NHS England

NHS Standard Contract 2015/16

Technical Guidance

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Description	The NHS Standard Contract is the key lever for Commissioners to secure improvements in quality and cost effectiveness in their secondary healthcare contracts. The Technical Guidance outlines the changes made to the 2015/16 Contract, provides general guidance on contracting, and outlines the key topics in the Contract. It also includes a summary guide to competing the Contract.
Cross Reference	NHS Standard Contract 2015/16 (http://www.england.nhs.uk/nhs-standard-contract/15-16/)
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Document Status

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NHS Standard Contract 2015/16

Technical Guidance

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Updates

Version 2 March 2015:

Page 10 – update to paragraph 2.13 dealing with submission of Local Variations to Monitor

Page 63 – flowchart for SC28 (Information Requirements) updated

Page 77 – flowchart for SC36 (Payment and Reconciliation – Other Providers) updated

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.

Executive Summary

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Executive Summary

1 Introduction

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

2 Key changes to the NHS Standard Contract for 2015/16

2.1 The development of the NHS Standard Contract for 2015/16 was underpinned by a stakeholder engagement exercise during the late summer of 2014. The feedback we received from this engagement process is summarised in the consultation document published with the draft Contract in December 2014.

2.2 The 2015/16 Contract retains the same three-part structure and much of the same detailed content as the 2014/15 version. The key changes to the Contract for 2015/16 are summarised in the tables below. A detailed clause-by-clause summary of where changes have been made is available at Appendix 1.

Changes affecting direct provision of services

Topic	Change	Reference
Fundamental Standards of Care	Updates 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 and the Health and Social Care Act 2008 (Regulated Activities) Amendment) Regulations 2015).	Service Condition 1, 16, 17 and 35
Infection control and antimicrobial resistance	Includes new provisions to require all relevant laboratory services to comply with PHE UK Standard Methods for Investigation; and to require compliance with the Infection Prevention and Control Code of Practice.	Service Condition 21
Safeguarding and the Mental Capacity Act	Includes stronger, clearer wording setting out provider's responsibilities on child and adult safeguarding and deprivation of liberty safeguards	Service Condition 32
Care of Dying People	Includes 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	Service Condition 34
Hospital food standards	Introduces new requirement to follow guidance issued by the Hospital Food Standards Panel.	Service Condition 19

Topic	Change	Reference
Acceptance of referrals	Introduces a 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.	Service Condition 6
Safety Thermometer	Includes a requirement for continued use of the Safety Thermometer tool and submission of data (after retirement of the related national CQUIN indicator)	Particulars Schedule 6B
Armed Forces Covenant	Includes a requirement to have regard to the Covenant (https://www.gov.uk/government/publications/the-armed-forces-covenant).	Service Condition 1
Learning disability services	Includes a requirement on relevant providers to have regard to Transforming Care, the national response to Winterbourne View, and subsequent guidance.	Service Conditions 6 and 11

Changes to give effect to supporting policies

Topic	Change	Reference
Redundancy	Introduces a requirement 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.	General Condition 5
Equality Delivery System 2 (EDS2)	Requires providers to implement EDS2.	Service Condition 13
Workforce race equality	Requires providers to implement the recently published national Workforce Race Equality Standard.	Service Condition 13
Social value and sustainable development	Adds 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.	Service Condition 18
Discharge summaries	Introduces 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	Updates Contract to require providers to have regard to NHS England's Open Application Programming Interfaces Policy.	Service Condition 23
Charging migrants and overseas visitors	Updates 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
Friends and Family Test	Includes requirement for providers to maximise number of FFT responses received	Service Condition 12

Information Governance	Includes 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
Tax Avoidance	New provisions to reflect Cabinet Office Guidance Procurement Policy note: Measures to Promote Tax Compliance, which should also be reflected in procurement exercises leading to appointment of a provider.	General Condition 25.1.8
Public Contracts Regulations	New rights of termination as required by the Public Contracts Regulations 2015	General Condition 17

Changes to improve contractual processes

Topic	Detailed change	Reference
Performance sanctions	Modifies the sanctions for A&E and elective care waiting times. Removes the Sanctions Variation flexibility, requires publication and reporting of sanctions applied by commissioners, and provides guidance on use of funding withheld by commissioners.	Particulars Schedule 4A and 4B, and Technical Guidance
Contract management	Streamlines the process for management of contractual breaches.	General Condition 9
Local prices	Adjusts 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
Counting and coding changes	Protects both parties against any immediate financial impact from agreed changes in counting and coding.	Service Condition 28
Information Breaches	Shortens, from six months to three months, the timescale within which providers must rectify Information Breaches, before the commissioner can retain permanently any sums withheld in respect of such Breaches.	Service Condition 28
Reporting requirements	Clarifies Contract wording to ensure that there is a comprehensive requirement on providers to submit all nationally-mandated datasets, including via Unify and SUS.	Particulars Schedule 6B
Sub-Contractors	Clarifies the definitions used in the Contract to describe Material Sub-Contractors and provides clearer technical guidance in this area.	General Condition 12 and Definitions
Variation	Simplifies the process for Contract Variation by removing the requirement for a separate Variation Proposal and Variation Agreement.	General Condition 13
Termination	Enables greater flexibility in the notice period for no-fault termination of contracts, and allows explicitly for immediate termination by mutual agreement.	General Condition 17

Topic	Detailed change	Reference
Contracting for primary care services	Provides for inclusion of a new optional schedule to make the NHS Standard Contract compliant with APMS Regulations, so that a commissioner can procure primary medical care and secondary care under a single contract.	Particulars Schedule 2L

eContract

2.3 NHS England is also launching a revised eContract system for 2015/16. The new system will be significantly simpler and easier to use. Only commissioners will need to access the system, which will focus on the production of tailored, shorter contract documentation, rather than the storage of contracts. Further details about the eContract system are available in paragraph 28 below and via https://www.econtract.england.nhs.uk/Pages/Home.aspx.

2.4 Shorter, more relevant contracts – excluding detail not applicable to the specific services being commissioned – will in particular help smaller provider organisations to deal with the complexity of NHS contracting. Commissioners are therefore strongly encouraged to use the revised eContract system to generate their contract documentation.

Model grant agreement

2.5 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 6 below.

Supporting new models of care and commissioning

2.6 During 2015, NHS England will work with stakeholders to develop new approaches to contracting to support the implementation of the new models of care set out in the NHS Five Year Forward View.

Tariff arrangements for 2015/16 in the Contract

2.7 NHS England and Monitor wrote to provider Chief Executives on 18 February 2015 (https://www.gov.uk/government/news/tariff-arrangements-for-201516-activity), setting out tariff arrangements for 2015/16, with a choice for providers between the Default Tariff Rollover and the Enhanced Tariff Option.

2.8 The 2015/16 NHS Standard Contract has been worded to be compatible with either of these options. The Contract wording (SC 36) makes clear that payments must be made in accordance with the current applicable National Tariff.

Default Tariff Rollover (DTR)

2.9 Where the provider has chosen to operate under DTR, the national prices, currencies and rules set out in the 2014/15 National Tariff will continue to apply. The commissioner and provider should complete the relevant sections of Schedule 3 of the Contract, covering Local Prices (3A), the baseline for the Marginal Rate Emergency Rule (3D) and Emergency Readmissions within 30 days (3E), all agreed in accordance with the 2014/15 National Tariff.

2.10 In terms of CQUIN, the Contract wording requires a CQUIN scheme to be implemented "where and as required by CQUIN Guidance" (Service Condition 38); CQUIN Guidance has now been published by NHS England (available at http://www.england.nhs.uk/nhs-standard-contract/15-16/) and this makes clear that providers operating under DTR are not eligible for CQUIN. The detailed provisions of Service Condition 38 relating to CQUIN will continue to appear in all contracts, but – for providers on DTR – these provisions should be 'read over', no actual CQUIN scheme should be included at Schedule 4E, and no CQUIN payments should be made.

2.11 It is not a requirement of the DTR that providers implement or report on national CQUIN indicators, but we would encourage all providers to work with their commissioners to improve service quality. Where DTR applies and no CQUIN scheme is implemented, commissioners may seek to negotiate with providers specific quality standards or Service Development and Improvement Plans for inclusion in their contracts; this is a matter for local negotiation.

Enhanced Tariff Option (ETO)

2.12 Where the provider has selected ETO, a CQUIN scheme should be agreed and included in the Contract at Schedule 4E, as set out in CQUIN Guidance.

2.13 To give effect to ETO, the commissioner and the provider will need to complete a Local Variation, upload this through the Monitor Pricing Portal and include it within their contract at Schedule 3B. A template for this Local Variation will be published by NHS England and Monitor shortly.

2.14 Under ETO, the commissioner and provider should also complete the other relevant sections of Schedule 3 of the Contract, covering Local Prices (3A), the baseline for the Marginal Rate Emergency Rule (3D) and Emergency Readmissions within 30 days (3E), where and as applicable.

SUS

2.15 Further guidance will be provided in relation to the operation of SUS PbR in 2015/16 in relation to ETO and DTR, but the expectation is, under both ETO and DTR, that providers of acute services must continue to submit data to SUS and that the payment reconciliation process set out in Service Condition 36 of the Contract will apply to providers on ETO and DTR, in line with the SUS timetable published by HSCIC at http://www.hscic.gov.uk/sus/pbrguidance.

3 Advice and support

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

Section A General guidance on contracting

4 Content of this section

4.1 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, non-contract activity and innovative contracting models.

5 Use of the NHS Standard Contract

When should the NHS Standard Contract be used?

5.1 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.

5.2 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 a 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.

5.3 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 involve payments for improving the quality of services provided under an existing GP contract, not the commissioning of additional services.

5.4 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.

5.5 Increasingly commissioners are exploring opportunities to commission combinations of primary and secondary care services, to be delivered by a single provider (or a lead provider and its sub-contractors) in an integrated fashion. There will be much greater focus on this approach in future, as highlighted in the NHS Five Year Forward View – among the new provider models it mentions, Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) are specifically envisaged as potential providers of such integrated service packages. We have been developing, and will continue to develop, in conjunction with stakeholders, contractual approaches to support these new care and provider models.

5.6 For 2015/16, we have included an additional schedule in the NHS Standard Contract (Schedule 2L) headed "Provisions Applicable to Primary Care Services". This Schedule may be used, where appropriate, to accommodate the further provisions required in order to make the Contract compliant with the Alternative Provider Medical Services (APMS) regulations. With this addition, the Contract will be both an NHS Standard Contract and an APMS contract – and therefore a vehicle which may legitimately be used to commission both secondary and primary care services from the same provider under a single contract. We are publishing a template form of those further provisions, for inclusion in Schedule 2L where appropriate, at http://www.england.nhs.uk/nhs-standard-contract/15-16/, along with guidance about their use.

5.7 In the immediate future, an APMS-compliant version of the NHS Standard Contract (ie 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.

5.8 There are thus two routes through which a CCG can commission out-of-hours primary medical services on behalf of NHS England – either, as previously, through a stand-alone APMS contract or (when, and only when, those out-of-hours services are being commissioned as part of an integrated service including services other than primary medical services) by use of an APMS-compliant version of the NHS Standard Contract.

5.9 Schedule 2L, with supporting templates for general practice services and potentially to cover other primary care services, has potential for use in a wide variety of circumstances in support of new care models over the coming years.

What elements of the Standard Contract can be agreed locally

5.10 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.

5.11 Commissioners must not

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

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

6 Use of grant agreements

6.1 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.

6.2 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 offered to all potential providers of the relevant service – which precludes the use of a grant agreement.)

6.3 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. This will apply to some hospice services, for example.

6.4 NHS England has published (initially in draft – for use but also for feedback) a non-mandatory model grant agreement for use with voluntary sector organisations which provide clinical services (available at http://www.england.nhs.uk/nhs-standard-contract/grant-agreement/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 at http://www.england.nhs.uk/nhs-standard-contract/grant-agreement/.

6.5 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.

7 NHS Continuing Health Care and Funded Nursing Care

7.1 We expect the NHS Standard Contract to be used where a commissioner is fully funding an individual's NHS Continuing Health Care (NHS CHC) placement in a care home or package of home care.

7.2 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.

7.3 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.

7.4 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.

7.5 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.

8 Collaborative contracting

8.1 The NHS Standard Contract may be used for both bilateral and multilateral commissioning ie for commissioning by a single commissioner or by a group of commissioners collaborating to commission together, with one acting as the co-ordinating commissioner.

8.2 There can be great benefits for commissioners from working closely together to negotiate and agree contracts with providers. Using the co-ordinating commissioner model enables a consistent approach to contracting and is more efficient for both commissioners and providers, avoiding a proliferation of small, separate contracts. However, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model. NHS England has published supporting guidance for commissioners considering the different ways of working with other commissioning bodies called The Framework for Collaborative Commissioning available at http://www.england.nhs.uk/wp-content/uploads/2012/03/collab-commiss-frame.pdf.

8.3 Where commissioners choose to contract collaboratively, they should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider in a formal collaborative commissioning agreement (CCA). The CCA is a separate document entered into by a group of commissioners and governs the way the commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, a contract which has been signed by all the parties (as outlined in paragraph 10 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.

8.4 A model CCA is available at http://www.england.nhs.uk/nhs-standard-contract/15-16/. The model agreement was updated in 2014 to allow for the situation where a local authority is party to the collaborative arrangements and to make appropriate provision for the revised arrangements for agreement of Variations (see paragraph 10), and for agreement of other key actions to be taken by the co-ordinating commissioner on behalf of all commissioners.

8.5 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.

9 Which commissioners can be party to the Standard Contract

9.1 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.

9.2 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.

9.3 By contrast, where an NHS commissioner has devolved commissioning responsibility to a local authority under a formal lead commissioning arrangement, the local authority would be able to contract on its own chosen basis. As the NHS commissioner would not be a party to the contract, there would be no requirement for the NHS Standard Contract to be used – 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.

10 Signature of contracts and variations

10.1 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.

10.2 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.

10.3 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.

10.4 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) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.

11 Legally binding agreements

11.1 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.

12 Contract duration

12.1 The NHS Standard Contract allows the commissioner to select the contract term it wishes. There is no default duration.

12.2 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.

12.3 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.

12.4 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 13) and/or the consequences of early termination (see paragraph 41).

- 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. Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.

- Where no competitive procurement is undertaken, increased flexibility in contract duration can still be considered, but we would advise commissioners to think carefully before placing contracts with a duration longer than three years in these circumstances.

- 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.

12.5 Alongside greater flexibility of contract duration, the Contract

- now 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 on a no-fault basis, with greater flexibility as to notice periods.

12.6 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).

13 Extension of contracts

13.1 Commissioners may wish, when procuring services on a competitive basis, to offer a contract with the possibility of extension – for example, a five year contract term with the potential for an extension, at the commissioner's discretion, by a further two years.

13.2 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.

13.3 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 a competitive procurement is undertaken for the contract and where the commissioner has made clear, from the very outset of the procurement process, the period and other details of any possible extension to the initial contract term.

- Commissioners should have regard to procurement guidance in determining whether it is appropriate to offer provision for contract extension. We would 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 contract at the point the contract is agreed and signed and must not be varied subsequently.

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

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

13.4 Where provision for extension is made in a contract, the actual extension can then be enacted 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).

14 Contracts not expiring at 31 March 2015

14.1 There will be contracts already in place which do not expire at 31 March 2015. To ensure that, for 2015/16, these contracts reflect the current legislative and policy framework, the parties should use the National Variation Agreement template which will be published at http://www.england.nhs.uk/nhs-standard-contract/15-16/ 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 2015/16 NHS Standard Contract form in its entirety, maintaining the current duration of the contract.

14.2 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.

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

15 Negotiation of new contracts for 2015/16

15.1 The majority of contracts are still on a one-year basis and will therefore expire automatically on 31 March 2015. 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.

15.2 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 32 below), then restrictions on the provider's ability to withdraw provision of the service will apply, in line with Monitor'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.

16 Heads of Agreement

16.1 We are sometimes asked about Heads of Agreement and whether these have a place in the negotiation of new contracts.

16.2 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.

17 Changes in counting and coding practice

17.1 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 paragraphs 38.10 to 38.20 below.

18 Resolution of disputes in relation to new contracts for 2015/16

18.1 NHS England, the NHS TDA and Monitor have published joint guidance on the resolution of disputes relating to the agreement of 2015/16 contracts between NHS commissioners and providers. The guidance describes the steps and timetable for the process, the final stage of which will involve formal arbitration. For contracts involving NHS Trusts, arbitration will be mandatory and will be organised by NHS England and the NHS TDA. The guidance is available at http://www.england.nhs.uk/nhs-standard-contract/15-16/. The arbitration process may also, by agreement, be used for disputes about unsigned contracts between commissioners and providers other than NHS Trusts.

19 What happens when there is no signed contract in place

19.1 Commissioners and providers should make every effort to have signed contracts in place for all services by, at the latest, 31 March 2015. Failure to do so creates a financial and legal risk for commissioners and providers, and uncertainty about the continued safe provision of services.

19.2 However, owing to the delays in confirming National Tariff arrangements and the publication of the NHS Standard Contract for 2015/16, there may be instances where commissioners and providers have not signed a new contract by 31 March 2015, but because the services being delivered are crucial for the local community they must continue to be delivered.

19.3 In this situation, a contract will be implied to exist between the parties. Even though there is no written contract, the following principles will apply:

- The terms of the implied contract will include the nationally drafted terms of the NHS Standard Contract for 2015/16.
- In respect of pricing:
  - where a provider has chosen the Enhanced Tariff Option (ETO), the pricing arrangements for ETO set out in the joint NHS England / Monitor letter of 18 February 2015 will apply, with a CQUIN scheme available in line with prevailing CQUIN Guidance;
  - where a provider has chosen the Default Tariff Rollover (DTR), the pricing arrangements for DTR set out in the joint NHS England / Monitor letter of 18 February 2015 will apply, with no eligibility for CQUIN; and
  - where a provider rejected DTR and ETO or did not respond to the joint NHS England / Monitor letter of 18 February 2015, the pricing arrangements for DTR set out in the joint letter will apply, with no eligibility for CQUIN.
- Further detail in relation to ETO and DTR is set out in a series of Questions and Answers provided by NHS England and Monitor.

20 Acceptance of referrals and non-contract activity

20.1 We have sought 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 have therefore introduced a specific contractual requirement on providers (SC6.5.2) 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 provision 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). NHS England will engage further with commissioners and providers during 2015/16 to evaluate the operation of this provision.

20.2 Conversely, we have also set out clearly (SC6.6) 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 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.

20.3 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.

20.4 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."*

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

20.6 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."*

20.7 In practice, acute NCA will need to be reported via SUS, with invoices raised by providers in line with the timescale set out in SC36.44. 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.

21 Letting of contracts following procurement

21.1 Where a contract is being let following a competitive procurement process, the commissioner must let the contract to the chosen provider exactly on the advertised basis. This 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.

21.2 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.

21.3 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.

22 Innovative contracting models

22.1 Commissioners looking at major service redesign projects have wanted the flexibility for longer-term contracts, and the 2015/16 Standard Contract retains the flexibility on contract term introduced for 2014/15. Equally, the National Tariff sets out the flexibility for commissioners and providers to agree Local Variations to national prices.

22.2 As noted in paragraph 5.5 above, commissioners and providers are looking increasingly at innovative contracting and service delivery models, particularly to facilitate closer integration of services. The focus on new models of care, blurring the divide between primary, community and hospital care, and involving networks of care rather than individual commissioner/provider relationships, will increase over the next few years, as signposted by the NHS Five Year Forward View.

22.3 Some of the innovative models which we know are being explored, and/or which may need to be explored in order to deliver the NHS Five Year Forward View are described briefly below.

Prime contractor / lead provider model

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

Integrated pathway hub (IPH)

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

Alliance contracting

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

How these models fit with the NHS Standard Contract

22.7 Both the prime provider and the IPH models can be used with the NHS Standard Contract. For 2014/15, we specifically strengthened the provisions in the Contract around sub-contracting, so that they better support these models. We have kept the operative provisions the same for 2015/16, but we have expanded on some of the associated definitions and guidance to make certain distinctions clearer.

22.8 One obvious limitation of the Standard Contract and other existing forms of clinical commissioning contract (GMS, PMS, APMS etc) is that (by law and regulation) none is capable of being legitimately used as a prime or lead contract under which a package of primary and secondary care services may be commissioned. We have sought to address this limitation as set out in paragraph 5.6 above.

22.9 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).

22.10 We are producing a template Alliance Agreement, which commissioners may use a starting point for development of their own alliancing arrangements with providers. The template and guidance on its use will be available on the NHS Standard Contract webpage in due course.

23 Contracting approaches to support personalisation

Integrated Personal Commissioning

23.1 The Integrated Personal Commissioning programme will be a demonstrator programme for areas wanting to lead the way in implementing a new integrated and personalised commissioning approach for people with complex needs. Sites will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used. 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 is due to begin 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

23.2 The NHS Mandate sets an ambitious objective that people with long term conditions who could benefit from a personal health budget (PHBs) will have the option to hold one, including one delivered by direct payment, from April 2015.

23.3 As a first step, a roll-out of PHBs for those eligible for NHS continuing health care and children and young people eligible for continuing care is already under way, with a “right to have" that came into force on 1st October 2014. However, PHBs are not restricted to these groups, so CCGs can offer PHBs more widely on a voluntary basis. Information regarding PHBs is available at: http://www.personalhealthbudgets.england.nhs.uk.

23.4 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 7.3 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.

23.5 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.

23.6 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.

24 Contracting fairly

24.1 The contract is an agreement between the commissioner(s) and the provider. Once entered into, the contract is a key lever for commissioners in delivering high-quality, safe and cost-effective services. However, the contract in isolation will not achieve this. An effective relationship between commissioner(s) and provider is a key element of successful contracting.

24.2 A good relationship will depend on the parties taking a fair and proportionate approach. In particular:

- relationships should be constructive and co-operative;
- locally-agreed requirements within contracts should be realistic and deliverable;
- there should be a fair balance of risk between commissioner and provider;
- any local financial sanctions should be proportionate;
- the contract is not intended as a lever to micro-manage providers;
- commissioners should set clear outcomes and appropriate quality standards, and not over-specify these; and
- commissioners should only request information from providers that is reasonable and relevant, with consideration given to the burden of provision of the information. Wherever possible, information that is already available, via central collections or otherwise, should be used.

25 Links to other resources

25.1 A number of useful links are set out below.

NHS Five Year Forward View
NHS England and national partner organisations

The Forward View into Action: Planning for 2015/16
NHS England and national partner organisations

CQUIN Guidance 2015/16
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

Who Pays? Information Governance Advice for Invoice Validation
NHS England

SUS 2015/16 PbR Submission Timetable
HSCIC

Section B Completing and using the Contract

26 Content of this section

26.1 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.

26.2 For each topic within this section, we highlight where specific changes have been made to the Contract for 2015/16. 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 2015/16;
- 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.

27 Structure of the NHS Standard Contract

27.1 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.

28 The e-Contract system

28.1 NHS England is launching a revised, simplified eContract system for the 2015/6 contracting round.

28.2 The existing eContract system is complex. It proved extremely challenging to develop and release a robust system in time for it to be used in the 2014/15 contracting round – and the complexity of the system has meant that uptake by commissioners in practice has remained very low.

28.3 Following stakeholder engagement in summer 2014, we have developed, with HSCIC, a revised system which will

- be much simpler and quicker to use, as well as more reliable
- focus on what was always intended to be 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.

28.4 Our intention is that this will encourage much greater use of the system by commissioners, particularly in the production of contracts for smaller provider organisations, where the ability to shorten and simplify contract paperwork, as much as possible, can be particularly important.

28.5 The new eContract system is essentially a contract generation system, rather than a contract storage system. Only commissioners will need to use the system. A commissioner will select basic contract options (for example, service categories and payment options) which drive changes to the Particulars or Service Conditions.

28.6 The system will then produce a tailored and shorter pdf 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. A commissioner can also create a contract proforma for use when the commissioner intends to use the same tailored Service Conditions multiple times.

28.7 The commissioner will then complete population of the Particulars locally (not within the eContract system) and will then issue the draft contract to the provider direct. The system will not store the final contract.

28.8 A user guide to the 2015/16 system will be available on the 2015/16 portal. An email helpdesk for the 2015/16 is available via england.econtract@nhs.net. The 2015/16 eContract system is designed to run on several internet browsers, including IE7, IE8, Mozilla Firefox or Google Chrome.

28.9 For queries relating to the 2014/15 eContract system, the 2014/15 helpdesk details should be used: exeter.helpdesk@hscic.gov.uk, 01392 251 289. The 2014/15 eContract system will be in use until 31 March 2015 and will be decommissioned during 2015. Existing contracts and variations cannot be migrated to the new system.

29 Contracts for new services or with new providers

29.1 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)

29.2 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.

29.3 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.

29.4 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.

Transition Arrangements (Schedule 2H and GC4.4)

29.5 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)), 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.

Contractual processes carried forward from previous contracts

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

30 Tailoring contract content

Service categories

30.1 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.

30.2 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.

30.3 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.

30.4 The one new category introduced for 2015/16 is *111 Services*. Two categories have been re-named for clarity (*End Of Life Care Services* and *Pharmacy Delivered Community Services*) – and one category has been deleted (*Substance Misuse Services*) because there is no longer any specific tailoring of the Service Conditions or Particulars for this particular service type.

30.5 Note that the *Community Services* and *Surgical Services in a Community Setting* categories are 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 service, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 5.6 above) must also be included to make the contract compliant with APMS regulations.

Small Provider

30.6 One of the other important ways in which the content of the Service Conditions can be tailored is through selection of the Small Provider category. This includes those providers whose aggregate annual income for the relevant Contract Year, in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000.

30.7 The Small Provider category has two functions.

- It triggers slightly different payment arrangements under SC 36. Where an Expected Annual Contract Value has been agreed, payment on account and subsequent reconciliation are organised on a quarterly basis, rather than monthly.

- It is used as a filter to ensure that some specific provisions within the Service Conditions do not apply to provider organisations doing only a small volume of business with NHS commissioners. This is to avoid placing an inappropriate and unrealistic burden on such small providers.

31 Service specifications

31.1 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.

31.2 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 31.3 below).

- A number of model specifications are available on the NHS Commissioning Assembly website; these cover diabetes, self harm, end of life care and venous thromboembolism.

- In response to reports from the National Audit Office and the Public Accounts Committee, NHS England has confirmed that all commissioners should put in place robust service specifications for maternity services with relevant providers and has published a resource pack to support CCGs in commissioning maternity care. This is available at: http://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf.

31.3 The concept of Derogations from mandatory national service specifications has been introduced into the Contract 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

31.4 Service specifications should be recorded in Schedule 2A of the Particulars. They should be in the form of the template set out in the Particulars.

31.5 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.

31.6 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, ie the service being commissioned, who is it for and any key links with other services;

- any generally applicable service standards which the service should adhere to eg NICE standards or any locally agreed standards;

- which quality requirements and CQUIN goals, as set out in Schedule 4, are relevant to each specific service specification;

- location of the service: this will not be relevant to all services but could be used where the location in which services is provided needs to be specified (eg in the case of services commissioned from a national provider with multiple locations where services are required to be delivered from only a limited number of the provider's units).

31.7 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?

31.8 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 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.

31.9 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').

31.10 Quality requirements and information requirements in relation to a specific service should not be included in the service specification. If there are any specific requirements relating to the particular service, these should be included in Schedule 4 (Quality Requirements), together with any associated information requirements in Schedule 6 Part B (Reporting Requirements). However, as noted above, it is possible to indicate in the service specification which of the quality and information requirements listed in the relevant contract schedules are relevant to each service specification by allocating a reference number to the requirement and listing the relevant reference numbers in the service specification.

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

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	Numbering the specification may be useful where you wish to identify which services particular quality requirements and/or payment regimes relate to.
Service	The level at which services are specified will depend on the particular service. For example, for acute hospital services, it is unlikely that you would wish to specify at HRG level. On the other hand, a specification which covers 'all elective services' is unlikely to be appropriate. It may also be appropriate to consider whether developing a specification on the basis of a care pathway would be appropriate.
Commissioner Lead	The name of the individual leading on the commissioning of the service should be inserted here.
Provider Lead	The name of the individual leading on this service for the provider should be inserted here (this may be the same or different for all services being commissioned).
Period	The period covered by this specification should be inserted here. This may be the same as the duration of the contract but where there is a long contract duration, you may wish to review the specification at an earlier date (subject to any procurement and competition considerations). There may be circumstances where the overall duration of the contract may be longer than a particular service is being commissioned. Where this is the case, it is important that a duration is clearly specified for the service being commissioned.
Date of Review	If you wish to review the specification mid-contract, then a date by which the specification is to be reviewed should be inserted here.

1. Population Needs

1.1 National/local context and evidence base

This section should set the context for the service being commissioned. For example, for a mental health service it may be relevant that one in six people at some stage will experience a mental health issue. Locally, prevalence may be higher or lower than national averages.

2. Outcomes

2.1 NHS Outcomes Framework domains & indicators

Domain 1	**Preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long-term conditions**
Domain 3	**Helping people to recover from episodes of ill-health or following injury**
Domain 4	**Ensuring people have a positive experience of care**
Domain	**Treating and caring for people in safe**

5	environment and protecting them from avoidable harm

Any relevant indicators from the NHS Outcomes Framework may be added here. If the provider is to be held accountable for them, they should be included in the locally agreed quality requirements.

2.2 Local defined outcomes

Any broad outcomes to which the service should be working should be inserted here.

3. Scope

3.1 Aims and objectives of service

A brief description of the aims and/ or objectives of the service may be included here. Service specifications should clearly set out requirements for protected groups where there is a need to do so.

3.2 Service description/care pathway

This section should include a brief description of the service being commissioned. For some services, it may be relevant to describe the care pathway.

3.3 Population covered

Where the service is not subject to patient choice and where the service is limited to a defined population, the description of that population should be included in this section.

3.4 Any acceptance and exclusion criteria

This section may be used to identify any clinical criteria used for the service.

3.5 Interdependence with other services/providers

The services commissioned under a contract may be part of a wider care pathway. If this is the case, how the service links into and works with other services or providers can be identified here.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.3 Applicable local standards

This section may be used to identify NICE standards, other national standards and any locally agreed standards that are relevant to the service.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

The reference numbers for quality requirements and CQUIN goals which apply to the service can be listed here. This allows clarity about the requirements relating to specific services.

6. Location of Provider Premises

The Provider's Premises are located at:

Where it is considered important to specify that a service is provided from a particular location, this may be specified here.

7. Individual Service User Placement

This section may be used to include details of any 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.

32 Commissioner Requested Services / Essential Services

32.1 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 Monitor and which applies to all providers other than NHS Trusts
- the regime of Essential Services which applies to NHS Trusts only.

32.2 Detailed guidance on CRS is available on the Monitor website. 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.

32.3 Under Monitor's CRS guidance, individual commissioners (CCGs and NHS England) have until 31 March 2016 to complete the process of determining whether individual services at specific providers should be designated as CRS or not. 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 Monitor via CRS@monitor.gov.uk, using the spreadsheet available on the Monitor website.

32.4 The Contract requires both parties to comply with the respective obligations under CRS Guidance, but any potential interventions by Monitor 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 Monitor and are expected to publish them on their websites.

32.5 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 Monitor). 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.

32.6 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).

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

32.8 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.

33 Sub-contracting

33.1 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.

33.2 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.

33.3 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, 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.

33.4 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.

33.5 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.

33.6 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.

33.7 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.

33.8 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).

33.9 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.

33.10 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

33.11 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 33.13 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).

33.12 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 – but no such requirement applies where a provider is paying a sub-contractor.

33.13 Often, NHS providers placing sub-contracts can appropriately use the standard NHS terms and conditions for procuring goods and services, published by the Department of Health. Where the sub-contract relates to a whole clinical service or a significant element of it, the goods and services contract will be less suitable. The Department of Health and NHS England are working together to develop a model sub-contract for use by providers for clinical service sub-contracting. This will give a systematic way of flowing down the relevant provisions from the main contract to the sub-contractor. The model sub-contract will be available shortly, along with guidance on its use. It will be non-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.

33.14 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

33.15 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 commissioner does have powers to require the replacement of sub-contractors in specific situations, as set out in GC12.13.

34 Quality of care

34.1 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

34.2 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) deliver. 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). Note that the duty of candour provisions have been updated to reflect the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended by the Health and Social Care Act 2008 (Regulated Activities) Amendment Regulations 2015) and so the definition of Notifiable Safety Incident – the event which triggers the duty – differs depending on whether the provider is an NHS organisation or not.

- 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), 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).

34.3 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.

34.4 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

34.5 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.

34.6 For 2015/16, there have been changes to the financial consequences for 18-weeks performance and A&E four-hour waits. On A&E, the performance 'floor' for any given month (that is, the level of performance beyond which there is no further increase in the value of the sanction applied) has been reduced from 92% to 85%, but the sanction per excess breach has also been reduced from £200 to £120.

34.7 On 18-weeks performance, the sanctions remain at £400 for admitted pathway breaches and £100 for non-admitted, but the sanction for incomplete pathways has been increased from £100 to £150. In practice, there are much larger numbers of incomplete pathways than of admitted or non-admitted completed pathways – and therefore, although the sanction per breach for individual incomplete pathways is relatively low at £150, the overall financial impact on providers of failing to achieve the 92% incomplete standard is likely to be high. Broadly, we estimate that over 50% of the weight of 18-weeks sanctions, nationally, will now be due to performance on incomplete pathways, reflecting the critical importance of ensuring that backlogs of long-wait patients do not build up.

34.8 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.

34.9 We have provided some worked examples of how to calculate financial consequences at Appendix 4.

Local Quality Requirements

34.10 Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. 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 39 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.

34.11 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.

34.12 Appendix 5 contains further guidance on using local quality requirements and sets out a list of nationally approved quality requirements derived from NICE quality standards, the core set of quality indicators for mandatory reporting in provider quality accounts, and from previous years' NHS contracts. Commissioners may wish to select relevant indicators from this list. However, this is not an exhaustive or definitive list, and there may be more appropriate local indicators.

CQUIN and local incentive schemes

34.13 CQUIN (*Commissioning for Quality and Innovation*) is the national quality incentive scheme. Guidance on CQUIN is available at http://www.england.nhs.uk/nhs-standard-contract/15-16/; this guidance sets out whether CQUIN will be available to providers in 2015/16, depending whether they have chosen to operate under the Default Tariff Rollover or the Enhanced Tariff Option (see also paragraphs 2.7 – 2.15 above).

34.14 It is possible to agree local quality incentive schemes in addition to CQUIN or as an alternative to the national CQUIN scheme, where the CQUIN Variation flexibility is used as described in the CQUIN guidance.

Former national CQUIN indicators

34.15 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.

34.16 In such cases, additional requirements in relation to the 'retired' indicators will be included in the NHS Standard Contract – and this is now 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 6B).

- **NHS Safety Thermometer.** Schedule 6B 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.

34.17 In all three areas, commissioners should use the levers in the Contract, including the processes and sanctions set out in SC 28, to ensure that providers submit the required data and reports. Commissioners may wish to consider agreeing local CQUIN indicators or quality requirements to sustain and continue performance improvements. On VTE specifically, the recent All-Party Parliamentary Thrombosis Group Annual Report has indicated that fewer than half of acute Trusts are routinely undertaking root cause analysis for all relevant patients, and commissioners should ensure that they address this issue with their local providers.

Never Events, Serious Incidents and Patient Safety Incidents

34.18 Never Events are serious patient safety events which are largely preventable. The current framework, including the detailed list of Never Events, is available at http://www.england.nhs.uk/ourwork/patientsafety/. NHS England expects to publish an updated Never Events Policy Framework shortly, including a revised list of the events themselves.

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

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

Safeguarding and the Mental Capacity Act

34.20 Safeguarding individuals remains a very high priority for both commissioners and providers of NHS services, and the Contract wording has been strengthened for 2015/16 in relation to safeguarding arrangements (SC 32). More specific requirements have been included to comply with relevant law and guidance, along with clearer provisions on staff training and audit.

34.21 The new wording refers explicitly to compliance with the Mental Capacity Act 2005 (MCA). A House of Lords Select Committee report identified serious shortfalls in implementation of the MCA across the NHS, and the Government published its response in June 2014 (Valuing every voice, respecting every right: Making the case for the Mental Capacity Act).

34.22 The Select Committee report indicates that significant numbers of people may be being treated unlawfully and that decisions regarding care and accommodation are not being made in the person's best interest, according to the definition in the Act. It is important the commissioners use the contractual levers available to them to ensure that safeguarding and MCA practice in their local providers is fully in line with the requirements of the law. Commissioners may, for instance, wish to include local quality requirements in relation to safeguarding. It is particularly important that commissioners ensure that the new provision for audit of local practice (SC 32.5) is enforced. The contract does not specify the precise form of audit to be undertaken, but it is recommended that consideration is given to using local Safeguarding Adult Assurance Frameworks for safeguarding adult practice and performance and Section 11 audit or Markers of Good Practice for auditing children's safeguarding arrangements. Annual case file audit should be undertaken with regard to assuring MCA compliance. Where local audits indicate that the provider is failing to meet key safeguarding or MCA requirements, commissioners should ensure that Remedial Action Plans are immediately put in place to address this.

Health Care Associated Infections and Anti-Microbial Resistance

34.23 The Contract includes new requirements for 2015/16 in relation infection control and antimicrobial resistance, including compliance with the *Code of Practice on the Prevention and Control of Infections*.

34.24 The HCAI reduction plan is a mandatory requirement for all service types other than 111. The plan should set out the provider's role in controlling and reducing infections. For an acute hospital provider, the HCAI plan may be quite complex and wide-ranging. For a small provider, the plan will be more limited, for example, ensuring clean equipment or washing of hands.

Electronic transmission of discharge summaries

34.25 As part of the move towards common digital standards, interoperable clinical information systems and a paperless NHS, new contractual requirements are being introduced with effect from 1 October 2015 in relation to Discharge Summaries and (for 111 services) Post-Event Messages.

34.26 There are two aspects to the new requirements, which are set out in SC11.6 and in the definition of the Delivery Method.

34.27 The first relates to the Delivery Method for Discharge Summaries and Post-Event Messages and applies to Discharge Summaries and (for 111 services) Post-Event Messages

- sent by any provider of Acute services or by any NHS Trust / NHS Foundation Trust
- to any GP or NHS Trust / NHS Foundation Trust.

The change is that, for the above situations, use of secure fax is no longer permitted as a Delivery Method with effect from 1 October 2015 – Discharge Summaries and Post-Event Messages must instead be sent by secure email or direct electronic transmission. There is strong encouragement that organisations should adopt a direct electronic transmission approach for sending Discharge Summaries and this should use the "Transfers of Care" Interoperability Toolkit specifications that are aligned with the Academy of Medical Royal Colleges endorsed clinical headings. These will be available from March 2015 at HSCIC TRUD.

34.28 The second new requirement is on all providers to be able to send and receive Discharge Summaries or Post-Event Messages using all applicable Delivery Methods. For situations other than those described in 34.27 above, the 'applicable' Delivery Method for particular providers should be set out in Schedule 2J (Transfer of and Discharge from Care Protocols) – this could set out, for instance, that, where discharge summaries are being sent to a care home, this could continue to be done by fax.

34.29 Commissioners should take a reasonable and proportionate approach in managing performance against the new requirements. They should focus initially on ensuring that providers can provide electronic discharge summaries for GPs within their local catchment area and must support providers in resolving any issues about GP preparedness (in terms of IT systems) to receive electronic discharge summaries.

35 Financial consequences in relation to Quality Requirements

Mandatory application of financial consequences ('sanctions')

35.1 In the 2014/15 Contract, we introduced a new flexibility to vary or disapply financial sanctions in relation to nationally-mandated quality requirements set out in Schedules 4A and 4B. This was known as the Sanction Variation flexibility. The intention of this was to enable a more flexible local approach, consistent with that set out in the National Tariff in respect of national prices (Local Variation) – but on condition that the flexibility was a) agreed in advance and b) reported transparently to NHS England. Where no Sanction Variation was in place, application of sanctions for breaches of Schedules 4A and B was mandatory under the Contract.

35.2 In practice, very few Sanction Variations have been reported to us, while there is anecdotal evidence of commissioners not applying sanctions even though these have not been formally disapplied. The intended effect of sanctions is to reinforce the critical importance of meeting minimum national standards, such as NHS Constitution requirements on waiting times. We have therefore removed the flexibility for Sanction Variation from the Contract; financial sanctions must be applied without exception for breaches of the national quality standards in Schedule 4A and 4B.

Public reporting of sanctions applied by commissioners

35.3 To ensure greater transparency on the application of sanctions, commissioners must now publish on their websites details of the sanctions due and actually applied to each of their major providers for failure to achieve national standards. Reports must indicate how the commissioner has spent, or intends to spend, the funding withheld from providers through the application of sanctions.

35.4 Commissioners should publish their first data by the end of April 2015, in respect of sanctions applied in Quarter 4 of 2014/15, with publication continuing on a quarterly basis thereafter. Appendix 6 sets out brief guidance notes on publication, with a link to a template for this purpose.

Use by the commissioner of funding retained through sanctions

35.5 For the first time, we are setting out below guidance on 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.

35.6 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.

35.7 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 Monitor in the required format.

Calculation and apportionment of sanctions

35.8 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.

35.9 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.

35.10 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.

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

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

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

- The exception to this is Clostridium difficile, which operates on the basis of a threshold which is for the provider as a whole. Specific arrangements for the calculation of any relevant sanction in relation to Clostridium difficile performance are set out in Schedule 4G of the Contract and described in detail in paragraph 35.17 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).

Caps on value of sanctions

35.12 The Contract includes a provision, set out at SC36.47, 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 per cent of Actual Quarterly Value. The cap does not apply to funding which commissioners may withhold under other sections of the contract, for example Contract Management (GC9) or Information Requirements (SC28). The cap does not apply to sanctions for Never Events.

35.13 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.

35.14 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 per cent. A worked example is given in Appendix 4.

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

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

Sanctions for Clostridium difficile performance

35.17 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), NHS England sets a national target 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 4G. NHS England has published provider targets for 2015/16, alongside updated guidance on the application of potential financial consequences.

35.18 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.

35.19 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 4G. These can be allocated to the relevant commissioner, as it is possible to attribute each case to a specific commissioner.

35.20 NHS England sets provider-level C difficile targets 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 by NHS England. 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.

35.21 For the purposes of the quarterly cap on the value of local and national sanctions (see paragraph 35.12 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.

36 The Service Development and Improvement Plan (SDIP)

36.1 The Service Development and Improvement Plan (SDIP, Schedule 6E) 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.

36.2 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 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.

36.3 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).

36.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6E 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).

36.5 Agreement of SDIPs will be mandatory in some specific situation in 2015/16, as set out below.

Seven-day services

36.6 For 2014/15, we asked commissioners to ensure that contracts with acute providers contained an initial action plan, set out in an SDIP, to deliver the ten clinical standards for seven day working (NHS Services, Seven Days a Week Forum review) into seven-day services.

36.7 For 2016/17, the NHS Standard Contract is expected to require providers to comply with at least five of the ten Seven Day Service standards, with compliance with the remaining five standards required from April 2017 onwards. For 2015/16, therefore, commissioners should agree updated SDIPs with acute providers; these should build on steps taken in 2014/15 and make significant further progress towards implementation of at least five standards which will have the greatest impact locally. We strongly recommend that the SDIP agreed between commissioners and providers for 2015/16 involves reporting by the provider based on NHSIQ Seven Day Service Self-Assessment Tool.

New standards for mental health services

36.8 New access standards are being introduced for a number of mental health services during 2015/16. These standards cover

- early intervention in psychosis programmes (EIP), where the requirement is that more than 50% of people experiencing a first episode of psychosis should receive a NICE-concordant package of care within two weeks of referral; and

- Improving Access to Psychological Therapies (IAPT) programmes, where the requirement is that 75% of people referred to an IAPT programme are treated within six weeks of referral, with a minimum of 95% being treated within 18 weeks.

36.9 These new standards are being introduced during 2015/16, with compliance with them being mandated from 1 April 2016 onwards, so we expect to include them in the 2016/17 NHS Standard Contract.

36.10 For 2015/16, commissioners must agree SDIPs with mental health providers which set out how the provider will prepare for and implement the new EIP and IAPT standards (as applicable to their specific services) during the year, so that they can be achieved on an ongoing basis from 1 April 2016.

36.11 Additional funding is also being made available to commissioners in 2015/16 for investment in improving the liaison psychiatry services available in acute hospitals. Commissioners will be expected to make significant progress towards ensuring that adequate and effective levels of liaison psychiatry provision are in place across acute settings to ensure that the mental health needs of people receiving care in acute hospitals are met, their outcomes improved and the cost of their care reduced. Commissioners must therefore agree SDIPs with acute providers for 2015/16, setting out how providers will ensure there are adequate and effective levels of liaison psychiatry services in acute settings. These SDIPs should be backed by appropriate investment and revised service specifications as appropriate.

36.12 Further details are set out at http://www.england.nhs.uk/2015/02/13/mh-standards/.

Innovation and digital technology

36.13 Providers should by now have completed implementation of the high-impact innovations set out in Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS. However, commissioners should continue to use SDIPs as a way of encouraging providers to make progress in adopting specific innovations to improve patient care.

36.14 The National Information Board's recent publication, Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens, sets out an ambitious agenda for the transition to a fully digital NHS. Commissioners should also look to use SDIPs as a means of encouraging rapid progress within and between providers towards the adoption of modern interoperable clinical information systems.

36.15 In particular, it is important that, wherever possible, providers of NHS unscheduled care services make progress with their local partners, during 2015/16, in implementing, or preparing for implementation of, the Child Protection Information Sharing Project. This initiative aims to link local authority social care IT systems with those in NHS unscheduled care settings, so that healthcare practitioners have immediate access to the information that could help them to form a clear assessment of a child's risk. Details of the Project are available at http://systems.hscic.gov.uk/cpis, and an Information Standards Notice (ISN 1609) is expected to be approved early in 2015/16. We would strongly encourage commissioners to agree SDIPs with relevant providers (A&E, acute, MIU / WIC, emergency ambulance), setting out a locally-agreed approach to implementation from the earliest possible date.

37 Managing activity and referrals

37.1 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.

37.2 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 7.

Responsibilities of commissioners and providers

37.3 The contract identifies the respective responsibilities of commissioners and providers in managing activity.

- Commissioners are responsible for managing external demand for services: this means they are responsible for primary care referrals to providers and for ensuring that referrals comply with any agreed protocols.

- Providers are responsible for managing internal demand for services: this means they should work within caseloads, occupancy levels and clinical thresholds that have either been agreed by the parties or been published in their directory of services on Choose and Book, as well as the Activity Planning Assumptions referred to below. Any changes must be agreed with the commissioner.

Indicative Activity Plan and Activity Planning Assumptions

37.4 Prior to the start of the contract year, the parties should agree, where relevant, an indicative activity plan (IAP). This plan is an indication of the activity that is estimated by the two parties but it is not a guarantee of activity or a cap on activity.

37.5 The IAP should include sufficient detail for both parties to understand the indicative activity that has been agreed and any thresholds for reporting purposes that are required by the commissioner. Any thresholds should act as a trigger for discussion to understand why activity is over or under the indicative levels and are not intended as a cap on activity.

37.6 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.

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

37.8 APAs are for inclusion at the discretion of the commissioner. Where the commissioner wishes to use them, they should be notified to the provider before the start of the contract year. APAs should not be set in such a way that, as a result, a provider cannot provide the Services in line with Good Clinical Practice or that patient choice of provider (where this applies under 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.

37.9 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.

37.10 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. By contrast, the provider is under a contractual obligation to use all reasonable endeavours to manage activity in accordance with APAs.

Early Warning and Activity Query Notices

37.11 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.

37.12 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.

37.13 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

37.14 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.

37.15 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.

37.16 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)

37.17 Otherwise, an AMP may be agreed. Where this cannot be agreed, the parties should refer the matter to dispute resolution.

37.18 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.

37.19 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.

Prior Approval Schemes

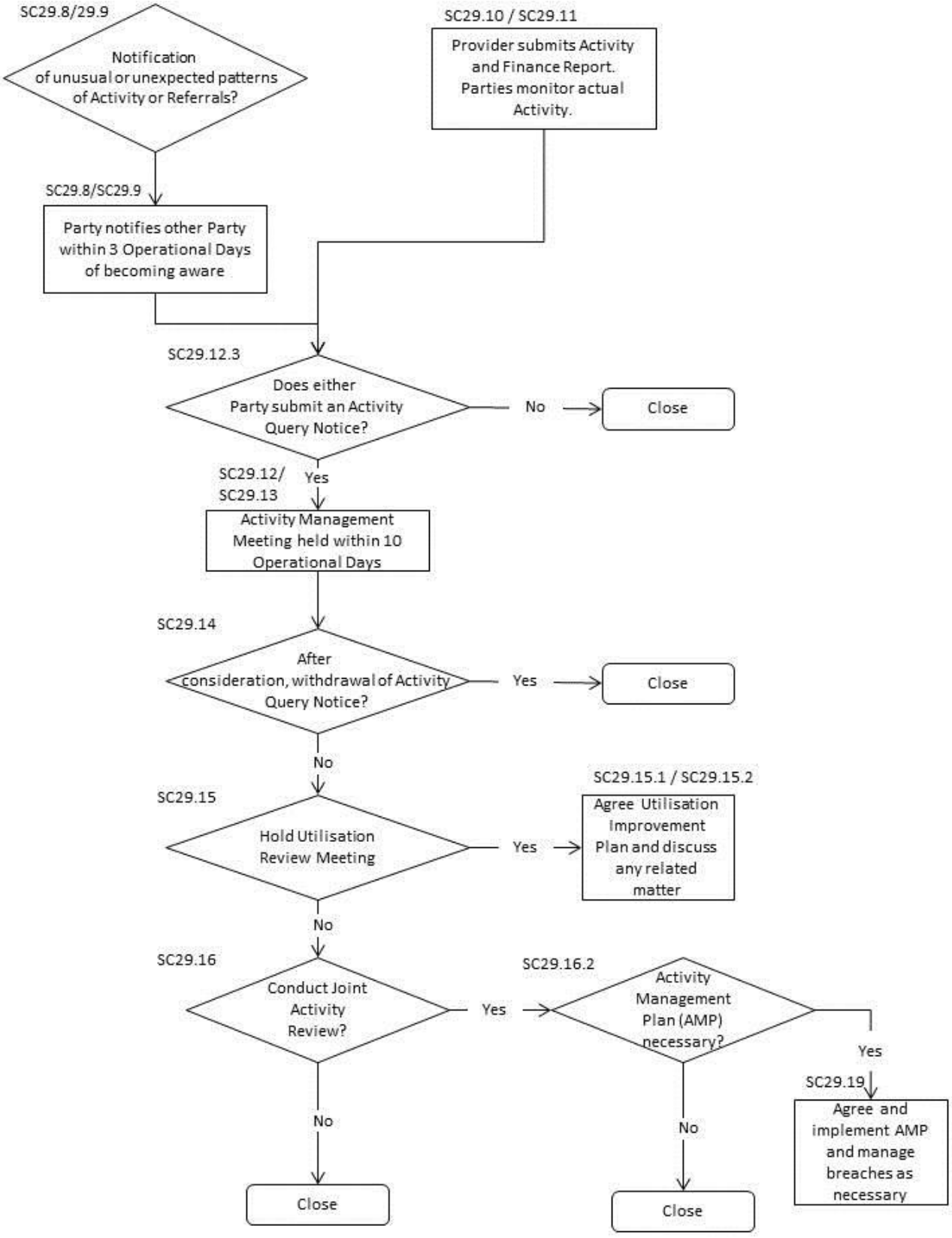
37.20 A Prior Approval Scheme will typically set out a commissioner policy for access to a certain service or treatment – a high-cost drug, for instance, or a treatment of perceived low clinical value. By setting out the clinical criteria or access thresholds in advance, the commissioner enables the provider to offer treatment to patients without needing to seek specific approval from the commissioner on an individual patient basis.

37.21 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. Schemes may be recorded at Schedule 2G (*Other Local Agreements, Policies and Procedures*) if required.

37.22 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.

37.23 Where the commissioner determines, prior approval may also operate on an individual patient basis, with the provider seeking approval for each individual case. In this situation, commissioner and provider should agree a standard for responses to requests for approval. SC29.26 makes clear that failure by the commissioner to respond within the agreed timescale may be taken as approval to treat.

Service Condition 29 – managing activity and referrals



38 Information, audit and reporting requirements

38.1 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).

38.2 Further background details on information requirements and governance are contained in Appendix 8. 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 6B (*Reporting Requirements*), SC28 (*Information Requirements*), and GC15 *(Governance, Transaction Records and Audit).*

Reporting Requirements

38.3 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 clear purpose or to answer a clearly articulated question, which may be required on a regular or occasional basis;
- the parties should recognise that some requests for information may require system improvements over a period of time;
- requests for information should be proportionate to the balance of resources allocated between clinical care and meeting commissioner requirements;
- unless there are justifiable reasons for doing so, commissioners should not request information directly from providers where this information is available through national systems; and
- information provided should be of good quality.

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

- **National requirements reported centrally.** This references the list of assessed collections and extractions published on the HSCIC website. Providers must submit data returns as appropriate for their organisation type and the services they provide from the list. This also includes the delivery of any data or definition set out in the HSCIC guidance, and any Information Standard Notice (ISN) relevant to the service being provided.

- **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.

38.5 Some key changes have been made to Schedule 6B for 2015/16.

- We have added requirements to report the new National Workforce Race Equality Standard and on NHS Safety Thermometer performance (this will no longer form part of the national CQUIN scheme in 2015/16).

- We have converted the Monthly Activity Report into an Activity and Finance Report and have amended the timescale for reporting of both this and the Service Quality Performance Report.

- We have included a new overarching requirement for providers of specialised services to report on specific issues required by NHS England, as set out in the national reporting template.

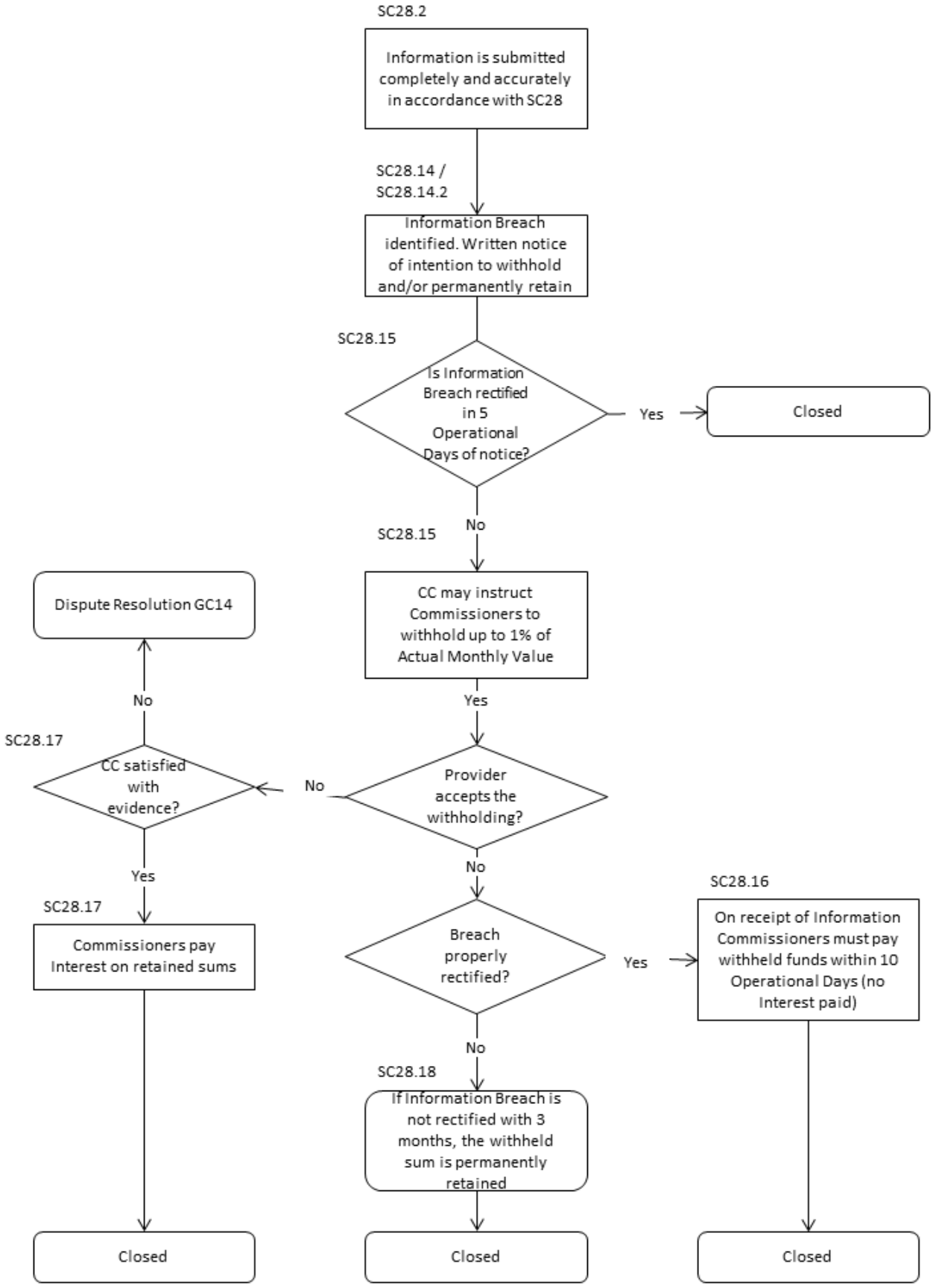
- To make sure reporting requirements remain proportionate, we are allowing much greater flexibility for local agreement of frequency of reporting for Small Providers.

Information Breaches

38.6 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 6B (Reporting Requirements)". The process for identifying and managing Information Breaches is set out in the flowchart below.

38.7 Where an Information Breach occurs, the co-ordinating commissioner must notify the provider of it, and commissioners may then withhold up to 1 per cent of Actual Monthly Value, pending rectification of the Breach. We have strengthened the subsequent arrangements so that the provider must now rectify the Breach within three months of the notification of the Breach, failing which the commissioners are entitled to retain the sums withheld.

Service Condition 28 – Information requirements



38.8 It is important to be clear that rectification may require both retrospective and prospective action. So 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.

38.9 The 1% withholding described above can now be actioned more simply 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.

Counting and coding changes

38.10 SC28 sets out how changes in the counting and coding of activity should be managed. The following key points apply.

- The underlying requirement in SC28.7 is that activity should be recorded correctly in relation to national guidance (the NHS Data Dictionary, for instance).

- However, there will be instances where systematic incorrect recording is identified, and in such cases the process for notifying, agreeing and implementing changes to recording practice (to bring recording into line with national rules and guidance) set out in SC28.8 onwards must be followed.

- 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. Formal notification in advance is required even where a contract will expire at the end of the Contract Year.

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

- Where changes are agreed to be in line with national recording guidance, implementation should normally take effect at the start of the following Contract Year (meaning that notice of changes must generally be given no later than 30 September). However, the parties may instead agree a different (earlier or later) implementation date. 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.

38.11 The intention underpinning any recording changes must be to ensure that recording is correct, in line with guidance – not to produce a financial gain for either commissioner or provider. However, for activity-based contracts, especially where there are national prices, the risk is that recording changes may cause destabilising short-term financial impacts for providers or commissioners.

38.12 To protect against this, we have altered the contractual provisions relating to the financial impact of any agreed counting and coding changes. The new arrangement, set out in SC28.11, is that the parties must make financial adjustments so that the overall financial impact of agreed changes is neutral

- in the case of changes notified by 30 September 2015 and implemented with effect from 1 April 2016 or later, for the whole of the 2016/17 Contract Year;

- in the case of changes notified by 30 September 2015 and implemented before 1 April 2016, for the relevant part of the 2015/16 Contract Year and for the whole of the 2016/17 Contract Year.

38.13 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 Monitor.

38.14 This new provision affects counting and coding changes notified during 2015/16 for implementation before or from 1 April 2016. Changes which have already been duly notified with six months' notice under 2014/15 contracts should, where the changes are agreed between the parties to be technically correct, be implemented and take financial effect from 1 April 2015.

38.15 This provision is only intended to manage the consequences of changes in counting and coding practice where services are unaltered, but where the result of such changes might be a windfall financial gain for either provider or commissioner. Where commissioner or provider wish to change the way in which services are provided, this should be effected through the Variation process set out in GC13 and can be agreed between the parties at any time (see paragraph 41.1 onwards).

38.16 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 Monitor.

38.17 Where a provider becomes aware only after the event that a change in recording practice has taken place, it must notify the commissioner at once. The commissioner will then be justified in challenging payment, specifically in respect of the financial impact of the revised recording basis, subject to the process and timescales set out in for validation and challenge of invoices and reconciliation accounts set out in SC36.

38.18 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.

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.

38.19 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 planned 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 recording changes is to avoid short-term windfall financial gains or losses to either party.

38.20 For further guidance, please refer to the case studies set out in Appendix 7.

SUS

38.21 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://www.isb.nhs.uk/documents/isb-0092/amd-16-2010/index_html. Providers should be aware that SUS Guidance also requires that all providers have moved from BULK to NET submission to SUS by March 2016.

Data Quality Improvement Plans

38.22 Reliable, high quality data is essential for the delivery, monitoring, planning and developing of safe and effective services and for supporting audit, research and development. The National Information Board's recent publication, Personalised Health and Care 2020, A Framework for Action, sets out that

"The HSCIC, CQC, Monitor and NHS Trust Development Authority (NHS TDA) will publish by October 2015 data quality standards for all NHS care providers, including the progressive improvement in the timeliness accuracy and completeness with which data is entered into electronic records and made accessible to carers and patients. The CQC will from April 2016 take performance against these data quality standards into consideration, as part of its regulatory regime."

38.23 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.

38.24 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.

38.25 Multiple DQIPs can be included within the same contract. DQIPs should be included in Schedule 6C 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).

38.26 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;
- Completeness – that where a data set is produced, all relevant data 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).

38.27 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 HSCIC 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 HSCIC relating to the Mental Health and Learning Disabilities 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.

PTL returns

38.28 NHS England has decided not to include a new standard, within the 2015/16 Contract, for consistency between weekly PTL returns and monthly RTT returns for acute providers. However, NHS England will continue to seek mandation of the weekly PTL return through the SCCI approval mechanism.

38.29 Assuming that submission of the PTL return is mandated during 2015/16, submission will automatically become a contractual requirement for relevant providers, as set out in Schedule 6B (Reporting Requirements). From this point, NHS England will expect commissioners to take prompt contractual action against providers which are not providing comprehensive, accurate and timely PTL data, including use of the financial sanctions set out in SC28.

Sharing data about violent assaults

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

38.31 A new Information Standard has now been introduced, confirming the requirement for submission of this data.

38.32 To ensure that there is progress against this important Mandate commitment, commissioners should

- take steps to understand whether providers are collecting information appropriately;

- take steps to understand whether their local Community Safety Partnership and police force are receiving the necessary data from providers; and

- take prompt contractual action against providers which are not providing comprehensive and timely data, including use of the financial sanctions set out in SC28.

Audit and invoice validation

38.33 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);
- 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); and
- what should happen as a result of the reports of independent audits and who should pay for them (GC15.9-15.13).

38.34 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 therefore makes clear that access to such data must be 'subject to any applicable Service User consent requirements'.

39 Contract management

Contract review process

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

39.2 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.

39.3 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.

39.4 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.

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

Contract management process

39.6 In response to feedback, the contract management process (GC9) has been significantly streamlined for 2015/16, so that it will provide a more robust and timely process. The stages of the process are set out in the flowchart overleaf, but we have also clarified some points below about the way in which the revised process is intended to work.

Informal queries and Contract Performance Notices:

39.7 We have changed the terminology from Contract Query to Contract Performance Notice. 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.

39.8 The separate stage of the Excusing Notice has been removed – but the party issuing the Contract Performance Notice can of course withdraw it after initial discussion, if it becomes clear that no breach has occurred.

Joint Investigations:

39.9 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:

39.10 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. As part of the streamlining of the GC9 process, the Contract now makes provision for only one Exception Report to be issued in relation to a specific breach, rather than two.

39.11 GC9 gives the co-ordinating commissioner the power to withhold funding following the issue of an Exception Report – see 39.13 below.

Remedial Actions Plans and financial consequences:

39.12 We have clarified the contractual wording in relation to the content of RAPs, making clear that 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 of these.

39.13 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 of 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.

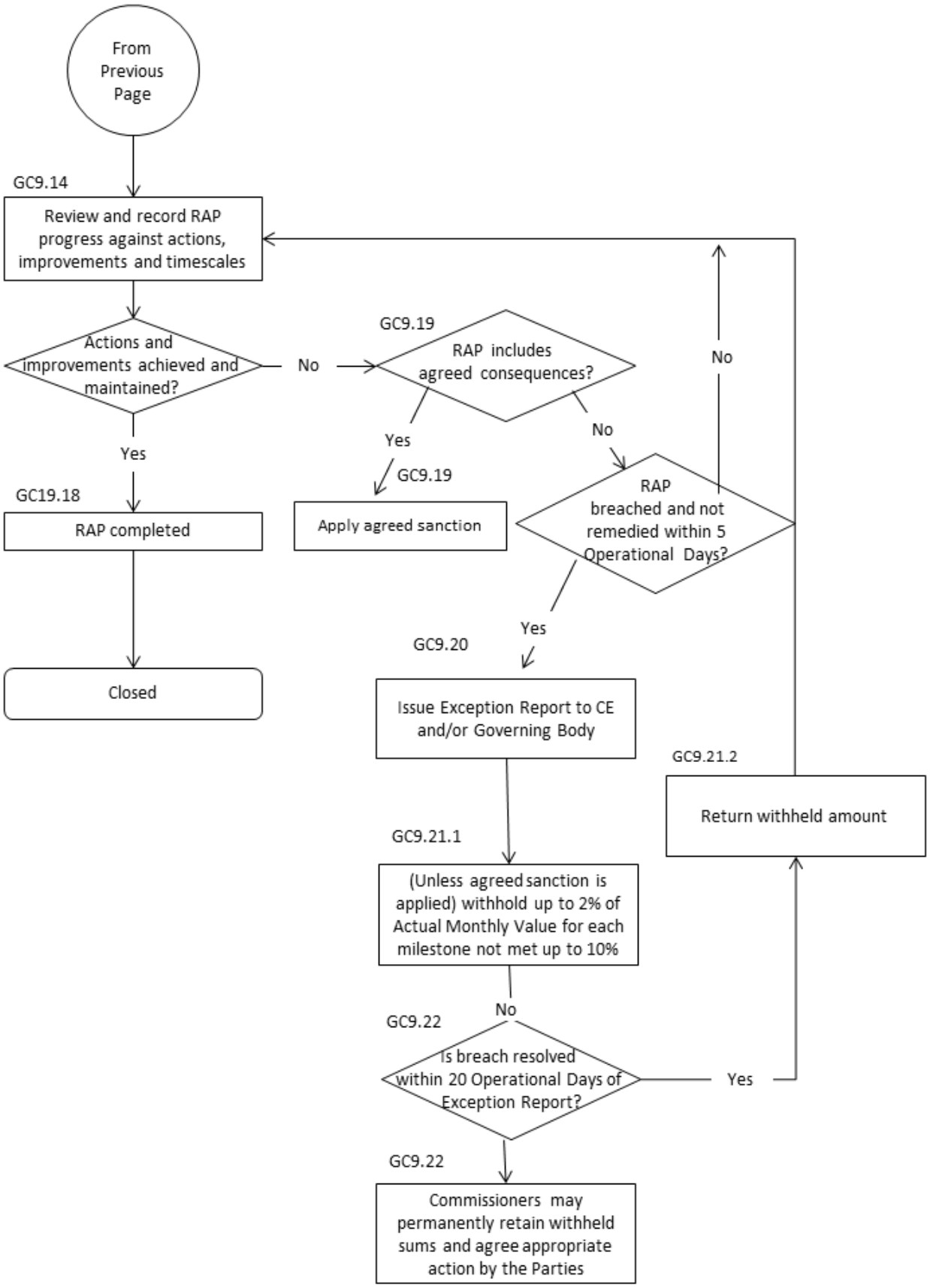
39.14 The intention of these revised provisions is a) to emphasise that financial consequences should be reasonable and proportionate and b) to create a greater incentive for specific, appropriate financial consequences to be agreed between the parties as part of RAPs, rather than encouraging reliance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

GC9 and breaches of Quality Requirements:

39.15 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).

39.16 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 of any such RAP, so long as these are reasonable and proportionate.

General Condition 9 – contract management


From Previous Page
GC9.14
Review and record RAP progress against actions, improvements and timescales
Actions and improvements achieved and maintained?
No
GC9.19
RAP includes agreed consequences?
No
Yes
GC9.19
Apply agreed sanction
Yes
GC19.18
RAP completed
Closed
RAP breached and not remedied within 5 Operational Days?
No
Yes
GC9.20
Issue Exception Report to CE and/or Governing Body
GC9.21.1
(Unless agreed sanction is applied) withhold up to 2% of Actual Monthly Value for each milestone not met up to 10%
No
GC9.22
Is breach resolved within 20 Operational Days of Exception Report?
Yes
GC9.21.2
Return withheld amount
GC9.22
Commissioners may permanently retain withheld sums and agree appropriate action by the Parties

40 Payment

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

Payment schedules

40.2 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 Monitor).

- 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 40.8 below.

- Schedule 3G and 3H allow respectively for noting of aggregation or disaggregation of payments across commissioners and recording of timing of payments in the first or final contract year.

40.3 There is no longer a separate schedule for risk-sharing agreements to be recorded in the Contract, as there was 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*).

Invoicing, payment and reconciliation

40.4 Detailed arrangements for invoicing, payment and financial reconciliation are set out in SC36 and in the flowcharts below.

40.5 These payment arrangements vary between contracts depending on three sets of 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 applies for all the Services provided under the contract (SC36.37 to 36.40), 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 (SC36.41).

- **Small Provider / other provider.** For a Small Provider with an agreed EACV, invoicing and payment take place quarterly, whereas for all other providers (and for Small Providers with no EACV) the process stakes place monthly.

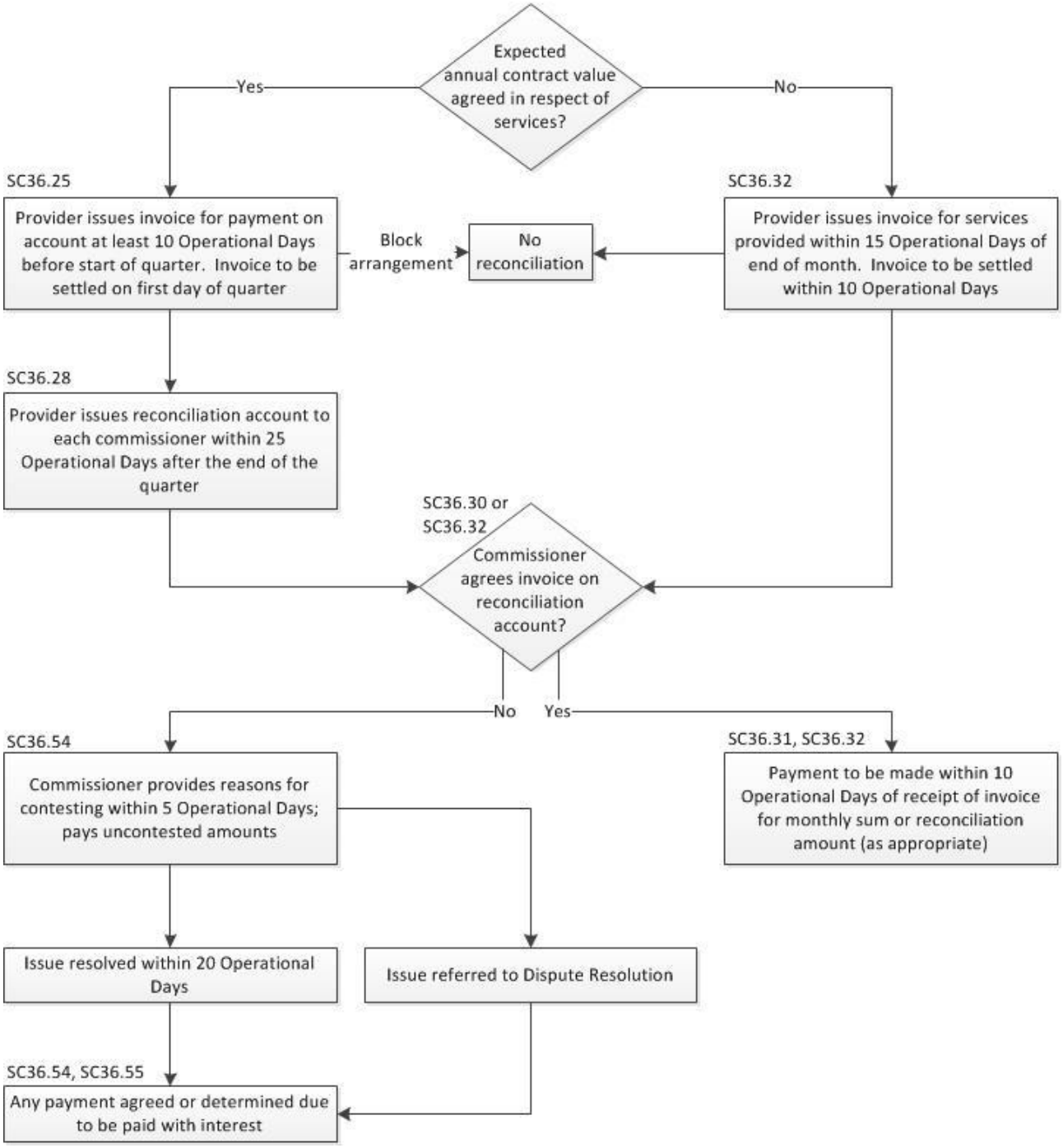
40.6 Note that HSCIC has now published the SUS 2015/16 PbR Submission Timetable, which sets out specific timescales for data submission and reconciliation in 2015/16. As set out in paragraph 2.15 above, providers of acute services, regardless whether they have chosen to operate under the Default Tariff Rollover (DTR) or the Enhanced Tariff Option (ETO), must continue to submit data to SUS. Again, regardless of DTR or ETO, all acute providers will be bound by the payment reconciliation process set out in SC36, including the requirements of the SUS 2015/16 PbR Submission Timetable.

40.7 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 SC36.54. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.

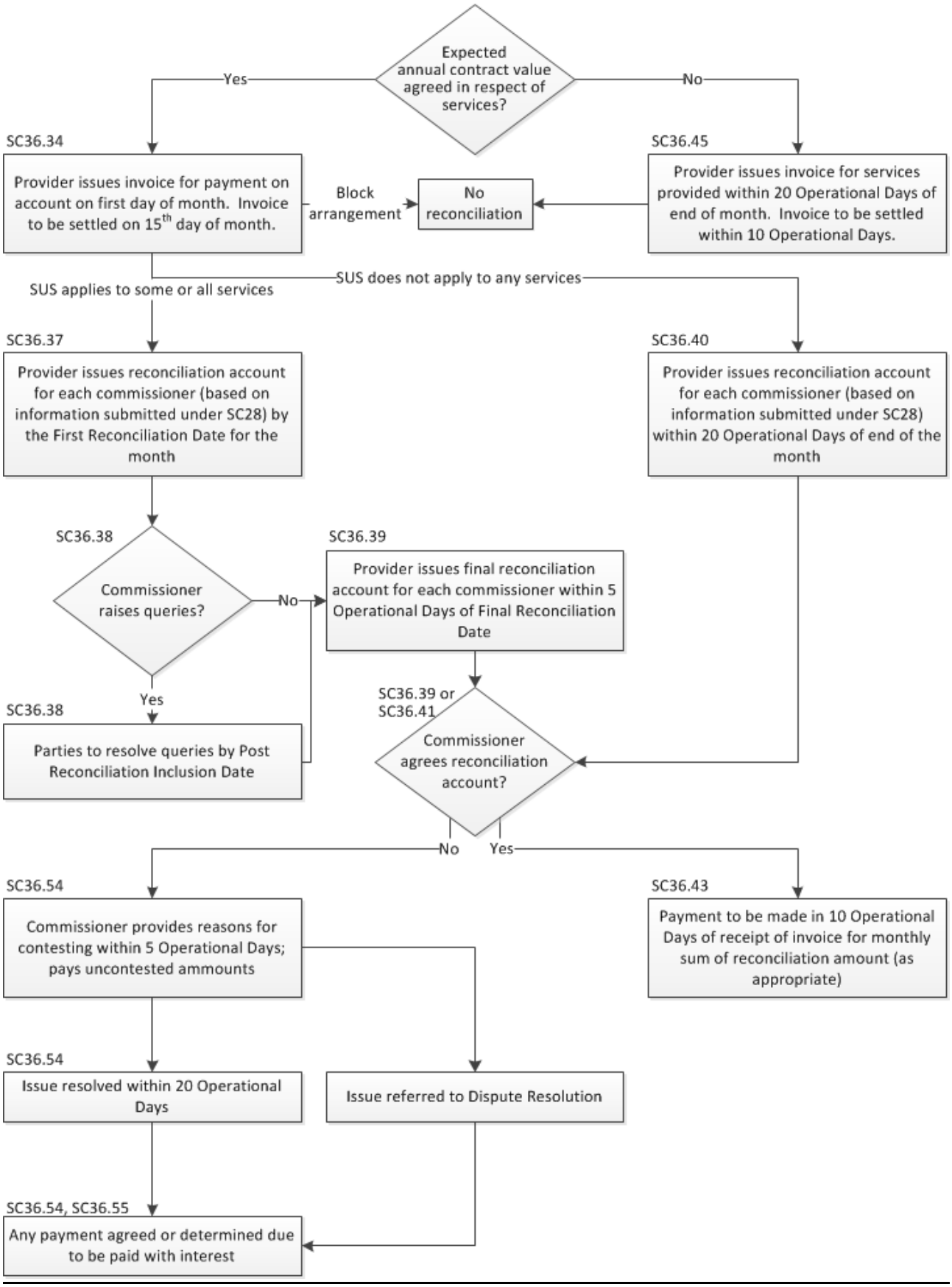
Payment of CQUIN

40.8 As described in paragraph 40.2 above, expected CQUIN payments should not be included within the EACV in Schedule 3F. Rather, agreed payments on account in respect of CQUIN can be set out in Table 2 of Schedule 4E (CQUIN). The level of any CQUIN payment on account is for local agreement. Providers then invoice separately on account for CQUIN under SC38.2.

Service Condition 36: Payment and Reconciliation – Small Providers



Service Condition 36: Payment and Reconciliation – Other Providers



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

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

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

40.11 The CQUIN guidance also sets out a flexibility for commissioners and providers, by agreement, to vary the nationally set terms of the CQUIN scheme (reflected in SC38.15). Where this approach is used, commissioners should

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

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

- ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed in the normal way, excluding any value to be paid under the locally-varied CQUIN scheme.

40.12 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

40.13 We have added new provisions at SC36.50 to expand on requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the new Regulations and guidance governing this area.

40.14 In summary, under the new regime, providers are to charge overseas patients who are liable to charges 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.

40.15 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.

40.16 The statutory provisions which enable overseas visitors to be charged for NHS treatment are set out in section 175 of the National Health Service Act 2006. Additional regulations and guidance relating to the new arrangements above are expected to be published shortly.

41 Other contractual processes

Variation

41.1 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.

41.2 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 (GC 13.13). Guidance on 2015/16 National Variations and template Variation Agreements to update existing contracts to the 2015/16 form will be published on the NHS Standard Contract 2015/16 webpage shortly.

41.3 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 2015/16 webpage). 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 13 above.

41.4 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.

41.5 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).

41.6 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.

41.7 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.

41.8 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).

41.9 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 appropriate long-form National Variation Agreement template (to be published shortly on the NHS Standard Contract 2015/16 webpage). They may, instead, wish to do so simply by adopting the 2015/16 NHS Standard Contract in full. 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-14/15 contract, by all commissioners and the provider). As noted above, guidance on the process for 15/16 National Variations will be issued shortly.

41.10 The parties should be aware that a Variation may constitute a “material change” to the Contract, which can create the risk of challenge for breach of procurement rules. This might be the case, for instance, if a commissioner was considering commissioning significant new additional services from its incumbent provider by adding these to its existing contract through a Variation. If in doubt, therefore, the parties should seek their own legal advice before proceeding with a Variation.

Dispute resolution

41.11 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 the NHS TDA and NHS England where the provider is an NHS Trust, and will be by CEDR or another independent body in other cases.

41.12 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.

41.13 The dispute resolution process at GC14 applies only once a contract has been signed. As outlined in paragraph 18.1, NHS England, the NHS TDA and Monitor have published joint guidance on the resolution of disputes relating to the agreement of new contracts for 2015/16 between NHS commissioners and providers. The guidance is available on NHS Standard Contract 2015/16 webpage.

Suspension

41.14 The provisions governing suspension of services (GC16) remain largely unchanged, but it is worth commissioners reminding themselves of the scope which these provisions give to require a suspension, particularly when concerned about patient safety.

41.15 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.

41.16 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

41.17 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)

41.18 GC 17 now makes explicit the ability of the parties to terminate the contract at any time by mutual consent.

41.19 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). Different periods of notice may be agreed for provider-instigated and co-ordinating commissioner-instigated termination. The parties may agree that the right to terminate voluntarily may not take effect before a specific date (ie that the contract must be allowed to run for at least a set period of time before being terminated). (See GC17.2 and 17.3 and the related definitions).

41.20 See paragraphs 41.2 and 41.5 above in relation to termination where the provider refuses to accept a variation to the contract

41.21 At GC17.8, we have introduced a right for the co-ordinating commissioner to terminate (on a no-fault basis) in specific circumstances as required by the (forthcoming) Public Contracts Regulations.

Termination for commissioner default (GC17.9)

41.22 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. The provider may also now terminate if any warranty given by a commissioner under the contract is found to be materially untrue or misleading.

Termination for provider default (GC17.10)

41.23 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. We have however added new specific grounds:

- relating to material breach of the provider's obligations to comply with law, with the Fundamental Standards of Care, and with the NHS Constitution;
- relating to breach of warranty by the provider;
- relating to the provider's conduct during the procurement process, as required by the forthcoming Public Contracts Regulations.

Consequences of expiry or termination

41.24 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.

41.25 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

41.26 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.

41.27 Any such arrangements should be set out, as clearly as possible, in Schedule 2l (*Exit Arrangements*).

41.28 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.

41.29 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 2l 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).

41.30 Commissioners should consider taking expert legal and financial advice before agreeing exit arrangements and should refer to Treasury guidance.

New Fair Deal for staff pensions

41.31 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 (GC17.7.14), entitling the co-ordinating commissioner to terminate the contract if the NHS Business Services Authority notifies the commissioners that the provider or any sub-contractor is materially failing to comply with its obligations under the NHS Pension Scheme;
- Schedule 7 (Pensions), at which commissioners may (in the appropriate circumstances – ie where TUPE applies to transfer NHS staff to an independent sector provider or sub-contractor) include further provisions dealing with
  - the provider's obligations to ensure that transferring staff are able to stay, or remain eligible to become, members of the NHS Pension Scheme
  - allowing commissioners to set off any arrears of contributions to the NHS Pension Scheme where requested to do so by the Business Services Authority
  - the offer of broadly comparable benefits, where appropriate
  - the treatment of pension benefits on expiry or termination of the contract or Services.

42 Status of this guidance

42.1 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.

42.2 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.

43 Advice and support

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

Appendix 1

Clause-by-clause guide to changes to the NHS Standard Contract

This Appendix is intended to give users of the Standard Contract a simple clause-by-clause guide identifying what has changed, what has moved and what has stayed the same for 2015/16 when compared to the 2014/15 Contract. Delta View comparison documents showing changes made to the Service Conditions and the General Conditions for 2015/16 will also be made available on the NHS Standard Contract 2015/16 webpage.

What has changed in the final 2015/16 Contract when compared to the draft 2015/16 Contract issued in December 2014 is also shown.

Particulars

Section or Schedule	**Extent of changes made to 2015/16 draft Contract compared to 2014/15 Contract**	**Further changes made to 2015/16 final Contract compared to 2015/16 draft Contract**
Contract	No change	
Service Commencement and Contract Term	Changed	Minor change
Services	Changed	Minor change
Payment	Changed	
Quality	Changed	
Governance and Regulatory	Changed	
Contract Management	No change	
Pensions	Deleted	
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM		
A. Conditions Precedent	No change	Minor change
B. Commissioner Documents	No change	
C. Extension of Contract Term	No change	Minor change
SCHEDULE 2 – THE SERVICES		
A. Service Specifications	No change	
A1. Specialised Services – Derogations from National Service Specifications	**New**	
B. Indicative Activity Plan	No change	
C. Activity Planning Assumptions	No change	
D. Essential Services	Changed	
E. Essential Services Continuity Plan	Changed	
F. Clinical Networks, National Clinical Audit and Patient Outcomes Programme	No change	
G. Other Local Agreements, Policies and Procedures	No change	
H. Transition Arrangements	No change	
I. Exit Arrangements	No change	

J. Social Care Provisions	**Deletion proposed**	Deleted
J. Transfer of and Discharge from Care Protocols	No change	
K. Safeguarding Policies and MCA Policies	Changed	
L. Provisions applicable to Primary Care Services	**New**	
SCHEDULE 3 – PAYMENT		
A. Local Prices	No change	
B. Local Variations	No change	
C Local Modifications	No change	
D. Marginal Rate Emergency Rule: Agreed Baseline Value	No change	
E. Emergency Re-admissions Within 30 Days: Agreed Threshold	No change	
F. Expected Annual Contract Values	No change	
G Notices to Aggregate/Disaggregate Payments	No change	
H. Timing and Amounts of Payments in First and/or Final Contract Year	No change	
I. Stated Base Value for Gain and Loss Sharing Arrangement for Acute Specialised Services	**New**	Deleted
SCHEDULE 4 – QUALITY REQUIREMENTS		
A. Operational Standards	**Significant changes**	
B. National Quality Requirements	Changed	Changed
C. Local Quality Requirements	No change	
D. Never Events	Changed	Changed
E. Commissioning for Quality and Innovation (CQUIN)	No change	
F. Local Incentive Scheme	No change	
G. Clostridium difficile	No change	
H. CQUIN Variations	**Moved from 4 I; Sanctions Variation deleted**	
I.	**Deleted**	
SCHEDULE 5 – GOVERNANCE		
A. Documents Relied On	No change	
B1. Provider's Mandatory Material Sub-Contractors	No change	
B2. Provider's Permitted Material Sub-Contractors	No change	
C. IPR	No change	
D. Commissioner Roles and Responsibilities	**Deletion proposed**	Retained
E. Partnership Agreements	No change	

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS		
A. Recorded Variations	No change	
B. Reporting Requirements	**Significant changes**	Changed
C. Data Quality Improvement Plan	No change	
D. Incidents Requiring Reporting Procedure	No change	
E. Service Development and Improvement Plan	No change	
F. Surveys	Changed	
SCHEDULE 7 – TUPE AND PENSIONS	No change	

Service Conditions

Clause	**Title**	**Extent of changes made to 2015/16 Contract compared to 2014/15 Contract**	**Further changes made to 2015/16 final Contract compared to 2015/16 draft Contract**
SC1	Compliance with the Law and the NHS Constitution	Changed	
SC2	Regulatory Requirements	No change	
SC3	Service Standards	Changed	
SC4	Co-operation	Changed	Minor change
SC5	Commissioner Requested Services/Essential Services	No change	
SC6	Choice, Referral and booking	**Significant changes**	Changed
SC7	Withholding and/or Discontinuation of Service	Changed	
SC8	Unmet Needs	Changed	Minor change
SC9	Consent	No change	
SC10	Personalised Care Planning and Shared Decision Making	No change	
SC11	Transfer of and Discharge from Care Obligations	Changed	Changed
SC12	Service User, Public and Staff Involvement	Changed	
SC13	Equity of Access, Equality and Non-Discrimination	**Significant changes**	
SC14	Pastoral, Spiritual and Cultural Care	No change	
SC15	Places of Safety	Moved from SC16; no change	
SC16	Complaints	Moved from SC17; changed	Minor change
SC17	Services Environment and Equipment	Moved from SC15; changed	
SC18	Sustainable Development	**New** (partly from	

		SC15)	
SC19	Food Standards	**New**	
SC20	Service Development and Improvement Plan	Moved from SC18; no change	
SC21	Antimicrobial Resistance and Healthcare Associated Infections	**Moved from SC19; significant changes**	Minor change
SC22	Venous Thromboembolism	Moved from SC20; changed	
SC23	Service User Health Records	Changed	
SC24	NHS Counter Fraud and Security Management	No change	
SC25	Procedures and Protocols	No change	
SC26	Clinical Networks, National Audit Programmes and Approved Research Studies	No change	
SC27	Formulary	No change	
SC28	Information Requirements	**Significant changes**	Changed
SC29	Managing Activity and Referrals	Changed	Changed
SC30	Emergency Preparedness and Resilience Including Major Incidents	Changed	
SC31	Force Majeure: Service-specific provisions	No change	
SC32	Safeguarding, Mental Capacity and Prevent	**Significant changes**	Changed
SC33	Incidents Requiring Reporting	Changed	
SC34	Care of Dying People and Death of a Service User	Changed	
SC35	Duty of Candour	**Significant changes**	
SC36	Payment Terms	**Significant changes**	Changed
SC37	Local Quality Requirements and Quality Incentive Scheme	**Significant changes**	
SC38	Commissioning for Quality and Innovation	Changed	Changed

General Conditions

Clause	**Title**	**Extent of changes made to 2015/16 Contract compared to 2014/15 Contract**	**Further changes made to 2015/16 final Contract compared to 2015/16 draft Contract**
GC1	Definitions and Interpretation	No change	
GC2	Service Commencement	No change	
GC3	Effective Date and Duration	No change	
GC4	Transition Period	No change	
GC5	Staff	**Significant changes**	Changed
GC6	Not used	No change	
GC7	Partnership Arrangements	No change	
GC8	Review	No change	
GC9	Contract Management	**Significant changes**	Changed

GC10	Co-ordinating Commissioner and Representatives	No change	
GC11	Liability and Indemnity	No change	
GC12	Assignment and Sub-Contracting	Definitions changed	
GC13	Variations	Changed	Minor change
GC14	Dispute Resolution	Changed	
GC15	Governance, Transaction Records and Audit	Changed	Minor change
GC16	Suspension	No change	
GC17	Termination	**Significant changes**	Minor change
GC18	Consequence of Expiry or Termination	No change	
GC19	Provisions Surviving Termination	No change	
GC20	Confidential Information of the Parties	No change	
GC21	Data Protection, Freedom of Information and Transparency	Changed	Minor change
GC22	Intellectual Property	No change	
GC23	NHS Branding, Marketing and Promotion	No change	
GC24	Change in Control	No change	
GC25	Warranties	Changed	Minor change
GC26	Prohibited Acts	No change	
GC27	Conflicts of Interest	No change	
GC28	Force Majeure	No change	
GC29	Third Party Rights	Changed	Minor change
GC30	Entire Contract	No change	
GC31	Severability	No change	
GC32	Waiver	No change	
GC33	Remedies	No change	
GC34	Exclusion of Partnership	No change	
GC35	Non-Solicitation	No change	
GC36	Notices	No change	
GC37	Costs and Expenses	No change	
GC38	Counterparts	No change	
GC39	Governing Law and Jurisdiction	No change	Minor 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. 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. The eContract system has been revised and simplified for 2015 to make the system easier and quicker to use, and assistance in using the eContract system is available on the portal or at england.econtract@nhs.net. The eContract system can be accessed at https://www.econtract.england.nhs.uk/eContract/Home.

The scope of the contract

The NHS Standard Contract 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 ie who will play the role of co-ordinating commissioner in respect of specific, or all, provisions in which the co-ordinating commissioner is mentioned. A template collaborative commissioning agreement (unchanged from 2014/15) is available on the NHS Standard Contract webpage.

The contract contains provisions which are either:

- mandatory and non-variable, whether for all NHS services or only for specific types of service;
- mandatory, but for local agreement and definition;
- non-mandatory and for local agreement and definition.

For ease these three levels have been colour coded:

	All of the **General Conditions** are mandated and cannot be amended, or deleted. They apply to all services and to all providers of NHS funded clinical services. The **Service Conditions** apply automatically to all services or to the relevant service, as indicated, and are mandated for all services or the relevant service, as appropriate. The Service Conditions applicable to the relevant service cannot be changed, amended or deleted.	
	The **Particulars** contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green'. Action is required on all items that are amber coloured and must be completed prior to signing the contract. The parties must not leave any amber marked element for later completion.	
	Any element indicated as 'green' is optional and may be left blank, although for good practice and clarity any 'green' element that is not used should be marked as 'not applicable'.	

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.

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 in 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 2015 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). Commissioners should refer to paragraphs 12-13 above regarding contract duration and any provisions to extend the contract.	
Commissioners	Enter the full legal name and address of each commissioner organisation (CCGs, NHS England and, if appropriate, the local authorities) which will be a commissioning party to the contract. Include the relevant ODS code for each as this will aid identification and is linked to the information flows. All Commissioners to this contract will need an ODS code. Information on ODS codes can be found at http://systems.hscic.gov.uk/data/ods/guidance.	
Co-ordinating Commissioner	This is the Commissioner (or Commissioners) identified by the other Commissioners fulfilling the role (or roles) of Co-ordinating Commissioner for this contract. This links to Schedule 5D 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 must sign the contract. Insert additional signature blocks as required for the number of Commissioners that are party to the contract. The Provider must sign the contract. Refer to paragraph 10 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 may be the date of contract or a later date.	
Expected Service Commencement Date	Enter the date (or dates) when the services are expected to start to be delivered. The Provider must satisfy all Conditions Precedent by this date. Services may not start until it has done so.	
Longstop Date	This is the longstop date for satisfying Conditions Precedent. This should be no later than three months after the Expected Service Commencement Date in most instances. If the Longstop Date is reached and the Conditions Precedent have still not been met, the Co-ordinating Commissioner can then terminate the contract under GC17.10.1. 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 15/16 this will usually be 1 April 2015. 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 1 Part A) 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.	
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 13 above), and the length of the permitted extension	
Expiry Date	Insert the date on which the initial period contract will expire.	
Commissioner Notice Period	Enter the Commissioner Notice Period for termination under GC17.2.	
Commissioner Earliest Termination Date GC17.2	Enter the earliest date on which a commissioner notice to terminate may take effect	
Provider Notice Period GC17.3	Enter the Provider Notice Period for termination under GC17.3.	
Provider Earliest Termination Date	Enter the earliest date on which a provider notice to terminate may take effect	

GC17.3		
Service Categories		
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. For Commissioners not using the eContract the selection of the services relevant to the Provider will give an indication which of the Service Conditions is applicable. The Service Conditions that are not applicable will be 'read over'. Where a service is added to or removed from an existing contract, this section will need to be updated. The process set out in GC13 (Variations) should be used. See paragraph 30 above for further detail on service categories.		
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), Schedule 3I (Stated Base Value for Gain and Loss Sharing Arrangement for Acute Specialised Services), part of Schedule 6B (Reporting Requirements) and SC36.22A apply.	
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 31 on completion of the Service Specification template.	
Indicative Activity Plan SC29.5, SC29.6, SC29.11A, SC29.12.3A	Completing this will determine whether Schedule 2B (Indicative Activity Plan) and certain clauses in SC29 apply and appear for completion in the eContract.	
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.	
Essential Services SC5	Completing this will determine whether Schedule 2D (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 2015/16.	
Services to which 18-Week applies SC6.4	Completing this will determine whether SC6.4 and parts of Schedule 4 (Quality Requirements) apply and appear in the eContract. Answer 'yes' or 'no'.	
Payment		
National Prices	Where National Prices apply to all or some of the Services, state Yes. The specific Services to which National Prices apply may be listed here, by specification number, if desired. Where no National Prices apply, state 'not applicable'.	

Small Providers	A “Small Provider” is defined in the contract as an organisation whose aggregate income for the relevant contract year in respect of services provided to NHS commissioners under an NHS Standard Contract is not expected to exceed £200,000. Where the Provider falls within the definition, answer ‘yes’ and if not answer ‘no’. Certain Service Conditions, especially but not only in the Payment Terms (SC36.24 - SC36.32) apply only to Small Providers. The requirements in Schedule 6B (Reporting Requirements) are reduced for Small Providers.	
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’.	
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 4G Clostridium Difficile).	
Clostridium Difficile Baseline Threshold	The threshold for each NHS Trust and NHS Foundation Trust will be available on the NHS England website early in 2015. For other providers the C. diff. threshold should be set at zero.	
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.	
Provider ‘s Nominated Individual SC3.8	The name and contact details of the Provider’s Nominated Individual must be inserted here.	
Provider ‘s Information Governance Lead GC21.3.1	The name and contact details of the Provider’s Information Governance Lead must be inserted here.	
Provider’s Caldicott Guardian GC21.3.2	The name and contact details of the Provider’s Caldicott Guardian must be inserted here.	
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.	
Provider’s	The name and contact details of the Provider’s Accountable	

Accountable Emergency Officer GC21.3.2, GC21.3.3, GC21.3.4	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 Metal Capacity and Deprivation of Liberty Lead SC32.2	The name and contact details of the Provider's Metal 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.	
Contract Management		
Addresses for service of notices GC36	Insert for each Party the name and address to which notices relating to the contract should be sent.	
Frequency of Review Meetings GC8	Insert the frequency of the contract review meetings between the parties. The review meeting will focus on the quality and performance of the Services. The frequency of the review meetings should reflect the nature of the Services and the relationship between the parties. It is recommended that the minimum frequency should be every six months.	
Commissioner Representative(s) GC10.3	Insert for each Commissioner the name and contact details of the person that will be the primary contact point for the Provider. Where the CCG(s) have contracted with a commissioning support service, then the name and the contact details of the relevant contact point within the commissioning support service may be entered.	
Provider Representative GC10.3	Insert the name and contact details of the person that will be the Provider's primary contact point for the Commissioners.	

Schedule 1 – Service Commencement		
A - Conditions precedent GC2.1.2	Insert details of any documents that must be provided and/or actions which must be completed by the Provider before it can start providing services. The items/actions on the list should be provided/completed prior to the Expected Service Commencement Date. Where this is not done by the Longstop Date, the Co-ordinating Commissioner is able to terminate the contract under GC17.20.1. Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to: • Sub-contracts, see paragraph 33 above • Direction Letters, see paragraph 41.31 above.	

B - Commissioner Documents GC4.2	Insert details of any specific documents that have to be provided by the Commissioner(s) to the Provider prior to Service Commencement.	
C – Extension of Contract Term	To be used only as described in paragraph 13 above. Where applicable, insert the extension period of the contract, as advertised to potential providers during the procurement process.	
Schedule 2 – The Services		
A - Service Specification	Commissioners and Providers should agree Service Specifications for all services commissioned under this contract. See paragraph 31 above for further details.	
A1 – Specialised Services – Derogations from National Service Specifications	For specialised services, enter any derogations here.	
B – Indicative Activity Plan (IAP) SC29.5, SC28.6	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 37 above. The overall Indicative Activity Plan should include a breakdown of individual commissioner plans.	
C – Activity Planning Assumptions (APA) SC29.7	Insert any APA for the relevant Contract Year, specifying a threshold for each assumption. See paragraph 37 above for further details.	
D –Essential Services SC5	Commissioners should list here any Essential Services that are applicable to the contract. The concept of Essential Services applies only to NHS Trusts for 2015/16. (See paragraph 32 above for further information on Essential Services and Commissioner Requested Services.)	
E –Essential Services Continuity Plan SC5	If there are Essential Services, the Provider must have a Continuity Plan in relation to those Services. That plan (or a link or reference to it) must be inserted here. Where there are no Essential Services identified in Schedule 2D, mark this Part E as 'not applicable'.	
F – Clinical Networks SC26	Set out here any Clinical Networks in which the Provider is required to participate. If there are no relevant clinical networks applicable to the Services, enter 'not applicable'.	
G – Other Local Agreements, Policies and Procedures SC25.3	If there are specific local agreements, policies and procedures with which the Provider and/or Commissioner(s) are to comply, enter details of them here.	
H – Transition Arrangements GC4	The contract Transition Period is the time between the Effective Date and the Service Commencement Date. There may be certain things that need to be done during that period in order that services commence smoothly. Details of any such arrangements should be inserted here.	
I – Exit arrangements GC18.9	Where the parties agree specific payments to be made by one or more parties, and/or other specific arrangements which are to take effect, on the expiry or termination of the	

	contract or termination or any service, these should be set out in this section. Where there are no exit payments or other arrangements, this section should be marked 'not applicable'. See paragraph 41.26 – 41.30 above.	
J – Transfer of and Discharge from Care Protocols SC11	Any local agreement or protocols relating to Service Users' transfer and discharge from various care settings should be set out here. There is no mandatory format for this. A single protocol will not necessarily satisfy the needs of all types of Service User. Equally, separate local requirements for each Commissioner will need to be balanced against the provider's ability to accommodate different protocols for similar service users. Ideally, a single set of protocols will apply to all Commissioners. Where any individual Commissioner needs different transfer and discharge protocols, the collaborative commissioning group should discuss. Several protocols may be tabled for agreement with the Provider. The exact number will be for negotiation but it is expected that providers and commissioners will agree a sufficient number of different protocols broadly to satisfy local requirements without over-burdening the provider's ability to deliver.	
K – Safeguarding Policies and MCA Policies SC32	The Provider's written policies for safeguarding children and adults should be appended in Schedule 2L 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 paragraph 5.6 above.	
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: • identifies the Service; • describes any agreement to depart from an applicable national currency (in respect of which the appropriate summary template available at http://www.monitor.gov.uk/locallydeterminedprices should be copied or attached) • describes any currencies (including national currencies) to be used to measure activity; • describes the basis on which payment is to be made (that is, whether (and if so how) dependent on activity, quality or outcomes, or a block payment) • sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s).	
B – Local Variations SC36.11 – SC36.15	For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by Monitor (available at http://www.monitor.gov.uk/locallydeterminedprices)	

	– or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.	
C – Local Modifications SC36.16 – SC36.20	For each Local Modification Agreement (as defined in the National Tariff) which applies to this Contract, copy or attach the completed submission template required by Monitor (available at http://www.monitor.gov.uk/locallydeterminedprices) - or state Not Applicable. For each Local Modification application granted by Monitor, copy or attach the decision notice published by Monitor. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.	
D - Marginal Rate Emergency Rule: Agreed Baseline Value SC36.21	Enter the baseline value for emergency admissions as agreed between the Parties in line with National Tariff Guidance – or enter 'not applicable'. (This Schedule only applies to acute services providers.)	
E – Emergency Readmission Within 30 Days: Agreed Threshold SC36.22	Enter the threshold for emergency readmissions within 30 days, as agreed between the Parties in line with National Tariff Guidance – or enter 'not applicable'. (This Schedule only applies to acute services providers.)	
F - Expected Annual Contract Values SC36	Insert the total Expected Annual Contract Value (EACV) for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). The EACV must not be seen as an upper or lower cap on the provider delivering choice services. Where there is no EACV, enter 'not applicable'. Where applicable, specify EACV including and excluding anticipated values of any high cost drugs, devices and procedures (as listed in the National Tariff) expected to be used in connection with the relevant Services. (CQUIN calculations will be based on contract values excluding costs of these drugs, devices and procedures.)	
G - Notices to aggregate/disaggregate payments SC36.23	The Commissioners may agree to aggregate payments to the Provider into one payment to be made by the Co-ordinating Commissioner. Notices to the Provider informing it of the intention to aggregate payments, or to disaggregate payments, must be inserted here.	
H – Timing and Amounts of Payments in First and/or Final Contract Year SC36.35, SC36.36	If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here. Where the first and final Contract Year is 1 April – 31 March, enter 'not applicable'.	
Schedule 4 – Quality Requirements		
A - Operational Standards	These Operational Standards cannot be changed or amended. Elements for local insertion are indicated by the amber highlight. These Standards link to the service categories in the	

	Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraph 34 above.	
B - National Quality Requirements	Elements of National Quality Requirements that are for local agreement or insertion are indicated by the amber highlight. The remainder of the table cannot be amended. These Requirements link to the service categories in the Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraph 34 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 34 above.	
D - Never Events SC36.48	Never Events are now no longer listed separately within the Contract. NHS England's Never Events Policy Framework lists all of the individual Never Events. An updated Framework, with a revised list of Never Events, will be published early in 2015. The Framework and any revised versions will be available at: http://www.England.nhs.uk/ourwork/patientsafety/	
E - Commissioning for Quality and Innovation (CQUIN) SC38	Commissioners should complete this section in accordance with applicable CQUIN guidance.	
F - Local Incentive Scheme	If the parties have agreed a Local Incentive Scheme (or do so at any time during the contract term), the details should be inserted here.	
G - Clostridium difficile (C. diff)	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.	
H - CQUIN Variations	Where the Parties have agreed to vary the application of the national CQUIN scheme (as set out in CQUIN guidance), they must complete the template available in the CQUIN guidance. The completed template should be inserted here as Schedule 4H and returned to NHS England via e.cquin@nhs.net.	
Schedule 5 – Governance		
A - Documents relied on	If there are any documents, consents or certificates that have been relied on by any party in deciding whether to enter the contract, these should be identified and referenced here. However, the documents should not include letters of intent that relate to commissioning assumptions, nor should this	

	Schedule be used to endeavour to contradict or circumvent the mandated terms and conditions of the contract.	
B1 - Provider's Mandatory Material Sub-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 33 above.	
B2 – Provider's Permitted Material Sub-contracts GC12	Details of any Permitted Material Sub-contractors should be inserted here. If there are no Permitted Material Sub-contractors this section will be identified as 'not applicable'. Further guidance is set out in paragraph 33 above.	
C – IPR (Intellectual Property Rights) GC22	Commissioner IPR: any IPR owned or licensed by any Commissioner to be used by the Provider in the delivery of the Services should be agreed and listed here. Provider IPR: any IPR owned or licensed by the Provider or the Provider's Sub-Contractor to be used by Commissioners in the exercise of their functions and to derive full benefit from the Services should be agreed and listed here.	
D - Commissioner Roles and Responsibilities GC10	The Commissioners must set out in this Schedule the roles and responsibilities that each Commissioner has in relation to this contact – in essence, who will be the Co-ordinating Commissioner for all, or for some specific, purposes under the contract. The roles and responsibilities must be set out in the separate Collaborative Commissioning Agreement document entered into by all the Commissioners who are parties to the contract.	
E - Partnership Agreements GC7	This table is used to record any partnership arrangements (i.e. s75 agreements) between the Commissioner(s) and a local authority or the Provider and a local authority. If there are no Partnership Agreements, enter 'Not Applicable' in the relevant table(s).	
Schedule 6 – Contract Management, Reporting and Information		
A - Recorded Variations GC13	This table is used to record any variations to the contract agreed during the contract term. It should be left blank unless and until any variations are agreed.	
B - Reporting Requirements SC28	This table sets out the information that is required to be reported under the contract. See also paragraph 38 above. Reporting requirements are reduced in 2015/16 for small providers. Where the 'Small Provider' option has been selected in eContract, only the relevant reporting requirements in Schedule 6B will be shown.	
C - Data Quality Improvement Plan (DQIP) SC28.16, SC28.17, SC28.18	This table is used to record any agreed DQIP.	
D – Incidents Requiring Reporting Procedure	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient	

SC33	Safety Incidents and Other Patient Safety Incidents.	
E – Service Development and Improvement Plan SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 36 above, which sets out certain situations in which an SDIP must be included.	
F – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys.	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 41.31 above.	

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	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with the published guidance). **Denominator:** Number of adults who were admitted as inpatients (includes day cases, maternity and transfers, both elective and non-elective admissions)
Threshold	95% rate of inpatients undergoing risk assessment each month
Reporting	Nationally through Unify2 (monthly) and to commissioners through the Service Quality Performance Report (monthly)
Application of any sanctions	Monthly
Further information	A range of resources are available to local health economies to tackle VTE: National VTE Risk Assessment Tool. Hospital Associated Thrombosis and Root Cause Analysis guidance and tools (housed on national VTE prevention website). NICE clinical guideline CG92, and NICE Quality Standard for VTE Prevention (QS3) Other resources and information are available on the VTE Prevention website.

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

National Quality Requirement	Completion of a valid NHS Number field in mental health and acute Commissioning Data Set records submitted to SUS (excluding A&E services)
Rationale	This is a required Information Standard and has been set out as a priority in national planning guidance. National Patient Safety Agency guidance has identified risks to patient safety of not using the NHS Number as the national identifier for all patients.
Definition	% of all mental health and acute Commissioning Data Set records submitted to SUS in which a valid NHS Number for the Service User was included A "valid NHS Number" means the correct number for the specific Service User. The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Commissioning Data Set records submitted to SUS for mental health services and for acute outpatient, daycase and inpatient services and in which a valid NHS Number for the Service User was included **Denominator:** Total number of Commissioning Data Set records submitted to SUS for mental health services and for acute outpatient, daycase and inpatient services
Threshold	99% rate of completion of NHS Number
Reporting	To commissioners through the monthly Service Quality Performance Report It may be possible to rely on HSCIC monthly Data Quality Dashboard reports – see below. Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	HSCIC produces monthly Data Quality Dashboard reports, which commissioners and providers may be able to use as an effective method of monitoring this indicator, and we encourage this wherever possible. These reports operate at the level of the provider as a whole and include data for the most recent month – so, in some situations, they may not provide sufficiently accurate information to enable performance to be measured for the purposes of the calculation of any contractual sanction. The Co-ordinating Commissioner may therefore determine, at its discretion, that the provider will need to generate separate specific performance data for commissioners as part of the monthly Service Quality Performance Report. For a number of sensitive diagnoses and procedures (e.g. IVF, Genitourinary Medicine), where SUS removes all patient identifiable data including the NHS Number, a blank NHS Number should be classed as valid. Data on overseas and private patients should be excluded from the numerator and denominator, together with data on any cross-border activity with providers outside England (for example in Scotland) where NHS Number requirements are not mandated.

NHS Number – A&E services only

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

Mental Health Minimum Data Sets – completion of ethnicity field

National Quality Requirement	Completion of the ethnicity field in Mental Health Minimum Data Set records
Rationale	Improvement in the standard of completion of Mental Health Minimum Data Set records has been defined as an important priority by clinical stakeholders.
Definition	% of all Mental Health Minimum Data Set records in which the ethnicity code for the Service User was properly completed (HSCIC Data Quality Measure 6.) The indicator is the numerator divided by the denominator, expressed as a percentage **Numerator:** Number of Mental Health Minimum Data Set records in which the ethnicity code for the Service User was properly completed **Denominator:** Total number of Mental Health Minimum Data Set records 'Proper completion' is defined as meaning: • inclusion of a code showing the Service User's ethnicity (defined as 'Valid' in the HSCIC summary data; or • inclusion of a code showing that the Service User had been asked about their ethnicity but had declined to answer (defined as 'Other' in the HSCIC summary data.
Threshold	90% rate of proper completion of the ethnicity field
Reporting	To commissioners through the monthly Service Quality Performance Report It may be possible to rely on HSCIC monthly summary analysis of MHMDS data quality and consistency – see below Measurement against this requirement should take place at the point of the Final Reconciliation Date for the month in question, with performance reported to the commissioner as part of the next available Service Quality Performance Report
Application of any sanctions	Monthly
Further information	HSCIC publishes monthly summary analysis of MHMDS data quality and consistency at http://www.hscic.gov.uk/mhmdsmonthly. Commissioners and providers may be able to use these as an effective method of monitoring this indicator, and we encourage this wherever possible. These reports operate at the level of the provider as a whole and include data for the most recent month – so, in some situations, they may not provide sufficiently accurate information to enable performance to be measured for the purposes of the calculation of any contractual sanction. The Co-ordinating Commissioner may therefore determine, at its discretion, that the provider will need to generate separate specific performance data for commissioners as part of the monthly Service Quality Performance Report.

IAPT Minimum Data Sets – completion of IAPT outcome data

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

Appendix 4

Worked examples of calculation of financial consequences

E.B.1 Percentage of admitted Service Users starting treatment within a maximum of 18 weeks from Referral

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

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

NHS England has published provider C difficile targets for 2015/16 at http://www.england.nhs.uk/ourwork/patientsafety/associated-infections/clostridium-difficile/.

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

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

Y = 0

Z = ((A – B) x 10,000) x C

where:

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

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

$$C = \frac{\text{no. of inpatient bed days in respect of Service Users in the Contract Year}}{\text{no. of inpatient bed days in respect of all NHS patients treated by the Provider in the Contract Year}}$$

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

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

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

ii) Attribution of sanction value to a specific contract

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

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

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

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

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

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

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 <u>is not</u> 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 <u>is</u> 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

Appendix 5

Local quality requirements

Selecting local quality requirements

The CCG Outcomes Indicator Set will help guide local commissioning for outcomes. In addition commissioners can look at NICE's evidence and the indicators in the Outcomes Framework, with the existing data on outcomes for their population, to think carefully about where services might need to improve for the future. Improved services will help lead to improved outcomes.

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

In considering the local quality requirements, it is important to consider:

- whether you are trying to measure improvement or absolute standards;
- whether your proposed requirements are measurable and achievable;
- how many indicators you should be measuring – generally, fewer is better: identifying a smaller number of key indicators may be more effective in providing an early alert system to potential problems than requiring reporting on hundreds of less targeted quality requirements;
- using process measures to assess progress on achievement of broad outcomes and building on initial measures over a period of time.

When commissioning for outcomes, it is not always possible to commission improvements in the high-level outcomes contained in the NHS Outcomes Framework or associated measures in the CCG Outcomes Indicator Set. However, commissioners can use a range of quality requirements and associated indicators. For example, reduced mortality following fragility fractures will cumulatively support the high-level outcome in domain 1 (Preventing premature death).

In determining how quality requirements are measured, the whole time span of the contract should be considered. Where it is not possible to utilise outcome measures from the outset or to collect the information necessary for demonstrating the outcomes desired, a developmental approach should be employed. This may mean that the quality indicator for a given quality requirement is the development and implementation of a relevant policy or the definition and establishment of a collection methodology for new information requirements.

Where a new contract is subsequently awarded, or in the next contract year, there might be an audit to establish whether specific aspects of service delivery have been achieved. This in turn may lead to more challenging requirements relating to improvements in clinical outcomes or patient experience against the known baseline.

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

In considering the data collection requirements associated with establishing quality indicators, commissioners and providers should discuss how data can most efficiently and effectively be collected, eg whether electronically or through manual collection, and consider the resource implications of data collection. Data quality, such as timeliness, reliability, accuracy, verifiability and comparability, should be considered. In developing measurement processes, it is also important to consider the risk of introducing perverse incentives. Additionally, the size of the organisation should be considered, to ensure that information requests are proportionate for the monitoring of the contract.

Wherever possible, existing data collections should be used. The Health and Social Care Information Centre (HSCIC) website is a key source of nationally collected data to support commissioners make better decisions about care. It also publishes information and indicators, including the NHS and Social Care Outcomes Frameworks and the CCG Outcomes Indicator Set:

- HSCIC website
- HSCIC Indicator Portal
- Assessed list of Mandated Collections

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

The quality requirements should be agreed annually prior to the start of the contract year as set out in SC37. Only in exceptional circumstances should these requirements be lower than those which they are to supersede. The quality requirements can be used to embed high quality care, achieved through the previous year's CQUIN or local incentive scheme, as a baseline contractual requirement. Review of performance against quality indicators should be included in the regular contract review meetings (GC8).

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

Pick list of local quality indicators

Quality Requirement	Data Collection	Source	Service type
Domain 1: Preventing people dying prematurely			
Antenatal assessments <13 weeks	National IQI- VSB06 https://mqi.ic.nhs.uk/	COF/OF	Acute/ community
Mortality within 30 days of hospital admission for stroke	National CCG Outcomes Indicator Set 1.34	COF/OF	Acute
Evidence of local arrangements to ensure that patients with suspected stroke are admitted directly to a specialist acute stroke unit and are assessed for thrombolysis, receiving it if clinically indicated.	National (SINAP) CCG Outcomes Indicator Set 3.33 & 3.34	NICE QS	Acute
People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support. (evidenced by 4-week quit rates)	Vital Signs VSB05	NICE QS	All
People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.		NICE QS	Acute
People with lung cancer stage I–III and good performance status who are offered radiotherapy with curative intent receive planned treatment techniques that optimise the dose to the tumour while minimising the risks of normal tissue damage.	National (Lung Cancer Audit)	NICE QS	Acute
People with small-cell lung cancer have treatment initiated within 2 weeks of the pathological diagnosis.	National (Lung Cancer Audit)	NICE QS	Acute
Children and young people who have had bacterial meningitis or meningococcal septicaemia have a follow-up appointment with a consultant paediatrician within 6 weeks of discharge.	National	NICE QS	Acute
Summary Hospital-Level Mortality Indicator - SHMI value and banding - Percentage of admitted	National (HSCIC) HSCIC Indicator Portal	Quality Account Standard	All

patients whose treatment included palliative care - Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care			
Cardiac Rehabilitation	National (NACR)		Acute
Ambulance trust clinical outcomes: - Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle - Suspected stroke patients assessed face to face who received the appropriate care bundle - Ambulance outcome from cardiac arrest- return of spontaneous circulation - Ambulance outcome cardiac arrest – survival to discharge (also Domain 3)	National DH Ambulance Quality Indicators Also HSCIC Indicator Portal Quality Accounts/Domain 1	Quality Account Standard	Ambulance
The number of patients who were recruited to participate in research approved by a research ethics committee within the National Research Ethics Service (also domains 2.3.4.and 5)	Local	Quality Account Report	All
Domain 2: Enhancing the quality of life of people with long-term conditions			
People with COPD and MRC dyspnoea scale >/= 3 referred to pulmonary rehab	Local	COF/OF	Acute
Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.	National (SINAP)	NICE QS	Acute
People using mental health services who may be at risk of crisis are offered a crisis plan.	National (CPA dataset)	NICE QS	Mental health
COPD Discharge bundle - referral of	Local		Acute

smokers to smoking cessation; referral for pulmonary rehab; provision of management plan; optimisation of inhaler technique			
All patients with long-term conditions will be offered a personalised care plan.	Local	Mandate	All
The number of new cases of psychosis served by early intervention teams year to date			Mental health
Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team	National HSCIC Indicator Portal Quality Accounts/Domain 2/17		Mental health
Domain 3: Helping people to recover from episodes of ill-health or following injury			
PROMs for i. Groin hernia surgery ii. Varicose vein surgery iii. Hip replacement surgery iv. Knee replacement surgery	National HSCIC Indicator Portal Quality Accounts/Domain 3/18 https://indicators.ic.nhs.uk/webview/ or http://www.ic.nhs.uk/proms/	Quality Account Standard	Acute
People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.	National- Heart failure audit http://www.ucl.ac.uk/nicor/audits/heartfailure	NICE QS	Acute
Emergency readmissions to hospital with 28 days of discharge	National (HSCIC) HSCIC Indicator Portal Quality Accounts Domain 3	Quality Account Standard	Acute
Improving Access to Psychological Therapies (IAPT): Of those completing treatment it is expected that at least 50% will recover. - Rate of recovery higher than previous quarter until 50% recovery rate is achieved and when achieved maintained	National (HSCIC)		Mental health
Domain 4: Ensuring that people have a positive experience of care			
Percentage of patients seen within 18	National		Acute/

weeks for direct access audiology			community
Friends and Family Test	National	COF/OF Quality Account Standard	Acute/ community
Improving people's experience of outpatient care	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.1 https://indicators.ic.nhs.uk/webview/	COF/OF	All
Responsiveness to inpatients personal needs	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.2	COF/OF	Acute
Women's experience of maternity services	National HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.5 https://indicators.ic.nhs.uk/webview/	COF/OF	Acute
Patient experience of mental health services	National	COF/OF	Mental health
Parents of babies receiving specialist neonatal care are encouraged and supported to be involved in planning and providing care for their baby, and regular communication with clinical staff occurs throughout the care pathway.	National NNAP (Q5)	NICE QS	Acute
Mothers of babies receiving specialist neonatal care are supported to start and continue breastfeeding, including being supported to express milk.	National NNAP (Q4)	NICE QS	Acute
Babies receiving specialist neonatal care have their health outcomes monitored.	National NNAP (Q8)	NICE QS	Acute
Percentage of people who are supported to die in their usual place of residence	Local		All
Number of health visitors	http://www.ic.nhs.uk/healthvisitors		Community

Ambulance call abandonment rate	Ambulance Quality Indicators (DH)		Ambulance
Ambulance re-contact rate following discharge from care	Ambulance Quality Indicators (DH)		Ambulance
Ambulance service experience			Ambulance
Ambulance time to answer call	Ambulance Quality Indicators (DH)		Ambulance
Ambulance calls closed with telephone advice or managed without transport to A & E (where clinically appropriate)	Ambulance Quality Indicators (DH)		Ambulance
A & E unplanned re-admission rate	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E left department without being seen rate	Search for latest releases under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E total time spent in A & E department	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E time to initial assessment (95th percentile)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
A & E time to treatment in department (median)	Search for latest release under 'A&E Indicators' at www.ic.nhs.uk		Acute
Percentage of A & E attendances for cellulitis and DVT that end in admission	National – HES		Acute
Number of admissions for cellulitis and DVT per head of weighted population			Acute
A & E service experience	HSCIC Indicator Portal NHS Outcomes Framework/ Domain 4/ Improvement areas/4.3		Acute
Delayed transfers of care to be maintained at a minimal level			
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Patient safety incidents resulting in severe harm or death	NRLS/ local	Quality Account Standard	All
Incidence of newly-acquired category 2, 3 and 4 pressure ulcers	National		All
Rostered continuing consultant presence on both Saturday and Sunday in emergency medicine,	Local		Acute

emergency surgery or both.			
Reducing the number of suicides and incidents of serious self-harm or harm to others	Local	Mandate	Mental health
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged			Acute

Appendix 6

Public reporting of contractual sanctions applied by commissioners

As described in paragraph 35.3 above, commissioners must now publish on their websites details of the financial sanctions due and actually applied to each of their major providers for failure to achieve national standards set out in their contracts.

Commissioners should publish their first data by the end of April 2015, in respect of sanctions applied in Quarter 4 of 2014/15, with publication continuing on a quarterly basis thereafter.

Reporting must

- cover all of the national Operational Standards and the National Quality Requirements set out in Schedules 4A and 4B of the Particulars;

- identify, for each of the above standards, by named provider, the value of the sanction applied by the commissioner;

- indicate how the commissioner has spent, or intends to spend, the funding withheld from providers through the application of sanctions.

Commissioners must report individually on sanctions for all their contracts, whether they are the co-ordinating commissioner or not. Values need only be reported where the sanction in respect of a particular standard for that commissioner at the relevant provider exceeds £1,000 in the reporting period. Where a sanction is applied only annually, the position need only be reported annually.

A non-mandatory model template for publication of sanctions is provided at http://www.england.nhs.uk/nhs-standard-contract/15-16/.

Appendix 7

Hypothetical case studies

Activity management

Scenario

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:

- Clearly, the provider cannot control and is not responsible for the level of external referral.

- 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.

- 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).

- 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. SC 29.22 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.

- In many cases, contract specifications will not specify all of the exact procedures which the provider may offer – rather, the expectation is that patents 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.

- 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

- Carrying out activity above the level of the IAP is not a breach of contract and is not grounds for non-payment.

- Providers should only be held responsible for activity levels which are within their control.

- Failure to adhere to APAs or to implement an agreed AMP may be a breach of contract.

- It is reasonable for AMPs to include financial consequences for non-implementation.

Reporting requirements

Scenario

A contract with a community services provider includes at Schedule 6B 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.

- 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.

- 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.

- 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 / counting and coding

Scenarios

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.

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.

In contractual terms, the first issue is straightforward. SC36.46 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 (unless it is a Small Provider, in which case the different arrangements set out in SC36.32 apply). Where the provider misses this deadline, the commissioner is under no obligation to pay the invoices.

The second scenario is more complex. Let's assume, in this instance, that this is a case where the provider accepts that

- 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

- the new method of recording is technically incorrect under national data definitions; and

- 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

- expect the provider to accept non-payment for the excess recorded activity in month 6; and

- 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.

Appendix 8

Information management and information governance

The following section outlines a number of key issues that commissioners and providers need to consider, relating to the provision of information under the contract:

- information governance;
- system compliance;
- reporting requirements;
- information services; and
- workforce minimum data set.

Information governance – service user data and its protection

GC21 – Data Protection, Freedom of Information and Transparency (GC21.1)	All providers and commissioners must manage service user identifiable data in accordance with the law and established good practice in health and social care settings. Key laws include the Freedom of Information Act 2000 (FOIA), the common law duty of confidence, Data Protection Act 1998 (DPA), and Human Rights Act 2000 (HRA). The parties acknowledge that they must assist each other in complying with the law, agree to general responsibilities and specific requirements relating to DPA and FOIA.
The Information Governance Toolkit and IGSoC (GC21.2, GC21.6)	It is a requirement of all providers wishing to provide NHS funded services that they meet the full range of information governance requirements and specifically the requirements set out in the relevant Information Governance Toolkit (IGT), at a minimum level 2. Where there is a requirement to integrate their IM&T solution to NHS systems and services, including Choose and Book, PDS, NHS Mail and N3, the provider will need to complete an information governance statement of compliance (IGSoC).The IGSoC process is agreed once for each organisation i.e. per legal entity. Continuing compliance is reconfirmed through the annual submission of the Information Governance Toolkit and acceptance of the IG Assurance Statement. The IGT and IGSoC require the nomination of a Caldicott Guardian and Senior Information Risk Owner. It is suggested that the provider additionally nominate an informatics lead to support the contract. Their role would be to implement Schedule 6 Part C and be responsible for meeting the requirements and any new information requirements that emerge

	during the life of the contract. It is the responsibility of all commissioners to ensure that appropriate IG assurance is obtained when contracting for the delivery of information services. Further information on the IGSoC and IGT can be found at http://systems.hscic.gov.uk/infogov
Senior Information Governance Roles (GC21.3, Particulars – Governance and Regulatory)	Information Governance Lead A representative from the senior level of management should be appointed to act as the overall Information Governance lead to co-ordinate the IG work programme. Senior Information Risk Owner (SIRO) The Senior Information Risk Owner (SIRO) should be an Executive Director or other senior member of the Board (or equivalent senior management group/committee). The SIRO may also be the Chief Information Officer (CIO) if the latter is on the Board, but should not be the Caldicott Guardian as the SIRO should be part of the organisation's management hierarchy rather than being in an advisory role. The *Information Security Management: NHS Code of Practice* can be found at: http://systems.hscic.gov.uk/infogov/codes/securitycode.pdf Caldicott Guardian The role of the Caldicott Guardian is to oversee the arrangements for the use and sharing of patient information. Acting as the 'conscience' of an organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information. The Caldicott Guardian also has a strategic role, which involves representing and championing confidentiality and information sharing requirements and issues at senior management level and, where appropriate, at a range of levels within the organisation's overall governance framework. The Caldicott Guardian should be, in order of priority: • an existing member of the senior management team; • a senior health or social care professional; • the person with responsibility for promoting clinical governance or equivalent functions. The nominated Information Governance Lead, Caldicott Guardian and Senior Information Risk Owner must be identified in the Governance and Regulatory section of the Contract Particulars. GC21.3.3 additionally requires that the Commissioner is kept informed of any changes to the individuals holding these roles. The *Caldicott Guardian Manual 2010* can be found at:

	http://systems.hscic.gov.uk/infogov/links/2010cgmanual.pdf The *Confidentiality: NHS Code of Practice* can be found at: https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice *A guide to confidentiality in health and social care* published by the HSCIC, with supporting references can be found at: http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf There is a requirement within the Caldicott Review to ensure that these individuals (Information Governance Lead, Senior Information Risk Owner and Caldicott Guardian) are given appropriate education and training to support them in being clear about the respective roles and supporting them in performing their functions well.
The Response to the Caldicott Review (GC21.4, SC23)	The Caldicott Information Governance Review, published in March 2013 has the overarching aim of ensuring that there is an appropriate balance between the protection of the patient or user's information and the use and sharing of such information to improve care. It refers to an imperative to meet the needs of an ageing population, particularly at the boundary between health and social care. There is a particular focus on the duty to share information for care purposes, now established in a new 7th Principle. The Government Response to the Review, published in September 2013 includes expectations and commitments for all health and social care organisations. These are summarised in a table of commitments. The Provider must implement the recommendations of the review as given in the Government Response, and in particular the commitments listed in the table of commitments under the headings: • All staff and workers within the health and care system expectation; • All health and care organisations expectations; • Local NHS providers expectation. In GC21 and the SC23 we have drawn attention to aspects that would benefit from strengthening in order to address the requirements of the Caldicott Review, specifically proactive fair processing, consent for the use of data, where applicable, anticipating data management requirements for contract termination and assurance through information governance audit. Whilst attention has been drawn to these it does not mean other requirements are unimportant.

	Information: To share or not to share? The Information Governance Review is available at: https://www.gov.uk/government/publications/the-information-governance-review *Information: To share or not to share? The Government Response to the Caldicott Review* is available at: https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response
NICE Clinical Guideline 138 (GC21.5)	The provider must audit its practices against quality statements regarding data sharing set out in *NICE Clinical Guideline 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services* (CG138). It is expected that by conducting this audit, and revising practice accordingly, the provider will be able to demonstrate assurance that whilst information is shared lawfully by their employees, there are no obstacles to meeting the requirements of the Guideline arising from a failure to share. The Caldicott Review includes 7 quality statements or recommendations taken from CG138 that emphasise the importance of appropriate sharing. *CG138 Patient experience in adult NHS services*, and the full guidance document including methods evidence and recommendations can be found at: http://guidance.nice.org.uk/CG138. *QS15 Quality standard for Patient experience in adult NHS services* can be found at: http://publications.nice.org.uk/quality-standard-for-patient-experience-in-adult-nhs-services-qs15 *CG138 Patient experience in adult NHS services: baseline assessment tool* can be found at: http://guidance.nice.org.uk/CG138/BaselineAssessment/xls/English
Data Breaches and Information Governance Breaches (GC21.7)	The Caldicott Review broadened the definition of data breaches and how they should be handled [see below]. Organisations need to have regard to these recommendations alongside following the HSCIC's *Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation*. Data breach reporting should be included in Schedule 6 to the contract.
Data Controller	The Provider is a Data Controller under the Data Protection Act,

responsibilities (GC21.8 – GC21.13)	and as such takes sole responsibility for its obligations under the Act for Personal Data it processes in the delivery of the Services. Where data are required by the Commissioner for the purposes of quality assurance, performance management and contract management, the parties acknowledge that they are acting as joint Data Controllers. As such they hold shared responsibility for ensuring that the requirements of the Data Protection Act and other information law requirements are met in respect of this data, including shared responsibility for incidents relating to this data. Commissioners must engage with their commissioned providers to ensure that their joint responsibilities are met, in particular provision of fair processing information, responding to subject access requests and respecting subjects' other rights under the Data Protection Act. Providers should be aware that commissioners cannot require providers to process data unlawfully. This is particularly important to consider where there are contract variations. Even though providers are data controllers they will still need to demonstrate to commissioners that they have appropriate organisational and technical measures in place to protect personal and confidential data in line with Data Protection principle 7 requirements.
Responsibilities when engaging sub-contractors (GC21.14, Particulars – Schedule 5)	When engaging a sub-contractor to process data on its behalf, the Provider takes full responsibility for ensuring that the requirements of the DPA and other legal requirements are met by the sub-contractor, who is acting as a Data Processor. The specified written agreement commits the sub-contractor to measures that ensure that the Provider can meet its responsibilities under the DPA and FOIA. Contract Particulars, Schedule 5 must be completed in B1 with the identities of any Mandatory Materials Sub-contractors, and in B2 with those of any Permitted Materials Sub-contractors. Against each of these there must be an indication of whether the sub-contract includes data processing on behalf of the provider, and therefore a need for contractual commitments as stated above.
Responsibilities as a Data Processor (GC21.15)	Where the Provider organisation is commissioned specifically to deliver an information service that involves the processing of personal data on behalf of the Commissioner, the Provider is acting as a Data Processor under the DPA. In this situation the Commissioner takes full responsibility for data protection compliance, and the Provider must only process the data in accordance with the Commissioners instructions. Guidance on identifying Data Controllers and Data Processors

	can be found at: http://ico.org.uk/for_organisations/guidance_index/data_protection_and_privacy_and_electronic_communications
Commissioning Datasets (Particulars – Schedule 6)	Datasets in support of this contract must be submitted to bodies that have a legal power to receive Personal Confidential Data for this purpose. Guidance on this can be found at: http://www.england.nhs.uk/ourwork/tsd/ig/in-val/ All local datasets must be listed in the Contract Particulars, Schedule 6 under Local Requirements Reported Locally, or with reference to guidance on Prescribed Specialised Services where this applies. The *Manual for prescribed specialised services* and *Identification rules for prescribed specialised services* published by NHS England can be found at: https://www.england.nhs.uk/commissioning/spec-services/key-docs/
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 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.

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	The SCRa is a web based portal by which service user information

Care Record application (SCRa)	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.
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.

To enable information flows and meet the requirements of the HSCIC, the provider may require access to a number of reporting systems. The main collection methods and links to key information websites for further explanation are set out below:

Secondary Uses Service (SUS)	SUS is the single comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS. SUS data is derived from commissioning data sets (CDS), which must be submitted to the system by the provider. The provider must register with SUS to enable submission and details of how to register can be found at www.ic.nhs.uk/susguidance
Unify2	Unify2 is the system for sharing and reporting NHS health care activity and performance information. The provider will be required to register for access to Unify. For further information and access to

	Unify, please contact unify@dh.gsi.gov.uk
NHS OMNIBUS Survey	Omnibus is an online tool managed by the HSCIC to help NHS and social care organisations submit data. The provider and commissioner where appropriate will need to register with the HSCIC to support data submissions. Further information on OMNIBUS is available at http://www.hscic.gov.uk/
Strategic Executive Information System (STEIS)	STEIS is used by NHS organisations for the collection of Incidents Requiring Reporting SC 33 and Situation Reports (SITREP). For further information and agreement of method, please contact the relevant commissioner.

Information services

Below are useful links for both providers and commissioners to ensure that they are aware of the information requirements and standards set:

Information standard notices (ISNs)	Providers and commissioners are required under the contract to implement all ISNs relevant to the services being provided that are issued during the life of the contract. An information standard describes a common way of managing information, which supports national initiatives. More information is available on the SCCI website.
NHS Data Model and Dictionary Service	A reference point for all information standards that support healthcare activities and data definitions:
Health and Social Care Information Centre (HSCIC)	The HSCIC is England's central, authoritative source of health and social care information. It manages the national data repository and routine data flows between the health and care system and the centre. It publishes national and official statistics, indicators and measures used for national accountability. It has a key role in information governance and data quality assurance in relation to nationally collected and published data. In 2013/14 the HSCIC is planning to produce more comprehensive, regular and consistent reports on the quality of data submitted nationally by NHS organisations. These reports can be used locally by both providers and commissioners to monitor local data quality and inform declarations and assessments of quality accounts. The HSCIC produces information and reports such as the secondary uses service (SUS) data quality dashboards and mental health minimum data sets (MHMDS) data quality reports, to identify issues with the quality of nationally submitted data. The HSCIC has a national role to reduce the administrative burden of data collections, and as part of this role provides a list of mandated and voluntary national collections for health and social care. See http://www.hscic.gov.uk/datacollections

	The HSCIC's National Casemix Office designs and refines currencies that are used to describe healthcare activity and which underpin policies from costing through to payment, supporting local and national commissioning and performance management. It also provides analytical services to support specialised commissioning.

Workforce minimum data set

The Health and Social Care Act 2012 places a duty on all organisations that deliver NHS funded care to provide data on their current workforce and to share their anticipated future workforce needs. It does this through the duty placed on:

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

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

All providers of NHS funded services are required to co-operate with Health Education England (HEE) and its Local Education and Training Boards (LETBs) to support them to:

- understand the current workforce;

- plan the future workforce and understand education and training needs; and

- manage the provision of education and training to the workforce.

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

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

Workforce planning requires an understanding of the external environment, internal environment, business strategy and plans, current workforce and forecasted impact of turnover, retirements, recruitment and continuing professional development. All areas of the workforce minimum data set will assist planners in understanding workforce demographics and in developing strategies and plans to ensure appropriate education commissioning to provide the future workforce.

Type of data	**Use**
Absence data	Absence data helps planners to understand one of the

	elements of the internal environment. It can help provide an understanding of temporary staff costs and the impact of those costs on overall staffing numbers.
Deployment data	The essential elements of this group of data allow planners to ascertain if there are any gaps in workforce provision against their organisational structure, how much the workforce is currently costing the organisation and the potential costs of future requirements.
Education, training and development data	Education, training and development are key elements in workforce planning. Analysis of the current workforce's professional registrations, skills and competencies and comparing that data with the current and future requirements provides an indication of any gaps that may need filling. Education, training and development data can also link to the LETB's workforce skills and development strategy.
Organisational data	Indicates the organisation relevant to the employee.
Personal/operational data	This data will help workforce planners by building an understanding of the age profile of the workforce to support understanding of turnover, retention and retirement data and the effect of gender on working patterns.
Staff movement data	This provides essential information on how the shape of the historical and current workforce has ebbed and flowed. Staff movement data provides current vacancies, where staff have come from and where they go to, retirements, churn and natural wastage. It also shows the relationship between those employed and the hours they work, the role they play and whether or not they hold a substantive contract.

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