Classification: Official

Publication reference: 00258

NHS Standard Contract 2023/24

Technical Guidance

Version 1, March 2023

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Contents

Executive Summary ... 4
1 Introduction ... 4
2 The 2023/24 Contract ... 4
3 Changes to Contract content for 2023/24 ... 5
4 Advice and support ... 15
Section A General guidance on contracting ... 16
5 Terminology ... 16
6 Content of this section ... 17
7 When should the NHS Standard Contract be used? ... 17
8 Legally binding agreements ... 18
9 When to use the shorter-form Contract ... 19
10 What elements of the Contract can be agreed locally ... 20
11 Use of grant agreements ... 20
12 NHS Continuing Health Care and Funded Nursing Care ... 21
13 Collaborative contracting ... 22
14 Which commissioners and providers can be party to the Contract ... 23
15 Provider selection and award of contracts ... 25
16 Contract expiry and notice requirements ... 25
17 Changes in counting and coding practice ... 26
18 Contract duration ... 26
19 Extension of contracts ... 28
20 Heads of Agreement ... 29
21 Signature of contracts and variations ... 29
22 Updating non-expiring contracts ... 30
23 Resolution of disputes ... 31
24 What happens when there is no signed contract in place? ... 31
25 Low Volume Activity and Non-Contract Activity ... 32
26 Promoting collaboration and contracting for integrated services ... 37
27 Use of the Contract for call-off arrangements ... 38
28 Contracting approaches to support personalised care ... 39
29 Contracting fairly ... 40
30 Advice and support ... 41

Section B Completing and using the Contract 42
31 Content of this section 42
32 Structure of the NHS Standard Contract 42
33 Online presentation of the Contract 43
34 Service categories 44
35 Contracts for new services or with new providers 45
36 Service specifications 47
37 Commissioner Requested Services / Essential Services 51
38 Assignment, novation and sub-contracting 52
39 Quality of care 56
40 Financial sanctions and incentives 64
41 The Service Development and Improvement Plan (SDIP) 66
42 Managing activity and referrals 67
43 Information, audit and reporting requirements 79
44 Counting and coding changes 86
45 Contract management 98
46 Payment 103
47 Other contractual processes 113
48 Status of this guidance 119
49 Advice and support 119
Appendix 1 Summary guide to completing the Contract 120
Appendix 2 Supplementary definitions 133
Appendix 3 Which form of contract or agreement to use when 142

Executive Summary

1 Introduction

1.1 The NHS Standard Contract is published by NHS England, and its use is mandated for use by Integrated Care Boards (ICBs) 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, and guidance on when the shorter-form version should be used is set out in paragraph 9 below.

2 The 2023/24 Contract

2.1 The updated Contract is intended to set national terms and conditions applicable for the 2023/24 financial year. As always, if urgent issues arise during 2023/24 which require any amendment to the Contract, NHS England will consult on material changes and publish revised terms and conditions.

2.2 **Written, signed contracts must be put in place, for the full 2023/24 financial year, between commissioners and all providers (that is, with both Trusts and non-NHS providers). Every effort must be made to agree and sign contracts by no later than 31 March 2023.**

2.3 Commissioners should collaborate with each other in their contractual arrangements with providers, with multiple commissioners often signing the same single contract with a large provider. A model Collaborative Commissioning Agreement is available on the NHS Standard Contract webpage to facilitate this.

2.4 In most instances, commissioners and providers will be signing new contracts for 2023/24. Where that is the case, the updated 2023/24 version of the Contract must be used – in its final post-consultation form, as published in due course.

2.5 Not all local contracts will expire at 31 March 2023, however. Where an existing contract (awarded prior to that date) continues into 2023/24:

- the updated General Conditions and Service Conditions, once published online by NHS England in final post-consultation form, will take automatic effect from 1 April 2023, without any need for local action; but
- the commissioner and provider may need to agree a Variation, locally between them, to update aspects of the Particulars (prices and contract values, for instance).

See paragraph 22 below for further detail.

2.6 Note the following points relating to procurement and delegation.

- **Procurement.** The new NHS Provider Selection Regime, the new set of rules governing the award of contracts and sub-contracts for healthcare services by public bodies, is not expected to be in use before July 2023 – so it will not be in effect in time for the 2023/24 NHS contracting round. For contracts and sub-contracts for service delivery to commence on 1 April 2023 onwards, NHS organisations should continue to operate on the basis of existing procurement regulations and guidance.

- **Delegation.** It has been confirmed that NHS England will delegate some more of its commissioning functions (in addition to those already delegated) to ICBs with effect from 1 April 2023. In relation to services covered by NHS Standard Contracts, this will affect only secondary and some community dental services. Delegation of functions to relevant ICBs will only take effect on or after 1 April 2023, and so 2023/24 contracts for the 'to-be-delegated' services must be awarded by NHS England and not the ICB. Once delegation is confirmed, through signature of a Delegation Agreement on or after 1 April 2023, NHS England will then delegate specific functions in respect of the agreed contract to each affected ICB; this is permitted under GC12 of the NHS Standard Contract and will be effected by NHS England issuing a contractual notice to each affected ICB, as provided for in the Delegation Agreement. At the same time, NHS England will inform each affected provider of which functions it is delegating to which ICBs in respect of which services / populations. There will be no need for affected contracts to be either novated to ICBs or varied to reflect the delegation. (The one exception to the above arrangements relates to those ICBs which have already taken on commissioning of secondary and community dental services in 2022/23. These ICBs will award contracts for those dental services for 2023/24.)

2.7 The main changes proposed to the Contract for 2023/24 are summarised in section 3 below.

3 Changes to Contract content for 2023/24

3.1 We describe below the main, material changes we have made to the content of the full-length version of the Contract for 2023/24. (The tables below also identify where changes have been caried over to the shorter-form version of the Contract.)

Changes to national waiting times standards

3.2 This section sets out changes which are aimed at supporting the specific requirements on waiting times, set out in the NHS Priorities and Operational Planning Guidance for 2023/24.

Topic	Change	New Contract Reference
Maximum RTT waiting times	We have amended the maximum RTT waiting time requirement from 104 weeks in the 2022/23 Contract to • no more than 78 weeks (to be achieved from April 2023); and • no more than 65 weeks (to be achieved by 31 March 2024).	Service Conditions, Annex A (FL and SF)

Four-hour A&E waiting times	We have amended the four-hour requirement for A&E waiting times so that the threshold is set at 76% (to be achieved by March 2024), rather than 95%.	Service Conditions, Annex A (FL only)
Ambulance response times	We have amended the requirement for mean Category 2 ambulance response times to no more than 30 minutes (to be achieved across 2023/24), rather than no more than 18 minutes.	Service Conditions, Annex A (FL only)
28-day cancer faster diagnosis standard	The Contract includes a requirement for patients to wait no more than 28 days from urgent cancer referral to diagnosis, with a threshold of 75%. We have retained the requirement and the threshold but have made clear that this is to be achieved by March 2024.	Service Conditions, Annex A (FL only)

3.3 The Contract continues to contain a range of other long-established national waiting times standards, many of them derived from the NHS Constitution. The Covid-19 pandemic affected delivery of many of these standards, and post-pandemic recovery is inevitably a gradual process. In that context, note the following key points.

- Except as described above, we have not amended these national standards in the 2023/24 Contract.
- In relation to some standards, the Planning Guidance sets a target for improvement over a longer timeframe than March 2024 (six-week diagnostic waits, for example). In these cases, commissioners and providers may wish to agree objectives and/or action plans, for inclusion in their local contracts, setting out the level of improvement the provider is expected to deliver by March 2024. These local objectives should then be used for local contract management purposes.
- All providers and systems which are able to deliver any or all of the national standards relevant to their services should of course continue to do so.
- Otherwise, commissioners should take a realistic approach in managing provider performance against other national standards which have not been prioritised for immediate recovery action in the Planning Guidance.

Clinical services – new additions to reflect national priorities

3.4 This section sets out a limited number of new additions to the Contract which are aimed at promoting improvements in how clinical services are delivered for patients, in line with the latest national policy direction.

Topic	Change	New Contract Reference
Peri-operative care guidance	In accordance with the requirement stated in the Delivery plan for tackling the COVID-19 backlog of elective care, we have added a requirement for acute providers to implement, by no later than 31 March 2024, a system of early screening, risk assessment and health optimisation for all adults waiting for inpatient surgery. The	Service Condition 3.20 (FL only)

	National Perioperative Care Programme has now developed a reference guide to support this initiative.	
Outpatient services	Redesigning outpatient services to make them more patient-centred and efficient is a key priority for elective recovery. To support this, we have included a new requirement in the Contract on providers to have regard to national guidance on implementing patient-initiated follow-up.	Service Condition 10.6 (FL only)
Hospital visiting	We have included a new provision requiring relevant providers to operate a clinically appropriate policy for visits to, and accompaniment of, Service Users in hospital settings. The local policy must be no more restrictive than the position described in existing NHS guidance.	Service Condition 17.11
National Infection Prevention and Control Manual	The National Infection Prevention and Control Manual was published in September 2022. For Trusts, implementation of the Manual's requirements is mandatory by no later than 31 March 2024, and we have included a corresponding requirement in the Contract. For other providers, the requirement will be to have regard to the Manual.	Service Condition 21.1 and Definitions (FL only)
Vaccination for Covid-19	In accordance with JCVI guidance and the Green Book, specified at-risk groups will continue to be eligible for vaccination against Covid-19 during 2023/24. We have included a new requirement around contacts which a provider's staff may have, in the course of delivering outpatient or community services, with two high-risk patient groups – those who are immunosuppressed or pregnant. The requirement is that Service Users from these two groups should, wherever possible, be offered brief advice on Covid-19 vaccination, including on how to access a vaccination service.	Service Condition 21.5 and Definitions (FL only)
Reporting deaths of people with a learning disability and/or autism	The NHS England Learning from Lives and Deaths (LeDeR) programme uses information on the deaths of people with a learning disability, autism or both to conduct reviews, to identify examples of good practice and opportunities to improve services. We have added a requirement on providers to notify, via the LeDeR website, deaths of Service Users with a learning disability, autism or both. This applies to Service Users whose death occurs while an inpatient or of whose death the provider otherwise becomes aware.	Service Condition 33.1 (FL and SF)
Medical Devices Safety Officer and Medication Safety Officer	We have included a requirement for providers of relevant services to appoint a Medical Devices Safety Officer and a Medication Safety Officer. These are vital roles to promote patient safety, the importance of which has been highlighted in existing national Patient Safety Alerts.	Service Condition 33.10 (FL only)

Clinical services – areas where updated Contract wording is needed

3.5 This section sets out areas where we have updated Contract wording in relation to clinical services, in order to keep the Contract consistent with published national standards or policies.

Topic	Change	New Contract Reference
Maternity and neonatal services	We have updated the wording of the Contract in relation to maternity and neonatal services, particularly in the light of the continuing need for the NHS to respond to the recommendations of the Ockenden Review and the East Kent Report. • These two reports have highlighted the vital importance of ensuring safe staffing levels in maternity services. We have therefore added a specific requirement to the Contract for providers of maternity services to have regard to NICE guideline NG4 (*Safe midwifery staffing for maternity settings*). • We have also included a new obligation on providers to comply with the requirements on providers set out in the Perinatal Quality Surveillance Model; this is an important tool for oversight of the safety and quality of maternity services. • Updated guidance has been published on midwifery continuity of carer (MCoC). This confirms that, where an individual provider can demonstrate that it meets safe staffing requirements, it can continue to use and roll out the MCoC model – but there is no national target or expectation that every provider must deliver MCoC. On this basis, we have removed the reference to MCoC from the Contract. • The current Contract requires providers to take forward the recommendations in the Ockenden Review. We have updated that with a broader requirement to work, through the relevant Local Maternity and Neonatal System, to implement the requirements of both the Ockenden Review and the East Kent Report. (NHS England's initial response to the East Kent review commits to the publication in 2023 of a single delivery plan for maternity and neonatal care, bringing together actions required following the two reports and from the NHS Long-Term Plan and Maternity Transformation Programme deliverables. We will build a reference to this plan into the Contract in due course.)	Service Condition 3.13 (FL only)
Antibiotic usage	Since 2019, the Contract has required acute providers to make year-on-year reductions in their per-patient usage of antibiotics from the "Watch and Reserve" categories, in line with the ambition for a 10% cumulative reduction set out in the UK 5-year action plan for antimicrobial resistance 2019 to 2024. To date, the Contract requirement for annual reductions has been expressed against the 2018 baseline of actual usage. For consistency with the UK 5-year AMR National Action Plan target, we have amended the Contract wording so that the requirement is for a 10% cumulative reduction by 31 March 2024 against the 2017 baseline (instead of a 6.5% reduction against a 2018 baseline). The threat to public health posed by antimicrobial resistance is significant, and there is strong evidence that providers can substantially reduce use of antibiotics from the "Watch and Reserve" categories by switching the treatment choice to antibiotics from the "Access" category wherever possible and safely using shorter courses where "Watch" and "Reserve" drugs are unavoidable.	Service Condition 21.3 and Definitions (FL only)

Patient safety	We have updated the Contract to reflect the requirements of the new national Patient Safety Incident Response Framework (PSIRF). The updated requirements are as follows. • The national expectation is that PSIRF will be adopted over the coming year, with the exact date for local adoption being agreed between the provider and its Co-ordinating Commissioner. Until the agreed adoption date, therefore, each provider must continue to comply with the NHS Serious Incident Framework; from the agreed adoption date, it must comply with PSIRF. • In order to adopt PSIRF, each provider must agree with its Co-ordinating Commissioner a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan, as described in detail in PSIRF. These must be published on the provider's website. • Under PSIRF, each provider must ➢ engage compassionately with affected patients, carers and staff following any patient safety incident; ➢ respond in a proportionate way to such incidents, undertaking investigations where appropriate; and ➢ ensure that improvements to services are implemented following responses to incidents. Given that changes introduced under PSIRF to incident reporting and investigation, we believe that it is no longer necessary to have a specific schedule in the Contract which sets out a local procedure for the provider to report all incidents to the commissioner. We have therefore removed what was previously Schedule 6C (Incidents Requiring Reporting Procedure).	Service Condition 33.2-3 Schedule 6C (briefer content in SF)
End of life care	The 2022/23 Contract required providers to have regard to Guidance on the Care of Dying People – defined by reference to national good practice documents. We have amended this to refer to an expanded set of up-to-date guidance documents, to include: • Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026; • Universal Principles for Advance Care Planning and • this letter sent to NHS organisations in March 2023, relating specifically to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for people with a learning disability and autistic people. We have also amended the term we use in the Contract, from Guidance on the Care of Dying People to Guidance on End of Life Care.	Service Condition 34.1 and Definitions (FL and SF)
Palliative care co-ordination	We have made two updates in this area. • The Contract refers specifically to Information Standard SCCI 1580 on palliative care co-ordination. This standard is being retired shortly, to be replaced the Palliative and End of Life Care Information Standard (now published in draft form on the Professional Record Standards Body website). We have amended the Contract wording accordingly. • We have removed a reference requiring compliance with a specific guidance document relating to the implementation of electronic palliative care co-ordination systems	Service Condition 34.1 and Definitions (FL and SF)

	(EPACCS). Note however that implementation of EPACCS continues to be encouraged as part of the general move to shared electronic records, as set out for instance in Palliative and End of Life Care Statutory Guidance for Integrated Care Boards.	

Workforce

3.6 This section sets out changes relating to workforce and staffing issues.

Topic	**Change**	**New Contract Reference**
Workforce Race and Disability Equality Standards	The Contract currently requires i) all providers to comply with the Workforce Race Equality Standard and ii) Trusts to comply with the Workforce Disability Equality Standard, in each case reporting to the commissioner annually on compliance. We have reflected that this "comply with" language is not quite suitable for these two standards, where the focus is on the provider improving its overall position against the indicators in the round. We have therefore amended the wording, so that there is instead a focus on improvement (through development of provider action plans to improve performance against the Standards) and on transparency (through publication on provider websites of Board-approved annual performance reports and action plans). But we emphasise that improving performance against WRES and WDES metrics will assist any provider in complying with its obligations under the Equality Act 2010. Existing reporting requirements (both nationally in accordance with national data collections and locally to the commissioner) remain in place.	Service Condition 13.6 and 13.8 (FL only)
Professional Nurse Advocate role	The Contract has for some time included requirements relating to clinical supervision for midwives, using a system of Professional Midwifery Advocates under the A-EQUIP model. Following successful national roll-out, we have now introduced equivalent requirements relating to clinical supervision for nurses through Professional Nurse Advocates.	General Condition 5.5 (FL only)
Workforce planning	The 2022/23 Contract required providers to co-operate with Local Education Training Boards (LETBs) and with Health Education England (HEE) in relation to the provision of education and training for healthcare workers. For 2023/24, we have amended the wording a) to add a requirement to co-operate in relation to healthcare workforce planning and b) to delete the references to LETBs and HEE and replace them with references to NHS England, local ICBs and local Trusts.	General Condition 5.7 (FL and SF)
Staff health and wellbeing	Reflecting the intention behind the NHS Health and Wellbeing Framework, we have included additional requirements in the Contract relating to staff health and wellbeing. • We have added a general requirement on providers to promote staff health and wellbeing. Providers are required to ensure that the issue is addressed in staff appraisals (through "wellbeing conversations") and that staff are made aware of any support services available and are enabled to access those services where needed.	General Condition 5.9 (FL only)

	• Each Trust is now required to appoint a board-level Wellbeing Guardian.	
Freedom to Speak Up	We have updated the Contract to refer to the new national Freedom to Speak Up policy and guidance, removing the now out-of-date reference to the former "Raising Concerns" policy.	General Condition 5.10 (FL and SF)

Procurement of medicines and devices

3.7 This section sets out changes relating to the procurement of medicines and high-cost devices.

Topic	**Change**	**New Contract Reference**
Procurement of medicines via national frameworks	As a way of ensuring best value, the Contract has for many years included a provision which allows the commissioner, on notice, to require the provider to purchase a particular high-cost drug or device from a specific supplier or framework. Where the provider does not comply, it is not entitled to payment for the drug / device. The provision applies to Trusts only. More national frameworks are now being put in place for the purchase of medicines, and full use of these by Trusts will maximise value for public money. We have therefore updated the Contract wording, so that – where a particular medicine is available via a national framework – a Trust must purchase that medicine through that framework. This is subject to the caveats that: • the product available via the framework must be clinically appropriate for the patient in question; • the clinically appropriate product must be available at the time the purchase needs to be made; if it is not, then purchase by another route is permissible; and • a Trust may first use up any existing stock of the same or a similar product purchased through other means. Trusts can access details of current national frameworks here (note that Patient Access Schemes are not currently in scope of the Contract provision). We have also included a new requirement for accountability – so that any Trust which breaches its contractual duty to use national frameworks must, on request, provide a written statement to its commissioner, to its public board and/or to NHS England, explaining its purchasing decision and what it will do to ensure compliance with the contractual requirement in future. NHS England's Commercial Medicines Directorate will shortly circulate FAQs relating to the detailed operation of the Frameworks.	Service Condition 39.2-4 (FL only)
Procurement of high-cost devices used in specialised services	The existing provision described above has been used routinely by NHS England in relation to high-cost devices used in specialised services. We have now separated this from the provision relating to procurement of medicines and amended it so that, where a high-cost device required in the provision of specialised services is available for purchase via NHS Supply Chain, the provider must purchase it via that route.	Service Condition 39.5 (FL only)

	FAQs on NHS England's Specialised Services Devices Programme are available here on FutureNHS and may be helpful for providers.	

Greener NHS and healthcare food and drink standards

3.8 This section sets out changes relating to the "greener NHS" agenda and to the provision of food and drink in healthcare settings.

Topic	**Change**	**New Contract Reference**
Desflurane	The Contract includes a revised requirement, for 2023/24, for providers to reduce the proportion of desflurane to all volatile gases used in surgery to 2% or less by volume. Since the draft Contract was published, NHS England has committed, with the support of the Royal College of Anaesthetists and the Association of Anaesthetists, to the more ambitious goal of decommissioning desflurane by early 2024. We have therefore clarified in the final Contract that the "2% or less" requirement is to be delivered across 2023/24 as a whole, and we have added a reference to the expectation that use of desflurane will be eliminated, broadly, by 31 March 2024. NHS England and the Royal College of Anaesthetists / Association of Anaesthetists will publish further guidance in due course setting out what exceptions, if any, will apply in terms of where desflurane can continue to be used from 1 April 2024 onwards.	Service Condition 18.3 (FL only)
Piped nitrous oxide	The 2022/23 Contract required providers to reduce the carbon impact of the use or release of nitrous oxide. A significant proportion of nitrous oxide emissions is caused by waste from manifolds and the associated piped infrastructure. We have amended the Contract to include a specific requirement to reduce piped nitrous oxide waste.	Service Condition 18.3 (FL only)
Electricity supplies	The 2022/23 Contract required Trusts to ensure that they source their electricity from certified renewable sources. Given the increased cost of renewable electricity, we have amended this requirement so that it applies only as far as reasonably feasible.	Service Condition 18.4 (FL only)
NHS Net Zero Supplier Roadmap	We added a requirement to the 2022/23 Contract, on Trusts, to comply with Cabinet Office guidance, Taking Account of Public Value. This meant that all Trust procurements needed to include a minimum 10% net zero and social value weighting. We now propose to broaden this duty, so that Trusts have to comply with the requirements of the NHS Net Zero Supplier Roadmap. In addition to the 10% weighting requirement, one key effect will be that, for 2023/24 onwards, for all contracts with an annual value of above £5 million, Trusts must require suppliers to publish a carbon reduction plan. Further detailed guidance on carbon reduction plan requirements has now been published.	Service Condition 18.5 (FL only)
National standards for healthcare food and drink	The 2022/23 Contract contained detailed provisions relating to the provision of food and drink to patients, visitors and staff. NHS England has now published new comprehensive national standards for healthcare food and drink. As a result, we have shortened the Contract wording, so that it simply requires providers to comply with the new standards as applicable ("as applicable" because a small number of the standards apply only to Trusts, not to non-NHS providers).	Service Condition 19 (FL only)

Payment and reporting

3.9 This section sets out changes to the arrangements set out in the Contract for payment, invoicing and financial reconciliation and reporting requirements.

Topic	Change	New Contract Reference
Withholding of payment / financial sanctions	For many years, the Contract included financial sanctions on providers for failure to achieve national waiting times standards. These were first suspended and then, in 2021, removed from the Contract altogether. With the 2022 Act now in place, requiring ICBs and Trusts to work to shared system-level financial objectives, we have further reviewed the remaining provisions in the Contract which involve application of financial sanctions or withholding of payment. We have now made further changes as follows. We have removed the detailed provisions which require commissioners to withhold payment i) for acute outpatient attendances made following acceptance of a GP referral not made via the NHS e-Referral Service (e-RS) and ii) for activity undertaken in breach of national Evidence Based Interventions (EBI) guidance. • Use of e-RS in the acute sector is very high, backed by a contractual requirement on GPs to use it; a specific financial incentive on acute providers is no longer needed. • The idea of financial transactions at a very granular, individual procedure level, is not consistent with the greater emphasis on fixed payments now built into the Aligned Payment and Incentive rules for Trusts. We have also removed the financial sanctions which apply to providers in relation to delays in undertaking Care Education and Treatment Reviews (CETRs). The Contract continues to require use of e-RS, compliance with EBI guidance and timely support to the CETR process. The point of the changes is simply to remove the very transactional "withholding of payment" / financial sanction element in each case. Financial incentives for Trusts to follow EBI guidance will instead be built into the API rules, and commissioners can of course use the processes at GC9 to manage provider performance in relation to any of these issues.	Service Conditions 6.3, 6.11-12 and 29.31 (FL only)
Reporting requirements	Following review, we have removed two requirements for providers to provide reports or data on specific issues to their local commissioners. These are: • the annual report on their success in reducing antibiotic usage (this is no longer required because performance data for each Trust is published separately on the national Fingertips database); and • the requirement to submit data on violence-related injuries in accordance with ISB1594 (it has been announced that compliance with this separate dataset will no longer be compulsory from 1 July 2023, with data instead being collected via the Emergency Care Data Set).	Service Condition 21.3 and Schedule 6A (FL only)
NHS Payment Scheme	Under the 2022 Act, NHS rules on the payment of providers are now referred to as the NHS Payment Scheme (NHSPS), rather than the National Tariff Payment System. NHS England has been	Service Condition 36, Schedules 3A-

	consulting on the NHSPS 2023/25 (the final version of which will be published shortly), and we have made changes in the Contract to give effect to the new Scheme. These should be read in conjunction with the NHSPS. As a result of these changes, we have been able to shorten SC36 considerably. We have also amended the order and content of the various related schedules. Under the NHS Payment Scheme 2023/25, the Aligned Payment and Incentive (API) rules (which include CQUIN) will now apply to all Trust contracts. Neither API nor CQUIN feature in the shorter-form version of the Contract, and including them would make that version longer and more complex. In consequence, therefore, our Contract Technical Guidance now makes clear that the shorter-form version of the Contract should not generally be used for Trusts; there are limited exceptions to this – see paragraph 9 below.	F and Definitions (FL and SF)
Charging of overseas visitors	There have been arrangements in place for many years for financial risk-sharing between commissioners and providers in relation to NHS charges levied on overseas visitors. These have been described in guidance (Improving Systems for Cost Recovery for Overseas Visitors) and given effect through wording in the Contract. These risk-sharing arrangements have required complex transactions at individual patient level between commissioners and providers and they have therefore been discontinued for 2023/24. They are being replaced with broadly equivalent, but much less burdensome arrangements under the Aligned Payment and Incentive rules within the NHS Payment Scheme. Further details are set out in paragraphs 96-99 of the Revenue finance and contracting guidance for 2023/24. We have simplified the Contract text as a result, and an updated version of Improving Systems for Cost Recovery for Overseas Visitors will be published separately.	Service Condition 36.26 (FL and SF)
Deadlines for contesting invoices and reconciliation accounts	Where a commissioner wishes to contest any element of payment in a provider's invoice or reconciliation account, the Contract requires that it must do so within five working days of receipt of that invoice or account. We have been made aware of (rare) instances where, because the provider submits its invoice or account very early, the Contract timescale means that the commissioner has to decide whether to contest any element of payment before it is able to view, in SUS, the provider's activity data for the relevant period. That is clearly inappropriate – and we have therefore amended the Contract wording, so that the five-day period for contesting payment runs from either receipt of the invoice / account or publication in SUS of the relevant period's activity data, whichever is the later.	Service Condition 36.21-22 and 36.31 (FL only)

4 Advice and support

Queries and updates

4.1 The NHS Standard Contract Team provides a helpdesk service for email queries. Please contact england.contractshelp@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.

Model grant agreement and model sub-contract

4.3 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 and associated guidance are available at on the NHS Grant agreement web page. See also paragraph 11 below.

4.4 Model sub-contracts suitable for use with the full-length Contract and with the shorter-form Contract are available on the NHS Standard Contract 2023/24 webpage. See also paragraph 38 below.

Model System Collaboration and Financial Management Agreement

4.5 For some years, we have published a model System Collaboration and Financial Management Agreement (SCFMA). This is a framework document which an ICB and its local partner Trusts can choose to use locally, to set out how they will work together to manage NHS system finances and manage in-year financial risks.

4.6 We recognise that alternative governance arrangements will often now have been put in place at local level (ICB sub-committees, for example, or joint committees with Trusts) through which the aspirations set out in the model SCFMA can be delivered. Use of the SCFMA is therefore not mandatory, but – in response to engagement feedback – we are continuing to publish it, on the NHS Standard Contract 2023/24 webpage, for use where local systems wish to adopt it, or to draw on it for their own locally-developed arrangements.

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 set out a brief guide to the commonly used terms below.

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.

6 Content of this section

6.1 This section of the Technical Guidance offers broad advice about general contracting issues. For 2023/24, we have re-ordered it to create a more logical flow.

- Paragraphs 7-14 deal with the NHS Standard Contract itself – when it should be used, its legal status, the elements which are for local completion, who can be party to it, and the distinction between the full-length and shorter-form versions. They also address collaborative contracting arrangements and alternatives to contracts such as grant agreements.

- Paragraphs 15-20 cover provider selection and the award of contracts. They describe the communications which will be needed in advance of contract expiry and explain what is possible in terms of contract duration and extension.

- Paragraphs 21-25 deal with contract signature, set out what happens when a contract is not signed and describe the arrangements for dispute resolution and "non-contract activity".

- Paragraphs 26-30 describe potential models for contracting for integrated services and for personalised care and offer brief advice on using the Contract to operate call-off arrangements under frameworks. They conclude with some pointers on contracting fairly and provide links to national helpdesks providing advice on contract-related issues.

6.2 We have also provided, at Appendix 3, some example scenarios illustrating which form of contract, sub-contract or other agreement should be used in different situations.

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. It also allows NHS England, by inclusion of specific requirements on local bodies, to promote implementation at local level of key national clinical and service priorities.

7.2 By its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended), NHS England mandates that the NHS Standard Contract must be used by ICBs and by NHS England when commissioning NHS-funded healthcare services. This mandate continues to apply, and must be complied with, notwithstanding the establishment of ICBs and the general move towards system working and system accountability.

7.3 In determining what are "healthcare services", a useful point of reference will be whether registration with the Care Quality Commission (CQC) is required in order for an organisation to be permitted to provide them. The CQC publishes scope of registration guidance on this. "Healthcare services" include acute, ambulance,

continuing healthcare, community-based, high-secure, mental health and learning disability services.

7.4 Note that the CQC's guidance includes a specific section on transport services, which makes clear that registration is required only for "transport (ambulance) services for the primary purpose of carrying a person who requires treatment". Where a package of services being commissioned includes transport services within scope of CQC registration, therefore, the NHS Standard Contract must be used. By contrast, a package of transport services outside the scope of registration should not be commissioned using the NHS Standard Contract.

7.5 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.

7.6 The only exceptions are:

- primary care services commissioned by NHS England (or by ICBs 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; and
- any primary care improvement schemes agreed by ICBs with GP practices (with contractual arrangements, involving a variation or supplement to existing general practice contract, agreed between local NHS England teams and ICBs). 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.

7.7 ICBs 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 ICB is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements.

7.8 The NHS Standard Contract must not be used by provider organisations when contracting with other provider organisations for the provision of clinical services. It is not designed for that purpose and is not fit for that purpose. 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 Legally binding agreements

8.1 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.

9 When to use the shorter-form Contract

9.1 The shorter-form Contract must not be used for contracts under which acute, cancer, NHS111, A&E, Urgent Treatment Centres 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 version of the Contract must not be used where the Aligned Payment and Incentive (API) rules under the NHS Payment Scheme apply. Given that the API rules now apply to virtually all contracts with Trusts, this now means in practice that the shorter-form version of the Contract should generally not be used for Trusts, only for non-NHS providers. However, the final 2023/25 NHS Payment Scheme will create a new exception to the API rules, covering a situation where "the service provided is a single non-acute service procured by an ICB from an NHS provider". This will allow some flexibility for commissioners to award shorter-form Contracts, on the basis of locally agreed prices, to Trusts as well as to non-NHS providers. This may be appropriate for instance, where an ICB wishes to arrange a small community-based service on an "any qualified provider" basis.

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 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.

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 national terms of the Contract. In the event of any such conflict or inconsistency, the national terms of the Contract will apply. GC1 makes clear that provisions in the General and Service Conditions will take precedence over the content of the Particulars – so any attempt to override the national terms will be ineffective.

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 ICBs 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 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.

12.2 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.

12.3 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 3C (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 3C 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.

12.4 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.

12.5 Further information is available on CHC in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care and on FNC in NHS-funded Nursing Care Practice Guidance.

12.6 DHSC has published Hospital Discharge and Community Support Guidance, which came into effect on 1 April 2022. It states that local areas should adopt discharge processes that best meet the needs of the local population. In situations where short-term residential care placements are to be provided in order for requirements for longer-term care to be properly assessed, and where these placements are to be funded in whole or in part by the NHS, they should be commissioned using the NHS Standard Contract.

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. Collaborative commissioning between ICBs remains an important tool, as it was between CCGs.

13.3 The "footprint" for collaborative arrangements is for local agreement – but it makes sense for it to be as wide as possible, ideally including all of the commissioners who will need to have a written, signed contract with that provider, rather than falling within the new Low Volume Activity arrangements for Trusts or traditional non-contract activity arrangements for other providers (see paragraph 25 below).

13.4 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.

13.5 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).

13.6 Updated model CCAs are available on the NHS Standard Contract web page.

13.7 One specific addition to the model CCAs should be highlighted. Certain management actions under the Contract fall to the co-ordinating commissioner to take, rather than to each individual commissioner; these are known as "Co-ordinating Commissioner Actions". It is important that each individual commissioner has confidence that the co-ordinating commissioner will take appropriate action on its behalf. In general, this should not be an issue – multiple ICBs commissioning the same services from a provider will all have the same interest in seeing performance issues with those services addressed, for example. But there may be instances (for instance in a joint contract signed between NHS England and ICBs) where an individual commissioner wants the co-ordinating commissioner to take action in respect of a service or population for which only that commissioner has responsibility. We have therefore added provisions to the model CCA at paragraph 7, making clear that, in the circumstances described above,

- a commissioner may request that the co-ordinating commissioner undertake a specific Co-ordinating Commissioner Action; and

- the co-ordinating commissioner must not unreasonably refuse to take such action.

13.8 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 – as 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 ICBs 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 provider 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 ICB that he or she has the wherewithal to deliver the contract in accordance with its terms.

14.6 Some non-NHS providers have complex structures involving parent companies and subsidiaries / group companies. Commissioners must ensure that the contract they sign states the correct legal entity as the provider. This will be established through the process through which the provider is selected and the contract is awarded. The organisation selected through that process will be the provider named in the contract awarded and the contract must be signed by an authorised signatory of that organisation.

14.7 Providers may wish to operate an arrangement whereby the contract is held in the name of a parent company, but the services are in practice delivered by a subsidiary or other group company. In that case, the requirements of GC12 in relation to sub-contracting must be followed – with the provider requesting approval from the commissioner for the proposed sub-contracting arrangement

and then, if that proposal is approved, putting in place a sub-contract between the provider company and the subsidiary / group company.

15 Provider selection and award of contracts

15.1 The new NHS Provider Selection Regime, the proposed new set of rules governing the commissioning and sub-contracting of healthcare services, will not be in effect in time for the 2023/24 NHS contracting round. For contracts and sub-contracts for service delivery to commence on 1 April 2023 or early in the 2023/24 financial year, NHS organisations should continue to operate on the basis of existing procurement regime – that is, the Public Contracts Regulations 2015 and the Procurement, Patient Choice and Competition Regulations 2013.

15.2 Note that, wherever more than one provider is a potential provider of a service, so that a process for selection of the provider to which the contract for that service is to be awarded has to be undertaken (currently under the "light touch" regime under the Public Contracts Regulations), the same form of contract must be offered to all potential providers, regardless of type. (The new Provider Selection Regime may provide more flexibility in this regard: guidance will be issued in due course.)

15.3 Similarly, where there are to be multiple providers of the same service, appointed through an "any qualified provider" regime, the same form of contract must be awarded to all qualifying providers, regardless of type.

16 Contract expiry and notice requirements

16.1 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 a specific service in the following year. 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 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 tends to be 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.

17 Changes in counting and coding practice

17.1 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.

18 Contract duration

18.1 The NHS Standard Contract allows the commissioner to select the contract term it wishes. There is no default duration.

18.2 In principle, 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.

18.3 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.

18.4 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.

18.5 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 (in addition to rights to terminate when a party is in default), 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).

18.6 Where a multi-year contract is in place, both commissioner and provider are able to propose variations to the local terms (for example to effect annual reviews of local prices, service specifications and local quality requirements). In respect of the updating of the national terms, see section 19 below.

19 Extension of contracts

19.1 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 or up to two years.

19.2 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.

19.3 It is essential that this provision is not misused. The guidance below is designed to reduce the risk of challenges for breach of current procurement rules. (We will update the guidance once final details of the proposed Provider Selection Regime (and its impact on contracts awarded under the current rules) are published.)

- 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, up to two years, but that means once, for any period of 2 years or less, not for one year then for another year).

19.4 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).

20 Heads of Agreement

20.1 We are sometimes asked about Heads of Agreement and whether these have a place in the negotiation of new contracts.

20.2 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 (which is why they generally include the caveat "Subject to Contract"). 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.

21 Signature of contracts and variations

21.1 A contract must be signed by an appropriately authorised signatory of each party to it. Where a group of commissioners wishes to enter into a contract with a provider, each of the commissioners must sign the contract and cannot delegate this responsibility to another commissioning body. By "signed" we mean (i) signed physically, in hard copy form, or (ii) subject to our further guidance below, signed electronically.

21.2 We have previously recommended that contracts (and other contractual documents) are signed physically, in hard copy form, by the authorised signatory of each party, unless the parties have taken legal advice on appropriate governance arrangements and on the risks involved (but see our updated guidance below). As set out in GC38, hard copy signatures can be applied to original and counterpart copies of the relevant document 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.

21.3 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.

21.4 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, and this practice has become much more widespread both as a necessary consequence of the Covid-19 pandemic and as a result of the Lord Chancellor's confirmation of the

Government's agreement with the Law Commission's report on Electronic Execution of Documents in March 2020. We continue to 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 and having consulted their own organisation's guidance and governance documents on the use and acceptance of electronic signatures.

21.5 Here are some general pointers on use and acceptance of electronic signatures in relation to the contracts, sub-contracts and variations which are the subject of this Technical Guidance. They should not be taken as a substitute for parties taking their own legal advice and consulting their own organisation's guidance and governance documents, nor as being applicable to all legal documents.

- An electronic signature is capable in law of being used to sign a document provided that: (i) all parties to the document intend that that electronic signature will authenticate the document on the relevant party's behalf; and (ii) any formalities (eg governance requirements) relating to the signing of that document by that party are satisfied. If these conditions are met, the document will be deemed signed just as it would if signed by hand in ink.

- Generally, only the following forms of electronic signature should be considered as 'safe': (i) the use of electronic signature software platforms, and (ii) uploading scanned photos of signatures.

- Security measures can help to provide evidence as to who exactly signed the document and when. Such security measures can include the signatory signing the document from their own account or a computer that they had to use a personal password, pin or encryption key to access. Electronic signature platforms can also give further evidence as to IP addresses and the time and date of signature.

- Documents may be signed electronically by a delegate of the authorised signatory, but only if the authorised signatory has given the delegated person the authority to do so. It is advisable to have an audit trail of confirmation of this delegated authority.

- A combination of wet signatures and electronic signatures can be used by different parties on signing. If the document is signed electronically by both parties, it is not necessary to keep a hard copy. Documents can be electronically signed in counterpart or the same document can be signed electronically by all parties.

22 Updating non-expiring contracts

22.1 Where a multi-year contract is in place and continues into a new financial year, the updated General Conditions and Service Conditions, once published online by NHS England in final post-consultation form, will take automatic effect from 1 April of the new financial year, without any need for local action. (Further detail about these online publication arrangements can be found in paragraph 33 below.)

22.2 In this situation, the commissioner and provider are very likely to need to agree a Variation locally between them to update aspects of the Particulars (prices and contract values, for instance). A Variation will also be helpful to reflect the changes we have had to make to the numbering of Schedules 3 and 6 in the 2023/24 Contract. We have therefore provided a model Variation template and guidance for 2023/24, offering two options for updating multi-year contracts.

- The first allows for a full set of Particulars to be updated in the re-numbered 2023/24 format, attached to the Variation Agreement and exchanged. This will automatically update the numbering of Schedules 3 and 6 and will be appropriate where there are changes to the local content of large number of the Schedules.

- The second updates the numbering of Schedules 3 and 6 and allows the inclusion and exchange of updated payment Schedules (and other updated Schedules as appropriate). This simpler option will be appropriate where most Schedules can be left unchanged from 2022/23 to 2023/24, but the parties need to update a small number of Schedules (payment, the Indicative Activity Plan or SDIPs, for example).

23 Resolution of disputes

23.1 Arrangements for resolution of disputes which arise once a contract has been agreed are dealt with under GC14.

23.2 In terms of the agreement of new contracts for 2023/24, the Revenue finance and contracting guidance for 2023/24 states (paragraph 106) that:

"System working is now well established and so NHS England does not propose to put in place a formal process for arbitration between commissioners and trusts where they cannot agree a contract by 31 March 2023. Rather, there will be a reliance on local NHS leaders to work together to ensure issues relating to contract agreement are resolved locally, collegiately, and in a timely manner. NHS England regional teams will track local progress and will help systems to resolve issues where necessary."

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 Low Volume Activity and Non-Contract Activity

25.1 Low-Volume Activity (LVA) and Non-Contract Activity (NCA) are terms 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.

Low Volume Activity arrangements

25.2 LVA arrangements apply to certain relationships between ICBs and NHS Trusts / NHS Foundation Trusts. Full detail is set out separately in the 2023/25 NHS Payment Scheme.

Non-Contract Activity arrangements

25.3 NCA arrangements will operate as described in the remainder of this section 25. They will be relevant for flows of activity between ICBs and non-NHS provider organisations where no written contract is in place, as well as for a small number of ICB / Trust activity flows specifically excluded from the LVA arrangements.

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 25.5b) 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 unit prices (where these apply and subject to any locally agreed adjustments) or (where there are no applicable unit prices listed in the NHS Payment Scheme) 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 unit 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 NHS Payment Scheme guidance;

c) arrangements for submission of activity datasets, invoicing and payment reconciliation should follow NHS Payment Scheme guidance and the terms and conditions set out in the NHS Standard Contract; this means in practice that non-NHS providers must invoice for NCA monthly in accordance with either SC36.22 or SC36.23 (full-length Contract) or SC36.16 (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 SC36.31 (full-length) and SC36.22 (shorter-form);

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; and

f) while a commissioner dealing with a provider on an NCA basis may take some comfort from the fact that that provider's host commissioner should be holding that provider to account under the terms of the host's contract, it should always remember that it is not the host's role to monitor the performance of services under the NCA commissioner's implied contract. That is an entirely separate contract, which is for the NCA commissioner to monitor and manage, using the provisions of GC9, SC28 and so on, as necessary.

From a public value-for-money perspective, it is very important that, where a commissioner receives an invoice for the first time from a provider with which it does not have a written contract, it checks the basis on which that invoice is being submitted before making any payment in respect of that invoice, rather than simply paying it without question. Checking that the provider does indeed hold an NHS Standard Contract with another commissioner, which properly entitles it to provide those specific services to the first commissioner's patients, at the location at which they have been provided, and on an NCA basis, will be a necessary first step. A provider wishing to provide services on an NCA basis must, on request, share with the NCA commissioner full details of the written, signed contract / contracts it holds with another commissioner / other commissioners and on which it is relying in order to undertake NCA.

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 non-NHS provider which is geographically distant from the commissioner.

25.8 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

25.9 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.

25.10 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 e-RS – see paragraph 42.19 below.)

25.11 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.

25.12 These provisions continue to apply to Trusts operating under the LVA arrangements described in paragraphs 25.2 above, as well as to non-NHS providers, and 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). It is therefore not acceptable (and is a breach of contract) for a provider, with or without the support of its main local commissioners, to adopt a systematic policy of rejecting "choice" referrals or emergency presentations from distant ICBs (including those operating on an NCA or LVA basis), whilst continuing to accept those from within its local area.

25.13 Conversely, we also set out clearly (SC6.13 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. (See paragraph 25.17 below for further detail on the application of the legal right of choice.)

Commissioner prior approval for NCA activity

25.14 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.

Under the LVA arrangements for Trusts, described in paragraphs 25.2 above, there is no requirement to seek prior authorisation.

25.15 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.

25.16 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

- where a provider is operating on an NCA basis, under an implied contract with a particular ICB, that ICB may notify it of its own specific Prior Approval Schemes, and the provider must then comply with them; but the ICB cannot expect the provider to be aware of its Prior Approval Schemes without having notified it of them; 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

25.17 Some respondents to our recent consultation on the 2023/24 Contract asked for our Contract Technical Guidance to provide greater clarity in relation to patients' rights to be offered a choice of provider for their first outpatient appointment with a consultant or a member of a consultant's team. Our Guidance must not in any way conflict with or contradict regulations and guidance specific to patient choice – and so, in revising this section of the Guidance, we have limited it so that it

- clarifies specific points in relation to provisions of the Contract which are relevant to the operation of patient choice; and

- signposts the regulations and guidance on the operation of patient choice.

25.18 Patient choice is currently underpinned by two separate sets of regulations. These are

- the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the Standing Rules"); and

- the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 ("the PPCCRs").

25.19 The provisions of Part 8 of the Standing Rules are relevant where choice is to apply on the basis of "non-contract activity" arrangements as set out in the earlier parts of this paragraph 25.

- Commissioners (ICBs and NHS England) must ensure that when a GP, dentist or optometrist makes an elective referral for a first outpatient appointment to a service led (for physical health) by a consultant or (for mental health) by a consultant or other health care professional, the patient can choose from any clinically appropriate health service provider which has a contract with a commissioner for the particular service required. The judgement on the clinical appropriateness of the referral is for the referring clinician to make.

- The Contract therefore includes provisions at SC6.8 which require that providers must accept all referrals / presentations which give effect to a patient's legal right of choice (or which are for emergency treatment) – even where the patient's responsible commissioner is not a direct party to the provider's contract. SC6.13 then makes clear that, in other circumstances, a provider has no entitlement to be paid for providing services to patients whose responsible commissioner is not a party to the contract.

- For the legal right of choice to apply to a particular service under the Standing Rules, the provider must have been commissioned to provide that service by at least one ICB. But this legal right of choice only applies to the service as commissioned – that is, on the basis specified in the provider's contract with the first ICB. So if the provider has a contract for service X to be provided in location A, that of itself does not allow that provider, on a non-contract activity basis, to open a new facility and offer service X in location B, a hundred miles away. Neither does it of itself allow that provider, on a non-contract activity basis, to offer service Y in location A or in location B. SC6.13 makes this explicit. (See paragraph 36.5 below for advice on recording service delivery locations within specifications.)

25.20 The PPCCRs create different, additional obligations on commissioners in relation to patient choice and the qualification of providers that can be considered a choice for patients when the constitutional rights to choice apply. For further information on the qualification of providers, please see Section 4 of the Substantive guidance on the Procurement, Patient Choice and Competition Regulations which provides

guidance to commissioners on how to establish and apply qualification criteria. Enquiries on the operation of patient choice and the relevant regulations can be sent to england.choice@nhs.net.

25.21 The continued operation of patient choice will be central to the recovery of NHS elective services from the pandemic, with the independent sector playing a key role. It is therefore essential that commissioners continue to comply in full and in a timely manner with their obligations under the PPCCRs and the Standing Rules. It is intended that the patient choice provisions in the Standing Rules will be amended, and new guidance will be issued. In the interim, the existing choice regulations will continue to have effect.

26 Promoting collaboration and contracting for integrated services

26.1 The principle that different providers should collaborate more closely with each other, providing their services in an integrated way to best meet the needs of patients, has been a key driver in the move towards NHS system working over several years – and new statutory arrangements have now of course been established by the Health and Care Act 2022. Separate guidance has been provided to the NHS about the development and governance of new system-level working arrangements. Contractual models for driving better integration of services continue to have relevance, though, and this section describes some of the available approaches. (Note that the proposed use of complex or novel contractual models for integration may trigger a requirement to undergo an NHS England assurance process.)

Contracting for integrated primary and secondary care

26.2 If a commissioner wishes to place a contract for integrated secondary and primary medical care services, it may 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. A template form of those further provisions, for inclusion in Schedule 2L where appropriate, is available on the NHS Standard Contract 2023/24 webpage, along with guidance about their use.

26.3 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 under a single contract.

Lead provider and alliancing models

26.4 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 8.3 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.

26.5 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 now published on FutureNHS 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 discuss an alliancing approach, please contact us via england.contractsengagement@nhs.net.

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. One way of doing this is where 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 3C. 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. A model IPA is available on the NHS Standard Contract web page.

27.2 The *Increasing Capacity Framework*, established by NHS England for a range of elective services, works a little differently and provides for either NHS Standard Contracts to be awarded by ICBs or NHS England, or for sub-contracts to be awarded by Trusts, to providers which have entered into a Framework Agreement with NHS England. Further details are available on the Increasing Capacity Framework web site and from increasingcapacityframework@nhs.net.

27.3 We strongly recommend that commissioners take legal advice if considering their own 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 published a detailed programme for the development of more personalised approaches (Universal Personalised Care: Implementing the Comprehensive Model).

28.2 The Contract 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. Updated advice on completion of the schedule is included in the Particulars.

Personal health budgets

28.3 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:

- adults eligible for NHS Continuing Healthcare and children / young people eligible for continuing care;
- people eligible for NHS wheelchair services; 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.

28.4 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 and support 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 PHB 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 independent of the commissioner, (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 PHB, 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 and support 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 and support plan, which is an agreement between the ICB 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.

28.5 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 procurement of goods and non-clinical services.

28.6 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 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. A key aim of the Health and Care Act 2022 is to promote local partnership working, and NHS England has published guidance for ICBs on governance and working arrangements.

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 is 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 model System Collaboration and Financial Management Agreement – see paragraphs 4.5-6 above.)

30 Advice and support

30.1 If you have questions about this Guidance or the operation of the NHS Standard Contract in general, please contact england.contractshelp@nhs.net.

30.2 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.

30.3 We have a page on the FutureNHS platform, where we post slides packs from, and recordings of, different webinars we have run on contracting topics. See https://future.nhs.uk/NHS_Standard_Contract.

30.4 Other useful contacts are set out below.

- Queries relating to *Who Pays?* can be sent to england.responsiblecommissioner@nhs.net
- Queries about the NHS Payment Scheme can be sent to pricing@england.nhs.uk
- Queries relating to CQUIN can be sent to e.cquin@nhs.net
- Queries about the NHS terms and conditions for the procurement of goods and non-clinical services can be sent to england.commercialqueries@nhs.net
- Queries on patient choice can be sent to england.choice@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 2022/23. Please refer also to Appendix 1, 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.

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 Service Conditions.** This section contains the generic, system-wide clauses which relate to the delivery of services. Some of these apply only to particular services. The column in the right-hand margin identifies which clauses apply to which service categories; clauses which are not relevant in a particular contract should be "read over" (see paragraph 34 below).

- **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.

33 Online presentation of the Contract

The same arrangements for online presentation apply to the ***shorter-form Contract*** *as to the full-length version, as set out below.*

33.1 The General Conditions and Service Conditions of the Contract no longer need to be exchanged between the local parties as part of their local agreement. Rather, the GCs and SCs will apply to local contracts in their up-to-date online form, as published by NHS England from time to time. Under the wording set out on page 7 of the Particulars, they are incorporated into, and apply automatically as part of, each local contract by reference only. The only element of the Contract to be exchanged between the parties locally is the Particulars, which set out the locally agreed elements.

33.2 There is thus no longer any requirement for the previous process for National Variations, through which the parties to a contract would update it when directed by NHS England to do so to introduce changes made periodically by NHS England to the national provisions. Instead, any changes published by NHS England to the GCs and SCs will apply automatically from the date of publication (or whatever later implementation date may be specified in the wording of the relevant GC/SC). If a provider no longer wishes to provide services on the basis of the updated national terms, it will continue to have the option to terminate its contract, on notice, on a “no fault” basis under GC17.

33.3 The points below should be noted in relation to the arrangements for online presentation.

- The existing “order of precedence” within the Contract remains unchanged. As set out in GC1, the GCs take precedence over the SCs which in turn take precedence over the local content in the Particulars. So it is not possible for local parties to set aside or depart from the national provisions of the GCs and SCs by seeking to agree alternative wording in the Particulars, and any attempt to do so will be invalid.

- NHS England will continue to consult formally on any proposed material changes to the Contract. No material changes will be made without input from stakeholders, and no changes will be introduced without prior notice. We envisage that the process for consultation and updating the Contract will remain annual, other than where there is an urgent need for an in-year change, as has been the case since 2013. There is no intention that the content of the Contract will become subject to rolling in-year updates.

- We will continue to publicise proposed changes in advance, on our website, through national bulletins and via email to our stakeholder list. The outcome of every consultation will be confirmed in the same way, with updated Contract documentation published on the Contract webpages.

- There is no need for commissioners to send “notice letters” to providers, informing them of changes to the national terms. Commissioners may choose, if they wish, to contact relevant providers to alert them to specific changes in

the national terms, but the onus will be on both commissioners and providers to keep themselves informed of the current terms.

- The current Particulars, GCs and SCs will always be published at https://www.england.nhs.uk/nhs-standard-contract/, but NHS England will also continue to publish previously applicable GCs and SCs, so that there is always an accurate, accessible record of which versions applied at which time.

- The Service Conditions continue to allow for "tailoring" of the applicability of Contract provisions using service categories (acute, mental health etc) to denote whether or not the clause applies to the contract in question. Contract clauses which are not relevant to a specific contract, because the provider does not provide the services to which those clauses apply, will simply be "read over" as not applicable. There is specific wording on page 9 of the Particulars making this clear ("Note that certain provisions of the Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others"). See paragraph 34 below for further detail on Service Categories.

- Other aspects of "tailoring" (for example, where a provision applies only to a provider which is a Trust and not to other providers) are now dealt with through the actual Contract text, rather than through the "applicability" column in the SCs.

34 Service categories

> *Within the **shorter-form Contract**, there is much less tailoring of the applicability of the Service Conditions and Particulars through the use of 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, especially, the Service Conditions apply to a specific contract.

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, 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. Contract clauses which are not relevant to a specific provider, because it does not provide the services to which those clauses apply, will simply be "read over" as not applicable. There is specific wording on page 9 of the Particulars making this clear ("Note that certain provisions of the Service Conditions and Annex A to the Service Conditions apply in respect of some service categories but not others").

34.4 A number of points should be noted in relation to the Community Services category.

- It is aimed at out-of-hospital services – which 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 26.2 above) must also be included to make the contract compliant with APMS regulations (and in these circumstances the full-length Contract must be used).
- We have amended both the full-length and shorter-form versions of the Contract so that RTT 18-week-wait requirements now also apply to the Community Services category. This does not mean that the RTT requirements apply to all community services – just to the small number of consultant-led elective services which are provided in community settings. See the RTT Rules Suite for full definitions.

34.5 The Contract continues to include a Service Category for patient transport services (PT). In this context, however, note our guidance (set out at paragraph 7.4 above) that, where a package of services being commissioned includes transport services within scope of CQC registration, the NHS Standard Contract must be used – but that a package of transport services outside the scope of registration should not be commissioned using the NHS Standard Contract.

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 renewal of an expiring 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, the provider 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. 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.

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 GC5.14 (TUPE) (Schedule 8 in the shorter-form Contract)), the transfer of premises and equipment, transfer of care of Service Users, transfer of patient records, 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, 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 Service specifications are recorded in Schedule 2A of the Particulars; a non-mandatory model template for local determination and population is provided there. The template is a streamlined one, enabling specifications in contracts to be less restrictive and input-driven where desired, with more scope for the provider to adapt and refine over time how services are best delivered to meet the commissioner's long-term objectives and desired outcomes.

36.3 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.

36.4 The specification template is intended as a guide, and the sub-headings are intended to act as suggestions. It is possible to add additional sections to the specification, if required. Commissioners may retain this structure, they may add additional sections, or they may determine their own. Where a commissioner chooses to determine their own structure, the guidance below is still relevant.

36.5 Considerations in completing the streamlined template are set out below.

Service name	Use this as your shorthand description of this particular service or bundle of Services
Service specification number	Use this to give this particular specification a unique reference number
Population / geography to be served	Use this to define the population for whom the Service is to be provided and/or the geographical area which it is to cover
Service aims and desired outcomes	Use this to describe the overall aims of the Service and the outcomes you want it to achieve or to contribute towards. • Outcomes can be for the population served as a whole or for individuals accessing specific Services. • They can relate to specific improvements in health delivered through the health Services being provided, overall improvements in population health status or narrowing of inequalities in health between different sub-populations. • The NHS Outcomes Framework will be a useful point of reference. • Be sure to describe aims and outcomes which can be realistically achieved over the duration of the contract. If your contract has a one-year term, don't include outcomes which will take ten years to deliver. • Be clear whether you are expecting the Provider to deliver specific outcomes which are fully within its own control – or

	to help make progress towards broader outcomes which will require action by multiple organisations to achieve.
Service description and location	Use this to describe, in an appropriate level of detail, the Service which is to be provided. A specification should not be a detailed operational policy for a service. It is important to cover, at least: • the nature of the Service to be provided (that is, a clinical description); and • the locations from which the Service is to be provided (or criteria for how accessible such locations must be for Service Users). In terms of specific locations for service delivery, you should only list those locations which you (and any other commissioners with whom you are collaborating under paragraph 13 above) have commissioned to meet the needs of your local population(s) and which you have satisfied yourself, through your usual assurance process, are suitable for the provision of high-quality and effective services. Beyond this, you may wish to consider: • specifying hours of operation and/or levels of service capacity; • what specific standards or guidance, relevant to the particular Service (and over and above those referenced in the General Conditions and Service Conditions), the Provider must comply with or have regard to – noting that specific Quality Requirements which the provider is required to achieve and report to the commissioner against should be set out separately in Schedule 4 (Local Quality Requirements) and Schedule 6A (Reporting Requirements), cross-referencing the relevant service specification; • how the Provider will tailor the services to individual Service Users' needs (adding service-specific detail to any general requirements on personalised care in Schedule 2M); and • how this Service fits into the wider care pathway for the Service Users affected – showing how it links to other services / providers and describing any referral / treatment protocols under SC29 (including any applicable clinical criteria / exclusions) and linking to transfer / discharge processes in Schedule 2J. Remember to strike the right balance between detail and flexibility. Try to ensure that the specification is precise enough so that the Provider must seek the Commissioner's permission, through a Variation, to make really material changes (including as a minimum those which would trigger a requirement for public consultation, for instance) – but, otherwise, leaves adequate scope for the way the Provider organises the services to evolve, so as best to deliver the desired aims and outcomes.

Other points about specifications

36.6 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 GC1.2, 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').

36.7 Where the provider is to play a part in local delivery of the Enhanced Health in Care Homes and/or Primary and Community Mental Health Services care models, in collaboration with local Primary Care Networks, the service specifications templates at Schedule 2Ai) and/or ii) should be included, as appropriate, and completed / supplemented locally as required.

36.8 Where the commissioning of services is the responsibility of NHS England (including where commissioning functions have been, or are in future, delegated by NHS England to ICBs), 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.

36.9 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 ICBs when commissioning regional ambulance services.

36.10 NHS England has also produced guidance on commissioning, contracting and core standards for non-emergency patient transport services (NEPTS); this is available here on FutureNHS. (See also paragraphs 7.4 and 34.5 above on the use of the NHS Standard Contract for the commissioning of NEPTS.) NHS England has also published NEPTS eligibility criteria, and ICBs and local partners should have regard to these criteria when commissioning NEPTS.

36.11 A service specification included in a local contract may be supplemented by one or more specific Individual Placement Agreements (IPAs). Where, for instance, a Commissioner has commissioned a care home Provider to provide NHS CHC packages of varying complexity, then an IPA can be used to record agreement to the placement of an individual and can describe the care package that individual is to receive and the price payable. The IPA should be exchanged between the parties and signed separately. NHS England publishes a model IPA which can be used for this purpose.

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 currently applies to all providers other than NHS Trusts; and
- the regime of Essential Services which currently applies to NHS Trusts only.

Note that changes are in hand which will bring NHS Trusts in scope of the CRS regime – see further detail at paragraph 37.8 below.

37.2 National guidance sets out how services can potentially be designated as CRS 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.

37.8 As a result of changes to the Provider Licence regime introduced under the 2022 Act, the concept of Essential Services will gradually become redundant, as NHS England issues NHS Trusts with Provider Licences and thus brings them within scope of the Commissioner Requested Services regime in the Licence provisions. The process of issuing Licences will commence no earlier than April 2023, which is when the relevant change to legislation comes into effect – so opening 2023/24 contracts with NHS Trusts will need to be agreed on the basis that the Essential Services regime applies, with Schedules 2D and 2E completed in the normal way. As and when an individual Trust is then issued with a Licence, the Essential Services provisions in SC5 and Schedules 2D and 2E will automatically become redundant (there will be no need for a local Variation to bring this about). Each commissioner will, in readiness for any NHS Trust which it commissions being issued with a Provider Licence, need to consider, under CRS Guidance, whether to designate some or all of the Trust's services as CRS, submitting its designation decisions to nhsi.crs@nhs.net in the normal way as soon as it can.

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 or the new Provider Selection Regime. 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. Providers should, however, always be mindful of the default position in the Contract, which is that sub-contracting without prior written approval is a breach of contract entitling the co-ordinating commissioner to terminate the contract if it chooses (see GC17.10.15).

38.9 GC12.4 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 (if any) proposed sub-contracts it considers to be Material Sub-Contracts (to be detailed in Schedule 5B);
- which (if any) Material Sub-Contracts must be in place, in a form approved by the co-ordinating commissioner, at the point of contract award;
- which (if any) Material Sub-Contracts must be in place, in a form approved by the co-ordinating 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 NHS Payment Scheme. The Standard Contract requires the commissioner to pay the provider in accordance with the NHS Payment Scheme (meaning the principles and rules set out in the current NHS Payment Scheme guidance) – but no such requirement applies where a provider is paying a sub-contractor.

38.13 We have provided, at Appendix 3, some example scenarios illustrating which form of contract, sub-contract or other agreement should be used in different situations.

38.14 Where NHS providers are placing sub-contracts for goods and non-clinical services, they may appropriately use the standard NHS terms and conditions (queries on which may be directed to england.commercialqueries@nhs.net) Where the sub-contract is of a clinical service, the national terms and conditions for goods and non-clinical services will not be suitable.

38.15 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, which we refer to as NHS Standard 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 in due course to reflect the 2023/24 Contract and republished on the NHS Standard Contract 2023/24 webpage. Note that we publish a version of the model sub-contract under which multiple head providers can place a single sub-contract with a chosen sub-contractor.

38.16 Use of the model sub-contract is not generally mandatory (but is mandatory when Trusts or FTs are awarding sub-contracts under the Increasing Capacity Framework – on which see paragraph 27.2 above), but its use will save providers time and offer greater assurance to commissioners that robust sub-contracting arrangements are in place.

38.17 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.

38.18 We are aware of some confusion concerning sub-contracting arrangements where

GP practices, operating through Primary Care Networks (PCNs), seek to sub-contract certain obligations under their primary medical care contracts to other providers such as Trusts. Use of the NHS Standard sub-contract is not appropriate in such cases; rather, NHS England has published a sub-contract for the provision of services related to the Network Contract Directed Enhanced Service, and this is the form of sub-contract which should be used (queries on its use can be directed to england.gpcontracts@nhs.net).

Management of sub-contracts

38.19 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 infection control (SC21), safeguarding (SC32), end of life care (SC34) and the duty of candour (SC35).

- The Contract sets specific national quality standards which the provider must achieve in Annex A of the Service Conditions, with scope for additional local quality requirements (Schedule 4). Other national standards to be complied with are stated elsewhere in the SCs – National Standards of Healthcare Cleanliness in SC17 and National Standards for Healthcare Food and Drink in SC19, for instance.

- In addition to these nationally mandated requirements, commissioners can describe appropriately 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 and clinical outcome review programmes (GC15 and SC26), consent (SC9), patient, carer and staff involvement and surveys (SC10, SC12), complaints (SC16) and the response to patient safety 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 and Patient Safety Incidents, and implementing improvements as a result (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 the CQUIN incentive scheme (where applicable) to improve quality (SC38), requiring Remedial Action Plans to address service deficiencies (GC9), 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. The National Quality Board's recently published guidance on quality risk response and escalation in Integrated Care Systems describes where local quality concerns may need to be escalated, so that there can be appropriate input from regulators such as CQC and NHS England.

39.4 Detailed guidance on reporting 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.

National Quality Requirements

39.5 These are set out in Annex A of the Service Conditions. As a general principle, all providers are expected to achieve all of the National Quality Requirements which relate to the commissioned services – but see also paragraph 3.2-3 above. Links to the detailed definitions for the National Quality Requirements are provided within Annex A of the Service Conditions.

Local Quality Requirements

39.6 Local Quality Requirements are to be included in Schedule 4 and 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.

39.7 Schedule 4 provides a simple template for documenting Local Quality Requirements. The headings used are explained in the table below.

Quality Requirement	What is the specific standard the provider must achieve?
Threshold	This means the numeric measure of success – better than the threshold is satisfactory, worse than it is not
Method of Measurement	This describes how the provider's performance is going to be measured – what's the data source, what are the definitions?
Period over which the Requirement is to be achieved	Does the provider have to achieve this standard at all times, with zero tolerance of breaches? Or is the standard to achieve a certain minimum (%) level of performance over a month, or quarter or year?
Applicable Service Specification	Which Service(s) is this standard relevant to?

39.8 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 The Contract no longer makes provision for financial consequences to be applied where a provider breaches a Local Quality Requirement. See paragraph 40 below for further detail.

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.

39.11 Note that the Getting It Right First Time programme publishes standards for a range of medical and surgical specialties; these will be a useful source of potential local quality requirements.

Patient Safety

39.12 For 2023/24, we have updated the full-length Contract to reflect the requirements of the new national Patient Safety Incident Response Framework (PSIRF). The requirements, set out in SC33, are as follows.

- PSIRF will be adopted over the coming year (2023/24), with the exact date for local adoption being agreed between the provider and its co-ordinating commissioner. Where a single provider holds separate contracts with different co-ordinating commissioners, there will need to be discussion between them to agree a single PSIRF adoption date. Until the agreed adoption date, therefore, each provider must continue to comply with the NHS Serious Incident Framework; from the agreed adoption date, it must comply with PSIRF.

- The Never Events Policy Framework remains in force, and providers must continue to comply with it.

- In order to adopt PSIRF, each provider must agree with its co-ordinating commissioner a Patient Safety Incident Response Policy and a Patient Safety Incident Response Plan, as described in detail in PSIRF. These must be published on the provider's website.

- Under PSIRF, each provider must
  - ➢ engage compassionately with affected patients, carers and staff following any patient safety incident;
  - ➢ respond in a proportionate way to such incidents, undertaking investigations where appropriate; and
  - ➢ ensure that improvements to services are implemented following responses to incidents.

- Providers must be able to report incidents via the National Reporting and Learning System (to be replaced in due course by the Learn from patient safety events service) and must provide information on incidents to the co-ordinating commissioner as agreed under Schedule 6A.

39.13 Given the changes introduced under PSIRF to incident reporting and investigation, it is no longer necessary to have a specific schedule in the Contract which sets out a local procedure for the provider to report all incidents to the commissioner. We have therefore deleted what was previously Schedule 6C (Incidents Requiring Reporting Procedure).

39.14 In the shorter-form version of the Contract, we have included a brief reference to the adoption by the provider of PSIRF – but on a lighter-touch basis than in the full-length version, allowing the provider discretion over the timing of its transition from the (current) NHS Serious Incident Framework to the (new) PSIRF.

Contract provisions relating to the primary / secondary care interface

39.15 The Contract has always contained requirements on secondary care providers relating to communication and engagement with primary care providers – 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.

39.16 A summary of the Contract interface requirements, for clinicians and managers, was published in 2017. In brief, they 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).

39.17 Implementation of these requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices. The Contract therefore includes a requirement for the provider and the co-ordinating commissioner to undertake, by 30 September of each Contract Year, an assessment of the effectiveness of their interface working arrangements, to discuss their findings with the relevant Local Medical Committees and to agree and implement an action plan to address any deficiencies. It remains an extremely important priority for NHS England that the Contract requirements in this area are fully implemented at local level.

39.18 Further detail on some of the interface requirements is set out below.

Referral, management of DNAs and onward referral

39.19 The NHS Standard Contract is not a vehicle which can place direct requirements on individual primary care clinicians, but it does require ICBs 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/).

39.20 The requirement in relation to DNAs is sometimes misunderstood. SC6.6.6.2 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 NHS England on the Future NHS website; providers should review their existing policies and ensure that they are consistent with this model version.

39.21 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 ICB 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 though the care system.

Discharge summaries, clinic letters and other communications to primary care

39.22 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/.

39.23 Guidance is available 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 resource library. NHS England has published separate guidance on the NHS Standard Contract requirements on discharge summaries and clinic letters and on interoperability of clinical IT systems. An Information Standard was published in 2022 relating to the electronic transmission to GPs of hospital discharge summaries following acute inpatient care (DAPB4042: Transfer of Care – Acute Inpatient Discharge Standard). The new Standard is for full implementation by 31 October 2022. (This is the first of four message standards to be approved for transfer of care in due course, the others being Inpatient and Day Case Discharge Summary for Mental Health, Emergency Care Discharge Summary, and Outpatient Clinic Letter.)

39.24 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.

39.25 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).

39.26 Note that an Information Standard (DAPB4017) has been published to enable the sharing of pathology results across the NHS, including across care settings and organisational boundaries.

39.27 Apart from DAPB4017 and the above 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

39.28 The Contract requires the parties to have regard to high-level national guidance on prescribing responsibilities. 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.

39.29 These nationally 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

39.30 SC26 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 (under SC26.4) do so in accordance with the National Directive on Commercial Contract Research Studies published jointly by NIHR, HRA and NHS England (current version published in January 2022). (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.

- 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.

40 Financial sanctions and incentives

Automatic financial sanctions – applied to providers which breach national or local quality standards – no longer feature in either the full-length or ***the shorter-form version of the Contract****.*

Application of financial consequences ('sanctions')

40.1 For 2021/22 onwards, we removed from the Contract

- the nationally mandated financial consequences (usually referred to as "sanctions"), applied by the commissioner to the provider for failure to achieve National Quality Requirements; and

- the ability for financial sanctions to be included in relation to locally agreed quality standards.

40.2 We are conscious that commissioners may, in some cases, have used locally agreed sanctions as a way of building a "pay-for-performance" regime into a specific contract. Where a multi-year contract including locally agreed sanctions in Schedule 4 is in place with a provider and does not expire at 31 March 2023, the commissioner will be able, at its discretion, to retain those sanctions within the local contract for 2023/24.

40.3 For new contracts operating on the basis of Local Prices, commissioners wishing to build in financial incentives or a "pay-for-performance" regime can do so by setting out their approach in Schedule 3C.

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 6C) 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.

41.4 Multiple SDIPs can be included within the same contract. SDIPs should be included in Schedule 6C at the point where the contract is signed or incorporated into the contract subsequently by a locally initiated 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 Clearly, in many cases, providers are not currently achieving these standards. Where that is the case, the commissioner and provider should agree – and include in their local contract – a Service Development and Improvement Plan,

41.6 We normally set out national requirements for specific areas in which commissioners and providers should agree SDIPs for the coming year. Commissioners should agree SDIPs for 2023/24:

- with **all acute Trusts**, setting out how the Trust will complete population of the My Planned Care digital platform with supporting patient information across all specialties it provides elective services in, to help patients manage their health and wellbeing whilst they wait and how the Trust will promote the My Planned Care website to patients on their waiting lists. (My Planned Care is a key element of the national Delivery plan for tackling the COVID-19 backlog of elective care); and

- with **all providers who offer services to people with a learning disability, autism or both** (including children and young people) to set out how the provider will use the Ask Listen Do resources and embed the practice into how the provider supports people with a learning disability, autism, or both, and their families and carers, to provide feedback on services and to raise a concern or complaint.

41.7 As in previous years, the intention of these recommended 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; and

- where an Indicative Activity Plan has been agreed at the start of the year, activity is managed within the agreed levels 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 paragraph 42.40 onwards.

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.)

(Note that, for the legal right of choice to apply to a particular service, the provider must have been commissioned to provide that service by at least one ICB. And the provider can then offer the service to other ICBs only as commissioned – that is, on the basis specified in the provider's contract with the first ICB. See paragraph 25.17 above for further detail.)

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 wholly fixed payment approach, 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 fixed 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, with full or marginal prices? 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 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.

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, SC29.24 clarifies that the new or amended Scheme will apply to treatment which is offered after the date on which the new or amended Scheme comes into effect.

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). This is particularly important now that ICBs and local partner Trusts have legal duties, under the Health and Care Act 2022, to work together to deliver system financial balance. It will not be in the interests of an ICB to insist on the operation of a burdensome Prior Approval Scheme, adding to the costs of its local providers, unless it is confident that a net overall saving to the local NHS will result. It is therefore important that commissioners:

- ensure that they place the onus on the right part of the system – if an ICB 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 ICBs. Clearly, it is ultimately for each ICB 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. ICBs 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 Guidance

42.14 Initial statutory guidance on evidence-based interventions published in 2018 was supplemented by further guidance in 2020 covering a second tranche of interventions. Taken together, the two guidance documents (referred to in the Contract as Evidence-Based Interventions Guidance) set out the commissioning arrangements which are to apply to 48 specific treatment interventions. Guidance covering a third tranche of interventions has been the subject of consultation, with the final version expected to be published shortly. Queries on the Evidence-Based Interventions programme may be addressed to england.EBInterventions@nhs.net.

42.15 The Guidance is given contractual effect through provisions included at SC29.28-29, which require

- commissioners to use all reasonable endeavours to ensure that referrers (GPs and others) act in accordance with the Guidance; and

- providers to manage referrals and provide the Services in accordance with the Guidance.

As described in paragraph 3.9 above, we have now removed the specific provision allowing commissioners to withhold payment for interventions undertaken in contravention of the Guidance. Financial incentives for Trusts to follow the Guidance are instead built into the API rules (see NHS Provider Payment Mechanisms, paragraph 2.7). Non-compliance with the Guidance by a non-NHS provider can be dealt with through the contract management provisions at GC9.

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 (e-RS) at SC6, summarised in the table below.

Any provider must hold a contract with an NHS commissioner (ICB or NHS England) for a service, in order to be able to list that service on e-RS at all. **Acute providers** must • publish their (relevant) services on e-RS; • use all reasonable endeavours to ensure that sufficient slots are available to enable direct booking of appointments via e-RS; and • ensure that they accept all referrals made through e-RS 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 use reasonable endeavours to publish their (relevant) services on e-RS and be in a position to accept GP referrals. **All providers** using e-RS must ensure that their services are listed on the correct menu within e-RS. • The "secondary care menu" (available to referrals from all ICBs in England) must be used only for services to which the legal right of choice applies under the NHS Choice Framework. • The "primary care menu" must be used for services outside the scope of the legal right of choice, which have been commissioned specifically by one or more ICBs; these services will then be available to receive referrals from those ICBs only. **Commissioners** must use all reasonable endeavours to ensure that all GP referrals • are made via e-RS; and • contain accurate patient contact details and the clinical information required under agreed referral protocols.

42.18 It is essential that providers take a responsible approach when seeking to change the listing their services on e-RS.

- Where a service is covered by a contract, that contract will normally specify a location or locations from which the service is to be delivered. Where that is the case, the provider is not entitled to, and must not, simply list additional

locations on e-RS. If the provider wishes to add additional locations, it must approach

- its current commissioner to seek a variation to its existing contract (if the new locations are chiefly to be used for referrals from the commissioner which holds that contract); or
- a new commissioner, with responsibility for patients in the area most obviously served by the new location, to seek a new contract (to cover the delivery of services in a completely different location, primarily to attract potential referrals from that new commissioner).

- If a provider wishes to provide additional services (beyond those specified in its contract) from an existing or new location, it must not simply list these on e-RS. As above, it must approach the relevant commissioner, requesting a contract variation / new contract as appropriate.

42.19 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 e-RS; rather, the provider will be able to return any non-e-RS referral to the GP;

- the provider must implement a process under which, in every case, it notifies any non-acceptance of a non-e-RS 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/); and

- each commissioner must ensure that local GPs are made aware of this process.

Indicative Activity Plan

42.20 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.

42.21 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.

42.22 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.

42.23 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.

42.24 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.

42.25 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

42.26 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.

42.27 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.

42.28 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.

42.29 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.

42.30 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 42.29 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

42.31 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.

42.32 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.

42.33 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

42.34 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.

42.35 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.

42.36 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)

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

42.38 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.

42.39 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.

Financial consequences under SC29

42.40 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.

42.41 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".

42.42 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

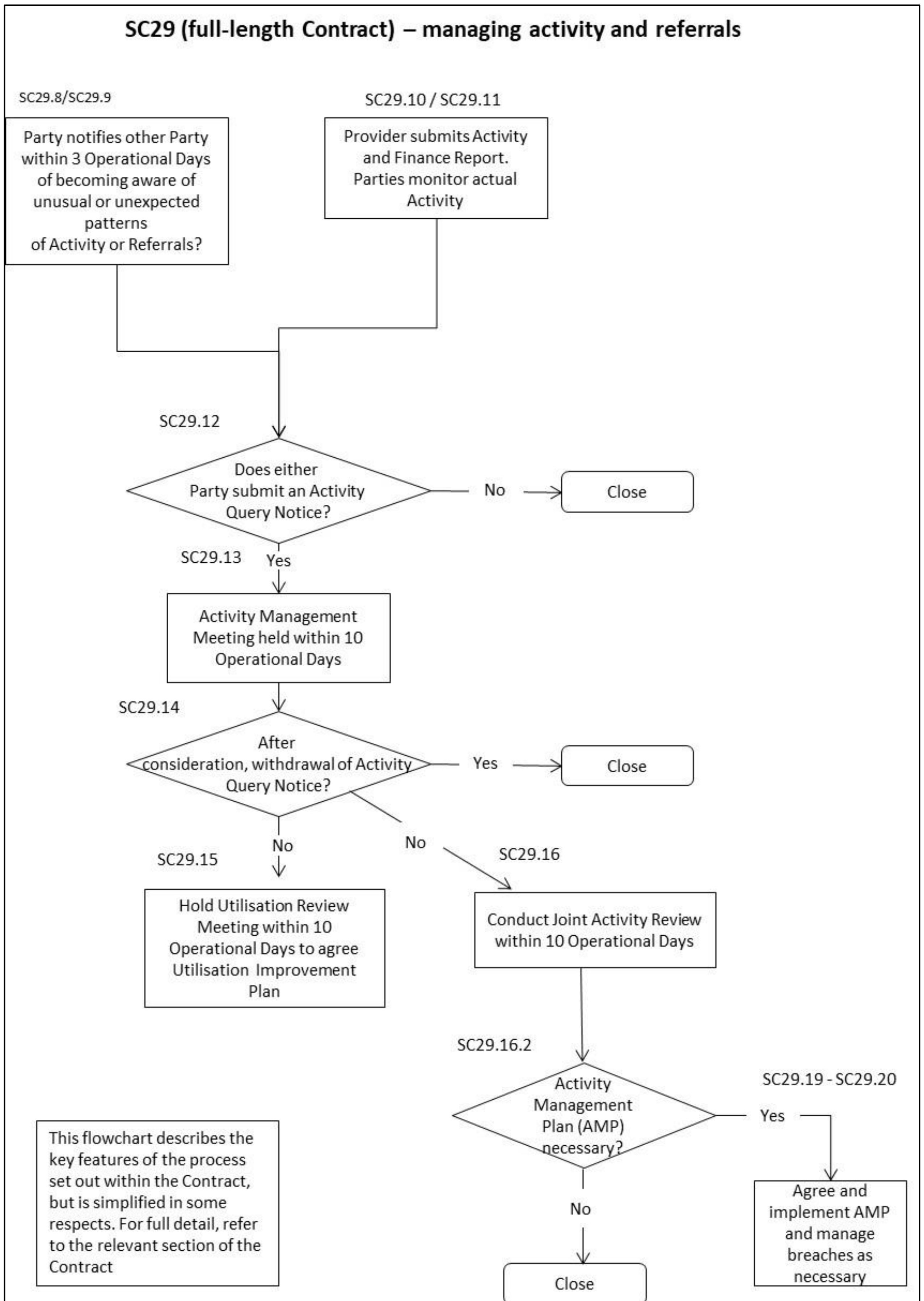
- seek to apply the provisions of GC11.2 (indemnity for losses incurred as a result of the provider's negligence or breach of contract – see section 47.32 onwards).

42.43 Equally, a provider's response to an AQN may prompt the commissioner to contest payment under SC36.31 (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).

42.44 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).


SC29 (full-length Contract) – managing activity and referrals
SC29.8/SC29.9
Party notifies other Party within 3 Operational Days of becoming aware of unusual or unexpected patterns of Activity or Referrals?
SC29.10 / SC29.11
Provider submits Activity and Finance Report. Parties monitor actual Activity
SC29.12
Does either Party submit an Activity Query Notice?
No
Close
SC29.13
Yes
Activity Management Meeting held within 10 Operational Days
SC29.14
After consideration, withdrawal of Activity Query Notice?
Yes
Close
No
No
SC29.15
Hold Utilisation Review Meeting within 10 Operational Days to agree Utilisation Improvement Plan
SC29.16
Conduct Joint Activity Review within 10 Operational Days
SC29.16.2
Activity Management Plan (AMP) necessary?
SC29.19 - SC29.20
Yes
Agree and implement AMP and manage breaches as necessary
No
Close
This flowchart describes the key features of the process set out within the Contract, but is simplified in some respects. For full detail, refer to the relevant section of the Contract

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 The focus of this section of our guidance 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 Alliance Partnership Board. 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 relevant national guidance, and any Information Standards 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 Schedule 6A provides a simple template for documenting local reporting requirements. The headings used are explained in the table below.

Local Reporting Requirement	What is the specific requirement here? A report covering what indicators for what Services?
Reporting Period	Is the report to be provided to cover a month, a quarter or a year?
Format of Report	How is the report to be presented? Written document or spreadsheet? How granular is the data to be – provider-wide, or broken down by site / locality / commissioner?
Timing and Method for delivery of Report	How soon is the report to be produced after the end of the period to which it refers? Is it to be sent to a particular person or presented to a particular meeting?

43.6 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.

43.7 As with Local Quality Requirements (see paragraph 39.7 above), a targeted approach with a limited number of well-chosen Local Reporting Requirements is likely to be 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. Particularly given the new legal duties on ICBs and local partner Trusts, under the Health and Care Act 2022, to work together to deliver system financial balance, 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 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.

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.

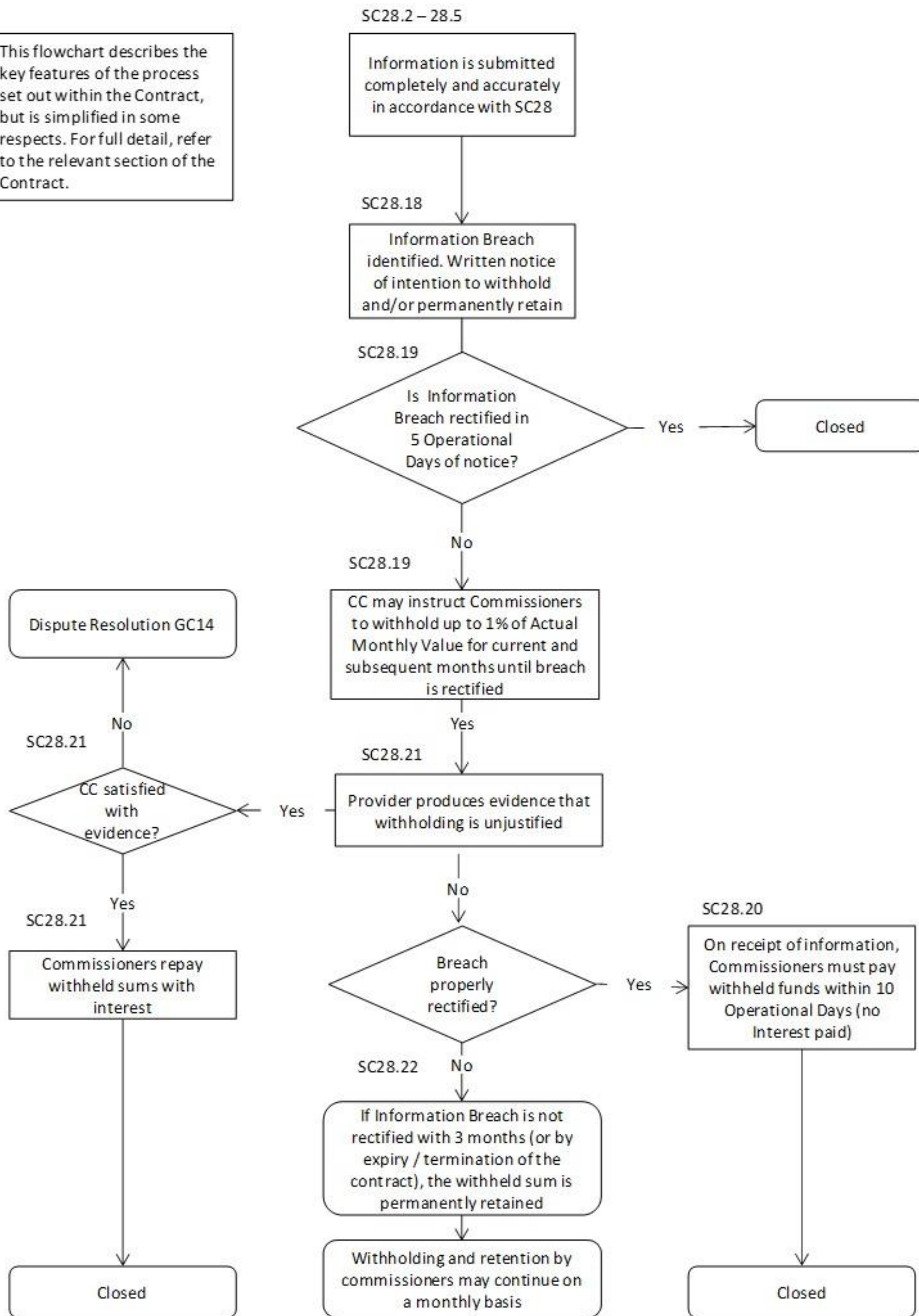
43.10 These financial withholding provisions require that any sum withheld by the commissioner must be 'reasonable and proportionate' (SC28.19) and to limit the amount withheld for all Information Breaches in any month to a maximum of 5% of Actual Monthly Value (SC28.23). The approach on Information 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 be actioned by the co-ordinating commissioner on behalf of all the commissioners (see SC28.18).


SC28 (full-length contract) – Information requirements
This flowchart describes the key features of the process set out within the Contract, but is simplified in some respects. For full detail, refer to the relevant section of the Contract.
SC28.2 – 28.5
Information is submitted completely and accurately in accordance with SC28
SC28.18
Information Breach identified. Written notice of intention to withhold and/or permanently retain
SC28.19
Is Information Breach rectified in 5 Operational Days of notice?
Yes
Closed
No
SC28.19
CC may instruct Commissioners to withhold up to 1% of Actual Monthly Value for current and subsequent months until breach is rectified
Yes
SC28.21
Provider produces evidence that withholding is unjustified
Yes
SC28.21
CC satisfied with evidence?
No
Dispute Resolution GC14
Yes
SC28.21
Commissioners repay withheld sums with interest
Closed
No
Breach properly rectified?
Yes
SC28.20
On receipt of information, Commissioners must pay withheld funds within 10 Operational Days (no Interest paid)
Closed
SC28.22
No
If Information Breach is not rectified with 3 months (or by expiry / termination of the contract), the withheld sum is permanently retained
Withholding and retention by commissioners may continue on a monthly basis

SUS

43.13 SC28.17 mandates submission of datasets by providers to the Secondary Uses Service (SUS), where required under national guidance.

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 the Data Quality Maturity Index (DQMI).

43.15 Note that SC28 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 a locally initiated 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 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 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.

- 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 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, guidance is published on the 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. 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 2023/24, commissioners should agree DQIPs:

- **with providers of mental health and learning disability services** to set out actions which the provider will take to improve the accuracy and completeness of its Mental Health Services Data Set submissions, focussing particularly on data items on the use of restrictive practices. The specific focus should be on completion of the data fields covering MHS505 Restrictive Intervention Incident and MHS515 Restrictive Intervention Type. This DQIP builds on the SDIP which was required for 2020/21 and 2021/22 in relation to the provision of training for staff in the use of restrictive practices; and

- **with providers of inpatient services** to set out actions which the provider will take to improve the accuracy and completeness of its recording of diagnoses of learning disability and autism within the relevant fields in the applicable commissioning datasets and medical records systems.

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. In the past, this has often been a complex and contentious area, but – encouragingly – recently very few disputes have been brought to our attention. So we have retained the counting and coding provisions in the Contract for 2023/24, but we are now making clear that – in certain situations – it is open to commissioners and providers to implement them in a light-touch way. This applies where:

- an ICB is commissioning services from a partner Trust in the same local system (given that the ICB and the Trust are now under a legal duty to work together to deliver system financial balance, local disagreements about the financial impact of counting and coding changes should simply not be allowed to arise); and
- an ICB is commissioning services from a provider on an Aligned Payment and Incentive (API) basis, as set out in the NHS Payment Scheme (most counting and coding disputes have tended to be in relation to "coding drift" in non-elective services – but API involves fixed payment for non-elective care, so this issue should no longer arise).

In these situations, the parties must continue to follow the principles of SC28. It is important that the commissioner is always made aware of material changes in how the provider is recording activity, as there can be no shared basis for planning and monitoring without this. There should be no unplanned financial impacts from counting and coding changes. Within that, however, the parties can adopt – for example – a more flexible local approach to the deadlines and process set out in SC28 for notifying changes and neutralising their financial impact.

We will keep under review whether the detailed requirements on counting and coding changes, in the Contract and this Guidance, remain necessary for the future.

44.2 SC28 distinguishes explicitly between

- counting and coding changes made in order to comply with specific new national coding guidance (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 previously published national coding guidance which is already in effect ("locally-proposed changes", covered in SC28.11-28.14).

NHS Digital merged with NHS England on 1 February 2023. Prior to that date, the "national coding guidance" described above will have been published by NHS Digital; from that date onwards, it will be published by NHS England.

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 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 NHS Payment Scheme guidance does not itself set rules for how patient activity is to be recorded – these are contained in the NHS Data Dictionary. Rather, the NHSPS 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 NHSPS (and under the National Tariff Payment System and 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 payment scheme is designed, the impact of changes to that design – such as the new grouping structure of HRG4+ for the 2017-19 iteration – 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 payment scheme 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 scheme's development. Changes in recording practice could, under an activity-based payment system, 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 SC28 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 NHS Payment Scheme unit 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 <u>not</u> 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 <u>not</u> 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 locally-initiated 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 NHSPS.

- Clearly, the provisions of SC28 are <u>not</u> intended to prevent or delay the adoption of new prices, currencies and rules mandated through the NHSPS. Providers and commissioners do <u>not</u> need to give each other notice under SC28 of the application of new NHSPS arrangements, and the impact of the new NHSPS is not subject to the provisions in SC28 for financial neutrality.

- Applying new NHSPS 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 NHSPS arrangements is another. The latter definitely <u>does</u> 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 NHSPS 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 payment scheme 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 locally-initiated 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.)

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 be 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 2022 will be too late for implementation from 1 April 2023 (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 2023), with a consequent delay in potential implementation, if agreed, and full financial impact.

Nationally mandated counting and coding changes

44.33 Information about formal changes to requirements for clinical coding, activity recording and submission of datasets is available as follows.

- Guidance on clinical coding, and Coding Clinic publications, can be accessed via the Resource Library page of the Delen system at https://nhsengland.kahootz.com/t_c_home/grouphome;
- 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 national guidance (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 national 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 paragraph 44.27 above for locally proposed changes – also give the commissioner its best available estimate of the impact of the change.)

44.36 Our understanding is that, for 2023/24, there are two material changes planned.

- One is to implement OPCS version 4.10 for the classification of interventions and procedures.

- The other is to implement version 4 of the Emergency Care Data Set (ECDS). An Information Standards Notice on this has now been published, for implementation from 1 July 2023 onwards. Implementing ECDS v4 will involve recording all Same Day Emergency Care activity via ECDS, rather than as inpatient admission or outpatient attendance.

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 national 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 national 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 2024.

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 2023/24, therefore, for locally proposed changes which are notified up to and including 30 September 2022:

- If a change is implemented with effect from 1 April 2023 or later, the financial impact is neutralised for the whole of the 2023/24 Contract Year.

- If a change is implemented before 1 April 2023, the financial impact is neutralised for the relevant part of the 2022/23 Contract Year and for the whole of the 2023/24 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 new national guidance is published 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 out in the guidance; 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 national 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 SC28.18-23. 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 SC36.31 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 SC36.31).

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 ICB 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 national 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. As we have noted above, the moves to system working and the API model for payments to Trusts should also make rigid application of much of the Contract mechanism for counting and coding changes increasingly unnecessary.

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 below, 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 <u>and</u> improvements to be <u>achieved and maintained</u>, 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.

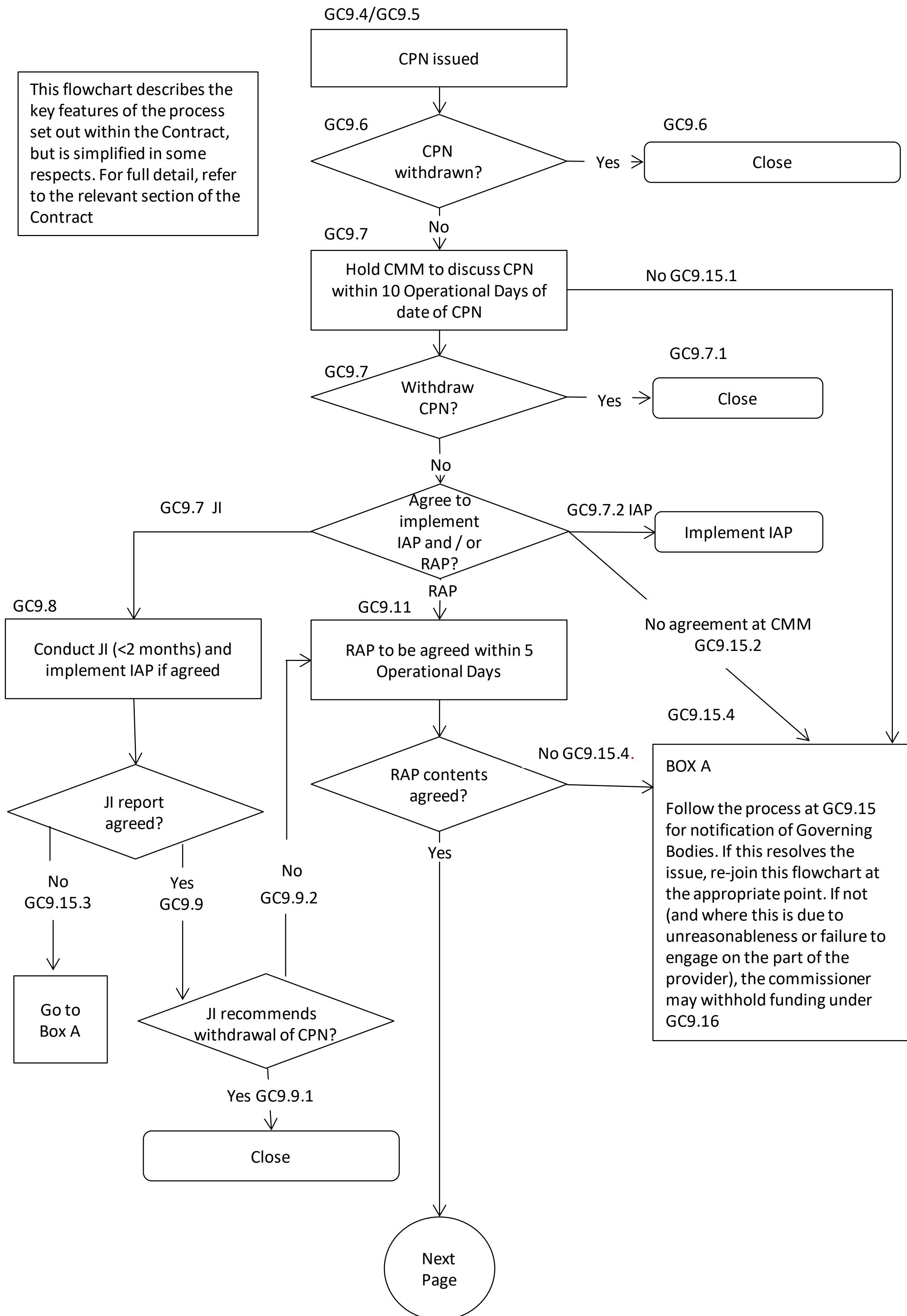
- We anticipate that these withholding provisions should need to be used only very infrequently – and any withholding must be "reasonable and proportionate", as the Contract wording requires. This is especially true in the context of the new legal duties, under the Health and Care Act 2022, on ICBs and local partner Trusts to work together to deliver system financial balance.

- 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.

Breach of new national requirements in the Contract

45.15 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
GC9.4/GC9.5
CPN issued
This flowchart describes the key features of the process set out within the Contract, but is simplified in some respects. For full detail, refer to the relevant section of the Contract
GC9.6
CPN withdrawn?
Yes
GC9.6
Close
GC9.7
No
Hold CMM to discuss CPN within 10 Operational Days of date of CPN
No GC9.15.1
GC9.7
Withdraw CPN?
Yes
GC9.7.1
Close
No
GC9.7 JI
Agree to implement IAP and / or RAP?
GC9.7.2 IAP
Implement IAP
RAP
No agreement at CMM GC9.15.2
GC9.8
Conduct JI (<2 months) and implement IAP if agreed
GC9.11
RAP to be agreed within 5 Operational Days
GC9.15.4
RAP contents agreed?
No GC9.15.4.
BOX A
Follow the process at GC9.15 for notification of Governing Bodies. If this resolves the issue, re-join this flowchart at the appropriate point. If not (and where this is due to unreasonableness or failure to engage on the part of the provider), the commissioner may withhold funding under GC9.16
JI report agreed?
No GC9.15.3
Yes GC9.9
No GC9.9.2
Yes
Go to Box A
JI recommends withdrawal of CPN?
Yes GC9.9.1
Close
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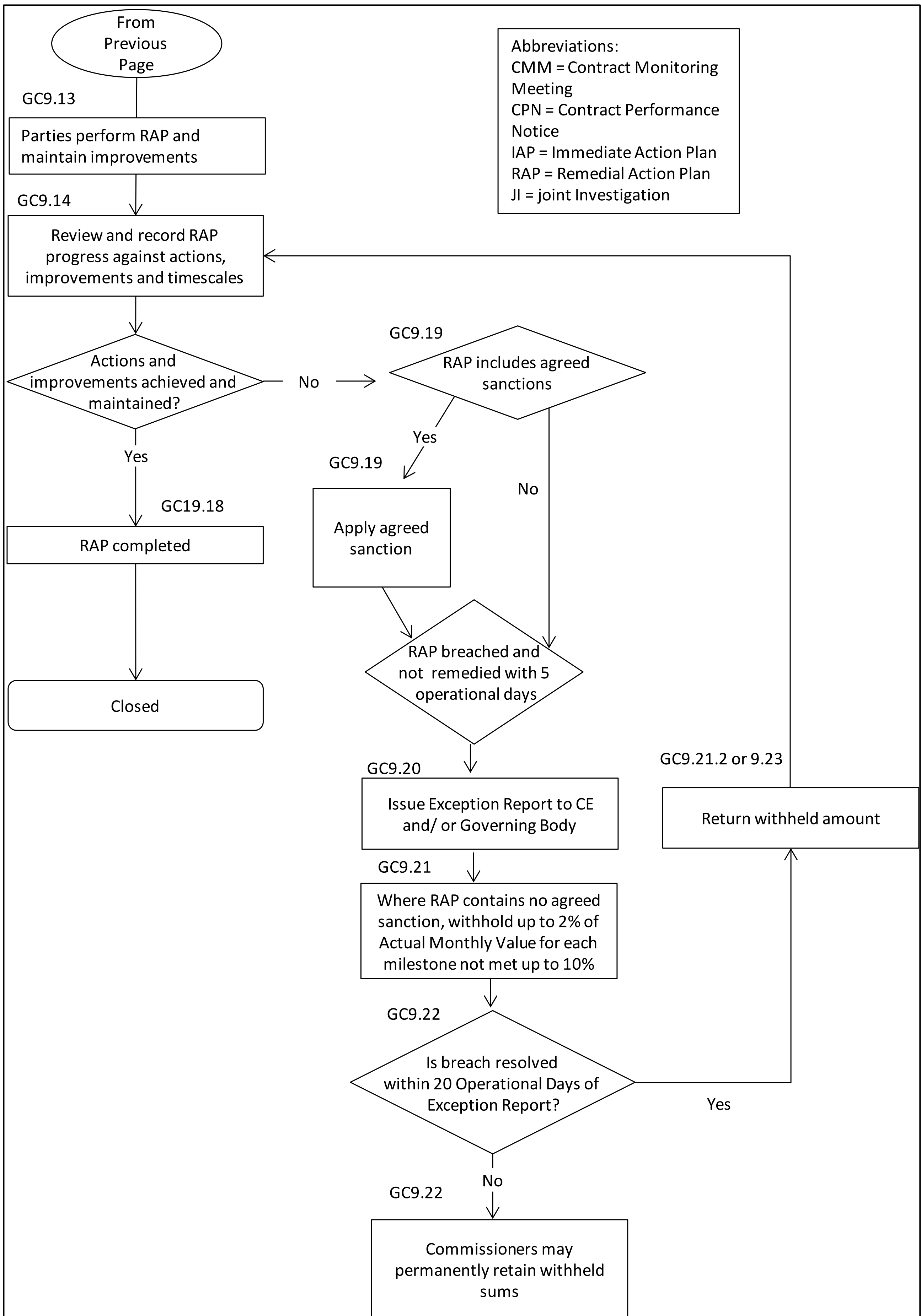

From Previous Page
GC9.13
Parties perform RAP and maintain improvements
GC9.14
Review and record RAP progress against actions, improvements and timescales
Actions and improvements achieved and maintained?
No
Yes
GC19.18
RAP completed
Closed
GC9.19
RAP includes agreed sanctions
Yes
GC9.19
Apply agreed sanction
No
RAP breached and not remedied with 5 operational days
GC9.20
Issue Exception Report to CE and/ or Governing Body
GC9.21
Where RAP contains no agreed sanction, withhold up to 2% of Actual Monthly Value for each milestone not met up to 10%
GC9.22
Is breach resolved within 20 Operational Days of Exception Report?
Yes
No
GC9.22
Commissioners may permanently retain withheld sums
GC9.21.2 or 9.23
Return withheld amount
Abbreviations:
CMM = Contract Monitoring Meeting
CPN = Contract Performance Notice
IAP = Immediate Action Plan
RAP = Remedial Action Plan
JI = joint Investigation

46 Payment

> The *payment provisions in the **shorter-form Contract** are similar to those in the full-length version but omit certain details. The shorter-form Contract no longer references CQUIN.*

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

Payment schedules

46.2 Under the Health and Care Act 2022, the previous National Tariff Payment System has been replaced by the NHS Payment Scheme. Prices payable under an NHS Standard Contract must always be agreed in accordance with the rules set out in the NHS Payment Scheme.

46.3 There have been some changes in approach and terminology in the NHS Payment Scheme for 2023/25, and we have made changes as a result, both to the wording of SC36 and the relevant Schedules (3A-F).

46.4 Under the 2023/25 NHS Payment Scheme, the approach to the pricing of Services varies depending on the type of provider.

- All non-NHS providers (that is, providers which are not NHS Trusts or NHS Foundation Trusts) will be paid,
  - for certain elective acute services, on the basis of Unit Prices published under the “activity based payment” rules at section 6 of the NHS Payment Scheme (note that the Contract deliberately does not contain a specific schedule where relevant Unit Prices are to be recorded; rather, the published Unit Prices, subject to applicable MFF and specialist top-ups, apply automatically); and/or
  - for all other services, on the basis of Local Prices, agreed in accordance with the “local payment arrangements” rules at section 7 of the NHS Payment Scheme.
- All NHS Trusts and NHS Foundation Trusts will be paid primarily on the basis of the “aligned payment and incentive” (API) rules at section 4 of the NHS Payment Scheme.
  - Within this approach, all services other than elective activity will be paid for through a single commissioner-level fixed payment.
  - Elective activity (as defined within the API rules) will be paid for on the basis of actual volumes at 100% of Unit Prices (where published), subject to applicable MFF and specialist top-ups, or at agreed Local Prices.
  - The CQUIN financial incentive scheme will apply only under API. It will apply only to those commissioner-Trust relationships where the Expected

Annual Contract Value is £10m or above. Its value will be 1.25% of the total of the fixed API payment and the amount included in the Expected Annual Contract Value in respect of elective activity.

- In respect of services in scope of rules 4 and 5 of the API rules, Trusts will be paid on the basis of agreed Local Prices; these payments are outside the scope of CQUIN.

46.5 Locally agreed details relating to prices and payment are to be recorded in Schedule 3, as set out below. Not all of the sub-schedules with Schedule 3 will need to be completed for every contract. Schedules 3A on API and 3F on CQUIN will only be used for Trust contracts, for example.

- Schedule 3A records agreed API arrangements for each commissioner-Trust relationship. Detailed guidance on completion of this schedule is contained in italics in the schedule itself.

- Schedule 3B records any Locally Agreed Adjustments to Unit Prices. These are local agreements between a commissioner and a provider to depart from the Unit Prices set out in the NHS Payment Scheme. Adjustments may only be agreed specifically as set out in the NHS Payment Scheme. The commissioner must publish any Locally Agreed Adjustments using the template provided by NHS England and must also notify the Adjustments to NHS England. See the NHS Payment Scheme for full details.

- Schedule 3C records Local Prices (including details of the basis on which payment is made for each locally priced Service – "activity x price", block payment, marginal rate etc). In the case of a contract covering more than one Contract Year, there is a specific provision (SC36.6) for the parties to record within Schedule 3C any agreement they reach in terms of how local prices should be adjusted for subsequent Contract Years.

- Schedule 3D sets out the Expected Annual Contract Value (EACV). This is the figure on which any payment on account is then based – see below for further detail. Note that, under SC36.12 of the full-length version of the Contract, an EACV must be agreed if the provider is an NHS Trust or an NHS Foundation Trust and may be agreed if the provider is a non-NHS organisation. This reflects the expectation that, under the full-length Contract, Trusts will operate under API and will therefore always have an agreed EACV.

- Schedule 3E allows for recording of timing of payments in the first or final contract year (required only where a local contract does not commence on 1 April or expire on 31 March).

- CQUIN is governed by the API rules and is now only applicable to Trusts, not to non-NHS providers. Schedule 3F records the relevant national CQUIN indicators which the Trust is incentivised to achieve. Further detail on the applicability and value of CQUIN is set out in the NHS Payment Scheme; the national indicators for 2023/24 are available on the CQUIN webpage.

46.6 The arrangements for payment for high-cost drugs, devices and innovative products require explanation.

- A workbook published as Annex A to the NHS Payment Scheme identifies a range of specified high-cost drugs, devices and products, the costs of which have been excluded from Unit Prices.

- The NHS Payment Scheme sets a general rule for how these are to be paid for – the "excluded items pricing rule" at section 3.4.

46.7 What this means for provider payment is set out below.

- Where Unit Prices or Local Prices apply, the items identified in Annex A above are therefore to be paid for separately by commissioners, in addition to the Unit Price or Local Price.

- Where payment for a drug, device or product is to be made separately, this is generally handled on a "pass-through" (i.e. actual cost) basis, but – under the "excluded items pricing rule" – specific prices for some items may in some cases apply or be agreed. There should generally be no need to list all of the excluded items in any of the schedules above, but any specific agreements on prices for excluded items do need to be recorded in Schedule 3C.

- The EACV in Schedule 3D can – where agreed locally – include an estimate for any excluded items, with in-year reconciliation to ensure final payment reflects actual costs; this approach will mean that that the provider receives an in-advance payment in relation to the excluded items. Otherwise, payment for excluded items can be purely retrospective.

Invoicing, payment and reconciliation

46.8 Detailed arrangements for invoicing, payment and financial reconciliation are set out in SC36 and in the flowcharts below.

46.9 The arrangements will vary between contracts in a number of ways. (Note that although the wording below refers to the raising of invoices, commissioners and Trusts may instead be able to rely on a simpler approach.)

- **EACV agreed with block payment.** The simplest arrangement will be where the commissioner and provider agree that the EACV will be paid on a block basis, with no adjustments to payment to reflect actual in-year activity volumes. In this case, under SC36.13, the provider invoices the commissioner for the agreed amount, in advance, on the first day of each month. Note that, although the default remains that up-front payments are made in equal 12ths, SC36.13 (SC36.10 in the shorter-form Contract) allows the parties to agree a more realistic, tailored profile – to reflect expected seasonal patterns or the phased impact of recovery plans, for example.

- **EACV agreed with reconciliation required.** In this situation, commissioner and provider have agreed an EACV which is being paid in advance in the same way – but they have also agreed that payment will be adjusted in-year, for example to reflect whether the provider over- or under-performs against the Indicative Activity Plan in the contract. As well as invoicing monthly on-account, as described above, the provider also submits quarterly reconciliation

accounts to the commissioner, adjusting for any difference between the payment already made and the actual sum due. Reconciliation accounts are always submitted quarterly, but the arrangements and timescales differ depending on whether the provider is required to submit any data to SUS – see further detail below.

- **No EACV agreed.** In this situation, the provider invoices retrospectively, on a monthly basis, for activity actually undertaken. (For 2023/24 onwards, this only applies to non-NHS providers, as all Trusts will be operating on API with an EACV in each case.) Again, the arrangements and timescales differ depending on whether the provider is required to submit any data to SUS – see further detail below.

Invoicing and reconciliation under SUS

46.10 The provider must submit data to SUS in accordance with SUS Guidance (SC28.17).

46.11 Where the provider has an agreed EACV and 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 (SC36.16-17), with the provider submitting to the commissioner both a first and a final reconciliation account, in accordance with the national SUS process and timeline.

46.12 Key deadlines from the SUS Submission Timetable for 2023/24, by which data for each month must be submitted, are shown below. The Reconciliation Inclusion date is what is informally known as the “flex” date and provides an initial non-binding view of the month’s data. The Post-Reconciliation Inclusion date is the point at which a provider’s submitted data for the month is “frozen” and may not subsequently be changed for payment purposes. The Delivery date in each case is the date on which the SUS data is made available for commissioners to view.

	Reconciliation		Post-Reconciliation	
Activity Month	Inclusion	Delivery	Inclusion	Delivery
Apr 2023	Thu 18 May 23	Wed 24 May 23	Mon 19 Jun 23	Thu 22 Jun 23
May 2023	Mon 19 Jun 23	Thu 22 Jun 23	Wed 19 Jul 23	Mon 24 Jul 23
Jun 2023	Wed 19 Jul 23	Mon 24 Jul 23	Thu 17 Aug 23	Tue 22 Aug 23
Jul 2023	Thu 17 Aug 23	Tue 22 Aug 23	Tue 19 Sep 23	Fri 22 Sep 23
Aug 2023	Tue 19 Sep 23	Fri 22 Sep 23	Wed 18 Oct 23	Mon 23 Oct 23
Sep 2023	Wed 18 Oct 23	Mon 23 Oct 23	Fri 17 Nov 23	Wed 22 Nov 23
Oct 2023	Fri 17 Nov 23	Wed 22 Nov 23	Mon 18 Dec 23	Thu 21 Dec 23
Nov 2023	Mon 18 Dec 23	Thu 21 Dec 23	Thu 18 Jan 24	Tue 23 Jan 24
Dec 2023	Thu 18 Jan 24	Tue 23 Jan 24	Mon 19 Feb 24	Thu 22 Feb 24
Jan 2024	Mon 19 Feb 24	Thu 22 Feb 24	Tue 19 Mar 24	Fri 22 Mar 24
Feb 2024	Tue 19 Mar 24	Fri 22 Mar 24	Thu 18 Apr 24	Tue 23 Apr 24
Mar 2024	Thu 18 Apr 24	Tue 23 Apr 24	Mon 20 May 24	Thu 23 May 24

46.13 Reconciliation and retrospective invoicing, and validation by commissioners of provider data, take place in the context of these dates, as explained further below.

Data queries at the flex stage (SC36.30):

46.14 Providers should do all they can to make their data as accurate as possible at the initial flex stage.

46.15 Once the Reconciliation Delivery date for a month has passed, the commissioner can see the provider's SUS data and can raise any data queries from this point onwards. It is in the interests of both parties that such queries are raised – and answered by the provider – promptly, so that any inaccuracies in the data can be corrected by the freeze point for that month (the Post-Reconciliation Inclusion date) a month later. 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.

Quarterly reconciliation (SC36.16-17):

46.16 Where, as described above, quarterly reconciliation applies, the Contract requires the provider to submit, for each quarter:

- an initial (flex) reconciliation account by what the Contract calls the First Quarterly Reconciliation Date – that is, the relevant Reconciliation Delivery date in the table above; and

- a final (freeze) reconciliation account “within five Operational Days after the Final Quarterly Reconciliation Date” – that is, within five working days of the relevant Post-Reconciliation Delivery date in the table above.

46.17 The quarterly deadlines, in 2023/24, for submission under the Contract of quarterly reconciliation accounts to the commissioner are therefore as follows:

	Initial reconciliation account	Final reconciliation account
Quarter 1	Mon 24 Jul 2023	Tue 22 Aug 2023 plus five working days = Weds 30 Aug 2023
Quarter 2	Mon 23 Oct 2023	Weds 22 Nov 2023 plus five working days = Weds 29 Nov 2023
Quarter 3	Tues 23 Jan 2024	Thurs 22 Feb 2024 plus five working days = Thurs 29 Feb 2024
Quarter 4	Tues 23 Apr 2024	Thurs 23 May 2024 plus five working days = Fri 31 May 2024

46.18 So, as an example, the initial reconciliation account for quarter 1 must be based on frozen SUS data for April and May (in each case frozen at the relevant monthly deadline shown in the table at paragraph 46.12 above) and flex SUS data for June. The final reconciliation account for quarter 1 must be based on frozen data for April, May and June (in each case frozen at the relevant monthly deadline shown in the table at paragraph 46.12 above).

Monthly retrospective invoicing (SC36.22):

46.19 As described above, monthly retrospective invoicing only applies for non-NHS providers with no agreed EACV.

46.20 The provider must issue a monthly invoice to the commissioner “within five Operational Days after the Final Monthly Reconciliation Date” – that is within five working days of the Post-Reconciliation Delivery date in the table at paragraph 46.12 above. For April 2023, the deadline for invoicing is Thurs 22 June 2023 plus five working days – i.e. Thurs 29 June 2023. The same approach then applies in each succeeding month.

Invoicing and reconciliation where SUS does not apply

46.21 The arrangements where SUS does not apply to any of the provider’s Services are simpler.

- Where an EACV has been agreed, then the commissioner makes monthly payments in advance in the normal way under SC36.13. However, the provider then only submits a single quarterly reconciliation account (SC36.18) – there is no flex and freeze process. The quarterly reconciliation account must be submitted within 20 working days of the end of the relevant quarter.

- Where there is no agreed EACV (non-NHS providers only), invoices for actual activity undertaken must be submitted retrospectively each month (SC36.23).

The invoice must be submitted within 20 working days of the end of the relevant month.

Other points

46.22 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 SC36.31. Providers should include in their reconciliation accounts the calculated impact of any contractual sanctions due.

46.23 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.

Applicability and payment of CQUIN

46.24 Under the NHS Payment Scheme for 2023/25, CQUIN is covered by the API rules and applies only to NHS Trusts and NHS Foundation Trusts, not to other providers. See the NHS Payment Scheme and CQUIN Guidance for further detail.

46.25 As described at paragraph 46.4 above, the value of the CQUIN scheme, for any individual commissioner-Trust relationship, will be 1.25% of the total of the fixed API payment and the amount included in the Expected Annual Contract Value in respect of elective activity.

46.26 This value is to be paid in full to the provider in advance in monthly instalments, as part of the EACV. The provider reports its CQUIN performance periodically to the commissioner (via the CQUIN Performance Report), and there is an annual financial reconciliation (via the CQUIN Reconciliation Account), through which the commissioner will claw back any underperformance, depending on the provider's performance against the CQUIN indicators include in Schedule 3F. These arrangements are set out in SC38 and are managed by the co-ordinating commissioner on behalf of the other commissioners.

46.27 Any claw-back of CQUIN is calculated by reference to the opening value described at paragraph 46.25 above. CQUIN payments do not need to be adjusted to reflect changes in actual elective activity levels compared to the opening planned value.

46.28 It is important to distinguish correctly 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 SC38.4 – 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 SC38.8 the deadline here being five working days from receipt).

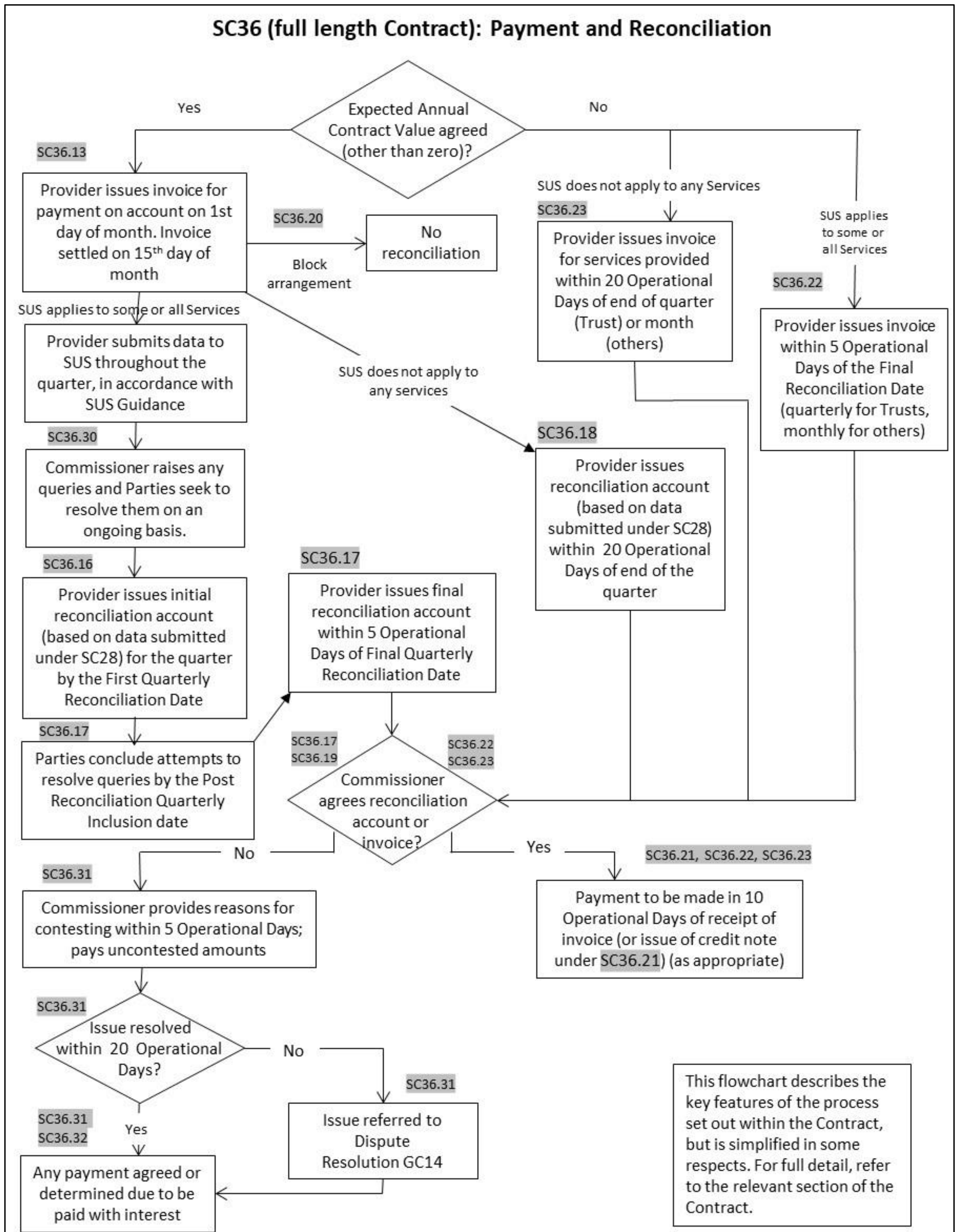
- The key point is that the CQUIN Reconciliation Account can only be challenged in relation to whether it "gets the maths right"- that is, whether it sets out accurately what CQUIN payment the provider is entitled to, reflecting the payment on account made and the level of CQUIN performance demonstrated. 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 SC38.4.

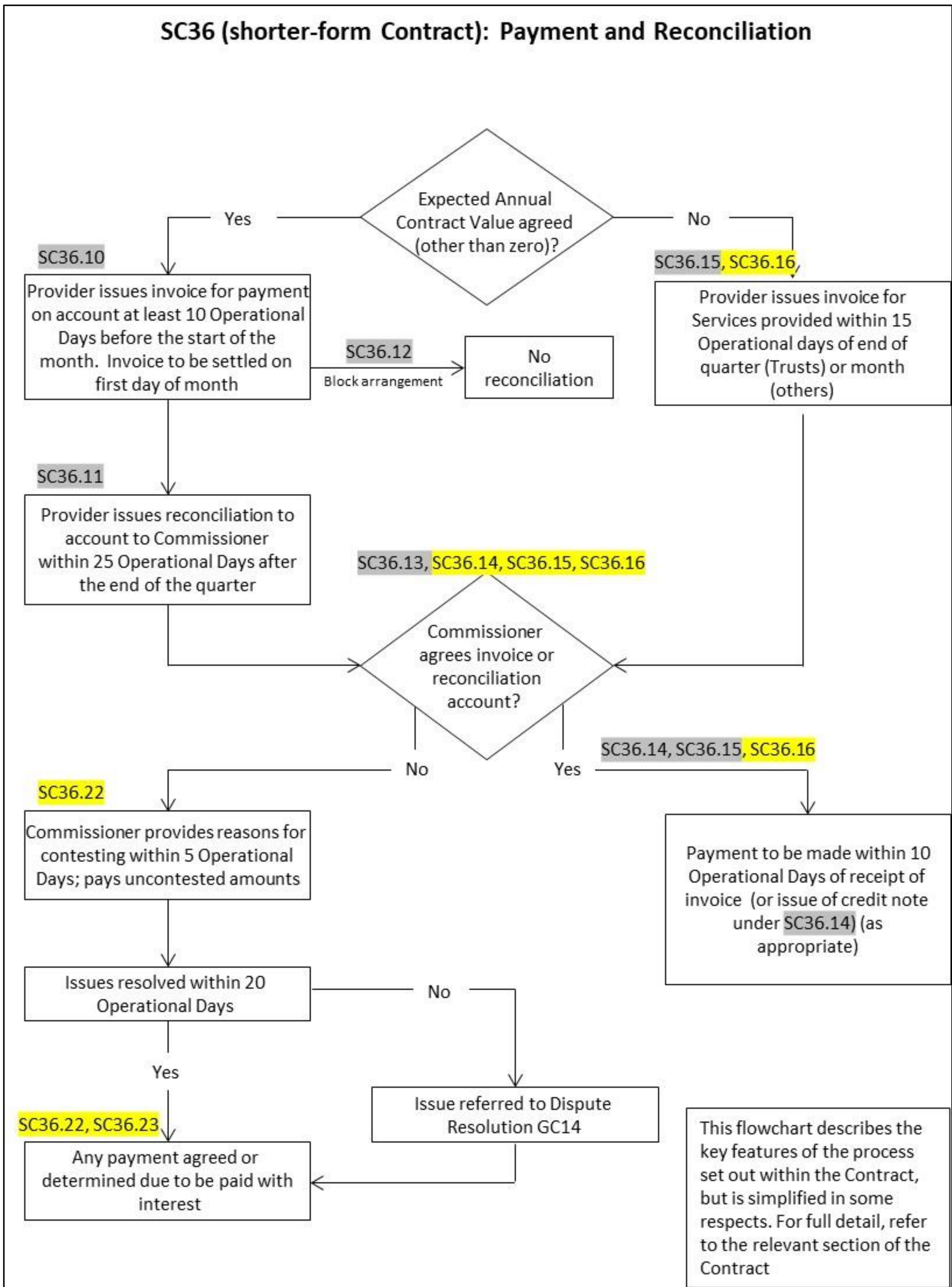
46.29 CQUIN is not referenced in the shorter-form version of the Contract, and CQUIN does not apply to non-contract activity or in LVA arrangements.

Charging overseas visitors and migrants

46.30 SC36.26 (full-length Contract) / SC36.19 (shorter-form) contain 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.

46.31 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.Resources for 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?


SC36 (full length Contract): Payment and Reconciliation
Expected Annual Contract Value agreed (other than zero)?
Yes
No
SC36.13
Provider issues invoice for payment on account on 1st day of month. Invoice settled on 15th day of month
SC36.20
No reconciliation
Block arrangement
SUS applies to some or all Services
Provider submits data to SUS throughout the quarter, in accordance with SUS Guidance
SC36.30
Commissioner raises any queries and Parties seek to resolve them on an ongoing basis.
SC36.16
Provider issues initial reconciliation account (based on data submitted under SC28) for the quarter by the First Quarterly Reconciliation Date
SC36.17
Parties conclude attempts to resolve queries by the Post Reconciliation Quarterly Inclusion date
SC36.17
Provider issues final reconciliation account within 5 Operational Days of Final Quarterly Reconciliation Date
SUS does not apply to any services
SUS does not apply to any Services
SC36.23
Provider issues invoice for services provided within 20 Operational Days of end of quarter (Trust) or month (others)
SUS applies to some or all Services
SC36.22
Provider issues invoice within 5 Operational Days of the Final Reconciliation Date (quarterly for Trusts, monthly for others)
SC36.18
Provider issues reconciliation account (based on data submitted under SC28) within 20 Operational Days of end of the quarter
SC36.17
SC36.19
SC36.22
SC36.23
Commissioner agrees reconciliation account or invoice?
No
Yes
SC36.21, SC36.22, SC36.23
Payment to be made in 10 Operational Days of receipt of invoice (or issue of credit note under SC36.21) (as appropriate)
SC36.31
Commissioner provides reasons for contesting within 5 Operational Days; pays uncontested amounts
SC36.31
Issue resolved within 20 Operational Days?
No
SC36.31
Issue referred to Dispute Resolution GC14
SC36.31
SC36.32
Yes
Any payment agreed or determined due to be paid with interest
This flowchart describes the key features of the process set out within the Contract, but is simplified in some respects. For full detail, refer to the relevant section of the Contract.


SC36 (shorter-form Contract): Payment and Reconciliation
Expected Annual Contract Value agreed (other than zero)?
Yes
No
SC36.10
Provider issues invoice for payment on account at least 10 Operational Days before the start of the month. Invoice to be settled on first day of month
SC36.12
Block arrangement
No reconciliation
SC36.15, SC36.16,
Provider issues invoice for Services provided within 15 Operational days of end of quarter (Trusts) or month (others)
SC36.11
Provider issues reconciliation to account to Commissioner within 25 Operational Days after the end of the quarter
SC36.13, SC36.14, SC36.15, SC36.16
Commissioner agrees invoice or reconciliation account?
No
Yes
SC36.14, SC36.15, SC36.16
SC36.22
Commissioner provides reasons for contesting within 5 Operational Days; pays uncontested amounts
Payment to be made within 10 Operational Days of receipt of invoice (or issue of credit note under SC36.14) (as appropriate)
Issues resolved within 20 Operational Days
No
Yes
Issue referred to Dispute Resolution GC14
SC36.22, SC36.23
Any payment agreed or determined due to be paid with interest
This flowchart describes the key features of the process set out within the Contract, but is simplified in some respects. For full detail, refer to the relevant section of the Contract

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 contracts are set out in GC13 (Variations). The only variations which may be made locally to contracts are variations to locally agreed insertions, selections or content of the Particulars. Nationally-mandated elements of the NHS Standard Contract may not be varied locally (GC13.2), and it is essential that commissioners and providers do not try to vary, depart from or disapply the terms of the NHS Standard Contract as nationally mandated from time to time.

47.2 As explained at paragraph 33 above, for 2022/23 onwards, the GCs and SCs now exist in their up-to-date form online, as published by NHS England from time to time, and will be incorporated into, and will apply automatically as part of, each local contract by reference. This will mean that it will not be necessary for contracts in the 2022/23 or later form to be updated periodically via local signing of mandatory National Variations. References to National Variations have therefore been deleted from GC13. However, see paragraph 22.2 above for advice on updating non-expiring multi-year contracts for 2023/24.

47.3 Commissioners and providers may agree Variations as permitted by GC13.2. 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/. 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 21 above.

47.4 There is no specific period of notice which must be given for 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 Acceptance of a 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 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 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) – and equivalent provisions which are likely to be included in the proposed NHS Provider Selection Regime. The parties should seek their own legal advice before proceeding with any Variation which might be caught by the applicable regime.

Dispute resolution

47.8 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.

47.9 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.

47.10 The dispute resolution process at GC14 applies only once a contract is in operation. In relation to the agreement of new contracts, see paragraph 23 above.

Suspension

47.11 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.

47.12 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.

47.13 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 and other national organisations have published a Joint Working Protocol: when a hospital, services or facility closes at short notice.

Termination

47.14 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)

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

47.16 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).

47.17 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).

47.18 See paragraph 47.5 above in relation to termination where the provider refuses to accept a variation to the contract.

47.19 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 (or equivalent provisions under the proposed NHS Provider Selection Regime).

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

47.20 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)

47.21 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.

Consequences of expiry or termination

47.22 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.

47.23 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

47.24 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.

47.25 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).

47.26 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.

47.27 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).

47.28 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

47.29 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))

47.30 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 GC5.14 to 5.17) is now well-established: incoming and outgoing providers are given rights to enforce those indemnities directly by GC29 (Third Party Rights).

New Fair Deal for staff pensions

47.31 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 on the NHS Standard Contract webpage 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

47.32 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.

47.33 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. NHS Resolution has 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.

47.34 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).

47.35 We have, at the request of the Department of Health and Social Care and NHS Resolution, included, 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. 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 england.contractshelp@nhs.net if you have questions about this Guidance or the operation of the NHS Standard Contract in general. 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 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: england.contractshelp@nhs.net.

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.

(red)	As explained in paragraph 33 above, the General Conditions and Service Conditions (as published online by NHS England from time to time) will be incorporated in their up-to-date online form into, and will apply automatically as part of, each local contract by reference only. All of the **General Conditions**, as applicable from time to time, will be mandated and cannot be amended or deleted or disapplied locally. They apply to all services and to all providers of NHS funded clinical services. The **Service Conditions**, as applicable from time to time, will apply automatically to all services or to the relevant service, as indicated, and will be mandated for all services or the relevant service, as appropriate. The Service Conditions applicable to the relevant service cannot be changed, amended, deleted or disapplied locally.	(red)
(amber)	The **Particulars** contain all the elements in the contract that are for local completion, colour coded in this guide as 'amber' or 'green'. 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.	(amber)
(green)	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'.	(green)

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 or spreadsheet 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 an embedded document is inserted within a schedule. 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. Our advice is as follows:

- Commissioners should not delete inapplicable requirements from the Particulars, in case of error. Any requirements which are not applicable to the services being commissioned are simply 'read over'.

- 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 (ICBs, 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 https://digital.nhs.uk/services/organisation-data-service	
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.

Completion of the tables in the Particulars headed **Service Commencement and Contract Term** and **Services** will determine whether certain of the Service Conditions or the content of certain of the schedules apply to the contract.

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.
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 GC17.2	Enter the earliest date on which a commissioner notice to terminate may take effect. (Not applicable under the shorter form)
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	
Commissioners **must** select all 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. The selection of the services relevant to the Provider will determine which of the Service Conditions are applicable. The Service Conditions that are not applicable will be 'read over'. 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. Note that the service categories listed in the shorter form are limited to those for which the shorter form may be used.	
Service Requirements	
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)

Governance Note: the parties to a contract may prefer to keep a separate, shared record (available to and capable of being updated by each party) of the individuals holding each of the roles listed below and of their contact details, in a form which is easier to update from time to time than the Particulars themselves. If so, they are free to do so.	
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 England. (Not applicable to shorter form)
Provider's Nominated Individual SC3.10 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.
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.
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.

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.	
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 Leads / named professionals for safeguarding SC32.2	The name and contact details of the Provider's Safeguarding Leads / named professionals for safeguarding must be inserted here – separately for adults and children.	
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) GC5.10	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 here.	
Provider's UEC DoS Contact SC6.14	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 SC6.14	The name and contact details of the Commissioner's UEC DoS Lead must be inserted here (ICBs only). Insert additional blocks as required for the number of ICBs that are party to the contract. (Not applicable to the shorter form)	
Provider's Infection Prevention Lead SC21.1	The name and contact details of the Provider's Infection Prevention Lead must be inserted here. (Not applicable to the shorter form)	
Provider's Health Inequalities Lead SC13.10	The name and contact details of the Provider's Health Inequalities Lead Contact must be inserted here. (Not applicable to the shorter form)	
Provider's Net Zero Lead SC18.2	The name and contact details of the Provider's Net Zero Lead must be inserted here. (Not applicable to the shorter form)	
Provider's Responsible Person for the Mental Health	Where required by the Mental Health Units (Use of Force) Act 2018, the name and contact details of the Provider's Responsible Person – the board-level individual with	

Units (Use of Force) Act 2018 SC3.19	responsibility for overseeing its compliance with the Act – must be inserted here. (Not applicable to the shorter form)	
Provider's Wellbeing Guardian (NHS Trusts and Foundation Trusts only) GC5.10	The name and contact details of the Provider's Information Wellbeing Guardian must be inserted here. (Not applicable to the shorter form)	
Contact Management Note: the parties to a contract may prefer to keep a separate, shared record (available to and capable of being updated by each party) of the individuals holding the roles of Commissioner Representative and Provider Representative and of their contact details, in a form which is easier to update from time to time than the Particulars themselves. If so, they are free to do so.		
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 ICBs 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.	

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: • 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 SC4.9	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'. 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.	
2Aii – Service Specifications – Primary and Community Mental Health Services SC4.10	Requirements shown are mandatory for any Provider of community mental health services which is to have a role in the delivery of the Primary and Community Mental Health Services Model. (Not applicable to the shorter form)	
B – Indicative Activity Plan (IAP) SC29.5, SC29.6 SC29.3	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 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 Schedule 2E as 'not applicable'. (Not applicable to the shorter form)	
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 or 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 provider's ability to accommodate different protocols for similar service users. Ideally, a single set of protocols will apply to all Commissioners. Where any individual Commissioner needs different transfer and discharge protocols, the collaborative commissioning group should discuss. 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.	
K – Safeguarding Policies and MCA Policies SC32	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. The policy should reflect the local multi-agency safeguarding policy.	
L – Provisions Applicable to Primary Medical Services	See paragraphs 8.4 and 34.4 above. (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.)	
M – Development Plan for Personalised Care SC10.1	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. (Not included in the shorter form.)	
N – Health Inequalities Action Plan SC13.9	This optional schedule allows the parties to set out specific actions which each will take, aimed at reducing inequalities in access to, experience of and outcomes from care and treatment. Further detail is provided within the schedule itself. (Not included in the shorter form.)	
Schedule 3 – Payment		
A – Aligned Payment and Incentive Rules SC36.3	Where the Aligned Payment and Incentives Rules apply, insert details as agreed locally for each relevant Commissioner, as shown in the schedule itself. (Not included in the shorter form.)	
B – Locally Agreed Adjustments to NHS Payment Scheme Unit Prices SC36.4.1.2	For each Locally Agreed Adjustment which has been agreed for this contract, copy or attach the template required – or state 'not applicable'. Additional locally agreed detail may be included as necessary by attaching further documents or spreadsheets.	
C - Local Prices SC36.4.1.3, SC36.6-10	Insert the detail of any Local Prices, entering text (or attaching documents or spreadsheets) which, for each separately priced Service, as shown in the schedule itself.	
D - Expected Annual Contract Values SC36.12	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 or an EACV of zero, enter 'not applicable'.	
E – Timing and Amounts of Payments in First and/or Final Contract Year SC36.14-15	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 3C.)	
F – CQUIN SC38	Where the Aligned Payment and Incentives Rules apply, include here the relevant national CQUIN indicators, in	

	accordance with NHS Payment Scheme Guidance and CQUIN Guidance. (Not included in the shorter form.)	
Schedule 4 – Local Quality Requirements		
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.	
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	If different Commissioners are to perform different Co-ordinating Commissioner functions, the Commissioners must set out in this schedule the roles and responsibilities that each Commissioner has in relation to this contact – in essence, who will be the Co-ordinating Commissioner for specific purposes under the contract. The roles and responsibilities should also 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 Plans (DQIP) SC28.24 and SC28.25	This table is used to record any agreed DQIP. See paragraph 43 above, which sets out certain situations in which a DQIP should be included. (Not included in the shorter form.)	
C – Service Development and Improvement Plans 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 should be included. (Not included in the shorter form.)	

D – Surveys SC12.6	Insert here the requirements for frequency, reporting and publication of any locally agreed surveys. (Not included in the shorter form.)
Schedule 6E – Data Processing Services ***Note: the Provider Data Processing Agreement is now at Annex B of the Contract Service Conditions***	
Data Processing Services Annex B, Service Conditions, Provider Data Processing Agreement	This schedule is to be read and completed in conjunction with the Provider Data Processing Agreement. This schedule must be completed (and the terms of the Provider Data Processing Agreement will apply) only where the Provider is acting as a Data Processor on behalf of one or more of the Commissioners. Otherwise state Not Applicable. For shorter-form contracts, Schedule 6E will need to be added manually to the local contract where the Provider is acting as a Data Processor on behalf of one or more of the Commissioners. For this purpose, a separate Schedule 6E (including the Provider Data Processing Agreement itself) has been published at https://www.england.nhs.uk/nhs-standard-contract/23-24/ **Update: International Transfers of Personal Data** In the last year there have been regulatory changes concerning international transfers of personal data from the UK. The circumstances in which commissioners or providers transfer personal data to recipients abroad are likely to be limited. However, where such arrangements are in place or proposed they must comply with UK GDPR requirements as described on the Information Commissioner's Office (ICO) website. The following overview is provided for information only and should not be relied upon by commissioners or providers when considering international transfers: specialist legal advice (including as to any necessary additional information to be included in Schedule 6E) should be taken in those circumstances. Where a transfer is to a country recognised by the UK as having adequate arrangements for the protection of personal data, the transfer can be made on the same terms as if the transferee was located in the UK. All EU Member States and EU institutions and agencies are recognised by the UK as having adequate arrangements for data protection. A list of additional countries to which full or partial adequacy decisions apply is published on the ICO website. It should be noted that the USA is not included in this list. Where a transfer is to a country which has not been recognised by the UK as having adequate data protection

	arrangements, the data controller will need to undertake a Transfer Risk Assessment (TRA) to determine whether adequate safeguards can be put in place to facilitate the transfer. The most commonly used safeguard is likely to be an International Data Transfer Agreement (IDTA). The ICO website provides comprehensive guidance on the use of TRAs and the IDTA.	
Schedule 7 – Pensions		
Pensions	Please refer to paragraph 47.31 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.	

Appendix 2 Supplementary definitions

This Appendix provides definitions for certain of the National Quality Requirements set out in Annex A of the Service Conditions.

For the other national standards within Annex A, definitions are set out (or linked to) in Annex A itself.

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	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). 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: Immediate - Immediate (A) lifesaving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate. Urgent - Acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate. 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. Elective - Surgical procedure planned or booked in advance of routine admission to hospital. 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. 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).
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.7: Ambulance handover delays to accident and emergency (A&E) of over 15 / 30 / 60 minutes	
Definition	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). 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. 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.
Rationale	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.
Numerator	Total ambulance handover delays of over 15 / 30 / 60 minutes
Denominator	Total number of ambulance handovers
National data source	Urgent and Emergency Care Daily Situation Reports: https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/
Calculation	N/A
Operational standard	Operational standard is: 100% within 60 minutes 95% within 30 minutes 65% within 15 minutes

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

E.B.S.8: Ambulance crew delays of over 30 minutes following handover to accident and emergency (A&E)	
Definition	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. 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. 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. 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.
Rationale	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.
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.

VTE risk assessment

All inpatient service users undergoing risk assessment for venous thromboembolism (VTE)	
Definition	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. 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.
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	Of the sample described below, the number who had a VTE risk assessment on admission to hospital using a tool published by a national UK body, professional network or peer-reviewed journal (including those whose needs for VTE prophylaxis were assessed using NICE guidance that requires universal VTE prophylaxis for a cohort).
Denominator	A locally audited random sample of 100 Service Users in each Quarter (subject to the exclusions described in the Definition section above) Note – where a provider chooses to do so, it may continue to report both Numerator and Denominator on the basis of total inpatients in each Quarter, rather than just a sample.
National data source	N/A
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	Of the sample described below, the number • who were screened for sepsis; and • who, if found to have suspected sepsis, received IV antibiotics within one hour of diagnosis. This timing starts from when the clinical decision maker has decided the patient has suspected sepsis, and stops when effective antibiotics have been administered.
Denominator	A locally audited random sample of 50 Service Users in each Quarter • 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	Of the sample described below, the number • who were screened for sepsis; and • who, if found to have suspected sepsis, received IV antibiotics within one hour of diagnosis. This timing starts from when the clinical decision maker has decided the patient has suspected sepsis, and stops when effective antibiotics have been administered.
Denominator	A locally audited random sample of 50 Service Users in each Quarter • 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	All people discharged from ICB-commissioned inpatient mental health services should be followed up within 72 hours. This applies to everyone who is discharged from an ICB-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.
Rationale	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. 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 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. 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.
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 an ICB 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%

Waits in A&E from arrival to discharge, admission or transfer

Proportion of Service Users attending A&E who wait more than 12 hours from arrival to discharge, admission or transfer	
Definition	Proportion of Service Users attending A&E who wait more than 12 hours from arrival to discharge, admission or transfer
Rationale	Better patient experience and more appropriate clinical care
Numerator	Number of Service Users attending A&E during the period who wait more than 12 hours from arrival to discharge, admission or transfer
Denominator	Number of Service Users attending A&E during the period
	For both numerator and denominator: • The measure is of the number of Service Users who have stayed in the A&E department for 12 hours or more since their arrival in the department • All waits in excess of 12 hours should be counted, regardless of whether the patient is admitted, transferred or discharged. • The measure applies to all types of A&E department (types 1, 2 and 3). • The clock starts from the point at which the patient enters the department breaches if they have not left the department by the time 12 hours has elapsed.
National data source	N/A
Calculation	Performance is calculated as the numerator divided by the denominator, expressed as a percentage
Operational standard	Operational standard is no more than 2%.

Appendix 3 Which form of contract or agreement to use when

Some example scenarios are set out below to help organisations select the correct contract template.

Note that, wherever more than one provider is a potential provider of a service, so that a process for selection of the provider to which the contract for that service is to be awarded has to be undertaken (currently under the "light touch" regime under the Public Contract Regulations), the same form of contract must be offered to all potential providers, regardless of type. (The new Provider Selection Regime may provide more flexibility in this regard: guidance will be issued in due course.)

Agreements between commissioners and providers

	Scenario	Recommended form
1	An ICB is commissioning a range of hospital inpatient and community mental health services from a local Trust.	The NHS Standard Contract (full-length version) must be used.
2	An ICB is commissioning and fully funding a single, community-based mental health service from a small charity.	The NHS Standard Contract must be used (use of the shorter-form version is recommended).
3	A charity provides a range of services and support for people with chronic disease. The local ICB does not commission any specific service from the charity, but wants to provide general financial support for its activities, to supplement its income from donations.	A grant agreement must be used (use of our model version is recommended, but not mandatory).
4	An ICB wishes to place an individual patient into an out-of-area care home for a package of NHS Continuing Healthcare.	The NHS Standard Contract must be used (use of the shorter-form version is recommended). (Where multiple placements are made into the same home, use of our model Individual Placement Agreement for each individual is recommended, alongside use of the NHS Standard Contract.)

	Scenario	Recommended form
5	An ICB wants to set up a service to provide blood pressure monitoring equipment for suitable patients to use at home. It intends to contract with a private company for this service. The company will supply and maintain the equipment, but will not be involved in patient treatment or in advising patients about their clinical care.	The NHS Standard Contract must not be used. Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended.
6	NHS England has delegated responsibility for commissioning primary medical services to an ICB. The ICB has identified a sub-group of its population which is under-provided for in terms of core GP services. It therefore wishes to commission a new provider to provide list-based GP services for that population, and is keen to open the opportunity up to the broadest range of potential providers.	The NHS Standard Contract must not be used. An APMS contract should be used – see https://www.england.nhs.uk/gp/investment/gp-contract/.
7	An ICB is commissioning a non-emergency patient transport service using taxis; the provider will not be required to register with the CQC.	The NHS Standard Contract must not be used. Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The ICB may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a provider. The relevant framework agreement is likely to specify the form of contract to be used.
8	An ICB is commissioning a non-emergency patient transport service, using ambulances, for unwell patients requiring some level of clinical supervision; the provider will be required to register with the CQC.	The NHS Standard Contract must be used (in either full-length or shorter form version).

	Scenario	Recommended form
9	NHS England has delegated the function of commissioning primary medical services to an ICB. The ICB has identified a part of its area which is under-provided for, in terms of both routine GP services and urgent care. It therefore wishes to commission a provider to provide, under a single contract, both list-based and non-list-based GP services (primary medical services) and an open-access urgent care service (not primary medical services).	The NHS Standard Contract must be used, in the full-length version, with Schedule 2L included (the schedule which imports the relevant APMS provisions).
10	A local authority is commissioning NHS Health Checks from a GP Federation established as a Community Interest Company.	The local authority may choose its own form of contract. It may use the NHS Standard Contract if it wishes (and, if asked, we would recommend that it does so), but use of the NHS Standard Contract by a local authority in this scenario is not mandatory.
11	A local authority and an ICB are contracting jointly for a range of community-based health and care services, to be supplied by a private company. Each will sign, and make payments under, the contract with the provider.	The NHS Standard Contract must be used (in either full-length or shorter form version). Additional information can be included in local schedules as necessary to cover the specific requirements of the local authority.
12	A local authority and an ICB have agreed a s75 pooled budget, for a range of learning disability health and care services, under which the local authority is to act as lead commissioner, awarding contracts to providers in its own name only.	The local authority may choose its own form of contract. It may use the NHS Standard Contract if it wishes (and, if asked, we would recommend that it does so), but use of the NHS Standard Contract by a local authority in this scenario is not mandatory.

Sub-contracts and other agreements between providers

	Scenario	Recommended form
13	A Trust holds a full-length NHS Standard Contract with its local ICBs for elective and emergency acute hospital services. To maintain those services over the winter, it wishes to "buy in" additional capacity from a local independent sector hospital – so that it can arrange for appropriate patients to be transferred there for treatment.	The NHS Standard Contract must not be used. The Trust should instead put in place a sub-contract (use of our template sub-contract, in the full-length version, is recommended but not mandatory).
14	A Trust holds a full-length NHS Standard Contract with its local ICBs for elective and emergency acute hospital services. To maintain those services over the winter, it wishes to "buy in" additional capacity from a local independent sector hospital – so that it can arrange for appropriate patients to be transferred there for treatment – **and does so via the Increasing Capacity Framework**.	The NHS Standard Contract must not be used. The Trust must instead put in place a sub-contract, and use of our template sub-contract, in the full-length version, **is mandatory**.
15	A Trust contracts out cleaning services, including for clinical areas, to a private company.	The NHS Standard Contract itself must not be used – but nor should our template sub-contract be used, because that is designed for use when sub-contracting clinical services. Instead, use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The Trust may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a contractor. The relevant framework agreement is likely to specify the form of contract to be used.

	Scenario	Recommended form
16	A Trust arranges for a mobile scanner, owned by a private company and operated by that company's clinical staff, to visit the Trust's site weekly, in order to provide extra scanning capacity for the Trust's NHS patients (a clinical service).	The NHS Standard Contract must not be used. The Trust should instead put in place a sub-contract (use of our template sub-contract, in the full-length version, is recommended but not mandatory). The private company may propose that its own preferred form of sub-contract is used; any Trust in this situation should take its own legal advice before agreeing to do that. The key is for the Trust to ensure that the sub-contract protects it by "flowing down" to the sub-contractor the relevant terms and conditions of its NHS Standard Contract with its commissioners.
17	A Trust buys in a communications and PR service from a private company.	Use of the NHS terms and conditions for procuring goods and non-clinical services (which comes in several versions) is recommended. The Trust may consider using a suitable Crown Commercial Services framework agreement as the route through which to select a contractor. The relevant framework agreement is likely to specify the form of contract to be used.
18	Two NHS Trusts each rely on, and make payments to, the other for certain things in a mutual aid / collaboration arrangement. None of these things are "whole" clinical services; some relate to clinical time (where one Trust employs staff who spend some of their time working in the other Trust), some to non-clinical support services (where one provides a function such as HR which the other uses) and some to premises (where one uses buildings owned by the other to provide clinical services).	It is unlikely that any published template will be fit-for-purpose to document an arrangement which involves several types of contractual relationship (secondment, sub-contracting of non-clinical services, licence to use premises). It may be better to document the different arrangements separately, using the appropriate form in each case. Trusts may need to take their own legal advice on how best to document them.
19	A Trust "buys in" clinical staff from a neighbouring private hospital to work in its operating theatres, as part of clinical teams managed by the Trust.	This is probably best characterised as a staff secondment arrangement. Neither the NHS Standard Contract nor our template sub-contract should be used. The two parties will need to document the arrangement on a locally agreed basis.

	Scenario	Recommended form
20	Two or more Trusts arrange to deploy staff on a flexible basis across their respective sites and services.	This is probably best characterised as a mutual staff secondment or staff sharing arrangement, on which we recommend Trusts refer to *Enabling staff movement between NHS organisations: A toolkit for sharing staff appropriately and efficiently*.

Note that scenarios 13-16 above (and elements of scenario 18) all involve sub-contracting.

- For those scenarios, therefore, under GC12.1 of the Trust's NHS Standard Contract with its commissioners, prior written approval is required from the co-ordinating commissioner for the sub-contracting (and, at the commissioner's option, the sub-contract itself).

- Under GC12.4, it is for the co-ordinating commissioner to determine whether or not the sub-contracts are Material Sub-Contracts. Each Material Sub-Contract should be recorded in Schedule 5B of the Trust's NHS Standard Contract.

- The definition of a Material Sub-Contract set out at the rear of the General Conditions refers to "a Sub-Contract for the delivery of any clinical or clinical support service which comprises (irrespective of financial value) all of any Service, or a significant and necessary element of any Service, or a significant and necessary contribution towards the delivery of any Service". In that context, in our view, it would probably be appropriate for all of the sub-contracts at 13-17 to be considered Material Sub-Contracts.

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