Draft NHS Standard Contract for 2015/16

A consultation

Draft NHS Standard Contract 2015/16: A consultation

Summary of stakeholder feedback and proposed changes to the NHS Standard Contract for 2015/16

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1 Introduction

The NHS Standard Contract is mandated by NHS England for use by NHS commissioners to contract for all healthcare services other than primary care. In August 2014, NHS England published a discussion document, asking for stakeholder feedback on how we should develop the Contract for 2015/16.

We received over 180 separate responses from individuals and organisations. This paper summarises the main themes in the feedback we received, and the way we have responded in developing the draft NHS Standard Contract for 2015/16. We hope these changes will make the Contract more robust and useful for the coming year. These changes arising from the engagement exercise are set out in part 2 of the document.

We have also included some wider changes, to keep the contract up-to-date and relevant, for example: to ensure it correctly relates to new legislation; to ensure it reflects significant new policies that have already been published over the last year; and to deliver technical improvements. The changes arising from this internal exercise are set out in part 3 of the document.

Stakeholder comments on the revised draft Contract should be sent to england.contractsengagement@nhs.net by Wednesday 31 December 2014. We will then publish the final version of the Contract in the New Year.

2 Issues on which we asked for feedback

2.1 Issue 1 The Contract as a commissioning lever

We asked whether the NHS Standard Contract should be used to support longer term strategic changes in local health systems, and what specific changes to it might strengthen the ability of commissioners to use it to support the longer term strategic direction in local health systems.

Consistent themes emerging from the responses to these questions were that:

- The Contract can and should be used locally to support longer term strategic changes and reinforcing system-wide behaviours.
- Specifically, providers can be incentivised via their contracts to work together better to co-ordinate and consolidate services for the benefit of patients, and to deliver system-wide outcomes.
- But many commissioners are not using existing contract levers effectively, or only for short-term goals.
- Use of longer-term contracts on a wider and more consistent basis would be helpful, as would longer-term CQUIN and other incentive schemes.
- But ultimately, contracts should only be seen as vehicles through which system-wide visions and plans, developed with input from all stakeholders,

are delivered. Each contract is only a stepping stone towards achievement of a shared strategic vision.
- It was felt that there is a need for greater and more widespread understanding of the local flexibilities and levers already available to commissioners.

Our response for 2015/16

In the short term, we will continue to promote the local flexibilities available to commissioners, in terms of contract duration and payment and incentives. As part of the work on implementing the NHS Forward View, NHSE with partners will lead work on innovative commissioning, contracting and pricing arrangements in order to support the development of new models of care.

2.2 Issue 2 Changes made to the Contract for 2014/15

We asked about the impact of the changes we made to the Contract for the current year.

Overall, the responses were positive about the changes made.

- The introduction of new standards relating to staffing was generally welcomed, although these new requirements are of course still bedding in.
- In general, stakeholders were keen to see continuity from year to year in the structure and content of the Contract.

Our response for 2015/16

We will maintain the existing three-part structure of the Contract, with limited changes to clarify or simplify contractual provisions or address important new priorities.

2.3 Issue 3 Mandated use of the NHS Standard Contract

We asked whether commissioners are now routinely using the NHS Standard Contract in accordance with NHS England's mandate and guidance, or whether there are still examples of other forms of contract being used. We asked whether there were specific issues with the Standard Contract which result in other forms being used:

- Responses indicated that the mandate and guidance are now well understood and complied with, in almost all circumstances. There is some residual misunderstanding about the use of the Standard Contract by local authorities (NHS England has no power to mandate them to use it, although they may choose to), or for purchase of non-clinical services (which it is not designed or mandated for), or as a sub-contract (on which see Question 9 below).
- There are isolated incidences of other forms of contract being used when the NHS Standard Contract should be, but these are few and far between.
- Nevertheless, it was felt that further guidance as to the circumstances in which the Standard Contract must be used, could be used, or should not be used, and where a grant agreement may be used, would be useful.
- A number of respondents raised the issue of the Standard Contract's suitability for small providers and low value contracts.

Our response for 2015/16

We will clarify and expand on our guidance. We will continue to look for opportunities to enable tailoring of the NHS Standard Contract to suit the needs of smaller providers and lower value contracts, within the parameters afforded by procurement rules and policy. See issue 6 on grants.

2.4 Issue 4 Tailoring the contract for different service types

We asked whether it was felt that there are provisions in the Contract which are inappropriate or redundant for particular service types, where alternative provisions might be appropriate, and where particular provisions might be omitted because they do not add value.

Specific suggestions and observations included:

- There needs to be a broader understanding of the extent to which the Contract can already be tailored. Further guidance may be helpful on the use of service categories and particular Schedules. NHS England could provide a grid indicating the applicability/non-applicability of individual provisions to particular service categories, as part of Contract Technical Guidance.
- Further tailoring might be appropriate to cater for different payment arrangements (block, cost & volume etc) and to restrict the application of the activity management provisions, which are not well-suited to all types of service.
- There could be further tailoring to suit the circumstances and organisational nature of smaller providers and community-based services (examples being those provided by community pharmacies and those provided by GP practices).
- Given the integration agenda, there will be benefits in ensuring that the Contract is fit for purpose for use by Local Authorities.

Our response for 2015/16

As described above, we will continue to look for opportunities to enable tailoring of the NHS Standard Contract to suit the needs of smaller providers and lower value contracts – and we will facilitate this by production of a simpler, more user-friendly eContract system. We do not intend at this stage to develop a short-form version of the Contract for use with low-value contracts – but we will produce a model grant agreement for use with voluntary sector providers (see issue 6 below).

2.5 Issue 5 NHS England as direct commissioner

We asked whether certain national requirements of NHS England as direct commissioner of services should be built into the nationally-mandated text of the NHS Standard Contract (but perhaps to be included or excluded by appropriate selection of option via the eContract system).

There were significant differences of opinion on this issue:

- NHS England commissioners were in support of the inclusion of nationally-mandated content related to specialised services, for inclusion or exclusion as required depending on the services being commissioned.
- Other commissioners were mostly in favour of this as well, with the clear proviso that specialised commissioning requirements should not appear in contracts under which only non-specialised services are being commissioned.
- Providers were less supportive. Some thought it might be helpful, but only if providers nationally are given the opportunity to review and provide feedback on proposed mandatory specialised services content before its inclusion on the Contract.

Our response for 2015/16

We will avoid overloading the Contract with mandatory text specific to directly-commissioned services – but, for 2015/16, we intend to mandate, through the Contract, compliance with NHS England's specifications (subject to any agreed derogations) and reporting requirements for specialised services, so that these have the status of non-negotiable national requirements within the Contract.

See Service Condition 1, Definitions, Particulars Schedule 2 and Schedule 6B.

2.6 Issue 6 Grant agreements

We asked whether commissioners would welcome the publication of a model grant agreement template, for use by a commissioner when providing part-funding to a voluntary sector provider, and the response was overwhelmingly positive.

Our response for 2015/16

In the NHS Forward View, we said we would seek "to reduce the time and complexity associated with securing local NHS funding, by developing a short national alternative to the NHS standard contract where grant funding may be more appropriate than burdensome contracts". We will publish a non-mandatory template grant agreement on the NHS Standard Contract webpage in January 2015. We will include additional guidance in the NHS Standard Contract 2015/16 Technical Guidance.

2.7 Issue 7 Contract management (General Condition 9) and financial sanctions

We asked about the impact of changes made to financial sanctions in the Contract for 2014/15 – and how about how workable commissioners and providers find the detailed contract management process set out in General Condition 9.

- There was recognition that commissioners do not always impose sanctions where they should do, which undermines their purpose.
- There were strong views, particularly from providers, that there should be more transparent rules around how funding withheld through sanctions should be used.
- There is acceptance that non-financial factors (regulatory intervention, reputational damage) are important influences on behaviour, alongside financial sanctions.
- Views varied on the appropriate sanction value for individual standards.
- Technically, the new methodology for sanctions in 2014/15, using a fixed-value sanction per breach, is perceived as easier to understand and simpler to operate in practice.
- In general, feedback was that the performance management provisions in the Contract are logical and workable, though they are sometimes viewed as lengthy and cumbersome. There is variability in the extent to which local health economies default to using the formal contractual provisions as the first resort, as opposed to first seeking informal resolution to problems.

Our response for 2015/16

The contractual position in 2015/16 will be that the application of financial sanctions will, without exception, be automatic for breaches of national quality standards. NHS England will ensure that this is followed in all its direct commissioning activity, and we will take action to ensure that CCGs similarly understand the requirement to apply mandatory sanctions. As part of this move, we will remove the flexibility for Sanction Variation which we introduced for 2014/15, as this has not, in practice, had the effect of increasing the transparency of commissioner decisions on application of sanctions.

To increase transparency, we will require all NHS commissioners (both CCGs and NHS England) to publish, on their public websites, details of financial sanctions which were due under their contracts with major providers – together with information on the level of sanctions actually applied. We intend to introduce a new data return for commissioners on the application of contractual sanctions.

We will also provide guidance on how commissioners should use the funding they withhold from providers through the application of financial sanctions in relation to national quality standards.

The value of most sanctions will stay the same, but we are concerned that in some key areas, patients are not receiving their Constitutional rights. We know that commissioners and providers take this seriously, and are working hard to address these challenges. We are enhancing existing levers within the Contract to support this focus. We are proposing to amend the sanction arrangements for 18-week waits and A&E four-hour waits, given the importance of delivering NHS Constitution requirements for patients in these two areas.

On 18 weeks, the vast majority of providers are already submitting weekly PTL returns, and we intend to make this return mandatory. This will ensure that accurate data to support the management of patients waiting for treatment is available at both local and national levels. We will develop a contractual standard to measure consistency between weekly and monthly returns, with a financial sanction for non-achievement. We will increase the value of the sanction applied per excess breach in respect of the three RTT standards by 25%.

On emergency care, the changes announced for 2015/16 to the marginal rate emergency rule in the National Tariff will provide additional funding for emergency activity in hospitals. We want to reinforce the work the NHS already has underway on delivering the Urgent and Emergency Care Review. We are concerned that our existing sanction on A&E breaches does not treat all patient breaches the same, because of the sanction "floor". Through the Contract, we propose altering the 'stop-loss' arrangements for sanctions. At present, there is no increased financial consequence for providers that achieve less than 92% performance in any month. We will reduce this 'floor' to 85% for 2015/16. At the same time, we propose reducing the financial sanction per excess breach from £200 to £150. For those trusts furthest from delivering the NHS Constitution standards for their patients, this

change is intended to encourage more radical transformation, as envisaged by the Urgent and Emergency Care Review.

We will make changes to simplify and shorten the process in the Contract, so that:

it is clear that the formal contractual performance management process should only commence where there is a known performance issue, rather than for an informal query;

the separate stages involving the Excusing Notice and the second Exception Report are removed, and the default will be to move to agree a Remedial Action Plan without the stage of a Joint Investigation;

it is made explicit that a Remedial Action Plan may include both required actions and required improvements in key indicators.

See General Condition 9 and Particulars Schedule 4A, 4B and 4H.

2.8 Issue 8 Never Events

We asked whether the approach within the Contract to Never Events should be changed, with financial sanctions focusing on failure to report, rather than applying to each individual Never Event.

Some respondents felt that a revised approach which would foster a culture of openness and learning in relation to Never Events, rather than penalising each individual occurrence. Equally, others stressed that Never Events should be viewed as very significant failures of care and that financial sanctions were appropriate in such cases. There was certainly a sense that commissioners needed access to strong contractual levers where there was evidence of a provider not learning from Never Events, with Events of the same kind recurring over a period of time within the same service or provider.

Our response for 2015/16

NHS England has just completed a separate consultation on a revised Never Events Policy Framework, with potential for changes both to the list of Never Events and to the way in which financial sanctions for Never Events operate within the Contract. We will consider the feedback received as part of the consultation process and publish any revised contract wording in the final Contract in December.

See Service Condition 33 and Schedule 4D.

2.9 Issue 9 Sub-contracting (General Condition 12)

We asked for views as to what would constitute a proportionate approach to commissioner oversight of provider sub-contracting arrangements. We asked whether the expectations implicit in the current Contract on sub-contracting unreasonable or unrealistic – and, if so, why. We asked whether we should publish a non-mandatory template for sub-contracts.

- There were significant differences of opinion about the degree to which commissioners should, or should even be entitled to, monitor sub-contracting arrangements.
- It was certainly felt that further clarification and guidance could usefully be offered around "materiality", the type of sub-contracts over which commissioners should exercise scrutiny, and what degree of scrutiny might be appropriate.
- The idea of a non-mandatory template for sub-contracts was widely welcomed.

Our response for 2015/16

We will review the provisions of GC12 and look to expand on the guidance we provide around sub-contracting.

We are already working with the Department of Health with a view to producing a non-mandatory template sub-contract for use by providers when sub-contracting clinical services commissioned under the NHS Standard Contract, which we hope will be published early in 2015.

See General Condition 12 and Definitions.

2.10 Issue 10 Dispute resolution (General Condition 14)

We asked how frequently commissioners and providers follow the formal dispute resolution process, rather than resolving in-year differences informally. We asked whether the process of Expert Determination set out in the Contract is workable in practice.

We asked whether there is sufficient clarity about the basis on which disputes relating to the agreement of a new contract should be handled, and whether further national guidance in this area would be helpful.

- It seems that in most cases in-year disputes are resolved informally and / or by the first few steps of escalation, and as a result there is very little experience of expert determination.
- Some concerns were expressed about the roles and perceived vested interests of NHS England and the TDA in the arrangement of mediation under the Contract disputes process.
- Pressures on both sides when agreeing new contracts were highlighted. It was widely felt that clearer national guidance around the resolution of pre-contract negotiations would be very useful.

Our response for 2015/16

We do not intend to make any material changes to the Contract dispute resolution process – but we will publish, with partners, updated guidance on resolution of pre-contract disputes.

2.11 Issue 11 Managing activity and referrals (Service Condition 29)

We asked stakeholders whether the activity management provisions are being used in practice and whether they create the right balance of responsibility and incentive between commissioner and provider.

- Some felt the current provisions struck the right balance.
- More providers tended to say that the activity management provisions favoured commissioners and were abused by them as a means of controlling expenditure.
- More commissioners felt that the provisions were not strong enough to offset the ability of providers to increase their income through growth in activity.

Although the provisions were seen as applying more to contracts with activity-based currencies, there were also comments about the need for controls on demand into services funded on a block basis.

There was some feedback that it would be helpful to streamline the process set out in the Contract.

Our response for 2015/16

Although we are mindful of the pressures on hospitals from rising referral levels, we intend to address concerns that some patients seeking to exercise their rights to choice, under the NHS Constitution, may be prevented from doing so by the implementation of policies by certain providers under which referrals from outside their immediate local area are declined. We are therefore proposing the introduction

of a specific contractual requirement on providers 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 provision could then be enforced by the Responsible Commissioner of any affected patient via GC29.1 (Third Party Rights). NHS England will engage with commissioners and providers during 2015/16 to evaluate the operation of this provision.

We will also provide clearer guidance on how the existing activity management provisions in the Contract are intended to be used, with example scenarios or case studies. We will do this through our Contract Technical Guidance.

See Service Condition 6.

2.12 Issue 12 Information flows, payment and financial reconciliation

We asked how effective the processes were within the Contract for providers to report to commissioners on activity, performance and quality and for the submission and validation of invoices and reconciliation accounts – and whether the Contract requirements for supporting data flows were proportionate.

In general, most respondents felt that the Contract processes, though complex, were reasonably logical and proportionate. Commissioners were generally keen to see stronger contractual provisions requiring patient level datasets to support all payments, whereas there was more concern from providers about the burden of data submission and reporting. Other themes included

- whether reporting requirements could reasonably be reduced for smaller providers
- whether the national timescales for financial reconciliation could be made clearer, particularly for non-contracted activity.

<u>Our response for 2015/16</u>

We propose a change in relation to the notification and implementation of counting and coding changes. The prior notification requirement will remain at six months, with agreed changes normally to be implemented at the start of each financial year – but we propose that both parties should be protected against any financial impact from agreed changes for the first full year from implementation. We believe that this is important in order to ensure that annual efficiency improvements required in the National Tariff are delivered, rather than being offset by gains or losses from recording changes.

We also propose to shorten, from six months to two months, the timescale within which providers must rectify Information Breaches, before the commissioner can retain permanently any sums withheld in respect of such Breaches. We will widen

the coverage of Information Breaches to include failure to use the NHS Number under SC23.5.

We will not, at this stage, include new requirements within the Contract about patient-level datasets to support payment. We will seek to clarify the reconciliation timescales and audit provisions, and we intend to propose that, for small providers, more of the content of the Reporting Requirements schedule should be for local agreement, rather than nationally prescribed.

See Service Condition 28, General Condition 15 and Particulars Schedule 6B.

2.13 Issue 13 The electronic contract system

Whilst acknowledging that there have been continuing difficulties with the timeliness and reliability of the eContract system, it is clear that there are still benefits in the eContract approach. In our discussion paper, we asked for feedback on what the next steps for the eContract system should be, and we also undertook a separate specific stakeholder engagement exercise.

Overall, there was considerable support for the principle of an eContract system – but even more frustration with the reliability and timeliness of the 2014/15 system. There was a strong theme that, for 2015/16, the system must be:

- available as early as possible in the contracting round
- easy to use
- reliable
- supported by a helpdesk and training.

Our response for 2015/16

Working with HSCIC, we will provide a significantly simplified, easy to use and robust eContract system for the 2015/16 contracting round, in January 2015. User guides will be available on the portal, and NHS England will provide an email helpdesk. Further details are available at https://www.econtract.england.nhs.uk/Pages/Home.aspx

2.14 Issue 14 Staff engagement and equality

We asked whether a new workforce race equality standard should be included in the 2015/16 NHS Standard Contract and whether providers should be mandated to use the Equality Delivery System (EDS2). Further engagement on this question was also carried out by the Equality and Health Inequalities Team in October 2014.

Overall, there was strong support for the inclusion of a Workforce Race Equality Standard in the 2015/16 Contract, although some respondents questioned whether it was reasonable to focus on race, rather than the full range of nine protected characteristics. There was general support for the adoption of EDS2.

We also asked whether there would be value in extending the current requirement on NHS Trusts and Foundation Trusts to undertake the NHS Staff Survey, so that this also applied to non-NHS providers. There was strong support for this from NHS providers. The responses from independent and voluntary sector providers were less positive, stressing that NHS models were not necessarily better than those used in the independent sector and should not be imposed.

Our response for 2015/16

The national Equality and Diversity Council met to consider responses to the consultation. In line with its recommendations, we will amend the Contract to include a requirement on all providers to implement the National Workforce Race Equality Standard (when published) and on NHS providers to implement EDS2.

We will engage further with independent and voluntary sector providers and others to explore whether it is practical and desirable to mandate use of the NHS Staff Survey for all providers in 2015/16. We will confirm the position on this in due course.

See Service Condition 12 and 13 and Particulars Schedule 6F.

2.15 Issue 15 Minimising redundancy costs when senior NHS staff are subsequently re-employed

We asked whether stakeholders felt that it would be appropriate for a new provision to be included in the Contract to disincentivise providers from re-hiring senior NHS staff made redundant by another NHS employer.

Respondents were in agreement with the underlying aim of reducing the financial cost to the NHS of 'revolving door' re-hiring, while concerns were expressed about the operation of a financial sanction within the contract.

Our response for 2015/16

We propose to include a requirement in the Contract that, where a provider hires an individual who has received an NHS redundancy settlement as a Very Senior Manager within the last twelve months, it must include in that person's contract of employment terms under which some or all of the redundancy payment will be clawed back from the individual (with the proportion depending on time elapsed since redundancy).

Separately, we will ensure that the same provisions are put in place relating to re-employment of individuals by NHS England or CCGs.

See General Condition 5.16.

2.16 Issue 16 Contract support from NHS England

We asked for views on whether what support the NHS Standard Contract team offer to commissioners and providers is useful and what more we should be doing. Responses were positive with stakeholders reporting a high level of satisfaction with the NHS Standard Contract Technical Guidance, the training offered and with the helpdesk. Some stakeholders commented on the timeliness of availability of key documents and suggested that FAQs could be published.

Our response for 2015/16

We will publish the NHS Standard Contract 2015/16 Technical Guidance in draft form on the new NHS Standard Contract webpage as early as possible in December 2014. We will provide training sessions on the NHS Standard Contract 2015/16 in January 2015. These will be advertised in the CCG Bulletin, the Area Team Bulletin, NHS News, and to our stakeholder list. If you would like to be added to our stakeholder list, please email your contact details to england.contractsengagement@nhs.net.

Taking confidentiality concerns into account, we will consider how FAQs could be published.

During 2015, NHS England will develop new approaches to commissioning, contracting and pricing where this can support the development of new models of care set out in the NHS Five Year Forward View.

Wider contract changes

2.17 New legislation, policy and guidance

These changes have to be 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
Fundamental Standards of Care	Update Contract wording, particularly with regard to Duty of Candour requirements, to ensure that the Contract is consistent with new regulations *(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)*	Service Condition 1, 16, 17 and 35
Antimicrobial resistance (AMR)	Include new provisions on AMR to require all relevant laboratory services to comply with PHE UK Standard Methods for Investigation; and to require compliance with the new Infection Prevention and Control Code of Practice. https://www.gov.uk/government/collections/standards-for-microbiology-investigations-smi https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance	Service Condition 21
Safeguarding and the Mental Capacity Act	Include stronger, clearer wording setting out provider's responsibilities on child and adult safeguarding and deprivation of liberty safeguards https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf	Service Condition 32
Care of Dying People	Include requirement to have regard to guidance on Care of Dying People, following publication of *One Chance to Get it Right: improving people's experience of care in the last few days and hours of life* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf	Service Condition 34
Hospital food standards	Introduce new requirement to follow guidance issued by the Hospital Food Standards Panel. https://www.gov.uk/government/publications/establishing-food-standards-for-nhs-hospitals	Service Condition 19
Armed Forces Covenant	Include a contractual requirement to have regard to the Covenant. https://www.gov.uk/government/publications/the-armed-forces-covenant	Service Condition 1

Topic	Change	Contract Reference
Social value and sustainable development	Add requirements on the provider to have regard to the Sustainable Development Strategy for the NHS, Public Health & Social Care System 2014-2020 and Public Services (Social Value) Act 2012. http://www.sduhealth.org.uk/delivery/plans.aspx	Service Condition 18
E-Referral system	Update Contract references to refer to E-referral rather than Choose and Book.	Service Condition 6
Discharge summaries	In line with the direction of travel towards a digital, paperless NHS, introduce a requirement for discharge summaries to be provided only by secure email or electronic transfer, rather than by secure fax. This requirement will apply to all NHS Trusts / Foundation Trusts and to all acute providers and will come into effect from 1 October 2015.	Service Condition 11 and Definitions
API Policy	Update Contract to require providers to have regard to NHS England's Open Application Programming Interfaces (API) Policy. http://www.england.nhs.uk/ourwork/tsd/sst/the-open-api-policy	Service Condition 23
National Tariff	Include additional Contract schedule relating to gain/loss-share funding arrangements for acute specialised services.	Particulars Schedule 3 I
Local prices	Adjust Contract wording about the agreement of Local Prices in a multi-year contract, so that it is clear that the parties may agree a specific annual price adjustment mechanism, but – failing that – must have regard to the efficiency and uplift factors set out in the National Tariff.	Service Condition 36
Charging migrants and overseas visitors	Update references within the Contract to reflect planned new DH requirements in relation to the levying of charges on migrants and overseas visitors using NHS services.	Service Condition 36.50
EPRR	Shorten Contract content by including requirement for providers to have regard to separate EPRR guidance.	Service Condition 30
Information Governance	Include an explicit requirement in the Contract for providers to undertake audits of their compliance with Level 2 of the Information Governance Toolkit, in line with existing guidance.	General Condition 21
Reporting requirements	Clarify Contract wording to ensure that there is a comprehensive requirement on providers so submit all nationally-mandated datasets and, including via Unify and SUS. http://www.isb.nhs.uk/documents/isb-0092/amd-16-2010/index_html)	Service Condition 28

2.18 Changes in response to proposals for 2015/16 CQUIN

Where national CQUIN indicators are 'retired', as part of previously planned changes to incentives schemes for 2015/16, we propose making the following changes to the Contract to place ongoing requirements on providers.

Topic	Change	Contract Reference
Safety Thermometer	Include requirement for continued use of Safety Thermometer tool and submission of data	Particulars Schedule 6B
Friends and Family Test	Include requirement for providers to maximise number of FFT responses received	Service Condition 12

2.19 Technical Changes

We propose to make a number of technical changes, because we believe they will make the Contract more effective in practice. They are being made in response to specific queries raised with the Contract team during the year by commissioners and providers.

Topic	Detailed change	Contract Reference
Termination	Enable greater flexibility in the notice period for no-fault termination of contracts, and allow explicitly for immediate termination by mutual agreement.	General Condition 17
Sub-Contractors	Clarify the definitions used in the Contract to describe Material Sub-Contractors.	General Condition 12 and Definitions
Variation	Simplify the process for Contract Variation by removing the requirement for a separate Variation Proposal and Variation Agreement.	General Condition 13

3 Consultation Responses

We invite you to review these materials and provide us with feedback on any of these proposals. The detailed draft Contract is available at http://www.england.nhs.uk/nhs-standard-contract/.

Stakeholder comments on the revised draft Contract should be sent to england.contractsengagement@nhs.net **by Wednesday 31 December 2014**. We will then publish the final version of the Contract in the New Year.