



# **Draft shorter-form NHS Standard Contract for 2016/17**

## **A consultation**

# **Draft shorter-form NHS Standard Contract 2016/17: A consultation**

**Proposed content of the shorter-form NHS Standard Contract for 2016/17**

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<b>Description</b>	For use from April 2016, for the first time NHS England intends to publish a shorter-form version of the NHS Standard Contract for use in defined circumstances. This will complement the full-length version of the Contract, which will continue to be used in respect of the bulk of services by value. This paper describes the basis on which we have developed the draft shorter-form Contract.
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<b>Contact Details for further information</b>	NHS Standard Contract Team 4E64 Quarry House Quarry Hill Leeds LS2 7UE <a href="mailto:england.contractsengagement@nhs.net">england.contractsengagement@nhs.net</a>  <a href="https://www.england.nhs.uk/nhs-standard-contract/16-17/">https://www.england.nhs.uk/nhs-standard-contract/16-17/</a>

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## 1 Introduction and background

The NHS Standard Contract is published by NHS England and is mandated for use by NHS commissioners when contracting for healthcare services other than primary care. For the first time, for use for commissioning of services from April 2016, NHS England intends to publish a shorter-form version of the Contract, for use in defined circumstances. This will complement the full-length version of the Contract, which will continue to be used in respect of the bulk of services by value.

To date, the Contract has included a mix of mandatory national requirements (set out in the General and Service Conditions) and scope for local detail to be included (within the Particulars) – service specifications, local quality standards and so on. It has also been the case that, while the General Conditions have been the same for all contracts, some of the content of the Service Conditions can be tailored to reflect the specific services being commissioned – so that, for instance, provisions relating specifically to acute services could be omitted from a contract for mental health or community services.

This has meant that Contract has not been a “one-size-fits-all” document – and the level of additional local detail which is included within contracts obviously differs widely, depending on the extent of services being provided. But the feedback we have received about use of the Contract in practice suggests that, as currently designed, it can often feel over-complex and burdensome for certain kinds of provider organisations (particularly voluntary sector organisations and small businesses) typically delivering less complex services.

This paper describes the basis on which we have developed the draft shorter-form Contract, which is now available in full at <https://www.england.nhs.uk/nhs-standard-contract/16-17/>. We would welcome comments on any aspect of the draft, and we have raised a number of specific consultation questions below. **Comments 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 shorter-form Contract shortly afterwards. NHS England reviews the standard commissioning contracts it publishes on an annual basis, so there will be further engagement and consultation in future years.

(At the same time, NHS England is also consulting on proposed changes to the full-length version of the Contract for 2016/17. A separate consultation document, and the full-length draft Contract, are available through the same weblink above, and the email address and timescale for comments to be received are the same. You may wish to read both consultation documents, as the shorter-form Contract reflects many of the updates we propose making to the full-length Contract, which we explain in the separate consultation document.)

## 2 Development and engagement process

In developing our thinking about the shorter-form Contract, we have been aided particularly by Regional Voices, who undertook a survey of voluntary bodies (222

responses) about their experiences of NHS procurement and contracting processes. We have tested our developing proposals in two workshops with providers from the voluntary and care home sectors, and we have received helpful feedback on an early draft of the shorter-form Contract.

Overall, stakeholder views so far have been positive. For example, 82% of respondents to the Regional Voices survey said that a shorter-form Contract would be helpful to them.

### 3 Overall objective

Our overarching intention in producing a shorter-form version of the Contract is to reduce the complexity and burden involved in doing business with the NHS for smaller healthcare providers, particularly those from the voluntary and independent sectors – whilst, at the same time, delivering a robust contract which commissioners can use effectively to hold providers to account for the provision of safe, high-quality services to patients.

*Consultation question 1: Do you support our overall objective?*

### 4 Criteria for use of the shorter-form Contract

Although the shorter-form Contract has been developed with the needs of these smaller providers in mind, we cannot offer a separate form of Contract which would be available only to providers from certain sectors. This would be contrary to the “level playing field” approach required under procurement law. We therefore need to consider carefully the criteria for when the shorter-form Contract may be used – and when it must not be used.

Our proposal is that the shorter-form Contract **must not be used** for contracts:

- under which acute (or any other hospital inpatient services, including for mental health), cancer, A&E, minor injuries, 111, or emergency ambulance services are being commissioned; and / or
- where any services are being paid for at the national prices set out in the National Tariff guidance.

Restricting use of the shorter-form Contract in this way significantly reduces the number of detailed requirements which it has to include, and the providers of services for which we propose that the shorter-form Contract must not be used tend to be larger organisations.

Commissioners **would have the option to use** the shorter-form Contract for commissioning all other services – for non-inpatient mental health and learning

disability services, for any community services, including those provided by general practices, pharmacies, optometrists and voluntary sector bodies, for end of life care services outside acute hospitals, for care provided on a residential basis in care homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.

We would not set a binding upper financial limit on use of the shorter-form Contract, but we would, in guidance, **strongly encourage commissioners to use the shorter-form for contracts with lower annual values**, which will tend to include those held by the smaller provider organisations which this new contract form is intended to assist.

The end result of this approach, in practice, should be that the shorter-form Contract would be used for the majority of contracts with smaller providers such as voluntary organisations, hospices (where grant agreements were not being used), care homes and providers of enhanced services such as general practices, pharmacies and optometrists.

The availability of the shorter-form Contract will not, of course, change our firm steer to commissioners that, where voluntary sector organisations receive funding for their services from a variety of sources, grant agreements should be used rather than commissioning contracts.

*Consultation question 2: Do you agree with the criteria we have suggested above for when to use the shorter-form Contract?*

## 5 Content of the shorter-form Contract

The Regional Voices survey gave us an opportunity to test opinion as to what should be included within a shorter-form Contract. There was

- very strong support for the inclusion of
  - local service specifications;
  - desired outcomes and quality standards;
  - pricing and payment mechanisms;
  - appropriate contract management processes; and
  - necessary legal clauses (covering issues such as liability and indemnity, intellectual property rights, confidential information and information governance)
  
- strong support for the inclusion of
  - detailed requirements around safe service provision / fundamental standards of care; and
  - requirements to comply with relevant legislation and guidance and to adhere to the NHS Constitution

- little support for the inclusion of requirements to deliver on national policy areas not directly related to the clinical quality of services.

In designing the shorter-form Contract, we have therefore sought to

- retain the ability to specify crucial detail in locally-agreed schedules (specifications, standards, prices)
- retain core requirements relating to patient safety and clinical quality;
- remove or abbreviate other significant policy requirements that feature in the full-length Contract; and
- simplify and streamline contract management processes.

What does this mean for providers and commissioners?

- The proposed shorter-form Contract will be under 70 pages in length, against the 210 pages of the current full-length version. Of this, 31 pages contain the operative, mandatory provisions. The remaining pages comprise a glossary of terms, the template schedules and tables for local completion (not all of which will be relevant to all contracts), and the table of contents and cover pages. So, while this is not a flimsy document, it is significantly shorter – and, we hope, therefore less overwhelming in its complexity for smaller providers with limited management capacity.
- The shorter-form Contract does mean a lighter touch in respect of some of the specific requirements placed on providers. So, for example, providers under this Contract will not be obliged to publish a formulary or to put in place a sustainable development plan. But removal of explicit contractual provisions on specific policy areas does not necessarily let providers ‘off the hook’ – rather, it will sometimes mean that greater reliance is placed on the requirement in the Contract (Service Condition 1) for providers to operate in line with good clinical and healthcare practice. So, as one example, in the interests of abbreviation we have omitted the specific requirement relating to maintaining a ‘consent to treatment’ policy – but providers must, of course, still ensure that they follow recognised good practice in seeking and recording informed consent to treatment.
- As a tool for contract management, the shorter-form Contract is significantly less detailed. Most of the processes have been significantly abbreviated (those relating to activity management, contract management and information requirements, for instance). Some tools have been removed altogether (the Service Development and Improvement Plan, the concept of an Information Breach). So the shorter-form Contract will be more suited to relatively simple contractual relationships for the provision of services with lower overall financial values, as we have suggested above. The provisions for service suspension and contract termination remain within the shorter form, of course,



offering protection for commissioners in the event that a provider is providing unsafe or consistently low-quality services.

In many instances, the detailed wording of the shorter-form Contract mirrors the wording of the full-length version, just with certain elements omitted or with minor abbreviations. In a few other cases, however, more significant redrafting has been undertaken to condense significantly the existing provisions. To help users to navigate the new shorter-form Contract, though, we have retained the three-part structure of the full-length version, and we have used the same numbering of sections and schedules. People have told us it will be helpful for there to be consistency across the two Contracts in this way. This does mean that, in the shorter form, some sections are marked with the words “Intentionally Omitted”.

For simplicity, the draft shorter-form Contract does not feature the same scope for tailoring as the full-length version. The nationally-mandated provisions are broadly the same, regardless of the type of services being commissioned. Some specific options will not be available through the shorter-form Contract (for instance, the ability to bolt on an additional schedule of primary care provisions). But we have built in a small amount of tailoring, to make use of the shorter form as flexible as possible – so, for example, it allows for the payment provisions to work either on the basis of a contract value agreed at the start of the year (with payments made in advance and retrospective reconciliation as necessary) or with a contract value of zero (in which case the provider invoices in arrears).

*Consultation question 3: Is the content we have proposed for the shorter-form Contract reasonable? What should we add, remove or amend?*

## 6 Consultation responses

We have highlighted three specific questions above, and we would welcome feedback on these – and on any other aspects of the draft shorter-form Contract (available at <https://www.england.nhs.uk/nhs-standard-contract/16-17/>).

Comments on the draft shorter-form 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.