

NHS Standard Contract 2020/21 Technical Guidance

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Executive Summary

1 Introduction

- 1.1 The NHS Standard Contract is published by NHS England and is mandated for use by CCGs and NHS England for all their clinical services contracts, with the exception of those for primary care services.
- 1.2 The Contract continues to be published in both full-length and shorter-form versions. This Guidance document is relevant to both forms of the Contract, but a separate [User Guide](#) for the shorter-form version is also available. Guidance on when the shorter-form version should be used is set out in paragraph 9 below.

2 The 2020/21 Contract

- 2.1 The updated Contract is intended to set national terms and conditions applicable for the 2020/21 financial year. As always, if urgent issues arise during 2020/21 which require any amendment to the Contract, NHS England will consult on and publish an in-year National Variation for implementation locally. It is possible that this will be necessary, during 2020/21, to give effect to the recommendations of the ongoing [Clinical Review of NHS Access Standards](#). The eContract system will also be updated to reflect any changes made to the 2020/21 Contract as a result of any in-year National Variation.
- 2.2 Not all local contracts will expire at 31 March 2020, of course. Alongside the final 2020/21 Contract, NHS England has therefore published a [National Variation](#), which commissioners and providers must implement to their non-expiring contracts, to ensure that these continue to reflect up-to-date national requirements.
- 2.3 Commissioners and providers must seek to ensure that new contracts are signed, or existing contracts appropriately varied, by no later than 27 March 2020, the deadline set out in the [NHS Operational Planning and Contracting Guidance 2020/21](#).
- 2.4 NHS England and NHS Improvement have published guidance on contract dispute resolution (in [Annex D2 of the planning guidance document](#)), setting out the process to be followed where a new contract, or annual contract variation, cannot be agreed between a commissioner and an NHS Trust or Foundation Trust.
- 2.5 The fact that the national terms of the Contract (and the rules of the National Tariff Payment System) are being set only for 2020/21 does not, of course, mean that commissioners may only award contracts covering the single financial year of 2020/21. There will continue to be situations where commissioners decide that it is appropriate to award longer-term contracts covering multiple years; that is a matter for local judgement. (See sections 17 and 18 below for further advice.)

3 Key changes to the full-length Contract

- 3.1 The 2020/21 Contract retains the same three-part structure and much of the same detailed content as the 2019-20 version. The main changes made to the 2020/21 Contract are summarised in the sections below. A detailed clause-by-clause summary of where changes have been made is available at Appendix 1.

Key changes affecting specific clinical services

- 3.2 This section sets out changes which are aimed at improving care in specific clinical services.

Topic	Change	Contract Reference
Maternity services	The 2019/20 Contract introduced a standard for the proportion of women who receive continuity of carer during their maternity care. Continuing the gradual upward trend in this standard, in line with the published national trajectory, we have raised the threshold from 35% at March 2020 to 51% at March 2021. We have also amended the definition of the standard, reflecting the requirement for women to experience continuity across the whole pathway, rather than simply to be booked onto a continuity of carer pathway. Note that the Contract wording requires the provider to use “reasonable endeavours” to achieve the standard. Significant transformation funding is being made available in 2019/20 and 2020/21 to enable implementation.	Service Condition 3 and Definitions
Eating disorder services for children and young people	The 2019/20 Contract introduced a requirement on providers of eating disorder services for children and young people to maximise the number of service users starting treatment within the timescales set out in the Access and Waiting Time Standard. We have now amended this to require providers to achieve the Access and Waiting Time Standard in full by March 2021.	Service Condition 3 and Definitions
Procurement of emergency ambulance vehicles	The Contract already includes a requirement for providers of emergency ambulance services to source any new vehicles they procure in accordance with a new national specification. We have expanded this requirement so that the provider must source the vehicle under nationally-specified supply contracts for a) the base vehicle and b) the conversion.	Service Condition 39
Guidance on inter-facility transfers	National guidance was published in July 2019 setting out a framework for arranging emergency inter-hospital ambulance transfers . The Contract now requires providers to comply with this framework; the framework is now included within the definition of Transfer and Discharge Guidance and Standards, referenced in Service Condition 11.	Definitions

Early Intervention in Psychosis standards	The Contract contains a National Quality Requirement in relation to patients experiencing a first episode of psychosis. Again, continuing the gradual upward trend in this standard, in line with the published national trajectory, we have raised the threshold from 56% of Service Users waiting less than two weeks to access treatment in 2019/20 to 60% from 1 April 2020.	Particulars Schedule 4B
72-hour post-discharge follow-up in mental health services	For many years, the Contract has contained a standard for patients discharged from inpatient mental health care to be followed up within seven days. Following the successful implementation of a CQUIN indicator during 2019/20, we have tightened the standard to 72 hours for CCG-commissioned mental health services.	Particulars Schedule 4A
Cancer waiting times	We have included the new cancer 28-day Faster Diagnosis Standard in the Contract to take effect from 1 April 2020. The performance threshold is set at 75% for each quarter of 2020/21.	Particulars Schedule 4A

Integrated system working and Primary Care Networks (PCNs)

- 3.3 This section sets out changes which are aimed at promoting effective system-wide collaboration between commissioners and providers within a local health community.

Topic	Change	Contract Reference
System-wide collaboration to manage performance and finance	As set out in NHS Operational Planning and Contracting Guidance 2020/21 , the Contract reflects the expectation that CCGs and NHS Trusts / Foundation Trusts within each ICS/STP will sign, and act in accordance with, an overarching System Collaboration and Financial Management Agreement (SCFMA), setting out how they will work together to deliver system financial balance. NHSE/I regional teams will also be party to these agreements. A model version of this SCFMA, for local adaptation, is available on the NHS Standard Contract 2020/21 web page ; our approach is intended to set a minimum requirement, not to prevent partners within an ICS/STP from adopting (or retaining) a more ambitious collaboration agreement. See also paragraph 3.10 onwards below.	Service Condition 4 Particulars Schedule 9

Supporting implementation of system-level plans	We have updated existing references to Local System Operating Plans so that these relate to the long-term plans which have now been agreed at ICS/STP level for 2020/21 onwards. The Contract thus continues to require both commissioner and provider to contribute towards implementation of such system-level Plans, with Schedule 8 allowing each party's obligations under the relevant Plan to be set out in detail, if required, thereby giving them contractual force.	Service Condition 4, Particulars Schedule 8
Supporting PCNs to deliver Enhanced Health in Care Homes	We have included new requirements for relevant providers of community physical and mental health services to work with PCNs to implement the new national service model for Enhanced Health in Care Homes, details of which have been published in Update to the GP contract agreement 2020/21 - 2023/24 (see pages 44-45).	Service Condition 4 Particulars Schedule 2Ai
Alignment of community mental health services with PCNs	In order to facilitate the move towards new integrated primary and community mental health models in all STPs/ICSs from April 2021 as set out in the NHS Mental Health Implementation Plan 2019/20 – 2023/24 and the Community Mental Health Framework , providers of community mental health services for adults and older adults must put in place arrangements with all PCNs within their footprints, by March 2021, to organise and begin delivering services in an integrated manner. An equivalent obligation is being placed on PCNs under their contractual arrangements. As stated in the NHS Operational Planning and Contracting Guidance 2020/21 , this is a vital step in ensuring that community mental health service providers are adequately prepared to benefit as fully as possible from the first of three years' of transformation funding in 2021/22 that will be made available to all STPs/ICSs in England to deliver new integrated models, on top of the significant year-on-year uplifts in all CCGs' baseline funding for adult and older adult community mental health from 2019/20 to 2023/24.	Service Condition 4
Supplying or recommending medication for ongoing use in primary care	We have added a new requirement on providers – when supplying medication to patients on discharge or in clinic or when recommending medications for GPs to supply – to have regard to guidance published by NHS England for GPs on conditions for which over-the-counter items should not routinely be prescribed and items which should not be routinely prescribed .	Service Condition 11

Changes relating to patient safety

3.4 This section sets out changes which are aimed at improving patient safety, partly in response to the new [NHS Patient Safety Strategy](#) launched in July 2019.

Topic	Change	Contract Reference
Medical Examiners of Deaths	<p>The Contract contains provisions which give effect to the national system of Medical Examiners. Medical Examiners will provide independent scrutiny of deaths not referred to the coroner; initially, their focus will be on such deaths occurring in acute hospitals hosting medical examiner offices, but this will expand to cover other settings.</p> <ul style="list-style-type: none"> The requirement remains for all acute Trusts to establish a Medical Examiner's Office, other than where the National Medical Examiner approves exceptions (for some very small Trusts, for example). We have amended the Contract wording to allow for this. Acute Trusts for which such an exception has been approved and providers other than acute Trusts will be required to begin planning arrangements for deaths of patients on their premises or under their care to be scrutinised by Medical Examiners at another acute Trust. NHSE/I will publish further guidance on this in due course, but – with this in view – we have included an additional requirement on <u>all</u> providers to comply with this guidance as applicable. <p>(Note also that the National Medical Examiner has already published additional guidance on implementing and funding the Medical Examiner system.)</p>	Service Condition 3
Common sources of harm to patients in hospital / Safety Thermometer	<p>Feedback suggests that the existing Contract requirements on use of the Safety Thermometer are creating too great a bureaucratic burden, and not facilitating learning. We have therefore removed the specific requirements relating to use of the Safety Thermometer and, instead, introduced new obligations on acute providers to ensure and monitor standards of care in the four clinical areas which the Safety Thermometer addresses – venous thromboembolism, catheter-acquired urinary tract infections, falls and pressure ulcers.</p>	Service Conditions 3 and 22, Particulars Schedule 6A
Patient Safety Incident Response Framework	<p>The NHS Patient Safety Strategy indicates that the current NHS Serious Incident Framework and Never Events Policy Framework will be replaced, over the next two years, by a new single Patient Safety Incident Response Framework. To accommodate and signpost this planned change, we have added a specific reference to “successor frameworks” to the existing requirements relating to the current Frameworks.</p>	Service Condition 33

National Patient Safety Alerts	The National Patient Safety Alerting Committee is establishing new, co-ordinated and accredited arrangements for the issuing of National Patient Safety Alerts to providers. We have included a new requirement for providers to ensure that they can receive each relevant National Patient Safety Alert, identify appropriate staff to coordinate and implement actions required within the timescale the Alert prescribes, and confirm and record when those actions have been completed.	Service Condition 33
Patient Safety Specialists	The NHS Patient Safety Strategy envisages the establishment of a network of patient safety specialists, one in each provider, to lead safety improvement across the system. We have therefore included a requirement on each provider to designate an existing staff member as its Patient Safety Specialist. NHS England and NHS Improvement are consulting on model role descriptions for Patient Safety Specialists and will publish final versions in due course.	Service Condition 33
Infection control targets	The Contract has for many years included targets relating to MRSA and C difficile (CDI). The NHS has continued to achieve year-on-year reductions in the rates of these infections, but rates of gram-negative bloodstream infections (E.Coli, Klebsiella and Pseudomonas) have generally risen, and these now pose a more significant challenge. NHS England and NHS Improvement will now set annual targets for Trusts to reduce the number of these gram-negative bloodstream infections (GNBSI), and these targets are now referenced in the Contract. GNBSI targets for individual Trusts will be published shortly, alongside those for CDI.	Particulars, Schedule 4B
Infection control sanctions	Feedback from stakeholders indicated that the arrangements in the 2019/20 Contract for financial sanctions for MRSA and CDI were no longer fit for purpose. We have therefore removed from the Contract the financial sanctions relating to MRSA and CDI, and sanctions will not apply in relation to the new GNBSI targets.	Particulars Schedules 4B and 4F

Other broader policy initiatives

3.5 This section sets out changes which are aimed at promoting other more general improvements in how care and treatment are delivered for patients.

Topic	Change	Contract Reference
EU Exit	We have included a new requirement for providers to comply with applicable EU Exit Guidance. The specific no-deal guidance previously published by DHSC has now been withdrawn, but it is possible that further guidance may be issued as the end of the transition period nears, and it will be essential that the NHS implements any such guidance in full.	Service Condition 2
Choice of provider for long-wait patients	The Contract requires commissioners and providers to comply with <i>NHS Managed Choice Guidance</i> . This will require them to work together to offer choice of provider for long-wait patients on RTT pathways, with the offer being made as close as possible to the point at which the patient has waited 18 weeks (and no later than 26 weeks). NHS England and NHS Improvement will publish the Guidance shortly, setting out detailed expectations and timescales for 2020/21.	Service Condition 6
Care and Treatment Reviews	It is essential that Care and Treatment Reviews (CTRs) (for people in inpatient learning disability units) are carried out at the intervals set out in Care and Treatment Review Guidance . We have included a specific new requirement on providers to collaborate with commissioners to ensure that CTRs are completed within the applicable timescales, both immediately post-admission and on an ongoing basis during a hospital stay. Where this is not done, through any error or omission of the provider, a financial sanction will apply.	Service Condition 6
Patient choice of clinician	We have expanded the scope of an existing provision to require that a provider may withhold treatment where a patient displays behaviour which constitutes discrimination or harassment (within the meaning of the Equality Act 2010) towards staff or other patients. The provider must take into account the patient's mental health and clinical presentation, as well as any other health conditions. Note also that this clause is subject to Service Condition 7.1, which makes clear that "Nothing in this SC7 allows the Provider to refuse to provide or to stop providing a Service if that would be contrary to the Law".	Service Condition 7

Screening and onward referral to smoking cessation and alcohol advisory services	The 2019/20 Contract already included a broad requirement relating to onward referral of appropriate patients to smoking cessation and alcohol advisory services. There has been a more specific CQUIN indicator in this area in 2019/20, which has been “retired” for 2020/21. We have therefore amended the Contract wording to reflect more closely the requirements of the current CQUIN indicator as “business as usual”, focussing on the screening of inpatients for alcohol or tobacco use, with brief advice or intervention being offered where appropriate and/or onward referral to local authority services where available .	Service Condition 8
Smoke-free premises	We have amended the Contract to include a requirement for all NHS Trusts and NHS Foundation Trusts to use reasonable endeavours to ensure that their premises and grounds are smoke-free. (This applies to the smoking of any product including, but not exclusive to tobacco, that is lit and burned; it does not apply at this stage to e-cigarettes.)	Service Condition 17
NHS Premises Assurance Model	We have included a new requirement for each NHS Trust / NHS Foundation Trust to complete the safety and the patient experience domains of the <u>NHS Premises Assurance Model</u> and to report the findings to its Governing Body.	Service Condition 17
NHS car parking	We have included a new requirement on NHS Trusts and NHS Foundation Trusts to comply with the existing <u>NHS Car Parking Principles</u>, as updated by further guidance to be published, by spring 2020, to support and provide funding for implementation of the Government’s commitment to enabling free parking for certain groups, as set out at https://www.gov.uk/government/news/free-hospital-parking-for-thousands-of-patients-staff-and-carers.	Service Condition 17
NHS Food Standards	We have amended the Contract provision so that each provider must ensure that, from retail outlets and vending machines, catering provision and facilities as appropriate, patients, staff and visitors are offered ready access 24 hours a day to healthy eating and drinking options and that products provided and/or offered for sale meet the requirements set out in NHS Food Standards, including in respect of labelling and portion size.	Service Condition 19

Evidence-Based Interventions	We have included a new requirement for commissioners and providers to agree clinically-appropriate activity goals in relation to the interventions covered by the national Evidence-Based Interventions guidance. The intention here is to encourage commissioners and providers to focus on this important issue, first through early discussion and engagement and then through ongoing monitoring. Material over-performance against the activity goals in-year should prompt review and action to ensure that EBI policy is being fully implemented, but no individual patient should be prevented from accessing clinically appropriate treatment, in accordance with EBI guidance criteria, simply because the overall activity goal has been exceeded.	Service Condition 29
COVID-19 response	<p>Both the full-length and shorter-form versions of the Contract already require providers to comply with national Emergency Preparedness, Resilience and Response (EPRR) Guidance and to provide necessary support and assistance in the event of public health emergencies or incidents.</p> <p>Given the developing position in relation to COVID-19, we have</p> <ul style="list-style-type: none"> • amended the Contract definition of EPRR Guidance to include, specifically, national guidance on COVID-19; and • removed from SC30.4 (SC30.3 in the shorter-form version) the references to “at the request of the Coordinating Commissioner”, reflecting that requirements will be passed down to the NHS direct from national bodies. 	Service Condition 30 and Definitions

Changes relating to workforce issues

3.6 This section sets out proposed changes in provisions of the Contract relating to staff working in the NHS.

Topic	Change	Contract Reference
Workforce diversity	We have added a new requirement to the Contract in accordance with the requirement in the NHS Operational Planning and Contracting Guidance 2020/21 for NHS Trusts and NHS Foundation Trusts to work towards their bespoke targets for black and minority ethnic representation in their workforce at senior levels – as outlined in the Workforce Race Equality Standard Model Employer strategy . The NHSE/I national team has already shared and agreed targets with each individual Trust.	Service Condition 13

Influenza vaccinations	We have included a new requirement on providers to use reasonable endeavours to ensure that all front-line staff in contact with patients are vaccinated against influenza.	Service Condition 21
NHS People Plan	We have included a new requirement on providers to develop a plan to implement in full the NHS People Offer (that is, the core standards in relation to work environment and experience of work for staff working in NHS services) to be published in conjunction with the final NHS People Plan.	General Condition 5
Redundancy and re-hiring	<p>The Contract has for some time included provisions relating to the re-hiring, by providers, of Very Senior Managers (VSMs) who have recently been made redundant by an NHS employer. Under these arrangements, the new employer must ensure that provisions are included in the employment contract of the individual, requiring – in specified circumstances – repayment of some or all of the redundancy payment the individual has received.</p> <p>We have now broadened the scope of the provisions so that they also apply to redundant VSMs re-hired by commissioners and to any VSM who is re-hired, following redundancy, by a management consultancy and whose time is then “sold back” to the NHS.</p> <p>We have also expanded the definition of NHS Employer, to ensure that a VSM made redundant by NHS Improvement is subject to the same regime as a VSM made redundant by other NHS organisations.</p> <p>Note also that the provisions apply to those made redundant from VSM positions, regardless of whether their new employment is as a VSM or in a lower-paid role.</p>	General Condition 5
Declarations of interest	<p>The Contract already requires compliance with Guidance on Managing Conflicts of Interest in the NHS, where applicable. We have included a new requirement for providers to publish the names of those decision-making staff not completing declarations or making nil-returns. However, we have added wording to make clear that each provider must ensure that an appropriate Privacy Notice is provided to Staff to enable publication of such information. Guidance on Managing Conflicts in the NHS will be updated shortly to reflect these new requirements. Note also the following.</p> <ul style="list-style-type: none"> • These requirements apply, on a mandatory basis, only to NHS Trusts and NHS Foundation Trusts, but other providers are invited to adopt the same approach. • Detailed advice on the definition of “decision-making staff” is included in the Guidance, but the duty to make a declaration or submit a nil-return will normally apply, at least, to all board members, all medical consultants and all Agenda for Change staff 	General Condition 27

	<p>at band 8d and above. Annual Governance Statements to be completed by trusts in respect of 2019/20 will ask for confirmation that registers covering these groups have been published.</p> <ul style="list-style-type: none"> • The Electronic Staff Record is being adapted to include new functionality to enable simpler submission of declarations. 	
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Changes to bring about a greener NHS

3.7 New provisions in Service Condition 18 of the full-length Contract require each provider to put in place and implement a “Green Plan”. Green Plans must set out the provider’s detailed plans and actions for 2020/21 in pursuit of NHS Long Term Plan commitments on:

- reducing air pollution – including by transitioning its fleet to low and ultra-low emission vehicles; by 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-emission vehicles;
- cutting carbon emissions – by reducing emissions from the provider’s premises generally; by (as clinically appropriate) reducing the use, or atmospheric release, of environmentally-damaging anaesthetic agents such as desflurane; and by reducing carbon impacts from the prescription and disposal of propellant inhalers;
- adapting its premises and the way in which services are delivered to mitigate risks associated with climate change and severe weather;
- 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
- reducing levels of waste and water usage and making provision for the return of walking aids for re-use or recycling.

Each provider must quantify its environmental impacts and publish annual quantitative progress data, covering as a minimum carbon emission in tonnes, emissions reduction projections and the way in which those projections will be achieved.

We have also clarified the requirements on providers arising from the Public Services (Social Value) Act 2012; these are now spelled out more fully in Service Condition 18.5.

Changes relating to technology, booking systems and data

3.8 This section sets out changes relating to the use of technology, booking systems and data in the NHS.

Topic	Change	Contract Reference
Funding for medical technology	Following consultation, NHS England and NHS Improvement are about to publish a Medical Technology Funding Mandate . The Mandate requires providers to use specific innovative technologies, with arrangements for funding of these by commissioners set out in the National Tariff rules and with the arrangement underpinned by the inclusion of new obligations in the NHS Standard Contract.	Service Conditions 2 and 39
Booking of appointments from 111 services into Urgent Treatment Centres	We have added a new requirement on providers of Urgent Treatment Centres to ensure that, when replacing or updating IT systems and software, they enable direct booking of UTC appointments by providers of NHS 111 and UEC Clinical Assessment Services, in accordance with new standards published by NHS Digital.	Service Condition 6
Health and Social Care Network	We have updated the Contract wording on transition from N3 to the Health and Social Care Network , requiring transition to be completed by 31 August 2020, in line with the previously-published national deadline.	Service Condition 23
Internet First and Code of Conduct for Data-Driven Technology	We have included a new requirement on providers, when updating, developing or procuring any information technology system or software, to have regard to the NHS Internet First Policy and the Code of Conduct for Data-Driven Health and Care Technology .	Service Condition 23
Data sharing principles and framework	DHSC has published data sharing principles to help the NHS realise benefits for patients and the public where the NHS shares data with researchers. We have included a new requirement for commissioners and providers to have regard to the principles.	General Condition 21
Daily submission of Emergency Care Data Sets (ECDS)	NHS Digital already mandates that providers of A&E and Urgent Treatment Centre services must submit ECDS daily. It is essential that all providers submit accurate, up-to-date ECDS data on a timely basis. NHS Digital will shortly be issuing guidance (to be published at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds) to support the relevant Information Standard , making explicit the expectation that ECDS data must be submitted each day for the previous day. We have included a specific requirement in the Contract to support this.	Particulars Schedule 6A

Technical improvements and other smaller changes

3.9 This section describes technical changes, which we believe will make the Contract more effective in practice.

Topic	Detailed change	Contract Reference
Service categories and eContract	In some instances, the Contract sets out, in respect of the same issue, slightly different provisions which are apply to different services a provider may offer. We use “service categories” to differentiate between these different provisions, and this approach generally works well. There can be some lack of clarity, however, where the same provider provides a range of different services, and we have therefore made changes to a small number of Service Conditions to ensure that, where the eContract system is used, the resulting contract documentation makes absolutely clear which provisions apply to which services.	Service Conditions 3, 7 and 29
WRES and WDES	We have aligned the provisions of the Contract relating to the Workforce Race Equality Standard and the Workforce Disability Equality Standard to make them more consistent.	Service Condition 13
Antibiotic prescribing	We have made a minor change to ensure clarity on the required reduction in rates of antibiotic prescribing. The new requirement introduced a year ago was for a 1% year-on-year reduction from the 2018 baseline level. In accordance with this, the specific requirement in 2020/21 is therefore for a cumulative reduction of 2% from the 2018 baseline level; the wording change makes this clear.	Service Condition 21
Safeguarding	We have made minor changes to: <ul style="list-style-type: none"> • update definitions for Prevent Guidance, Safeguarding Guidance and intercollegiate guidance on safeguarding training; • include a reference to the requirements of the Modern Slavery Act; and • reflecting the introduction, via amendments to the Mental Capacity Act, of Mental Capacity and Liberty Protection Safeguards Leads. 	Service Condition 32 and Definitions
Dispute resolution	We have amended the arrangements for dispute resolution, reflecting the arrangements which have been put in place at national level over recent years. Specifically, <ul style="list-style-type: none"> • mediation will be arranged jointly by NHS England and NHS Improvement for disputes involving NHS Foundation Trusts (as well as for NHS Trusts, as currently); and • Expert Determination for disputes involving NHS Trusts and NHS Foundation Trusts will be undertaken by an independent and suitably experienced Expert allocated by NHS England and NHS Improvement, rather than via CEDR or any other body. This is in accordance with the dispute resolution process set 	General Condition 14

Topic	Detailed change	Contract Reference
	out in Annex D1 of the NHS Operational Planning and Contracting Guidance 2020/21.	
Local reporting requirements	For 2019/20, we introduced a requirement for local patient datasets (under Local Requirements Reported Locally) to be submitted via NHS Digital's Data Landing Portal . We have amended the wording slightly to clarify that this requirement applies only to patient-identifiable data, not pseudonymised or aggregate data.	Particulars Schedule 6A

System Collaboration and Financial Management Agreement

- 3.10 As described above, the national expectation for 2020/21 is that, [under ICS/STP leadership](#), every CCG, NHS Trust and NHS Foundation Trust within an ICS/STP (and the relevant NHSE/I Regional team) will sign up to and act in accordance with a System Collaboration and Financial Management agreement (SCFMA). This is given effect by an additional requirement in Service Condition 4.
- 3.11 The SCFMA is expected to complement the broader collaborative arrangements which are likely to exist already at ICS/STP level and which will typically involve a wider set of partners, including the relevant local authorities and provider organisations from the independent and voluntary sectors.
- 3.12 The key aim of the SCFMA is to promote collaboration across the NHS organisations with each local system in the delivery of the system financial improvement trajectory for 2020/21 and of the sustainable management of NHS finances in the longer term.
- 3.13 A model SCFMA is published on the NHS Standard Contract webpage. This is not a mandatory template; local systems are encouraged to use it as a starting point, but may adapt the content as appropriate, building it as appropriate into equivalent local agreements where these already exist. The key point is that each ICS/STP must have in place an agreement which meet the minimum requirements set out in the Contract definition of an SCFMA, namely that it
- describes the collaborative behaviours expected of the 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 financial and other resources available to the ICS/STP; and
 - sets out a mechanism for management of the aggregate financial position of the parties to achieve and maintain the system financial improvement trajectory for the ICS/STP.

The model SCFMA provides more detailed suggestions for what should be covered in each of the above areas. Note that the template envisages NHS

England being a party, in its role as commissioner of specialised and other services from the Trusts within an ICS/STP: its expenditure in the local system will have a bearing on the overall financial position, and so it is right that it has a voice in discussions.

- 3.14 Nothing within any SCFMA agreed locally must compromise patients' rights to choice or seek to prevent or deter NHS bodies from complying with their responsibilities under the various regulations which govern procurement and competition within the NHS (including the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and the Public Contract Regulations 2015).
- 3.15 Most Trusts will ultimately be party to just one SCFMA, although ambulance services Trusts, for example, may need to sign up to more than one. We are conscious that agreeing the terms of an SCFMA will be a challenge for some systems. 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 agreement on the SCFMA cannot be reached ahead of the national deadline for contract signature of 27 March 2020, this should not be a reason for delaying contract signature. But parties should reach agreement and sign their SCFMA as soon as possible after contract signature.
- 3.16 Details of any SCFMA to which the provider and relevant commissioners are party should be listed in (new) Schedule 9, but the full SCFMA itself should not be included in the Schedule as the intention is not that the provisions of the SCFMA should be legally binding.
- 3.17 NHSE/I Regional Directors of Finance will review whether an appropriate SCFMA is in place in each system, by reference to the minimum requirements set out in the published model version, ensuring sign-off and ongoing implementation.
- 3.18 The SCFMA provides an opportunity to address locally how commissioners will decide on re-investment of any funding withheld through contractual sanctions applied to local Trusts or of any element of CQUIN funding not earned by Trusts. These questions of re-investment can therefore be considered locally within the SCFMA for 2020/21, rather than being overseen by NHS England and NHS Improvement as in 2019/20.
- 3.19 Further information and support to systems on collective financial management can be found on the FutureNHS Collaboration Platform via <https://future.nhs.uk/connect.ti/Finance/grouphome>. (Note that you will need to create an account to access FutureNHS.)

Suspension of financial sanctions

- 3.20 It remains a key national priority to ensure that the NHS provider sector returns to overall financial balance. As part of this, all NHS Trusts and NHS Foundation Trusts have been asked to sign up to financial improvement trajectories for 2020/21. We propose that any Trust which does so will continue to be protected from the impact of certain contractual sanctions, broadly in line with the arrangements which have applied since 2016. The Contract wording giving effect

to this suspension of sanctions continues to be set out in Service Condition 36.38 and General Condition 9.26 (SC36.28 and GC9.9 in the shorter-form Contract), with appropriate amendment from the 2019/20 provisions.

- 3.21 This measure affects the financial sanctions which would otherwise apply where providers fail to deliver certain of the national standards set out in Schedules 4A and 4B of the Particulars of the Contract. The only national standards in those Schedules for which sanctions remain active for all providers are those covering cancelled operations, mixed sex accommodation, the duty of candour and 52-week waits; the latter remains set at £2,500 per breach. (As described above, sanctions in relation to infection control targets have been discontinued.)
- 3.22 The suspension of these sanctions applies only as set out in paragraphs 3.20 to 3.21 above; in all other situations, commissioners must continue to apply the national sanctions set out in Schedules 4A and 4B.
- 3.23 The suspension of sanctions in specific circumstances does not affect the ability of commissioners to use other levers available within the Contract to manage the general performance of providers (including, for instance, the provisions of General Condition 9 on Remedial Action Plans (RAPs) and Service Condition 28 on Information Breaches).
- 3.24 However, although commissioners should monitor and manage providers' performance, they must not withhold or retain funding under GC9 if providers fail to achieve the trajectories in full. We have included a provision at GC9.26 (GC9.9 in the shorter form) to make clear that financial sanctions must not be applied in the above circumstances.
- 3.25 For the future, as we implement in full the outcome of the Clinical Review of NHS Access Standards, we will review the ongoing appropriateness of the current sanctions regime.

Changes to the National Tariff Payment System

- 3.26 NHS England and NHS Improvement have recently completed a consultation on changes to the [National Tariff Payment System for 2020/21](#) and have confirmed that the objection threshold was not triggered by the consultation responses received. The final Tariff package will therefore reflect the consultation proposals and will be published in March 2020.
- 3.27 The new Tariff establishes new blended payment arrangements for outpatient care and maternity services. Blended arrangements will be mandatory for outpatient care, whereas for maternity services Local Maternity Systems will be able to choose between retaining the current pathway tariff approach and moving to a blended payment model.
- 3.28 We have added a new provision at Service Condition 36 to give effect to the new outpatient rule; detailed local agreements in respect of both outpatients and maternity (where applicable) should be set out in Schedule 3A (Local Prices).

4 Advice and support

Queries and updates

- 4.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact nhs.cb.contracts@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general.
- 4.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.

eContract

- 4.3 The eContract system will remain available for 2020/21. The basic approach will be unchanged, focussing on the production of tailored contract documentation, rather than the storage of contracts. The eContract allows users to create tailored contracts in either the full-length or shorter-form versions.
- 4.4 The eContract system will be updated to reflect the changes made in the 2020/21 Contract. Further details about the eContract system are available in paragraph 33 below and via <https://www.econtract.england.nhs.uk/Home/> and england.econtract@nhs.net.

Model grant agreement and model sub-contract

- 4.5 NHS England has also developed a model grant agreement as a funding vehicle for voluntary bodies, for commissioners to use where a commissioning contract may not be appropriate. The model agreement (last updated in May 2018) and associated guidance are available at <http://www.england.nhs.uk/nhs-standard-contract/grant-agreement/>. See also paragraph 11 below.
- 4.6 [Model sub-contracts](#) suitable for use with the full-length Contract and with the shorter-form Contract, updated in line with the final National Variation, will be made available in due course on the [NHS Standard Contract 2020/21 web page](#). See also paragraph 38 below.

Section A General guidance on contracting

5 Terminology

- 5.1 Throughout this guidance, we continue to use the generic term “the NHS Standard Contract” or “the Contract” to refer collectively to both the full-length and shorter-form versions. Where there are material differences in approach between the two versions of the Contract, we identify these below.
- 5.2 Obligations under the Contract are expressed in different ways. We are sometimes asked to explain what expressions such as “use reasonable endeavours to” or “have regard to” mean, in practical terms. We have included a one-page guide to the commonly-used terms in Appendix 9.

6 Content of this section

- 6.1 This section of the Technical Guidance offers broad advice about general contracting issues – including when the NHS Standard Contract should be used, contract signature, collaborative contracting, contract duration and extension, dispute resolution, and non-contract activity.

7 When should the NHS Standard Contract be used?

- 7.1 The NHS Standard Contract exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of provider and allowing economies in the drafting and production of contracts, for example in respect of legal advice.
- 7.2 By its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, NHS England mandates that the NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services). The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.
- 7.3 The only exceptions are:
- primary care services commissioned by NHS England (or by CCGs under delegated authority), where the relevant primary care contract should be used;
 - Direct Enhanced Services commissioned from GP practices through Primary Care Network arrangements via additional services specifications being introduced for 2020/21; and

- any primary care improvement schemes agreed by CCGs with GP practices (with contractual arrangements, involving a variation or supplement to existing general practice contract, agreed between local NHS England teams and CCGs). Such Local Improvement Schemes (LIS) involve payments for improving the quality of services provided under an existing GP contract, not the commissioning of additional services.

- 7.4 CCGs must use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that were previously commissioned as Local Enhanced Services. This will apply where the CCG is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements.
- 7.5 The NHS Standard Contract is neither mandated nor intended for use by provider organisations when contracting with other provider organisations for the provision of clinical services. In most circumstances such arrangements will be correctly categorised as a sub-contracting of services commissioned under an NHS Standard Contract – on which see paragraph 38 below.

8 Contracting for integrated services

Integrated Care Provider Contract

- 8.1 A variant of the NHS Standard Contract, designed specifically for use for commissioning an integrated package of services for a population through a lead provider (the [Integrated Care Provider \(ICP\) Contract](#)), is now available. The ICP Contract will be updated for 2020/21 following completion of consultation on the generic Contract: changes which are made to the final version of the generic Contract will be carried over as appropriate to the ICP Contract and an updated version will be published in spring 2020.

Contracting for integrated primary and secondary care

- 8.2 Outside of the ICP approach, if a commissioner wishes to place a contract for integrated secondary and primary medical care services, it can do so using the NHS Standard Contract with the addition of Schedule 2L (Provisions Applicable to Primary Medical Services). This Schedule introduces the further provisions required in order to make the Contract compliant with the Alternative Provider Medical Services (APMS) directions. With this addition, the Contract will be both an NHS Standard Contract and an APMS contract. The current template form of those further provisions, for inclusion in Schedule 2L where appropriate, is available on the [NHS Standard Contract 2020/21 web page](#) along with guidance about their use.
- 8.3 The APMS-compliant version of the NHS Standard Contract (i.e. one including template APMS provisions) is likely to be useful where, for instance, a commissioner wishes to commission an integrated NHS 111 and out-of-hours primary medical service from the same provider through a single procurement process.

Lead provider and alliancing models

- 8.4 The NHS Standard Contract can readily be used as a “lead” or “prime” contract. Under this model, the commissioners enter into a contract with a single lead provider / prime contractor. That contract allocates risk and reward as between the commissioner and the prime contractor. The prime contractor then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The prime contractor remains responsible to the commissioners for the delivery of the entire service, and for the co-ordination of its ‘supply chain’ (i.e. its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime contractor is likely to be a provider of clinical services itself, but it could sub-contract all but the co-ordination role. The optional schedule of primary care provisions (see paragraph 8.2 above) enables the Contract to be used as a prime or lead contract under which a package of primary and secondary care services may be commissioned.
- 8.5 The key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability; contracting for outcomes; and an expectation of innovation. Some forms of alliance contracting are not currently compatible with the NHS Standard Contract, specifically where multiple providers are signatories to a single commissioning contract – but the key characteristics of alliance contracting can be accommodated in a structure involving one or more NHS Standard Contracts (and, where appropriate, other forms of commissioning contract). We have produced a model Alliance Agreement and supporting materials which commissioners may use as a starting point for development of their own alliancing arrangements with providers. If you would like to see a copy or discuss an alliancing approach, please contact us via england.contractsengagement@nhs.net.

Integrated Support and Assurance Process for novel and complex contracts

- 8.6 Innovative contracting approaches can offer benefits, but they may also involve risks. In this context, NHS England and NHS Improvement have published the [Integrated Support and Assurance Process: guidance on assuring novel and complex contracts](#) (ISAP). ISAP has two purposes: to support the work of local commissioners and providers in creating successful and safe contracts, and to provide a means of assurance that this has happened.
- 8.7 Examples of complex contracting arrangements, likely to fall within the scope of ISAP, will include any use of the ICP Contract, but also more generally:
- commissioning systemically significant new care models that result in significant changes in local health systems;
 - contracts aiming to integrate services along a care pathway, such as for older people or cancer patients; and
 - contracts which include complex delivery and reimbursement mechanisms for specialised services or with population-based budgets or significant levels of payment conditional on outcomes.

- 8.8 The ultimate decision on whether the ISAP should apply to a complex contract is at NHS England's and NHS Improvement's discretion. Commissioners should engage with their regional NHSE/I team as early as possible to establish whether their procurement or other arrangement would benefit from going through the ISAP.

9 When to use the shorter-form Contract

- 9.1 The shorter-form Contract must not be used for contracts under which acute, cancer, A&E, minor injuries, 111 or emergency ambulance services, or any other hospital inpatient services, including for mental health and learning disabilities, are being commissioned.
- 9.2 Restricting use of the shorter-form Contract in this way significantly reduces the number of detailed requirements which it has to include, and these providers (that is, providers of those services for which the shorter-form Contract must not be used) tend to be larger organisations.
- 9.3 Commissioners may use the shorter-form Contract for all other services for which the NHS Standard Contract is mandated – for non-inpatient mental health and learning disability services, for any community services, including those provided by general practices, pharmacies, optometrists and voluntary sector bodies, for hospice care / end of life care services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.
- 9.4 The shorter-form Contract may also be used for diagnostic, screening and pathology services, including where the National Tariff guidance sets a mandatory national price. This allows the shorter-form Contract to be used in a wider range of appropriate situations. Including the provisions relation to mandatory national prices adds to the length of the Contract, so we strongly recommend that commissioners use the e-Contract functionality, to ensure that this additional wording only appears in those contracts where it is required.
- 9.5 Within the parameters set out in this Guidance, it is for commissioners to determine when they wish to use the shorter-form version of the Contract, as opposed to the longer form.
- 9.6 We have not set a specific financial threshold for use of the shorter-form contract, but we strongly encourage commissioners to use it for appropriate services (as described in 9.3 above) with lower annual values, which will tend to include the great majority of contracts held by the smaller provider organisations which this new contract form is particularly intended to assist. The end result of this approach should be that the shorter-form Contract is used for most contracts with smaller providers, including voluntary organisations, hospices (where grant agreements are not being used – see paragraph 11 below), care home operators and providers of enhanced services such as general practices, pharmacies and optometrists.
- 9.7 However, in deciding whether to use the shorter-form Contract to commission services for which it may be used, commissioners should consider carefully the differences in the management process and other provisions between the shorter-

form and full-length Contracts. If the “lighter touch” approach of the shorter-form is not thought appropriate to the services, the relationship or the circumstances, the full-length Contract may be used. Also, if the provider is providing other services under the full-length Contract, it may be more appropriate to keep all services on this form.

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

10 What elements of the Contract can be agreed locally

- 10.1 The elements of the Contract for local agreement fall within the Particulars. The Service Conditions may be varied only by selection of applicability criteria, determining which clauses do and do not apply to the particular contract. The content of any applicable Service Condition may not be varied. The General Conditions must not be varied at all.
- 10.2 Commissioners must not:
- put in place locally-designed contracts or service level agreements for healthcare services, instead of the NHS Standard Contract; or
 - vary any provision of the NHS Standard Contract except as permitted by GC13 (Variations); or
 - seek to override any aspect of the NHS Standard Contract.
- 10.3 Where commissioners and providers wish to record agreements they have reached on additional matters, they may use Schedule 2G (Other Local Agreements, Policies and Procedures) or (in the full-length Contract) Schedule 5A (Documents Relied On) for this purpose. Commissioners are reminded that any such local agreements must not conflict with the provisions of the Contract. In the event of any such conflict or inconsistency, the provisions of the Contract will apply, as set out in GC1.

11 Use of grant agreements

- 11.1 Where voluntary sector organisations provide healthcare services, or other services in support of the healthcare needs of the local community, commissioners may choose to provide funding support for those services through grant agreements, rather than using the NHS Standard Contract.
- 11.2 Use of the Standard Contract is, however, necessary where it is clear that the commissioner is commissioning (as distinct from providing funding support for) a specific clinical service (as distinct from non-clinical or clinical support services) from a voluntary sector organisation. (Note also that, whatever the nature of the services being provided, if those services are being competitively tendered and potential providers include both voluntary sector and other types of provider, the same form of contract must be offered to all potential providers of the relevant

service – which precludes the use of a grant agreement.)

- 11.3 However, where the commissioner is providing funding support towards the costs a voluntary sector provider faces in running a service (and especially where some of the providers' costs are being met by donations and/or payments by service users), it will generally be more appropriate for commissioners to use a grant agreement rather than the Standard Contract, and we would strongly urge them to do so. This will apply to some hospice services, for example.
- 11.4 NHS England has published a non-mandatory model grant agreement for use by CCGs with voluntary sector organisations which provide clinical services (available on the [NHS Grant Agreement web page](#)). This has been designed to provide an appropriate level of assurance for commissioners about the quality of care to be provided by the voluntary organisation – but without replicating the more onerous requirements of a full contract. Additional guidance on grant funding is available on the NHS Grant Agreement web page.
- 11.5 Where commissioners choose not to use the national model grant agreement, they should ensure that any locally-drafted grant agreements are very clear as to the purpose for which the grant is being made, suitably robust (particularly in terms of clinical governance requirements) and properly managed.

12 NHS Continuing Health Care and Funded Nursing Care

- 12.1 A new [National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care](#), published by the Department of Health and Social Care, took effect on 1 October 2018. The NHS England CHC Operating Model is available at <https://www.england.nhs.uk/healthcare/>.
- 12.2 The NHS Standard Contract (typically the shorter-form version) must be used where an NHS commissioner is funding an individual's NHS Continuing Health Care (NHS CHC) placement in a care home or package of home care. Commissioners must not rely on locally-drafted alternatives to the NHS Standard Contract or on purchase orders alone. Nor are Non-Contract Activity approaches suitable in a CHC context. CHC is, typically, planned activity, meaning that there should be time to put appropriate contract documentation in place; and the interests of service users and commissioners will be best served if this is always done.
- 12.3 It is clear that there will often be benefits from collaborative commissioning of, and contracting for, NHS CHC services – producing economies of scale for commissioners and reducing the number of separate contracts a care home needs to hold, for instance. Collaborative contracting will also enable commissioners to work jointly in respect of quality oversight of NHS CHC services, ensuring that their limited resource is used effectively and without placing multiple burdens on providers.
- 12.4 When contracting for NHS CHC, commissioners may put in place standardised care packages with fixed prices for different levels of complexity of need, and these should be set out in Schedule 3A (Local Prices). Where individually priced packages of care for new patients are likely to be agreed in-year based on differing inputs from different staff types, Schedule 3A can also record the agreed

unit prices for such inputs. It should be possible to avoid having to vary the contract formally in-year to record each new or revised individual care package. The call-off / framework arrangements described in section 27 below will often work well for CHC, allowing the detailed requirements for an individual service user to be set out in a specific Individual Placement Agreement, which sits within an over-arching contract with the provider.

- 12.5 We do not mandate use of the NHS Standard Contract in respect of NHS Funded Nursing Care (NHS FNC) (where, following assessment, the NHS makes a nationally-set contribution to the costs of a nursing home resident's nursing care). If commissioners and providers agree locally that use of the Contract offers an effective route through which NHS FNC payments can be administered, they may do so.

13 Collaborative contracting

- 13.1 The NHS Standard Contract may be used for both bilateral and multilateral commissioning i.e. for commissioning by a single commissioner or by a group of commissioners collaborating to commission together, with one acting as the co-ordinating commissioner.
- 13.2 Clearly, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model – but it is an approach which we strongly encourage. There can be great benefits for commissioners from working closely together to negotiate and manage contracts with providers. Using the co-ordinating commissioner model enables a consistent approach to contracting and is more efficient for both commissioners and providers, avoiding a proliferation of small, separate contracts.
- 13.3 In particular, we would encourage commissioners to work together to use, where they can, consistent contract metrics for the same provider – local quality and reporting requirements, local agreements, policies and procedures, Activity Planning Assumptions or Prior Approval Schemes. This will help to reduce the administrative burden which providers face.
- 13.4 Where commissioners choose to contract collaboratively, they should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider, and how they are to make decisions in relation to the contract and instruct the co-ordinating commissioner to act on their behalf, in a formal collaborative commissioning agreement (CCA). The CCA is a separate document entered into by a group of commissioners and governs the way the commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, a contract which has been signed by all the parties (as outlined in paragraph 15 below) is still legally effective and binding on all the parties without a collaborative agreement in place. The CCA should not be included in the contract (though the allocation of roles and responsibilities between commissioners which are party to a contract can, where necessary, be set out in Schedule 5C (Commissioner Roles and Responsibilities) to that contract).
- 13.5 Model CCAs are available on the [NHS Standard Contract web page](#).

- 13.6 Where NHS England is the sole commissioner party to a contract, but the lead for commissioning of particular services from the provider is being taken by different NHS England teams, use of a formal CCA is not appropriate – NHS England is one legal entity. However, it is important to ensure that the different teams understand what role each will play in managing the contract and communicate this clearly to the provider.

14 Which commissioners and providers can be party to the Contract

- 14.1 The Standard Contract must be used by CCGs and by NHS England in the circumstances explained in paragraph 7 above and may be used by local authorities and by other public bodies such as the police. Any combination of these commissioners may agree to work together to hold a single contract with a given provider, identifying a co-ordinating commissioner and putting in place a collaborative agreement as set out above.
- 14.2 Even where they are placing separate contracts from NHS commissioners, local authorities may wish to use the NHS Standard Contract, for example to commission services from a provider whose main business is the supply of services to NHS commissioners. In this situation, it is not mandatory for local authorities to use the NHS Standard Contract, but they may choose to do so. In a situation where NHS commissioners and a local authority are intending to sign the same single contract with a provider, however, and where the service being commissioned involves a healthcare service, then the NHS Standard Contract must be used.
- 14.3 By contrast, where an NHS commissioner has devolved commissioning responsibility to a local authority under a formal lead commissioning (section 75) arrangement, the local authority would be able to contract on its own chosen basis. As the NHS commissioner would not be a party to the contract, there would be no requirement for the NHS Standard Contract to be used – although, again, the local authority may choose to do so. The NHS commissioner should, however, satisfy itself that the arrangements being put in place are such that it can meet its statutory obligations.
- 14.4 There is no restriction on the types of provider organisation which can hold an NHS Standard Contract. These can include (but are not limited to) NHS Trusts, NHS Foundation Trusts, charities and private companies of different types.
- 14.5 We are sometimes asked about whether a sole trader can be a provider under an NHS Standard Contract. There is no prohibition on awarding a commissioning contract to a sole trader, but the commissioner will need to satisfy itself (as it would in respect of any other type of provider) that the sole trader:
- is appropriately skilled, qualified and experienced to deliver the service in question; and
 - holds a Monitor licence where required (and the facilities from which it intends to deliver the service are CQC registered); and

- has appropriate insurance or other indemnity arrangements in place; and
- has sufficient financial assets (and/or can provide an appropriate third-party guarantee or other form of security) to provide assurance to the CCG that he or she has the wherewithal to deliver the contract in accordance with its terms.

15 Signature of contracts and variations

- 15.1 A contract must be signed by an appropriately authorised signatory of each party to it. Where a group of commissioners wishes to enter in to a contract with a provider, each of the commissioners must sign the contract and cannot delegate this responsibility to another commissioning body.
- 15.2 We strongly recommend that contracts (and other contractual documents) are signed physically, in hard copy form, by the authorised signatory of each party, unless legal advice has been taken in accordance with paragraph 15.4 (below). As set out in GC38, this can be done in counterpart form where necessary. Such hard copy signatures can be physically returned to the co-ordinating commissioner by post, but can alternatively be scanned and returned to the co-ordinating commissioner by email. The co-ordinating commissioner should maintain a record of all contract signatures and should provide copies to other commissioners for audit purposes.
- 15.3 We recognise that the collection of signatures from commissioners is a time-consuming process. Variations may therefore be signed by the provider and the co-ordinating commissioner (on behalf of all commissioners) only, rather than by all commissioners (see GC13.3). Commissioners must therefore ensure that their collaborative agreements set out very clear arrangements through which Variations are agreed amongst commissioners, prior to signature by the co-ordinating commissioner. The co-ordinating commissioner must maintain a record of evidence that each variation has been properly approved by all commissioners (whether or not they are directly affected by the variation – because all are parties to the contract being varied) and must be prepared to confirm to the provider that it has the agreement of all commissioners, before a variation is signed.
- 15.4 We recognise that use of electronic signatures (via appropriate internal governance procedures and IT software) for signing of legal documents is becoming common in some areas of commerce. Law and practice in this area is still developing. We recommend that parties do not use or accept electronic signatures for signing of contracts (or other contractual documents) without having taken their own legal advice on appropriate governance arrangements and on the risks involved.

16 Legally binding agreements

- 16.1 The contract creates legally binding agreements between NHS commissioners and Foundation Trust, independent sector, voluntary sector and social enterprise providers. Agreements between commissioners and NHS Trusts are 'NHS contracts' as defined in Section 9 of the National Health Service Act 2006. NHS Trusts will use exactly the same contract documentation, and their contracts should be treated by NHS commissioners with the same degree of rigour and

seriousness as if they were legally binding. Agreements that involve a local authority as a commissioner and an NHS Trust will be legally binding between those parties.

17 Contract duration

- 17.1 The NHS Standard Contract allows the commissioner to select the contract term it wishes. There is no default duration.
- 17.2 Longer-term contracts can be a key tool for commissioners in transforming services and delivering significant, lasting improvements in service quality and outcomes. A longer-term contract allows time for providers to plan and deliver substantial service reconfiguration, for example. Where significant up-front capital investment is needed, a longer-term contract allows the provider to recoup this over the full duration of the contract. In both cases, offering contracts with a longer term has the potential to attract a wider range of providers, thus strengthening the pool of bidders from which the commissioner can select its preferred provider.
- 17.3 Equally, there will, of course, be situations where contracts with a shorter term may be appropriate, for example where the commissioning requirement is for a short-term or pilot service or where the service or supplier landscape is changing rapidly.
- 17.4 There is no nationally-mandated limit to contract duration, nor is there a central approval process for contract terms beyond a certain duration. It is for commissioners to determine locally, having regard to the guidelines below, the duration of the contract they wish to offer.
- Commissioners will need to consider carefully what benefits they can expect from offering providers the increased certainty of a longer-term contract, setting this against the need to ensure that they are able to use a competitive procurement approach when this will be in patients' best interests, in line with regulations and guidance. Commissioners should consider patient choice, competition, the likelihood of technological and other developments affecting service delivery models, all relevant commercial and market considerations, in determining the appropriate length of contract. Contract length should be considered in conjunction with consideration of including any right to extend the contract (see paragraph 18) and/or the consequences of early termination (see paragraph 47).
 - Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.
 - Commissioners must ensure that the duration of any contract (and any proposed right to extend that period) is in compliance with their own standing financial instructions (SFIs) and other governance requirements, and that any approvals are obtained in line with those requirements. NHS England commissioners should note that NHS England's own SFIs set out specific arrangements for the approval, prior to advertisement, of procurement processes; commissioning teams should ensure that they review the SFIs in

advance of advertisement to ensure that all required approvals have been obtained.

17.5 Alongside flexibility of contract duration, the Contract:

- includes an explicit acknowledgement of the parties' rights to terminate the Contract or any Service by mutual agreement (GC17.1); and
- continues to include provisions for early termination of the Contract or a Service on a no-fault basis, with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).

17.6 The Contract also continues to allow for National Variations to be mandated by NHS England, in particular to reflect annual updates to the NHS Standard Contract. Both commissioner and provider are able to propose other variations (for example to effect annual reviews of local prices, service specifications and local quality requirements).

18 Extension of contracts

18.1 Commissioners may wish to offer a contract with the possibility of extension – for example, a five-year contract term with the potential for an extension, at the commissioner's discretion, by a further two years.

18.2 The NHS Standard Contract therefore includes an optional provision (Schedule 1C Extension of Contract Term) so that details of any potential extensions can be recorded at the start of the contract.

18.3 It is essential that this provision is not misused. The guidance below is designed to reduce the risk of challenges for breach of procurement rules, and so should be complied with in all cases.

- The provision may be used only where the commissioner has made clear to all potential providers of the service, from the very outset of the procurement process, the period and other details of any possible extension to the initial contract term.
- We strongly advise against including the provision in contracts awarded without a Prior Information Notice being issued, or the contract being advertised, in accordance with the Public Contracts Regulations.
- Commissioners should have regard to procurement guidance in determining whether it is appropriate to offer provision for contract extension. We would generally advise commissioners not to provide for extensions of more than two years – and certainly not for extensions longer than the original contract term.
- Any provision for extension must be made clear in the Prior Information Notice, in any advertisement, in communications with potential providers and in the contract at the point the contract is agreed and signed and must not be varied subsequently.

- Any extension provision must apply to all the Services within the contract and to all the commissioners who are party to it.
- The option may be exercised once and once only (i.e. it may be an option to extend for, for example, one year or two years, but not for one year then for another year).

18.4 Where provision for extension is made in a contract, the actual extension can then be effected by the co-ordinating commissioner giving notice to the provider that it wishes to implement the extension. Where such notice is given, the contract term is then automatically extended; no Variation is necessary to effect it, and the provider may not refuse an extension (though it may of course give notice to terminate the contract under the provisions of GC17).

19 Updating non-expiring contracts through National Variation

19.1 Where contracts are in place which do not expire on 31 March 2020, the parties will need to update their terms by implementing a National Variation. This will ensure that their local contract reflects up-to-date national policy requirements and the current legislative framework.

19.2 To do this, the co-ordinating commissioner and provider may simply sign the National Variation Agreement template (which will be made available in due course on the [NHS Standard Contract web page](#)). As an alternative, they can choose to use the [eContract system](#) to transfer their existing contract into the updated 2020/21 NHS Standard Contract form in its entirety, maintaining the current duration of the contract. (An existing contract should not be transferred onto the shorter-form version, as that will almost certainly constitute a material change to the terms of the contract, in contravention of procurement rules.)

19.3 Where providers and commissioners are unable to agree either of these options, they should use the mediation and disputes process set out in their existing contract.

19.4 Where neither option is agreed, commissioners will be able to issue a notice to terminate the existing contract on three months' notice, as set out in GC13.13 (GC13.4 of the shorter form).

20 Contract expiry, new contracts and notice requirements

20.1 We are often asked how, where contracts are approaching their expiry date, commissioners and providers should communicate with each other about their future intentions and what timescales apply, and some general guidelines on this are set out below.

- Where a contract is expiring, there is no contractual requirement on either party to give notice to terminate the contract or a specific service at the point at which the contract expires.

- Equally, there is no contractual requirement for commissioners to publish generic 'commissioning intentions' by a given date. Issuing of generic commissioning intentions documents, often aimed at a commissioner's providers collectively, rather than setting out specific information for individual providers, is at the discretion of the relevant commissioner.
- However, early communication of both commissioner and provider intentions is always good practice. In terms of a possible new contract for a new financial year, it is in both parties' interests to set out their intentions clearly in time for necessary negotiations, or other processes, to be completed before any new contract is intended to take effect.
- In advance of the expiry of a contract, the commissioner **should as a matter of good practice**, for instance, notify the provider that it no longer wishes to commission any services (or a specific service) from that provider in the following year, perhaps because it intends to undertake a competitive procurement process. In such a case, the requirements for the procurement process to be transparent and for the incumbent provider to share information about the services and the potential impact of handover to a new provider (for example, workforce information in expectation of TUPE applying), will mean that early communication of commissioner intentions is always required.
- Similarly, a provider **should as a matter of good practice** notify the commissioner that it no longer wishes to provide a particular service in the following year. If the service has been designated as a Commissioner Requested Service (CRS) (see paragraph 37 below), then restrictions on the provider's ability to withdraw provision of the service will apply, in line with NHS Improvement's CRS guidance.
- There will be other instances where either party is seeking changes, in a new contract for the following year, to services commissioned or to detailed contractual provisions (local quality and reporting requirements, say). As with in-year variations to agreed contracts, there is no specific period of notice which must be given for such changes; rather, the complexity of the issues involved and the time realistically needed to implement the specific changes proposed should drive the timescale for discussions. Both parties should remember that agreeing a contract is a process of negotiation; it makes sense for all major changes which either party wishes to propose to be 'on the table' before detailed negotiations get under way, but it will often be possible to accommodate smaller changes after that point.

21 Heads of Agreement

- 21.1 We are sometimes asked about Heads of Agreement and whether these have a place in the negotiation of new contracts.
- 21.2 Heads of Agreement are different to contracts. They are typically pre-contract agreements and are not intended to create a binding arrangement between the parties. In complex procurement and contract negotiation scenarios, Heads of Agreement (sometimes also referred to as Heads of Terms) may be useful as a way of documenting progress towards intended signature of a binding contract –

but in most NHS commissioning situations, both parties will be better advised to focus on agreeing and signing the actual contract itself.

22 Changes in counting and coding practice

- 22.1 One instance where formal notification is required in advance of a new financial year, even where a contract is expiring, is in relation to changes in counting and coding practice, as set out in SC28. This requires that each party gives the other at least six months' notice of locally-proposed counting and coding changes, with the change normally taking effect from the start of the following Contract Year. Further detail, covering how the financial impact of counting and coding changes should be managed, is set out in paragraph 44 below.

23 Resolution of disputes

- 23.1 NHSE/I have now published joint guidance on contract dispute resolution for 2020/21 (in Annex D of the [NHS Operational Planning and Contracting Guidance 2020/21](#)). Two separate documents have been published.
- One deals with the resolution of disputes relating to the agreement of new contracts for 2020/21 between commissioners and NHS providers. The guidance describes the steps and timetable for the process, the final stage of which involves arbitration through an Independent Arbitration Panel convened by NHSE/I.
 - The second relates to the resolution of any disputes regarding the terms of any local variation to non-expiring contracts which are intended to take effect for 2020/21. Here, the parties must follow the process set out in GC14 of their contract – escalated negotiation, then mediation, then expert determination by an independent expert.
- 23.2 Note the changes made to GC14 for 2020/21, which will mean that, in line with the arrangements which have operated in practice in recent years,
- mediation must be arranged jointly by NHSE/I for disputes involving NHS Foundation Trusts (as well as for NHS Trusts, as currently); and
 - expert determination for disputes involving NHS Trusts and NHS Foundation Trusts must be undertaken by an independent and suitably experienced Expert allocated by NHSE/I, rather than via CEDR or any other body.
- 23.3 We have also published a brief [“top tips” document](#) with advice, based on recent expert determinations, on how to minimise contractual disputes.

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

- 24.1 There may be instances where commissioners and providers have not signed a new contract by the time at which the current contract expires – but, because the services being provided are crucial for the local community, they must continue to be delivered.

- 24.2 In this situation (assuming services continue to be provided and paid for), a contract will be implied between the parties. The local terms of that implied contract will reflect what can be inferred as having been agreed between them – based on correspondence between them, notes of meetings, drafts exchanged and so on. It would be reasonable to assume that the implied contract would incorporate the nationally drafted terms of the NHS Standard Contract for the relevant year (since those are the only terms on which NHS commissioners are permitted to commission the services in question).
- 24.3 However, in the absence of clear evidence of terms agreed, aspects of the implied “deal” between the parties may be uncertain. For this reason, it is very important that the parties continue to make every effort to reach agreement and sign a contract as soon as possible.

25 Non-contract activity

- 25.1 Non-contract activity (NCA) is the term used to refer to NHS-funded services delivered to a patient by a provider which does not, at the point at which those services are delivered, have a written contract in place with that patient’s responsible commissioner, but which does have a written contract for the delivery of that service in place with at least one other NHS commissioner.
- 25.2 National guidance on NCA was previously set out in the *Who Pays?* guidance. An [updated version of Who Pays?](#) will be published shortly, and this will confirm that the normal rules for determining the commissioner responsible for payment apply to NCA in the same way as they do to activity covered by written contracts. We have taken the view that it is more appropriate for other detailed aspects of NCA arrangements to be described in this Contract Technical Guidance.
- 25.3 For 2021/22, NHS England and NHS Improvement are intending to review the operation of financial arrangements for NCA and other low-volume flows of activity, with a view to reducing the associated burden of invoice production and payment if possible. We will engage with stakeholders on this issue in the summer of 2020, so that any new arrangements can be put in place well ahead of the 2021/22 contracting round.

What contractual terms apply under an NCA approach?

- 25.4 NCA is undertaken by the provider on the terms of the NHS Standard Contract in place between that provider and its host commissioner(s). A contract on those terms will be implied as between the patient’s responsible commissioner and the provider (except where specific different arrangements are agreed between the responsible commissioner and the provider, for example in respect of prices as set out in 2.4b) below).
- 25.5 Note in particular that:
- a) services will be delivered in accordance with the service specifications and other terms and conditions of the provider’s contract with its host commissioner;
 - b) prices for services will be either the relevant national prices (where these apply

and subject to any agreed Local Variations or Local Modifications) or (where there are no applicable national prices) the local prices set out in the provider's contract with its host commissioner(s) – but noting that, where the host contract provides for a service to be paid for as part of a block or similar arrangement, the price payable for the NCA will be (a) the national price, where there is one for that service or (b) a local price to be agreed between the provider and the responsible commissioner in accordance with National Tariff guidance;

- c) arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance and the terms and conditions set out in the NHS Standard Contract; this means in practice that providers must invoice for NCA in accordance with either SC36.35 or SC36.36 (full-length Contract) or SC36.26 (shorter-form Contract);
- d) commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements – but must, if they intend to do so, contest payment within the timescales set out in SC36.45 (full-length) and SC36.34 (shorter-form); and
- e) commissioners and providers should work together in good faith to minimise disagreements relating to prices and payment for NCA, but any formal disputes must be resolved in accordance with the dispute resolution procedure set out in GC14 of the Contract.

When can an NCA approach be adopted?

- 25.6 Having a written contract will always be more robust and clearer than having an implied contract on an NCA basis; there will be less scope for misunderstanding and dispute with a written contract in place. Our advice therefore remains that written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider in all cases where there are established flows of patient activity with a material financial value.
- 25.7 NCA arrangements are not intended as a routine alternative to formal contracting but are likely to be necessary in some circumstances, usually for small, unpredictable volumes of patient activity delivered by a provider which is geographically distant from the commissioner.
- 25.8 The NCA approach can be appropriate for acute hospital services in some circumstances. On the one hand, the national rules about patient choice of provider for elective care – and the simple fact that patients can require emergency treatment anywhere, anytime – mean that there are small, irregular and unpredictable flows of patients between most CCGs and most hospital providers. And as most acute hospital services are covered by national currencies and prices, there is less risk involved in relying on an implied contract – because both commissioner and provider understand the terms on which payment will be based. Nonetheless, as a guideline, we would strongly recommend that any CCG with an anticipated value of activity of over £200,000 per annum with an acute provider should put in place a written contract with that provider, rather than relying on the NCA approach.

- 25.9 The NCA approach may work less well – involving greater risk of lack of clarity – for services covered by local prices, such as mental health and community services or those which are the subject of a local variation or modification to national price – simply because the responsible commissioner will not have oversight or influence of the local prices or local variations or modifications agreed in the provider's contract with its host commissioner. We therefore recommend that, where possible, commissioners minimise use of the NCA approach for such services and situations. Similar limitations apply to services covered by block arrangements, as described in paragraph 2.4b) above.
- 25.10 Bespoke, high-cost, locally-priced residential placements of individual patients should always be covered by a written contract in the form of the NHS Standard Contract. Reliance on an NCA approach in this situation creates too great a risk of uncertainty as to what has been agreed. Agreed details can be set out in individual placement agreements called off under the contract, as described in paragraph 27 below.

Acceptance of referrals by NCA providers

- 25.11 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.
- 25.12 The Contract (full-length) includes a specific requirement on providers (SC6.8.2) to accept every referral, regardless of the identity of the responsible commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the responsible commissioner for the patient affected is a party to a written contract with the provider. (Note, however, the restrictions which apply in respect of GP referrals to elective acute services not made via eRS – see paragraph 42.18 below.)
- 25.13 There is also an equivalent provision in relation to the acceptance of emergency referrals and presentations which are within the scope of the services it provides (SC6.8.3 of the full-length Contract). Again, this requirement applies whether or not the responsible commissioner for the affected patient is a party to a written contract with the provider. There will be instances where a provider cannot safely accept an emergency referral, and so should reject it, and the Contract wording makes provision for this.
- 25.14 These provisions can be enforced by the responsible commissioner of any affected patient, either through the co-ordinating commissioner for the provider's main contract or directly via GC29.1 (Third Party Rights).
- 25.15 Conversely, we also set out clearly (SC6.10 in the full-length Contract) that the existence of a contract with one commissioner does not automatically entitle a provider to accept referrals in respect of, provide services to, nor to be paid for providing services to, individuals whose responsible commissioner is not a party to the contract, except (where appropriate) where such an individual is exercising their legal right to choice as set out in the [NHS Choice Framework](#) or where necessary for the individual to receive emergency treatment.

Commissioner prior approval for NCA activity

25.16 In this context, the following arrangements apply, within England, in terms of commissioner approval processes for NCA.

- a) No prior commissioner approval is required for emergency treatment on a non-contract basis.
- b) No prior commissioner approval is required for consultant-led elective care or in the case of mental health, services led by a healthcare professional, where the patient has exercised choice of provider under the legal rights set out in the NHS Constitution. A GP, dentist or optometrist referral is required in such cases, however: self-referral is not sufficient.
- c) In other circumstances than those set out in paragraphs a) and b) above, there is no presumption that a provider may see and treat patients, on a non-contract basis, and expect to be paid by commissioners. Commissioners have the right to determine which services they wish to commission and from which providers. Rather, the provider must seek prior authorisation from the responsible commissioner before assessing and treating the patient. Where prior authorisation is not granted, commissioners are under no obligation to pay for activity which is carried out by providers on a non-contract basis.

25.17 For elective NCA referred into an English provider across a UK border, the provider is advised to seek and obtain prior approval from the relevant NHS body in Scotland, Wales or Northern Ireland before providing care or treatment.

25.18 The NHS Standard Contract allows Prior Approval Schemes to be notified to a provider via its Co-ordinating Commissioner. These Schemes typically set out commissioner policies for a certain service or treatment (a high-cost drug, for instance, or a treatment of perceived limited clinical value). Further detail on Prior Approval Schemes is set out in paragraph 42.8-13 below. In the context of NCA, the key points to note are that

- a CCG cannot require a provider operating on an NCA basis to implement that CCG's Prior Approval Schemes; and
- a Prior Approval Scheme must not be used to restrict a patient's legal right of choice of provider.

Legal right of choice of provider

25.19 We often receive queries about the operation in practice of the legal right of choice of provider, as set out in the NHS Choice Framework, especially where written contracts are not in place.

25.20 Two fundamental points should be borne in mind.

- The legal right of choice of provider currently applies at the point of referral from primary care practitioners for first outpatient appointments for a physical or mental health condition to clinically appropriate providers which have a commissioning contract for the service required, that is, which have been

commissioned by a CCG or by NHS England to provide that service. In the case of physical health, the service must be led by a consultant. In the case of mental health, the service must be led by a consultant or a healthcare professional. At the point of referral, patients have the legal right to choose any clinically appropriate provider (the specific legal entity) in England which has been commissioned by at least one NHS commissioning body, to provide the particular service required. In this context, “the particular service” must be taken to mean the service as described in a written commissioning contract, including where and how that service is to be delivered.

- As well as the requirement to uphold the right of choice of provider, however, CCGs also have a more general duty, set out in legislation, to enable patients to make choices in respect of the care provided to them. In this context, CCGs should in principle welcome, rather than seeking to resist, the expansion of available choices for patients, so long as this is managed in an appropriate way.

26 Letting of contracts following advertisement

- 26.1 All commissioners should ensure that they are fully aware of, and comply with, the requirements and implications of the Public Contracts Regulations 2015, which came into force in 2016, in respect of the advertisement, procurement, award, variation and assignment or novation of contracts for healthcare services, and which now apply alongside the Procurement, Patient Choice and Competition Regulations 2013. Both sets of Regulations remain in force and will continue to be so unless and until amended or repealed.
- 26.2 The commissioner must let a contract to the chosen provider exactly on the basis notified to potential providers in the Prior Information Notice and/or otherwise advertised. This means that there must be a separate, specific contract put in place for the procured service, rather than – if the tender has been won by a provider which already has a contract with the commissioner – the new service being ‘added in’ to that existing contract. To do otherwise raises a risk of challenge from other potential providers on the grounds of a breach of procurement rules and should be avoided.

27 Use of the Contract for call-off arrangements

- 27.1 We know that many commissioners have successfully used the Contract in the context of a framework for, for example, care home placements. An NHS Standard Contract is entered into with each provider appointed to the framework, with processes for “call-off” of activity set out in Schedule 2A and prices/day rates for activity (perhaps based on a needs assessment) set out in Schedule 3A. The Commissioner then raises a purchase order (PO) or individual placement agreement (IPA) for each placement, and the PO or IPA references the Contract which is in place between the parties. (To be clear, a PO or IPA may only be used when there is an NHS Standard Contract in place with the provider; they must not be used in isolation.) Either the full-length or the shorter-form version would be fit for purpose in this context – but, as noted above, the same form of contract must be used with each provider appointed under a framework procurement. (We have developed a model IPA, which we will share with commissioners on request; if you

would like to see a copy, please contact us via nhscontractshelp@nhs.net.)

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

28 Contracting approaches to support personalised care

Universal Personalised Care

- 28.1 Ensuring that patients receive personalised care tailored to their individual needs is at the heart of the NHS Long Term Plan, and NHS England has now published a detailed programme for the development of more personalised approaches ([Universal Personalised Care: Implementing the Comprehensive Model](#)). The Contract now includes provision for inclusion of a Development Plan for Personalised Care at Schedule 2M. This can be used to set out actions which the commissioner and provider will take to give patients greater choice and control over the way in which their care is delivered. This is an optional schedule, but its use will be appropriate in many local contracts and is strongly encouraged. Further advice on completion of the Schedule is included in the Particulars.

Personal health budgets

- 28.2 Personal health budgets (PHBs) are one important tool in the delivery of personalised care. General information regarding PHBs is available at <https://www.england.nhs.uk/personal-health-budgets/>. Under current legislation, certain patient groups have a legal right to a PHB, and commissioners and providers should ensure that, as a minimum, these rights are upheld and promoted. Legal rights to have a PHB are currently in place for:

- people entitled to NHS CHC (or Continuing Care for Children);
- people who are entitled to NHS wheelchairs; and
- people who require aftercare services under section 117 of the Mental Health Act.

Schedule 2M can be used to set out plans and operational arrangements for the implementation of PHBs.

- 28.3 The guidelines below are intended to help commissioners determine the appropriate contracting model for each of the three options of managing a PHB, but commissioners will need to exercise local discretion and common sense to ensure that a proportionate approach is adopted.
- **Notional budget.** Where an NHS commissioning organisation itself commissions healthcare services funded by a PHB on behalf of an individual (a notional budget), use of the NHS Standard Contract is likely to be appropriate. Individuals' needs will be established through the care planning process, and the commissioner may need to contract with a provider to provide part or all of a package of care for one individual patient or for a number of patients, funded from a personal budget in each case. The contract should reflect how the needs of each individual patient will be met from his/her PHB. Individual care

packages can be handled within the contract as set out at paragraph 12.3 above.

- **Third party.** Where a PHB is being managed by a third party, (for example where the third party is a trust fund set up on behalf of the individual), the commissioner will contract with the third party organisation to organise, purchase and be responsible for, the patient's care and support. In these instances it may be appropriate to use the NHS Standard Contract to govern the relationship between the commissioner and the third party organisation managing the health budget, but the commissioner should consider on a case by case basis what approach to take. When the third party purchases the services and products on behalf of the individual as agreed in their care plan, the NHS Standard Contract should not be used.
- **Direct payment.** Where a commissioner makes a direct payment to an individual (or their representative or nominee) who then holds the PHB and contracts directly with a provider, the individual (or their representative or nominee) will not need to use the NHS Standard Contract, nor is there a need for a contract between the commissioner and the provider. The care plan, which is an agreement between the CCG and the individual, will set out the details of the needs to be met and the outcomes to be achieved by the services to be provided.

28.4 PHBs may in some cases be spent on non-clinical services or items not routinely commissioned by the NHS. Where this is the case, under the notional budget or third party options, use of the NHS Standard Contract is not appropriate; rather, the commissioner will wish to use the [NHS terms and conditions](#) for the supply of goods and the provision of services.

28.5 Funding for PHBs should not be about new money but money that would have been spent on that person's care using already commissioned NHS services. However, the funding that could be offered as a PHB may often be included in existing contracts, with many of these operating on a block basis. It is therefore important to ensure that both a clear strategic direction and relevant processes are in place to enable the freeing-up of funding for PHBs. From a contracting perspective, this can be addressed through agreement of appropriate local provisions in Schedule 2M (whether negotiated annually or through in-year variations). Therefore, alongside the technical steps to establish PHBs, commissioners also need to work closely with providers to influence change and improve services in key areas so that they are more responsive to the needs of individual users. This should be set out clearly in the local offer for PHBs.

29 Contracting fairly

29.1 The contract is an agreement between the commissioner(s) and the provider. Once entered into, the contract is a key lever for commissioners in delivering high-quality, safe and cost-effective services. However, the contract in isolation will not achieve this. An effective working relationship between commissioner(s) and provider is a key element of successful contracting.

29.2 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues for fear of upsetting each other – but nor will it

be one where each party focusses, aggressively and continuously, on protecting what it perceives to be its own narrow, individual interests.

29.3 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioners and providers across a healthcare system:

- have a shared vision for services, with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;
- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;
- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and
- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other.

(This is the approach that is encapsulated in our template System Collaboration and Financial Management Agreement – see paragraphs 3.10-19 above.)

30 Links to other resources

30.1 [NHS Operational Planning and Contracting Guidance 2020/21](#) has been published separately and includes the dispute resolution procedure guidance in [Annex D](#) (see paragraph 23 above); the Technical Definitions annex ([F1](#)) to the Planning and Operational Guidance continues to contain definitions for some of the Operational Standards and National Quality Requirements in Schedules 4A and 4B of the Contract.

30.2 Other useful links are set out below.

- [CQUIN Guidance and Indicators](#)
Queries relating to CQUIN can be sent to e.cquin@nhs.net
- [Who Pays? Determining the responsible commissioner](#)
Queries relating to *Who Pays?* can be sent to england.responsiblecommissioner@nhs.net
- [National Tariff Payment System for 2020/21](#)
Queries about the National Tariff Payment System can be sent to nhsi.pricing@nhs.net.

Section B Completing and using the Contract

31 Content of this section

- 31.1 The aim of this part of the Technical Guidance is to offer advice about both how key sections of the Contract should be completed and how the main contract management processes should be used in practice.
- 31.2 For each topic within this section, we highlight where specific changes have been made to the Contract for 2020/21. Please refer also to:
- Appendix 1, which lists each heading within the Particulars, Service Conditions and General Conditions and identifies whether each has changed at all for 2020/21;
 - Appendix 2, which goes through the different elements of the Particulars on a line-by-line basis, describing what each is for and how each should be completed.
- 31.3 The Technical Guidance is written primarily with the more complex, full-length version of the Contract in mind. Where appropriate, at the start of each section, we highlight briefly any key considerations in relation to the shorter-form Contract. A separate brief [User Guide](#) to the shorter-form Contract is also available.

32 Structure of the NHS Standard Contract

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

- 32.1 The Contract is divided into three parts.
- **The Particulars.** These contain all the sections which require local input, including details of the parties to the contract, the service specifications and schedules relating to payment, quality and information. The Particulars also drive the eContract in that commissioners are required to identify in the Particulars which categories of provider type and service are relevant. The selections made here then drive the content of the Schedules to the Particulars and the Service Conditions which will be included in the eContract form.
 - **The Service Conditions.** This section contains the generic, system-wide clauses which relate to the delivery of services. Some of these will be applicable only to particular services or types of provider. The eContract will automatically produce a contract with only the relevant clauses included, based on the choices made by the commissioner in the Particulars. For commissioners using a paper-based version of the contract, all variants of the clauses are included. The margin clearly identifies which clauses apply to which service types. The content of the provisions which are applicable to the services commissioned and the provider type cannot be varied.

- **The General Conditions.** This section contains the fixed standard conditions which apply to all services and all types of provider, including mechanisms for contract management, generic legal requirements and defined terms. These are not open to variation.

33 The e-Contract system

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

- 33.1 The [eContract system](#) hosts both the full-length and the shorter-form versions of the Contract.
- 33.2 The eContract system:
- is simple, quick to use, and reliable
 - focuses on the key benefit of the eContract approach – the production of tailored, shorter contract documentation which strips out content that is not relevant to the services being commissioned.
- 33.3 The eContract system is essentially a contract generation system, rather than a contract storage system. A system user selects basic contract options (for example, service categories and payment options) which both assist the user to select the right form of Contract to use (full-length or shorter-form) and drives changes to the Particulars or Service Conditions of the chosen form.
- 33.4 The system will then produce a tailored and shorter pdf version of the relevant version of the Service Conditions, including only those which are relevant to the specific services being commissioned. The system will also produce a tailored and partially populated Word version of the Particulars (full-length or shorter-form as appropriate). A system user can also create a contract proforma for use when the user intends to use the same tailored Service Conditions multiple times.
- 33.5 The user will then complete population of the Particulars locally (not within the eContract system) and will then issue the draft contract to the other party directly. The system will not store the final contract.
- 33.6 A user guide to the system is available on the [eContract portal](#), and an email helpdesk is available via england.econtract@nhs.net. The eContract system is designed to run on several internet browsers, including IE7, IE8, Mozilla Firefox or Google Chrome.

34 Tailoring contract content

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

Service categories

- 34.1 The service specifications (set out in Schedule 2A) describe the full detail of the services the provider is required to offer. The service categories, listed in the Particulars, are broad descriptions of different types of services; as set out above, their sole purpose in the contract is to determine whether or not certain provisions within the Particulars and Service Conditions apply to a specific contract. The most convenient way to apply this “tailoring” of the Contract content is through the [eContract system](#).
- 34.2 For this reason, the service categories are not an exhaustive list of all the possible types of service. Rather, the list reflects the way in which the content of contracts can be tailored to reflect the nature of the service being provided.
- 34.3 When completing the contract documentation, to ensure that all of the relevant contractual provisions are included, commissioners should tick as many of the service categories as are relevant to the specific contract. There is inevitably some imprecision with the categories; if in doubt, tick all of those that could potentially apply.
- 34.4 Note that the Community Services category is aimed at out-of-hospital services. These could be provided by NHS Trusts, independent and voluntary providers, GPs or optometrists. If a provider of community services also runs community hospitals with inpatient beds, and acute contractual provisions are relevant, then the commissioner may also wish to tick the Acute Services category. Where primary medical services (for example, GP out-of-hours services) are being commissioned under an NHS Standard Contract as part of a package of services, these should also be considered as within the Community Services category, but Schedule 2L (see paragraph 8.2 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).
- 34.5 We have clarified the distinction between the service categories of A&E (which covers Type 1 and Type 2 A&E departments and U (which covers Urgent Treatment Centres and any remaining minor injuries units and walk-in centres). Further information on relevant definitions is available in [FAQs](#) published by NHSE/I.
- 34.6 Note the new functionality to indicate whether or not the provider is to have a role to play in delivering the Enhanced Health in Care Homes service model, in collaboration with local Primary Care Networks (see paragraph 3.3 above). If it is indicated YES, the eContract system will include the appropriate service specification template in the contract, for completion as determined locally.

35 Contracts for new services or with new providers

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

- 35.1 Completion of the relevant Schedules of the Particulars is obviously a requirement for all contracts – but agreement of a contract with either a new provider or for a new service is likely to mean a focus on certain aspects of the contract which are sometimes less critical where the contract is a ‘roll-over’ contract with an existing provider for an existing service.

Conditions Precedent (Schedule 1A and GC4.1)

- 35.2 Conditions Precedent are things which the provider must do, and documents which it must provide, after contract signature, to establish to the satisfaction of the co-ordinating commissioner that it is ready and able to start providing the Services as required by the Contract. So they are necessary pre-conditions to the start of Services (and not, as is unfortunately sometimes assumed, a to-do list for later, once Services are already up and running). Those listed in Schedule 1A of the Standard Contract without square brackets will apply in all cases. Those in square brackets will apply in many, if not most, cases. Additional Conditions Precedent required by commissioners may relate to, for example, works to premises being completed, equipment being safely installed and operational, and/or appropriate staff being in post and fully inducted. These additional requirements will need to be agreed locally, and will differ according to local circumstances.
- 35.3 While the commissioner will wish to have sight of documents referenced in Conditions Precedent (e.g. CQC registrations, NHS Improvement’s licence etc.), the documents do not need to be included in the contract itself.
- 35.4 The general rule is that each Condition Precedent must be satisfied by the Expected Service Commencement Date. If any Conditions Precedent have not been satisfied by the stated Longstop Date (a date after the Expected Service Commencement Date, which allows for an acceptable amount of “slippage”), the co-ordinating commissioner may terminate the Contract.
- 35.5 There may be circumstances in which it is appropriate to fix a Longstop Date for satisfaction of certain Conditions Precedent as a date before the Expected Service Commencement Date – for example, if there are staged tests or gateways which the provider must pass in order to establish its readiness to deliver the Services (as has been the case for NHS 111). By fixing such an early Longstop Date, the co-ordinating commissioner is given the ability to terminate the Contract before the Expected Service Commencement Date has passed, once it becomes apparent that the Provider has not passed early tests and so is incapable of getting itself into a position to provide the Services. But this type of arrangement will be the exception, not the rule.

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

35.7 Note that Schedule 1B may be used to set out details of any documents which the commissioners are to provide to the Provider before the Expected Service Commencement Date. These may include, for example, records and other documents which are to be obtained from a previous provider of the services. Note the inclusion of a new requirement, applicable to contracts with NHS Trusts or NHS Foundation Trusts, for a signed System Collaboration and Financial Management Agreement (see paragraphs 3.10-16 above).

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

35.8 The parties may set out in Schedule 2H actions which each must take (and/or, in the case of the commissioners, which they must ensure that the outgoing provider of the Services must take) in order to ensure continuity of service and to effect an orderly transition of provision from the outgoing provider to the new provider, and/or from the old service model to the new. These might cover arrangements in relation to the transfer of staff (linking to GC5.11 (TUPE) (Schedule 8 in the shorter-form Contract)), the transfer of premises and equipment, transfer of care of Service Users, and so on. Clearly, there may be overlap between Schedule 1A and Schedule 2H, and it may be appropriate to specify completion of actions on the part of the provider under Transition Arrangements as a Condition Precedent, in order to ensure that the right to terminate the Contract applies if the provider fails to complete those actions. (If using the shorter-form Contract, transition arrangements may be set out in Schedule 2G (Other Local Agreements, Policies and Procedures) if required).

Contractual processes carried forward from previous contracts

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

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

35.11 However, at the end of a contract of any length, unless commissioners take appropriate action, the default position will be that contractual processes begun under that contract will not automatically be carried forward to a new contract. Rather, the contractual process will have to re-start from the beginning.

- 35.12 This issue can be addressed by the inclusion of the Plan agreed under the expiring contract within a Service Development and Improvement Plan under the new contract. In this situation, a commissioner may wish to treat the agreement of that Service Development and Improvement Plan as a Condition Precedent for the purposes of the new contract (in other words, that agreement of the continuing application of the Plan is a pre-requisite of the new Contract). Where, under an expiring contract, a commissioner has reached the stage of withholding or retaining funding in respect of a provider failure (under GC9 or SC28, for example), the commissioner may also seek to specify in the Service Development and Improvement Plan to be included in the new contract that withholding or retention of funding will continue under the new contract, until such point as the original failure is rectified.

36 Service specifications

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

- 36.1 The service specifications are one of the most important parts of the contract, as they describe the services being commissioned and can, therefore, be used to hold the provider to account for the delivery of the services, as specified.
- 36.2 Generally, specifications are for commissioners to develop locally. Where the provider is to play a part in local delivery of the Enhanced Health in Care Homes care model, in collaboration with local Primary Care Networks, the new addition to the service specification template (Schedule 2Ai) should be included, as appropriate, and completed / supplemented locally as required.
- 36.3 Where services are being commissioned by NHS England, there will often be one national service specification for the particular service, which has been designed with clinical input and signed off at national level. For specialised services, for instance, the Contract mandates that national specifications must be used.
- 36.4 The [Commissioning Framework and the National Urgent and Emergency Ambulance Services Specification](#) supports system leaders in reducing unwarranted variation in the way ambulance services are provided and commissioned and is strongly recommended for use by CCGs when commissioning regional ambulance services.

Developing service specifications

- 36.5 Service specifications should be recorded in Schedule 2A of the Particulars. A non-mandatory model template for local determination and population is provided at Schedule 2A, and Commissioners may retain this structure or may determine their own. Where a Commissioner chooses to determine their own structure, the

guidance in paragraphs 36.6-12 below is still relevant.

- 36.6 The way in which service specifications are developed will vary according to local circumstances. It is the commissioner's responsibility to develop service specifications. However, the commissioner may, subject to procurement advice, wish to involve prospective providers in developing a specification. A high level of clinical engagement is essential, and it is good practice to involve service users in the development of specifications wherever possible.
- 36.7 A service specification should set out a brief summary of the service being commissioned, including:
- any relevant context to the service either at a national or local level;
 - the broad outcomes that are required from the service; any applicable measures relating to these should be set out in Schedule 4 (Quality Requirements);
 - scope, i.e. the service being commissioned, who is it for and any key links with other services;
 - any generally applicable service standards which the service should adhere to e.g. NICE standards or any locally agreed standards;
 - which quality requirements and CQUIN goals, as set out in Schedule 4, are relevant to each specific service specification;
 - location of the service: this will not be relevant to all services but could be used where the location in which services is provided needs to be specified (e.g. in the case of services commissioned from a national provider with multiple locations where services are required to be delivered from only a limited number of the provider's units).
- 36.8 The level of detail required in a specification will depend on the services being provided. A specification should not be a detailed operational policy for a service; specifications that are no longer than 4-5 pages may be sufficient, especially if they focus on the outcomes required from the service rather than the inputs.

Can I add additional detail to the service specification template?

- 36.9 The specification template is intended as a guide to the minimum amount of detail that should be included in a specification. The sub headings are intended to act as suggestions. It is possible to add additional sections to the specification, if required.
- 36.10 Commissioners should avoid replicating, in the service specification, wording or clauses which already appear in the General or Service Conditions – or, worse, setting out requirements in a service specification which contradict the content of the General or Service Conditions, or re-state such content in slightly different language. Doing so will simply cause confusion and, potentially, disputes. (Note that, in the case of conflict or inconsistency, the Contract makes clear, at General Condition 1.2, that the provisions in the General and Service Conditions will take

precedence over the content of the Particulars, including any detail within a service specification.) However, commissioners should ensure that, within their service specifications, they use correct contract terminology listed in the Definitions in the General Conditions (for example, 'Service User' rather than 'patient').

36.11 Quality requirements and information requirements in relation to a specific service should not be included in the service specification. If there are any specific quality requirements relating to the particular service, these should be included in Schedule 4 (Quality Requirements), with any associated information requirements included in Schedule 6 Part A (Reporting Requirements). However, as noted above, it is possible to indicate in the service specification which of the quality and information requirements listed in the relevant contract schedules are relevant to each service specification by allocating a reference number to the requirement and listing the relevant reference numbers in the service specification.

36.12 Considerations in completing each section of the service specification template are detailed below.

Service Specification No.	Numbering the specification may be useful where you wish to identify which services particular quality requirements and/or payment regimes relate to.
Service	The level at which services are specified will depend on the particular service. For example, for acute hospital services, it is unlikely that you would wish to specify at HRG level. On the other hand, a specification which covers 'all elective services' is unlikely to be appropriate. It may also be appropriate to consider whether developing a specification on the basis of a care pathway would be appropriate.
Commissioner Lead	The name of the individual leading on the commissioning of the service should be inserted here.
Provider Lead	The name of the individual leading on this service for the provider should be inserted here (this may be the same or different for all services being commissioned).
Period	The period covered by this specification should be inserted here. This may be the same as the duration of the contract but where there is a long contract duration, you may wish to review the specification at an earlier date (subject to any procurement and competition considerations). There may be circumstances where the overall duration of the contract may be longer than a particular service is being commissioned. Where this is the case, it is important that a duration is clearly specified for the service being commissioned.
Date of Review	If you wish to review the specification mid-contract, then a date by which the specification is to be reviewed should be inserted here.

1. Population Needs											
1.1 National/local context and evidence base	This section should set the context for the service being commissioned. For example, for a mental health service it may be relevant that one in six people at some stage will experience a mental health issue. Locally, prevalence may be higher or lower than national averages.										
2. Outcomes											
2.1 NHS Outcomes Framework domains & indicators	<table><tr><td>Domain 1</td><td>Preventing people from dying prematurely</td></tr><tr><td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td></tr><tr><td>Domain 3</td><td>Helping people to recover from episodes of ill-health or following injury</td></tr><tr><td>Domain 4</td><td>Ensuring people have a positive experience of care</td></tr><tr><td>Domain 5</td><td>Treating and caring for people in safe environment and protecting them from avoidable harm</td></tr></table> <p>Any relevant indicators from the NHS Outcomes Framework may be added here. If the provider is to be held accountable for them, they should be included in the locally agreed quality requirements.</p>	Domain 1	Preventing people from dying prematurely	Domain 2	Enhancing quality of life for people with long-term conditions	Domain 3	Helping people to recover from episodes of ill-health or following injury	Domain 4	Ensuring people have a positive experience of care	Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm
Domain 1	Preventing people from dying prematurely										
Domain 2	Enhancing quality of life for people with long-term conditions										
Domain 3	Helping people to recover from episodes of ill-health or following injury										
Domain 4	Ensuring people have a positive experience of care										
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm										
2.2 Local defined outcomes	Any broad outcomes to which the service should be working should be inserted here.										
3. Scope											
3.1 Aims and objectives of service	A brief description of the aims and/ or objectives of the service may be included here. Service specifications should clearly set out requirements for protected groups where there is a need to do so.										
3.2 Service description/care pathway	This section should include a brief description of the service being commissioned. For some services, it may be relevant to describe the care pathway.										
3.3 Population covered	Where the service is not subject to patient choice and where the service is limited to a defined population, the description of that population should be included in this section.										
3.4 Any acceptance and exclusion criteria	This section may be used to identify any clinical criteria used for the service.										
3.5 Interdependence with other services/providers	The services commissioned under a contract may be part of a wider care pathway. If this is the case, how the service links into and works with other services or providers can be identified here.										
4. Applicable Service Standards											
4.1 Applicable national standards (e.g. NICE)											
4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)											
4.3 Applicable local standards											

This section may be used to identify NICE standards, other national standards and any locally agreed standards that are relevant to the service.	
5.	Applicable quality requirements and CQUIN goals
5.1	Applicable quality requirements (See Schedule 4 Parts A-C)
5.2	Applicable CQUIN goals (See Schedule 4 Part D) The reference numbers for quality requirements and CQUIN goals which apply to the service can be listed here. This allows clarity about the requirements relating to specific services.
6.	Location of Provider Premises
The Provider's Premises are located at: Where it is considered important to specify that a service is provided from a particular location (or that any premises from which services are to be provided must be within a certain area, or easily accessible from it), this may be specified here.	
7.	Individual Service User Placement
This section may be used to include details of any long-term individual service user placements (or Individual Placement Agreement as described in paragraph 27 above). This is likely to be relevant where the service provides tailored specialist placements. It may also be used to record any specialist equipment that is provided as part of an individual care pathway.	
8	Applicable Personal Care Requirements
This section may be used to set out service-specific requirements for personalisation of care, aligned with the generic content of Schedule 2M, Development Plan for Personalised Care.	

37 Commissioner Requested Services / Essential Services

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

- 37.1 The NHS Standard Contract refers to two sets of arrangements under which the provision of services can be protected where the continued availability of those services is regarded as essential. These are covered in SC5 and are:
- the regime of Commissioner Requested Services (CRS) which applies to all providers other than NHS Trusts;
 - the regime of Essential Services which applies to NHS Trusts only.
- 37.2 [Published national guidance on CRS](#) sets out how services can potentially be designated as Commissioner Requested Services where there is no alternative provider close enough, where removing them would increase health inequalities, or where removing them would make other related services unviable. The guidance sets out a detailed process for designation, including a right of providers to appeal against the commissioner's assessment. Commissioners should submit any new designation decisions via nhsi.crs@nhs.net.

- 37.3 The Contract requires both parties to comply with the respective obligations under CRS Guidance, but any potential regulatory interventions under the guidance would not come within the remit of the contractual arrangements between the parties. There is no requirement for decisions on CRS designation to be listed in their local contracts.
- 37.4 By contrast, the Essential Services arrangements for NHS Trusts are set out within the Contract itself, not within separate guidance (although the definition of Essential Services is consistent with that for CRS). The key contractual requirements are:
- for any agreed Essential Services to be listed at Schedule 2D; and
 - for the provider to maintain its ability to provide the Essential Services; and
 - for the provider's Essential Services Continuity Plan to be included at Schedule 2E.
- 37.5 Under the Contract,
- any party proposing a Variation must have regard to the impact of the proposed Variation on other Services, and in particular any CRS or Essential Services (GC13); and
 - the provider must ensure that, when Services are suspended or terminated, there is no interruption in the availability of CRS or Essential Services (GC16 and 18).
- 37.6 Whereas CRS designation is for each individual commissioner to determine in respect of each service at a particular provider, as set out the national guidance, Essential Services are defined at contract level, not at commissioner level, in agreement between the co-ordinating commissioner and the provider.
- 37.7 Commissioners should ensure that they make very clear their requirements in respect of designation of Commissioner Requested Services / Essential Services in procurement documentation and in pre-contract discussions with providers.

38 Assignment, novation and sub-contracting

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

- 38.1 GC12 governs assignment, novation and sub-contracting.
- 38.2 There may be circumstances where the provider wants another party to take over as provider under the contract – for example, if the provider is a company and is selling its business and assets to another company. GC12 states that the provider cannot assign or novate any of its rights or obligations under the Contract without the prior written approval of the co-ordinating commissioner. (This situation may be contrasted with the sale of shares in a provider company, to which the Change in Control provisions at GC24 apply.) An assignment and a novation are slightly different things in legal terms. An assignment of a contract by a provider will not release that provider from its obligations under the contract. A novation, on the other hand, will effectively cancel the original contract and replace it with a new one between the commissioner(s) and the new provider. Either may have material implications under the Public Contract Regulations. Either will need to be appropriately legally documented. If approached by a provider for consent to an assignment or novation, commissioners should, before giving consent or even considering doing so:
- ask the provider to give them as much information as possible about the proposed transaction, including the reason for it, the parties involved, and the experience and capability of the proposed new provider;
 - explain to the provider that the commissioners will need to take legal advice on the request, any procurement implications, and any documentation related to the assignment or novation;
 - require the provider to confirm that it will cover the commissioners' costs (including legal costs) in relation to the application for consent and all matters connected with it; and
 - take legal advice, as above, and proceed in accordance with that advice.
- 38.3 We are aware that there can be confusion about the extent to which commissioners should be involved in decisions around sub-contracting, and guidance on this is therefore set out below.
- 38.4 The provider is wholly responsible to the commissioners for the delivery of the services and for the performance of all of the obligations on its part under the contract. The default assumption is that the provider will actually provide the services, and everything required in order to deliver those services in accordance with the contract, itself. However, in practice, most providers will wish to or need to sub-contract elements of the services, or contributions towards their delivery, to others.
- 38.5 What do we mean by a sub-contract? For the purposes of the Contract, a sub-contract is defined very broadly: it is any contract entered into by the provider or by any sub-contractor for the purpose of the performance of any of the provider's obligations under the contract. So that would include contracts entered into by the provider or by its sub-contractors with providers of clinical services (often known as "provider-to-provider" contracts), clinical support services, goods and equipment on which the provider or the sub-contract relies in order to be able to

deliver the services in accordance with the contract entered into with the commissioners.

- 38.6 It is important for both commissioners and providers to recognise that sub-contracting in no way relieves the provider from responsibility for delivery of the services and for the performance of all of the obligations on its part under the contract: failure on the part of a sub-contractor does not excuse the provider from its obligations to the commissioners.
- 38.7 Nevertheless, commissioners will have an interest in sub-contracting arrangements. Depending on the scope and nature of the service or contribution being sub-contracted, they will need a greater or lesser degree of assurance as to the identity, level of competence and experience of the sub-contractor and the terms on which it is being appointed. Overall, the level of scrutiny which any sub-contract requires from the commissioner should be in proportion to its materiality, in terms of its potential impact on patient care. Commissioners will need to strike a careful balance, aiming for an appropriate and manageable level of oversight and not for micro-management of operational detail.
- 38.8 GC12.1 states that the provider is not to sub-contract any of its obligations under the contract without the written approval of the co-ordinating commissioner. So the co-ordinating commissioner is able to exercise control over what, how and to whom the provider sub-contracts the performance of those obligations. The extent to which it does or should exercise that control in practice will, as suggested above, depend on the scope and nature of what is to be sub-contracted. It is important that commissioners and providers reach an understanding, in the context of their contract, as to when and how this control will be exercised. It may, for example, be readily agreed between the parties that the provider will be free to contract with suppliers of consumables and providers of support services such as catering and cleaning without seeking consent to each individual sub-contract: in effect a blanket consent is granted at the outset. On the other hand, who supplies particular consumables may, in the context of a particular commissioning contract, be very important to the commissioners, and they may therefore wish to exercise the right of approval over sub-contracts for those consumables.
- 38.9 GC12.2 allows the co-ordinating commissioner to designate a sub-contract as a Material Sub-Contract. “Material” in this context means that it relates to all or a significant and necessary element, or contribution towards, the delivery of a service. Materiality is not about the value of the sub-contract, or necessarily about whether or not the subject matter of the sub-contract is itself a clinical service; the key is the importance of the sub-contract and the sub-contractor to the delivery of the provider’s services. If a sub-contract is designated by the commissioner as a Material Sub-Contract, specific controls will apply, governing its termination, variation or replacement (see GC12.5).
- 38.10 It is important that the co-ordinating commissioner makes it clear to the provider, before awarding a contract:
- which proposed sub-contracts it considers to be Material Sub-Contracts (to be detailed in Schedule 5B);
 - which Material Sub-Contracts must be in place, in a form approved by the co-

ordinating commissioner, at the point of contract award;

- which Material Sub-Contracts must be in place, in a form approved by the coordinating commissioner, by the (relevant) Expected Service Commencement Date, as a pre-condition to the commencement of delivery of the Services (or the relevant Services) (to be detailed in Schedule 1A). (Note that it is possible to specify staggered Expected Service Commencement Dates for different Services, with conditions precedent attaching to each, if service commencement is to be phased.)

Form of sub-contract

- 38.11 It is for the provider to put the sub-contract in place, but the commissioner has the right to approve the terms of the sub-contract if it wishes. There is no mandated form of sub-contract (see paragraph 38.14 below), but the NHS Standard Contract places a number of specific requirements on the main provider in relation to the conditions of any sub-contracts (see, for example, GC21.15-17 of the full-length Contract – requirements relating to patient confidentiality and data protection).
- 38.12 The NHS Standard Contract itself is not designed for use, and should not be used, as a sub-contract. One simple, practical example of why this is the case relates to the National Tariff. The Standard Contract requires the commissioner to pay the provider in accordance with the National Tariff (meaning the principles and rules set out in the current National Tariff Payment System guidance) – but no such requirement applies where a provider is paying a sub-contractor.
- 38.13 Where NHS providers are placing sub-contracts for non-clinical goods and services, they may appropriately use the [standard NHS terms and conditions for procuring goods and services](#), published by the Department of Health and Social Care. Where the sub-contract is of a clinical service, the goods and services contract will not be suitable.
- 38.14 NHS England produces model sub-contracts for use by providers for clinical service sub-contracting, for use with the full-length NHS Standard Contract and with the shorter form Contract. These model sub-contracts provide a systematic means of flowing down the relevant provisions from the provider's contract to the sub-contractor. These model sub-contracts will be updated shortly to reflect the 2020/21 Contract and republished on the [NHS Standard Contract 2020/21 web page](#).
- 38.15 Use of the model sub-contract is not mandatory, but its use will save providers time and offer greater assurance to commissioners that robust sub-contracting arrangements are in place.
- 38.16 Where a provider does not use the national model sub-contract, it should ensure that the sub-contract it does put in place reflects the relevant elements and requirements of the NHS Standard Contract.

Management of sub-contracts

- 38.17 Management of the sub-contractor is the responsibility of the provider. The provider is responsible to the commissioner for all of the services, including any

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

39 Quality of care

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

- 39.1 The Health and Social Care Act 2012 defines quality as encompassing three dimensions: clinical effectiveness, patient safety and patient experience. Where we refer to quality below, we are referring to all three elements. In considering how quality is reflected in the contracting process, commissioners should take all three dimensions of quality into account.

Using the Contract to manage quality – an overview

- 39.2 Ensuring that patients have access to a range of high-quality services is the core function of NHS commissioning. The Contract supports this by giving a robust framework through which a commissioner can set clear standards for a provider and hold it to account for the quality of care it (and any sub-contractors) delivers. The key elements of the Contract dealing with quality are summarised below.
- The Contract requires providers to run services in line with recognised good clinical or healthcare practice, and providers must comply with national standards on quality of care – the NHS Constitution, for instance, and the Fundamental Standards of Care regulations (SC1).
 - The Contract sets clear requirements in respect of clinical staffing levels (GC5). Providers must continually evaluate individual services by monitoring actual numbers and skill mix of clinical staff on duty against planned numbers and skill mix, on a shift-by-shift basis; they must carry out and publish detailed reviews of staffing levels, and their impact on quality of care, at least every twelve months; they must undertake quality impact assessments before making material changes to staffing levels; and they must implement a standard operating procedure for responding to day-to-day shortfalls in staff numbers.
 - The Contract requires providers to adhere to national guidance on specific service areas, such as hospital food standards (SC19), infection control (SC21), safeguarding (SC32), the care of dying people (SC34) and the duty of candour (SC35).

- The Contract sets specific national quality standards which the provider must achieve (Schedules 4A and 4B), with scope for additional local quality requirements (Schedule 4C).
- In addition to these nationally-mandated requirements, commissioners can describe detailed service requirements – whether in terms of outcomes, quality measures or inputs and processes – through locally-designed service specifications (Schedule 2A).
- The Contract requires the provider to put in place policies and procedures which will support high-quality care. Among these are the provisions on clinical audit (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and incidents and Never Events (SC33).
- The Contract requires the provider to demonstrate that it is continually reviewing and evaluating the services it provides, taking into account patient feedback, complaints and surveys, Patient Safety Incidents and Never Events, learning lessons and implementing improvements (SC3).
- Finally, the Contract provides processes through which commissioners can intervene to ensure that high-quality care is delivered – by requiring regular submission of monitoring information (SC28), agreeing Service Development and Improvement Plans (SC20), offering incentive schemes to improve quality (SC37 and SC38), requiring Remedial Action Plans to address service deficiencies (GC9), applying financial sanctions for failure to achieve national standards (SC36), and ultimately by suspending services temporarily (GC16) or terminating them permanently (GC17).

39.3 It is essential that commissioners use the tools within the Contract to set high standards for providers and to monitor service quality continually, alongside expenditure and activity levels – and that they maintain a constant and close dialogue with providers about any issues relating to service quality. Local Quality Surveillance Groups offer an important forum through which commissioners can share information and intelligence about service quality with their local commissioning and regulatory partners. Updated [guidance](#) on how to run an effective Quality Surveillance Group has been produced by the National Quality Board.

39.4 Detailed guidance on reporting requirements, on financial sanctions for breaches of quality requirements and on the use of contract management processes is set out slightly later in this document. The remainder of this section focuses on specific quality aspects.

Operational Standards and National Quality Requirements

39.5 These are set out in Schedules 4A and 4B. Both are sets of nationally-mandated standards, with the Operational Standards derived specifically from the NHS Constitution. All providers are expected to achieve all of the Operational Standards and National Quality Requirements which relate to the commissioned services. Consequences for failure to achieve these standards are set nationally, but note the specific **Financial Improvement Trajectory** arrangements set out in

paragraphs 3.17 to 3.22 above.

- 39.6 Links to the detailed definitions for the Operational Standards and National Quality Requirements in Schedules 4A and 4B are now provided within the Schedules.
- 39.7 Commissioners and providers should have regard to [Managing long waiting cancer patients – policy on “backstop” measures](#). This sets out a process for providers to manage cancer patients experiencing waits over 62 days and requires root cause analyses and clinical harm reviews to be carried out in certain situations, with the potential for cases to be reported as Serious Incidents where appropriate.

Local Quality Requirements

- 39.8 Local Quality Requirements are for local agreement. They should be clinically appropriate and realistically achievable. As a general rule, focussing on a small number of key indicators is likely to be more effective than requiring dozens of separate indicators to be monitored. It is important for commissioners to bear in mind the burden which Local Quality Requirements may create for providers, in terms of service management and data collection and reporting. Commissioners must ensure that any Local Quality Requirements which they propose (and the associated Local Reporting Requirements) will really add value. Provisions are set out in SC28 to address this (see paragraph 43.6 below).
- 39.9 It is reasonable for specific financial consequences to be agreed for non-achievement, so long as these are proportionate. Regardless of whether specific financial consequences have been agreed in relation to Local Quality Requirements, commissioners may of course use the contract management process set out in GC9 to address any breaches – see paragraph 45 below. Where no specific financial consequences are agreed for a Local Quality Requirement, the words ‘Issue of a Contract Performance Notice and subsequent process in accordance with GC9’ should be inserted as the relevant consequence in Schedule 4C.
- 39.10 Commissioners should work closely with local Healthwatch representatives in the design and monitoring of local Quality Requirements and in assessing the extent to which providers are implementing service improvements as a result of Lessons Learned. Note that the Getting It Right First Time programme has now published [Good Practice Commissioning Guidance](#) for orthopaedics and spinal surgery; this will be a useful source of potential local quality requirements.

CQUIN and local incentive schemes

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

- 39.11 CQUIN (*Commissioning for Quality and Innovation*) is the national quality incentive

scheme. Guidance on CQUIN is available at <https://www.england.nhs.uk/nhs-standard-contract/cquin/>

- 39.12 It is possible to agree local quality incentive schemes in addition to CQUIN; these should be documented at Schedule 4E of the Particulars.

Former national CQUIN indicators

- 39.13 Where national CQUIN indicators have been in place for a number of years, with most providers having embedded the good practice described in the indicator within their local working arrangements, it is normal for the indicator to be retired from the national CQUIN scheme, with its place taken by new, more challenging national indicators. In such cases, ongoing requirements in relation to the 'retired' indicators will often be included in the NHS Standard Contract.
- 39.14 This is now the case for a number of such indicators.
- **Venous Thromboembolism (VTE).** The national quality requirement (set out in Schedule 4B) remains that acute providers must undertake risk assessments for at least 95% of Service Users each month. Requirements to undertake root cause analyses and audits of provision of prophylaxis are set out in SC22, and the provider must report on these under the Reporting Requirements (Schedule 6A).
 - **Friends and Family Test (FFT).** SC12 sets out specific requirements in relation to implementation of FFT, including an expectation on maximising response levels. Note that [revised guidance on FFT implementation](#) takes effect from 1 April 2020.
 - **Sales of sugary drinks.** SC19 includes a requirement that sales of sugar-sweetened beverages must account for no more than 10% by volume of all beverages which are sold in any year on Trust / FT premises.
 - **Antimicrobial resistance.** SC21 requires providers to have regard to national guidance on antimicrobial stewardship and (for NHS Trusts / Foundation Trusts only) to strive to achieve ongoing reductions in antibiotic usage.
 - **Sepsis.** SC22 requires providers to comply with NICE and NHS England guidance on sepsis, with specific standards for sepsis screening and initial treatment, for acute services, set out in Schedule 4B.
 - **Physical healthcare for people with severe mental illness.** SC8 requires providers to monitor the physical health of patients with severe mental illness and to arrange for further assessment or treatment where indicated.
 - **Provision of advice and guidance.** SC6 requires agreed advice and guidance requirements to be described in local service specifications, with the prices payable for these set out in Schedule 3A.
 - **72-hour follow-up.** The 2019/20 CQUIN indicator on 72-hour follow-up for patients discharged from CCG-commissioned mental health inpatient services is now included as a standard in Schedule 4A.

- 39.15 The national CQUIN indicator on **dementia and delirium** has been 'retired'.
- 39.16 In all of these areas previously covered by national CQUIN indicators, commissioners should use the levers in the Contract, including the processes and sanctions set out in GC9 and SC28, to ensure that providers maintain high standards of care and submit the required data and reports. Commissioners may wish to consider agreeing local quality requirements to sustain and continue performance improvements.

Patient Safety

- 39.17 NHSE/I have published a new [NHS Patient Safety Strategy](#). In response to this, as set out in paragraph 3.4 above, new provisions have been added to the Contract at SC33 for 2020/21, covering National Patient Safety Alerts, the National Reporting and Learning System, arrangements for Medical Examiners of Deaths, and the introduction of Patient Safety Specialists.
- 39.18 The [Serious Incident Framework](#) and [Never Events Policy and Framework](#) remain in place, but are intended to be replaced in due course by a new Patient Safety Incident Response Framework. SC33 requires providers to comply with the existing frameworks and any successors.
- 39.19 In finalising and agreeing Schedule 6A (Reporting Requirements) and Schedule 6C (Incidents Requiring Reporting Procedure), commissioners should ensure that the following requirements are clear:
- The provider must report any Serious Incidents (SIs) via the [Strategic Executive Information System \(STEIS\)](#) in line with the timeframes set out in the Serious Incident Framework and ensure such incidents are also reported to the [National Reporting and Learning System](#).
 - The provider must investigate any SI using appropriate Root Cause Analysis methodology as set out in the NHS Serious Incident Framework and relevant guidance or, where reasonably required by the commissioner in accordance with the Serious Incident Framework, commission a fully independent investigation.
 - The outcomes of any investigation, including the investigation report and relevant action plan should be reported to the commissioner within the timescales set out in the Serious Incident Framework.
 - The provider and commissioner must ensure that the processes and principles set out in the Serious Incident Framework are incorporated into their organisational policies and standard operating procedures.
 - The provider must operate an internal system to record, collate and implement learning from all patient safety incidents and will agree to share such information with the commissioner as the commissioner reasonably requires. (This is a requirement under the more general provisions for Lessons Learned under SC3.4.)

- The commissioner should address any failure by the provider to comply with the requirements specified in Schedule 6A or 6C by using the provisions for Review (GC8) and Contract Management (GC9). However, commissioners and providers should recognise the primary importance of encouraging and supporting the reporting of incidents in order to promote learning and the improvement of patient safety. Incident reports must be welcomed and appreciated as opportunities to improve, not automatic triggers for sanction. Only where the provider fails to report, or does not comply with the specific requirements of Schedule 6A or 6C, or where the reporting of patient safety incidents or SIs identifies a specific breach of contractual terms leading to the incident in question occurring, should the commissioner address these using the formal processes of Review and Contract Management.

Contract provisions relating to the primary / secondary care interface

39.20 The Contract has always contained requirements on secondary care providers relating to communication and engagement with primary care – but this has become more important than ever in recent years, both to improve the convenience of care for patients and to ensure the most efficient use of clinical time. The Contract provisions have therefore been gradually strengthened over recent years, overseen since September 2016 by the national [Primary and Secondary Care Interface Working Group](#).

39.21 The Contract “interface” provisions now cover

- referral, including the management of DNAs and onward (consultant-to-consultant) referrals (SC6, SC8 and SC29);
- communication with primary care on discharge from hospital and following clinic attendance (SC11);
- provision of medication following hospital admission or attendance, and use of shared care protocols (SC11);
- provision of fit notes to patients (SC11); and
- managing patient care and investigations and communicating with patients and dealing with their enquiries (SC12).

Further detail on some of these areas is set out below.

39.22 The Working Group has overseen publication of a number of useful resources for providers and commissioners, including a summary of the Contract requirements for clinicians and managers and a practical implementation toolkit. Further detail is available at <https://www.england.nhs.uk/gp/gpfv/workload/interface/resources/>. It remains an extremely important priority for NHSE/I that the Contract requirements in this area are fully implemented at local level.

Referral, management of DNAs and onward referral

39.23 The NHS Standard Contract is not a vehicle which can place direct requirements on individual primary care clinicians, but it does require CCGs to do all that they

reasonably can to ensure that GP referrals are made in accordance with agreed protocols, specifications and Prior Approval Schemes and via the NHS e-Referral Service, with the necessary personal and clinical information provided in the format approved by the Professional Record Standards Body (see <https://theprsb.org/standards/clinicalreferralinformation/>).

39.24 The requirement in relation to DNAs is sometimes misunderstood. SC6.7 requires the provider to operate and publish a Local Access Policy, which will, amongst other things, describe how the provider will manage situations where a patient does not attend a booked appointment. The key additional requirement, as set out in the definition of Local Access Policy in the General Conditions, is that this is done “ensuring that any decisions to discharge patients after non-attendance are made by clinicians in the light of the circumstances of individual Service Users and avoiding blanket policies which require automatic discharge to the GP following a non-attendance”. Where providers automatically discharge all patients who do not attend a clinic appointment back to their GP, this can create inconvenience and delays for patients and cause significant additional work for practices in simply re-referring many of the patients. The Contract therefore requires that a provider’s Local Access Policy must not involve blanket administrative policies under which all DNAs are automatically discharged; rather, any decisions to discharge are to be made by providers on the basis of clinical advice about the individual patient’s circumstances. Note that a model [Local Access Policy](#) has been published by NHSE/I; providers should review their existing policies and ensure that they are consistent with this model version.

39.25 The provisions on onward referral in SC8 have the similar aim of avoiding duplication of effort. In summary, SC8 enables onward referral by a secondary care clinician where

- the onward referral is directly related to the condition for which the original GP referral was made or which caused the emergency presentation (unless there is a specific local CCG policy in place requiring a specific approach for a particular care pathway); or
- the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, SC8 does not permit a secondary care clinician to refer onwards where a patient’s condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused the original GP referral or emergency presentation. In this situation, the Contract requires the clinician to refer back to the patient’s GP. The Academy of Medical Royal Colleges has published [Clinical Guidance: Onward Referral](#), which outlines clear principles for how to avoid unnecessary “doubling up” of referrals and help patients move more easily through the care system.

Discharge summaries, clinic letters and other communications to primary care

39.26 The Contract requirements have three aspects.

- **Timing.** Discharge summaries following inpatient / daycase care and A&E attendance must be issued to general practice within 24 hours; clinic letters

must be issued within seven days. (Note that this standard is not expressed in Operational Days, but normal calendar days.)

- **Transmission.** Discharge summaries and clinic letters must be sent to general practice only by direct electronic transmission.
- **Structure.** To gain the full benefit from electronic transmission, discharge summaries and clinic letters must be constructed using coded data and standardised clinical headings, so that data can be automatically extracted into GP records. This must be done in accordance with the standards for structure and content set out by the Professional Record Standards Body at <https://theprsb.org/standards/>.

39.27 NHS Digital has provided [guidance](#) to support providers in implementing electronic discharge summaries and clinic letters, and further details on the structured approach to sharing clinical information are set out in the [Transfer of Care Domain Message Specification](#), also published by NHS Digital. NHS England has now published separate [guidance](#) on the NHS Standard Contract requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems.

39.28 Commissioners must support providers in resolving any issues about GP preparedness (in terms of IT systems) to receive electronic transmissions (see SC11.8). Commissioners should also take a reasonable and proportionate approach in managing performance against the electronic transmission requirements. The policy direction is clearly to ensure electronic transmission to all GPs, but commissioners may wish to focus first on ensuring that providers can transmit electronically to GPs within their local catchment area.

39.29 Note the following points.

- A provider is not necessarily required to send a clinic letter to the GP after each individual clinic attendance – this will depend on the individual clinical circumstances, as set out in SC11.7.
- For discharges from care where the Service User has not been admitted to hospital or treated in A&E, there is no nationally-mandated requirement for a discharge summary to be sent in all cases. Instead, SC11.6 allows an appropriate locally-specified requirement, including content, format, method of delivery and timescale, to be agreed and set out in Schedule 2J (Transfer of and Discharge from Care Protocols).
- We do not envisage that discharge summaries would ever be required from Patient Transport Services, and the wording of SC11.6 (SC11.3 in the shorter-form Contract) reflects this.
- 111 Services are subject to a separate requirement to send electronic Post Event Messages, rather than discharge summaries (SC11.6A).

39.30 Apart from these provisions for transfer of or discharge from care and clinic attendance, the Contract does not set out other nationally-mandated requirements for communication from the provider to the GP whilst a Service User is receiving

ongoing care at that provider. But where a commissioner wishes to set out other local requirements for communication to GPs during a pathway of care (as opposed to at discharge), this can be done by using Schedule 2G (Other Local Agreements, Policies and Procedures).

Medication on discharge and following clinic attendance

- 39.31 The Primary and Secondary Care Interface Working Group has overseen publication of high-level [national guidance on prescribing responsibilities](#), and the Contract now requires the parties to have regard to this guidance.
- 39.32 The Contract also contains specific provisions relating to supply of medication to patients on discharge from inpatient or daycase care and following outpatient clinic attendance. We are aware that there is different practice around the country in respect of both issues. To be clear, the purpose of the measures in the Contract is, in summary, to set minimum requirements which all providers must meet. These are:
- for discharge from inpatient or daycase care, a minimum of 7 (calendar) days' supply; and
 - following clinic attendance, sufficient supply for a patient's immediate needs, at least up to the point where the clinic letter has reached the GP and the GP can then prescribe on an ongoing basis.

In each case, the Contract wording deliberately sets these as minimum requirements; if local practice and protocols require supply for a longer period, this must be honoured unless alternative local arrangements are agreed. Note that a new requirement has been added, requiring providers – when supplying medication to patients on discharge or in clinic or when recommending medications for GPs to supply – to have regard to guidance published by NHS England for GPs on [conditions for which over-the-counter items should not routinely be prescribed](#) and [items which should not be routinely prescribed](#).

- 39.33 These national-mandated requirements only cover medication. Clearly, hospitals may also supply dressings or appliances, and requirements in relation to these may be specified locally within Schedule 2J (Transfer of and Discharge from Care Protocols).

Contract provisions relating to research

- 39.34 Service Condition 26 of the full-length Contract contains provisions relating to research studies.
- The Contract continues to place an overarching obligation on every provider of NHS-funded services to support research activity by assisting with the recruitment of suitable subjects (whether patients or staff) into properly-approved research studies (including where these are being conducted by a different organisation) (SC26.3).
 - The Contract does not require providers of healthcare services to participate in research studies and fund these from within the income they receive from

commissioners. Rather, research studies will be set up with separate funding streams and with specific agreements in place between the research sponsor and the organisation carrying out / participating in the study.

- However, the Contract does require that, for commercial contract research studies, any provider operating under the Contract wishing to conduct or participate in the study must do so in accordance with the [National Directive on Commercial Contract Research Studies](#), developed and now published jointly the NIHR, HRA and NHS England (SC26.4). (This provision will apply to the provider at organisational level, not to individual clinicians acting in a personal capacity as Chief Investigators for a multi-site study.)
- The intention of the new arrangements is to speed up the process for getting multi-site research projects under way, by adopting streamlined nationally-set processes, rather than relying on multiple separate time-consuming local negotiations.
- The Contract also requires (SC26.5) that providers conducting research studies must comply with guidance from HRA and NIHR on reporting the progress of research studies. The current guidance (which may be updated in due course) is available at <https://www.nihr.ac.uk/research-and-impact/nhs-research-performance/hra-approvals-and-nihr-metrics.htm>.
- Finally, the Contract continues to require (SC26.6) commissioners and providers to comply with their obligations under NHS Treatment Costs Guidance. This includes guidance on meeting excess treatment costs; the existing guidance on this is available at <https://www.england.nhs.uk/wp-content/uploads/2015/11/etc-guidance.pdf>.

40 Financial consequences in relation to Quality Requirements

*Fewer national Quality Requirements are included in the **shorter-form Contract**, and there are therefore fewer mandatory financial sanctions – but the principles set out below generally apply equally in both versions of the Contract.*

Application of financial consequences ('sanctions')

- 40.1 Under the arrangements described in paragraph 3.21 onwards, the application of financial sanctions in respect of breaches of certain of the national standards in Schedules 4A and 4B has been suspended in some situations for 2020/21. The detailed national sanctions remain within the Contract at Schedules 4A and 4B, but Service Condition 36.38 sets out the circumstances under which some of these sanctions are suspended.
- 40.2 Note that, as set out in paragraph 3.4, sanctions no longer apply in relation to MRSA and C difficile performance, nor to performance against the new national targets for gram-negative bloodstream infections (GNBSI). Provider targets for C difficile and GNBSI for 2020/21 will be published in due course.

Timing of the application of sanctions

- 40.3 The Contract does not set a time limit within which the sanction for breach of a particular Quality Requirement must be applied; SC36.37 simply requires that the appropriate adjustment is made to payment between commissioner and provider.
- 40.4 Factually, therefore, there is no “expiry date” beyond which sanctions under SC36.37 may no longer be applied. There may be good reasons why application of a sanction may follow some months after the occurrence of the breach in question: late reporting, insufficient information, or the need to query information provided, for example. In a multi-year contract, this may very well mean that sanctions are applied in the contract year after the year in which the breaches in question occurred. As a matter of good practice, however, financial sanctions should be applied as soon as practicable following the commissioner’s receipt of the Service Quality Performance Report in which the relevant breach is reported.

Public reporting of sanctions applied by commissioners

- 40.5 Commissioners are no longer required to publish on their websites details of the sanctions applied to each of their major providers for failure to achieve national standards.

Use by the commissioner of funding retained through sanctions

- 40.6 The investment by commissioners of funding withheld through contractual sanctions or of any element of CQUIN funding not earned by provider will now fall, for NHS Trusts and Foundation Trusts, within the scope of the System Collaboration and Financial Management Agreement described at paragraph 3.10-16 above, rather than being overseen by NHS England and NHS Improvement as in 2019/20.

Calculation and apportionment of sanctions

- 40.7 We are aware that there can be confusion about the basis on which performance against the Quality Requirements in Schedule 4 is measured and about the attribution of financial consequences across commissioners. The guidelines below are intended to provide some clarification; where doubt remains, commissioners and providers should use common sense and good faith to arrive at reasonable solutions. Worked examples are provided in Appendix 4.
- 40.8 The simplest sanctions apply to each single breach of an agreed standard; 52-week breaches and sleeping accommodation breaches are examples. In these instances, the Responsible Commissioner can be identified for each patient breaching the standard, and any financial adjustment should be made in favour of the specific commissioner affected.
- 40.9 The situation is more complicated where there is a national target with a performance threshold (18-weeks or cancer waiting times, for example). In these cases, a certain number of breaches may be permitted, and the sanction only applies to breaches beyond the permitted tolerance. It is therefore not usually possible to identify the specific cases which are responsible for causing the

sanction and attribute these to individual commissioners. It can also be difficult to distinguish between CCG-commissioned activity and NHS England-commissioned activity – and these are of course usually covered by separate contracts.

40.10 The following principles therefore apply for nationally-mandated Quality Requirements with a performance threshold:

- For any nationally-mandated Quality Requirement, the contractual requirement on the provider is to achieve the performance threshold for the specific contract as a whole. Providers should of course strive to achieve the threshold separately for each commissioner within the contract, but this is not a contractual requirement.
- Measurement of performance against nationally-mandated Quality Requirements should therefore take place at the level of the contract as a whole.
- Where a provider has multiple contracts in place, it should only ever face a sanction under one contract for a breach of a Quality Requirement relating to a specific Service User. “Double jeopardy”, whereby the provider faces multiple sanctions for the same patient-level breach under separate contracts, must be avoided.
- In some situations, where it is agreed that local performance information cannot support analysis of provider performance at contract level, the provider and its co-ordinating commissioners may need to agree a pragmatic approach to attribution of financial sanctions, using reasonable proxies where an exact split is not possible. In the absence of agreed alternatives, the default position is that the value of any sanction across the provider as a whole should be split across contracts in proportion to total actual contract value for the period in question.
- Commissioners may wish to set out their agreed approach to this as part of a collaborative agreement (in relation to attribution and allocation of sanctions as between commissioners who are party to a specific contract) and/or in a separate memorandum of understanding (as between one contract and another).

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

Caps on value of sanctions

40.12 The Contract includes a provision, set out at SC36.37, to cap the value of sanctions in respect of Operational Standards, National Quality Requirements and Local Quality Requirements (Schedules 4A, B and C), taken together, on a quarterly basis. The cap is set at 2.5% of Actual Quarterly Value. The cap does not apply to funding which commissioners may withhold under other sections of the contract, for example Contract Management (GC9) or Information Requirements (SC28).

- 40.13 For consistency with the approach to CQUIN, the calculation of the Actual Quarterly Value must exclude payments for items on which CQUIN is not payable, as outlined in CQUIN guidance.
- 40.14 In addition, there is a specific cap on the monthly impact of the sanction relating to four-hour waits in A&E. Effectively, the sanction ceases to increase if the provider's performance in the month falls below 85%. A worked example is given in Appendix 4.
- 40.15 The 2.5% cap is a cap on the actual value of sanctions imposed. It is not in any sense intended as a norm for the level of sanctions that commissioners should expect to impose in practice; rather, it is a maximum which must not be exceeded. However, the cap does not mean that a contract can only include sanctions which, if all were triggered to their maximum extent, would total less than the 2.5% value; the point is to cap the actual, not theoretical, value.
- 40.16 Equally, the 2.5% cap on sanctions is not intended to prevent commissioners from setting payment structures within contracts which reward quality or outcomes, rather than simply levels of activity – so long as any such arrangements are in line with National Tariff guidance. To ensure that they do not fall within the scope of the 2.5% cap, such outcome- or quality-based payment arrangements should be structured very clearly as comprising elements of payment for achievement of specified goals, and not as deductions from payments for failure to achieve specified goals, and should be set out in Schedule 3A (Local Prices), 3B (Local Variations) or 4E (Local Incentive Scheme) as appropriate.
- 40.17 We have been asked why we do not place an overall cap on the value of funds which can be withheld from a provider. To clarify:
- The 2.5% cap deliberately only applies to sanctions applied in relation to Operational Standards, National Quality Requirements and Local Quality Requirements, as described above.
 - There are separate arrangements which limit the amounts that can be withheld under the contract management arrangements at GC9 (see paragraph 45) and under the Information Breach provisions at SC28 (see paragraph 43); in both cases, Contract wording emphasises that sums withheld must be reasonable and proportionate.

We believe that maintaining separate arrangements and caps ensures that the provider is appropriately incentivised across the board. And, of course, there is no overall limit or cap on one party's liability to the other under the Contract: see GC11 (Liability and Indemnity).

41 The Service Development and Improvement Plan (SDIP)

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

- 41.1 The Service Development and Improvement Plan (SDIP, Schedule 6D) allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.
- 41.2 SDIPs differ from Remedial Action Plans (RAPs) under GC9 (Contract Management). RAPs are put in place to rectify contractual breaches or performance failures, whereas an SDIP is generally about developing an aspect of the services beyond the currently agreed standard. (Note however that, where specific actions and consequences are set out in a RAP under a contract which is soon to expire, commissioners may opt to roll those requirements into an SDIP under the provider's new contract, to ensure that the matters agreed are not lost in the switch from one contract to the next). Once included in the Contract, commitments set out in SDIPs are contractually binding.
- 41.3 Unless specifically mandated in the guidance below, SDIPs are for local agreement between the parties. SDIPs may for instance include:
- productivity and efficiency plans agreed as part of the provider's contribution to local commissioner QIPP plans; or
 - any agreed service redesign programmes; or
 - any priority areas for quality improvement (where this is not covered by a quality incentive scheme).

SDIPs offer an excellent route through which commissioners and providers can agree a programme of work to implement innovation projects – from medical technologies to service and pathway re-design. Further detail on the different ways in which NHSE/I are supporting innovation in practice can be found at <https://www.england.nhs.uk/ourwork/innovation/>.

- 41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6D at the point where the contract is signed or incorporated into the contract subsequently by Variation. Progress against the plan should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9).

- 41.5 For 2020/21, commissioners are required to agree SDIPs

- **with providers of mental health and learning disability services and with providers of mental health secure services**, to set out how the provider will prepare for implementation, to commence no later than 1 April 2021, of

certified training in restrictive practices for all relevant staff; the SDIP must identify how the provider will secure a training supplier (whether in-house or external) certified (by a UKAS accredited certification body) as complying with the Restraint Reduction Network Training Standards published at <http://restraintreductionnetwork.org>. Where the provider has already secured a certified provider, the SDIP must set out how the provider will start to roll out the training to relevant staff;

- with **providers of maternity services**, setting out the steps they will each take during the year to achieve the goal of 51% of women receiving a continuity of carer pathway by March 2021, in accordance with SC3;
- with **providers of elective ophthalmology services**, setting out the steps the provider will take to ensure that it responds appropriately to recommendations which are expected to be made in the forthcoming report by the Healthcare Safety Investigation Branch on timely monitoring for patients with glaucoma. (Specifically, providers should be: risk rating patients; recording a recommended follow-up date (by completing the Earliest Clinically Appropriate Date field in relevant outpatient datasets) [NHS Digital and NECT guidance on PAS](#); reporting compliance with the [Portfolio of Indicators for Eye Health and Care follow-up performance standard](#) (95% of hospital appointments to be within no more than an additional 25% of their intended follow up period, including rescheduling of hospital initiated cancellations); and addressing full implementation of failsafe prioritisation processes for follow-up patients, as described in [Elective Care High Impact Interventions: ophthalmology](#).)
- with **providers of acute hospital services**, to set out how, with the support of their local Academic Health Sciences Network (AHSN), they will jointly take forward implementation of the Transfers of Care Around Medicines (TCAM) initiative. (TCAM is a national scheme, supported by changes to the national Community Pharmacy Contractual Framework for 2020/21 and facilitated by AHSNs locally, which focuses on specified categories of high-risk patients being discharged from inpatient care; prescribing information for these patients is shared electronically by the hospital with the patient's nominated community pharmacy, so that the patient's community pharmacy can undertake a medicines reconciliation review and ensure the next medicines supply reflects changes made during a hospital admission, thereby reducing the risk of adverse effects from incorrect medication being taken. Further information is available at via AHSNs, including for instance at <https://wessexahsn.org.uk/projects/54/transfers-of-care-around-medicines-tcam>.)
- with **providers of emergency ambulance services**, setting out how those providers will make progress towards full implementation of the requirements of Service Condition 23.4 (availability and use of the NHS Number) and Service Condition 23.6 (viewing of patients' Summary Care Records).

41.6 As in previous years, the intention of these mandatory SDIPs is not to require significant additional investment from commissioners or providers; rather, it is to encourage joint management action to tackle these important priorities to the extent possible within available resources.

42 Managing activity and referrals

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

- 42.1 The key aims of the provisions in SC29 (Managing Activity and Referrals) are to ensure that:
- where patients have a legal right to choose their provider, this is always enabled;
 - activity carried out under a contract is clinically appropriate;
 - activity is managed within the levels the parties have agreed at the start of the year or – where there are variances – these happen for good clinical or patient care reasons (including as a result of the exercise by patients of their legal right to choice) that are understood and accepted by the commissioner and provider.
- 42.2 There will be situations where it is appropriate for commissioners to use the provisions within SC29 to put downward pressure on activity levels within a contract – but SC29 should not be used by commissioners as a blunt instrument simply to control costs. For further guidance on appropriate use of the contractual provisions on activity management, reporting requirements and payment arrangements, please refer to section 42.39 onwards and to the hypothetical case studies set out in Appendix 6.

Access to services

- 42.3 The Contract must function as a robust tool through which commissioners can secure access to the services which their population needs. At the same time, commissioners need to be able to use the Contract to prevent access to care or treatment which they deem to be unnecessary, ineffective or inefficient. This will enable commissioners to commission services in line with the [NHS Right Care](#) approach. In this context, it is useful to re-cap how the Contract governs access to services.
- 42.4 SC6 requires the provider
- to accept any clinically appropriate referral where a patient is exercising his / her legal right to choice of provider – even where the patient’s Responsible Commissioner is not a party to the local contract; and
 - to accept any emergency referral or presentation for treatment within the scope of the services a provider runs, again even where the patient’s Responsible Commissioner is not a party to the local contract. (There is an important caveat here that the provider must be able to provide such emergency

treatment safely – we recognise that, for instance, an intensive care unit with fixed bed capacity may not be able to accept transfers from outside its local network if all of its beds are full of very sick ‘local’ patients. But the general principle is that a provider of NHS-funded emergency services must be open to any emergency presentation, regardless of the identity of the patient’s Responsible Commissioner.)

42.5 SC29.3-4 deal with referral protocols and clinical thresholds for treatment and make clear that such documents may be included within service specifications or other aspects of the contract which are agreed between commissioner and provider – but that, in other circumstances, they may instead be notified by the commissioner to the provider as a Prior Approval Scheme (described more fully below).

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

- Where a service operates on a block contract basis or with marginal prices for under- or over-performance, then the basis on which patients are to access that service (that is, the clinical threshold for patients to be referred and receive care or treatment) is, effectively, a critical determinant of the price. So, for example, it is probably not realistic to expect an intermediate care service which is funded to deal with referrals for patients over 85 to start accepting referrals from over-75s and operate within the same block contract price. In such a situation, it is appropriate for the ‘referral and treatment criteria’ under which the service is to operate to be included within the service specification (or separately within Schedule 2G, Other Local Agreements, Policies and Procedures). If either party wishes to change them, this can only be done by agreement using the Variation provisions at GC13. And discussion on a Variation may, of course, also involve varying the price for the service.
- But what about the situation where a service operates on an “activity x price” basis (such as the majority of consultant-led acute services)? In this instance, the price is not dependent on a fixed or guaranteed level of activity. So, for instance, if the commissioner identifies that it wishes to restrict access to certain treatments when specific clinical criteria are met, it is perfectly reasonable for it to do so – so long as what it is requiring the provider to do remains consistent with Good Practice as defined in the Contract. In this situation, therefore, referral and treatment protocols are best kept separate from service specifications and treated instead as Prior Approval Schemes, which the commissioner can introduce or change through notification to the provider (SC29.21 onwards), but which do not require provider consent.

42.7 What happens if a provider starts to offer and charge for new services which the commissioner has not deliberately chosen to commission? The answer will depend in part on what is documented in the local contract and whether the legal right of choice of provider applies. In summary:

- Where the local contract contains precise service specifications, the commissioner will in principle be able to argue that, by introducing a new service or treatment beyond the scope of what is described in the specifications, the provider has breached its duties under SC3. The

commissioner may therefore be on strong ground in refusing to pay for the new service.

- By contrast, where the specifications in the contract are much looser, the provider will have a stronger argument that it is reasonable for its services to evolve gradually in line with good clinical practice.

We explore this issue in more detail in scenario 4 of Appendix 6.

Prior Approval Schemes

- 42.8 A Prior Approval Scheme will typically set out a commissioner policy for access to a certain service or treatment – a high-cost drug, for instance, or a treatment of perceived low clinical value. By setting out the clinical criteria or access thresholds in advance, the commissioner enables the provider to offer treatment to patients without needing to seek specific approval from the commissioner on an individual patient basis. In determining potential Prior Approval Schemes, commissioners will wish to review the evidence base and consider the need for appropriate consultation.
- 42.9 The commissioner should notify the provider of any Prior Approval Schemes before the start of the contract year. Schemes can be amended and new Schemes introduced in-year with one month's notice. Where this happens, commissioners must ensure that they set reasonable expectations about the applicability of the Scheme in relation to patients who have been referred or have already commenced assessment or treatment.
- 42.10 Where patients have a legal right of choice of provider, any Prior Approval Scheme which simply restricts that choice is void and cannot be used to restrict payment for activity carried out by the provider.
- 42.11 Where the commissioner determines, prior approval may also operate on an individual patient basis, with the provider seeking approval for each individual case (an "individual funding request" or IFR). The Contract sets out a requirement to include a response time standard for prior approval requests in the Particulars. The commissioner must respond to a request for approval for treatment within this Prior Approval Scheme Response Time Standard or will be deemed to have given approval under SC29.25. SC29.26 also makes it clear that prior approval arrangements must not place at risk achievement of quality or waiting times standards.
- 42.12 The Contract makes clear that commissioners must have regard to the burden which Prior Approval Schemes can create for providers (SC29.21). It is important, for instance, that commissioners:
- ensure that they place the onus on the right part of the system – if a CCG does not wish to commission a particular procedure, it can appropriately inform its GPs of this and advise them not to refer patients for that procedure; in other cases, where the decision to offer a specific treatment would be made only by the hospital clinician after diagnosis, a Prior Approval Scheme operated by the hospital provider is likely to be necessary;

- reserve the more onerous IFR arrangements for a small number of high-cost treatments and complex scenarios (where the decision as to who should access treatment will require detailed information about patients' individual circumstances); and
- review the cost-effectiveness of their prior approval arrangements – if a labour-intensive Scheme requiring approval of an IFR in advance is consistently resulting in every patient receiving approval for treatment, it should probably be converted into a commissioning policy of the kind described in paragraph 42.8 above.

42.13 Providers, particularly those which deal with many different commissioners, often raise with us the burden which is caused by having to operate multiple different Prior Approval Schemes, covering the same conditions or treatments, but featuring slightly different requirements for different individual CCGs. Clearly, it is ultimately for each CCG to determine its own commissioning policies, and the Contract must allow these policies to be given effect. However, SC29.21 states a requirement for those commissioners operating under a single contract with a provider to use reasonable endeavours to minimise the number of separate Schemes they operate. CCGs must therefore seek to collaborate across local patches to adopt consistent clinical thresholds and administrative processes in their Prior Approval Schemes as far as possible, thus lessening the number and variability of different Schemes which any individual provider has to deal with.

Evidence-Based Interventions Policy

- 42.14 Statutory guidance has been published on [evidence-based interventions](#) (referred to in the Contract as Evidence-Based Interventions Policy). This sets out the commissioning arrangements which are to apply to 17 specific treatment interventions, distinguishing between two categories:
- Category 1 Interventions – interventions which should not be routinely commissioned or performed, and for which an IFR, approved in advance by the commissioner, is always required; and
 - Category 2 Interventions – interventions which should only be routinely commissioned or performed when specific criteria are met.
- 42.15 The Policy is given contractual effect through provisions included at SC29.28-31. Note the new requirement in 2020/21 for the co-ordinating commissioner and the provider to agree **clinically-appropriate** goals for the annual number of procedures in each category to be undertaken. **The intention here is to encourage commissioners and providers to focus on this important issue, first through early discussion and engagement and then through ongoing monitoring. Material over-performance against the activity goals in-year should prompt review and action to ensure that EBI policy is being fully implemented, but no individual patient should be prevented from accessing clinically appropriate treatment, in accordance with EBI guidance criteria, simply because the overall activity goal has been exceeded.**

Overall responsibilities for managing referrals and activity

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

- Commissioners (SC29.3) (SC29.1 in the shorter-form Contract) must seek to ensure that referrals comply with any agreed protocols and (full-length version only) any relevant Activity Planning Assumptions. In practice, the reasonable expectation will be that commissioners should be making vigorous efforts to ensure that GPs and other primary care referrers are following agreed protocols.
- Providers (SC29.4) (SC29.2 in the shorter-form Contract) must also seek to ensure that referrals comply with agreed protocols. They will bear a particular responsibility for managing referrals which are internally generated (consultant-to-consultant referrals, say), but may also reasonably be expected to assist commissioners in ensuring that primary care referrals are in line with agreed protocols.
- Providers will also bear particular responsibility for ensuring that the decisions made by their clinical staff to provide treatment to patients are made in line with clinical thresholds set out the Contract or notified through Prior Approval Schemes. They must also seek to work within the Activity Planning Assumptions relating to referrals and other metrics.

NHS e-Referral Service

42.17 The Contract contains provisions in relation to use of the NHS e-Referral Service (eRS) at SC6, summarised in the table below.

Acute providers must

- publish their (relevant) services on eRS;
- use all reasonable endeavours to ensure that sufficient slots are available to enable direct booking of appointments via eRS;
- ensure that they accept all referrals made through eRS via the “appointment slot issues” route (that is, where a GP or patient is unable to book an appropriate slot, but still wishes to make the referral).

Mental health providers must publish their (relevant) services on eRS and be in a position to accept GP referrals.

Commissioners must use all reasonable endeavours to ensure that all GP referrals

- are made via eRS; and

- contain accurate patient contact details and the clinical information required under agreed referral protocols.

42.18 The provisions of SC6.3, which apply only to GP referrals into consultant-led elective acute services, deserve particular attention. Under these:

- a provider need not accept any GP referral into a consultant-led acute outpatient service unless it is made through eRS; rather, the provider will be able to return any non-eRS referral to the GP;
- the provider must implement a process under which, in every case, it notifies any non-acceptance of a non-eRS referral to the patient's GP without delay (that is, in accordance with specific locally-agreed timescales, as described in the guidance at <https://www.england.nhs.uk/digitaltechnology/nhs-e-referral-service/>);
- each commissioner must ensure that local GPs are made aware of this process; and
- subject to the detailed provisions (and flexibility for discretion) within the guidance referred to above, the commissioner will not be required to pay the provider for any first outpatient attendance which results from a non-eRS GP referral.

Indicative Activity Plan

- 42.19 Prior to the start of the contract year, the parties should agree, where relevant, an indicative activity plan (IAP). This plan is an indication of the volume of activity that is estimated by the two parties but it is not a guarantee of a given volume of activity nor a cap on the volume of activity of any particular type which will be paid for by the commissioners.
- 42.20 The IAP should include sufficient detail for all parties to understand the indicative activity that has been agreed and any thresholds for reporting purposes that are required by the commissioner. Any thresholds should act as a trigger for discussion to understand why activity is over or under the indicative levels and are not intended as a cap on activity.
- 42.21 An IAP should reflect the expected impact of demographic changes and any firm trends in demand; it may also need to factor in requirements for additional non-recurrent activity to reduce waiting times so that national standards can be achieved. Equally, an IAP can reflect planned service expansions – or expected reductions in activity within a given service, because of commissioner development of other services elsewhere or plans to improve referral practice. The net effect should be a realistic plan, shared between commissioner and provider, giving the provider sufficient confidence to put in place an agreed level of capacity which should be sufficient to cope with the expected demand and achieve national access standards. This shared confidence is particularly important where providers are being expected to shrink their capacity as a result of commissioner plans to manage demand or shift care between hospital and community settings.

- 42.22 The IAP, as the name suggests, is indicative. For a provider to provide more or less activity than is included within the IAP is not a breach of a contractual requirement, and the commissioner cannot withhold payment simply on this basis. For most acute services, payment under the National Tariff rules will fluctuate (though only to a limited extent under the “blended payment” approach now being established for some services) to reflect the actual level of activity provided, rather than being a fixed block for a planned level of capacity.
- 42.23 Where activity planning discussions identify genuine limitations in capacity in a particular service at a provider, commissioners may need to seek to commission additional providers for patients to choose from – or look at whether, within the confines of Good Practice, more appropriate referral criteria for that service should be introduced. However, the underlying requirement within the Contract remains that providers will need to be able to flex their capacity up and down as demand fluctuates, accepting referrals and treating patients rather than turning them away.
- 42.24 For some contracts, an IAP may not be relevant. This may be the case for small contracts commissioned to enable patient choice between multiple providers or for a care home contract. In these cases, the parties may dispense with an IAP or agree an IAP of zero.

Activity Planning Assumptions

- 42.25 The commissioner may also wish to set Activity Planning Assumptions (APAs). These may include assumptions about the expected level of external demand for the Services to be provided under the specific contract and / or assumptions relating to how the particular provider will manage activity once a referral has been accepted. Adherence to APAs is monitored as part of the activity management process.
- 42.26 Whether or not to set APAs is a matter for the commissioner. Where the commissioner wishes to use them, they should be notified to the provider before the start of the contract year. APAs must be consistent with the IAP and should not be set in such a way that, as a result, a provider cannot provide the Services in line with Good Clinical Practice or that patient choice of provider (where this applies under the NHS Choice Framework) is restricted. For multi-lateral contracts, commissioners should seek to have common APAs for all commissioners. Where this is not possible, the number of different APAs in the contract must be kept to a minimum.
- 42.27 SC29.7 makes clear that APAs are to be notified by the co-ordinating commissioner to the provider. The Contract provides a schedule (Schedule 2C) in which the notified APAs can be recorded, and we think that it is sensible that this schedule should be used as a matter of normal practice. However, for the avoidance of doubt, as the Contract definition of APAs now makes clear, APAs are valid so long as they are properly notified to the provider in accordance with SC29.7, regardless of whether or not they are included in the local contract schedule. However, the definition also makes clear that APAs must be consistent with the relevant IAP. The effect is that
- a commissioner can only notify APAs which align with the agreed IAP; and

- a provider cannot prevent properly-notified APAs, consistent with the IAP, from taking contractual effect by refusing to include them in Schedule 2C.

42.28 APAs are likely to be used particularly for acute hospital services. To be effective, they should be measurable and evidence-based. Potential APAs include:

- first to follow up outpatient ratios;
- consultant to consultant referrals;
- emergency readmissions; and
- non-elective admissions as a proportion of A&E attendances.

42.29 By contrast with an IAP, the provider is under a contractual obligation to use all reasonable endeavours to manage activity in accordance with APAs, and the commissioner can use the processes set out in SC29 (Activity Management Plans, for instance) to ensure that this happens. Commissioners should act reasonably, however, in assessing providers' compliance with APAs, reflecting that APAs such as those listed in paragraph 42.28 above tend to be statistical constructs, giving indicative information about the way in which services are being delivered, rather than setting precise standards requiring precise compliance.

Early Warning and Activity Query Notices

42.30 Either party must give early warning to the other, as soon as it becomes aware of any unexpected or unusual patterns of activity or referrals. This would be outside the normal process for monitoring activity.

42.31 Either party may issue an Activity Query Notice (AQN), either on receipt of an activity report or where an unexpected or unusual pattern of activity has been notified.

42.32 Where an AQN is received, the parties must meet to review referrals and activity and the exercise of patient choice. There are three possible outcomes of the meeting:

- the AQN is withdrawn;
- a utilisation meeting is held; or
- a joint activity review is held.

Utilisation Improvement Plan (UIP) and joint activity review

42.33 Following an activity management meeting, the parties may agree that they need to understand how resources and capacity are being used. If this is the case, they may agree a UIP. This would identify any agreed actions to be undertaken by both parties to change or improve the way that resources and capacity are used.

42.34 A joint activity review will be used to identify the reasons for variances in activity and may result in an Activity Management Plan being agreed.

42.35 Where it is found that the variation in activity is due wholly or mainly to the exercise of patient choice, no further action should be taken.

Activity Management Plan (AMP)

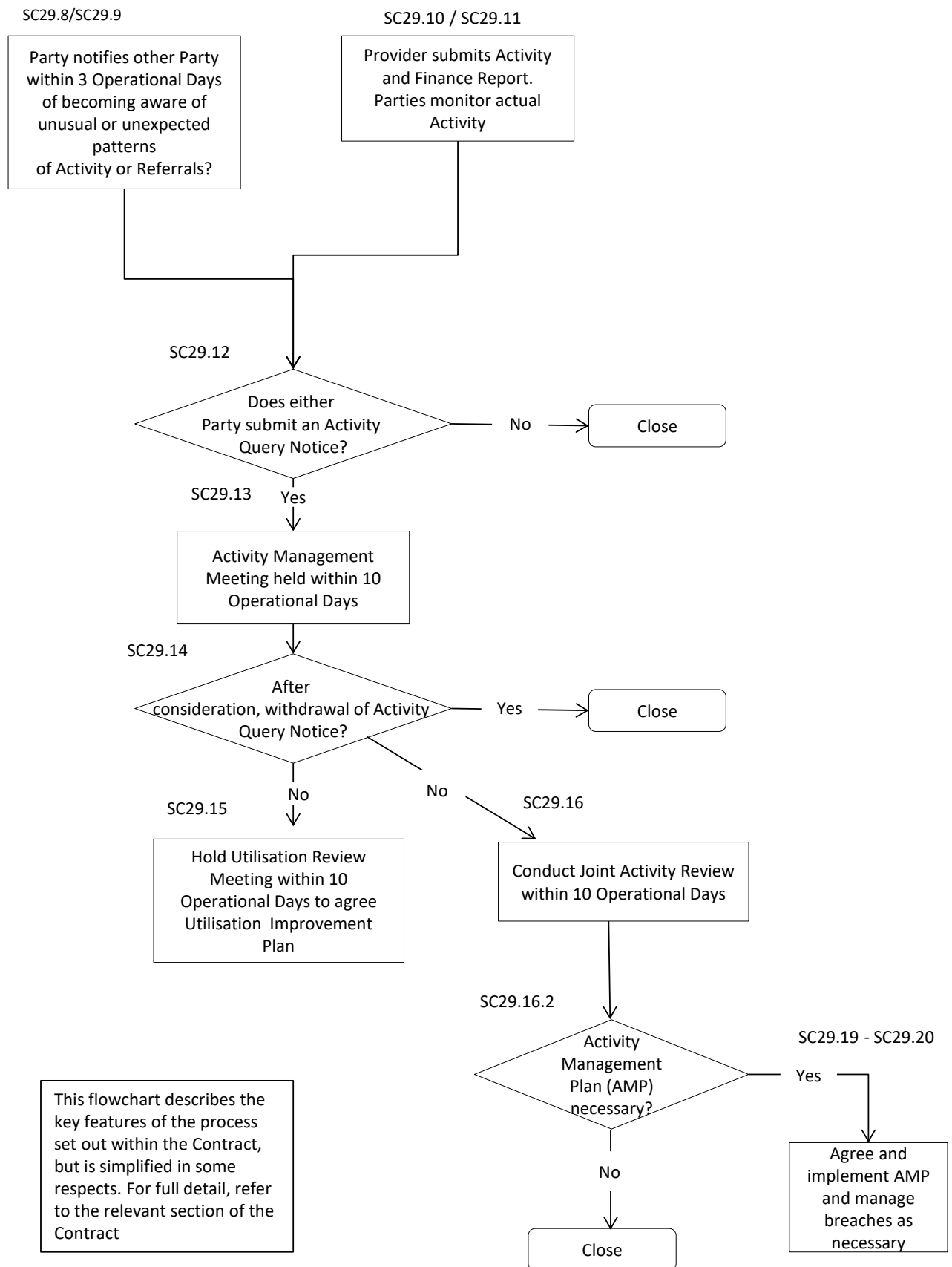
42.36 Otherwise, an AMP may be agreed. Where this cannot be agreed, the parties should refer the matter to dispute resolution.

42.37 The AMP may include agreements on how activity should be managed for the remainder of the contract period. The plan should not in any way restrict patient choice of provider. Where it is found that the provider's actions have been causing increased internal demand for services, for example by reducing clinical thresholds, changing clinical pathways or introducing new services without the agreement of the commissioner, the plan may include an immediate consequence of non-payment for that activity.

42.38 An AMP could include the following elements:

- details of the APA threshold that has been breached including a breakdown of actual activity, actual cost of activity (where appropriate) and actual variance;
- evidence of review of the activity, including source data (waiting lists, interviews, sample of patient notes, clinical process and patient flow) and analysis of the likely causes of any breach;
- provider-specific actions to improve the management of internal demand and timescales for those actions to be completed;
- commissioner-specific actions to manage external demand and timescales for those actions to be completed; and/or
- any proportionate financial consequences where actions are not completed on time.

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



Financial consequences under Service Condition 29

- 42.39 It is evident from the queries we receive that there is some misunderstanding about the ability of a commissioner to withhold funding from a provider under SC29. Clarification is set out below.
- 42.40 Exceeding the level of activity described in the IAP or breaching a ratio (or similar) set in an APA does not create an automatic entitlement for the commissioner to withhold funding. Rather, the contractual requirement is for an AQN to be served and an Activity Management Meeting to take place, followed by agreement and implementation of an AMP where indicated. By agreement, an AMP may include financial consequences (on either party) for failing to implement the actions set out in the AMP, but the primary purpose of the AMP (as made clear in the Contract definition) is to “restore levels of Referrals and/or Activity to within agreed thresholds”.
- 42.41 More broadly, failure by the provider to comply with its SC29 obligations may properly lead a commissioner to
- pursue remedy under the GC9 contract management process (which may ultimately result in withholding of funding – see section 45 of this Guidance); or
 - seek to apply the provisions of GC11.2 (indemnity for losses incurred as a result of the provider’s negligence or breach of contract – see section 47.36 onwards).
- 42.42 Equally, a provider’s response to an AQN may prompt the commissioner to contest payment under SC36.45 (see section 46), either on the basis of simple inaccuracy or because of failure to notify a locally-proposed change in the counting and coding of activity under SC28 (see section 44).
- 42.43 The only ways, however, in which a commissioner can properly withhold funding directly under SC29 are
- to apply a financial consequence agreed in an Activity Management Plan (SC29.20); or
 - to withhold payment for activity carried out in contravention of the terms of a duly-notified Prior Approval Scheme (SC29.22) or of the national Evidence-Based Interventions Policy (SC29.31).

43 Information, audit and reporting requirements

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

- 43.1 The Contract sets out a range of provisions relating to records and data, whether used for clinical or management purposes. Some of these are contained, for instance in SC23 (Service User Health Records), GC20 (Confidential Information of the Parties) and GC21 (Data Protection, Freedom of Information and Transparency).
- 43.2 Further background details on information requirements and governance are contained in Appendix 7. The focus of this section of our guidance, however, is on processes through which commissioners can access information about how the provider is providing services – under Schedule 6A (Reporting Requirements), SC28 (Information Requirements), and GC15 (Governance, Transaction Records and Audit).

Reporting Requirements

- 43.3 Good quality information is essential to enable providers and commissioners to monitor their performance under the contract. The following guiding principles should underpin the provision of information to support contract management:
- the provision of information should be used for the overall aim of high-quality service user care;
 - it should be for a clearly-communicated purpose or to answer a clearly articulated question, which may be required on a regular or occasional basis;
 - the parties should recognise that some requests for information may require system improvements over a period of time;
 - requests for information should be proportionate to the balance of resources allocated between clinical care and meeting commissioner requirements;
 - unless there are justifiable reasons for doing so, which they can explain to providers, commissioners should not request information directly from providers where this information is available through national systems; and
 - information provided should be of good quality.
- 43.4 Schedule 6A outlines the reports required under the Contract:

- **National requirements reported centrally.** This references the list of mandatory national-level data collections, approved by the Data Coordination Board and set out on the [NHS Digital website](#). Providers must submit data returns as appropriate for their organisation type and the services they provide from the list. This also includes the delivery of any data or definition set out in the NHS Digital guidance, and any Information Standard Notice (ISN) relevant to the service being provided.
- **National requirements reported locally.** This lists data and reporting requirements which are set nationally, but where the reporting is to commissioners locally.
- **Local requirements reported locally.** This is where any locally agreed requirements should be inserted. Commissioners should be clear why these reports are required and whether the information requirement is occasional or routine and should set the timeframe, content and method of delivery for these reports accordingly. Note the requirement to ensure that local datasets **containing patient-identifiable data** are submitted via the Data Landing Portal.

- 43.5 Despite the established principles above and the existing Contract wording which supports them in SC28, we receive consistent feedback about the high level of burden for providers which is generated by Local Reporting Requirements under the Contract.
- 43.6 As with Local Quality Requirements (see paragraph 39.8 above), commissioners are likely to find that a targeted approach with a limited number of well-chosen Local Reporting Requirements is the most effective approach. SC28.4 requires that commissioners must have regard to the burden their information requests will impose on providers and that they must be able to demonstrate the purpose which any new local information flow serves and the benefits which it yields. In the current context where NHS finances are under considerable stress, it is essential that commissioners are rigorous in reviewing the information burden they place on providers, ensuring that they only require information which they will actually use in practice, that the benefit from having the information is in proportion to the costs the provider incurs in collating it and that the information is not already being submitted via a different route.
- 43.7 NHS Digital offers a [Collection Referral Service](#) which providers may contact confidentially if they believe that a proposed new local data requirement would benefit from objective, independent scrutiny.

Information Breaches

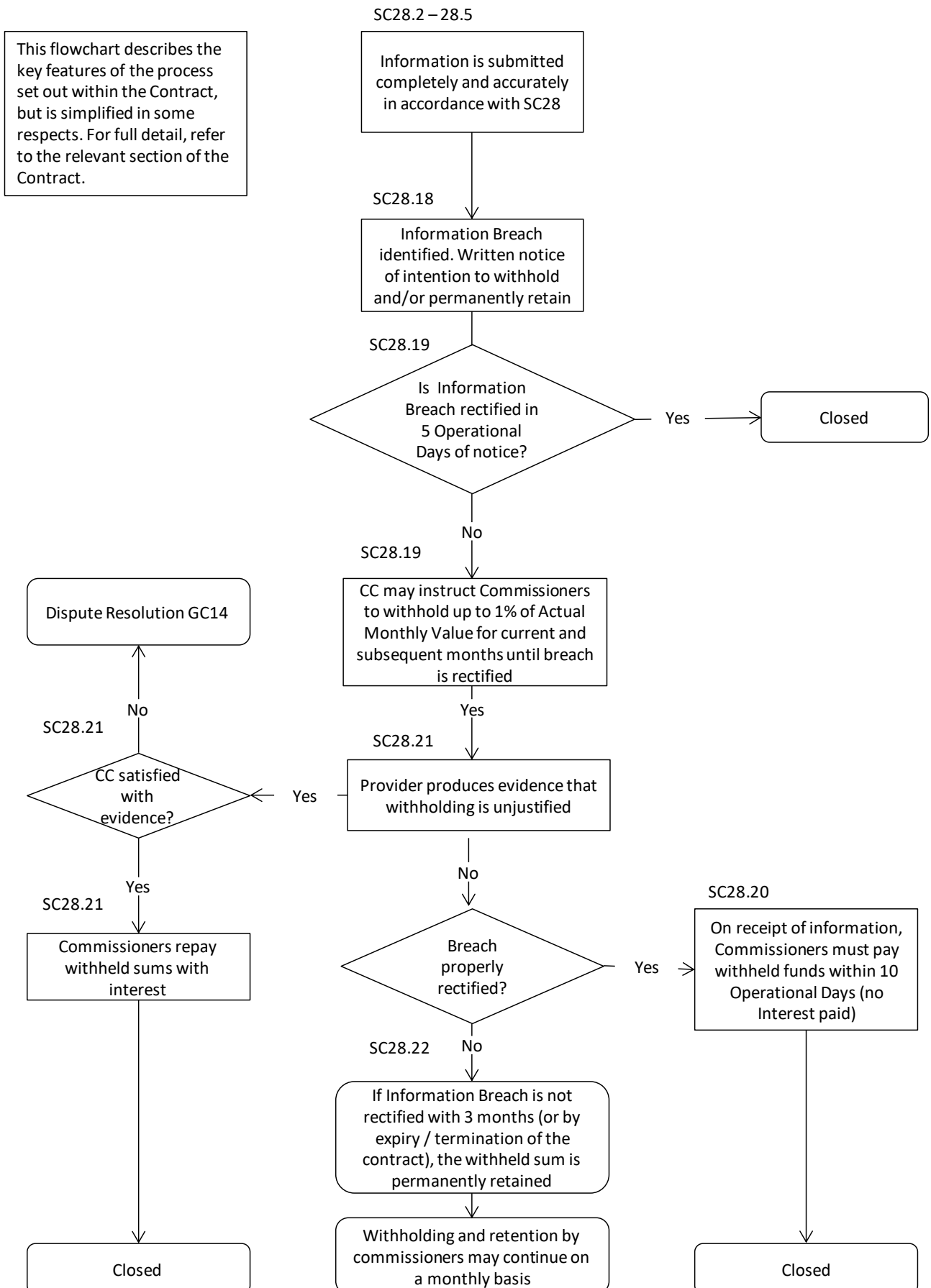
- 43.8 SC28 sets out the way in which Information Breaches are identified and managed. An Information Breach is defined as “any failure on the part of the Provider to comply with its obligations under SC23.5 (Service User Health Records), SC28 (Information Requirements) and Schedule 6A (Reporting Requirements)”. The process for identifying and managing Information Breaches is set out in the flowchart below.

- 43.9 Where an Information Breach occurs, the co-ordinating commissioner must notify the provider of it, and commissioners may then withhold a reasonable and proportionate sum of up to 1% of Actual Monthly Value, pending rectification of the Breach. The provider must rectify the Breach within three months of the notification of the Breach, failing which the commissioners are entitled to retain permanently the sums withheld. Beyond this initial three-month period, the commissioners are entitled to continue to withhold and retain a reasonable and proportionate sum of up to 1% of Actual Monthly Value for each subsequent month at the end of which the Breach remains un-rectified. There is no need for the commissioner to issue a new notice, although the commissioner should inform the provider of the continued withholding.
- 43.10 These financial withholding provisions require that any sum withheld by the commissioner must be 'reasonable and proportionate' (SC28.19) and to limit the amount withheld for all Information Breaches in any month to a maximum of 5% of Actual Monthly Value (SC28.23). The approach on Information Breaches is thus broadly consistent with the provisions for financial withholding under Remedial Action Plans under GC9.
- 43.11 It is important to be clear that rectification "to the reasonable satisfaction of the Co-ordinating Commissioner" (SC28.19) may involve retrospective and/or prospective action.
- Where a Breach involves a failure to supply information or the provision of inaccurate or incomplete information, rectification may require the provider both to submit (or re-submit corrected) information for the missing period and to ensure that accurate, complete and timely information is provided for subsequent period. So, for example, where a provider fails to submit its Service Quality Performance Report on time in September, subsequently submits the September Report three weeks after the due date, and then fails to submit the October Report on time, this amounts to a failure to rectify the September Breach.
 - In other cases, retrospective rectification may be impossible. If the data underpinning a reporting requirement has not been fully captured at the appropriate point in the care pathway (ambulance handover times, say), then the rectification is likely to focus solely on ensuring that data capture and reporting for the future is comprehensive.
- 43.12 The Information Breach withholding described above can now be actioned by the co-ordinating commissioner on behalf of all the commissioners (see SC28.18), and we hope this will increase the readiness of commissioners to use this important lever to improve performance, both where local reporting requirements are not being met and where mandated national data sets are not being submitted.

SUS

- 43.13 SC28.17 mandates submission of datasets by providers to the Secondary Uses Service (SUS), where required under NHS Digital's guidance.

SC28 (full-length contract) – Information requirements



Data Quality and Data Quality Improvement Plans

- 43.14 Data Quality Improvement Plans (DQIPs) allow the commissioner and the provider to agree a local plan to improve the capture, quality and flow of data to meet the requirements of Schedule 6A and to support both the commissioning and contract management processes. Although completion of a DQIP is not mandatory for each contract, we nonetheless encourage commissioners to use DQIPs routinely to address data quality issues highlighted through direct reporting at point of submission or through NHS Digital's [Data Quality Maturity Index](#) (DQMI).
- 43.15 Note that SC28 now includes a specific requirement for the provider to use all reasonable endeavours to optimise its performance under the DQMI, where applicable, demonstrating its progress through implementation of a DQIP or other appropriate mean. The DQMI currently covers the national datasets for admitted patient care, A&E, community services, diagnostic imaging, IAPT, mental health, maternity and outpatients.
- 43.16 Commissioners will need to differentiate between situations where a provider's data quality is acceptable overall, but with some improvements needed (in which case a DQIP will be appropriate) and where an Information Breach has occurred which is unacceptable and which needs to be managed formally using the provisions in SC28. Putting in place a DQIP means that, in relation to any information requirements contained within the DQIP, the provider will be held to account under SC28 only if the requirements of the DQIP are not achieved.
- 43.17 Multiple DQIPs can be included within the same contract. DQIPs should be included in Schedule 6B at the point where the contract is signed or incorporated into the contract subsequently by Variation. Once included in the Contract, however, commitments set out in DQIPs are contractually binding. Progress against the DQIP should be reviewed through the contract review process (GC8) and any issues addressed through the contract management process (GC9). In a multi-year contract, DQIPs should be updated periodically, as initial issues relating to data quality are resolved and new ones are identified.
- 43.18 In terms of coverage, DQIPs should provide quantified assurance that action is being taken in each of the following areas:
- Coverage – that where a data set exists and is relevant to a provider it is completed for all relevant services;
 - Consistency – that is, where a data set is produced, the volume of submitted records is consistent over a timeseries;
 - Completeness – that is, where a data set is produced, all relevant items hold expected values;
 - Validity – that all data conforms to recognised national standards. Codes must map to national values and wherever possible, computer systems should be programmed to only accept valid entries;
 - Defaults - the level to which default values specified in applicable information standards have not been used in excessively within the data collected;

- Timeliness – that all data is recorded to a deadline in line with the national reporting, and extract and refresh deadlines;
- Cleansing – covering duplication (that all necessary processes are in place to remove duplicated records), merging (that steps are being taken to ensure that separate records are not merged inappropriately) and auditing (that clinical coding checks are undertaken on a regular basis).

43.19 Commissioners are encouraged to use a range of evidence sources to inform what should be included in a DQIP as well as to identify and quantify the progress they need to make through DQIPs, including in particular the DQMI. Other possible sources are set out below.

- The NHS Digital monthly SUS data quality dashboard provides benchmarked evidence that commissioners should use to drive improvements in quantitative and process-based data quality indicators for admitted patient care, outpatients and Emergency Care data sets as well as for maternity and critical care. Each of the SUS Commissioning Data Sets are covered by the DQMI.
- Other data quality reports are published by NHS Digital relating to national data collections including the Mental Health Services Data Set, the IAPT Data Set, Community Services Data Set and Diagnostic Imaging Data Set. Each of these data sets is also covered by the DQMI.
- GC21.6 requires each provider to undertake audits of its performance against the Data Security and Protection Toolkit, and these audits will be a valuable source of information about where data quality needs to be improved, including clinical information assurance and aspects of patient safety-related data quality. In particular, Assertion 1.7 of the Toolkit requires providers to have in place policies and processes to assure the quality of their data. [Guidance](#) specific to this assertion has been developed to support this and covers many of the points discussed in this section.
- The DQMI is used across a number of different frameworks, including the Single Oversight Framework within the Digital, Data & Technology Dashboard of the Model Hospital published by NHS Improvement and is collected by the Care Quality Commission as part of their Well-Led Domain. To ensure consistency across each of these and to assist in setting thresholds for the DQMI within DQIPs, NHS Digital has published guidance on its [Data Quality web page](#).

43.20 DQIPs may be particularly useful where new national reporting requirements or datasets have been introduced and where providers are not yet routinely complying with these. This may be the case, for instance, with the Mental Health Services Data Set. Commissioners should therefore ensure that they monitor closely the data submitted by providers of the relevant services and consider whether use of one of the available contractual levers (DQIP or Information Breach) would be appropriate to ensure that any problems with the quality of data submitted by individual providers are swiftly rectified.

- 43.21 For 2020/21, commissioners are required to agree DQIPs with providers of maternity services to set out actions which the provider will take to improve the accuracy and completeness of its submissions to the [Maternity Services Data Set v2 \(MSDS v2.0\)](#). The DQIP should set out the actions which the provider will take to fully conform with Information Standards Notice [DCB1513 \(MSDSv2\)](#) as soon as possible, and with Information Standards Notice [DCB3066 \(Digital Maternity Record Standard\)](#) by 30 November 2020. Key areas of focus within providers' MSDSv2 data submissions should be data fields covering births, bookings, continuity of carer, personalised care and support plans, aspects of the Saving Babies' Lives Care Bundle, ethnicity and deprivation.

Audit

- 43.22 GC15 covers Governance, Transaction Records and Audit and makes clear:

- the Provider's responsibilities for carrying out a programme of audit at its own expense (GC15.7 in the full-length Contract, GC15.5 in the shorter-form);
- the right of the Commissioner to appoint independent auditors (who must be appropriately qualified) to review clinical service provision, activity and performance recording, financial reconciliation and local prices (GC15.8 in the full-length contract, GC15.6 in the shorter-form); and
- what should happen as a result of the reports of independent audits and who should pay for them (GC15.9-15.13 in the full-length Contract).

- 43.23 Note that the Contract now requires the co-ordinating commissioner to give the provider at least ten Operational Days' notice of its intention to appoint an independent auditor (GC15.8).

- 43.24 We have been asked about the relationship between independent audits and information governance requirements in relation to personal confidential data. This issue may obviously arise in the case of audits focusing on clinical services. Providers need a legal basis for disclosing personal confidential data. Without this they are entitled, and indeed required, not to disclose such information, and GC15.8 (GC15.6 in the shorter-form) therefore makes clear that access to such data must be "subject to compliance with Data Protection legislation (including any applicable Service User consent requirements)".

44 Counting and coding changes

*As the **shorter form Contract** is not used for acute services, in which activity recording issues tend to be more contentious, it does not include specific provisions for the management of counting and coding changes.*

- 44.1 SC28 sets out how changes in the counting and coding of activity should be managed. This is a complex and contentious area. Please also refer to the case studies set out in Appendix 6.

- 44.2 SC28 distinguishes explicitly between
- counting and coding changes made in order to comply with specific new formal coding guidance from NHS Digital (which we refer to below as “nationally-mandated changes” and which are now covered in SC28.8-28.9); and
 - changes proposed in order to comply with existing coding guidance from NHS Digital which is already in effect (“locally-proposed changes”, covered in SC28.11-28.14).
- 44.3 The requirement to neutralise, in the short term, the financial impact of counting and coding changes applies to both categories. But there is a distinction between the two categories in terms of the requirements around giving notice of proposed changes.
- The party putting forward a locally-proposed change must do so by 30 September, for implementation on the following 1 April; whereas
 - there is no requirement for the provider to give advance notice of a nationally-mandated change; all new NHS Digital guidance requiring such a change will be published on a publicly-accessible website, allowing commissioners direct access to the details and removing the necessity for notice. However, the provider must inform the commissioner when it commences implementation of new guidance.
- 44.4 SC28 makes clear that, ultimately, the need for, and extent of, any “neutralising” financial adjustment is triggered by the actual financial impact, in practice, of a counting and coding change, rather than solely by the impact which is estimated in advance, before the change is implemented. (This is made clear in SC28.9 and SC28.14.)
- 44.5 Local disputes over transactional issues such as these must be kept to a minimum, so that commissioners and providers can focus their efforts on more important matters relating to patient care. SC28.15 therefore requires the parties to work jointly and in good faith to monitor the actual impact of counting and coding changes and to agree the extent of any necessary financial adjustments.

Rationale for the national policy on counting and coding changes

- 44.6 For clarity, we have set out below the rationale for why the Contract must continue to contain requirements for the short-term neutralisation of the financial impact of counting and coding changes.
- 44.7 The National Tariff Payment System guidance does not itself set rules for how patient activity is to be recorded – these are contained in the [NHS Data Dictionary](#) published by NHS Digital. Rather, the Tariff guidance sets the basis on which recorded activity is to be grouped into different categories (e.g. healthcare resource groups (HRGs) for inpatient spells) and the prices which are to apply to those categories.

- 44.8 The national prices in the National Tariff (and under Payment by Results before that) have always been based on historic actual reference costs submitted by providers. So national prices are a product of:
- the historic actual costs of providing specific forms of patient activity; and
 - the way in which providers have, historically, actually recorded that patient activity.
- 44.9 When each new national tariff is designed, the impact of changes to that design – such as the new grouping structure of HRG4+ for the 2017-19 tariff – is carefully modelled at national level, alongside other important factors such as inflation uplifts and efficiency requirements. This informs the eventual national prices, which aim to strike a reasonable balance between commissioners and providers.
- 44.10 For any national tariff to achieve its intended financial impact, it is fundamental that patient activity continues to be recorded on broadly the same basis that informed the calculations underpinning the tariff's development. Changes in recording practice could, under an activity-based payment system such as the National Tariff, have destabilising financial effects. For this reason, there have always been provisions in national guidance for managing changes in recording practice. These provisions were originally included in the PbR Code of Conduct and then, when that was discontinued in 2013, transferred into Service Condition 28 of the NHS Standard Contract.
- 44.11 The Contract provisions aim to strike a reasonable balance between
- on the one hand, promoting, in the medium term, accurate recording of activity in line with national data definitions, with providers being rewarded on the basis of accurately-recorded activity data; and
 - on the other, offering protection in the short-term, for commissioners and providers, against the financial impact of changes in the way activity is recorded.
- 44.12 We believe that it is essential that the short-term financial protection provided by the Contract provisions applies both to locally-proposed and to nationally-mandated changes, because neither can have been built into the national calculations for the setting of tariff prices described in paragraphs 44.6-44.9 above.

What do we mean by a counting and coding change?

- 44.13 The SC28 provisions relate to the counting and coding (that is, recording) of activity (that is, how Service Users are cared for or treated clinically under the contract).
- 44.14 In that context, a change in counting and coding practice is:
- a change from a previous, historically-established way of recording activity which affects or would affect how or whether that activity is visible (i.e.

reported) to the commissioner, through submission of datasets through SUS or other local reporting routes;

- a change which is systematic, in that it affects a group of patients in a similar way or ways, rather than just affecting an individual patient; and
- a change which may affect whether a certain activity is recorded at all or how it is recorded, in terms of how it is classified (as inpatient, outpatient etc.) and/or the extent of any detailed clinical coding of diagnoses and procedures.

44.15 There are two key points to bring out from the first element of this.

Is this a change from historically-established practice?

44.16 Realistically, we know that activity recording practice is not static. A provider may record a particular activity on basis A for five years, then a key member of staff may leave and his or her replacement may, in error, start recording on basis B. This may go on for, say, three months before the provider or commissioner spots the change. Clearly, the historically-established practice here is basis A. So the provider has been at fault in making the change to basis B (firstly because it has not given prior notice and secondly because basis B is technically incorrect), but there is no question of it having to give notice in order to revert to basis A.

44.17 Not all cases will be so clear-cut, of course. A good rule-of-thumb is that a particular activity recording practice should be considered 'historically-established' to the extent that it has informed the Expected Annual Contract Value for the current Contract Year.

Is this a change in what is or would be visible to the commissioner?

44.18 What matters is what the commissioner has been and will be able to see about a particular activity. If there is a change in this, then that is a counting and coding change.

44.19 Some cases will be very straightforward – a provider may start recording a certain group of cases as daycases, rather than outpatient procedures, say. This will immediately flow through to SUS in a way that is visible to the commissioner – so it will be a counting and coding change.

44.20 But take a different example. A provider has always recorded data about a particular clinic on its own PAS but has never charged for the activity. It realises that there is a national price for that service which it has not been applying and starts to apply it. Is this a counting and coding change? It depends:

- If the provider has historically submitted the relevant datasets to SUS (or to the commissioner / CSU via another local route), then the commissioner has always been able to see the activity data for the clinic. All that has changed is that the provider has started to apply the national price. This is not a counting and coding change, and the provider may therefore start to charge for the clinic prospectively as soon as it is able.

- But if the provider has never submitted the relevant datasets for the clinic, but starts to do so for the first time as backing data for the charges it is wishing to make, then that is a change in what the commissioner can see about the service – so it *is* a counting and coding change, the provider cannot start to charge immediately, and the provisions of SC28 must be followed.

44.21 The following are therefore not counting and coding changes.

Changes in service provision:

44.22 A change solely in the way in which services are provided may have a knock-on effect on the type, volume or casemix (and therefore cost) of activity recorded (because Service Users are now experiencing a different service). For a service change of this kind to proceed, it is likely that agreement of a Variation under GC13 will be required, but a service change such as this does not fall within the provisions of SC28 on counting and coding changes.

Changes in charging:

44.23 A change solely in the way in which activity is charged for, where there is no change in the way in which that activity is recorded and made visible to the commissioner (as described in the first bullet point of 44.21 above, for instance), is not a counting and coding change.

44.24 It is worth saying a little more about the interplay between the counting and coding provisions in SC28 and the National Tariff.

- Clearly, the provisions of SC28 are not intended to prevent or delay the adoption of new prices, currencies and rules mandated through the National Tariff. Providers and commissioners do not need to give each other notice under SC28 of the application of new National Tariff arrangements, and the impact of the new Tariff is not subject to the provisions in SC28 for financial neutrality.
- Applying new Tariff arrangements without changing the way in which activity is recorded is one thing; making changes to how activity is recorded in order to increase, or with the effect of increasing, income under those new Tariff arrangements is another. The latter definitely does fall within the scope of the counting and coding provisions at SC28.
- The two examples below explain this further.
 - A national change such as the introduction of HRG4+ and the associated payment grouper does not, per se, fall within the requirement for financial neutralisation at SC28. HRG4+ is not about how patient activity is recorded in terms of activity classification and diagnostic and procedure codes; it is about how recorded activity is grouped and then charged for. The crucial difference is that the financial impact of HRG4+ has been allowed for, to the extent possible, as part of commissioner allocations and National Tariff setting – there is therefore no need for local adjustments to neutralise its impact.

- By contrast, if a provider makes a change to its historically-established approach to the counting and coding of activity, in order to benefit financially from a change to the national structure of the tariff such as HRG4+, then that does qualify as a counting and coding change under SC28.
- Best Practice Tariffs are worth particular mention here. The whole intention of the national BPT approach is to give providers an incentive to adopt proven new approaches to service delivery. So, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a Variation to be agreed in respect of any change of service provision necessary to achieve this, and the implementation of the BPT would not fall with the prior notification requirements for counting and coding changes under SC28 – because the BPT is about service delivery, not activity recording. (The one exception to this is where a provider intends to achieve compliance with a BPT simply by changing how it records activity – see scenario 10 in Appendix 6 for further details.)

Notifying and implementing locally-proposed counting and coding changes

- 44.25 Providers must notify any locally-proposed changes which they intend to make to their recording practice to their commissioners six months in advance. Equally, if commissioners wish to propose local changes in how a provider records activity, they must give that provider six months' notice.
- 44.26 The Contract does not set explicit requirements for the form which notifications of proposed changes should take, but they must be made in writing and delivered in accordance with the notice provisions set out in GC36.
- 44.27 The issue of whether notice has been properly given can cause disputes, and so we have sought to clarify the requirements below.
- The notice must describe the nature of the change proposed (that is, what actual change is proposed relative to the provider's current practice) and the rationale for it (that is, why it is technically correct under NHS Data Dictionary definitions and national guidance on clinical coding). A notice letter which simply states a broad intention to improve recording or coding, without any specific detail, would not be valid; there must be a concrete actual proposal.
 - As a matter of good practice, notice should contain the best available estimate of the impact on the type and mix of activity recorded and of the impact, at current prices, on payments between the parties. However, it is not always possible to quantify in advance – either accurately or at all – the financial impact of a particular proposed counting and coding change. Failure to quantify, when giving notice, the expected financial impact of a proposed change does not render that notice invalid.
- 44.28 The expectation in the Contract is that any locally-proposed changes agreed will be implemented
- (for multi-year contracts not in their final year) at the start of the Contract Year following the Contract Year in which notification is given;

- (for single-year contracts or expiring multi-year contracts), from the start of the contract covering the year following the one in which notification is given (assuming of course that such a contract is awarded to the same provider).

- 44.29 As a general rule, notice of locally-proposed changes must therefore be given no later than 30 September in any year, with the changes to be implemented on the following 1 April. However, the parties may instead agree a different implementation date.
- 44.30 Changes proposed by either party should be discussed and agreement reached on whether they are consistent with national recording guidance and should be implemented.
- 44.31 Where agreement cannot be reached on whether a change should be implemented, the parties may refer the matter for dispute resolution.
- 44.32 Any locally-proposed changes which are notified after 30 September 2019 will be too late for implementation from 1 April 2020 (unless the party not proposing the change agrees that it can go ahead then). They should instead be re-submitted for the following year (that is, by 30 September 2020), with a consequent delay in potential implementation, if agreed, and full financial impact.

Nationally-mandated counting and coding changes

- 44.33 NHS Digital makes available, in public, information about formal changes to requirements for clinical coding, activity recording and submission of datasets.
- Guidance on clinical coding, and Coding Clinic publications, can be accessed via the Resource Library page of NHS Digital's Delen system at [https://hscic.kahootz.com/connect.ti/t_c_home/viewdatastore?dsid=356868&adv=S&showAllColumns=N&datViewMode=list&showSingleItem=N&shownum=10&startRow=1&sortCol1=Col_11&sortDir1=desc&sortCol2=Col_0&sortDir2=asc&sortCol3=0&sortDir3=asc](https://hscic.kahootz.com/connect.ti/t_c_home/viewdatastore?dsid=356868&adv=S&showAllColumns=N&datViewMode=list&showSingleItem=N&shownum=10&startRow=1&sortCol1=Col_11&sortDir1=desc&sortCol2=Col_0&sortDir2=asc&sortCol3=0&sortDir3=asc;);
 - Information Standards Notices are published at <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/information-standards-notices>; and
 - Approved Collections relating to the NHS Standard Contract are listed at <https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/nhs-standard-contract-approved-collections>.
- 44.34 Since commissioners can access and view new guidance of this kind in the same way that providers can, the provisions of SC28 make it explicit that providers are not required to give advance notice to commissioners of their intention to implement changes to the counting and coding of activity as a result of specific, new formal guidance issued by NHS Digital (that is, a nationally-mandated change).

44.35 Rather, the expectation in the Contract will be that the provider will automatically implement any nationally-mandated change on the date required in the relevant NHS Digital guidance – but will inform the commissioner when it commences implementation, so that the parties can then discuss and agree appropriate payment adjustments to neutralise the financial impact, as described further below. (At the point of informing the commissioner of implementation, the provider should – as described at 44.27 above for locally-proposed changes – also give the commissioner its best available estimate of the impact of the change.)

44.36 Commissioners and providers should be aware of two areas in which changes are being or may be nationally mandated for 2020/21.

- The first is the move to OPCS4.9 (details can be found at https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14270896#14270896).
- The second relates to the recording of Same Day Emergency Care (SDEC) and is set out on page 12 of the [NHS Operational Planning and Contracting Guidance 2020/21](#).

Neutralising the financial impact of counting and coding changes

44.37 Whenever a counting and coding change is implemented, SC28 provides for time-limited protection against the financial effect (if there is one), by requiring that the parties must make a payment adjustment, so that the financial impact of each agreed change is rendered neutral in the short term. This applies to both locally-proposed and nationally-mandated changes.

44.38 What this means specifically is as follows.

For nationally-mandated changes, the period of neutralisation is

- where, for any reason, the change is implemented during the Contract Year during which the relevant new NHS Digital guidance was published, for the remainder of that Contract Year; and
- in any event, for the full Contract Year following the Contract Year in which the relevant new NHS Digital guidance was published.

For clarity, if the nationally-mandated changes described in paragraph 44.36 above do have a financial impact locally, this must be neutralised until 31 March 2021.

For locally-proposed changes, the period of neutralisation is

- where, for any reason, the change is implemented during the Contract Year in which it was proposed, for the remainder of that Contract Year; and
- in any event, for the full Contract Year following the Contract Year in which the change was proposed.

- 44.39 For 2020/21, therefore, for locally-proposed changes which are notified up to and including 30 September 2019:
- If a change is implemented with effect from 1 April 2020 or later, the financial impact is neutralised for the whole of the 2020/21 Contract Year.
 - If a change is implemented before 1 April 2020, the financial impact is neutralised for the relevant part of the 2019/20 Contract Year and for the whole of the 2020/21 Contract Year.
- 44.40 Where a reasonable estimate of the expected impact of a change can be made in advance, the parties should make a provisional neutralising adjustment, at the start of the Contract Year, to the Expected Annual Contract Value. But, in all cases, the parties will need to agree a process for monitoring the actual financial impact of the change in practice. Where an estimated up-front adjustment has been made, this can then be amended to reflect the actual impact through the year – and where no up-front adjustment has been made and in-year monitoring establishes that there has been an impact, an adjustment (both retrospective and ongoing, as appropriate) can be made as a result. SC28.15 sets out a requirement for the parties to approach this jointly and in good faith.

Delays in implementing changes

- 44.41 When NHS Digital publishes new national guidance on activity recording or clinical coding, the expectation is of course that providers will implement this on the date or phased sequence of dates set by NHS Digital; indeed, doing so is a contractual requirement. However, we recognise that implementation by a particular provider may occasionally be delayed – advertently or inadvertently. If the provider realises, after the mandated implementation date, that it has not implemented the required change, can it still do so as a national-mandated change – or must it now give notice of its intention to do so as a locally-proposed change?
- 44.42 Equally, where a provider has given proper notice of a locally-proposed change, and the parties have agreed that it should be implemented on a certain date, then the provider is under a contractual duty to implement the change on that date. But if the provider nonetheless fails to implement the change to the agreed timescale, what is the consequence? Can the provider still proceed to implement the change later than agreed, or must it give notice again in the next annual cycle?
- 44.43 A simple rule of thumb applies in both these situations. If actual implementation is delayed but still takes place within six months of the intended implementation date (either as set out in NHS Digital guidance or, for locally-proposed changes, as agreed between the parties – in both cases, typically 1 April), then no further notice is required. If implementation is delayed beyond this point, the provider must notify the change (as a locally-proposed change) by the next relevant deadline under SC28.11, and the period of financial neutrality will be extended accordingly.

Counting and coding changes for services with local prices

- 44.44 The provisions relating to counting and coding changes are of most relevance where services are being provided at National Prices. With services covered by Local Prices:
- the requirement for prior notification of proposed changes applies (so that neither party can be financially disadvantaged by application of an in-year counting change); and
 - the impact of any proposed counting changes should be considered as part of the review of Local Prices for the following year, with the likely outcome being that the Local Price will be rebased to reflect the revised activity levels implied by the different approach to recording – this will have the effect of ensuring that any change is financially neutral.

What a provider should do if evidence of inaccurate recording emerges

- 44.45 There is inevitably a tension between the underlying requirement in SC28.7 that activity should be recorded correctly as required under relevant national guidance (the NHS Data Dictionary, for instance) – and the recognition, through the arrangements elsewhere in SC28 for locally-proposed counting and coding changes, that provider recording is, in practice, not always accurate. What does this mean for how providers should behave?
- 44.46 Technically, a commissioner could take the view that any instance of systematically inaccurate counting and coding amounted to an Information Breach by the provider, with consequences flowing in accordance with SC28.18-28.23. For the provider, therefore, the correct response on identifying such an instance is to notify the commissioner immediately of a locally-proposed counting and coding change. By doing so, the provider is taking the appropriate action under the Contract to rectify the Information Breach, and the commissioner will therefore not be in a position to apply the financial sanction available for Information Breaches.

Implementation of local changes without prior notice

- 44.47 SC28.10 makes clear that providers must not implement local changes in counting and coding practice without prior notification and agreement. But if a provider nonetheless does so, what should happen?
- 44.48 Where a provider becomes aware only after the event that its staff have implemented a local change without proper prior notification of the commissioner, it must notify the commissioner at once, identifying the financial impact of the change as accurately as possible.
- 44.49 Similarly, if the commissioner is the first to become aware of such a change, it should notify the provider and, to protect its position, should contest payment for the financial impact of the change (as accurately as it can reasonably assess), at the earliest opportunity, under the arrangements for financial reconciliation at SC36. (Remember that a commissioner contesting payment under SC36.45 must always give its reasons “in reasonable detail”; so the commissioner should, in such an instance, set out to the provider proper evidence that a counting and coding

change has taken place and that it has had the direct effect of increasing commissioner payments.)

- 44.50 In either case, because the provider has not given proper notice, the commissioner is likely to be justified in challenging payment in respect of any adverse financial impact for itself of the revised recording basis. This will apply both prospectively (until such point as proper notification of the change has taken place and the necessary period of financial neutrality has been enforced, as required under SC28) and retrospectively (to the date at which it contested payment under SC36.45).
- 44.51 If an un-notified counting and coding change is identified only well after its implementation, the question then arises as to whether the commissioner can properly seek retrospective financial protection back to the date of implementation, even if this pre-dates by some months the point at which the commissioner contested payment. Two points are relevant here.
- The wording on financial neutrality in SC28.9 and 28.14 now includes a reference to changes “found following implementation to have had” a financial impact. The intention of this wording is to ensure that neutralising financial adjustments are based on the actual impact of the change, not just on an in-advance estimate which may prove inaccurate. The wording of SC28 does not, however, create an automatic entitlement for a commissioner to receive financial redress for an un-notified counting and coding change back to the point of implementation.
 - The provider may of course offer such retrospective redress voluntarily, but – if not – the commissioner may instead seek it using the provisions of GC11.2 (Liability and Indemnity). These provisions of GC11 allow either party to claim redress for losses it may suffer as a direct result of the other party’s negligence or breach of contract. Note, however, that GC11.12 requires the party seeking to make such a claim to “take all reasonable steps to minimise and mitigate” its losses – so, for a retrospective claim under GC11 to be successful, a commissioner is likely to have to demonstrate that it has been vigilant in identifying and contesting the un-notified counting change at the earliest reasonable opportunity.

Assessing whether a change has happened and what its impact has been

- 44.52 Counting and coding changes are not always easy to identify or assess. There can be local disagreements over whether an un-notified change has actually taken place and over what the impact of a change (notified or un-notified) has been. This is particularly true where the issue relates to a gradual increase in the acuity of reported inpatient casemix, for instance, with an associated increase in the depth of diagnostic coding at episode level.
- 44.53 There are two important points here.
- Firstly, an un-notified counting and coding change is easiest to detect where it is a step-change – that is, for instance, where a provider reclassifies activity as daycase rather than outpatient. A change of this kind will usually be readily apparent from a straightforward analysis of commissioning datasets. However,

a gradual but sustained change – for example, an increase over a year in the average number of diagnostic codes per episode in a particular service from three to four – may also be a counting and coding change. A counting and coding change does not have to be an “overnight” step-change.

- However, a reported increase in depth of diagnostic coding may have many potential explanations. A counting and coding change may be one (or indeed the only) factor in some cases. In other cases, an increase in reported casemix complexity for one commissioner may be explained by planned service developments / pathway changes or changes in patient flows between providers, change in attribution of patients between CCG and NHS England, genuine increase in patient acuity and, more basically, normal fluctuations in casemix from year to year – as well as, or instead of, a change in recording practice by the provider. So an increase in depth of coding cannot be automatically construed as a counting and coding change under SC28 of the Contract; that may be the explanation, or part of the explanation, or it may not, depending on the precise circumstances of the individual case.

44.54 Where issues of this kind arise – as SC28.15 requires – the local parties therefore need to review the evidence and work together, openly and in good faith, to reach a shared understanding, on the balance of probabilities, of what has occurred and what the financial impact has been.

Counting and coding changes and financial reconciliation and audit

44.55 Care must be taken to distinguish between:

- issues which a commissioner may legitimately challenge through the financial reconciliation process in SC36 and the audit process in GC15; and
- situations where the appropriate action is for the commissioner to propose a recording change under SC28.

44.56 Legitimate challenges under SC36 / GC15 may focus, for example, on inaccuracies in recording at individual patient level, allocating patients to the wrong commissioner, double-counting or inaccurate calculations. But where the commissioner questions a historically-established, systematically-adopted recording approach by a provider, use of which has informed the Expected Annual Contract Value agreed by both parties, then the correct approach will be for this to be handled as a locally-proposed counting and coding change under SC28, rather than as an issue to be handled in-year under SC36 or GC15. For the avoidance of doubt, this applies even where the provider’s recording practice is not compliant with NHS Digital’s standards and guidance.

44.57 By contrast, an audit under GC15 may appropriately be instigated by the commissioner as a way of assessing whether an un-notified counting and coding change has indeed taken place and what its financial impact has been. But, in such cases, it is essential that the audit is set up and undertaken as GC15 intends – with the Auditor acting as “an appropriately qualified, independent third party” (as the Contract definition in the General Conditions describes it), with a duty to establish the factual position impartially and objectively, taking into account all reasonable evidence and arguments. The role of the auditor under GC15 must not

be confused with that of an external consultant to the commissioner. The auditor's role is emphatically not to provide the commissioner with advice on how best to interpret the evidence to its advantage; rather, GC15 must be used with the aim of providing the local parties with a "single version of the truth" from an authoritative, impartial source, albeit one appointed by the commissioner.

Conclusion

- 44.58 Although the Contract provisions on counting and coding changes remain absolutely necessary, we recognise that they can be complex to operate in practice. Many cases will be very clear-cut, but others will involve an element of interpretation and judgement, and quantifying the financial impact of counting and coding changes is not always a precise science. Good management of potential counting and coding changes will therefore rely on a reasonable approach from both commissioner and provider at local level. Both should work in good faith to the common goal that – while in the medium term the provider should be reimbursed in relation to accurately recorded activity – the aim of the contractual provisions on notification and financial impact of counting and coding changes is to avoid short-term financial gains or losses to either party.

45 Contract management

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

Contract review process

- 45.1 The contract review process is set out in GC8 (Review).
- 45.2 The necessary frequency of reviews will generally depend on the subject matter and size of the contract and the level of financial or clinical risk involved. The parties may agree a suitable interval between reviews, which should be at least every six months. The review frequency agreed should be set out in the Particulars. (Under the shorter-form Contract, we expect review meetings to be held as and when required, rather than on a fixed schedule.)
- 45.3 The matters for review will depend on the type of contract. Potential areas for review will include service quality, finance and activity, information, and general contract management issues. Commissioners and providers should identify those areas which require review, taking into account the reporting requirements set out in the quality and Information schedules.
- 45.4 Either party may call an emergency review meeting at any time. Representation at meetings is left to local discretion. However, the parties will wish to ensure appropriate senior clinical representation, where relevant to the services.

Contract management process

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

Informal queries and Contract Performance Notices:

- 45.6 Factual queries to aid understanding should normally be handled informally between the parties or, if necessary, more formally under SC28. By contrast, the formal Contract Management process is initiated through a Contract Performance Notice when either party has a clear understanding that the other has, or may have, breached a contractual obligation.

Joint Investigations:

- 45.7 Where a Contract Performance Notice has been discussed and is not withdrawn, the default position is that a Remedial Action Plan (RAP) is agreed (and/or, if the safety of patients, staff or the public is at risk, an Immediate Action Plan is implemented). However, where there is disagreement between the parties about whether either form of action plan is required, they must undertake a Joint Investigation (to be completed within two months).

Failure to engage or agree:

- 45.8 The expectation in the Contract is that the parties will engage in good faith to remedy breaches of any contractual obligations. However, where the remedial process described at GC9.7 (Contract Management Meeting) or GC9.8-9 (Joint Investigation) is stalled for any reason, GC9.15 makes provision for the governing bodies of the parties to be notified. If, after a further ten Operational Days, it has still not been possible “due to unreasonableness or failure to engage on the part of the Provider” to move the process to the next stage of GC9, GC9.16 allows the co-ordinating commissioner to withhold a reasonable and proportionate sum of up to 2% of the Actual Monthly Value for each further month in which no progress is made.

Exception Reports:

- 45.9 GC9.20 makes provision for the issue of an Exception Report where a party has breached the requirements of a RAP. Exception Reports offer the opportunity for the injured party to set out formally, to the highest management tier within the other party, the contractual requirement which has been breached and the remedial action which is urgently required.
- 45.10 GC9.21 gives the co-ordinating commissioner the power to withhold funding following the issue of an Exception Report – see 45.12 below.

Remedial Actions Plans and financial consequences:

- 45.11 A RAP may set out both actions to be undertaken and improvements to be achieved and maintained, with the RAP setting out required timescales for each.

- 45.12 Clearly, the intention of a RAP is that it leads to remedy of the contractual obligation that has been breached. But the Contract sets out provisions which apply where this is not the outcome.
- By agreement, a RAP may include reasonable and proportionate financial consequences (on either the provider or the commissioners) which are to be applied where the actions / outcomes set out in the RAP are not undertaken / achieved as the RAP requires. Where this is the case, these financial consequences may be applied immediately the breach of the RAP is clear. No Exception Report is required in order for these financial consequences to be exercised.
 - Alternatively, where no immediate financial consequences are agreed as part of the RAP itself and where the provider breaches the RAP, the co-ordinating commissioner has the opportunity under GC9 to issue an Exception Report. The co-ordinating commissioner may at this point withhold funding (“a reasonable and proportionate sum of up to 2% of the Actual Monthly Value” in respect of each action not completed or improvement not met, “subject to a maximum monthly withholding in relation to each Remedial Action Plan of 10% of the Actual Monthly Value”). Following issue of the Exception Report, the Contract then allows the provider a further 20 Operational Days to resolve the breach of the RAP. If the breach remains unresolved at this point, the co-ordinating commissioner may permanently retain, at its discretion, the sums it has previously withheld.
- 45.13 The intention of these provisions is a) to emphasise that financial consequences should be reasonable and proportionate and b) to create a greater incentive for specific, appropriate financial consequences to be agreed between the parties as part of RAPs, rather than encouraging reliance on the broader provisions for withholding of up to 2% of Annual Monthly Value.
- 45.14 These broader provisions for withholding funding under GC9 are deliberately available to the commissioner only – since the priority here is to protect services to patients, which it is the provider’s role to provide. But note the following.
- We anticipate that these withholding provisions should need to be used only very infrequently – and any withholding must be “reasonable and proportionate”, as the Contract wording requires.
 - Funding is withheld temporarily in the first instance and is repayable to the provider, once the provider engages properly in the remedial process (if the withholding is under GC9.16) or fully implements an agreed Remedial Action Plan (if the withholding is under GC9.21). Funding may only be retained permanently by commissioners in the specific circumstances set out in GC9.22 or GC9.24-25.
 - Where a provider believes that a commissioner is refusing to address its own breaches of contract under GC9, it may a) pursue the matter through the dispute resolution process at GC14 and/or b) seek compensation under GC11 for losses which it can demonstrate that it has incurred as a direct result of the commissioner’s negligence or breach of contract.

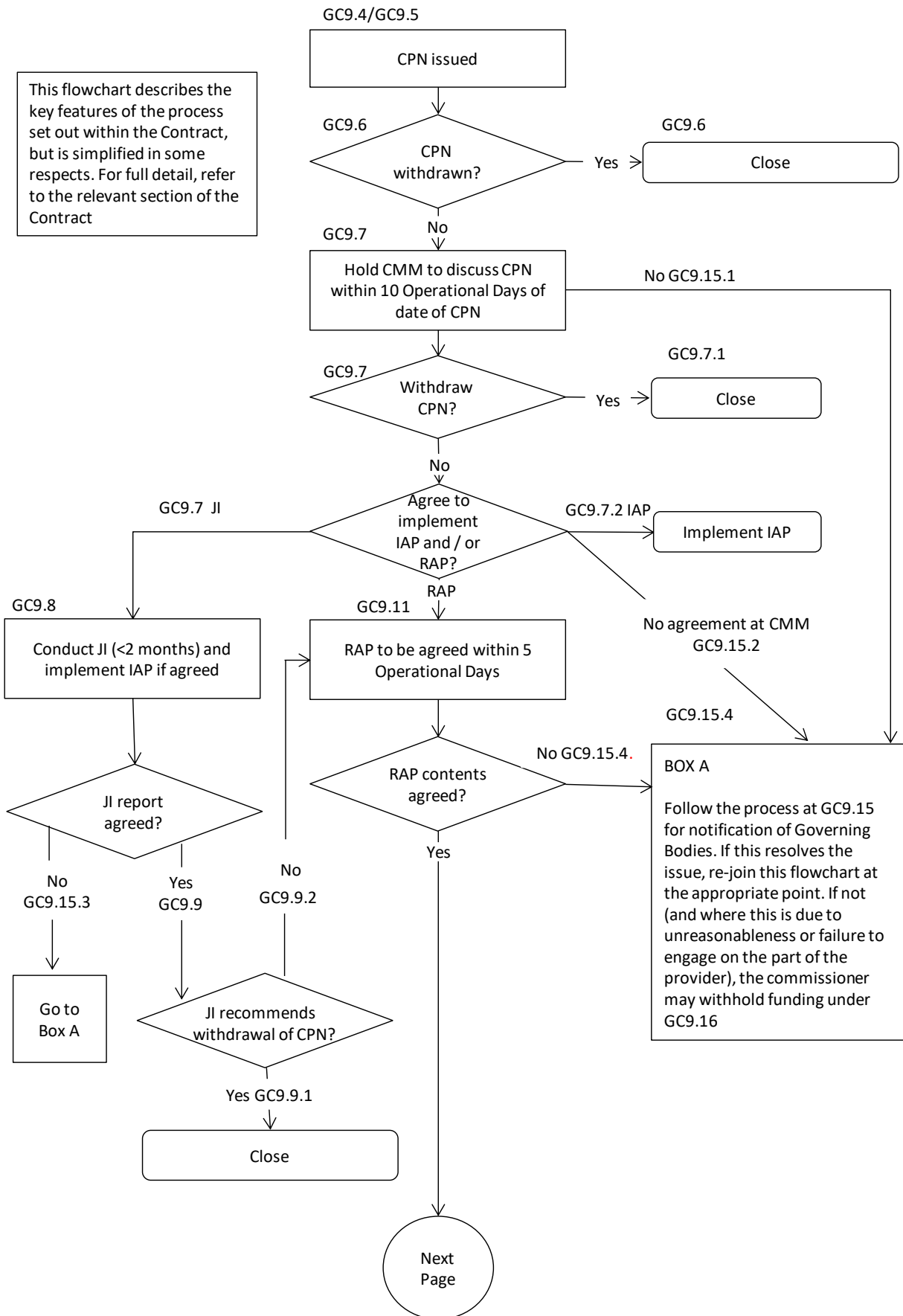
GC9 and breaches of Quality Requirements:

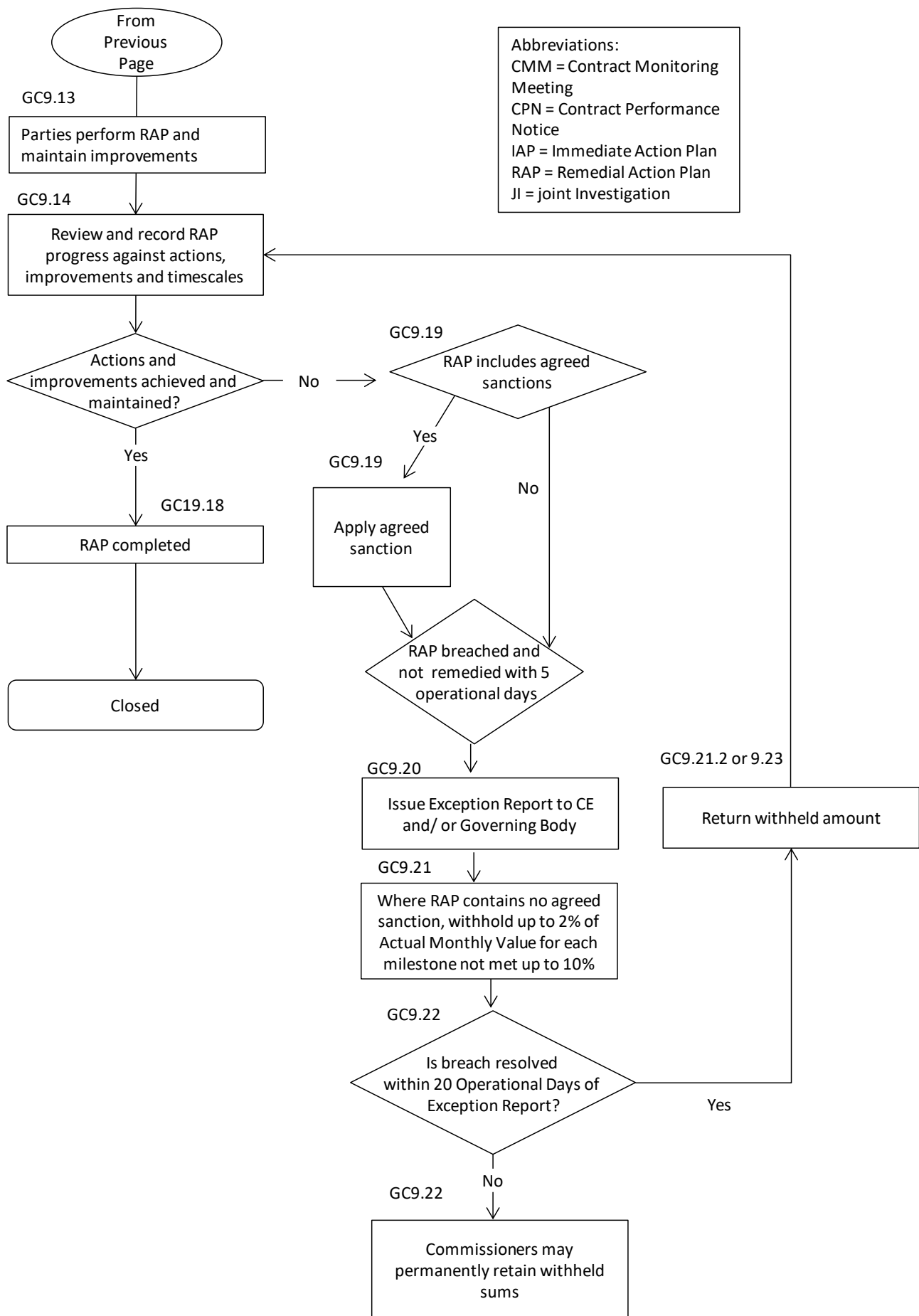
- 45.15 Where the provider breaches the national quality standards set out in Schedules 4A and 4B, the commissioner must automatically apply the relevant financial sanctions (subject, of course, to the arrangements for the suspension of sanctions described in paragraphs 3.17 onwards above); sanctions may also be agreed and applied in relation to Local Quality Requirements in Schedule 4C. There is no requirement for the commissioner to go through the process in GC9 in order to apply these sanctions (see GC9.1).
- 45.16 It is also important to stress that application of the sanctions set out in Schedules 4A, B and C does not remove the commissioner's right to use GC9 to seek remedy of breaches of Quality Requirements. It will often be appropriate for a RAP to be agreed to put right breaches of Quality Requirements, and commissioners may use the provisions of GC9 to apply further financial consequences for breach.

Breach of new national requirements in the Contract

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

GC9 (full-length Contract) – contract management





46 Payment

*The payment provisions in the **shorter-form Contract** are similar to those in the full-length version but omit certain details.*

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

Payment schedules

46.2 Agreed local details relating to payment are recorded in Schedule 3. Not all of the sub-schedules with Schedule 3 will need to be completed for every contract.

- Schedule 3A records Local Prices (including details of the basis on which payment is made for each Service – block payment, activity-based, marginal rate etc.). In the case of a contract covering more than one Contract Year, there is a specific provision (SC36.4) for the parties to record within Schedule 3A any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years.
- Schedule 3A should also be used to record locally-agreed blended payment arrangements for outpatient care and, where relevant, maternity services (as proposed in the 2020/21 National Tariff Payment System consultation).
- Schedules 3B and 3C record any Local Modifications and Local Variations to National Prices (in the format in which these must be submitted to NHS Improvement).
- Schedule 3D records the Emergency Care Rule: Agreed Blended Payment Arrangements. Worked examples for completing this schedule are set out in Appendix 8.
- Schedule 3F sets out the Expected Annual Contract Value (EACV). This is the figure on which any core contractual payment on account is based and should exclude expected CQUIN payments – see 40.14 above.
- Schedule 3G allows for recording of timing of payments in the first or final contract year.

46.3 There is no separate schedule for risk-sharing agreements to be recorded in the Contract, as there would be potential for confusion between this and the provisions for Local Variations (see above). Any agreements to share financial risk in relation to services covered by National Prices should be recorded as Local Variations. Any agreements on risk-sharing in relation to services covered by Local Prices can be recorded either in Schedule 3A (Local Prices) or in Schedule 2G (Other Local Agreements, Policies and Procedures).

46.4 Note that NHS Improvement and NHS England have published [Local Payment Design Examples](#) on multi-lateral gain and loss-sharing.

Invoicing, payment and reconciliation

- 46.5 Detailed arrangements for invoicing, payment and financial reconciliation are set out in SC36 and in the flowcharts below.
- 46.6 These arrangements vary between contracts depending on two parameters:
- **EACV agreed / not agreed.** Where there is an agreed EACV, the provider invoices the commissioner on-account and the commissioner makes up-front payments. (Note that, although the default remains that up-front payments are made in equal 12ths, SC36.25 (SC36.21 in the shorter-form Contract) now allows the parties to agree a more realistic, tailored profile – to reflect expected seasonal patterns or the phased impact of commissioner QIPP plans, for example.) The provider then submits reconciliation accounts to the commissioner, adjusting for any difference between the payment already made and the actual sum due (for example because of variation in activity levels). Where there is no agreed EACV (or the EACV is zero), the provider invoices retrospectively for activity undertaken. (Clearly, where payment works on a simple block basis, no reconciliation is necessary.)
 - **SUS applies / does not apply.** Where the provider provides any Services for which data must be submitted to SUS, then a two-stage reconciliation process (commonly referred to as “flex and freeze”) applies for all the Services provided under the contract (SC36.28 to 36.31), with the provider submitting to the commissioner both a first and a final reconciliation account, in accordance with the national SUS process and timeline. Where SUS is not relevant to any of the Services, the provider only submits a single reconciliation account (SC36.32).
- 46.7 There has been some confusion about the status of the first reconciliation account under the two-stage process and any requirements on commissioners to contest payment at this stage. To clarify:
- Providers should do all they can to make their data as accurate as possible at the initial ‘flex’ stage.
 - Equally, commissioners should raise any informal data validation queries following receipt of flex data, and both parties must seek to resolve these before the freeze date, as required by SC36.29. This is particularly important in giving providers the opportunity to recode any activity initially attributed to the wrong commissioner, so that they still have time to recoup income from the correct commissioner.
 - But it makes no sense for commissioners to contest payment formally at the stage of receiving an initial flex reconciliation account under SC36.28. The initial reconciliation account is not a demand for payment and is subject to amendment in the final version a month later.
 - This is the reason SC36.45.1.1 is as it is. The effect is that – just as the provider can potentially amend, at freeze, any aspect of the data submitted at flex – so the commissioner must ultimately decide, once it has received the provider’s final reconciliation account under SC36.30, whether to contest any

element of that account – and failure to raise or resolve a query following flex (under SC36.29) is no bar to payment being formally contested at the final reconciliation stage (under SC36.45).

- 46.8 Note that payments to providers to be made from the Provider Sustainability Fund should not be included within the EACV. These amounts are not payments for services under the Contract, they are separate pass-through payments. They do not attract CQUIN.
- 46.9 Each year, NHS Digital publishes a SUS PbR Submission Timetable, setting out specific timescales for data submission and reconciliation in that year (available at <https://digital.nhs.uk/services/secondary-uses-service-sus/payment-by-results-guidance>).
- 46.10 Throughout SC36, the onus is on the provider to submit invoices and reconciliation accounts and on the commissioner to validate these, paying uncontested elements promptly in line with the timescales set out in the Contract and challenging any contested elements through the process set out in SC36.45. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.
- 46.11 Note that guidance about technical aspects of financial reconciliation and invoice validation is available at <https://www.england.nhs.uk/ig/in-val/>. This provides advice on how to ensure that any processing of Personal Confidential Data, for the purposes of invoice validation, is undertaken lawfully.

Payment of CQUIN

- 46.12 As described in paragraph 46.2 above, expected CQUIN payments should not be included within the EACV in Schedule 3F. Rather (under the full-length Contract), agreed payments on account in respect of CQUIN can be set out in Table 2 of Schedule 4D (CQUIN). The level of any CQUIN payment on account is for local agreement. Providers then invoice separately on account for CQUIN under SC38.2. (Under the shorter-form, payment of CQUIN is annual in arrears.)
- 46.13 CQUIN guidance makes clear that “it may not always be a good use of time for commissioners and providers to develop and agree detailed CQUIN schemes for very low-value contracts. At their sole discretion, therefore, commissioners may choose simply to pay the CQUIN value to providers where the 1.25% CQUIN value would be non-material, rather than develop a specific CQUIN scheme.”
- 46.14 Where commissioners do choose to adopt this approach, they should:
- note within the CQUIN Schedule (4D) that this is the approach being taken (the Schedule includes wording to be used for this); and
 - ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed at full value (that is, including any value which would otherwise have been paid as CQUIN) – as is specifically required under SC38.15.

- 46.15 A separate financial reconciliation operates in respect of CQUIN, as set out in SC38.10 to 38.14. Again, the onus is on the provider to report its performance against the agreed CQUIN scheme at agreed intervals (through CQUIN Performance Reports) and to submit an annual CQUIN Reconciliation Account for the commissioner to validate.
- 46.16 It is important to distinguish between the CQUIN Performance Report and the CQUIN Reconciliation Account.
- The CQUIN Performance Report is what demonstrates whether or not the provider has met the requirements of the relevant CQUIN indicators. If the commissioner wishes to challenge the content of the provider's CQUIN Performance Report (in other words, to disagree with the provider's report on its own performance), it can do so under SC38.7 – but it must do this within ten working days of receipt of the CQUIN Performance Report.
 - The CQUIN Reconciliation Account sets out the provider's calculation of the financial impact, for the full Contract Year, of the agreed outcomes from the various CQUIN Performance Reports which it has submitted during that year. Again, the commissioner can challenge the content of the CQUIN Reconciliation Account (under SC38.12, the deadline here being five working days from receipt).
 - The key point is that the CQUIN Reconciliation Account can only be challenged in relation to whether it "gets the maths right" - that is, whether it sets out accurately what CQUIN payment the provider is entitled to, reflecting the payment on account made, the level of CQUIN performance demonstrated and the actual overall value of activity undertaken in the year. A commissioner cannot use the CQUIN Reconciliation Account process to challenge whether, in fact, the provider met the requirements of the CQUIN indicators; this must be done in relation to each CQUIN Performance Report as it is submitted during the year, in accordance with the timescales set out in SC38.7.

Charging overseas visitors and migrants

- 46.17 SC36.41 (full-length Contract) / SC36.21 (shorter-form) contains requirements on providers relating to identification of, and collection of charges from, Service Users who are overseas visitors or migrants, reflecting the Regulations and guidance governing this area.
- 46.18 Current DHSC guidance in this area, referred to in the Contract, is available at <https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme>. One important aspect of the recent changes is to require providers to receive advance payment for treatment from overseas visitors, except in the case of immediately necessary or urgent treatment, which should not be delayed. This in turn has knock-on implications for the financial arrangements set out in [Improving Systems of Cost Recovery for Overseas Visitors](#). The effect is that the cost recovery arrangements described in paragraphs 46.16 and 46.18 below do not apply in situations where costs are recovered in advance or at the time the care is provided.

- 46.19 In summary, in those situations where overseas patients are liable to charges, under the new regime, providers are to charge 150% of the tariff or local price for the relevant treatment. Commissioners are to pay at 75% of tariff or local price pending recovery from the overseas patient. If payment is recovered, the provider will refund that 75% payment to the commissioner and retain the balance; if it fails to recover payment from the patient, liability for the cost of treatment (at tariff or the agreed local price) is effectively shared 75% / 25% between commissioner and provider.
- 46.20 If, however, the provider fails to take appropriate steps to identify an overseas visitor liable to charges for NHS services, or fails to take reasonable steps to recover payment, liability for cost of all chargeable treatment for that patient falls on the provider.
- 46.21 It may often take some time for providers to recoup charges from overseas patients – or for patients to provide definitive evidence that they are exempt from charges. It will therefore generally be sensible for commissioners and providers, by local agreement, to apply the reconciliation timescales set out in SC36 in a more flexible way in respect of such patients. This will allow more time for the correct payments to be assessed and made – enabling providers to make the 75% refunds to commissioners described above, or to apply the full 100% charge to the commissioner in a situation where a patient has, after some delay, confirmed their charge-exempt status.
- 46.22 Resources for NHS Trusts to help manage overseas visitors and migrant charging have been published by the Department of Health and Social Care and are available at <https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants?>

Moving to block, “aligned incentive” or “guaranteed income” arrangements

- 46.23 We are aware that some commissioners and providers of acute services have moved to, or are considering moving, away from an “activity x price” system of payment, and instead using the flexibilities inherent in the National Tariff Payment System to adopt, instead, an approach which fixes in advance, to a much greater extent, the amount which the commissioner will pay the provider for delivering services for a specific period, regardless of (or not wholly dependent on) actual levels of activity delivered.
- 46.24 There can be good reasons for taking this sort of approach. It can help both parties to ensure that they live within the level of NHS funding available within their local system; it gives each greater financial certainty in advance, allowing plans to be implemented on a firmer basis; and it can reduce the amount of time which has to be devoted to in-year financial validation and reconciliation, freeing up resources to focus on more important matters. **Proposals for the 2020/21 National Tariff will, if approved, involve a further move in this direction, adding blended payment arrangements for outpatient care and maternity services to those introduced for emergency care in 2019/20.**
- 46.25 There are arguments in favour of the “activity x price” approach too, of course, and commissioners need to consider sensible alignment across their main acute contracts. A commissioner with two main acute providers, for example, should

consider very carefully whether it makes sense to agree a block arrangement with one whilst remaining on an “activity x price” basis with the other; there is clear risk of perverse incentives in such an approach which could unwittingly encourage behaviour contrary to the proper operation of patient choice, for instance.

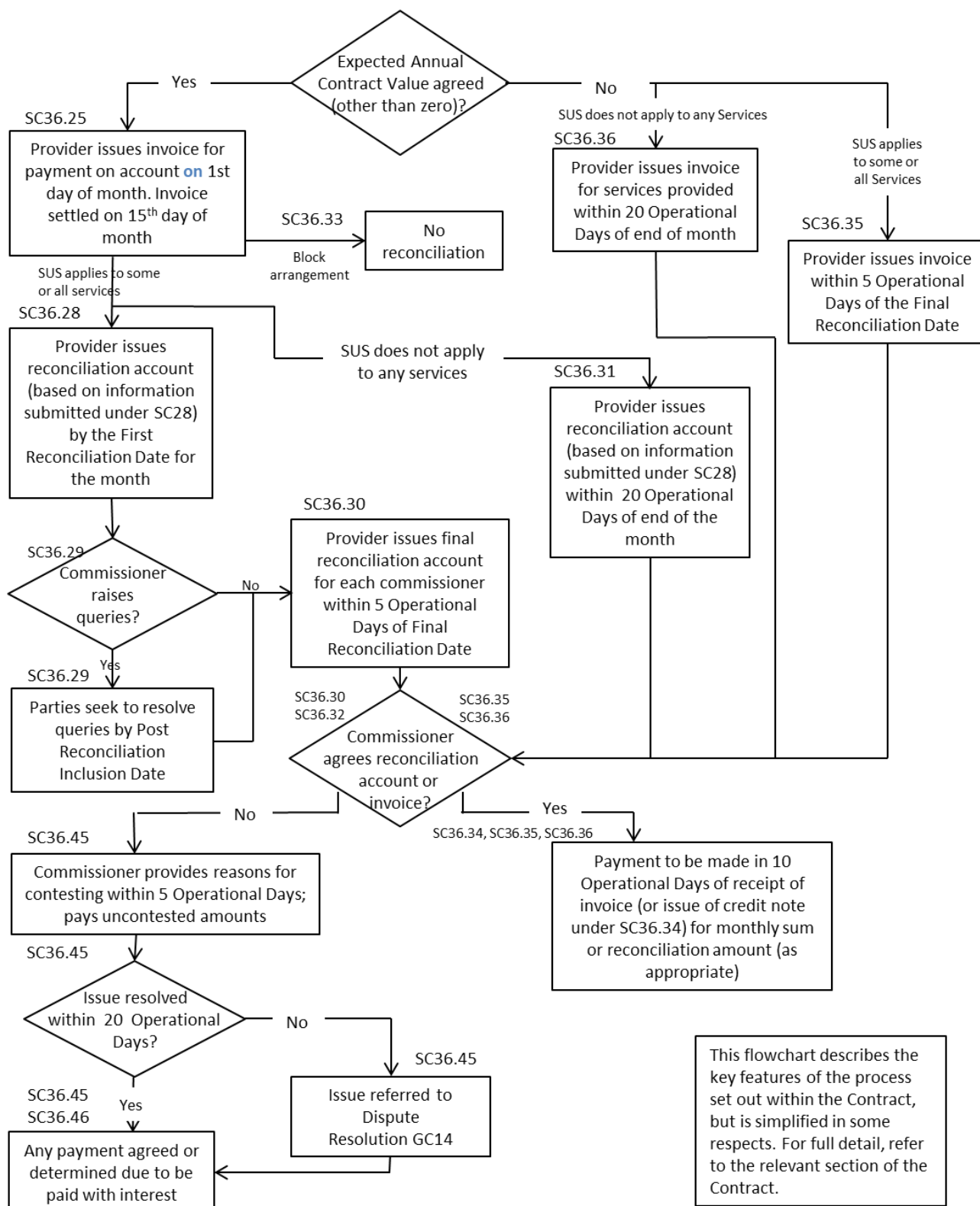
- 46.26 Local Variations, to National Prices or currencies, need to be agreed in accordance with the principles and rules set out in the National Tariff. Similarly, local prices (where national prices do not exist) also need to be agreed in accordance with the principles and rules set out in the National Tariff. The National Tariff Payment System Guidance sets out the principles and rules for agreeing Local Variations and Local Prices.
- 46.27 Where block arrangements are initiated without careful consideration, things can easily go wrong – and we have seen a number of serious disputes arising in these circumstances. We therefore set out below some advice on issues to consider in advance and to address properly in local contract documentation.
- **Local Variation.** If the block arrangement will include services for which the National Tariff sets a National Price, the block arrangement will require a Local Variation to be agreed and submitted to NHS Improvement in accordance with the requirements set out in the National Tariff, and included in the local contract at Schedule 3B. Details of the criteria which Local Variations must meet, the process for submitting them and the template which must be used are available at <https://www.gov.uk/guidance/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor>. A Local Variation must be agreed between the parties; it cannot simply be imposed on one party by the other.
 - **Duration of any Local Variation.** Note that Service Conditions 36.11-15 of the Contract address Local Variations, setting out the expectation that a Local Variation may be agreed “for one or more Contract Years”.
 - Where the local contract has a duration of several years, it is therefore important that the intended duration of the Local Variation (whether for one Contract Year or more) is made clear in Schedule 3B.
 - In the context of a local contract with the duration of just one year, however, this means that the Local Variation will apply for the whole of that year and for that year only; it will not automatically remain in force into any new contract which the parties may enter for the following year: a new Local Variation will need to be agreed and documented in respect of that new contract.
 - **Scope of the block arrangement.** It is essential that the scope of the block arrangement and Local Variation, in terms of the services covered and not covered, is made clear in Schedule 3B. If, for example, services for which the National Tariff does not set a National Price and/or locally-priced services such as Tariff-excluded drugs and devices, are to remain outside the block, the relevant local pricing arrangements for those services and items should be set out in Schedule 3A (Local Prices). Equally, under a multi-commissioner contract, it must be clearly documented in Schedule 3B which commissioners the block arrangement applies to and which will continue to operate on the

normal “activity x price” basis. This may involve some cross-referencing between Schedule 3A and Schedule 3B.

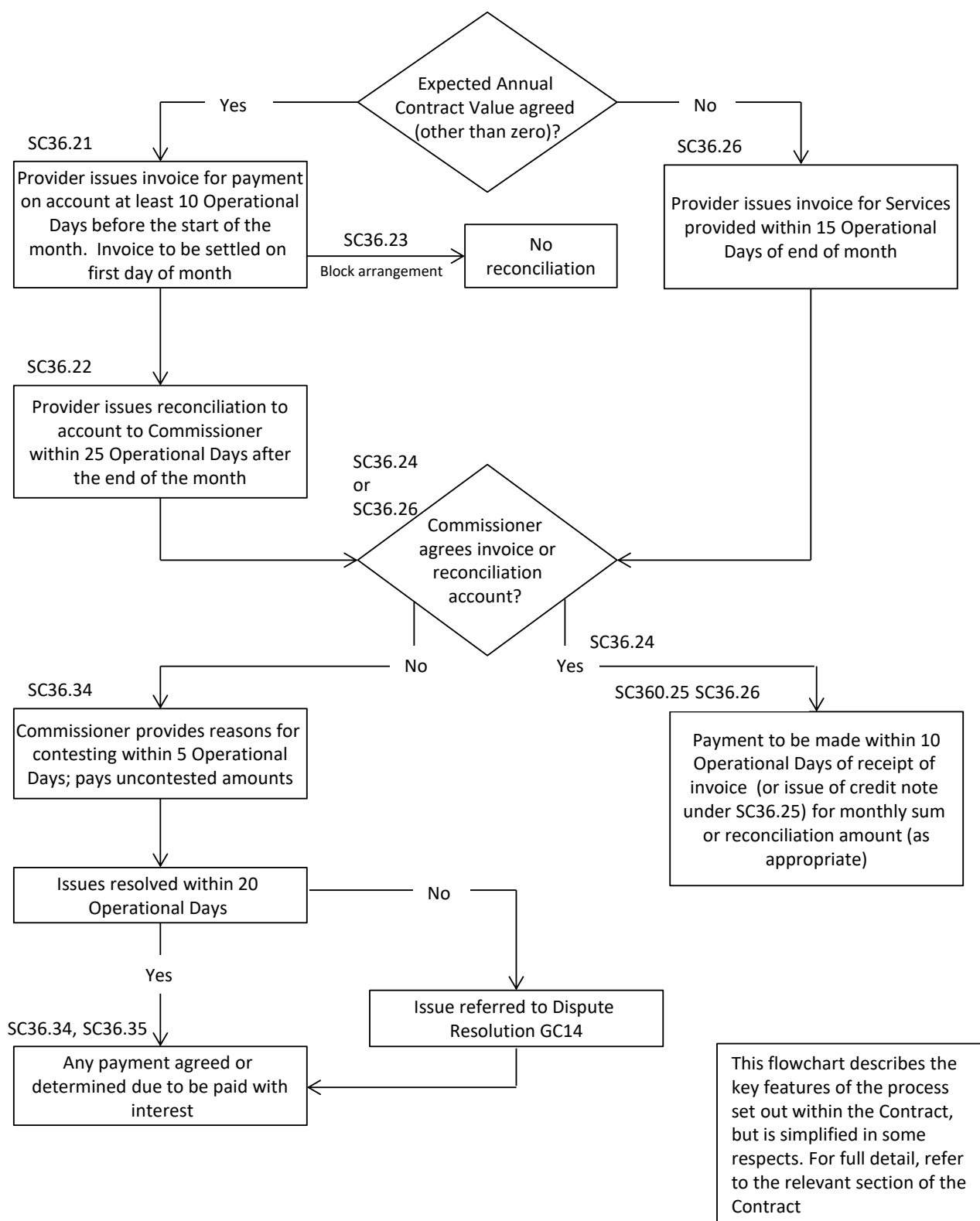
- **Chargeable Overseas Visitors.** [Improving Systems for Cost Recovery for Overseas Visitors](#) sets out financial risk-sharing arrangements which create incentives for providers to ensure that, where applicable, charges from overseas visitors are recovered in full. It is important that these separate incentives remain in place, and activity and income related to chargeable overseas visitors should therefore not be included in local block arrangements.
- **Impact for other Contract schedules.** A Local Variation agreed and documented in Schedule 3B will have implications for the Expected Annual Contract Value set out in Schedule 3F; the latter must be consistent with the former. Equally, the Indicative Activity Plan (Schedule 2B) and Activity Planning Assumptions (if used, Schedule SC) should be stated on a basis which is consistent with the way in which the block value has been calculated.
- **Limitations of block arrangements.** Whilst a Local Variation, properly agreed and documented, enables divergence from National Prices and/or the currencies applicable to services with National Prices, it does not enable or entitle commissioners and providers to vary, or suspend, any elements of the General Conditions or Service Conditions of the Contract itself. Since the General Conditions and Service Conditions automatically take precedence over the locally-agreed content of the Particulars, any attempt to do this will be invalid and will have no binding contractual effect.
- **Thresholds or tolerances.** Local parties may agree a completely fixed block, which will not vary under any circumstances, irrespective of actual activity levels – but they may also agree an approach where, if actual activity exceeds specific tolerances or thresholds, certain consequences will take effect (payment at marginal price for activity beyond the agreed tolerance, for instance). Documenting exactly what has been agreed can be complex, but is essential; this should be done in Schedule 3B (and/or 3A, as appropriate). Equally, even if the entire financial risk of activity over-performance is agreed to sit with the provider, the parties may wish to agree what should happen in the event of material over-performance and, in particular, what the commissioner will do to assist the provider and mitigate the impact. Commissioners and providers should take time to ensure that any local wording agreed here is unambiguous; it is a good idea to “stress-test” draft wording, checking, before signature, that there is a shared understanding of what would happen under a range of different foreseeable scenarios.
- **Prior Approval Schemes.** It is important that the parties agree how existing Prior Approval Schemes under SC29 are to be managed under any block arrangement. In principle, a block approach should reduce reliance on such Schemes, allowing providers greater freedom to treat patients within agreed criteria, rather than having to apply for individual patient-specific prior approval in advance of offering treatment. For some conditions, however, commissioners may wish to retain the discipline of individual prior approval in advance, to ensure consistency of decision-making across their whole population and across all providers.

- **Unintended consequences.** Moving from “activity x price” to block is a fundamental shift in the financial incentives for both provider and commissioner. This should not be a problem where the impact is managed transparently and in good faith. But local parties should be vigilant in monitoring the impact of new arrangements on service quality, access to services and patterns of referrals and activity delivered, to ensure that there are no unintended negative consequences.
- **Monitoring and reconciliation.** For those elements covered by block arrangements, there is no process of financial reconciliation (see SC36.33), and this should therefore allow a reduction in the level of time in-year spent on validating activity and charges. However:
 - Ongoing monitoring of activity levels remains essential.
 - Shadow-monitoring of the financial position, on the previous “activity x price” is likely to be desirable, at least to some extent.
 - The arrangements in SC28 for notice and neutralisation of counting and coding changes will continue to apply and will remain relevant, in terms of their potential application to a future contract or Contract Year in which the block arrangement may not apply.

SC36 (full-length Contract): Payment and Reconciliation



SC36 (shorter-form Contract): Payment and Reconciliation



47 Other contractual processes

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

Variation

- 47.1 Arrangements for varying the NHS Standard Contract are set out in GC13 (Variations). Not all elements of the NHS Standard Contract may be varied (GC13.2), and it is essential that commissioners and providers do not vary the nationally-mandated terms of the Contract. The permissible scope for variations is as set out in Appendix 5 to this Guidance.
- 47.2 NHS England may issue mandatory National Variations. This is typically done on an annual basis, so that longer-term contracts can be updated to take account of changes to nationally-mandated terms and conditions through the updated NHS Standard contract for the coming year. Commissioners should always seek to implement National Variations, and failure by the provider to accept a National Variation is grounds for termination of the contract with three months' notice (GC13.13 in the full-length Contract, GC13.4 in the shorter-form).
- 47.3 Commissioners and providers may of course also agree locally-initiated Variations. The process for this is straightforward. In summary, the issuing party submits a draft Variation Agreement to the receiving party (a template is provided at <https://www.england.nhs.uk/nhs-standard-contract/20-21/>). The receiving party responds within ten operational days; there is discussion as necessary, and, if agreed, the final Variation Agreement is then signed by the co-ordinating commissioner and the provider, as set out at paragraph 15 above.
- 47.4 There is no specific period of notice which must be given for locally-initiated Variations. Rather, the agreed timescale for implementation should be set out in the Variation Agreement and should reflect the complexity of the issues involved and the time realistically needed to implement the specific changes proposed – and, of course, when the parties wish the changes to take effect.
- 47.5 As with National Variations, acceptance of a locally-initiated Variation by the provider cannot be compelled – but, where such a Variation is refused, the commissioner has the option to terminate, with notice, the specific Services affected (GC13.14) (or, in the case of the shorter-form Contract, to terminate the Contract altogether under GC17.2).
- 47.6 Whenever a contract is being varied, the parties must ensure that they use, as the starting point for that Variation, the latest version of the contract (which may be the original contract or the contract as most recently updated by a signed and dated Variation Agreement). Parties to a contract should not progress more than one

Variation to it – local or National – in parallel or in competition with another, as doing so is likely to result in confusion and, potentially, dispute as to the terms of each proposed Variation and of the contract itself.

- 47.7 For this reason, if a National Variation is mandated by NHS England while a local Variation is in process, the ongoing local Variation should be put on hold, as the National Variation must take precedence. If the local Variation is then re-initiated as a new Variation, it will take as its starting point the contract as varied by the National Variation. Alternatively, the parties may agree to effect both Variations together – in other words, to incorporate the matters to be covered by the proposed local Variation into the Variation Agreement effecting the National Variation.
- 47.8 Locally-initiated Variations, involving only changes to particular contract schedules, will not normally be processed using the eContract system. However, where a Variation involves the provision of a new service – meaning that a different combination of the provisions of the Service Conditions and Particulars will now apply to the provider – or another change to the eContract selections which created the tailored Service Conditions and Particulars for the contract, the commissioner should use the eContract system to generate revised documentation, based on an updated selection of service categories (but, of course, retaining the term of the original contract, as this will be a continuation of the existing contract not a new contract). This revised set of Service Conditions and Particulars should then be referred to in and appended to the Variation Agreement to be signed by the co-ordinating commissioner and the provider (or, if the contract being varied is a pre-14/15 contract, by all commissioners and the provider).
- 47.9 Where the parties are seeking to implement the annual National Variation to a longer-term contract, they may do so by retaining their existing contract and using the long-form National Variation Agreement template (published at <https://www.england.nhs.uk/nhs-standard-contract/20-21/>). They may, instead, wish to do so simply by adopting the 2020/21 NHS Standard Contract in full.
- 47.10 In this case, the co-ordinating commissioner can use the eContract system in the normal way to generate an updated set of Particulars and Service Conditions – again, retaining the term of the original contract, as this will be a continuation of the existing contract, not a new contract. This updated set of Service Conditions and Particulars, and the new General Conditions, will then be referred to in, and appended to, a brief National Variation Agreement to be signed by the co-ordinating commissioner and the provider (or, if the contract being varied is a pre-2014/15 contract, by all commissioners and the provider).
- 47.11 In relation to any variations, commissioners should take into account the provisions of regulation 72 of the Public Contracts Regulations 2015, which limit the extent and scope of variations which may be made to existing contracts without re-advertising the contract. The parties should seek their own legal advice before proceeding with any Variation which might be caught by regulation 72.

Dispute resolution

- 47.12 The dispute resolution procedure (GC14) requires the parties in dispute to try to resolve their differences by negotiation, escalating to senior managers and then board-level representatives as required. If the dispute remains unresolved, the parties must refer it to mediation, under which the appointed mediator will attempt to facilitate the agreement of a satisfactory settlement of the dispute.
- 47.13 If mediation fails to resolve matters, the dispute must be referred to an independent expert for determination. The expert's ruling on the dispute will be binding on the parties.
- 47.14 The dispute resolution process at GC14 applies only once a contract has been signed. Changes made to the dispute resolution process for NHS Trusts and Foundation Trusts are described in paragraph 23. NHS England and NHS Improvement have now published [updated guidance](#) on the resolution of disputes, relating both to the agreement of new contracts and to disputes which may arise in relation to updating of existing non-expiring multi-year contracts.

Suspension

- 47.15 The provisions governing suspension of services are set out in GC16. It is worth commissioners reminding themselves of the scope which these provisions give to require a suspension, particularly when concerned about patient safety.
- 47.16 If commissioners and/or a regulatory body are concerned about the quality or outcomes of services being provided, or that the provider may not be meeting legal requirements (including, now, its duties in respect of the Fundamental Standards of Care), or about patient safety more generally, they should consider using commissioners' powers to require a suspension of services under the provider's contract. Services may be suspended until the provider is able to demonstrate that it can and will provide services to the required standard.
- 47.17 If considering exercising the right to require suspension of services on such grounds, commissioners should liaise with others commissioning services from the same provider, and of course with the regulatory authorities, with a view to acting in a concerted and consistent manner. Note that NHS England, NHS Improvement and other national organisations have published a [Joint Working Protocol](#): when a hospital, services or facility closes at short notice.

Termination

- 47.18 The provisions for termination in GC17 cover different circumstances under which the contract may be terminated – for commissioner default, provider default or where there is no fault.

No fault termination (GC17.1 – 17.8) (GC17.1 – 17.3 in the shorter-form)

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

- 47.20 It also provides for flexibility in the notice period required for either the provider or the co-ordinating commissioner (on behalf of all commissioners) to terminate the contract, or a particular service, in circumstances where neither is at fault. The notice period required for no fault termination is for local agreement (at the outset of the contract).
- 47.21 Under the full-length Contract, different periods of notice may be agreed for provider-instigated and co-ordinating commissioner-instigated termination, and the parties may agree that the right to terminate voluntarily may not take effect before a specific date (i.e. that the contract must be allowed to run for at least a set period of time before being terminated).
- 47.22 See paragraphs 47.2 and 47.5 above in relation to termination where the provider refuses to accept a variation to the contract.
- 47.23 Under GC17.8 (GC17.3 in the shorter-form), there is a right for the co-ordinating commissioner to terminate (on a no-fault basis) in specific circumstances as required by the Public Contracts Regulations.

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

- 47.24 The provider may terminate the contract (as a whole or in respect of the relevant commissioner only) in the event of significant late payment or material breach on the part of a commissioner.

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

- 47.25 The Contract sets out (in abbreviated form in the shorter-form) the grounds of provider default on which the co-ordinating commissioner (on behalf of all commissioners) may terminate the contract or a service. GC17.10.6 (GC17.5.6 in the shorter-form Contract) gives the commissioner a specific right to terminate the contract without notice where, in relation to a personal data breach connected to the Services, i) the Information Commissioner's Office (ICO) takes specific enforcement action or ii) the provider or a member of Staff is found guilty of / pleads guilty to a criminal offence.

Consequences of expiry or termination

- 47.26 GC18 contains provisions governing what is to happen when the contract expires or is terminated, the primary objective of which is to ensure that the parties act in such a way as to effect a smooth transition of services and provider, with least inconvenience or risk to patients. This may involve the agreement (on or just before expiry or termination) of a Succession Plan (which might deal with patient handover, staffing matters, handover of premises and equipment and so on) with a new provider, and if so, all parties will be required to comply with their obligations under that plan.

- 47.27 Commissioners must ensure that they put in place clear arrangements with incoming and outgoing providers for the maintenance and storage of patients' health records at the expiry or termination of a contract. SC23.2 enables the commissioner to require an outgoing provider to deliver such records to a new provider (where they may be needed to support ongoing delivery of care or require

storage until they have met the required retention period) – but, when putting in place the contract with an incoming provider, the commissioner itself must build into that contract clear requirements as to whether that provider will be expected to receive, store and maintain ongoing and/or historic records transferred from the outgoing provider. In that way, a situation will be avoided where neither the outgoing nor the incoming provider will take responsibility for records storage.

Exit arrangements

- 47.28 The parties may agree, at the outset of the contract, more wide-ranging actions and consequences to take effect on expiry or termination of the contract. These may include:
- arrangements in relation to staff and TUPE, supplementing the provisions of GC5;
 - arrangements in relation to staff redundancies;
 - arrangements for transfer of freehold or leasehold premises, or of major items of equipment;
 - requirements for exit payments to be made by commissioners or by the provider, depending on the circumstances in which the contract (or provision of a service) comes to an end; and/or
 - arrangements for the secure transfer of active and inactive Service User Health Records to the incoming Provider or to any third-party Provider.
- 47.29 Any such arrangements should be set out, as clearly as possible, in Schedule 2I (Exit Arrangements) (or Schedule 2G (Other Local Agreements, Policies and Procedures of the shorter-form Contract)).
- 47.30 GC18.2 provides a right for commissioners, if the contract or a service is terminated for provider default, to recover from the provider additional costs they incur (over and above what they would have paid the provider) to secure provision of the relevant services for six months following termination.
- 47.31 Commissioners may feel it appropriate (depending on the nature of the contract and the relationship with the provider) to supplement this provision by including in Schedule 2I (or Schedule 2G of the shorter-form Contract) requirements for:
- payment of additional compensation by the provider to the commissioners in the event of termination for provider default, or of voluntary termination by the provider; and/or
 - payment of compensation by the commissioners to the provider in the event of termination for commissioner default, or of voluntary termination by the commissioners (for example, to compensate the provider for otherwise irrecoverable capital expenditure incurred in the expectation of the contract running its full term).

- 47.32 Commissioners should consider taking expert legal and financial advice before agreeing exit arrangements and should refer to [Treasury guidance](#).

Change in control, novation and assignment

- 47.33 It is important to distinguish correctly between the provisions for change in control at GC24 and the arrangements under which a contract may be novated or assigned.
- The change in control provisions apply where the legal entity which holds the contract remains the same, but the effective control of that organisation (through voting rights at general meetings), usually as a result of a transfer of shares, changes hands. (Note that the change in control provisions do not apply where the provider is a public company listed on a stock exchange.)
 - By contrast, where the intention is that one of the legal entities which are a party to the contract should change, the process of assignment or novation may be considered, for which the consent of the co-ordinating commissioner is required. See paragraph 38.2 above.

TUPE (Transfer of Undertakings (Protection of Employment))

- 47.34 Note that the Contract no longer includes an obligation on commissioners (previously at GC5.16 in the 2015/16 Contract) to use reasonable endeavours to procure TUPE indemnities from an incoming provider in favour of the outgoing provider. This is because the “chain” of indemnities from outgoing and incoming providers (now at GC5.12 to 5.14) is now well-established: incoming and outgoing provider are given rights to enforce those indemnities directly by GC29 (Third Party Rights).

New Fair Deal for staff pensions

- 47.35 The Department of Health and Social Care has published [guidance](#) on the treatment of staff pensions on the transfer of staff from public bodies to the independent sector. The NHS Standard Contract includes provisions in line with that guidance:
- a Provider Default Event (GC17.10.16, GC17.5.7 in the shorter-form), entitling the co-ordinating commissioner to terminate the contract if the NHS Business Services Authority notifies the commissioners that the provider or any sub-contractor is materially failing to comply with its obligations under the NHS Pension Scheme (including those under any Direction/Determination Letter);
 - Schedule 7 (Pensions), at which commissioners may (in the appropriate circumstances – i.e. where TUPE applies to transfer NHS staff to an independent sector provider or sub-contractor) include further provisions (template wording and guidance available at <https://www.england.nhs.uk/nhs-standard-contract/20-21/>) dealing with, among other things:
 - the provider’s obligations to ensure that transferring staff are able to stay, or remain eligible to become, members of the NHS Pension Scheme;

- the offer of broadly comparable benefits, where appropriate; and
- the treatment of pension benefits on expiry of termination of the contract or Services.

We strongly recommend that both commissioners and providers take expert legal advice in relation to NHS Pensions before seeking to use or amend Schedule 7.

Liability and Indemnity

- 47.36 GC11 (Liability and Indemnity) imposes mutual obligations on commissioner and provider to indemnify the other in respect of costs and claims (for instance, for personal injury and damage to property) arising from their negligence or breach of contract.
- 47.37 The provider is required to put in place appropriate indemnity cover, whether under CNST, [CNSGP](#) (in respect of any primary medical services being delivered under Schedule 2L provisions) and/or other risk pooling arrangements or under commercial insurance, in respect of its potential liabilities as employer, and to the public, and for clinical and professional negligence liability to Service Users. Note that NHS Resolution has recently published helpful [guidance](#) for NHS commissioners of clinical services seeking to ensure that providers with which they are proposing to contract have in place adequate indemnity arrangements.
- 47.38 In relation to the latter, it is very important that cover is maintained to meet claims made after (sometimes long after) a Contract expires or is terminated in respect of treatment delivered under it. That is why GC11.7 (GC11.3 in the shorter-form Contract) requires the provider to ensure that its indemnity arrangements remain in force “until...liability may reasonably be considered to have ceased” (in other words, until the statutory limitation periods on potential claims have expired).
- 47.39 We have, at the request of the Department of Health and Social Care and NHS Resolution, added, as GC11.8 (GC11.5 in the shorter-form Contract), a requirement to support that existing obligation to ensure that “run-off” cover is in place. The provider must provide evidence that this cover is in place, and if it fails to do so the commissioners may put cover in place themselves (which they would do by paying the appropriate additional contribution to NHS Resolution for CNST / CNSGP cover) and charge the provider for the costs they incur in doing so. This is to address concerns that a provider may go out of business **following expiry or termination of a contract**, leaving “uninsured” potential claims for its clinical negligence, and both Service Users and the public purse therefore at risk.

48 Status of this guidance

- 48.1 This Contract Technical Guidance is intended to support commissioners in using the NHS Standard Contract and sets out clear expectations for how certain aspects should be addressed.
- 48.2 In the event of conflict between this guidance document and the Contract, the terms of the Contract will prevail. Commissioners and providers should seek their own legal advice as necessary.

49 Advice and support

- 49.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact nhs.cb.contracts@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general.
- 49.2 If you would like to be added to our stakeholder list to receive updates on the NHS Standard Contract, please email your contact details to england.contractsengagement@nhs.net.

Appendix 1

Clause-by-clause guide to changes (full-length and shorter-form)

This Appendix gives a simple clause-by-clause guide identifying what has changed and what has stayed the same from the 2019/20 Contract to the draft 2020/21 version (published in December 2019) and then the final 2020/21 version (published in March 2020). Fewer changes have been made to the shorter-form Contract, and these are shown below by exception. (Comparison documents showing changes made to the Service Conditions and the General Conditions for 2020/21 will also be made available on the [NHS Standard Contract 2020/21 web page](#)).

Particulars

Schedule	Changes	
	From 2019/20 Contract to 2020/21 draft Contract	Further changes made from 2020/21 draft Contract to 2020/21 final Contract
SCHEDULE 1 – SERVICE COMMENCEMENT AND CONTRACT TERM		
A. Conditions Precedent	Changed	Changed
B. Commissioner Documents	No change	No change
C. Extension of Contract Term	No change	No change
SCHEDULE 2 – THE SERVICES		
A. Service Specifications	Changed	No change
2Ai Service Specifications - Anticipatory Care	New schedule (incl SF)	Removed
2Aii Service Specifications - Enhanced Health in Care Homes	New schedule (incl SF)	Now 2Ai Changed (incl SF)
B. Indicative Activity Plan	No change	No change
C. Activity Planning Assumptions	No change	No change
D. Essential Services	No change	No change
E. Essential Services Continuity Plan	No change	No change
F. Clinical Networks	No change	No change
G. Other Local Agreements, Policies and Procedures	Changed	Changed
H. Transition Arrangements	No change	No change
I. Exit Arrangements	No change	No change
J. Transfer of and Discharge from Care Protocols	No change	No change
K. Safeguarding Policies and MCA Policies	No change	No change
L. Provisions applicable to Primary Medical Services	No change	No change
M. Development Plan for Personalised Care	Changed	No change

SCHEDULE 3 – PAYMENT		
A. Local Prices	Changed	No change
B. Local Variations	Changed (incl SF)	No change
C. Local Modifications	Changed (incl SF)	No change
D. Emergency Care Rule: Agreed Blended Payment Arrangements	Changed	No change
E. Intentionally Omitted	No change	No change
F. Expected Annual Contract Values	Changed (incl SF)	Changed (incl SF)
G. Timing and Amounts of Payments in First and/or Final Contract Year	No change	No change
SCHEDULE 4 – QUALITY REQUIREMENTS		
A. Operational Standards	Changed (incl SF)	Changed
B. National Quality Requirements	Changed	Changed
C. Local Quality Requirements	No change	No change
D. Commissioning for Quality and Innovation (CQUIN)	No change	No change
E. Local Incentive Scheme	No change	No change
F. Clostridioides difficile	Removed	No change
SCHEDULE 5 – GOVERNANCE		
A. Documents Relied On	No change	No change
B. Provider's Material Sub- Contractors	No change	No change
C. Commissioner Roles and Responsibilities	No change	No change
SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS		
A. Reporting Requirements	Changed (incl SF)	No change
B. Data Quality Improvement Plan	Changed	No change
C. Incidents Requiring Reporting Procedure	No change	No change
D. Service Development and Improvement Plan	Changed	No change
E. Surveys	No change	No change
F. Provider Data Processing Agreement	No change	No change
SCHEDULE 7 – PENSIONS	No change	No change
SCHEDULE 8 – TUPE (shorter-form Contract only)	No change	No change
SCHEDULE 8 – LOCAL SYSTEM PLAN OBLIGATIONS (full length Contract only)	Changed	No change

SCHEDULE 9 – SYSTEM COLLABORATION AND FINANCIAL MANAGEMENT AGREEMENT	NA	Added
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Service Conditions

Clause number	Changes	
	From 2019/20 Contract to 2020/21 draft Contract	Further changes made from 2020/21 draft Contract to 2020/21 final Contract
SC1 Compliance with the Law and the NHS Constitution	No change	No change
SC2 Regulatory Requirements	Changed (incl SF)	No change
SC3 Service Standards	Changed (incl SF)	Changed
SC4 Co-operation	Changed (incl SF)	Changed (incl SF)
SC5 Commissioner Requested Services / Essential Services	No change	No change
SC6 Choice and Referral	Changed	Changed
SC7 Withholding and/or Discontinuation of Service	Changed	Changed
SC8 Unmet Needs and Making Every Contact Count	Changed (incl SF)	Changed
SC9 Consent	No change	No change
SC10 Personalised Care	Changed	No change
SC11 Transfer of and Discharge from Care	Changed	No change
SC12 Communicating with and Involving Service Users, Public and Staff	No change	No change
SC13 Equity of Access, Equality and Non-Discrimination	Changed	No change
SC14 Pastoral, Spiritual and Cultural Care	No change	No change
SC15 Urgent Access to Mental Health	No change	No change
SC16 Complaints	No change	No change
SC17 Services Environment and Equipment	Changed	Changed
SC18 Sustainable Development	Changed (incl SF)	No change
SC19 Food Standards	Changed	Changed
SC20 Service Development and Improvement Plan	No change	No change
SC21 Antimicrobial Resistance, Healthcare Associated Infections and Influenza Vaccination	Changed	Changed
SC22 Assessment and Treatment for Acute Illness	Changed	No change
SC23 Service User Health Records	Changed (incl SF)	No change
SC24 NHS Counter-Fraud and Security Management	No change	Changed (incl SF)

SC25 Procedures and Protocols	No change	No change
SC26 Clinical Networks, National Audit Programmes and Approved Research Studies	No change	No change
SC27 Formulary	No change	No change
SC28 Information Requirements	No change	No change
SC29 Managing Activity and Referrals	Changed	Changed
SC30 Emergency Preparedness, Resilience and Response	No change	No change
SC31 Force Majeure: Service-specific provisions	Changed	No change
SC32 Safeguarding Children and Adults	Changed (incl SF)	Changed (incl SF)
SC33 Incidents Requiring Reporting	Changed (incl SF)	No change
SC34 Care of Dying People and Death of a Service User	No change	No change
SC35 Duty of Candour	No change	No change
SC36 Payment Terms	Changed (incl SF)	No change
SC37 Local Quality Requirements and Quality Incentive Schemes	No change	No change
SC38 Commissioning for Quality and Innovation (CQUIN)	No change	No change
SC39 Procurement of Goods and Services	Changed	No change

General Conditions

Clause number	Changes	
	From 2019/20 Contract to 2020/21 draft Contract	Further changes made from 2020/21 draft Contract to 2020/21 final Contract
GC1 Definitions and Interpretation	No change	No change
GC2 Effective Date and Duration	No change	No change
GC3 Service Commencement	No change	No change
GC4 Transition Period	No change	No change
GC5 Staff	Changed (incl SF)	No change
GC6 Intentionally Omitted	No change	No change
GC7 Intentionally Omitted	No change	No change
GC8 Review	No change	No change
GC9 Contract Management	Changed (incl SF)	No change
GC10 Co-ordinating Commissioner and Representatives	No change	No change
GC11 Liability and Indemnity	No change	No change
GC12 Assignment and Sub-Contracting	Changed (incl SF)	No change
GC13 Variations	No change	No change
GC14 Dispute Resolution	Changed (incl SF)	Changed (incl SF)
GC15 Governance, Transaction Records and Audit	No change	No change

GC16 Suspension	No change	No change
GC17 Termination	No change	No change
GC18 Consequence of Expiry or Termination	No change	No change
GC19 Provisions Surviving Termination	No change	No change
GC20 Confidential Information of the Parties	No change	No change
GC21 Patient Confidentiality, Data Protection, Freedom of Information and Transparency	Changed (incl SF)	No change
GC22 Intellectual Property	No change	No change
GC23 NHS Identity, Marketing and Promotion	No change	No change
GC24 Change in Control	No change	No change
GC25 Warranties	No change	No change
GC26 Prohibited Acts	No change	No change
GC27 Conflicts of Interest and Transparency on Gifts and Hospitality	No change	Changed (incl SF)
GC28 Force Majeure	No change	No change
GC29 Third Party Rights	No change	No change
GC30 Entire Contract	No change	No change
GC31 Severability	No change	No change
GC32 Waiver	No change	No change
GC33 Remedies	No change	No change
GC34 Exclusion of Partnership	No change	No change
GC35 Non-Solicitation	No change	No change
GC36 Notices	No change	No change
GC37 Costs and Expenses	No change	No change
GC38 Counterparts	No change	No change
GC39 Governing Law and Jurisdiction	No change	No change

Appendix 2

Summary guide to completing the contract

This Appendix provides a summary of the key elements of the Contract which are for local agreement and completion prior to signature and a guide to some of the key clauses in the Contract. Initial advice on the general interpretation of NHS Standard Contract terms and use of the NHS Standard Contract is available through the NHS Standard Contract help email at: nhsccb.contractshelp@nhs.net.

Use of the eContract system is recommended, although not mandated, for creation of local contracts in both full-length and shorter form format. The eContract system allows commissioners to indicate which categories of service are being commissioned under a contract. The Service Conditions and national Quality Requirements that are not applicable to the selected service categories are automatically deleted by the operation of the eContract, resulting in a shorter, more tailored contract which is easier for commissioners and providers to use. Assistance in using the eContract system is available via the User Guide on the portal or at england.econtract@nhs.net. The eContract system can be accessed at <https://www.econtract.england.nhs.uk/Home/>.

The scope of the contract

The NHS Standard Contract (full-length or shorter form) may be used as:

- a multilateral contract to be entered into by a number of commissioners and a single provider; or
- a bilateral contract entered into by a single commissioner and a single provider.

For multilateral contracts, the roles and responsibilities table set out in the collaborative commissioning agreement will be used to identify the roles each commissioner will play in relation to the contract i.e. who will play the role of co-ordinating commissioner in respect of specific, or all, provisions in which the co-ordinating commissioner is mentioned.

The Contract contains provisions which are either:

- mandatory and non-variable, whether for all NHS services or only for specific types of service; or
- mandatory, but for local agreement and definition; or
- non-mandatory and for local agreement and definition.

For ease these three levels have been colour coded:

All of the **General Conditions** are mandated and cannot be amended, or deleted. They apply to all services and to all providers of NHS funded clinical services.

The **Service Conditions** apply automatically to all services or to the relevant service, as indicated, and are mandated for all services or the relevant service, as appropriate. The Service Conditions applicable to the relevant service cannot be changed, amended or deleted.

	<p>The Particulars contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green'.</p> <p>Action is required on all items that are amber coloured and must be completed prior to signing the contract. The parties must not leave any amber marked element for later completion.</p>	
	<p>Any element indicated as 'green' is optional and may be left blank, although for good practice and clarity any 'green' element that is not used should be marked as 'not applicable'.</p>	

Where a term in the contract is capitalised, this means that the term is defined in the definitions section at the end of the General Conditions.

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

We are often asked about the best way of populating the Contract Schedules and, particularly, about embedding documents within contracts. Our recommendation has always been that either

- text is entered in full into the relevant schedule itself, within the Particulars (this will work where the text is reasonably brief); or
- the schedule contains a reference to a separate document which is then appended to the contract as a separate attachment.

We envisage that most complex contracts will need a series of such attached schedules, often in EXCEL, and it is obviously vital that there is a clear audit trail so that there can be no doubt as to the agreed final versions. Where it can be avoided, we do not recommend an approach where a weblink is inserted within a schedule, linking to where the relevant agreed contract wording can be found on-line. That is fraught with risk, in that the on-line documents may be moved and the weblinks will then no longer work. Equally, our view is that the approach of attaching documents in full as separate schedules is safer than embedding those documents electronically in the Particulars. There is a risk that the embedded documents may become corrupted and cease to open, in which case the agreed wording is lost.

We are also asked about whether requirements which are not applicable to the services being commissioned may be deleted from the Particulars and / or Service Conditions. Our advice is as follows:

- Commissioners should not themselves delete inapplicable requirements from the Particulars or Service Conditions, in case of error. Any requirements which are not applicable to the services being commissioned are simply 'read over'.
- Inapplicable requirements will, however, be removed from the Contract by appropriate use of the eContract system (on which, please see s33 above).
- Note that, in some of the Schedules within the Particulars, guidance notes are included in italics. These should be deleted locally when the Particulars are completed.

Front page		
Contract reference	Enter a local contract reference number or identifier	
Particulars		
Date of Contract	Once the contract has been signed on behalf of all parties, that has been confirmed to all parties and all parties have agreed that the contract should be dated, that day's date must be inserted as the Date of Contract. This is the date the contract is legally executed and is not (necessarily) either the date from which it has been agreed it will be effective (the Effective Date) - or the date on which services start to be provided under it (the Service Commencement Date).	
Service Commencement Date	Enter the date when the services actually start delivery. This will usually be 1 April in the relevant year but will be the date agreed between the Commissioner and the Provider (the Expected Service Commencement Date) or the date on which any Conditions Precedent to Service Commencement (see GC3 and Schedule 1A) are satisfied, whichever is later. (See further below.)	
Contract Term	Enter the initial contract term, excluding any potential extension period (which may be stated in Schedule 1C), and the date on which that term begins (usually the Expected Service Commencement Date). Commissioners should refer to paragraphs 17-18 above regarding contract duration and any provisions to extend the contract.	
Commissioners	Enter the full legal name and address of each commissioner organisation (CCGs, NHS England and, if appropriate, the local authorities) which will be a commissioning party to the contract. Include the relevant ODS code for each as this will aid identification and is linked to the information flows. All Commissioners to this contract will need an ODS code. Information on ODS codes can be found at http://systems.digital.nhs.uk/data/ods/guidance	
Co-ordinating Commissioner	This is the Commissioner (or Commissioners) identified by the other Commissioners fulfilling the role (or roles) of Co-ordinating Commissioner for this contract. This links to Schedule 5C and the Collaborative Commissioning Agreement. Where the contract is a bilateral contract, the sole Commissioner will be the Co-ordinating Commissioner.	
Provider	Enter the full legal name, address and ODS code of the Provider.	

Inside Page		
Table of contents	The table of contents must not be changed.	
Contract		
Signatures	The contract must be signed by an authorised signatory of each Commissioner which is a party to it, and by an authorised signatory of the Provider. Refer to paragraph 15 above. The date on which each signatory signs, and their title or position with the relevant organisation, should be inserted beneath their signature where indicated.	

	Insert additional signature blocks as required for the number of Commissioners that are party to the contract.	
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Completion of the tables in the Particulars headed **Service Commencement and Contract Term, Services, Payment and Quality** will determine whether certain of the Service Conditions or Schedules apply to the contract. Where the eContract is used, the Service Conditions affected will then either appear in full or show as 'not used'; the Schedules affected will either appear as open fields, so that they can be completed or marked as not used.

Service Commencement and Contract Term		
Effective Date	Insert the date on which the contract is to take effect (i.e. the date on which the rights and obligations on the parties become operational). This will usually be the Date of Contract, but could be a later date.	
Expected Service Commencement Date	Enter the date (or dates) when the services are expected to start to be delivered. The Provider must satisfy all Conditions Precedent by this date. Services may not start until it has done so.	
Longstop Date	This is the longstop date for satisfying Conditions Precedent. This should be no later than three months after the Expected Service Commencement Date in most instances. If the Longstop Date is reached and the Conditions Precedent have still not been met, the Co-ordinating Commissioner can then terminate the contract under GC17.10.1. The longstop date must not be used to 'park' issues which the parties have not been able to agree by the time of contract signature, for later resolution.	
Service Commencement Date	Enter the date when the services actually start delivery. For contracts being renewed for 2020/21, this will usually be 1 April 2020. For new arrangements, it will be the date agreed between the Commissioner and the Provider (the Expected Service Commencement Date) or the date on which any Conditions Precedent to Service Commencement (see GC3 and Schedule 1A) are satisfied, whichever is later (obviously in this situation it will not be possible to insert this date at contract signature, so either state TBC or leave blank for confirmation later).	
Contract Term	Enter the initial contract term excluding any extension period, and the date on which that term begins (usually the Expected Service Commencement Date).	
Option to extend Contract Term	Indicate here whether the Commissioners are to have an option to extend the term of the contract (noting and complying with guidance at paragraph 18 above), and the length of the permitted extension.	
Commissioner Notice Period	Enter the Commissioner Notice Period for termination under GC17.2. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)	
Commissioner Earliest Termination Date	Enter the earliest date on which a commissioner notice to terminate may take effect. (Not applicable under the shorter form)	

GC17.2		
Provider Notice Period GC17.3	Enter the Provider Notice Period for termination under GC17.3. (Not applicable in the shorter form, as the same Notice Period applies whichever party serves notice)	
Provider Earliest Termination Date GC17.3	Enter the earliest date on which a provider notice to terminate may take effect. (Not applicable under the shorter form)	
Notice Period	Enter the notice period for termination by either the Co-ordinating Commissioner or the Provider.	
Service Categories		
<p>Commissioners must select <u>all</u> the categories of service that are to be provided under the contract. Failure to indicate accurately which service categories are applicable will result in uncertainty as to which provisions of the NHS Standard Contract apply or do not apply to the contract in question. When using the eContract, the selection made will drive the content of the Service Conditions.</p> <p>For Commissioners not using the eContract the selection of the services relevant to the Provider will give an indication which of the Service Conditions is applicable. The Service Conditions that are not applicable will be 'read over'.</p> <p>Where a service is added to or removed from an existing contract, this section will need to be updated. The process set out in GC13 (Variations) should be used. See paragraph 34 above for further detail on service categories.</p> <p>Note that the service categories listed in the shorter form are limited to those for which the shorter form may be used.</p>		
Specialised Services		
Services comprise or include Specialised Services and/or other services directly commissioned by NHS England	Completing this will determine whether certain requirements in Schedules 4A, 4B and 6A will apply. (Not applicable under the shorter form)	
Co-operation with PCN(s) in service models		
Enhanced Health in Care Homes	Indicating YES here will mean that Schedule 2Ai applies, describing the Provider's role in delivering the ECCH care model in collaboration with local PCNs. This will be relevant for providers of community physical and mental health services, depending on the exact nature of the services they provide.	
Service Requirements		
Service Specification	The Service Specification(s) for each service to be provided under the contract must be included in Schedule 2 Part A. See paragraph 36 on completion of the non-mandatory Service Specification template. (No template is included in the shorter form)	
Indicative Activity Plan SC29.5, SC29.6, SC29.11A, SC29.12.3A (SC29.3)	Answer 'yes' where the parties have agreed an Indicative Activity Plan. Certain clauses in SC29 will then apply and appear in the eContract, along with Schedule 2B (Indicative Activity Plan). (The shorter form does not require the Commissioner to indicate whether an IAP applies here, but one may be included if required: see Schedule 2B and SC29.3 of the shorter form)	

Activity Planning Assumptions SC29.7, 29.11A, 29.11B, 29.12.3A, 29.12.3B	Answer 'yes' where the co-ordinating commissioner has notified Activity Planning Assumptions to the provider in accordance with SC29.7. Certain provisions of SC29 will then apply and appear in the eContract, along with Schedule 2C (Activity Planning Assumptions). See paragraphs 42.25-29 above and also below. (Not applicable under the shorter form)	
Essential Services SC5	Answer 'yes' where the provider is an NHS Trust. (The concept of Essential Services applies only to NHS Trusts – see paragraph 37 above for further information). SC5.2-5.4 will then apply and appear in the eContract, along with Schedule 2D (Essential Services). See also below.	
Services to which 18-Weeks applies SC6.4, SC6.5	Answer 'yes' where the 18-week RTT standard applies to any of the Services which are to be provided under the contract. SC6.4, SC6.5 and parts of Schedule 4 (Quality Requirements) will then apply and appear in the eContract. (Not applicable under the shorter form, as the shorter form must not be used for services to which the 18-week standard applies)	
Prior Approval Scheme Response Time Standard SC29.25	Indicate the timescale in which the relevant Commissioner must respond to a requirement for approval for treatment of an individual Service User under a Prior Approval Scheme to the Provider. (Not applicable to the shorter form)	
Is the Provider acting as a Data Processor on behalf of one or more Commissioners for the purposes of this Contract? GC21	Answer 'yes' where the Provider will be acting as a Data Processor on behalf of one or more of the commissioners for the purposes of the relevant contract. Schedule 6F will then apply and appear in the eContract. The Parties should refer to the Data Protection Act 2018 and to guidance on when an organisation is a data controller and when it is a data processor set out at https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/key-definitions/controllers-and-processors/ . Please refer to Appendix 7 for more information.	
Is the Provider providing CCG-commissioned services which are to be listed in the UEC DoS? SC6.11-6.13	Answer 'yes' where the Services to be provided under the contract include any CCG-commissioned urgent or emergency services, other than NHS 111 or emergency ambulance services. The provisions of SC6.11-6.13 relating to the UEC DoS will then apply and appear in the eContract, along with the requirement to complete the details of the CCGs' UEC DoS Leads and of the Provider's UEC DoS Contact on page X of the Particulars. (Not applicable to the shorter form)	
Payment		
National Prices Apply to Some or All Services (including Local Modification and Local Variation) SC36.10-36.19	Indicate whether National Prices (which may have been subject to a Local Modification and / or Local Variation) apply to some or all Services – indicate 'yes' or 'no'. (Applicable to shorter form only)	

Local Prices Apply to Some or All Services SC36.3-36.9	Indicate whether Local Prices apply to some or all Services – indicate ‘yes’ or ‘no’. (Applicable to shorter form only)	
Expected Annual Contract Value Agreed SC36	Indicate whether an Expected Annual Contract Value has been agreed – indicate ‘yes’ or ‘no’.	
SUS applies SC36	Indicate whether SUS applies – indicate ‘yes’ or ‘no’. (Not applicable to the shorter form)	

Quality		
Provider type	Indicate whether the Provider is an NHS Trust / NHS Foundation Trust, or another type of provider. This will determine whether certain Service Conditions (those marked “NHS Trust/FT”) apply. (Not applicable to the shorter form, as the shorter form must not be used for acute services)	
Governance		
Nominated Mediation Body GC14.4	This links to GC14 (Dispute Resolution). Insert the details of the organisation that will act as the external mediator. Where the Provider is an NHS Trust or an NHS Foundation Trust, GC14.4.1 requires that mediation is arranged jointly by NHS Improvement and NHS England. (Not applicable to shorter form)	
Provider ‘s Nominated Individual SC3.8 of the full-length Contract; definitions in the full length and the shorter-form Contracts	The name and contact details of the Provider’s Nominated Individual must be inserted here (this will be the same person as the nominated individual for the provider’s CQC registration, where relevant). The Nominated Individual will be the person responsible for supervising the management of the Services, and such an individual must be identified whether or not the Provider is required to be CQC-registered for the purposes of the Services to be delivered under the Contract.	
Provider’s Information Governance Lead GC21.3.1, GC21.3.3, GC21.3.4	The name and contact details of the Provider’s Information Governance Lead must be inserted here. Please refer to Appendix 7 for more information.	
Provider ‘s Data Protection Officer GC21	The name and contact details of the Provider’s Data Protection Officer must be inserted here, where it is required by law to have one. Please refer to Appendix 7 for more information.	
Provider’s Caldicott Guardian GC21.3.2, GC21.3.3, GC21.3.4	The name and contact details of the Provider’s Caldicott Guardian must be inserted here. Please refer to Appendix 7 for more information.	
Provider’s Senior Information Risk Owner GC21.3.2, GC21.3.3, GC21.3.4	The name and contact details of the Provider’s Senior Information Risk Owner must be inserted here. Please refer to Appendix 7 for more information.	

Provider's Accountable Emergency Officer SC30.1	The name and contact details of the Provider's Accountable Emergency Officer must be inserted here.	
Provider's Safeguarding Lead SC32.2	The name and contact details of the Provider's Safeguarding Lead must be inserted here.	
Provider's Child Sexual Abuse and Exploitation Lead SC32.2	The name and contact details of the Provider's Child Sexual Abuse and Exploitation Lead must be inserted here. Note that this role is applicable for all services, including those provided just to adults, as children may visit the provider's site or come into contact with staff or service users.	
Provider's Mental Capacity and Liberty Protection Safeguards Lead SC32.2	The name and contact details of the Provider's Mental Capacity and Liberty Protection Safeguards Lead must be entered here.	
Provider's Prevent Lead SC32.2	The name and contact details of the Provider's Prevent Lead must be inserted here. (Not applicable to the shorter form)	
Provider's Freedom To Speak Up Guardian(s) GC5.8	The name and contact details of the Provider's Freedom To Speak Up Guardian(s) must be inserted here. More information on Freedom To Speak Up Guardians is available on the CQC website .	
Provider's UEC DoS Contact SC6.11	The name and contact details of the Provider's UEC DoS Contact must be inserted here. (Not applicable to the shorter form)	
Commissioners' UEC DoS Leads SC6.12	The name and contact details of the Commissioner's UEC DoS Lead must be inserted here (CCGs only). Insert additional blocks as required for the number of CCGs that are party to the contract. (Not applicable to the shorter form)	
Contract Management		
Addresses for service of notices GC36	Insert for each Party the name and address to which notices relating to the contract should be sent.	
Frequency of Review Meetings GC8	Insert the frequency of the contract review meetings between the parties. The review meeting will focus on the quality and performance of the Services. The frequency of the review meetings should reflect the nature of the Services and the relationship between the parties. It is recommended that the minimum frequency should be every six months. (Not applicable to the shorter form; review meetings are to be held on an ad hoc basis.)	
Commissioner Representative(s) GC10	Insert for each Commissioner the name and contact details of the person who will be the primary contact point for the Provider. Where the CCG(s) have contracted with a commissioning support service, then the name and the contact details of the relevant contact point within the commissioning support service may be entered.	

Provider Representative GC10	Insert the name and contact details of the person who will be the Provider's primary contact point for the Commissioners.	
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Schedule 1 – Service Commencement		
A - Conditions precedent GC3, GC4	Insert details of any documents which must be provided and/or actions which must be completed by the Provider before it can start providing services. The items / actions on the list should be provided / completed prior to the Expected Service Commencement Date. Where this is not done by the Longstop Date, the Co-ordinating Commissioner is able to terminate the contract under GC17.10.1 (GC17.5.1). Square brackets indicate that an item can be deleted at the Commissioner's discretion. In relation to: <ul style="list-style-type: none"> • Sub-contracts, see paragraph 38 above • Determinations / Direction Letters, see paragraph 47.35 above 	
B - Commissioner Documents GC4.2	Insert details of any specific documents that have to be provided by the Commissioner(s) to the Provider prior to Service Commencement. (Not applicable to the shorter form)	
C – Extension of Contract Term	To be used only as described in paragraph 18 above. Where applicable, insert the extension period of the contract, as advertised to potential providers during the procurement process.	
Schedule 2 – The Services		
A - Service Specifications	Commissioners and Providers should agree Service Specifications for all services commissioned under this contract. See paragraph 36 above for further details.	
2Ai – Service Specifications – Enhanced Health in Care Homes SC4.10	Indicative requirements marked YES are mandatory requirements for any Provider of community physical and mental health services which is to have a role in the delivery of the EHCH care model. Indicative requirements marked YES/NO will be requirements for the Provider in question if so agreed locally – so delete as appropriate to indicate requirements which do or do not apply to the Provider. The EHCH model is to cover all CQC-registered care home services, with or without nursing. Whether a specific care home is included in the scope of the EHCH model will be determined by its registration with CQC, which can be found by filtering column C in the CQC's 'care home directory with filters', here . This directory is updated monthly. All care homes in this directory are in the scope of the EHCH service model. The specific care homes in that directory in respect of which the provider in question is to be involved in delivering the EHCH service model are to be agreed locally and listed in Schedule 2Ai where indicated.	
B – Indicative Activity Plan (IAP) SC29.5, SC29.6	Insert any IAP identifying the anticipated indicative activity for each service (which may be zero) for the relevant Contract Year. See paragraph 42 above. The overall	

SC29.3	Indicative Activity Plan should include a breakdown of individual commissioner plans.	
C – Activity Planning Assumptions (APA) SC29.7	Insert any APA for the relevant Contract Year, specifying a threshold for each assumption. See paragraph 42 above for further details. (Not applicable to the shorter form)	
D – Essential Services SC5	Commissioners should list here any Essential Services that are applicable to the contract. The concept of Essential Services applies only to NHS Trusts. (See paragraph 37 above for further information on Essential Services and Commissioner Requested Services.)	
E – Essential Services Continuity Plan SC5	If there are Essential Services, the Provider must have a Continuity Plan in relation to those Services. That plan (or a link or reference to it) must be inserted here. Where there are no Essential Services identified in Schedule 2D, mark this Part E as ‘not applicable’. (The shorter form does not require a Continuity Plan to be included in the contract itself)	
F – Clinical Networks SC26	Set out here any Clinical Networks in which the Provider is required to participate. If there are no relevant clinical networks applicable to the Services, enter ‘not applicable’. (Not included in the shorter form, but if the Provider is to be required to participate in a Clinical Network the appropriate details may be included in Schedule 2G.)	
G – Other Local Agreements, Policies and Procedures SC25	If there are specific local agreements, policies and procedures with which the Provider and/or Commissioner(s) are to comply, enter details of them here.	
H – Transition Arrangements GC4	The contract Transition Period is the time between the Effective Date and the Service Commencement Date. There may be certain things that need to be done during that period in order that services commence smoothly. Details of any such arrangements should be inserted here. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 1A and/or Schedule 2G.)	
I – Exit arrangements GC18.9	Where the parties agree specific payments to be made by one or more parties, and/or other specific arrangements which are to take effect, on the expiry or termination of the contract or termination of any service, these should be set out in this section. Where there are no exit payments or other arrangements, this section should be marked ‘not applicable’. See paragraphs 47.28 – 47.32 above. (Not included in the shorter form, but if necessary arrangements can be set out in Schedule 2G.)	
J – Transfer of and Discharge from Care Protocols SC11	Any local agreement or protocols relating to Service Users’ transfer and discharge from various care settings should be set out here. There is no mandatory format for this. A single protocol will not necessarily satisfy the needs of all types of Service User. Equally, separate local requirements for each Commissioner will need to be balanced against the	

	<p>provider's ability to accommodate different protocols for similar service users. Ideally, a single set of protocols will apply to all Commissioners.</p> <p>Where any individual Commissioner needs different transfer and discharge protocols, the collaborative commissioning group should discuss.</p> <p>Several protocols may be tabled for agreement with the Provider. The exact number will be for negotiation but it is expected that providers and commissioners will agree a sufficient number of different protocols broadly to satisfy local requirements without over-burdening the provider's ability to deliver.</p>	
K – Safeguarding Policies and MCA Policies SC32	<p>The Provider's written policies for safeguarding children and adults should be appended in Schedule 2K and may be varied from time to time in accordance with SC32.</p> <p>The policy should reflect the local multi-agency safeguarding policy.</p>	
L – Provisions Applicable to Primary Medical Services	<p>See paragraphs 8.4 and 34.4 above.</p> <p>(Not applicable to the shorter form. If a package of general practice and secondary care services are being commissioned the full-length contract must be used, with Schedule 2L.)</p>	
M – Development Plan for Personalised Care	<p>This optional schedule allows the parties to set out specific actions which each will take to implement the universal model of personalised care and to support the roll-out of personal health budgets. Further detail is provided within the Schedule itself.</p> <p>(Not included in the shorter form.)</p>	
Schedule 3 – Payment		
A - Local Prices SC36.4 -36.10	<p>Insert the detail of any Local Prices in Schedule 3A, entering text (or attaching documents or spreadsheets) which, for each separately priced Service:</p> <ul style="list-style-type: none"> • identifies the Service; • describes any agreement to depart from an applicable national currency (in respect of which the appropriate NHS Improvement summary template should be copied or attached; • describes any currencies (including national currencies) to be used to measure activity; • describes the basis on which payment is to be made (that is, whether (and if so how) dependent on activity, quality or outcomes, or a block payment); • sets out any agreed regime for adjustment of prices for the second and any subsequent Contract Year(s). <p>Include here blended payment arrangements agreed for outpatient care and, where applicable, maternity services.</p>	
B – Local Variations SC36.11 – SC36.15	<p>For each Local Variation which has been agreed for this Contract, copy or attach the completed publication template required by NHS Improvement – or state Not Applicable. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.</p>	

C – Local Modifications SC36.16 – SC36.20	For each Local Modification Agreement (as defined in the National Tariff) which applies to this contract, copy or attach the completed submission template required by NHS Improvement - or state Not Applicable. For each Local Modification application granted by NHS Improvement, copy or attach the decision notice published by NHS Improvement. Additional locally-agreed detail may be included as necessary by attaching further documents or spreadsheets.	
D – Emergency Care Rule: Agreed Blended Payment Arrangements SC36.21	Enter the agreed arrangements for blended payment for emergency acute care, in line with National Tariff Guidance – or enter ‘not applicable’. See worked examples in Appendix 8. (This Schedule only applies to providers of A&E and acute services.) (Not applicable to the shorter form, as it must not be used for acute services.)	
E – Intentionally Omitted	Leave this schedule blank.	
F - Expected Annual Contract Values SC36	Insert the total Expected Annual Contract Value (EACV) for each Commissioner (this will provide the basis of calculation of the monthly payments or quarterly payments as appropriate). The EACV must not be seen as an upper or lower cap on the provider delivering choice services. Where there is no EACV, enter ‘not applicable’. Where applicable, specify EACV including and excluding anticipated values of any high cost drugs, devices and procedures (as listed in the National Tariff) expected to be used in connection with the relevant Services. (CQUIN calculations will be based on contract values excluding costs of these drugs, devices and procedures.)	
G – Timing and Amounts of Payments in First and/or Final Contract Year SC36.26, SC36.27	If the first or final Contract Year is not 1 April - 31 March, enter the timing and amounts of payments here. Where the first and final Contract Year is 1 April – 31 March, enter ‘not applicable’. (Not included in the shorter form, but if necessary appropriate provisions may be included in Schedule 3A.)	
Schedule 4 – Quality Requirements		
A - Operational Standards (Combined with NQRs in Schedule 4A in the shorter form)	These Operational Standards cannot be changed or amended. Elements for local insertion are indicated by the amber highlight. These Standards link to the service categories in the Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraph 39 above.	
B - National Quality Requirements (Combined with Operational Standards in Schedule 4A in the shorter form)	Elements of National Quality Requirements that are for local agreement or insertion are indicated by the amber highlight. The remainder of the table cannot be amended. These Requirements link to the service categories in the Particulars section; where the eContract is used, only those applicable to the commissioned services will appear in the contract. See also paragraph 39 above.	

C - Local Quality Requirements	Commissioners may wish to agree additional quality requirements with the Provider. Where these are agreed, they should be recorded here. See also paragraph 39 above.	
D - Commissioning for Quality and Innovation (CQUIN) SC38	Commissioners should complete this section in accordance with applicable CQUIN guidance.	
E - Local Incentive Scheme	If the parties have agreed a Local Incentive Scheme (or do so at any time during the contract term), the details should be inserted here. (Not included in the shorter form.)	
Schedule 5 – Governance		
A - Documents relied on	If there are any documents, consents or certificates that have been relied on by any party in deciding whether to enter the contract, these should be identified and referenced here. However, the documents should not include letters of intent that relate to commissioning assumptions, nor should this Schedule be used to endeavour to contradict or circumvent the mandated terms and conditions of the contract. (Not included in the shorter form.)	
B - Provider's Material Sub-contracts GC12	Details of any Material Sub-contracts should be inserted here. If the Sub-Contractor is processing Personal Data, state whether they are a Data Processor, Data Controller or joint Data Controller. If there are no Material Sub-contracts, this section will be identified as 'not applicable'. Further guidance is set out in paragraph 38 above. (Not included in the shorter form.)	
C - Commissioner Roles and Responsibilities GC10	The Commissioners must set out in this Schedule the roles and responsibilities that each Commissioner has in relation to this contract – in essence, who will be the Co-ordinating Commissioner for all, or for some specific, purposes under the contract. The roles and responsibilities must be set out in the separate Collaborative Commissioning Agreement document entered into by all the Commissioners who are parties to the contract. (Not included in the shorter form.)	
Schedule 6 – Contract Management, Reporting and Information		
A - Reporting Requirements SC28	This table is used to set out the information that is required to be reported under the contract. See also paragraph 43 above.	
B - Data Quality Improvement Plan (DQIP) SC28.24, SC28.25, SC28.26	This table is used to record any agreed DQIP. See paragraph 43 above, which sets out certain situations in which a DQIP must be included. (Not included in the shorter form.)	

C – Incidents Requiring Reporting Procedure SC33	Insert here the details of the agreed procedures for reporting, investigating, and implementing and sharing lessons learned from Serious Incidents, Reportable Patient Safety Incidents and Other Patient Safety Incidents.	
D – Service Development and Improvement Plan SC20	This table is used to record any agreed Service Development and Improvement Plan. See paragraph 41 above, which sets out certain situations in which an SDIP <u>must</u> be included. (Not included in the shorter form.)	
E – Surveys SC12	Insert here the requirements for frequency, reporting and publication of mandated surveys and any additional locally agreed surveys. (Not included in the shorter form.)	
Schedule 6F - Provider Data Processing Agreement		
Provider Data Processing Agreement Annex A Data Processing Services	Include this Schedule <u>only where the Provider is acting as a Data Processor to deliver the services</u> , in accordance with the question on page 10 of the Particulars. For contracts generated using the eContract system, Schedule 6F will be included or excluded depending on the answer to this question. For shorter-form contracts generated locally, rather than via the eContract system, Schedule 6F will need to be added manually to the local contract where required. For this purpose, a separate Schedule 6F has been published at https://www.england.nhs.uk/nhs-standard-contract/20-21/ . Please refer also to Appendix 7 below.	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 47.35 above.	
Schedule 8 - TUPE		
TUPE	Applicable to the shorter form only. It may in certain circumstances be appropriate to omit the text of this Schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.	
Schedule 8 – Local System Operating Plan Obligations		
Local System Plan Obligations	This optional schedule may be used to set out actions which the commissioner and provider have agreed to take through the Local System Plan for 2020/21. These actions may be to improve the provision of services under this specific contract or to ensure that services provided under this contract integrate with and support those provided by other organisations within the local health system. Further detail is provided within the Schedule itself. (Not included in the shorter form)	
Schedule 9 – System Collaboration and Financial Management Agreement		
System Collaboration and Financial	This schedule should be used where necessary to list the details of any SCFMA to which the provider and relevant commissioners are party. The full SCFMA itself should not	

Management Agreement (SCFMA)	be included in the Schedule as the intention is not that the provisions of the SCFMA should be legally binding. See paragraphs 3.10-17 above. (Not included in the shorter form)	
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Appendix 3

Supplementary Definitions for Operational Standards and National Quality Requirements

This Appendix provides definitions for certain of the Operational Standards and National Quality Requirements set out in Schedules 4A and 4B of the Contract.

For the other national standards within Schedules 4A and 4B, definitions are set out (or linked to) in the Contract itself, in Schedule 4A or 4B as applicable, or in Annex B of the [2020/21 Planning Guidance](#).

E.A.S.4: Healthcare acquired infections (MRSA)

E.A.S.4: Zero tolerance methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	
Definition	MRSA bacteraemia: monthly data by post infection review (PIR) assignment. The acute provider requirement covers the following two categories of healthcare associated MRSA cases: <ul style="list-style-type: none">• Hospital-Onset Healthcare Associated (HOHA) –where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1)• Community-Onset Healthcare Associated (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).
Rationale	The risk of healthcare acquired infections to patients should be reduced. While there are a number of factors that may increase the risk of acquiring an infection, high standards of hygiene and cleanliness can minimise the risk of occurrence. A high incidence of MRSA compared to the national rate may indicate issues with the provider's infection control procedures.
Numerator	Sum of Hospital-Onset and Community-Onset Healthcare Associated MRSA infections by provider, as defined above
Denominator	N/A
National data source	Public Health England (PHE) healthcare associated infections data capture system https://www.gov.uk/government/statistics/mrsa-bacteraemia-monthly-data-by-post-infection-review-assignment
Calculation	N/A
Operational standard	Operational standard is 0.

E.A.S.5: Healthcare acquired infections (*C. difficile*)

E.A.S.5: Minimise rates of <i>Clostridioides difficile</i> (<i>C. difficile</i>)	
Definition	<p><i>C. difficile</i> counts by acute provider from patients aged 2 years and over. <i>C. difficile</i> cases are reported by the trust whose laboratory processed the specimen. This may not always reflect where the infection was acquired.</p> <p>The acute provider requirement covers the following two categories of healthcare associated <i>C. difficile</i> cases:</p> <ul style="list-style-type: none"> • Hospital-Onset Healthcare Associated (HOHA) –where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1) • Community-Onset Healthcare Associated (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).
Rationale	The risk of healthcare acquired infections to patients should be reduced. While there are a number of factors that may increase the risk of acquiring an infection, high standards of hygiene and cleanliness can minimise the risk of occurrence. A high incidence of <i>C. difficile</i> compared to the national rate may indicate issues with the trust's infection control procedures.
Numerator	Sum of Hospital-Onset and Community-Onset Healthcare Associated <i>Clostridioides difficile</i> infections by provider, as defined above
Denominator	N/A
National data source	Public Health England (PHE) healthcare associated infections data capture system https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust
Calculation	N/A
Operational standard	Operational standard is the baseline threshold for provider, as published nationally by NHS England and NHS Improvement.

E.A.S.5: Healthcare acquired infections (gram negative bloodstream infections or GNBSI)

E.A.S.5: Minimise rates of gram negative bloodstream infections (GNBSI)	
Definition	<p>The requirement on gram negative bloodstream (GNBSI) infections covers three categories of infection:</p> <ul style="list-style-type: none"> • <i>Escherichia coli</i> • <i>Pseudomonas aeruginosa</i> • <i>Klebsiella</i> spp.

	<p>GNBSI cases are reported by the trust whose laboratory processed the specimen. This may not always reflect where the infection was acquired.</p> <p>The acute provider requirement covers the following two categories of healthcare associated GNBSI cases:</p> <ul style="list-style-type: none"> • Hospital-Onset Healthcare Associated (HOHA) –where days from admission to specimen date is equal to or greater than 3 days (where day of admission is day 1) • Community-Onset Healthcare Associated (COHA) – where days from admission to specimen date is equal to or less than 2 days (where day of admission is day 1), and patient has been discharged from the reporting trust within the last 28 days of this specimen date (where day 1 is day of discharge).
Rationale	The risk of healthcare associated infections to patients should be reduced. While there are a number of factors that may increase the risk of acquiring an infection, high standards of hygiene and cleanliness can minimise the risk of occurrence. A high incidence of GNBSI compared to the national rate may indicate issues with the trust's infection control procedures.
Numerator	Sum of Hospital-Onset and Community-Onset Healthcare Associated GNBSI infections by organism and provider, as defined above
Denominator	N/A
National data source	Public Health England (PHE) healthcare associated infections data capture system
Calculation	N/A
Operational standard	Operational standard is the baseline threshold for provider, as published nationally by NHS England and NHS Improvement.

E.B.S.6: Urgent operations cancelled for a second time

E.B.S.6: No urgent operation should be cancelled for a second time	
Definition	<p>Include all urgent operations that are cancelled, including emergency patients (i.e. non-elective), who have their operations cancelled. In principle the majority of urgent cancellations will be urgent elective patients, but it is possible that an emergency patient has their operation cancelled (e.g. patient presents at A&E with complex fracture which needs operating on, but patient's operation is arranged and subsequently cancelled).</p> <p>The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) should be followed. Broadly these are:</p>

	<p>Immediate - Immediate (A) lifesaving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate.</p> <p>Urgent - Acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate.</p> <p>Expedited - Stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Operation target time within days of decision to operate.</p> <p>Elective - Surgical procedure planned or booked in advance of routine admission to hospital.</p> <p>Broadly, Immediate, Urgent and Expedited should be regarded as 'urgent' for the purpose of meeting this requirement. The full text of the NCEPOD Classification of Interventions is available online.</p> <p>An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. For postponements, the following apply: the 24 hour period is strictly 24 hours and not 24 working hours, i.e. it includes weekend / other non-working days; the patient should not be discharged from hospital during the 24 hour period; a patient cannot be postponed more than once (if they are then they count as a cancellation).</p>
Rationale	Improved patient experience and patient outcomes.
Numerator	Number of urgent operations that are cancelled by the provider for non-clinical reasons which have already been previously cancelled once for non-clinical reasons.
Denominator	N/A
National data source	NHS England, monthly situation report (SitRep) collections https://www.england.nhs.uk/statistics/statistical-work-areas/critical-care-capacity/
Calculation	N/A
Operational standard	Operational standard is 0.

E.B.S.7: Handover times from ambulance service to A&E

E.B.S.7a: Ambulance handover delays to accident and emergency (A&E) of over 30 minutes	
Definition	<p>The guideline is that all handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes. Data is collected for the number of handover delays longer than 30 minutes and of handover delays over one hour.</p> <p>Clock start - arrival to Patient Handover performance (acute trusts): when an ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the MDT).</p> <p>Clock stop - Patient Handover / Trolley Clear performance (acute trusts): the time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.</p> <p>Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E. Do not count non-emergency patients. Patients being transported between locations / trusts / hospitals (e.g. for outpatient clinics, tertiary care) should not be counted. Ambulance trusts should not count the time required for crews to complete record forms, clean vehicles, re-stock vehicles or have a break.</p>
Rationale	<p>Delaying ambulances outside A&E as a result of a temporary mismatch between A&E / hospital capacity and numbers of elective / emergency patients arriving is not acceptable. Implementation of the full hospital escalation plan should ensure that A&Es have significant capacity to avoid most instances of ambulance queuing. Patients waiting in the back of ambulances is not acceptable, and there are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E.</p>
Numerator	Total ambulance handover delays of over 30 minutes.
Denominator	N/A
National data source	<p>Winter daily situation report (SitRep) data on 30 minute handovers collected at acute trusts</p> <p>https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/</p>
Calculation	N/A
Operational standard	Operational standard is 0.

E.B.S.7b: Ambulance handover delays to accident and emergency (A&E) of over 1 hour	
Definition	<p>The guideline is that all handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes. Data is collected for the number of handover delays longer than 30 minutes and of handover delays over one hour.</p> <p>Clock start - arrival to Patient Handover performance (acute trusts): when an ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the MDT).</p> <p>Clock stop - Patient Handover / Trolley Clear performance (acute trusts): the time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.</p> <p>Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E. Do not count non-emergency patients. Patients being transported between locations / trusts / hospitals (e.g. for outpatient clinics, tertiary care) should not be counted. Ambulance trusts should not count the time required for crews to complete record forms, clean vehicles, re-stock vehicles or have a break.</p>
Rationale	<p>Delaying ambulances outside A&E as a result of a temporary mismatch between A&E / hospital capacity and numbers of elective / emergency patients arriving is not acceptable. Implementation of the full hospital escalation plan should ensure that A&Es have significant capacity to avoid most instances of ambulance queuing. Patients waiting in the back of ambulances is not acceptable, and there are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E.</p>
Numerator	Total ambulance handover delays of over 1 hour.
Denominator	N/A
National data source	<p>Winter daily situation report (SitRep) data on 1 hour handovers collected at acute trusts</p> <p>https://www.england.nhs.uk/statistics/statistical-work-areas/winter-daily-sitreps/</p>
Calculation	N/A
Operational standard	Operational standard is 0.

E.B.S.8: Ambulance service crew clear time following handover

E.B.S.8a: Ambulance crew delays of over 30 minutes following handover to accident and emergency (A&E)	
Definition	<p>The guideline is that following handover between ambulance and A&E the ambulance crew should be ready to accept new calls within 15 minutes. Data is collected for the number of crew clear delays of longer than 30 minutes and of crew clear delays over one hour.</p> <p>Clock start - Patient Handover / Trolley Clear performance (ambulance service): the time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.</p> <p>Clock stop - Crew Clear performance (ambulance service) and the ambulance turnaround process as a whole: the time at which the ambulance crew has repatriated equipment, finalised paperwork, restocked where appropriate and cleaned the vehicle ready for the next call.</p> <p>Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E. Do not count non-emergency patients. Patients being transported between locations / trusts / hospitals (e.g. for outpatient clinics, tertiary care) should not be counted.</p>
Rationale	<p>Delaying ambulances outside A&E as a result of delays in crews being ready to respond to further calls is not acceptable. There are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E and ambulance service capacity is severely constrained if crews do not promptly declare themselves clear to respond.</p>
Numerator	Number of crew clear delays of over 30 minutes.
Denominator	N/A
National data source	N/A
Calculation	N/A
Operational standard	Operational standard is 0.

E.B.S.8b: Ambulance crew delays of over 1 hour following handover to accident and emergency (A&E)	
Definition	<p>The guideline is that following handover between ambulance and A&E the ambulance crew should be ready to accept new calls within 15 minutes. Data is collected for the number of crew clear delays of longer than 30 minutes and of crew clear delays over one hour.</p> <p>Clock start - Patient Handover / Trolley Clear performance (ambulance service): the time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.</p> <p>Clock stop - Crew Clear performance (ambulance service) and the ambulance turnaround process as a whole: the time at which the ambulance crew has repatriated equipment, finalised paperwork, restocked where appropriate and cleaned the vehicle ready for the next call.</p> <p>Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E. Do not count non-emergency patients. Patients being transported between locations / trusts / hospitals (e.g. for outpatient clinics, tertiary care) should not be counted.</p>
Rationale	<p>Delaying ambulances outside A&E as a result of delays in crews being ready to respond to further calls is not acceptable. There are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E and ambulance service capacity is severely constrained if crews do not promptly declare themselves clear to respond.</p>
Numerator	Number of crew clear delays of over 1 hour.
Denominator	N/A
National data source	N/A
Calculation	N/A
Operational standard	Operational standard is 0.

VTE risk assessment

All inpatient service users undergoing risk assessment for venous thromboembolism (VTE)	
Definition	<p>Inpatients aged 16 and over at the time of admission who have had a VTE risk assessment on admission to hospital using the clinical criteria of a national tool including: surgical inpatients; inpatients with acute medical illness (e.g. myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease), trauma inpatients or trauma patients discharged from A&E who are immobilised with a cast or brace; patients admitted to intensive care units; cancer inpatients; people undergoing long-term rehabilitation in hospital; patients admitted to a hospital bed for day-case medical or surgical procedures; private patients attending an NHS hospital.</p> <p>The following specific groups of patients are not covered by NICE NG89 and are therefore outside the scope of this data collection: people under the age of 16 at admission; people attending hospital as outpatients (other than patients admitted to a hospital bed for day-case medical or surgical procedures, as listed above); people attending hospital emergency departments who are not admitted as inpatients (other than patients being immobilised with a cast or brace); people who are admitted to hospital because they have a diagnosis or signs and symptoms of deep vein thrombosis (DVT) or pulmonary embolism.</p>
Rationale	Improved outcomes for patients. Previous national CQUIN indicator included as a National Quality Requirement in the NHS Standard Contract for 2014/15 onwards, as described in NICE Guideline NG89 (https://www.nice.org.uk/guidance/ng89).
Numerator	Number of inpatient admissions (aged 16 and over at the time of admission) reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of a national tool (including those risk assessed using a cohort approach).
Denominator	Number of patients (aged 16 and over at the time of admission) who were admitted as inpatients (includes day cases, maternity and transfers, both elective and non-elective admissions).
National data source	NHS Digital, Strategic Data Collection Service https://improvement.nhs.uk/resources/vte/
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage.
Operational standard	Operational standard is 95%.

Sepsis identification, screening and treatment for Service Users presenting as emergencies

Proportion of Service Users presenting as emergency admissions who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	
Definition	Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis
Rationale	Improved outcomes for patients. Previous national CQUIN indicator, included as a National Quality Requirement in the NHS Standard Contract for 2019/20 onwards
Numerator	<p>Of the sample described below, the number</p> <ul style="list-style-type: none"> • who were screened for sepsis; <u>and</u> • who, if found to have suspected sepsis, received IV antibiotics within one hour of diagnosis. <p>This timing starts from when the clinical decision maker has decided the patient has suspected sepsis, and stops when effective antibiotics have been administered.</p>
Denominator	<p>A locally-audited random sample of 50 Service Users in each Quarter</p> <ul style="list-style-type: none"> • this applies to all adult patients arriving in hospital as emergency admissions • who were appropriate, at the time of presentation, for screening for sepsis on the basis of the local protocol on NEWS2 (a score of greater than or equal to 5 plus a senior clinical decision-maker using their judgement to decide if it's likely that the patient has sepsis. Excluding those where an alternative diagnosis is clinically more likely, e.g. major trauma and where a patient's normal baseline NEWS2 is 5 or more)
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage and is assessed on a random sample of 50 Service Users each Quarter. Providers with low activity should calculate performance on the basis of all suspected patients if there are fewer than 50 per Quarter.
Operational standard	Operational standard is 90%.

NB: standard excludes pregnant women and children aged under 16

Sepsis identification, screening and treatment for inpatient Service Users

Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	
Definition	Proportion of Service User inpatients who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis
Rationale	Improved outcomes for patients. Previous national CQUIN indicator, included as a National Quality Requirement in the NHS Standard Contract for 2019/20 onwards
Numerator	<p>Of the sample described below, the number</p> <ul style="list-style-type: none"> • who were screened for sepsis; <u>and</u> • who, if found to have suspected sepsis, received IV antibiotics within one hour of diagnosis. <p>This timing starts from when the clinical decision maker has decided the patient has suspected sepsis, and stops when effective antibiotics have been administered.</p>
Denominator	<p>A locally-audited random sample of 50 Service Users in each quarter</p> <ul style="list-style-type: none"> • who were being treated in an inpatient ward; and • who, on the basis of a deterioration of their condition after admission, became appropriate for screening for sepsis on the basis of the local protocol on NEWS2 (a score of greater than or equal to 5, plus a senior clinical decision-maker using their judgement to decide if it's likely that the patient has sepsis. Excluding those where an alternative diagnosis is clinically more likely, e.g. major trauma and where a patient's normal baseline NEWS2 is 5 or more)
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage and is assessed on a random sample of 50 Service Users each Quarter. Providers with low activity should calculate performance on the basis of all suspected patients if there are fewer than 50 per Quarter.
Operational standard	Operational standard is 90%.

NB: standard excludes pregnant women and children aged under 16

E.B.S.3: Follow up from psychiatric in-patient care

E.B.S.3: The percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	
Definition	<p>All people discharged from CCG-commissioned inpatient mental health services should be followed up within 72 hours.</p> <p>This applies to everyone who is discharged from a CCG-commissioned adult mental health inpatient bed to their place of residence, care home, residential accommodation, or to non-psychiatric care. All avenues need to be exploited to ensure patients are followed up within 72 hours of discharge.</p>
Rationale	<p>There is evidence that people are at greater risk of dying by suicide in the period shortly after discharge from hospital. The latest report in 2018 from The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), which provides findings relating to people who died by suicide in 2006-2016 across the UK, showed that in 2016 there were 227 suicides in the 3 months after hospital discharge. This equated to 17% of all patient suicides that year. Further, the highest risk is shown to be in the first 2 weeks after discharge, with the highest number of deaths occurring on day 3.</p> <p>While the overall rate of post-discharge suicide has reduced since 2011, the proportion of people who died in the first week after discharge did not change over the full reporting period (2006-2016). This provides compelling evidence that all patients are followed up within 3 days post discharge (not only those on CPA) and the report recommends this as a key measure that services should take to reduce patient suicide risk. By completing follow up within 72 hours, providers are therefore supporting the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge.</p> <p>While the central metric of the new standard focuses on timeliness of follow up, the overarching expectation is that this will incentivise focus on overall quality of discharge planning and support. This is expected to have a direct impact on patient experience as well as outcomes.</p>
Numerator	Of the denominator, those who have a follow up within 72 hours (commencing at 12am the day after discharge).
Denominator	Number of people discharged from a CCG commissioned adult mental health inpatient setting of the reporting period
National data source	Mental Health Services Dataset
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage.
Operational Standard	The operational standard is 80%

Appendix 4

Worked examples of calculation of financial consequences

E.B.6 Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment

Number of Service Users referred urgently with suspected cancer who attended outpatient clinic in the quarter (under this Contract)	=	3,000
Operating Standard for the proportion seen within two weeks (threshold)	=	93%
Permitted number of breaches of the standard in the quarter (under this Contract)	=	210
Actual performance against the Operating Standard across the quarter as a whole	=	90%
Actual number of breaches of the standard in the quarter (under this Contract)	=	300
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	90
Financial sanction per breach	=	£200
Total value of financial sanctions in the quarter (under this Contract)	=	£18,000

E.B.5 A&E four hour waiting times

Number of Service Users who attended A&E in the month (under this Contract)	=	6,000
Operating Standard for the proportion admitted, transferred or discharged within four hours (threshold)	=	95%
Permitted number of breaches of the standard in the month (under this Contract)	=	300

Where the 85% floor is not triggered:

Actual performance against the Operating Standard in the month	=	93%
Actual number of breaches of the standard in the month (under this Contract)	=	420
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	120
Financial sanction per breach	=	£120
Total value of financial sanctions in the month (under this Contract)	=	£14,400

Where the 85% floor is triggered:

Actual performance against the Operating Standard in the month	=	82%
Actual number of breaches of the standard in the month (under this Contract)	=	1080
Excess number of breaches beyond the tolerance permitted by the threshold (under this Contract)	=	780
Level of performance at which sanction is capped	=	85%
Maximum number of breaches to which sanction can apply	=	600
Financial sanction per breach	=	£120
Total value of financial sanctions in the month (under this Contract)	=	£72,000

Ambulance response times

Category 2 (emergency) incidents – proportion of incidents resulting in an appropriate response arriving within 40 minutes

Category 2 incidents at the Provider in the quarter	=	60,000
National standard for 90 th centile performance	=	40 minutes
Actual 90 th centile performance by the Provider for Category 2 incidents in the quarter	=	55 minutes, 30 seconds
Number of seconds by which the Provider has exceeded the 90 th centile performance standard in the quarter	=	930
Financial sanction from Schedule 4A		£3.50 per second per 1,000 Category 2 incidents
Calculation of financial sanction	=	$930 \times £3.50 \times 60,000$ \div 1000
Total value of financial sanctions in the quarter (under this Contract)	=	£195,300

Appendix 5

Permissible Variations

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

- (i) Particulars: Service Commencement and Contract Term – local insertions and selections only
- (ii) Particulars: Services – local insertions only
- (iii) Particulars: Payment – local insertions and selections only
- (iv) Particulars: Quality – local insertions and selections only
- (v) Particulars: Governance and Regulatory – local insertions and selections only
- (vi) Particulars: Contract Management – local insertions and selections only
- (vii) Schedule 1A (*Conditions Precedent*) – local insertions only
- (viii) Schedule 1B (*Commissioner Documents*) – local insertions only
- (ix) Schedule 1C (*Extension of Contract Term*) – if used, insertion of notice period in paragraph 1 only
- (x) Schedule 2A (*Service Specifications*) - local insertions only
- (xi) Schedule 2Ai (*Service Specifications – Enhanced Health in Care Homes*) - if used, local insertions only
- (xii) Schedule 2B (*Indicative Activity Plan*) – application/local insertions only
- (xiii) Schedule 2C (*Activity Planning Assumptions*) – application/local insertions only
- (xiv) Schedule 2D (*Essential Services*) – application/local insertions only
- (xv) Schedule 2E (*Essential Services Continuity Plan*) – application/local insertions only
- (xvi) Schedule 2F (*Clinical Networks*) – application/local insertions only
- (xvii) Schedule 2G (*Other Local Agreements, Policies and Procedures*) – application/local insertions only
- (xviii) Schedule 2H (*Transition Arrangements*) – application/local insertions only
- (xix) Schedule 2I (*Exit Arrangements*) – application/local insertions only

- (xx) Schedule 2J (*Transfer of and Discharge from Care Protocols*) – local insertions only
- (xxi) Schedule 2K (*Safeguarding and Mental Capacity Act Policies*) – local insertions only
- (xxii) Schedule 2L (*Provisions Applicable to Primary Care Services*) – application/local insertions only
- (xxiii) Schedule 2M (*Development Plan for Personalised Care*) – application/local insertions only
- (xxiv) Schedule 3A (*Local Prices*) – application/local insertions only
- (xxv) Schedule 3B (*Local Variations*) application/local insertions only
- (xxvi) Schedule 3C (*Local Modifications*) – application/local insertions only
- (xxvii) Schedule 3D (*Emergency Care Rule: Agreed Blended Payment Arrangements*) – application/location insertions only
- (xxviii) Schedule 3F (*Expected Annual Contract Values*) – application/local insertions only
- (xxix) Schedule 3G (*Timing and Amounts of Payments in First and/or Final Contract Year*) – application/local insertions only
- (xxx) Schedule 4A (*Operational Standards*) – application (selected Service categories); Thresholds/Consequence of Breach/Monthly or Annual application of consequence, where indicated in the NHS Standard Contract as being for local determination, only
- (xxxi) Schedule 4B (*National Quality Requirements*) – application (selected Service categories)
- (xxxii) Schedule 4C (*Local Quality Requirements*) – local insertions only
- (xxxiii) Schedule 4D (*Commissioning for Quality and Innovation (CQUIN)*) – local insertions only
- (xxxiv) Schedule 4E (*Local Incentive Scheme*) – application/local insertions only
- (xxxv) Schedule 5A (*Documents Relied On*) – application/local insertions only
- (xxxvi) Schedule 5B (*Provider's Material Sub-Contracts*) – application/local insertions only
- (xxxvii) Schedule 5C (*Commissioner Roles and Responsibilities*) – local insertions only

- (xxxviii) Schedule 6A (*Reporting Requirements*) – application (selected Service categories; Small Provider/other); open fields; Local Requirements Reported Locally only
- (xxxix) Schedule 6B (*Data Quality Improvement Plan*) – application/local insertions only
- (xl) Schedule 6C (*Incidents Requiring Reporting Procedure*) – local insertions only
- (xli) Schedule 6D (*Service Development and Improvement Plan*) – application/local insertions only
- (xlii) Schedule 6E (*Surveys*) – local insertions only
- (xlili) Schedule 6F (*Provider Data Processing Agreement*) – application/local insertions only
- (xliv) Schedule 7 (*Pensions*) – local insertions only (template wording: refer to Technical Guidance)
- (xliv) Schedule 8 (*Local System Operating Plan Obligations*) – application/local insertions only (full-length version of the Contract only)
- (xlvi) Schedule 8 (*TUPE*) – application/local insertions only (shorter-form version of the Contract only)

It may in certain circumstances be appropriate to omit the text in this Schedule or to amend it to suit the circumstances - in particular, if the prospect of employees transferring either at the outset or on termination/expiry is extremely remote because their work in connection with the subject matter of the Contract will represent only a minor proportion of their workload. However, it is recommended that legal advice is taken before deleting or amending these provisions.

- (xlvii) Schedule 9 (*System Collaboration and Financial Management Agreement*) – application/local insertions only (full-length version of the Contract only)
- (xlviii) Service Conditions – application (selected Service categories; Provider type) only

Appendix 6

Hypothetical case studies

Activity planning during contract negotiations

Scenario 1

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

Contractual approach

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

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

Scenario 2

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

Contractual approach

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

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

- i. work actively with referrers to encourage them to look at alternative local providers for their referrals (the NHS e-Referral Service will show waiting time information for all providers that offer options for the patient's referral, enabling referrers to choose suitable alternatives where capacity issues exist)
- ii. consider whether it can commission other providers to offer capacity in the same specialty, so that there is an additional local choice option for referrals – or whether it would be clinically appropriate to introduce narrower criteria for referral to the specialty.

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

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

Scenario 3

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

Contractual approach

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

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

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

Activity management

Scenario 4

At month 3, an acute hospital is over-performing by 20% on activity and value for elective orthopaedics. This is causing a significant financial overspend for its main commissioner; the commissioner desperately wants the provider to ‘slow down’.

Contractual approach

Service Condition 29 (Managing activity and referrals) will be the most relevant section of the Contract. The first steps in SC29 involve the issue (in this instance by the commissioner) of an Activity Query Notice, leading to an Activity Management Meeting between the commissioner and the provider. These essential first steps will allow the parties to develop a shared understanding of why the over-performance is happening. Carrying out a formal Joint Activity Review if necessary, they can then move to agree an Activity Management Plan (AMP) – which will aim, over time, to bring the activity level back within the expected range.

The content of the AMP will depend very much on what has caused the over-performance and, in particular, whether any Activity Planning Assumptions (APAs) have been breached.

If the activity over-performance is solely a direct consequence of an increase in GP referrals

In this situation:

- i. Clearly, the provider cannot control and is not responsible for the level of external referral.
- ii. Given that it is the commissioner who has raised the Activity Query Notice (AQN), the parties may agree that no further action is needed under the contract. The commissioner is already facing a financial consequence (because it is having to fund additional activity above its planned level) and may want to take demand management action outside of the contract to ensure that, say, GPs are following agreed referral pathways and protocols.
- iii. On the other hand, if the level of referral is causing the provider operational issues, it may seek to agree with the commissioner a formal AMP, setting out what the commissioner will do to bring referrals back within the expected levels (set out in APAs).
- iv. By agreement, such an AMP could include additional financial consequences for the commissioner for failure to implement (on top of the requirement to pay for excess activity).

If the activity over-performance is solely a direct consequence of “under-commissioning” – that is, the Indicative Activity Plan (IAP) has been set unrealistically low

In this situation – perhaps where the commissioner has assumed an impact from demand management actions which has not, in practice, subsequently been achieved – there would logically be no requirement on the provider to contribute to an AMP.

If referrals are in line with APAs, but the activity over-performance is wholly the result of the provider treating patients more quickly than agreed

If the parties have agreed an APA relating to waiting times or numbers – perhaps relating to numbers on a waiting list or average waiting times – then it would be reasonable for the parties to agree an AMP requiring the provider to reduce activity levels and allow average waiting times to increase back to the agreed level.

By agreement, such an AMP could include financial consequences for the provider for failure to implement.

However, the AMP must not require the provider to put patient safety at risk (setting unreasonable waiting times for urgent patients, say) or to jeopardise its achievement of national quality standards (18 week waits).

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

If Prior Approval Schemes are in place and a provider fails to abide by them, this is a breach of a contractual obligation. This is different from the preceding examples in that the Contract allows immediate financial redress for the commissioner. SC29.22 makes clear that, in this situation, the commissioner is under no obligation to pay for activity which has been undertaken by the provider in contravention of agreed Prior Approval Schemes.

If the activity over-performance is partly the result of the provider introducing new clinical treatments without explicit commissioner agreement

This is a more nuanced situation.

- i. In many cases, contract specifications will not specify all of the exact procedures which the provider may offer – rather, the expectation is that patients are referred for assessment and treatment at the provider's discretion, in line with good clinical practice. In this situation, commissioners should accept that there will rightly be gradual evolution of clinical practice, without such changes always needing to be viewed as formal Variations under the Contract. Where gradual clinical change of this kind identifies controversial cases, it would generally not be appropriate for commissioners to contest payment retrospectively – but they could of course review the clinical evidence for the new procedure concerned and decide that, for the future, this was not a treatment they wished to commission or that they wished to govern access through a new Prior Approval Scheme.
- ii. On the other hand, where the service specification is much more prescriptive in setting out a defined range of commissioned treatments, providers cannot reasonably expect to provide different treatments, without prior discussion, and still be paid. Introduction of new treatments in such cases might reasonably lead the commissioner to withhold payment for the 'excess' activity, on the grounds that the provider has breached the requirement in SC1 to provide services in accordance with the service specifications.

Good communication – and reasonable expectations on both sides – will be the key to minimising disputes in this area.

Activity management in block contracts

Where block contracts are in place, then payments between the parties do not flex depending on activity levels – but SC29 may still be relevant. It may be particularly important, in a block contract, that expected levels of referrals are specified as APAs; if these referral levels are then exceeded, leaving the provider with an imbalance between demand and capacity, the parties can use the provisions of SC29 (for instance, an AMP) to set out how both commissioner and provider are to respond, both in terms of managing the flow of referrals and of ensuring the continued provision of safe service to patients.

Key messages

- i. Carrying out activity above the level of the IAP is not a breach of contract and is not grounds for non-payment.
- ii. Providers should only be held responsible for activity levels which are within their control.
- iii. Failure to adhere to APAs or to implement an agreed AMP may be a breach of contract.
- iv. It is reasonable for AMPs to include financial consequences for non-implementation.

Scenario 5

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

Contractual approach

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

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

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

- i. The provider must not unilaterally 'switch off' the affected service on the NHS e-Referral Service. This will simply prompt more (less efficient) paper referrals from GPs.
- ii. Nor may it unilaterally start to reject GP referrals from some or all commissioners (perhaps those outside what it may consider to be its local catchment area). This would contravene the requirements in SC6.

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

- i. Such a suspension should only occur in truly exceptional circumstances, but may be considered appropriate if the demand / capacity imbalance is so severe that there is simply no prospect of patients receiving treatment, meaning that patients' safety and health may be at significant risk.
- ii. A suspension can be applied to new referrals (or new, non-urgent referrals) only (so that the provider can continue working to clear the backlog of existing cases) and it can be applied only to an element of a service (in this instance, the sub-specialty under particular pressure), rather than necessarily the whole service.
- iii. But, for a service to which the legal right of choice applies, suspension must not be used to enable patients from some CCGs to continue to access the service, whilst those from other cannot.
- iv. The co-ordinating commissioner will need to liaise with other organisations and consider the impact of a potential suspension in the round, including the effect it is likely to have on services at other available providers.
- v. Clear communication to referrers and, where appropriate, the general public will be essential.

Reporting requirements

Scenario 6

A contract with a community services provider includes at Schedule 6A a new local reporting requirement on waiting times to access physiotherapy services. This was to be reported on monthly, and the first report was due at the end of May. The provider has not supplied the report, but has apologised, saying that it hasn't been able to set up the new reporting system yet because of staffing difficulties – but it will do so in time for the report due by the end of September.

Contractual approach

Here, the commissioner has various options for action under the Contract, depending how formally it wishes to address the issue.

- i. It can treat the situation as an Information Breach under SC28 and (in line with SC28.19) withhold up to 1% of Monthly Actual Contract Value until such point as the required report starts to be provided.

- ii. It can require a formal Remedial Action Plan from the provider under GC9, so that the steps the provider will take to remedy the position are fully documented, with timescales – potentially with specific financial consequences agreed for non-compliance.
- iii. It can take the similar (but contractually lower profile) approach of requiring the provider to put in place a Data Quality Improvement Plan.

Equally, however, the commissioner may reasonably decide to take a less formal approach, accepting the explanations it has received from the provider and relying on the assurances the provider has given for the future. The context will obviously be crucial – the importance of the new report, the level of trust between the parties and the working relationship they are aspiring to.

Invoicing and payment

Scenario 7

A provider of community services with a zero-value contract does not invoice the commissioner for the first six months of the year, but then – in mid-October – sends an invoice for activity across all of months 1-6.

Scenario 8

A commissioner has reviewed the month 6 final reconciliation account from its main acute provider. There is a big overspend against plan in outpatient care in a number of specialties. Analysis suggests that this has been wholly caused by a recording issue – there is evidence of double-counting (two attendances for the same patient in the same specialty on the same day), going back to month 1.

Contractual approach

These two contrasting scenarios both relate to the operation of SC36 (Payment Terms), although the second also brings in the section of SC28 which deals with the notification of counting and coding changes. Again, the scenarios also raise questions about how the contracting parties want their working relationship to operate.

Scenario 7

In contractual terms, Scenario 7 is straightforward. SC36.36 is clear that, where there is no Expected Annual Contract Value, the provider must send invoices in arrears for each month within 20 Operational Days of the month end. Where the provider misses this deadline, the commissioner is under no obligation to pay the invoices. This would be the case, technically, even if the provider had been sending monthly activity data to SUS on time throughout months 1-6; the provision of the invoice is what triggers the requirement to pay.

Scenario 8

Scenario 8 is more complex. Let's assume, in this instance, that this is a case where the provider accepts that

- i. it has indeed made, in error, a locally-proposed change in recording practice on 1 April which it did not notify to the commissioner by the preceding 30 September (as required under SC28.11 onwards); and
- ii. the new method of recording is technically incorrect under national data definitions; and
- iii. the new method of recording increases income for the provider, although the nature and volume of the service being provided has not changed.

In this situation, the commissioner can reasonably

- i. expect the provider to accept non-payment for the excess recorded activity in month 6; and
- ii. require the provider to rectify the recording error going forward (or to make ongoing payment adjustments if this is not immediately possible).

However, because the final reconciliation deadlines for months 1-5 have all passed, the commissioner cannot automatically refuse to pay for the excess activity in those months. The Contract does, however, offer commissioner scope to seek redress under GC11 (see paragraph 44.51 above) or GC15 (see paragraph 44.55 above).

The above sets out the default position under the Contract. It is, of course, open to the parties to reach alternative agreements – so, in the first scenario, a “reasonable” commissioner may accept a provider’s explanation for late invoicing and agree to make full payment on an exceptional basis; and similarly, under the second scenario, a “reasonable” provider may accept that it should not make a windfall gain from incorrect recording and offer to adjust payment for the full six months. The parties’ working relationship – the track record of how they behave towards each other – is likely to be key in determining how “reasonable” each is inclined to be.

Counting and coding

Scenario 9

A provider has notified its co-ordinating commissioner in November 2016 of a change in recording practice which it believes it must make in order to comply with the NHS Data Dictionary. The provider believes that the change will result in an increase in income from commissioners of around £500,000 in a full year. The provider believes that its notification allows it to implement the change from 1 April 2017 and to receive the full income gain from that point onwards. The co-ordinating commissioner, by contrast, believes that the provider should not make the change at all, because it should never be allowed to make a 'windfall' gain from improved counting and coding.

Contractual approach

There are two separate issues to be resolved here.

- i. Should the change in recording practice proceed at all?
- ii. When should the change be implemented and its financial impact take effect?

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

Assuming that this first issue is resolved and the parties agree that the change is technically appropriate and should therefore proceed – what happens then about implementation and financial impact? In this respect, the commissioner's view – that a provider can never make a financial gain from changes in recording practice – is not correct. But neither is the provider's view. In this particular scenario, the provider has not given a valid notification of a counting change under the 2016/17 Contract – because it only gave notice in November 2016, rather than doing so before the end of September 2016.

The provider has effectively missed the deadline for notification of proposed counting changes during 2016/17. It will need to resubmit its proposal for consideration in 2017/18, making sure that it does so before 30 September 2017. Assuming the change is agreed, it can then be implemented on 1 April 2018, but its financial effect will be neutralised for the 2018/19 Contract Year – meaning that the provider will start to get the financial benefit only from 1 April 2019.

(This scenario happens to feature a counting and coding change from which the provider would benefit financially. It is important to remember that the protections in

the Contract cut both ways – they apply to changes from which either provider or commissioner would benefit.)

Note that, under the revised wording of SC28 which applies from 1 April 2019, this example would meet the definition of a locally-proposed change – so notice in advance would still be required under SC28.11, as would short-term financial neutralisation under SC28.14.

Scenario 10

The updated National Tariff Payment System for a particular year introduces a new Best Practice Tariff (BPT). This creates a financial incentive for providers to treat a certain group of patients as outpatient procedures, rather than as daycases. Once the new Contract Year starts, a commissioner duly sees at its main provider an increase in the volume of the relevant outpatient procedures and a balancing reduction in daycases – and, because the BPT has been applied, an increase in cost to itself, the commissioner then claims that this is a counting and coding change, for which notice should have been given in advance, and states that it is not liable to pay. Is this right?

In principle, as set out in paragraph 44.25 above, our expectation is that attempts by a provider to earn a BPT would not constitute counting and coding changes; rather, they would be changes in the actual pattern of service delivery. And paragraph 44.25 also makes clear that, whilst it is good practice for providers to alert commissioners to their intention to achieve a BPT, there should be no requirement for a Variation to be agreed in respect of any change of service provision necessary to achieve this.

Care would be needed in this particular instance, however.

- i. If the provider has made a genuine change to the way in which services are provided to patients – moving from being done on a general anaesthetic basis in a fully-equipped daycase unit to a less lengthy, complex or invasive approach in a lower-tech clinic setting – then that would clearly constitute a change in service delivery and not a counting and coding change.
- ii. However, in a situation where the provider simply reclassified the activity from daycase to outpatient, without making any material change to the way in which the service was delivered, this would indeed constitute a counting and coding change and would be subject to the provisions of SC28.

Appendix 7

Information management and information governance

The following section outlines a number of key issues that commissioners and providers need to consider, relating to the provision of information under the contract:

- i. information governance;
- ii. system compliance;
- iii. reporting requirements;
- iv. Data Services for Commissioners programme;
- v. information services; and
- vi. workforce minimum data set.

Information governance – service user data and its protection

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

GC21 – Data Protection, Freedom of Information and Transparency (GC21.1)	<p>Providers and commissioners must comply with Data Protection Legislation (defined below). They must also comply with the Freedom of Information Act 2000 (FOIA) and Environmental Information Regulations 2000 (EIR). They agree to assist each other where necessary.</p> <p>Data Protection Legislation includes (from definitions):</p> <ul style="list-style-type: none">• the EU General Data Protection Regulation (GDPR), now incorporated into UK legislation by DPA 2018• the EU Law Enforcement Directive (LED)• any applicable national Laws implementing the GDPR and LED as amended from time to time• the Data Protection Act 2018 – this brings the GDPR into UK law, enacts derogations as permitted, and addresses the LED• all applicable Law concerning privacy, confidentiality or the processing of personal data including but not limited to the Human Rights Act 1998, the Health and Social Care (Safety and Quality) Act 2015, the common law duty of confidentiality and the Privacy and Electronic Communications (EC Directive) Regulations
The Data Security and Protection Toolkit, and IGSoC	<p>It is a requirement of all providers wishing to provide NHS funded services that they meet the full range of information governance requirements and specifically the requirements set out in the Data Security and Protection Toolkit.</p>

(GC21.2, GC21.6)	<p>Where there is a requirement to integrate their IM&T solution to NHS systems and services, including the NHS e-Referral Service, PDS, NHS Mail and N3 (being replaced by the Health and Social Care Network), the provider will need to complete an information governance statement of compliance (IGSoC). The IGSoC process is agreed once for each organisation i.e. per legal entity. Continuing compliance is reconfirmed through the annual submission of the Data Security and Protection Toolkit and acceptance of the IG Assurance Statement.</p> <p>The IGT and IGSoC require the nomination of a Caldicott Guardian and Senior Information Risk Owner. Further information on the IGSoC can be found at: https://digital.nhs.uk/data-security-information-governance</p>
<p>Senior Information Governance Roles (GC21.3, Particulars – Governance and Regulatory)</p>	<p><u>Information Governance Lead</u> A representative from the senior level of management should be appointed to act as the overall Information Governance lead to co-ordinate the IG work programme.</p> <p><u>Senior Information Risk Owner (SIRO)</u> The Senior Information Risk Owner (SIRO) should be an Executive Director or other senior member of the Board (or equivalent senior management group/committee). The SIRO may also be the Chief Information Officer (CIO) if the latter is on the Board, but should not be the Caldicott Guardian as the SIRO should be part of the organisation's management hierarchy rather than being in an advisory role.</p> <p>The <i>Information Security Management: NHS Code of Practice</i> can be found at: https://digital.nhs.uk/article/1201/Information-security-management-NHS-code-of-practice</p> <p>The National Data Guardian for Health and Social Care has published a review of Data Security, Consent and Opt-Outs which can be found at: https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs This provides the basis for the Data Security and Protection Toolkit.</p> <p><u>Caldicott Guardian</u> The role of the Caldicott Guardian is to oversee the arrangements for the use and sharing of patient information. Acting as the 'conscience' of an organisation, the Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information. The Caldicott Guardian also has a strategic role, which involves representing and championing confidentiality and</p>

information sharing requirements and issues at senior management level and, where appropriate, at a range of levels within the organisation's overall governance framework.

The Caldicott Guardian should be, in order of priority:

1. an existing member of the senior management team;
2. a senior health or social care professional;
3. the person with responsibility for promoting clinical governance or equivalent functions.

The nominated Information Governance Lead, Caldicott Guardian and Senior Information Risk Owner must be identified in the Governance and Regulatory section of the Contract Particulars. GC21.3.4 additionally requires that the Commissioner is kept informed of any changes to the individuals holding these roles.

The *Manual for Caldicott Guardians 2017* can be found at:

<https://www.ukcg.org.uk/>

The *Confidentiality: NHS Code of Practice* can be found at:

<https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice>

A guide to confidentiality in health and social care published by NHS Digital, with supporting references can be found at:

<https://digital.nhs.uk/article/1226/A-Guide-to-Confidentiality-in-Health-and-Social-Care->

There is a requirement within the Caldicott Review to ensure that these individuals (Information Governance Lead, Senior Information Risk Owner and Caldicott Guardian) are given appropriate education and training to support them in being clear about the respective roles and supporting them in performing their functions well.

In a small organisation, it may be appropriate for the same individual to take on more than one of the roles described above. It is recommended that the roles of Caldicott Guardian and SIRO should be held by different people to avoid potential conflicts of interest.

Data Protection Officer

The GDPR requires that Public Authorities appoint a DPO. (Note that all Trusts, Foundation Trusts and NHS commissioners are Public Authorities. So too, in respect of at least some of their activities, are GP practices and community pharmacies.) Data controllers and processors which conduct systematic monitoring or process special categories data on a large scale must also appoint a DPO.

	<p>The DPO is responsible for informing and advising the organisation on data protection matters, monitoring compliance and must report to the highest management level. He or she must have expert knowledge of data protection law and ability to perform the tasks specified in the GDPR.</p> <p>Guidance on the precise circumstances in which a DPO is required and on the role of the DPO can be found at: https://digital.nhs.uk/information-governance-alliance/General-Data-Protection-Regulation-guidance</p>
National Data Guardian – Security Standards (GC21.4)	<p>The Provider must comply with the National Data Guardian’s Data Security Standards, which are published in the Review of Data Security, Consent and Opt-Outs. This is available at: https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs</p> <p>These standards form the basis for the assertions of the Data Security and Protection Toolkit.</p> <p><i>Information: To share or not to share? The Information Governance Review</i> is available at: https://www.gov.uk/government/publications/the-information-governance-review</p> <p><i>Information: To share or not to share? The Government Response to the Caldicott Review</i> is available at: https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response</p> <p>Information on the role of the National Data Guardian is available at: https://www.gov.uk/government/organisations/national-data-guardian/about</p>
NICE Clinical Guideline 138 (GC21.5)	<p>The provider must audit its practices against quality statements regarding data sharing set out in <i>NICE Clinical Guideline 138: Patient experience in adult NHS services: improving the experience of care for people using adult NHS services</i> (CG138).</p> <p>It is expected that by conducting this audit, and revising practice accordingly, the provider will be able to demonstrate assurance that whilst information is shared lawfully by their employees, there are no obstacles to meeting the requirements of the Guideline arising from a failure to share.</p> <p>The Caldicott Review includes 7 quality statements or recommendations taken from CG138 that emphasise the importance of appropriate sharing.</p>

	<p>CG138 <i>Patient experience in adult NHS services</i>, and the full guidance document including methods evidence and recommendations can be found at: https://www.nice.org.uk/guidance/cg138.</p> <p>QS15 <i>Quality standard for Patient experience in adult NHS services</i> can be found at: https://www.nice.org.uk/guidance/qs15/chapter/introduction-and-overview</p> <p>CG138 <i>Patient experience in adult NHS services: baseline assessment tool</i> can be found at: https://www.nice.org.uk/guidance/cg138/resources</p>
Data Breaches and Information Governance Breaches (GC21.7)	<p>The Provider must report and publish and Data Breach or Information Governance Breach in accordance with IG Guidance for Serious Incidents.</p> <p>The GDPR introduces a duty on data controllers to report certain types of personal data breach to the relevant supervisory authority (i.e. the ICO). The data controller must do this within 72 hours of becoming aware of the breach, where feasible. Where it is required to do this, the Provider must inform the Co-ordinating Commissioner as soon as reasonably practicable and before notifying the ICO.</p> <p>If the breach is likely to result in a high risk of adversely affecting individuals' rights and freedoms, you must also inform those individuals without undue delay.</p> <p>Where it is required to do these things, the Provider must inform the Co-ordinating Commissioner as soon as reasonably practicable and before notifying the ICO or the individuals affected.</p> <p>Information on breach reporting can be found here: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/personal-data-breaches/</p>
Data Controller responsibilities (GC21.8, GC21.13)	<p>GC21.8 The Provider must have in place a communication strategy that meets GDPR transparency requirements. ICO guidance can be found at: https://ico.org.uk/for-organisations/guide-to-data-protection/privacy-notice-transparency-and-control/</p> <p>GC21.9 Whether either party or a sub-contractor is a data controller and/or a data processor will be determined by the law and ICO guidance. A data processor is an organisation that processes personal data entirely on the instructions of a data controller.</p>

Where the provider is to act as a data processor for the Commissioner this must be indicated in the Particulars. Where this is the case, Schedule 6 F of the Particulars – *Provider Data Processing Agreement* applies, and *Annex A – Data Processing Services* must be completed.

GC21.10

The Provider must processes personal data in accordance with Data Protection Legislation, and must ensure that any sub-contractor or data processor acting on the Provider's behalf does so also.

GC21.11

The Provider must publish and maintain the listed policies and protocols and apply them conscientiously.

GC12.12

Where data are required by the Commissioner for the purposes of quality assurance, performance management and contract management, this should be provided in anonymised or aggregate form wherever possible. Under the GDPR pseudonymised data are personal data. The Provider therefore requires a legal basis to meet GDPR Article 6 (Lawfulness of processing and Article 9 (for special categories) to process and share such data.

GC21.13

Providers should be aware that commissioners cannot require providers to process data unlawfully. This is particularly important to consider where there are contract variations.

Commissioners must ensure that requirements placed on providers to submit Personal Data have an established legal basis in common law, and that they and their support organisations have a legal basis to receive it. Whilst the provider's obtaining a patient's consent to disclose the information would establish such a basis, this is only likely to be practical in particular contexts, such as individual requests for funding.

Commissioners and Providers must establish the legal basis for the submission and use of datasets. Existing national datasets are supported by standards and directions, which require submission to NHS Digital. Similarly there is a legal basis for data sets identified in the Particulars: Schedule 6A *Reporting Requirements – Local Requirements Reported Locally* to be submitted to NHS Digital's Data Services for Commissioners Regional Offices (DSCROs).

NHS England has specific approval under the NHS Act 2006 s251 which enables commissioners to receive data which

includes one identifier for the purposes of Risk Stratification and Invoice Validation. This approval is provided from the Secretary of State for Health and Social Care on the recommendation of the Confidentiality Advisory Group (CAG).

To support a range of commissioning purposes, NHS England currently has the following s251 approvals in place as follows:

- CAG 2-03(a)/2013 – This approval originally enabled commissioners to receive datasets with one identifier, usually NHS Number for their commissioning purposes. This data is now de-identified in line with the ICO Anonymisation Code of Practice by NHS Digital. However as this underpins the use of commissioning data as outlined in CAG 2-03(a)/2013, this approval remains in force but is only used to enable the continued use of commissioning data which includes one identifier for Risk Stratification (CAG 7-04(a)/2013) and Invoice Validation (CAG 7-07(a-c)/2013 purposes).
- CAG 7-07(a-c)/2013 – This approval supports the use of a specified backing data set for invoice validation purposes within a controlled environment for finance. Please refer to *Who Pays? Information Governance Advice for Invoice Validation* which can be found here: <https://www.england.nhs.uk/wp-content/uploads/2013/12/who-pays-advice.pdf>

Guidance on the processes which have been implemented by NHS Digital/DSCROs to de-identify data for commissioning purposes has been developed jointly by NHS England and NHS Digital and distributed to commissioners.

Under the Health and Social Care Act 2012, and NHS England Directions, both national and local identifiable data flows required for secondary use purposes to support commissioners to meet their statutory duties, must flow directly to NHS Digital (if a national flow) or via the CCG's nominated DSCRO (if a local flow identified in Schedule 6A). Providers must not flow identifiable data directly to a commissioner or their data processor (CSU) unless a specific legal basis supports the disclosure. For clarification, identifiable data items within a dataset include (but are not limited to) an NHS number, Date of Birth, Post Code. Statutory bodies are also reminded of their obligation to have regard to NHS Digital's Confidentiality Code of Practice when making decisions around sharing identifiable patient confidential data for secondary use purposes.

'Section 251 support' refers to approval by the Secretary of State under the Health Service (Control of Patient Information)

	<p>Regulations 2002, on the recommendation of the Confidentiality Advisory Group (CAG). The regulations are enacted under section 251 of the NHS Act 2006. This support provides a statutory basis for the flow of personal data where a duty of confidentiality is owed, without seeking the consent of individuals.</p> <p>Even where providers are data controllers, they will still need to demonstrate to commissioners that they have appropriate organisational and technical measures in place to protect personal and confidential data in line with Data Protection legislation requirements. This is achieved by compliance with the Information Security requirements of the IG Toolkit.</p>
Responsibilities as a Data Processor (GC21.15, Particulars Schedule 6F)	Where the Provider organisation is commissioned specifically to deliver an information service that involves the processing of personal data on behalf of the Commissioner, the Provider is acting as a Data Processor under the GDPR. In this situation the Provider must only process the data in accordance with the Commissioner's instructions. Where this is the case, Schedule 6 F of the Particulars – <i>Provider Data Processing Agreement</i> applies, and <i>Annex A – Data Processing Services</i> will apply and must be completed as appropriate.
Responsibilities when engaging sub-contractors (GC21.15-17, Particulars – Schedule 5B in full-length)	<p><u>GC21.15</u> When engaging a sub-contractor to deliver part of the service (not as a Data Processor), the provider must ensure that the IG and data protection requirements in the relevant sub-contract are no less onerous than GC21.</p> <p><u>GC21.16 and 21.17</u> When engaging a sub-contractor as a Data Processor, i.e. specifically to process data on its behalf, the Provider takes full responsibility for ensuring that the requirements of data protection legislation and other legal requirements are met by the sub-contractor. A binding written agreement must be in place that commits the sub-contractor to act only on the instructions of the provider and to the other listed provisions. GC21.16 sets out the requirements of such an agreement.</p> <p>Contract Particulars, Schedule 5 should be completed in B with the identities of any Material Sub-contractors. Against each of these, the parties should indicate whether the sub-contract involves processing of personal data, and if so whether the sub-contractor is to do so as data processor (triggering the need for contractual requirements as referred to above), data controller or joint data controller. See also the guidance on GC21.9.</p> <p>Guidance on DPA requirements when engaging a Data Processor can be found on the ICO website.</p>

Commissioning Datasets (Particulars – Schedule 6A)	All local datasets must be listed in the Contract Particulars, Schedule 6A under Local Requirements Reported Locally.
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System compliance

NHS number	The NHS number is the national unique service user identifier that is critical to the sharing of information and is used to help healthcare staff and service providers match the service user to their health records. All providers will be expected to use the NHS Number as primary identifier in their clinical correspondence and when investing in their systems so that it becomes the primary identifier in their internal systems. It is a required field within data returns to commissioners and should be contained in all referrals.
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To help facilitate the use of the NHS number, centrally managed applications for the retrieval of the NHS number are provided as follows:

Personal demographic service (PDS)	PDS is the national electronic database of demographic details for service users and is available via a PDS compliant patient administration system (PAS).
Summary Care Record application (SCRa)	The SCRa is a web based portal by which service user information held on the Spine (a national, central database where, for example, summary patient records are stored) can be accessed. As with other centrally managed applications, access is controlled.
Demographic Batch Service (DBS)	DBS enables a user to submit a file containing service user demographics for multiple service users, for tracing against the PDS. The correct NHS number and demographics for each service user will be returned where an exact match is found. DBS will also return a deceased status for service users and information where no match has been made.

Reporting requirements

To enable reporting, the provider may during the life of the contract require access to a number of NHS systems and services and, following registration for an IGSoC, the provider will be required to apply for access to some or all of the following:

Organisation data services (ODS)	The provider must acquire a unique ODS code for their organisation and separate site codes, where relevant, to support all central reporting. This code is the provider's unique ID that allows publication of services and activity undertaken for the NHS.
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NHS mail	NHS mail is the secure, web based email and directory designed for NHS staff, providing secure email services for the transmission of service user identifiable data. All providers will be required to register for NHS mail and will need to discuss this provision with their commissioner.
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To enable information flows and meet the requirements of NHS Digital, the provider may require access to a number of reporting systems. The main collection methods and links to key information websites for further explanation are set out below:

Secondary Uses Service (SUS)	SUS is the single comprehensive repository for healthcare data which enables a range of reporting and analyses to support the NHS. SUS data is derived from commissioning data sets (CDS), which must be submitted to the system by the provider. The provider must register with SUS to enable submission and details of how to register can be found at https://digital.nhs.uk/services/secondary-uses-service-sus/secondary-uses-services-sus-guidance .
Strategic Data Collection Service	The Strategic Data Collection Service (SDCS) is a secure data collection system used by health and social care organisations to submit data. See: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/strategic-data-collection-service-sdcs
Strategic Executive Information System (STEIS)	STEIS is used by NHS organisations for the collection of Incidents Requiring Reporting SC 33 and Situation Reports (SITREP). For further information and agreement of method, please contact the relevant commissioner.

Information services

Below are useful links for both providers and commissioners to ensure that they are aware of the information requirements and standards set:

NHS Digital	<p>NHS Digital is England's central, authoritative source of health and social care information. It manages the national data repository and routine data flows between the health and care system and the centre. It publishes national and official statistics, indicators and measures used for national accountability. It has a key role in information governance and data quality assurance in relation to nationally collected and published data.</p> <p>NHS Digital has a national role to reduce the administrative burden of data collections and works closely with the Data Coordination Board to ensure appropriate burden assessment of all new data collections. All</p>
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	<p>mandated and voluntary collections are listed on the DCB Schedule of Approved Collections: https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections.</p> <p>NHS Digital's National Casemix Office designs and refines currencies that are used to describe healthcare activity and which underpin policies from costing through to payment, supporting local and national commissioning and performance management. It also provides analytical services to support specialised commissioning.</p>
Data Coordination Board	The Data Coordination Board has responsibility for the system-wide oversight of information standards and data collections, acting under delegated authority from the Digital Delivery Board and the Secretary of State for Health and Social Care.
NHS Data Model and Dictionary Service	A reference point for all information standards that support healthcare activities and data definitions (https://digital.nhs.uk/services/nhs-data-model-and-dictionary-service).
Information standard notices (ISNs)	Providers and commissioners are required under the contract to implement all ISNs relevant to the services being provided that are issued during the life of the contract. An information standard describes a common way of managing information, which supports national initiatives. More information is available on the Data Co-ordination Board webpages at https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions .

Workforce minimum data set

The [Health and Social Care Act 2012](#) places a duty on all organisations that deliver NHS funded care to provide data on their current workforce and to share their anticipated future workforce needs. It does this through the duty placed on:

- i. the Secretary of State to put in place an effective education and training system;
- ii. providers of NHS funded care to co-operate within the new education and training system; and
- iii. NHS England and CCGs to ensure that providers from whom they commission services have regard to education and training when carrying out their functions.

All providers of NHS funded services are required to co-operate with Health Education England (HEE) and its Local Education and Training Boards (LETBs) to support them to:

- i. understand the current workforce;
- ii. plan the future workforce and understand education and training needs; and
- iii. manage the provision of education and training to the workforce.

The detailed guidance on the workforce information that providers need to supply is signposted from the following web page: <http://digital.nhs.uk/workforce>.

Schedule 6A of the Contract requires providers to supply information in accordance with all relevant ISNs, and, therefore, to supply information on the workforce minimum data set.

Workforce planning requires an understanding of the external environment, internal environment, business strategy and plans, current workforce and forecasted impact of turnover, retirements, recruitment and continuing professional development. All areas of the workforce minimum data set will assist planners in understanding workforce demographics and in developing strategies and plans to ensure appropriate education commissioning to provide the future workforce.

Type of data	Use
Absence data	Absence data helps planners to understand one of the elements of the internal environment. It can help provide an understanding of temporary staff costs and the impact of those costs on overall staffing numbers.
Deployment data	The essential elements of this group of data allow planners to ascertain if there are any gaps in workforce provision against their organisational structure, how much the workforce is currently costing the organisation and the potential costs of future requirements.
Education, training and development data	Education, training and development are key elements in workforce planning. Analysis of the current workforce's professional registrations, skills and competencies and comparing that data with the current and future requirements provides an indication of any gaps that may need filling. Education, training and development data can also link to the LETB's workforce skills and development strategy.
Organisational data	Indicates the organisation relevant to the employee.
Personal/operational data	This data will help workforce planners by building an understanding of the age profile of the workforce to support understanding of turnover, retention and retirement data and the effect of gender on working patterns.
Staff movement data	This provides essential information on how the shape of the historical and current workforce has ebbed and flowed. Staff movement data provides current vacancies, where staff have come from and where they go to, retirements, churn and natural wastage. It also shows the relationship between those employed and the hours they work, the role they play and whether or not they hold a substantive contract.

Appendix 8

Emergency Care Rule: Agreed Blended Payment Arrangements – worked examples for completion of Schedule 3D

These worked examples are not intended in any way to set default expectations for what local parties should agree – they are simply offered to illustrate potential different ways in which the schedule can be completed.

Example 1 – simple and symmetrical

Commissioner	Value of Planned Activity (£)	Blended Payment applies	Emergency Care Threshold(s)	Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)
NHS XXX CCG	£100,000,000	YES	Where the Emergency Care Activity Value:	
			<95% of the Value of Planned Activity	(50)
			>95% - 100% of the Value of Planned Activity	(20)
			>100% - 105% of the Value of Planned Activity	20
			>105% of the Value of Planned Activity	50
NHS YYY CCG	£5,000,000	NO	Not applicable	

Example 2 – complex, but symmetrical

Commissioner	Value of Planned Activity (£)	Blended Payment applies	Emergency Care Threshold(s)	Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)
NHS XXX CCG	£100,000,000	YES	Where the Emergency Care Activity Value:	
			<90% of the Value of Planned Activity	(100)
			>90% - <91% of the Value of Planned Activity	(90)
			>91% - 92% of the Value of Planned Activity	(80)
			>92% - 93% of the Value of Planned Activity	(70)
			>93% - 94% of the Value of Planned Activity	(60)
			>94% - 95% of the Value of Planned Activity	(50)
			>95% - 100% of the Value of Planned Activity	(20)
			>100% - 105% of the Value of Planned Activity	20
			>105% - 106% of the Value of Planned Activity	50
			>106% - 107% of the Value of Planned Activity	60
			>107% - 108% of the Value of Planned Activity	70
			>108% - 109% of the Value of Planned Activity	80
			>109% - 110% of the Value of Planned Activity	90
			>110% of the Value of Planned Activity	100
NHS YYY CCG	£5,000,000	NO	Not applicable	

Example 3 – simple but asymmetrical

Commissioner	Value of Planned Activity (£)	Blended Payment applies	Emergency Care Threshold(s)	Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)
NHS XXX CCG	£100,000,000	YES	Where the Emergency Care Activity Value:	
			<96% of the Value of Planned Activity	(40)
			>96% - 100% of the Value of Planned Activity	(20)
			>100% - 102% of the Value of Planned Activity	20
			>102% of the Value of Planned Activity	80
NHS YYY CCG	£5,000,000	NO	Not applicable	

Example 4 – complex and asymmetrical

(This example demonstrates that agreement could be reached for payments at a variable rate of above 100%. NHS England and NHS Improvement would only expect variable rates of over 100% to be considered in very specific and limited circumstances.)

Commissioner	Value of Planned Activity (£)	Blended Payment applies	Emergency Care Threshold(s)	Emergency Care Marginal Price Percentage (being the percentage of Unit Price to be paid or deducted for Emergency Care Services delivered above or below the Value of Planned Activity)
NHS XXX CCG	£100,000,000	YES	Where the Emergency Care Activity Value:	
			<95% of the Value of Planned Activity	(40)
			>95% - 100% of the Value of Planned Activity	(20)
			>100% - 102% of the Value of Planned Activity	20
			>102% - 104% of the Value of Planned Activity	40
			>104% - 106% of the Value of Planned Activity	60
			>106% - 108% of the Value of Planned Activity	80
			>108% - 110% of the Value of Planned Activity	100
			>110% of the Value of Planned Activity	120
NHS YYY CCG	£5,000,000	NO	Not applicable	

Appendix 9

How obligations in the Contract are expressed

Obligations under the Contract are expressed in different ways. We are sometimes asked to explain what these expressions mean in practical terms.

- If the Contract says that the relevant party **must** do something (for example, “must comply”, “must submit”, “must implement”), it means that that party has an absolute obligation to do that something, regardless of the cost or inconvenience to them it entails – no excuses (but see below).

But many obligations are expressed in other ways. As a general rule of thumb:

- If the Contract says that the relevant party **must use all reasonable endeavours** to do something, it means that that party must pursue every reasonable course of action open to it to achieve the required objective. It can’t simply try one course of action and, if that doesn’t work, give up. But it isn’t an absolute obligation: it doesn’t mean that the relevant party has to spend unlimited or disproportionate sums of money or other resources in pursuing the relevant objective, but rather what is reasonable in the circumstances.
- If the Contract says that the relevant party **must use reasonable endeavours** to do something, that’s a slightly lesser obligation. It means that that party must pursue a reasonable course of action open to it to achieve the required objective, but it doesn’t necessarily have to pursue lots of different courses of action. Again, it isn’t an absolute obligation: it doesn’t mean that the relevant party has to spend unlimited or disproportionate sums of money or other resources in pursuing the relevant objective, but rather what is reasonable in the circumstances.
- If the Contract says that a party **must have regard to** something (usually Guidance) it means that the party must make sure that it is aware of what that Guidance says, and takes account of it in its decisions and actions. The party should assume that it would need to have a good reason to justify departing from that Guidance.

Note that, however the obligation is expressed, a party may be entitled to relief from liability under the Contract for any failure to comply with it, if that failure is caused by matters beyond the reasonable control of that party: see GC28 and the definition of Event of Force Majeure.

Equality and diversity are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have given due regard to the need to:

- reduce health inequalities in access and outcomes of healthcare services
integrate services where this might reduce health inequalities
- eliminate discrimination, harassment and victimisation
- advance equality of opportunity and foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

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