirements to local patient-level commissioning data flows will be delivered incrementally via series of releases of the Data Services Platform from April 2017 onwards. The content of these releases is still being finalised but some of the general requirements are described in Appendix 7.

43.12 Further information on the specific local data flow requirements and associated guidance can be found on the [Data Services for Commissioners webpage](#).

43.13 We have included a reference to the Programme within Schedule 6A of the Particulars for 2017-19. Commissioners are encouraged to work with the DSfCP and their providers during the 2017/18 financial year to understand the requirements of the Programme and prepare for implementation during 2017/18. Where a provider will need time to make adjustments to move to use of any new data sets, a Data Quality Improvement Plan should be agreed locally to describe how the transition will be managed and over what period.

Information Breaches

43.14 SC28 sets out the way in which Information Breaches are identified and managed. An Information Breach is defined as “any failure on the part of the Provider to comply with its obligations under SC23.5 (Service User Health Records), SC28 (Information Requirements) and Schedule 6A (Reporting Requirements)”. The process for identifying and managing Information Breaches is set out in the flowchart below.

43.15 Where an Information Breach occurs, the co-ordinating commissioner must notify the provider of it, and commissioners may then withhold up to 1% of Actual Monthly Value, pending rectification of the Breach. The provider must rectify the Breach within three months of the notification of the Breach, failing which the commissioners are entitled to retain the sums withheld.

43.16 These financial withholding provisions require that any sum withheld by the commissioner must be ‘reasonable and proportionate’ (SC28.15) and to limit the amount withheld for all Information Breaches in any month to a maximum of 5% of Actual Monthly Value (SC28.19). The approach on Information Breaches is thus broadly consistent with the provisions for financial withholding under Remedial Action Plans under GC9.

43.17 It is important to be clear that rectification “to the reasonable satisfaction of the Co-ordinating Commissioner” may involve retrospective and/or prospective action.

- Where a Breach involves a failure to supply information or the provision of inaccurate or incomplete information, rectification may require the provider both to submit (or re-submit corrected) information for the missing period and to ensure that accurate, complete and timely information is provided for subsequent period. So, for example, where a provider fails to submit its

Service Quality Performance Report on time in September, subsequently submits the September Report three weeks after the due date, and then fails to submit the October Report on time, this amounts to a failure to rectify the September Breach.

- In other cases, retrospective rectification may be impossible. If the data underpinning a reporting requirement has not been fully captured at the appropriate point in the care pathway (ambulance handover times, say), then the rectification is likely to focus solely on ensuring that data capture and reporting for the future is comprehensive.

43.18 The Information Breach withholding described above can now be actioned by the co-ordinating commissioner on behalf of all the commissioners (see SC28.12), and we hope this will increase the readiness of commissioners to use this important lever to improve performance, both where local reporting requirements are not being met and where mandated national data sets are not being submitted.

SUS

43.19 Where SUS is applicable for a service, submission of datasets to SUS in CDSv6.2 format is already mandated through the definition of SUS Guidance in the Contract, which refers in turn to <http://content.digital.nhs.uk/isce/publication/isb0092?tabid=2>.

Data Quality Improvement Plans

43.20 Data Quality Improvement Plans (DQIPs) allow 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.

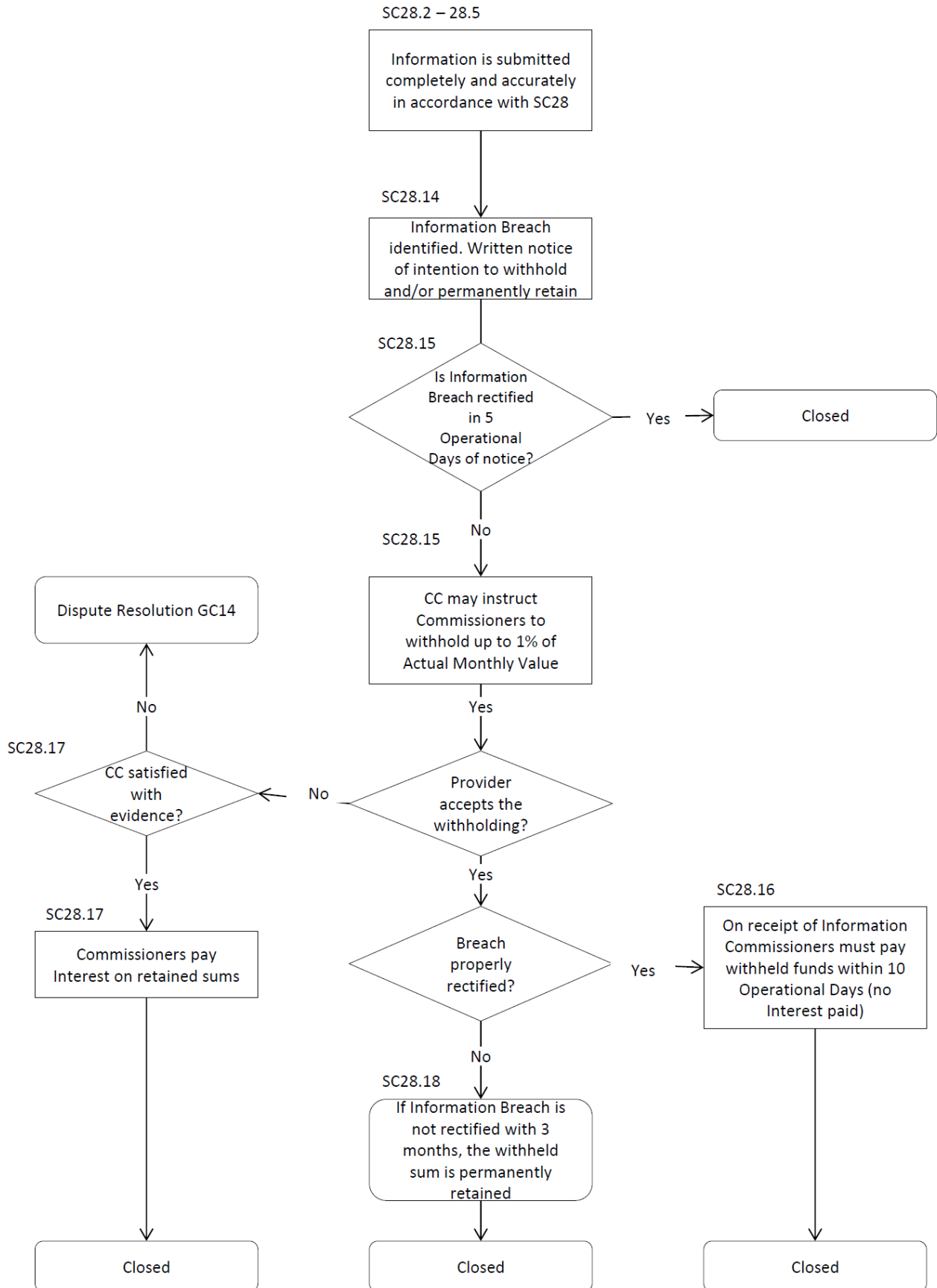
43.21 Commissioners will need to differentiate between situations where a provider's data quality is acceptable overall, but with some improvements needed (in which case a DQIP will be appropriate) and where an Information Breach has occurred which is unacceptable and which needs to be managed formally using the provisions in SC28. Putting in place a 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.

43.22 Multiple DQIPs can be included within the same contract. DQIPs should be included in Schedule 6B at the point where the contract is signed or incorporated into the contract subsequently by Variation. Once included in the Contract, however, commitments set out in DQIPs are contractually binding. Progress against the DQIP should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9).

43.23 Although completion of a DQIP is not mandatory for each contract, we nonetheless encourage commissioners to consider their use routinely. In terms of coverage, DQIPs should provide quantified assurance that action is being taken in each of the following areas:

- Coverage – that where a data set exists and is relevant to a provider it is completed for all relevant services;

SC28 (full-length contract) – Information requirements



- Completeness – that is, where a data set is produced, all relevant items are completed;
- Validity – that all data conforms to recognised national standards. Codes must map to national values and wherever possible, computer systems should be programmed to only accept valid entries;
- Timeliness – that all data is recorded to a deadline in line with the national reporting, and extract and refresh deadlines;
- Cleansing – covering duplication (that all necessary processes are in place to remove duplicated records), merging (that steps are being taken to ensure that separate records are not merged inappropriately) and auditing (that clinical coding checks are undertaken on a regular basis).

43.24 Commissioners can use a range of evidence sources to identify and quantify the progress they need to make through DQIPs. Possible sources are set out below.

- The NHS Digital monthly SUS data quality dashboard provides benchmarked evidence that commissioners should use to drive improvements in quantitative and process-based data quality indicators for admitted patient care, outpatients and A&E data sets as well as for maternity and critical care.
- Other data quality reports are published by NHS Digital relating to the Mental Health Services Data Set, the IAPT Data Set and Diagnostic Imaging Data Set.
- GC21.6 requires each provider to undertake audits of its performance against the Information Governance Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality.

43.25 DQIPs may be particularly useful where new national reporting requirements or datasets have been introduced and where providers are not yet routinely complying with these. This may be the case, for instance, with the Mental Health Services Data Set and the Children's and Young People's Health Services Dataset. Commissioners should therefore ensure that they monitor closely the data submitted by providers of the relevant services and consider whether use of one of the available contractual levers (DQIP or Information Breach) would be appropriate to ensure that any problems with the quality of data submitted by individual providers are swiftly rectified.

The Workforce Disability Equality Standard

43.26 We have included a new requirement in the full-length Contract on providers to implement the National Workforce Disability Equality Standard from 1 April 2018, and to submit annual reports to the Co-ordinating Commissioner, the first of which must be submitted by 31 March 2019.

Audit and invoice validation

43.27 GC15 covers Governance, Transaction Records and Audit and makes clear:

- the Provider's responsibilities for carrying out a programme of audit at its own expense (GC15.7 in the full-length Contract, GC15.5 in the shorter-form);
- 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 (GC15.8 in the full-length contract, GC15.6 in the shorter-form); and
- what should happen as a result of the reports of independent audits and who should pay for them (GC15.9-15.13 in the full-length Contract).

43.28 We have been asked about the relationship between independent audits and information governance requirements in relation to personal confidential data. This issue may obviously arise in the case of audits focusing on clinical services. Providers need a legal basis for disclosing personal confidential data. Without this they are entitled, and indeed required, not to disclose such information, and GC15.8 (GC15.6 in the shorter-form) therefore makes clear that access to such data must be 'subject to any applicable Service User consent requirements'.

44 Counting and coding changes

*As the **shorter form Contract** is not used for acute services, in which activity recording issues tend to be more contentious, it does not include specific provisions for the management of counting and coding changes.*

44.1 SC28 sets out how changes in the counting and coding of activity should be managed. This is a complex and contentious area, on which we receive many queries. We have therefore reviewed and expanded our guidance below and we welcome feedback on this. Please also refer to the case studies set out in Appendix 6.

Scope and intention

44.2 These provisions relate to the counting and coding (that is, recording) of activity (that is, how Service Users are cared for or treated clinically under the contract).

44.3 As an underlying principle, it is of course important that providers should record activity correctly, in line with national data definitions, and that they should be reimbursed on the basis of accurately recorded activity. In a context where national prices within the National Tariff are set on the basis of historic recording, however, there is a risk of short-term gaming, where either commissioner or provider sees the opportunity to make an immediate financial gain from a change in recording practice. The intention of the Contract provisions is to prevent any

short-term financial impacts on either party from changes simply in how activity is counted and coded.

What do we mean by a counting and coding change?

44.4 A change in counting and coding practice is:

- a change from a previous, historically-established way of recording activity which affects or would affect how or whether that activity is visible (i.e. reported) to the commissioner, through submission of datasets through SUS or other local reporting routes;
- a change which is systematic, in that it affects a group of patients in a similar way or ways, rather than just affecting an individual patient; and
- a change which may affect whether a certain activity is recorded at all or how it is recorded, in terms of how it is classified (as inpatient, outpatient etc.) and/or the extent of any detailed clinical coding of diagnoses and procedures.

44.5 There are two key points to bring out from the first element of this.

Is this a change from historically-established practice?

44.6 Realistically, we know that recording practice is not static. A provider may record a particular activity on basis A for five years, then a key member of staff may leave and his or her replacement may, in error, start recording on basis B. This may go on for, say, three months before the provider or commissioner spots the change. Clearly, the historically-established practice here is basis A. So the provider has been at fault in making the change to basis B (firstly because they have not given prior notice and secondly because basis B is technically incorrect), but there is no question of them having to give notice in order to revert to basis A.

44.7 Not all cases will be so clear-cut, of course. A good rule-of-thumb is that a particular recording practice should be considered 'historically-established' to the extent that it has informed the Expected Annual Contract Value for the current Contract Year.

Is this a change in what is or would be visible to the commissioner?

44.8 What matters is what the commissioner has been and will be able to see about a particular activity. If there is a change in this, then that is a counting and coding change.

44.9 Some cases will be very straightforward – a provider may start recording a certain group of cases as daycases, rather than outpatient procedures, say. This will immediately flow through to SUS in a way that is visible to the commissioner – so it will be a counting and coding change.

44.10 But take a different example. A provider has always recorded data about a particular clinic on its own PAS, but has never charged for the activity. It realises

that there is a national price for that service which it has not been applying and starts to apply it. Is this a counting and coding change? It depends:

- If the provider has historically submitted the relevant datasets to SUS (or to the commissioner / CSU via another local route), then the commissioner has always been able to see the activity data for the clinic. All that has changed is that the provider has started to apply the national price. This is not a counting and coding change, and the provider may therefore start to charge for the clinic prospectively as soon as it is able.
- But if the provider has never submitted the relevant datasets for the clinic, but starts to do so for the first time as backing data for the charges it is wishing to make, then that is a change in what the commissioner can see about the service – so it *is* a counting and coding change, the provider cannot start to charge immediately, and the provisions of SC28 must be followed.

44.11 The following are therefore not counting and coding changes.

Changes in service provision:

44.12 A change solely in the way in which services are provided may have a knock-on effect on the type, volume or casemix (and therefore cost) of activity recorded (because Service Users are now experiencing a different service). For a service change of this kind to proceed, it is likely that agreement of a Variation under GC13 will be required, but a service change such as this does not fall within the provisions of SC28 on counting and coding changes.

Changes in charging:

44.13 A change solely in the way in which activity is charged for, where there is no change in the way in which that activity is recorded and made visible to the commissioner (as described in the first bullet point of 44.10 above, for instance), is not a counting and coding change.

44.14 It is worth saying a little more about the interplay between the counting and coding provisions in SC28 and the National Tariff.

- Clearly, the provisions of SC28 are not intended to prevent or delay the adoption of new prices, currencies and rules mandated through the National Tariff. Providers and commissioners do not need to give each other notice under SC28 of the application of new National Tariff arrangements, and the impact of the new Tariff is not subject to the provisions in SC28 for financial neutrality.
- Applying new Tariff arrangements without changing the way in which activity is recorded is one thing; making changes to how activity is recorded in order to increase, or with the effect of increasing, income under those new Tariff arrangements is another. The latter definitely does fall within the scope of the counting and coding provisions at SC28.

- Best Practice Tariffs are worth particular mention here. The whole intention of the national BPT approach is to give providers an incentive to adopt proven new approaches to service delivery. So, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a Variation to be agreed in respect of any change of service provision necessary to achieve this, and the implementation of the BPT would not fall with the prior notification requirements for counting and coding changes under SC28 – because the BPT is about service delivery, not activity recording. (The one exception to this is where a provider intends to achieve compliance with a BPT simply by changing how it records activity – see scenario 10 in Appendix 6 for further details.)

Process for handling counting and coding changes under SC28

44.15 Providers must notify any changes which they intend to make to their recording practice to their commissioners six months in advance. Equally, if commissioners wish to propose changes in how a provider records activity, they must give that provider six months' notice.

44.16 The Contract does not set explicit requirements for the form which notifications of proposed changes should take, but they must be made in writing and delivered in accordance with the notice provisions set out in GC36, and should describe the nature of the change proposed, the rationale for it (that is, why it is technically correct under NHS Data Dictionary definitions and national guidance on clinical coding), the best available estimate of the impact on the type and mix of activity recorded and of the impact, at current prices, on payments between the parties.

44.17 The expectation in the Contract is that any changes agreed will be implemented

- (for multi-year contracts not in their final year) at the start of the Contract Year following the Contract Year in which notification is given;
- (for single-year contracts or expiring multi-year contracts), from the start of the contract covering the year following the one in which notification is given (assuming of course that such a contract is awarded to the same provider).

44.18 As a general rule, notice of proposed changes must therefore be given no later than 30 September in any year, with the changes to be implemented on the following 1 April. (However, the parties may instead agree a different implementation date, and national guidance issued to accompany a particular change may sometimes explicitly require a specific implementation date, in which case this implementation date must be followed.)

44.19 Changes proposed by either party should be discussed and agreement reached on whether they are consistent with national recording guidance and should be implemented.

44.20 Where agreement cannot be reached on whether a change should be implemented, the parties may refer the matter for dispute resolution.

44.21 Where a change is implemented by agreement, SC28.11 provides for time-limited protection against the financial effect, by requiring that the parties must make a payment adjustment, so that the financial impact of each agreed change is rendered neutral in the short term. “In the short term” means specifically:

- where, for any reason, the change is implemented during the Contract Year in which it was proposed, for the remainder of that Contract Year; and
- in any event, for the full Contract Year following the Contract Year in which the change was proposed.

44.22 Where recording changes are agreed and implemented in respect of Services to which national prices apply and where financial adjustments are made as described above, commissioners should complete and submit Local Variation templates to NHS Improvement. These should also be included within the local contract at Schedule 3B, giving a record which the parties can refer to of what has been agreed.

44.23 For 2017/18, therefore, for changes which are notified up to and including 30 September 2016:

- If a change is implemented with effect from 1 April 2017 or later, the financial impact is neutralised for the whole of the 2017/18 Contract Year.
- If a change is implemented before 1 April 2017, the financial impact is neutralised for the relevant part of the 2016/17 Contract Year and for the whole of the 2017/18 Contract Year.

44.24 Any proposed changes which are notified after 30 September 2016 will be too late for implementation from 1 April 2017 (unless the party not proposing the change agrees that it can go ahead then). They should instead be re-submitted for the following year (that is, by 30 September 2017), with a consequent delay in potential implementation, if agreed, and full financial impact.

44.25 The default position under the Contract is that the financial impact of each agreed counting and coding change must be neutralised for a limited period, as described above. Having reviewed the agreed changes for a particular Contract Year, commissioner and provider may consider that their overall impact will be broadly neutral and may then agree locally not to make any financial adjustments – but this can only be done where both parties agree.

44.26 It is not always easy to quantify in advance the financial impact of counting and coding changes. The financial adjustments referred to above should therefore be kept under review as the Contract Year progresses, to check that the actual impact is in line with the expected impact. Where this is not the case, the level of financial adjustment should be amended in-year to reflect the actual impact, as accurately as this can reasonably be established.

44.27 If, for any reason, implementation of an agreed change is delayed materially beyond the normal implementation date of 1 April, the provider must inform the

commissioner. If the delay is expected to extend beyond 30 September, then – as part of the process for notifying proposed changes for the following year – the party which proposed the change should re-state its expectation that this particular agreed change will be implemented. (A delay in implementation does not mean that the requirement for financial neutralisation should be extended; if an agreed change originally intended to be implemented on 1 April 2017 is actually only implemented on 1 April 2018, the party adversely affected has already had a year's protection against the financial impact, so the financial impact can take full effect from 1 April 2018.)

Counting and coding changes for services with local prices

44.28 The provisions relating to counting and coding changes are of most relevance where services are being provided at National Prices. With services covered by Local Prices:

- the requirement for prior notification of proposed changes applies (so that neither party can be financially disadvantaged by application of an in-year counting change);
- the impact of any proposed counting changes should be considered as part of the review of Local Prices for the following year, with the likely outcome being that the Local Price will be rebased to reflect the revised activity levels implied by the different approach to recording – this will have the effect of ensuring that any change is financially neutral;
- there is no requirement to submit Local Variations to NHS Improvement.

Changes identified only after implementation / failure to notify changes

44.29 The underlying requirement in SC28.7 is that activity should be recorded correctly as required under relevant national guidance (the NHS Data Dictionary, for instance). Technically, therefore, a commissioner could take the view that any instance of systematically inaccurate counting and coding amounted to an Information Breach by the provider.

44.30 For the provider, therefore, the correct response on identifying such an instance is to notify the commissioner immediately of a proposed counting and coding change. By doing so, the provider is taking the appropriate action under the Contract to rectify the Information Breach, and the commissioner will therefore not be in a position to apply the financial sanction available for Information Breaches.

44.31 Equally, where a provider becomes aware only after the event that a change in recording practice has taken place, it must also notify the commissioner at once, identifying the financial impact of the change. In such a case, or where the commissioner can itself demonstrate that a provider has implemented a counting and coding change without proper notification under SC28, the commissioner:

- is likely to be justified in challenging payment in respect of any adverse financial impact for itself of the revised recording basis, both prospectively (until

such point as proper notification of the change has taken place and the necessary period of financial neutrality has been enforced, as required under SC28) and retrospectively (but only to the extent allowed by the timescales for validation and challenge of invoices and reconciliation accounts set out in SC36); and

- may wish to seek further retrospective redress, if necessary, using the provisions of GC11.2 (Liability and Indemnity).

Counting and coding changes and financial reconciliation and audit

44.32 In other respects, care must be taken to distinguish between:

- issues which a commissioner may legitimately challenge through the financial reconciliation process in SC36 and the audit process in GC15; and
- situations where the appropriate action is for the commissioner to propose a recording change under SC28.

44.33 Legitimate challenges under SC36 / GC15 may focus, for example, on inaccuracies in recording at individual patient level, allocating patients to the wrong commissioner, double-counting or inaccurate calculations. But where the commissioner questions a historically-established, systematically-adopted recording approach by a provider, use of which has informed the Expected Annual Contract Value agreed by both parties, then the correct approach will be for this to be handled as a proposed recording change under SC28, rather than as an issue to be handled in-year under SC36 or GC15.

Conclusion

44.34 It is important that data quality and accuracy continue to improve, and we recognise that it can be difficult to distinguish between gradual improvements in the accuracy of recording, based on better coding at individual patient level, and more systematic changes. And quantifying in advance the expected impact of proposed counting and coding changes is not always a precise science. Good management of potential counting and coding changes will therefore rely on a reasonable approach from both commissioner and provider at local level. Both should work to the common goal that – while in the long term the provider should be reimbursed in relation to accurately recorded activity – the aim of the contractual provisions on notification and financial impact of counting and coding changes is to avoid short-term financial gains or losses to either party.

45 Contract management

*The provisions in the **shorter-form Contract** for contract management are very significantly simplified. Either party may issue a Contract Performance Notice, and the parties may then agree and must subsequently implement appropriate remedial actions.*

Contract review process

- 45.1 The contract review process is set out in GC8 (Review).
- 45.2 The necessary frequency of reviews will generally depend on the subject matter and 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. (Under the shorter-form Contract, we expect review meetings to be held as and when required, rather than on a fixed schedule.)
- 45.3 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. Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the quality and Information schedules.
- 45.4 Either party may call an emergency review meeting at any time. Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.
- 45.5 The review process will be used to agree any amendments for each contract year.

Contract management process

- 45.6 The stages of the contract management process are set out in the flowchart overleaf, but we have also clarified some points below about the way in which the process is intended to work.

Informal queries and Contract Performance Notices:

- 45.7 Factual queries to aid understanding should normally be handled informally between the parties or, if necessary, more formally under SC28. By contrast, the formal Contract Management process is initiated through a Contract Performance Notice when either party has a clear understanding that the other has, or may have, breached a contractual obligation.

Joint Investigations:

- 45.8 Where a Contract Performance Notice has been discussed and is not withdrawn, the default position is that a Remedial Action Plan (RAP) is agreed (and/or, if the safety of patients, staff or the public is at risk, an Immediate Action Plan is implemented). However, where there is disagreement between the parties about whether either form of action plan is required, they must undertake a Joint Investigation (to be completed within two months).

Exception Reports:

- 45.9 GC9 makes provision for the issue of an Exception Report where a party has breached the requirements of a RAP. Exception Reports offer the opportunity for the injured party to set out formally, to the highest management tier within the other party, the contractual requirement which has been breached and the

remedial action which is urgently required.

45.10 GC9 gives the co-ordinating commissioner the power to withhold funding following the issue of an Exception Report – see 45.12 below.

Remedial Actions Plans and financial consequences:

45.11 A RAP may set out both actions to be undertaken and improvements to be achieved and maintained, with the RAP setting out required timescales for each.

45.12 Clearly, the intention of a RAP is that it leads to remedy of the contractual obligation that has been breached. But the Contract sets out provisions which apply where this is not the outcome.

- By agreement, a RAP may include reasonable and proportionate financial consequences (on either the provider or the commissioners) which are to be applied where the actions / outcomes set out in the RAP are not undertaken / achieved as the RAP requires. Where this is the case, these financial consequences may be applied immediately the breach of the RAP is clear. No Exception Report is required in order for these financial consequences to be exercised.
- Alternatively, where no immediate financial consequences are agreed as part of the RAP itself and where the provider breaches the RAP, the co-ordinating commissioner has the opportunity under GC9 to issue an Exception Report. The co-ordinating commissioner may at this point withhold funding (“a reasonable and proportionate sum of up to 2% of the Annual Monthly Value” in respect of each action not completed or improvement not met, “subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value”). Following issue of the Exception Report, the Contract then allows the provider a further 20 Operational Days to resolve the breach of the RAP, following which the co-ordinating commissioner may permanently retain, at its discretion, the sums it has previously withheld.

45.13 The intention of these revised provisions is a) to emphasise that financial consequences should be reasonable and proportionate and b) to create a greater incentive for specific, appropriate financial consequences to be agreed between the parties as part of RAPs, rather than encouraging reliance on the broader provisions for withholding of up to 2% of Annual Monthly Value.

GC9 and breaches of Quality Requirements:

45.14 Where the provider breaches the national quality standards set out in Schedules 4A and 4B, the commissioner must automatically apply the relevant financial sanctions; sanctions may also be agreed and applied in relation to Local Quality Requirements in Schedule 4C. There is no requirement for the commissioner to go through the process in GC9 in order to apply these sanctions (see GC9.1).

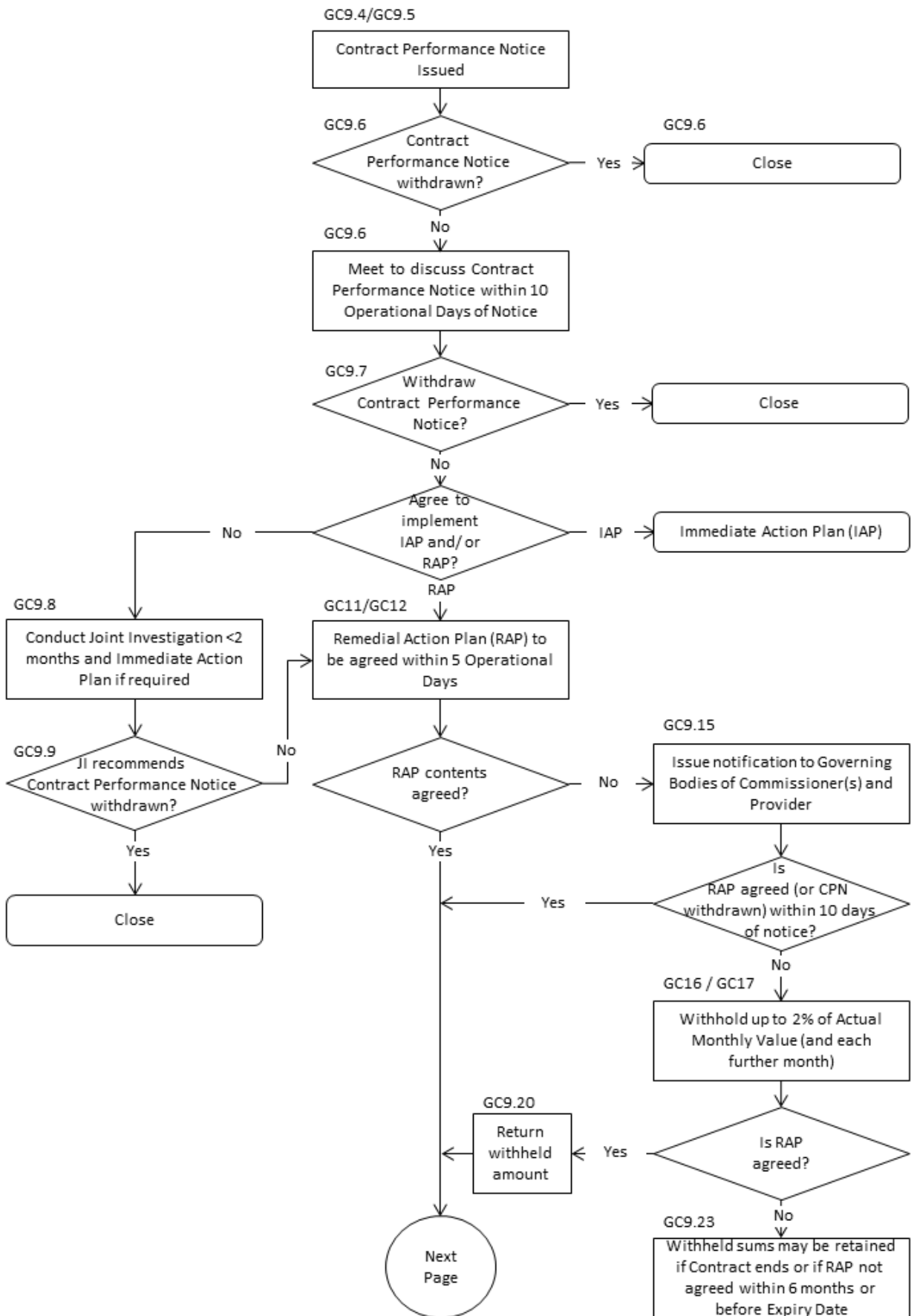
45.15 It is also important to stress that application of the sanctions set out in Schedules 4A, B and C does not remove the commissioner’s right to use GC9 to seek remedy of breaches of Quality Requirements. It will often be appropriate for a

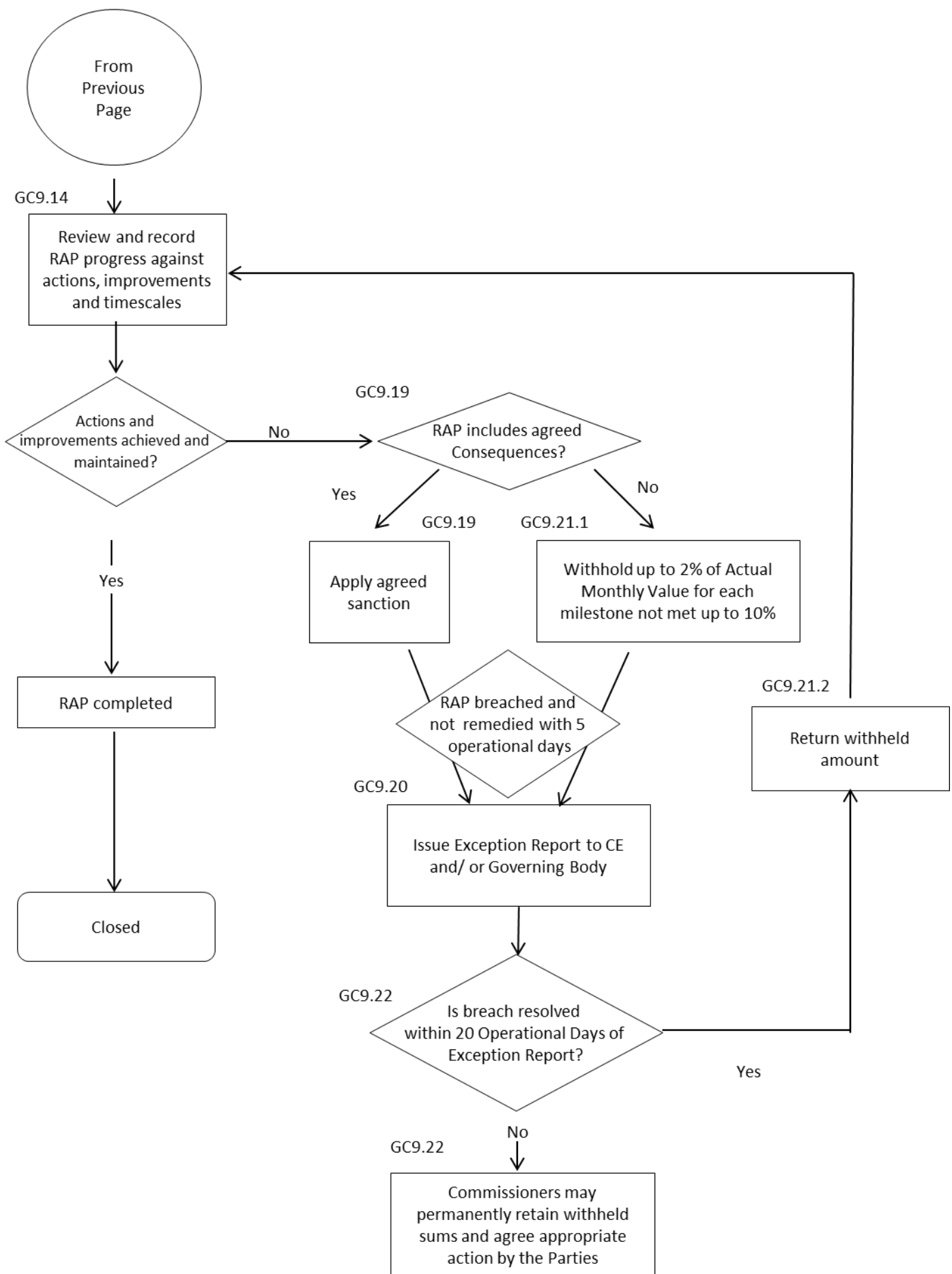
RAP to be agreed to put right breaches of Quality Requirements, and commissioners may use the provisions of GC9 to apply further financial consequences for breach.

Breach of new national requirements in the Contract

- 45.16 The annual update of the NHS Standard Contract typically introduces a range of new policy requirements. Not all providers will be in a position to comply fully with all such requirements from the first day on which the new Contract takes effect. Where this is the case, commissioner and provider should discuss a prompt, but realistic, timescale for implementation, with this recorded in the local contract as a Remedial Action Plan or Service Development and Improvement Plan if required.

GC9 (full-length Contract) – contract management





46 Payment

*The payment provisions in the **shorter-form Contract** are similar to those in the full-length version, but omit certain details.*

46.1 This section describes the contractual processes and schedules relating to the making of payments between the parties.

Payment schedules

46.2 Agreed local details relating to payment are recorded in Schedule 3. Not all of the sub-schedules with Schedule 3 will need to be completed for every contract.

- Schedule 3A records Local Prices (including details of the basis on which payment is made for each Service – block payment, activity-based, marginal rate etc.). In the case of a contract covering more than one Contract Year, there is now a specific provision for the parties to record within Schedule 3A any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years.
- Schedules 3B and 3C record any Local Modifications and Local Variations to National Prices (in the format in which these must be submitted to NHS Improvement).
- Schedule 3D records the Agreed Baseline Value for the Marginal Rate Emergency Rule, and Schedule 3E the Agreed Threshold for Emergency Re-admissions within 30 Days (both acute providers only).
- Schedule 3F sets out the Expected Annual Contract Value (EACV). This is the figure on which any core contractual payment on account is based and should exclude expected CQUIN payments – see 40.12 above.
- Schedule 3G allows for recording of timing of payments in the first or final contract year.

46.3 There is no separate schedule for risk-sharing agreements to be recorded in the Contract, as there would be potential for confusion between this and the provisions for Local Variations (see above). Any agreements to share financial risk in relation to services covered by National Prices should be recorded as Local Variations. 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).

46.4 Note that NHS Improvement and NHS England have published [Local Payment Design Examples on multi-lateral gain and loss-sharing](#).

Invoicing, payment and reconciliation

- 46.5 Detailed arrangements for invoicing, payment and financial reconciliation are set out in SC36 and in the flowcharts below.
- 46.6 These arrangements vary between contracts depending on two parameters:
- **EACV agreed / not agreed.** Where there is an agreed EACV, the provider invoices the commissioner on-account and the commissioner makes up-front payments. The provider then submits reconciliation accounts to the commissioner, adjusting for any difference between the expected payment and the actual sum due (for example because of variation in activity levels). Where there is no agreed EACV (or the EACV is zero), the provider invoices retrospectively for activity undertaken. (Clearly, where payment works on a simple block basis, no reconciliation is necessary.)
 - **SUS applies / does not apply.** Where the provider provides any Services for which data must be submitted to SUS, then a two-stage reconciliation process (commonly referred to as “flex and freeze”) applies for all the Services provided under the contract (SC36.28 to 36.31), with the provider submitting to the commissioner both a first and a final reconciliation account, in accordance with the national SUS process and timeline. Where SUS is not relevant to any of the Services, the provider only submits a single reconciliation account (SC36.32).
- 46.7 Note that payments to providers to be made from the Sustainability and Transformation Fund should not be included within the EACV. These amounts are not payments for services under the Contract, they are separate pass-through payments. They do not attract CQUIN.
- 46.8 Later in the year, NHS Digital will publish an updated SUS [PbR Submission Timetable](#), which will set out specific timescales for data submission and reconciliation in 2017/18.
- 46.9 Throughout SC36, the onus is on the provider to submit invoices and reconciliation accounts and on the commissioner to validate these, paying uncontested elements promptly in line with the timescales set out in the Contract and challenging any contested elements through the process set out in SC36.45. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.

Payment of CQUIN

- 46.10 As described in paragraph 46.2 above, expected CQUIN payments should not be included within the EACV in Schedule 3F. Rather (under the full-length Contract), agreed payments on account in respect of CQUIN can be set out in Table 2 of Schedule 4D (CQUIN). The level of any CQUIN payment on account is for local agreement. Providers then invoice separately on account for CQUIN under SC38.2. (Under the shorter-form, payment of CQUIN is annual in arrears.)
- 46.11 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% CQUIN value would be non-material, rather than develop a specific CQUIN scheme.”

46.12 Where commissioners do choose to adopt this approach, they should:

- note within the CQUIN Schedule (4D) that this is the approach being taken; and
- ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed at full value (that is, including any value which would otherwise have been paid as CQUIN).

46.13 A separate financial reconciliation operates in respect of CQUIN, as set out in SC38.10 to 38.14. Again, the onus is on the provider to report its performance against the agreed CQUIN scheme at agreed intervals and to submit reconciliation accounts for the commissioner to validate.

Charging overseas visitors and migrants

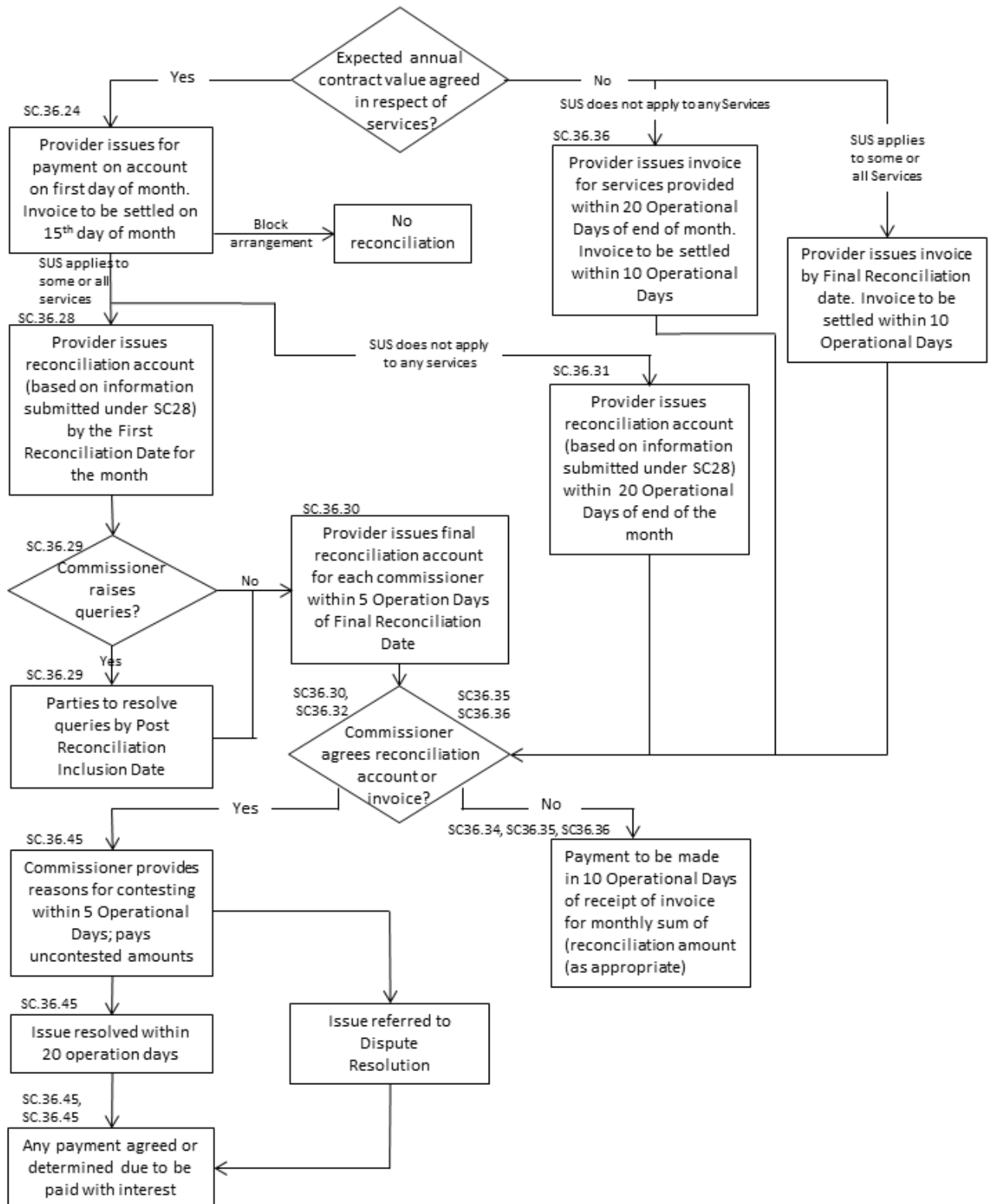
46.14 SC36.41 (full-length Contract) / SC36.21 (shorter-form) contains requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the Regulations and guidance governing this area.

46.15 In summary, in those situations where overseas patients are liable to charges, under the new regime, providers are to charge 150% of the tariff or local price for the relevant treatment. Commissioners are to pay at 75% of tariff or local price pending recovery from the overseas patient. If payment is recovered, the provider will refund that 75% payment to the commissioner and retain the balance; if it fails to recover payment from the patient, liability for the cost of treatment (at tariff or the agreed local price) is effectively shared 75% / 25% between commissioner and provider.

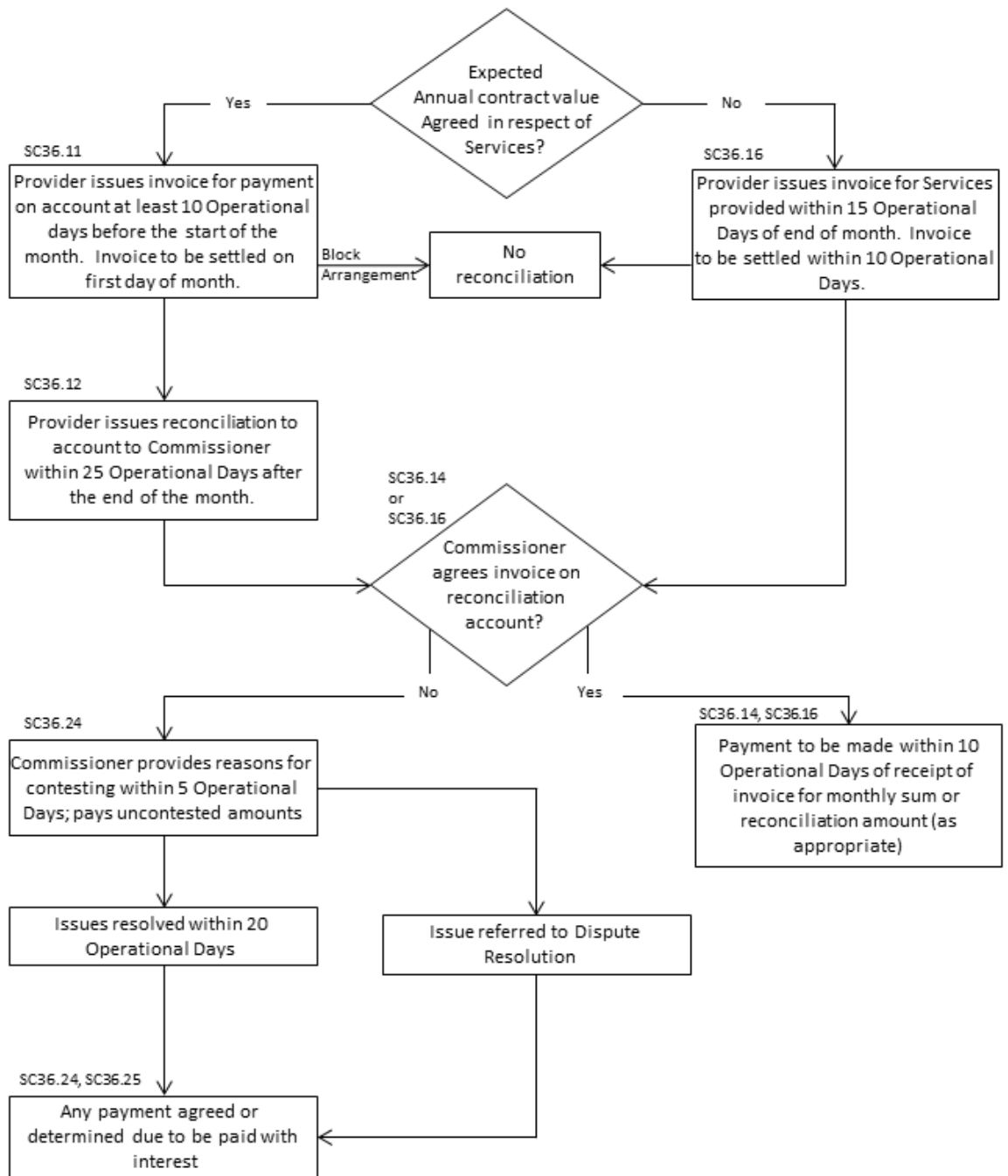
46.16 If, however, the provider fails to take appropriate steps to identify an overseas visitor liable to charges for NHS services, or fails to take reasonable steps to recover payment, liability for cost of all chargeable treatment for that patient falls on the provider.

46.17 It may often take some time for providers to recoup charges from overseas patients – or for patients to provide definitive evidence that they are exempt from charges. It will therefore generally be sensible for commissioners and providers, by local agreement, to apply the reconciliation timescales set out in SC36 in a more flexible way in respect of such patients. This will allow more time for the correct payments to be assessed and made – enabling providers to make the 75% refunds to commissioners described above, or to apply the full 100% charge to the commissioner in a situation where a patient has, after some delay, confirmed their charge-exempt status.

SC36 (full-length Contract): Payment and Reconciliation



SC36 (shorter form Contract): Payment and Reconciliation



47 Other contractual processes

*The provisions in the **shorter-form Contract** for variation, dispute resolution, suspension of services, termination of the contract and exit arrangements are all significantly abbreviated and simplified. Where necessary, additional locally-agreed requirements may be included at Schedule 2G. As with the full-length version, optional provisions relating to staff pensions rights can be included within the shorter-form Contract at Schedule 7 where necessary.*

Variation

- 47.1 Arrangements for varying the NHS Standard Contract are set out in GC13 (Variations). Not all elements of the NHS Standard Contract may be varied (GC13.2), and it is essential that commissioners and providers do not vary the nationally-mandated terms of the Contract. The permissible scope for variations is now as set out in Appendix 5 to this Guidance, rather than being listed in detail within the Definitions in the General Conditions.
- 47.2 NHS England may issue mandatory National Variations. This is typically done on an annual basis, so that longer-term contracts can be updated to take account of changes to nationally-mandated terms and conditions through the updated NHS Standard contract for the coming year. Commissioners should always seek to implement National Variations, and failure by the provider to accept a National Variation is grounds for termination of the contract with three months' notice (GC13.13 in the full-length Contract, GC13.4 in the shorter-form). Guidance on 2017-19 National Variations and a template Variation Agreement to update existing contracts to the 2017-19 form will be published shortly on the NHS Standard Contract [2017/18 web page](#).
- 47.3 Commissioners and providers may of course also agree locally-initiated Variations. The process for this is straightforward. In summary, the issuing party submits a draft Variation Agreement to the receiving party (a template is provided on the NHS Standard Contract [2017/18 web page](#)). The receiving party responds within ten operational days; there is discussion as necessary, and, if agreed, the final Variation Agreement is then signed by the co-ordinating commissioner and the provider, as set out at paragraph 15 above.
- 47.4 There is no specific period of notice which must be given for locally-initiated Variations. Rather, the agreed timescale for implementation should be set out in the Variation Agreement and should reflect the complexity of the issues involved and the time realistically needed to implement the specific changes proposed – and, of course, when the parties wish the changes to take effect.
- 47.5 As with National Variations, acceptance of a locally-initiated Variation by the provider cannot be compelled – but, where such a Variation is refused, the commissioner has the option to terminate, with notice, the specific Services affected (GC13.14) (or, in the case of the shorter-form Contract, to terminate the Contract altogether under GC17.2).

- 47.6 Whenever a contract is being varied, the parties must ensure that they use as the starting point for that Variation the latest version of the contract (which may be the original contract or the contract as most recently updated by a signed and dated Variation Agreement). Parties to a contract should not progress more than one Variation to it – local or National – in parallel or in competition with another, as doing so is likely to result in confusion and, potentially, dispute as to the terms of each proposed Variation and of the contract itself.
- 47.7 For this reason, if a National Variation is mandated by NHS England while a local Variation is in process, the ongoing local Variation should be put on hold, as the National Variation must take precedence. If the local Variation is then re-initiated as a new Variation, it will take as its starting point the contract as varied by the National Variation. Alternatively, the parties may agree to effect both Variations together – in other words, to incorporate the matters to be covered by the proposed local Variation into the Variation Agreement effecting the National Variation.
- 47.8 Locally-initiated Variations, involving only changes to particular contract schedules, will not normally be processed using the eContract system. However, where a Variation involves the provision of a new service – meaning that a different combination of the provisions of the Service Conditions and Particulars will now apply to the provider – or another change to the eContract selections which created the tailored Service Conditions and Particulars for the contract, the commissioner should use the eContract system to generate revised documentation, based on an updated selection of service categories (but, of course, retaining the term of the original contract, as this will be a continuation of the existing contract not a new contract). This revised set of Service Conditions and Particulars should then be referred to in and appended to the Variation Agreement to be signed by the Co-ordinating Commissioner and the Provider (or, if the contract being varied is a pre-14/15 contract, by all commissioners and the provider).
- 47.9 Where the parties are seeking to implement the annual National Variation to a longer-term contract, they may do so by retaining their existing contract and using the long-form National Variation Agreement template (shortly to be published on the NHS Standard Contract [2017/18 webpage](#)). They may, instead, wish to do so simply by adopting the 2017-19 NHS Standard Contract in full.
- 47.10 In this case, the co-ordinating commissioner can use the eContract system in the normal way to generate an updated set of Particulars and Service Conditions – again, retaining the term of the original contract, as this will be a continuation of the existing contract, not a new contract. This updated set of Service Conditions and Particulars, and the new General Conditions, will then be referred to in, and appended to, a brief National Variation Agreement to be signed by the Co-ordinating Commissioner and the Provider (or, if the contract being varied is a pre-2014/15 contract, by all commissioners and the provider). As noted above, guidance on the process for 2017/18 National Variations will be issued shortly.
- 47.11 In relation to any variations, commissioners should take into account the provisions of regulation 72 of the Public Contract Regulations 2015, which limit the extent and scope of variations which may be made to existing contracts without

re-advertising the contract. The parties should seek their own legal advice before proceeding with any Variation which might be caught by regulation 72.

Dispute resolution

- 47.12 The dispute resolution procedure (GC14) requires the parties in dispute to try to resolve their differences by negotiation, escalating to senior managers and then board-level representatives as required. If the dispute remains unresolved, the parties must refer it to mediation, under which the appointed mediator will attempt to facilitate the agreement of a satisfactory settlement of the dispute. The mediation will be arranged jointly by NHS Improvement and NHS England where the provider is an NHS Trust, and will be by CEDR or another independent body in other cases.
- 47.13 If mediation fails to resolve matters, the dispute must be referred to an independent expert for determination. The expert's ruling on the dispute will be binding on the parties.
- 47.14 The dispute resolution process at GC14 applies only once a contract has been signed. As outlined in paragraph 23.1, NHS England and NHS Improvement has published [joint guidance](#) on the resolution of disputes relating to the agreement of new contracts for 2017/18 between NHS commissioners and providers.

Suspension

- 47.15 The provisions governing suspension of services are set out in GC16. It is worth commissioners reminding themselves of the scope which these provisions give to require a suspension, particularly when concerned about patient safety.
- 47.16 If commissioners and/or a regulatory body are concerned about the quality or outcomes of services being provided, or that the provider may not be meeting legal requirements (including, now, its duties in respect of the Fundamental Standards of Care), or about patient safety more generally, they should consider using commissioners' powers to require a suspension of services under the provider's contract. Services may be suspended until the provider is able to demonstrate that it can and will provide services to the required standard.
- 47.17 If considering exercise the right to require suspension of services on such grounds, commissioners should consider liaising with others commissioning services from the same provider, and of course with the regulatory authorities, with a view to acting in a concerted and consistent manner

Termination

- 47.18 The provisions for termination in GC17 cover different circumstances under which the contract may be terminated – for commissioner default, provider default or where there is no fault.

No fault termination (GC17.1 – 17.8) (GC17.1 – 17.3 in the shorter-form)

- 47.19 GC17 now makes explicit the ability of the parties to terminate the contract at any time by mutual consent.

- 47.20 It also now provides for greater flexibility in the notice period required for either the provider or the co-ordinating commissioner (on behalf of all commissioners) to terminate the contract, or a particular service, in circumstances where neither is at fault. The notice period required for no fault termination is now for local agreement (at the outset of the contract).
- 47.21 Under the full-length Contract, different periods of notice may be agreed for provider-instigated and co-ordinating commissioner-instigated termination and the parties may agree that the right to terminate voluntarily may not take effect before a specific date (i.e. that the contract must be allowed to run for at least a set period of time before being terminated),
- 47.22 See paragraphs 47.2 and 47.5 above in relation to termination where the provider refuses to accept a variation to the contract.
- 47.23 Under GC17.8 (GC17.3 in the shorter-form), there is a right for the co-ordinating commissioner to terminate (on a no-fault basis) in specific circumstances as required by the Public Contracts Regulations.

Termination for commissioner default (GC17.9) (GC17.4 in the shorter-form)

- 47.24 As under past contracts, the provider may terminate the contract (as a whole or in respect of the relevant commissioner only) in the event of significant late payment or material breach on the part of a commissioner.

Termination for provider default (GC17.10) (GC17.5 in the shorter-form)

- 47.25 The grounds of provider default, on which the co-ordinating commissioner (on behalf of all commissioners) may terminate the contract or a service remain much as under past contracts (in abbreviated form in the shorter-form).

Consequences of expiry or termination

- 47.26 GC18 contains provisions governing what is to happen when the contract expires or is terminated, the primary objective of which is to ensure that the parties act in such a way as to effect a smooth transition of services and provider, with least inconvenience or risk to patients.
- 47.27 This may involve the agreement (on or just before expiry or termination) of a Succession Plan (which might deal with patient handover, staffing matters, handover of premises and equipment and so on) with a new provider, and if so, all parties will be required to comply with their obligations under that plan.

Exit arrangements

- 47.28 The parties may agree, at the outset of the contract, more wide-ranging actions and consequences to take effect on expiry or termination of the contract. These may include:
- arrangements in relation to staff and TUPE, supplementing the provisions of GC5;

- arrangements for transfer of freehold or leasehold premises, or of major items of equipment;
- requirements for exit payments to be made by commissioners or by the provider, depending on the circumstances in which the contract (or provision of a service) comes to an end;
- arrangements for the secure transfer of active and inactive Service User Health Records to the incoming Provider or to any third party Provider.

47.29 Any such arrangements should be set out, as clearly as possible, in Schedule 2I (Exit Arrangements) (or Schedule 2G (Other Local Agreements, Policies and Procedures of the shorter-form Contract)).

47.30 GC18.2 provides a right for commissioners, if the contract or a service is terminated for provider default, to recover from the provider additional costs they incur (over and above what they would have paid the provider) to secure provision of the relevant services for 6 months following termination.

47.31 Commissioners may feel it appropriate (depending on the nature of the contract and the relationship with the provider) to supplement this provision by including in Schedule 2I (or Schedule 2G of the shorter-form Contract) requirements for:

- payment of additional compensation by the provider in the event of termination for provider default, or of voluntary termination by the provider;
- payment of compensation by commissioners to the provider in the event of termination for commissioner default, or of voluntary termination by the commissioners (for example, to compensate the provider for otherwise irrecoverable capital expenditure incurred in the expectation of the contract running its full term).

47.32 Commissioners should consider taking expert legal and financial advice before agreeing exit arrangements and should refer to [Treasury guidance](#).

TUPE (Transfer of Undertakings (Protection of Employment))

47.33 Note that, for 2016/17, we removed the obligation on commissioners – at GC5.16 in the 2015/16 Contract – to use reasonable endeavours to procure TUPE indemnities from an incoming provider in favour of the outgoing provider. This is because the “chain” of indemnities from outgoing and incoming providers (now at GC5.12 to 5.14) is now well-established: incoming and outgoing provider are given rights to enforce those indemnities directly by GC29 (Third Party Rights).

New Fair Deal for staff pensions

47.34 The Department of Health has published [guidance](#) on the treatment of staff pensions on the transfer of staff from public bodies to the independent sector. The NHS Standard Contract includes provisions in line with 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 Provider Default Event (GC17.10.15, GC17.5.6 in the shorter-form), 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;
- Schedule 7 (Pensions), at which commissioners may (in the appropriate circumstances – i.e. where TUPE applies to transfer NHS staff to an independent sector provider or sub-contractor) include further provisions (template available at <https://www.england.nhs.uk/nhs-standard-contract/16-17/>) 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 of termination of the contract or Services.

Liability and Indemnity

- 47.35 GC11 (Liability and Indemnity) imposes mutual obligations on commissioner and provider to indemnify the other in respect of costs and claims for personal injury and damage to property arising from their negligence or breach of contract.
- 47.36 The provider is required to put in place appropriate indemnity cover, whether under CNST or other risk pooling arrangements or under commercial insurance, in respect of its potential liabilities as employer, and to the public, and for clinical and professional negligence liability to Service Users.
- 47.37 In relation to the latter, it is very important that cover is maintained to meet claims made after (sometimes long after) a Contract expires or is terminated in respect of treatment delivered under it. That is why GC11.7 (GC11.3 in the shorter-form Contract) requires the provider to ensure that its indemnity arrangements remain in force “until...liability may reasonably be considered to have ceased” (in other words, until the statutory limitation periods on potential claims have expired).
- 47.38 We have, at the request of the Department of Health and the NHSLA, added, as GC11.8 (GC11.5 in the shorter-form Contract), an additional requirement to support that existing obligation to ensure that “run-off” cover is in place. The provider must provide evidence that this cover is in place, and if it fails to do so the commissioners may put cover in place themselves (which they would do by paying the appropriate additional contribution to NHSLA for CNST cover) and charge the

provider for the costs they incur in doing so. This is to address concerns that a provider may go out of business leaving “uninsured” potential claims for its clinical negligence, and both Service Users and the public purse therefore at risk.

48 Status of this guidance

- 48.1 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.
- 48.2 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.

49 Advice and support

- 49.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact nhscontractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general
- 49.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.

Appendix 1

Clause-by-clause guide to changes (full-length and shorter-form)

This Appendix is intended to give a simple clause-by-clause guide identifying what has changed and what has stayed the same for 2017-19 when compared to the 2016/17 Contract. Few changes have been made to the shorter-form Contract, and these are shown below by exception. (Delta View comparison documents showing changes made to the Service Conditions and the General Conditions for 2017-19 will also be made available on the [NHS Standard Contract 2017/18 webpage](#).)

Particulars

Schedule	Changes	
	from 16/17 final to 17-19 draft	from 17-19 draft to 17-19 final
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM		
A. Conditions Precedent	No change	No change
B. Commissioner Documents	No change	No change
C. Extension of Contract Term	Minor changes	No change
SCHEDULE 2 – THE SERVICES		
A. Service Specifications	Minor changes	No change
A1. Specialised Services – Derogations from National Service Specifications	No change	No change
B. Indicative Activity Plan	Minor changes	No change
C. Activity Planning Assumptions	Minor changes	No change
D. Essential Services	No change	No change
E. Essential Services Continuity Plan	No change	No change
F. Clinical Networks	No change	No change
G. Other Local Agreements, Policies and Procedures	Minor changes	Changed
H. Transition Arrangements	No change	No change
I. Exit Arrangements	No change	No change
J. Transfer of and Discharge from Care Protocols	No change	No change
K. Safeguarding Policies and MCA Policies	No change	No change
L. Provisions applicable to Primary Care Services	No change	No change
SCHEDULE 3 – PAYMENT		
A. Local Prices	Minor changes	No change
B. Local Variations	Minor changes (added to SF)	No change
C. Local Modifications	Minor changes (added to SF)	No change
D. Marginal Rate Emergency Rule: Agreed	No change	No change

Baseline Value		
E. Emergency Re-admissions Within 30 Days: Agreed Threshold	No change	No change
F. Expected Annual Contract Values	Minor changes	No change
G. Timing and Amounts of Payments in First and/or Final Contract Year	No change	No change
SCHEDULE 4 – QUALITY REQUIREMENTS		
A. Operational Standards	Minor changes	No change (SF changed)
B. National Quality Requirements	Minor changes	Changed
C. Local Quality Requirements	No change	No change
D. Commissioning for Quality and Innovation (CQUIN)	Minor changes	No change (SF changed)
E. Local Incentive Scheme	No change	No change
F. Clostridium difficile	No change	No change
G. CQUIN Disapplication	Changed	Deleted
SCHEDULE 5 – GOVERNANCE		
A. Documents Relied On	No change	No change
B1. Provider's Mandatory Material Sub-Contractors	No change	No change
B2. Provider's Permitted Material Sub-Contractors	No change	No change
C. Commissioner Roles and Responsibilities	No change	No change
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS		
A. Reporting Requirements	Minor changes	Changed
B. Data Quality Improvement Plan	No change	No change
C. Incidents Requiring Reporting Procedure	No change	No change
D. Service Development and Improvement Plan	Significant changes	No change
E. Surveys	No change	No change
SCHEDULE 7 – PENSIONS		
	No change	No change
SCHEDULE 8 – TUPE		
	NA	No change

Service Conditions

Clause number	Changes	
	from 16/17 final to 17-19 draft	from 17-19 draft to 17-19 final
SC1 Compliance with the Law and the NHS Constitution	No change	No change
SC2 Regulatory Requirements	No change	No change
SC3 Service Standards	Significant changes	Changed
SC4 Co-operation	Changed	No change
SC5 Commissioner Requested Services/Essential Services	No material change	No change
SC6 Choice, Referral and Booking	Significant changes	Changed
SC7 Withholding and/or Discontinuation of Service	No change	No change
SC8 Unmet Needs and Making Every Contact Count	Changed (incl SF)	No change
SC9 Consent	No change	No change
SC10 Personalised Care Planning and Shared Decision Making	Changed (incl SF)	Changed (incl SF)
SC11 Transfer of and Discharge from Care	Significant changes (incl SF)	Significant changes
SC12 Communicating With and Involving Service Users, Public and Staff	Significant changes	Changed
SC13 Equity of Access, Equality and Non-Discrimination	Changed	No material change
SC14 Pastoral, Spiritual and Cultural Care	No change	No change
SC15 Places of Safety	No change	No change
SC16 Complaints	No change	No change
SC17 Services Environment and Equipment	No change	No change
SC18 Sustainable Development	No change	Changed
SC19 Food Standards	Options for change flagged	Changed
SC20 Service Development and Improvement Plan	No change	No change
SC21 Antimicrobial Resistance and Healthcare Associated Infections	No change	No change
SC22 Venous Thromboembolism	No change	No change
SC23 Service User Health Records	Significant changes (incl SF)	Significant changes
SC24 NHS Counter-Fraud and Security Management	No change	No change
SC25 Procedures and Protocols	No change	No change
SC26 Clinical Networks, National Audit Programmes and Approved Research Studies	No change	No change
SC27 Formulary	No change	No change
SC28 Information Requirements	No material	No change

	change	
SC29 Managing Activity and Referrals	Significant changes	Significant changes
SC30 Emergency Preparedness, Resilience and Response	No change	No change
SC31 Force Majeure: Service-specific provisions	No change	No change
SC32 Safeguarding, Mental Capacity and Prevent	Changed (incl SF)	No change
SC33 Incidents Requiring Reporting	No change	No change
SC34 Care of Dying People and Death of a Service User	No material change	No change
SC35 Duty of Candour	No change	No change
SC36 Payment Terms	Changed (esp SF)	Changed (incl SF)
SC37 Local Quality Requirements and Quality Incentive Schemes	No change	No change
SC38 Commissioning for Quality and Innovation (CQUIN)	Changed (incl SF)	Changed (incl SF)

General Conditions

Clause number	Changes	
	from 16/17 final to 17-19 draft	from 17-19 draft to 17-19 final
GC1 Definitions and Interpretation	No change	No change
GC2 Effective Date and Duration	No change	No change
GC3 Service Commencement	No change	No change
GC4 Transition Period	No material change	No change
GC5 Staff	Changed	Minor changes
GC6 Intentionally Omitted	No change	No change
GC7 Intentionally Omitted	No change	No change
GC8 Review	No change	No change
GC9 Contract Management	Changed (incl SF)	No change
GC10 Co-ordinating Commissioner and Representatives	No change	No change
GC11 Liability and Indemnity	No change	No change
GC12 Assignment and Sub-Contracting	No change	Minor changes
GC13 Variations	No material change	No change
GC14 Dispute Resolution	No change	No change
GC15 Governance, Transaction Records and Audit	Changed (incl SF)	No change
GC16 Suspension	No change	No change
GC17 Termination	No material change	No change
GC18 Consequence of Expiry or Termination	No change	No change
GC19 Provisions Surviving Termination	No change	No change
GC20 Confidential Information of the Parties	No change	No change
GC21 Patient Confidentiality, Data Protection, Freedom of Information and Transparency	Changed (incl SF)	Changed
GC22 Intellectual Property	No change	No change
GC23 NHS Identity, Marketing and Promotion	No change	No change
GC24 Change in Control	No change	No change
GC25 Warranties	No change	No change
GC26 Prohibited Acts	No change	No change
GC27 Conflicts of Interest and Transparency on Gifts and Hospitality	Significant change (incl SF)	Minor changes
GC28 Force Majeure	No change	No change
GC29 Third Party Rights	No change	No change
GC30 Entire Contract	No change	No change
GC31 Severability	No change	No change
GC32 Waiver	No change	No change
GC33 Remedies	No change	No change
GC34 Exclusion of Partnership	No change	No change
GC35 Non-Solicitation	No change	No change
GC36 Notices	No change	No change
GC37 Costs and Expenses	No change	No change
GC38 Counterparts	No change	No change
GC39 Governing Law and Jurisdiction	No change	No change

Appendix 2

Summary guide to completing the contract

This Appendix provides a summary of the key elements of the contract which are for local agreement and completion prior 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. CQUIN queries should be directed to the CQUIN help email address at: e.cquin@nhs.net.

Use of the eContract system is recommended although not mandated for creation of local contracts in both full-length and shorter form format. The eContract system allows commissioners to indicate which categories of service are being commissioned under a contract. The Service Conditions and national Quality Requirements that are not applicable to the selected service categories are automatically deleted by the operation of the eContract, resulting in a shorter, more tailored contract which is easier for commissioners and providers to use. Assistance in using the eContract system is available via the User Guide on the portal or at england.econtract@nhs.net. The eContract system can be accessed at <https://www.econtract.england.nhs.uk/Home/>.

The scope of the contract

The NHS Standard Contract (full-length or shorter form) may be used as:

- a multilateral contract 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 i.e. 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:

	<p>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.</p> <p>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.</p>	
	<p>The Particulars contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green'.</p> <p>Action is required on all items that are amber coloured and must be completed prior to signing the contract. The parties must not leave any amber marked element for later completion.</p>	
	<p>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 should be marked as 'not applicable'.</p>	

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

Text in red highlights where the position differs under the shorter-form Contract.

Commissioners should be aware that embedding documents within contracts 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	Enter a local contract reference number or identifier
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 (necessarily) either the date on which it becomes effective or the date of service commencement.
Service Commencement Date	Enter the date when the services actually start delivery. This will usually be 1 April 2017 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 1A) are satisfied, whichever is later. (See further below)
Contract Term	Enter the initial contract term, excluding any potential extension period (which may be stated in Schedule 1C), and the date on which that term begins (usually the Expected Service Commencement Date). Commissioners should refer to paragraphs 17-18 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.digital.nhs.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 5C 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 must not be changed.
Contract	
Signatures	Each Commissioner who is a party to the contract <u>must</u> 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. Refer to paragraph 15 above.

Completion of the tables in the Particulars headed **Service Commencement and Contract Term, Services, Payment and Quality** will determine whether certain of the Service Conditions or Schedules apply to the 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 (i.e. the date on which the rights and obligations on the parties become operational). This will usually be the date of contract, but could be 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 GC17.10.1. The longstop date must not be used to 'park' issues which the parties have not been able to agree by the time of contract signature, for later resolution.
Service Commencement Date	Enter the date when the services actually start delivery. For contracts being renewed for 2017/18 this will usually be 1 April 2017. For new arrangements it 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 1A) are satisfied, whichever is later (obviously in this situation it will not be possible to insert this date at contract signature, so either state TBC or leave blank for confirmation later).
Contract Term	Enter the initial contract term excluding any extension period, and the date on which that term begins (usually the Expected Service Commencement Date).
Option to extend Contract Term	Indicate here whether the Commissioners are to have an option to extend the term of the contract (noting and complying with guidance at paragraph 18 above), and the length of the permitted extension.
Commissioner Notice Period	Enter the Commissioner Notice Period for termination under GC17.2. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)
Commissioner Earliest Termination Date	Enter the earliest date on which a commissioner notice to terminate may take effect. (Not applicable under the shorter form)

GC17.2		
Provider Notice Period GC17.3	Enter the Provider Notice Period for termination under GC17.3. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)	
Provider Earliest Termination Date GC17.3	Enter the earliest date on which a provider notice to terminate may take effect. (Not applicable under the shorter form)	
Notice Period	Enter the notice period for termination by either the Co-ordinating Commissioner or the Provider.	
Service Categories		
<p>Commissioners must select <u>all</u> the categories of service that are to be provided under the contract. Failure to indicate accurately which service categories are applicable will result in uncertainty as to which provisions of the NHS Standard Contract apply or do not apply to the contract in question. When using the eContract, the selection made will drive the content of the Service Conditions.</p> <p>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’.</p> <p>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 34 above for further detail on service categories.</p> <p>Note that the service categories listed in the shorter form are limited to those for which the shorter form may be used.</p>		
Specialised Services		
Services comprise or include Specialised Services commissioned by NHS England	Completing this will determine whether Schedule 2A1 (Specialised Services – Derogations from National Service Specifications), part of Schedule 6A (Reporting Requirements) and SC36.22A apply. (Not applicable under the shorter form)	
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 36 on completion of the Service Specification template. (No template is included in the shorter form)	
Indicative Activity Plan SC29.5, SC29.6, SC29.11A, SC29.12.3A (SC29.3)	Completing this will determine whether Schedule 2B (Indicative Activity Plan) and certain clauses in SC29 apply and appear for completion in the eContract. (The shorter form does not require the Commissioner to indicate whether an IAP applies here, but one may be included if required: see Schedule 2B and SC29.3 of the shorter form)	
Activity Planning Assumptions SC29.7, 29.11A, 29.11B, 29.12.3A, 29.12.3B	Completing this will determine whether Schedule 2C (Activity Planning Assumptions) applies and appears for completion in the eContract, and whether certain provisions of SC29 apply. See also below. (Not applicable under the shorter form)	
Essential Services	Completing this will determine whether Schedule 2D	

SC5	(Essential Services) applies and appears for completion in the eContract, and whether SC5.2 – 5.4 apply. See also below. The concept of Essential Services applies only to NHS Trusts for 2017-19.
Services to which 18-Week applies SC6.4, SC6.5	Completing this will determine whether SC6.4, SC6.5 and parts of Schedule 4 (Quality Requirements) apply and appear in the eContract. Answer 'yes' or 'no'. (Not applicable under the shorter form, as the shorter form must not be used for services to which the 18-week standard applies)
Prior Approval Scheme Response Time Standard SC29.25	Indicate the timescale in which the relevant Commissioner must respond to a requirement for approval for treatment of an individual Service User under a Prior Approval Scheme to the Provider. (Not applicable to the shorter form)
Payment	
National Prices Apply to Some or All Services (including Local Modification and Local Variation) SC36.10-36.19	Indicate whether National Prices (which may have been subject to a Local Modification and / or Local Variation) apply to some or all Services – indicate 'yes' or 'no'. (Applicable to shorter form only)
Local Prices Apply to Some or All Services SC36.3-36.9	Indicate whether Local Prices apply to some or all Services – indicate 'yes' or 'no'. (Applicable to shorter form only)
Expected Annual Contract Value Agreed SC36	Indicate whether an Expected Annual Contract Value has been agreed – 'yes' or 'no'.
SUS applies SC36	Indicate whether SUS applies – 'yes' or 'no'. (Not applicable to the shorter form)
Quality	
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 (Schedule 4F Clostridium Difficile). (Not applicable to the shorter form, as the shorter form must not be used for acute services)
Clostridium Difficile Baseline Threshold	The threshold for each NHS Trust and NHS Foundation Trust will be published in due course. For other providers the C. diff. threshold should be set at zero. (Not applicable to the shorter form, as the shorter form must not be used for acute services)
Governance	
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. (Not applicable to shorter form)
Provider 's Nominated Individual SC3.8	The name and contact details of the Provider's Nominated Individual must be inserted here (this will be the same person as the nominated individual for the provider's CQC registration, where relevant).
Provider 's Information Governance Lead GC21.3.1, GC21.3.3, GC21.3.4	The name and contact details of the Provider's Information Governance Lead must be inserted here. Please refer to Appendix 7 for more information.
Provider's Caldicott Guardian GC21.3.2, GC21.3.3, GC21.3.4	The name and contact details of the Provider's Caldicott Guardian must be inserted here. Please refer to Appendix 7 for more information.
Provider's Senior Information Risk Owner GC21.3.2, GC21.3.3, GC21.3.4	The name and contact details of the Provider's Senior Information Risk Owner must be inserted here. Please refer to Appendix 7 for more information.
Provider's Accountable Emergency Officer SC30.1	The name and contact details of the Provider's Accountable Emergency Officer must be inserted here.
Provider's Safeguarding Lead SC32.2	The name and contact details of the Provider's Safeguarding Lead must be inserted here.
Provider's Child Sexual Abuse and Exploitation Lead SC32.2	The name and contact details of the Provider's Child Sexual Abuse and Exploitation Lead must be inserted here. Note that this role is applicable for all services, including those provided just to adults, as children may visit the provider's site, or come into contact with staff or service users.
Provider's Mental Capacity and Deprivation of Liberty Lead SC32.2	The name and contact details of the Provider's Mental Capacity and Deprivation of Liberty Lead must be entered here.
Provider's Prevent Lead SC32.2	The name and contact details of the Provider's Prevent Lead must be inserted here. (Not applicable to the shorter form)
Provider's Freedom To Speak Up Guardian GC5.8	The name and contact details of the Provider's Freedom To Speak Up Guardian must be inserted here. More information on Freedom To Speak Up Guardians is available on the CQC website .
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	Insert the frequency of the contract review meetings

Meetings GC8	<p>between the parties. The review meeting will focus on the quality and performance of the Services.</p> <p>The frequency of the review meetings should reflect the nature of the Services and the relationship between the parties.</p> <p>It is recommended that the minimum frequency should be every six months.</p> <p>(Not applicable to the shorter form: review meetings are to be held on an ad hoc basis)</p>	
Commissioner Representative(s) GC10	<p>Insert for each Commissioner the name and contact details of the person that will be the primary contact point for the Provider.</p> <p>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 may be entered.</p>	
Provider Representative GC10	<p>Insert the name and contact details of the person that will be the Provider's primary contact point for the Commissioners.</p>	

Schedule 1 – Service Commencement		
A - Conditions precedent GC3, GC4	<p>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 GC17.10.1 (GC17.5.1).</p> <p>Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to:</p> <ul style="list-style-type: none"> • Sub-contracts, see paragraph 38 above • Direction Letters, see paragraph 47.34 above. 	
B - Commissioner Documents GC4.2	<p>Insert details of any specific documents that have to be provided by the Commissioner(s) to the Provider prior to Service Commencement.</p> <p>(Not applicable to the shorter form)</p>	
C – Extension of Contract Term	<p>To be used only as described in paragraph 18 above. Where applicable, insert the extension period of the contract, as advertised to potential providers during the procurement process.</p>	
Schedule 2 – The Services		
A - Service Specification	<p>Commissioners and Providers should agree Service Specifications for all services commissioned under this contract.</p> <p>See paragraph 36 above for further details.</p>	
A1 – Specialised Services – Derogations from National Service Specifications	<p>For specialised services, enter any derogations here.</p> <p>(Not applicable to the shorter form, as it is not to be used for specialised services)</p>	

B – Indicative Activity Plan (IAP) SC29.5, SC28.6 SC29.3	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 42 above. The overall Indicative Activity Plan should include a breakdown of individual commissioner plans.	Yellow
C – Activity Planning Assumptions (APA) SC29.7	Insert any APA for the relevant Contract Year, specifying a threshold for each assumption. See paragraph 42 above for further details. (Not applicable to the shorter form)	Green
D – Essential Services SC5	Commissioners should list here any Essential Services that are applicable to the contract. The concept of Essential Services applies only to NHS Trusts. (See paragraph 37 above for further information on Essential Services and Commissioner Requested Services.)	Green
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 2D, mark this Part E as ‘not applicable’. (The shorter form does not require a Continuity Plan to be included in the contract itself)	Green
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’. (Not included in the shorter form, but if the Provider is to be required to participate in a Clinical Network the appropriate details may be included in Schedule 2G)	Yellow
G – Other Local Agreements, Policies and Procedures SC25	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.	Yellow
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. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 1A and/or Schedule 2G)	Yellow
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 of 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 paragraphs 47.28 – 47.32 above. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 2G)	Yellow
J – Transfer of and	Any local agreement or protocols relating to Service Users’	Yellow

Discharge from Care Protocols SC11	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.
K – Safeguarding Policies and MCA Policies SC32	The Provider's written policies for safeguarding children and adults should be appended in Schedule 2K and may be varied from time to time in accordance with SC32. The policy should reflect the local multi-agency safeguarding policy.
L – Provisions Applicable to Primary Care Services	See paragraphs 8.4 and 34.4 above. (Not applicable to the shorter form. If a package of general practice and secondary care services are being commissioned the full-length contract must be used, with Schedule 2L)
Schedule 3 – Payment	
A - Local Prices SC36.4 -36.10	Insert the detail of any Local Prices in Schedule 3A, entering text (or attaching documents or spreadsheets) which, for each separately priced Service: <ul style="list-style-type: none"> • identifies the Service; • describes any agreement to depart from an applicable national currency (in respect of which the appropriate NHS Improvement summary template 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 NHS Improvement – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets. (Not applicable to the shorter form contract, as it must not be used for services for which there is a national price)

<p>C – Local Modifications SC36.16 – SC36.20</p>	<p>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 NHS Improvement - or state Not Applicable. For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.</p> <p>(Not applicable to the shorter form contract, as it must not be used for services for which there is a national price)</p>	
<p>D - Marginal Rate Emergency Rule: Agreed Baseline Value SC36.21</p>	<p>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.)</p> <p>(Not applicable to the shorter form, as it must not be used for acute services)</p>	
<p>E – Emergency Readmission Within 30 Days: Agreed Threshold SC36.22</p>	<p>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.)</p> <p>(Not applicable to the shorter form, as it must not be used for acute services)</p>	
<p>F - Expected Annual Contract Values SC36</p>	<p>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.)</p>	
<p>G – Timing and Amounts of Payments in First and/or Final Contract Year SC36.26, SC36.27</p>	<p>If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here.</p> <p>Where the first and final Contract Year is 1 April – 31 March, enter ‘not applicable’.</p> <p>(Not included in the shorter form, but if necessary appropriate provisions may be included in Schedule 3A)</p>	
Schedule 4 – Quality Requirements		
<p>A - Operational Standards</p> <p>(Combined with NQRs in Schedule 4A in the shorter</p>	<p>These Operational Standards cannot be changed or amended. Elements for local insertion are indicated by the amber highlight.</p> <p>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</p>	

form)	contract. See also paragraph 39 above.	
B - National Quality Requirements (Combined with Operational Standards in Schedule 4A in the shorter form)	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 paragraph 39 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 paragraph 39 above.	
D - Commissioning for Quality and Innovation (CQUIN) SC38	Commissioners should complete this section in accordance with applicable CQUIN guidance. (In the shorter form CQUIN Variations should also be recorded in schedule 4D)	
E - 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. (Not included in the shorter form)	
F - Clostridium difficile (C. diff)	Applies to Acute services only. The formula applicable will depend on the provider type – NHS Trust/FT or Other. 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. (Not included in the shorter form, as it must not be used for acute services)	
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. (Not included in the shorter form)	
B1 - Provider's Mandatory Material Sub-contracts 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 38 above. (Not included in the shorter form)	
B2 – Provider's Permitted Material	Details of any Permitted Material Sub-contractors should be inserted here.	

Sub-contracts GC12	If there are no Permitted Material Sub-contractors this section will be identified as 'not applicable'. Further guidance is set out in paragraph 38 above. (Not included in the shorter form)	
C - 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 contract – 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. (Not included in the shorter form)	
Schedule 6 – Contract Management, Reporting and Information		
A - Reporting Requirements SC28	This table sets out the information that is required to be reported under the contract. See also paragraph 43 above.	
B - Data Quality Improvement Plan (DQIP) SC28.20, SC28.21, SC28.22	This table is used to record any agreed DQIP. (Not included in the shorter form)	
C – 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.	
D – Service Development and Improvement Plan SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 41 above, which sets out certain situations in which an SDIP <u>must</u> be included. (Not included in the shorter form)	
E – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys. (Not included in the shorter form)	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 47.34 above.	
Schedule 8 - TUPE		
TUPE	Applicable to the shorter form only. It may in certain circumstances be appropriate to omit the text of this Schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.	

Appendix 3

Definitions of recent 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 onwards
Definition	<p>% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool</p> <p>The indicator is the numerator divided by the denominator, expressed as a percentage</p> <p>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).</p> <p>Denominator: Number of adults who were admitted as inpatients (includes day cases, maternity and transfers, both elective and non-elective admissions)</p>
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	Not applicable
Further information	<p>A range of resources are available to local health economies to tackle VTE: National VTE Risk Assessment Tool.</p> <p>Hospital Associated Thrombosis and Root Cause Analysis guidance and tools (housed on national VTE prevention website).</p> <p>NICE clinical guideline CG92, and NICE Quality Standard for VTE Prevention (QS3)</p> <p>Other resources and information are available on the VTE Prevention website.</p>

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	<p>% 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.</p> <p>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</p> <p>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</p> <p>Denominator: Total number of Commissioning Data Set records submitted to SUS for mental health services and for acute outpatient, daycase and inpatient services</p>
Threshold	99% rate of completion of NHS Number
Reporting	<p>To commissioners through the monthly Service Quality Performance Report</p> <p>It may be possible to rely on NHS Digital 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</p>
Application of any sanctions	Monthly
Further information	<p>NHS Digital 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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	<p>% of all A&E Commissioning Data Set records submitted to SUS in which a valid NHS Number for the Service User was included</p> <p>A “valid NHS Number” means the correct number for the specific Service User.</p> <p>The indicator is the numerator divided by the denominator, expressed as a percentage</p> <p>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</p> <p>Denominator: Total number of Commissioning Data Set records submitted to SUS for A&E services</p>
Threshold	95% rate of completion of NHS Number
Reporting	<p>To commissioners through the monthly Service Quality Performance Report</p> <p>It may be possible to rely on NHS Digital monthly Data Quality Dashboard reports – see below</p> <p>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</p>
Application of any sanctions	Monthly
Further information	<p>NHS Digital 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

Mental Health Services Data Sets – completion of ethnicity field

National Quality Requirement	Completion of the ethnicity field in Mental Health Services Data Set records
Rationale	Improvement in the standard of completion of Mental Health Services Data Set records has been defined as an important priority by clinical stakeholders.
Definition	<p>% of all Mental Health Services Data Set records in which the ethnicity code for the Service User was properly completed (NHS Digital Data Quality Measure 6.)</p> <p>The indicator is the numerator divided by the denominator, expressed as a percentage</p> <p>Numerator: Number of Mental Health Services Data Set records in which the ethnicity code for the Service User was properly completed</p> <p>Denominator: Total number of Mental Health Services Data Set records</p> <p>‘Proper completion’ is defined as meaning:</p> <ul style="list-style-type: none"> • inclusion of a code showing the Service User’s ethnicity (defined as ‘Valid’ in the NHS Digital summary data; 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 NHS Digital summary data.
Threshold	90% rate of proper completion of the ethnicity field
Reporting	<p>To commissioners through the monthly Service Quality Performance Report</p> <p>It may be possible to rely on NHS Digital monthly summary analysis of data quality and consistency – see below</p> <p>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</p>
Application of any sanctions	Monthly
Further information	<p>NHS Digital publishes monthly summary analysis of data quality and consistency on their Mental Health and Learning Disabilities Statistics (MHLDS) web page. Commissioners and providers may be able to use these as an effective method of monitoring this indicator, and we encourage this wherever possible.</p> <p>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.</p>

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	<p>% 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</p> <p>The indicator is the numerator divided by the denominator, expressed as a percentage</p> <p>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</p> <p>Denominator: Total number of Services Users completing IAPT treatment during the period</p> <p>* 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.</p> <p>** 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.</p>
Threshold	90% rate of completion
Reporting	<p>To commissioners through the monthly Service Quality Performance Report</p> <p>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</p>
Application of any sanctions	Monthly
Further information	http://content.digital.nhs.uk/iapt

Appendix 4

Worked examples of calculation of financial consequences

E.B.6 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

E.A.S.5 Minimise rates of Clostridium difficile

Provider C difficile targets for 2017/18 will be published shortly.

Schedule 4F 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:

$$Y = 0$$

$$Z = ((A - B) \times 10,000) \times C$$

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 (i.e. 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

E.B.5 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

Where the 85% floor is not triggered:

Actual performance against the Operating Standard in the month	=	93%
Actual number of breaches of the standard in the month (under this Contract)	=	420
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	120
Financial sanction per breach	=	£120
Total value of financial sanctions in the month (under this Contract)	=	£14,400

Where the 85% floor is triggered:

Actual performance against the Operating Standard in the month	=	82%
Actual number of breaches of the standard in the month (under this Contract)	=	1080
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	780
Level of performance at which sanction is capped	=	85%
Maximum number of breaches to which sanction can apply	=	600
Financial sanction per breach	=	£120
Total value of financial sanctions in the month (under this Contract)	=	£72,000

E.B.15 ii Ambulance response times (Red 2)

Number of Red 2 journeys in the year (under this Contract)	=	150,000
Standard for the proportion where the emergency response arrives within 8 minutes (threshold)	=	75%
Permitted number of breaches of the standard in the year (under this Contract)	=	37,500
Actual performance against the standard in the year	=	72%
Actual number of breaches of the standard in the year (under this Contract)	=	42,000
Excess number of breaches beyond the tolerance permitted by the % threshold (under this Contract)	=	4,500
Financial sanction per breach	=	£100
Total value of financial sanctions in the year (under this Contract)	=	£450,000

Appendix 5

Permissible Variations

The following are “Variable Elements” of the NHS Standard Contract, which may be varied by local agreement in accordance with GC13:

- (i) Particulars: Service Commencement and Contract Term – local insertions and selections only
- (ii) Particulars: Services – local insertions only
- (iii) Particulars: Payment – local insertions and selections only
- (iv) Particulars: Quality – local insertions and selections only
- (v) Particulars: Governance and Regulatory – local insertions and selections only
- (vi) Particulars: Contract Management – local insertions and selections only
- (vii) Schedule 1A (*Conditions Precedent*) – local insertions only
- (viii) Schedule 1B (*Commissioner Documents*) – local insertions only
- (ix) Schedule 1C (*Extension of Contract Term*) – if used, insertion of notice period in paragraph 1 only
- (x) Schedule 2A (*Service Specifications*), Schedule 2A1 (*Specialised Services – Derogations from National Service Specifications*) – local insertions only; no variation to or derogations from National Service Specifications unless mandated by NHS England
- (xi) Schedule 2B (*Indicative Activity Plan*) – application/local insertions only
- (xii) Schedule 2C (*Activity Planning Assumptions*) – application/local insertions only
- (xiii) Schedule 2D (*Essential Services*) – application/local insertions only
- (xiv) Schedule 2E (*Essential Services Continuity Plan*) – application/local insertions only
- (xv) Schedule 2F (*Clinical Networks*) – application/local insertions only
- (xvi) Schedule 2G (*Other Local Agreements, Policies and Procedures*) – application/local insertions only
- (xvii) Schedule 2H (*Transition Arrangements*) – application/local insertions only
- (xviii) Schedule 2I (*Exit Arrangements*) – application/local insertions only

- (xix) Schedule 2J (*Transfer of and Discharge from Care Protocols*) – local insertions only
- (xx) Schedule 2K (*Safeguarding and Mental Capacity Act Policies*) – local insertions only
- (xxi) Schedule 2L (*Provisions Applicable to Primary Care Services*) – application/local insertions only
- (xxii) Schedule 3A (*Local Prices*) – application/local insertions only
- (xxiii) Schedule 3B (*Local Variations*) application/local insertions only
- (xxiv) Schedule 3C (*Local Modifications*) – application/local insertions only
- (xxv) Schedule 3D (*Marginal Rate Efficiency Rule: Agreed Baseline Value*) – application/location insertions only
- (xxvi) Schedule 3E (*Emergency Readmissions Within 30 Days: Agreed Threshold*) – application/local insertion only
- (xxvii) Schedule 3F (*Expected Annual Contract Values*) – application/local insertions only
- (xxviii) Schedule 3G (*Timing and Amounts of Payments in First and/or Final Contract Year*) – application/local insertions only
- (xxix) Schedule 4A (*Operational Standards*) – application (selected Service categories); Thresholds/Consequence of Breach/Monthly or Annual application of consequence, where indicated in the NHS Standard Contract as being for local determination, only
- (xxx) Schedule 4B (*National Quality Requirements*) – application (selected Service categories); E.A.S.5 (CDiff) Threshold, only
- (xxxi) Schedule 4C (*Local Quality Requirements*) – local insertions only
- (xxxii) Schedule 4D (*Commissioning for Quality and Innovation (CQUIN)*) – local insertions only
- (xxxiii) Schedule 4E (*Local Incentive Scheme*) – application/local insertions only
- (xxxiv) Schedule 4F (*Clostridium difficile*) – application/ selection of appropriate provisions by Provider type only
- (xxxv) Schedule 5A (*Documents Relied On*) – application/local insertions only

- (xxxvi) Schedule 5B1 (*Provider's Mandatory Material Sub-Contractors*) – application/local insertions only
- (xxxvii) Schedule 5B2 (*Provider's Permitted Material Sub-Contractors*) – application/local insertions only
- (xxxviii) Schedule 5C (*Commissioner Roles and Responsibilities*) – local insertions only
- (xxxix) Schedule 6A (*Reporting Requirements*) – application (selected Service categories; Small Provider/other); open fields; Local Requirements Reported Locally only
- (xl) Schedule 6B (*Data Quality Improvement Plan*) – application/local insertions only
- (xli) Schedule 6C (*Incidents Requiring Reporting Procedure*) – local insertions only
- (xlii) Schedule 6D (*Service Development and Improvement Plan*) – application/local insertions only
- (xliii) Schedule 6E (*Surveys*) – local insertions only
- (xliv) Schedule 7 (*Pensions*) – local insertions only (template wording: refer to Technical Guidance)
- (xlv) Service Conditions – application (selected Service categories; Provider type) only

Appendix 6

Hypothetical case studies

Activity planning during contract negotiations

Scenario 1

During the annual contract negotiation, an acute provider believes that its main local commissioner is “under-commissioning” for certain elective specialties – that is, planning to set the Indicative Activity Plan (IAP) at an unrealistically low level, relying on initiatives to control GP referrals which the provider does not understand or have confidence in.

Contractual approach

The right outcome here is a shared, realistic IAP which both parties will work to. So the commissioner should share more detail about its demand management plans. Either the provider will gain confidence in the plans, accepting that they give a robust basis for the IAP – or, alternatively, the commissioner may accept that its plans are over-ambitious and may scale down its estimate of their impact to a more realistic level.

However good the planning which underpins the IAP, actual activity levels are always likely to differ from plan to some extent. Ultimately, of course, payment under the National Tariff rules will be based on the actual level of activity undertaken, not on the IAP. So it is possible, contractually, for the IAP within the contract to be set at one level for a particular specialty, but for the provider to plan internally for a higher level. But this is not desirable. The whole aim of the activity planning process should be to produce a shared, realistic and affordable plan, on which the provider will base the level of capacity it makes available.

Scenario 2

During the annual contract negotiation, the commissioner and acute provider review referral trends and waiting time data for a particular specialty and agree that, in principle, a 15% increase in capacity is required for the coming year. However, the provider maintains that it cannot, in practice, deliver a 15% increase and refuses to agree the Indicative Activity Plan (IAP) on this basis.

Contractual approach

Here again, the parties need to do further work to seek a jointly acceptable resolution.

They will need to understand what the basis is for the provider's view that capacity cannot be increased – have all the possible options (more efficient working, pathway redesign, recruitment of additional staff, sub-contracting to other providers) been fully explored? Equally, the commissioner will need to

- i. work actively with referrers to encourage them to look at alternative local providers for their referrals (the NHS e-Referral Service will show waiting time information for all providers that offer options for the patient's referral, enabling referrers to choose suitable alternatives where capacity issues exist)
- ii. consider whether it can commission other providers to offer capacity in the same specialty, so that there is an additional local choice option for referrals – or whether it would be clinically appropriate to introduce narrower criteria for referral to the specialty.

As suggested in scenario 3 below, the commissioner may also be able to offer the provider some comfort by clarifying, in advance, what approach it will take to the reinvestment of such sanctions (see para 40.5 onwards above).

If a solution cannot be found through these routes, then – whatever level the IAP within the contract is eventually pitched at – it is possible that, even if the provider puts in place the maximum capacity it can, this may be significantly exceeded by the actual level of demand. Handling this situation is dealt with in scenario 5 below.

Scenario 3

The commissioner has radical plans to invest in new out-of-hospital services which it believes will significantly reduce the requirement for bed-based emergency hospital services. The plans would logically mean that the main acute provider would close several wards. The acute provider supports the plans in principle, but both parties are nervous about the risks involved; everyone agrees it is the right thing to do, but no one is totally confident about predicting the likely financial outcome under normal National Tariff rules.

Contractual approach

The brief description above could mask several different realities. At one end of the spectrum, if the commissioner's plans are poorly thought through, proceeding with them may be a bad idea. At the other, 'total' confidence in any plan is probably an unrealistic aspiration; a robust, well worked-up plan will always involve some level of risk, so the commissioner may be confident enough to proceed.

The point of this scenario, though, is simply to offer a reminder that it is possible for commissioners and providers to move away, by agreement, from 'pure' application of the 'activity x price' approach to payment for services covered by national prices under the National Tariff. They can agree a time-limited Local Variation in line with the criteria set out in the National Tariff; to give all parties greater certainty about their expected level of income or expenditure, for instance, they could move to more of a block payment arrangement, or perhaps adopt a risk- and gain-share approach, along the lines of the [Local Payment Design Example](#) published by NHS Improvement. If, say, the provider is concerned at the potential for performance sanctions to be levied under the contract (if it downsizes its capacity as requested by the commissioner, but then finds that activity levels do not reduce as planned), the commissioner may, as part of any risk-sharing agreement, be able to provide comfort by clarifying, in advance, what approach it will take to the reinvestment of such sanctions (see para 40.5 onwards above).

These flexibilities are not easy answers – considerable local effort will be required to make them work effectively – but they will be an option worth explored locally in some situations.

Activity management

Scenario 4

At month 3, an acute hospital is over-performing by 20% on activity and value for elective orthopaedics. This is causing a significant financial overspend for its main commissioner; the commissioner desperately wants the provider to 'slow down'.

Contractual approach

Service Condition 29 (Managing activity and referrals) will be the most relevant section of the Contract. The first steps in SC29 involve the issue (in this instance by the commissioner) of an Activity Query Notice, leading to an Activity Management Meeting between the commissioner and the provider. These essential first steps will allow the parties to develop a shared understanding of why the over-performance is happening. Carrying out a formal Joint Activity Review if necessary, they can then move to agree an Activity Management Plan (AMP) – which will aim, over time, to bring the activity level back within the expected range.

The content of the AMP will depend very much on what has caused the over-performance and, in particular, whether any Activity Planning Assumptions (APAs) have been breached.

If the activity over-performance is solely a direct consequence of an increase in GP referrals

In this situation:

- i. Clearly, the provider cannot control and is not responsible for the level of external referral.
- ii. Given that it is the commissioner who has raised the Activity Query Notice (AQN), the parties may agree that no further action is needed under the contract. The commissioner is already facing a financial consequence (because it is having to fund additional activity above its planned level) and may want to take demand management action outside of the contract to ensure that, say, GPs are following agreed referral pathways and protocols.
- iii. On the other hand, if the level of referral is causing the provider operational issues, it may seek to agree with the commissioner a formal AMP, setting out what the commissioner will do to bring referrals back within the expected levels (set out in APAs).
- iv. By agreement, such an AMP could include additional financial consequences for the commissioner for failure to implement (on top of the requirement to pay for excess activity).

If the activity over-performance is solely a direct consequence of “under-commissioning” – that is, the Indicative Activity Plan (IAP) has been set unrealistically low

In this situation – perhaps where the commissioner has assumed an impact from demand management actions which has not, in practice, subsequently been achieved – there would logically be no requirement on the provider to contribute to an AMP.

If referrals are in line with APAs, but the activity over-performance is wholly the result of the provider treating patients more quickly than agreed

If the parties have agreed an APA relating to waiting times or numbers – perhaps relating to numbers on a waiting list or average waiting times – then it would be reasonable for the parties to agree an AMP requiring the provider to reduce activity levels and allow average waiting times to increase back to the agreed level.

By agreement, such an AMP could include financial consequences for the provider for failure to implement.

However, the AMP must not require the provider to put patient safety at risk (setting unreasonable waiting times for urgent patients, say) or to jeopardise its achievement of national quality standards (18 week waits).

If the activity over-performance is partly the result of the provider treating patients outside the terms of agreed Prior Approval Schemes

If Prior Approval Schemes are in place and a provider fails to abide by them, this is a breach of a contractual obligation. This is different from the preceding examples in that the Contract allows immediate financial redress for the commissioner. SC29.22 makes clear that, in this situation, the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed Prior Approval Schemes.

If the activity over-performance is partly the result of the provider introducing new clinical treatments without explicit commissioner agreement

This is a more nuanced situation.

- i. In many cases, contract specifications will not specify all of the exact procedures which the provider may offer – rather, the expectation is that patients are referred for assessment and treatment at the provider’s discretion, in line with good clinical practice. In this situation, commissioners should accept that there will rightly be gradual evolution of clinical practice, without such changes always needing to be viewed as formal Variations under the Contract. Where gradual clinical change of this kind identifies controversial cases, it would generally not be appropriate for commissioners to contest payment retrospectively – but they could of course review the clinical evidence for the new procedure concerned and decide that, for the future, this was not a treatment they wished to commission or that they wished to govern access through a new Prior Approval Scheme.
- ii. On the other hand, where the service specification is much more prescriptive in setting out a defined range of commissioned treatments, providers cannot reasonably expect to provide different treatments, without prior discussion, and still be paid. Introduction of new treatments in such cases might reasonably lead the commissioner to withhold payment for the ‘excess’ activity, on the grounds that the provider has breached the requirement in SC1 to provide services in accordance with the service specifications.

Good communication – and reasonable expectations on both sides – will be the key to minimising disputes in this area.

Activity management in block contracts

Where block contracts are in place, then payments between the parties do not flex depending on activity levels – but SC29 may still be relevant. It may be particularly important, in a block contract, that expected levels of referrals are specified as APAs; if these referral levels are then exceeded, leaving the provider with an imbalance between demand and capacity, the parties can use the provisions of SC29 (for instance, an AMP) to set out how both commissioner and provider are to respond, both in terms of managing the flow of referrals and of ensuring the continued provision of safe service to patients.

Key messages

- i. Carrying out activity above the level of the IAP is not a breach of contract and is not grounds for non-payment.
- ii. Providers should only be held responsible for activity levels which are within their control.
- iii. Failure to adhere to APAs or to implement an agreed AMP may be a breach of contract.
- iv. It is reasonable for AMPs to include financial consequences for non-implementation.

Scenario 5

Building on Scenario 2 above, an acute provider finds, part-way through the year, that referrals into one sub-specialist element of its elective orthopaedic service are exceeding capacity by 25%. The standard for RTT incomplete pathways is not being met, and the waiting list is spiralling out of control. The commissioner is applying financial sanctions as required under the Contract. The parties have met to discuss a Remedial Action Plan, but the provider cannot identify any way in which it can increase its capacity to meet the current level of demand.

Contractual approach

Whereas, under scenario 4, the commissioner is concerned about the cost of activity it has not planned for, here in scenario 5 it is the provider which is anxious that it cannot practically deliver the necessary volume of activity.

In scenario 5, exactly the same questions arise about what is driving the demand / capacity imbalance as in scenario 4. And the responses in scenario 2 also apply – has the provider done everything it can to expand its capacity? Can the commissioner encourage a voluntary redirection of referrals to providers with more capacity and shorter waits or introduce additional capacity or tighter referral criteria?

But let's assume that these discussions all happen and that no workable solution can be found. What then?

- i. The provider must not unilaterally 'switch off' the affected service on the NHS e-Referral Service. This will simply prompt more (less efficient) paper referrals from GPs.
- ii. Nor may it unilaterally start to reject GP referrals from some or all commissioners (perhaps those outside what it may consider to be its local catchment area). This would contravene the requirements in SC6.

The only way in which new referrals into a service can properly be stopped in this scenario is if the Co-ordinating Commissioner requires the provider to suspend the service temporarily under GC16.

- i. Such a suspension should only occur in truly exceptional circumstances, but may be considered appropriate if the demand / capacity imbalance is so severe that there is simply no prospect of patients receiving treatment, meaning that patients' safety and health may be at significant risk.
- ii. A suspension can be applied to new referrals (or new, non-urgent referrals) only (so that the provider can continue working to clear the backlog of existing cases) and it can be applied only to an element of a service (in this instance, the sub-specialty under particular pressure), rather than necessarily the whole service.
- iii. But, for a service to which the legal right of choice applies, suspension must not be used to enable patients from some CCGs to continue to access the service, whilst those from other cannot.
- iv. The Co-ordinating Commissioner will need to liaise with other organisations and consider the impact of a potential suspension in the round, including the effect it is likely to have on services at other available providers.
- v. Clear communication to referrers and, where appropriate, the general public will be essential.

Reporting requirements

Scenario 6

A contract with a community services provider includes at Schedule 6A a new local reporting requirement on waiting times to access physiotherapy services. This was to be reported on monthly, and the first report was due at the end of May. The provider has not supplied the report, but has apologised, saying that it hasn't been able to set up the new reporting system yet because of staffing difficulties – but it will do so in time for the report due by the end of September.

Contractual approach

Here, the commissioner has various options for action under the Contract, depending how formally it wishes to address the issue.

- i. It can treat the situation as an Information Breach under SC28 and (in line with SC28.15) withhold up to 1% of Monthly Actual Contract Value until such point as the required report starts to be provided.
- ii. It can require a formal Remedial Action Plan from the provider under GC9, so that the steps the provider will take to remedy the position are fully documented, with timescales – potentially with specific financial consequences agreed for non-compliance.
- iii. It can take the similar (but contractually lower profile) approach of requiring the provider to put in place a Data Quality Improvement Plan.

Equally, however, the commissioner may reasonably decide to take a less formal approach, accepting the explanations it has received from the provider and relying on the assurances the provider has given for the future. The context will obviously be crucial – the importance of the new report, the level of trust between the parties and the working relationship they are aspiring to.

Invoicing and payment

Scenario 7

An AQP provider of community services with a zero-value contract does not invoice the commissioner for the first six months of the year, but then – in mid-October – sends an invoice for activity across all of months 1-6.

Scenario 8

A commissioner has reviewed the month 6 final reconciliation account from its main acute provider. There is a big overspend against plan in outpatient care in a number of specialties. Analysis suggests that this has been wholly caused by a recording issue – there is evidence of double-counting (two attendances for the same patient in the same specialty on the same day), going back to month 1.

Contractual approach

These two contrasting scenarios both relate to the operation of SC36 (Payment Terms), although the second also brings in the section of SC28 which deals with the notification of counting and coding changes. Again, the scenarios also raise questions about how the contracting parties want their working relationship to operate.

Scenario 7

In contractual terms, Scenario 7 is straightforward. SC36.36 is clear that, where there is no Expected Annual Contract Value, the provider must send invoices in arrears for

each month within 20 Operational Days of the month end. Where the provider misses this deadline, the commissioner is under no obligation to pay the invoices. This would be the case, technically, even if the provider had been sending monthly activity data to SUS on time throughout months 1-6; the provision of the invoice is what triggers the requirement to pay.

Scenario 8

Scenario 8 is more complex. Let's assume, in this instance, that this is a case where the provider accepts that

- i. it has indeed made, in error, a change in recording practice on 1 April which it did not notify to the commissioner by the preceding 30 September (as required under SC28.8 onwards); and
- ii. the new method of recording is technically incorrect under national data definitions; and
- iii. the new method of recording increases income for the provider, although the nature and volume of the service being provided has not changed.

In this situation, the commissioner can reasonably

- i. expect the provider to accept non-payment for the excess recorded activity in month 6; and
- ii. require the provider to rectify the recording error going forward (or to make ongoing payment adjustments if this is not immediately possible).

However, because the final reconciliation deadlines for months 1-5 have all passed, the commissioner cannot automatically refuse to pay for the excess activity in those months. The Contract does, however, offer commissioner scope for action against the provider under GC15 (Governance, Transaction Records and Audit) – see GC15.12.2 in particular.

The above sets out the default position under the Contract. It is, of course, open to the parties to reach alternative agreements – so, in the first scenario, a “reasonable” commissioner may accept a provider’s explanation for late invoicing and agree to make full payment on an exceptional basis; and similarly, under the second scenario, a “reasonable” provider may accept that it should not make a windfall gain from incorrect recording and offer to adjust payment for the full six months. The parties’ working relationship – the track record of how they behave towards each other – is likely to be key in determining how “reasonable” each is inclined to be.

Counting and coding

Scenario 9

A provider has notified its co-ordinating commissioner in November 2016 of a change in recording practice which it believes it must make in order to comply with the NHS Data Dictionary. The provider believes that the change will result in an increase in income from commissioners of around £500,000 in a full year. The provider believes that its notification allows it to implement the change from 1 April 2017 and to receive the full income gain from that point onwards. The co-ordinating commissioner, by contrast, believes that the provider should not make the change at all, because it should never be allowed to make a 'windfall' gain from improved counting and coding.

Contractual approach

There are two separate issues to be resolved here.

- i. Should the change in recording practice proceed at all?
- ii. When should the change be implemented and its financial impact take effect?

The first question is simply a matter of what is technically correct under the definitions set out in the NHS Data Model and Dictionary and related rules. Commissioner and provider should seek, in good faith, to reach an agreement on how the rules are to be interpreted in this particular case. They may be able to seek expert advice to help them. Ultimately, if they are unable to reach agreement, they may need to resort to the dispute resolution process in the Contract.

Assuming that this first issue is resolved and the parties agree that the change is technically appropriate and should therefore proceed – what happens then about implementation and financial impact? In this respect, the commissioner's view – that a provider can never make a financial gain from changes in recording practice – is not correct. But neither is the provider's view. In this particular scenario, the provider has not given a valid notification of a counting change under the 2016/17 Contract – because it only gave notice in November 2016, rather than doing so before the end of September 2016.

The provider has effectively missed the deadline for notification of proposed counting changes during 2016/17. It will need to resubmit its proposal for consideration in 2017/18, making sure that it does so before 30 September 2017. Assuming the change is agreed, it can then be implemented on 1 April 2018, but its financial effect will be neutralised for the 2018/19 Contract Year – meaning that the provider will start to get the financial benefit only from 1 April 2019.

(This scenario happens to feature a counting and coding change from which the provider would benefit financially. It is important to remember that the protections in

the Contract cut both ways – they apply to changes from which either provider or commissioner would benefit.)

Scenario 10

The updated National Tariff Payment System for a particular year introduces a new Best Practice Tariff (BPT). This creates a financial incentive for providers to treat a certain group of patients as outpatient procedures, rather than as daycases. Once the new Contract Year starts, a commissioner duly sees at its main provider an increase in the volume of the relevant outpatient procedures and a balancing reduction in daycases – and, because the BPT has been applied, an increase in cost to itself, the commissioner then claims that this is a counting and coding change, for which notice should have been given in advance, and states that it is not liable to pay. Is this right?

In principle, as set out in paragraph 44.14 above, our expectation is that attempts by a provider to earn a BPT would not constitute counting and coding changes; rather, they would be changes in the actual pattern of service delivery. And 44.14 also makes clear that, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a Variation to be agreed in respect of any change of service provision necessary to achieve this.

Care would be needed in this particular instance, however.

- If the provider has made a genuine change to the way in which services are provided to patients – moving from being done on a general anaesthetic basis in a fully-equipped day case unit to a less lengthy, complex or invasive approach in a lower-tech clinic setting – then that would clearly constitute a change in service delivery and not a counting and coding change.
- However, in a situation where the provider simply reclassified the activity from daycase to outpatient, without making any material change to the way in which the service was delivered, this would indeed constitute a counting and coding change and would be subject to the provisions of SC28.

Appendix 7

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:

- i. information governance;
- ii. system compliance;
- iii. reporting requirements;
- iv. information services; and
- v. workforce minimum data set.

Information governance – service user data and its protection

The information governance sections in the Standard Contract and the Short Form Contract are the same as the requirement for compliance is the same for organisations of any size and any type of service. However some sections may not be applicable where the activity referred to is not part of the contracted service. Where this is the case it is indicated below.

GC21 – Data Protection, Freedom of Information and Transparency (GC21.1)	<p>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).</p> <p>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.</p>
The Information Governance Toolkit and IGSoC (GC21.2, GC21.6)	<p>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.</p> <p>Where there is a requirement to integrate their IM&T solution to NHS systems and services, including the NHS e-Referral Service, PDS, NHS Mail and N3 (shortly to be replaced by the Health and Social Care Network), 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.</p>

	<p>The IGT and IGSoC require the nomination of a Caldicott Guardian and Senior Information Risk Owner.</p> <p>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.</p> <p>Further information on the IGSoC and IGT can be found at: http://systems.hscic.gov.uk/infogov</p>
<p>Senior Information Governance Roles (GC21.3, Particulars – Governance and Regulatory)</p>	<p><u>Information Governance Lead</u> 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.</p> <p><u>Senior Information Risk Owner (SIRO)</u> 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.</p> <p>The <i>Information Security Management: NHS Code of Practice</i> can be found at: http://systems.hscic.gov.uk/infogov/codes/securitycode.pdf</p> <p><u>Caldicott Guardian</u> 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.</p> <p>The Caldicott Guardian should be, in order of priority:</p> <ol style="list-style-type: none"> i. an existing member of the senior management team; ii. a senior health or social care professional; iii. the person with responsibility for promoting clinical

	<p>governance or equivalent functions.</p> <p>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.</p> <p>The <i>Caldicott Guardian Manual 2010</i> can be found at: http://systems.hscic.gov.uk/infogov/links/2010cgmanual.pdf</p> <p>The <i>Confidentiality: NHS Code of Practice</i> can be found at: https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice</p> <p><i>A guide to confidentiality in health and social care</i> published by NHS Digital, with supporting references can be found at: http://content.digital.nhs.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf</p> <p>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.</p> <p>In a small organisation it may be appropriate for the same individual to take on more than one of the roles described above. It is recommended that the roles of Caldicott Guardian and SIRO should be held by different people to avoid potential conflicts of interest.</p>
<p>The Response to the Caldicott Review (GC21.4, SC23)</p>	<p>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.</p> <p>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</p>

of commitments under the headings:

- i. All staff and workers within the health and care system expectation;
- ii. All health and care organisations expectations;
- iii. Local NHS providers' expectations.

In GC21 and 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.

In June 2016 the National Data Guardian for Health and Care published the Review of Data Security, Consent and Opt-Outs. At the time of writing the conclusions of the Review are subject to consultation.

GC21.4 requires providers to comply with guidance published by the Independent Information Governance Overview Panel (the Caldicott Review Recommendations), and guidance to be published following the consultation on the Review of Data Security, Consent and Opt-Outs. The Independent Information Governance Overview Panel is the fore runner for the National Data Guardian Panel.

Review of Data Security, Consent and Opt-Outs is available at: <https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs>

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>

Information on the role of the National Data Guardian is available at: <https://www.gov.uk/government/organisations/national-data-guardian/about>

<p>NICE Clinical Guideline 138 (GC21.5)</p>	<p>The provider must audit its practices against quality statements regarding data sharing set out in <i>NICE Clinical Guideline 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services</i> (CG138).</p> <p>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.</p> <p>The Caldicott Review includes 7 quality statements or recommendations taken from CG138 that emphasise the importance of appropriate sharing.</p> <p><i>CG138 Patient experience in adult NHS services</i>, and the full guidance document including methods evidence and recommendations can be found at: https://www.nice.org.uk/guidance/cg138.</p> <p><i>QS15 Quality standard for Patient experience in adult NHS services</i> can be found at: https://www.nice.org.uk/guidance/qs15/chapter/introduction-and-overview</p> <p><i>CG138 Patient experience in adult NHS services: baseline assessment tool</i> can be found at: https://www.nice.org.uk/guidance/cg138/resources</p>
<p>Data Breaches and Information Governance Breaches (GC21.7)</p>	<p>The Caldicott Review broadened the definition of data breaches and how they should be handled. Organisations need to have regard to these recommendations alongside following NHS Digital's Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation.</p>
<p>Data Controller responsibilities (GC21.9, GC21.13)</p>	<p>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.</p> <p>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</p>

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.

Commissioners must ensure that requirements placed on providers to submit Personal Data have an established legal basis, and that they and their support organisations have a legal basis to receive it. Whilst the provider's obtaining a patient's consent to disclose the information would establish such a basis, this is only likely to be practical in particular contexts, such as individual requests for funding.

In addition, to meeting the obligations of the Data Protection Act both providers and commissioners must be mindful of the common law duty of confidence that is owed to the patient.

Commissioners and Providers must establish the legal basis for the submission and use of datasets. Existing national datasets are supported by standards and directions, which require submission to the NHS Digital.

The current Section 251 support for Accredited Safe Havens (CAG 2-03(a)/2013) is due to expire at the end of March 2017 and will not be extended. Support for Controlled Environments for Finance (CAG 7-07(a-c)/2013), which also expires at the end of March 2017, may be extended. Without Section 251 support, data disseminated by NHS Digital/DSCROs to commissioners or to their CSUs/data processors acting on their behalf to process data for commissioning purposes, will be anonymised in accordance with the Information Commissioner's Anonymisation Code of Practice. Guidance on the processes which will be implemented by NHS Digital/DSCROs to anonymise data for commissioning purposes has been developed jointly by NHS England and NHS Digital and this will be communicated directly to DSCROs/CCGs and CSUs and third party CSU data processors during September 2016.

Under the Health and Social Care Act 2012, and NHS England Directions, both national and local identifiable data flows required for secondary use purposes to support commissioners to meet their statutory duties, must flow directly to NHS Digital (if a national flow) or via the CCGs nominated DSCRO (if a local flow agreed via the NHS Contract). Providers must not flow identifiable data directly to a commissioner or their data processor

	<p>(CSU) unless a specific legal basis supports the disclosure (i.e. section 251 support). For clarification, identifiable data items within a dataset include (but are not limited to) an NHS number, Date of Birth, Post Code. Statutory bodies are also reminded of their obligation to have regard to NHS Digital's Confidentiality Code of Practice when making decisions around sharing identifiable patient confidential data for secondary use purposes.</p> <p>'Section 251 support' refers to approval by the Secretary of State under the Health Service (Control of Patient Information) Regulations 2002, on the recommendation of the Confidentiality Advisory Group (CAG). The regulations are enacted under section 251 of the NHS Act 2006. This support provides a statutory basis for the flow of personal data where a duty of confidentiality is owed, without seeking the consent of individuals.</p> <p>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. This is achieved by compliance with the Information Security requirements of the IG Toolkit.</p>
<p>Responsibilities when engaging sub-contractors (GC21.14, GC21.15 Particulars – Schedule 5B in full-length)</p>	<p>When engaging a sub-contractor to deliver part of the service (not as a Data Processor), the provider must ensure that the IG requirements in contracts are no less onerous than GC21.</p> <p>When engaging a sub-contractor as a Data Processor, i.e. specifically 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 on its behalf. A contract must be in place that commits the sub-contractor to act only on the instructions of the provider and to have measures in place to meet the provider's obligations under the seventh principle of the DPA – technical and organisational security. The contract should also include requirements to support the provider's responses to subject access and freedom of information requests.</p> <p>Contract Particulars, Schedule 5 must be completed in B1 with the identities of any Mandatory Material Sub-contractors, and in B2 with those of any Permitted Material 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.</p> <p>Guidance on DPA requirements when engaging a Data Processor can be found on the ICO website.</p>

	This section is not applicable to organisations that do not engage sub-contractors.
Responsibilities as a Data Processor (GC21.16)	<p>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.</p> <p>Guidance on identifying Data Controllers and Data Processors can be found on the ICO website.</p> <p>This section is not applicable to organisations that have not been specifically commissioned to provide a service that involves the processing of personal data as instructed solely by the commissioner.</p>
Commissioning Datasets (Particulars – Schedule 6A)	<p>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 on the NHS England website.</p> <p>All local datasets must be listed in the Contract Particulars, Schedule 6A under Local Requirements Reported Locally, or with reference to guidance on Prescribed Specialised Services where this applies.</p> <p>The <i>Manual for prescribed specialised services and Identification rules for prescribed specialised services</i> published by NHS England can be found at: https://www.england.nhs.uk/commissioning/spec-services/key-docs/</p>
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 is critical to the sharing of information and is used to help healthcare staff
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	and service providers match the service user to their health records. All providers will be expected to use the NHS Number as primary identifier in their clinical correspondence and when investing in their systems so that it becomes the primary identifier in their internal systems. It is a required field within data returns to commissioners and should be contained in all referrals.
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To help facilitate the use of the NHS number, centrally managed applications for the retrieval of the NHS number are provided as follows:

Personal 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).
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.
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.

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.
N3	In order to use NHS IT services the provider must obtain an N3 connection. There are several methods of connecting to the network. (Note that N3 is shortly to be replaced by a new national system, the Health and Social Care Network .)
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.

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To enable information flows and meet the requirements of NHS Digital, 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 NHS Digital to help NHS and social care organisations submit data. The provider and commissioner where appropriate will need to register with NHS digital to support data submissions. Further information on OMNIBUS is available at http://content.digital.nhs.uk/omnibussurvey .
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.

Data Services for Commissioners Programme

The [Data Services for Commissioners Programme](#) is a joint programme between NHS England and the NHS Digital which will deliver a new national technical solution ('Data Services Platform') for the submission, processing and dissemination of patient-level commissioning data sets from April 2017. Please refer to paragraph 43.8 above.

The specific change requirements to local patient-level commissioning data flows will be delivered incrementally via series of releases of the Data Services Platform from April 2017 onwards. The content of these releases is still being finalised however the general requirements will include:

- i) Ensuring all flows of national patient-identifiable commissioning data continue to be submitted by providers to the current NHS Digital system for each flow type until it is agreed to incrementally transition the submission of these flows,

in the agreed prioritised order, to the Data Services Platform when the relevant data landing functionality becomes available

- ii) Ensuring all flows of local patient-identifiable commissioning data continue to be submitted by providers to a DSCRO until it is agreed to incrementally transition the submission of these flows, in the agreed prioritised order, to the Data Services Platform when the relevant data landing functionality becomes available
- iii) Ensuring all local patient-level commissioning data flow submissions from providers are consistent and aligned with national patient-level commissioning data flows with regard to the inclusion of the full suite of the Consistent Identification Data Items (CIDs) as per the [specification](#) on the Data Services for Commissioners webpages
- iv) The Consistent Identification Data Items are already included in most national datasets and an Information Standards Notice is being developed so they are common to all. It is assumed there should be minimal additional burden on providers to include CIDs within local patient-level commissioning data flow submissions as they are in the main data already held on provider systems
- v) The need to ensure that all of the CIDI data fields in provider submissions of local patient-level commissioning data flows conform to NHS Data Model and Dictionary definitions
- vi) The need to ensure that providers take every reasonable effort, in line with existing national guidance and legislation and using enablers such as PDS, to establish and maintain the CIDI data items at the highest possible level of quality within local patient-level commissioning data submissions
- vii) The need for commissioners to consider the use of the incentive mechanisms within the contract to encourage providers to establish and maintain CIDI data items at the highest possible level of quality in local patient-level commissioning data flow submissions
- viii) The need to ensure that the CIDI data items and any other patient-identifiable data items in local commissioning data flows are only ever submitted in their designated fields in provider submissions
- ix) Considering the adoption and implementation of the [conformed data set and data item definitions](#) published on the Data Services for Commissioners webpage, as an alternative to current local patient-level commissioning data flows variants

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. More information is available on the SCCI webpages.
NHS Data Model and Dictionary Service	A reference point for all information standards that support healthcare activities and data definitions.
NHS Digital (formerly HSCIC)	<p>NHS Digital, formerly known as the Health and Social Care Information Centre, 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.</p> <p>NHS Digital 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. See https://www.digital.nhs.uk/article/578/Data-collections.</p> <p>NHS Digital'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.</p>

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:

- i. the Secretary of State to put in place an effective education and training system;
- ii. providers of NHS funded care to co-operate within the new education and training system; and
- iii. 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:

- i. understand the current workforce;

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

The detailed guidance on the workforce information that providers need to supply is signposted from the following web page: <http://digital.nhs.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.

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