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To: CCG Clinical Leads
CC: CCG Accountable Officers

11 November 2013

Dear Colleague

Re: NHS Standard Contract and incentives for 2014/15

As you will be aware, NHS England has taken over responsibility from the Department of Health for development and publication of the NHS Standard Contract, and we are currently working on a revised Contract for 2014/15, for publication in December. We have also completed a review of incentives, rewards and sanctions, as we committed to do in Everyone Counts: Planning for Patients 2013/14.

On 4 November, the four oversight bodies for health and care planning issued a joint letter on assumptions from 2014/15. The letter reflected feedback we have received from commissioners that we need to be better at getting information out there sooner and for greater alignment across commissioning and provision. This letter is part of that process where we want to inform you about the direction of travel on the Standard Contract.

We have engaged with a range of stakeholders about what our priorities should be in developing the Standard Contract alongside our review of incentives, rewards and sanctions. We have had an excellent response to the discussion papers which we issued in July, and the joint workshops which we ran with Monitor on payment and incentives were also very well attended. All of this valuable stakeholder feedback is influencing our thinking as we work out our detailed proposals for next year. As annexes to this letter, I attach updates setting out early messages on the broad changes we are proposing to make to the Contract and package of incentives for 2014/15.

Under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, NHS England is specifically required to consult with CCGs on the re-drafting of the Standard Contract, and we are keen to ensure that we fulfil our duties in this

respect. We will shortly have a revised draft Contract available to share, but the Contract is a substantial set of documents, and we do not wish to overload CCGs by circulation of unwelcome material.

So, if your CCG wishes the opportunity to receive and comment on a copy of the revised draft Standard Contract for 2014/15, please register your interest, **by Friday 15 November 2013,** by sending an email with contact details for your contracting lead to

England.ContractsEngagement@nhs.net

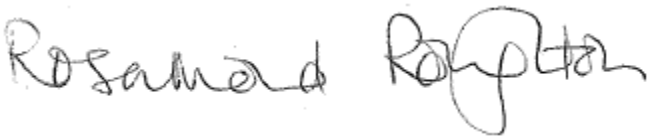
There is no obligation at all to respond, but we will welcome any further input from CCGs, as we seek to ensure that the Contract is as robust and useful as possible for the future.

In order for us to publish a revised Contract during December, the consultation process will necessarily be short, with a tight turn-around by late November for comments to be received. We will set out the precise timescale when we send out the draft Contract to those individuals notified to us by CCGs.

With best wishes

Yours sincerely

Paul Baumann
Chief Financial Officer



Rosamond Roughton
National Director : Commissioning Development

Annex A

NHS Standard Contract for 2014/15 – Direction of Travel

Introduction

The NHS England Standard Contract team is now working on the development of the revised Standard Contract for 2014/15. This paper gives stakeholders an idea of what changes to expect when the revised Contract is published, alongside other planning guidance, before Christmas.

Feedback from stakeholders so far

Thank you to all of those who provided feedback on the two discussion papers we published in July – one on the review of incentives, rewards and sanctions, the other on the wider development of the Standard Contract for 2014/15 – and also to all of those who attended our workshops over the summer.

On the Standard Contract, our discussion paper set out twelve key questions. We've summarised the feedback we received, and this is available separately at Annex B below.

How the Contract will change for 2014/15

The drafting of specific changes to the Contract for next year is still under way, but we can say some things about what the main changes will be – and also about what will be staying the same.

Mandatory use of the Standard Contract

The NHS Standard Contract will continue to be mandated for the commissioning of all clinical services other than mainstream primary care. That includes services which have up till now been covered by local enhanced services contracts. So please don't use other contract forms than the Standard Contract or try to vary the mandatory terms and conditions! If you think there is real obstacle to use of the Standard Contract in a specific local situation, please tell us – email us at nhscb.contractshelp@nhs.net.

At the same time, we will be reminding commissioners in our Technical Guidance that they remain able to make grants to voluntary bodies such as hospices, where they believe this would be more appropriate than placing contracts. Clearly, commissioners using grant agreements will need to ensure that these offer appropriate assurance about clinical safety, quality and value for money.

Continuity from 2013/14

The 2014/15 Standard Contract will be recognisably in the same format as the current version, and there will be a lot of continuity in terms of the detailed contract text – we will not be making changes for change's sake. The current three-part structure (Particulars, General Conditions and Service Conditions) will remain, and we are not planning to make significant changes to the main contract management clauses, for instance.

A more flexible approach to contract duration

For the last two years, the NHS Standard Contract has had a default duration of one year. Stakeholders have requested the ability to let contracts of longer duration, and our intention is to enable a more flexible approach for 2014/15 onwards.

In principle, it will be for commissioners to determine locally – within recommended parameters – the duration of contract which they wish to offer. We do not propose to set an arbitrary limit to contract duration, nor to establish a central approval process for contracts beyond a certain term. Our guidance is likely to suggest the following parameters.

- Where commissioners are seeking, through competitive procurement, transformative solutions requiring major investment and service reconfiguration, contracts with a duration of five to seven years may often be appropriate. We would advise commissioners not to offer contracts with a duration longer than seven years other than in exceptional circumstances.

- Where no competitive procurement is undertaken (for instance where services have been identified as Commissioner Requested Services because there is at that point only one available and viable provider), the commissioner will also have flexibility to place contracts longer than a single year. At this stage, our advice will be that it would not be appropriate to place a contract with a longer duration than three years.

The Standard Contract will continue to include provisions for early termination (but locally-agreed financial exit arrangements will offer protection to both parties in this situation) and for mandated National Variations which commissioners and providers will be required to implement.

Revised coverage and methodology for mandatory sanctions

The nationally-mandated sanctions set out in the Contract (in Schedule 4, Quality Requirements) will be overhauled to reflect the outcome of the review of incentives. We intend that this will result in a more balanced, proportionate, consistent and workable set of financial sanctions. See Annex C for additional detail.

Implementing the recommendations of the Francis report

Taking forward the actions set out in the Francis report will require a number of changes to the Contract. It is likely that these will include:

- strengthening commissioners' powers to intervene where sub-standard services are being provided;

- a new requirement for providers to use an evidence-based approach, reflecting guidance, to setting staffing levels, to review intended and actual staffing levels regularly, and to share the outcome of these reviews with commissioners;

- setting out clearer requirements on providers to assess and manage clinical risk;

- placing an unambiguous requirement on sub-contractors to meet all of the service standards required of the main provider (including abiding by the NHS Constitution); and

- restricting the use of "gagging" or non-disparagement clauses.

Other changes to the content of the Contract

We will make a series of other changes to the text of the Contract

- to implement policy priorities (on care planning and shared decision-making, for instance, or use of the NHS Number and the Summary Care Record Service)

- to respond to specific feedback on our discussion document (changing the financial reconciliation process, for instance, so that the onus is on the provider to produce reconciliation statements)

- to reflect the changing regulatory environment (updating contract clauses on Commissioner Requested Services, for example, on the National Tariff and on staff pensions).

The eContract

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

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

For 2014/15, we are looking to extend the tailoring functionality of the eContract, and we want to see a step-change in use of the eContract. In our *Prescribed Specialised Services Commissioning Intentions 2014/15-2015/16*, for instance, NHS England has set out that 'use of the eContract approach will become the norm for specialised services contracts for 2014/15'.

The eContract team has been in active discussion with system users and has listened to feedback on how to develop and refine the current eContract. Significant improvements are planned for introduction by late December 2013, including

- moving to an updated SharePoint platform, so that the system will be more versatile in its operating, for example faster and more responsive

- 'de-bugging' the system, eradicating some of the common problems which users have experienced, such as copy and paste and PDF errors

- enhancing the system with new features, including template approaches allowing multiple similar contracts to be produced easily and enabling auto-population of some fields

We would urge all commissioners to ensure that they familiarise themselves with the eContract ahead of the 2014/15 contracting round, so that they can maximise their use of the system. Until the enhancements, updated platform and 2014/15 Standard Contract are available via the eContract portal (scheduled for late December), it will remain in its current 2013/14 format but this will provide a good understanding for those new to the eContract.

The eContract portal can be accessed at:

https://commissioning.supply2health.nhs.uk/eContracts/Pages/default.aspx

If you would like to be added to the eContract mailing list to be kept up to date with changes and enhancements being made to the eContract, please email england.econtracthelp@nhs.net .

Technical Guidance

We will be reviewing and updating the Contract Technical Guidance for publication alongside the Contract in December.

Our Technical Guidance will explain the changes we are making to the Contract. Specifically, in response to stakeholder feedback, we are intending to:

- provide a template for a collaborative agreement for use where a local authority is a party to an NHS Standard Contract with an NHS commissioner acting as Co-ordinating Commissioner; and

- clarify how the NHS Standard Contract can be used to accommodate innovative contracting models such as the prime provider approach.

If there are any specific topics which you would like the Technical Guidance to cover, please let us know by emailing nhscb.contractshelp@nhs.net.

We will also be publishing a document detailing the key changes we have made to the 2014/15 Contract on our website at the same time that the Contract is published: http://www.england.nhs.uk/nhs-standard-contract/

Training for staff using the new Contract

We will be running workshops on the 2014/15 Contract from early January onwards. We'll publish the details in December. Training will also be available on the new eContract, primarily through webinars.

Again, if you have views on issues we should plan to cover in our training package, please email us. Equally, if you would like to register to receive a direct email with details of the training events, just let us know at nhscb.contractshelp@nhs.net.

Links and reminders

The NHS England has a dedicated website page relating to the NHS Standard Contract: http://www.england.nhs.uk/nhs-standard-contract/

All of the current Contract documentation is available here, as well as the Technical Guidance and National Variation templates. CQUIN guidance and in-year FAQs (for instance, clarifying the payment rules for the national Friends and Family Test indicator) are available on the same page.

NHS England published updated guidance in August 2013 on determining responsibility for payments to providers. This updated *Who Pays?* guidance includes a revised section clarifying the arrangements for non-contract activity and is available at:
http://www.england.nhs.uk/wp-content/uploads/2013/08/who-pays-aug13.pdf

Annex B

Summary of feedback received from CCGs, CSUs, providers and provider associations, regulators, charities and professional bodies

The 12 questions in the discussion document for stakeholders (CCGs, CSUs, providers and provider associations, regulators, charities and professional bodies) are given below with their feedback:

Q1. Do you support our intention to retain the current three-part structure for the Contract for 2014/15?

Feedback was overwhelmingly in favour of retaining the current Contract structure, with 98% of respondents supporting this. Comments included that Contract users are comfortable with the three-part structure and are accustomed to working with it.

Q2. Do you support our intention not to make material changes for 2014/15 to the clauses of the Contract dealing with contract management processes?

Feedback was overwhelmingly in favour of not changing the contract management provisions in the Contract. 95% of respondents supported this in order to give the changes made in the 2012/13 Contract time to bed in. Some respondents requested further information in the technical guidance document, and this will be considered by the NHS Standard Contract team.

Q3. Do you support our intention to provide a Contract with greater flexibility in terms of duration?

Feedback was overwhelmingly in favour of providing a Contract with greater flexibility of duration, with 98% of respondents supporting this. Both commissioners and providers provided feedback that a longer duration of term would reduce their administrative burden and would facilitate the delivery of improved outcomes over time.

Q4. Do you agree that the current Contract can support innovative commissioning models such as the 'prime contractor' approach? If not, what changes do you think are needed?

Two thirds of respondents believed that the current Contract can support innovative commissioning models, although there were requests for further guidance around this.

Q5. Can you suggest additional quality or service standards for community, mental health and other non-acute services which could be reflected in, and possibly incentivised through, the Contract in 2014/15?

Relatively few specific suggestions were put forward, although there were some specific comments, which will be considered by the NHS Standard Contract team.

Q6. Is the current guidance on collaborative contracting sufficiently comprehensive, detailed and clear? If not, which specific areas and issues require further clarification?

80% of stakeholders felt that current guidance is not sufficiently clear, and requested further guidance, particularly on collaborative contracting with local authorities.

Q7. If an improved, more reliable and responsive eContract system is made available for 2014/15, will your organisation plan to make use of it for the majority of its contracts?

98% of respondents stated that they would make more use of an improved eContract system, though there was also considerable feedback about problems with the current system. The Department of Health eContract team has engaged with system users and is implementing significant improvements to the system for 2014/15.

Q8. Are there types of contract or provider for which use of the NHS Standard Contract is proving particularly problematic? How can these problems best be overcome?

85% of respondents stated that the Contract is considered too large and unwieldy for certain types of provider and for smaller value contracts. This can be addressed in part by the further tailoring available via the eContract system for the 2014/15 Contract.

Q9 Do you agree that it would be appropriate to amend the Payment Terms clause, so that providers issue monthly reconciliation accounts, which each commissioner can then accept or contest?

There was very strong support amongst respondents for the proposal to amend the Payment Terms clause to include provision for reconciliation accounts. Most respondents commented that this is a realistic approach which reflects current practice.

Q10. Do you have suggestions for specific changes to the Reporting Requirements schedule of the Contract, with a view to safely reducing the information collection burden?

There was a general view from providers that the reporting burden should be reduced, but with relatively few specific proposals for how this could be done. There were some practical suggestions which will be considered by the NHS Standard Contract team.

Q11. In terms of practical completion of the Contract documentation, can you suggest ways in which this could be streamlined, eliminating any current requirements which are not seen as adding value locally? And do you have suggestions for the type of support you would like in understanding and using the Contract?

There was no consistent theme to the feedback received on this question. Several respondents provided general and specific comments, which will be considered by the NHS Standard Contract team.

Q12. Do you think that the Contract gets the balance right, in terms of the extent to which existing guidance on specific policy areas is re-stated within it? Should specific content be removed, or additional areas added?

There were very mixed views on this issue. Just over half of the respondents stated that the Contract balance is right in terms of how specific policy areas are re-stated.

Annex C

Review of incentives, rewards and sanctions

Introduction

NHS England is in the process of finalising the package of incentives, rewards and sanctions for 2014/15, following the conclusion of our review. This paper gives stakeholders an idea of what changes to expect when the CQUIN guidance, Quality Premium and revised Contract is published, alongside other planning guidance, before Christmas.

Feedback from stakeholders so far

Thank you to all of those who provided feedback on the two discussion papers we published in July – one on the review of incentives, rewards and sanctions, the other on the wider development of the Standard Contract for 2014/15 – and also to all of those who attended our workshops over the summer.

We've summarised the feedback we received on the review of incentives, rewards and sanctions, and this is available separately at http://www.england.nhs.uk/wp-content/uploads/2013/11/rev-incent.pdf.

Key messages

The conclusions of the review can be distilled into the following key messages:

The payment & incentive scheme is a vehicle to support and enable transformation (alongside other regulatory and market shaping tools) but cannot alone drive transformation.

- Different payment or incentive models are not an end in themselves

Transformation is best initially done, and then evaluated, through local freedom to innovate

- We should not pull national levers without a robust evidence base for doing so
- We cannot radically redesign incentives in isolation from payment and contract redesign
- There is an urgency to transforming services locally to deliver the QIPP challenge

Outside of local innovation, we should maintain stability, increase rigour and transparency, and simplify where possible

- We should improve national incentives & sanctions where there is a clear case for doing so
- We should use evidence based indicators unless we are seeking to experiment
- We should publish details of local innovations in our contracts

In summary, we propose for 2014/15, *"A national default position, but with freedom, support and encouragement for genuine innovation"*

Rules on local flexibility

Where commissioners and providers are seeking to transform services, through radically different contracting and payment models, we will allow flexibility in the application of national rules, including CQUIN and contract sanctions, where this complies with the following principles.

- It is in patients' best interests
- It is fair and transparent, published with clear justification
- Providers and commissioners engage constructively
- It is within the existing legal framework

These principles are consistent with those set out within the National Tariff consultation notice and we would expect Providers and commissioners to follow the same principles and processes as for local variations to national tariff prices.

We will confirm the requirements on publication in due course, but would as a minimum expect any local variations to the application of CQUIN or sanction rules to be clearly set out within the NHS Standard Contract, with rationale, and available on request.

These flexibilities do not apply to the Quality Premium.

Contract Sanctions

Calculation of sanctions

Respondents to our discussion document consistently told us that the current package of contract sanctions was not proportionate. The particular issues raised were: lack of consistency between national sanctions; sanctions disproportionate to the 'harm' done; excessive sanctions for C Difficile against sometimes very challenging standards; the definitional difficulties in applying sanctions as a % of a particular service line.

We are testing the feasibility of using a standard methodology for all contract sanctions (except Never Events and Ambulance response times), based on applying a sanction per patient for any patients over an agreed threshold. For example where the 18-week standard is 95%, any patient beyond that 95% threshold will incur a sanction. (Where the threshold is 100%, the sanction is simply applied per patient breach)

Content of sanctions

We are proposing the following changes, subject to final agreement in December:-

Ambulance
Implementation of sanctions for **ambulance response times** should move from annual to quarterly.

Acute
Updating the **C Difficile** thresholds
A new sanction based on **95% of patients risk assessed for VTE**

Mental Health
A national sanction for **follow-up on a Care Program Approach**
National sanctions for failure to submit MHMDS items, including Mental Health Act compliance and ethnicity

This sets out our current position, which may change. The final package of contract sanctions will be agreed by NHS England's executive team in December 2013.

Commissioning for Quality and Innovation (CQUIN)

We are removing the current requirement for providers to have met specific milestones with respect of high impact innovations in order to be eligible for any CQUIN payments, but will require provider and commissioner to agree a Service Development and Improvement Plan

We will clarify in the national rules that CQUIN payments do not apply to drugs and devices excluded from National Tariff.

We expect to have 4 national CQUIN indicators, in the following areas: Friends and Family Test; Dementia and Delirium (Acute Trusts only); Diagnosis coding and associated quality improvement (Mental Health Trusts only); NHS Safety Thermometer. Each should be worth a minimum of 0.125% of the total value of the Contract (excluding drugs and devices)

We will provide a non-mandated list of evidence based indicators for CCGs to use in developing local CQUIN schemes where appropriate, including where possible indicators that support transformation.

This sets out our current position, which may change. The final CQUIN scheme will be agreed by NHS England's executive team in December 2013.

Quality Premium

We plan to retain the same basic structure for the Quality Premium as in 2013/14, including carrying forward the rules on reduction or withholding quality premium funding, but providing greater clarity on the requirements.

We plan to have six indicators in total, five covering the domains of the outcomes framework and one for a local Health and Wellbeing Board priority.

The indicators associated with the five domains are to be as follows: Local improvement goal for potential years of life lost; achieving a nationally set level of IAPT access, or delivering improved access where this level is already being met; composite indicator for reducing avoidable emergency admissions; improvement in Friends & Family test scores; and improved reporting of medication error safety incidents.

This sets out our current position, which may change. The final Quality Premium scheme will be agreed by NHS England's executive team, including the relative weighting of each of the indicators, in December 2013.

Conclusion

We believe that the package of incentives, rewards and sanctions for 2014/15 resulting from the review will support and enable commissioners to deliver transformational change in 2014/15 and we've worked hard to align our work with other interdependencies. Figure 1 below gives a practical example of how the contract, payment and incentives could support transformation:

Figure 1 Improving diabetes care

On the basis of their needs assessment, a CCG wishes to develop an integrated diabetes service for their population, which is expected to improve quality of care for patients, improve outcomes and reduce emergency admissions and secondary care resource utilisation.

Providers and commissioners could **contract** for this service for five years using a prime provider model (this is just one of many options), with a single community provider subcontracting elements of care from secondary care physicians. (The CCG would need to follow procurement regulations in setting up this contract)

They could **pay** for this integrated service provision through a local variation to the diabetes tariff, agreeing a core payment, based on cost and assumed cost reductions, with a 20% performance bonus, based on delivering improved outcomes in patient satisfaction, care planning, blood glucose levels and blood pressure controls. (This could result in a net saving)

Alongside this they could **incentivise GPs** referring into the community service to improve the quality of their referrals and ongoing care (over and above the requirements of the core GMS contract), through use of a local incentive scheme agreed with their Area Team.