NHS England

Shorter-form NHS Standard Contract for 2017/18 - 2018/19

User guide

Shorter-form NHS Standard Contract 2017/18-2018/19: User guide

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given regard to the need to

- eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Contents

1. What is this Guide about and who is it for?

This Guide is about the shorter-form version of the NHS Standard Contract 2017/18-2018/19. It is for commissioners and providers who may use the shorter-form Contract, and who will have to deal with contracts. It explains when and how the shorter-form Contract should be used.

The NHS Standard Contract must be used by NHS commissioners (Clinical Commissioning Groups and NHS England) when commissioning clinical healthcare services other than primary care. The shorter-form Contract was first published for commissioning relevant clinical services with effect from April 2016, and with effect from April 2017 has been updated to extend the circumstances in which it may be used.

Where the eContract system is used to generate tailored documentation, a shorter-form contracts will typically be a third of a full-length Contract. Please refer to s9 of this User Guide for more information on using the eContract system.

The shorter-form Contract is intended to be used when NHS commissioners commission clinical healthcare services of relatively low complexity and value.

- The shorter-form Contract may be used 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.

- For other non-primary care clinical services, including 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, the full-length NHS Standard Contract must be used.

New for 2017/18-2018/19, the shorter-form Contract may be used for contracts for diagnostic, screening and pathology services for which the National Tariff guidance sets a mandatory national price (as well as where that mandatory national price is to be the subject of a Local Variation or Local Modification).

2. Grant agreements and contracts – a reminder

If they want to provide funding to a voluntary sector organisation, NHS commissioners can either make a grant to that organisation or award a contract to purchase services from the organisation.

Where the commissioner is providing funding support towards the costs a voluntary sector provider faces in running a service, it will generally be appropriate to use a grant agreement.

If, on the other hand, commissioners are buying a specific service and covering its full cost, it will be necessary to put a contract in place for that service.

There is no mandated form of grant agreement which CCGs must use, but NHS England has published a model grant agreement, guidance and a bitesize guide to grants.

If a contract is the appropriate route, the right form of contract to use will depend on whether the organisation is providing clinical healthcare services or other services:

- For services other than clinical healthcare, NHS commissioners are likely to use the Department of Health standard terms and conditions.
- For clinical healthcare (other than core primary care provided by GPs, optometrists, dentists and pharmacies), the NHS Standard Contract must be used – in either the full-length or the shorter-form version. The commissioner must decide which version is appropriate for the specific package of services it is commissioning.

3. Structure of the shorter-form NHS Standard Contract

The shorter-form Contract has a three-part structure, mirroring that of the full-length version.

- 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 Service Conditions. This section contains the generic, system-wide clauses which relate to the delivery of services. A few of these will be applicable only to particular services or particular scenarios. The key in 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 scenario cannot be varied or overridden.
- 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 and cannot be overridden.

The shorter-form Contract is under 80 pages in length (before the local Schedules are completed), against the 200 pages of the current full-length version.

4. Terms we use in the Contract

We have tried to avoid complicated jargon in both the full-length and the shorter-form Contract, but it is important that both are very clear about what has been agreed between the commissioner and provider. Where words or phrases or abbreviations we have used need explaining we have used a capital letter at the start. There is a glossary explaining all of these words, phrases and abbreviations at the end of the General Conditions section ("Definitions and Interpretation").

We use the term "Service User" instead of "patient" to be more inclusive of the different types of services that may be commissioned using the contract (such as those for residents of a care home).

5. Completing the Contract

The only section of the Contract which requires completion locally is the Particulars.

The key elements of the Particulars which should be agreed and completed locally are the Schedules. These describe what the provider is expected to do and how much it will be paid. The main sections to focus on are:

- the contract details, which are the basic details about the parties to the contract and how long the contract will run;
- the service specification, which describes the services to be provided (Schedule 2A);
- the financial schedules which set out the price for the services (Schedules 3A, 3B and 3C) and the overall expected annual value (Schedule 3F);
- the CQUIN scheme (Schedule 4D) (CQUIN stands for Commissioning for Quality and Innovation; it is a national financial incentive scheme for providers of NHS services); and
- any local quality standards (Schedule 4C) and reporting requirements (Schedule 6A).

It is important that commissioners make sure that only an appropriate level of detail is included in these schedules. If the schedules become too lengthy and complex, the benefits of a shorter contract will be lost.

6. Obligations on the service provider

All **specific local requirements** relating to the services to be delivered will be included in the Schedules listed above.

But, in the General and Service Conditions, the shorter-form Contract sets out a range of other **more general, nationally-mandated obligations** on the provider. These are generally less detailed than what is included in the full-length version – but this is still a contract for the provision of clinical healthcare services, after all, which needs to ensure safe, high-quality care for patients and value for money for taxpayers.

These general obligations include the following provisions on the safety and quality of care.

- 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 out high-level requirements in respect of clinical staffing (GC5), requiring sufficient appropriately registered, qualified and experienced staff to be available at all times, with systems in place for induction, supervision, training and professional development.
- The Contract requires providers to adhere to national guidance or requirements on specific service areas, such as infection control (SC21), safeguarding (SC32), the care of dying people (SC34) and the duty of candour (SC35).
- The Contract sets a small number of specific national quality standards which a provider of relevant services must achieve (Schedules 4A and 4B).
- 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), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16), safeguarding (SC32) 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).

Other more general provider responsibilities under the Contract include:

- creating, storing and retaining appropriate Service User Health Records and developing inter-operable IT systems (SC23);
- maintaining appropriate indemnity cover (GC11);
- responsibilities in relation to confidential information and information governance (GC20 and GC21); and
- responsibilities in relation to business continuity and emergency preparedness (SC30).

This serves to emphasise that providing NHS-funded services is a serious business, and any organisation which puts itself forward to do so will need to be able to demonstrate competence across this full range of responsibilities.

7. Payment

For contracts commencing from 1 April 2017, the shorter form Contract may be used with diagnostic, screening and pathology services, including where the National Tariff guidance sets a mandatory national price. The shorter-form Contract contains less detail on payment and does not require submissions to SUS. NHS Improvement publishes rules around the setting of prices for NHS-funded clinical services – the National Tariff. The commissioner and provider will need to follow these rules in agreeing the prices to be paid for the services provided – but they have considerable freedom to agree how payment is to be structured.

This can be on the basis of

- a simple block payment, fixed at the start of the year
- an 'activity x price' approach, with no guaranteed level of income for the provider, with this determined instead by the actual volume of services it provides
- other hybrid approaches involving marginal prices for additional activity above given thresholds or payment based in part on the achievement of specific outcomes or quality standards.

Whatever approach is taken, payment under the shorter-form Contract will be on a monthly basis. However, it can be either in advance or retrospective; commissioner and provider need to agree this at the outset and record it in the Particulars. So:

- If they agree an Expected Annual Contract Value (EACV) at the start of the year, then the provider invoices and the commissioner pays on-account monthly. Where payment is based on actual activity levels, the provider then submits reconciliation accounts to the commissioner, adjusting for any difference between the expected payment and the actual sum due.

- Where there is no agreed EACV (or the EACV is zero), the provider invoices retrospectively for activity undertaken, again on a monthly basis.

8. Managing the contract once it is agreed

The sections of the shorter-form Contract which deal with the management of the relationship between the parties are deliberately much more streamlined than their equivalents in the full-length version, reflecting the less complex nature of the services to be commissioned under it. Note in particular:

- SC29 (Managing Activity and Referrals): this describes the process through which the parties must monitor and manage activity levels, and agree actions to be taken when referrals or activity levels depart from the expected patterns.

- GC9 (Contract Management): this allows the parties to notify each other of any failures to comply with their respective obligations, and to agree the actions to be taken to rectify those failures and improve performance. If a provider is in breach of its obligations, its commissioner may be entitled also to suspend the services (GC16), to terminate the contract (GC17) and/or to recover from the provider the costs and expenses it incurs as a result of that breach (GC11).

- SC28 (Information Requirements): the provider must provide information and reports as specified in the contract and as requested by the commissioner. A failure to do so will be a breach of contract, in respect of which the provisions described above may be implemented by the commissioner.

- GC12 (Assignment and Sub-contracting): the provider may not sub-contract any of its obligations without the consent of the commissioner.

- GC13 (Variations): as explained in the NHS Standard Contract 2017/18-2018/19 Technical Guidance Appendix 5, only the locally-agreed content of a contract may be varied.

- GC21 (Patient Confidentiality, Data Protection, Freedom of Information and Transparency): the provider must comply with specified requirements including annual submission of an Information Governance Toolkit return, and minimum compliance at level 2 in all requirements. The information governance sections in the full-length Contract and the shorter-form Contract are the same, as the requirement for compliance is the same regardless of the size of the provider organisation or type of service. Please refer to Appendix 8 of the NHS Standard Contract 2017/18-2018/19 Technical Guidance, for further information.

9. eContract

Like the full-length Contract, the shorter-form Contract can be tailored and shortened by use of the NHS Standard Contract eContract system.

Including the provisions relating to mandatory national prices adds to the length of the Contract, so we strongly recommend that commissioners use the e-Contract functionality, to ensure that this additional wording only appears in those contracts where it is required.

Information on how to use the system is available in the eContract User Guide, and queries may be sent to england.econtract@nhs.net

10. Frequently Asked Questions

Why can't CCGs just draft their own contracts?

Regulations under the Health and Social Care Act 2012 allow NHS England to mandate the terms of commissioning contracts used by CCGs. NHS England does so each year by publishing the NHS Standard Contract. The benefits of this are that

- there is one standard set of contracting rules which everyone can understand;
- there is a level playing field, so that providers of the same services are working to the same terms and conditions; and
- there is less duplication of effort and expense in the local drafting of contracts.

Why does the shorter-form Contract have sections which are 'intentionally omitted'? Why is numbering of sections and schedules not always consecutive?

To help people to navigate the new shorter-form Contract, we have used the same numbering of sections and schedules as in the full-length version, even though some sections or schedules have been omitted. People have told us it will be helpful for there to be consistency across the two versions of the Contract in this way, as it makes managing contracts easier and means there is less likelihood of confusion when discussing different contracts. This does mean that, in the shorter form, some sections are marked with the words "Intentionally Omitted".

As a provider, can I insist that a commissioner uses the shorter-form Contract?

No. We will be encouraging commissioners to use the shorter-form Contract where it is appropriate to do so, and making it very clear to them when they definitely must not do so. But there will be circumstances where commissioners feel that there are good reasons to use the full-length version even if they are not absolutely required to do so – that is a matter for their judgement and discretion.

If I think that parts of the shorter-form Contract are inappropriate for my organisation and the services to be provided, can I insist that they are deleted or amended?

No. The content of the schedules is to be determined locally, and may therefore be a matter for negotiation with commissioners, but other provisions of the Contract are mandated by NHS England and must not be altered or deleted. If you have comments or queries on any of those provisions, please raise them with us via nhscb.contractshelp@nhs.net. We will not be able to agree to any amendment for 2017/18-2018/19, but we will take your comments into account for future iterations of the shorter-form Contract.

11. Help and support

You may find the following helpful:

NHS Standard Contract2017/18-2018/19 Contract Technical Guidance, published by NHS England.

Queries on the full-length and shorter-form Contracts and guidance can be sent to NHS England via nhscb.contractshelp@nhs.net

2017/18-2018/19 CQUIN guidance, published by NHS England.

Queries on the national CQUIN guidance can be sent to NHS England via e.cquin@nhs.net

Model grant agreement, guidance and Bitesize Guide to Grants published by NHS England

National Tariff, published by NHS Improvement and NHS England

eContract system

Queries on the eContract system may be sent to england.econtract@nhs.net

www.england.nhs.uk/nhs-standard-contract

nhscb.contractshelp@nhs.net

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