NHS England

NHS Standard Contract 2016/17 Technical Guidance

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Document Status

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NHS Standard Contract 2016/17

Technical Guidance

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NHS England

This is the final version of the NHS Standard Contract Technical Guidance 2016/17.

Yellow highlighting indicates that text has been significantly updated from the 2015/16 Guidance.

Green highlighting indicates that text has been significantly updated from the draft version to the final version of the 2016/17 Guidance.

This updated version, published in April 2016, includes minor corrections, for consistency, including at paragraphs 38.14, 39.22, 39.25 and 45.7 and the flowchart on page 89.

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

Section A: General guidance on contracting

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Appendices

Executive Summary

1 Introduction

1.1 The NHS Standard Contract is published by NHS England and is mandated for use by CCGs and NHS England for all their clinical services contracts, with the exception of those for primary care services.

2 The full-length and shorter-form versions of the Contract

2.1 Since it took over responsibility for the NHS Standard Contract, NHS England has published a single version of the Contract, containing 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). Because elements of the Contract can be tailored to reflect the specific services being commissioned, the Contract has not been a "one-size-fits-all" document – 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 smaller provider organisations (charities, for instance, or care home operators).

2.2 For the first time, therefore, for use for commissioning services with effect from April 2016, NHS England is publishing 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 (and indeed will remain mandatory) in many situations.

3 Key changes to the full-length Contract for 2016/17

3.1 The development of the NHS Standard Contract for 2016/17 was underpinned by a stakeholder engagement exercise carried out during the summer of 2015.

3.2 The 2016/17 Contract retains the same three-part structure and much of the same detailed content as the 2015/16 version. The key changes to the Contract for 2016/17 are summarised in the tables below. A detailed clause-by-clause summary of where changes have been made is available at Appendix 1; this also shows where further changes have been made between the draft and final versions of the 2016/17 Contract.

Changes to give effect to new legislation, policy and guidance

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. In response to consultation feedback, we have also included a new requirement on mental health providers and	Schedule 4B and SC4

Topic	Change	Contract Reference
	commissioners to cooperate to ensure that patients requiring admission to an acute bed can be admitted as close to their own home as possible.	
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. *Who Pays? Guidance* requires commissioners to pay for all emergency activity carried out on a non-contract basis.	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, by 1 October 2016, a Freedom to Speak up Guardian, as recommended in *Learning Not Blaming*, 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 (http://www.rightcare.nhs.uk/).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 *Making Every Contact Count*.	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. Further guidance will be produced in 2016/17 on how providers should implement this, addressing, amongst other issues, the implications for independent sector providers (especially in relation to staff who work both in NHS-funded services and in private services). In the interim, providers should ensure that their internal processes in these areas are consistent with the principles set out in the Committee on Standards of Public Life in their guidance "*Ethical Standards for Providers of Public Services*".	GC27
Accessible Information Standard	We have included a requirement to comply with the Accessible Information Standard published by NHS England in August 2015.	SC12

Topic	Change	Contract Reference
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). In response to consultation feedback we have clarified the need for existing supply agreements, entered into before 1 October 2015, to be respected.	SC36
Electronic invoicing	We have introduced a new requirement on commissioners and providers to use the new national electronic invoicing system, *Tradeshift*, or other appropriate e-invoicing system.	SC36

Changes affecting the interface between provider and GP

We have introduced 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 all patients who do not attend clinic are automatically discharged back to their GP. (Note that this is particularly intended to address patients who DNA for the first time, rather than those who DNA repeatedly.)	SC6
Discharge summaries	We have clarified arrangements for discharge summaries, requiring direct electronic or email transmission of discharge summaries for inpatient, daycase or A&E care within 24 hours and enabling local standards to be agreed for discharge summaries from other settings. Discharge Summaries from inpatient or daycase care must use the Academy of Medical Colleges endorsed clinical headings. In response to consultation feedback, we have also introduced a requirement on commissioners to provide all reasonable assistance to providers in implementing electronic transmission.	SC11 and Definitions

Topic	Change	Contract Reference
Clinic letters	We have included a new requirement on providers to communicate within 14 days 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, setting a tighter timescale and requiring electronic transmission of clinic letters to practices.	SC11
Onward referral	We have amended the Contract to clarify that, for a non-urgent condition directly related to the complaint or condition which caused the original referral, onward referral to and treatment by another professional within the same provider is permitted, without reference to the patient's GP – unless referral back to the GP is specifically required as a condition of an Activity Planning Assumption or Prior Approval Scheme in the local contract. (The position remains that hospital clinicians are not permitted to refer onwards for non-urgent, unrelated conditions; in this situation, they must refer back to the GP, for the GP to determine whether onward referral is appropriate).	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	We have introduced a new requirement on providers to supply patients with medication following discharge from inpatient or daycase care. In response to feedback, we have amended the proposed requirement; medication must now be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically appropriate or where a repeat prescription is already in place).	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

Changes to simplify and shorten the Contract

Topic	Change	Contract Reference
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

Topic	Change	Contract Reference
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
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

Technical improvements to the Contract

Topic	Detailed 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.	SC23.5
Local reporting requirements	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
Information Breaches	We have 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.	SC28

Financial sanctions and the Sustainability and Transformation Fund

3.3 Where a provider

- is granted funding from the general element of the Sustainability and Transformation Fund (STF) during 2016/17; and

- has agreed a financial control total for 2016/17 and other associated conditions with NHS Improvement; and

- has agreed, with its lead commissioner and with the national teams of NHS Improvement and NHS England, performance improvement trajectories for 2016/17, or has provided assurance statements with regard to its performance to those national teams,

then the operation of certain contractual sanctions will be suspended, on a temporary basis for 2016/17. The suspension is described in Service Condition 36.37A (SC36.17A of the shorter-form Contract).

3.4 This temporary measure applies to the 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 sanctions 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 following GP referral, ambulance response times (Red1, Red 2, other Category A) and ambulance handover standards (affecting both A&E and ambulance providers).

3.5 The suspension of a specific sanction in paragraph 3.4 applies only where, for the relevant standard, the provider has agreed a specific performance improvement trajectory for that standard or has provided an alternative assurance statement to NHS Improvement as to its performance against that standard in 2016/17.

3.6 The suspension of these sanctions applies only as set out in paragraphs 3.3 to 3.5 above; and providers for whom sanctions are suspended will face the withdrawal by NHS Improvement of STF funding if they fail to deliver their improvement trajectories. In all other situations, commissioners must continue to apply the national sanctions set out in Schedules 4A and 4B. Any individual provider will therefore fall into one of two possible regimes for the whole of 2016/17:

- either it will be within the STF regime, in which case the sanction which it will face for failing to deliver the required level of performance against national standards will be the withdrawal of STF funding; or

- it will be required to achieve the national standards set out in the Contract in full and will face the normal contractual sanctions if it does not do so.

This fulfils the promise in the NHS Planning Guidance that no provider will face ‘double jeopardy’.

3.7 Commissioners are working with relevant providers to agree the performance improvement trajectories described above for sign-off by NHS England and NHS Improvement. Once agreed, the trajectories – and the assurance statements described above – should be included in local contracts as Service Development and Improvement Plans (SDIPs) at Schedule 6D of the Particulars. (We have made available a separate template for this purpose.) Note that the trajectories and assurance statements will operate on a whole-provider basis – so if a provider holds multiple contracts, the same SDIP will be included in each.

3.8 The suspension of sanctions in specific circumstances does not affect the ability of commissioners to use other levers available within the Contract to manage the

general performance of providers (including, for instance, the provisions of General Condition 9 on Remedial Action Plans (RAPs) and Service Condition 28 on Information Breaches).

3.9 However, specifically in relation to the agreed improvement trajectories and assurance statements described above,

- although commissioners should monitor and manage providers' performance and support them in delivering their trajectories, they must not withhold or retain funding under GC9 if providers fail to achieve the trajectories in full; and

- where a RAP has been agreed in 2015/16 and would normally be carried forward into 2016/17 as an SDIP (under the arrangement described in paragraph 35.12 below), it must be superseded by the SDIP described at paragraph 3.7 above; again, no financial sanctions must be applied in relation to this SDIP.

We have included a new provision at GC9.26 (GC9.9 in the shorter form) to make clear that – in order to avoid "double jeopardy" – financial sanctions must not be applied in the above circumstances.

Other changes to sanctions

3.10 We have also amended aspects of the regime of sanctions in the 2016/17 Contract, to reflect the specific outcomes of the review of sanctions which we have undertaken. The amendments are described briefly below.

3.11 We have included new national standards for access to Early Intervention Programmes and to Improving Access to Psychological Therapy services. From 2017/18, these new standards will attract sanctions for non-compliance, as happens with acute services standards.

3.12 We have also significantly amended the operation of sanctions for ambulance response times and introduced a new standard and sanction in relation to the implementation of electronic prescribing for chemotherapy, in line with the recommendation in the Cancer Taskforce report. In response to feedback to our consultation and in recognition of the greater complexity relating to electronic prescribing for children, we have now set a longer timescale for full implementation of chemotherapy e-prescribing for children, teenagers and young adults (September 2017) as opposed to adults (March 2017).

3.13 We have removed the national sanctions relating to VTE risk assessment and formulary publication from the Contract for 2016/17. 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.

Service Development and Improvement Plans

3.14 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 6D in their local contracts with relevant providers. For 2016/17, the following issues should be addressed through local SDIPs (further detail is set out in section 41 below).

- **Seven day services.** CCGs should continue to agree SDIPs in their contracts with all acute providers and 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, CCGs should 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. They should also agree SDIPs with providers of children's and young people 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.

- **Digital transformation.** CCGs should 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 for outpatient referral and booking remains patchy. CCGs should 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 directly bookable, the SDIP should include a plan for transitioning towards them being so. The aim is for over 80% of referrals to be made by e-Referral by March 2017, and we intend to introduce new financial incentives for both providers and commissioners for 2017/18 to support this.

eContract

3.15 The eContract system will continue to be available in 2016/17. The basic approach will be unchanged, focussing on the production of tailored contract documentation, rather than the storage of contracts. The 2016/17 eContract will allow users to create tailored contracts in either the full-length or shorter-form versions.

3.16 Further details about the eContract system are available in paragraph 33 below and via https://www.econtract.england.nhs.uk/Home/.

Model grant agreement and model sub-contract

3.17 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 11 below. We have made some minor changes to the model grant agreement for 2016/17 to reflect recently published government policy.

3.18 In 2015 NHS England and the Department of Health produced a model sub-contract for use with the NHS Standard Contract 2015/16. An updated version for use with the full-length 2016/17 Contract will be published on our website shortly after publication of the final Contract. Note**:** neither the 2015/16 model sub-contract nor the forthcoming 2016/17 model sub-contract are designed for use with the new shorter-form Contract. Depending on feedback, we may consider producing a sub-contract for use with the shorter-form Contract in due course.

4 Advice and support

4.1 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

5 Terminology

5.1 Throughout this guidance, we continue to use the generic term "the NHS Standard Contract" or "the Contract" to refer collectively to both the full-length and shorter-form versions that are now available for 2016/17. Where there are material differences in approach between the two versions of the Contract, we identify these below.

6 Content of this section

6.1 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, and non-contract activity.

7 When should the NHS Standard Contract be used?

7.1 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.

7.2 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 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.

7.3 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.

7.4 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.

7.5 The NHS Standard Contract is neither mandated nor intended for use by provider organisations when contracting with other provider organisations for the provision of clinical services. In most circumstances such arrangements will be correctly categorised as a sub-contracting of services commissioned under an NHS Standard Contract – on which see paragraph 38 below.

8 Contracting for integrated primary and secondary care

Contracting with Vanguards

8.1 To support the integrated provision of services, commissioners may increasingly wish to commission both secondary and primary medical care services from the same provider under a single contract. This is the approach under some of the New Models of Care being commissioned from Vanguard providers, in particular with the Multi-specialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) models.

8.2 NHS England is working to develop tailored contractual products for use with New Models of Care, and these will be available for the 2017/18 contracting round. However, if a commissioner is in a position to place a contract for integrated secondary and primary medical care services with an MCP or PACS provider from April 2016 onwards, it can do so using the 2016/17 NHS Standard Contract with the addition of Schedule 2L (Provisions Applicable to Primary Care Services).

8.3 This Schedule introduces the further provisions required in order to make the Contract compliant with the Alternative Provider Medical Services (APMS) directions. With this addition, the Contract will be both an NHS Standard Contract and an APMS contract. A template form of those further provisions, for inclusion in Schedule 2L where appropriate, is available at https://www.england.nhs.uk/nhs-standard-contract/16-17/, along with guidance about their use.

8.4 As well as with MCP or PACS models, the 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.

Lead provider and alliancing models

8.5 The NHS Standard Contract can readily be used as a "lead" or "prime" contract. Under this model, the commissioners enter into a contract with a single lead provider / prime contractor. 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. The optional schedule of primary care provisions (see paragraph 7 above) enables the

Contract to be used as a prime or lead contract under which a package of primary and secondary care services may be commissioned.

8.6 The 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. 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). We have produced a model Alliance Agreement, which commissioners may use as a starting point for development of their own alliancing arrangements with providers. If you would like to see a copy or discuss an alliancing approach, please contact us via england.contractsengagement@nhs.net.

9 When to use the shorter-form Contract

9.1 For the first time, for use in contracts from April 2016, NHS England has published a shorter-form version of the Contract.

9.2 The shorter-form Contract must not be used for contracts:

- under which acute, cancer, A&E, minor injuries, 111 or emergency ambulance services, or any other hospital inpatient services, including for mental health and learning disabilities, are being commissioned; and / or

- for any service for which the National Tariff guidance sets a mandatory national price (whether or not that mandatory national price is to be the subject of a Local Variation or Local Modification). (We appreciate that this means that the shorter-form Contract may not be used in circumstances in which it would otherwise be appropriate, but that is a consequence of keeping it as brief as possible.)

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

9.4 Subject to the restriction around national prices above, commissioners may use the shorter-form Contract for all other services for which the NHS Standard Contract is mandated – 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 hospice care / end of life care services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.

9.5 Within the parameters set out in this Guidance, it is for commissioners to determine when they wish to use the shorter-form version of the Contract, as

opposed to the longer form.

9.6 We have not set a specific financial threshold for use of the shorter-form Contract, but we strongly encourage commissioners to use it for appropriate services (as described in 9.4 above) with lower annual values, which will tend to include the great majority of contracts held by the smaller provider organisations which this new contract form is particularly intended to assist. The end result of this approach should be that the shorter-form Contract is used for most contracts with smaller providers, including voluntary organisations, hospices (where grant agreements are not being used – see paragraph 11 below), care home operators and providers of enhanced services such as general practices, pharmacies and optometrists.

9.7 However, before in deciding whether to use the shorter-form contract to commission services for which it may be used, commissioners should consider carefully the differences in the management process and other provisions between the shorter-form and full-length contracts. If the "lighter touch" approach of the shorter-form is not thought appropriate to the services, the relationship or the circumstances, the full-length contract may be used. Also, if the provider is providing other services under the full-length Contract, it may be more appropriate to keep all services on this form.

9.8 Note that when services are being tendered (whether competitively or under AQP) the same form of contract must be offered to all potential providers of those services. The form of contract offered (whether shorter-form or full-length) should be made clear in the Prior Information Notice, advertisements and other communications with potential providers.

10 What elements of the Contract can be agreed locally

10.1 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.

10.2 Commissioners must not

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

10.3 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 (in the full-length Contract) 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.

11 Use of grant agreements

11.1 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.

11.2 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.)

11.3 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, and we would strongly urge them to do so. This will apply to some hospice services, for example.

11.4 NHS England has published a non-mandatory model grant agreement for use by CCGs 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/.

11.5 The model grant agreement has been updated slightly for 2016/17 to reflect new Government policy regarding use of grant monies for lobbying activities.

11.6 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.

12 NHS Continuing Health Care and Funded Nursing Care

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

12.2 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.

12.3 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.

12.4 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.

12.5 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. The NHS England CHC Operating Model is available at: http://www.england.nhs.uk/ourwork/pe/healthcare/

13 Collaborative contracting

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

13.2 Clearly, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model – but it is an approach which NHS England strongly encourages. There can be great benefits for commissioners from working closely together to negotiate and manage 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.

13.3 In particular, we would encourage commissioners to work together to use, where they can, consistent contract metrics for the same provider – local quality and reporting requirements, local agreements, policies and procedures, Activity Planning Assumptions or Prior Approval Schemes – this will help to reduce the administrative burden which providers face.

13.4 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, and how they are to make decisions in relation to the contract and instruct the co-ordinating commissioner to act on their behalf, 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 15 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 (though the allocation of roles and responsibilities between commissioners which are party to a contract can, where necessary, be set out in Schedule 5C (Commissioner Roles and Responsibilities) to that contract).

13.5 We have published updated model CCAs. These have been revised slightly for 2016/17 primarily to accommodate both full-length and shorter-form Contracts.

13.6 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.

14 Which commissioners can be party to the Contract

14.1 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.

14.2 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.

14.3 By contrast, where an NHS commissioner has devolved commissioning responsibility to a local authority under a formal lead commissioning (section 75) 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.

15 Signature of contracts and variations

15.1 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.

15.2 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.

15.3 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.

15.4 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 – because all are parties to the contract being varied) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.

16 Legally binding agreements

16.1 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.

17 Contract duration

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

17.2 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.

17.3 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.

17.4 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 18) and/or the consequences of early termination (see paragraph 46).

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

- 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.

17.5 Alongside flexibility of contract duration, the Contract

- 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 of the Contract or a Service on a no-fault basis, with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).

17.6 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).

18 Extension of contracts

18.1 Commissioners may wish 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.

18.2 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.

18.3 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 the commissioner has made clear to ALL potential providers of the service, from the very outset of the procurement process, the period and other details of any possible extension to the initial contract term.

- We strongly advise against including the provision in contracts awarded without a Prior Information Notice being issued, or the contract being advertised, in accordance with the Public Contract Regulations.

- 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 Prior Information Notice, in any advertisement, in communications with potential providers and 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).

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

19 Contracts not expiring at 31 March 2016

19.1 There will be contracts already in place which do not expire at 31 March 2016. To ensure that, for 2016/17, 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/16-17/ 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 2016/17 NHS Standard Contract form in its entirety, maintaining the current duration of the contract. (An existing contract should not be transferred onto the shorter-form version, as that will almost certainly constitute a material change to the terms of the contract, in contravention of procurement rules.)

19.2 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.

19.3 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 (GC13.4 of the shorter form) (or the equivalent provision of the relevant contract).

20 Negotiation of new contracts for 2016/17

20.1 The majority of contracts are still on a one-year basis and will therefore expire automatically on 31 March 2016. 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.

20.2 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 37 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.

21 Heads of Agreement

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

21.2 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.

22 Changes in counting and coding practice

22.1 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 43.19 to 43.28 below.

23 Resolution of disputes in relation to new contracts

23.1 NHS England and NHS Improvement have published joint guidance on the resolution of disputes relating to the agreement of new contracts for 2016/17 between NHS commissioners and providers. The guidance will describe the steps and timetable for the process, the final stage of which will involve formal arbitration.

24 What happens when there is no signed contract in place?

24.1 Commissioners and providers should make every effort to have signed contracts in place for all services by, at the latest, 31 March 2016. Failure to do so creates a financial and legal risk for commissioners and providers, and uncertainty about the continued safe provision of services.

24.2 However, there may be instances where commissioners and providers have not signed a new contract by 31 March 2016, but because the services being provided are crucial for the local community they must continue to be delivered.

24.3 In this situation (assuming services continue to be provided and paid for), a contract will be implied between the parties. The local terms of that implied contract will reflect what can be inferred as having been agreed between them – based on correspondence between them, notes of meetings, drafts exchanged and so on. It would be reasonable to assume that the implied contract would incorporate the nationally drafted terms of the NHS Standard Contract for 2016/17 (since those are the only terms on which NHS commissioners are permitted to commission the services in question for 2016/17).

24.4 However, in the absence of clear evidence of terms agreed, aspects of the implied "deal" between the parties may be uncertain. For this reason, it is very important that the parties continue to make every effort to reach agreement and sign a contract as soon as possible.

25 Acceptance of referrals and non-contract activity

25.1 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.

25.2 The Contract (full-length) already includes a specific requirement on providers (SC6.6.2) 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 applies whether or not the Responsible Commissioner for the patient affected is a party to a written contract with the provider.

25.3 For 2016/17, we have introduced an equivalent provision in relation to the acceptance of emergency referrals and presentations which are within the scope of the services it provides (SC6.6.3 of the full-length Contract). Again, this requirement applies whether or not the Responsible Commissioner for the affected patient is a party to a written contract with the provider. There will be instances

where a provider cannot safely accept an emergency referral, and the Contract wording makes provision for this.

25.4 These provisions 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).

25.5 Conversely, we also set out clearly (SC6.8 in the full-length Contract, SC6.3 in the shorter form) 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 appropriate) 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.

25.6 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.

25.7 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."*

25.8 The concept of NCA is most relevant to acute hospital services, most of which are covered by national currencies and prices 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.

25.9 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."*

25.10 We have heard of both commissioners and providers refusing to enter into written contract with their counterparts even where regular activity flows are substantially above the level referred to in 25.8, seemingly believing that it is in their interests to operate under NCA principles instead. We advise strongly against this sort of approach.

25.11 In practice, acute NCA will need to be reported via SUS, with invoices raised by providers in line with the timescale set out in SC36.35. 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.

26 Letting of contracts following procurement

26.1 Where a contract is being let following a procurement process, the commissioner must let the contract to the chosen provider exactly on the basis notified to potential providers in the Prior Information Notice and/or otherwise advertised. 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.

26.2 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.

26.3 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.

27 Use of the Contract for call-off arrangements

27.1 We know that many commissioners have successfully used the Contract in the context of a framework for, for example, care home placements. An NHS Standard Contract is entered into with each provider appointed to the framework, with processes for "call-off" of activity set out in Schedule 2A and prices/day rates for activity (perhaps based on a needs assessment) set out in Schedule 3A. Either the full-length or the shorter-form version would be fit for purpose in this context – but,

as noted above, the same form of contract must be used with each provider appointed under a framework procurement.

27.2 We strongly recommend that commissioners take legal advice if considering a framework procurement.

28 Contracting approaches to support personalisation

Integrated Personal Commissioning

28.1 The Integrated Personal Commissioning programme is a demonstrator programme involving nine areas wanting to lead the way in implementing a new integrated and personalised commissioning approach for people with complex needs. For the first time, sites will blend comprehensive health and social care funding for individuals, and give them more control over how this is used though person-centred care and support planning and personal budgets . 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 started 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

28.2 The new NHS Mandate sets an objective that 50-100,000 people should have a personal health budget or integrated personal budget (PHB) by 2020.General information regarding PHBs is available at: http://www.england.nhs.uk/healthbudgets/.

28.3 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 12.3 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.

28.4 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.

28.5 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.

29 Contracting fairly

29.1 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 working relationship between commissioner(s) and provider is a key element of successful contracting.

29.2 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues for fear of upsetting each other – but nor will it be one where each party focusses, aggressively and continuously, on protecting what is perceives to be its own narrow, individual interests.

29.3 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioner and provider

- have a shared vision for services, with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;

- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;

- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and

- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other.

30 Links to other resources

30.1 A number of useful links are set out below.

Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21
NHS England and national partner organisations

CQUIN Guidance 2016/17
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

NHS National Tariff Payment System
Monitor and NHS England
Queries about the National Tariff Payment System can be sent to pricing@monitor.gov.uk

Technical Definitions
NHS England
Describes the indicators in Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

Section B Completing and using the Contract

31 Content of this section

31.1 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.

31.2 For each topic within this section, we highlight where specific changes have been made to the Contract for 2016/17. 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 2016/17;
- 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.

31.3 The Technical Guidance is written primarily with the more complex, full-length version of the Contract in mind. Where appropriate, at the start of each section, we highlight briefly any key considerations in relation to the shorter-form Contract. A separate brief user guide to the shorter-form Contract will be made available shortly at https://www.england.nhs.uk/nhs-standard-contract/16-17/.

32 Structure of the NHS Standard Contract

*The **shorter-form Contract** uses the same three-part structure as the full-length version.*

32.1 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.

33 The e-Contract system

*The e-Contract system can be used to generate tailored copies of the **shorter-form Contract** documentation, as well as for the full-length version.*

33.1 The 2014/15 eContract system has now been decommissioned.

33.2 For the 2015/16 contracting round, NHS England launched a revised, simplified eContract system. Following feedback obtained through stakeholder engagement, the format of this simplified system has been retained for 2016/17. The eContract system for 2016/17 will host both the full-length and the shorter-form versions of the Contract.

33.3 The new system has proved to:

- be simple, quicker to use, and reliable
- focus on 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.

33.4 The eContract system is essentially a contract generation system, rather than a contract storage system. A system user selects basic contract options (for example, service categories and payment options) which (for 2016/17) both assist the user to select the right form of Contract to use (full-length or shorter-form) and drives changes to the Particulars or Service Conditions of the chosen form.

33.5 The system will then produce a tailored and shorter pdf version of the relevant 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 (full-length or shorter-form as appropriate). A system user can also create a contract proforma for use when the user intends to use the same tailored Service Conditions multiple times.

33.6 The user will then complete population of the Particulars locally (not within the eContract system) and will then issue the draft contract to the other party directly. The system will not store the final contract.

33.7 A user guide to the 2016/17 system will be available on the eContract portal, and an email helpdesk is available via england.econtract@nhs.net. The 2016/17 eContract system is designed to run on several internet browsers, including IE7,

IE8, Mozilla Firefox or Google Chrome.

34 Tailoring contract content

*The **shorter-form Contract** includes only limited scope for tailoring of the national terms within the Service Conditions and Particulars. Tailoring for the shorter-form Contract can be done using the eContract system.*

Service categories

34.1 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. The most convenient way to apply this "tailoring" of the Contract content is through the eContract system.

34.2 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.

34.3 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.

34.4 Two service categories have been deleted for 2016/17 (Pharmacy-delivered Community Services and Surgical Services in a Community Setting) – these can simply be included within the Community Services category.

34.5 Note that the Community Services category is 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 services, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 8.2 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).

Small Provider

34.6 Note that we have removed the Small Provider tailoring functionality from the full-length Contract for 2016/17. Our expectation is that new contracts awarded to those providers who have previously been classed as Small Providers will, for

2016/17, typically be on the terms of the shorter-form Contract. Where multi-year contracts are in place which include the Small Provider tailoring, the National Variation for 2016/17 will allow for this to continue.

35 Contracts for new services or with new providers

*The **shorter-form Contract** allows for Conditions Precedent to be recorded, but does not make specific provision for Transitional Arrangements. These may be included in Schedule 2G (Other Local Agreements, Policies and Procedures) if required.*

35.1 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)

35.2 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.

35.3 While the commissioner will wish to have sight of documents referenced in Conditions Precedent (eg CQC registrations, Monitor's licence etc), the documents do not need to be included in the contract itself.

35.4 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.

35.5 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.

35.6 It is important to note that the Longstop Date is not a contractual means of allowing a contract to be signed with various contentious issues parked for resolution by a later date. Commissioners, and the provider must make their own individual judgements about whether a contract contains an acceptable package which they are prepared to sign and be bound by. They may each be prepared to note that some non-material issues are not yet agreed at the point of signature (lesser schedules, for instance), with the expectation that these will be incorporated into the contract at a later stage, once agreed, through a variation. But it is usually very unwise to sign a contract with material issues unresolved. Indeed, unless key elements, such as service specifications and financial terms, are agreed, there will be uncertainty as to whether a contract has been created at all.

35.7 Note that Schedule 1B may be used to set out details of any documents which the commissioners are to provide to the Provider before the Expected Service Commencement Date. These may include, for example, records and other documents which are to be obtained from a previous provider of the services.

Transition Arrangements (Schedule 2H and GC4.4 – full-length Contract only)

35.8 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) (Schedule 8 in the shorter-form Contract)), 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. (If using the shorter-form Contract, transition arrangements may be set out in Schedule 2G (Other Local Agreements, Policies and Procedures) if required).

Contractual processes carried forward from previous contracts

35.9 Where an existing contract is about to expire and the commissioner is intending to enter a new contract with the same provider, questions arise about what happens to contractual processes unfinished during the previous contract (a Remedial Action Plan or an Activity Management Plan, for instance).

35.10 Commissioners can, of course, minimise the impact of this issue by entering into multi-year contracts, so that the contractual process automatically carries forward from one Contract Year to the next, until the contract expires.

35.11 However, at the end of a contract of any length, unless commissioners take appropriate action, the default position will be that contractual processes begun

under that contract will not automatically be carried forward to a new contract. Rather, the contractual process will have to re-start from the beginning.

35.12 This issue can be addressed by the inclusion of the Plan agreed under the expiring contract within a Service Development and Improvement Plan under the new contract. In this situation, a commissioner may wish to treat the agreement of that Service Development and Improvement Plan as a Condition Precedent for the purposes of the new contract (in other words, that agreement of the continuing application of the Plan is a pre-requisite 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.

36 Service specifications

*A specification for the services to be provided should always be included within the **shorter-form Contract** at Schedule 2A. There is no mandated format for a specification in the shorter-form version, but commissioners should ensure that each specification clearly sets out at minimum the service to be provided, the population and geography to be covered, acceptance/exclusion criteria, where the service is to be provided and other key requirements.*

36.1 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.

36.2 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 36.3 below).

- A number of model specifications were previously available on the NHS Commissioning Assembly website; these covered diabetes, self-harm and end of life care. If you would like to see a copy, please contact nhscb.contractshelp@nhs.net.

- 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.

36.3 The Contract continues to include the concept of Derogations from mandatory national service specifications 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

36.4 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.

36.5 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.

36.6 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).

36.7 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?

36.8 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.

36.9 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').

36.10 Quality requirements and information requirements in relation to a specific service should not be included in the service specification. If there are any specific quality requirements relating to the particular service, these should be included in Schedule 4 (Quality Requirements), with any associated information requirements included in Schedule 6 Part A (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.

36.11 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 headings 5-7. Optional to use, detail for local determination and agreement.	
All subheadings are 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 5	**Treating and caring for people in safe 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-C)**
5.2	**Applicable CQUIN goals (See Schedule 4 Part D)** 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.	

37 Commissioner Requested Services / Essential Services

*The arrangements for CRS and Essential Services in the **shorter-form Contract** are similar to those in the full-length version, but slightly abbreviated.*

37.1 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.

37.2 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.

37.3 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.

37.4 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.

37.5 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.

37.6 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).

37.7 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.

37.8 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.

38 Sub-contracting

The provisions relating to sub-contracting in the shorter-form Contract are very much shorter than those in the full-length version, and there is no expectation that sub-contractors will be recorded within a Schedule to the Particulars. Our expectation is that sub-contracting of material elements of the services will typically not be a feature of the type of commissioning arrangements which are to be governed by the shorter-form Contract, and so more detailed provisions are not necessary (if they are required, the full-length Contract should be used). But the basic position remains that the Provider may not sub-contract without the Co-ordinating Commissioner's prior written approval and that the Provider remains liable to the Commissioners for any Sub-contractor's acts and omissions.

38.1 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.

38.2 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.

38.3 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 (often known as "provider-to-provider" contracts), 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.

38.4 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.

38.5 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.

38.6 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.

38.7 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.

38.8 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).

38.9 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.

38.10 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

38.11 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 38.15 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 of the full-length Contract).

38.12 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 (meaning the principles and rules set out in the current National Tariff document) – but no such requirement applies where a provider is paying a sub-contractor.

38.13 Where NHS providers are placing sub-contracts for non-clinical goods and services, they may appropriately use the standard NHS terms and conditions for procuring goods and services, published by the Department of Health. Where the sub-contract is of a clinical service, the goods and services contract will not be suitable.

38.14 The Department of Health and NHS England have worked together to develop a model sub-contract for use by providers for clinical service sub-contracting. This model sub-contract gives a systematic way of flowing down the relevant provisions from the main contract to the sub-contractor. The model sub-contract (suitable for use with the 2016/17 full-length Contract), and its accompanying guidance have been published on our website.

38.15 Use of the model sub-contract is not 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.

38.16 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.

Sub-contracts and access to the NHS Pension Scheme

38.17 Any provider operating under an NHS Standard Contract (whether it is an NHS organisation or from another sector) is able, in principle, to access the NHS Pension Scheme for its directly-employed staff, subject to certain conditions being met. To date, however, it has not been possible for any member to pension earnings from sub-contracted work.

38.18 A national consultation is has recently been completed on potential changes to the treatment of sub-contract work done by GPs and GP practices. This is in response to evolving models of service delivery, particularly in respect of GP federations and their constituent practices. In brief, there is recognition that some

of the new models of care being developed under the *Five Year Forward View*, which encourage GPs to operate at scale through federations, currently mean that such work cannot be pensioned. The consultation proposes changes which would address this for GPs and practice staff, but it should be noted that – under the proposed arrangements –this is dependent upon use of the model sub-contract form described above.

Management of sub-contracts

38.19 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 co-ordinating commissioner does have powers to require the replacement of sub-contractors in specific situations, as set out in GC12.13 (full-length Contract).

39 Quality of care

*The core requirements on providers in relation to the provision of safe and effective care are the same under the **shorter-form Contract** as in the full-length version – but there is far fewer applicable national standards, less detail about specific national policy requirements and a greater reliance on the concept of "Good Practice" (as defined in the Contract). Contract management processes are generally abbreviated in the shorter form, but the provisions for service suspension or contract termination provide protection of commissioners in the event that a provider is providing unsafe or consistently low-quality services.*

39.1 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

39.2 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).

- 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, SC12), 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).

39.3 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.

39.4 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

39.5 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.

39.6 There have been a number of changes to Schedule 4A and 4B.

- The two Operational Standards relating to 18-week RTT completed pathways have been removed, in line with announcements earlier in the year.
- New National Quality Requirements have been added in relation to access to mental health services, covering Improving Access to Psychological Therapies (IAPT) and Early Intervention in Psychosis (EIP) programmes.
- A new National Quality Requirement has been introduced in relation to implementation of electronic prescribing for chemotherapy.
- The National Quality Requirement relating to formulary publication has been removed, although this continues to be a requirement under SC27.

39.7 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.

39.8 Commissioners and providers should have regard to *Managing long waiting cancer patients – policy on "backstop" measures.* This sets out a process for providers to manage cancer patients experiencing waits over 62 days and requires root cause analyses and clinical harm reviews to be carried out in certain situations, with the potential for cases to be reported as Serious Incidents where appropriate.

Local Quality Requirements

39.9 Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. As a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value. New provisions have been added to SC28 to address this (see para 43.6 below).

39.10 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 44

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.

39.11 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.

39.12 We have previously provided a separate appendix with a pick-list of possible local quality requirements. We have discontinued this for 2016/17, although the list remains available for reference in the 2015/16 Contract Technical Guidance.

CQUIN and local incentive schemes

Note that, while under the full-length Contract it may be agreed that payments are made on account of CQUIN by instalments through the year, with a reconciliation based on actual performance at year end, the shorter-form Contract provides only for a single, end of year payment. This approach is taken in the interests of more streamlined contract management.

39.13 CQUIN (*Commissioning for Quality and Innovation*) is the national quality incentive scheme. Guidance on CQUIN is now available at https://www.england.nhs.uk/nhs-standard-contract/cquin/.

39.14 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

39.15 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. In such cases, additional requirements in relation to the 'retired' indicators will typically be included in the NHS Standard Contract.

39.16 This is already 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 6A).

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

39.17 For 2016/17, the national CQUIN indicator on **dementia and delirium** is also being 'retired'. The indicator contained three elements:

- two relating to staff training and surveying carers' needs, which are covered at a generic level by the existing provisions within GC5 and SC12; and

- one relating to the FAIRI (Find, Assess, Investigate, Refer and Inform) data return.

39.18 As part of the CQUIN process, this data return was expanded for 2015/16 to cover community services providers and commissioners. These additional requirements will no longer apply in 2016/17, but the original FAIR return will remain a mandatory, BAAS-approved data submission for all acute providers.

39.19 In all of these areas previously covered by national CQUIN indicators, commissioners should use the levers in the Contract, including the processes and sanctions set out in GC9 and SC28, to ensure that providers maintain high standards of care and submit the required data and reports. Commissioners may wish to consider agreeing local CQUIN indicators or quality requirements to sustain and continue performance improvements.

Never Events, Serious Incidents and Patient Safety Incidents

39.20 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 has published an updated Never Events Policy Framework, including a revised list of the events themselves. The sanction associated with Never Events is now set out in SC36.38 (SC36.17 in the shorter-form Contract), rather than in Schedule 4: this change in no way downgrades the importance of the Never Event Framework .

39.21 In finalising and agreeing Schedule 6A (Reporting Requirements) and Schedule 6C (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 6A or 6C 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 6A or 6C, 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.

Discharge summaries and other communications to GPs

39.22 We have clarified the requirements for discharge summaries for 2016/17. There are now the following separate requirements.

- For all discharges from inpatient, daycase and A&E care, SC11.5 requires the provider to issue a Discharge Summary to the GP / Referrer within 24 hours, either by secure email or (preferably) by direct electronic transmission.

- For discharges from inpatient and daycase care only, the Discharge Summary must use the Academy of Medical Colleges endorsed clinical headings. Joint guidance from HSCIC and NHS England is that providers should have completed introduction of the clinical headings by no later than 1 December 2016.

- For discharges from care where the Service User has not been admitted to hospital or treated in A&E, there is no nationally-mandated requirement for a Discharge Summary to be sent in all cases. Instead, SC11.6 allows an appropriate locally-specified requirement, including content, format, method of delivery and timescale, to be agreed and set out in Schedule 2J (Transfer of and Discharge from Care Protocols).

- We do not envisage that Discharge Summaries would ever be required from Patient Transport Services, and the wording of SC11.6 (SC11.3 in the shorter-form Contract) reflects this.

- 111 Services are subject to a separate requirement to send electronic Post Event Messages, rather than Discharge Summaries (SC11.6A).

39.23 Information to support providers in implementing electronic 24-hour Discharge Summaries is available at http://systems.hscic.gov.uk/interop/tci/edischarge. All providers are strongly encouraged to adopt the structured approach to sharing clinical information set out in the Transfer of Care Domain Message Specification published by HSCIC (which in turn supports use of the standardised clinical headings endorsed by the Academy of Medical Royal Colleges).

39.24 Commissioners should take a reasonable and proportionate approach in managing performance against the new requirements for electronic transmission of Discharge Summaries. They should focus initially on ensuring that providers can provide these 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 transmission.

39.25 In addition to the requirements on Discharge Summaries, the Contract now includes a requirement on providers of outpatient services to communicate with GPs following a patient's clinic attendance, where there is information to share which the GP will need to act on. (This is not to say that a provider must necessarily send a clinic letter to the GP after each individual clinic attendance – this will depend on the individual clinical circumstances.) For 2017/18, we intend to strengthen this requirement further, requiring electronic transmission of structured clinic letters to practices as with Discharge Summaries and to a tighter timescale than 14 days. Providers will wish to prepare for this new requirement during 2016/17.

39.26 Apart from these provisions for transfer of or discharge from care and clinic attendance, the Contract does not set out other nationally-mandated requirements for communication from the provider to the GP whilst a Service User is receiving ongoing care at that provider. But where a commissioner wishes to set out other local requirements for communication to GPs during a pathway of care (as opposed to at discharge), this can be done by using Schedule 2G (Other Local Agreements, Policies and Procedures).

40 Financial consequences in relation to Quality Requirements

Application of financial consequences ('sanctions')

40.1 As described in paragraph 3.3 onwards, the application of financial sanctions in respect of breaches of certain of the national standards in Schedules 4A and 4B has been suspended in some situations for 2016/17.

40.2 This is a temporary measure only. We anticipate that application of sanctions will return to its current mandatory basis for 2017/18 onwards. All of the detailed national sanctions remain within the Contract at Schedules 4A and 4B, but Service Condition 36.37A sets out the circumstances under which some of these sanctions are suspended for 2016/17.

Public reporting of sanctions applied by commissioners

40.3 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.

40.4 Commissioners should publish data 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

40.5 The guidance below sets out 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.

40.6 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.

40.7 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

40.8 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. Worked examples are provided in Appendix 4.

40.9 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.

40.10 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.

40.11 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 40.17 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).

40.12 Note that

- while the sanction in relation to RTT incomplete pathway performance is measured at specialty level (as reported on Unify), the sanction in relation to six-week diagnostic waits is measured not at the level of each individual type of test, but on an aggregated basis across all the test types recorded by the provider; and

- NHS England is about to publish new guidance on the allocation of breaches of cancer wait standards across the different providers involved in a pathway.

Caps on value of sanctions

40.13 The Contract includes a provision, set out at SC36.37, 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.

40.14 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.

40.15 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.

40.16 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.

40.17 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

40.18 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 4F. NHS England has now published provider targets for 2016/17.

40.19 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.

40.20 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 4F. These can be allocated to the relevant commissioner, as it is possible to attribute each case to a specific commissioner.

40.21 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.

40.22 For the purposes of the quarterly cap on the value of local and national sanctions (see paragraph 40.13 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.

41 The Service Development and Improvement Plan (SDIP)

*The concept of a Service Development and Improvement Plan is not generally part of the **shorter-form Contract.** Under the shorter form, if the parties wish to record their agreement of a plan to address a specific service issue, they can include this in their local contract at Schedule 2G (Other Local Agreements, Policies and Procedures). (Note also SC36.17A in relation to SDIPs linked to the Strategic Transformation Fund.)*

41.1 The Service Development and Improvement Plan (SDIP, Schedule 6D) 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.

41.2 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.

41.3 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).

SDIPs offer an excellent route through which commissioners and providers can agree a programme of work to implement innovation projects – from medical technologies to service and pathway re-design. NHS England has published a set of Innovation Case Studies, showcasing real life examples of innovative practice which has already been implemented at local level in the NHS. Commissioners and providers are encouraged to review these case studies and to take forward relevant initiatives locally, through agreement of SDIPs where appropriate.

41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6D 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).

41.5 Agreement of SDIPs is strongly recommended for relevant large-scale providers in some specific situations in 2016/17, as set out below. (The intention of these mandatory SDIPs is not to require significant additional investment from commissioners or providers; rather, it is to encourage joint management action to tackle these important priorities to the extent possible within available resources.)

Seven-day services

41.6 In 2013, the NHS Services, Seven Days a Week Forum review developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every

day of the week. For 2014/15 and 2015/16, we asked commissioners to ensure that contracts with acute providers contained SDIPs setting out plans to make progress towards implementation of these standards.

41.7 After discussions with the Academy of Medical Royal Colleges, the following four standards have been identified as being most likely to have the most impact on reducing risk of weekend mortality. These are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

41.8 CCGs should continue to agree SDIPs in their contracts with all acute providers and assure progress towards implementation the four key 7DS standards locally during 2016/17. The SDIP agreed between commissioners and providers for 2016/17 should require the provider to report the results of bi-annual surveys of progress which will take place in September and March, using the national Seven Day Service Self-Assessment Tool.

41.9 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.

New standards for mental health services

41.10 New access standards have been introduced into the 2016/17 Contract covering Early Intervention in Psychosis programmes (EIP) and Improving Access to Psychological Therapies (IAPT) programmes. These standards are now included at Schedule 4B of the Contract.

41.11 A further access standard is in development in relation to services for children and young people with an eating disorder (available via http://www.england.nhs.uk/resources/resources-for-ccgs/#local-trans). This standard is expected to be introduced during 2017/18. Work at local level to prepare for implementation of this standard will be one part of the Local Transformation Plans for Children and Young People's Mental Health and Wellbeing which commissioners have submitted in autumn 2015.

41.12 For 2016/17, CCGs should agree SDIPs

- with providers of EIP services, setting out how together they will ensure that sufficient staff of the requisite skill-mix are employed and appropriately trained to ensure compliance with the requirements of the new access standard, that people experiencing first episode psychosis access care in line with NICE recommendations from an EIP service with at least 50% commencing treatment within two weeks. The SDIP should include a commitment by the provider to sign-up to and engage with the new national accreditation quality

assessment and improvement programme.

- with providers of IAPT services, setting out how the provider intends to improve practice and service management so as consistently to achieve a minimum of 50% recovery rates. This should involve developing sufficient capacity and capability to deliver NICE recommended treatments for particular conditions and using data to identify and address unacceptable practitioner variation, as well as committing to the nationally-approved accreditation programme;

- with providers of children's and young people 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 and engage with the nationally-approved accreditation programme.

41.13 Note that new national tariff payment rules have been proposed for mental health services for implementation in 2017/18. They require providers and commissioners of adult and older people's mental health care to implement either a capitated or episodic / year of care payment approach. With either option, providers and commissioners need to embed outcomes as an integral part of the chosen payment approach. Commissioners should therefore take steps during 16/17 to ensure the building blocks are in place to support implementation of new payment rules in April 2017 – this includes improving data quality and analysis, collaborative governance arrangements, agreeing local outcomes measures and the processes for working closely with local stakeholders.

Digital technology

41.14 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, encouraging rapid progress within and between providers towards the adoption of modern interoperable clinical information systems.

41.15 Local Digital Roadmaps will be key in delivering this agenda. CCGs have already identified, with local providers, the "footprint" for each Roadmap (that is, the providers it will cover), and local health and social care communities will submit their Roadmaps by June 2016. SDIPs within local contracts offer an appropriate way of ensuring that providers are committed to implementing Roadmaps.

41.16 Key elements of the digital agenda include standardising clinical terminology, digitising medicines management and ensuring positive patient identification. For 2016/17, CCGs should therefore put in place an SDIP with each major provider, setting out how the provider will contribute to the implementation of the Local Roadmap and develop and implement its local strategy for

- adopting SNOMED-CT as the standard clinical terminology within its core clinical information systems;

- digitising medicines management, using the NHS dictionary of medicines and devices, to support the electronic transfer of information relating to medicines

prescribing across different care settings and providers (with the intention that this can be achieved by no later than June 2017);

- utilising positive patient identification and asset tracking technologies, including compliance with GS1 standards; and

- making progress in protecting IT systems from cyber threat, based on industry best practice and a proven cyber security framework such as the Government's Cyber Essentials Scheme, including ensuring that all IT systems in use are updated so that they are within warranty and covered by appropriate technical support.

41.17 SNOMED-CT is the standard clinical terminology for the NHS to support recording of clinical information, in a way that supports data management and analysis to support patient care, while enabling data extraction and data exchange. SNOMED CT is specified as the single terminology to be used across the health system in *Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens*. Further details are available at http://systems.hscic.gov.uk/data/uktc/snomed.

41.18 The NHS dictionary of medicines and devices (http://www.nhsbsa.nhs.uk/1121.aspx) is the NHS standard for communicating medicines information and uniquely identifying medicines and medical devices.

41.19 GS1 is an organisation which develops standards for identification of patients and assets such as lab samples and equipment, more information can be found at: http://www.gs1.org/healthcare.

E-referral

41.20 Use of the new national NHS e-Referral Service for outpatient referral and booking remains patchy. CCGs should work with providers and GP representatives to put in place, in relevant contracts, 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 March 2017, and we intend to introduce new financial incentives for both providers and commissioners for 2017/18 to support this.

42 Managing activity and referrals

*The provisions in the **shorter-form Contract** for managing activity and referrals are very significantly simplified. There is the potential to include an Indicative Activity Plan if needed, but no reference to Activity Planning Assumptions or Prior Approval Schemes, as these would not generally be expected in relation to the types of service for which the shorter-form may be used.*

42.1 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.

42.2 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.

Access to services

42.3 The Contract must function as a robust tool through which commissioners can secure access to the services which their population needs. At the same time, commissioners need to be able to use the Contract to prevent access to care or treatment which they deem to be unnecessary, ineffective or inefficient. This will enable commissioners to commission services in line with the NHS Right Care approach.

42.4 Reflecting on this, we have made some important amendments for 2016/17 to the arrangements in the Contract governing access to services.

42.5 Firstly, we have expanded the provisions of SC6. These already require the provider to accept any clinically appropriate referral where a patient is exercising his / her legal right to choice of provider – even where the patient's Responsible Commissioner is not a party to the local contract. For 2016/17, there is an additional provision requiring acceptance of any emergency referral or presentation for treatment within the scope of the services a provider runs, again even where the patient's Responsible Commissioner is not a party to the local contract. There is an important caveat here that the provider must be able to provide such emergency treatment safely – we recognise that, for instance, an intensive care unit with fixed bed capacity may not be able to accept transfers from outside its local network if all of its beds are full of very sick 'local' patients. But the general principle is that a provider of NHS-funded emergency services must be open to any emergency presentation, regardless of the identity of the patient's responsible commissioner.

42.6 Secondly, we have made small (but significant) changes to the Contract wording around referral protocols and clinical thresholds for treatment (SC29.3-4). These make clear that such documents may be included within service specifications or other aspects of the contract which are agreed between commissioner and provider – but that, in other circumstances, they may instead be notified by the

commissioner to the provider as a Prior Approval Scheme (described more fully below).

42.7 It is worth explaining how these revised provisions are intended to operate.

- Where a service operates on a block contract basis or with marginal prices for under- or over-performance, then the basis on which patients are to access that service (that is, the clinical threshold for patients to be referred and receive care or treatment) is, effectively, a critical determinant of the price. So, for example, it is probably not realistic to expect an intermediate care service which is funded to deal with referrals for patients over 85 to start accepting referrals from over-75s and operate within the same block contract price. In such a situation, it is appropriate for the 'referral and treatment criteria' under which the service is to operate to be included within the service specification (or separately within Schedule 2G, Other Local Agreements, Policies and Procedures). If either party wishes to change them, this can only be done by agreement using the Variation provisions at GC13. And discussion on a Variation may, of course, also involve varying the price for the service.

- But what about the situation where a service operates on an "activity x price" basis (such as the majority of consultant-led acute services)? In this instance, the price is not dependent on a fixed or guaranteed level of activity. So, for instance, if the commissioner identifies that it wishes to restrict access to certain treatments when specific clinical criteria are met, it is perfectly reasonable for it to do so – so long as what it is requiring the provider to do remains consistent with Good Practice as defined in the Contract. In this situation, therefore, referral and treatment protocols are best kept separate from service specifications and treated instead as Prior Approval Schemes, which the commissioner can introduce or change through notification to the provider (SC29.21 onwards), but which do not require provider consent.

Prior Approval Schemes

42.8 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. In determining potential Prior Approval Schemes, commissioners will wish to review the evidence base and consider the need for appropriate consultation.

42.9 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. Where this happens, commissioners must ensure that they set reasonable expectations about the applicability of the Scheme in relation to patients who have been referred or have already commenced assessment or treatment.

42.10 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.

42.11 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, the commissioner should commit itself, in the Prior Approval Scheme, to a timescale by which it will respond 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.

42.12 Commissioners must be mindful of the administrative burden which Prior Approval Schemes can create for providers. It is good practice for commissioners to

- ensure that they place the onus on the right part of the system – if a CCG does not wish to commission a particular procedure, it can appropriately inform its GPs of this and advise them not to refer patients for that procedure; in other cases, where the decision to offer a specific treatment would be made only by the hospital clinician after diagnosis, a Prior Approval Scheme operated by the hospital provider is likely to be necessary;

- collaborate to adopt consistent clinical thresholds and administrative processes in their Prior Approval Schemes as far as possible, thus lessening the number and variability of different Schemes which any individual provider has to deal with (noting of course that it remains ultimately for each CCG to determine its own commissioning policies);

- reserve the more onerous individual prior approval arrangements for a small number of high-cost treatments and complex scenarios (where the decision as to who should access treatment will require detailed information about patients' individual circumstances); and

- review the cost-effectiveness of their prior approval arrangements – if a labour-intensive Scheme requiring individual prior approval in advance is consistently resulting in every patient receiving approval for treatment, it should probably be converted into a commissioning policy of the kind described in paragraph 42.8 above.

Overall responsibilities for managing referrals and activity

42.13 The Contract identifies that both the commissioner and the provider have responsibilities for managing referrals and activity.

- Commissioners (SC29.3) must seek to ensure that referrals comply with any agreed protocols and any relevant Activity Planning Assumptions. In practice, the reasonable expectation will be that commissioners should be making vigorous efforts to ensure that GPs and other primary care referrers are following agreed protocols.

- Providers (SC29.4) must also seek to ensure that referrals comply with agreed protocols. They will bear a particular responsibility for managing referrals which are internally generated (consultant-to-consultant referrals, say), but may also reasonably be expected to assist commissioners in ensuring that primary care

referrals are in line with agreed protocols.

- Providers will also bear particular responsibility for ensuring that the decisions made by their clinical staff to provide treatment to patients are made in line with clinical thresholds set out the Contract or notified through Prior Approval Schemes. They must also seek to work within the Activity Planning Assumptions relating to referrals and other metrics.

Indicative Activity Plan

42.14 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 volume of activity that is estimated by the two parties but it is not a guarantee of a given volume of activity nor a cap on the volume of activity of any particular type which will be paid for by the commissioners.

42.15 The IAP should include sufficient detail for all 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.

42.16 An IAP should reflect the expected impact of demographic changes and any firm trends in demand; it may also need to factor in requirements for additional non-recurrent activity to reduce waiting times so that national standards can be achieved. Equally, an IAP can reflect planned service expansions – or expected reductions in activity within a given service, because of commissioner development of other services elsewhere or plans to improve referral practice. The net effect should be a realistic plan, shared between commissioner and provider, giving the provider sufficient confidence to put in place an agreed level of capacity which should be sufficient to cope with the expected demand and achieve national access standards. This shared confidence is particularly important where providers are being expected to shrink their capacity as a result of commissioner plans to manage demand or shift care between hospital and community settings.

42.17 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. For most acute services, payment under the National Tariff rules will fluctuate to reflect the actual level of activity provided, rather than being a fixed block for a planned level of capacity.

42.18 Where activity planning discussions identify genuine limitations in capacity in a particular service at a provider, commissioners may need to seek to commission additional providers for patients to choose from – or look at whether, within the confines of Good Practice, more appropriate referral criteria for that service should be introduced. However, the underlying requirement within the Contract remains that providers will need to be able to flex their capacity up and down as demand fluctuates, accepting referrals and treating patients rather than turning them away.

42.19 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.

Activity Planning Assumptions

42.20 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 to be provider under the specific contract and / or assumptions relating to how the particular provider will manage activity once a referral has been accepted. APAs are monitored as part of the activity management process.

42.21 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 be consistent with the IAP and 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.

42.22 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.

42.23 By contrast with an IAP, the provider is under a contractual obligation to use all reasonable endeavours to manage activity in accordance with APAs, and the commissioner can use the processes set out in SC29 (Activity Management Plans, for instance) to ensure that this happens.

Early Warning and Activity Query Notices

42.24 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.

42.25 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.

42.26 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

42.27 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.

42.28 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.

42.29 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)

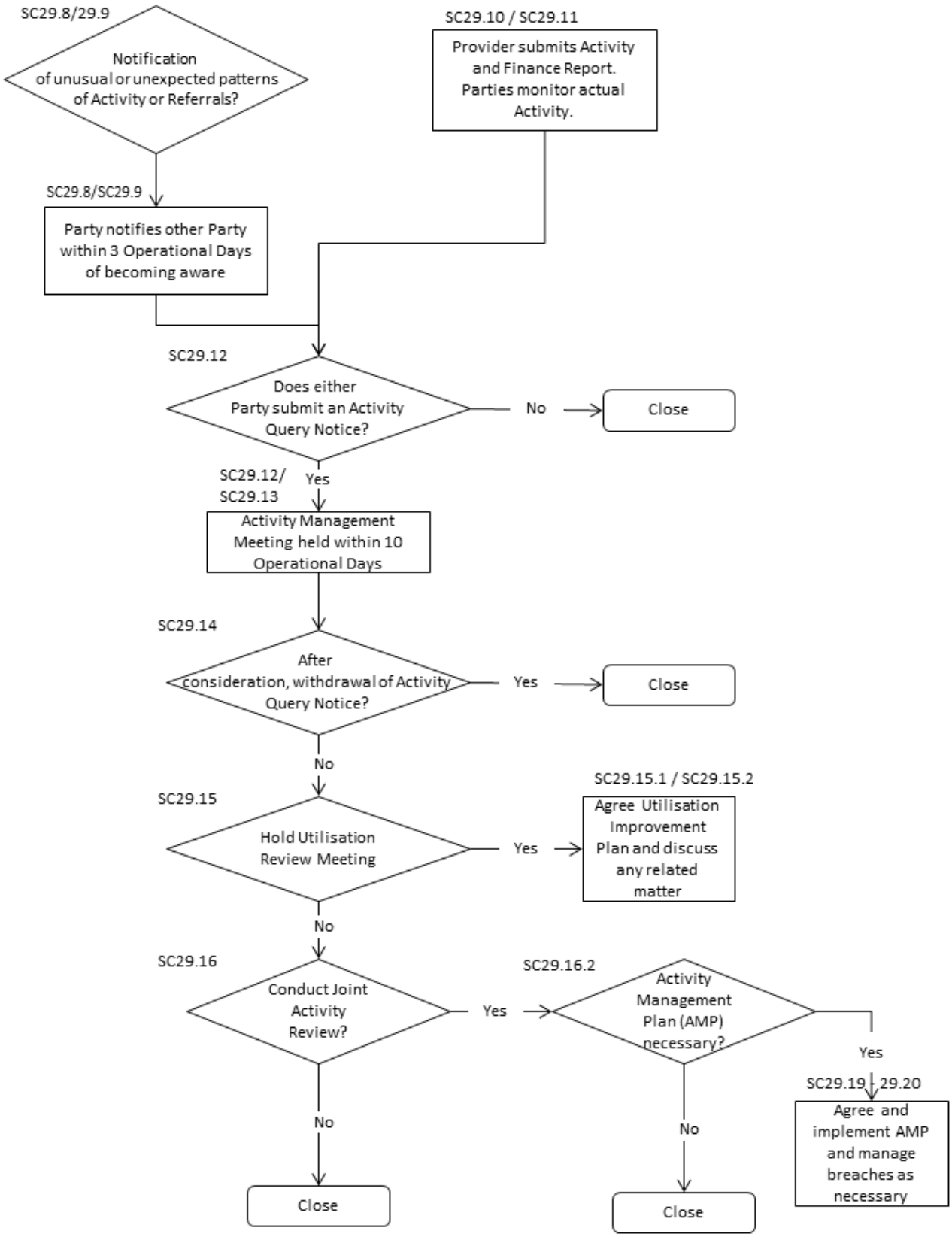
42.30 Otherwise, an AMP may be agreed. Where this cannot be agreed, the parties should refer the matter to dispute resolution.

42.31 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.

42.32 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.

SC29 (full-length Contract) – managing activity and referrals



Yellow = updated from 15/16 version; Green = updated from 16/17 consultation draft

43 Information, audit and reporting requirements

*The **shorter-form Contract** does not include the specific processes and sanctions relating to Information Breaches. Failure to comply with reporting and information requirements under the shorter form should be dealt with via the GC9 provisions.*

43.1 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).

43.2 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 6A (Reporting Requirements), SC28 (Information Requirements), and GC15 (Governance, Transaction Records and Audit).

Reporting Requirements

43.3 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.

43.4 Schedule 6A 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.

43.5 Despite the established principles above and the existing Contract wording which supports them in SC28, we receive consistent feedback about the high level of burden for providers which is generated by Local Reporting Requirements under the Contract.

43.6 As with Local Quality Requirements (see paragraph 39.9 above), commissioners are likely to find that a targeted approach with a limited number of well-chosen Local Reporting Requirements is the most effective approach. To encourage appropriate behaviour, we have strengthened SC28.4 for 2016/17 to stress that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields.

43.7 HSCIC is developing Burden Impact Assessment Tool for use by commissioners when they are looking to introduce new local data returns for providers; more information will be available on this during 2016. HSCIC also offers a Collection Referral Service which providers may contact confidentially if they believe that a proposed new local data requirement would benefit from objective, independent scrutiny.

Data Services for Commissioners Programme

43.8 The proliferation of local patient-level commissioning data sets – setting similar requirements for similar services, but in a non-standardised way – is a particular concern. The Data Services for Commissioners Programme (DSfCP) aims to address this, through a joint programme between NHS England and HSCIC which will deliver a new national technical solution for the transmission and distribution of de-identified patient-level commissioning data sets from 1 April 2017.

43.9 As part of the DSfCP, NHS England and HSCIC have been working together to review existing local flows of patient-level commissioning data, and to identify areas where such flows could be improved, particularly in key service areas where local data appears to be supplementing or duplicating nationally-mandated flows.

43.10 In addition, the deployment of the new national technical solution will also require providers to make a number of changes to existing local commissioning patient-level data flows to ensure that received data flows can be successfully validated, processed and distributed. These changes are likely to be mandated in the 2017/18 NHS Standard Contract or via new Information Standard Notices.

43.11 The specific change requirements to local commissioning patient-level data flows will only be known once the detailed design for the technical solution has been finalised (due date 31 March 2016). Some of the likely general requirements are described in Appendix 8.

43.12 Specific local data flow requirements and associated guidance can be found on the Data Services for Commissioners Online Resources webpage. Content will be released incrementally from March 2016.

43.13 We have included a reference to the Programme within Schedule 6A of the Particulars for 2016/17. Commissioners are encouraged to work with the DSfCP and their providers during the 2016/17 financial year to understand the requirements of the Programme and prepare for implementation from April 2017. Where a provider will need time to make adjustments to move to use of the new data sets, a Data Quality Improvement Plan should be agreed locally to describe how the transition will be managed and over what period.

Information Breaches

43.14 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 6A (Reporting Requirements)". The process for identifying and managing Information Breaches is set out in the flowchart below.

43.15 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. The provider must rectify the Breach within three months of the notification of the Breach, failing which the commissioners are entitled to retain the sums withheld.

43.16 For 2016/17, we have amended the wording of these financial withholding provisions to require that any sum withheld by the commissioner must be 'reasonable and proportionate' (SC28.15) and to limit the amount withheld for all Information Breaches in any month to a maximum of 5% of Actual Monthly Value (SC28.19). These two changes bring the approach on Information Breaches more into line with the existing provisions for financial withholding under Remedial Action Plans under GC9.

43.17 It is important to be clear that rectification "to the reasonable satisfaction of the Co-ordinating Commissioner" may involve retrospective and/or prospective action.

- 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.

- In other cases, retrospective rectification may be impossible. If the data underpinning a reporting requirement has not been fully captured at the appropriate point in the care pathway (ambulance handover times, say), then the rectification is likely to focus solely on ensuring that data capture and reporting for the future is comprehensive.

43.18 The Information Breach 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

43.19 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).

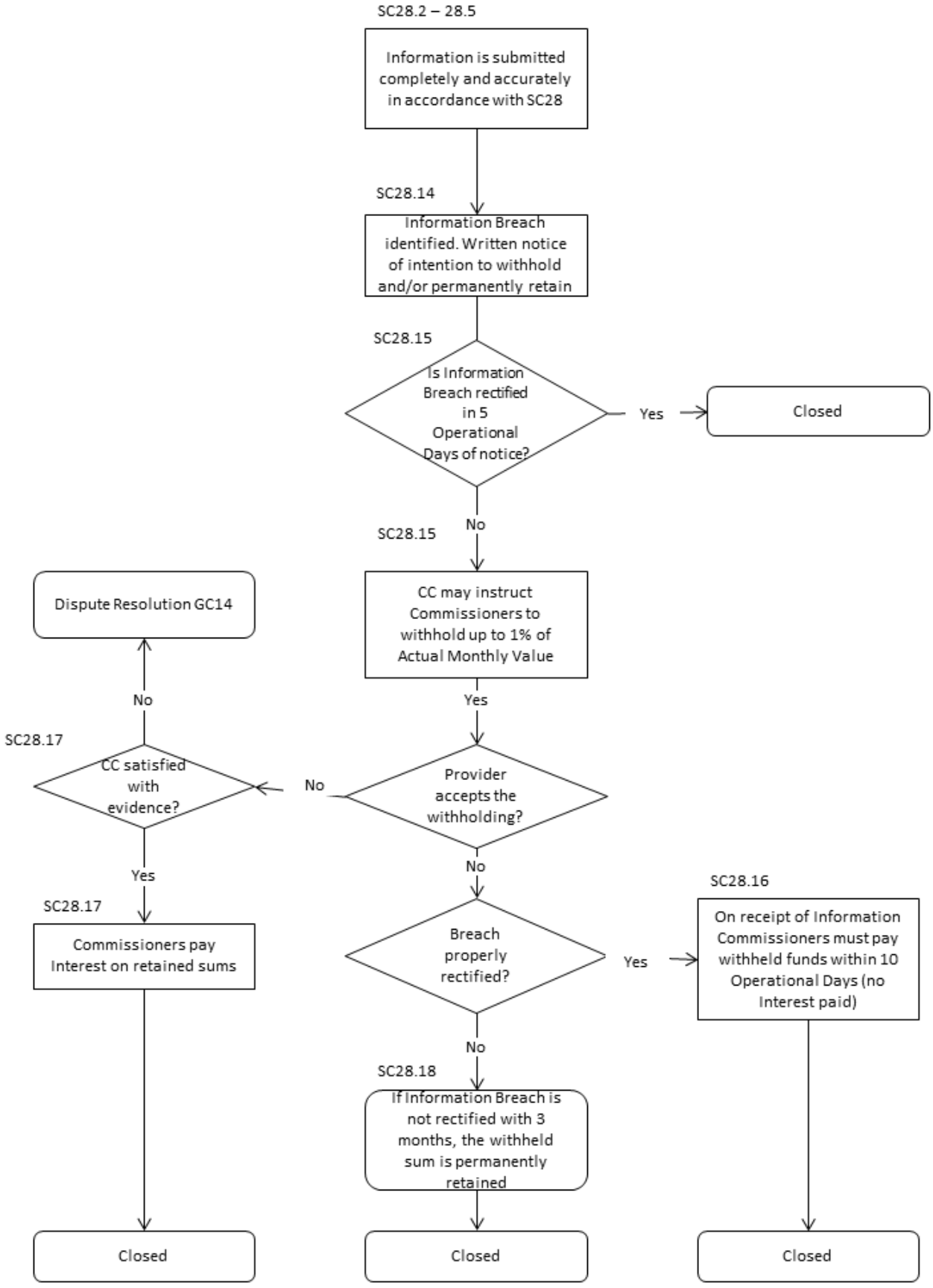
- However, there will be instances where systematic incorrect recording is identified, and in such cases the process for notifying, agreeing and implementing changes to recording practice (to bring recording into line with national rules and guidance) set out in SC28.8 onwards must be followed.

- 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.

SC28 (full-length contract) – Information requirements



Yellow = updated from 15/16 version; Green = updated from 16/17 consultation draft

43.20 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.

43.21 The contractual provisions relating to the financial impact of any agreed counting and coding changes provide protection against this for both parties. SC28.11 sets out that the parties must make financial adjustments so that the overall financial impact of agreed changes is neutral.

43.22 We receive many queries about these provisions, so we have set out in detail below how we expect them to work, both for changes which have already been notified and for those which will be notified in the future.

Changes which were notified up to and including 30 September 2014:

- Any changes agreed will have been implemented from 1 April 2015 and will have taken full financial effect from that date, unless the parties chose to agree transitional payment arrangements as permitted under the 2014/15 Contract.

Changes which were notified after 30 September 2014 and up to and including 30 September 2015:

- If changes are implemented with effect from 1 April 2016 or later, the financial impact is neutralised for the whole of the 2016/17 Contract Year.

- If changes are implemented before 1 April 2016, the financial impact is neutralised for the relevant part of the 2015/16 Contract Year and for the whole of the 2016/17 Contract Year.

Changes which are notified after 30 September 2015 and up to and including 30 September 2016:

- If changes are implemented with effect from 1 April 2017 or later, the financial impact is neutralised for the whole of the 2017/18 Contract Year.

- If changes are implemented before 1 April 2017, the financial impact is neutralised for the relevant part of the 2016/17 Contract Year and for the whole of the 2017/18 Contract Year.

43.23 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.

43.24 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 Variations process set out in GC13 and can be agreed between the parties at any time (see paragraph 46.1 onwards).

43.25 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.

43.26 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.

43.27 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.

43.28 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.

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

SUS

43.30 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.

Data Quality Improvement Plans

43.31 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.

43.32 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.

43.33 Multiple DQIPs can be included within the same contract. DQIPs should be included in Schedule 6B 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).

43.34 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 is, where a data set is produced, all relevant 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).

43.35 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 Services 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.

Data quality in mental health services

43.36 With the introduction of the new Mental Health Services Data Set and of new access standards for mental health services, it becomes even more important that mental health providers of submitting comprehensive and accurate data returns as required under national guidance. Without this, it will be impossible, for instance, to measure progress towards delivery of the new access standards.

43.37 Commissioners must therefore ensure that they monitor closely the data submitted by mental health providers and make prompt and effective use of contractual levers, such as a Data Quality Improvement Plan or the Information Breach provisions, to ensure that any problems with the quality of data submitted by individual providers are swiftly rectified.

Monitoring progress against the Workforce Race Equality Standard

43.38 The full-length Contract (SC13.5-6) requires providers to implement the national Workforce Race Equality Standard (WRES). NHS providers are also required to implement the Equality Delivery System for the NHS (EDS2).

43.39 It is obviously important that good monitoring data is available to track progress nationally in these areas. NHS England is seeking approval for a new Information Standard which will, in time, mandate WRES data submissions by providers. In the interim, we strongly encourage providers to report during 2016/17, using the WRES report template, publishing this on their websites. The next national WRES return is due in July 2016, and providers should look out for separate guidance in the New Year on a simple process for uploading their WRES indicator data via the UNIFY 2 system, so that progress can be measured at national level. Further guidance on WRES will be published shortly on the WRES webpage. We also strongly encourage providers to use the EDS2 report template to publish their

most up-to-date EDS2 report on their websites.

Audit and invoice validation

43.40 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 in the full-length Contract, GC15.5 in the shorter-form);
- 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 in the full-length contract, GC15.6 in the shorter-form); and
- what should happen as a result of the reports of independent audits and who should pay for them (GC15.9-15.13 in the full-length Contract).

43.41 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 (GC15.6 in the shorter-form) therefore makes clear that access to such data must be 'subject to any applicable Service User consent requirements'.

44 Contract management

*The provisions in the **shorter-form Contract** for contract management are very significantly simplified. Either party may issue a Contract Performance Notice, and the parties may then agree and must subsequently implement appropriate remedial actions.*

Contract review process

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

44.2 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. (Under the shorter-form Contract, we expect review meetings to be held as and when required, rather than on a fixed schedule.)

44.3 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.

44.4 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.

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

Contract management process

44.6 The stages of the contract management process are set out in the flowchart overleaf, but we have also clarified some points below about the way in which the process is intended to work.

Informal queries and Contract Performance Notices:

44.7 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.

Joint Investigations:

44.8 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:

44.9 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.

44.10 GC9 gives the co-ordinating commissioner the power to withhold funding following the issue of an Exception Report – see 44.12 below.

Remedial Actions Plans and financial consequences:

44.11 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.

44.12 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 or 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.

44.13 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:

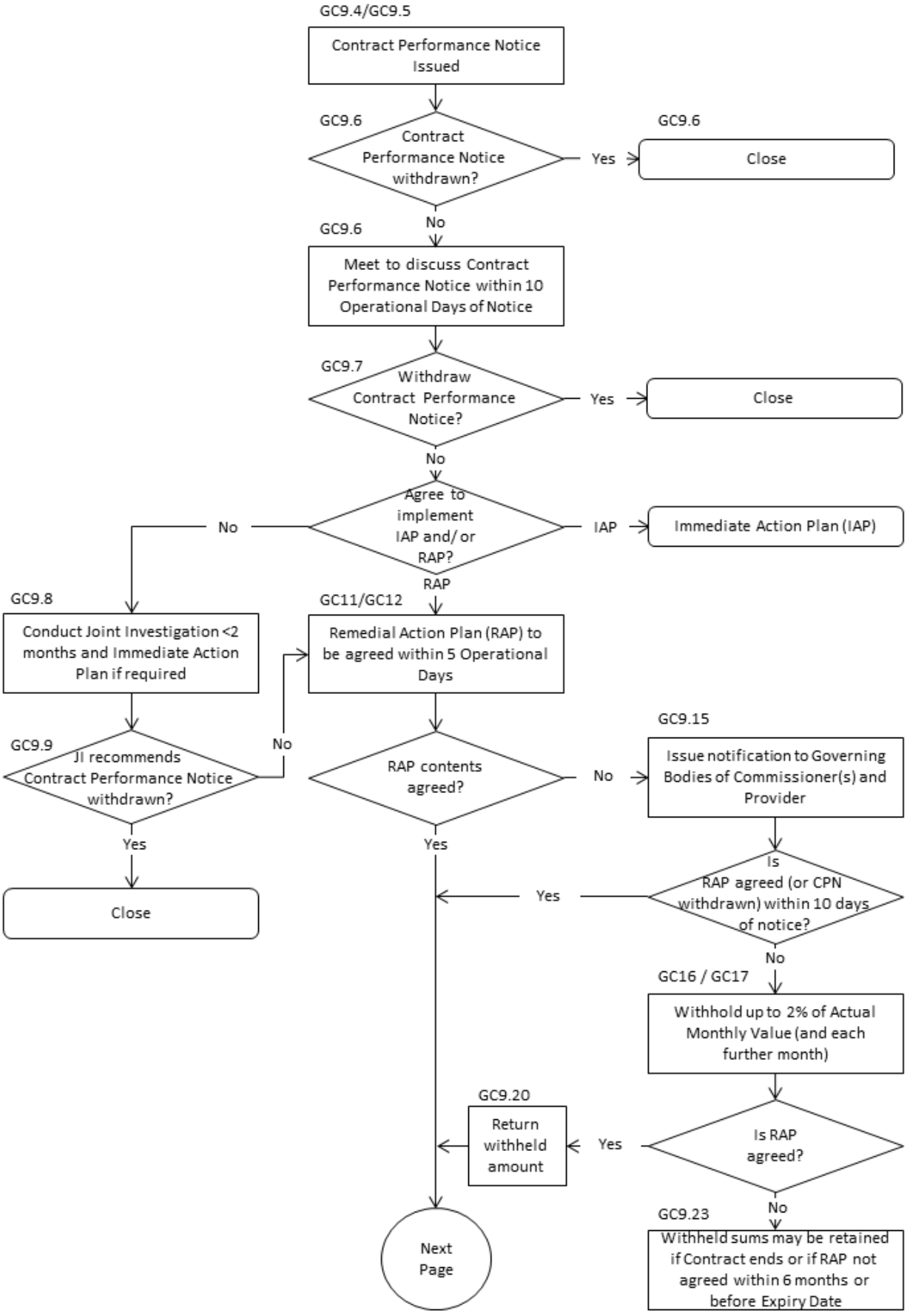
44.14 Where the provider breaches the national quality standards set out in Schedules 4A and 4B, the commissioner must automatically apply the relevant financial sanctions; sanctions may also be agreed and applied in relation to Local Quality Requirements in Schedule 4C. There is no requirement for the commissioner to go through the process in GC9 in order to apply these sanctions (see GC9.1).

44.15 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.

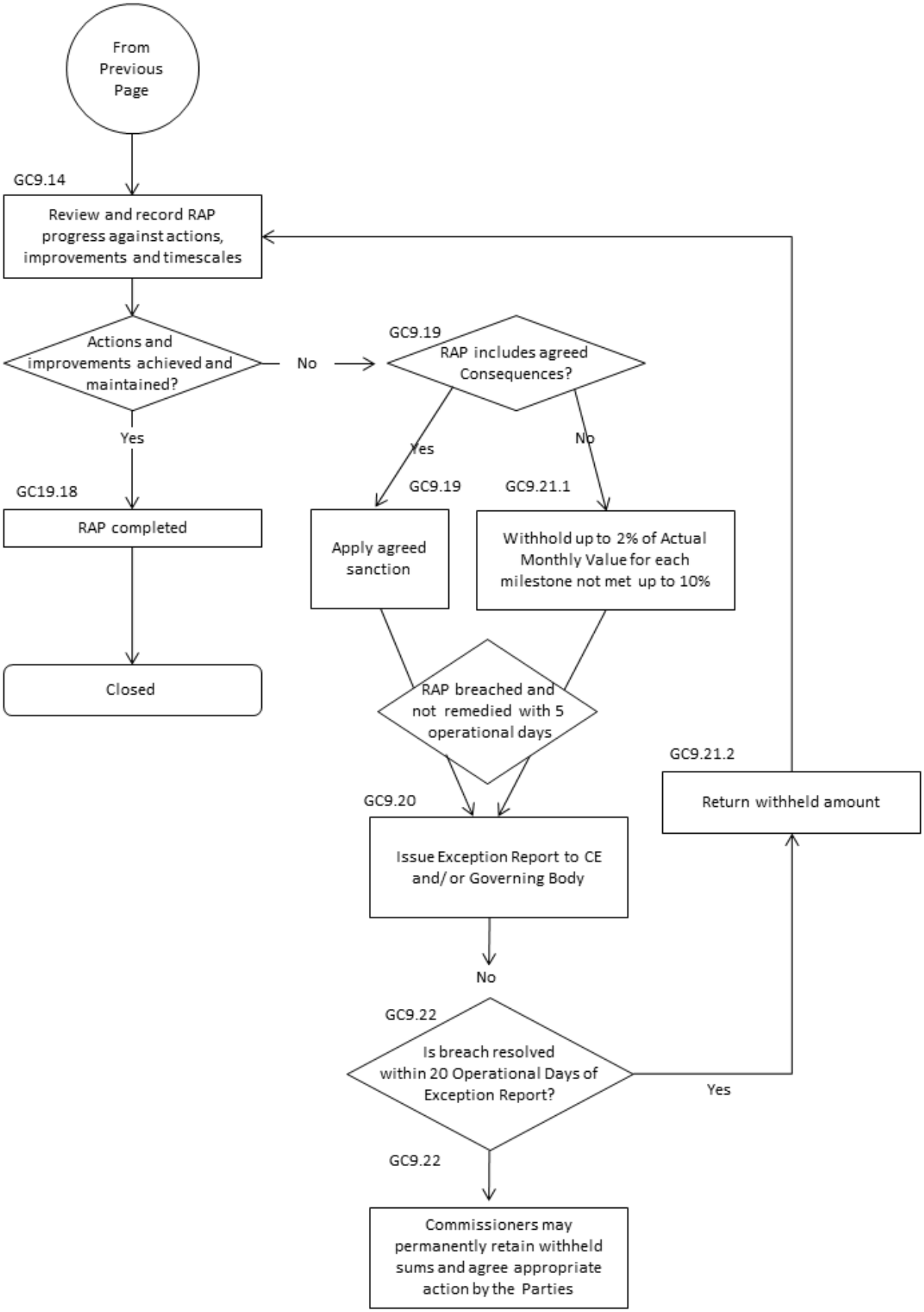
Breach of new national requirements in the Contract

44.16 The annual update of the NHS Standard Contract typically introduces a range of new policy requirements. Not all providers will be in a positon to comply fully with all such requirements from the first day on which the new Contract takes effect. Where this is the case, commissioner and provider should discuss a prompt, but realistic, timescale for implementation, with this recorded in the local contract as a Remedial Action Plan or Service Development and Improvement Plan if required.

GC9 (full-length Contract) – contract management



Yellow = updated from 15/16 version; Green = updated from 16/17 consultation draft


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?
Yes
No
Yes
GC19.18
RAP completed
Closed
GC9.19
Apply agreed sanction
GC9.21.1
Withhold up to 2% of Actual Monthly Value for each milestone not met up to 10%
RAP breached and not remedied with 5 operational days
GC9.20
Issue Exception Report to CE and/ or Governing Body
No
GC9.22
Is breach resolved within 20 Operational Days of Exception Report?
Yes
GC9.22
Commissioners may permanently retain withheld sums and agree appropriate action by the Parties
GC9.21.2
Return withheld amount

45 Payment

*The payment provisions in the **shorter-form Contract** are similar to those in the full-length version. Because the shorter form is not for use with services covered by National Prices under the National Tariff, it contains much less detail and does not require submissions to SUS.*

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

Payment schedules

45.2 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 40.14 above.

- Schedule 3G allows for recording of timing of payments in the first or final contract year.

45.3 There is no separate schedule for risk-sharing agreements to be recorded in the Contract, as there would be 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).

45.4 Note that Monitor and NHS England have published Local Payment Design Examples on multi-lateral gain and loss-sharing.

Invoicing, payment and reconciliation

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

45.6 These arrangements vary between contracts depending on two 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 (commonly referred to as "flex and freeze") applies for all the Services provided under the contract (SC36.28 to 36.31), 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 (SC36.32).

45.7 Within the full-length Contract, the distinction between Small Providers and Other Providers has been removed (see 34.6 above).

45.8 HSCIC has now published the SUS 2016/17 PbR Submission Timetable which sets out specific timescales for data submission and reconciliation in 2016/17.

45.9 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 SC36.45. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.

Payment of CQUIN

45.10 As described in paragraph 45.2 above, expected CQUIN payments should not be included within the EACV in Schedule 3F. Rather (under the full-length Contract), agreed payments on account in respect of CQUIN can be set out in Table 2 of Schedule 4D (CQUIN). The level of any CQUIN payment on account is for local agreement. Providers then invoice separately on account for CQUIN under SC38.2. (Under the shorter-form, payment of CQUIN is annual in arrears.)

45.11 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."

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

- record the disapplication of all national CQUINs in Schedule 4G 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).

45.13 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 (SC38.7 in the shorter-form Contract)). Where this approach is used, commissioners should

- record the variation to or disapplication of any national CQUINs in Schedule 4G 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 4D; and

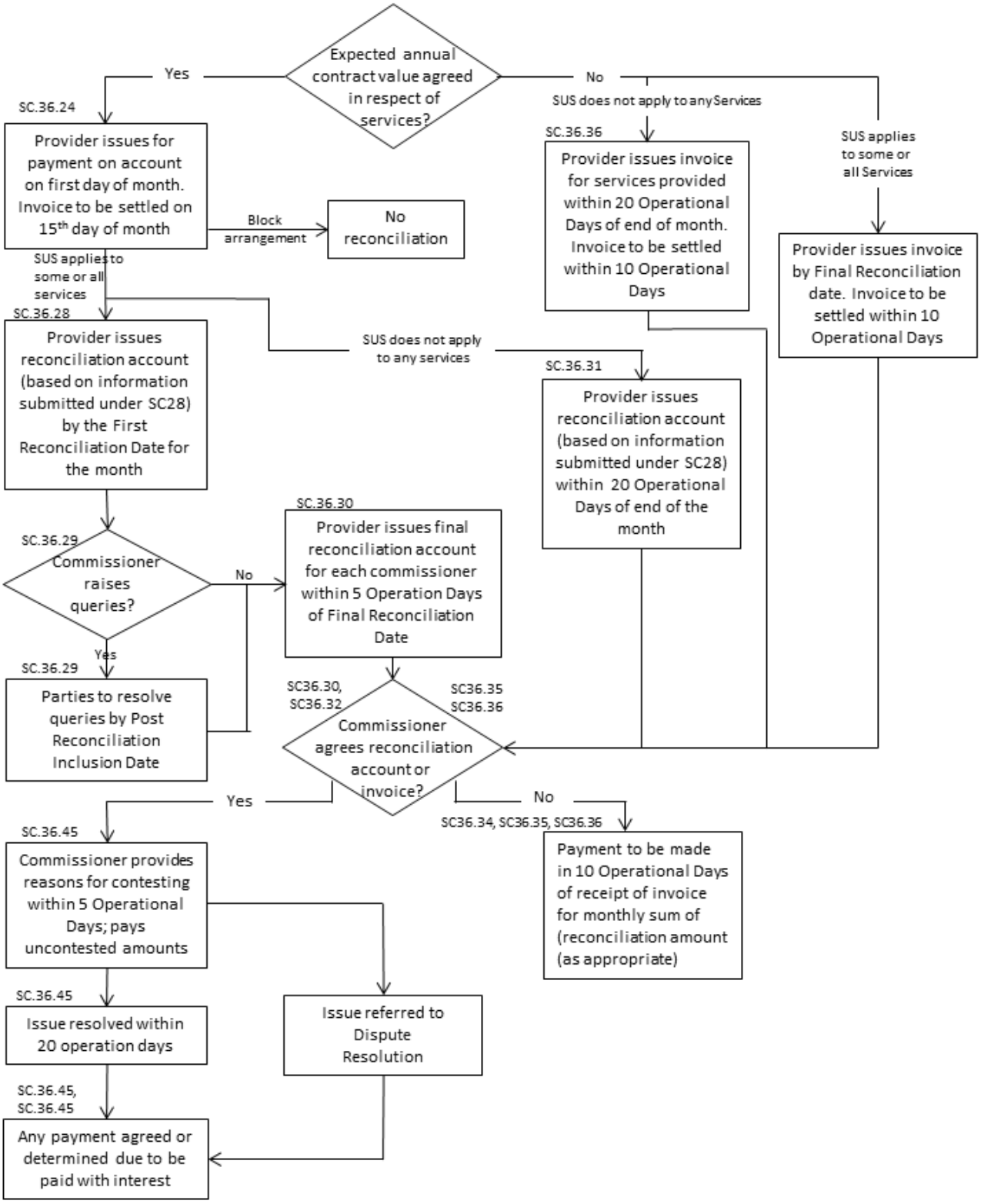
- ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed in the normal way, excluding any value to be paid under the locally-varied CQUIN scheme.

45.14 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

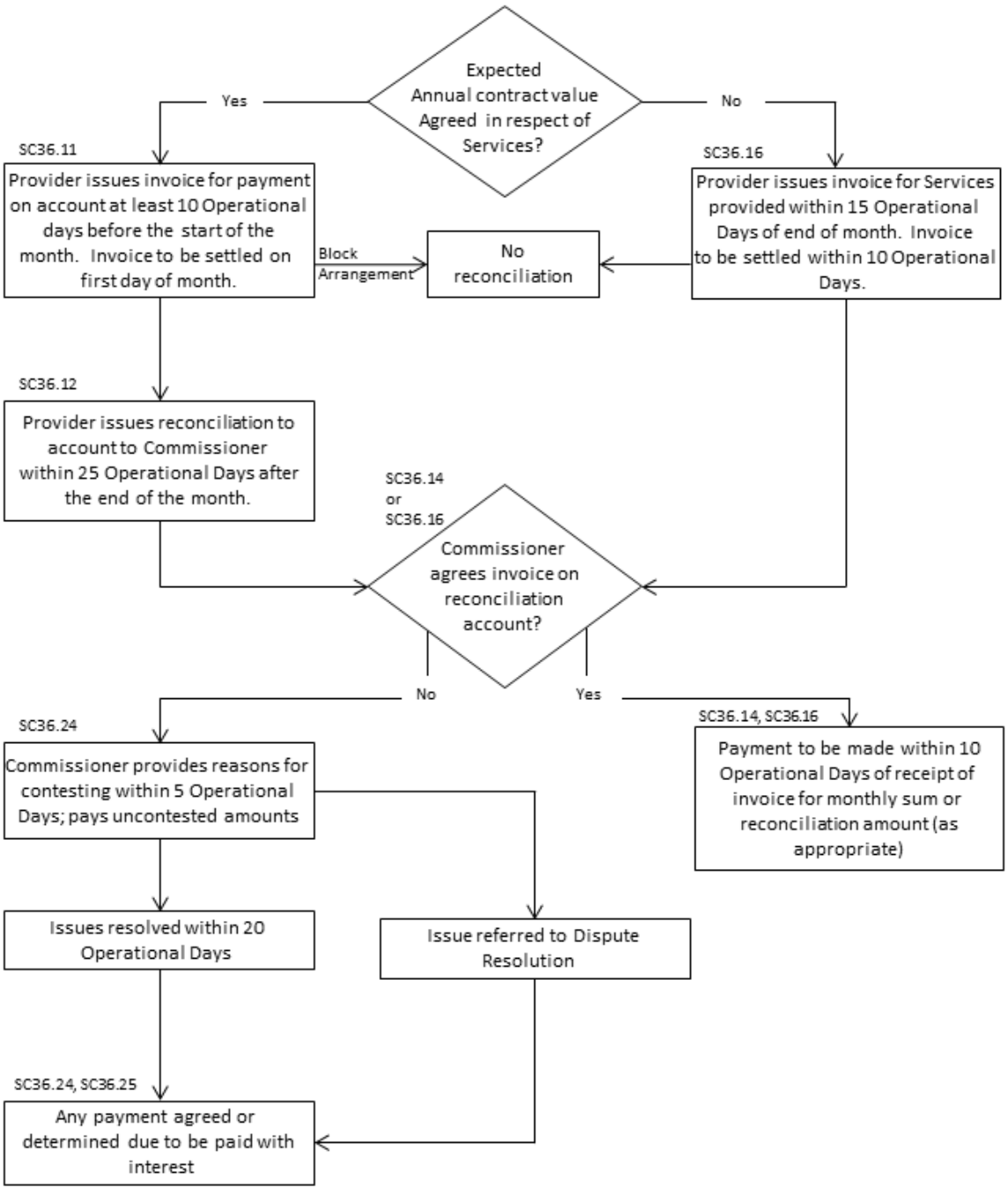
45.15 SC36.41 (full-length Contract) / SC36.21 (shorter-form) contains requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the Regulations and guidance governing this area.

SC36 (full-length Contract): Payment and Reconciliation



Yellow = updated from 15/16 version; Green = updated from 16/17 consultation draft

SC36 (shorter form Contract): Payment and Reconciliation



45.16 In summary, in those situations where overseas patients are liable to charges, under the new regime, providers are to charge 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.

45.17 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.

45.18 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. Further regulations and guidance are likely to be published during 2016, which are expected to extend the scope of the charging regime – hence the inclusion of the relevant provisions in the shorter form.

46 Other contractual processes

*The provisions in the **shorter-form Contract** for variation, dispute resolution, suspension of services, termination of the contract and exit arrangements are all significantly abbreviated and simplified. Where necessary, additional locally-agreed requirements may be included at Schedule 2G. As with the full-length version, optional provisions relating to staff pensions rights can be included within the shorter-form Contract at Schedule 7 where necessary.*

Variation

46.1 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. The permissible scope for variations is now as set out in Appendix 5 to this Guidance, rather than being listed in detail within the Definitions in the General Conditions. Note that we have omitted from the 2016/17 Contract the Recorded Variations schedule (formally Schedule 6A): on reflection we felt it somewhat anomalous to suggest recording agreed variations to a contract within the contract itself: it would be more usual and easier to maintain a separate log of agreed variations.

46.2 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 (GC13.13 in the full-length Contract, GC13.4 in the shorter-form). Guidance on

2016/17 National Variations and a template Variation Agreement to update existing contracts to the 2016/17 form have now been published on the NHS Standard Contract 2016/17 webpage.

46.3 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 2016/17 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 15 above.

46.4 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.

46.5 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) (or, in the case of the shorter-form Contract, to terminate the Contract altogether under GC17.2).

46.6 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.

46.7 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.

46.8 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).

46.9 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 long-form National Variation Agreement template (now published on the NHS Standard Contract 2016/17 webpage). They may, instead, wish to do so simply by adopting the 2016/17 NHS Standard Contract in full.

46.10 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-2014/15 contract, by all commissioners and the provider). As noted above, guidance on the process for 2016/17 National Variations has now been issued.

46.11 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

46.12 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.

46.13 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.

46.14 The dispute resolution process at GC14 applies only once a contract has been signed. As outlined in paragraph 23.1, NHS England, the NHS TDA and Monitor have published joint guidance on the resolution of disputes relating to the agreement of new contracts for 2016/17 between NHS commissioners and providers. The guidance is now available via the NHS Standard Contract 2016/17 webpage.

Suspension

46.15 The provisions governing suspension of services (GC16) remain largely

unchanged. It is worth commissioners reminding themselves of the scope which these provisions give to require a suspension, particularly when concerned about patient safety.

46.16 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.

46.17 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

46.18 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) (GC17.1 – 17.3 in the shorter-form)

46.19 GC17 now makes explicit the ability of the parties to terminate the contract at any time by mutual consent.

46.20 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).

46.21 Under the full-length Contract, different periods of notice may be agreed for provider-instigated and co-ordinating commissioner-instigated termination and 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),

46.22 See paragraphs 46.2 and 46.5 above in relation to termination where the provider refuses to accept a variation to the contract.

46.23 Under GC17.8 (GC17.3 in the shorter-form), there is a right for the co-ordinating commissioner to terminate (on a no-fault basis) in specific circumstances as required by the Public Contracts Regulations.

Termination for commissioner default (GC17.9) (GC17.4 in the shorter-form)

46.24 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.

Termination for provider default (GC17.10) (GC17.5 in the shorter-form)

46.25 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 (in abbreviated form in the shorter-form).

Consequences of expiry or termination

46.26 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.

46.27 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

46.28 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.

46.29 Any such arrangements should be set out, as clearly as possible, in Schedule 2I (Exit Arrangements) (or Schedule 2G (Other Local Agreements, Policies and Procedures of the shorter-form Contract).

46.30 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.

46.31 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 2I (or Schedule 2G of the shorter-form Contract) 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).

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

TUPE

46.33 Note that, for 2016/17, we have removed the obligation on commissioners – at GC5.16 in the 2015/16 Contract – to use reasonable endeavours to procure TUPE indemnities from an incoming provider in favour of the outgoing provider. This is because the "chain" of indemnities from outgoing and incoming providers (now at GC5.12 to 5.14) is now well-established: incoming and outgoing provider are given rights to enforce those indemnities directly by GC29 (Third Party Rights).

New Fair Deal for staff pensions

46.34 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 (GC17.10.15, GC17.5.6 in the shorter-form), 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 (template available at https://www.england.nhs.uk/nhs-standard-contract/16-17/) 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.

Liability and Indemnity

46.35 GC11 (Liability and Indemnity) imposes mutual obligations on commissioner and provider to indemnify the other in respect of costs and claims for personal injury and damage to property arising from their negligence or breach of contract.

46.36 The provider is required to put in place appropriate indemnity cover, whether under CNST or other risk pooling arrangements or under commercial insurance, in respect of its potential liabilities as employer, and to the public, and for clinical and professional negligence liability to Service Users.

46.37 In relation to the latter, it is very important that cover is maintained to meet claims made after (sometimes long after) a Contract expires or is terminated in respect of treatment delivered under it. That is why GC11.7 (GC11.3 in the shorter-form Contract) requires the provider to ensure that its indemnity arrangements remain in force "until…liability may reasonably be considered to have ceased" (in other words, until the statutory limitation periods on potential claims have expired).

46.38 We have, at the request of the Department of Health and the NHSLA, added, as GC11.8 (GC11.5 in the shorter-form Contract), an additional requirement to support that existing obligation to ensure that "run-off" cover is in place. The provider must provide evidence that this cover is in place, and if it fails to do so the commissioners may put cover in place themselves (which they would do by paying the appropriate additional contribution to NHSLA for CNST cover) and charge the provider for the costs they incur in doing so. This is to address concerns that a provider may go out of business leaving "uninsured" potential claims for its clinical negligence, and both Service Users and the public purse therefore at risk.

47 Status of this guidance

47.1 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.

47.2 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.

48 Advice and support

48.1 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 full-length Contract and comparison to shorter-form Contract

This Appendix is intended to give users of the full-length Contract a simple clause-by-clause guide identifying what has changed, what has moved and what has stayed the same for 2016/17 when compared to the 2015/16 Contract. Delta View comparison documents showing changes made to the Service Conditions and the General Conditions for 2016/17 will also be made available on the NHS Standard Contract 2016/17 webpage.

This Appendix is also intended to give users of the shorter-form Contract a detailed comparison of each clause in the full-length Contract, against each clause in the shorter-form Contract. Where a clause is retained and renumbered in the shorter-form Contract, this is also shown.

Particulars

Section or Schedule	Extent of changes made to 2016/17 draft Contract compared to 2015/16 Contract	Further changes made to 2016/17 final Contract compared to 2016/17 draft Contract	Extent of changes made to shorter-form Contract compared to 2016/17 full-length Contract
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM			
A. Conditions Precedent	No material change	No change	Shortened
B. Commissioner Documents	No change	No change	Omitted
C. Extension of Contract Term	Minor change	No change	No change
SCHEDULE 2 – THE SERVICES			
A. Service Specifications	No change	No change	Shortened
A1. Specialised Services – Derogations from National Service Specifications	No change	No change	Omitted
B. Indicative Activity Plan	No change	No change	No change
C. Activity Planning Assumptions	No change	No change	Omitted
D. Essential Services	No change	No change	No change
E. Essential Services Continuity Plan	No change	No change	Omitted
F. Clinical Networks	No change	No change	Omitted
G. Other Local Agreements, Policies and Procedures	No change	No change	No change
H. Transition Arrangements	No change	No change	Omitted
I. Exit Arrangements	No change	No change	Omitted
J. Transfer of and Discharge from Care Protocols	No change	No change	No change
K. Safeguarding Policies and MCA Policies	No change	No change	No change
L. Provisions applicable to Primary Care Services	No change	No change	Omitted
SCHEDULE 3 – PAYMENT			

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A. Local Prices	No change	No change	No change
B. Local Variations	No change	No change	Omitted
C Local Modifications	No change	No change	Omitted
D. Marginal Rate Emergency Rule: Agreed Baseline Value	No change	No change	Omitted
E. Emergency Re-admissions Within 30 Days: Agreed Threshold	No change	No change	Omitted
F. Expected Annual Contract Values	No change	No change	No change
[G Notices to Aggregate/Disaggregate Payments]	Deleted	No change	Omitted
G. Timing and Amounts of Payments in First and/or Final Contract Year	No change	No change	Omitted
SCHEDULE 4 – QUALITY REQUIREMENTS			
A. Operational Standards	**Significant changes**	No change	Shortened
B. National Quality Requirements	**Significant changes**	Changed	Omitted
C. Local Quality Requirements	No change	No change	No change
[D. Never Events]	Deleted	No change	Omitted
D. Commissioning for Quality and Innovation (CQUIN)	No change	No change	Changed
E. Local Incentive Scheme	No change	No change	Omitted
F. Clostridium difficile	No change	No change	Omitted
G. CQUIN Variations	No change	No change	Omitted
SCHEDULE 5 – GOVERNANCE			
A. Documents Relied On	No change	No change	Omitted
B1. Provider's Mandatory Material Sub-Contractors	No change	No change	Omitted
B2. Provider's Permitted Material Sub-Contractors	No change	No change	Omitted
[C. IPR]	Deleted	No change	Omitted
C. Commissioner Roles and Responsibilities	No change	No change	Omitted

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[E. Partnership Agreements]	Deleted	No change	Omitted
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS			
[A. Recorded Variations]	Deleted	No change	Omitted
A. Reporting Requirements	Minor changes; Small Provider alternative deleted	Minor change	Shortened
B. Data Quality Improvement Plan	No change	No change	Omitted
C. Incidents Requiring Reporting Procedure	No change	No change	No change
D. Service Development and Improvement Plan	**Significant changes**	Minor change	Omitted
E. Surveys	Changed	No change	Omitted
SCHEDULE 7 – PENSIONS	No change	No change	No change
SCHEDULE 8 – TUPE	NA	No change	New

Service Conditions

Clause number	Extent of changes made to 2016/17 draft Contract compared to 2015/16 Contract	Further changes made to 2016/17 final Contract compared to 2016/17 draft Contract	Clause number	Extent of changes made to shorter-form Contract compared to 2016/17 full-length Contract
SC1 Compliance with the Law and the NHS Constitution	Changed	Minor change SC1.4	SC1.1	Combined with SC1.2 as SC1.2 in shorter-form
			SC1.2	Combined with SC1.1 as SC1.2 in shorter-form
			SC1.3	No change
			SC1.4	Omitted
SC2 Regulatory Requirements	No change	NA	SC2.1.1	Combined with SC2.1.2 as SC2.1.1 in shorter-

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				form
			SC2.1.2	Shortened Combined with SC2.1.1 as SC2.1.1 in shorter-form
			SC2.1.3	Shortened Combined with SC2.1.1 as SC2.1.1 in shorter-form
			SC2.1.4	SC2.1.2
			SC2.1.5	SC2.1.3
			SC2.1.6	SC2.1.4
			SC2.1.7	SC2.1.5
			SC2.1.8	Omitted
SC3 Service Standards	Changed	NA	SC3.1	Shortened Combined in SC3.1.1 / SC3.1.2 in shorter-form
			SC3.2	Shortened
			SC3.3	Omitted
			SC3.4	Shortened SC3.3 in shorter-form
			SC3.5 – SC3.8	Omitted
SC4 Co-operation	Changed	Changed SC4.5	SC4.1	No change
			SC4.2	Omitted
			SC4.3	Shortened SC4.1 in shorter-form
			SC4.4	Omitted
			SC4.5	Omitted
SC5 Commissioner Requested Services/Essential Services	Minor changes	NA	SC5.1 – SC5.2	No change
			SC5.3	Shortened Combined with SC5.4 in SC5.3 in shorter-form

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			SC5.4	Shortened Combined with SC5.3 in SC5.3 in shorter-form
SC6 Choice, Referral and Booking	**Significant changes**	NA	SC6.1	No change
			SC6.2 – SC6.5	Omitted
			SC6.6	Shortened SC6.2 in shorter-form
			SC6.7	Omitted
			SC6.8	Shortened SC6.3 in shorter-form
SC7 Withholding and/or Discontinuation of Service	Changed	NA	SC7.1 – SC7.5	Omitted
SC8 Unmet Needs and Making Every Contact Count	Changed	Changed SC8.3	SC8.1 – SC8.5	Omitted
			SC8.6	Shortened SC8.1 in shorter-form
SC9 Consent	No change	NA	SC9.1	Omitted
SC10 Personalised Care Planning and Shared Decision Making	Changed	NA	SC10.1	No change
			SC10.2-SC10.4	Omitted
SC11 Transfer of and Discharge from Care	Changed	Changed SC11.7	SC11.1	Shortened
			SC11.2	No change
			SC11.3 – SC11.5	Omitted
			SC11.6	Shortened SC11.3 in shorter-form
			SC11.6 – SC11.9	Omitted
SC12 Communicating With and Involving Service Users, Public and Staff	Changed	NA	SC12.1	Shortened
			SC12.2	No change SC12.1 in shorter-form
			SC12.3	No change SC12.2 in shorter-form
			SC12.4	Omitted
			SC12.5	Shortened

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				SC12.3 in shorter-form
SC13 Equity of Access, Equality and Non-Discrimination	Changed	NA	SC13.1	No change
			SC13.2	Shortened
			SC13.3 – SC13.6	Omitted
SC14 Pastoral, Spiritual and Cultural Care	No change	Minor change SC14.2	SC14.1	Omitted
			SC14.2	Omitted
SC15 Places of Safety	Changed	NA	SC15.1	No change
SC16 Complaints	No material change	NA	SC16.1 – SC16.2	No change
SC17 Services Environment and Equipment	No material change	NA	SC17.1 – SC17.3	No change
SC18 Sustainable Development	No change	NA	SC18.1 – SC18.3	Omitted
SC19 Food Standards	No change	NA	SC19.1 – SC19.5	Omitted
SC20 Service Development and Improvement Plan	No material change	NA	SC20.1 – SC20.3	Omitted
SC21 Antimicrobial Resistance and Healthcare Associated Infections	No change	NA	SC21.1	No change
			SC21.2 – SC21.3	Omitted
SC22 Venous Thromboembolism	No change	NA	SC22.1	Omitted
SC23 Service User Health Records	Changed	NA	SC23.1	No change
			SC23.2.1 – SC23.2.2	Shortened Combined in SC23.2 in shorter-form
			SC23.3 – SC23.5	No change
			SC23.6 – SC23.8	Omitted
SC24 NHS Counter-Fraud and Security Management	Changed	NA	SC24.1 – SC24.2	No change
			SC24.3 – SC24.4	Shortened Combined in SC24.3 in shorter-form
			SC24.4	Omitted
			SC24.5	Shortened

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				SC24.4 in shorter-form
			SC24.6	Omitted
SC25 Procedures and Protocols	No change	NA	SC25.1 – SC25.2	Omitted
			SC25.3	No change SC25.1 in shorter-form
SC26 Clinical Networks, National Audit Programmes and Approved Research Studies	No change	NA	SC26.1 – SC26.4	Omitted
SC27 Formulary	Minor change	NA	SC27.1	Omitted
SC28 Information Requirements	Changed	NA	SC28.1	Omitted
			SC28.2	Shortened SC28.1 in shorter-form
			SC28.3	No change SC28.2 in shorter-form
			SC28.4	Shortened SC28.3 in shorter-form
			SC28.5	No change SC28.4 in shorter-form
			SC28.6	No change SC28.5 in shorter-form
			SC28.7	No change SC28.6 in shorter-form
			SC28.8 – SC28.22	Omitted
SC29 Managing Activity and Referrals	Changed	NA	SC29.1 – SC29.2	Omitted
			SC29.3	Shortened SC29.1 in shorter-form
			SC29.3A	Omitted
			SC29.4	Shortened SC29.2 in shorter-form
			SC29.5	Shortened SC29.3 in shorter-form

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			SC29.6 – SC29.7	Omitted
			SC29.8 – SC29.9	Combined SC29.6 in shorter-form
			SC29.10	SC29.4 in shorter-form
			SC29.11A – SC29.1C	Shortened Combined in SC29.5 in shorter-form
			SC29.12 – SC29.13	Combined SC29.7 in shorter-form
			SC29.14 – SC29.27	Omitted
SC30 Emergency Preparedness, Resilience and Response	Changed	NA	SC30.1	No change
			SC30.2	Shortened
			SC30.3	Omitted
			SC30.4	No change SC30.3 in shorter-form
			SC30.5 – SC30.10	Omitted
SC31 Force Majeure: Service-specific provisions	No change	NA	SC31.1 – SC31.4	Omitted
SC32 Safeguarding, Mental Capacity and Prevent	Changed	NA	SC32.1	No change
			SC32.2	Shortened
			SC32.3	Shortened
			SC32.4	Shortened
			SC32.5	Shortened
			SC32.6 – SC32.9	Omitted
SC33 Incidents Requiring Reporting	Changed	NA	SC33.1	Shortened
			SC33.2 – SC33.4	No change
			SC33.5	Shortened
SC34 Care of Dying People and Death of a Service User	No change	NA	SC34.1	No change
			SC34.2	Omitted
SC35 Duty of Candour	**Significant changes**	NA	SC35.1 – SC35.2	No change
			SC35.3 – SC35.4	Omitted
SC36 Payment Terms	**Significant changes**	Changed	SC36.1	No change

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		SC36.37 SC36.49 SC36.50	SC36.2	Omitted
			SC36.3	Shortened
			SC36.4	Shortened SC36.3 in shorter-form
			SC36.5	No change SC36.4 in shorter-form
			SC36.6	No change SC36.5 in shorter-form
			SC36.7	No change SC36.6 in shorter-form
			SC36.8	No change SC36.7 in shorter-form
			SC36.9	No change SC36.8 in shorter-form
			SC36.10	No change SC36.9 in shorter-form
			SC36.11 – SC36.23	Omitted
			SC36.24	No change SC36.10 in the shorter-from
			SC36.25	Changed SC36.11 in the shorter-form **Note change to SC36.11 compared to draft version**
			SC36.26 – SC36.27	Omitted
			SC36.28	Changed SC36.12 in shorter-form **Note change to SC36.12 compared to draft version**

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			SC36.29 – SC36.30	Omitted
			SC36.32	Changed SC36.14 in shorter-form
			SC36.33	No change SC36.13 in shorter-form
			SC36.34	Changed SC36.15 in shorter-form
			SC36.35	Omitted
			SC36.36	Changed SC36.16 in shorter-form
			SC36.37	Changed SC36.17 in shorter-form
			SC36.37A	Changed SC36.17A in shorter-form **Note change to SC36.17A compared to draft version**
			SC36.38	No change SC36.18 in the shorter-form
			SC36.39	No change SC36.19 in the shorter-form
			SC36.40	No change SC36.20 in the shorter-form
			SC36.41	No change SC36.21 in the shorter-form
			SC36.42	No change SC36.22 in the shorter-form

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			SC36.43	Omitted
			SC36.44	No change SC36.23 in the shorter-form
			SC36.45	Changed SC36.24 in shorter-form
			SC36.46	No change SC36.25 in shorter-form
			SC36.47	No change SC36.26 in shorter-form
			SC36.48	No change SC36.27 in shorter-form
			SC36.49	No change SC36.28 **Note change to SC36.28 compared to draft version**
			SC36.50	Omitted
SC37 Local Quality Requirements and Quality Incentive Schemes	Minor changes	NA	SC37.1	Shortened
			SC37.2	No change
			SC37.3	Shortened
			SC37.4 – SC37.5	Omitted
SC38 Commissioning for Quality and Innovation (CQUIN)	Minor changes	NA	SC38.1 – SC38.2	No change
			SC38.3 – SC38.4	Omitted
			SC38.5 - SC38.6	Combined SC38.3 in shorter-form
			SC38.7 – SC38.10	Omitted
			SC36.11	Changed, shortened SC38.4 in shorter-form
			SC38.12	Omitted
			SC38.13	Changed, shortened SC38.5 in shorter-form

			SC38.14	Changed SC38.6 in shorter-form
			SC38.15	Changed SC38.7 in shorter-form
			SC38.16	Changed SC38.8 in shorter-form

General Conditions

Clause number	Extent of changes made to 2016/17 draft Contract compared to 2015/16 Contract	Further changes made to 2016/17 final Contract compared to 2016/17 draft Contract	Clause number	Extent of changes made to shorter-form Contract compared to 2016/17 full-length Contract
GC1 Definitions and Interpretation	No material change	No change	GC1.1 – GC1.2	No change
			GC1.3	No change
GC2 Effective Date and Duration	No change	No change	GC2.1 – GC2.2	No change
GC3 Service Commencement	No change	No change	GC3.1	No change
GC4 Transition Period	No material change	No change	GC4.1	No change
			GC4.2	Omitted
			GC4.3	No change GC4.2 in shorter-form
			GC4.4	Omitted
			GC4.5	GC4.3 in shorter-form
GC5 Staff	No material change	Change to GC5.8	GC5.1	No change
			GC5.2	Changed, shortened
			GC5.3 – GC5.4	No change
			GC5.5	Omitted
			GC5.6	No change GC5.5 in shorter-form
			GC5.7	No change GC5.6 in shorter-form
			GC5.8	No change GC5.7 in shorter-form **Note change to GC5.7 compared to draft version**
			GC5.9	No change

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				GC5.9 in shorter-form
			GC5.10	No change GC5.9 in shorter-form
			GC5.11 – GC5.14	Schedule 8 in shorter-form
			GC5.15 – GC5.17	Omitted
GC6 Intentionally Omitted	No change	No change	GC6	Omitted
GC7 Intentionally Omitted	Deleted	No change	GC7	Omitted
GC8 Review	No change	No change	GC8.1	Changed, shortened
			GC8.2 – GC8.4	Omitted
GC9 Contract Management	No material change	Change to GC9.26	GC9.1 – GC9.2	No change
			GC9.3	Omitted
			GC9.4	No change GC9.3 in shorter-form
			GC9.5	No change GC9.4 in shorter-form
			GC9.6	No change GC9.5 in shorter-form
			GC9.7	Changed, shortened GC9.7 in shorter-form
			GC9.8 – GC9.12	Omitted
			GC9.13	Changed, shortened GC9.7 in shorter-form
			GC9.14 – GC9.19	Omitted
			GC9.20	Changed, shortened GC9.8 in shorter-form
			GC9.21 – GC9.25	Omitted
			GC9.26	No change **Note change to GC9.26 compared to draft version**
GC10 Co-ordinating	No change	No change	GC10.1	Omitted

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Commissioner and Representatives			GC10.2	No change GC10.1 in shorter-form
			GC10.3	No change GC10.2 in shorter-form
GC11 Liability and Indemnity	No change	Change to GC11.6	GC11.1	No change
			GC11.2	No change
			GC11.3	No change
			GC11.4	No change
			GC11.5	No change GC11.6 in shorter-form
			GC11.6 – GC11.7	Omitted
			GC11.8	GC11.5 in shorter-form **Note change to GC11.5 compared to draft version**
			GC11.9	Omitted
			GC11.10	No change GC11.7 in shorter-form
			GC11.11	No change GC11.8 in shorter-form
			GC11.12	No change GC11.9 in shorter-form
GC12 Assignment and Sub-Contracting	No material change	Change to GC12.10.3	GC12.1	Changed, shortened
			GC12.2 – GC12.6	Omitted
			GC12.7	No change GC12.2 in shorter-form
			GC12.8	No change GC12.3 in shorter-form
			GC12.9 – GC12.16	Omitted
			GC12.12	No change GC12.2 in shorter-form
			GC12.13 – GC12.16	Omitted

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			GC12.17	No change GC12.4 in shorter-form
GC13 Variations	Changed	No change	GC13.1 – GC13.3	No change
			GC13.4	Omitted
			GC13.5	Changed GC13.4 in shorter-form
			GC13.6 – GC13.12	Omitted
			GC13.13	Shortened GC13.4 in shorter-form
			GC13.14 – GC13.16	Omitted
GC14 Dispute Resolution	No material change	No change	GC14.1	Changed GC14.7 in shorter-form
			GC14.2 – GC14.6	Omitted or shortened GC14.2 in shorter-form
			GC14.7 – GC14.9	Changed, shortened GC14.3 in shorter-form
			GC14.10 - GC14.12	Omitted
			GC14.13-GC14.14	Changed, combined GC14.4 in shorter-form
			GC14.15	Omitted
			GC14.16	Changed GC14.5 in shorter-form
			GC14.17 – GC17.18	Omitted
			GC14.19	No change GC14.6 on shorter-form
			GC14.20 – GC14.21	Omitted
GC15 Governance, Transaction Records and Audit	No material change	No change	GC15.1	No change
			GC15.2 – GC15.3	Shortened GC15.2 in shorter-form Additional requirement at GC15.2.2
			GC15.4	Omitted

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			GC15.5	No change GC15.3 in shorter-form
			GC15.6	No change GC15.4 in shorter-form
			GC15.7	Shortened GC15.5 in shorter-form
			GC15.8	Shortened GC15.6 in shorter-form
			GC15.9 – GC15.13	Omitted
GC16 Suspension	No material change	No change	GC16.1	Shortened
			GC16.2	No change
			GC16.3	Omitted
			GC16.4	Changed, shortened GC16.3 in shorter-form
			GC16.5	No change GC16.4 in shorter-form
			GC16.6	No change GC16.5 in shorter-form
			GC16.7 – GC16.9	Omitted
GC17 Termination	Changed	No change	GC17.1	No change
			GC17.2 – GC17.3	Shortened, combined GC17.2 in shorter-form
			GC17.4 – GC17.7	Omitted
			GC17.8	No change GC17.3 in shorter-form
			GC17.9	Changed, shortened GC17.4 in shorter-form
			GC17.10	Changed, shortened GC17.5 in shorter-form
GC18 Consequence of Expiry or Termination	No material change	No change	GC18.1	No change
			GC18.2 – GC18.3	Omitted
			GC18.4	Changed, shortened

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				GC18.2 in shorter-form
			GC18.5 – GC18.9	Omitted
GC19 Provisions Surviving Termination	No change	No change	GC19.1	No change
GC20 Confidential Information of the Parties	No material change	No change	GC20.1	No change
			GC20.2	Changed, shortened GC20.1 in shorter-form
			GC20.3	Shortened
			GC20.4	Changed GC20.2 in shorter-form
			GC20.5 – GC20.9	Omitted
GC21 Patient Confidentiality, Data Protection, Freedom of Information and Transparency	Changed	Change to GC21.13A	GC21.1 – GC21.21	No change **Note new GC21.13A**
GC22 Intellectual Property	**Significant changes**	No change	GC22.1 – GC22.4	No change
GC23 NHS Identity, Marketing and Promotion	**Significant changes**	Change to GC23.2 and GC23.23	GC23.1 – GC23.3	No change **Note change to GC23.2 and GC23.3 compared to draft version**
GC24 Change in Control	No change	No change	GC24.1	No change
			GC24.2	Shortened
			GC24.3 – GC24.8	Omitted
			GC24.9	No change GC24.3 in shorter-form
			GC24.10 – GC24.12	Omitted
GC25 Warranties	No material change	No change	GC25.1	Shortened GC25.1 – GC25.2 in shorter-form
			GC25.2 – GC25.4	Omitted
GC26 Prohibited Acts	No change	No change	GC26.1 – GC26.2	No change

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GC27 Conflicts of Interest and Transparency on Gifts and Hospitality	**Significant changes**	No change	GC27.1 – GC27.3	No change
GC28 Force Majeure	No change	No change	GC28.1	Omitted
			GC28.2	No change GC28.1 in shorter-form
			GC28.3	Shortened GC28.2 in shorter-form
			GC28.4	GC28.3 in shorter-form
			GC28.5	Omitted
GC29 Third Party Rights	Changed	Change to GC29.1.6	GC29.1	Changed
			GC29.2	No change
GC30 Entire Contract	No change	No change	GC30.1	No change
			GC30.2 – GC30.3	Omitted
GC31 Severability	No change	No change	GC31.1	No change
GC32 Waiver	No change	No change	GC32.1	No change
GC33 Remedies	No change	No change	GC33.1	No change
GC34 Exclusion of Partnership	No change	No change	GC34.1	Omitted
GC35 Non-Solicitation	No change	No change	GC35.1 – GC35.2	Omitted
GC36 Notices	No change	No change	GC36.1 – GC36.2	No change
GC37 Costs and Expenses	No change	No change	GC37.1	No change
GC38 Counterparts	No change	No change	GC38.1	No change
GC39 Governing Law and Jurisdiction	No change	No change	GC39.1 – GC39.2	No 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 for creation of local contracts in both full-length and shorter form format. 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 for 2016/17 is very similar to that for 2015/16, but with additional functionality to enable shorter from contracts to be generated in appropriate circumstances. Assistance in using the eContract system is available via the User Guide on the portal or at england.econtract@nhs.net. The eContract system can be accessed at https://www.econtract.england.nhs.uk/Home/.

The scope of the contract

The NHS Standard Contract (full-length or shorter form) 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.

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.

Text in red highlights where the position differs under the shorter-form Contract.

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 2016 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), and the date on which that term begins (usually the Expected Service Commencement Date). Commissioners should refer to paragraphs 17-18 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 5C 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 15 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 will usually be the date of contract, but could be 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 16/17 this will usually be 1 April 2016. 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 1A) 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, and the date on which that term begins (usually the Expected Service Commencement Date).	
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 18 above), and the length of the permitted extension.	
Commissioner Notice Period	Enter the Commissioner Notice Period for termination under GC17.2. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)	
Commissioner Earliest Termination Date GC17.2	Enter the earliest date on which a commissioner notice to terminate may take effect. (Not applicable under the shorter form)	

Provider Notice Period GC17.3	Enter the Provider Notice Period for termination under GC17.3. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)	
Provider Earliest Termination Date GC17.3	Enter the earliest date on which a provider notice to terminate may take effect. (Not applicable under the shorter form)	
Notice Period	Enter the notice period for termination by either the Co-ordinating Commissioner or the Provider.	
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 34 above for further detail on service categories. Note that the service categories listed in the shorter form are limited to those for which the shorter form may be used.		
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), part of Schedule 6A (Reporting Requirements) and SC36.22A apply. (Not applicable under the shorter form)	
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 36 on completion of the Service Specification template. (No template is included in the shorter form)	
Indicative Activity Plan SC29.5, SC29.6, SC29.11A, SC29.12.3A (SC29.3)	Completing this will determine whether Schedule 2B (Indicative Activity Plan) and certain clauses in SC29 apply and appear for completion in the eContract. (The shorter form does not require the Commissioner to indicate whether an IAP applies here, but one may be included if required: see Schedule 2B and SC29.3 of the shorter form)	
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. (Not applicable under the shorter form)	
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 2016/17.	
Services to which 18-Week applies SC6.4, SC6.5	Completing this will determine whether SC6.4, SC6.5 and parts of Schedule 4 (Quality Requirements) apply and appear in the eContract. Answer 'yes' or 'no'. (Not applicable under the shorter form, as the shorter form must not be used for services to which the 18-week standard applies)	
Payment		
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'. (Not applicable to the shorter form)	
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 4F Clostridium Difficile). (Not applicable to the shorter form, as the shorter form must not be used for acute services)	
Clostridium Difficile Baseline Threshold	The threshold for each NHS Trust and NHS Foundation Trust will be available on the NHS England website early in 2016. For other providers the C. diff. threshold should be set at zero. (Not applicable to the shorter form, as the shorter form must not be used for acute services)	
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. (Not applicable to shorter form)	
Provider 's Nominated Individual SC3.8	The name and contact details of the Provider's Nominated Individual must be inserted here (this will be the same person as the nominated individual for the provider's CQC registration, where relevant).	
Provider 's Information Governance Lead GC21.3.1, GC21.3.3, GC21.3.4	The name and contact details of the Provider's Information Governance Lead must be inserted here.	
Provider's Caldicott Guardian	The name and contact details of the Provider's Caldicott Guardian must be inserted here.	

GC21.3.2, GC21.3.3, GC21.3.4		
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 Accountable Emergency Officer SC30.1	The name and contact details of the Provider's Accountable 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 Child Sexual Exploitation Lead SC32.2	The name and contact details of the Provider's Child Sexual Exploitation 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. (Not applicable to the shorter form)	
Provider's Freedom To Speak Up Guardian GC5.8	The name and contact details of the Provider's Freedom To Speak Up Guardian (to be nominated by 1 October 2016) 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. (Not applicable to the shorter form: review meetings are to be held on an ad hoc basis)	
Commissioner Representative(s) GC10	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	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 GC3, GC4	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 GC17.10.1 (GC17.5.1). Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to: • Sub-contracts, see paragraph 38 above • Direction Letters, see paragraph 46.33 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. (Not applicable to the shorter form)	
C – Extension of Contract Term	To be used only as described in paragraph 18 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 36 above for further details.	
A1 – Specialised Services – Derogations from National Service Specifications	For specialised services, enter any derogations here. (Not applicable to the shorter form, as it is not to be used for specialised services)	
B – Indicative Activity Plan (IAP) SC29.5, SC28.6 SC29.3	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 42 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 42 above for further details. (Not applicable to the shorter form)	
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. (See paragraph 37 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'. (The shorter form does not require a Continuity Plan to be included in the contract itself)	
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'. (Not included in the shorter form, but if the Provider is to be required to participate in a Clinical Network the appropriate details may be included in Schedule 2G)	
G – Other Local Agreements, Policies and Procedures SC25	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. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 1A and/or Schedule 2G)	
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 paragraphs 46.28 – 46.32 above. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 2G)	
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 2K 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 paragraphs 8.5 and 34.5 above. (Not applicable to the shorter form. If a package of general practice and secondary care services are being commissioned the full-length contract must be used, with Schedule 2L)	
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. (Not applicable to the shorter form contract, as it must not be used for services for which there is a national price)	
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. (Not applicable to the shorter form contract, as it must not be used for services for which there is a national price)	

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.) (Not applicable to the shorter form, as it must not be used for acute services)	
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.) (Not applicable to the shorter form, as it must not be used for acute services)	
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 – Timing and Amounts of Payments in First and/or Final Contract Year SC36.26, SC36.27	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'. (Not included in the shorter form, but if necessary appropriate provisions may be included in Schedule 3A)	
Schedule 4 – Quality Requirements		
A - Operational Standards (Combined with NQRs in Schedule 4A in the shorter form)	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 39 above.	
B - National Quality Requirements (Combined with Operational Standards in Schedule 4A in the shorter form)	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 39 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 39 above.	
D - Commissioning for Quality and Innovation (CQUIN) SC38	Commissioners should complete this section in accordance with applicable CQUIN guidance. (In the shorter form CQUIN Variations should also be recorded in schedule 4D)	
E - 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. (Not included in the shorter form)	
F - 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. (Not included in the shorter form, as it must not be used for acute services)	
G - 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 4G and returned to NHS England via e.cquin@nhs.net. (In the shorter form, CQUIN Variations should also be recorded in schedule 4D)	
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. (Not included in the shorter form)	
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 38 above. (Not included in the shorter form)	
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 38 above. (Not included in the shorter form)	

C - 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. (Not included in the shorter form)	
Schedule 6 – Contract Management, Reporting and Information		
A - Reporting Requirements SC28	This table sets out the information that is required to be reported under the contract. See also paragraph 43 above.	
B - Data Quality Improvement Plan (DQIP) SC28.20, SC28.21, SC28.22	This table is used to record any agreed DQIP. (Not included in the shorter form)	
C – Incidents Requiring Reporting Procedure SC33	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.	
D – Service Development and Improvement Plan SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 41 above, which sets out certain situations in which an SDIP must be included. (Not included in the shorter form)	
E – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys. (Not included in the shorter form)	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 46.33 above.	
Schedule 8 - TUPE		
TUPE	Applicable to the shorter form only. It may in certain circumstances be appropriate to omit the text of this Schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.	

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	Not applicable
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 Services Data Sets – completion of ethnicity field

National Quality Requirement	Completion of the ethnicity field in Mental Health Services Data Set records
Rationale	Improvement in the standard of completion of Mental Health Services Data Set records has been defined as an important priority by clinical stakeholders.
Definition	% of all Mental Health Services 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 Services Data Set records in which the ethnicity code for the Service User was properly completed **Denominator:** Total number of Mental Health Services 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 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 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.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 will shortly publish provider C difficile targets for 2016/17.

Schedule 4F 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 = no. of inpatient bed days in respect of Service Users in the Contract Year / 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

E.B.15 ii Ambulance response times (Red 2)

Number of Red 2 journeys in the year (under this Contract)	=	150,000
Standard for the proportion where the emergency response arrives within 8 minutes (threshold)	=	75%
Permitted number of breaches of the standard in the year (under this Contract)	=	37,500
Actual performance against the standard in the year	=	72%
Actual number of breaches of the standard in the year (under this Contract)	=	42,000
Excess number of breaches beyond the tolerance permitted by the % threshold (under this Contract)	=	4,500
Financial sanction per breach	=	£100
Total value of financial sanctions in the year (under this Contract)	=	£450,000

Appendix 5

Permissible Variations

The following are "Variable Elements" of the NHS Standard Contract, which may be varied by local agreement in accordance with GC13:

(i)	Particulars: Service Commencement and Contract Term – local insertions and selections only
(ii)	Particulars: Services – local insertions only
(iii)	Particulars: Payment – local insertions and selections only
(iv)	Particulars: Quality – local insertions and selections only
(v)	Particulars: Governance and Regulatory – local insertions and selections only
(vi)	Particulars: Contract Management – local insertions and selections only
(vii)	Schedule 1A (*Conditions Precedent*) – local insertions only
(viii)	Schedule 1B (*Commissioner Documents*) – local insertions only
(ix)	Schedule 1C (*Extension of Contract Term*) – if used, insertion of notice period in paragraph 1 only
(x)	Schedule 2A (*Service Specifications*), Schedule 2A1 (*Specialised Services – Derogations from National Service Specifications*) – local insertions only; no variation to or derogations from National Service Specifications unless mandated by NHS England
(xi)	Schedule 2B (*Indicative Activity Plan*) – application/local insertions only
(xii)	Schedule 2C (*Activity Planning Assumptions*) – application/local insertions only
(xiii)	Schedule 2D (*Essential Services*) – application/local insertions only
(xiv)	Schedule 2E (*Essential Services Continuity Plan*) – application/local insertions only
(xv)	Schedule 2F (*Clinical Networks*) – application/local insertions only
(xvi)	Schedule 2G (*Other Local Agreements, Policies and Procedures*) – application/local insertions only
(xvii)	Schedule 2H (*Transition Arrangements*) – application/local insertions only
(xviii)	Schedule 2I (*Exit Arrangements*) – application/local insertions only

(xix) Schedule 2J (*Transfer of and Discharge from Care Protocols*) – local insertions only

(xx) Schedule 2K (*Safeguarding and Mental Capacity Act Policies*) – local insertions only

(xxi) Schedule 2L (*Provisions Applicable to Primary Care Services)* – application/local insertions only

(xxii) Schedule 3A (*Local Prices*) – application/local insertions only

(xxiii) Schedule 3B (*Local Variations*) application/local insertions only

(xxiv) Schedule 3C (*Local Modifications*) – application/local insertions only

(xxv) Schedule 3D (*Marginal Rate Efficiency Rule: Agreed Baseline Value*) – application/location insertions only

(xxvi) Schedule 3E (*Emergency Readmissions Within 30 Days: Agreed Threshold*) – application/local insertion only

(xxvii) Schedule 3F (*Expected Annual Contract Values*) – application/local insertions only

(xxviii) Schedule 3G (*Timing and Amounts of Payments in First and/or Final Contract Year*) – application/local insertions only

(xxix) Schedule 4A (*Operational Standards*) – application (selected Service categories); Thresholds/Consequence of Breach/Monthly or Annual application of consequence, where indicated in the NHS Standard Contract as being for local determination, only

(xxx) Schedule 4B (*National Quality Requirements*) – application (selected Service categories); E.A.S.5 (CDiff) Threshold, only

(xxxi) Schedule 4C (*Local Quality Requirements*) – local insertions only

(xxxii) Schedule 4D (*Commissioning for Quality and Innovation (CQUIN)*) – local insertions only

(xxxiii) Schedule 4E (*Local Incentive Scheme*) – application/local insertions only

(xxxiv) Schedule 4F (*Clostridium difficile*) – application/ selection of appropriate provisions by Provider type only

(xxxv) Schedule 4G (CQUIN Variations) – local insertions only

(xxxvi) Schedule 5A (*Documents Relied On*) – application/local insertions only

(xxxvii) Schedule 5B1 (*Provider's Mandatory Material Sub-Contractors*) – application/local insertions only

(xxxviii) Schedule 5B2 (*Provider's Permitted Material Sub-Contractors*) – application/local insertions only

(xxxix) Schedule 5C (*Commissioner Roles and Responsibilities*) – local insertions only

(xl) Schedule 6A (*Reporting Requirements*) – application (selected Service categories; Small Provider/other); open fields; Local Requirements Reported Locally only

(xli) Schedule 6B (*Data Quality Improvement Plan*) – application/local insertions only

(xlii) Schedule 6C (*Incidents Requiring Reporting Procedure*) – local insertions only

(xliii) Schedule 6D (*Service Development and Improvement Plan*) – application/local insertions only

(xliv) Schedule 6E (*Surveys*) – local insertions only

(xlv) Schedule 7 (Pensions) – local insertions only (template wording: refer to Technical Guidance)

(xlvi) Service Conditions – application (selected Service categories; Provider type) only

Appendix 6

Public reporting of contractual sanctions applied by commissioners

As described in paragraph 40.3 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 data on a quarterly basis. Data for quarter 1 should be published by the end of quarter 2 and so on.

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 https://www.england.nhs.uk/nhs-standard-contract/16-17/

Appendix 7

Hypothetical case studies

Activity planning during contract negotiations

Scenario 1

During the annual contract negotiation, an acute provider believes that its main local commissioner is "under-commissioning" for certain elective specialties – that is, planning to set the Indicative Activity Plan (IAP) at an unrealistically low level, relying on initiatives to control GP referrals which the provider does not understand or have confidence in.

Contractual approach

The right outcome here is a shared, realistic IAP which both parties will work to. So the commissioner should share more detail about its demand management plans. Either the provider will gain confidence in the plans, accepting that they give a robust basis for the IAP – or, alternatively, the commissioner may accept that its plans are over-ambitious and may scale down its estimate of their impact to a more realistic level.

However good the planning which underpins the IAP, actual activity levels are always likely to differ from plan to some extent. Ultimately, of course, payment under the National Tariff rules will be based on the actual level of activity undertaken, not on the IAP. So it is possible, contractually, for the IAP within the contract to be set at one level for a particular specialty, but for the provider to plan internally for a higher level. But this is not desirable. The whole aim of the activity planning process should be to produce a shared, realistic and affordable plan, on which the provider will base the level of capacity it makes available.

Scenario 2

During the annual contract negotiation, the commissioner and acute provider review referral trends and waiting time data for a particular specialty and agree that, in principle, a 15% increase in capacity is required for the coming year. However, the provider maintains that it cannot, in practice, deliver a 15% increase and refuses to agree the Indicative Activity Plan (IAP) on this basis.

Contractual approach

Here again, the parties need to do further work to seek a jointly acceptable resolution.

They will need to understand what the basis is for the provider's view that capacity cannot be increased – have all the possible options (more efficient working, pathway redesign, recruitment of additional staff, sub-contracting to other providers) been fully explored? Equally, the commissioner will need to

- work actively with referrers to encourage them to look at alternative local providers for their referrals (the NHS e-Referral Service will show waiting time information for all providers that offer options for the patient's referral, enabling referrers to choose suitable alternatives where capacity issues exist)

- consider whether it can commission other providers to offer capacity in the same specialty, so that there is an additional local choice option for referrals – or whether it would be clinically appropriate to introduce narrower criteria for referral to the specialty.

As suggested in scenario 3 below, the commissioner may also be able to offer the provider some comfort by clarifying, in advance, what approach it will take to the reinvestment of such sanctions (see para 40.5 onwards above).

If a solution cannot be found through these routes, then – whatever level the IAP within the contract is eventually pitched at – it is possible that, even if the provider puts in place the maximum capacity it can, this may be significantly exceeded by the actual level of demand. Handling this situation is dealt with in scenario 5 below.

Scenario 3

The commissioner has radical plans to invest in new out-of-hospital services which it believes will significantly reduce the requirement for bed-based emergency hospital services. The plans would logically mean that the main acute provider would close several wards. The acute provider supports the plans in principle, but both parties are nervous about the risks involved; everyone agrees it is the right thing to do, but no one is totally confident about predicting the likely financial outcome under normal National Tariff rules.

Contractual approach

The brief description above could mask several different realities. At one end of the spectrum, if the commissioner's plans are poorly thought through, proceeding with them may be a bad idea. At the other, 'total' confidence in any plan is probably an unrealistic aspiration; a robust, well worked-up plan will always involve some level of risk, so the commissioner may be confident enough to proceed.

The point of this scenario, though, is simply to offer a reminder that it is possible for commissioners and providers to move away, by agreement, from 'pure' application of the 'activity x price' approach to payment for services covered by national prices under the National Tariff. They can agree a time-limited Local Variation in line with the criteria set out in the National Tariff; to give all parties greater certainty about their expected level of income or expenditure, for instance, they could move to more of a block payment arrangement, or perhaps adopt a risk- and gain-share approach, along the lines of the Local Payment Design Example published by Monitor. If, say, the provider is concerned at the potential for performance sanctions to be levied under the contract (if it downsizes its capacity as requested by the commissioner, but then finds that activity levels do not reduce as planned), the commissioner may, as part of any risk-sharing agreement, be able to provide comfort by clarifying, in advance, what approach it will take to the reinvestment of such sanctions (see para 40.5 onwards above).

These flexibilities are not easy answers – considerable local effort will be required to make them work effectively – but they will be an option worth explored locally in some situations.

Activity management

Scenario 4

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).

<u>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</u>

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.

<u>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</u>

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).

<u>If the activity over-performance is partly the result of the provider treating patients outside the terms of agreed Prior Approval Schemes</u>

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. SC29.22

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.

Scenario 5

Building on Scenario 2 above, an acute provider finds, part-way through the year, that referrals into one sub-specialist element of its elective orthopaedic service are exceeding capacity by 25%. The standard for RTT incomplete pathways is not being met, and the waiting list is spiralling out of control. The commissioner is applying financial sanctions as required under the Contract. The parties have met to discuss a Remedial Action Plan, but the provider cannot identify any way in which it can increase its capacity to meet the current level of demand.

Contractual approach

Whereas, under scenario 4, the commissioner is concerned about the cost of activity it has not planned for, here in scenario 5 it is the provider which is anxious that it cannot practically deliver the necessary volume of activity.

In scenario 5, exactly the same questions arise about what is driving the demand / capacity imbalance as in scenario 4. And the responses in scenario 2 also apply – has the provider done everything it can to expand its capacity? Can the commissioner encourage a voluntary redirection of referrals to providers with more capacity and shorter waits or introduce additional capacity or tighter referral criteria?

But let's assume that these discussions all happen and that no workable solution can be found. What then?

- The provider must not unilaterally 'switch off' the affected service on the NHS E-Referral Service. This will simply prompt more (less efficient) paper referrals from GPs.

- Nor may it unilaterally start to reject GP referrals from some or all commissioners (perhaps those outside what it may consider to be its local catchment area). This would contravene the requirements in SC6.

The only way in which new referrals into a service can properly be stopped in this scenario is if the Co-ordinating Commissioner requires the provider to suspend the service temporarily under GC16.

- Such a suspension should only occur in truly exceptional circumstances, but may be considered appropriate if the demand / capacity imbalance is so severe that there is simply no prospect of patients receiving treatment, meaning that patients' safety and health may be at significant risk.

- A suspension can be applied to new referrals (or new, non-urgent referrals) only (so that the provider can continue working to clear the backlog of existing cases) and it can be applied only to an element of a service (in this instance, the sub-specialty under particular pressure), rather than necessarily the whole service.

- But, for a service to which the legal right of choice applies, suspension must not be used to enable patients from some CCGs to continue to access the service, whilst those from other cannot.

- The Co-ordinating Commissioner will need to liaise with other organisations and consider the impact of a potential suspension in the round, including the effect it is likely to have on services at other available providers.

- Clear communication to referrers and, where appropriate, the general public will be essential.

Reporting requirements

Scenario 6

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

Scenario 7

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.

Scenario 8

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.

Scenario 7

In contractual terms, Scenario 7 is straightforward. SC36.36 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. Where the provider misses this deadline, the commissioner is under no obligation to pay the invoices. This would be the case, technically, even if the provider had been sending monthly activity data to SUS on time throughout months 1-6; the provision of the invoice is what triggers the requirement to pay.

Scenario 8

Scenario 8 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.

Scenario 9

A provider has notified its co-ordinating commissioner in March 2015 of a change in recording practice which it believes is must make in order to comply with the NHS Data Dictionary. The provider believes that the change will result in an increase in income from commissioners of around £500,000 in a full year. The provider did not intend to implement the change in 2015/16, but believes that its notification allows it to implement from 1 April 2016 and to receive the full income gain from that point onwards. The co-ordinating commissioner, by contrast, believes that the provider should not make the change at all, because it should never be allowed to make a 'windfall' gain from improved counting and coding.

Contractual approach

There are two separate issues to be resolved here.

- Should the change in recording practice proceed at all?
- When should the change itself and its financial impact take effect?

The first question is simply a matter of what is technically correct under the definitions set out in the NHS Data Model and Dictionary and related rules. Commissioner and provider should seek, in good faith, to reach an agreement on how the rules are to be interpreted in this particular case. They may be able to seek expert advice to help them. Ultimately, if they are unable to reach agreement, they may need to resort to the dispute resolution process in the Contract.

Assuming that this first issue is resolved and the parties agree that the change is technically appropriate and should therefore proceed – what happens then about implementation and financial impact? This is complex, because the relevant provisions of the Contract changed between 2014/15 and 2015/16.

Under both the 2014/15 and 2015/16 Contracts, parties were required to notify recording changes at least six months before the date proposed for implementation, with the expectation being that changes would be implemented from 1 April of the following contract year.

The difference in contractual terms between the two years is about the financial impact.

- For changes properly notified under the 2014/15 Contract (that is, by 30 September 2014), implementation could proceed at 1 April 2015, with the full financial effect applying immediately.
- Under the 2015/16 Contract, however, the financial impact of agreed changes must be neutralised for the first full year after implementation. So a change

notified by 30 September 2015 could be implemented on 1 April 2016, but the financial effect would have to be neutralised until 1 April 2017.

So, the commissioner's view – that a provider can never make a financial gain from changes in recording practice – is not correct. But neither is the provider's view. In this particular scenario, the provider has not given a valid notification of a counting change under the 2014/15 Contract – because it only gave notice in March 2015, rather than doing so before the end of September 2014.

Its notification therefore needs to be considered under the 2015/16 Contract. It has provided notification before 30 September 2015, so the change it is proposing can be implemented from 1 April 2016. But SC28.11 of the 2015/16 Contract requires that the full financial impact is neutralised for the first full year of implementation – meaning that the provider cannot start to gain the £500,000 income increase until 1 April 2017.

(This scenario happens to feature a counting and coding change from which the provider would benefit financially. It is important to remember that the protections in the Contract cut both ways – they apply to changes from which either provider or commissioner would benefit.)

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

The information governance sections in the Standard Contract and the Short Form Contract are the same as the requirement for compliance is the same for organisations of any size and any type of service. However some sections may not be applicable where the activity referred to is not part of the contracted service. Where this is the case it is indicated below.

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)	<u>Information Governance Lead</u> 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. <u>Senior Information Risk Owner (SIRO)</u> 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 <u>Caldicott Guardian</u> 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. In a small organisation it may be appropriate for the same individual to take on more than one of the roles described above. It is recommended that the roles of Caldicott Guardian and SIRO should be held by different people to avoid potential conflicts of interest.
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' expectations. In GC21 and 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. At the time of writing a report on a further review in relation to data security conducted in 2015 is due to be published by the Secretary of State. *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. 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 Controller responsibilities (GC21.8, GC21.10 – GC21.13)	The Provider is a Data Controller under the Data Protection Act, 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. Commissioners must ensure that requirements placed on providers to submit Personal Data have an established legal basis, and that they and their support organisations have a legal basis to receive it. Whilst the provider's obtaining a patient's consent to disclose the information would establish such a basis, this is only likely to be practical in particular contexts, such as individual requests for funding. In addition, to meeting the obligations of the Data Protection Act both providers and commissioners must be mindful of any duty of confidence owed to patient's information. Commissioners and Providers must establish the legal basis for the submission and use of datasets. Existing national datasets are supported by standards and directions, which require submission to the Health and Social Care Information Centre.

	In addition, there is a current legal basis for commissioning and invoice validation established through applications approved by the Secretary of State under Regulations enabled by Section 251 of the NHS Act 2006. These applications enable flows of specified data sets under precise terms from providers to commissioners. The "Section 251 regulations" refers to The Health Service (Control of Patient Information) Regulations 2002, enacted under section 251 of the NHS Act 2006. This provides a statutory basis for the flow of personal data where a duty of confidentiality is owed, without seeking the consent of individuals. These applications place additional obligations and assurance on both provider and commissioner. Both parties are advised to seek further information about the use of Stage 1 Accredited Safe Havens, Controlled Environments for Finance and the HSCIC's Data Services for Commissioners Regional Offices (DSCROs) under these applications. Information for CCGs and CSUs on becoming an Accredited Safe Haven can be found on the HSCIC website. Information for CCGs and CSUs on invoice validation and establishing a Controlled Environment for Finance can be found on the NHS England website. Organisations are advised to seek and implement the latest information about information governance. 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. This is achieved by compliance with the Information Security requirements of the IG Toolkit.
Responsibilities when engaging sub-contractors (GC21.14, GC21.15 Particulars – Schedule 5B in full-length)	When engaging a sub-contractor to deliver part of the service (not as a Data Processor), the provider must ensure that the IG requirements in contracts are no less onerous than GC21. When engaging a sub-contractor as a Data Processor, i.e. specifically 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 on its behalf. A contract must be in place that commits the sub-contractor to act only on the instructions of the provider and to have measures in place to meet the provider's obligations under the seventh principle of the DPA – technical and organisational security. The contract should also include requirements to support

	the provider's responses to subject access and freedom of information requests. Contract Particulars, Schedule 5 must be completed in B1 with the identities of any Mandatory Material Sub-contractors, and in B2 with those of any Permitted Material 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. Guidance on DPA requirements when engaging a Data Processor can be found on the ICO website. This section is not applicable to organisations that do not engage sub-contractors.
Responsibilities as a Data Processor (GC21.16)	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 on the ICO website. This section is not applicable to organisations that have not been specifically commissioned to provide a service that involves the processing of personal data as instructed solely by the commissioner.
Commissioning Datasets (Particulars – Schedule 6A)	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 on the NHS England website. All local datasets must be listed in the Contract Particulars, Schedule 6A 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	The Provider must ensure that where new systems and technologies are introduced that they are implemented using an

controls are in place when introducing new technologies and applications.	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 Care Record application (SCRa)	The SCRa is a web based portal by which service user information 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	The provider must acquire a unique ODS code for their organisation and separate site codes, where relevant, to support all central

services (ODS)	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.

Data Services for Commissioners Programme

The Data Services for Commissioners Programme is a joint programme between NHS England and the HSCIC which will deliver a new national technical solution for the

transmission and distribution of de-identified patient-level commissioning data sets from April 2017. Please refer to paragraph 43.8 above.

The specific change requirements to local commissioning patient-level data flows will only be known once the detailed design for the technical solution has been finalised (due date 31 March 2016). However the general requirements will include:

- Ensuring all local commissioning patient-level data flows are consistent and aligned with national commissioning patient-level data flows with regard to the inclusion of designated patient-identifiable data (to include at least the following: NHS Number, NHS Number Status Indicator, Date of Birth, Full Postcode of Place of Usual Residence, Gender and GP Practice Code, plus Name and Address of place of usual residence if NHS Number not present)

- The need to ensure that all of the designated patient-identifiable data fields conform to NHS Data Model and Dictionary definitions

- The need to ensure that providers take every reasonable effort, in line with existing national guidance and legislation and using enablers such as PDS, to establish and maintain the designated patient-identifiable data items at the highest possible level of quality in local commissioning patient-level data flows

- The need for commissioners to consider the use of the incentive mechanisms within the contract to encourage providers to establish and maintain the designated data items at the highest possible level of quality in local commissioning patient-level data flows

- The need to ensure that the data items above and any other patient-identifiable data items in local commissioning data flows are only ever submitted in their designated fields

- Inclusion of a field that describes the date of the activity event in all local commissioning patient-level data flows

- The need to ensure inclusion of other specified data fields in all local commissioning patient-level data flows (e.g. provider code)

- Inclusion of the all specified data fields in specific predetermined locations within submission files for local commissioning patient-level data flows

- Mandatory provision to a nominated recipient of a metadata file that describes the content and format of all local commissioning patient-level data flows, and any changes to a flow previously declared via this process
- The need to ensure that all local commissioning patient-level data flows are submitted via prescribed submission methods

- The development of conformed data sets for specified local commissioning patient-level data flow types (covering at least urgent care, mental health and community data sets) and the intention that these will become new information standards, or changes to existing standards, from April 2017

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 webpages.
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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