NHS Standard Contract 2017/18 and 2018/19

Video presentations - audio transcript

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Presentation 1 (approx. 20 mins) - Overview of the NHS Standard Contract

Slide number and approx. timing	Transcript
Slide 1 [00:00:30]	Welcome to our presentation on the updated NHS Standard Contracts for 2017 to 19. My name is Alastair Hill. I'm the lead for the NHS Standard Contract at NHS England, and you'll shortly be hearing from my colleague, Michelle Coleman. We've divided our presentation into three sections. In this first one, I'll talk a bit about the basic principles of the contract, what it's for, and when it must be used. I'll cover the difference between the traditional full-length version of the contract, and the new shorter-form version that we've issued for the first time in 16-17.
[00:01:00]	Then I'll say a little bit about grant agreements and sub-contracts. Then I'll hand over to Michelle, who will talk about the eContract system, about the range of supporting tools and publications we're providing alongside the Contract, and also something about where to go for advice and support. Finally in this section, Michelle will hand back to me to talk a little bit about processes for dispute resolution.
Slide 2 [00:01:30]	Moving on then. What's the Standard Contract for, and when should it be used? The NHS Standard Contract is the model commissioning contract which NHS England publishes for use by NHS commissioners, that's itself, and clinical commissioning groups when commissioning clinical services other than primary care. Use of the contract is actually mandatory. It's something we publish under the Standing Rules Regulations and CCGs must use it - it's not an option. But it's a flexible beast. The Contract isn't a straight jacket. It's got an awful lot of scope for local completion.
[00:02:00] [00:02:30]	The bulk of the Particulars, the schedules and the Particulars in the Contract are for local completion, and the Service Conditions in the Contract don't apply in a one-size-fits-all manner. They apply taking account of the service categories that have been selected. If you've selected acute services, you'll get one set of tailored Service Conditions, whereas if you've selected mental health services, for instance, then you'll get a slightly different set. It's not a one-size-fits all contract. But I would say it's really important for commissioners to remember: don't put in place your own locally drafted contracts or service level agreements instead of the standard contract; and don't change the mandated national wording that the Contract contains.
Slide 3	The Contract comes now in both full length and shorter-form versions, and I'd like to say a little bit about those and when to use

[00:03:00]	each one. The shorter-form version was a new product for 2016-17. It has the same structure and clause and schedule numbering system as the full-length version, but a range of the specific policy requirements on providers are omitted from the shorter-form, and the contract management processes in the shorter-form are much more simple. Those are the main differences.
[00:03:30]	The shorter-form version is intended for use when commissioning particular services only, and we'll come onto that on the next slide. It's aimed generally at services and contracts with a lower financial value. We've not set a specific threshold for that, but we're talking about using it when what's being commissioned is a single community-based service or a small package of such services, not for the complicated mix of services that a big NHS Trust might provide, say. Bear that in mind in terms of its use.
[00:04:00]	Overall, the idea with the shorter-form Contract is that it's both easier to understand and much simpler, less onerous for the provider to deliver. The idea of what we're trying to do here is to reduce, where we can, the complexity and burden involved in providers doing business with the NHS. This really is more about those small providers, the voluntary sector organisations, the non-NHS bodies like pharmacies or care homes or hospices, who aren't used to doing business so much with the NHS compared to big NHS Trusts.
Slide 4 [00:04:30]	To say a little bit more, then, about when to use which version. The full length version must be used in certain circumstances, particularly where what you're commissioning is acute or other inpatient services, mental health inpatient and secure services, cancer services, A&E, minor injuries, NHS 111, or ambulance services. For all of those, the full length contract must be used because only the full length contract contains the necessary provisions that relate to those services.
[00:05:00] [00:05:30]	On the other hand, the shorter-form may be used for commissioning any of the list on the right-hand side of this slide: Non-inpatient mental health and learning disability services, the full range of community services, end-of-life care outside an acute hospital, care home, care placements, diagnostic screening and pathology, and patient transport. You've got a pretty clear set of distinctions for when the short-form may be used and when the full length version must be used.
Slide 5	In general terms, the changes that we've made to the full length contract for 17-19, which we're going to come on to talk about later in our presentation, have been carried over into the shorter-form version where that's relevant and appropriate. Not all of them have, but some of them have. There's one significant design change to the shorter-form version which we've made for 17-19.

[00:06:00]	We've included the detailed provisions that relate to payment for services where there's a national price under the National Tariff Payment System. That's adding back quite a bit of text. The reason we've done that is to respond to feedback we've had which said with were artificially narrowing the situations in which the shorter-form contract could be used.
[00:06:30] [00:07:00]	Particularly, we were preventing it from being used where there were maybe relatively small contracts for community-based diagnostic services in place, where there is a national price (quite often) under the Tariff, and we were saying, "No, you can't use the shorter-form Contract for that because we haven't set it up to include the provisions of that national prices." That's the thing we've changed for 2017-19 in the shorter-form version. What I would say is, be careful about this. This doesn't mean that you can use the shorter-form version for commissioning acute services covered by national prices. It's not intended for that purpose, so please don't do that.
	Remember as well that the new wording we've added back into the shorter-form contract around national prices, it does make the contract that bit longer and that bit more complicated. Please do use the eContract system to tailor your contract documentation so that the national price wording only appears in those contracts where it's relevant and needed, and drops out and doesn't clutter up other contracts where it's not required.
Slide 6 [00:07:30] [00:08:00]	I'm going to say a little now about two other things, grant agreements and sub-contracts. With grant agreements, I suppose the main message is for commissioners to remember that they do have the power to make grants to voluntary sector organisations rather than necessarily always thinking they have to place a contract instead. There are some situations where a grant approach is likely to be more appropriate than using the Standard Contract, particularly, and this is the example that we often give, if a CCG is for instance contributing partially to the costs of a hospice, rather than commissioning the whole of the hospice's services and paying the full cost of those services, then that's the sort of situation where a grant agreement is probably more appropriate than the Contract. Bear that in mind. We do publish a model grant agreement, and we provide guidance with that, and they're both available on our website.
[00:08:30]	Then, sub-contracts. Well, the Standard Contract is a contract between the commissioner and the provider. It's not intended as a sub-contract or a provider to provider a contract. Providers, of course, can sub-contract under the NHS Standard Contract - they may choose to employ another organisation to deliver part of the services for them, basically, and the Contract sets out the rules on subcontracting at General Condition 12.

[00:09:00] [00:09:30]	In the past, we have made a template model sub-contract available for people to use, and we're planning to do that again for 17-19. It's not a mandatory form. Its use isn't required, but we do think it's a reliable way of passing down the obligations from the main commissioning contract, and making sure they appear as appropriate in any sub-contract. Do have a look at it. We'll be publishing that as soon as we can on the website, and for the first time, as well as producing a sub-contract to go with the full length version, we're also planning for this year to produce one to go with the shorter-form version of the Contract too.
Slide 7 [00:10:00]	Finally from me in this section, for now, a little piece about what we call non-contract activity. Stating the obvious, as a general rule, we'd expect commissioners to put in place a written contract in the form of the full length or shorter-form version of the Standard Contract whenever they commission a relevant clinical service from a provider. That's really regardless of how much the service is worth, or how long it's going to be provided for. The bottom line is, if you're buying a clinical service, you ought to aim to have a contract in place.
   [00:10:30]	However, there are clearly going to be situations where that doesn't work, and the provider does have to undertake some sort of patient care or treatment without there being a written contract in place with the CCG that is responsible for that patient. The most obvious example of that is when a patient is far from home on holiday, is taken ill, requires emergency admission to hospital somewhere two or three hundred miles from home, the chances are there won't be a written contract in place for that.
   [00:11:00]	That's the scenario we call non-contract activity. The thing I wanted to point you towards here is that the detailed arrangements around how non-contract activity is expected to be handled are set out in the Who Pays? Guidance, not in detail in our Contract Technical Guidance, but in the separate Who Pays? Guidance, and you can see the link to that on the slide.
   [00:11:30]	In particular, do look at paragraphs 38 to 46 of that guidance, which talk about the fact that the non-contract activity is carried out on the basis of the terms and conditions of the provider's contract with its local host commissioner. The requirements in that contract apply to non-contract activity too, and particularly the requirements in terms of the timescales for payment and reconciliation. I'm now going to hand over to Michelle, who's going to talk about the eContract and other matters.
Slide 8	Hello, my name's Michelle Coleman, and I work with Alastair Hill on the NHS Standard Contract team at NHS England. My job title is NHS Standard Contract Manager and Engagement Lead. The first

[00:12:00]	thing we're going to talk about is the eContract system, and then I'm going to talk about what we've published already on our website, and what is to come. Then I'm going to talk a bit about how you can find further help and guidance from the NHS Standard Contract team.
Slide 9 [00:12:30]	Starting with eContract. The eContract system will remain largely unchanged for 2017-19, as most stakeholders have told us that they like the simple and easy-to-use system. The system will host both the full length and the shorter-form contracts, and will remain essentially a document generation system. No log in or password is required to access eContract, and it can be used by commissioners and by providers alike. The eContract functionality is largely unchanged.
[00:13:00] [00:13:30]	A user works through a series of screens inputting some basic information and ticking boxes to indicate service categories and contract options. The system then generates a set of partially completed and tailored Particulars in Word, and a set of tailored Service Conditions in PDF. The user then saves these to their local drive and completes the population of the Particulars later, locally, or can create a contract template for later use. The system retains what were always intended to be the benefits of eContract, a quick and efficient way of creating tailored contract documents. The thing that's changed for 17-19 is the addition of national pricing for the shorter-form Contract.
Slide 10 [00:14:00]	The e-Contract URL is the same - there is it is on the slide. A user guide is presented on the portal so that you can work your way through it to create eContracts. Help and assistance is available through the eContract email address, and again, that is on the slide. eContract will go live as soon as possible following the publication of the Contracts. We'll also be providing training by webinar, and we'll email people separately about this once the eContract system is live.
Slide 11 Slide 12 [00:14:30]	Looking at publication, guidance and support – what have we published so far on our 17-18 web page? Obviously the final Contracts have been published, alongside the final Technical Guidance and the shorter-form User Guide. We've also published the model Collaborative Commissioning Agreements, the optional Pensions and Primary Care Schedules, and the Contract Management Forms. This video presentation (the slides, and the transcripts) are also available, as are the Local Variations Guidance.
	To come - obviously the eContract system is to go live, and that will host the User Guide on the same portal. The National Variations will be published shortly, as will the updated model sub-contracts

[00:15:00]	for use with the full length Contract and with the shorter-form Contract. New for 17-19, we'll be publishing the shorter-form Contract as an interactive PDF, designed as a training aid.
Slide 13 [00:15:30] Slide 14	For help and support, obviously there's a lot of resources available on our webpage, and that's the URL there. Have a look at the Contract Technical Guidance and at the shorter-form Contract User Guide. Also, have a look at the eContract User Guide which will be hosted on the eContract portal when it goes live shortly. If you have any queries on the NHS Standard Contract, they can be sent to NHSCB.contractshelp@NHS.net. Queries on the eContract system can be sent to England.econtract@NHS.net. Please do give us feedback on this video presentation - let us know what you thought and how it went down by emailing the contracts engagements email address which is England.contractsengagements@NHS.net. Now I'm going to hand back to Alastair, who's going to talk to you about dispute resolution.
Slide 15 [00:16:00] [00:16:30]	Thanks Michelle. As Michelle said, I'm just going to say a word or two about dispute resolution processes. Clearly, once you've got a signed and agreed contract, the dispute resolution procedure within that contract applies. If you fall out, then General Condition 14 of the Contract tells you how you handle a dispute resolution where you have a signed contract in place. There is a different scenario where what happens is that the commissioner and the provider are unable to agree a new contract where their old contract is expiring. That can be a difficult scenario in an NHS context because the option to walk away and simply not provide services for patients doesn't really exist so readily.
[00:17:00]	For that scenario, you can't use the dispute resolution process in the Contract because this is about a new contract that you haven't agreed yet. Instead, NHS England and NHS Improvement have published again for 17-19 a separate dispute resolution procedure relating to failure to agree new contracts. That's set out as an annex to the main planning guidance and the web link to it is on the screen.
[00:17:30]	As part of that process and time scale for the dispute resolution procedure, there's a deadline which you will all know, have engraved on your hearts already for contract signature - a very challenging deadline of the 23rd of December. Following that, then, the deadline for submission of paperwork into this joint arbitration process is the 9th of January 2017. That's a date to bear in mind.
Slide 16	A word or two about ways of minimising disputes, because of course, disputes are time consuming and their expensive, and you don't want to go down that route unless you absolutely have to.

[00:18:00]	The first thing to emphasise, really, is that if it comes to an arbitration under the joint NHS Improvement / NHS England procedure, the first point of reference for the arbitration panel is going the be, "What does the national guidance say about a particular issue in dispute?" Whether that's our Contract technical guidance, the National Tariff guidance, or the guidance on CQUIN schemes, the first thing the panel will be looking at is, "Are these people doing what it says in the national guidance?"
[00:18:30] [00:19:00]	A first piece of really strong advice would be anyone who's thinking about going into dispute on an issue: make sure you understand what the national guidance says, and that you're complying reasonably with that guidance. Otherwise, you're likely to lose. Where can you get advice on those sorts of technical issues? Well, as Michelle was saying earlier, there's an awful lot of that in our Standard Contract Technical Guidance which is available on the web site. If the Technical Guidance doesn't provide you with the answers, do email ContractsHelp email address. There are similar addresses and sources of advice and guidance on the slide now, relating to CQUIN and the National Tariff System.
[00:19:30]	If you approach any of those email address with a question and ask for an answer, you'll get a response. Do bear in mind that if a commissioner asks one question one way with one bit of backing information, and the provider asks a slightly different question a slightly different way, giving slightly different information, don't be surprised if you get slightly different responses.
	Again, a tip would be, where you can, try to make a joint approach. If you're clear about the issue that you're disagreeing about - if you can state it clearly to us from commissioner and provider combined - then we've got more chance of giving you one clear answer on the basis of a shared submission of evidence, as it were. I hope that makes sense as a way forward with dispute resolution.
Slide 17 [00:20:00]	That's the end of the first section of our presentation on the new Standard Contracts. Please do go on and look at the second and third sections where we'll talk about new policy requirements that have been included in the Contract, and aspects of using and managing the Contract in practice. Thank you very much for listening.

Presentation 2 (approx. 32 mins) - New policy requirements

Slide number and approx. timing	Transcript
Slide 1	Welcome back. I'm Alistair Hill. I'm lead for the NHS Standard Contact for NHS England, and as I say, welcome back to the second part of our presentation about the new Standard Contracts for 2017 to 2019.
	As I described before, the presentation's in three chunks, and in this second chunk we want to go through some of the new policy requirements that we've included in the Contract for the next two years.
[00:00:30]	I'll start by going through some of the changes that are particularly around the interface between secondary care and primary care. Then I'll hand back over to Michelle, who'll take you through some of the other main policy changes that we've included in the Contract as new requirements for next year, and finally, I'll say a little bit about service development and improvement plans.
Slide 2 Slide 3 [00:01:00]	The Contract says quite a lot now about the interface between primary care and secondary care, and why is this so important? This has been something we've been pushing in the Contract in both 16-17 and now for 17-19. Why is it so important?
	It won't surprise anybody if I say that GP practices are under a very considerable workload pressure, and NHS England is committed to helping to try to minimise the administrative burden on practices so that clinician time and administrator time can be freed up to best clinical effect.
[00:01:30]	Sadly, one of the key sources of avoidable extra work for practices is when secondary care providers organise things in a less than good way. If they don't organise patient care efficiently, or if they don't communicate well with patients or practices, that's when extra workload for practices can build up.
[00:02:00]	That's why we're taking action through the Standard Contract to try to bring hospitals particularly towards a better position in some of these areas, so that the way they're operating is both better for patients, and doesn't cause this extra workload, avoidable workload for general practice.

[00:02:30]	That's also why in July of this year a letter went from the top of NHS England and NHS Improvement to chief executives of Trusts and CCG accountable officers stressing the importance of fully implementing the new requirements around this area that we'd included in the Contract for this year, 16-17, so this is really important territory in terms of NHS England policy requirements.
[00:03:00]	I would say, though, that nobody is putting all of their eggs in the NHS Standard Contract basket in this respect. Everybody recognises that the Contract can help with some of this stuff but it's not the only answer. There's a working group made up of eminent people from national clinical organisations, the national medical bodies and colleges, which has been set up within NHS England and NHS Improvement involved to drive further action, not just through the Contract, to try to improve the interface between primary care and secondary care.
Slide 4	Then coming back to the detail of what's in the Contract. There are a number of requirements which are unchanged from 2016 and 2017 and it's worth going through those quickly.
[00:03:30]	The first of these is about local access policies. Local access policies generally set out how a hospital will deal with situations where a patient has an appointment but cancels, or DNAs. What the Contract wording is making clear is that the provider must publish a local access policy (which has always been the case under guidance), but that that policy must not have a blanket approach whereby any patient who DNAs for an attendance, for a clinic attendance, is automatically discharged back to their GP.
[00:04:00]	The situation has to be that that's a clinical decision made in the light of the individual patient's circumstances, so that the idea is we're not just seeing patients discharged back to general practice land who will automatically be re-referred, just creating an extra appointment in general practise to no real purpose. That's local access policies.
[00:04:30]	Then there are arrangements in the Contract about onward referral. These have been in place for some time, particularly as a control, I suppose, on the ability of the secondary care provider to refer patients on for extra treatment in an uncontrolled way that could potentially just generate more income for them. The Contract has always prevented providers from referring on patients for unrelated, non-urgent conditions, so conditions that aren't related to the reason for the original referral. In that situation, you have to refer back to the GP, because the GP may decide that that can be dealt with in a different way, can be dealt with locally in the practice or doesn't need referral. So that's still the case.

[00:05:00]	What we changed in the Contract for 16-17 was to emphasise the reverse, I suppose, that where you have a referral that is related to the reason for the original referral, so you're trying to refer someone on to the next step in a logical care pathway. In that situation, there's no need to refer back to the GP. The hospital can simply make that referral. There's no need to put an extra step in the process and make the patient go back to see their GP again in order to get that onward referral.
[00:05:30]	The third area on this slide is a relatively simple one about GP feedback, making sure that hospitals take account of GP feedback and involve GPs when they're thinking about how they design their services. Again, a fairly straightforward and unsurprising inclusion.
[00:06:00]	Finally, on this slide, we included some new requirements for the 16-17 Contract about medication that's given to patients when they're discharged from inpatient or day case care in hospital. We worded this very carefully, to say that the medication to be supplied must be for whatever period is set out in local protocols or in established in local practice, but it must at least be for a minimum of seven days. So setting a minimum standard, not preventing you from having an agreement which was for a longer period than that.
Slide 5 [00:06:30]	Then, moving on to things that we've added or changed for 17-19 then. The first of these relates to "fit notes" which, if you're slightly less than au fait with the terminology, you might still think of (as I do) as "sick notes". Anyway, hospitals are required to offer fit notes to patients where they need them, and that's been the case under Department of Work and Pensions Guidance for many years. We've simply reflected that guidance more clearly into the Contract now, but it's worth pointing out what we're trying to achieve here.
[00:07:00]	Basically, what we're trying to avoid is a situation where the hospital doesn't bother doing a fit note for a patient when it could, and instead the patient then has to traipse back to the GP surgery as an extra visit to get that fit note there and then. We're not saying that hospitals should call patients in for extra appointments simply for the purpose of getting fit notes. This is about offering fit notes in the course of normal care and treatment that you would be doing for the patient as part of the patient's care pathway.

[00:07:30] [00:08:00]	Then moving on to discharge summaries - the next area on the slide. A lot of this was in the Contract prior to 16-17, but the basic requirement is that providers must issue discharge summaries for every patient discharged from in patient or day case care within 24 hours of discharge and they must do so electronically to the practice and using a structured message format with standardised clinical headings.
[00:08:30]	What changes for 17-19 is that this requirement is extended to cover discharges from A&E (and that comes in from October of 2018), and also, that the whole set of requirements for transmission of discharge summaries and clinic letters (which we'll come on to) moves from being an option between doing that by email or by direct electronic transmission. From October 2018, it becomes direct electronic transmission only.
	Those are important changes for discharge summaries from acute hospital care but it's worth saying as well that if, as commissioner, you want to specify discharge communication requirements from other services, community services say, we don't mandate that through the Contract's national wording but you can set that out locally in Schedule 2J, the Schedule with Transfer and Discharge Protocols.
Slide 5 [00:09:00] [00:09:30]	We then come onto clinic letters where again there was provision within the 16-17 Contract which we have tightened for 17-19. An important difference here between clinic letters and discharge summaries. A discharge summary has to be provided for every patient. We're not saying that that's the case with the clinic letter. There are situations where a clinic letter won't be needed but where there is information which the GP needs, needs to access quickly in order to manage the patient's ongoing care, that's the situation where the provider must provide a clinic letter to the GP.
[00:10:00]	Now in the 16/17 Contract, the timescale for that is within 14 days of the attendance and that's what's reducing in the 17-19 Contract. So the requirement from April 17 is for that to be done within 10 days, and then from April 18 it falls to 7 days and, as I said before, the requirements moves to being one to transmit by direct electronic transmission from October 2018 using, again, structured message format and standardised headings.
[00:10:30]	The point about the delayed timescale from some of this is that for clinic letters and A&E discharges, the standardised clinical structure still needs to be finally developed and published, so that's why there's a gap, if you like, in the implementation timescale for those requirements.

	The next point is about medication following clinic attendance and we've added new provisions here which are about requiring the hospital provider to supply medication to the patient following clinic attendance if the patient has immediate needs.
[00:11:00]	Now, again, we've said that that should be for the period set out in any local protocol or established in local practice but it must at least be sufficient to cover the patient to the point at which the clinic letter is going to reach the GP, because what we're trying to prevent is situations where the patient runs out of medicine that the hospital's prescribed after four days, goes along to their GP surgery asking for a new prescription, and the GP hasn't yet got the clinical advice from the hospital consultant saying what needs to be prescribed. That's going to be a wasted appointment in primary care that they can well do without.
[00:11:30]	Finally on this slide then, a different requirement this time on the commissioner side of the equation, a new requirement around commissioners trying to make sure that GPs supply proper accurate referral information with every referral (patient contact details, other clinical and administrative information that's needed).
Slide 7 [00:12:00]	Finally on this section, two more points about how care is organised and communicated to GPs and patients, and how queries are dealt with.
	The Contract sets out a clear requirement on the provider to organise the different steps in a care pathway in a logical and efficient manner, and to communicate this clearly to patients. It's particularly important that test results and the results for treatments in the investigations are notified by the hospital to the patient, direct rather than expecting the practice, the general practice, to be the middle man for that process.
[00:12:30] [00:13:00]	Then similarly on patient and GP queries, we've strengthened the Contract wording in this area quite a bit for 17-19, making clear that we're expecting hospitals to have efficient arrangements in each service for dealing with queries from patients and from GPs, and for publicising those arrangements so everybody knows who to contact about what,. And particularly, that in dealing with queries from patients, hospitals deal with them themselves rather than referring something the hospital knows the answer to and should be dealing with, referring it to the general practice and saying, "Go ask your practice about this" - because the practice probably won't know the answer.

	Please follow those points in how you organise communications with patients and handling of queries.
Slide 8	I'm now going to hand over to Michelle who's going to take you through some of the other new policy requirements in the Contract for 17-19.
[00:13:30]	Thanks, Alistair. This section of our presentation deals with other new policy requirements which were included in the 17-19 Contract.
	The areas that I'm going to talk through are all the things that are included in the full length contract. Where relevant, they're also included in the shorter-form but in many cases it was not felt that that was necessary.
Slide 9 [00:14:00]	One of the most important areas of these new policy requirements refers to the use of the E-Referral System. So, the NHS E-Referral System. Ever since the instruction of choose and book and its successor, ERS, the key goal in policy terms has been to maximise the number of GP referrals made on the electronic system rather than on paper.
[00:14:30]	This isn't just about the benefits of going digital. It's also because the use of ERS is much more likely to prompt GPs to have proper discussions with patients about their choice of preferred provider, and choice remains another key national policy.
[00:15:00]	Uptake of the ERS is being incentivised by two complementary national policies over 17/18 and 18/19. Firstly, for 17/18, there's a national CQUIN indicator and this will incentivise providers to maximise ERS slot availability during 17-19. The goal behind this is to get as close as possible to the 100% uptake of ERS for GP referrals by March 2018.
	From October 2018, the Contract then introduces new requirements on ERS, at Service Condition 6. Our original proposal in the draft Contract was that providers would no longer be paid for activity resulting from referrals made by GPs other than through ERS, but that equally providers would be able to return such referrals to GPs.

[00:15:30] [00:16:00]	This proposal generated a lot of feedback during consultation and we've made some changes as a result. The key changes are to clarify two points. Firstly, that non-payment relates to the first out-patient attendance following any non-ERS GP referral. Secondly, that guidance will be issued on referral and return and non-payment, with the Contract wording explicit that the provisions will operate in the context of this further guidance.
	This means that we will be able over the coming months to clarify the policy aspects on which there were most feedback. These were: whether there should be specific exemptions to the referral return and non-payment approach; how to return referrals to be managed to ensure patient safety; and whether there should be specific services or scenarios where use of ERS for all GP referrals would not be mandated.
Slide 10 [00:16:30]	The next area to cover is around standard for seven day services in hospitals. The seven day services standards were announced some years ago, but we've always recognised that most hospitals are not in a position to achieve them all. For several years, this has been an area where we've required a service development and improvement plan (an SDIP) to be agreed locally, setting out what would be done within the available resources to move towards compliance.
[00:17:00]	For 17-19, we're moving away from the SDIP approach. Instead, for the first time, compliance with the four key priority standards is becoming a Contract requirement at Service Condition 3. However: this is only for providers of the specific services listed on the screen; it is only in relation to those specific services; and it is only from the 1st of November 2017. But all hospitals are required to complete the National Seven Day Services Self-Assessment and to share a copy of this with their commissioner.
[00:17:30]	Another really important area is around discharge from care. We've strengthened the requirements here in a number of ways, all set out in Service Condition 11 and in the associated Definitions. The most important change is in Service Condition 11.2. This already set out a best effort requirement on the provider, to do everything it can to avoid circumstances which are likely to lead to emergency re-admissions.
[00:18:00]	We've amended this in two ways for the 17-19 Contract. First, we've turned it into a requirement on the provider and on each commissioner. Second, we've made it about supporting safe, prompt discharge from hospital as well as avoiding re-admission.

[00:18:30]	Best efforts is a strong statement so the Contract does now give providers an explicit lever which they can use if they believe that inaction by commissioners is causing delayed discharge and knock on effects in hospital services. Otherwise, on discharge, it is worth noting that we have significantly updated the definition of the transfer and discharge guidance and standards which the provider must comply with.
[00:19:00] [00:19:30]	This now refers to two recent NICE guidelines, NT27 and NT53, Dealing with the Transition Between Acute or Mental Health Inpatient Care and Community or Care Home Settings. The Transfer and Discharge Guidance and Standards also refer to statutory guidance published in respect of the Care Act and to the new information standard, SCCI2075, around the use of assessment, discharge and withdrawal notices between hospitals and social services. Also, the Transfer and Discharge from Care Protocol, which is agreed locally and is included at Schedule 2J to the Contract, must now include content based on the national template policy, which is supporting patients' choices to avoid long hospital stays.
	Links to all of these guidance documents can be found in the relevant definitions at the back of the General Conditions.
Slide 11 [00:20:00]	I'm now going to talk about a number of other new but relatively small scale requirements in the 17-19 Contract. The first of these are around self-care and coordinated care. We've included new requirements in these two areas at Service Conditions 8 and 12 respectively. They're both quite high level, but we think they set a reasonable expectation for what a good provider should be doing.
[00:20:30]	On self-care, the requirement is around supporting patients to develop the knowledge, the skills and confidence they need to take increasing responsibility for managing their own ongoing care. On coordinated care, the aim is to insure that the provider's staff work effectively and efficiently together across professional boundaries, so that patients experience coordinated, high quality care without any unnecessary duplication of process.
Slide 12 [00:21:00]	The next change is on Education, Health and Care Needs Assessments. These are joint assessments for children and young people with special educational needs and disabilities, which providers of clinical services are often asked to input into. Existing legislation requires providers to respond to such requests for input within six weeks, but the evidence is that his standard is often not being met locally. To remind the providers of the importance of complying, we've included this as a new Contract requirement as Service Condition 10.

[00:21:30]	The next change is about the Workforce Disability Equality Standard, or WDES. This is another case of the Contract referring to a new requirement which will come into force in the future, rather than on the 1st of April 2017. The Contract already includes a requirement for providers for implementation of the National Workforce Race Equality Standard. As recommended by the Equality and Diversity Council, a new National Workforce Equality Standard, for disability, is now being developed. The Contract includes a requirement on providers to comply with this from April 2018.
Slide 13 [00:22:00]	The next change to highlight relates to managing conflicts of interest. As people know, NHS England has just completed a consultation on new system-wide guidance on the management of conflicts of interest and gifts and hospitality. The final guidance is expected to be published shortly and the Contract requires compliance with this at General Condition 27.
[00:22:30]	The final change in this section is a wider public health provision relating to food and drink sold on NHS premises. The Contract already requires the provider to have regard to, or when mandatory, comply with what we term food standards guidance. This includes the Government Buying Standards, which set out a range of mandatory and best practise requirements in relation to healthy eating and drinking options and environmental factors. We've extended this for 17-19.
[00:23:00]	When a provider is negotiating contractual arrangements under which a tenant or equivalent will sell food and drink from the provider's premises, then the provider must firstly ensure that the contractual arrangements require the tenant to provide and to promote healthy eating and drinking options including outside normal working hours, where relevant. Secondly to adopt the full range of mandatory requirements and the Government Buying Standards - and note that this applies to the mandatory requirements only and not the best practice ones.
Slide 14 [00:23:30]	The next group of new provisions I want to come onto relate to the various aspects of data and information technology. So firstly, data security and information governance. The Department of Health is expected to publish the final standards shortly, along with guidance on implementation, and the Contract requires providers to be able to demonstrate compliance with the new standards, over time, in line with the detailed requirements to be set out in that guidance.

[00:24:00] [00:24:30]	This is another example of where, within the context of the two year Contract, we're having to refer forward slightly to those new standards and guidance which will apply, but which haven't yet been published in their final form. The wording on this is at General Condition 21. Similarly, the recommendation in the National Data Standards is that the current information governance toolkit should be replaced in time by new data security toolkit. There's some wording on this in General Condition 21 which now refers to providers demonstrating satisfactory compliance with the IG toolkit or any successor framework. Just to be clear on this - the wording "satisfactory compliance" is carefully chosen, because this is how the current IG toolkit describes Level 2 compliance. The requirement under the Contract remains for providers to be able to demonstrate Level 2 compliance with the current toolkit until such time as it is replaced.
Slide 15 [00:25:00]	Moving on, we've included a new requirement in Service Condition 23 on data sharing agreements in relation to urgent and emergency care services. Detailed guidance on this requirement has now been published. It's available via the 17/18 Contract web page. The whole point of this new provision is that commissioners need to be able to analyse service use utilisation and effectiveness across all providers in the whole system, and that's what the data sharing agreements, which have been successfully trialled in parts of the country already, are all about delivering.
[00:25:30] [00:26:00]	There are two new requirements in Service Condition 23 on IT. The first is on the HSCN (or Health and Social Care Network), and the second is on interoperable IT systems. N3 is a system which runs the NHS E-Referral Service, for instance, and most providers operating in the contract at the moment will already have an N3 connection. But N3 is getting old and is being replaced by a new approach, to be known as Health and Social Care Network. This will be a different arrangement - whereas N3 is a single supplier system, HSCN will allow providers of clinical services to select from a range of different network suppliers, all operating through the same core specification.
[00:26:30]	The process of the transition over the next two years or so, from N3 to HCSN, needs to be managed carefully and for that reason, we've included a broad requirement on providers to collaborate with NHS Digital on the procurement and implementation process.

[00:27:00]	The second requirement is on interoperable IT systems. The Contract already includes requirements which relate to ensuring that new clinical IT systems are procured with open interfaces, so that they're able to exchange data with other systems in other providers, subject to the right IG safeguards, of course. Interoperability of systems will be crucial for the sharing of clinical data in the future, so in the 17-19 Contract, we firmed this current requirement. It's now a requirement for each provider to ensure that all of its major clinical information technology systems enable key clinical data fields to be accessible as structured information through open interfaces to all other providers of services to service users.
[00:27:30] [00:28:00]	Three things are worth pointing out about this new requirement. Firstly, further detailed technical guidance will be published, describing the clinical data which needs to be shared and the format to be used. Secondly, this requirement only kicks in from January 2019, so there's a lot of time to prepare for this implementation. Thirdly, colleagues who lead on IT assure us that this is not about providers buying whole new IT systems. It should be possible at relatively low cost to bolt on interoperability capability onto existing systems in most cases.
Slide 16 [00:28:30]	Finally, it's worth pointing out two new changes which are more about how the Contract operates than about new service policy issues. The first of these is about CQUIN, the national Quality Incentive payment scheme. In the past, there's been a specific schedule for CQUIN variation to be recorded in the Contract. That is, situations where the commissioner and the provider had agreed not to apply particular nation CQUIN indicators, but to use a CQUIN payment to incentivise something different.
   [00:29:00]	The national guidance on CQUIN for 17-19 has now been published. You can find it via the Contract webpage, and it now no longer allows this sort of flexibility. So the wording on CQUIN variation (which used to be in Service Condition 38) has been removed from the Contract, as has Schedule 4G where variations were recorded.
	The CQUIN guidance does make clear that for very low value contracts, where agreeing a specific CQUIN scheme would be more trouble than it's worth, the commissioner can instead simply agree to make the CQUIN payment in full to the provider. We used to suggest that, where this was agreed, that it was recorded within the old CQUIN variation schedule. That has now been deleted and we suggest that the main CQUIN schedule is used instead. That's CQUIN Schedule 4D.

[00:29:30] [00:30:00]	The second point, and the last one this section, is about interest on late payments. Obviously, prompt payment in line with the timescales set out in Service Condition 36 is a requirement of the Contract. The Contract has always contained provisions under which interest is payable on late payments, and this has in the past been set at 2% on top of the basic LIBOR rate. It's been pointed out that this is out of line with current guidance from the Department of Business Innovation and Skills, so we've updated the wording. But late payers be warned - this now means that the interest rate applied to base rate plus 8%, applies to late payments.
Slide 17	Now, I'll hand back over to Alistair who's going to talk about service development and improvement plans.
Slide 18	Thanks, Michelle. So, as Michelle said, I'm just going to say a word or two about service development and improvement plans.
[00:30:30]	SDIPs, as we call them, can express actions that are agreed between the commissioner and the provider that either party is going to take, aimed at improving any aspect of the services, and they can be agreed and included in the contract locally at any stage, at the beginning or during the contract. Once they are in the contract they are binding, so only sign up to an action in an SDIP if you expect and are prepared to be held to account for it.
[00:31:00]	SDIPS are a local tool in that way, but they're also a national one. So as we've said once or twice along the way already, our guidance does sometimes require certain things to be set out in local SDIPS on particular topics or particular services.
Slide 19	For 2017 to ‘19 that national focus is shifting to two particular areas, and these are the two where we're expecting commissioners to agree SDIPS in their contracts with their major local providers.
[00:31:30]	The first of these is that territory I was talking about earlier in this section of the presentation, about the secondary / primary care interface. We're saying that a local SDIP should set out actions that the parties can take locally to make organisation at that interface more efficient for patients, for GPs and for hospital staff.
	That's about local actions - but it's also about specifically making sure there is full implementation of the requirements that we've nationally put into the contract, and that they're fully delivered. That's one element of SDIP.

[00:32:00]	The other one (which is quite different) is around moving towards smoke-free premises, and this applies specifically to providers of acute, maternity and mental health services. If those providers aren't smoke-free already, they need to be setting out in an SDIP what action they're going to take so that by December 2018, their premises, grounds, vehicles are all entirely smoke-free, as required in NICE guideline PH48.
Slide 20 [00:32:30]	That's the end of the second section of our three part presentation. Thank you very much for listening to it. Please do now have a listen to the final third section, where we talk about various aspects of how to use and manage the contract in practice.

Presentation 3 (approx. 24 mins) - Contract management

Slide number and approx. timing	Transcript
Slide 1 [00:00:30]	Welcome back to our presentation on the NHS Standard Contracts for 2017 to '19. My name is Alastair Hill. I'm lead for the Standard Contract at NHS England. In this third section of the presentation, we're going to be talking about aspects of using and managing the Standard Contract in practice. In particular, I want to go through some of the implications of the two-year contract approach that's been taken nationally for 2017 to '19; to talk about the way we've changed the arrangements in the Contract for prior approval schemes; to talk a little bit about management of counting and coding changes; and finally to talk about how the sustainability and transformation fund interfaces with the Contract in terms of the application of financial sanctions under the Contract. That's the plan for this section.
Slide 2 [00:01:00] [00:01:30]	Starting off then with the two-year contract approach, and I'd like to think about this first of all from the national point of view. The national planning guidance makes clear that all the key NHS business rules have been set for a two-year period, from April '17 through to March 2019 - and that's the Contract, that's the national tariff, that's the CQUIN, that's the overall planning priorities for the system. The underlying idea of this is about giving the NHS greater long-term stability and clarity, so there's less need for organisations to adapt from year to year to a new set of rules, and more scope for them to focus on meaningful long-term change and improvement to services.
[00:02:00]	This has given us some food for thought in terms of producing a Standard Contract to cover this two-year period, and also doing so earlier than we have done in the last two years in terms of producing it by November rather than maybe by March (which has been the case in the last couple of years). The result of this is that our Contract is now different in a couple of ways. It's placing slightly more reliance than we would have done previously on policy or guidance or advice that are still to be published. For example on conflicts of interest, on data security standards or on e-Referral, we're always referring forward to guidance that is still to come.
[00:02:30] [00:03:00]	Equally, the Contract more than in the past introduces some requirements on a staged basis over the two-year period, so they don't all kick in from 1 April 2017. For instance, the requirements on clinic letters and discharge summaries are staged over the two years. So the Contract will look and feel slightly different as a result of that from how it has been in the past. We've done the very best we can to future-proof the Contract by scanning for policy requirements that we need to know about now and that we need to include now, but I have to say it is possible that we may, over the next two years, need to issue a national variation, to update the contract if there is some

	pressing new requirement, a significant new piece of legislation that we need to take account of, or a particularly important new policy development. We may have to do that, and of course, we'll consult on that if that proves to be necessary.
Slide 3 [00:03:30]	Then thinking about two-year contracts and contract duration from local perspective - it's a long time ago now that the Standard Contract had a default duration of a single year. In recent times, contract duration has been a matter for the local commissioner to decide at local level at its discretion. There was no default contract term or mandatory upper limit that we were setting nationally. Multi-year contracts do have real benefits. They can offer greater stability, and many of the contractual processes actually work more effectively over that longer time span.
[00:04:00] [00:04:30]	Equally, it has to be said, there are some situations where a shorter duration of contract is going to be more appropriate - where a new service is being piloted, say, or where some big procurement is underway and an existing service is only needed until such point as that new procured service kicks in. You have to choose your length of contract for the situation you're contracting for, obviously. Now, the expectation in the national planning guidance is generally that commissioners will be offering two-year contracts to cover the whole two-year period, '17 to '19. The national process for managing the contract round through the contract tracker returns will focus on the bigger contracts, those with a value of a £5 million threshold.
[00:05:00]	They'll be the ones that we'll be, if you like, monitoring in terms of the contract tracker return, but there's no reason why that two-year contract / longer-term contract approach shouldn't also apply for all the large number of smaller value contracts below that threshold, that won't get near being reported on the contract tracker. It's important to say though that this isn't an absolute requirement for every single contract to be offered on a two-year basis. Some commissioners will have existing multi-year contracts, say, they might be just entering the third year of a contract that they agreed two years ago. It's fine to let that contract run for a further year, and then decide to do what you want to do after that when it's expired.
[00:05:30] Slide 4 [00:06:00]	Equally, a commissioner may be thinking about procuring a new multi-specialty community provider, say, model for 2018/19, and therefore only wants to put a one-year contract in place for the first year of our two-year planning period. Both of those things are fine. Just make sure that you're considering whether to be offering a longer term contract, and only really defaulting back to a short contract if there's a good reason to do so. Then to come on to what two-year agreements can realistically cover - which is likely to be a vexed issue locally, I suspect. Commissioners and providers are going to need to balance, on the one hand, trying to

[00:06:30] [00:07:00]	achieve as much clarity as they can at the outset of their contract negotiation, so that their contract is as clear as possible about what applies for the whole two-year period, that on the one hand - with on the other hand, recognising that in some cases, they're probably going to need to update their contract and vary it from year to year. As for instance, with acute contracts, we'd anticipate that it would be possible for a commissioner and provider to agree definitively at the point of contract signature, the local prices that would apply for the full two-year period, and the CQUIN scheme that would apply for that period. Those should be possible to agree and put to bed. Equally, it's probably possible to agree indicative activity plans and expected contract values for each of the two years as well, at that same point of agreeing the contract by December. But to be honest, it's likely that any indicative activity plan for the second year, and therefore the contract value that goes with it, is going to become out of date.
[00:07:30] Slide 5 [00:08:00]	Activity values don't always stick to what people have planned - things change. The likelihood is that to keep the contract relevant and accurate, the commissioner and provider may well need to agree a variation to introduce a revised indicative activity plan or contract value for year two. That's the sort of example of what we're thinking could be agreed up front, but what also might need to be revisited as you go through the contract period. Do remember, a multi-year contract is not static. There is likely to be some need for a process of updating through variations as you go from year to year. The next area I want to talk about is prior approval schemes in contracts, which is an area where we have made a number of changes for 17/19.
Slide 6 [00:08:30]	What are prior approval schemes? They're a means through which commissioners can give contractual effect to their commissioning policies, policies that set out the basis on which patients should be able to access particular services or treatments. At the simplest level, prior approval schemes simply set a framework within which the provider must work. A prior approval scheme for Treatment X says that, "These are the access criteria and the provider just has to treat patients who meet those criteria." Fine.
[00:09:00]	At a more complicated level, and this is typically, or should be typically where we're talking about access to quite high cost and unusual treatments, a prior approval scheme may mean that the provider needs to submit detailed information in advance about a particular patient to the commissioner, and the commissioner will then make a decision on that individual patient basis whether to approve treatment or not - and treatment doesn't start until that approval is given. The arrangement for prior approval schemes are set out in Service Condition 29 of the Contract, and in summary, they are that prior approval schemes are notified by the commissioner to the provider, either in advance of the contract year, or the new schemes can be

	introduced in-year or changes to schemes can be brought in on one month's notice.
[00:09:30] Slide 7 [00:10:00]	That's how the technicalities of prior approval schemes work in the Contract. What have we changed in the Contract provisions in this area for 17/19? There are four changes overall set out over the next two slides. The first two on this slide relate to the burden which prior approval schemes can have, the administrative complexity which they can cause for providers. The first one is to say that in introducing or deciding whether to introduce or change or keep a prior approval scheme, the commissioner has to have regard to that burden that it's going to place on the provider.
[00:10:30]	Commissioners, think about what the benefit is you're expecting from a particular prior approval scheme. Are you confident that it's going to be a genuine benefit in terms of delivering more appropriate access to services, and have you designed it in a way that keeps that burden on the provider, the administrative side of things, to a minimum? Similarly, so the second change is around a requirement on commissioners to use reasonable endeavours to minimise the number of separate commissioner-specific schemes that they have in relation to any particular condition or treatment in one contract, because this can be a source of significant burden and complexity for the provider, trying to manage multiple different schemes for the same treatment.
[00:11:00] Slide 8 [00:11:30]	Now, we're not saying that all commissioners under a contract must sign up to a single scheme. That would infringe on the commissioner's ability to set its own commissioning policies. That's what they're there to do. We are saying they have to make the effort to try to collaborate and minimise the number of separate schemes, minimise the difference between them, so that we keep the burden for the provider in reasonable bounds. Two more changes around prior approval schemes which have a slightly different focus. The first of these is about making sure that the operation in practicing prior approval doesn't cause undue delay in patients accessing treatment. It will cause some, but it mustn't cause undue delay, and it mustn't put at risk the achievement of national waiting time standards, for instance. That's a fairly common sense requirement.
[00:12:00]	The second one is around introducing a standard for response times to prior approval requests. Now, the Contract used to say that these should be set out in each individual scheme, and we've changed that. We think it's more straightforward for that to be set out once for the contract as a whole, so you now need to note that response time standard within the Particulars of your contract.

Slide 9	The third area I want to touch on in this section of the presentation is around the vexed topic of managing counting and coding changes. That is, changes in the way in which activity (patient treatment) is recorded.
Slide 10 [00:12:30] [00:13:00]	Now, I'm not going to say a huge amount about this, but the arrangements for managing counting and coding changes are set out in Service Condition 28, as they always have been, and they are primarily relevant where we're talking about services which are funded on an activity x price basis at national prices. We've not changed the provisions in the Contract for 17/19. What they say, at a very simplified level, is this. Potential changes that either party wishes to make have to be notified six months in advance, by the 30th of September in any year. The changes are then discussed between the parties in the context of what the national rules say, that is the NHS Data Dictionary, national guidance on clinical coding - do those rules say that this is the right thing, change to make? We will be complying better with national guidance if we change our current recording practice.
[00:13:30] [00:14:00]	If a change is agreed in that context, then it should be implemented from the following 1st of April. This is then the big thing - the financial impact of an agreed change is then neutralised between the parties by a payment adjustment for the whole of that first contract year. If you notify a change by 30th of September 2016, it would usually (if agreed) be implemented from the 1st of April 2017. Its financial effect is neutralised for the whole of 17/18, and then the full financial effect has its impact from the 1st of April 2018. None of that has changed.
   [00:14:30]	However, we are aware that this whole area of counting and coding changes can generate significant disagreement locally, difficulty of interpreting the rules and so on. We have therefore significantly expanded the section of our Contract Technical Guidance with this, this is Section 44, that deals with this area, trying to pick up the consistent themes of the questions that we've been asked over the last year or two on this subject. Please do read this new guidance carefully. We hope it will answer your questions, as will the illustrative case studies we've included in Appendix 6 to the Guidance. If you are then still stuck, do please approach us. We're happy to try to answer questions on this. Email us via the ContractsHelp email address.
Slide 11 [00:15:00] Slide 12 [00:15:30]	Finally, saving the best for last, the last topic to cover is contract sanctions in the context of the sustainability and transformation fund. The arrangements here continue broadly as in 2016/17, so where trusts accept the offer of funding from the STF, and the conditions that are associated with that, then the application of certain financial sanctions under the Contract will be suspended. The difference between our position for 17/19 and where we were when we published the 16/17 Contract in March, is that the process this year is already

[00:16:00]	much more advanced. NHS Improvement has published indicative guidance already on the new system for 17/19, and it's made specific offers to trusts of the STF funding they're being offered, and the associated financial control totals they would be expected to deliver. Trusts have until the 24th of November to respond to those offers.
[00:16:30] [00:17:00] [00:17:30]	What are the conditions that apply for contract sanctions to be suspended? First of all, the provider must, in respect of either 17/18, or 18/19, or both, have accepted the offer of funding from the general element of the STF. That's one. Secondly, it must have signed up to, for the relevant year or years, a financial control total – that's its aiming point for the level of surplus it's going to make, or deficit it's going to make, for the year in question. Those two things are given. Then the provider must agree a mix of performance trajectories or assurance statements. These need a bit of explanation. A performance trajectory would only ever be required in relation to one of three national standards – the 18 week RTT standard, the four-hour A&E wait standard and the 62 day cancer standard. As the name 'trajectory' suggests, it's a statement of your monthly intended performance against that standard. It's saying, "We won't be meeting the national standard from the start of April 2017, but our plan is to improve our performance gradually over the months of the year and hit that standard at 'Point X'. That's a performance trajectory. The second one is that the provider must have accepted and signed up its financial control total - that's the financial performance that it will deliver for the year in question, a level of surplus or deficit. And then the provider must have must have agreed a mixture of performance trajectories and assurance statements with NHS Improvement.
[00:18:00] Slide 13	So, that's a performance trajectory. An assurance statement is much simpler – it's simply the provider saying, "We commit to delivering the national standard in full." That's the mix that is needed. In some cases, providers have existing trajectories that say they're not going to be able to deliver full compliance with all the national standards by the end of 16/'17, so that's the situation where performance trajectories are likely to be needed. In all other cases, it's likely to be assurance statements. Which are the sanctions that are affected by these suspension arrangements then? This all relates to standards that are set out in schedules 4A and 4B of the Contract, and the standards that are affected are A&E waits, so four hours but also 12-hour trolley waits, RTT (referral to treatment time) waits, so the 18-week wait but also 52-week waits and six-week diagnostic waits. Cancer 62-day waits, as I said, and then the three ambulance response time standards and

	the ambulance handover and crew clear standards.
[00:19:00] [00:19:30]	All of those sanctions would be suspended in the event of a provider meeting those criteria that I outlined on the previous slide about access to the STF. Also, it's really important to point out that there can be financial consequences for a provider under the contract management provisions of the Contract, that's General Condition 9, as well as under the specific sanctions in Schedules 4A and B. Those provisions in GC9 in terms of financial withholding are also suspended under the terms of the sanction suspension under STF arrangement. The detail of how this is done within the Contract is set out in two places, Service Condition 36.37A and General Condition 9.26. That's where to look for the detailed wording that contractually makes this happen.
[00:21:00]	The net effect of that whole arrangement is that any individual provider will either, if it's failing to deliver required performance against standards, it'll either face withdrawal by NHS Improvement of its STF funding, or it'll be outside the STF arrangements and it'll face contract sanctions by its commissioner if it's missing national standards. But no provider will face the double jeopardy of both. That's the intention of the sanction suspension arrangement.
Slide 14 [00:21:30]	What does this mean in practical terms for how you manage contracts locally? The expectation is that performance trajectories and assurance statements (which should be confirmed and published by NHS Improvement by no later than March next year), that those things should be recorded in local contracts in an SDIP, and we've published a specific template for that that's available on the website. What this means is that the performance trajectories and assurance statements do become contractual obligations on the provider because they're in an SDIP in the contract.
[00:21:00] [00:21:30]	Commissioners, of course, can't apply financial sanctions in relation to those, but they can hold the provider to account for delivery and they can also assist the provider with doing everything they can to help ensure that those performance trajectories and assurance statements are delivered and complied with. Now, clearly, there are a lot of fingers in the pie here with commissioners and providers, with NHS England and NHS Improvement local teams, and it's going to be helpful if there is at local level joint discussion between all those different parties about how progress is monitored, and how any remedial action is discussed and agreed to avoid duplicatory or contradictory processes. So we would encourage you at local level to try to take that approach.
Slide 15 [00:22:00]	That brings us to the end of the three-part presentation, about the new standard contracts for 2017 to 19. Thank you very much for listening to us. As these are not face-to-face workshops, you haven't had to endure our normal quota of bad jokes, so we hope you're duly grateful. Please do feed back to us about how you felt this

	presentation worked by giving us an email to the ContractsEngagement inbox. Thanks again for listening and good luck with your contracting endeavours for the forthcoming contracting round.