NHS England

NHS Standard Contract 2021/22

Summary of key changes made in response to consultation feedback

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Introduction

Following our consultation which ended in January 2021, NHS England has now published the final NHS Standard Contract and Contract Technical Guidance for 2021/22 at https://www.england.nhs.uk/nhs-standard-contract/21-22/. This document describes, by exception, the material changes we have made in the final full-length Contract in response to stakeholder feedback received during the consultation process. Changes have been carried over to the shorter-form Contact where relevant.

We also carried out an earlier consultation, which ended in December 2020, on the arrangements for contracting and paying for low-volume flows of activity between CCGs and NHS Trusts and NHS Foundation Trusts. This document also sets out our response to the feedback we received to this consultation and describes the next steps.

New provisions proposed in the draft 2021/22 Contract

We received feedback from 214 organisations or individuals in relation to the 20 specific proposals we included in the draft 2021/22 Contract. Most responses received were from providers (58%); CCGs/CSUs accounted for 31%. For each of the 20 proposed changes, the consultation feedback demonstrated majority support amongst those responding with a view on that specific change.

However, there were many helpful suggestions for ways in which the wording of the Contract itself could be improved. We list below the areas in which we have made changes in response.

Topic	Change	Contract Reference
Interface with primary medical care	The majority of respondents were in favour of the principle of the change we proposed, which required each provider to undertake a self-assessment of its performance against the existing "interface with primary care" requirements and to agree and to implement an action plan to address any deficiencies. However, the feedback raised some pertinent issues, and as a result we have amended the Contract wording as follows. • The requirement to assess the effectiveness of interface working, with a specific focus on the provider's compliance with the Contract interface requirements – and to agree and implement an appropriate action plan to address any deficiencies – now rests jointly with the provider and the co-ordinating commissioner. • The timescale for completing the assessment has been moved back to 30 September 2021. • Rather than requiring reporting of the self-assessment on the provider's website, the requirement is now for the agreed action plan to be approved, in public, by the Board of both provider and commissioner.	Service Conditions 3.17-18

Topic	Change	Contract Reference
Interface with primary medical care (continued)	We do not envisage that the assessment process should be an over-burdensome process, particularly for clinicians. The toolkit we have published offers ways of assessing compliance effectively with local partners. And where there is local agreement that interface arrangements are working well, the assessment could be a light-touch process. The key point is that there is regular local review of the effectiveness of working arrangements that involve the provider, the CCG and local primary medical care representatives. In relation to the provider's compliance with its specific contractual obligations (SC6.7, SC8.2-5, SC11.5-7, SC11.9-10, SC11.12 and SC12.2) and more broadly, the focus should be on making improvements that will benefit patient care and the functioning of the whole local health system.	
Community and mental health services and Primary Care Networks	Following the publication of the contractual arrangements for general practice in the coming year (Supporting General Practice in 2021/22) and the feedback to our consultation, we have made a number of changes to the Contract wording. • We have retained the Contract provisions supporting the Enhanced Health in Care Homes model. • We have withdrawn the Contract provisions relating to the Anticipatory Care model, as the introduction of this service into the GP contract has been deferred. The timetable for implementation remains under discussion between NHS England and the BMA GP Committee. If it is agreed that implementation of this model will begin during 2021/22, we will make available an Anticipatory Care schedule for inclusion, by local variation, into CCGs' contracts with relevant community services providers. • We have retained the Contract provisions relating to the employment of mental health practitioners by secondary care providers to work on an embedded basis in PCN teams. In response to issues raised in our consultation, we have clarified, in the relevant Schedule, expectations for existing "early implementer" sites.	Service Conditions 4.9-10 and Schedules 2Ai and 2Aii
Remote consultations	The draft Contract included a new requirement on providers to offer patients a choice, where clinically appropriate, between a face-to-face appointment and a telephone or video appointment. Consultation feedback has highlighted that the way we had expressed the requirement – as the systematic offering of choice – could create a significant administrative burden for providers. This was not our intention, and we have amended the Contract wording to refer more simply to providers using all reasonable endeavours to offer patients, where clinically appropriate, the option of a remote appointment.	Service Condition 10.5

Topic	Change	Contract Reference
Green NHS	Some providers told us that they are tied into multi-year contracts for electricity supply which they cannot change or terminate without penalty. We have therefore amended the Contract wording so that providers are required to change to REGO certified electricity as soon as possible – which may be when their current supply contract ends, or sooner if they are able to change (or if necessary exit) their current arrangements on reasonable terms.	Service Condition 18.5
Safeguarding, looked after children and domestic abuse	We have made minor changes to the Contract as below. We have: • amended the definition of Safeguarding Guidance to remove the reference to the Working Together transitional guidance • amended the references to safeguarding leads to make it clear that the provider must have separate leads for adults and for children, and that the children's safeguarding lead responsibilities include looked after children. We have withdrawn the proposed change which would have broadened the applicability of the Child Protection Information Sharing Project beyond providers of unscheduled care. NHSE/I are looking to extend the coverage of the CPIS to scheduled care and to mental health services, but we recognise that it would be premature to make this a contractual requirement at this stage. We received feedback to the consultation asking us to include new requirements in the Contract relating to the role of Independent Domestic Violence Advisors. Under the existing requirement in Service Condition 32 to comply with Safeguarding Guidance, providers must already follow NICE Quality Standard QS116 on domestic violence and abuse and NHSE's Safeguarding Accountability and Assurance Framework (SAAF). Once the Domestic Abuse Bill is enacted and statutory guidance published, we will look to update the SAAF accordingly; the updated SAAF will then take automatic contractual effect in-year. The NHS continues to explore domestic abuse provision, including the role of Independent Domestic Violence Advisors and how this can be utilised across an integrated care footprint.	Service Conditions 32.2 and 32.8 Particulars Definitions
Reduced frequency of financial reconciliation	We have amended the wording from our consultation draft so that monthly reconciliation is now only required for non-NHS providers with an Expected Annual Contract Value of zero; this is necessary to protect their cashflow. For all other situations, including Trusts invoicing CCGs for non-contract activity, the process and deadlines now apply quarterly. This also now applies under the shorter-form Contract.	Service Condition 36 (various)
Core Skills Training Framework	The Core Skills Training Framework specifies the statutory / mandatory training which staff working in the provision of NHS-funded services must regularly undergo. There are two versions of the CSTF, one for Trusts and one for other providers (independent sector providers, voluntary sector bodies, and so on). We have clarified the Contract wording to make clear that providers should have regard to the Framework when providing training for their staff.	General Condition 5.5 Definitions

Topic	Change	Contract Reference
EU Exit	Following the end of the EU exit transition period on 31 December 2020, we have made minor updates to the Contract provisions relating to processing of personal data, and to data legislation and guidance. Note in particular that new regulations have been now approved, and updated guidance published by DHSC, on overseas visitors charging, both referenced from the Contract.	General Condition 21.16.3 Schedule 6F and Annex A Definitions
Counter-fraud arrangements	The NHS Counter-Fraud Authority (NHSCFA) has now published revised counter-fraud requirements for CCGs and providers of NHS-funded services, and we have updated the definition of NHSCFA Requirements accordingly.	Definitions
Contract monitoring reports	Information Standards covering contract monitoring reports were first published by NHS Digital in 2019. The Standards cover aggregate contract monitoring, patient level activity and separately charged drugs and devices. NHS Digital will shortly announce the outcome of its recent consultation on mandating, under Information Standards Notice DCB 2050, these reports. We have amended the Contract wording to make it clear that these reports will be mandated for providers of acute and mental health services operating under the full-length version of the Contract, as and when this is specified in an Information Standards Notice.	Schedule 6A

Aligning the Contract with the 2021/22 National Tariff Payment System

In our Contract consultation, we indicated that it was likely that we would need to build in additional changes to the final Contract, to reflect changes to the National Tariff Payment System (NTPS) for 2021/22. The proposed NTPS for 2021/22 has now been published, and we have accordingly made the following changes to the final Contract.

Topic	Change	Contract Reference
Aligned Payment and Incentive rules under the National Tariff Payment System	The 2021/22 NTPS introduces new "Aligned Payment and Incentive" (API) rules which apply to: • all CCG-Trust relationships within the same ICS; • all other CCG-provider relationships with an Expected Annual Contract Value of more than £10m (but not to contracts awarded under the Increasing Capacity Framework); and • all specialised services commissioned from providers by NHS England. The API rules feature • a fixed element of payment; • a variable element (relating to the volume of elective inpatient, daycase and outpatient procedure activity); and • a quality-related element, comprising payment in relation to Best Practice Tariffs and CQUIN.	Service Conditions 36.3 and 36.21 and Particulars, Schedule 3D

Topic	Change	Contract Reference
	We have included new references in the Contract to the API rules, with a schedule in which the agreed API details can be recorded.	
CQUIN	From April 2021, CQUIN will be governed by the API rules above and will apply only in those relationships which fall within scope of those rules. The financial value of CQUIN will remain at 1.25% (as a proportion of the fixed element of payment). It will be paid in full to the provider in advance in monthly instalments (as part of the Expected Annual Contract Value), but the commissioner will claw back any underperformance, depending on the provider's performance against the relevant nationally set CQUIN indicators. To enable these changes, we have made amendments to the wording of SC38 (which deals with arrangements for monitoring CQUIN performance and validating payment). The key changes are to make clear that CQUIN applies where required under the National Tariff rules; to remove the requirement for separate agreement on payment on account for CQUIN; to remove the requirement for reconciliation of CQUIN payments to reflect actual activity levels (since CQUIN now only applies to the fixed element of payment); to remove the Small-Value Contract Exception; and to remove references to CQUIN from the shorter-form version of the Contract. We have also moved the schedule which sets out the detailed CQUIN indicators to become Schedule 3E, part of the set of schedules dealing with payment. CQUIN will now no longer apply to many contractual relationships with lower financial values. In consequence, the National Prices and unit prices published as part of the 2021/22 National Tariff Payment System have been uplifted by 1.25%. For contractual relationships governed by Local Prices, rather than by National Prices or the API rules, those prices are of course a matter for local negotiation. But our clear expectation is that, as a starting position (before other adjustments are considered), Local Prices in place during 2020/21 should also be uplifted by 1.25% for 2021/22; this will mean that the change to the applicability of CQUIN will not cause a cost pressure for providers. Further detail is set out in our Contract Technical Guidance.	Service Condition 38 and Particulars Schedule 3E

Additional requirements

In response to consultation feedback, we have added new provisions into the final version of the Contract, or changed existing provisions, as follows.

Topic	Change	Contract Reference
Clinical audit / clinical outcome review programmes	Service Condition 26 of the Contract requires providers to participate in national clinical audits within the National Clinical Audit and Patient Outcomes Programme. Following feedback from the Healthcare Quality Improvement Partnership (HQIP), we have extended this requirement to include participation in clinical outcome review programmes managed or commissioned by HQIP; and	Service Conditions 2.1.4, 3.4, 26.1

	national programmes included within the NHS England Quality Accounts List, where applicable to the services.	General Condition 15.5.3 Definitions
Maternity services – Ockenden Review	Following feedback from DHSC, we have amended the Contract to include a requirement for relevant providers to put in place an action plan setting out how they will implement the immediate and essential actions set out in the Ockenden Review.	Service Condition 3.13 Definitions

Low-volume flows of activity between CCGs and NHS Trusts and NHS Foundation Trusts

In late 2020 we undertook a separate consultation on potential changes to the Contract and to CCG financial allocations, to simplify how the NHS deals with paying for low-volume flows of activity (that is, typically, flows between a CCG in one part of the country and a Trust in another, which we termed Low Volume Activity or LVA).

In summary, our outline proposal was that, rather than billing and being paid by the distant CCG in such a scenario, a Trust would bill and be paid by its local “host” CCG. This would be enabled by some quite significant changes to the Contract and a new, much more directive national approach as to which CCG must sign a contract with which Trust. NHSE/I would move money between CCGs, via adjustments to allocations, to achieve a neutral financial effect. Overall, the proposal would significantly reduce the number of separate invoices being raised and the associated transactional burden.

We received 166 written responses to the consultation. Overall, there was strong support for our intention, but some significant issues were raised about practical implementation. In particular, we had proposed financial values, based on historic invoice data, to use as the basis for adjustments to CCG allocations – and a significant minority of CCGs and Trusts did not recognise these as accurate. Other concerns were raised about the appropriateness of the proposed arrangements for inpatient mental health services.

We have reviewed the consultation responses and reflected further.

- Given the national decision to “roll-over” existing CCG/Trust financial arrangements for the first part of 2021/22, it will not now be appropriate or necessary to introduce the new LVA arrangements from 1 April 2021.

- Analysis of activity data shows that the pandemic has, so far, had a larger effect in reducing LVA flows than on “local” activity. Predicting what will happen to LVA flows in 2021/22 is difficult, as we do not yet know what the longer-term changes to commuting, holiday and leisure travel patterns, and their impact on patient flows, will be. It may not be sufficiently accurate to use historic pre-pandemic data as the basis for LVA allocation adjustments for 2021/22.

- Dealing with part-year implementation would be challenging. LVA flows are highly seasonal in some parts of the country and less so in others. Any in-year LVA allocation adjustments would therefore need very precise calibration, making the exercise more complex.

- Other actions already in hand will have a significant impact on the volume of LVA invoices. CCG mergers planned for April 2021 – and the move from monthly to quarterly invoicing and reconciliation being implemented under the Contract – should reduce invoice volumes by more than 70%. The intention is that, subject to the passing and implementation of proposed legislation, the number of separate NHS commissioners should reduce radically from April 2022, with around 40 ICSs replacing CCGs – giving a further significant reduction in LVA invoices.

- Other potential impacts of the proposed legislation may also be an issue. Any devolution of commissioning responsibility from NHS England to ICSs would have a direct consequence for the LVA values, for instance. We do not want to put new LVA arrangements into place for a part-year effect in 2021/22, only to find that they are not sustainable and need radical further review for the following year.

We remain determined to avoid a return to over-burdensome invoicing and validation arrangements. So we will engage further with systems, over the coming months, to establish a workable and sustainable way of implementing a more streamlined system from the point at which the “rollover” ends and the NHS reverts to locally negotiated contractual arrangements.

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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