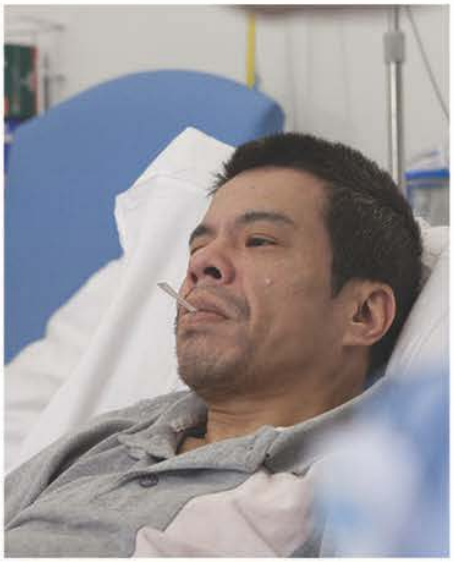
NHS
Commissioning Board

The NHS Standard Contract: a guide for clinical commissioners



THE NHS CONSTITUTION
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The NHS Standard Contract

A guide for clinical commissioners

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Prepared by the NHS Standard Contracts Team
on behalf of the NHS Commissioning Board

Contents

Aim of the guide

This guide is intended to introduce clinical commissioners to the NHS standard contract and how it can be used as a key enabler for commissioners to secure improvements in the quality of services for patients and service transformation.

Introduction

The NHS standard contract is the main mechanism for commissioners to hold providers to account for the quality and cost effectiveness of the services they provide and to drive service innovation and transformation.

The contract will support commissioners in ensuring providers deliver the pledges and obligations of the NHS Constitution and can also contribute to the achievement of the outcomes set out in the NHS Outcomes Framework.

The move to clinical commissioning provides the opportunity for greater local control of decision-making to lead to better patient outcomes and service improvements, and a chance to do things differently. From April 2013, commissioners will wish to review the contracts that they have inherited and may want to look towards procuring services differently for future years.

Where transformational change is needed, the NHS standard contract provides the flexibility to commission innovatively, using a range of service models and incentives.

What is the NHS standard contract?

The NHS standard contract is the contract that must be used by:

- CCGs when entering into contracts for clinical services (with the exception of any local improvement schemes commissioned on behalf of the Board and proposed transitional arrangements for current locally enhanced service agreements);
- the NHS CB when entering into contracts for non-primary care clinical services.

The contract is legally binding on all providers (ie Foundation Trusts, independent, voluntary and social enterprise sectors) with the exception of NHS Trusts[1]. However, the contract should be used with the same level of rigour with NHS Trusts, as if the agreement was legally binding.

The 2013/14 contract, together with detailed technical guidance, can be found on the NHS Commissioning Board website[2]. The contract is published as an eContract which will allow commissioners to produce a contract on-line which is tailored to the type of provider and the services being commissioned.

[1] Agreements between commissioners and NHS Trusts are 'NHS contracts' as set out in section 9 of the National Health Services Act 2006

[2] http://www.commissioningboard.nhs.uk/nhs-standard-contract/

https://commissioning.supply2health.nhs.uk/econtracts

How can the contract be used to drive and support the delivery of high quality services?

The NHS standard contract contains a number of levers to hold the provider to account for providing high quality services:

- **the service specification** which sets out the outcomes and standards required from the services;
- **quality requirements** and associated information which enable measurement of quality so that performance and progress against key outcomes can be measured and sanctions applied where agreed standards are not being met;
- **incentive schemes** (including, but not limited to, CQUIN) to recognise and reward quality improvement;
- **contract management processes** to safeguard against any deterioration in quality and performance.

Contracting fairly

The NHS standard contract provides the flexibility for commissioners to enter into a contractual agreement that meets the needs of their local health economy. It provides commissioners with contractual levers for use where necessary to address any situations where the provider is not delivering the service to the standards that have been set. Commissioners need to take a fair and proportionate approach to contracting. In particular:

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

Consideration over the use of choice and competition will play an important role in contracting fairly. Beyond upholding patients' statutory rights to choice as set out in the NHS Constitution, when procuring local clinical services it is for commissioners to decide if, and when, to use competition where it would improve services and outcomes for patients. In taking these decisions, commissioners will be required to work within and comply with a statutory set of rules to ensure that their procurement decisions are transparent and fair, that they purchase services from the providers best placed to meet patients' needs, and that they enable patients to exercise their rights to choose as set out in the NHS Constitution.

How can the contract support innovative commissioners?

To meet the challenges facing the NHS, CCGs will need to commission and contract differently and innovatively – for outcomes, for service integration, for transformation and for sustainability.

Annex 1 provides a summary of some of the commissioning and pricing approaches which can be used to achieve transformational change and, in particular, to support the provision of integrated care which will be crucial both in delivering a high quality service and experience to patients and in improving productivity and efficiency. Annex 2 contains a glossary of terms used.

None of these models is mutually exclusive.

Innovative commissioning and pricing approaches

- Commissioning a care pathway;
- Commissioning for a population/care group;
- Year of care models;
- Commissioning on payment for outcomes;
- Gain share/ risk share arrangements.

How does innovative commissioning differ from traditional approaches?

The innovative approaches to commissioning described in Annex 1 can help commissioners to deliver strategic transformation. These approaches will not be relevant or appropriate for every situation but can provide benefits for both patients and commissioners, where used appropriately.

The use of these approaches is only one element in delivering service transformation. Achieving strategic transformation in services relies not just on the use of innovative contractual approaches but on a range of other factors, including input from patients and effective relationships between commissioners and providers.

Commissioning support

Commissioners will need reliable, efficient and high quality support and specialist advice to enable them to commission and contract effectively to secure the best health outcomes, performance and value for their communities.

Commissioning Support Units (CSUs) have been established to provide these services at scale while at the same time tailoring them where needed to the requirements of individual CCGs. As a result, CSUs are ideally positioned to deliver financial economies for their customers, as well as service resilience.

CSUs are now operational across England and are providing a growing range of industry standard, benchmarked products and services to their customers. Their collective aim is to help commissioners develop and deliver high quality clinical commissioning and ensure the maximum return on investment in frontline healthcare

services, whilst ensuring high quality service delivery and the best possible outcomes for patients.

CSUs can enable the development of excellent clinical commissioning within the NHS by:

- attracting and securing the best people with the greatest expertise and knowledge and sharing, developing and retaining that talent through the provision of greater opportunities from scale and variety;
- allowing CCGs to focus on their accountabilities by providing the right skills at the right time;
- providing a lower cost of delivery through a focus on best practice ways of working, greater utilisation of people, synergy and sharing, and a reduction in duplication;
- better quality of service enabled by a critical mass of expertise, focused investment in people, project and service discipline, and a customer-focused mindset;
- supporting major service re-design and transformation to help CCGs meet improve quality, innovation, prevention and productivity (QIPP);
- providing additional strategic value through connecting thinking, insight and information across the system, facilitating collaborative innovation and transformation, and through providing specialist expertise and advice.

A list of CSUs is provided at Annex 3. In addition to CSUs, there is a range of non-NHS providers of commissioning support services that commissioners can also use to help meet the challenges they face.

NHS standard contract help

If you want to understand the NHS standard contract in more detail, detailed contractual guidance for the 2013/14 NHS standard contract is available at:

http://www.commissioningboard.nhs.uk/nhs-standard-contract/

https://commissioning.supply2health.nhs.uk/econtracts

Support on understanding and using the NHS standard contract is available by emailing nhscb.contractshelp@nhs.net

Other useful guidance

Current guidance which may be of relevance includes:

Commissioning primary care type services

http://www.commissioningboard.nhs.uk/files/2012/03/fact-enhanced-serv.pdf

Procurement guidance and briefings

http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

Personal health budgets

http://www.dh.gov.uk/health/category/policy-areas/nhs/personal-budgets/

Choice guidance

http://www.dh.gov.uk/health/tag/patient-choice/

Any Qualified Provider

https://www.supply2health.nhs.uk/AQPResourceCentre/Pages/AQPHome.aspx

Collaborative commissioning guidance

http://www.commissioningboard.nhs.uk/files/2013/01/model-comm-agreement.doc

Payment by Results

http://www.dh.gov.uk/health/2012/12/pbr-acute-mental/

Year of Care

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133652.pdf

Annex 1 - Summary of some of the commissioning and pricing approaches

Commissioning approaches

Commissioning approach	Conventional approach	Transformational approach	Potential benefits	Considerations	Pricing approaches
Care pathway commissioning	Contract with individual providers, each covering part of the care pathway	Contract with prime contractor who is responsible for management and delivery of whole care pathway, with parts of care pathway subcontracted to other providers (**Prime Contractor model**). The prime contractor may not be the largest provider in the pathway but the role is focused on the pathway service delivery	• Reduced inefficiency and improved pathway co-ordination. • Commissioner has one contract to manage rather than several.	• Consideration will need to be given to how patient choice can be supported. • The commissioner retains accountability for the services commissioned but is reliant on the prime contractor to hold subcontractors to account.	• Risk share. • Gain share. • Capitation funding (subject to PbR rules and Code of Conduct).
		Separate contracts with individual providers but with shared objectives (including **Alliance Contracting**)	• Reduced inefficiency and improved pathway co-ordination.	• Relies on strong working relationships between providers. • Need to be clear on where responsibility lies for delivery.	• Risk share. • Gain share.
		Providers jointly set up separate company to provide the service (Special Purpose Vehicle)	• Reduced inefficiency and improved pathway co-ordination.	• Needs formal governance/ accountability arrangements. • Need to consider	• Risk share. • Gain share. • Capitation funding.

Commissioning approach	Conventional approach	Transformational approach	Potential benefits	Considerations	Pricing approaches
			• Commissioner has one contract to manage rather than several.	how provider registration is achieved.	
		Contract with principal provider who subcontracts parts of the care pathway where needed (this differs from prime contractor model in that the provider will usually be the major provider of services	• Reduced inefficiency and improved pathway co-ordination. • Commissioner has one contract to manage rather than several.	• Consideration will need to be given to how patient choice can be supported; • The commissioner retains accountability for the services commissioned but is reliant on the prime contractor to hold subcontractors to account.	• Risk share. • Gain share. • Capitation funding.
Year of Care model	Focus on episodic care which isn't always based on individual patient needs	Focus on developing care packages derived from population needs that meet the specific needs of groups of patients. **Care pathway commissioning** approaches may be used to underpin this approach	• More appropriate care packages based on patient need.	• Consideration will need to be given to the most appropriate method of contracting. • Arrangements can be very complex.	• Risk share. • Gain share. • Capitation funding.

Pricing approaches

Pricing approach	Conventional approach	Transformational approach	Potential benefits	Considerations	Commissioning approaches
Outcome based payment (non-PbR services only)	Payment based on inputs ie individual items of service	Payment/ part payment based on **outcomes**	• Greater focus on achieving good outcomes and reduction in payment for services which do not add value.	• Outcomes need to be carefully set and measurable. • It could create perverse incentives for providers to set thresholds for treatment that increase health inequalities. • Reliant on good quality data being available. • Impact of variables outside the control of the provider should be considered. • May not be appropriate for some types of provider eg small providers reliant on cash flow. • Long term outcomes may require a longer contract duration.	• Year of care. • Care pathway models.
Capitation funding (non-PbR services only)	Payment based on inputs ie individual items of service	Funding provided on a fixed per person **capitation payment**. Can be used in conjunction with risk sharing, gain share	• Potential transfer of risk to provider. • Focus on providing the most efficient care pathways.	• Needs formal governance and accountability arrangements. • Can need specialist actuarial input.	• Year of care. • Care pathway models.

Pricing approach	Conventional approach	Transformational approach	Potential benefits	Considerations	Commissioning approaches
Risk sharing	Risk sits with commissioner for increased activity/ expenditure or provider for lower than expected activity / income	**Sharing of risk** of fluctuating activity/ expenditure with provider	• Incentive for provider to provide efficient, cost effective care closer to the patient's home. • Can reduce both commissioner and provider risk. • Supports collaborative, co-operative relationships. • Can support management of provider initiated internal demand.	• If significant fluctuations in activity/ expenditure beyond a certain level, may dis-incentivise provider action.	• Care pathway models. • Year of care.
Gain share	Provider or Commissioner cost savings remain with the provider or Commissioner	Any cost savings achieved are shared between the provider and commissioner	• Allows provider and commissioner to work together collaboratively to identify savings. • Supports development of long term strategic partnerships. • Facilitates new patterns of provision.	• Need to use robust and transparent indicators to ensure behaviours are not distorted towards savings at the expense of clinical safety and quality. • The length of time of the arrangement should be carefully considered, to avoid gain sharing cost reductions which could have been achieved without intervention. • Requirements for QIPP and efficiency need to be	• Care pathway models. • Year of care model.

Pricing approach	Conventional approach	Transformational approach	Potential benefits	Considerations	Commissioning approaches
				taken account of when determining the gain share agreement.	

Annex 2 - Glossary of terms

Prime contractor model

A single provider is responsible for managing an entire care pathway and enters into subcontracts with other providers for parts of the care pathway. The prime contractor may not be the largest provider but the role is focused on the management of the care pathway.

Principal provider model

The commissioner commissions a main provider to provide a pathway or service. This provider then subcontracts parts of the pathway, where needed. This provider will be providing the major part of the care pathway.

Alliance contract

An alliance contract works on the basis of equal, but separate parties, who work together collaboratively to deliver elements of a care pathway or service. This may be through an SPV.

Special Purpose Vehicle (SPV)

An SPV is a legal entity which is created for a specific purpose or remit. They can be used to shield the parent company from risk relating to that specific activity.

Year of Care model

Currently used for commissioning of some long-term conditions, this approach involves identifying care needs for individual patients and then using the aggregated information on the needs of the particular patient group to commission services.

Capitation funding

Using this approach, the commissioner pays the provider a fixed per person payment for delivery of a care pathway. Payments may be actuarially set, depending on the complexity of the arrangements.

Risk share

A risk share involves the provider and commissioner sharing the financial risk of fluctuations in either activity or cost. There may be upper and/ or lower limits to the level of financial risk shared.

Gainshare

This is a tool that allows commissioners and providers to identify and share savings, for example from providing a service in a different way.

Annex 3 - CSU contact details

Commissioning Support Unit	Managing director	Email	PA email	Telephone
NHS North of England Commissioning Support Unit	Stephen Childs	stephen.childs@nhs.net	suecureton@nhs.net	0191 374 4180
NHS Cheshire and Merseyside Commissioning Support Unit	Tim Andrews	timandrews@nhs.net	paula.gahan2@wirral.nhs.uk, sarah.bennett19@nhs.net	0151 6513926
NHS Greater Manchester Commissioning Support Unit	Dr Leigh Griffin	leighgriffin@nhs.net	Geraldine.jackson@nhs.net	0161 2124816
NHS Lancashire Commissioning Support Unit	Derek Kitchen	Derek.Kitchen@staffordshirecss.nhs.uk	paula.chivers@staffordshirecss.nhs.uk	03001 230995 (ext 4033)
NHS North Yorkshire and Humber Commissioning Support Unit	Maddy Ruff	maddy.ruff@nhs.net	sam.hart1@nhs.net, alison.kuppusamy@nhs.net	01482 672080
NHS South Yorkshire and Bassetlaw Commissioning Support Unit	Alison Hughes	alison.hughes@wycss.nhs.uk	amanda.jenkinson@wycss.nhs.uk	01484 464125
NHS West Yorkshire Commissioning Support Unit	Alison Hughes	alison.hughes@wycss.nhs.uk	amanda.jenkinson@wycss.nhs.uk	01484 464125

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NHS Norfolk and Waveney Commissioning Support Unit	Robert Garner	robert.garner@nhs.net	shirley.chusonis@nhs.net	01603 595823
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NHS North & East London Commissioning Support Unit	Andrew Ridley	Andrew.ridley@elc.nhs.uk	sophie.powling@elc.nhs.uk	0207 683 4469
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NHS South Commissioning Support Unit	Keith Douglas	keith.douglas@hampshire.nhs.uk	Caroline.Rogers@hampshire.nhs.uk	02380 627462
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