



# **Draft full-length NHS Standard Contract for 2016/17**

## **A consultation**

# **Draft full-length NHS Standard Contract 2016/17: A consultation**

## **Proposed changes to the full-length NHS Standard Contract for 2016/17**

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## Contents

.....	1
Contents.....	4
1 Introduction .....	5
2 Proposed changes to the full-length Contract .....	5
2.1 New legislation, policy and guidance .....	5
2.2 Changes affecting the interface between provider and GP .....	7
2.3 Financial sanctions.....	8
2.4 Simplifying and shortening the Contract.....	10
2.5 Technical improvements .....	11
2.6 Service Development and Improvement Plans .....	11
2.7 Other changes.....	12
3 Consultation responses.....	12
4 Appendix A.....	13

## 1 Introduction

The NHS Standard Contract is published by NHS England and is mandated for use by NHS commissioners to contract for all healthcare services other than primary care.

NHS England has been considering a range of changes to the Contract for 2016/17 – to keep the Contract up-to-date and relevant; to ensure it correctly relates to new legislation; to ensure it reflects significant new policies; and to deliver technical improvements.

Throughout the year, we have received feedback about the Contract from commissioners and providers who use it in practice. We ran a specific engagement process from July to September 2015 and received over 100 separate responses from individuals and organisations. This valuable feedback (the key themes of which are summarised at Appendix A) has influenced our proposals for changes to the Contract for next year.

We have now published, for consultation, a draft full-length Contract for 2016/17, which is available at <https://www.england.nhs.uk/nhs-standard-contract/16-17/>. This paper describes the main, material changes we are proposing in the draft full-length Contract, and we would welcome comments from stakeholders on our proposals, along with any other suggestions for improvement.

**Comments on the draft full-length Contract should be sent to [england.contractsengagement@nhs.net](mailto:england.contractsengagement@nhs.net) by Wednesday 16 March 2016. We will then publish the final version of the Contract shortly afterwards.**

For the first time, NHS England is also publishing a **shorter-form version of the NHS Standard Contract** for 2016/17. This is also available, with a separate consultation document, via <https://www.england.nhs.uk/nhs-standard-contract/16-17/>. The consultation on the shorter-form Contract runs to the same timetables as set out above.

## 2 Proposed changes to the full-length Contract

This section of the paper describes the main, material changes we have proposed to the full-length version of the Contract for 2016/17.

### 2.1 New legislation, policy and guidance

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

Topic	Change	Contract Reference
Mental health access	We have included new national standards for access to Early Intervention Programmes and to Improving Access to Psychological Therapy services.	Schedule 4B
Emergency presentations and referrals	We have strengthened requirements in relation to acceptance of emergency presentations or referrals. Providers will be required to accept emergency presentations of patients which are clinically appropriate for their services, where they can safely do so, even where the patient is from a CCG with which the provider does not have a contract. This mirrors the new requirement introduced for 2015/16 regarding acceptance of elective out-of-area referrals made under the legal right of choice.	SC6
Crisis care	Commissioners and providers will be required to have regard to the Crisis Care Concordat and good practice guidance on identifying places of safety.	SC15
Freedom to Speak Up Guardians	We have included a requirement on providers to identify a Freedom to Speak up Guardian, as recommended in <i>Learning Not Blaming</i> , the government response to the Morecambe Bay Investigation.	GC5
Right Care	We have amended some provisions with the aim of supporting commissioners to implement Right Care ( <a href="http://www.rightcare.nhs.uk/">http://www.rightcare.nhs.uk/</a> ). This includes strengthening the requirements on providers in relation to the use of Patient Decision Aids and the adoption of evidence-based good practice.	SC1 and SC10
Making Every Contact Count	We have included a new requirement on providers to implement brief, opportunistic, health-promoting interventions with appropriate patients, in line with <i>Making Every Contact Count</i> .	SC8
Conflicts of interest	We have included a new requirement on providers to maintain and publish a register of gifts, hospitality and conflicts of interest.	GC27
Accessible Information Standard	We have included a requirement to comply with the Accessible Information Standard published by NHS England in August 2015.	SC12
High-cost devices	In view of NHS England's forthcoming procurement in respect of high-cost devices used in specialised services, the Contract includes a new requirement to purchase such devices from the nominated supplier (once confirmed).	SC36
Electronic invoicing	We have introduced a new requirement on commissioners and providers to use the new national electronic invoicing system, <i>Tradeshift</i> .	SC36

We also intend to issue new guidance for providers in relation to the sale of high-sugar drinks and unhealthy food from NHS premises. This will be subject to a separate consultation process shortly, with the potential for any changes to be introduced in-year during 2016/17 through a National Variation to the Contract.

## 2.2 Changes affecting the interface between provider and GP

We are proposing a number of changes which will clarify the expectations across the primary care / secondary care interface and reduce avoidable extra workload for GPs. These changes will help to address concerns raised in *Making Time in General Practice*.

Topic	Change	Contract Reference
Local access policies	We have included a new requirement on providers to publish local access policies, in line with existing guidance. Hospitals will not be able to adopt blanket policies under which patients who do not attend clinic are automatically discharged back to their GP.	SC6
Discharge summaries	We have clarified arrangements for discharge summaries, requiring direct electronic or email transmission of discharge summaries (using the Academy of Medical Colleges endorsed clinical headings) for inpatient, daycase or A&E care within 24 hours and enabling local standards to be set for discharge summaries from other settings. We are also encouraging providers to adopt the structured approach to sharing clinical information set out in the Domain Message Specifications published by HSCIC.	SC11 and Definitions
Clinic letters	We have included a new requirement on providers to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage a patient's care. For 2017/18, we intend to strengthen this requirement, requiring electronic transmission of clinic letters to practices as with discharge summaries to a similar timescale.	SC11
Onward referral	We have amended the Contract wording to clarify that, for a non-urgent condition related to the original referral, onward referral to another professional within the same provider is permitted; there is no requirement to refer back to the GP. Re-referral (or GP approval) is only required for onward referral of a non-urgent, unrelated condition.	SC8
GP feedback	We have built in new requirements for providers to take account of GP feedback and to involve GPs when considering service development and redesign.	SC3 and SC12
Medication on discharge	For discharges from inpatient or daycase care, we have included new requirements to ensure that patients are supplied with at least 14 day's medication (unless a shorter period is clinically appropriate or where a further supply will be available via the Service User's GP or other primary care provider within 14 days).	SC11
Communication and organisation of care	We have included a new overarching requirement on providers to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes notification to patients of the results of clinical investigations and treatments.	SC12

## 2.3 Financial sanctions

NHE England has undertaken detailed work to review the financial sanctions which apply under the Contract, where providers do not achieve specified national standards.

### The overall approach to sanctions

Financial sanctions generate strong opinions, and we have received much feedback about them from CCGs, NHS Trusts and Foundation Trusts.

NHS England has considered these views. We believe that financial incentives do have a part to play in helping to deliver the best possible standards of care for patients. Of course, these financial incentives should operate alongside other non-financial drivers – the underlying pursuit of excellent patient care which motivates individual NHS staff, for instance, or the desire at organisational level to serve patients well and avoid regulatory intervention. And our underlying aim is that financial incentives should help to create and sustain a position where providers routinely achieve national standards and sanctions rarely have to be applied. But we do believe that, in principle, those providers who fail to deliver the core standards which matter most to patients should experience a financial consequence for that failure.

However, in the specific context of 2016/17, where we will be deploying the new Sustainability and Transformation Fund (STF), we believe that a revised approach is appropriate. We are therefore proposing to suspend, as a temporary measure for 2016/17, the operation of financial sanctions which would otherwise apply where providers fail to deliver certain of the national standards set out in Schedules 4A and 4B of the Particulars of the Contract. The suspension of relevant sanctions will only take effect where providers are subject instead to the conditionality and sanctions that will apply in respect of the provider-facing STF.

The sanctions which will be affected are those covering A&E waits (four-hour wait and twelve-hour trolley waits), RTT waits (18-week incomplete pathway, 52-week waits and six-week diagnostic waits), cancer 62-day waits, ambulance response times (Red1, Red 2, other Category A) and ambulance handover standards (affecting both A&E and ambulance providers).

This suspension will operate as follows. Where, as a condition of accessing Sustainability and Transformation funding or agreeing a financial control total with NHS Improvement, providers agree a financial control total and/or performance trajectories for 2016/17, the financial sanctions described above will not be applied by commissioners in respect of 2016/17. Rather, if a provider fails to adhere to its agreed trajectory, NHS Improvement and NHS England will withhold an element of the Sustainability and Transformation funding. This fulfils the promise made in the [NHS Planning Guidance](#) that such providers will not face ‘double jeopardy’ in 2016/17.

Given that this is a temporary measure, application of incentives is expected to return to its current basis for 2017/18 onwards. For this reason, we have retained the



detailed national incentives within the draft Contract at Schedules 4A and 4B, but included a new provision at Service Condition 36.37 to enact their suspension during 2016/17 for relevant providers.

### Electronic prescribing for chemotherapy

The Cancer Taskforce report recommended that a new financial sanction should be introduced for 2016/17 in relation to failure to use electronic prescribing for chemotherapy. This follows several years in which this has been a quality-related service requirement of cancer care, but a number of providers have been in derogation. We are introducing a new requirement that every provider of cancer care must produce a robust implementation plan for cancer e-prescribing by 30 June 2016, providing for full system implementation to be achieved by no later than 31 March 2017. The sanction is set at 5% of the monthly value of the relevant chemotherapy services, for each month from July 2016 for which an implementation plan is not delivered. Furthermore, we intend that relevant cancer drugs will only be reimbursed by the reconstituted Cancer Drugs Fund where full-e-prescribing is in place, in line with recommendations of the National Audit Office and the House of Commons Public Accounts Committee.

### Sanctions to be removed

We are proposing to remove the national sanctions relating to VTE risk assessment and formulary publication from the Contract for 2016/17, in recognition of progress that has been made. In both cases, although the specific automatic sanction is being removed, the contractual requirements on providers will remain unchanged, and it remains essential that providers continue to meet these.

### Revised sanctions for ambulance response times

The review we have undertaken has led us to propose changes to the sanctions for the three different standards for ambulance response times. We intend to introduce these changes for 2016/17, even though – as set out above – these sanctions will be suspended for certain providers for the coming year. The proposed amendments are set out below.

The current sanction for each standard is a fixed percentage (2%) of the provider's total contract value, regardless of the margin by which the provider has missed the performance standard. There are two problems with this.

- The total financial exposure from sanctions for ambulance providers (6% of total contract value for response times, plus further exposure on handover standards) is much higher than for providers of other services.
- The fixed percentage approach can result in a very disproportionate sanction (where a provider only narrowly misses a standard) and can also leave a provider with little financial incentive to improve (where it is missing the standard by a large margin).

We are therefore proposing to change the construction of these sanctions, so that they mirror the way similar sanctions work in other areas – that is, a sanction of a specific value for each “excess breach” of the standard, beyond the % tolerance allowed by the standard. This means that the sanctions are more proportionate (because the sanction increases for every additional journey by which the provider misses the standard) and that the provider always has an incentive to improve (because better performance will mean a lower sanction).

We propose that the sanction per excess breach should be set at £300 for Red 1 journeys (reflecting the greater clinical risk for patients of breaches of this standard) and £100 for Red 2 and all Category A journeys. We estimate that this will significantly reduce the overall financial exposure of ambulance service providers.

Where individual ambulance providers are part of national schemes to pilot new methods of recording waiting times (on Red 2 / Category A journeys), the proposed Contract wording allows flexibility for commissioners to agree with providers to amend the national sanction to reflect the impact of the pilot locally.

#### Mental health access standards

It is obviously important that we treat mental health and physical health services even-handedly through the Contract. We have a duty to commission with regard to equity of access. We therefore propose that the new standards for access to IAPT services and Early Intervention Programmes should, over time, attract sanctions for non-compliance, as happens with acute services standards. We intend to introduce such sanctions into the Contract for 2017/18.

#### Further detail

Further detail can be found within Schedules 4A and 4B of the Particulars of the draft Contract.

## **2.4 Simplifying and shortening the Contract**

We are able to propose some changes for 2016/17 which will shorten or simplify aspects of the Contract.

<b>Topic</b>	<b>Change</b>	<b>Contract Reference</b>
RTT completed pathways	In line with changes announced earlier in the year, the 18-week RTT standards for completed pathways are no longer included for 2016/17.	Schedule 4A
Duty of Candour	We have simplified the lengthy provisions in the Contract relating to the Duty of Candour. Following amendments to NHS England’s Standing Rules, these can be expressed much more briefly, removing duplication and confusion between the contractual duty of candour and the statutory duty of candour.	SC35

Topic	Change	Contract Reference
Small Provider	Given that we are now separately publishing a shorter-form version of the Contract, we have removed the tailoring relating to Small Providers from within the full-length version.	SCs and Ps

## 2.5 Technical improvements

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

Topic	Change	Contract Reference
Co-operation	We have amended the provision of the Contract on co-operation to ensure that this applies equally to commissioners as to providers.	SC4
NHS Number	We have introduced a new requirement for commissioners to ensure that referrers use the NHS Number in referral letters.	SC23
Local reporting requirements	To ensure that any local reporting requirements are kept to proportionate levels, we have clarified that a provider need not supply any information locally for which the commissioner cannot demonstrate purpose and value in connection with the discharge of its statutory duties and functions.	SC28
Information Breaches	To ensure that any local reporting requirements are kept to proportionate levels, we have clarified that commissioners must have regard to the burden which their information requests place on providers and that a provider need not supply any information locally for which the commissioner cannot demonstrate purpose and value in connection with the discharge of its statutory duties and functions.	SC28

## 2.6 Service Development and Improvement Plans

As in previous years, we have identified that certain issues can most effectively be taken forward by requiring CCGs to agree Service Development and Improvement Plans (SDIPs) at Schedule 6E in their local contracts with relevant providers. We propose that, for 2016/17, the following issues should be addressed through local SDIPs.

- Seven day services.** We will continue to require CCGs to agree SDIPs in their contracts with all acute providers and to assure progress towards implementation the four key 7DS standards locally during 2016/17. Where individual providers have agreed, as part of the national roll-out programme, to implement standards 2, 5, 6 and 8 in full by March 2017, this additional requirement should be set out clearly within the agreed SDIP within their local contract.

- **Mental health access standards.** For 2016/17, we will require CCGs to agree SDIPs
  - with providers of EIP and IAPT services, setting out how those providers will ensure that staff are fully trained to deliver the new access standards, including a commitment by the provider to sign-up to nationally-approved accreditation programmes;
  - with providers of children's and young people's mental health services, setting out how each will contribute to the implementation of the Local Transformation Plan and how each will prepare for implementation of the new access standard for eating disorder services, including a commitment by the provider to sign-up to the nationally-approved accreditation programme.
- **Digital transformation.** We will require CCGs to put in place an SDIP with each major provider, setting out how the provider will contribute to the implementation of the Local Digital Roadmap and develop and implement its local strategy for standardising clinical terminology (through adoption of SNOMED-CT), digitising medicines management, improving cyber security and ensuring all IT systems are appropriately supported, and ensuring positive patient identification, including compliance with GS1 standards.
- **E-referral.** Use of the new national NHS e-Referral Service system for outpatient referral and booking remains patchy. We will require CCGs to work with service providers and GP representatives to put in place an SDIP which sets out what each will do to increase use of the system during 2016/17, in terms of service publication and slot availability from the hospital/provider perspective and use of the system for booking by referrers. Where services are not currently able to be directly bookable, the SDIP should include a plan for transitioning towards this. The aim is for over 80% of referrals to be made by E-referral by April 2017, and we intend to introduce new financial incentives for both providers and commissioners for 2017/18 to support this.

## 2.7 Other changes

We have, in addition, made minor changes to rationalise and improve the Contract where we have considered it appropriate to do so.

## 3 Consultation responses

We invite you to review this consultation document and the draft Contract itself (available at <https://www.england.nhs.uk/nhs-standard-contract/16-17/>) and provide us with feedback on any of our proposals.

Comments on the draft Contract should be sent to [england.contractsengagement@nhs.net](mailto:england.contractsengagement@nhs.net) by **Wednesday 16 March 2016**. We will then publish the final version of the Contract shortly afterwards.

## 4 Appendix A

### Key themes from external stakeholder engagement

Over 100 separate responses were received from organisations and individuals, split broadly evenly between commissioners and providers. The following key themes were evident in the responses.

#### 1 Shorter-form Contract

Our intention to produce a streamlined, shorter-form version of the Contract was consistently welcomed, particularly by providers from outside the NHS.

##### *How we are responding*

We have published a draft shorter-form version of the Contract for consultation. We will aim to ensure, through guidance to commissioners, that it is used to its full potential in 2016/17.

#### 2 Local quality standards and reporting requirements

Respondents commented frequently on the increasing burden placed on providers by local quality requirements within contracts and the associated data flows.

##### *How we are responding*

Given the very wide range of different services commissioned under the Contract, we cannot mandate appropriate quality and reporting requirements at national level, and it is obviously essential that commissioners are able to require the information they need from providers to assure them about the safety and quality of care.

For 2016/17, we have included a specific new requirement that a provider need not supply any information locally for which the commissioner cannot demonstrate purpose and value in connection with the discharge of its statutory duties and functions.

#### 3 Information Breaches

Some providers raised concerns about the high level of financial exposure they face under the contractual provisions for managing overall breaches of contractual requirements (GC9) and for managing Information Breaches (SC28).

These provisions are additional to the regime of financial sanctions for breaches of specific national standards. Where contractual processes are followed through without the provider remedying its breach, they allow withholding by commissioners of significant further sums (up to 2% of monthly contract value for each performance

breach, with a cap of 10%, up to 1% of monthly contract value for each Information Breach but without a cap).

Providers pointed out that current Contract wording across the two areas was inconsistent and that a ceiling on the sanction that can be applied in relation to Information Breaches would also be appropriate.

#### *How we are responding*

We believe that there is merit in the arguments put forward and that the current wording could indeed be improved. We have therefore clarified the provisions relating to Information Breaches, so that financial sums withheld by commissioners must be “reasonable and proportionate” (in line with similar provisions for Remedial Action Plans), with the maximum impact in any month set at 5% of monthly contract value.

#### **4 Timely publication**

Many responses emphasised the need for timely publication of the 2016/17 Contract.

#### *How we are responding*

We anticipate publishing the final Contract as soon as possible following the consultation period.

#### **5 Counting and coding changes**

The 2015/16 Contract introduced a revised requirement in relation to the financial impact of agreed changes in the counting and coding of activity, largely affecting acute services. The previous arrangement had required only a six-month notice period for such changes to take financial effect, regardless of the (often significant) financial impact for either commissioner or provider. The new arrangement retained this six-month notice requirement, but added a further provision that any financial impact from an agreed change should be made neutral (as between commissioner and provider) for a further 12 months.

The impact of this change will be felt for the first time in the coming (2016/17) contracting round. A number of providers felt that the delay was now too long.

#### *How we are responding*

The change has not yet been tested in practice, and it would be perverse for us to reverse direction on this issue at this stage. We have therefore made no change for the 2016/17 Contract, but we will review the impact of the new approach thereafter. Commissioners and providers can provide feedback on this at any point in the contract year to [england.contractsengagement@nhs.net](mailto:england.contractsengagement@nhs.net).

#### **6 Contract sanctions**

See section 2.3 above.