NHS England

Draft NHS Standard Contract 2020/21

Audio presentations - transcript

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1 Presentation 1 (approx. 30 mins) - Introduction to the Contract

Slide 1

Hello everybody, and welcome to our presentations on the draft Standard Contract for 2020/21. My name is Alistair Hill. I'm the lead for the Standard Contract at NHS England and NHS improvement and I'll be delivering these presentations with my colleagues, David Savage and Michelle Coleman.

So we're publishing these presentations now, in January 2020, and the idea is to try to explain the changes we're proposing for next year so that you can see what those main changes are, have a chance to give us feedback, and also understand some more about what's staying the same in the Contract for 20/21 as well.

Slide 2

You can see on this slide that we're planning to present four separate presentations and the slide outlines the content of the four separate shows we're running, as it were. So this particular first one, which I'll be delivering with Michelle, gives you a basic introduction to the Contract, what the Contract is, how it's to be used, what for, when, etc. So it's a reminder of the fundamentals of what the Standard Contract is about.

The second presentation (which will be delivered by David) is about using the Contract in the context of today's NHS, which is all about local collaboration at system level, commissioners and providers working together to deliver joined-up integrated services for their local populations. And David will be talking about how the Contract can be used to promote that sort of integrated, joined-up working.

The third presentation (which will be a triple act involving all three of us) will cover the new national policy initiatives (or at least the main ones) we're including in the Contract for 2020/21.

And finally, we'll do a presentation around national standards and what we're loosely calling the NHS business rules for the next year. This will be one which I'll be doing and it'll cover things around access standards, financial sanctions, the National Tariff, dispute resolution and so on. We hope you find the presentations helpful and do remember that you can feedback comments or raise queries with us via the different email addresses which we'll be showing later in the presentations.

Slide 3

What is the NHS Standard Contract? Well, it's the form of commissioning contract mandated for use by NHS commissioners, that's CCGs and NHS

England, for all of their health care commissioning contracts other than core primary care. And you can find details of everything to do with the Contract on our website, the link to which is shown on the slide.

Worth remembering for now and we'll come back to all of these points in more detail, the Contract comes in two main versions, the full length version and the shorter-form version.

Slide 4

We've had a Standard Contract, a standardised approach to contracting in the NHS for many years and it's worth reminding ourselves of why. Why is that a good idea? And from the perspective of national bodies (the Department of Health and Social Care, NHS England, NHS improvement), one of the key benefits of having a Standard Contract is it gives a way of helping to get local implementation of national policy priorities. If we include requirements on providers in the NHS Standard Contract, it gives more chance of getting those things to happen in practice at local level. So that's one reason.

But there are also more local benefits in that sort of standardised approach as well.

Having a Standard Contract gives one set of rules which (hopefully) everybody will understand across the system.

It gives a level playing field for the different types of provider that operate in the NHS.

And it also gives economies of scale in terms of producing contracts and taking legal advice. There's no point in every CCG in the country having to pay lawyers to develop contract terminology and language if we can do it once nationally in a way that works for everybody.

So those are some of the reasons why we have the Standard Contract.

Slide 5

But the Contract is a balance between national and local content. There are some elements which we set nationally and these are shown on the slide here, what we would call the legal boilerplate to the contract (the content which any self-respecting contract needs to have). Stuff around payment, around how you manage performance under the contract, how you deal with disputes, how you make variations, how you suspend services, how you terminate the contract. All of those things are written once into the Contract at national level.

Similarly, the Contract sets out certain national quality standards and reporting requirements, typically things taken from the NHS Constitution or other key national policy documents. Things which every provider of a particular service must deliver. So the Contract at that level is specifying national requirements.

But there's an awful lot of scope in each contract for local negotiation of local detail. We're not saying from the centre who must contract with whom for what service. And that inevitably means that there's a great variation in what needs to be in each local contract. So the service specifications for the range of services a provider is providing for instance - they have to be locally defined. The prices that they're being paid for services, if they're not national prices for acute services set out in the National Tariff - then they need to be locally negotiated and locally expressed in the contract.

And similarly, for many services, where there aren't national quality requirements, you need to think about local quality standards (how do you measure what makes a good service for the service your commissioning and what reporting do you need to ensure that you know how well the service is being delivered). So it's really important to think of the Contract as a balance between national and local.

Slide 6

To help deliver that, the Contract remains/continues to be structured in three main sections. So, first, there are the General Conditions, and these set out terms which apply in all contracts in the same way. And that's mostly where we set out what we described before in terms of the legal boilerplate elements.

Then there are the Service Conditions. Now, these again set out national terms but which apply where specific services are being commissioned. So, for instance, there may be some Service Conditions that apply only to acute services, others that apply only to mental health services, others that apply to ambulance services, and so on.

And finally, then, there are the Particulars of the Contract. Now, this is largely for local completion. The Particulars set out who the contracting parties are to a particular contract, what the duration of the contract is going to be, and they include all the key local schedules that allow you to set out specifications, prices, reporting arrangements and the like.

It's also worth a word or two about terminology in the Contract, and particularly our use of what we call defined terms. These are words or phrases that you'll see in the Contract documents which are capitalised and start with capital letters. Whenever you see one of those, that's what we call the defined term and that means that it has a definition and all the definitions are listed at the rear of the General Conditions. If in doubt, always remember to look up what a defined term actually means. Don't assume you know it - look it up in the list at the back of the General Conditions.

Slide 7

Hopefully it's coming across that this isn't a one-size-fits-all approach of a straight jacket national contract that has to be the same in all respects for every local scenario. Yes, the General Conditions are the same in each contract.

The Service Conditions and Particulars can vary in terms of their contract content, depending on the specific services being commissioned.

What that means is that we can engineer a position where provisions in the national drafting of the Contract (particularly in the Service Conditions) that aren't relevant in a particular local context, simply don't apply.

And that's what we call tailoring of the Contract, tailoring to suit local circumstances. And this tailoring approach works in two ways. One is around the use of what we term service categories to say which services are within scope of a particular contract. And then the other relates to the use of the electronic contract system or eContract, which Michelle will be talking about a bit later on in this presentation.

Slide 8

This slide shows the list of different service categories that we use in the Contract for 20/21. They're reasonably self-explanatory. The way the service categories work are that you select in the Particulars of the Contract from a list which ones apply, and which ones don't apply, in your particular contract. You can select as many or as few as are appropriate. It will often be appropriate to include quite a number of these different service categories. A DGH contract, for instance, might include acute, A&E and cancer services.

One thing perhaps worth pointing out is that the community services service category is a pretty broad one. Fundamentally, that's for out of hospital services that don't have any other obvious home in terms of these service categories. So if in doubt, if it doesn't belong anywhere else, and it's an out-of-hospital service, count it as a community service.

Slide 9

So the Contract is a flexible beast. You can adapt it locally in the ways we've been describing to reflect local circumstances, local needs. But there are some limits, there are some things you must not do and must not change. And it's worth us explaining what those are.

So you mustn't remove wording from the General Conditions of the Contract. Nor must you remove wording from the Service Conditions other than through the tailoring process we've just described.

Equally, don't substitute amended wording, put your own version in replacing what's been nationally drafted, or add in additional wording to the General or Service Conditions.

If you need to say something extra, if you need to go beyond what the core terms of the Contract say (and you probably will in many situations), then you do that by using the schedules to the Contract, in the right schedule for whatever it is you want to say. If you need to talk about pricing, then put it in the local prices

schedule, etc. But do remember the particular catch-all schedule we have for what's neatly termed 'other local agreements, policies and procedures' - that's schedule 2G. That's our catch-all schedule where you can put something that just doesn't fit anywhere else.

But when you're thinking about content for the schedules, do remember that you can't use the schedules to override the national elements of the Contract in the General Conditions in the Service Conditions. There's a clear order of precedence set out in General Condition 1: what's in the General Conditions takes overall precedence; then what's in the Service Conditions; and finally, what's in the Particulars. If you write into the Particulars, for example, something which contradicts or seeks to override the payment provisions in Service Condition 36, or the dispute resolution provisions in General Condition 14, what you've written into the Particulars will have no effect. It won't be binding, so don't do it.

Slide 10

It's worth reminding ourselves that use of the Contract is mandatory rather than optional. The Standing Rules Regulations passed in support of the Health and Social Care Act give NHS England the legal power to publish, model commissioning contract terms, and say that if we do publish them, CCGs must use them. So using the Standard Contract is not optional, it's a legal requirement.

Slide 11

But when precisely do you use it? So this is coming back to explain a bit more about what I touched on in the earlier slide. Well, you use the Standard Contract for commissioning any healthcare service other than core primary care. What does mean? Well, a healthcare service is usually pretty clear cut - you know what it is when you see it. There are some calls around the margins of what is a health care service and what isn't. A good rule of thumb is probably to look at whether the CQC is going to regulate it as a service, is it going to be subject to CQC inspections, and the like? If in doubt, you can always ask us for our view on whether a particular contract needs to be contracted for using the Standard Contract or whether an alternative form of contract would do.

In terms of core primary care - what do we mean? Well, we're referring there to the separate contractual arrangements which are nationally put in place for primary medical care for general practice, for primary dental care, for optometry, and for pharmaceutical services. All of those four services have their own national contracts put in place at national level and you don't use the Standard Contract when you're commissioning those services. However, do bear in mind that sometimes CCGs choose to commission additional local services often referred to as Enhanced Services from those primary care providers. Now, when that happens, you do need to use the NHS Standard Contract. Those Enhanced Services aren't covered by the core service national contracts. You use the Contract for health care services other than primary care, you use it for any type

of provider. It's not just a contract to be used with NHS Trusts and Foundation Trusts - it's regardless of the provider type.

And you use it for any value or duration of contract. So obviously, you want a written contract if you're talking about a five-year contract for £500 million for a huge package of services for your population. But you also want a written contract if you're talking about a pilot service that's going to run for six months for £50,000 - each of these need their own appropriate form of contract. For the latter, you might be talking about using the shorter-form version, which Michelle will say more about later. But do remember that you want a contract in place for all of those scenarios.

And finally, on this slide, just remember there are no circumstances in which commissioners should be drafting their own local alternative forms of contract or SLA. If you're contracting and commissioning healthcare services other than core primary care, the Standard Contract is what you use.

Slide 12

Who can be party to an NHS Standard Contract? On the commissioner side, you can have one single commissioner, but you can also have multiple commissioners party to the same contract. These can be a group of CCGs, but the Standard Contract can also be with NHS England as commissioner, and potentially with local authorities (if they wish to be involved and if their NHS partners are happy that they should be). So on the commissioner side, you can have multiple players signing up to a contract

But on the provider side, there is only a single provider organisation which is responsible for providing services to the commissioners. The provider can take many different organisational forms. An NHS trust and NHS Foundation Trust, a charity, all those different potential forms of company - but it does need to be a legal entity which can hold the contract. Now the provider can, of course, choose with the commissioner's permission, to sub-contract elements of service provision to other organisations, but it remains responsible to the commissioners for the delivery of the range of services under the contract.

Slide 13

It’s worth saying a little bit more about that collaborative contracting approach, where multiple CCGs or commissioners more generally sign up to or are party to the same contract with a single provider.

This is an approach which we do strongly encourage, because it saves everybody time, and it avoids the confusion and bureaucracy of having multiple separate contracts knocking about the place. Instead, you can deal with multiple commissioners to provide a relationship through a single contract, which helps everybody.

But to make this work, commissioners need to do two particular things. One is to put in place a collaborative commissioning agreement between them, signed by them, setting out how they will work together to make the contract work in all of their interests. And we provide a model version of that sort of CCA, as we call it, on our website.

The other thing they then need to do is identify one of their number to act as what we call the coordinating commissioner under the contract, and I'll say a bit more about that role on the next slide.

It is important to remember, if you're involving a local authority in these sorts of collaborative contracting and commissioning arrangements, that does tend to make things more complicated. Our model CCA is probably aimed more at use within the NHS. It's a non-legalistic document. If you start involving local authorities in collaborative commissioning arrangements,you may find you need more formality in the inter-commissioner agreements. You may end up going down the track of Section 75 agreements on pooled budgets and lead commissioner arrangements, and so on. So do bear that in mind if local authorities are part of the mix.

Slide 14

To say a bit more than about the role of the coordinating commissioner under the Contract. This is a really important role where there are multiple commissioners and you must identify one of the commissioners, as I say, as coordinating commissioner in the Particulars of the Contract.

And the way this works in the Contract is that each individual commissioner still has some specific responsibilities, duties, entitlements of their own under the contract. I've put two examples on the slide here. One around making, validating and contesting payment under Service Condition 36, and the other one around initiating and resolving disputes under General Condition 14. So those are things which an individual commissioner can do itself.

However many of the other contract management actions under the Contract fall to the coordinating commissioner to initiate and undertake on behalf of the commissioners collectively. And this includes, for instance:

- managing provider performance under General Condition 9 - that's to do with issuing contract performance notices, agreeing and overseeing remedial action plans, and all that sort of stuff.
- agreeing and approving proposed subcontractors and the actual subcontracts under General Condition 12 - that's something which falls to the coordinating commissioner to do.
- proposing and agreeing variations to the contract- again, a coordinating commissioner action.

- suspending services, terminating the contract or any individual services - again, something that only the coordinating commissioner can do, not an individual commissioner.
- And, finally, notifying prior approval schemes to the provider.

A prior approval scheme in the Contract is a scheme through which access by patients to particular services is controlled either through a set of criteria which patients must meet in order to access a particular service, or through a specific prior approval arrangement where the case has to be reviewed by, say, a CCG panel and approval given for the provider to treat.

Those sorts of prior approval schemes have to be notified to the provider by the coordinating commissioner, not by any individual commissioner.

Where it's just one commissioner under the contract, that commissioner is automatically going to be the coordinating commissioner. But, in situations where there's multiple commissioners, making sure that the coordinating commissioner carries out its role in a way which is on behalf of everybody, not just for its own benefit, is clearly a really important thing. And that's where the collaborative commissioning agreement that we described before comes in in terms of the way in which the different commissioners are going to work together, and particularly how they will hold the coordinating commissioner to account for its management on their behalf of the contract.

Slide 15

Since 2016/17, the NHS Standard Contract has been published in two versions, the full length version and the shorter-form version.

Use of the shorter-form Contract is determined by the type of service being commissioned.

It can't be used for acute, cancer, accidents and emergency, NHS 111, emergency ambulance, or any hospital inpatient service.

But it can be used for non-inpatient mental health services, for any community services (including those provided by GP practices, pharmacists, optometrists, and voluntary sector bodies). It can be used for hospital care, end of life services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services, and for patient transport. The circumstances in which the shorter-form Contract can be used are not affected by the type of provider, or the contract value or duration. Its use is only determined by the type of service being commissioned.

Its use is at the commission's discretion. But we do encourage commissioners to review their contracts, and to see what types of contracts could be moved to the shorter-form version when they are next retendered.

The shorter-form Contract is much shorter than the full length version. It's 84 pages long compared to 210 and is lighter touch than the full length Contract.

It's less onerous in terms of performance requirements on the provider and contains less detailed contract management processes.

Moving onto the NHS grant agreement - remember that the grant agreement is not a contract, and it can't be used in circumstances where the use of the Contract is mandated. It can only be used by CCGs when they are awarding a grant to a voluntary organisation. A CCG would do this when the CCG wishes to support the activities of the organisation, because they complement the services that the CCG commissions. For example, the CCG may award a grant to contribute funding to support a hospice's activities. The grant agreement is not a mandated template - it can be changed to suit local purposes, and it is available with guidance in its use at the link on the slide.

Slide 16

We're updating the eContract system in line with the 20/21 Contract, and it will be available at the link towards the bottom of the slide as soon as possible after the final version of the Contract is published.

As in previous years, the eContract system will host both the full length and the shorter-form Contracts and there are no changes to its functionality. It's very easy and very intuitive to use, and it really only does take five minutes to create a set of Particulars and Service Conditions.

A user goes onto the system and to some basic information such as commissioner and provider details, and ticks boxes to select which service categories are applicable to the contract. Based on these selections, the system then offers the user the choice of using the full length or the shorter-form Contract, and the user then selects their contract options such as indicative activity plan, planning assumptions, et cetera. The system then generates a set of Particulars and Service Conditions which are partly completed and are tailored for the services being commissioned. This means that any term in the Contract which are not applicable to the services are automatically removed by the system, resulting in a shorter and more relevant contract.

The user then saves the contract to their local drive and completes the Particulars for issue to the provider, along with the tailored Service Conditions plus the General Conditions.

A user can also create a template on the system which the user can rerun to run off contract documents time and time again. For example, if you have a lot of very similar care home contracts, you can create an eContract template using the same service category and contract options, and run off a new contract at any point. The eContract system is really very easy to use and the user guide is available via the portal. Queries and issues can be directed to the eContract helpdesk - the eContract help desk email is available on the slide.

Slide 17

Contract duration and national variations. Where the commissioner is awarding a new contract from the 1st of April 2020 onwards, they should just use the 20/21 Contract.

But where you have a contract, the end date for which is beyond the 31st of March 2020, you must update it by way of national variation. So, as usual, we will be publishing national variations and guidance alongside the new Contract for commissioners to use when updating these ongoing contracts. Please do read the guidance when it is published as a few ways in which you can enact a national variation and the guidance sets out these options step-by-step.

We're publishing a 12 month contract for 20/21, but you can of course award a contract for a longer duration if you wish to do so. Please just remember that any such contracts will need to be updated in line with each new Standard Contract - so a multi-year contract would need to be updated for the 1st of April 2021, the 1st of April 2022, and so on. More information is available in the Contract Technical Guidance sections 17 and 19.

One thing to watch out for this year - we may need to issue an in-year national variation during 20/21 to give effect to the clinical review of standards. If we do this, the variation will be published on our website, along with guidance for commissioners and providers to use.

Slide 18

Before we finish this presentation - a word or two about the help and support that's available to commissioners and providers out there in terms of using the NHS Standard Contract. And some of that is set out on this slide here. Our website, first of all, that important link hosts the full length and shorter-form versions of the Contract, the Contract Technical Guidance and various other publications that we've been referring to along the way, including the model collaborative commissioning agreement, the model subcontracts and guidance and in due course, things like the national variation documents and guidance, and so on.

The website also hosts the model grant agreement and guidance which we refer to in the presentations.

There are a number of different email help desks run by NHS England and NHS Improvement covering the Contract, the eContract system, CQUIN, Who Pays? queries about the responsible commissioner, and the National Tariff. All of those email inboxes are shown there, and you're welcome to submit queries to them.

Slide 19

It's worth a plug for our Contract Technical Guidance specifically. This is a really comprehensive document setting out detailed advice on use and interpretation of

the NHS Standard Contract, and more broadly on commissioning and contracting in the NHS at a general level. The slide sets out some of the main areas the Technical Guidance covers, and we really do recommend that it's something you use as a source of information and reference, in terms of helping to give you the answers to the queries which we often receive.

Slide 20

It's worth remembering that our Contract consultation (our consultation on the draft Contract for 2020/21) is still ongoing, and you are welcome to feed back your views on the different changes we're proposing to the Contract for next year, and you can do this in two ways, as set out on the slide.

You can do it by an online survey, which is available via a web link shown there on the slide.

Or you can do it using a template response document, a Word document, which you can then email to our ContractsEngagement inbox. and we really do hope you will take the opportunity to feed back to us.

The Contract consultation closes on Friday the 31st of January.

We'll then spend time reviewing all the consultation responses and we'll publish the final version of the contract on the website as soon as we can after that.

Slide 21

To conclude then - thank you very much for listening to us, and do remember that you can feed back to us on whether these presentations have been helpful. Just drop a line to our ContractsEngagement email address. And also remember there are three other presentations besides this one, which you're welcome to dive into on the NHS England / Improvement YouTube channel as and when you've got the time. Thanks for listening.

2 Presentation 2 (approx. 18 mins) - Local system collaboration and integration

Slide 1

Hello everybody, and welcome to our presentations on the draft Standard Contract for 2020/21. My name is Alistair Hill. I'm the lead for the Standard Contract at NHS England and NHS improvement and I'll be delivering these presentations with my colleagues, David Savage and Michelle Coleman.

So we're publishing these presentations now, in January 2020, and the idea is to try to explain the changes we're proposing for next year so that you can see what those main changes are, have a chance to give us feedback, and also understand some more about what's staying the same in the Contract for 20/21 as well.

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Slide 3

The first thing I'm going to cover is what we're calling the System Collaboration and Financial Management Act, or SCFMA. Members of an integrated care

system or a system transformation partnership need to work together to achieve both their system financial improvement trajectory, which they've agreed with NHS England and NHS improvement, and indeed also longer-term financial balance for their system.

Our expectation for 20/20 and 20/21 is that every CCG, NHS Trust and NHS Foundation Trust within an ICS or STP will sign up to, and act in accordance with, an SCFMA.

You'll see we've added a new Service Condition at 4.9 which requires the provider to be and to remain a party to its local SCFMA and act in good faith and cooperation with the other parties to it in accordance with its terms. We've also added an additional condition precedent at Schedule 1A requiring the local SCFMA to be signed before service commencement under that contract. You'll note that NHS England will also sign each SCFMA. It isn't a party to the system financial improvement trajectory, but NHS E commissioning spend will have a bearing on the local system's financial position. So it's important that NHS England can listen to local discussions and can contribute its own views and intentions.

Slide 4

Each local SCFMA should complement broader collaborative arrangements likely to exist already at ICS or STP level. These will typically involve a wider set of partners including, perhaps, relevant local authorities and other provider organisations from the independent and voluntary sectors. For example, local system plans which would cover operational matters. We'll look at those a bit more later.

A key aim of each local SCFMA is to promote collaboration across the NHS organisations within the local system in the delivery of the system financial improvement trajectory for the coming year, and of the sustainable management of NHS finances in the longer term.

When we talk about collaboration here, what we mean is there being shared objectives, openness and transparency between the parties, and collective decision-making about the use of system resources.

Slide 5

We've published a model SCFMA on our [NHS Standard Contract webpage](#).

It's not intended to be a mandatory template. Local systems are encouraged to use it as a starting point, but are free to adapt its contents as they feel appropriate, building elements of it into existing local agreements. So, in other words, we're not expecting people to tear up what they've already agreed and are already implementing, but rather perhaps to use the template we've published to supplement what they've already agreed.

What's really key is that each ICS and STP must have in place an agreement which meets the minimum requirements set out in the Contract definition of an SCFMA, namely:

- that the agreement describes the collaborative behaviour expected of the local parties;
- requires open book accounting by, and financial transparency between, the parties;
- describes processes for reaching consensus and resolving disputes about how best to use the system's financial and other resources;
- sets out a mechanism for management to the aggregate financial position of the parties to achieve, and maintain the system financial improvement trajectory for the local system.

Our model SCFMA provides more detailed suggestions for what should be covered in each of these areas. So I strongly suggest you have a look at that and discuss it within your local system.

Slide 6

The SCFMA also provides an opportunity to address, locally, how commissioners will decide on reinvestment of any funding that they withhold through contractual sanctions applied to local trusts, or indeed of any element of unknown CQUIN funding. And that can be informed by discussions that the commissioners have with their SCFMA partners.

What this means is that reinvestment of those funds can be considered locally under the SCFMA regime with all relevant parties at the table, rather than being a matter overseen by NHS England and NHS Improvement, as in 2019/20.

Slide 7

It's important that nothing within any local SCFMA compromises patients' right to choice, or seeks to prevent or deter the parties from complying with their responsibilities under the various regulations which govern procurement and competition within the NHS.

Most Trusts will ultimately be party to just one local SCFMA, but it is important to note that some, particularly ambulance Trusts for example, may need to sign up to more than one, because the footprint they cover covers more than one SCFMA area.

Agreeing the terms of an SCFMA will be a challenge for some systems. We acknowledge that. Partners within each system should do all they can to ensure that an SCFMA is agreed and signed alongside each local commissioning contract.

But where local organisations can't agree their SCFMA by the national deadline for contract signature (currently scheduled for 27 March), this should not delay signing contracts.

Slide 8

SCFMAs are is a part of wider moves towards greater system-level accountability, collaboration, and cooperation.

All of these are in support of the Triple Aim set out in the Long Term Plan of better health for everyone, better care for patients, and sustainability for the NHS locally and throughout England.

Each ICS and STP has to produce a local system plan, setting out locally agreed actions to deliver Long Term Plan commitments and local improvements.

For last year, we introduced a new SC4.6, requiring commissioners and providers to use all recent endeavours to contribute towards the implementation of local system plans in support of that Triple Aim. And we introduced the new Schedule 8, in which parties could set out specific obligations for the commissioner and / or the provider derived from those local system plans, so that each could be held to account and performance managed by the other parties under their contract for delivering their agreed contributions.

Slide 9

Local system plans may not have been sufficiently developed this time last year to make full use of Schedule 8, but they definitely should be by now. And so we would expect that parties to local contracts would use Schedule 8 to its full potential this time round.

We provided notes in Schedule 8 to the Contract to give you an idea of what could be covered. For example:

- specific actions for parties derived from local system plans, which perhaps might cover integration with other providers and services;
- actions which commissioners will take to ensure that other providers play their part;
- cooperation in respect of specific patient groups or patient pathways.

You'll get the point that what Schedule 8 should cover is primarily operational, rather than financial, matters.

Slide 10

We'll now come on to the area of primary care networks, and what providers of Community Services might contribute towards what primary care networks are doing locally, particularly how they might work together to deliver new national service models for anticipatory care and enhanced health in care homes.

In January last year, NHS England and GPC England agreed a document called Investment and Evolution, which is a five-year GP contract framework.

That framework commits additional funding through core GP contracts and through a new network contract DES, or direct enhanced service, as part of a commitment to a £4.5 billion rise in spending on primary care and community services by 2023/24.

A cornerstone of the new framework is the creation of primary care networks, or PCNs, through a new network contract direct enhanced service, in addition to the core GP contract. If a GP practice opts to take on the DES, and delivers the requirements set out in that specification, then it gets paid extra money.

Seven new service specifications will be added to the DES by April 2021. These must all be delivered by PCNs. They support delivery of the Triple Aim (improving health and saving lives, improving the quality of care for people with multimorbidity and helping to make the NHS more sustainable). And they're supported by a strong clinical evidence base and they complement each other. Delivering one enables the delivery of the other specifications.

Slide 11

The specifications for enhanced health in care homes and for anticipatory care will be delivered in partnership with providers of community services. These service models will include requirements that are phased in over the next four years.

These models can only be delivered by an integrated multidisciplinary team, drawing staff from both general practice and community services providers.

It's important that primary care and community services providers act as equal partners in delivery of these new service models, holding joint responsibility for delivery of the services and the model of care they comprise.

Slide 12

Over the summer and autumn of last year, NHS E and NHS I convened expert working groups to produce service descriptions for enhanced health in care homes and anticipatory care.

Drawing on the work done with those expert working groups, we plan to incorporate community services requirements into the NHS Standard Contract for next year, for inclusion in contracts for providers of services which have a role to play in the delivery of those specific service models.

Slide 13

The draft Contract, in both its full length and shorter-form versions, sets out brief proposed wording in Service Condition 4 which refers, in general terms, to the service descriptions, with service -specific detail then contained in the new

Schedules 2Ai and 2Aii, which align closely with the content of the published service descriptions document.

It's important to note that not every provider of services in the community will have a role to play in delivery of these models. The intention is that CCGs will indicate in their relevant contracts whether the provider in question is, in fact, to be involved in the delivery of the enhanced health in care homes and / or the anticipatory care models. And if so, in partnership with which primary care networks it is to do so, and in the delivery of which particular specific requirements.

The commissioner would then supplement those headline requirements with specific locally determined service obligations, which ideally would be co-designed with the PCNs and community services providers as necessary.

Slide 14

We'll continue to develop and refine proposals through the annual GP contract negotiations with GPC England, and in response to feedback from engagement activities that we've been carrying out over the last couple of months. That engagement exercise has now closed. But if you wish to provide further feedback or raise questions, you should do so to the email address we've set out in the slide.

The final NHS Standard Contract requirements in relation to the role of community services providers in delivery of these models will be confirmed on the basis of that engagement exercise, and any further feedback we receive via this consultation.

Further implementation support will be provided between the time that the GP contract is agreed and the implementation of the relevant service models.

Slide 15

You'll note, of course, that alignment and cooperation with primary care providers through primary care networks is a developing theme.

For 19/20, we introduced a requirement for providers of community services to use reasonable endeavours to organise and deliver their services so as to integrate effectively with local PCN configurations.

For the coming year, we've added a similar requirement for providers of community mental health services for adults and older adults.

Those providers must use reasonable endeavours to agree with their local PCNs by 31 March 2021, local arrangements for integration of those community mental health services with compeimentary services being provided by the practices which are members of those local PCNs.

In other words, what the party should be doing during the coming year is to plan for more integrated delivery from 21/22 onwards.

Slide 16

Before we finish this presentation - a word or two about the help and support that's available to commissioners and providers out there in terms of using the NHS Standard Contract. And some of that is set out on this slide here. Our website, first of all, that important link hosts the full length and shorter-form versions of the Contract, the Contract Technical Guidance and various other publications that we've been referring to along the way, including the model collaborative commissioning agreement, the model subcontracts and guidance and in due course, things like the national variation documents and guidance, and so on.

The website also hosts the model grant agreement and guidance which we refer to in the presentations.

There are a number of different email help desks run by NHS England and NHS Improvement covering the Contract, the eContract system, CQUIN, Who Pays? queries about the responsible commissioner, and the National Tariff. All of those email inboxes are shown there, and you're welcome to submit queries to them.

Slide 17

It's worth a plug for our Contract Technical Guidance specifically. This is a really comprehensive document setting out detailed advice on use and interpretation of the NHS Standard Contract, and more broadly on commissioning and contracting in the NHS at a general level. The slide sets out some of the main areas the Technical Guidance covers, and we really do recommend that it's something you use as a source of information and reference, in terms of helping to give you the answers to the queries which we often receive.

Slide 18

It's worth remembering that our Contract consultation (our consultation on the draft Contract for 2020/21) is still ongoing, and you are welcome to feed back your views on the different changes we're proposing to the Contract for next year, and you can do this in two ways, as set out on the slide.

You can do it by an online survey, which is available via a web link shown there on the slide.

Or you can do it using a template response document, a Word document, which you can then email to our ContractsEngagement inbox. and we really do hope you will take the opportunity to feed back to us.

The Contract consultation closes on Friday the 31st of January.

We'll then spend time reviewing all the consultation responses and we'll publish the final version of the contract on the website as soon as we can after that.

Slide 19

To conclude then - thank you very much for listening to us, and do remember that you can feed back to us on whether these presentations have been helpful. Just drop a line to our ContractsEngagement email address. And also remember there are three other presentations besides this one, which you're welcome to dive into on the NHS England / Improvement YouTube channel as and when you've got the time. Thanks for listening.

3 Presentation 3 (approx. 38 mins) - New national policy initiatives included in the draft Contract for 2020/21

Slide 1

Hello everybody, and welcome to our presentations on the draft Standard Contract for 2020/21. My name is Alistair Hill. I'm the lead for the Standard Contract at NHS England and NHS improvement and I'll be delivering these presentations with my colleagues, David Savage and Michelle Coleman.

So we're publishing these presentations now, in January 2020, and the idea is to try to explain the changes we're proposing for next year so that you can see what those main changes are, have a chance to give us feedback, and also understand some more about what's staying the same in the Contract for 20/21 as well.

Slide 2

You can see on this slide that we're planning to present four separate presentations and the slide outlines the content of the four separate shows we're running, as it were. So this particular first one, which I'll be delivering with Michelle, gives you a basic introduction to the Contract, what the Contract is, how it's to be used, what for, when, etc. So it's a reminder of the fundamentals of what the Standard Contract is about.

The second presentation (which will be delivered by David) is about using the Contract in the context of today's NHS, which is all about local collaboration at system level, commissioners and providers working together to deliver joined-up integrated services for their local populations. And David will be talking about how the Contract can be used to promote that sort of integrated, joined-up working.

The third presentation (which will be a triple act involving all three of us) will cover the new national policy initiatives (or at least the main ones) we're including in the Contract for 2020/21.

And finally, we'll do a presentation around national standards and what we're loosely calling the NHS business rules for the next year. This will be one which I'll be doing and it'll cover things around access standards, financial sanctions, the National Tariff, dispute resolution and so on. We hope you find the presentations helpful and do remember that you can feedback comments or raise queries with us via the different email addresses which we'll be showing later in the presentations.

Slide 3

In this presentation, we're talking about new national policy initiatives, which we're giving space to in the Contract for next year. And I'm going to start by talking about some that come under the broad heading of patient safety. Some of them have their root in the new national NHS Patient Safety Strategy, which was published last year. The first shown on the slide here is around the establishment of a network of patient safety specialists, one in each main provider to lead safety improvement work across the system.

Slide 4

We've included in Service Condition 33 a new requirement in the Contract on each provider to designate a staff member as its patient safety specialist to be in place by 30 June 2020. It's important that this is about, not necessarily a new staff member, but designation likely to be of an existing staff member, with the role described in the Contract as being to provide leadership and visibility and expert support to patient safety, in relation to the services. The National Patient Safety team is expecting to provide more guidance shortly, including a detailed model role description for what a patient safety specialist is to do, and some further ideas about how this networking approach of patient safety specialists in different organisations working together is intended to work.

Slide 4

A second patient safety strand is around National Patient Safety alerts. Now, there's been a system for many years of these sorts of alerts being sent out to providers of different services and generally, they're things warning providers of potential risks involved in the use of particular devices or medications or procedures. So it's action which providers need to take urgently in order to keep patients safe that's being promoted in these alerts. There's been some concern that the process for issuing alerts has been, shall we say, loosely coordinated and bit muddly. The wonderfully entitled National Patient Safety Alerting Committee or NaPSAC is taking control of that issue and developing a new coordinated and accredited system for alerts to be issued to providers. And you can find more details about what they're doing at the web link shown on the slide.

So to support all of that, we're proposing to include, again in Service Condition 33, a new requirement for providers to ensure that:

- they have in place arrangements to receive these National Patient Safety alerts;
- that they identify appropriate staff who coordinate and implement actions required within the timescale that the alert prescribes;
- and then confirm and record when that has all been done as the alerts require.

We're hoping that that overall will strengthen the approach to patient safety in the Contract.

Slide 5

A third area, and again one that's been underway in 2019/20, is around a new system of medical examiners of deaths. This is about providing proper scrutiny of all those deaths, which are not referred to the coroner for more detailed examination.

In the Contract, we're requiring now acute providers (and this is only NHS Trusts and Foundation Trusts at this stage) to establish what we're calling a medical examiner’s office. And this is in line with guidance that's been published by the National Medical Examiner, which you can again find via the web link on the slide.

So the new Contract requirement is in Service Condition 3.

And what it requires is that the office established in each acute trust will review deaths occurring on the premises on those which are not referred to the coroner, ensuring firstly that the certification of death and the cause of death is accurate and scrutinising the care that the patient received before death as a way of ensuring and checking whether there are any consistent patterns, any consistent problems, any lessons which the organisation needs to learn.

It's worth saying that in time, this system of medical examiners is intended to expand so that each acute Trust's medical examiner office will cover all of the deaths that happen in a specified geographical area. So not just those in the hospital itself, but those in other NHS or care home type of settings, and in the community itself. But that's for the future. For this year, for now, for 20/21 the requirement is around Trusts setting up arrangements to review and scrutinise deaths that happen in their own hospital.

Now we understand the new system is being funded in part through income from cremation forms and that NHS England and Improvement are agreeing with trusts the other costs that will be met by us for this new service.

And there's also a helpful email address there for queries about the new arrangements for medical examiners of deaths, which you can see on the slide.

Slide 6

The next area then is around what we're terming common sources of harm to patients. And relates in large part to the contract requirements which have been in place for several years around completion and submission of the NHS safety thermometer. Now for acute services, the safety thermometer has involved the submission of really quite detailed information about four clinical areas (venous thromboembolism, catheter acquired, urinary tract infections, falls and pressure ulcers).

Now, feedback, which the patient safety team has been receiving from local systems has been that these requirements (the safety thermometer requirements) have been becoming too onerous in their bureaucratic burden compared to the amount of learning that they're generating, which was the original intention of the approach.

So at the request of the Patient Safety team, we're making some changes to the Contract for next year.

We're removing the references to the NHS safety thermometer in Service Condition 3 and Schedule 6A.

We're reducing the level of detail that was previously specified in SC22 on venous thromboembolism.

And we're introducing a new but quite high-level requirement in Service Condition 22 for acute providers to assure and monitor standards of care in those four clinical areas (VTE, catheter acquired UTIs, falls and pressure ulcers).

So overall, we're reducing the level of detail and burden associated with this area in the Contract and the requirement on the provider is now just to produce one annual report to the coordinating commissioner on its performance in these four clinical areas, and that's set out in Schedule 6A.

Slide 7

Finally from me in this section, a little bit about infection control targets. Now people will know that there've been targets for the number of cases of major infections for many years in the Contract. So there's been a system of Trust-specific targets for the number of cases of C difficile, and there's been a zero-tolerance approach to targets for cases of MRSA. Those targets will remain in place for next year unchanged. However, there will also be a new set of targets for 20/21, for gram-negative bloodstream infections. These are E. Coli and other things [pseudomonas aeruginosa and klebsiella]. And the point is here that while C difficile and MRSA numbers have broadly been falling and are reasonably well controlled in most cases by the NHS now, numbers of these gram-negative bloodstream infections have been rising, and pose more of a risk and a challenge to patient safety. So the decision's been taken to take the same approach of setting national targets for reduction, in the same way as has been done for C difficile.

Now the annual reduction targets are likely to be published at the web link we're showing on the slide. They haven't been published yet. We're expecting they will appear before the end of the financial year. The requirement in the Contract to achieve those new targets is set out in Schedule 4B of the Particulars ,and the definition of the new target is shown in Appendix three of our Technical Guidance.

And finally, on this subject, it's worth noting that we've taken the view across the board with infection control standards to remove the financial sanctions that have applied in different ways to C diff and MRSA in the Contract up to now. For 20/21, there will be no financial sanctions in relation to performance on infection control targets.

Slide 8

Moving on to mental health. Firstly, we've updated the Contract in two areas in line with an already published performance trajectory. The first is eating disorder services for children and young people, and the second is the early intervention in psychosis standard. The eating disorder services requirement was introduced into the Contract for 19/20 when the requirement on providers was to maximise the number of patients commencing care within the required timescales of one week for urgent cases and four weeks for non-urgent cases. As signalled to in the access and waiting time standard, the requirements on providers for 20/21 will be to meet the standard in full. That is, ensuring that 95% of patients commence treatment within one week or four weeks.

We're also updating the early intervention in psychosis standard. For 19/20, the standard was that 56% of service users experiencing a first episode of psychosis should start treatments within two weeks. This will increase to 60% of service users for 20/21.

We're proposing to change the care programme approach standard found in Schedule 4A. A 19/20 CQUIN has incentivised providers to follow up on adult service users discharged from a mental health inpatient setting within 72 hours, as evidence shows that service users are most at risk at suicide in the first three days after discharge. We're now proposing to replace the current requirement in the Contract, which requires that 95% of service users are followed up within seven days, with the CQUIN requirement that 80% of service users are followed up within 72 hours. The follow-up must be a meaningful one. It can be done by phone, but contact does need to be made with the service user. The provider can't just leave a message, or of course, it can be a face to face contact. There's more information on this in Appendix C of the Contract Technical Guidance. And please note that for 20/21, in line with the CQUIN, this requirement only applies to services commissioned by CCGs, rather than to services commissioned by NHS England.

Slide 9

We don't really need to talk about the effects of harmful alcohol and tobacco use. They're amongst the most significant health risk factors in England. The home office estimated over 2009-11, harmful alcohol use cost the NHS, £3.5 billion per annum, and the alcohol-related crime costs £11 pounds per annum. Harmful alcoholic use is responsible for an estimated 24,000 premature deaths a year and contributes to more than 1 million hospital admissions. Smoking is estimated cost the NHS £2 billion a year and causes almost 80,000 premature deaths and

contributes to 1.7 million hospital admissions. Service Condition 8.6 of the Contract already requires providers to wear appropriate onward refer service users to smoking cessation, and to alcohol advisory services. We're now proposing to include the current CQUIN requirements on screening and the provision of brief advice into the Contract.

The proposed new wording will require providers of acute, mental health, and mental health secure services, to firstly screen patients for alcohol and tobacco use. And then, where a service user is identified as drinking above a low-risk level, or is identified as a tobacco user, the provider must give brief advice, or offer referral for further assessment and specialist support.

Public Health England has updated its guidance and estimates that the screening and brief intervention should take about two minutes to complete.

Health Education England has also published an E-learning module to show how staff can undertake the screening and deliver the intervention. The links to these resources are on the slide.

We also propose to include the requirement on Trusts and FTs to use reasonable endeavours to ensure that their premises are smoke-free. This applies to the smoking of any product including tobacco that is lit and burnt. At this stage, it doesn't apply to e-cigarettes.

The new Contract requirement is found as Service Condition 17.8. And the definition of provider's promises in the Contract has also been expanded to include land and areas not directly connected with the provision of services to give effect to this requirement.

Slide 10

NHS Food Standards. The existing Contract provisions around Food Standards are found at Service Conditions 19.1, and 19.2. We're proposing to amend these, in anticipation of the review being undertaken by NHS England and Improvement on food standards for patients, services, and visitors, and the hospital food standard review announced last year by the Secretary of State.

The updated requirements will require all providers to develop a food and drink strategy. This strategy must set out how the provider will ensure that service users, staff and visitors are offered access 24 hours a day, where of course the provider's premises are open 24 hours, to healthy eating and drinking options which meet the requirements set out in the NHS Food Standards, including in respect of labelling and portion size.

The new requirements are found in Service Condition 19 and the new future-proofed definition of NHS Food Standards.

Slide 11

Data sharing and internet first. We propose to include a new requirement at GC21.23 on commissioners and providers to comply with the data sharing principles.

If your organisation is going to share data with researchers, please do review these. They are published on the Gov.uk website and they set out that the use of data must have an explicit aim to improve the health, welfare and care of patients within the NHS (such as the discovery of new treatments or diagnostics), and they also set out requirements of the terms of any agreements the NHS enters into with researchers. The Department of Health and Social Care is seeking feedback on the principles, and details are available at the link on the slide.

We propose to include two requirements on providers when procuring or updating their IT systems or software at Service Condition 23.9.

Firstly, the internet first policy. This is published by NHS Digital at the link on the slide and sets out nine principles associated with making all health and social care digital services available over the internet. The principles include a requirement that any new externally accessible digital services should be securely internet-facing by default, and that existing digital services must transition to the internet when they're updated or changed. The aim is that this will support health and social care professionals to work flexibly from a variety of locations, and using a range of access methods. This will require providers to have sufficiently scaled and functional internet connectivity, and for providers to engage suppliers of IT services who can offer suitable secure user access over the internet to any application interfaces.

There's a lot of information on NHS Digital's website at the link on the slide. So please do look at it if you're procuring new digital services or if you're updating them.

Secondly, the code of conduct for data-driven health and care technology was originally published by the Department of Health and Social Care in 2018, and has recently been updated following an engagement exercise. The code of conduct sets out ten principles, which providers must follow, and includes principles around understanding users' needs, defining outcomes and the commercial model to be used. It's available at the link at the bottom of the slide.

Slide 12

We're aiming for a green, non-polluting NHS. The Long Term Plan includes specific system-wide commitments on the NHS's roll in reducing air pollution, recognising the adverse impact that pollution has on people's health.

We also recognise the role that the NHS has to play in addressing climate change, and the overuse of plastics.

Collectively, NHS providers have a huge estate and a huge vehicle fleet, and use a huge volume of plastics and other non-biodegradable products. Collectively their actions can make a huge difference.

With that in mind, we've proposed significant changes to the requirements of the Contract relating to environmental issues.

Slide 13

We propose that SC18 of the full length Contract requires each provider to put in place and implement a green plan. Those green plans must set out in detail, the provider's proposed actions for 20/21:

- in relation to reducing air pollution - including by transitioning its fleet to low and ultra-low emission vehicles; replacing oil and coal for primary heating, with less polluting alternatives; by implementing expenses policies for staff which promote sustainable travel choices; and by ensuring that any car leasing schemes restrict the availability of high emissions vehicles;
- in relation to the cutting carbon emissions - by reducing emissions from the provider's premises generally; by (as clinically appropriate) reducing the use or the atmospheric release of environmentally damaging anaesthetic agents, such as desflurane; and by reducing carbon impacts from the prescription and disposal of propellant asthma inhalers;
- in relation to adapting its premises and the way in which services are delivered to mitigate risks associated with climate change in severe weather;
- in relation to reducing the use of single-use plastic products and observing the NHS plastics pledge - to eliminate avoidable single-use plastics in NHS catering facilities; and
- in relation to reducing the levels of waste and water usage and making provision for the return of walking aids for reuse or recycling.

Of course, it's no good just having plans in these areas. We expect that the action set out in the provider's green plans must be implemented diligently.

Slide 14

The proposed new SC18 also requires providers to quantify their environmental impacts and publish annual quantitive progress data, covering as a minimum, carbon emissions in tons, emissions reductions projections, and the way in which those projections will be achieved.

Slide 15

Redundancy and rehiring. There is ongoing concern and press coverage of a perceived ‘revolving door’ in the NHS. Senior managers being made redundant and receiving large redundancy payments, only then to be re-employed by

another commissioner or provider very soon afterwards. Several years ago we introduced detailed provisions at GC5 of the full length Contract requiring providers:

- firstly to ensure that the people they employ or take on as contractors, disclose whether they have received a redundancy payment on leaving a VSM post from an NHS employer in the previous 12 months; and
- secondly to ensure that anyone who has left such a VSM post repays an appropriate proportion of their redundancy payment (based on a formula set out on the Contract) to their former employer, either through direct arrangements with that employer or via deductions from their income from the provider.

Slide 16

For the coming year, we're proposing some key changes to those provisions:

- First to ensure that commissioners, both CCGs and NHS England are subject to the same obligations as providers when employing or engaging people recently made redundant from NHS VSM roles.
- And second to ensure that people made redundant from VSM roles with NHSI are subject to the same clawback regime as applies to ex-employees of NHSE, CCGs, NHS Trusts and Foundation Trusts.

We're also proposing a further provision to ensure that management and other consultants engaged by NHS commissioners or providers don't sell back to the NHS, the time and expertise of ex-VSMs that they've recruited unless those VSMs have already paid back to their former employer the appropriate proportion of their redundancy payment.

Slide 17

Evidence-based interventions. The [evidence-based interventions or EBI policy] is about minimising the number of interventions which are clinically inappropriate or which are appropriate only when performed in specific circumstances. This is so that patients are spared from treatments that are unlikely to do them any good, and so the NHS resources and clinicians' time are better spent on treatments which are proven to be clinically effective. There's a link to the EBI policy set out in the slides.

In 19/20 we introduced (at SC29 of the full length Contract) an obligation on commissioners and providers to comply with the EBI policy, managing referrals and providing services accordingly. Commissioners are not liable to pay for interventions covered by the EBI policy, where the requirements of that policy haven't been complied with.

To reinforce that, we propose for the coming year to include a new requirement for commissioners and providers to agree local activity goals, in relation to the interventions covered by the EBI policy.

In other words, to have in place local targets for the number of relevant interventions carried out. with the aim of focusing minds on minimising unnecessary or ineffective treatments.

Slide 18

Funding for medical technology. NHS England and NHS improvement have recently consulted on proposals for a new medical technology funding mandate. The consultation proposed that new guidance should be issued, mandating the use by NHS providers of specific innovative technologies, with arrangements for funding those set out under the National Tariff rules.

The technologies which we propose are covered initially are:

- placental growth factor-based testing, to help diagnose pre-eclampsia;
- SecurAcath, a device to secure catheters; and
- HeartFlow FFRCT, which is software to allow non-invasive testing of fractional flow reserve and diagnosis of coronary disease.

The consultation proposed that these arrangements would be underpinned by the inclusion of new obligations in the NHS Standard Contract.

Slide 19

The MedTech consultation has now closed, but our policy colleagues have not yet announced their response to the feedback they've received.

In the interim, we've included proposed draft provisions in the Contracts at Service Condition 2 and Service Condition 39, to give effect to the funding mandate as envisaged by the consultation.

These require providers and commissioners to comply with their respective obligations under the funding mandate. In other words, for providers to use the specified innovative technologies where appropriate, and for commissioners to pay for them as pass through costs were indicated in Annex 8 of the National Tariff.

We'll confirm the final position on the contract wording once the response to the consultation on the funding mandate has been published, and we've reviewed any responses we get to our consultation on the Contract wording.

Slide 20

Conflicts of interest and transparency on gifts and hospitality. The existing GC27 of the Contract requires providers to comply with, and ensure that their staff comply with, NHS England guidance on managing conflicts of interest (a link to

which is set out in the slide), and with other law and guidance on accepting gifts, hospitality, and other inducements, and actual or potential conflicts of interest that may arise.

One of the things that this guidance requires is that staff who are involved in making procurement and other decisions involving spending of public money must make declarations of actual or potential conflicts of interest and of gifts and other potential inducements they've received.

It has become apparent that this isn't being done in many organisations.

So, we're proposing an addition to GC27, which requires the provider to publish on its website (as soon as possible after the end of each contract year) the names of any decision-making staff who have neither completed a declaration of interest nor submitted a nil return in respect to that contract year.

Our hope is that this additional transparency will encourage individuals to make full and accurate disclosures as a matter of course.

Slide 21

In this next section, I'm going to be talking a little bit about service development and improvement plans and data quality improvement plans. These are well-established tools in the contract already (SDIPs and DQIPs as we refer to them). They can be agreed and included in a local contract at any point in the contract year. An SDIP goes in Schedule 6D, a DQIP in 6B. They pretty much do what the name describes - they set out agreed steps that either the provider will take or potentially the provider and the commissioners will take to deliver an improvement in a service or in the flow of data and information that supports that service.

SDIPs and DQIPs are different from remedial action plans agreed under General Condition 9. Those generally address serious breaches of contract by the provider, and set out rectification to be taken pretty urgently, whereas an SDIP or a DQIP will be about achieving an improvement in service or data in a gradual agreed way. SDIPs and DQIPs are a useful tool to address local priorities at any point, and you can find more about their use in our Contract Technical Guidance (signposted on this slide and the next one).

We also take the view from the national point of view that it's a good idea in some situations to recommend the use of the SDIP or DQIP approach for particular service priorities - things that don't yet cut the mustard if you like to include as national requirements in the Contract, but where we nonetheless would wish to see action taken at local level. I'm going to run through the recommendations we're making. Again, you can find more about these in our Technical Guidance for SDIPs and DQIPs for particular situations in 20/21.

The first of those relates to providers of mental health and mental health secure services, and is all about preparing for the rollout of staff training on restrictive

and restraint practices. The likelihood is that this might well become a contractual requirement for 21/22, and so the SDIP intention is to get ahead of the game and get ready for that during 20/21. The idea is that the provider needs to source training from either its own in-house team or an external supplier for staff (training complying with the restraint reduction networks training standards published at the link on the slide), with the idea that it will be in a position to roll out training either during this coming year (20/21) if possible, or certainly from the beginning of 21/22.

The second SDIP area is one that's actually referenced specifically in the Contract at Service Condition 3 and that's about continuity of care in maternity services. So, we've had a requirement for the last couple of years in the Contract in this area with a gradually increasing proportion of women receiving continuity of carer to be delivered over time. That was 35% in 19/20, and it's rising so that it's more than half of women by the end of 20/21. The SDIPs that we're talking about here need to set out what the commissioner and provider will be doing to ensure that that increasing proportion at least 51% (more than half) of women are receiving a continuity of care pathway by March 2021.

The third area is then around providers of emergency ambulance services. And this is about making progress towards full implementation of two particular Service Conditions in the Contract which, to be fair, are particularly challenging in that emergency ambulance service environment. That's about Service Condition 23.4 (which is making available and using at the scene the patient's NHS number) and very much linked to that 23.6 (which is about accessing the patient's summary care records). Now both of those things can contribute to a provider being able to offer better care to patients at the scene, which is why we're proposing an SDIP for providers to complete to show how far they can go towards full implementation of those Contract requirements.

Slide 22

Two more areas to flag on this slide - one around elective hospital ophthalmology services. This is in relation to recommendations being made in a report by the Healthcare Safety Investigation Branch now published, all about timely monitoring of patients with glaucoma. And the issue which each HSIB uncovered is fundamentally that too many patients are not receiving the sort of levels of follow up which they really need to keep them safe. And so the suggestion here is that providers should be agreeing SDIPs with their commissioners setting out what they're going to do to respond to those recommendations. You can find out more obviously via the link on the slide, but also there's more detail about what specific actions should be taken in our Contract Technical Guidance.

The final SDIP recommendation is around the TCAM or transfer of care around medicines initiative. This is a national initiative involving both acute providers and community pharmacies, around providing extra support where high-risk patients receiving multiple medications are discharged from hospital. The idea is that the hospital will share with a nominated community pharmacy details of the new

medications that are being prescribed on discharge, so that the community pharmacy (along with the patient's general practice) can review the potpourri of medications that the patient is now receiving, and make sure that before and after hospital discharge, the right arrangements are now in place so that the patient is receiving safe and effective medication.

Slide 23

On to data quality improvement plans.

The one recommended national DQIP for 20/21 is around providers of maternity services again and relates to the newly reissued and updated maternity services dataset version two. The idea is of a DQIP that sets out how the provider will now take forward improving the accuracy and completeness of its submission of MSDS data over time, to comply with the two information standards notices which are described in detail on the slide.

Slide 24

Before we finish this presentation - a word or two about the help and support that's available to commissioners and providers out there in terms of using the NHS Standard Contract. And some of that is set out on this slide here. Our website, first of all, that important link hosts the full length and shorter-form versions of the Contract, the Contract Technical Guidance and various other publications that we've been referring to along the way, including the model collaborative commissioning agreement, the model subcontracts and guidance and in due course, things like the national variation documents and guidance, and so on.

The website also hosts the model grant agreement and guidance which we refer to in the presentations.

There are a number of different email help desks run by NHS England and NHS Improvement covering the Contract, the eContract system, CQUIN, Who Pays? queries about the responsible commissioner, and the National Tariff. All of those email inboxes are shown there, and you're welcome to submit queries to them.

Slide 25

It's worth a plug for our Contract Technical Guidance specifically. This is a really comprehensive document setting out detailed advice on use and interpretation of the NHS Standard Contract, and more broadly on commissioning and contracting in the NHS at a general level. The slide sets out some of the main areas the Technical Guidance covers, and we really do recommend that it's something you use as a source of information and reference, in terms of helping to give you the answers to the queries which we often receive.

Slide 26

It's worth remembering that our Contract consultation (our consultation on the draft Contract for 2020/21) is still ongoing, and you are welcome to feed back your views on the different changes we're proposing to the Contract for next year, and you can do this in two ways, as set out on the slide.

You can do it by an online survey, which is available via a web link shown there on the slide.

Or you can do it using a template response document, a Word document, which you can then email to our ContractsEngagement inbox. and we really do hope you will take the opportunity to feed back to us.

The Contract consultation closes on Friday the 31st of January.

We'll then spend time reviewing all the consultation responses and we'll publish the final version of the contract on the website as soon as we can after that.

Slide 27

To conclude then - thank you very much for listening to us, and do remember that you can feed back to us on whether these presentations have been helpful. Just drop a line to our ContractsEngagement email address. And also remember there are three other presentations besides this one, which you're welcome to dive into on the NHS England / Improvement YouTube channel as and when you've got the time. Thanks for listening.

4 Presentation 4 (approx. 24 mins) - Changes affecting national standards and NHS "business rules" for 2020/21

Slide 1

Hello everybody, and welcome to our presentations on the draft Standard Contract for 2020/21. My name is Alistair Hill. I'm the lead for the Standard Contract at NHS England and NHS improvement and I'll be delivering these presentations with my colleagues, David Savage and Michelle Coleman.

So we're publishing these presentations now, in January 2020, and the idea is to try to explain the changes we're proposing for next year so that you can see what those main changes are, have a chance to give us feedback, and also understand some more about what's staying the same in the Contract for 20/21 as well.

Slide 2

You can see on this slide that we're planning to present four separate presentations and the slide outlines the content of the four separate shows we're running, as it were. So this particular first one, which I'll be delivering with Michelle, gives you a basic introduction to the Contract, what the Contract is, how it's to be used, what for, when, etc. So it's a reminder of the fundamentals of what the Standard Contract is about.

The second presentation (which will be delivered by David) is about using the Contract in the context of today's NHS, which is all about local collaboration at system level, commissioners and providers working together to deliver joined-up integrated services for their local populations. And David will be talking about how the Contract can be used to promote that sort of integrated, joined-up working.

The third presentation (which will be a triple act involving all three of us) will cover the new national policy initiatives (or at least the main ones) we're including in the Contract for 2020/21.

And finally, we'll do a presentation around national standards and what we're loosely calling the NHS business rules for the next year. This will be one which I'll be doing and it'll cover things around access standards, financial sanctions, the National Tariff, dispute resolution and so on. We hope you find the presentations helpful and do remember that you can feedback comments or raise queries with us via the different email addresses which we'll be showing later in the presentations.

Slide 3

This presentation is covering something of a mishmash of different areas that we've bandaged loosely under the heading of standards and business rules. So specifically what we're planning to cover is:

- the clinical review of standards (the national review of access standards for patients);
- financial sanctions;
- patient choice;
- counting and coding changes;
- payment and the National Tariff payment system changes; and
- dispute resolution.

Slide 4

The first of those, the clinical review of standards - people will be aware that this national review of access standards to key services has been ongoing. It is still ongoing, and you can find details of it at the web link on the slide. A recent progress report for instance has been published by the national team.

The idea of the review is that it's looking the existing standards for urgent care (for A&E four hour waits), for cancer (two week / 31 day / 62 day standards), and for elective care (the 18-week RTT standard).

It's also looking at introducing new access standards for mental health services where there haven't been those types of standards in the past.

New standards agreed following the clinical review, we'll replace and / or augment many of those which are in the contract already in Schedules 4A and 4B. As we said on one of the other presentations, it's possible that we may need to introduce some of them via an in-year national variation during 20/21.

As we understand it though is separate engagement process is planned on the standards for early 2020. Watch this space for that. As things stand, all we have done for the draft 20/21 contract is to add in the long-planned and long-awaited faster diagnosis standard for for cancer. Now that's been something that's been at least two years in the making, and systems and data flows are all set up to support that from April 21 onwards.

The key question though in relation to that faster diagnosis standard is where is the performance threshold to be set, in terms of the acceptable level of performance that providers would need to achieve? In the draft Contract we've positioned that as between 70% and 85%, and have specifically invited feedback from stakeholders on where we should position it initially, and how it should develop over time.

Slide 5

Moving on to financial sanctions. The Contract continues to include for next year a range of financial sanctions which apply where providers fail to achieve certain of the national standards set out in schedule 4A and 4B.

But, as in the last three years, most of those sanctions are going to be suspended again for those NHS Trusts and NHS Foundation Trusts which agree a financial improvement trajectory with NHS England and Improvement for 20/21. Where that's the case (where such a financial improvement trajectory has been agreed), the commissioner cannot apply the sanctions set out in Schedules 4A and 4B, nor can they withhold funding under General Condition 9.

This is all part of the long term effort to get the NHS provider sector back into financial balance, which is a major priority for the NHS overall.

The deal is, if providers sign up to a sufficiently challenging financial improvement trajectory (doing their bit to get their financial position and the provider sector financial position back into balance), then they get protected in return from financial sanctions under the Contract.

Sll of these arrangements are given contractual effect by wording included in Service Condition 36 and GC9 (in slightly different places, depending on whether it's the full length or the shorter-form version).

Just to remind you which tnctions remain active for all providers and which are not suspended in any case. And these are the four I've listed on the slide:

- those for 52 week wait breaches;
- those for canceled operations;
- for mixed sex accommodation breaches; and
- breaches of the duty of candor.

Slide 6

We need to spend some time talking about a new sanction - the timely completion of care and treatment reviews. Care and treatment reviews (which also include care, education and treatment reviews for children) are carried out for people with learning disabilities and autism before, and periodically during, any admission to hospital. And the whole aim is about ensuring that admission to and stay in hospital is clinically appropriate - it's the right thing for that individual. That's in the context of national policy being for people with disabilities to be cared for out of hospital, wherever possible.

We'd already included a requirement in the Contract (at Service Condition 6.9) on providers to comply with CTR guidance, which you can find by the web link on the slide. That guidance sets out timescales within which CTRs must be carried out. But the policy team at national level have been really concerned about the timeliness of carrying out these CTRs, and therefore we're proposing new

financial sanctions (in Service Condition 6), which would apply where an in-hospital CTR is not completed on time.

It's really important that these sanctions would only apply to the provider, where the failure to complete the CTR on time is wholly or partly due to some act or emission by that provider.

Commissioners have their part to play in the CTR process too. If the failure is basically due to the commissioner not doing its part, then clearly it cannot apply a sanction to the provider in that case.

To explain a bit more about what the sanctions are and how they work. The theory is, the intention is that a CTR should normally be carried out prior to hospital admission. But where that's not been possible, for whatever reason, there's a requirement in the guidance for a CTR to be completed at least within 28 days of admission for adults, or 14 days for those under 18. This is the really serious issue the policy team have identified, and therefore the sanction is set at quite a high level - a sanction of £5,000 as a one off, plus £300 for each additional day beyond the 14 or 28 day deadline, until the CTR is completed.

But CTRs also have to be completed on an ongoing basis once a service user has been admitted - every 12 months for adults in secure settings, or every six months in non-secure, or every three months for those under 18. Where those timescales are not achieved for in-hospital CTRs, there would be a sanction at a lower level set at £300 for each additional day until the CTR is completed.

Now, we recognise that providers, in particular, may have strong views about the level at which those sanctions are pitched, and about their appropriateness. Of course, that's something that you are welcome to feedback to us on in relation to the Contract consultation, as indeed you are on any of the issues we're talking about today.

Slide 7

Just quickly to mention some other changes relating to sanctions.

As we've said, elsewhere in our presentations, we are removing the sanctions for infection control for 20/21. Those are the slightly different and rather confusing arrangements for sanctions on MRSA and C difficile, we’re stripping those out of the system and we're not introducing new sanctions for the new gram-negative bloodstream infection targets. So that is a sanction-free zone for 20/21.

And then, as David was saying in presentation 2 on the SCFMA, we're changing the arrangements around re-use of funding, which commissioners withhold from providers through sanctions, and indeed, any unspent CQUIN funding. So, the expectation is that that will be something that would be considered and dealt with as appropriate, within the scope of those system collaboration and financial management agreements during 20/21. That's going to replace the arrangements that were tried out in 19/20, under which NHS England and Improvement

regional teams oversaw the re-use of such funding, and the arrangement in 19/20 where there was a virtual 52 breached sanction on commissioners as well.

So those 19/20 arrangements will be superseded for 20/21 by an expectation that SCFMAs will be where re-use of this sort of funding is considered.

Slide 8

Moving on then to look for a moment at issues around patient choice of provider. You'll remember that the 19/20 planning guidance for the first time introduced the idea of choice at 26 weeks for patients. If they were waiting over 26 weeks, they should be offered a choice of provider. Since that, planning guidance came out, a national process has been on the way to explore implementation, and pilot sites around the country have been trying out implementation of that 26-week choice offer.

So, based on that, we have included in the draft Contract a new requirement in Service Condition 6 on commissioners and providers to implement 26-week choice as a new initiative, with the expectation that the national policy team will fairly shortly will be able to publish detailed guidance setting out for all commissioners and providers have they should take this forward.

But it's complicated. There is already a legal entitlement for patients to ask to move provider, if they're told they're likely to wait over 18 weeks, so, we're at risk of setting up a system where there is one choice offer at 18 weeks (but it's optional, and the owner is on the page to ask for it), and there's another at 26 weeks (but that's mandatory and something which the commissioner and provider must offer to the patient). The question we're asking in the Contract consultation is whether it would actually make better sense to amalgamate these two choice offers so that, effectively, choice must then be offered at the point the patient actually breaches 18 weeks, or is informed that he or she is likely to do so.

So, that's another point on which you can feedback through the Contract consultation, but it might also be worth watching out for what the 20/21 planning guidance is going to say on this issue when it gets published (hopefully within the next week or two).

Slide 9

A word or two then about one of our favourite topics - counting and coding changes. A counting and coding change is, just to remind you, changes in the way in which a provider records patient activity.

The 20/21 Contract is going to continue to feature the existing provisions for notification and time-limited financial neutralisation of these counting and coding changes. These are in Service Condition 28 - they aren't being changed for next year. The requirement for neutralisation, just to remind you, applies whether or not a change is nationally mandated through new guidance that NHS Digital

might publish, or locally proposed by a provider or a commissioner aiming to secure better compliance locally with existing guidance that's already been published (potentially long since) by NHS Digital. In both cases, financial neutralization, generally for a period of a year at least, is necessary.

The contract provisions here aren't changing (huge sigh of relief!). They are explained in great detail in Section 44 of the Technical Guidance. So if you are in any doubt, please do use that as a source of reference, or if you and your partners in commissioner and provider land are disagreeing, have a look at what the Technical Guidance says, because the likelihood is that it will give you a good idea of the answer.

The key point of this slide is to alert you to two areas where nationally mandated changes are going to happen or maybe going to happen for 20/21. You will need to be thinking about whether there is a financial impact here to be neutralised.

The first of these is definitely happening, and that's the move to an updated version of the OPCS recording system for operative procedures. You can see the link to that on the NHS Digital website on the slide.

The second is more speculative, and you'll need to keep your eye open for what the NHS planning guidance says on this when it's published - it's about same-day emergency care. There may be some change relating to recording of that in-year during 20/21, in which case, again, it may have financial implications which would require neutralisation.

Slide 10

Our colleagues in the pricing team at NHS England and Improvement are consulting separately on changes to the National Tariff Payment System for 20/21. Their new proposals involve an extension of the blended payment arrangements, to cover outpatient and maternity services, and that complements what was introduced in 19/20 for emergency care. Assuming that the arrangements that they've proposed are confirmed following their consultation on the Tariff, the way we're handling them in the Contract is set out on this slide.

The emergency care blended payment will remain as it is in the 19/20 contract. That's at Service Condition 36.21, which gives it effect, and the detailed schedule, Schedule 3D, where a commissioner and provider can set out their agreed detail local arrangements.

We're continuing to provide a detailed template for that schedule and a model - various model completed examples are shown in Appendix 8 of our Contract Technical Guidance. Hopefully, that will continue to assist people in completing the rather complex arrangement for emergency care blended payment.

What then, in terms of the new blended payment arrangements? Well, the outpatient care blended payment approach will be mandatory for 20/21. We've again included a new provision within the Contract, Service Condition 36.22 to

give that effect. However, there's a lot more local flexibility about the way you do outpatient blended payment at local level compared to the emergency care blended payment. And so, we're thinking we don't actually need to provide a specific template for how that should be recorded. Rather you should record the agreed arrangements in your local contract in Schedule 3A, the local price schedule.

Maternity services is a bit different. Systems are going to have a choice. Either they can retain the current pathway pricing methodology, or they can move to the blended payment model. That's a local option which commissioners and providers within a local system will need to agree consistently across the patch. Once agreed, the approach in detail which is going to be adopted should be set out again in Schedule 3A, the local prices schedule.

Slide 11

Dispute resolution procedures. As in previous years, NHS England and Improvement will shortly publish joint guidance on contract dispute resolution for next year. There'll be two procedures:

- One will deal with the resolution of disputes around the agreement of new contracts for next year certainly between commissioners and NHS Trusts and Foundation Trusts. And those disputes will ultimately be resolved by arbitration through an independent arbitration panel, which is convened by NHS E/I.
- The second procedure is around disputes which arise about updating non-expiring contracts (contracts which don't expire at the 31st of March next year, but which nonetheless need to be updated for 20/21). In those cases, clearly, resolution needs to be using the General Condition 14 process in the Contract, which ultimately involves expert determination by an independent expert.

Look out for those two documents which will be published as part of the planning guidance very shortly.

Slide 12

We have proposed some slight changes to the dispute resolution arrangements in the contract for 20/21 (those set out in General Condition 14), with a view to reflecting the approach we've taken in those procedures over recent years.

- The specific changes are that for the future mediation in disputes will be arranged jointly by NHS England and Improvement, for disputes that involve Foundation Trusts as well as (as currently) those that involve NHS Trusts. So that's one change.
- The other change will be that where there is expert determination required for NHS Trusts or Foundation Trusts, this will be undertaken by an expert

allocated by NHS England and Improvement rather than one identified via the Centre for Effective Dispute Resolution (CEDR) or any other body.

So those changes are consistent with the practice that we've been adopting over recent years as set out in the two dispute resolution procedure documents I've just described.

One practical implication to point out for people completing their contracts is that this now means that the nominated mediation body, which is flagged on page 11 of the Contract the Contract Particulars, only now needs to be completed where the provider is neither an NHS Trust nor an NHS Foundation Trust. In those cases, you can leave that blank.

Slide 13

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by NHS Standard Contract team, Strategy and Innovation Directorate.

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 due 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

- given regard to the need to 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

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